

JANUARY 2023

SUMMARY

POQAT

PRIMARY CARE FACILITY QUALITY OF
CARE ASSESSMENT TOOL FOR
HUMANITARIAN SETTINGS

GLOBAL HEALTH CLUSTER AND WHO

ACKNOWLEDGEMENTS

Many people contributed to this guidance for assessing the quality of care at primary care facilities in humanitarian setting (PQAT), which started with a workshop in Geneva, 6–8 December 2018. This was organized as part of the workplan of the Global Health Cluster and WHO Task Team on Essential Packages of Health Services in humanitarian settings, hosted by Save the Children, during which partners shared their approaches to quality improvement.

Different draft versions of the tool and its guidance were developed since then. One of them was piloted during a workshop in Tunis, organised by Dr Mondher Letaief from the WHO Eastern Mediterranean Regional Office, with colleagues from the Libyan Ministry of Health.

While we acknowledge and thank everybody below who in different ways contributed to the PQAT, we give special thanks to Dr Nigel Pearson (consultant) who did the groundwork, Dr Dirk Horemans (WHO) for his technical leadership, and Oriane Bodson (WHO) who also automated the tool and did the lay-out.

Acknowledgement of key contributions since 2018:

Cordaid, Dr Endris Seid and Jos Dusseljee
ECHO, Ian van Engelgem
Global Health Cluster, Eba Pasha
Health Cluster Iraq, Dr Fawad Khan
International Rescue Committee, Dr. Khaldoun M. Al-Amire
Medair, Trina Helderma and Wendy Dymont
Médecins Sans Frontières, Anna Freeman
Save the Children, Dr Louisa Baxter and Rachael Cummings
UNHCR, Allen Maina and Vincent Kahi
University of North Carolina, Sheila Leatherman
WHO, Boris Pavlin, Florian Tille, Dr Ian Norton, Nancy Fronczak, Philippa White, Samuel Petragallo, and Shamsuzzoha Babar Syed

On behalf of the former GHC-WHO EPHS Task Team,
Dr Andre Griekspoor (WHO)

1.BACKGROUND AND RATIONALE OF THE TOOL

Need for a health performance tool in humanitarian settings

Effective and efficient use of resources in the delivery of health services is a top priority in progress toward Universal Health Coverage (UHC) for communities in any country, and as relevant in humanitarian contexts as in more stable settings. While measuring the availability of facilities and their functionality in the delivery of services is a first step, a health system needs also to demonstrate that facilities and services meet quality standards against measurable performance thresholds. Ministries of Health (MOH) and international agencies have prioritized the need for good performance assessment tools which reflect on service availability, functionality and quality. While some of the existing tools can be very effective at looking at quality, they are either too resource-intensive to be used in emergency settings (such as the WHO Harmonized Health Facility Surveys) or do not measure all key aspects of performance quality.

Purpose

The purpose of the Global Health Cluster (GHC)'s Primary Care Facility Quality of Care Assessment Tool (PQAT) is to improve quality in primary care facilities in humanitarian settings. It is part of a collaborative effort to create a generic quality of care monitoring and evaluation framework for health services. It will allow countries with FCV settings to collect data on an important number of quality indicators of the Primary Health Care monitoring and evaluation framework.

Recognizing this gap and building on discussions on quality management systems that would monitor adherence to existing guidance on performance in humanitarian contexts, the Global Health Cluster and WHO have developed the **Primary Care Facility Quality of Care Assessment Tool**.

PQAT is a standardised tool that can be used soon after the acute phase and in protracted emergencies that facilitates the monitoring of key quality domains that should be guaranteed in primary care (PC) centres and smaller health units. The PQAT permits comparison between facilities and hence provides relevant data to MOHs and health clusters to assess and monitor performance as part of a broader quality improvement approach.

The tool is designed to capture the most important areas of quality in PC facilities, and if quality is substandard, there are direct implications for the safety of staff and patients, as well as for the effectiveness of services provided.

This proposed tool can be used by MOHs, UN agencies, Red Cross and Red Crescent Societies, international and national non-gouvernemental organizations (NGO) to rapidly assess health facilities in any country experiencing acute and protracted crises.

2. DESCRIPTION OF THE TOOL

Alignment with existing tools and scope

The PQAT has been developed considering existing tools, standards and best practices in humanitarian settings, as well as the tools used by MOHs, WHO, GHC, and GHC partners assessing quality of health facilities. The PQAT should be used when facilities are at least partially functional, and at least having partial availability of priority health services and the required resources for their delivery, such as reported by the [Health Resources and Services Availability Monitoring System](#) (HeRAMS). It is aligned with the position paper on [Quality of Care in Humanitarian Settings](#) by the GHC Quality Task Team, specifically all its aspects that are applicable to health facilities.

The tool is designed to capture five quality of care domains (Physical environment and resources, Patient and staff safety, Clinical effectiveness, People-centred care, and Management) broken down in 26 sub-domains, through which the tool examines various components of the service, notably the health information system, management of medicines, human resource management and maintenance of the facility infrastructure (Figure 1). The assessment of cross-cutting functions including infection prevention and control (IPC), water sanitation and hygiene (WASH), clinical effectiveness, prescribing and communication, and community engagement is embedded across the tool. Key functions of a health centre are examined, including registration, out-patient consultations, uncomplicated deliveries, pharmacies and dispensary, laboratories, and records management. PQAT is not a deep-dive tool, it aims at providing a quick assessment of PC facilities' performance. It raises red flags for areas that require improvements, potentially triggering more granular analysis of a particular area based on a detailed assessment with tools specifically designed for these areas.

Figure 1: Presentation of quality of care domains and sub-domains captured by the PQAT

	Physical environment and resources	- Adequate physical infrastructure, furniture & accessibility - Security (Staff & patient, and health facility assets)
	Patient and staff safety	- Adequate WASH - IPC - Waste management - Safe injection procedures - Medical incidents reporting - Occupational health & safety
	Clinical effectiveness	- Staff clinical skills & knowledge for diagnosis and investigating (incl. history taking, physical examination) - Laboratory - Prescribing - Adherence to clinical standards, guidelines and protocols, including clinical record audit - Triage, referral, emergency care and isolation of cases
	People-centred care	- Communicating information about illness & treatment, and health promotion - Comfort, dignity & respect, timeliness & attention, privacy & confidentiality (responsiveness) - Equity, inclusiveness and safeguarding (gender, disability, age, culture, ethnicity) - Patient and community engagement: Transparency, accountability (including feedback mechanisms), participation
	Management	- Availability and adherence to non-clinical, non-therapeutic, administrative guidelines and standards - HR management & good work (incl. staff training and adequate staffing) - Equipment, pharmaceutical and supply management (including storage, cold chain, maintenance, etc.) - Financial management and protection of the poor - Medical record keeping - Health information system - Surveillance, including EWARS - Preparedness - Quality improvement system

Methodology, context adaptation and use

PQAT makes use of different methods such as record review, observation, and interviews. It requires a physical visit of the facility by a small, two to three-person, team of assessors. This team requires a mixed skill set, combining clinical, health facility management and data analysis capacities. Assessors will use tablets to digitally complete the PQAT questionnaires when conducting assessments.

While covering all main quality attributes that were developed during an expert consultation, the tool remains light and rapid and adapted to the humanitarian context. A single health facility assessment can be done within a maximum of 2–2.5 hours, by a team of 2–3 assessors. The PQAT provides a set of core quality attributes formulated as questions. While it is expected that these are relevant in all contexts, they may need further adaptation to specific contexts. There are additional attributes in the PQAT that can be used for an extended version of the assessment questionnaire.

Similar to other assessments tools, PQAT requires country specific adaptation to consider the national and local health system specificities and terminology. The different stakeholders will be involved in this process, which will also ensure better ownership and acceptability of its application by the different partners and service providers.

The PQAT may be used by MOHs, UN agencies, Red Cross and Red Crescent Societies, international and national NGOs to rapidly assess and monitor over time the PC facilities in settings of acute and protracted crises. It can be used 1) for self-assessment by health service providers, 2) for internal assessment or supervisory visits by partners that support local health care facilities and 3) by a third party to monitor whether quality criteria are fulfilled.



3. SCORING AND REPORTING

Results from assessments are computed automatically, providing scores for comparison with previous assessments to show improvement over time, and with other health facilities and across districts/regions. Statistics and graphs are automatically generated to provide a breakdown of the score for cross-cutting functions, allowing pinpointing of specific areas needing focused action for performance improvement.

The scores can be reported using a traffic-light system, with a score of 0 – 50% colored in red, a score of 51 – 60% in orange, a score of 61 – 79% in amber and a score of 80 – 100% in green, or through ‘dials’ so that dashboard data can be interpreted more easily and quickly.

Scoring and the design of dashboards for the report is based on quality-of-care domains and their subdomains as proposed below. Most subdomains will draw on the answers collected through more than one of the different methods. The tool indicates under which of the subdomains each attribute is classified. As several quality subdomains overlap with others, some attributes may belong to more than one subdomain. E.g., several IPC attributes also belong to occupational health and safety.

All quality attributes are formulated as a question, with a ‘yes’ answer leading to a score of one point, and a ‘no’ answer leading to a score of zero points. Each sub-domain then receives an aggregate score, as measured by the proportion of the attributes that scored one point divided by the total number of attributes in that subdomain: for example, the IPC subdomain has 15 attributes; if 10 attributes scored 1 point each, the aggregate score for the subdomain is 10/15, or 67%.

Analysis and interpretation of scores will be used to:

- identify specific quality and availability issues by categories/topics or items for the facility that was assessed
- put actions for improvement in the action tracker
- use action tracker to monitor trends and progress (rapid progress in case of important safety issues)
- input to generate analyses for all facilities in a district, or all facilities supported by a partner



4.RESOURCE IMPLICATIONS OF PERFORMANCE ASSESSMENT

It will be important to develop a workplan and budget considering the resources needed for different steps and activities, such as setting up of a PQAT coordination group and implementation team, tool adaptation, digitization, hardware procurement, conducting the assessments, data dissemination and policy dialogue.

The PQAT assessment per facility is estimated to take a 2–3 person team approximately 2 hours to complete, inclusive of 15–20 minutes for a short introduction and next steps message to the PC team. Depending on the time it takes to travel to different facilities, an assessment team could conduct two assessments in a single day.

