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DHS-7 MID-TERM EVALUATION: SERVICE PROVISION ASSESSMENT IMPLEMENTATION, UTILIZATION, AND PROMOTION

September 2017

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Cover Photo: Antenatal Care and Delivery Services in 2014-15 Tanzania Service Provision Assessment. Credit: USAID Demographic and Health Survey-7 Program.

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ABSTRACT

The Global Health Program Cycle Improvement Project (GH Pro) conducted the mid-term evaluation of the seventh generation of the Demographic and Health Surveys (DHS) Program, implemented by ICF International and partners. The Service Provision Assessment (SPA) is a health facility assessment that describes a country's health service delivery system. Twenty-four SPAs have been conducted in 15 countries since the SPA was added to the DHS Program in 1997. The evaluation's purpose was to assess how well the SPA is positioned "to improve the collection, analysis, and presentation of population, health, and nutrition data and to facilitate use of these data for planning, policy-making, and program management."

The evaluation was guided by three questions: (1) What is the perceived value of SPA at global and country levels? (2) How are SPA data being used at global and country levels? and (3) What are USAID's and ICF's perceptions about opportunities and challenges facilitating SPA implementation?

The evaluation design was largely qualitative. The evaluation team conducted 77 interviews with 104 respondents, reviewed documents, and made country visits to Bangladesh and Kenya.

The evaluation found that the SPA has a strong global reputation for producing comprehensive, high-quality information. However, few SPAs have been conducted and their number is not increasing, unlike the Service Availability and Readiness Assessment (SARA) and Service Delivery Indicator (SDI) surveys. The level of investment in the SPA is inadequate in some areas, including the number of surveys conducted and the dissemination and use of results. The evaluation team recommends concerted action to strengthen the SPA initiative.

ACKNOWLEDGMENTS

The evaluation team would like to thank those colleagues, in particular the USAID/Global Health Bureau DHS management team members, ICF staff, and USAID Mission staff in Bangladesh and Kenya, who helped to organize our country visits, and all of the respondents whom we interviewed, for their time and help in providing our team with the information that we needed to conduct an evidence-based evaluation.

We were moved by the passion, hard work, and commitment to improving the delivery of health services of the colleagues with whom we worked during the evaluation. We ask that any criticisms that we have made regarding the Service Provision Assessment (SPA) initiative are understood to be a critique of the program—with the intention of strengthening it in the future—and not of the dedicated individuals who work tirelessly to take it forward.

We feel that the field of health facility surveys holds great potential to contribute to the improvement of health service delivery in the future and that the SPA has a critically important role to play in contributing to the realization of that potential.

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ACRONYMS

ACPR	Associates for Community and Population Research
ANC	Antenatal Care
AWP	Annual Work Plans
BHFS	Bangladesh Health Facility Survey
CDC	U.S. Centers for Disease Control and Prevention
DGFP	Directorate General of Family Planning
DHS	Demographic and Health Survey
DHS-7	Seventh Generation of the Demographic and Health Survey Program
DHIS	District Health Information Software
EmOC	Emergency Obstetric Care
FEC	Field Evaluation Coordinator
FP	Family Planning
GH Pro	Global Health Program Cycle Improvement Project
GHB	USAID Global Health Bureau
HFA	Health Facility Assessment
HMIS	Health Management Information System
HW	Health Workers
ICF	ICF International
KHFA	Kenya Health Facility Assessment
KIs	Key Informant Interviews
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NGO	Non-governmental Organization
NHSSP	National Health Sector Strategic Plan
NIPORT	National Institute of Population Research and Training
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PPH	Post-partum Hemorrhage
SACMO	Sub-assistant Community Medical Officer
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals

SDI	Service Delivery Indicator
SOTA	State of the Art
SOW	Scope of Work
SPA	Service Provision Assessment
STIs	Sexually Transmitted Infections
THE	Total Health Expenditure
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The Global Health Program Cycle Improvement Project (GH Pro) conducted a mid-term evaluation of the Demographic and Health Surveys (DHS) 7 Program (DHS-7), an internationally recognized program for collecting and disseminating accurate, nationally representative data on key health indicators since 1984. The program is funded by the United States Agency for International Development (USAID) with contributions from other donors. It is implemented by ICF International (ICF) in collaboration with the Johns Hopkins Center for Communications Programs, PATH, Avenir Health, Vysnova, Blue Raster, Kimetrica, and EnCompass.

The purpose of this mid-term evaluation was to assess how well the Service Provision Assessment (SPA) survey is positioned to meet the DHS Program's objective: "To improve the collection, analysis, and presentation of population, health and nutrition data and to facilitate use of these data for planning, policy-making, and program management." Specifically, the evaluation provided an opportunity for the USAID/Washington DHS-7 management team to obtain a better understanding of the challenges and successes of SPA implementation, utilization, and promotion.

PROJECT BACKGROUND

The SPA is one of a number of surveys conducted by the DHS-7 Program. It was added to the DHS portfolio in 1997 with the idea that such a large health facility survey would be of high quality if it were built on the DHS infrastructure, reputation, knowledge, and the expertise of its staff. The SPA contains four core questionnaires: 1) facility inventory, 2) provider interview, 3) observation of care provision, and 4) patient exit interview. The facility inventory questionnaire was harmonized with the World Health Organization (WHO) Service Availability and Readiness Assessment (SARA) in 2012. When implemented in a country, SPA generates a comprehensive portrait of service delivery with a nationally representative sample or a census of health facilities, to provide information on availability, readiness, quality of care, and client and provider satisfaction that is representative at national and sub-national levels. The SPA provides service-specific information on child health, maternal and newborn health, family planning, HIV/AIDS, sexually transmitted infections, malaria, tuberculosis, basic surgery, and non-communicable diseases.

In the 20 years that the SPA has been part of the DHS portfolio, only 24 SPAs have been completed in 15 countries. This is dramatically fewer than the DHS, of which more than 320 have been completed in 90 countries since 1984, including more than 180 DHS since 1997. In reviewing these results, the DHS management team agreed that the SPA has not followed the same or similar trajectory as the DHS. The overarching question for the evaluation team was whether or not the SPA is meeting the objectives of DHS-7, which are to: ensure quality data collection (Result 1); strengthen capacity (Result 2); ensure data availability (Result 3); conduct data analysis (Result 4); and facilitate the use of data (Result 5) for data-driven decisions that would in turn improve plans and policies and, ultimately, health outcomes.

EVALUATION QUESTIONS, DESIGN, METHODS, AND LIMITATIONS

Specific questions that guided this performance evaluation are stated in the Evaluation Scope of Work and were discussed in detail with the DHS-7 management team at USAID/Washington. These questions were as follows:

1: What is the perceived value of SPA at global and country levels?

Specific focus of the evaluation was on the purpose, quality, and utility of SPA and the added value of SPA compared to household surveys and health information systems, and compared to other health facility assessments (HFAs). We also evaluated stakeholders' perceptions of the SPA compared with those of the DHS-7 management team. We explored the reasons why stakeholders set aside resources to conduct an HFA and the reasons why countries that conduct HFAs choose (or do not choose) SPA.

2: How are SPA data being used at global and country levels?

Specific focus was on capturing examples of SPA data use, missed opportunities for using SPA data, challenges in using SPA data, and perceived opportunities for increasing the use of SPA data.

3: What are USAID's and ICF's perceptions about opportunities and challenges in facilitating SPA implementation?

Specific focus was on capturing perceptions around the level of investment from USAID and ICF on SPA, USAID and ICF interest in continuing with the SPA, and future direction of HFAs in general. We explored specific areas for improving the SPA, opportunities for better collaboration between the DHS and SPA, and ICF's relationship with USAID Missions and other key stakeholders.

EVALUATION METHODS

Evaluation design: Cross-sectional design with mixed methods for data collection.

Data collection methods: The team attempted to collect data from all 15 countries that have implemented a SPA, plus an additional five countries that have never conducted a SPA and two countries that began but dropped the process of SPA implementation before its completion. All countries were selected by USAID. Methods used included: review of documents provided by USAID and other stakeholders; key informant interviews with a starter list provided by USAID that grew using snowball sampling methods; business process analysis for integrating SPA into DHS programs; focused country visits in Bangladesh and Kenya; and focus group discussions with the USAID DHS-7 management team and ICF. Data analysis was descriptive and based on themes derived from the evaluation sub-questions.

Ethical considerations and assurances: The team obtained verbal informed consent from every participant and protected their identity in reporting the findings. The team obtained special additional written permission from participants whose pictures or videos were taken.

Limitations

This evaluation was quite comprehensive in that the team attempted to recruit participants from all 15 countries that have conducted a SPA. The evaluation was balanced by including perspectives from countries that had not conducted a SPA or that dropped the SPA during the process of implementation. Certain aspects limited the validity of evaluation findings, however,

specifically the fact that data were collected only at one point in time and that the data were from a purposive sample of individuals. The evaluation's limited timeframe and financial resources led to the selection of only two countries for further in-depth study, thus limiting generalizability of findings from those countries to all countries that have conducted a SPA.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Findings

Question 1: Perceived value of the SPA

Stakeholders reported that the SPA was the **most comprehensive** HFA, as it is the only HFA to provide data on health facility inventory, health provider knowledge and training, quality of care through direct observation, and client perspectives through exit interviews. The SPA process and data produced from the SPA were perceived to be of **higher quality** compared to other HFA. SPA is the only HFA that makes its **data publicly available**, thus contributing to the global good. A number of USAID Missions consider the SPA's value interlinked with its ability to **provide them with insight** on the quality of services offered, availability of necessary equipment, and level of training of health workers that helped them better manage implementing partners and further assess needs and programmatic investments.

As such, some ministries and USAID Missions expressed strong preference for the SPA to first be useful to **meet country needs** and considered the ability to make cross-country comparisons as important but secondary. SPA has helped ministries of health realize, in some instances, how many and what type of facilities are functional, while in other cases, how many facilities did or did not have required materials to provide care according to government standards. For researchers, SPA data have helped to define **quality of care measures** and, in some instances, to **validate data** obtained from routine health information systems.

To global donors, SPA data have helped to **make the case for their investments** in systems strengthening. The donor and research community expressed frustration, however, that **very few SPAs are conducted** (two to three countries per year) as compared to other HFAs (12 or more countries per year), thus limiting their ability to use SPA data for analysis and decision-making. While the DHS management team was concerned that the lack of global indicators was affecting perceived value of the SPA, most ministries of health (MOH) and USAID Missions interviewed did not say this. Rather, for USAID Missions, **not knowing about the SPA greatly affected their decision to not implement the SPA**.

Question 2: Use of SPA data

While there was general agreement on the importance and value of the SPA from all stakeholders, many agreed that it was underused. Data use was viewed least favorably by USAID/Washington and USAID Missions, while MOHs and other donors were more optimistic about its use, although they, too, agreed that the current use of SPA data was well below its potential use. The need to make SPA data more user-friendly was highlighted by ministries of health, particularly in the form of two-page (or shorter) policy briefs for policy-makers that highlight key messages. Even in countries that completed a SPA, a dissemination strategy that effectively omitted sub-national units minimized its potential use.

Nevertheless, the team did find several examples of SPA data use. SPA data influenced maternal, child health, and reproductive health **policy** in Kenya; helped the Government of Bangladesh set targets to **plan and measure progress** of MOH operations; were used by USAID Missions in

Haiti, Tanzania, Kenya and Senegal to **plan and drive implementing partner performance, identify priorities and target resources**; helped a Kenya-based United Nations (UN) donor **make an investment case and mobilize resources**; were used in weekly calls between national and district health directorates in Nepal for **program management** within the MOH; and were used by the USAID Mission to **design new interventions** in Bangladesh. USAID/Kenya **includes SPA data within their results framework** and the USAID Mission in Haiti **used SPA data in requests for proposals**. The Government of Bangladesh, in particular, has included SPA indicators within their monitoring and evaluation (M&E) framework to **monitor health sector plans** and are conducting the SPA regularly every two or three years.

In Kenya, the team noted that SPA data were used **in pre-service training** of medical providers at universities to highlight and plan against common pitfalls in the provision of care. Journalists in Malawi and Nepal have been engaged and published SPA results. SPA data have stimulated **international collaboration between in-country and international researchers**, particularly in Haiti and Kenya. Researchers have used SPA data for **development and analysis of quality of care indicators**, as well as to conduct research on access to health services. Donors have used SPA data for **prioritization of initiatives**.

Question 3: Opportunities and challenges in facilitating SPA implementation

DHS-7 is a centrally managed mechanism, so the SPA can only be implemented if USAID Missions request and buy into the mechanism with funding. When a USAID Mission expresses interest, initial funding for the trip to further discuss the SPA is funded by USAID/Washington. Once a Mission decides to implement the SPA, all other costs are borne by that Mission and other interested donors. USAID Missions have funded 41% to 100% of all implementation costs of SPAs. To date, however, only 15 Missions have bought into the DHS mechanism for the SPA, resulting in 24 SPAs over 20 years. With such **limited buy-in**, ICF reports it is **difficult to justify hiring many technical experts** whose role would be solely to focus on the SPA. While they did this initially, these experts eventually worked on other surveys within the DHS portfolio, leaving the **SPA with limited full-time staff**. Similarly, within the USAID/Washington DHS management team of six, there is only one person whose focus is specifically on the SPA.

Nevertheless, there is reason to be optimistic about the SPA. Stakeholders report that overall **HFA data are increasing in importance** and that demand for HFA is expanding. Additionally, SPA is considered the most comprehensive HFA and there is strong respect for its data collection process, including training and field supervision, which leads to higher perceived reliability of the SPA data. Unlike outcome data from the DHS and other sources, SPA data focus on inputs and processes and, as such, provide the kind of information that is conducive to being improved.

There are also numerous challenges. A number of stakeholders expressed the need for HFAs (including the SPA) to provide more flexibility with regards to questions asked, timing, and sampling procedures in order to respond more robustly to country needs. The DHS Program must balance this desire for flexibility with the quality of the data product. Missions are waiting for guidance from USAID/Washington with regards to harmonization of SPA tools, indicators, and methods, yet the DHS management team was relatively reticent, stating that the time and effort that real harmonization would take and a lack of global consensus on indicators as limitations to the harmonization process. Members of the DHS-7 management team said that

funding decisions that USAID may have to make in the near future could negatively affect the SPA. Finally, USAID Missions in countries that did not implement the SPA stated they were either not aware of the SPA or that the country already had other methods for obtaining the data they would otherwise obtain from the SPA.

Conclusions

SPA is perceived to be of value at both global and country levels. The team obtained agreement globally on the quality of the data produced using SPA tools and SPA methodology. Even when compared to other HFA, the quality of the data produced from the SPA, as well as its comprehensiveness, makes it a valuable source of data. However, the limited number of SPAs conducted yearly makes it harder for global stakeholders to rely on SPA data for decision-making globally. The team concluded that while SPA data are certainly underused, they have a variety of uses and are used more at country levels than at global level. Given that SPA data are viewed as high quality, opportunities exist to make the SPA more relevant to the work of USAID Missions and governments. Some Missions have already begun by including SPA data in their results frameworks, while some governments, such as Bangladesh and Nepal, are beginning to use SPA data to manage their health sector. Nevertheless, key challenges remain, including funding, awareness of the SPA, and the balance that the DHS Program must maintain between flexibility and SPA implementation quality.

Recommendations

To increase the value of the SPA, the team recommends the following:

Conduct More SPAs

- **Increase funding through Mission buy-in for SPA** implementation, dissemination, and data use. In order to do this, the DHS management team will need to **dedicate time** for strategic advocacy for the SPA.

Make the SPA Valuable for USAID and Its Initiatives

- For strategic advocacy to result in Mission buy-in the team must make the SPA valuable for USAID and its initiatives. To do this, the evaluation team suggests the following:
 - Develop indicators that fit USAID needs;
 - Start using these indicators immediately (with existing SPA data) and modify definitions and calculations based on feedback;
 - Increase awareness within USAID/Washington and USAID Missions about the SPA;
 - **Integrate the SPA into USAID program cycle:** SPA results → identify problems → intervention → remeasure. Use SPA for baseline/midline/endline measurement of USAID projects; and
 - Create a stronger link between USAID quality improvement (QI) efforts and the SPA, for example by making it integral to evaluation of QI efforts.

Make SPA Valuable for Individual Countries and Their Priorities

- Increased Mission buy-in would also mean increased engagement of ministries of health in these new countries. The team therefore recommends that ICF and the DHS management team develop for each country Data Use Strategies that:

- Support integration of SPA indicators into M&E frameworks and other M&E infrastructure in countries;
 - Support systematic use of SPA indicators in country policy, planning, advocacy, and evaluation processes at national and sub-national levels; and
 - Ensure data availability at sub-national levels.
- Allow Data Use Strategies to drive dissemination efforts.

And last, but not least, **improve communication about the links between health facility inventory, provider knowledge and training, provider actions (observation), and patient satisfaction with care received**—as this remains an under-exposed strength of the SPA and analysis of the data in this way is limited.

I. INTRODUCTION

EVALUATION PURPOSE

The Global Health Program Cycle Improvement Project (GH Pro) was asked to conduct the mid-term evaluation of the Demographic and Health Survey (DHS) 7 Program (DHS-7), a five-year contract (2013-2018) for the seventh generation of the DHS Program, funded by the United States Agency for International Development (USAID) and managed as a cost-plus-award-fee contract through USAID's Global Health Bureau (GHB). DHS-7 is implemented by ICF International (ICF) in partnership with the Johns Hopkins Center for Communication Programs, PATH, Avenir Health, Vysnova, Blue Raster, Kimetrica, and EnCompass.

The DHS Program was designed to provide reliable estimates for population, health, and nutrition indicators at national, rural-urban, and regional levels. Since its inception in 1984, more than 320 DHS Program surveys have been conducted in 90 countries. In 1997, the Service Provision Assessment (SPA) was added as a component of the DHS Program. Since that time, 24 SPAs have been conducted in 15 countries.

The purpose of this mid-term performance evaluation was to assess how well the SPA is positioned to meet the DHS-7 Program's objective: "To improve the collection, analysis, and presentation of population, health, and nutrition data and to facilitate use of these data for planning, policy-making, and program management." Findings are expected to contribute to USAID's understanding of the challenges and successes of SPA implementation, utilization, and promotion. USAID will use the results to inform the technical direction of the DHS Program, as well as the related management steps necessary to support said technical direction.

EVALUATION QUESTIONS

The three evaluation questions and their specific probes are listed in Table I below.

Table I. Evaluation Questions

#	Evaluation Question	Specific Probes
I	What is the perceived value of SPA at global- and country-levels?	<p>I.1 What are global, country-level perceptions of:</p> <ul style="list-style-type: none">• The purpose, quality, and utility of SPA?• The added value of SPA in the context of household surveys and routine health information systems? and• The value of SPA as compared to other HFA surveys (e.g., Service Availability and Readiness Assessment [SARA], Service Delivery Indicator [SDI], Malaria Quality of Care Surveys, and Emergency Obstetric Care [EmOC] Assessment)? <p>I.2 To what extent do stakeholders' perceptions align with those of the DHS management team both at USAID/Washington and at ICF?</p> <p>I.3 In countries that choose to implement a HFAs (whether it is SPA or a different type of HFA), why do stakeholders decide to prioritize resources for facility assessment implementation?</p>

#	Evaluation Question	Specific Probes
		1.4 What are reasons for selection or non-selection of the SPA in place of another type of HFA?
2	How are SPA data being used at global- and country-levels?	2.1 Examples of SPA data use by USAID/Washington, international organizations, researchers from the global north, Ministries of Health, USAID Missions, in-country donors, and local researchers. 2.2 Examples of missed opportunities for SPA data use (e.g., identified data needs are met by SPA, but key stakeholders believe that the data gap remains; systematic challenges are identified by SPA but no policy/programming changes result). 2.3 What are the perceived challenges in using SPA data? 2.4 What are perceived opportunities to increase use of SPA data?
3	What are USAID's and ICF's perceptions about opportunities and challenges in facilitating SPA implementation?	What are perceptions of: 3.1 The level of USAID's investment in SPA (funding amount, types of investments, USAID staff level of effort)? 3.2 The level of ICF investment in SPA (staffing levels, skills, level of technical assistance required)? 3.3 USAID and DHS Program interest in promoting, facilitating SPA implementation? 3.4 The future direction of HFAs, including and beyond SPA? 3.5 Areas for SPA improvement (tools, processes, products)? 3.6 Areas for SPA improvement under the control of USAID and/or ICF? 3.7 Opportunities for DHS/SPA coordination? 3.8 ICF's relationship with USAID Missions and other key stakeholders as related to SPA implementation?

EVALUATION TEAM

The evaluation was conducted by a team of two international experts:

Dr. Rachel Jean-Baptiste: Team Leader, Evaluation and Survey Specialist oversaw all aspects of the project, liaised with USAID and the other consultants, oversaw data collection and analysis, wrote sections of the report, and presented conclusions and recommendations to USAID. Dr. Jean-Baptiste has significant prior experience and expertise in program evaluation and assessment, research and survey implementation, as well as understanding of USAID programs and processes, and experience with international population and health technical areas. She has worked extensively with health facility staff and has also conducted facility assessments, including the use of SARA. Dr. Jean-Baptiste traveled to Kenya to interview key informants involved in the preparation for the upcoming SPA and, to the extent possible, also spoke with those involved in the implementation of the previous SPA in 2010.

Dr. Robert McPherson: Service Delivery Technical Consultant, has specialized evaluation expertise and programmatic experience in the design, implementation and analysis of service delivery quality assessments, especially as a researcher/evaluation specialist in the design and implementation of surveys in formal health facilities. Dr. McPherson is familiar with SPA survey methods, global data needs (e.g., service readiness indicators and quality of care), and

other health facility surveys. He brought the lens of his subject matter expertise and experience to bear on all aspects of the Scope of Work (SOW). He worked closely with the Team Leader to assess the quality and relevance of internal work practices and processes, and offered his perspectives on tasks associated with this assignment. He worked seamlessly with the Team Leader to interview key informants, conduct data collection and analysis, and write sections of the report. He was part of all planning and briefing meetings with USAID/Washington and traveled to Bangladesh to collect data on SPA activities there.

EVALUATION TIMEFRAME

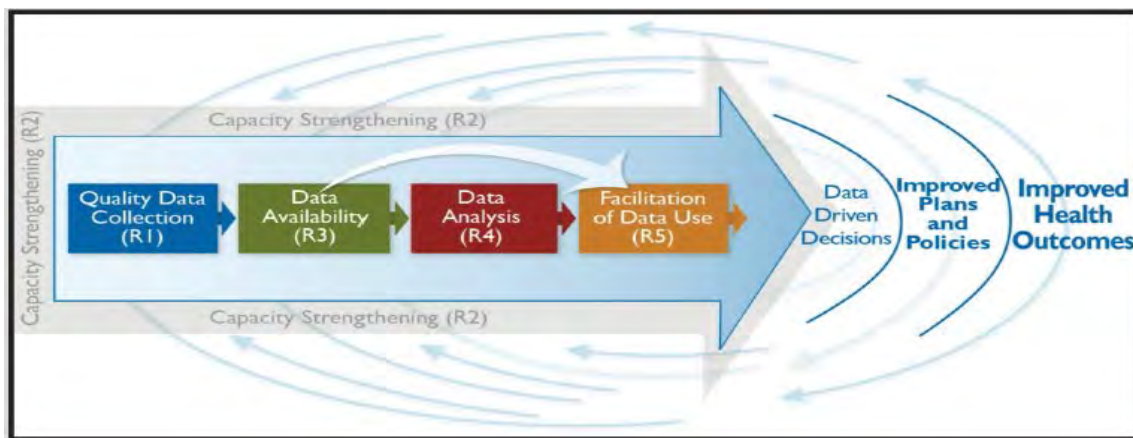
This evaluation took place between January and June 2017. Active data collection was from February to May 2017.

II. PROJECT BACKGROUND

For over three decades, the DHS Program, funded by USAID, has led the global effort to collect, analyze, and present population, health, and nutrition data at the country level among nations across the world. DHS is world-renowned as a leader in the production of rigorous data and information. Building on this reputation, USAID added a HFA survey, the SPA, in 1997. The intention was that the SPA, similar to the standard DHS survey, would be conducted periodically in low and middle-income countries across the world.

DHS-7 has five key results that focus on 1) improved tools, partnerships, and technical guidance; 2) increased in-country individual and institutional capacity; 3) improved availability of data and information; 4) advanced analysis and synthesis of DHS data; and 5) improved facilitation of DHS data use among global and country-level stakeholders. Figure 1 illustrates how these different results are designed to work together to achieve the overall program objective.

Figure 1: Strategic Design of DHS-7



DHS-7 follows six guiding principles during the implementation of all of its surveys, including the SPA. These principles are designed to help achieve the results described above. These principles include aligning all program activities with the overall program goal; fostering host-country ownership; strengthening South-to-South technical exchange; recognizing DHS stakeholder needs while maximizing quality at minimal costs; collaborating strategically with stakeholders to make best use of resources; and respecting individuals, families, and communities who participate in the Program's work.

The SPA is an HFA that generates a comprehensive portrait of the delivery of health services in the country where it is conducted. The SPA was added to the DHS portfolio based on the belief that HFAs could benefit from the infrastructure, knowledge, and expertise of the DHS Program. The SPA provides information at the national and regional levels regarding service availability, service readiness, quality of care, and client and provider satisfaction. The SPA also provides service-specific information regarding child health, maternal and newborn health, family planning (FP), HIV/AIDS, sexually transmitted infections, malaria, tuberculosis (TB), basic surgery, and non-communicable diseases. The SPA is a nationally representative sample survey of formal sector health facilities.

The SPA utilizes four core questionnaires to collect information: 1) facility inventory, 2) provider interview questionnaire, 3) observation protocol, and 4) patient exit interview questionnaire. With significant USAID investment, SPA questionnaires have been harmonized with the World Health Organization's (WHO) SARA in order to produce information on a set of core indicators that are common to both surveys.

III. EVALUATION METHODS AND LIMITATIONS

EVALUATION DESIGN

Using a cross-sectional and qualitative evaluation design, data collection included in-person or phone-based key informant interviews (KIIs) with staff from USAID/Washington, ICF, and USAID Missions within countries that have completed at least one SPA, countries that started but dropped the SPA before completion, and countries that have never implemented a SPA. For country visits, purposive sampling was applied to generate the initial list of key informants, followed by snowball sampling to ensure that the evaluation team interviewed as many relevant players as possible during their one-week visit. All countries, including case study countries (Bangladesh and Kenya), were selected by USAID.

DATA COLLECTION PLAN

The Evaluation Team relied on several sources for data collection: document review, KIIs, literature review and one focus group discussion that included respondents from USAID/Washington and ICF.

Review of project documents, including the DHS-7 SPA contract SOW, annual reports, work plans, performance management plans, survey reports, curricula for training activities, and research papers, among others. Review of these documents allowed the evaluation team to obtain a clear picture of what DHS-7 SPA was designed to do and has done, as well as strengths and weaknesses of its implementation.

Key informant interviews: USAID/Washington provided an initial, comprehensive list of potential key informants; additional people were added to the list as they were identified. Respondents included staff from USAID/Washington, specifically the DHS-7 management team and staff from the Office of Health Systems, including those that work on quality improvement, and staff from the nascent Data Analytics Unit; ICF DHS management staff; WHO; United Nations Children's Fund (UNICEF); the Global Fund to Fight AIDS, Tuberculosis and Malaria; Harvard School of Public Health; the United Nations Population Fund (UNFPA); the World Bank Group; Johns Hopkins Bloomberg School of Public Health; GAVI, the Vaccine Alliance; Metrics for Management; USAID Mission personnel; host-country governments; country implementation partners; and in-country donors, technical advisors, and nongovernmental organizations (NGOs).

A final list of key informants is included in Annex V. Many of the interviews were conducted by phone but, where feasible and cost-efficient, some were conducted in-person. The Evaluation Team used a standardized tool with a core set of questions asked across the different stakeholder types, further enhanced by questions specific to that stakeholder group. Data collection instruments are included in Annex IV.

Literature search: The team conducted a literature search in PubMed Central to document the number of articles or other publications that cite the SPA and to examine trends in citations over time. The search term “Service Provision Assessment” was used to generate lists of articles, which were then verified (to the extent possible given the resources available to the evaluation team) to contain valid references to the SPA.

COUNTRY VISITS

The team visited Bangladesh and Kenya to learn first-hand how the SPA has been implemented at country level and to document case studies of SPA. Both of these countries were in preparation stages for conducting their next SPA or HFA. In each country, we generated a list of key informants by working closely with USAID. The list included people within USAID Missions, other bilateral donor agencies, government ministries (e.g., ministries of statistics, ministries of health, and ministries of planning), research agencies, and members of the media, among others. Interviews during country visits were all conducted in-person (with two exceptions in Kenya, where distance and time did not permit a face-to-face encounter) using the same core data collection instrument.

DATA ANALYSIS

The evaluation team used Reframer and QDA Miner Lite v2.0 software to code the interview data and develop key themes for analysis. The data were analyzed on the basis of the three major evaluation questions. These results were triangulated whenever possible by available quantitative data. Data on perceptions of SPA implementation and the quality of SPA data were collected on a scale of 0 to 10 and Microsoft Excel was used to calculate percentages. Following preliminary analyses of findings for Evaluation Question 3, the evaluation team conducted a focused discussion with staff from USAID and ICF DHS management teams to further explore opportunities and challenges in facilitating SPA implementation. This focus group discussion was intended to help both parties develop a clearer vision for the future of SPA in terms of continued interest, level of investment, and areas for improvement.

ETHICAL CONSIDERATIONS

The evaluation team obtained and documented verbal informed consent from all participants as per GH Pro and USAID policies (see Annex VI for an example) and all interviews were done on a voluntary basis.

LIMITATIONS OF THE EVALUATION

Due to limited resources, a short time frame, and the convenience sampling method applied in this evaluation, the data collected may not be generalizable globally. However, identification of a wide range of respondent types, a sizeable number of respondents, and the wide geographic spread of countries represented all helped to make the data more generalizable. Site visits conducted for the case studies were eye-opening, but the limited sample of two country visits was also a limitation of this study.

IV. FINDINGS

These findings are organized by theme, with the overarching themes defined by the evaluation questions and sub-questions. Within each evaluation sub-question, themes are further defined by global and country-level perspectives and, within some sub-questions, by logical groupings of respondents' statements into domains.

In total, we conducted 77 KIs with 104 respondents, representing an 82% response rate from the 126 people identified to be interviewed for this evaluation (i.e., the USAID initial list plus those added along the way). Among those not interviewed, only one person refused outright; two others identified themselves as having been misidentified and scheduling conflicts prevented the other respondents from being interviewed.

Respondents were drawn from 17 countries, including 11 of 15 countries that had implemented a SPA, 5 countries that had never initiated the process for implementing a SPA, and 1 country that initiated discussions for implementing a SPA but then chose not to proceed. The team also conducted field visits to two countries—Bangladesh, where 13 interviews were conducted, and Kenya, where 12 interviews were conducted—as well as a visit to a county within Kenya where the team saw the types of data being used to create the county's M&E framework, to monitor progress, and to make data-driven decisions.

In addition, the team conducted a brief review of published literature from the PubMed Central database and reviewed a number of documents provided by the USAID DHS-7 management team and ICF.

EVALUATION QUESTION 1: PERCEIVED VALUE OF SPA

The first evaluation question was: “What is the perceived value of SPA at global and country-levels?” The question, the results of which are presented below, was further delineated to address four distinct aspects:

Evaluation Question 1.1	The purpose, quality, and utility of SPA at global and country levels
Evaluation Question 1.2	To what extent do stakeholders' perceptions align with those of the DHS management team both at USAID/Washington and at ICF?
Evaluation Question 1.3	In countries that choose to implement HFAs (whether it is SPA or a different type of assessment), why do stakeholders decide to prioritize resources for facility assessment implementation?
Evaluation Question 1.4	What are reasons for selection or non-selection of SPA in place of another type of HFA?

Key Findings: Evaluation Question 1: Perceived Value of SPA at Global and Country Levels

1. **Purpose, quality, and utility of SPA:** Stakeholders at global and country level expressed confidence in the quality of the data produced by the SPA. They found that it helped them better understand the real abilities of health facilities to deliver necessary services. They found that the SPA had additional value for existing health information systems; specifically, that it provides input and process data sometimes not included in health management information systems (HMIS) and, for the data included, provides a gold standard against which to make comparisons and improve HMIS. SPA's added value when compared to other HFA was in its comprehensiveness and quality, as well as the fact that the data are available to the public.
2. **Alignment of stakeholders' perceptions with those of DHS Management Team both at USAID/Washington and at ICF:** Stakeholders' perceptions and those of the DHS management team were aligned on the fact that the SPA implementation process produced good quality data. However, they had different perspectives in terms of what would increase the value of the SPA. Specifically, country-based stakeholders viewed globalization of the SPA as secondary to the ability of the SPA to meet country-level needs. They viewed insufficient dissemination leading to lack of awareness of SPA data availability, rather than lack of global indicators and requirements for global reporting, as the main restriction of the use of SPA data.
3. **Why stakeholders decide to prioritize resources for facility assessment implementation:** Two main reasons for conducting SPAs came to light. Ministries of Health stated that HFAs are conducted either to establish a baseline measure of readiness and quality of care (e.g., the SPA in Kenya, Bangladesh, Nepal, Haiti) or to measure mid-term performance as was done recently in Kenya (through the Mini-SARA-M conducted in late 2015 to support 2016 mid-term review of the health sector plan). USAID Missions also conduct SPAs to inform baselines, as well as to inform the design or re-design interventions, as in Bangladesh and Nepal.
4. **Reasons for selection or non-selection of SPA in place of other HFAs:** The team found four types of countries: 1) those that do the SPA on a regular basis do so because they have found it useful; 2) those that did one or two SPAs but stopped did so because the data were not used or were discredited; 3) countries that started then stopped the SPA process did so largely due to issues around timing; and 4) among the five countries that had never done a SPA despite having an active DHS, three had not heard of the SPA at the time they were deciding on an HFA.

1.1 The purpose, quality, and utility of SPA

Purpose and Utility of SPA at Global Level

Overall, the SPA process and end product are perceived positively at global and country levels; this is summarized in Figure 2. Globally, stakeholders reported several important purposes for the SPA. Some of those interviewed viewed conducting a SPA as an opportunity to **identify what health services are provided (and where), their level of quality, and what are the gaps**. They also viewed it as an opportunity to **better understand (via patient satisfaction measures) if they are**

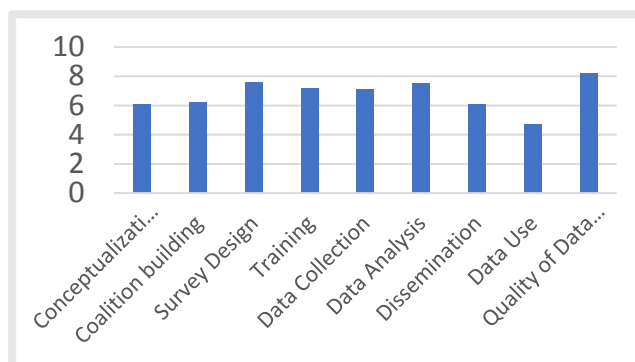
meeting the needs of patients and clients who receive health services. Others saw its purpose as **helping countries prioritize their quality improvement efforts** because the SPA can be viewed as providing a baseline and can help shed light on ways to prioritize investments. Since the SPA does not currently provide data on utilization rates of facilities or services within facilities, stakeholders are not able, through a SPA, to understand coverage and gaps in coverage. However, they view SPA data as enabling them to **assess the overall capacity of the health system** to provide care and to **measure progress** in efforts to strengthen the health system. To the extent that service provision is considered a key output for population level health, SPA serves the role of helping to **better understand bottlenecks to service delivery**.

One international technical advisor highlighted the case of pregnant

“The SPA provides a representative sample for understanding service readiness at health facilities as well as helps to validate or provide additional data points for validation of routine information. It provides some of the only data we have on quality of care at health facilities as well as the patient experience. [This is] often not available at any other data source.”

– Donor Community Member

Figure 2: Overall Perception of the Process of SPA Implementation and Data Produced on a Scale of 0-10



“For many years at USAID we relied on impact measures, which don’t provide guidance for how to improve. If you only measure impact on maternal mortality and it is not dropping even though you have a maternal mortality program, you don’t know what you need to do. Measuring impact is good, necessary, and important, but does not provide information about the process, [about what’s] being done properly and what’s not being done properly.”

– USAID/Washington staff

women as a population of patients who need significant input from health facilities throughout the life of their pregnancy. “A country may have 90% ANC [antenatal care] attendance,” she said, “but are they getting good quality ANC? SPA’s role is to understand facility-level stories and bottlenecks.” A number of stakeholders within Ministries of Health believed that SPA data help to **validate routine information** from national health management information systems like the HMIS.

SPA Value at Global Level

Of major value to most global stakeholders was how **comprehensive** the SPA is, its production of **high quality data**, and the **availability of data to all** as a global good. These points were underscored by a member of the donor community who recently used SPA data: “[T]he really true benefits of the SPA is open access to the data from all countries. [It is] truly a global good that data are made accessible. Other surveys are slower to make that happen; [and the] quality of the data is great.” Another donor provided a concrete example of this: “SPA provided data on indicators such as training in a more comprehensive way. Also, SPA shares the raw data, others don’t.”

The fact that the SPA is an **independent assessment** conducted by people external to government health facilities, as opposed to self-reported data, is a major reason cited by stakeholders for their perception of the quality and reliability of SPA data.

“External validation of self-reporting is important. People do not always tell the truth; health facilities will not maintain standards and will start to take shortcuts unless there is external validation. We are starting to get agreement on that [globally].”

– Global Technical Advisor

Another group of stakeholders saw that the SPA’s focus on **processes of care** was itself of significant value, since such information lends itself to improvement more readily than traditional measures of impact. One technical advisor from USAID/Washington said “everyone involved in global health needs to be able to understand processes in order to improve them and change the impact.” The SPA is viewed as a gold standard measure of quality of services. Comparing the SPA to other efforts to evaluate quality, one respondent asserted that the SPA is “a rigorous effort that sets the gold standard of comparison for subsequent efforts to do this in a less rigorous way.”

SPA Purpose and Utility at Country Level

Within countries, SPAs serve several important and practical purposes. First, respondents felt that the SPA allows them to **evaluate the ability of existing inputs, such as human resources, materials, equipment, and training to deliver health services and satisfy client needs**. Respondents from Haiti and Senegal further highlighted the SPA’s role in helping to **deepen understanding and documentation of service availability and readiness for the entire country** on the supply side. As noted by a respondent from Haiti, “It [the SPA] is to assess the availability of the type and quality of services offered to the Haitian people and to see how the current situation corresponds to the needs of the population.” He further noted that the SPA is important “especially in countries like Haiti where we are facing many challenges. When you need to plan for a population already with low access, to improve access, you need to know what you have already.” Similarly, in Senegal, where SPAs have been conducted yearly since 2012, the SPA is used to **evaluate quality at myriad health service provision structures**, such as the “caisses de santé” that are found in villages that do not have other types of health facilities.

“SPA gives some information on service provision, as well as the environment within which services are provided. It helps us identify what can create a problem or facilitate good results.”

– Ministry of Health, Senegal

In some countries, the SPA also facilitates health managers’ ability to **compare service delivery and quality between different types of health facilities**. In Nepal, the SPA helps to compare public and private health facilities, while the team was told that in Rwanda, prior to the SPA conducted in 2007, the Ministry of Health did not have information regarding the

distribution of faith-based and public sites and, though dated, the SPA report remains the only credible source of that information to date.

SPA Value at Country Level

Countries that have implemented a SPA regularly consider that, outside of the national HMIS, it is the only dataset that is nationally representative, and that its data are perceived to be of much higher quality and reliability than the HMIS. As

noted by a researcher in a country that conducts SPA, “before the SPA, very little was known about the performance of health facilities. The SPA stimulated thinking about provision of health services and availability of necessary inputs.” Donors and ministries of health consider that SPA provides sufficient information to inform investment planning.

“SPA gives wider picture of the health structure. It shows this is the hospital, and what it is like with regards to staffing skills and type of equipment. If you have infrastructure and not the right staff, or the right staff but not the right equipment, you immediately know what to do.”

– USAID Mission

“What caught my attention was the proportion of health facilities that do not have materials recommended by the Ministry. This showed that even when an institution exists, there are many things they should have that they do not have, so they cannot function within all norms. These types of information are only obtained by the SPA”

– Ministry of Health, SPA country

Lastly, ministries of health greatly value the Health Facility Master List that is sometimes generated as part of the sampling process of the SPA. In many cases prior to the SPA, such a list did not exist or, if it did, it was severely outdated. As such, it allows for an update on the location of all health facilities throughout the country and the services that each offers.

The added value of SPA in the context of household surveys and routine health information systems

Added value of SPA compared to household surveys

When compared to the DHS, stakeholders agreed that SPA had a very different focus and population of interest. The SPA is focused on the ability of health facilities to supply needed services, while the DHS captures the demand for key services. Because of this, some people, particularly in the research community both globally and within countries, feel that DHS and SPA should complement each other and, specifically, that the SPA should try to answer the “why” of some clinical indicators in the DHS.

According to a researcher in a country that implements the SPA and the DHS, the SPA should inform results from the DHS that require more explanation. For example, if results show that 58% of mothers of a child with diarrhea went to a health facility, the SPA that follows should collect information on why some mothers did not come to the health facility. To do this, some countries with SPA have added community focus group discussions as part of their SPA.

“At the facility level, we need to know what kind of equipment is lacking, and that information is not in the DHS, that is only a results-based survey. We haven’t looked at process and inputs before the HFS.”

– Ministry of Health, Country with SPA

Added value of SPA compared to Health Management Information System

When comparing SPA to HMIS, respondents highlighted several differences, including the lack of most inventory within HMIS; the fact that HMIS tends to focus only on inputs and outputs while SPA includes process data that shed light on how services are provided; and that the quality of the data in the SPA is more reliable than in the HMIS in most countries. They

asserted that HMIS only provides information on inputs and outputs, but no information on how services are provided, what equipment is available, or their level of functionality. The information from the SPA is also independent and less likely to be biased.

“The SPA contains much more detailed information than is possible to obtain from routine HMIS currently. For example, with sick child care, they get the diagnosis and treatment plan as reported by the provider.”

– Global SPA Researcher

The added value of SPA as compared to other HFA surveys

When compared with other HFAs (e.g., SARA, SDI, Malaria Quality of Care Surveys, and EmOC Assessment), results of interviews indicate that the SPA is viewed as the most respected and

“With the SPA, you get a massive inventory. The health worker focus is added value; no other survey is looking at it that way. And the mix of observation and exit interview is interesting.”

– Donor

trusted HFA among researchers and donors. They find it to be the most methodologically sound, though certain interviewees did bring up a difference of opinion on the best ways to capture provider knowledge. They also liked its

comprehensiveness and, in particular: its more detailed capture of process of care through observations; the large, nationally and often regionally representative sample size; and its rigorous implementation process that puts high emphasis on training of data collectors.

Compared to other HFA platforms, they feel that the SPA is uniquely positioned to link the patient experience to provider knowledge, actual provision of care, and available resources for service delivery.

Compared to the SPA, several advantages of the SARA were highlighted. Specifically, the SARA is viewed as being slightly broader than the SPA in its ability to capture service availability and readiness, particularly for services like surgery and cancer screening. SARA is viewed as being more nimble and cheaper. However,

the SARA is also perceived to be less rigorous compared to the SPA. The SARA is implemented using different and less standardized methodologies; for example, the sampling strategy is

often not clear and inventory data are based on written records and not on direct observation. The SARA data are not centrally available and are much harder to access by members of the public. Traditionally, SARA does not record much on the process of care or on the patient experience, though the team did hear that WHO is considering adding these pieces. The SARA is implemented by independent consultants hired by WHO. Some respondents expressed that the quality of the SARA was linked to the quality of the consultant, and as such varied, unlike the

“SPA covers the overall health services readiness, client satisfaction, and quality of care. The other HFAs don’t cover as much. We also have made an observation of the service providers, we can also look at the quality of service that was provided in specific encounters, observed the quality of equipment, functionality of the equipment. This information is lacking in other HFA platforms”

– SPA Researcher, In-country

SPA that is implemented with robust technical assistance from the DHS Program, thus benefiting from the DHS Program's expertise in conducting large-scale surveys.

Several advantages of the World Bank's SDI survey were also noted. Specifically, respondents from the World Bank expressed that provider vignettes may be more helpful in assessing provider knowledge than what is currently used in the SPA. For example, provider vignettes allow for testing provider knowledge on conditions that are more rare, like birth asphyxia and post-partum hemorrhage (PPH), that are not dependent on who walks in the clinic at the time the data collection team is there. However, respondents—particularly researchers—said that data from the vignettes were difficult to use and of questionable quality.

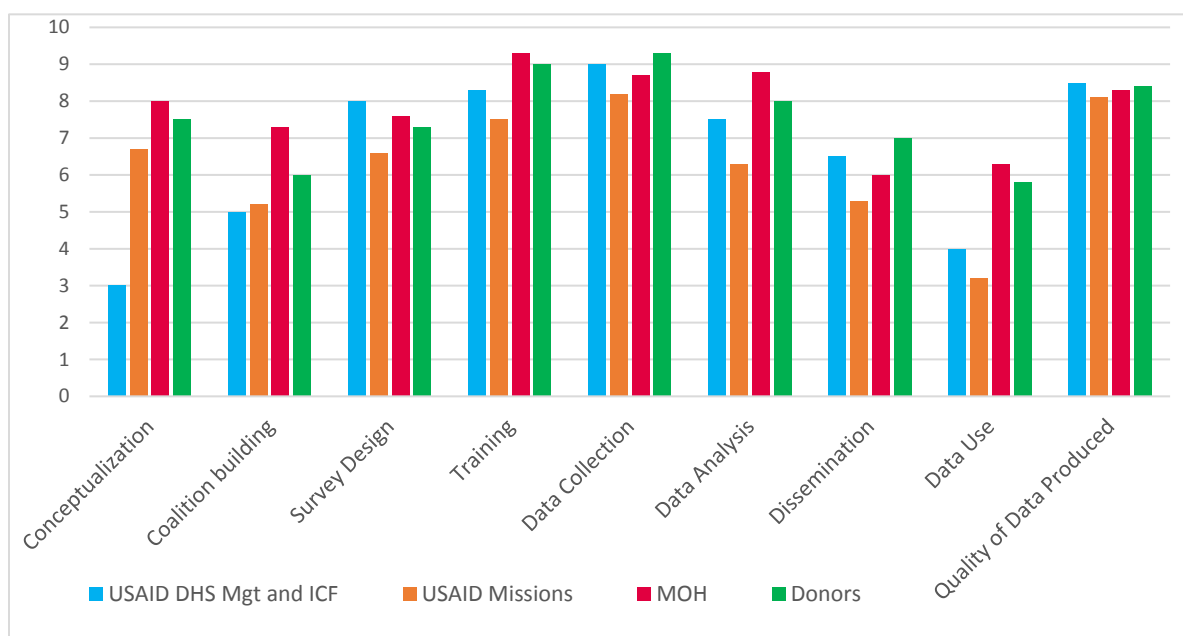
“The difference between client observation and the vignette is that for the observation, you can only take who comes in the door that particular day. You can't observe birth asphyxia, PPH because they are so rare and it's difficult to stay in the room while they are occurring. So, with the vignette approach you are not constrained by the patient mix that you have that day. You are only constrained by the time of the provider. The second thing is that for the client observation, you can look at whether the doctor asked x or y, but you don't know what the child really has, you don't know if the right diagnosis has been reached. With the vignettes, you know if the diagnosis is correct.”

– Donor

1.2 To what extent do stakeholders' perceptions align with those of the DHS Management Team both at USAID/Washington and at ICF?

Analysis of the data revealed several differences in perception between respondents from Washington, DC (specifically both ICF and the DHS management team at USAID/Washington) and other stakeholders. First, in Washington, USAID and ICF expressed their belief that the SPA would have more value if it were standardized globally, with global indicators. For stakeholders based in countries (USAID Missions, ministries of health, and donors based in-country), however, the SPA should first prioritize meeting country needs and facilitating comparisons between in-country sub-national units and over time. Global standardization is of secondary importance to them. They also did not feel restricted in their use of the SPA by its lack of global indicators. Second, Washington-based staff perceived that Missions receive information about the SPA from ICF staff who travel to countries to support the DHS survey. USAID/Washington has used the standard channels to share information about the SPA with USAID Missions and ICF told the evaluation team that, when ICF sends a DHS team, this team also speaks to Missions about the SPA. However, the data collected in this evaluation reveals that Missions are less aware of the SPA than previously thought. Of the five USAID Missions interviewed that had not conducted a SPA, most (Liberia, Nigeria, Zimbabwe, and Cambodia) said they had not heard of the SPA or knew very little about the SPA prior to making other decisions about HFA. One asked to be connected to the “right people” so they could learn more and evaluate its possibilities for their country. Third, Washington-based staff believed that linking DHS and SPA is very important, yet among stakeholders, we found that only researchers cared about this link. Others could understand the concept but did not see it as necessary to their current use of the data. Fourth, Washington-based staff believed that Missions buy into SPA because they understand the value of the SPA, when in fact, the full value of the SPA is often not communicated or absorbed. For example, few understood that the four modules of the SPA are interconnected. Missions and country-based stakeholders are often aware mostly of their immediate critical need that can be met by the SPA (for example, a master facility list or an

Figure 3: Perception of the Quality of SPA Process and Data (rated on a scale of 1-10)



inventory). The fifth difference has to do with perceptions along the continuum of implementation of the SPA (see Figure 3). In particular, Washington-based staff perceived the conceptualization of the SPA more poorly than in-country stakeholders and donors, and both Washington-based staff and USAID Missions perceived data use as much lower than ministries of health and donors.

1.3 In countries that choose to implement HFA survey(s) (whether it is SPA or a different type of assessment), why do stakeholders decide to prioritize resources for facility assessment implementation?

Reasons for implementing a health facility assessment

Two main reasons for conducting an HFA were identified. The most common one from ministries of health was the need **to establish a baseline measure of readiness and quality of care**. Evidence for this comes from Kenya, Bangladesh, Nepal, and Haiti, among others. In Kenya, the upcoming SPA will serve as a baseline for the newly created 47 counties. While in Nepal, the hope is to do targeted district-based programming based on the results of their first SPA. In the upcoming SPA, Bangladesh will oversample NGO health facilities that are currently being transitioned into a more sustainable model of operation and the data from that SPA will further inform the implementation process of upcoming activities of both USAID and the MOH. USAID also relies on SPA data **to design interventions**: the Missions in Bangladesh and Tanzania are two such examples.

Reasons for not implementing a HFA

Missions that do not implement the SPA or other HFAs say it may be because the country has not made any improvements to report on or assess, or that **funding is not available** for such an exercise

(Guatemala, Liberia). In some other countries, however, often the **timing of when the data**

"We are very focused on the implementation of our program. The purpose [of an HFA] is less to track overall functioning of the health facility and more to report on indicators we have identified"

– USAID Mission that dropped SPA

will become available is not conducive to their needs, and at times there is also a misalignment of priorities.

1.4 What are reasons for selection or non-selection of SPA in place of another type of HFA?

The team found that there were four kinds of countries. In countries that have institutionalized the SPA (Tanzania, Kenya, Bangladesh, Senegal, and Haiti), the data from the **SPA are being integrated into donor**

funding plans (Senegal) and **government M&E frameworks** (Bangladesh), and being used to **steer project implementation** (Haiti, Tanzania, and Kenya). In countries that did one or two SPAs and then stopped (Rwanda, Guatemala) **the data were either discredited or were undervalued and not used**. For example, in Rwanda, availability of soap was defined differently by the SPA team (liquid soap) than by the country (bar soap). At the time the SPA was conducted, most facilities had bar soap, but drainage of sinks in many health facilities was not working. Health staff would go outside, find a spot where they could use water, and wash their hands with bar soap. When the results came out that 50% of the facilities did not have soap, many would not accept it. Results like these, plus the fact that it was perceived as labor extensive and expensive, all led to discrediting the SPA.

“DHS is not selling itself well for SPA. We didn’t know about this – we were involved with the DHS survey, but didn’t know about SPA. It is a missed opportunity”

– USAID Mission that never implemented a SPA

In Guatemala, the data were undervalued and not used, and the sentiments were captured in this quote: *“Probably the main reason why Guatemala did not do another SPA was the fact that the government has not taken strategic actions to improve the infrastructure, equipment and supplies for the public sector,”* (USAID Guatemala).

In Jordan, the USAID Mission had extra funds left from the DHS and began discussions about conducting a SPA to inform the design of a new intervention about a year and a half ago. A couple months into planning, however, the Mission canceled the SPA. During the interview, the Mission gave several reasons for their decision to cancel. First, after a couple of months into the process, the Mission realized that **the SPA was going to take too long**, and the timing was not going to work out. *“There were delays in implementation, the timeline kept slipping, we realized after a couple of months into the process, after a couple of visits from the ICF team, that it would take over a year to get useable results. We were under pressure to move forward with our project design, we had to move more quickly. We couldn’t wait for a year to do our design. So we decided to go ahead with our own project design and award process and implementation, essentially by building our facility assessment into the design of our assistance package. So the survey was done as part of the project,”* (USAID Jordan). Second, the **Mission also realized that they would have to support the process far more than they were able to** and decided it was not worth the amount of time they would have to put in to it. A third reason had to do with the context of healthcare within Jordan and how **difficult it would be for an external partner to build the coalition needed** to conduct a meaningful SPA. To put it in the Mission’s own words, *“it’s hard for an external partner like ICF to send people to a country like Jordan—people who have no relationship with a country—for a couple of weeks per visit and expect that they will understand the landscape and understand the context and build a coalition. It’s a political process that depends on relationships. ICF staff didn’t have that specific skill set or set of relationships.”* When the evaluation team pressed the Mission about its perception of its own role in the coalition building process, they acknowledged

that indeed the Mission has an important role to play, but that their lack of understanding of what was needed for a successful SPA made it more challenging. The Mission felt they needed to be more informed by the ICF team. Finally, the Mission really wanted to focus on maternal and child health (MCH), and conduct a very thorough analysis that included some questions not answered by the SPA. Specifically, these include client flow, access groups, flow of services, missed opportunities, and dropped or missed services, all within the context of a country (Jordan) that has a fairly developed health system but is in the midst of an influx of refugees from Syria. The Mission was quite satisfied with their option to not go with the SPA and to integrate this baseline within the project itself. *“The project itself is founded on this very thorough facility assessment that we commissioned and built into the project activities, HWs [health workers] at each facility made a plan for change, it is an integrated service delivery improvement collaborative, facility-driven improvement approach. The way that we did the facility assessment was the best way to go in our context, that way we weren’t relying on how an external expert said things were, it was better for us than the SPA,”* (USAID Jordan).

Some respondents from countries that have never conducted a SPA (e.g., Nigeria, Liberia, and Zimbabwe) were not at all familiar with the SPA nor **did they know that it was part of the suite of activities of the DHS-7 program**. They also mentioned constraints due to timing, funding, lack of flexibility of the SPA to meet their current needs, or the fact that there are other HFAs being implemented that are meeting the needs of the MOH.

EVALUATION QUESTION 2: HOW ARE SPA DATA BEING USED AT GLOBAL AND COUNTRY LEVELS?

The second evaluation question was “How are SPA data being used at global and country levels?” The question was further delineated to address four distinct aspects of data use. Based on data from respondents, a summary of findings for the following four aspects of SPA data use are presented below:

- | | |
|--------------------------------|---|
| Evaluation Question 2.1 | Examples of SPA data use |
| Evaluation Question 2.2 | Examples of missed opportunities for SPA data use |
| Evaluation Question 2.3 | What are the perceived challenges in using SPA data? |
| Evaluation Question 2.4 | What are perceived opportunities to increase use of SPA data? |

Key Findings: Evaluation Question 2: How are SPA data being used at global and country levels?

- 1. Examples of SPA data use:** Stakeholders have used SPA data in a wide variety of ways at global and country levels. This includes informing policy, guiding planning activities, advocacy for fundraising and targeting resources, analysis to establish benchmarks and measure progress over time, identifying gaps in health service delivery, guiding intervention design, managing and evaluating programs, training analysts in the use of SPA data, supporting efforts to increase government accountability, and conducting and publishing research studies.
- 2. Examples of missed opportunities for SPA data use:** Respondents stated that missed opportunities to use SPA data at the global level are due to factors that include a lack of awareness regarding the existence of SPA data, a tendency to undervalue data that measure inputs, processes and outputs (i.e., the type of data that SPA produces), and a failure of some professionals to make use of available SPA data. Missed opportunities at the country level include underuse of data and information from the SPA, delays in releasing SPA data and reports (that have resulted in SPA data not being used for planning), and the failure to adequately associate data from SPA and DHS surveys in countries where the two surveys have been conducted close in time to each other.
- 3. Perceived challenges in using SPA data:** Global-level stakeholders noted that challenges in using SPA data include a relative lack of data (few SPAs have been conducted) and a dearth of analysis tools specifically designed to analyze SPA data. Country-level stakeholders stated that challenges to using SPA data include lack of familiarity with the SPA and the data it produces, a tendency for some officials to disown or distrust SPA if they show unfavorable results, the perception that SPA data can become dated quickly, and difficulties in making SPA data understandable to users of the data. Respondents also noted that SPA data are presented in reports in ways that can make using them for program management a distinct challenge and that translating SPA results to use in managing programs is challenging for many program managers and officials.
- 4. Perceived opportunities to increase use of SPA data:** Themes regarding how respondents perceive that the use of SPA data might be increased include: increasing investment in the SPA and creating new paradigms for supporting the SPA; strengthening awareness and marketing of the SPA and dissemination of SPA results; creating slimmer, more useful SPA products; clarifying responsibilities with regards to data use; and continuing and expanding activities to train users of SPA data.

2.1 Examples of SPA data use

The different ways that SPA data are used have been grouped into 13 categories. The inclusion of an example of data use means that it has been used at least once and does not imply widespread use. Examples of data use at global level are followed by examples at country level.

Global level

SPA data have been used at the global level by a consultant working with United Nations agencies to identify bottlenecks in health service delivery, which in turn has been used to **advocate** for investment from a global funding source. SPA data have formed the basis of **global and regional analyses** in a number of ways by personnel from US Government and UN agencies, including: analyses of quality of care;

“We use SPA like a cheat sheet with so much of our work. We keep using it to help develop workplans and hone in on all the bottlenecks. All of us use it to influence and persuade, it's like data from DHS, we use it as a benchmark for where we want to go. We also use the data to talk to USAID/Washington about where the problems are.”

– USAID Mission

comparison of government services vs. faith-based organization services; development of more informative measures of coverage (e.g., effective coverage); use of SPA indicators by the Mission in Senegal to analyze regional performance for USAID planning purposes; and thinking through priorities regarding provision of support for health service delivery programming. Respondents noted that the U.S. Centers for Disease Control and Prevention (CDC) and UNICEF both use SPA data to assess **quality of care**. Universities and other organizations use SPA data to **conduct research and publish** on

various topics at the global level. Compared to earlier years, the number of articles referencing the SPA has been increasing since 2011 (see Table 2). **Other uses of SPA data** that were reported included using SPA tools as a resource for the development of derivative survey tools.

Country level

SPA data have been used at the country level to **influence policy** in Bangladesh and in Kenya, where SPA data were used by the First Lady to increase access to maternal delivery services. The development of policy briefs is an increasingly common method for using SPA results and has been employed in Nepal, Kenya, and Bangladesh. Mission representatives noted that they support the **use of SPA data for planning** as part of a larger effort to have government decision-making processes be data-driven. They stated that SPA data have been used to identify problems

Categories of data use

Policy	Evaluation
Planning	Quality of care
Advocacy	Training
Analysis	Promoting accountability
Identifying gaps	Research and publications
Designing interventions	Other
Program management	

Table 2: Number of articles in PubMed Central referencing “service provision assessment”, January 1, 2000 – June 1 2017

Year	# of citations	Year	# of citations
2017	18	2008	3
2016	28	2007	0
2015	29	2006	3
2014	19	2005	0
2013	22	2004	0
2012	9	2003	1
2011	7	2002	0
2010	0	2001	0
2009	3	2000	0
Total	135		7

Note: citations for 2017 are through June 1, 2017

and gaps, at times by linking SPA results to government standards for human resources and equipment. This then provides an empirical basis for planning-related discussions and guides investment decisions. The Government of Bangladesh uses SPA data and indicators to set targets and measure progress for various planning documents, including the Program Implementation Plan for the health sector, while the MOH and Mission there both use SPA data when developing workplans and budgets. A UN agency used SPA data for **in-country advocacy** to raise funds, noting that no donor will listen to you without evidence. Similarly, the Kenyan MOH used SPA data to advocate with partners to target resources.

Both the MOH in Kenya as well as the Mission in Bangladesh **use SPA data** to establish benchmarks and, following the completion of the upcoming SPAs, to show trends over time. The SPA was cited by country-level stakeholders in Bangladesh, Kenya, and Tanzania as a reliable, trustworthy source of information **to identify health service gaps**. The MOH and its partners in these countries used SPA measures to identify weak areas and “low-hanging fruit” where service readiness could be easily improved. The 2014 Bangladesh Health Facility Survey (SPA) showed low levels of in-service training among health staff, which led the Mission there to support the development and implementation of a program to conduct training activities. Another use of SPA data is to **design interventions**. Missions in Bangladesh, Haiti, Kenya, and Tanzania have used SPA results to inform design for programming led by implementing partners. A respondent from one Mission reported plans to oversample one group of facilities in the upcoming SPA to provide data for intervention design in the future. A donor agency in Kenya noted that it used SPA data when mobilizing resources for proposed interventions.

The use of SPA data for **program management** and evidence-based decision-making was cited by the MOH in Bangladesh as filling a critical need. The Ministry also noted their focus on improving the quality of data for use in program management and the role of the SPA in that effort. Data from the SPA in Bangladesh have been used for **evaluation** of the MaMoni Project. The Mission in Bangladesh has included SPA indicators in their results framework to evaluate their overall efforts. The Government of Bangladesh uses SPA data and indicators to evaluate performance of long-term plans. SPA data are used in **trainings** of data users that ICF has conducted at regional and country levels. A respondent in Kenya noted that SPA data have been used in workshops that have been conducted there to teach report writing and that Kenya also has used SPA data from patient-provider observations in continuing medical education and in-service training activities to show health workers

“Key issues in SPA data are human resources, commodities and equipment. There is a need to support the government to have an action agenda; the SPA helps us to do that.”

– USAID Mission

“SPA is better positioned than other surveys to promote accountability because it focuses on service provision as a whole. It includes aspects of quality that are not part of SARA, such as client rights, which makes it better for accountability. WHO's focus is very much on clinical aspects of care.”

– USAID/Washington

(HWs) and medical students where most mistakes are made when providing specific services. SPA data have been used by a donor to raise issues of **accountability** with the government, as it allows donors to discuss not only presence of HWs but also their readiness to provide services. Several respondents noted that SPA can be used as an external measure of accountability by validating internal government measures such as the HMIS. In Nepal, stakeholders compared data on stock-outs of commodities as measured by the SPA with the

same indicator as measured by the government Logistics Management Information System and noted discrepancies between the two data sources. In Kenya, immunization data from the District Health Information Software (DHIS) are compared against the SPA data routinely, despite the fact that the most recent SPA was conducted in 2010. Journalists also used SPA results to promote accountability; in Nepal, the publishing of SPA results in leading newspapers triggered a public discussion of the status of Nepal's health services. At the country level, academics and students use SPA data to **conduct research and publish** on various topics. Research institutes and universities in Haiti and Kenya have used SPA data as reference materials for teaching students.

The evaluation team conducted a literature search in PubMed Central to characterize the use of SPA data in the published literature. The search term "service provision assessment" was used across all articles from 2000 onwards. Table 2 above shows the number of citations listed in PubMed Central per year from January 1, 2000 until June 1, 2017. The trend for use is clearly increasing and has risen markedly beginning in 2013.

The team also took the 10 most recent citations from 2015, 2016, and 2017 and characterized them in terms of how the SPA was referenced or used in each publication. The results of this analysis are presented in Table 3 below.

Table 3: Characterization of how SPA is referenced in citations in PubMed Central

Categories of use	2015	2016	2017	Total
SPA data used in study				
Manuscript based on analysis that uses SPA data	3	3	5	11
SPA report cited or SPA referred to				
Manuscript cites SPA survey report	3	2	1	6
Manuscript cites other manuscript or document regarding the SPA	1	2	1	4
Manuscript refers to SPA initiative without citation	1	2	0	3
Other use of SPA product				
Manuscript describes study that uses SPA master list of facilities	0	0	1	1
Manuscript describes study that adapted and used SPA questionnaire	2	0	1	3
Manuscript used other information from SPA	0	1	1	2
Total	10	10	10	30

Note: One study from 2015 did not include any reference to the SPA and was replaced in the analysis.

The team's review of how SPA data are used or referenced in the literature shows that the most frequent uses of SPA are (1) to analyze SPA data and report the findings and (2) to cite a SPA survey report or other document that references the SPA. Other published studies reported using the SPA master list of facilities and adapting and using the SPA questionnaire.

A number of **other uses of SPA data** were shared by respondents. The master list of all health facilities that is sometimes prepared as part of the SPA to use as the sampling frame represents the best listing of health facilities in some countries and was used in Haiti as the sampling frame for another survey of health facilities. The MOH in Kenya reports that SPA inventory data have been used to resupply health facilities; data from the health worker interviews have been used to plan trainings; and data from observations have been used as the

best available measure of quality of care. In Bangladesh, building on problems identified through the SPA, the MOH conducted a systematic census and mapping of all union-level facilities, collected new data from all these facilities, graded them, and used the data to target the weakest facilities for support.

2.2 Examples of missed opportunities for SPA data use

The evaluation collected information from respondents regarding their perceptions of missed opportunities to use SPA data at global and country levels. Findings are summarized below.

Global level

Respondents noted a **lack of knowledge and awareness** among some key public health professionals at the global level regarding the existence of the SPA, the data that it generates, and how those data can be used. Respondents felt that a missed opportunity derives from a general preference among public health professionals for outcome and impact-level data from household surveys, and a resultant tendency to **underuse and undervalue data on inputs, processes, and outputs** that the SPA provides. Other respondents noted that they were aware of good data on quality of care and malaria from SPA surveys but that they have **not made use of available data**. Finally, one respondent felt that **not loading SPA data into STATcompiler** was a missed opportunity to encourage use of SPA data.

Country level

Respondents cited the **underuse of data and information from the SPA** as a central missed opportunity. Respondents from nearly every country that has conducted an SPA recently noted that data stay at the national level and that peripheral level workers do not have access to information from the SPA. It was felt that tools to make the data more useful, such as policy briefs, are underused and that secondary analysis of SPA data has not been pursued adequately, reflecting a preference of local researchers for conducting research using population-based data. One respondent noted that USAID could do more to encourage USAID-funded projects to use SPA data, similar to the way that USAID encourages projects to use DHS data. **The failure to adequately associate data from the SPA and DHS surveys** that have been conducted close in time to each other in countries such as Senegal was felt to be another missed opportunity. **Delays in releasing SPA data and reports** have resulted in missed opportunities to use the data in planning and intervention design in Bangladesh and Nepal.

2.3 What are the perceived challenges in using SPA data?

The evaluation also explored respondents' perceptions with regards to challenges they or others faced in using data from the SPA. Their perceptions are grouped by challenges at the global and country levels.

Global

Respondents cited two significant challenges to using SPA data at the global level. The first was the relative **lack of data**, as only a small number of countries have conducted SPAs.

"We had the raw data, and those data were used to form aggregate indices, but the aggregate indices were not very helpful. The SPA report is full of indices. We had to go into the raw data because some components are not applicable to our health system. It's an example of where the boiler-plate approach of the SPA is not appropriate at the country level."

– Implementing Partner, Country-level

The second was a **lack of analysis tools** (such as STATcompiler) to facilitate cross-country analyses.

Country

Respondents noted that a **lack of familiarity with the SPA** represents a challenge to its use.

Awareness of the SPA is low among the public health community and, when SPA data are quoted, people often do not recognize the source. This challenge extends to using SPA data; one respondent noted that people resist change and that learning how to work with data on inputs and healthcare processes represents a

“A basic challenge is understanding the data. How do we present the data in a way that is acceptable, make it understandable, so that it can be absorbed?”

– Mission Representative

change for many professionals. Another challenge is that officials may **disown or distrust the data** if they do not represent their interests or if the results differ from what they expected.

This is related to another challenge, which is that **SPA data can become dated** rather quickly: indeed, if SPA results are released a long time after data were collected and the results reflect negatively on certain organizations or individuals, doubt may be cast on the findings by stating that the data do not reflect the current situation. Information managers and

communication experts noted that **making SPA data understandable** to potential users of the data is a major challenge. They report that SPA reports are dense, long, and that results are hard for many users to remember.

The way that SPA data are presented and some indicators are defined

presents an additional challenge. One respondent from an implementing partner noted that the way SPA data were framed

“There is no end to how much data there is. Our strategy was to look at the SARA indicators and stick to them. We distill things down, try to find a word that sticks. We talk about readiness for deliveries. ‘Readiness’ is a word that sticks.”

– Mission Representative

and presented in the report were not helpful to his work and that he had to pull data out of tables and present them in a new format to make them understandable to partners. Similarly, the emphasis on indices in the SPA report created challenges as some of the components of the indices were not relevant to the country’s health system, resulting in index values that were artificially low and lacked meaning. A respondent from Rwanda noted that some of the standard indicator definitions in the SPA were not applicable to the country’s context; for example, the use of bar soap at health facilities in Rwanda is standard, while the SPA asks to note the presence of liquid soap. This resulted in low values for indicators that measure handwashing and infection prevention in health facilities that did not reflect the reality of that country. A respondent from Bangladesh felt that some service indicators included data from facilities that normally did not provide that service, thus driving down the value of the indicator and presenting an inaccurate picture of the situation. Another challenge is **translating SPA findings to use**. Several respondents noted that it is difficult not only for managers to understand the report, but also to determine what to do once handed the results, as they are not used to taking action based on results from a survey like the SPA. Another said that there is no system for training people how to use SPA data to make improvements.

2.4 What are perceived opportunities to increase use of SPA data?

The final aspect of data use that was explored by the evaluation centered on respondents' perceptions regarding opportunities to increase the use of SPA data. The findings below can be seen as recommendations from respondents for strengthening data use.

New paradigms and investment in SPA

Many respondents with a global perspective have cited the lack of standardized global indicators that measure various aspects of health service readiness, availability, and quality of care—and **the lack of requirements for countries to report values for these indicators on a regular basis—as a reason why there is not more demand for surveys such as the SPA.** Agreement on a set of such indicators has remained elusive despite significant efforts over the past decade by various organizations. Efforts to develop standardized health facility indicators at the global level (and standardized survey instruments to measure them) are somewhat at odds with country-level needs for information regarding their own health systems, which tend to vary notably by country and often are not met by the standard SPA questionnaires. Responding to this issue, some respondents suggested that ICF and the DHS management team change direction, stop focusing on standardizing the SPA across countries in pursuit of a global standard, and instead **focus more on country-level information needs** and dissemination of results at lower levels of country health systems. This would enhance use of the data and give a more accurate, relevant picture of the health system than that which is generated through a standardized global questionnaire. Another respondent felt that there was a significant opportunity to build on the model used by the Mission in Bangladesh with the MaMoni project and **encourage Missions to incorporate SPA surveys into intervention design, project management, and M&E** activities for Mission-funded programming. Some respondents felt that **investment in the SPA should be increased** by directly funding additional SPAs as well as through support for strengthened dissemination and data use, which would further establish the SPA and create greater demand for SPA data.

Awareness, marketing, and dissemination

Respondents felt that raising awareness regarding the SPA, advocating for and marketing its use, and disseminating results of SPAs are opportunities to increase the use of SPA data. They felt that **awareness regarding the SPA should be increased at all levels:** global, national, within departments at MOHs and among directors and administrators of health services, and at regional and district levels. Some respondents said that use of SPA data could be increased by **raising the profile of the SPA and other health facility survey platforms** and working to include SPA indicators in key documents, such as USAID's Report to Congress or the UN's Sustainable Development Goals (SDGs). Once awareness has been raised, it was felt that **the SPA needs to be marketed more effectively.** As one respondent stated, *"I need to know that something exists before I will want to use it."* Another respondent suggested **promoting experience-sharing among countries and organizing observational visits** from countries that are considering implementation of a SPA to countries that have conducted one. Regarding dissemination, a respondent suggested that **countries should develop a communication plan** that facilitates informing all relevant stakeholders about the results of the SPA and showing its usefulness. It was felt that **dissemination should be more targeted and strategic** and should reach lower levels of the health system. Finally, it was felt that the **timing of the release of SPA results should be optimized so that it meets needs for**

planning. Late dissemination of reports in Bangladesh and Nepal resulted in missed opportunities to have SPA data inform planning activities.

Create slimmer, more useful products

Many respondents spoke about the difficulty of reading and understanding SPA reports. Indeed, ICF and its partners have made many efforts to make SPA data more accessible and

“There is a need to make the [SPA] survey report more user friendly. We need a one or two-page summary of key issues for the policy makers, a policy brief, something that makes it all a bit simpler for the Ministers and others, maximum 2 pages, with key messages.”

– MOH Official, Country with SPA

understandable, including production of different types of reports, flyers, and videos; adding graphs to tables; and redoing the key findings report (in Malawi) by adding icons and groupings to make it more user-friendly.

Continuing in this vein, some

respondents felt that **efforts should**

continue to develop simpler, more absorbable products, such as service-specific briefs and divisional reports, perhaps in lieu of the standard final report. Another respondent cited the need for **support for in-country use of data** in the form of “a person or organization that knows data analyses, health programs, and health

services and who can figure out how to use the data in order to provide useful information that monitors progress and shows changes over time and provide recommendations, all the while

working with the country to understand the context.” Some respondents felt that more could be done to **demonstrate how SPA data can be useful**, such as using SPA data to improve stock-out issues, develop a facility dashboard or report card that can be used to give feedback to individual facilities, or showing donors how problems can be identified using SPA data so that they can direct their inputs.

“The SPA needs to be pared down. It’s a behemoth.”

–USAID/Washington

Identifying responsibilities with regards to use of data

While it is clear that the responsibility for implementing the SPA and processing and analyzing the data is shared between ICF and the in-country agency that conducts the survey, in many countries it is not clear how use of SPA data can best be supported or who should support it. Some respondents felt that it would be helpful to **clarify who or which organization is responsible for making data easier to use** and helping stakeholders use it. Several respondents suggested that **responsibility for data collection and analysis should be separated from responsibility for supporting use of the data** and that these functions should be performed by different organizations. It was also felt that the capacity of sub-national HWs and institutions to use SPA data should be strengthened.

Trainings and workshops

It is recognized that a substantial amount of effort has already taken place to conduct trainings and workshops to support the use of SPA data, such as data-to-action workshops and data analysis workshops at country (Bangladesh, Egypt, and Malawi) and regional levels. Respondents did note that there is a need to **continue and expand activities to train users of SPA data** in use of the data and further analysis.

EVALUATION QUESTION 3: WHAT ARE USAID’S AND ICF’S PERCEPTIONS ABOUT OPPORTUNITIES AND CHALLENGES IN FACILITATING SPA IMPLEMENTATION?

The third evaluation question was “What are USAID’s and ICF’s perceptions about opportunities and challenges in facilitating SPA implementation?” The question, the results of which are presented below, was further delineated to address eight distinct aspects:

Evaluation Question 3.1	The level of USAID’s investment in SPA (funding amount, types of investments, USAID staff level of effort)
Evaluation Question 3.2	The level of ICF investment in SPA (staffing levels, skills, level of technical assistance required)
Evaluation Question 3.3	USAID and DHS Program interest in promoting, facilitating SPA implementation
Evaluation Question 3.4	The future direction of HFAs, including and beyond SPA
Evaluation Question 3.5	Areas for SPA improvement (tools, processes, products)
Evaluation Question 3.6	Areas for SPA improvement under the control of USAID and/or ICF
Evaluation Question 3.7	Opportunities for coordination of the DHS and SPA
Evaluation Question 3.8	ICF’s relationship with Missions and other stakeholders as related to SPA implementation

While the question asked specifically about USAID and ICF perceptions, the team thought it might be useful to also obtain the perception of other stakeholders on sub-questions 3.4 and 3.5. Sub-question 3.7 also includes views from SPA implementing agencies in country.

Key Findings for Evaluation

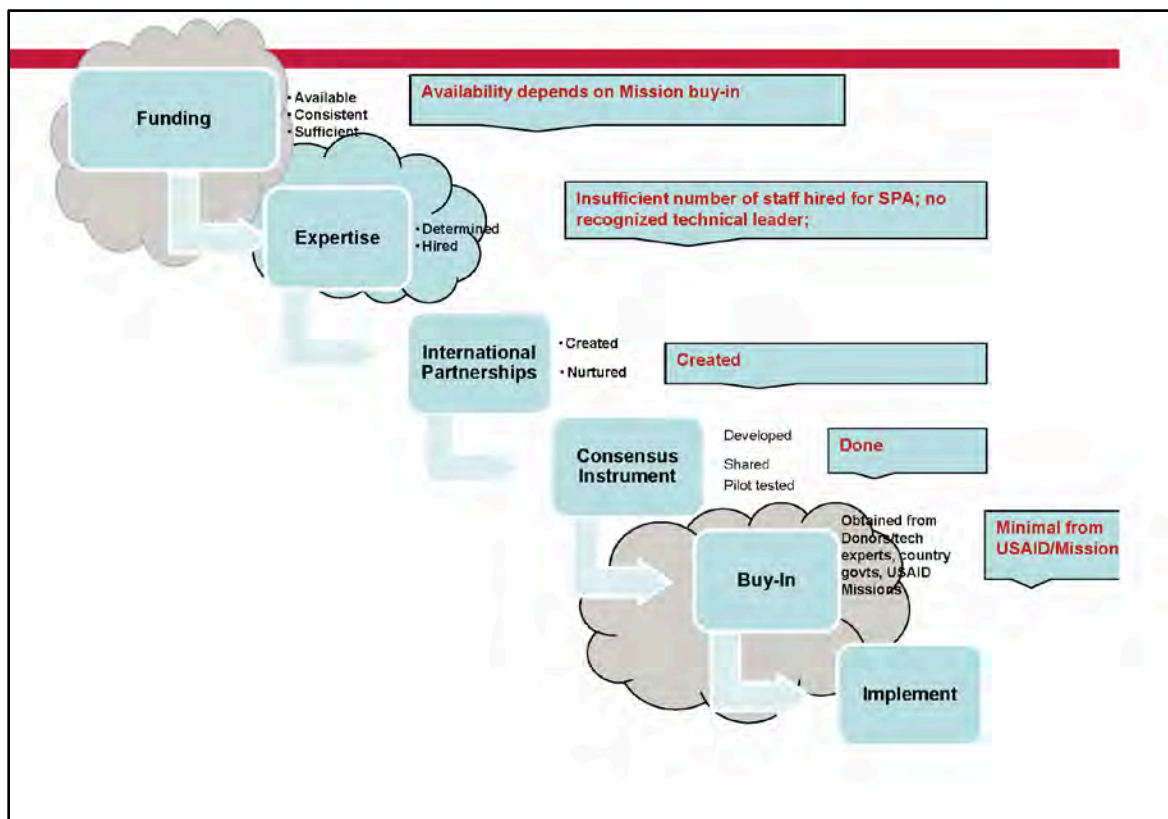
Question 3: Challenges and Opportunities in Facilitating SPA Implementation

1. **Level of USAID investment in SPA:** SPA implementation is financially dependent on USAID Mission buy-in. Mission buy-ins remain minimal, however, resulting in a lack of accountable and focused funding for the SPA. Once a Mission buys-in, and the SPA moves forward, the funding for implementing most of it is sufficient. Stakeholders expressed the need for additional resources for dissemination.
2. **Level of ICF investment in SPA:** The quality of staff from ICF that focuses on the SPA was deemed to be sufficient, though the quantity of staff or the amount of staff available was not viewed as sufficient by some stakeholders. A number of countries expressed that the technical assistance they receive from ICF for data analysis was insufficient, yet this is the area where they most need support from ICF for the SPA.
3. **USAID and DHS Program interest in promoting, facilitating SPA:** ICF is interested in keeping the SPA within the DHS Program portfolio and would be interested in doing many more SPAs should funding become available. USAID/Washington remains interested in continuing to support the SPA initiative. Both ICF and the DHS management team were in agreement that leveraging the expertise and experience of implementing national level surveys was the major benefit of keeping SPA and DHS together.
4. **Future direction of HFAs:** The team found that demand for HFAs has grown and other HFAs, like the SARA, SDI, and SDP are being completed more often than the SPA. In 2016, 12 SARAs and 20 SDPs were conducted, while only 2 SPAs were completed during that same time period. Globally, there is significant respect for the data collection process and reliability of SPA data. Donors, including USAID, agree that there is a need to move toward having a lean core set of questions, with additional options added in a modular approach with the belief that this might facilitate a more flexible approach that meets country needs.
5. **and 6. Areas for SPA improvement, including those under control of USAID and ICF:** Interviewees suggested that the SPA approach and tools should be slimmed down and made more flexible; advocacy for the SPA and dissemination of SPA results should be strengthened; the role of the MOH in SPA implementation should be increased; an overarching strategy for SPA data use at country level should be developed; efforts should continue to develop a core set of accepted global health service delivery indicators; and templates and guidelines for SPA products should be further developed and tested.
7. **Opportunities for coordination of the DHS and SPA:** Having both surveys managed by a single organization increases the potential for coordinating SPA and DHS. SPA and DHS data can be considered together during strategic planning with MOHs and their partners. Some respondents felt that the importance of coordinating the SPA and DHS has been overstated and is more appropriate for research than program management.
8. **ICF's relationship with Missions and stakeholders:** All stakeholder groups spoke positively about their relationships with ICF and the expertise that ICF brings to the support that they provide. Some respondents felt that ICF was over- or under-engaged in their support, highlighting different country experiences and the need for ICF to balance the level of their support dependent on local context. Some respondents felt that ICF should make a greater effort to engage the MOH in the implementation of the SPA while others noted the lack of MOH capacity in most countries to lead a survey effort. Some felt that ICF should be more flexible with regards to considering country needs in questionnaire design and analysis.

3.1 The level of USAID's investment in SPA (funding amount, types of investments, USAID staff level of effort)

At the beginning of our investigation, the evaluation team met with ICF and conducted an abridged version of a business process evaluation to identify the overall process that ICF employs when integrating a new component within the DHS Program. ICF has also integrated the Malaria Indicator Survey (MIS) into the DHS Program, as well as gender within the DHS questionnaire. Figure 4 shows the process used by ICF for integrating other components into the DHS Program. The steps with clouds behind them represent the areas for the SPA where the process did not go as usual. The team learned that several key components for this integration were limited, starting with consistent and sufficient funding. Currently, core funding from USAID/Washington supports initial discussions with Missions, but SPA implementation is financially dependent on Mission buy-in. **Mission buy-in remains minimal**, however, and lack of accountable and focused funding for the SPA is the main reason for ICF's inability to secure expertise dedicated to the SPA. Though ICF did hire staff to specifically focus on the SPA in the beginning, current staff are shared between the DHS and SPA since there was not enough work to do on the SPA and ICF could not justify fulltime pay for staff whose focus would be only the SPA. Some countries implementing SPA expressed concern that the staff is spread thin. Nevertheless, ICF successfully created and has nurtured a number of international partnerships and in 2012 obtained consensus on the SPA questionnaires used since then. Stakeholders interviewed in Washington and from countries, researchers, and donors all agree that the **SPA is conducted in too few countries and too infrequently to have the impact it could have**, although it is the highest quality HFA at the moment.

Figure 4. Process Analysis of SPA Integration into DHS Program



In addition to USAID Mission buy-in, other USAID investments that are perceived to be insufficient were highlighted. They include a **limited dedicated technical leadership from within USAID** with regards to the SPA. It was noted that the DHS-7 team of six has only one person who focuses on the SPA. While for other technical areas of interest the US Government will dedicate funds and personnel to develop indicators, as in the case of HIV Stigma and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), we did not see anything similar to that with the SPA. The USAID DHS management team also has limited time to strategically promote the SPA to colleagues and to Missions, which affects buy-in. As they are often asked by the GHB and Missions to not "sell" their projects or products to Missions, they will need to develop a robust and strategic plan for ensuring that Missions know about the SPA using existing channels like State of the Art (SOTA) Workshops, team teleconference calls, and perhaps by highlighting successes from countries that implement the SPA.

However, there are certain investments made by USAID that are deemed to be **sufficient**. USAID/Washington funded the **development of the SPA tools and methodology** and continues to fund development of **SPA standard recode files**, as well as **additional research and analyses of SPA data that fuels improvement in the SPA process** and within the larger health programs of USAID and donors. USAID Missions, once they do buy in, provide sufficient funding for implementation, though some question whether or not sufficient funds are set aside for dissemination of results. USAID Missions fund 41% to 100% of SPA implementation costs in country. They also take the lead in donor coordination around SPA implementation.

3.2 The level of ICF investment in SPA (staffing levels, skills, level of technical assistance required)

Similarly, ICF investments that are perceived as sufficient include the **quality of their staff**. The staff members that do focus on implementing the SPA were almost unanimously perceived to be highly skilled, though one country that implemented only one SPA did mention that ICF sent a very junior person to spearhead the implementation of their SPA and that this person, unsure of where to begin, made a few errors. Two other USAID Missions mentioned issues with communication related to lack of diplomacy among the staff sent. But, by and large, ICF SPA staff members were perceived to be professional and highly skilled in the area of survey implementation and the technical assistance they provide has been very well received. ICF staff play a major role in budget development, helping to legitimize budget line items particularly among the donor community. Donors interviewed all expressed a high level of respect for the technical abilities of ICF.

Nevertheless, as highlighted earlier, **the number of staff and the amount of time that ICF staff members have to invest in the SPA is viewed as insufficient** by some USAID

Missions. Some Missions expressed that their need for ICF support for the SPA was greater than for the DHS, yet the evaluation team notes that the DHS has more dedicated staff. SPA reports are produced one to two years after data collection, possibly in part due to lack of

"When we implemented the [SPA], there were three country managers from ICF throughout the duration of the survey, two were dropped and replaced, they kept changing. I think that ICF has staff shortages for the HFAs, two of the key positions are still vacant. It didn't affect our implementation much, but if they were fully staffed, we would have saved some time."

– USAID Mission with SPA

dedicated staff and/or to the back-and-forth that is often required with countries before the final product is produced. Contributing to that is the fact that there are not enough SPAs conducted per year to sustain a longer term investment in staff for the SPA. Our interviews revealed that the Harvard School of Public Health has developed software that can recode the SPA data and make it ready for analysis very quickly. In Ethiopia, respondents from Harvard said they were able to produce SPA-like data tables in two days. Innovations like this one could help to minimize the time delay for SPA results. The evaluation team did not get an opportunity to see the product and are not in position to say whether it is comparable to that produced by the DHS Program. ICF also does not appear to have a strategy for fully understanding country needs. This was played out in Jordan, and also in Rwanda, where the results of the SPA were not accepted by the MOH. In addition, the team found that in at least four countries where SPAs were done recently there was a reported minimum level of engagement with the MOH. In line with country constitutions or the normal way of work, local research firms, parastatal organizations, or even ministries are often hired to collect the data. However, particularly for the SPA, the ministry responsible for making changes based on the results is the MOH and their lack of engagement is negatively affecting the impact and use of SPA. ICF also does not have an overall strategy for data use that includes the various ways that data are currently being used in-country. A number of countries expressed that the technical assistance they receive from ICF for data analysis was insufficient, yet this is the area where they most need support from ICF for the SPA. And last, but not least, some Missions not currently implementing the SPA (e.g., in Liberia, Nigeria, and Zimbabwe) had not even heard about the SPA and concluded that ICF does not sufficiently promote the SPA when doing a DHS.

3.3 USAID and DHS Program interest in promoting, facilitating SPA implementation

In speaking with staff from both ICF and the USAID DHS-7 management team, it became apparent to the evaluation team that both ICF and the DHS management team were in agreement that **leveraging the expertise and experience of implementing national level surveys was the major**

benefit of keeping SPA and DHS together. USAID/Washington remains interested in continuing to support the SPA initiative.

“I am a believer in this. We need to do more. Our understanding of processes, which is a big step for improving them, is inadequate. We should be investing more in that area.”

– USAID/Washington Staff

Respondents who manage health programs could see its potential for helping them make decisions about their programs and they could also see its potential for monitoring progress towards strengthening health systems. The DHS management team was not certain of the best way forward, however, and was weighing the costs versus the benefits of continuing with SPA. USAID Missions currently implementing SPA were very interested in continuing with it, though some are waiting for guidance from Washington about how best to help countries either merge or select one HFA over another. Reactions from Missions that have not yet implemented the SPA were mixed. Some, such as in Liberia and Rwanda, were clearly not interested in putting funds into the SPA at this time. In Liberia, there is another HFA that is providing similar information and introducing the SPA to the MOH would add more confusion than value. Other Missions also felt that the SPA is not a good fit given what is happening in their country. In Jordan, the refugee situation is affecting the capacity of health facilities, yet the

comprehensiveness of the SPA, coupled with how long it would take to produce data, made it not conducive to meeting the needs of the Mission. Cambodia and the Philippines have already established HFA processes and would not find SPA value-added. Another group of Missions (e.g., Guatemala, Nigeria, and Zimbabwe) are interested in considering the value that the SPA could add to their current portfolio of health activities. Funding the SPA would be difficult for the Guatemala Mission. As for ICF, staff managing the DHS were **interested in continuing with the SPA, see it as a good complement to the DHS, and would respond positively to additional Mission buy-in**. However, they would like to focus additional resources on dissemination.

3.4 The future direction of HFAs, including and beyond SPA

In discussing the future direction of HFAs overall, we note that **demand for that type of data is growing** and that, compared to the SPA, some of the other platforms have been doing better at meeting that demand.

For example, in 2016, 12 SARAs and 20 SDPs were conducted, while only 2 SPAs were completed. The World Bank has plans to conduct 25 SDIs in the next three years in Africa. During that same time period, if SPA

“I think SPA is gaining in importance and recognition, like DHS did. We are now planning our next SPA, taking a similar approach to the last time. It will eventually become popular. When the officials talk about the system, the SPA gives them data to talk about. People who are working on quality of care talk about the SPA quite a bit.”

– USAID Mission with SPA

continues as it has in the past, there will be a lot fewer SPAs completed in comparison.

While funding for SPA within USAID remains uncertain, globally, there is **significant respect for the data collection process and reliability of SPA data**. Donors, including USAID, agree that there is **a need to move toward having a lean core set of questions**, with additional options added in a modular approach. Some donors, including some USAID Missions and international technical advisors, are in agreement with HFAs being more **based on country needs** and thus favor an increased **flexibility for data collection** in terms of type, schedule, and amount as a way forward for all HFAs, including the SPA. In addition, the need to **link HFA efforts to continuous quality improvement efforts** is important, as expressed here:

“It is very important that improvement be part of the SPA process – this is critical, especially for health workers. They really need to see this as just part of an effort to do better. The message should be ‘there is an objective parameter of good healthcare called the SPA; we will make an assessment and provide you with what you need to improve.’ This is the message that healthcare workers should hear from their managers [MOH] and USAID.”

– USAID/Washington Staff

3.5 Areas for SPA improvement (tools, processes, products)

Evaluation question 3.5 asked what USAID and ICF personnel consider to be areas for improving the SPA with regards to tools, processes and products. Evaluation question 3.6 asks which of those areas are under the control of USAID and/or ICF. Results for these two questions, presented together, can be seen as internal recommendations for SPA tools, processes and products.

Tools: Some respondents felt that the **SPA approach and tools should be streamlined, “slimmed down,” and made more flexible.** Respondents

mentioned that the SPA should have a lean core module, based on a key inventory tool, and then have options for additional modules that countries can choose to select, noting that countries will have their own questions that they want to add. These respondents felt that ICF staff should offer countries an open, flexible approach to SPA design, including lighter version options and a modular approach.

“ICF’s message to countries should be ‘these are the options’ rather than ‘this is what we do.’”

– USAID/Washington

Processes: Many respondents felt that **advocacy for the SPA needed to be strengthened.** They said that USAID/Washington needs to do more advocacy for SPA to global partners, disseminating SPA findings through international workshops and forums, and also should market the SPA to Missions more forcefully, underpinning the marketing with information about how to use the data for decision-making.

“We don’t do any marketing of SPA to Missions at all. If we had a better strategy for data use of the SPA, and how to use that data for decision making in the country, we can market in a more justified way.”

– USAID/Washington

It was felt that Missions need to increase their in-country advocacy for the SPA across all stakeholder groups. Finally, some respondents felt that ICF should increase advocacy to both Missions and governments. They stated that ICF staff need to become more conversant regarding the SPA, should be trained how to help Missions understand what the SPA offers, and need to talk about it more when

ICF visit countries to support the DHS. Some respondents felt that **dissemination of SPA results could be improved** by going beyond the national level to reach users at lower levels of the health system. Others felt that more could be done to **give the MOH a greater role** in implementing the SPA; not necessarily in the collection and analysis of data, where respondents noted that the MOH often does not have adequate expertise, but rather in overall responsibility for managing the survey and greater participation in tasks such as questionnaire design. Some stated that the SPA could be improved by **increasing funding** for implementation, dissemination, and data use and for observational tours by countries that are considering implementation of a SPA. These respondents felt that lack of funding at country level hampers the use of the SPA. Some respondents suggested that greater effort should be made to **integrate SPA into USAID program cycles**, or even government programs. One respondent gave as an example the MaMoni Project in Bangladesh, where SPA results are used to identify problems, inform intervention design, and then measure change over time. Some respondents noted a **need for an overarching strategy for SPA data use** at the country level in order to address the gap in support for helping countries use data for policy and programs. They felt that stakeholders need help understanding how to best use the data and present it in a way that programs will find it useful. Others stated that the need goes beyond the country level and that donors and even USAID need support in making greater use of SPA data. Finally, some respondents noted that there is a **communication gap** between USAID/Washington’s efforts to establish a global role and niche for the SPA and health facility

“There is a gap between what USAID/Washington thinks the SPA should be and what Missions need. We need more communication between USAID/Washington, ICF, and Missions regarding what countries need would be helpful.”

– USAID/Washington

surveys versus what Mission's need from the SPA (i.e., country-specific information that can be used to guide policy and programming).

Products: Respondents noted the importance of **developing a core set of accepted global health service delivery indicators** to create demand for data from health facility survey platforms such as the SPA. Respondents proposed different ways to develop such a set of indicators that include (1) linking SPA indicators to key indicators from the DHS household survey; (2) requiring Missions to report health service indicators for use in USAID's report to Congress; and (3) incorporating health service/SPA indicators into the SDGs. Respondents also noted that effective use of data is often linked to how it is presented to potential users. Respondents felt that the SPA could be improved by **developing and strengthening templates and guidelines for products** (such as policy briefs, summary findings, and action points for different components or modules) and talking points that can be used to present SPA data in such a way that it is more accessible, absorbable, and usable. Finally, several respondents suggested that **SPA data be added to STATcompiler** in order to increase its visibility and use.

3.6 Areas for SPA improvement under the control of USAID and/or ICF

The findings presented above for question 3.5 were discussed with USAID and ICF prior to the finalization of this report. There was general agreement that greater effort should be made to raise awareness regarding the SPA within USAID and with USAID partners and to advocate for and create demand for the SPA. It was also recognized that the MOH is the ultimate user of SPA data and represents a stakeholder group that USAID and ICF want to fully engage. USAID has long been engaged in efforts to develop a core set of accepted global health service indicators.

USAID and ICF both have significant roles to play with regard to other issues that are presented in question 3.5, such as streamlining the SPA approach and tools; developing an overarching strategy for SPA data use; strengthening the dissemination of SPA results as well as templates and guidelines for products; and adding SPA data to STATcompiler. USAID alone has control over additional issues that were raised, such as increasing funding for SPA implementation, dissemination and data use; integrating SPA into the USAID program cycle; and working to harmonize USAID/Washington's vision of the SPA with what Missions need from the SPA.

3.7 Opportunities for coordination of the DHS and SPA

Respondents from ICF and USAID were asked how the SPA could be improved through coordination with the DHS. It was noted that **having both surveys managed by a single organization**, as ICF now manages both the DHS and SPA, increases the ease of establishing linkages and conducting analyses using the two surveys. The SPA and DHS surveys must be conducted relatively close together timewise within a single country if they are to be co-analyzed; **respondents from some countries stated that they had the capacity to conduct DHS and SPA surveys simultaneously** (e.g., Haiti and Senegal), while respondents from other countries said that only one of the surveys could be conducted at any given time.

A number of analytical studies using DHS and SPA data have already been conducted. In addition to the complex analyses that these studies have conducted, one respondent felt that there was an **opportunity to bring SPA and DHS data together for use in strategic planning with ministries of health**: not necessarily through detailed quantitative analyses, but rather by putting the results from the two surveys next to each other and looking at how the results, taken together, might help officials to better understand the situation and decide on future actions and policies. Another respondent felt that **selected indicators from the SPA could be matched or related with key indicators from the DHS** in order to demonstrate the relationship between inputs/processes/outputs and outcomes/impact and thus better relate the two surveys.

“[Interest in linking DHS and SPA] comes mostly from researchers. I don’t hear about this issue from program people. It’s not a big part of the conversation in our country.”

– USAID Mission Respondent

Some respondents at both the global and country level pushed back regarding the perceived importance of coordinating the SPA with the DHS. Respondents at country level did not have a strong grasp of the potential for linking the surveys. Some felt that **SPA-DHS coordination was more applicable to research than for use managing programs**. A global-level respondent felt that **SPA data are important enough to stand on their own**; that “processes and inputs are important, and we understand enough about healthcare processes to be able to say this is the goal, (we) don’t need to link data like SPA data to impact data.” One respondent felt that the potential for linking the two was a promising opportunity, but that it **carried the risk of producing incorrect findings**, as it is based on the assumption that people living in a given area use the health facilities in that same area, which is not always the case.

3.8 ICF’s relationship with Missions and other stakeholders as related to SPA implementation

Respondents’ statements regarding ICF’s relationship with key stakeholders are presented below, grouped by ICF’s relationships with (1) USAID/Washington, (2) USAID Missions, (3)

“ICF has expertise in the subject of national surveys, they know every single detail. We rely on ICF staff, they are responsive to country needs, the [DHS] report is widely used, it is the main source of quality health information that we have. Something that is missing is that the government has not taken leadership in this process.”

– USAID Mission

host-country governments, and (4) general comments regarding ICF’s in-country relationships. With regard to **ICF’s relations with USAID/Washington**, respondent feedback was highly positive. ICF works closely with the USAID DHS management team, keeps them informed about all relevant matters, and is responsive to any issues that emerge. Some respondents within Missions and USAID/Washington

voiced frustration that ICF does not devote sufficient time to SPA. Respondents reported that **ICF’s relationships with Missions** differ by country, given the wide range of abilities and interest among Mission staff. Missions stated that their relations with ICF were for the most part good; they found ICF to be responsive and ICF staff to be excellent, although limited by lack of knowledge regarding the country context (which they acknowledged was to be expected). Mission staff reported varying level of their engagement in the SPA process; some respondents felt uninvolved and that ICF should do more to engage Mission staff, while others felt over-engaged due to absence of ICF staff.

With regard to **ICF's relationship with host-country governments**, government colleagues spoke highly of ICF. In some countries ICF does not have a direct relationship with the MOH and works more closely with the organization implementing the SPA. Some noted instances of disagreement between the SPA implementer and ICF but felt this is to be expected when designing and implementing a major survey. Some respondents felt that ICF should make greater effort to involve the MOH in the survey effort while others noted that the MOH in most countries does not have the capacity to actually conduct a major survey. Finally, while a respondent in one country reported that ICF was over-engaged (during the DHS) and needed to let the government take on a greater role, respondents in other countries reported that ICF needed to be more engaged (during SPA and DHS), highlighting different country contexts and the careful balancing role that ICF must play.

Respondents made a number of comments regarding **ICF's working relationship with other country-level stakeholders**. Some felt that ICF should be more flexible with regard to considering country needs, especially during questionnaire adaptation and data analysis. One respondent said that she understood the importance of standardizing the questionnaire across countries but that ICF could do more to help the MOH understand why standardization is important and convince them to accept it.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Overarching

There is a tendency within the global public health community to **underuse and undervalue data on inputs, processes, and outputs** that the SPA provides in favor of indicators of health outcomes and impact. In addition, public health specialists have not fully appreciated that data from health facility surveys that describe inputs, processes, and outputs will be used within countries in a very different way from household survey data and that most country-level stakeholders have limited capacity to analyze data from health facility surveys or use it effectively—with consequent implications for the type and level of support that will be required for the data to be used effectively.

The SPA is a valued product with a strong global reputation. The SPA is appreciated for its comprehensive content, the high-quality data it produces, and the open access it allows to all users. It is widely considered to be the HFA platform that produces the most useful data that measures quality of care. At the country level, where the SPA is perceived as the highest quality data describing health facility functions—much higher than data from government HMIS systems—the SPA provides a valuable snapshot of the health services. The SPA is uniquely positioned to link the patient experience to provider knowledge, actual provision of care, and available resources for service delivery. The SPA is supported by the DHS Program, which is renowned for its ability to produce high-quality data in every survey that it manages—a reputation that other HFA platforms do not enjoy.

Evaluation Question 1: What is the perceived value of SPA at global and country levels?

Overall, the team concluded that **the SPA is perceived to be of high quality and well respected globally**. As such, we found that it was achieving Result 1 of the DHS-7 program: Quality Data Collection. Nevertheless, we also found that when compared to the DHS, or to other HFA platforms, few SPAs have been conducted. This negatively affects SPA's ability to meet Result 2: Data Availability in terms of quantity. However, data from every SPA conducted are publicly available. Donors and researchers agree that this is a great public good and not available elsewhere. As for Result 3, ICF's analysis of the SPA data is largely limited to the tables produced for the SPA report, though periodically they receive additional funds for further studies. Researchers, on the other hand, are conducting research and publishing papers using SPA data. Outside of research, ICF's facilitation of data use is minimal. Dissemination of the SPA report to likely users is hampered by lack of funding. Use is further hampered by the fact that users often do not have the skills to read the data tables or to analyze the raw data (although both are accessible).

The SPA is perceived to fulfill a need not currently being met by the DHS since its focus is on health facilities and not households. The SPA is also fulfilling a need not perceived to be currently met by countries' HMIS, since it collects data on process of care as well as inputs and outputs of care, while HMIS only accumulates data on outputs (and some inputs of care). This

was also true for HFAs overall. When SPA was compared to other HFAs, respondents perceived SPA to be more comprehensive and of higher quality.

However, the SPA is a massive, bulky approach to HFA that is perceived and presented as a largely inflexible, time and resource-consuming package—and its benefits to country-level clients are not always clear to them. Countries that do not have the resources, time, and vision—or that have other options for gathering data from health facilities—often choose options other than the SPA.

The level of investment that USAID/Washington and ICF have made in SPA is inadequate in some key areas. Greater investment is clearly called for to ensure that more SPAs are conducted and to strengthen dissemination and use of SPA data.

There is a divide, or a communication gap, between global and country levels regarding the purpose of the SPA. The DHS management team and ICF are working to build a standardized, globally accepted basis for health facility surveys and, particularly, the SPA. The evaluators perceive that their focus is more on supporting advanced analysis of SPA data, including publications and coordination of the DHS and SPA data. Country-level stakeholders have little interest in international comparisons of data describing their health facilities. They are looking for an adaptable, flexible, light, user-friendly approach to health facility surveys that they can adapt and use to obtain the information they need to better manage their health system.

Evaluation Question 2: How are SPA data being used at global and country levels?

SPA data are being used in a wide variety of ways at both global and country levels in areas that include policy, planning, advocacy, analysis, gap identification, intervention design, program management, evaluation, quality of care, training, promoting accountability, and research and publications. **However, the use of SPA data has not come close to achieving its potential.** Prior to this evaluation, USAID/Washington and ICF appeared to have limited information regarding how SPA data are used at the country level – a somewhat surprising finding for an initiative that has been implemented for 20 years. The types of use of SPA data are much broader at the country level than at the global level, but due to funding restrictions and communication challenges, most of USAID/Washington’s and ICF’s efforts in Washington to promote use of SPA data are directed at global-level use.

There are significant challenges to using SPA data at the country level. Country-level stakeholders are not sure how to use the data and clearly use at the country level is sub-optimal, although it does take place. There is a perception of a gap in support for country-level data use; some stakeholders are not sure what they are supposed to do with the data and what type of support is available to them. There thus appears to be a **need for an overarching strategy for SPA data use** at country level in order to address the gap in support for helping countries use data for policy and programs.

Having a single project or organization manage both DHS and SPA does offer benefits that include the use of established rigorous methodology to implement both types of surveys, shared expertise across the two survey efforts, the association of the SPA with the established DHS “brand,” and opportunities to coordinate the use of DHS and SPA data.

There are problems regarding the timing of releasing results of the SPA in order to meet use for planning at country level, which has resulted in notable missed opportunities to use

SPA data. Plans to use SPA data for project and program planning were not realized in two countries because the SPA final reports were not complete at the time of specific planning activities and there were limited mechanisms for sharing preliminary or un-finalized data for planning purposes. The evaluation team understands through discussion with the DHS Program that, in fact, SPA data can be shared before it is finalized as long as the authorized parties in country approve the sharing of the data. However, people that the team spoke to at Missions were not aware of this possibility. Taking advantage of these opportunities can contribute to building the reputation of the SPA as a useful investment for countries.

Insufficient dissemination of SPA data to likely users is contributing to the lack of use and relevance of the SPA data. An argument can be made that the initiative to support the use of SPA data—especially at country level—could be managed more effectively through a different management structure that involved greater country presence for continuous engagement with stakeholders.

Evaluation Question 3: What are USAID’s and ICF’s perceptions about opportunities and challenges in facilitating SPA implementation?

USAID can see the need for the SPA, particularly its potential to help program managers make decisions about their programs and for monitoring progress towards strengthening health systems. Both USAID/Washington and ICF consider that having the SPA and the DHS within the same program is a benefit, as it helps to leverage expertise and facilitates implementation of the SPA at quality levels similar to that of the DHS because established and trusted processes for training and data collection are followed. One of the most glaring opportunities was increasing awareness of SPA data—both within USAID/Washington and within Missions overseas. USAID investments in the SPA were found to be lacking overall, in part due to lack of Mission buy-in. However, once Missions buy in, the investment in terms of funding was deemed sufficient. ICF’s investment was also found to be lacking, but in terms of staff time and focus. This could not be separated from USAID’s lack of investments. While the need for quality HFA data, such as what comes from the SPA, was not in doubt, some felt hampered by a lack of globally accepted indicators. As for the future of HFAs and SPA, USAID also expressed the need to have a core set of questions for the SPA (core SPA) supplemented as needed by additional modules.

Compared to the number of SARA and SDI surveys that have been and are planned to be conducted, **the SPA survey is in danger of becoming a minor player in the field of health facility surveys** in terms of numbers of surveys conducted. There have been very few SPAs conducted over the years and the numbers that are planned are not increasing, unlike the SARA and SDI surveys. In terms of reputation and potential, SPA is much more strongly positioned.

There appears to be a generally low level of awareness regarding the SPA survey among public health professionals at the global and, especially, country levels. Low levels of advocacy for and marketing of the SPA over the years may have limited its uptake.

From the perspective of the evaluation team, **the current situation calls for concerted action to strengthen the SPA initiative.** It appears possible that the SPA could be marginalized in the near- to mid-future due to lack of demand.

RECOMMENDATIONS

EVALUATION QUESTION 1: WHAT IS THE PERCEIVED VALUE OF SPA AT GLOBAL AND COUNTRY LEVELS?

USAID/Washington and the DHS-7 Team at ICF should **consider improving the messaging about SPA to better communicate the links between the different modules in the SPA**. The team found that, for the most part, people outside of ICF, USAID DHS management team, and researchers were not able to articulate the interrelationship between the modules and what it says about facility readiness to provide quality health services to a client. This is a great strength of the SPA and needs to be better communicated. ICF should improve its capacity to communicate about the links between the modules. This is an under-exposed strength of SPA and, to date, largely under-analyzed.

Towards this end, the DHS Program may consider doing the following:

- Tell the SPA story through the eyes of people. For example, Julia, mother of three children under five, is pregnant with her fourth child and needs medical care (demand). She needs to know if there is a health facility nearby that offers antenatal care (availability), with functional equipment, water, and electricity (or source of light), with trained providers that are respectful and welcoming (readiness), where she will not have to wait too long to be seen and where she will be provided appropriate care (quality). Once she comes to the facility, she needs to be satisfied with the encounter.
- Conduct analyses that link availability with readiness, quality of service delivery with training, and availability, readiness, and quality with patient satisfaction.
- Create one/two-page success stories (with pictures of people) that highlight at least one decision made from data from various components of the SPA. A good example may be found in Kenya, where a policy brief on maternal health from SPA data supported the First Lady to strengthen MCH care.

The DHS management team within USAID/Washington should consider **increasing the usefulness, relevance, and value of the SPA for health programs at USAID/Washington, USAID Missions, and for ministries of health** by doing the following:

- From the current SPA, **develop indicators that fit USAID needs**—at least some of which are guided by associations with key DHS indicators—and **start using them immediately**. The feedback and pushback from others will serve the significant role of indicator definitions and calculations.
- **Encourage formal integration of data from SPA into USAID Mission monitoring plans for implementing partners**. This is already happening, though informally, in Haiti, Kenya, and Tanzania.
- **Encourage formal integration of data from the SPA into MOH M&E frameworks**, as well as part of policy and strategic plan development and revision. This is already beginning to happen in Bangladesh.

The DHS management team within USAID/Washington should consider **creating a “SPA Awareness”** group that engages others within the GHB to develop ways to increase awareness of SPA within USAID Missions. These include actively discussing SPA at relevant USAID meetings, including SOTAs, as well as taking advantage of health and program officers currently in Washington, DC long-term or on TDY and exposing them to SPA. A SPA Awareness group, made up of the right people (program and health system), will be quite successful in coming up with the appropriate ways to increase awareness.

A significant amount of work has been done by researchers using the SPA data. Some of that work has been in the area of indicator development, while other aspects are more practical, having to do with handling of the SPA data with software. The DHS management team within USAID/Washington should consider harnessing the work currently done by researchers and, where possible, enhance their own efficiencies.

EVALUATION QUESTION 2: HOW ARE SPA DATA BEING USED AT GLOBAL- AND COUNTRY-LEVELS?

The recommendations below for issues related to data use are listed in order of descending priority.

- **The DHS Program should strengthen the focus of the SPA on meeting countries’ needs** with regards to the information countries need from a health facility survey to inform health sector planning and review, policies, trainings, and other uses. This may be in the areas of survey design, implementation, analysis, and presentation of the data.
- **The DHS Program should develop and measure a *minimal* standard set of USAID-proposed indicators** using SPA data, at least some of which are guided by associations with key DHS indicators. USAID may choose to do this empirically by reviewing current SPA data for similarities across countries. USAID may also begin by reviewing its own programmatic indicators that can be obtained from the SPA. Based on these indicators, **add SPA data to STATcompiler.**
- **The DHS Program should develop data use strategy(ies)** for global and country levels that move beyond data use/analysis workshops. Building on the findings of this evaluation, **develop and test an approach to improve country-level use of SPA data** with a focus on making data understandable and absorbable for different user groups. **Allow data use strategies to drive dissemination efforts.**
- **The DHS Program should continue to develop and test simpler, more absorbable products to present SPA results**, such as service-specific briefs and divisional reports, perhaps in lieu of the standard final report.
- **The DHS Program should ensure that the timing of the release of SPA results is optimized so that it meets needs for planning.** Identify in advance dates when data will be used and ensure that results are available, even if they are only preliminary.
- **The DHS Program should encourage and support Missions to incorporate SPAs into intervention design, project management, and M&E, and government programs.**

Evaluation Question 3: What are USAID's and ICF's perceptions about opportunities and challenges in facilitating SPA implementation?

The recommendations below for issues related to SPA implementation are listed in order of descending priority.

- **USAID should increase investment in the SPA** by directly funding additional SPAs as well as through support for strengthened dissemination and data use.
- **The DHS Program should develop options for the SPA to reduce its cost, size, and implementation burden that may include** different sampling models, breadth of questionnaire (e.g., develop a lean core set of questions, with additional modular add-ons), and geographic scope. Present countries with the full set of options when engaging them in discussions to design the SPA. Develop and test this flexible approach to SPA design. This may be accomplished by collaborating with similar efforts by SARA and SDI. However, issues around methodology will need to be addressed.
- The DHS management team should strengthen efforts to advocate for and market the SPA with USAID Missions. Explore the use of existing infrastructure, like SOTAs to highlight results of recent SPAs. Consider promoting experience-sharing among countries and organizing observational visits. As part of advocacy efforts, demonstrate the usefulness of SPA data for USAID Mission health portfolios and consider introducing requirements for Missions to report data for key health service delivery indicators.
- **The DHS management team, together with others within USAID/Washington should work together to create a stronger link between SPA and USAID quality improvement.** This could include using SPA data as a baseline for efforts to improve service delivery and/or making SPA data integral to the evaluation of USAID Quality Improvement projects.
- **The DHS Program should make a strong test effort to coordinate the use of DHS and SPA** at the country level. Bangladesh and Senegal may provide the best opportunity for this.

ANNEX I. BANGLADESH CASE STUDY

INTRODUCTION

The People's Republic of Bangladesh is located in the Bengal delta of South Asia. Bangladesh's Human Development Index ranks 139th out of 188 countries listed,¹ while its 2017 gross domestic product per capita ranks 147th out of 188 countries.² Bangladesh is segmented administratively into seven divisions, which are in turn divided into 64 districts. Bangladesh has made excellent progress improving key indicators of population

health over the years (see box) although utilization of government health services remains low compared to some countries. The level of prosperity is rising in Bangladesh and it is anticipated that Bangladesh will become a middle-income country by 2021.

Population: 160,996,000
MMR: 176
U5MR: 38
ANC-I: 64 %
SBA at delivery: 42 %
Demand met for FP: 82 %

Source: Countdown 2015

The health system in Bangladesh is complex with services provided by the Ministry of Health and Family Welfare (MOHFW), nongovernmental organizations (NGOs), and private sector health workers (HWs) – in addition to traditional providers at the community level. The MOHFW is divided into two directorates, each of which delivers health services. The Directorate General of Health Services focuses on curative services and oversees tertiary care facilities at medical colleges, secondary care at district hospitals, and some primary care services – both at sub-district health centers as well as at the community level. The Directorate General of Family Planning (DGFP) focuses more on preventive health and is responsible for most of the skilled care at delivery that is provided at the community level. The DGFP manages facilities and providers that includes Maternal Child Welfare Clinics in each district's headquarters and Family Welfare Clinics at the community level. The two directorates function quasi-independently at the national level and, in some districts, at the district level as well. From the sub-district level downwards the services of the two directorates are more intertwined. Bangladesh has a vibrant civil society that includes NGOs (such as BRAC and Red Crescent) that have established health clinics and provide delivery services. The private health sector in Bangladesh is large and growing; many physicians and nurses work during the day at government jobs and in private clinics during the evening.

History of the Bangladesh Health Facility Survey: Bangladesh conducted a MCH Service Provision Assessment (SPA) in 2000 but the results were felt to be too unstructured to be very useful. Tulane University then conducted the Bangladesh Health Facility Survey (BHFS) in 2009 and 2011, using the Balanced Scorecard approach, with the support of the World Bank. Stakeholders reported that while these surveys were an improvement on the 2000 SPA, they were still not as concrete and standardized as was needed and, as a result, the results were neither widely accepted nor used. The MOHFW never gave permission for the reports to be printed. A decision was taken to base future health facility assessments on a different platform and the 2014 BHFS was based largely on the SPA and SARA models. The MOHFW plans to

¹ <http://hdr.undp.org/en/countries/profiles/BGD>.

² World Economic Outlook Database-April 2017, International Monetary Fund.

conduct the BHFS every two years; the next BHFS, based on the 2014 SPA/SARA model, will be conducted in 2017.

The National Institute of Population Research and Training (NIPORT) is an institute under the MOHFW that develops human resources and generates evidence for improving health, population, and nutrition programs and policies in Bangladesh. NIPORT oversaw the conduct of the 2014 BHFS and contracted the private research agency Associates for Community and Population Research (ACPR) to conduct data collection for that survey. NIPORT is again overseeing the conduct of the 2017 BHFS. Icddr,b will provide technical support to the 2017 BHFS in the form of Master Trainers and will conduct supervision throughout the field work in order to strengthen the quality of the survey effort.

METHODS

This case study has been developed as part of the DHS-7 Mid-Term Evaluation by one of the evaluation team members (“Consultant”). The Consultant traveled to Bangladesh from April 1-7, 2017 to conduct interviews with key SPA stakeholders in Dhaka. The Consultant was supported by GH Pro staff members in Washington, DC and the GH Pro Field Evaluation Coordinator (FEC) in Bangladesh. The FEC accompanied the Consultant to all interviews and arranged for all logistics. Details regarding data collection methods are presented below.

Key informant interviews (KIs) and respondents: The Consultant conducted KIs with 19 stakeholders in 13 separate interviews in Dhaka. The list of stakeholders that were interviewed can be found in Annex V to this report and includes national-level government officials, technical and program specialists who work for local and international NGOs and research organizations, and personnel from the World Bank, ICF, and the USAID Mission. Respondents were selected through consultations between colleagues at USAID/Washington, the USAID Mission in Bangladesh, and the ICF consultant in Bangladesh.

Interview guides and process: Standardized semi-structured interview guides tailored to the respondent’s role in the SPA were prepared for all interviews. The Consultant conducted all interviews in person and took comprehensive computerized notes. Verbal informed consent was obtained from all respondents.

Document review: The Consultant reviewed various reports and documents related to the conduct of the SPA in Bangladesh.

RESULTS

The 2014 BHFS was national in scope and gathered information from 1,548 public, NGOs, and private health facilities. Sub-assistant community medical officers (SACMOs) served as data collectors and gathered information using two types of data collection tools: *Facility Inventory* and *Health Care Provider* questionnaires. In addition, in areas of the country served by the USAID-funded MaMoni Project, SACMOs used *Observation Protocols* and *Exit Interview Questionnaires* to gather information to inform intervention design and serve as a baseline measure of key indicators of health service delivery for MaMoni. Data for the BHFS were collected from May-July 2014. Readers interested in the results of the survey are referred to the survey report.³

³ National Institute of Population Research and Training (NIPORT), Associates for Community and Population Research (ACPR), and ICF International. 2016. Bangladesh Health Facility Survey 2014. Dhaka, Bangladesh: NIPORT, ACPR, and ICF International.

The text below describes country stakeholders' experiences regarding the process of planning for and conducting the BHFS and the use of the data following the survey.

Process of BHFS 2014 planning, implementation, dissemination and use of data

The **conception** of the 2014 BHFS took place in a context where country stakeholders were searching for a survey tool that would provide them with a broad picture of the health system. Some felt that the SPA came as a “foregone conclusion kind of package” that did not allow much flexibility regarding conceiving what the survey should cover, while others felt that the SPA was a helpful comprehensive package that, once adapted for local use, was useful. Most stakeholders felt that **coalition building** went well as key partners were able to capitalize on existing relationships and the sector-wide approach to public health in Bangladesh to form a coalition and work together. One respondent noted that government's (post-survey) resistance to the BHFS findings was a sign that the government was not effectively engaged during the coalition-building stage and thus did not feel ownership of the results when they were released. Regarding **the design of the survey and the tools**, respondents felt that the process was rushed and that ICF was not very open to adapting the standard SPA tools, which were of high quality but needed to be modified to fit the country context. Some noted that this led to problems later during the analysis stage, when questions that had not been properly adapted produced data that did not reflect the reality of the health system. Respondents felt that while the **training** went well overall, there were problems recruiting appropriate data collectors and that ACPR, the agency in charge of **data collection**, did not meet expectations. ACPR had been unable to recruit physicians as data collectors and it became clear during data collection that the presence of a physician on each team was necessary. In addition, it was felt that supervision of field activities was inadequate. Most respondents were happy with the **data analysis**. They noted that this activity took a long time as there were many cases where analysts had to reanalyze the data to make it appropriate for the Bangladesh context. ICF's willingness to accommodate and support the extended analysis was acknowledged and appreciated. Stakeholders did feel that the analysis was only done at a basic level and that much more could have been done with the data. Respondents were likewise pleased with the **dissemination** of the results, which proved to be a huge challenge but eventually resulted in widespread acceptance of disappointing results among all levels of the government. The BHFS results were disseminated through a stage-wise approach. They were first presented to a small number of high-level officials, including the Secretary of Health, following which the data were re-analyzed based on suggestions from the Secretary and his colleagues. A broader series of disseminations was conducted once BHFS results had been accepted among senior MOHFW officials. Respondents felt that **use of SPA data** was mixed. Excellent use was made of data at the national level for policy and planning and SPA indicators were included in the results framework for the health sector five-year plan. In addition, it was noted that problems that became apparent following review of the SPA data, such as lack of refresher trainings for HWs, had been noted by concerned public health officials and had resulted in new programming to address the deficiencies. However, little or no use was made of SPA data below the national level.

DISCUSSION

The text below presents examples of how data from the BHFS have been used in Bangladesh, challenges that have been faced in the use of BHFS data, and highlights of the use of the SPA platform in the 2014 BHFS.

Examples of how data from the BHFS have been used

Data from the BHFS have been used in a variety of ways to strengthen the delivery of health services in Bangladesh. BHFS data have **influenced policy** through processes that include the development of a policy brief for achieving high quality of care. The Ministry of Planning and the USAID Mission have both used BHFS results for **planning** programming initiatives. The MOHFW has used BHFS data to establish benchmarks and to **identify gaps in service provision** for remedial action. The USAID Mission and Save the Children have used data from the BHFS to **inform the design** of the MaMoni Project. The Mission also plans to oversample Shining Sun facilities in the upcoming 2017 BHFS and to use the resulting data to inform future intervention design. The MOHFW has used BHFS data for **program management** while Save the Children has used BHFS data for the **evaluation** of the MaMoni Project. The 2014 BHFS showed that most HWs were not receiving adequate opportunities to participate in refresher trainings which led to an initiative to **develop new programming to provide refresher trainings** for HWs. Finally, building on problems identified in the BHFS, the MOHFW conducted a systematic census and mapping of all union-level facilities, collected new data from all these facilities, graded them, and used the data to target the weakest facilities for support.

Challenges faced in the use of data from the BHFS

Users of BHFS data in Bangladesh faced several challenges to make effective use of data from the BHFS. Making SPA data understandable to data users met only limited success. One respondent in Bangladesh, noting that SPA reports are dense and that results can be difficult to grasp, faced difficulties in helping data users remember the main results, as the indicators and findings would not “stick.” Data presented in the BHFS reports using standard formats were at times either difficult to interpret or not helpful for the intended use, requiring further manipulation and reformatting to make them more useful and understandable. Many stakeholders had little or no previous experience working with data on inputs, healthcare processes, and outputs; for them, learning how to “translate” the findings and use them to strengthen health service delivery was not easy. One respondent stated that managers faced challenges not only in understanding the BHFS report, but also in determining what to do once they had results. Leaders of the BHFS survey effort also faced challenges in gaining acceptance of the findings from some health officials who found the results disappointing and initially disowned them. While this challenge was overcome, it did take time to convince some officials that the data reflected the true situation and could be used to strengthen the health system. This challenge was exacerbated by the calculation of some service indicators using data from facilities that normally did not provide that service, which resulted in a low value of the indicator and presented a picture of the situation that many felt was unfairly poor, leading to further distrust of the data.

Highlights of the use of the SPA platform in the 2014 BHFS

Bangladesh is, in many ways, a showcase for how the SPA platform can be used and has been a success story in terms of how a country can take the SPA package and modify and use it in a way that is most advantageous for the country. Among the highlights of the use of the SPA platform in the 2014 BHFS, several stand out, including the following:

1. Bangladeshi stakeholders decided to use only the inventory and health worker interview questionnaires, rather than the full SPA package, demonstrating that the SPA package and approach can be modified and slimmed down to meet country needs.
2. The USAID Mission in Bangladesh arranged to use the BHFS to inform the intervention and evaluation design of the MaMoni Project, demonstrating the potential for the SPA package to be directly used in programming.

3. The MOHFW has made extensive use of BHFS indicators to measure achievements of various planning initiatives, resulting in the inclusion of four BHFS indicators in the new health sector five-year plan and five BHFS indicators in the MOHFW results framework.
4. The Bangladesh public health community worked hard to ensure that the 2014 BHFS had a country-specific orientation that prioritized the usefulness of the information for Bangladesh. Substantial efforts were made to modify the standard questionnaires, revise the approach to analysis, and disseminate in a stage-wise manner to optimize the use of the data.

ANNEX II. KENYA CASE STUDY

INTRODUCTION

Kenya is considered one of the most stable and well-organized countries in East Africa, eager to adopt innovations, and a healthcare testbed for the region. Kenya's strong and capable workforce, continued economic growth, high proportion (44.9%) of its 46 million residents classified as middle-class, and increasing life expectancy (62.1 years in 2015⁴) all contributed to its attainment of lower middle-income country status in 2015.⁵ The public sector provides the bulk of health services, while commercial private and faith-based organizations provide a substantial proportion as well. Historically, communicable diseases made up the bulk of the disease burden in Kenya. As lifestyles have changed over recent years, however, increases in the prevalence of non-communicable diseases, including cancers and cardiovascular diseases, has also increased the burden for service delivery on the public sector. Simultaneously, the demand for quality service delivery has also increased. And while the Total Health Expenditure (THE) has increased in recent years, as of 2014 the Kenyan Government only spends 5.7% of its GDP on health, which is less than its neighbors in Rwanda and Uganda.⁶

Kenya enacted a new constitution in 2010 which resulted in a devolved government with 47 self-governing counties. Each county is governed by its own government, including its own equivalent of a Ministry of Health (MOH), and has a high degree of autonomy for decision-making on its budget, including its health budget. This change has significantly dwindled down the power of central government to provide oversight, implement programs, and ensure quality of service delivery. In the health sector, as in all sectors, County governments are now responsible for understanding their baseline and implementing known interventions that will lead to sustained improvement. Devolution is having a significant impact on various vital processes of the health sector, including supply chain, training, and funding of service delivery. This change has resulted in a 57% increase in county level health budget support from FY 2013/14 to 2014/15.⁷ However, while historically rich with health data, devolution has resulted in a lack of reliable county-level data on which county governments can make, evaluate, or validate health care decisions.

History of the Service Provision Assessment in Kenya

With funding from USAID and other donors, and technical assistance from ICF/Macro, the National Coordinating Agency for Population and Development in collaboration with the Ministry of Medical Services, the Ministry of Public Health and Sanitation, and the Kenya National Bureau of Statistics has been implementing the Service Provision Assessment (SPA) since 1998. Similar to other countries, Kenya SPA was designed to provide information on the availability, readiness and quality of service delivery. The first SPA report, published in 1999, focused exclusively on maternal and child health (MCH). When the Spa was conducted five years later in 2004, two separate reports were produced, one for MCH and another for HIV.

⁴ <http://data.worldbank.org/country/kenya>

⁵ <http://www.worldbank.org/en/news/press-release/2015/07/01/new-world-bank-update-shows-bangladesh-kenya-myanmar-and-tajikistan-as-middle-income-while-south-sudan-falls-back-to-low-income>

⁶ <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

⁷ https://www.healthpolicyproject.com/pubs/7887/Kenya_HFP.pdf

The most recent SPA in 2010 focused more broadly on the health sector, assessing progress towards the Millennium Development Goals and impact of activities implemented under the 2005-2010 National Health Sector Strategic Plan (NHSSP II) to improve child health, family planning (FP), maternal and newborn health (including antenatal delivery), sexually transmitted infections, tuberculosis, and HIV/AIDS. Data was collected from 703 health facilities, including hospitals, health centers, dispensaries, maternities, clinics, and voluntary counselling and testing (VCT) centers, and included all managing authority affiliations. Results provided national and provincial level data. However, devolution had not yet occurred, the sample selection and size did not permit for county-level analyses, and the data became less useful for governance once devolution took effect in 2013/2014. Following the five-year schedule Kenya had previously set for itself, data collection was due to take place in 2015 after the DHS. However, various events led to a delay in getting the process started for the SPA until 2016.

PURPOSE OF COUNTRY VISIT:

As part of the DHS-7 evaluation, Kenya was selected as one of two countries to be visited by the team, with the aim of writing a case study that describes its experience to date with the SPA. USAID selected Kenya from a short list of countries because, in Africa, it has the longest, most consistent history with the SPA and is well-positioned to provide diverse perspectives on the evaluation questions. The visit was conducted by Dr. Rachel Jean-Baptiste from March 26 to April 4, 2017 and focused on collecting information from Kenya on the three evaluation questions, namely: 1) perceived value of the SPA, 2) use of SPA data, and 3) perceptions about opportunities and challenges implementing the SPA.

METHODOLOGY FOR DATA COLLECTION

This one-week visit included **key informant interviews** with partners, implementers, and users of the SPA, starting with an initial list of informants provided by USAID/Kenya and others added in a snowball fashion. In total, 12 interviews were conducted with 16 participants. These included respondents from USAID Kenya, MOH (MCH, NASCOP, M&E Units), County (Machakos), WHO, UNFPA, UNICEF, researchers from University of Nairobi and Igatton University, and with the National Coordinating Agency for Population and Development (NCPD). The list of interviewees is included in Annex V. After obtaining informed consent, meetings were conducted using a structured qualitative interview guide that varied slightly depending on the informant type (donor versus MOH versus researcher, and so on). Interviewees were very open about their past experiences with the SPA and other HFAs and on their current views of the shaping of the next one. While every effort was made to conduct all interviews in person, two were done by phone because respondents were outside Nairobi at the time.

Documents identified as relevant by key informants along the way were also reviewed and include the Kenya 2010 (KSPA 2010) report. Various other sources of data, including the DHIS-2 were also reviewed, though not in-depth.

In addition, the consultant conducted a **visit to Machakos, a county** not far from Nairobi, to better understand the real issues around health data as faced by these newly created government entities.

RESULTS OF COUNTRY VISIT

Overall, the SPA is well received in Kenya, though only known to some, and mostly at the national level. Similar to what was found from the larger group of stakeholders, the SPA in Kenya collects information from health facilities about their preparedness and readiness to provide health services. The SPA sample looks at all kinds of health facilities—including public, private, and non-governmental organization (NGO) facilities—from all parts of the country. While earlier SPAs provided data based on a national sample, the SPA 2010 was stratified by provinces, as counties were not yet fully operational. Sampling for SPA or the Kenya Health Facility Assessment (KHFA) currently being planned will be at county level and the results will serve as a baseline for counties. If this is done every five years as intended, it will be a good source of data for monitoring improvements on the health sector within each county. The delay of the current SPA was unfortunate, since it coincided with the MOH's need for data to evaluate its mid-term strategy. This created a data vacuum that was eventually filled by the MOH conducting a mini-SARA-M (service availability and readiness assessment with mapping), with funding from the Global Fund and some USAID buy-in in early 2015. The MOH found the results extremely useful and many now feel wedded to this methodology.

"We did a SPA in 2010 when we were one national government, one entity responsible for health. We now have 47 governments in charge of health. We need to see what has happened for health for the country, and for each of the 47 counties. We are likely to have disparities within counties. With this SPA, one of the objectives would be to show what has happened in terms of availability and quality of services at national and within the 47 counties."

– MOH Kenya

The current timeline for the SPA is overlapping with that of other large-scale surveys, including the SARA from WHO and the SDP from UNFPA, all due to take place in late 2017/2018.

Governmental stakeholders, including the County Council of Governors, are all in favor of one HFA rather than several since they perceive that to be a more efficient use of resources while also

"The decision to do all three [surveys together] came about from the Health Data Collaborative Conference in Nairobi in May 2016. We later discussed this with the Director of Medical Services and the Permanent Secretary, and they were all in agreement."

– MOH Kenya

minimizing disruption of service delivery. NCPD, in its role as implementer of the SPA in Kenya, is leading the process of harmonizing the three tools (SPA, SARA, SDI) to create the KHFA. At the time of the country visit, this process was still fraught with disharmony and uncertainty. USAID/Kenya was not yet fully on board, thus affecting availability of funds and, according to one respondent, creating confusion among other donors. Meanwhile, the MOH's engagement was minimal, thus affecting stewardship. USAID/Kenya's lack of involvement was due, in part, to balancing support for what the MOH needs while also weighing communication and direction obtained from USAID/Washington. From this light, the MOH's lack of engagement made it difficult for USAID to figure out how it would support the process. The MOH's lack of engagement seems to fundamentally be about who would receive the funds to implement the SPA. The SPA has been traditionally implemented by NCPD, as per Kenya's constitution. The MOH is perceived to not have the capacity to administer the logistics of carrying out a SPA, though admittedly they have the technical knowledge. Our interviews took place as NCPD and the MOH were in discussions on how best to collaborate and move forward with the next health facility assessment (HFA).

Question 1: Perceived Value of SPA

SPA's importance and value is in its ability to provide a reliable and comprehensive view of Kenya's health system. For the MOH, the SPA is an evaluation of how well they are performing, and it tells them what's working and what needs to be improved. They expressed that all other support should be mapped against data from the SPA. However, a key challenge has been government stewardship, particularly from the MOH and—within the MOH—specifically HMIS, Department of Policy and Planning. One donor noted “if we lack leadership and stewardship from there, we will have a missing link,” and the recent doctor strike further crippled MOH leadership in the current SPA to date. Interviewees expressed a need for consensus between the government institutions involved in implementing the SPA to ensure that the SPA is prioritized. The Health Data Collaborative recently developed its Roadmap 2018 in which it outlines short-term, mid-term, and long-term priorities in strengthening health measurement and the SPA is included as one of the mid-term priorities.

“We’ve seen that 90% of facilities provide family planning services, but uptake has been low for a very long time. This shows that the problem is elsewhere, not with availability.”

– Government of Kenya

Nevertheless, SPA data have allowed the MOH to contemplate some key results. From previous surveys, they have been able to note strengths and weaknesses of health facility providers in terms of knowledge and quality service delivery and this provided insight into the quality of pre- and in-service training. They have been able to gauge to some extent the impact of low staffing numbers on subsequent quality of service delivery. They have also been able to follow up on issues such as youth-friendly services. It was highlighted as an issue in SPA 2004 and in the SPA 2010 it had actually gotten worse. Another example is FP services – 90% of health facilities offer this service, yet uptake is low. This type of data has facilitated discussions among MOH as to where the problem is and how to improve it. They noted as an example that uptake of FP will not be solved by increasing availability of FP in health facilities.

Question 2: Use of SPA Data

“The SPA revealed that we had very low Oral rehydration therapy corners in health facilities. This information was used to source equipment to establish ORT corners.”

– MOH Kenya

SPA data have been used in a number of ways by different stakeholders. The **MOH** said that this data were useful at their annual National Health Congress where they discuss current performance and achievements. They also see it is needed at planning, strategic reviews, and

increasingly at sub-national levels for planning of resources. One MOH official said “we used SPA to convince partners. For example, we found that 36% of facilities had IMCI child booklets in SPA. We convinced partners to supply the rest of facilities. Partner now supplies directly to each facility.” One other use of the SPA was with students on placement within the MOH. One MOH official stated that “when students come to us we use the SPA to train them.”

Within **USAID/Kenya**, the SPA 2010 was reported to be very useful. “We used it to make IPs review their implementation strategies based on the SPA,” said one USAID official. It was used to develop the five-year implementation plan and helped inform strategies for increasing utilization of health services. The SPA 2010 was also

“The SPA revealed that maternity wards are there, yet mothers do not deliver in health facilities. From the qualitative piece of the SPA, we learned that likely interventions that would increase delivery in health facilities were 1) improve provider attitudes, 2) availability of warm water, and 3) availability of a cup of tea. In health facilities where these interventions were put in place, we did see improvements.”

– **USAID Official**

used in annual workplans (AWP) of every district and USAID ensured that implementing partners linked each activity within that district to the district’s AWP. USAID remained pleased with the SPA: “[t]here are many examples of ways SPA transformed the way work is done,” said a USAID official. Kenya is one of the countries where modifications, in the form of adding a qualitative component to the SPA, were made and viewed as value-added.

Researchers interviewed said they used the SPA to teach both in terms of a database on which they can teach students about research methods and statistical analysis. In addition to writing peer review journal articles, researchers also use the SPA to teach health systems measurement. One researcher said that two years ago he had the opportunity to create a short course, and, out of nine modules, he dedicated one whole module to the SPA. Researchers have used the SPA to develop other short courses for healthcare workers. They also use the SPA to establish a baseline for key project indicators. Teaching students based on the content of the SPA was also noted by one researcher, as was comparing SPA data to DHIS data.

USAID-funded **implementing partners** are among SPA users in Kenya. As an example, the SPA 2010 provided an evaluation of what AFYA 2 had done in improving infrastructure and availability of services. The data made it possible to see what the situation was like in areas where the program was not implemented. AFYA was implemented as part of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) era of rapid epidemic response to HIV. It was followed by AFYA Plus, which focused more on sustaining gains. As one USAID/Kenya implementing partner said, “SPA was a critical reference document in the design of AFYA Plus because it provided more detailed information on health system levels for Kenya. All of our programs were guided by evidence illuminated from population-based studies, and spiced up with data from the DHIS-2.”

“We’ve used the SPA especially in 2015; we had a program that was dealing with maternal and newborn adolescent health services within six counties that had the highest opportunities for improvement. \$13M.”

– **UNFPA**

Technical partners, such as UNICEF and UNFPA, also rely on the SPA data to help raise funds. They find the SPA report has very comprehensive data and this helps when conceptualizing new programs. They are able to review SPA data to describe the current situation, see what gaps there are, and identify the opportunities for improvement. They often correlate SPA data about supply of services with that of the DHS, where demand for services is articulated.

Nevertheless, dissemination is viewed as the Achilles heel of the SPA. It did not reach many of its potential users and in its current form the data from the SPA are not easily absorbable for policy-makers. And because SPA 2010 was collected prior to the creation of county governments, the data are not stratified by county and are not as useful to counties.

Question 3: Opportunities and challenges implementing the SPA

The biggest challenge facing the SPA is its integration with two other HFA tools. When this happens, the “SPA” as it is will disappear. While many of the SPA questions would remain the same, the methodology of implementation would change. The SPA already is a huge instrument. Integrating it with two other instruments would make it even bigger. To date, USAID has not yet decided if it would support such an endeavor. However, USAID/Kenya views its role as supporting the position of MOH. At the time of the interviews, the MOH had not yet publicly shared its position, though in interviews with our evaluation team they did make it clear that they intend to have one HFA: the KHFA. The future of the SPA in Kenya—a separate HFA—seems unlikely and hinges on the decisions that USAID/Kenya and the MOH will make together in the upcoming weeks or months.

Another challenge for the SPA is devolution. Because 47 county governments exist and each one is calling the shots with regards to health service delivery in their county, sampling for the next SPA or SPA-like HFA would have to be completed at the county level. This would result in collecting data from more health facilities and lead to increases in cost and time for data collection.

Increasingly there is a need for data on curative and specialized services. Surgery may be a good example; the MOH would like to know if there are staff available to perform surgeries and what types of surgeries are people not trained to handle. Other areas include ICU, renal units, laboratory, and imaging. The MOH felt strongly that SPA should be relevant to them and the way to do that is to engage them.

Other opportunities and challenges are along the lines of dissemination and use. Respondents shared that it would be good if the SPA could be timed to provide data for central and county-level planning. This usually starts in May/June. There was a strong sense that dissemination of the next SPA or HFA should be linked to when people are more likely to use this data more efficiently. It was felt that this would lead to greater utilization of the data.

Nevertheless, respondents also highlighted the capacity needs within the MOH that would facilitate increase use. They spoke specifically about the need for additional training in data analysis and interpretation.

CONCLUSION

Overall, Kenya values data from HFAs. The SPA has been quite successful, has been used widely since its first implementation in 1998, and remains highly regarded in Kenya by a wide range of stakeholders. The interviews conducted revealed substantial and varied uses of SPA data and though data from the SPA is not yet integrated into any of Kenya’s data infrastructure, USAID has encouraged its use in annual workplans of districts. Since the 2010 SPA, Kenya’s political and governing landscape has changed, going from one governing body to 47 independent entities. In order to maximize data use, this will necessarily need to be taken into consideration when planning the next SPA.

Kenya is also at a crossroads with regards to HFAs. While the SPA is well appreciated, other technical advisors to the MOH, WHO, UNFPA, and the World Bank each have their own version of facility assessments. In 2017, the timeline for two of these overlap with the SPA. As conducting all three would result in undue stress to health workers and is deemed highly

inefficient by the MOH and others, Kenya has embarked on an effort to combine the two with the SPA and create, for the first time, a KHFA. While USAID/Kenya has not yet lent its full support, there is growing recognition that the future of the SPA in Kenya is intricately linked to its decision at this time.

ANNEX III. SCOPE OF WORK

Assignment #: 336 [assigned by GH Pro]

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: December 8, 2016

Last update: February 1, 2017

I. **TITLE: DHS-7 Mid-Term Evaluation: Service Provision Assessment Implementation, Utilization, and Promotion**

II. **Requester / Client**

☒ USAID/Washington

Office/Division: Madeleine Short Fabric, GH/PRH/PEC

III. **Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)**

Note: this evaluation is funded via Bureau-wide funding.

☒ 3.1.1 HIV

☒ 3.1.4 PIOET

☒ 3.1.7 FP/RH

☒ 3.1.2 TB

☒ 3.1.5 Other public health threats

☒ 3.1.8 WSSH

☒ 3.1.3 Malaria

☒ 3.1.6 MCH

☒ 3.1.9 Nutrition

☒ 3.2.0 Other (specify):
See NOTE below

IV. **Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW)**

V. **Performance Period**

Expected Start Date (on or about): February 1, 2017

Anticipated End Date (on or about): June 30, 2017

VI. **Location(s) of Assignment: (Indicate where work will be performed)**

Metro-DC ; TDY to one or two countries in sub-Saharan Africa or Asia.

(Note: GH/PRH FP/RH funds will be used until different GH program account splits scenario guidance is provided to GH Pro)

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

☐ **Performance Evaluation** (Check timing of data collection)

☒ Midterm

☐ Endline

☐ Other (specify): _____

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline

☐ Midterm

☐ Endline

☐ Other (specify): _____

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ **Other Analytic Activity (Specify)**

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

☒ **Process Evaluation** (Check timing of data collection)

☒ Midterm

☐ Endline

☐ Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline

☐ Midterm

☐ Endline

☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Project Title:	The Demographic and Health Surveys Program (DHS-7)
Contract Number:	OAA-C-13-00095
Contract Dates:	09/09/2013 – 09/08/2018
Project Funding:	\$189 million (ceiling)
Implementing Organization(s):	ICF International (prime)
Project COR:	Madeleine Short- Fabric, COR

Background of project/program/intervention:

The purpose of this mid-term performance evaluation is to assess how well the Service Provision Assessment (SPA) is positioned to meet the DHS Program's objective: "To improve the collection, analysis, and presentation of population, health and nutrition data and to facilitate use of these data for planning, policy-making, and program management."

Background on the overall DHS Program and SPA is provided herein. Details on the scope of the evaluation are provided in section IX.

USAID places a high premium on the collection, analysis, dissemination, and use of timely, quality, nationally representative health data for the purposes of program planning, monitoring, evaluation, and policy making. As a result, USAID has been the steadfast leader of the Demographic and Health Surveys (DHS) Program since launching it in 1984. In its 32 years, the DHS Program has provided technical assistance in the implementation of over 320 surveys in 90 countries. It is the largest and longest enduring program of its type. Thanks to a standardized methodology and approach, the surveys are comparable across time and place. And thanks to a long-standing open data approach, DHS data are freely available for download and widely used. Over time, the DHS Program has taken an increasingly larger role in strengthening local capacities, fostering data access, and facilitating data use. The current iteration of the Program, DHS-7, aims "to improve the collection, analysis, and presentation of population, health, and nutrition data and to facilitate the use of these data for planning, policy-making and program management to promote evidence-based decision-making."

The technical support that the DHS Program provides generally relates to a specific set of surveys and their related activities. Household surveys include: standard Demographic and Health Survey (DHS); AIDS Indicator Survey (AIS), which collects data for monitoring and

evaluating HIV/AIDS programs; and Malaria Indicator Survey (MIS), which collects data used for monitoring the performance of malaria programs. The Program also provides technical assistance for a facility-based survey, the Service Provision Assessment (SPA), which collects data on service availability, facility readiness to provide essential health services, the quality of those services, and the satisfaction of clients and providers alike. Further information regarding SPA is provided below as it is the focus of this mid-term evaluation.

DHS-7 is managed by USAID's Global Health Bureau via a cost-plus award fee contract. It is implemented by ICF International in partnership with Johns Hopkins Center for Communication Programs, PATH, Avenir Health, Vysnova, Blue Raster, Kimetrica, and EnCompass.

The Service Provision Assessment

Overview

SPA is a health facility assessment that provides a comprehensive overview of a country's health service delivery. SPAs gather national and often sub-national data on facility-based health care services to help answer several key questions:

1. **Service availability:** What is the availability of different health services in a country? Specifically, what proportion of facilities offer specific health services?
2. **Service readiness:** Do facilities have the infrastructure, resources and support systems that are necessary to provide essential services? For example, what proportion of facilities has regular electricity? What proportion has regular water supply?
3. **Quality of care:** To what extent does the service delivery process follow generally accepted standards of care? For example, do providers assess sick children according to recommended guidelines under Integrated Management of Childhood Illness?
4. **Client and Provider Satisfaction:** Are clients and service providers satisfied with the service quality and service delivery environment?

The key services assessed in a SPA survey include:

1. **Child Health:** service readiness for sick child care, vaccination, and growth monitoring; quality of care for sick child care; caregivers' satisfaction and knowledge; and provider adherence to standard of care for sick child.
2. **Maternal and Newborn Health:** service readiness for antenatal care, delivery services, newborn care, and emergency obstetric care; quality of care for antenatal care; antenatal care clients' satisfaction and knowledge; and provider adherence to standard of care for antenatal care.
3. **Family Planning:** service readiness; quality of care; clients' satisfaction and knowledge related to provider advice/instruction; and provider adherence to standard of care.
4. **HIV/AIDS:** service readiness for HIV testing services, HIV/AIDS care and support services, antiretroviral treatment, and prevention of mother-to-child-transmission.
5. **Sexually Transmitted Infections (STIs):** service readiness.
6. **Malaria:** service readiness; quality of care for febrile children; and caregivers' satisfaction and knowledge related to provider advice/instruction.
7. **Tuberculosis:** service readiness.
8. **Basic surgery:** service readiness.
9. **Non-communicable diseases:** service readiness for diabetes, cardiovascular diseases, and chronic respiratory diseases.

Source: <http://www.dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm>

Questionnaires

The SPA core questionnaire is composed of the following core instruments, which are described in further detail below: 1) facility inventory; 2) provider interview questionnaire; 3) observation protocol; and 4) patient exit interview questionnaire. In 2012, the SPA questionnaires were revised to improve data utilization and to provide comparable data, harmonized with WHO's Service Availability and Readiness Assessment (SARA). To achieve the second aim, USAID, the DHS Program, WHO, and other stakeholders collaborated and refined service readiness indicators – a set of tracer indicators identified to measure and track progress in health system strengthening. Subsequently, in technical consultation, WHO developed the core SARA questionnaire to measure the service readiness indicators. Since then, SPA's facility inventory instrument has included the core SARA questionnaire.

The core questionnaire reflects WHO recommended standards for health care services. In each country, local technical experts in collaboration with the DHS Program adapt the core instruments to meet the information needs of the country, while maintaining data comparability for key indicators across countries.

1. **Facility Inventory** – Includes 3 modules designed to measure service availability and service readiness indicators. Module 1 collects information on overall availability of different services in each health facility; Module 2 collects facility-level readiness indicators, including information on staff coverage, infrastructure, communication, water sources, electricity, facility infrastructure, health care waste management, processing of equipment for reuse, pharmaceuticals, and laboratory diagnostic capacity; and Module 3 collects information on service-specific readiness of each service mentioned above.
2. **Health Worker/Provider Interview Questionnaire** – Collects information from providers about their professional qualifications, the services they provide, recent in-service training, and their attitudes about the work environment.
3. **Observation Protocols** – Interviewers observe sick child, antenatal care, and family planning consultations to assess how often consultations follow generally accepted standards of care.
4. **Exit Interview Questionnaire** – Administered to clients after the observed consultations and before they leave the facility to assess the client's understanding and recall of provider instructions and other information, and the client's perception of the service delivery environment.

Source: <http://www.dhsprogram.com/What-We-Do/Survey-Types/SPA-Questionnaires.cfm>

Sampling

SPA is a sample survey of formal sector health facilities. Independent pharmacies and individual doctors' offices are typically not included. The sample is nationally and often regionally (i.e., first-level administrative) representative in a country, and sample sizes average 400-700 facilities, in order to estimate at both national and regional levels. Facilities are systematically sampled from a master facility list in a country (used as sampling frame), with stratification by region and facility type or managing authority (public and non-public). SPA can also be conducted as a census of facilities, depending on the total number of facilities in the country.

Usually, hospitals are oversampled, as they exist in small numbers in a country. Subsequently, the data are weighted during analysis in order to ensure that the results are representative. To do this, a multiplier (sampling weight) is applied to the data to ensure that the contribution of facilities to the total is proportionate to their existence in the country. In each sampled facility, providers are sampled systematically to ensure that the survey collects provider-level information for all services offered at the facility. In addition, clients are

systematically sampled for each of the three services (i.e., antenatal care, family planning, and sick child care) included in observation and exit interview protocols. For example, depending on the reported average number of clients for a specified service per day, usually up to nine providers per facility (three per each service observed) are selected for observation. For each selected provider, typically up to five consultations are systematically chosen for observation. The sample, when adjusted for sampling design, is representative of all clients at the time of

Field implementation

SPAs are typically fielded by 10–15 teams; each composed of 3–4 interviewers who mostly are health workers. These interviewers collect data from the facility in-charge, and conduct the inventory questionnaire in consultation with the most knowledgeable person(s) available for each service. Interviewers are trained to verify the existence of items that are being assessed, rather than relying on responses provided by interviewees.

Source: <http://www.dhsprogram.com/What-We-Do/Survey-Types/SPA-Methodology.cfm>

Costs

SPA costs vary based on country context, sample size, and number of field teams. Recent SPAs have ranged in cost from \$660K to \$1.8M with USAID funding 41% to 100% of total survey costs. USAID Missions pay costs related to survey implementation and dissemination, including technical assistance. USAID/Washington funds activities related to SPA core questionnaire revision, first country SPA planning visits, further analyses of SPA data, regional SPA data analysis workshops and the like.

Survey reports

Since initiation in 1997, there have been 23 SPAs completed in 14 different countries. Final Reports have been published for 21 surveys, and the final report for Nepal Health Facility Survey 2015 is expected to be published in late 2016. There is no global guidance on the frequency with which SPAs should be undertaken.

Source: <http://www.dhsprogram.com/publications/publication-search.cfm?type=21>

SPA Surveys by Date	
#	Title
	<u>Nepal SPA, 2015 - Preliminary Report (English)</u>
23	<u>Senegal SPA, 2015 – Final Report Continuous (French)</u>
22	<u>Bangladesh SPA, 2014 - Final Report (English)</u>
21	<u>Tanzania SPA, 2014-15 - Final Report (English)</u>
20	<u>Senegal SPA, 2014 - Final Report Continuous (French)</u>
19	<u>Malawi SPA, 2013-14 - Final Report (English)</u>
18	<u>Haiti SPA, 2013 - Final Report (French)</u>
17	<u>Senegal SPA, 2012-13 - Final Report Continuous (English, French)</u>
16	<u>Kenya SPA, 2010 - Final Report (English)</u>
15	<u>Namibia SPA, 2009 - Final Report (English)</u>
14	<u>Rwanda SPA, 2007 - Final Report (English/French)</u>
13	<u>Uganda SPA, 2007 - Final Report (English)</u>
12	<u>Tanzania SPA, 2006 - Final Report (English)</u>
11	<u>Zambia HIV SPA, 2005 - Final Report (English)</u>
10	<u>Guyana HIV SPA, 2004 - Final Report (English)</u>
9	<u>Kenya SPA, 2004 - Final Report - HIV SPA (English)</u>

8	Kenya SPA, 2004 - Final Report - MCH SPA (English)
7	Egypt MCH SPA, 2004 - Final Report (English)
6	Ghana MCH SPA, 2002 - Final Report (English)
5	Egypt MCH SPA, 2002 - Final Report (English)
4	Rwanda MCH SPA, 2001 - Final Report (English/French)
3	Bangladesh MCH SPA, 1999-00 - Final Report (English)
2	Kenya MCH SPA, 1999 - Final Report (English)
1	Guatemala MCH SPA, 1997- Final Report (Spanish)

Strategic or results framework for the project/program/intervention (*paste framework below*)

If project/program does not have a strategic/results framework, describe the theory of change of the project/program/intervention.

The DHS Program has five key results and six guiding principles to help achieve these results. It also has a robust internal system for monitoring these results.

Results Framework

Activity Objective: To improve the collection, analysis, and presentation of population, health and nutrition data and to facilitate use of these data for planning, policy-making, and program management.

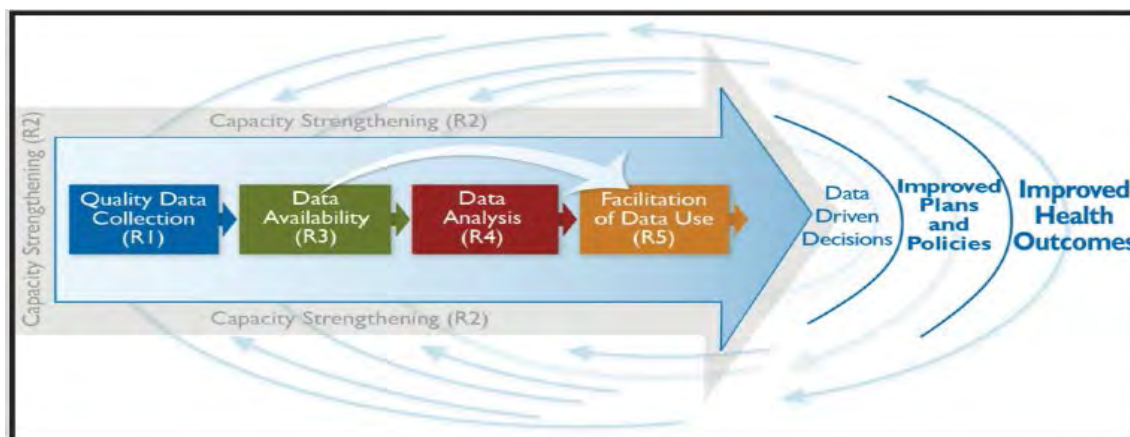
Result 1: Improved tools, partnerships, and technical guidance to collect quality population, health and nutrition data.

Result 2: Increased in-country individual and instructional capacity for identification of data needs and for survey design and management, data collection, data analysis, and information communication to meet those needs.

Result 3: Improved availability of data and information.

Result 4: Advanced analysis and synthesis of DHS data.

Result 5: Improved facilitation of DHS data use among global and country-level stakeholders.



Guiding Principles

1. Align all activities with the ultimate goal of DHS data informing population, health, and nutrition program and policy decision-making.
2. Foster host-country ownership.
3. Strengthen, utilize, and facilitate South-to-South technical exchange.
4. Recognize DHS stakeholder needs while maximizing quality at minimal costs.

5. Coordinate and collaborate strategically with host country and international stakeholders to focus resources and reduce duplication of efforts.
6. Respect individuals, families, and communities who participate in the Program's work.

Internal Monitoring and Evaluation Mechanisms

Data to monitor and evaluate results are available through the Program's:

- Performance Monitoring Plan (PMP)
- Annual Award Fee Reports and Review

Additional information of relevance is available through trip reports, a regularly updated survey tracking list, and yearly work plans.

The DHS Program's prime implementer, ICF, reports in its PMP on a set of indicators developed in consultation with the USAID DHS management team to monitor progress across each of the five result areas. Indicators specifically related to SPA include:

- Number of SPA datasets downloaded
- Number of analysis reports that use SPA data
- Number of SPAs with fieldwork that started during the reporting period
- Percentage of country survey activities that have been completed within one month of the time specified in the final survey time line agreed upon with the country
- Number of applications where advanced technologies* are used to improve survey implementation (*ex: computer assisted personal interviewing)
- Amount of non-USAID funds leveraged to support the implementation of SPA
- Number of individuals (and percentage female) trained to implement DHS-7 surveys, including interviewers and other field staff
- Percentage of countries where enhanced capacity strengthening efforts are being supported by in-country funds such as field support, other donor, and host-country
- Number of DHS-7 reports and dissemination materials produced and available online
- Use of DHS findings to monitor or enhance national, sub-national programs and policies

In addition to the PMP, the DHS Program's annual award fee performance evaluation provides important information of relevance to overall project management and evaluation, including information pertinent to the proposed evaluation. The USAID DHS Performance Evaluation Board works each year with the DHS implementer to define a set of criteria related to the five performance assessment areas-- management, quality, results, cost-control, and timeliness. The yearly award fee process allows USAID to evaluate both actual performance and the conditions under which results are achieved. The Year 3 award fee includes a criterion related to Result 4 that focuses on SPA data:

4. Promotion of SPA data use and analysis of SPA data	<p>The DHS Program will report on activities to promote SPA data use and support analysis of SPA data including:</p> <ul style="list-style-type: none"> • The development of the SPA data analysis training program • 2 SPA analysis trainings scheduled for Year 3 (Bangladesh and Malawi) • Regional SPA workshop in Ghana featuring blended learning techniques • Creation of the first ever SPA key findings video (Tanzania) • Availability of the SPA recode and report on download analytics • Assessment of plus/delta and recommendations for the future
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Finally, the USAID DHS Program management team holds biweekly meetings with ICF to provide technical input and monitor the contractor's performance. Given that the DHS Program is a cost-plus award fee contract and the performance of the contract is monitored annually through a rigorous measurement process that evaluates progress towards and achievement of established performance benchmarks, USAID's Bureau for Global Health and the DHS Program management team are interested in focusing closely on one particular area of the project's portfolio for the mid-term evaluation. This independent performance evaluation will focus on evaluating and documenting the performance of SPA.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Global

IX. SCOPE OF WORK

A. Purpose: Why is this evaluation or analysis being conducted (purpose of analytic activity)?

Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this mid-term performance evaluation is to assess how well SPA is positioned to meet the DHS Program's objective: "To improve the collection, analysis, and presentation of population, health and nutrition data and to facilitate use of these data for planning, policy-making, and program management." The evaluation will address both technical and management considerations to elucidate a better understanding of the challenges and successes of SPA implementation, utilization, and promotion. The evaluation will provide additional information that will expand beyond the current data that is available from the Program's existing, internal monitoring and evaluation systems by utilizing additional data collection methods such as expanded document review, key informant interviews, and site visits.

B. Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID will use the results from the mid-term performance evaluation to inform the technical direction of the DHS Program, as well as the related management steps necessary to take said technical direction

C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

These findings will inform Year 5 activities of the DHS Program as well as the direction of any potential future iteration of the DHS Program.

D. Evaluation/Analytic Questions & Matrix:

- a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**
- b) List the recommended methods that will be used to collect data to be used to answer each question.
- c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

Evaluation Question	Suggested methods for answering this question <i>What data sources and data collection and analysis methods will be used to produce the evidence for answering this question?</i>	Sampling Frame <i>Who is the best source for this information? What is the sampling criteria?</i>
<p>1 What is the perceived value of SPA at global- and country- levels?</p>	<p>Qualitative data collection and analysis based on open-coding of semi-structured interview data collected from key informants. Key data collection topics include:</p> <p>What are global, country-level perceptions of:</p> <ul style="list-style-type: none"> • The purpose, quality, and utility of SPA? • The added value of SPA in the context of household surveys and routine health information systems? • The value of SPA as compared to other health facility assessment surveys (e.g. SARA, SDI, Malaria Quality of Care Surveys, EmOC Assessment)? <p>To what extent do stakeholders' perceptions align with those of the DHS management team both at USAID/Washington and at ICF?</p> <p>In countries that choose to implement health facility assessment survey(s) (whether it is SPA or a different type of assessment), why do stakeholders decide to prioritize resources for facility assessment implementation?</p> <p>What are reasons for selection or non-selection of SPA in place of another type of health facility assessment?</p>	<p>Purposive sampling of key informants based on initial suggestions from USAID and ICF and expanded through snowball sampling.</p> <p>Global-level informants include staff from the DHS Program, USAID Bureau for Global Health, USAID partners, international organizations, other donors.</p> <p>Country-level informants include staff from country government partners and stakeholders, including donors and Mission colleagues.</p> <p>Case studies of 1-2 countries that have recent or active SPA survey schedules.</p>
<p>2 How are SPA data being used at global- and country-levels?</p>	<p>Data collection via key informant interviews, program document review, literature review, and online search of news articles, including:</p> <ul style="list-style-type: none"> • Examples of SPA data use by USAID/Washington, international organizations, researchers from the global north, Ministries of Health, USAID Missions, in-country donors, and local researchers • Examples of missed opportunities for SPA data use (e.g. identified data needs are met by SPA, but key stakeholders believe that the data gap remains; systematic challenges identified by SPA but no policy/programming changes result). 	<p>Case studies of 1-2 countries that have recent or active SPA survey schedules.</p> <p>Purposive sampling of key informants (per above).</p> <p>Review of program documents provided by USAID and ICF.</p> <p>Literature review based on key search terms and utilizing databases like JSTOR, Popline, PubMed.</p>

	What are the perceived challenges in using SPA data?	Google news search of key search terms.
	What are perceived opportunities to increase use of SPA data?	
3	<p>What are USAID's and ICF's perceptions about opportunities and challenges in facilitating SPA implementation?</p> <p>Qualitative data collection and analysis based on common themes arising via guided focus group discussions:</p> <p>What are the perceptions on:</p> <ul style="list-style-type: none"> • The level of USAID's investment in SPA (funding amount, types of investments, USAID staff level of effort)? • The level of ICF investment in SPA (staffing levels, skills, level of technical assistance required) • USAID and DHS Program interest in promoting, facilitating SPA implementation • The future direction of health facility assessments, including and beyond SPA • Areas for SPA improvement (tools, processes, products) • Areas for SPA improvement under the control of USAID and/or ICF • Opportunities for DHS/SPA coordination • ICF's relationship with Missions and other key stakeholders as related to SPA implementation 	<p>Guided participatory discussions via focus group(s) including USAID/Washington and ICF DHS Program management teams and other DHS Program staff identified by USAID and ICF.</p> <p>If feasible, SPA activity managers from USAID/Missions may also be invited to participate.</p>

Other Questions [OPTIONAL]

(**Note:** Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

None.

E. **Methods:** Check and describe the recommended methods for this analytic activity.

Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods: The evaluation team will work collaboratively with the USAID DHS management team to develop a detailed work plan as well as a data collection strategy including data collection instruments. Methods include but not limited to: document/literature review, key informant interviews, and focus group discussions. Data collection approaches and sources are described in more detail herein. Site visits are encouraged to facilitate data collection.

■ **Document and Data Review** (*list of documents and data recommended for review*)

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- Project documents

- DHS Program Contract Scope of Work
- Relevant DHS Award Fee Responses (Years 1-3)
- DHS Program annual work plans (Years 1-4)
- DHS Program annual PMP Report (Years 1-3)
- Project technical documents
 - SPA questionnaires
 - SPA survey interviewer's manual and interviewer's training micro-design
 - SPA tabulation plan
 - Guide to preparing SPA final and preliminary reports
 - Relevant trip reports
 - Country SPA Final and Preliminary Reports
 - Research/Analytical reports using SPA data
 - Capacity building materials, including SPA analysis workshop presentations
 - Communication materials using SPA data, including SPA brochures
- Other technical documents
 - USAID Evaluation Policy
 - WHO's Service Availability and Readiness Indicators
 - Other health facility assessment tools,
 - Meeting notes and documents from the Health Facility Assessment Survey sub Technical Working Group of the Global Health Data Collaborative
 - Selected grey literature (e.g. technical assessment, monitoring reports) that make use of health facility survey data
 - Selected peer-reviewed research papers using SPA data

☐ **Secondary analysis of existing data** (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

Data Source (existing dataset)	Description of data	Recommended analysis
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■ **Key Informant Interviews** (*list categories of key informants, and purpose of inquiry*)

The team will conduct semi-structured interviews with key stakeholders, including but not limited to the following list. A final list will be developed in consultation with the USAID/Washington DHS management team, which may also suggest additional persons who can provide insights useful to this evaluation.

- USAID/Washington
 - DHS management team
 - GH Bureau staff outside the management team who have expert knowledge of health information systems and/or need for facility-level data
- USAID/Mission Staff that support DHS and SPA surveys in selected countries
- DHS Program Staff
 - ICF team
 - Implementing partners for SPA
- External Informants - Project Partners / Key Stakeholders
 - Host country government stakeholders, including relevant policy makers requesting / using SPA data
 - Host country other non-governmental stakeholders, if applicable (e.g., TWG members, research firms, etc.)

- Stakeholders in the health facility assessment survey sub Technical Working Group, Global Health Data Collaborative
- SPA data users including USAID implementing partners and researchers
- Others will be added to the lists by the team as additional key informants are identified during the course of the evaluation.

Key informant interviews with domestic stakeholders will be conducted in Washington, DC at their respective on-site locations or by telephone; whichever is most expedient and cost effective. Additional telephone interviews with overseas interviewees with Mission staff and other external stakeholders may be conducted from the U.S.

■ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

To answer evaluation question #3, guided and participatory focus group discussion with:

- USAID/Washington DHS management team
- DHS Program Staff (ICF and subcontractors)

☐ **Group Interviews** *(list categories of groups, and purpose of inquiry)*

☐ **Client/Participant Satisfaction or Exit Interviews** *(list who is to be interviewed, and purpose of inquiry)*

☐ **Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

☐ **Facility or Service Assessment/Survey** *(list type of facility or service of interest, and purpose of inquiry)*

☐ **Observations** *(list types of sites or activities to be observed, and purpose of inquiry)*

☐ **Cost Analysis** *(list costing factors of interest, and type of costing assessment, if known)*

☐ **Data Abstraction** *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

■ **Case Study** *(describe the case, and issue of interest to be explored)*

USAID envisions that a select number of countries (likely two) with recent or active SPA survey schedules that are well positioned to provide diverse perspectives on the evaluation questions will be selected as case studies. The Short list countries include the following countries that have conducted SPA multiple times (*or are in planning discussions to conduct additional SPAs) as well as other health facility assessment surveys: Kenya, Tanzania, Bangladesh*, Nepal*, and Haiti*. Each country has different levels of stakeholder coordination, and all are well suited to provide answers to the evaluation questions. In addition, the following countries had preliminary discussions in recent years with USAID/Washington and ICF to conduct SPA, but SPA never went forward for myriad, diverse reasons also worth incorporating into the evaluation: Jordan, Egypt, Namibia, and Ghana.

The evaluation team will consult with and receive approval from the USAID management team prior to the final selection of countries for case studies.

☐ **Verbal Autopsy** (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

☐ **Rapid Appraisal Methods** (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

☐ **Other** (list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes

☐ No

List or describe case and counterfactual

Case	Counterfactual
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X. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data are to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple data sources and data collection methods will allow the Team to triangulate findings to produce more robust evaluation results. The Evaluation Report will describe analytic methods employed in this evaluation.

XII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background Reading – Several documents are available for review for this analytic activity. These include The Demographic and Health Surveys contract, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as SPA survey reports. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation. The team shall review a set of background documents prior to the Team Planning Meeting.

Team Planning Meeting (TPM) – A one-day team planning meeting (TPM) will be held before data collection begins. During this meeting, the Team will meet with USAID/DHS management team members to review the SOW and discuss expectations and deliverables, determine roles and responsibilities of all team members, and agree on a timeline for the evaluation effort. Specifically, meeting attendees will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Review and clarify any logistical and administrative procedures for the assignment

Draft Work Plan—Within five work days following the In-Brief with USAID, at the end of the Team Planning Meeting, the evaluation team will develop and submit to the USAID DHS management team a draft work plan that will include the following elements:

- Description of each team member's roles and responsibilities
- List of final evaluation questions and/or guidelines for questionnaires
- Approach to data collection, methodologies to be used, how data will be analyzed
- Data collection instruments (to be included in appendices)
- Draft outline of final report (including appendices)
- Dissemination plan of key findings
- Assignment timeline
- Deliverables deadline(s)

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include all the Evaluation Team experts, but will be determined in consultation with the USAID DHS Management Team. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Work plan and methodology review briefing**. After receiving the draft work plan, USAID may ask to meet with the Team to resolve outstanding questions and discuss suggestions related to data collection instruments/methodology and the like.
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing or in email.
- A **final debrief** between the Evaluation Team and USAID will be held after the Team conducts all data collection activities and has reached consensus on the preliminary conclusions and recommendations, but before the draft report is submitted. At the debrief, the Team will present preliminary findings to the USAID DHS Management Team and DHS Program senior leadership at ICF, including a summary of the data along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The Team will not discuss information that may be procurement-sensitive with ICF and shall reserve some time for a smaller discussion with USAID on such issues/recommendations. The evaluation team shall incorporate comments received during the debrief from USAID and ICF in the evaluation report. (*Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **Stakeholders' debrief/workshop** will be held with a larger USAID audience several days after the draft report has been submitted to the USAID DHS Management Team. The Evaluation Team will prepare a PowerPoint presentation for the debriefing, and will not include any information that may be procurement deemed sensitive or not suitable for distribution to a large audience.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct one to two site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field. The current country short list includes the following countries that have conducted SPA multiple times (*or are in planning discussions to conduct additional SPAs) as well as other health facility assessment surveys: Kenya, Tanzania, Bangladesh*, Nepal*, and Haiti*.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send comments and edits back to GH Pro
4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

Data Submission – Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	February 2 or 3, 2017 (morning preferred)
■ In-brief with USAID and ICF	February 13, 2017
■ Workplan and Protocol briefing with USAID	February 16, 2017
■ Workplan with timeline	February 17, 2017
■ Analytic protocol with data collection tools	February 17, 2017
■ Routine briefings with USAID	Weekly and as needed
■ Out-brief with USAID and ICF with PowerPoint presentation	April 3, 2017
■ Draft report	Submit to GH Pro: April 19, 2017 GH Pro submits to USAID: April 24, 2017
■ Findings review workshop with IP and stakeholders with PowerPoint presentation	TBD
■ Final report	Submit to GH Pro: May 15, 2017 GH Pro submits to USAID: 3May 18, 2017
■ Raw data (cleaned datasets in CSV or XML with data dictionary)	May 15, 2017
■ Report Posted to the DEC	June 30, 2017

In short, the evaluation team will provide the following deliverables:

- Draft Work plan for review
- Final Work plan for approval, including approved travel schedule
- Oral presentation with PowerPoint of preliminary results
- Draft report for review by DHS management team and ICF

- Oral presentation with PowerPoint of results for larger USAID audience
- Final report including annexes such as bibliography, interview summaries, list of data sources

Estimated USAID review time

Average number of business days USAID will need to review Report deliverables requiring USAID review and/or approval? 10 business days/deliverable

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team:

A two-member evaluation team is proposed; one person will be designated as the team leader and will be in charge of the overall design, data collection, analysis and writing of the evaluation report.

Note: ICF is interested in the outcomes of this evaluation. As such, USAID has requested their involvement throughout this evaluation, in any way that does not constitute a conflict of interest. Therefore, USAID may ask ICF to review the Evaluation workplan with the evaluation protocols and the data collection tools, as well as drafts of the report. ICF should not be involved in any data collection activities, as their presence may influence the results and present a conflict of interest. The Evaluation Team under the guidance of the Team Lead will determine if a conflict of interest exists.

The team will be composed of the following:

- **Team Leader, Evaluation and Survey Specialist** will oversee all aspects of the project, liaise with USAID and the other consultant(s), oversee data collection and analysis, write sections of the report, write the official report, present conclusions and recommendations to USAID. The team leader should have prior experience and expertise in program evaluation and assessment, survey implementation expertise, understanding of USAID program and processes, and experience with international population and health technical areas, preferably health service facility assessments.
- **Service Delivery Technical Consultant** will have a specialized evaluation expertise and programmatic experience in the design, implementation and analysis of service delivery quality assessments, especially as a researcher / evaluation specialist in the design and implementation of surveys in formal health facilities. The consultant will be preferably familiar with SPA survey methods, **global data needs (e.g., service readiness indicators and quality of care), and other** health facility surveys. The consultant will bring the lens of his/her subject matter expertise and experience to bear on all aspects of the Scope of Work. S/he will work closely with the Team Leader to assess the quality and relevance of internal work practices and processes, and offer his/her perspectives on tasks associated with this assignment. S/he will work seamlessly with the Team Leader to interview key informants, conduct data collection and analysis, and write sections of the report.

Team Qualifications: Please list technical areas of expertise required for this activity.

Overall Team requirements:

The combined skill sets of the consultants should include, at minimum:

- Longstanding experience and technical expertise in survey operations, especially in developing country contexts;

- Expertise in conducting evaluations and assessments of public health and facility based health service delivery in developing country contexts;
- Longstanding experience and technical expertise in population and health issues; clinical health services and health facility assessments;
- Excellent skills in project management;
- Excellent analytic and writing skills;
- Experience implementing key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data;
- Experience using analytic software;
- Demonstrated experience using qualitative evaluation methodologies, and triangulating multiple data sources.

Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

GH Pro will provide a **Program Assistant** who will provide logistics and administrative support for this evaluation. Working under the guidance of the Team Lead, she will arrange meetings and appointments, assist with managing with web-based survey, and other tasks as assigned and ensure the processes moves forward smoothly.

Local Logistics/Program Assistant (1 per country visited) will support the Evaluation Team for country site visits. The Logistics/Program Assistant support the Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations, including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments, including assisting booking interviews. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist with note taking at interviews and meetings, as well as with translation of data collection tools and transcripts.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:

☒ Significant Involvement anticipated – If yes, specify who: Madeleine Short Fabic

☐ No

Staffing Level of Effort (LOE) Matrix (Optional):

The USAID DHS Management Team and the Evaluation Team may request to meet on a periodic basis during the implementation of the evaluation for the purposes of clarification and sharing information. The following is a sample schedule. The evaluation team will finalize a schedule and exact dates for the evaluation at the Team Planning Meeting in collaboration with the USAID/DHS management team. Proposed LOE is 106 person days over 60 work days, distributed as follows:

Activities	Team Member(s) (#)	Total Person Days	Period of Performance (days)
Meet USAID DHS management team for launch	2	1	1
<i>*USAID DHS management team sends background documents to the evaluation team members</i>			
Conduct desk review	2	14	7
Meet USAID DHS management team for in-brief	2	2	1
Develop work plan and travel plan	2	4	2
Submit work plan and travel plan to USAID DHS management team for approval	1	0	0
<i>*USAID/DHS management team communicates with USAID/Mission staff *ICF and/or USAID/Mission staff communicate with host-country partners</i>			
Conduct key informant interviews and telephone interviews in Washington, DC	2	20	10
Travel to country (1 team member/country; 2 countries)	2	4	2
Debrief USAID/Mission staff and coordinate key stakeholder meetings	2	4	2
Conduct meetings and interviews with in-country key stakeholders	2	12	6 (if traveling together then 12 days per person)
Depart country	2	4	2
Analyze and synthesize information	2	20	10
Draft report and PPT presentation	2	14	7
Oral debriefing and PPT presentation to USAID DHS management team and ICF	2	2	1
Submit full draft to GH Pro for submission to USAID DHS management team and ICF	1	1	1
<i>*GH Pro Report QC Review & Formatting</i>			
<i>*USAID DHS management team sends technical feedback/comments on draft to Team Leader</i>			
Revise PPT presentation	1	1	1
Present draft findings at USAID	2	2	1
Revise the full draft by Team Leader	1	3	3
Edit and finalize report by all team members	2	4	2
Submit the final report	1	1	1
<i>*USAID DHS management team approves report</i>			
Final report/ Data Dissemination / Stakeholder review	2	2	1
<i>*GH Pro final formatting, 508 compliance editing, DEC submission</i>			
<i>*USAID DHS management team closes out the activity</i>			

Activities	Team Member(s) (#)	Total Person Days	Period of Performance (days)
TOTAL	...	114	60

If overseas, is a 6-day workweek permitted

☒ Yes

☐ No

Travel anticipated: List international and local travel anticipated by what team members.

One to two countries to be determined. USAID envisions that a select number of countries (likely two) with recent or active SPA survey schedules that are well positioned to provide diverse perspectives on the evaluation questions will be selected as case studies. The Short list countries include the following countries have conducted SPA multiple times (*or are in planning discussions to conduct additional SPAs) as well as other health facility assessment surveys: Kenya, Tanzania, Bangladesh*, Nepal*, and Haiti*. Each country has different levels of stakeholder coordination, and all are well suited to provide answers to the evaluation questions. In addition, the following countries had preliminary discussions in recent years with USAID/Washington and ICF to conduct SPA, but SPA never went forward for myriad, diverse reasons also worth incorporating into the evaluation: Jordan, Egypt, Namibia, and Ghana.

XV. LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

To be determined based on final country site visit decisions.

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
	<input type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it.

GH Pro can obtain **Secret Security Clearances** and **Facility Access (FA)** for our consultants, but please note these requests processed through USAID/GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking approximately 6 months to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access: _____

☒ Electronic County Clearance (ECC) (International travelers only) –TBD once countries to be visited are selected

☒ High Threat Security Overseas Seminar (HTSOS) (required with ECC)

☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____

☐ Travel -other than posting (specify): _____

☐ Other (specify): _____

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.

- Develop SOW.
- Peer Review SOW
- Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

The **Evaluation Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- The report must not exceed 35 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- Draft report must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).

- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.*** Two printed copies of the final report will also be provided to the USAID DHS Management Team.

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 5 pages);
- Table of Contents (1 page);
- Acronyms
- Body of the Report (not to exceed 35 pages)
 - Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
 - Background (1-3 pages)
 - Evaluation/Analytic Methods (1-3 pages)
 - Findings (organized by Evaluation/Analytic Questions)
 - Discussion and Limitations
 - Conclusions and Recommendations
- Annexes (the length of which should be approved by the USAID DHS management team)
- Annex I: Evaluation/Analytic Statement of Work
- Annex II: Detailed discussion of methodological, analytic, or technical issues, as appropriate
- Annex III: Data Collection Instruments
- Annex IV: Sources of Information
 - List of Types and Numbers of Persons Interviewed (note: names of interviewees as well as those contacted but for whom no interview was granted shall be provided in a separate, internal document to the USAID DHS management team)
 - Bibliography of Documents Reviewed
 - Databases
 - Sites visited
- Annex V: Disclosure of Any Conflicts of Interest
- Annex VI: Statement of Differences (if applicable)
- Annex VII: PowerPoint presentation on the preliminary results of the evaluation

- Annex VIII: Summary information about evaluation team members, including qualifications, experience, and role on the team

The Team Leader is responsible for the content of the final report. If there is disagreement among the team members conducting the evaluation, the Team Leader should have the final decision, with dissenting opinions provided in Annex VI.

The final report should be completed no more than one week after comments from the USAID DHS management team are received. The contractor will have the report edited, formatted, and printed within approximately 30 days of receiving final USAID approval of the content.

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement-sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Madeleine Short Fabic	Michelle Surdyk	
Title:	Public Health Advisor	Program Analyst	
USAID Office:	GH/PRH	GH/PRH	
Email:	mshort@usaid.gov	msurdyk@usaid.gov	
Telephone:	571-551-7047	571-551-7057	
Cell Phone:	202-679-4703		

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2
Name:	Amani Selim	
Title:	Evaluation Advisor	
USAID Office:	GH/PRH	
Email:	aselim@usaid.gov	
Telephone:	571 551 7528	
Cell Phone:	571 721 9577	

XX. OTHER REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

ANNEX IV. TOOLS

- A. KII Field Guide Respondent groups: USAID Washington
- B. DHS-7 SPA Midterm Evaluation KII Field Guide for ICF staff
- C. DHS-7 SPA Midterm Evaluation KII Field Guide Respondent groups: USAID Missions - Started, then stopped SPA
- D. DHS-7 SPA Midterm Evaluation KII Field Guide Respondent groups: USAID MISSIONS
- E. KII Field Guide Respondent groups: In-country donors, USAID IP, INGOs
- F. KII Field Guide Respondent groups: Country Partner

A. KII Field Guide Respondent groups: USAID Washington

0 Date of interview: _____ / _____ / _____
0

Type of Respondent ☐ USAID/W DHS-7 Mgt staff team ☐ USAID/W other staff

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, xxx on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation.

If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "USAID staff", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? ☐ YES ☐ NO

Name of Respondent JIM HEIBY _____
Age _____ Gender ☐ Male ☐ Female

Job Title _____

Email: _____@_____. _____

Phone number: _____

Name of Respondent _____

Age _____ Gender ☐ Male ☐ Female

Job Title _____

Email: _____@_____. _____

Phone number: _____

Name of Respondent _____

Age _____ Gender ☐ Male ☐ Female

Job Title _____

Email: _____@_____. _____

Phone number: _____

Name of Respondent _____

Age _____ Gender ☐ Male ☐ Female

Job Title _____

Email: _____@_____. _____

Phone number: _____

Name of Respondent _____
 Age _____ Gender ☐ Male ☐ Female
 Job Title _____
 Email: _____@_____._____
 Phone number: _____

Let's begin by talking your perceptions of HFAs, and SPA in particular

Q
I

- 01 How are you involved in the SPA?
 -Probe: if not involved, ask if they have been involved in other HFAs
- 02 Please describe the purpose of the SPA, in your own words.
 What do you know about the SPA?
 -How important are HFAs like SPA to your work? Why?
 To improving health outcomes? Why?
 -Probe: production of quality health facility data? Use of data to promote accountability among health managers and health workers? How?
 -Compared to other health facility assessments (HFAs), how well is SPA positioned to promote accountability?
- 03 [SKIP IF NOT INVOLVED IN SPA]
 How are decisions made to conduct a SPA? How does Washington work with countries during this process?
 What kind of factors come into play when the decision is made to conduct a SPA instead of/combined with a different type of HFA??
- 04 [SKIP IF NOT INVOLVED IN SPA]
 In a sense countries can be divided up into four different groups:
 1. Countries that do an initial SPA and then decide to do another one.
 2. Countries that do an initial SPA and have not done a second one.
 3. Countries that start the SPA process but drop it at some point.
 4. Countries that have never made any movement towards conducting a SPA.
- Please comment on why countries go down these different paths.
- 05 [SKIP IF NOT INVOLVED IN SPA]
 What contributions are made towards funding SPAs from the center level? Is this any different from how other types of HFAs are paid for?
 How adequate is the center-level funding that is put towards SPAs? Technical assistance?
- 06 What are the major groups that SPA results need to be communicated to above the country level?
 What kind of plans (formal / informal) are made to do so?
 Who develops these plans?
 How effective / helpful are they?
- [SKIP IF NOT INVOLVED IN SPA]**
- 07 The SPA is implemented along a continuum that starts with conception, and ends with use of the data. Here is a picture of what we mean [show/refer to drawing of continuum of SPA implementation]

Conceptualization → coalition-building → survey design → data collection → analysis → Dissemination → use of results

In thinking about each of the phases along the continuum of SPA implementation, how well would you say each step of the process go in general across countries that you are familiar with (0 = not well at all, 10 =extremely well)?

Why? [It's ok to state you are not familiar with one or more step]

-Conception _____

What works well?

What could be done better?

-coalition building _____

What works well?

What could be done better?

-Survey design/tool _____

What works well?

What could be done better?

-training _____

What works well?

What could be done better?

-Data Collection _____

What works well?

What could be done better?

-Data analysis _____

What works well?

What could be done better?

-Dissemination—Report and Presentation _____

What works well?

What could be done better?

-Use of the data _____

What works well?

What could be done better?

- 08 On a scale of 0 to 10, with 0 being absolutely lowest quality, to 10 being absolute highest quality, how would you rate the quality of the information coming from the SPA?

Why did you give it that rating? Where do the quality problems come from?

How does quality of data vary among the different SPA components?

- Probe: facility inventory, health worker/provider interview, observation protocol, and client exit interview questionnaire

- 09 In general, what information does SPA provide that routine government HMIS (or specifically DHIS 2) or health-related household surveys do not?

- 10 What other types of HFAs are you familiar with?

What is the added value of SPA compared to other HFAs (and vice-versa)?

-Probe: in terms of process, product, quality of data, ease of use of data, etc.)

How important is it to you that SPA (or a core set of questions) is standardized across other major HFA platforms?

- 11 How important is it to you that SPA (or a core set of questions) is standardized across countries?

How closely do you think the SPA and DHS should be spaced from each other?

Why do you think this?

- 12 What are some opportunities that you see for further DHS/SPA coordination?

Use of SPA data, missed opportunities, potential opportunities

- 13 Can you share examples of how you have used SPA data in your work?

What are different ways that SPA data has been used globally?

..... in countries where SPAs have been conducted?

Please comment on how this process has gone.

Has there ever been an occasion when you had data measuring the same indicators from a SPA and also from another data source?

Which one did you use? Why?

- 14 How would you compare the usefulness of data from the different SPA components?

Probe: service availability, service readiness, quality of care, client and provider satisfaction, other

Which data are used most often? Why?

- 15 Can you share examples where your work (a report, a presentation, or a decision) could have been better informed by data from a nationally representative health facility data, such as that produced by SPA, and the data were available, but you did not use it?

Why didn't you use it?

-Probe: availability? Knowledge of SPA? Ability to analyze/make use of SPA data?

Understandability/user-friendliness of SPA reports, timing?

- 16 Can you think of examples where other colleagues have not taken full advantage of SPA data?

-Probe: Within USAID/W or Missions; Within Donor community at large; UN

Agencies/initiatives? Within Ministries; Within implementing partners; within large multi-funded INGOs? Local NGOs?

Why do you think those opportunities got missed?

- 17 To what extent are there regular or upcoming opportunities to use data from the SPA within USAID?

- 18 What kind of challenges have you or colleagues in USAID faced in using SPA data to support:

-Policy change?

-Program management?

-Data analysis?

- 19 The (SPA) data can often expose problems and weaknesses in the health services and cause political tensions for the government of some countries. How much of a problem was this in the countries where a SPA has been done?

How has this been dealt with?

USAID and ICF perceptions of challenges, opportunities of SPA

3

- 20 **[SKIP IF NOT INVOLVED IN SPA]**

What are your comments regarding the level of USAID's investment in SPA?

-Probe: funding amounts, types of investments, USAID staff level of effort, etc.

- 21 **[SKIP IF NOT INVOLVED IN SPA]**

What are your comments regarding the level of ICF's investment in SPA?

-Probe: staffing levels, skills, level of technical assistance, etc.

- 22 **[SKIP IF NOT INVOLVED IN SPA]**

How well does the SPA fit with the other work that ICF does under the DHS-7 contract?

Please explain some of the issues with the SPA that are different than issues with the standard DHS survey.

Given these issues, how interested are you (USAID) in promoting and facilitating the SPA initiative? (scale of 0 = not interested at all, 10 = completely and passionately interested)
Why?

What would USAID need to do so that ICF could implement the SPA more effectively?

- 23 What is the future direction of HFAs in the global context?
Within this context, what is the best role for the SPA initiative?
- 24 What areas do you see that need to be improved in the SPA?
--Probes: tools/processes/products/other
Which of these opportunities are under USAID's or ICF's control? Which are not?
- 25 **[SKIP IF NOT INVOLVED IN SPA]**
Please describe the relationship between ICF and USAID at the central level as related to SPA implementation.
Please describe the relationship between ICF and USAID Missions (and other key stakeholders) as related to SPA implementation at the country-level.
- 26 Do you have any questions for us?

THANK YOU SO MUCH FOR YOUR TIME!

DHS-7 SPA Midterm Evaluation KII Field Guide for ICF staff

00 Date of interview: _____/_____/_____

Type of Respondent

☐ ICF STAFF ☐ ICF Partner

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, xxx on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation. If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion, or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "ICF", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? ☐ YES ☐ NO

Name of Respondent _____
Age _____ Gender ☐ Male ☐ Female
Job Title _____
Email: _____@_____.
Phone number: _____

Name of Respondent _____
Age _____ Gender ☐ Male ☐ Female
Job Title _____
Email: _____@_____.
Phone number: _____

Name of Respondent _____
Age _____ Gender ☐ Male ☐ Female
Job Title _____

Email: _____@_____.
Phone number: _____

Name of Respondent _____
Age _____ Gender ☐ Male ☐ Female
Job Title _____
Email: _____@_____.
Phone number: _____

Name of Respondent _____
Age _____ Gender ☐ Male ☐ Female
Job Title _____
Email: _____@_____.
Phone number: _____

Let's begin by talking about your perceptions SPA

Q

01 Please tell us a bit about the DHS program and how the SPA fits in to the overall program.

02 Please explain ICF's role and experiences in implementing SPAs?

I

-Probe: type(s) of staff involved, level of expertise, and how this differ per country

What is your personal involvement in SPAs?

03 How would you describe the purpose of the SPA, in your own words?

-How important is the SPA for improving health outcomes? Why?

-Probe: production of quality health facility data? Promotion of accountability?

*-Compared to other health facility assessment platforms, how well is SPA positioned to ...
(state the issues that the respondent feels are important)?*

04 How do countries get to know about SPA? How do Missions?

05 Please help us understand who makes the decisions to implement SPAs? How is ICF involved in this decision?

Who funds SPAs?

In general, how adequate is the funding? Technical assistance?

06 In a sense, countries can be divided up into four different groups:

5. Countries that do an initial SPA and then decide to do another one.
6. Countries that do an initial SPA and have not done a second one.
7. Countries that start the SPA process but drop it at some point.
8. Countries that have never made any movement towards conducting a SPA.

Please comment on why countries go down these different paths.

07 Who are the major groups that you or other organizations need to communicate the results of the SPA to?

Please describe to us your communications plan for SPA results at the global level.

At the country level.

Is there a formal written communication plan for each SPA?

How would you improve it, given the opportunity?

- 08 The SPA is implemented along a continuum that starts with conception, and ends with use of the data. Here is a picture of what we mean [show/refer to drawing of continuum of SPA implementation]. If you think that the continuum should be restructured please suggest.

Conceptualization → coalition-building → survey design → data collection → analysis → Dissemination → use of results

In thinking about each of the phases along the continuum of SPA implementation, how well would you say each step of the process goes in general at the country-level (0 = not well at all, 10 =extremely well)? Why? Please note the level of ICF's involvement in each phase as well.

-Conception _____

What works well?

What could be done better?

-coalition building _____

What works well?

What could be done better?

-Survey design/tool development _____

What works well?

What could be done better?

-training _____

What works well?

What could be done better?

-Data Collection _____

What works well?

What could be done better?

-Data analysis _____

What works well?

What could be done better?

-Dissemination—Report and presentation _____

What works well?

What could be done better?

-Use of the data _____

What worked well?

What could be done better?

Where along this continuum does ICF play the strongest role?

- 09 On a scale of 0 to 10, with 0 being absolutely lowest quality, to 10 being absolute highest quality, how would you rate the **quality** of the information coming from the SPA? _____ 1

Why did you give it this rating?

How is does it vary among the different SPA components?

- Probe: service availability, service readiness, quality of care, client and provider satisfaction, other

- 10 Compared to health-related HH surveys and government HMIS, what additional value and/or information does SPA provide?

- 11 What other types of HFAs are you familiar with?

What is the added value of SPA compared to other HFAs (and vice-versa)?

-Probe: in terms of process, product, quality of data, ease of use of data, etc.)

How important is it to you that SPA (or a core set of questions) is standardized across other major HFA platforms?

Why is that important?

- 12 How important is it to you that SPA (or a core set of questions) is standardized across countries?

What are the relative percentages of core vs. country-specific questions in a typical country for SPA? For DHS?

How closely do you think the SPA and DHS should be spaced to each other?

Why/why not?

What are some opportunities that you see for further coordination of the DHS and SPA efforts?

Use of SPA data, missed opportunities, potential opportunities

- 13 What are different ways that SPA data has been used in the countries where they have been conducted? 2

--Probe: also at different levels of government in countries where significant decentralization has taken place

- 14 How would you compare the usefulness of data from the different SPA components?

- Probe: service availability, service readiness, quality of care, client and provider satisfaction, other

Which data are used most often? Why?

- 15 Are there regular or upcoming opportunities to use data from SPAs at the global level? Please describe.

Are there regular or upcoming opportunities to use data from SPAs at the country level? Please describe and note which countries are especially conducive for these opportunities.

- 16 Can you think of examples where stakeholders have not taken full advantage of SPA data?

–Probe: *Within USAID/W or Missions; Within Donor community at large; UN Agencies/initiatives? Within Ministries; Within implementing partners; within large multi-funded INGOs? Local NGOs?*

Why do you think these opportunities are missed?

- 17 What kind of challenges has ICF faced in promoting the use of SPA data for:

-Policy change?
-Program management?
-Data analysis?
-Other?

Perceptions of challenges, opportunities, and future of SPA

3

- 18 What are your comments regarding the level of USAID's investment in SPA?

–Probe: *funding amounts, types of investments, USAID staff level of effort, etc.*

- 19 What are your comments regarding the level of ICF's investment in SPA?

–Probe: *staffing levels, skills, level of technical assistance, etc.*

- 20 How well does the SPA fit with the other work you do as implementer of The DHS Program?

Please explain some of the issues with the SPA that are different than with the DHS

Given these issues, how interested is ICF in continuing to manage the SPA? (scale of 0 = not interested at all, 10 = completely and passionately interested) _____

Why?

What would ICF need to (do to) better implement the SPA?

- 21 What do you think is the future direction of HFAs, globally?

What is the role for SPA globally, within the overall context of HFAs?

- 22 What areas do you see that need to be improved in the SPA?

–Probes: *tools/processes/products/other*

- 23 Please describe the relationship between ICF and the Mission (and other key stakeholders like the Ministries of Health) as related to SPA implementation in the countries where this has gone well.

Where it has not gone so well.

- 24 Do you have any questions for us?

THANK YOU SO MUCH FOR YOUR TIME!
B. DHS-7 SPA Midterm Evaluation KII Field Guide Respondent
groups: USAID Missions - Started, then stopped SPA

00 Date of interview: _____/_____/_____

Type of Respondent: USAID Mission [_____]

Names: _____

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, xxx on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation.

If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "USAID staff", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? [] YES [] NO

Evaluation Question 1: Perceptions of SPA

Q

- 01 We understand that [COUNTRY] has started discussions on conducting a SPA, but was not able to continue with the process and actually conduct a SPA. We would like to better understand why that was the case.

Can you please tell me what happened?

- 2 Let's discuss further the SPA you were going to conduct. We are going to ask you for each step along the process, whether you got that far, how well would you say that step went on a scale of 0 to 10 (0 = not well at all, 10 = extremely well), and why?

It's ok to state you are not familiar with one or more steps, and we will not ask questions beyond the step you tell us you reached. For example, if you only got to survey design, we will not ask you questions about data collection, analysis, report writing or dissemination.

-**Conception** _____ What worked well? What could be done better?
-**coalition building** _____ What worked well? What could be done better?
-**Survey design/tool** _____ What worked well? What could be done better?
-**training** _____ What worked well? What could be done better?
-**Data Collection** _____ What worked well? What could be done better?
-**Data analysis** _____ What worked well? What could be done better?
-**Report Writing** _____ What worked well? What could be done better?
-**Dissemination** _____ What worked well? What could be done better?
-**Use of the data** _____ What worked well? What could be done better?

- 03 Have you conducted other HFAs in [COUNTRY]? IF YES, WHICH ONES?

IF NO, SKIP TO QUESTION 5

- 04 On a scale of 0 to 10, with 0 being absolutely lowest quality, to 10 being absolute highest quality, how would you rate the quality of the information coming from the HFA?

Why?

- 05 What information does HFA provide that routine HMIS (or specifically DHIS 2) or health-related household surveys do not in [COUNTRY]? I

[IF NOT FAMILIAR WITH OTHER HFA, SKIP TO QUESTION 9]

Can you comment on the rigor with which this information is currently obtained in [COUNTRY]?

- 06 Of the various HFAs that you are familiar with, what is the added value of each compared to the others? *-Probe: in terms of process, product, quality of data, ease of use of data, etc.)*

How important is it to you that questions be standardized across HFA platforms?

- 07 How important is it to you that HFAs (or a core set of questions) is standardized across countries?

- 08 How closely do you think the HFAs and Household surveys should be spaced from each other?

- 09 **Evaluation Question 2: Use of SPA data, missed opportunities, potential opportunities**

Can you share examples of where your work could have benefited from SPA or other HFA data?

What are different ways that HFA data has been used in [COUNTRY]? How decentralized is the use of HFA data by the MOH?

How can results from the HFA best be used to improve the health services in [COUNTRY]?

How easy is it for you (and your MOH colleagues) to work with data from the (HFA)? To understand what the data are saying?

- 10 Are there regular or upcoming opportunities to use data from the HFA in [COUNTRY]? Please describe.

- 11 What kind of challenges have you or your organization or other colleagues in [COUNTRY] faced in using HFA data for:

-Policy change?

-Program management?

-Data analysis?

- 12 The (HFA) data can often expose problems and weaknesses in the health services and cause political tensions for the government of some countries. How much of a problem was this in [COUNTRY]?

How big of a problem do you think this would be in [COUNTRY]?

- 13 **USAID and ICF perceptions of challenges, opportunities of SPA**

How well does the SPA fit with the work that the Mission supports in [COUNTRY]? 3

- 14 When thinking of your relationship with ICF for the implementation of DHS, how well has that gone?
[SKIP IF NOT IMPLEMENTED DHS EITHER]
- 15 How best could ICF and USAID (central, country) build on existing DHS work to strengthen implementation of SPA?
[SKIP IF NOT IMPLEMENTED DHS EITHER]
- 16 How interested is the Mission in supporting the conduct of the SPA in the future? (scale of 0 = not interested at all, 10 = completely and passionately interested)?
Why?
- 17 Do you have any other questions for us?
THANK YOU SO MUCH FOR YOUR TIME!

C. DHS-7 SPA Midterm Evaluation KII Field Guide Respondent groups: USAID MISSIONS WITH SPA

00 Date of interview: _____ / _____ / _____

Type of Respondent: USAID Mission [_____]

Names: _____

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, xxx on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation.

If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "USAID staff", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? [] YES [] NO

Evaluation Question 1: Perceptions of SPA

Q

- 01 Please describe the purpose of the SPA, in your own words.
(probe: What do you know about the SPA? How important are HFAs like SPA to your work)
- 02 How are you involved in the SPA?
- 03 We understand that you last completed a SPA in _____. Please describe how the decision was made to conduct the SPA.

I

Why have you not completed one since then?

- 04 The SPA is implemented along a continuum that starts with conception, and ends with use of the data. Here is a picture of what we mean [show/refer to drawing of continuum of SPA

Conceptualization → coalition-building → survey design → data collection → analysis → Dissemination → use of results

implementation]

In thinking about each of the phases along the continuum of SPA implementation, how well would you say each step of the process has gone in [country] (0 = not well at all, 10 =extremely well)?

Why? [It's ok to state you are not familiar with one or more step]

- Conception** _____ What worked well? What could be done better?
- Coalition building** _____ What worked well? What could be done better?
- Survey design/tool** _____ What worked well? What could be done better?
- Training** _____ What worked well? What could be done better?
- Data Collection** _____ What worked well? What could be done better?
- Data analysis** _____ What worked well? What could be done better?
- Dissemination** _____ What worked well? What could be done better?
- Use of the data** _____ What worked well? What could be done better?

- 05 On a scale of 0 to 10, with 0 being absolutely lowest quality, to 10 being absolute highest quality, how would you rate the quality of the information coming from the SPA?

I

Why?

How does quality of data vary among the different SPA components?

■ Probe: facility inventory, health worker/provider interview, observation protocol, exit interview

- 06 What information does SPA provide that routine HMIS (or specifically DHIS 2) or health-related household surveys do not in [COUNTRY]?
- 07 What is the added value of SPA compared to other HFAs (SARA, SDI, etc.) (and vice-versa)?
-Probe: in terms of process, product, quality of data, ease of use of data, etc.)
- How important is it to you that SPA (or a core set of questions) is standardized across other major HFA platforms?
- 08 How important is it to you that SPA (or a core set of questions) is standardized across countries?
- 09 How closely do you think the SPA and DHS should be spaced from each other? Why?
What are some opportunities that you see for further DHS/SPA coordination [in specific country/countries]?

Evaluation Question 2: Use of SPA data, missed opportunities, potential opportunities

- 10 Can you share examples of how you have used SPA data in your work?
What are different ways that SPA data has been used in [COUNTRY]? How decentralized is the use of SPA data by the MOH?
How can results from the SPA best be used to improve the health services in [COUNTRY]?
How easy is it for you (and your MOH colleagues) to work with data from the (SPA)? To understand what the data are saying?
- 11 How would you compare the usefulness of data from the different SPA components?
■ Probe: facility inventory, health worker/provider interview, observation protocol, exit interviews

- Which data are used most often? Why?
- 12 Are there regular or upcoming opportunities to use data from the SPA in [COUNTRY]? Please describe.
 - 13 What kind of challenges have you or your organization or other colleagues in [COUNTRY] faced in using SPA data for:
 - Policy change?
 - Program management?
 - Data analysis?
 - 14 The (SPA) data can often expose problems and weaknesses in the health services and cause political tensions for the government of some countries. How much of a problem was this in [COUNTRY]?
How was this problem dealt with?
- 3**
- USAID and ICF perceptions of challenges, opportunities of SPA**
- 15 What are your comments regarding the level of USAID's investment in SPA?
-Probe: *funding amounts, types of investments, USAID staff level of effort, etc.*
 - 16 What are your comments regarding the level of ICF's investment in SPA?
-Probe: *staffing levels, skills, level of technical assistance, etc.*
 - 17 How well does the SPA fit with the work that the Mission supports in [COUNTRY]?
How interested is the Mission in supporting the conduct of the SPA in the future? (scale of 0 = not interested at all, 10 = completely and passionately interested)
What would ICF need to do to better support implementation of the SPA? What would other stakeholders need to do?
 - 18 What do you think is the future direction of HFAs in [COUNTRY]?
What is the role for SPA in [COUNTRY]?
 - 19 What areas do you see that need to be improved in SPA?
-Probes: *tools/processes/products*
 - 20 Please describe the relationship between ICF and the USAID Mission (and other key stakeholders) in [COUNTRY] as related to SPA implementation?
What is going really well?
What could be improved?
 - 21 Do you have any other questions for us?
- THANK YOU SO MUCH FOR YOUR TIME!**

D. KII Field Guide Respondent groups: In-country donors, USAID IP, INGOs

00 Date of interview: _____ / _____ / _____

Type of Respondent:

☐ Technical Expertise donor (WHO) ☐ INGO – in country ☐ Donor in country ☐

Researcher

Names: _____

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, xxx on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation.

If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "USAID staff", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? ☒ YES ☐ NO

- Let's begin by talking your perceptions of HFAs, and SPA in particular** Q
- 01 Please describe the SPA and your involvement with the SPA. I
- 02 How are HFAs like the SPA important to your work? To the data needs of the country?
(probe: production of quality health facility data? -Use of data to promote accountability among health managers and health workers? How?)
- 03 On a scale of 0 to 10, with 0 being absolutely lowest quality, to 10 being absolute highest quality, how would you rate the quality of the information coming from the SPA? I
Why?
How is does quality vary among the different SPA components?
Probe: facility inventory, health worker/provider interview, observation protocol, exit interview
- 04 What information does SPA provide that routine HMIS (or specifically DHIS 2) or national health-related household surveys do not?
- 05 Let's discuss added value. What is the added value of SPA compared to other HFAs and vice-versa?
-Probe: in terms of process, product, quality of data, ease of use of data, etc.)
How important is it to you that SPA (or a core set of questions) is standardized across other major HFA platforms?
- 06 How important is it to you that SPA (or a core set of questions)? is standardized across countries?
- 07 How closely do you think the SPA and DHS should be spaced from each other?
What are some opportunities that you see for further DHS/SPA coordination in your country?
- Use of SPA data, missed opportunities, potential opportunities** 2
- 08 Let's discuss communicating the results.
With the SPA that was completed in [YEAR], who were the results communicated to?
- 09 Can you share examples of how you have used SPA data in your work?
How easy is it for you and your colleagues to work with data from the (SPA)? To understand what the data are saying?
Has there ever been an occasion when you had data measuring the same indicators from a SPA and also from another data source?
Which one did you use? Why?
- 10 How would you compare the usefulness of data from the different SPA components?
Probe: facility inventory, health worker/provider interview, observation protocol, exit interview
Which category of data do you and the MOH use most often? Why?
- 11 Can you think of examples where other colleagues have not taken full advantage of SPA data?
- 12 Are there regular or upcoming opportunities to use data from the SPA within your organization? Please describe.
- 13 What kind of challenges have you or your organization faced in using SPA data?
-Policy change? –
-Data analysis?
- Perceptions of challenges, opportunities, and future of SPA** 3
- 14 What do you think is the future direction of HFAs in [COUNTRY]? Of the SPA?
- 15 What areas do you see for the improvement of SPA? –Probes: tools/processes/products
- 16 Please describe the relationship between you and ICF as related to SPA implementation here in your country.
What is going really well? What could be improved?
- 17 Do you have any other questions for us?

THANK YOU SO MUCH FOR YOUR TIME!

E. KII Field Guide Respondent groups: Country Partner

00 Date of interview: _____/_____/_____

Type of Respondent: ☐ MOH ☐ Statistics ☐ _____

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, xxx on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation.

If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "USAID staff", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

We may also take a few pictures and videos while discussing with you. They may be used in our reports and other materials as illustrative. If videos are used in any material, they will be silent. Photos and videos will not be linked with your answers.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? ☐ YES ☐ NO

Let's begin by talking your perceptions of HFAs, and SPA in particular

Q

- 01 Please describe what the purpose of the SPA is, in your opinion?
-Compared to other health facility assessments (HFAs), how well is SPA positioned to promote accountability?
- 02 How were you involved in the SPA? (Probe: planning / implementation / analysis / reporting)
- Which organization(s) worked with you during the (SPA)? Which one was the main one?
- 03 We understand that you recently completed a SPA in [COUNTRY] and are also considering conducting another one in the near future. Please describe how the decision was made to conduct the previous one?
Please describe how the decision was (or will be) made to conduct the future one?
- 04 How much demand is there from within the MOH/health services in (country) for HFA data? Where is the demand coming from?
- 05 The SPA is implemented along a continuum that starts with conception, and ends with use of the data. Here is a picture of what we mean [show/refer to drawing of continuum of SPA implementation]
In thinking about each of the phases along the continuum of SPA implementation, how well would you say each step of the process has gone in [country] (0 = not well at all, 10 =extremely well)?
Why? [It's ok to state you are not familiar with one or more step]
-**Conception** _____ What worked well? What could be done better?
What could be done better:
-**coalition building** _____ What worked well? What could be done better?
-**Survey design/tool** _____ What worked well? What could be done better?
-**Training** _____ What worked well? What could be done better?
-**Data Collection** _____ What worked well? What could be done better?
-**Data analysis** _____ What worked well? What could be done better?
-**Dissemination** _____ What worked well? What could be done better?
-**Use of the data** _____ What worked well? What could be done better?
What worked well:
- 06 On a scale of 0 to 10, with 0 being absolutely lowest quality, to 10 being absolute highest quality, how would you rate the quality of the information coming from the SPA?
_____. Why? How is does it vary among the different SPA components?
Probe: facility inventory, health worker/provider interview, observation protocol, exit interview
What could be better:
- 07 What information does SPA provide that routine HMIS (or specifically DHIS 2) or health-related household surveys do not in [COUNTRY]?
- 08 What is the added value of SPA compared to other HFAs and vice-versa?
-Probe: in terms of process, product, quality of data, ease of use of data, etc.)
How important is it to you that SPA (or a core set of questions) is standardized across other major HFA platforms?
- 09 How important is it to you that SPA (or a core set of questions) is standardized across countries?
- 10 How closely do you think the SPA and DHS should be spaced from each other? Why?
OPTIONAL: What are some opportunities that you see for further DHS/SPA coordination in your country?
- 11 We understand you completed your most recent SPA in (country) on _____. Please help us understand why the decision was made to prioritize resources to carry out a facility assessment rather than invest in another activity?
How was the SPA paid for? (if another HFA was done in recent years, how was that paid for?)
How adequate was the funding? Technical assistance?
Use of SPA data, missed opportunities, potential opportunities
- 12 For the most recent SPA, what do you know about what the results that the (SPA) showed?
- 13 Who were SPA results communicated with? How effective / helpful was the communication strategy?
- 14 Can you share examples of how you have used SPA data in your work?

2

Have used it to do analysis, to report to parliament (if they need availability of abc)

What are different ways that SPA data has been used in [COUNTRY]?

How decentralized is the use of SPA data by the MOH?

How can results from the SPA best be used to improve the health services in [COUNTRY]?

How easy is it for you (and your MOH colleagues) to work with data from the (SPA)? To understand what the data are saying?

Has there ever been an occasion when you had data measuring the same indicators from a SPA and also from another data source?

Which one did you use? Why?

- 15 How would you compare the usefulness of data from the different SPA components?

Probe: facility inventory, health worker/provider interview, observation protocol, exit interview

Which category of data do you and the MOH use most often? Why?

Observation protocol also useful

- 16 Can you think of examples where other colleagues have not taken full advantage of SPA data?

–Probe: Within USAID/W or Missions; Within Donor community at large; UN Agencies/initiatives? Within Ministries; Within implementing partners; within large multi-funded INGOs? Local NGOs?

Why do you think these opportunities were missed?

- 17 Are there regular or upcoming opportunities to use data from the SPA within your organization? Please describe.

- 18 What kind of challenges have you or your organization faced in using SPA data?

-using for policy change?

- using for program management?

- using for data analysis?

- 19 The (SPA) data can often expose problems and weaknesses in the health services and cause political problems for the government. How much of a problem was this in (country)? How was it dealt with?

Perceptions of challenges, opportunities, and future of SPA

3

- 20 What do you think is the future direction of HFAs in (country)?

What is the role for SPA in your [country]?

- 21 What areas do you see that need to be improved in SPA?

–Probes: tools/processes/products

- 22 Please describe the relationship between ICF and your Department (and other key stakeholders) as related to SPA implementation here in your country.

What is going really well? What could be improved?

- 23 Do you have any questions for us?

THANK YOU SO MUCH FOR YOUR TIME!

ANNEX V. INTERVIEWEE LIST

#	Name	Organization	Position	Date and Time	Status			
Senegal								
1	Dr. Ibou Guisse	Ministry of Health and Social Action	SPA Coordinator	March 20th	Completed	1	m	1
2	Dr. Moussa Diakhate	USAID Senegal	Technical Coordinator	March 21st	Completed	2	m	2
Haiti								
1	Emmanuel Charles	MOH/Haiti	Conseiller Technique	March 17th	Completed	3	m	3
2	Michel Cayemittes	IHE/Haiti	Director	April 27th	Completed	4	m	4
3	Valery Blot	IHE/Haiti		April 27th	Completed		f	
4	Elisabeth Metellus	ICF	ICF Consultant for 2013 HSPA	March 17th	Completed	5	f	1 5
5	Stephane Morriseau	USAID Haiti	Strategic Information Advisor	March 14th	Completed	6	m	6
Kenya								
1	Francis Kundu	National Council for Population and Development	Assistant Director of Population	March 29th	Completed	7	m	7
2	Washington Omwomo	USAID Kenya	COR Office of Health and Population	March 30th	Completed	8	m	8
3	Anna Wamae	Ministry of Health		March 28th	Completed	9	f	2 9
4	Otieno Agwanda	University of Nairobi		March 29th	Completed	10	m	10
5	Ngure Ezekial	UNFPA		March 30th	Completed	11	m	11
6	Dr. Maureen Kimani	NASCOP (ART)		April 3rd	Completed	12	f	3 12
7	Dr. Andolo Miheso	Ministry of Health		April 3rd	Completed	13	m	13
8	Jacinta Mbindyo	Machakos County- HIO (Health Information Officer)		March 31st	Completed	14	f	4 14
9	Hillary Kipruto	World Health Organization		March 28th	Completed	15	m	15
10	Kennedy Chitala	World Health Organization		March 28th	Completed	16	m	
11	Joyce Lavussa	World Health Organization		March 28th	Completed	17	f	5
12	Randolph Augustin	USAID Kenya		March 30th	Completed	18	m	
13	Samuel Abugua	Egerton University		March 28th	Completed	19	m	16
14	Pepela Wanjala	Ministry of Health		March 28th	Completed	20	f	6 17
15	Victor Achieng	UNICEF		March 31st	Completed	21	m	18
16	MacDonald Obudho	KNBS						

#	Name	Organization	Position	Date and Time	Status				
17	Wellington Mbuthi	UNICEF		March 31st	Completed	22	m		
18	Isabel Maina	Ministry of Health	Head of Health Sector M&E Unit	April 6th	Completed	23	f	7	19
Democratic Republic of the Congo									
1	Salomon Salumu Siyangoli	MOH/DRC	Resident Advisor/USAID/PMI	March 15th	Completed	24	m		20
		MOH/DRC		March 15th	Completed	25	m		
	Dr. Niang	PMI/DRC	Resident Advisor/CDC/PMI	March 16th	Completed	26	f	8	21
2	Aboubacar Sadou	PMI/DRC	Resident Advisor/USAID/PMI	March 16th	Completed	27	m		
Tanzania									
1	Mr. Erasmo Malekela,	USAID Tanzania	Project Management Specialist	April 18th	Completed	28	m		22
2	Mr. Stephen George Cosmas	NBS/Tanzania	Senior Statistician	April 21st	Completed	29	m		23
3	Dr. Geoffrey Somi	Ministry of Health	Principal Medical Officer	April 20th	Completed	30	m		24
4	Mr. Clement Kihinga	Ministry of Health	M&E/MCH	April 20th	Completed	31	m		25
5	Mrs. Sylvia Meku	NBS/Tanzania	Senior Statistician	Has not responded					
6	Mr. Mlemba Abassy	NBS/Tanzania	Senior Statistician	Has not responded					
Namibia									
1	Hailegiorgis Moges	USAID Namibia	Senior SI Advisor (no current/recent DHS Program activity)	Team member Brad Corner will fill in (no rescheduled date yet)					
Rwanda									
1	Kaendi Munguti	USAID Rwanda	DHS Activity Manager	Has not responded					
	Mary Kabanyana	USAID Rwanda	DHS Activity Manager	May 8th	Completed	32	f	9	26
2	Alice Mukaneza	USAID Rwanda	DHS Activity Manager	Has not responded					
Malawi									
1	Ruth Madison	USAID Malawi	DHS Activity Manager	No longer with team					
2	Vadan Stapleton	USAID Malawi	DHS Activity Manager	May 8th	Completed	33	f	10	27
3	Collins Kwizombe	USAID Malawi	DHS Activity Manager	May 8th					
4	Lilly Banda	USAID Malawi	DHS Activity Manager	May 8th					
5	Anteneh Worku	USAID Malawi	DHS Activity Manager	May 8th					
6	Violet Orchardson	USAID Malawi	DHS Activity Manager	May 8th					
Ghana									

#	Name	Organization	Position	Date and Time	Status				
1	Akua Kwateng-Addo	USAID Ghana	DHS Program Survey Manager	Does not believe that she is the best for the interview					
2	Melanie Luick-Martins	USAID Ghana	DHS Program Survey Manager	No longer with team					
Uganda									
1	Solome Sevume	USAID Uganda	DHS Activity Manager	Has not responded					
2	Joseph Mwangi	USAID Uganda	DHS Activity Manager	Has not responded					
Zambia									
1	Cynthia Bowa	USAID Zambia	DHS Activity Manager	Does not believe she is the best for the interview so finding a replacement					
Nigeria									
1	Allisyn Moran	USAID Nigeria	M&E	Has not responded					
2	Uche Ikenyei	USAID Nigeria	M&E	May 4	Completed	34	m		28
3	Heather Smith-Taylor	USAID Nigeria	M&E	Did not join interview					
Zimbabwe									
1	Matthews Maruva	USAID Zimbabwe	DHS Activity Manager	May 4th	Completed	35	m		29
2	Karen Kasan	USAID Zimbabwe	DHS Activity Manager	Did not join interview					
3	Sandra Bird	USAID Zimbabwe	DHS Activity Manager	did not join interview					
Liberia									
1	Laurie Priddy O'Neill	USAID Liberia	DHS Activity Manager	May 2nd	Completed	36	f	11	30
2	Tara Milani	USAID Liberia	DHS Activity Manager	May 2nd					
3	Lisa Childs	USAID Liberia	Service Delivery	May 2nd	Completed	37	f	12	
4	Pamela Bernard Sawyer	USAID Liberia	Service Delivery	May 2nd	Completed	38	f	13	
USAID Washington									

#	Name	Organization	Position	Date and Time	Status				
1	Amani Selim	USAID	Senior Monitoring and Evaluation Officer	March 15th	Completed	39	f	14	31
2	Misun Choi	USAID	Senior Monitoring and Evaluation Advisor (PMI), DHS Team Member	March 15th	Completed	40	f	15	32
3	Noah Bartlett	USAID	Senior Monitoring and Evaluation Advisor (OHA), DHS Team Member	March 15th	Completed	41	m		
4	Anne Palaia	USAID	Senior Evaluation Advisor, P3	March 15th	Completed	42	f	16	33
5	Jacob Adetunji	USAID	Senior Demographer, PRH (former DHS Program Team Lead)	April 21st	Completed	43	m		34
6	Bill Weiss	USAID	Senior Monitoring & Evaluation Advisor, EPCMD	April 27th	Completed	44	m		35
7	Jim Heiby	USAID	Senior Quality Assurance Advisor, OHS	April 17th	Completed	45	m		36
8	Altin Ilranji	USAID	Senior Global Health Data Strategist, P3	April 25th	Completed	46	m		37
9	Lisa Maniscalco	USAID	Health Specialist, OHA	March 22nd	Completed	47	f	17	38
10	Kelly Saldana	USAID	Office Director, OHS	April 18th	Completed	48	f	18	39
11	Rachel Lucas	USAID	Health Informatics Team Lead, OHA	Out of the Country; Emailed tool					
12	Mary Ellen Stanton	USAID	Senior Maternal Health Adviser	March 14th	Completed	49	f	19	40
13	Erin Eckert	USAID	Epidemiologist, PMI	March 15th	Completed	50	f	20	41
14	Madeline Short-Fabic	USAID		March 15th & 16th	Completed	51	f	21	42

ICF Washington

1	Bernard Barrere	ICF	Deputy Director of Survey Operations	March 13th	Completed	52	m		43
2	Erica Nybro	ICF	Senior Adviser for Communication	March 13th	Completed	53	f	22	
3	Tom Pullum	ICF	Senior Advisor for Research	March 13th	Completed	54	m		
4	Hamdy Moussa	ICF	SPA Survey Manager	March 13th	Completed	55	m		
5	Fred Arnold	ICF	Deputy Technical Director	March 13th	Completed	56	m		

#	Name	Organization	Position	Date and Time	Status			
6	Gulnara Semenov	ICF	Regional Coordinator of Survey Operations	March 13th	Completed	57	f	23
7	Abibata Handley	ICF	Sr. Advisor for Capacity Strengthening	March 13th	Completed	58	f	24
8	Sunita Kishor	ICF	DHS Director	March 13th	Completed	59	f	25

International Key Advisors

1	Kavitha Viswanathan	World Health Organization	Department of Information, Evidence and Research	May 1st	Completed	60	f	26	44
2	Bennett Nemser	UNICEF	Senior Monitoring and Evaluation Officer	April 27th	Completed	61	m		45
3	Annie Schwartz	The Global Fund to Fight AIDS, Tuberculosis and Malaria		Has not responded/Phone not working					
4	Hannah H. Leslie	Harvard T.H. Chan School of Public Health	Department of Global Health and Population	March 21st	Completed	62	f	27	46
5	Howard Friedman	UNFPA	Technical Division	Declined					
6	Nancy Fronczak	World Health Organization	Consultant	April 19th	Completed	63	f	28	47
7	Jeremy Veillard	World Bank Group	Health, Nutrition and Population Global Practice	Could not join					
8	Laure Mercereau	World Bank Group	Health, Nutrition and Population Global Practice	March 13th	Completed	64	f	29	48
9	Waly Wane	World Bank Group	Health, Nutrition and Population Global Practice	April 17th	Completed	65	m		
10	Yoonjoung "YJ" Choi	Johns Hopkins Bloomberg School of Public Health	Visiting Associate Scientist and Deputy Director, PMA2020	April 20th	Completed	66	f	30	49
11	Joanna Barczyk	The Global Fund to Fight AIDS, Tuberculosis and Malaria	GF - Geneva	Waiting for reschedule date					
12	Christophe Rockmore	World Bank Group		April 25th (rescheduled to 5/2)	Completed	67	m		50
13	Carine Gachen	cgachen@gavi.org former DHS Program Senior	GAVI	April 26th	Completed	68	f	31	51
14	Paul Ametepi	Medical Director; former SPA lead		April 20th	Completed	69	m		52

#	Name	Organization	Position	Date and Time	Status				
15	Nirali Chakraborty	Director of Research & Technical Assistance	Metrics for Management	April 27th	Completed	70	f	32	53
16	Sian Curtis	Senior Evaluation Advisor	MEASURE Evaluation Project, UNC	April 25th	Completed	71	f	33	54
BOB									
Nepal									
1	Yogendra Prasai	New Era	Senior Research Officer	March 30th	Completed	72	m		55
2	GD Thakur	Ministry of Health	Chief Public Health Administrator	March 31st	Completed	73	m		56
3	Sabita Tuladhar	USAID Nepal	AID Development Program Specialist	April 21st	Completed	74	f	34	57
4	Shanda Steimer	USAID Nepal	USAID/Nepal	xxxx	Cancelled				
5	Susheel Lekhak	WHO/Nepal	Information Coordinator	April 17	Completed	75	m		
Jordan									
1	Nicholas Kaufman	USAID Jordan	Population and Family Health Office	April 27	Completed	76	m		58
2	Dr. Sahar Jriesat	Ministry of Health	Assistant, General Director of Primary Health Care for Health Projects	May 4	Completed	77	m		59
3	Dr. Hani A Brosk Kurdi	High Health Council	Secretary General		Completed	78	m		60
4	Dr. Ali Arbaji	Eastern Mediterranean Public Health Network	Lead, Research and Information	Has not responded					
Cambodia									
1	Chantha Chak	USAID Cambodia		April 26	Completed	79	f	35	61
2	Noah Sprafkin	USAID Cambodia		April 27	Completed	80	m		
Guatemala									
1	Baudilio Lopez	USAID Guatemala		April 27	Completed	81	m		62
Guyana									
1	Navindra Persuad	FHI360	co-PI of original SPA in 2004	May 2	Completed	83	m		63
Philippines									
1	Reynalda Perez	USAID Philippines		April 27	Completed	83	f	36	64
Bangladesh									
1	Dr. Kanta Jamil	USAID Bangladesh	Senior M&E&R Advisor	April 3	Completed	84	f	37	65

#	Name	Organization	Position	Date and Time	Status				
2	Sukumar Sarker	USAID Bangladesh	Senior Technical and Policy Advisor	April 6th	Completed	85	m		
3	Melissa Jones	USAID Bangladesh	Office Director	April 4	Completed	86	f	38	66
4	Md. Rafiqul Islam Sarker	NIPORT	Director	April 2nd	Completed	87	m		
5	Shahin Sultana	NIPORT	Sr. Research Associate	April 2nd	Completed	88	m		
6	Dr. Farid Uddin Ahmed	MOHFW	Director of Family Planning	April 4th	Completed	89	m		
7	Abdus Salam Khan	MOHFW	Deputy Chief	April 4th	Completed	90	m		
8	MM Reza	PMMU, Planning Wing, MOHFW	Senior Technical Advisor	April 5th	Completed	91	f	39	67
9	A Waheed Khan	PMMU, Planning Wing, MOHFW	Senior Technical Advisor	April 5th	Completed	92	m		
10	Subrata K Bhadra	NIPORT	Senior Research Associate	April 2nd	Completed	93	f	40	
11	Shaila Sharmin Zaman	PMMU, Planning Wing, MOHFW	Senior Technical Advisor	April 5th	Completed	94	f	41	
12	Imteaz Mannan	Save the Children		April 5th	Completed	95	f	42	
13	Dr. Ishtiaq Mannan	Save the Children	Chief of Party, MaMoni-INtegrated	April 3rd	Completed	96	m		
14	Dr. Ahmed Al- Sabir	ICF	ICF Consultant	April 2nd	Completed	97	m		
15	Dr. Bushra Alam	World Bank	Senior Health Specialist	April 2nd	Completed	98	f	43	
16	Dr. Shakil Ahmad	World Bank	Senior Health Specialist	April 2nd	Completed	99	m		
17	Dr. Shams Arifeen	ICDDR, B	Head, MNCH Unit	April 3rd	Completed	100	m		
18	Dr. Ahmed Ehsanur Rahman	ICDDR, B	Assistant Scientist	April 3rd	Completed	101	m		
19	Sheik Masum Billah	ICDDR, B	Senior Research Investigator	April 3rd	Completed	102	m		
Researcher									
1	Anna Gage	Harvard University	Researcher	April 20th	Completed	103	f	44	

ANNEX VI. INFORMED CONSENT FORM

Informed Consent

Thank you for giving us the time to speak with you today. My name is _____, on the evaluation. As you know, we are conducting a mid-term evaluation focused on the Service Provision Assessment (SPA) that is implemented as part of the DHS Program implemented by ICF.

The purpose of this evaluation is to assess how well the SPA is positioned to achieve the DHS Program's objective "to improve the collection, analysis, and presentation of population, health and nutrition data to facilitate use of these data for planning, policy making, and program management."

Our questions are organized to obtain a good overview of how SPA is functioning operationally, and to answer the evaluation questions. Specifically, we will be asking you your perceptions on 1) the value of the SPA at global and country-levels 2) the use of SPA data at global and country levels, and 3) opportunities and challenges in facilitating SPA implementation.

If there are staff members who are particularly suited for specific questions, we would appreciate the opportunity to include them in the interview as part of our current discussion or separately.

All of the answers you provide will be treated confidentially. They will be summarized and included in our report, but without your name or references that would make you easily identifiable. We will further minimize the risks associated with breaking your confidentiality by triangulating all findings with interviews from others, and referring to quotes as from "USAID staff", as opposed to individuals, positions or offices. The benefits of participating in this midterm include contributions to deepen global understanding of the role for SPA within the context of the ongoing global dialogue on health facility assessments and shaping its future.

You have the right to not answer any question or to refuse participation at any time during the evaluation without suffering any consequences.

We may also take a few pictures and videos while discussing with you. They may be used in our reports and other materials as illustrative. If videos are used in any material, they will be silent. Photos and videos will not be linked with your answers.

Do you have any questions before we begin?

Do we have your consent to continue with this interview? ☐ YES ☐ NO

ANNEX VII. LIST OF DOCUMENTS REVIEWED

Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal] et ICF International. 2015.

Sénégal : Enquête Continue sur la Prestation des Services de Soins de Santé (ECPSS) 2015. Rockville, Maryland, USA : ANSD et ICF International.

Assaf S, Wang W, Mallick L. 2015. Quality of Care in Family Planning Services at Health Facilities in Senegal. DHS Analytical Studies No. 55. Rockville, Maryland, USA: ICF International.

Assaf S, Wang W, Mallick L. 2016. Provider Counseling and Knowledge Transfer in Health Facilities of Haiti, Malawi, and Senegal. DHS Analytical Studies No. 60. Rockville, Maryland, USA: ICF International.

Award Fee SPA Criteria. Criterion 1.4: Promotion of SPA data use and analysis of SPA data. (Part of ICF DHS 7 RFA).

Burgert C, and Prosnitz D. 2014. Linking DHS Household and SPA Facility Surveys: Data Considerations and Geospatial Methods. DHS Spatial Analysis Reports No. 10. Rockville, Maryland, USA: ICF International.

Concern Worldwide, 2007. Kabeho Mwana “The Living Child”. Rapid Child Health Service Provision Assessment for Quality and Access at the Health Center Level: Baseline Report. The Expanded Impact Child Survival Program USAID/CHSHP. Kigali, Rwanda.

DHS 7 Final Award Statement: Section C- Statement of Work. ICF International.

DHS 7 Final Year 1 Budget. ICF International, June 2014 (Revised).

DHS 7 Final Year 2 Budget. ICF International, September 15, 2014.

DHS 7 Final Year 3 Budget. ICF International, September 15, 2015.

DHS 7 Final Year 4 Budget. ICF International, September 21, 2016.

DHS 7 Guide to Preparing the Final and Preliminary Reports of a Service Provision Assessment. 2014. Rockville, Maryland, USA: ICF International.

DHS 7 Performance Management Plan Report, September 9, 2013-June 30, 2014. ICF Macro, August 1, 2014.

DHS 7 Performance Management Plan Report, August 1, 2014-Sept 30, 2015. ICF Macro, October 15, 2015.

DHS 7 Performance Management Plan Report, October 1, 2015-September 30, 2016. ICF Macro, October 14, 2016.

DHS 7 Sampling Strategies and Sampling Procedures in SPA Surveys. Rockville, Maryland, USA: ICF International.

DHS 7 Trip Report: Bangladesh, February 2015.

DHS 7 Trip Report: Bangladesh, May 2015.

DHS 7 Trip Report: Bangladesh, June 2015.

DHS 7 Trip Report: Malawi, January 2015.

DHS 7 Trip Report: Malawi, December 2015.

DHS 7 Trip Report: Nepal, January 2015.

DHS 7 Trip Report: Nepal, March 2015.

DHS 7 Trip Report: Nepal, April 2015.

DHS 7 Trip Report: Nepal, April 2016.

DHS 7 Trip Report: Nepal, July 2015.

Johnson K, Varallyay L, Ametepi P, 2012. Integration of HIV and Family Planning Health Services in Sub-Saharan Africa: A Review of the Literature, Current Recommendations and Evidence from the Service Provision Assessment Health Facility Surveys. DHS Analytic Studies No. 30. Rockville, Maryland, USA: ICF International.

Hannah H. Leslie, Address Malata, Youssoupha Ndiaye, Margaret E. Kruk. Effective coverage of primary care services in high-mortality settings: an eight-country study. Draft manuscript.

Harmonization of health facility assessment modules. Technical consultation, organized by WHO in collaboration with The Global Fund and The World Bank. Geneva, November 12-13, 2014

Institut Haïtien de l'Enfance (IHE) et ICF International. 2014. Évaluation de Prestation des Services de Soins de Santé, Haïti, 2013. Rockville, Maryland, USA : IHE et ICF International.

Kakoto DC, Ketting E, Kamazima SR, Ruben R, 2012. Provision of Family Planning Services in Tanzania: A Comparative Analysis of Public and Private Facilities. African J Reproductive Health/La Revue Africaine de la Santé Reproductive, vol 16, No. 4, pg 140-148.

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ANNEX VIII. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project
<p>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.</p> <p>Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:</p> <ol style="list-style-type: none">1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

<i>Rachel Jean-Baptiste</i>	December 23, 2016
Signature	Date
Rachel Jean-Baptiste	President, Oxford Epi
Name	Title

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Robert A. McPherson

December 30, 2016

Signature

Date

Robert A. McPherson

Independent consultant

Name

Title

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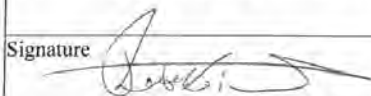
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

28.12.2016


Name

JENNIFER KARAHWA KATEKANE

Title

CONSULTANT

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<p>Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.</p> <p>9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:</p> <p>(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.</p>	
<p>ACCEPTANCE</p> <p>The undersigned accepts the terms and conditions of this Agreement.</p> <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="text-align: center;">  </div> <div style="text-align: right;"> <p style="color: blue;">29 Dec 2016</p> </div> </div>	
<p>Signature _____</p>	<p>Date _____</p>
<p>Name _____</p>	<p>Title _____</p>

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