



Enhanced
Responses to
Nutrition
Emergencies

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CONCERN
worldwide



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PILOT PROGRAMMATIC PARTNERSHIP

ASSESSING HEALTH FACILITY CAPACITY IN FRAGILE CONTEXTS

learning from a new approach and tool piloted in five countries

MAY 2022



DR MOHAMED TAHIR at the local health centre in Legahida, Ethiopia, 27 March 2022

Highlights

- **The Health Facility Assessment (HFA tool) developed by Concern provides a structured method for assessing the functionality of health and nutrition services at facility level across 14 core service domains.** The tool is based largely on existing WHO and UNICEF frameworks and tools and provides a scoring system for targeting support and evaluating progress over time.
- **The Concern HFA tool differs from the WHO/ UNICEF tools on which it is based in three key ways:** 1) a nutrition module has been added; 2) it focuses on a smaller set of essential child and maternal health services; and 3) it produces capacity scores for individual health facilities (overall and for each of the 14 domains), in addition to district level indicators so progress can be assessed at both levels.
- **The tool was piloted in the Democratic Republic of Congo (DRC), Ethiopia, Niger, South Sudan and Sudan to set a baseline for health facility capacity under Concern's ECHO-funded Enhanced Response to Nutrition Emergencies (ERNE) programme.** The full results for each country, with recommended actions, as well as a summary report can be found here at <https://www.concern.net/knowledge-hub/ERNE>
- **The weakest health service domains that require immediate attention across nearly all five countries are:** sanitation infrastructure, hygiene/ handwashing infrastructure, environmental cleaning, standard precautions, child health services, antenatal services and COVID-19 preparedness and response capacity.
- **Rapid but comprehensive health facility assessments are sorely needed in fragile contexts, but emergency funding cycles often don't support full assessments or the comprehensive health system strengthening efforts that are required.** Concern, with its government partners, has been able to undertake the HFA, prioritise needs and develop concrete action plans with partners in these fragile contexts via multi-year funding through the European Union's Pilot Programmatic Partnership. This would not have been possible under a short-term funding cycle.
- **Recommendations for improving the HFA tool and analysis process for future use include:**
 - » Ensure strong engagement of ministry of health and other partner staff from the outset.
 - » Streamline the analysis and report writing process; fine tune the immunisation and staffing module.
 - » Develop a set of companion tools to guide assessment teams in the HFA implementation, action planning, and the dissemination of results.
 - » Work with government counterparts to better integrate the HFA into existing assessment and supervision processes.
- **An endline HFA is planned for the five countries, after which a more comprehensive evaluation of the added value of the tool and necessary modifications will be undertaken.** For more information, please contact Concern kate.golden@concern.net

1. Background

In June, 2020, Concern embarked on a three year programme to promote Enhanced Responses to Nutrition Emergencies (ERNE) in five fragile countries: DRC¹; Ethiopia; Niger; Republic of Sudan; and South Sudan. The programme is funded by the European Union (Directorate-General for Civil Protection and Humanitarian Aid Operations, ECHO) under a Pilot Programmatic Partnership (PPP). The PPP is a new, strategic partnership model between ECHO and NGOs, intended to improve the effectiveness and efficiency of humanitarian action, based on Grand Bargain shared commitments. The principle aim of ERNE is to reduce morbidity and mortality linked to malnutrition in children under five, in part by strengthening health systems to deliver quality health and nutrition services, to the degree possible within a 36 month period. The five countries and the seven regions targeted within them all face recurring humanitarian emergencies, ranging from droughts and floods to disease outbreaks, conflict and displacement, all compounded by the COVID-19 pandemic.

The programme targets 19 health districts and 178 health facilities across the five countries (see Annex 1). The government health systems in each context differ considerably, including in terms of how health facilities and services are organised; staffing and supervision structures; general infrastructure; and provision of child health, immunisation, nutrition and antenatal services, for example. The essential health package is broadly similar across the five countries, but the local health systems face many challenges in delivering it with sufficient quality and reach. A major component of the ERNE programme is to ensure the essential health and nutrition services for children under five are delivered in each programme context. A core outcome indicator of the programme is, therefore, the percent of health facilities that increase their capacity during the lifetime of the programme.

In order to prioritise and tailor support and to measure progress in health capacity during the ERNE programme, Concern required a tool to assess the capacity of health service delivery within and across contexts and to provide a quantitative baseline score for key services, against which individual health facilities and health districts could assess their progress. Concern has used a variety of health capacity assessment tools in different contexts, but none provided the level of detail and standardised scoring system required for the ERNE programme.

The purpose of this learning paper is to share Concern Worldwide's experience of piloting an adapted tool to assess health facility capacity in DRC, Ethiopia, Niger, South Sudan and Sudan as well as suggestions for further adaptation.

1. DRC from 2020-2022 only

2. Designing the HFA tool

Concern began with a review of existing health service assessment tools. The World Health Organisation's (WHO) [Service Availability and Readiness Assessment](#) tool proved to be the most comprehensive and systematic. It was also most likely to be in line with the standards of the national ministries of health in the five countries, for which WHO is a lead, norm-setting agency. The SARA tool, however, includes modules on a very wide range of services including, for example, management of diabetes and cardiovascular disease, basic surgery, sexually transmitted infections, and extensive assessment of HIV and AIDS testing, counselling and care services. Concern aimed to focus the tool on a core set of child and maternal health services that had both the greatest potential to reduce the burden of malnutrition and could be effectively supported by Concern via the three-year ERNE programme.

Concern identified 14 essential health service domains for the tool (Table 1). Each domain is structured around a set of sub-domains that reflect its essential components. For eight of the domains, Concern based the questions/sub-domains almost directly on those in the SARA tool (with considerable adaptation to the management and supervision domain). For the four WASH domains, Concern drew from the indicators and questions outlined in the [UNICEF / WHO's Joint Monitoring Programme \(JMP\)](#) tool as these are more comprehensive than SARA and Concern is striving, as an organisation, to align its monitoring of WASH in health facilities with the JMP.² Finally, Concern developed three additional domains/ modules: nutrition (missing from the SARA tool), COVID-19 preparedness and response (missing from the SARA and JMP tool) and staffing (included in SARA but of limited use for individual facilities).

For the pilot of the HFA tool, Concern used tablets and a digital data gathering (DDG) platform (IForm Builder) to collect the data. The standard digital tool was translated into French (for use in DRC and Niger), Arabic (for use in Sudan), and Amharic and Somali (for use in Ethiopia). Country teams also modified terminology in the answer options as appropriate to each context. However, the questions and scoring (as a percent of the total possible points) remained the same to allow comparisons of scores across countries for all 14 domains.

2. The standard precautions for infection prevention domain is considered the fifth WASH module but was based entirely on the SARA tool as it was found to be comprehensive.

TABLE 1.

HEALTH SYSTEM BUILDING BLOCK	DOMAIN/ MODULE	SOURCE
Health workforce	1. Staffing	Concern (based on national standards)
Health information	2. Health information management system	SARA
Leadership & governance	3. Management and supervision	SARA, adapted
Service delivery	4. General infrastructure	SARA
Service delivery	5. Water infrastructure	JMP
Service delivery	6. Sanitation infrastructure	JMP
Service delivery	7. Hand hygiene infrastructure	JMP
Service delivery	8. Environmental cleaning	SARA/ JMP
Service delivery	9. Standard precautions for infection prevention	SARA
Service delivery + access to essential medicines	10. Child health service availability & readiness	SARA
Service delivery + access to essential medicines	11. Immunisation service availability & readiness	SARA
Service delivery + access to essential medicines	12. Nutrition service availability & readiness	Concern
Service delivery + access to essential medicines	13. Antenatal care service availability & readiness	SARA
Service delivery + access to essential medicines	14. COVID-19 preparedness & response capacity	Concern

Scoring system

The tool has a total of 106 questions which lay out conditions that must be met to 'achieve' each of the 54 sub-domains. There are between 1 and 8 conditions/questions that must be met for each sub-domain. Between 1 and 5 sub-domains make up each of the 14 domains.

The 106 questions/ conditions were scored as either 1 (a 'pass') or 0 (a 'fail') based on the response of the health facility staff being interviewed and/or direct observation of the enumerator during the visit. Similarly, sub-domains were scored as 1 if all the necessary conditions were met and 0 if not.

For each facility, a raw score was calculated for each domain by summing the scores of the sub-domains that make up that domain, with a total possible score of between 1 and 5 for each domain. The overall score for each health facility is the sum of all 54 sub-domain scores.

A percentage score was also calculated for each of the raw scores, using the corresponding total possible points as the denominator (between 1 and 8, depending on the sub-domain; between 1 and 5, depending on the domain; and 54 for the overall score). (Note: a sub-domain on child diagnostic testing capacity had to be removed from the analysis due to an error in the data collection tool making a total of 53 sub-domains for this report).

Next, Concern designed a scoring system for the tool's 14 domains and 54 corresponding sub-domains. This was necessary because while the SARA and JMP tools are designed to generate indicators on the percentage of health facilities in a given district meeting a certain standard (for example, providing a specific service, having a set of tracer drugs in stock, or having a useable latrine), they do not generate scores for individual facilities. In order to use the tool to effectively tailor support and track progress of individual health facilities over time, a system that could yield quantitative scores for both individual health facilities and across health districts was essential.

The Concern tool calculates a score for each sub-domain and subsequently each domain for each health facility based on a set of conditions that must be met for the service to be considered functional. These conditions were assessed through interviews with health facility staff and/or direct observations by the enumerator during the visit. For each health facility, a raw and percentage score was generated for each sub-domain and domain, as well as an overall score reflecting all 14 domains. Average scores for each health district and Concern country programme area were generated. The percentage of health facilities that 'achieved' each of the sub-domains that made up each of the 14 domains is also presented.

Assessment teams were trained by the Concern health and nutrition technical leads in each country with support from head office advisers. The digital questionnaires were tested and errors were addressed as much as possible by each survey team. The process of designing and finalising the base tool and orienting country teams took approximately four months.

3. Implementing the HFA

Baseline surveys were conducted in DRC, Niger and South Sudan in December 2020. Sudan and Ethiopia started data collection in May 2021. Ethiopia started with health centres (May 2021) and followed with health posts (July 2021). Only in Ethiopia was the main questionnaire adapted for a lower level facility type (health post) by adjusting answer options and, consequently, the total possible points for three domains. Unfortunately, twenty of the 198 health facilities originally targeted for the assessment could not be visited. These were all in Ethiopia and were not assessed due largely to insecurity linked to the current conflict in

Tigray, as well as poor road access and absence of staff at the health facilities. Enumerators were largely Concern health and nutrition staff. The contextualised survey questionnaire was piloted in each country using the digital devices and necessary adjustments were made before commencing data collection.

Data was almost immediately available for analysis through Concern's digital data management platform (Iform Builder). Analysis was carried out by Concern HQ advisers using a combination of a digital dashboard (Zoho reports) and excel to create tables for the final reports. Due to the novelty and complexity of the questionnaire and tool, significant data cleaning and trouble shooting was required to ensure that calculations (including skip logic) were executed as originally planned. In some cases, the original analysis plan was adapted for something more suitable. Unfortunately, an error in the skip logic syntax led to inconsistent assessment of the presence of rapid diagnostic tests for malaria, which meant the sub-indicator on child diagnostic tests had to be removed from the Child Health domain, bringing the total possible points from 54 to 53 for this assessment. Some data entry errors occurred leading to missing data for some modules.

The analysis and finalisation of reports took longer than originally planned. Concern's M&E team and Nutrition and Health Advisers at HQ level supported heavily in the analysis and write up, as the baseline required considerable troubleshooting and adaptation of the analysis and final outputs. Concern is working to streamline the analysis process for endline, building on what was learned during the baseline process (see What We Learned, below).

4. Results and priority actions

In many respects, the results presented few 'surprises'. The overall score across all 14 domains ranged from a low of 19% (DRC) to a high of 36% (Niger), with an average of 32% (Figure 1). This suggests that the 178 health facilities assessed were operating, on average, at around one-third of what would be considered an acceptable standard. While these scores were meant to represent the 'baseline' for each programme area, it is important to note that Concern activities were already underway under the ERNE programme in most contexts, particularly for nutrition. This was particularly true in Niger, which was continuing from a previous ECHO-funded programme in largely the same areas.

There were significant differences across domains - both generally and by country, as outlined in (Figure 2):

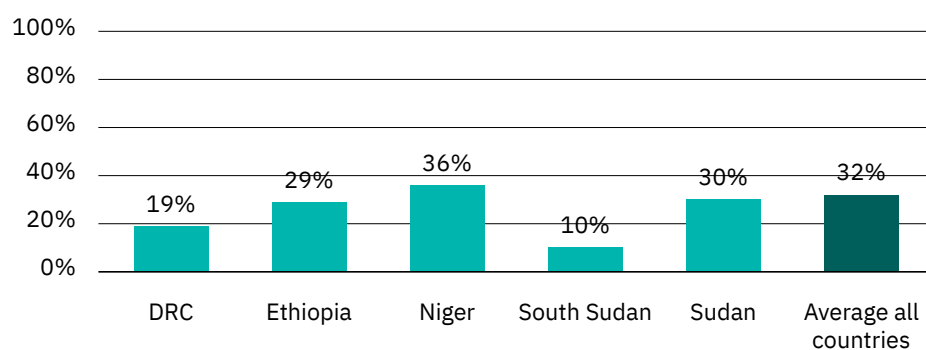


FIGURE 1. Average overall percent score by country

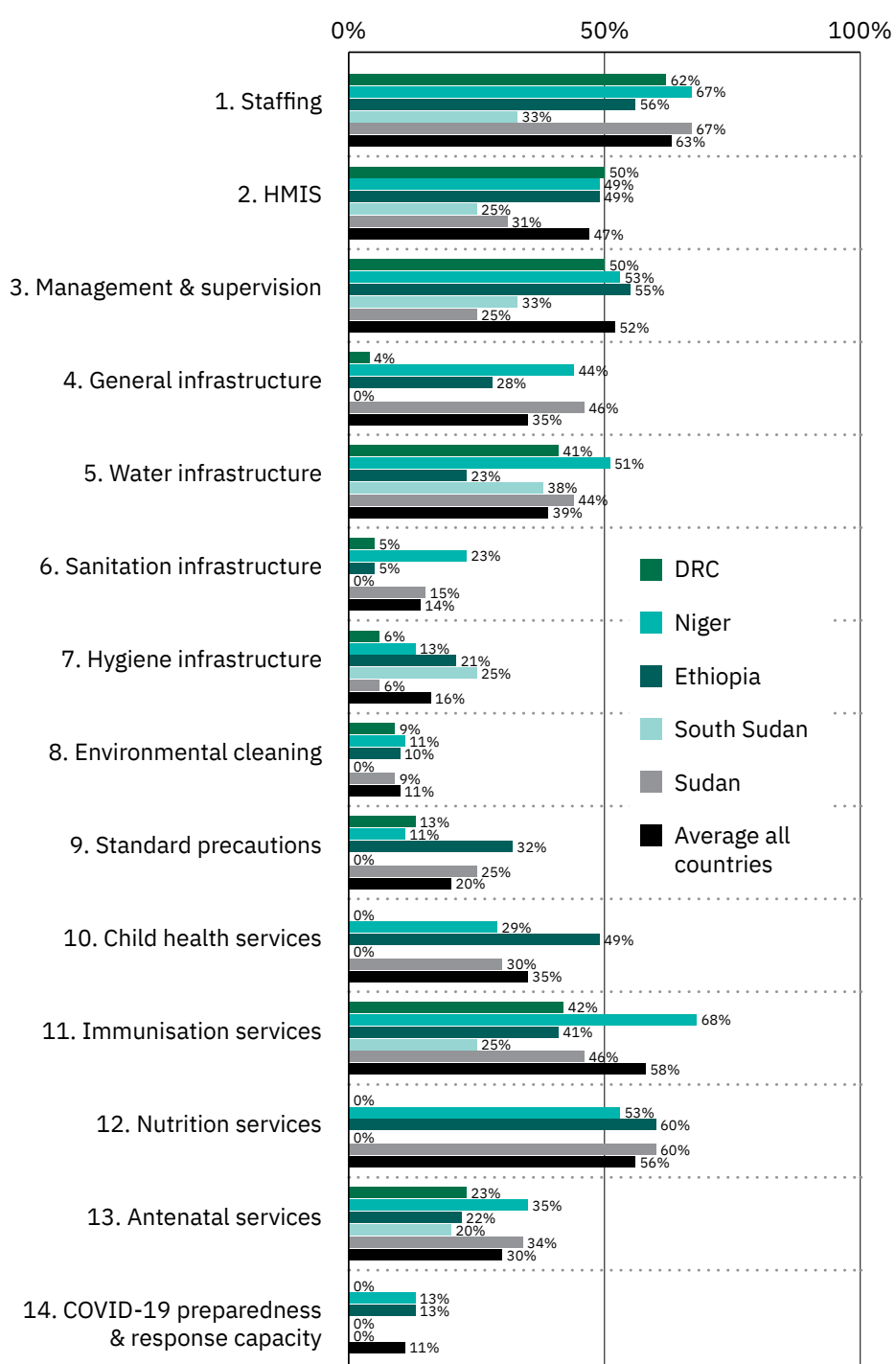


FIGURE 2. Average percent score per domain, by country and overall

The domains with the weakest capacity, requiring immediate attention are:

- Sanitation infrastructure (Domain 6, average score: 14%).** This was true across all countries, with Niger scoring slightly higher than the average (23%). Worryingly, less than half of the facilities assessed had a 'useable' latrine (that is accessible, private and functional). The proportion was highest in Niger (53%) followed by Sudan (38%), Ethiopia (17%), DRC (15%) and South Sudan (0%). Almost all facilities in all five countries also failed to meet the criteria for the other four sub-domains, which (based on the JMP tool) require the presence of four latrines to accommodate the following requirements: one useable latrine for female patients with menstrual hygiene management facilities; one to be designated for staff; and one to be accessible to people with limited mobility. The one exception was Niger, where 42% of facilities did have a toilet dedicated for staff.
- Environmental cleaning (Domain 8, average score: 10%).** The low score is consistent across all five countries and is due to poor performance across three of the four sub-domains: availability of cleaning protocols or rosters/ schedules, trained staff and adequate cleaning supplies, while scores were slightly higher for the fourth sub-domain: 'facilities look visibly clean'.
- Hygiene (handwashing) infrastructure (Domain 7, average score: 16%).** Again, scores were fairly consistent across countries. Only half or fewer of facilities in each country had a handwashing station in place and functioning: South Sudan (50% i.e. 1 facility), Ethiopia (43%), Niger (27%), DRC (13%), Sudan (13%). However, no facility had a handwashing station within five meters of all toilets per the JMP standard.
- Standard precautions (Domain 9, average score: 20%).** There was some variation between countries, with Ethiopia scoring the highest (32%) and South Sudan the lowest (0%). The biggest gaps were seen in two of the five sub-indicators: lack of safe waste separation (0% of health facilities for all countries but Ethiopia) and availability of functioning sterilisation equipment (less than 25% of health facilities in all countries).
- COVID-19 preparedness and response (Domain 14, average score: 11%).** Unfortunately, the majority of facilities in all countries scored badly across all four sub-domains. While in Niger and Ethiopia roughly one-third of facilities reported staff had received some training on COVID-19, the remaining three countries reported none. COVID-19 job aids were found to be absent in the vast majority of facilities, almost no facilities in all countries had essential personal protective equipment (PPE) or protocols or systems for triaging of suspected cases.
- Child health services (Domain 10, average score: 35%).** There were significant variations across countries with Ethiopia scoring the highest (49%), followed by Sudan (30%), Niger (29%) and DRC and South Sudan (both 0%). The main challenges were availability of essential child health equipment (less than 25% of facilities in all countries had this) and medicines (less 1% of health facilities in all countries, with the exception of 20% in Sudan). The proportion of facilities with a staff trained on Integrated Management of Childhood Illness (IMCI) and with IMCI guidelines present was high in Ethiopia (92%, 89%), modest in Sudan (40% for both) and Niger (36%, 52%), and nil for DRC and South Sudan (0%, 0%).
- General infrastructure (Domain 4, average score: 35%).** There was significant variation across countries: Sudan (46%), Niger (44%), Ethiopia (28%), DRC (4%) and South Sudan (0%). The reasons for the low score varied by country across the three sub-domains, with some lacking functioning power supply and/or functioning communication equipment and/or emergency transport. Note the tool did not assess the actual facility structure (e.g. walls, roof), but many facilities were observed during the assessment to need significant repair.

- **Antenatal services (Domain 13, average score 30%).** The average scores were fairly consistent across countries. The main gaps were seen in four of the five sub-domains: presence of antenatal guidelines, essential equipment, medicines, and diagnostic testing capacity. The main exception was Niger, where essential antenatal equipment was available in 88% of health facilities. More positively, presence of a staff trained in antenatal services (the fifth sub-domain) was reported for more than half of facilities in Ethiopia, South Sudan and Sudan, but only around a third of facilities in DRC and Niger.
- **Water infrastructure (Domain 5, average score 39%).** Scores varied somewhat across countries, from the highest in Niger (51%) to the lowest in Ethiopia (23%). Performance varied across the four sub-domains. While around half of facilities reported their main water supply came from an improved and functioning source, a much smaller proportion reported it was on the premises, half or less reported there had been no disruption to water provision in the past month and roughly half said the amount provided was sufficient for all the health facility's needs.

Domains with modest capacity, still requiring improvement:

- **Staffing (Domain 1, average score: 63%).** While this is the highest scoring domain, it is important to remember that this was based on a minimum of half of the health staff assigned to and expected at each facility (per national health staffing standards) being present on the day of the survey, which is a fairly 'soft' target.
- **Child immunisation services (Domain 11, average score: 58%).** While the child immunisation domain scored modestly, it may still be an area of concern because only facilities that reported 'routinely storing vaccines' were assessed due to the way the questionnaire was constructed. This meant that 61% (110/ 178) of the total health facilities were assessed for child immunisation services. The actual number of facilities that should be expected to deliver vaccination services was not established before the survey started – a lesson learned for the HFA tool in the future.
- **Nutrition (Domain 12, average score: 56%).** Despite gaps in availability of staff trained on nutrition in some countries and in availability of nutrition guidelines and nutrition equipment in all, nutrition scored high relative to the other domains. This was in spite of the nutrition score value being automatically set to zero for DRC and South Sudan because there had been no nutrition services prior to Concern beginning support in DRC and because at the time of the baseline in South Sudan nutrition services were being provided separately via three Concern-supported nutrition centres and not in the health facility itself. The percent of facilities with RUTF in stock on the day of the visit was relatively high in Ethiopia (71%), Niger (72%), and Sudan (88%).
- **Management and supervision (Domain 2, average score: 52%).** Scores were markedly lower in South Sudan (33%) and Sudan (25%). The absence of a functioning community health management committee contributed to low scores in most countries and, to a lesser degree, the absence of a functioning health facility management committee in all countries with the exception of Ethiopia (91%). Meanwhile, between 50% and 100% of facilities in each country reported having a supervision visit during the previous three months.
- **Health management information systems (Domain 2, average score: 47%).** While at least half of health facilities in all countries reported using and contributing data to the HMIS system, evidence of its use (in the form of wall charts or other visible displays) was found at less than one-third of facilities in all countries.

Priority actions identified jointly by the District Health Management Team (DHMT) and Concern in each country varied across contexts, but generally including:

- **Train relevant staff on IMCI, nutrition, child immunisation and antenatal care as well as environmental cleaning protocols**, prioritising facilities found to be lacking a trained staff. Concern is supporting the MoH to carry out trainings using MoH trainers and materials, many of which were already outlined in the MoH annual plan but not fully funded.
- **Rehabilitate latrines in priority facilities while further assessing water and sanitation needs/ developing an action plan for each facility using the WASH FIT approach³** in three of the five countries. The WASH FIT approach includes planning for the 'softer' side of WASH functions, ensuring maintenance of equipment and provision of essential supplies. Explore how health facilities with more than one latrine and designate one for female patients with menstrual hygiene management facilities and staff and be made accessible to people with limited mobility.
- **Rehabilitate water points, particularly in Ethiopia, including extensions to pipeline network, purchasing and installing roto tanks and explore rainwater harvesting schemes**. This will be started for some facilities while further assessing further needs using the WASH FIT approach.
- **Repair / establish handwashing stations with water and soap, ensuring there is one within 5 meters of toilets in all facilities, recognising the need to address water supply gaps**. The planned / ongoing WASH FIT assessments will also help develop action plans to keep hygiene infrastructure functioning.
- **Advocate for additional funding for WASH infrastructure rehabilitation**, as needs go far beyond what can be provided by MoH and Concern under the ERNE programme.
- **Train staff and provide equipment to ensure safe separation and disposal of sharps and infectious wastes**. In some cases, this may require rehabilitation / replacement of incinerators and sterilisation equipment, which may require additional budget and capacity building for maintenance.
- **Further assess reasons for stock outs of essential child health medicines, preventative treatments given during ANC (including oral iron supplementation and sulfadoxine-pyrimethamine for preventative treatment of malaria in pregnancy) and environmental cleaning supplies and identify actions to strengthen supply chains, including support to MoH for transport as needed**. Train staff on the rational use and management of child health medicines and antenatal preventive measures.
- **Print and provide essential guidelines and job aids, prioritising those facilities found to be without them, especially for COVID-19 prevention and control**.
- **Support ongoing supervision of health staff by DHMT members, focusing on the weakest areas identified in the HFA**. A schedule for supervision visits will already be established by the DHMT, but the HFA results and action plans may help target special support in some facilities.

3. [*WASH FIT: A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. Second edition \(who.int\)*](#) Geneva: World Health Organization; 2022.

5. What we learned

Through the process of developing the tool and piloting it across the five countries, the following learning has emerged:

- **The HFA has proven a useful tool for Concern and its government health counterparts to help tailor support to health facilities over the life of the ERNE programme and will help assess progress towards its capacity building objective as the programme comes to an end.** The tool was developed specifically for the ERNE programme but is showing potential for broader use (Concern, for example, has also used it for a USAID-funded programme in the same region in Ethiopia).
- **However, the Concern HFA tool requires a more robust review following the endline planned for four countries in 2023.**⁴ Concern plans to engage a range of stakeholders to review the tool and help assess its added value vis-a-vis other health capacity assessment tools in use in different countries. Further adaptations and alignment with other existing capacity assessment tools will likely be needed before expanding its use to further contexts, including the approach to scoring. Some of those initial changes are outlined below.
- **More active mapping and engagement of government health staff at District level and other partners in the planning, data collection, analysis and development of action plans is needed from the outset of the assessment.** Because this was a pilot, Concern focused more on the mechanics of the new tool. Government stakeholders were also – as always – juggling multiple priorities. As a consequence, partners were brought into the process later than hoped in some countries. Results have been shared and discussed with the DHMT in all countries and priority actions jointly agreed, but Concern will promote more active joint planning leading up to and during the endline.
- **Some of the identified needs went far beyond what the District health budget and Concern programme funding could address, meaning advocacy to other actors with specific mandates (such as WHO, UNICEF, UNFPA) or resources is essential to plan for before the baseline begins.** Understanding the remit and presence of different government departments, supporting agencies and donors is therefore a critical first step when planning the initial assessment to focus partner attention and advocate effectively for priority actions to be taken up.
- **WASH infrastructure proved one of the most significant gaps and potentially the most expensive to address. However, it is important to remember that addressing the softer side of WASH in health facilities is at least as important (and often less costly).** This includes supporting skills, protocols and supplies to ensure essential hygiene, environmental cleaning and maintenance and repair of existing equipment. It should also be noted that while not formally assessed by the HFA, basic infrastructure e.g. walls, roofs and store rooms were also observed to be in need of basic repair in many facilities.
- **The nutrition domain was a welcome addition to the tool, allowing a better understanding of specific gaps, particularly in the treatment of acute malnutrition which is a core service in the essential health package in all five countries.** The nutrition module provided important information on availability of ready-to-use therapeutic food (RUTF), nutrition equipment, guidelines and staff trained in nutrition, which was missing in the original SARA tool and others subsequently reviewed.
- **The core set of HFA domains and sub-domains (and related questions) should remain fairly fixed to allow comparison across areas and time.**

4. DRC will no longer be part of the ERNE programme as of mid-2022. Therefore, its endline HFA will be conducted in 2022.

However, it is critical that answer options are thoroughly adapted to each context before starting the assessment. This includes confirming the list of essential vaccines per in-country expanded programme of immunisation (EPI) standards, the list of essential child medicines, essential routine antenatal services and the list of staff assigned and expected at each facility. This could have been strengthened for this baseline assessment. While it was possible to retrospectively update the list of vaccines, some medicines were accidentally excluded, including, most critically, malaria medications for children (because they were not included in the essential child medicines list in the SARA tool but in a separate, more detailed malaria module which was not used).

- **The analysis and report writing process needs to be further streamlined and more joint reflection by country teams promoted as results emerge.** Data collection via digital devices was relatively quick, and dashboards built on the same digital platform allowed basic results to be viewed shortly after (by those with sufficient internet bandwidth). However, given the novelty and complexity of the tool, significant troubleshooting, data cleaning and reanalysis was required throughout the baseline process. This led to a somewhat disjointed and drawn-out analysis and report-writing process. Concern is taking steps to streamline the analysis and outputs for the endline to make it more efficient and country-led. More comprehensive training on how to use and refine analysis tools and templates will also help ensure a wider team is able to undertake and support finalisation of the results.
- **A set of companion tools to guide HFA implementation and action planning (and budgeting) is needed.** While a glossary was developed and multiple orientation sessions carried out for country staff and enumerators, a simple step-by-step guide is needed and will be developed to assist teams in the endline data collection, analysis and interpretation of scores. Meanwhile, as part of implementation, Concern teams are updating a basic District Health Profiles for each country to ensure essential details are mapped and available, including key stakeholders, essential health package elements, staffing standards, and geographic distribution of health facilities. Concern teams are also using the framework of sub-domains and baseline scores for each health facility to further direct activities to where improvement is needed by endline.
- **The child immunisation module should be administered at all health facilities where child immunisation services should be delivered – the full list of facilities must be confirmed prior to the assessment.** The original tool only assessed immunisation services at facilities reporting they 'routinely store vaccines', which excluded about 40% of facilities from the immunisation assessment. This may not provide an accurate picture of child vaccination service capacity.
- **The staffing domain is useful but may need revision.** Its structure and scoring are inherently different to the other domains. The staffing score currently tallies the number of staff present on the day versus those that should be assigned and expected at the health facility according to country-specific standards. Interpretation of the scores for individual facilities are somewhat less intuitive and the threshold for a 'pass' is that at least 50% of expected staff were present, which may be also be a low a bar to set.

6. Conclusion and next steps

The HFA tool developed by Concern provides a standardised measure of health service functionality at facility level. It covers 14 key service domains, made up of 54 sub-domains. The tool is broadly aligned with the global health service standards outlined in the WHO's Service Availability and Readiness Assessment tool and the Joint Monitoring Programme (JMP) for WASH from UNICEF/WHO, although the Concern tool focuses on a smaller subset of services than the SARA tool. The addition of a nutrition module and the more detailed WASH assessments modules from the JMP were particularly important for the fragile contexts assessed. The Concern tool also includes a scoring system to assess capacity at each health facility across the fourteen domains. This is in addition to the broader indicators of service availability and readiness at health district level present in the SARA and JMP tools. These additional elements were developed to increase the utility of the tool for prioritising actions and monitoring progress at both health facility and health district level.

Concern's experience piloting the tool in 178 health facilities across 19 health districts to set baselines for its ECHO-funded ERNE programme in DRC, Ethiopia, Niger, South Sudan and Sudan has been largely positive so far. It has helped Concern country teams and DHMT counterparts jointly identify gaps in essential health and nutrition service provision and target support in key domains and sub-domains under the ERNE programme. It has also provided data that can be used to advocate for more significant investments by stakeholders that go beyond the resources available to the DHMT/MOH and Concern. The five detailed country baseline reports as well as a five-country summary report are available at <https://www.concern.net/knowledge-hub/ERNE>

This learning paper provides an overview of the main learning to date from the development and use of the Concern HFA tool. To our knowledge, the health facility assessments conducted using the Concern tool contribute to a relatively small pool of assessments at health facility level in fragile contexts. Concern will continue to work with its government counterparts to address the health service gaps identified in each context, and to advocate for complementary and longer term investments by other partners, where appropriate. Endline assessments will be carried out in 2022 (DRC) and mid-2023 (Ethiopia, Niger, South Sudan and Sudan) after which Concern plans to share the full results and the revised tool and to engage stakeholders and peers in a more robust review of its potential use in the future.

7. Annex: Overview of countries, districts and facilities assessed

COUNTRY	REGION	HEALTH DISTRICT	FACILITIES ASSESSED
DRC	Tanganyika Province	Kiambi Health Zone	8
Ethiopia	Somali Region (Erer Zone)	Lagahida Woreda	70*
		Salahad Woreda	
	Amhara Region (North Gondar Zone)	Beyeda Woreda	
		Janamoura Woreda	
Niger	Tahoua Region	Tahoua Departmental Health District	90
		Tahoua Communal Health District	
		Illela Health District	
		Birnin-Konni Health District	
South Sudan	Unity State	Guit County	2
		Rubkona County	
Sudan	West Kordofan State	Abuzabad Locality	8
		Elnhoud Locality	
		Elodaya Locality	
		Ghebayish Locality	
		Lagawa Locality	
	South Kordofan State	Elleri West Locality	
		Talodi Locality	
		Gadeer Locality	
TOTAL	7	19	178

*11 health centres & 59 health posts

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