

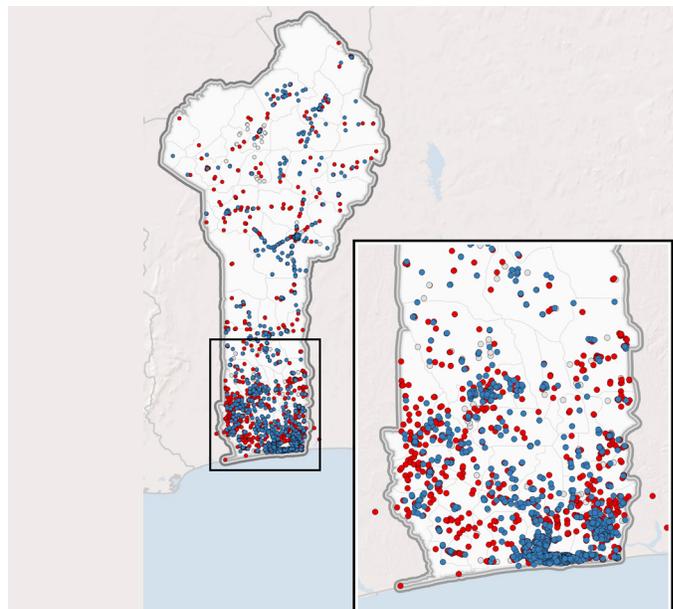
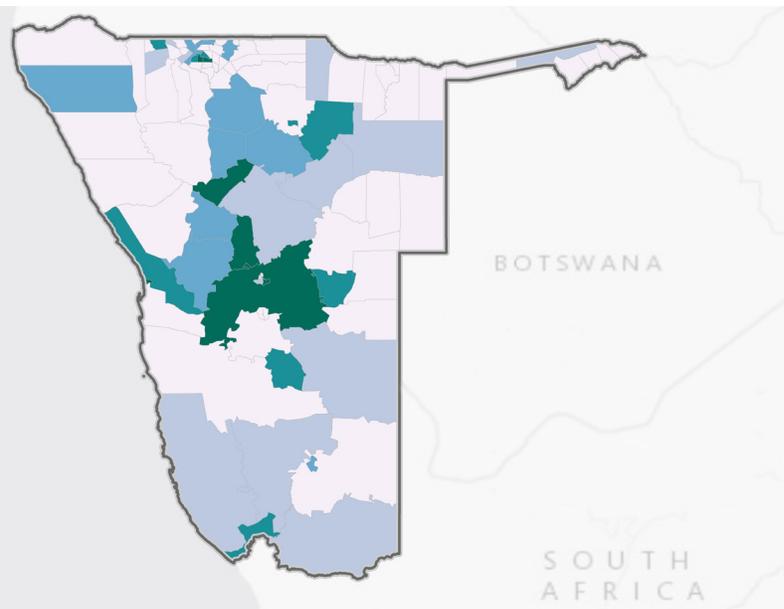
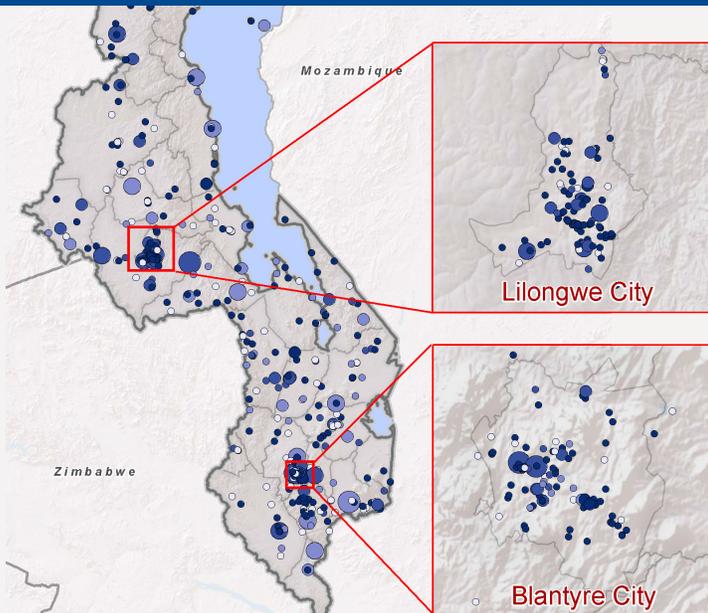


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Strengthening Health Outcomes
through the Private Sector

Facility Censuses: Revealing the Potential of the Private Health Sector



Summary: This primer sets forth the rationale for conducting a census and key steps in the implementation process. It builds on SHOPS's experience conducting private health sector censuses in eight countries in Africa and the Caribbean, and provides practical advice to potential donors on the methodology, potential benefits, and cost implications of carrying out a private facility census.

Keywords: AIDS, Benin, Caribbean, child health, family planning, HIV, Malawi, maternal health, Namibia, Nigeria, private sector assessment, reproductive health

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Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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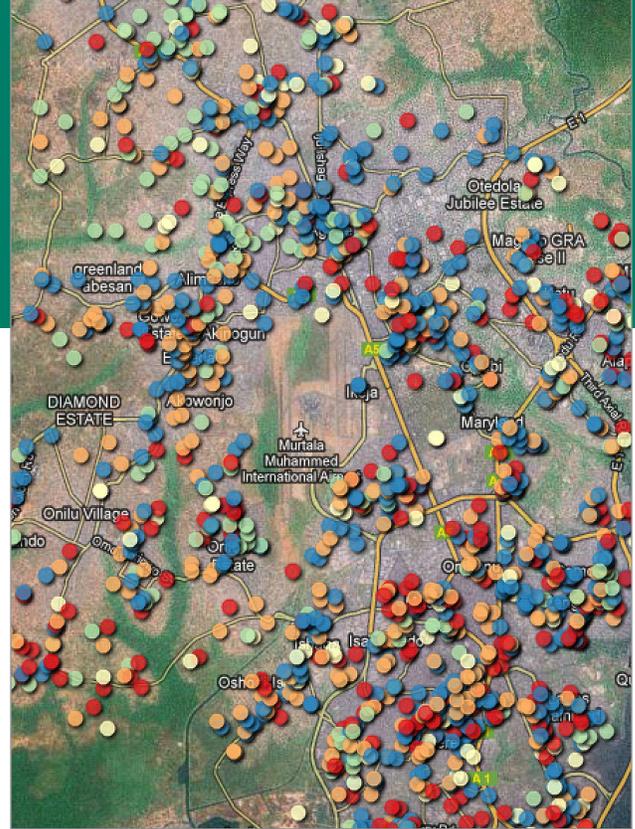
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Facility Censuses: Revealing the Potential of the Private Health Sector

The private health sector is a large and diverse community comprising both for-profit and nonprofit entities that lie outside the government health system. In most low- and middle-income countries, private sector actors play a large role in the delivery of health care services. Some estimates suggest that as much as 50 percent of health care in developing countries, even in the poorest countries, is obtained through private sector providers (Center for Global Development, 2009). Despite their critical role, data on the true number, distribution, and capacity of private sector facilities and providers are often unknown. The lack of accurate information about the private health sector leaves stakeholders, including donors, implementing partners, government agencies, and private providers, with little knowledge of the capacity of a key health resource.

A private facility census is a systematic count of all the private health facilities in a sample. The census may take a broad approach and gather data from the entire private health sector, or it may take a more targeted approach and focus on a specific aspect of the sector, such as facilities within a certain area of a country, or facilities that provide services for a specific health condition. While public health facilities can be included in a census, it is usually unnecessary because the government has information on the public health system. In addition to providing a complete picture of the number and types of health facilities, a private facility census provides information on the private health sector's overall composition, distribution, strengths, and most pressing gaps and needs. The type of information gathered will also depend on the priority health area of interest and the purpose for which the data will be used. Census results can be used for better informed and more effective health programming and future private sector engagement and research.

The basis of this primer is the experience of the Strengthening Health Outcomes through the Private Sector (SHOPS) project in conducting



SHOPS Project

private facility censuses in eight countries in Africa and the Caribbean.¹ The primer sets forth the rationale for conducting a census and key steps in the implementation process. Case studies from the Caribbean, Malawi, and Nigeria are provided as examples of how census data can be used to inform and strengthen family planning and reproductive health, HIV and AIDS, and maternal and child health programming.

¹ SHOPS conducted private health facility censuses in Antigua and Barbuda, Benin, Dominica, Malawi, Namibia, Nigeria (six states), St. Kitts and Nevis, and St. Vincent and the Grenadines.

RATIONALE FOR CONDUCTING PRIVATE HEALTH FACILITY CENSUSES

SHOPS has conducted censuses in response to a variety of stakeholder motivations. At the macro level, a census offers a clear picture of the health system to identify areas for greater private sector engagement and to make more informed policy decisions. The census can also be used to explore the role of the private health sector in addressing specific aspects of the health system. For example, the census in Nigeria focused on ways to identify and address gaps in private sector provision of family planning, reproductive health, and maternal and child health services, while censuses throughout the Caribbean focused on HIV services. Stakeholders may also choose to conduct a census for a much more targeted reason, including identifying providers to strengthen professional associations and pinpointing specific training needs within a given cadre. Each of these motivations is described in more detail below.

The basic rationale for conducting a private facility census is to better understand the size, scope, characteristics, and geographic distribution of the private health sector to inform program design. For

example, Demographic and Health Survey (DHS) data from Benin suggest that the private sector plays a large role in delivering health services: approximately 46 percent of childhood diarrhea cases and 38 percent of childhood fevers are treated in the private sector (INSAE 2012). However, the magnitude and distribution of the private health sector was largely unknown, and it was believed that unregistered private providers were vastly underrepresented in official figures. SHOPS's census helped capture these missing resources and offered a more comprehensive picture of the national health system. Annex A provides a snapshot of the types of high-level information captured during the Benin census.

In Nigeria, SHOPS aimed to engage the private health sector to improve family planning and maternal and child health outcomes. Program staff had difficulties determining the size of the private health sector and its needs. Official lists from professional associations and the Ministry of Health indicated 3,593 private facilities in the targeted regions, but a comprehensive census identified an additional 1,493 facilities.



Deji Adeyi

A private provider offers free blood pressure screenings at a community outreach day hosted by Unita Hospital in Lagos, Nigeria.

Many countries use census findings to facilitate greater private sector engagement and a total market approach to identifying and addressing priority health needs. The census can identify gaps in infrastructure, capacity, and training of private facilities and providers to inform programmatic interventions and improve the performance of the private health sector. In Malawi, SHOPS's census helped pinpoint training priorities.

In Namibia and the Caribbean, the impetus for the census was a reclassification to upper-middle income status and a shift in the President's Emergency Plan for AIDS Relief (PEPFAR) priorities to long-term sustainability and country ownership. These developments made it increasingly important to leverage private providers, about which little was known, to sustain the national HIV response. SHOPS's census filled this information gap by gathering detailed information to understand and quantify the private health sector. Census information was requested as a first step to better leverage private health resources in advance of PEPFAR withdrawal.

In some cases, census findings helped strengthen private provider associations. Professional associations play a vital role in advocating for health

providers and serve as a channel for government agencies, donors, and other stakeholders to help providers stay abreast of the latest developments. Leaders of professional associations can use census findings to identify new members and update data on existing members. In Malawi, census data revealed that while 96 percent of private providers belonged to a professional association, the associations themselves were isolated and highly fragmented. Collectively, the associations were strategically positioned to be powerful actors in strengthening Malawi's health sector. SHOPS used census findings to develop a program that brought associations together to network and learn from each other to strengthen their advocacy and communication roles and better shape private health sector growth.

Finally, census data can foster collaboration not only between the public and private sectors, but among private providers themselves, as was done in the virtual community of practice established in the eastern Caribbean.



Jessica Scranton

Nurse at St. Gabriel Hospital, a private Christian Health Association of Malawi facility.

Facilitating collaboration among providers in the Caribbean

Prior to SHOPS's census, most eastern Caribbean countries were unaware of the extent and capacity of the national and regional private health sector. The result was wasted resources and inefficiencies in service delivery as patients were sent to the United States for services available in-country or on neighboring islands. Stakeholders in Antigua and Barbuda, Dominica, St. Kitts and Nevis, and St. Vincent and the Grenadines sought to fill this knowledge gap through a comprehensive private health sector census. In total, the censuses identified approximately 540 health practitioners in more than 200 private facilities.

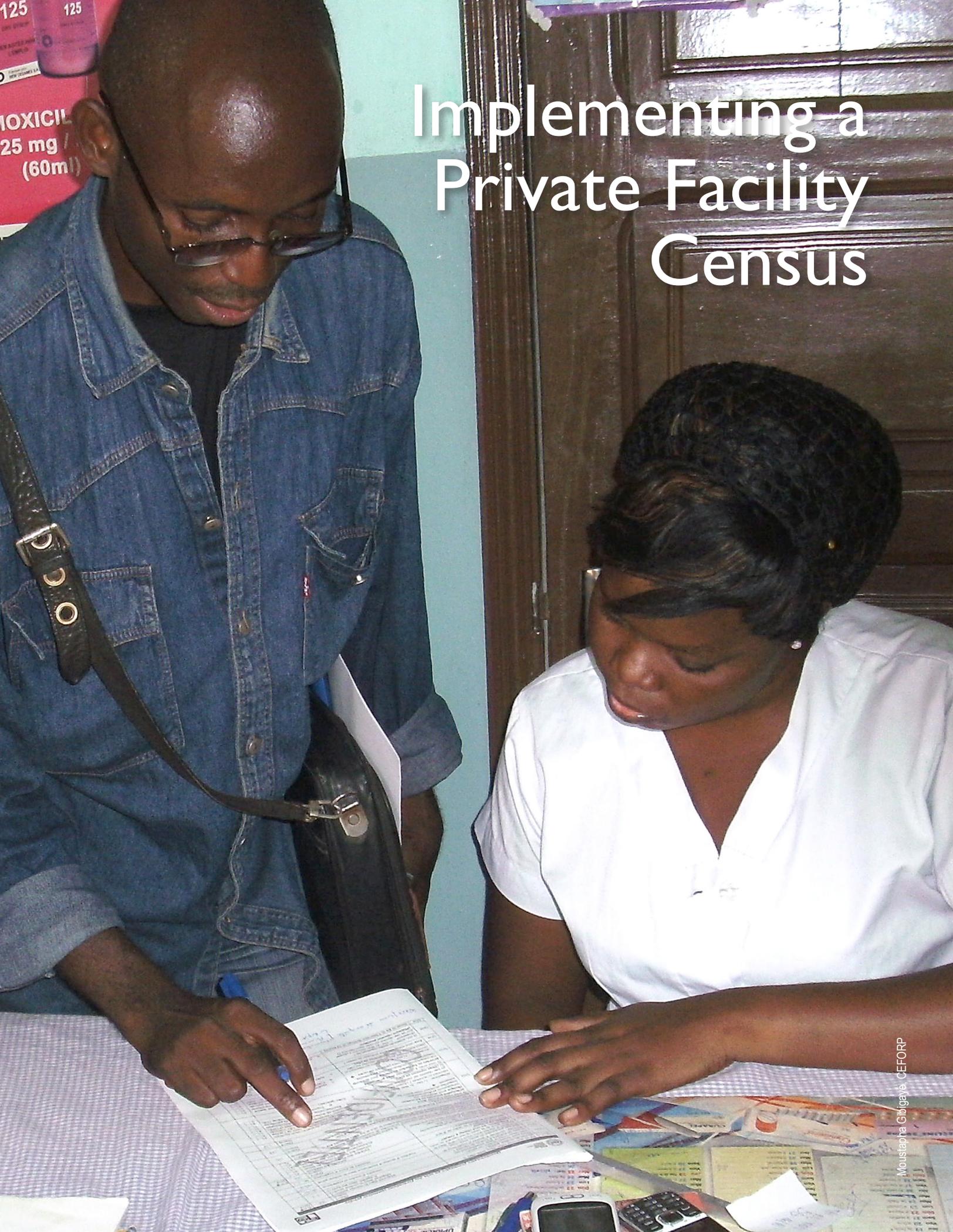


Census data revealed that while economies of scale prevent individual countries from providing all services, the region as a whole offered most priority services. To help practitioners better capitalize on these resources, SHOPS collaborated with seven regional organizations to design and launch the virtual Caribbean Health Connection (vCHC). The vCHC is an online community of practice for Caribbean health professionals to connect on matters related to the prevention and management of chronic diseases, with an emphasis on HIV and AIDS, across the region. It offers a sustainable platform for providers to communicate, coordinate, and collaborate for improved health outcomes.

Members access the site, which includes discussion groups, a resource library of relevant policies and publications, and a registry of health professionals that includes those captured during the censuses. To better capitalize on specialty services, members can also contribute to a shared calendar of visiting specialists, indicating when they expect to host their next specialist and how to reach them for an appointment.

The vCHC launched in December 2013. A year later, it had over 175 members from 24 countries.

Implementing a Private Facility Census



IMPLEMENTING A PRIVATE FACILITY CENSUS

The process for implementing a private facility census is not an exact science. The country context influences the steps required and the questions that the census will answer. The steps described below highlight some of the key decisions that census designers must make. These steps may overlap or occur at different levels of intensity based on specific need.

Step 1: Understand the Private Health Sector Landscape

SHOPS often conducts a private facility census in response to findings from an assessment of the overall private health sector landscape. A private sector assessment provides a snapshot of the private health sector, either as a whole or within a priority health area, and identifies opportunities to leverage the private sector for improved health outcomes. SHOPS has conducted 24 private sector assessments since 2009 and developed a tool to guide practitioners through the entire process. For more information, visit assessment-action.net.

Whether or not a private sector assessment is conducted, the following information should be gathered prior to conducting a census:

- What government agencies work with or are responsible for supervising and /or regulating private sector health facilities and providers?
- What professional associations of private health facilities or providers exist in the country and what are their respective roles?
- What are the policies and regulations affecting private health facilities and providers?
- What information on private health facilities and/or providers already exists and what does it reveal?

Answering these questions helps identify key stakeholders to engage in the census process and the priority questions that the census should address. They will also shed light on factors that should be considered when designing the census.

Step 2: Obtain Stakeholder Buy-In

Stakeholder buy-in helps ensure that the census design is context-specific, the findings are used to inform programming, and the data are maintained after primary data collection is complete. Obtaining active buy-in from relevant stakeholders may require different approaches depending on the country and political context. One approach is to identify all potential stakeholders, prioritizing as needed based on their influence and the impact the census will have on them. Once identified, stakeholders should be contacted and made aware of the census and the specific benefits that such an exercise would provide. Initial contact should be made as early as possible to give stakeholders an opportunity to provide input into census design and outputs. In some cases, a facilitated workshop may strengthen collaboration and a sense of mutual responsibility among stakeholders.

Stakeholders can also serve as a critical resource in conducting the census, including providing information on any data or platforms that already exist to support the exercise. Engagement of provider associations is particularly important because it can raise awareness and encourage participation among private providers that may be visited during data collection. All key stakeholders should have clear channels to contribute and provide feedback on census design, methodology, data collection instruments, and outputs. When appropriate, engagement could also include identifying a census data “owner” charged with validating and updating facility information. This individual or organizational unit will ultimately be responsible for maintaining census data, and should be included in any major discussion about design to ensure that the findings are presented in a format that best meets stakeholder needs. While a potentially time-consuming task, stakeholder engagement must be prioritized over the entire lifecycle of the census to foster the sense of ownership required to sustain outcomes.

Typical key stakeholders

- Ministry of Health
- District/regional government ministries
- Professional provider associations
- Networked private clinics or hospitals
- NGO-funded health sector projects

Step 3: Select Types of Facilities to Target

The structure of a private facility census is flexible and can be tailored to target specific populations, address stakeholder priorities, and answer questions that emerge during the private sector landscaping. In some cases, such as in the Caribbean, the assessment may reveal that very little is known about the health sector and a comprehensive census of all private sector resources for health is necessary to inform decisionmakers and program implementers. In other cases, as in Malawi, the primary objective is to gather information related to the provision of a specific health service such as child health. In the latter cases, it becomes important to determine which types of health facilities are the most important providers of the targeted health service. DHS data provide information on the source of provision for various basic health services including family planning, child diarrhea, child cough, sexually transmitted infection treatment, antenatal care, delivery, postpartum care, and HIV testing.² These data can be used to provide an overview of where care for the health service is being accessed and serve as the starting point for targeting appropriate facilities.

Step 4: Determine Census Outputs

Once facilities have been targeted, consensus should be built around desired outputs. SHOPS has consolidated census data into several different formats, including Microsoft Excel spreadsheets, Microsoft Access databases, STATA files, web-based platforms, and a series of geographical information systems (GIS) maps. The desired output will heavily influence the design of data collection instruments and the training requirements for data collectors. In

some cases, simple paper-based instruments can be used to collect data and the findings transferred to Excel. In the Caribbean, stakeholders wanted a database that could be easily updated and would automatically consolidate findings into concise reports. In response, SHOPS designed a data collection instrument where responses were entered directly into a Microsoft Access database. The databases were transferred to web-based platforms where providers, Ministry of Health personnel, and potential patients could view findings and suggest edits. Figure 1 on page 8 shows the St. Vincent and the Grenadines Ministry of Health website, which links directly to the new provider registry. In Benin and Malawi, stakeholders desired a combination of outputs, including STATA files and GIS maps. As a result, the census team had to develop instruments that collected information on global positioning system coordinates and had to ensure that data collection teams were properly trained in using the technology. Figure 2 on page 9 is an example map developed from GIS data.

Step 5: Develop Data Collection Instruments

Data collection instruments should be tailored to context-specific objectives and desired outputs. Other considerations include available budget, as some variables are more costly to collect than others, and identified sensitivities to specific topic areas. Based on these factors, several different types of data may be collected at the provider and health facility level. The discussion below provides an extensive, but not exhaustive, menu of variables that could be captured during a private facility census. It also provides examples of how these variables have informed program design. To the extent possible, the type of data collected and survey question wording should match that of other facility surveys so that data are comparable for external validity and future cross-country analysis (Annex B provides a list of facility surveys).

² Not all DHS surveys include questions related to all of these health services.

Figure 1. St. Vincent and the Grenadines' private provider registry



The homepage of the government of St. Vincent and the Grenadines links directly to the new registry of providers. The registry had 100 visitors in February 2015, and will be updated by the Ministry of Health.

Helpful hint: Developing instruments

Depending on the extent and focus of the census, it may be necessary to develop multiple questionnaires. Census questions for a large private health facility will differ from those for a pharmacy or nongovernmental organization. Instruments should be tailored to ensure optimal relevance and efficiency during data collection. In Benin, SHOPS used three survey instruments: one for private facilities, one for private providers, and one for private pharmacies.

Data types

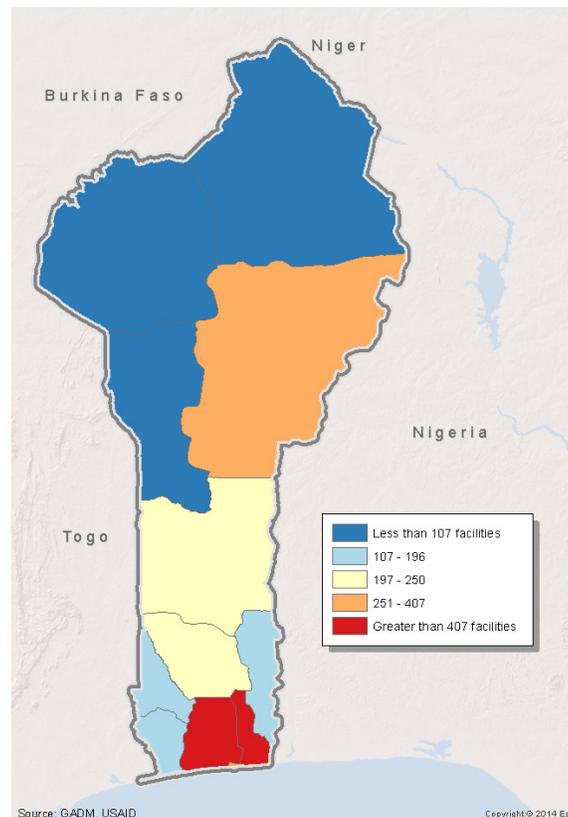
Basic facility information provides a general idea of the available resources, quality of care, and capacity of the facility. These inputs are typically included in censuses because they are easy to collect and have many uses.

- Facility location data reveal the geographic distribution of private health facilities and can influence where health interventions should be targeted. For example, Figure 2 shows the number of identified private facilities by geographic department in Benin.
- Data on basic infrastructure offer insights into the availability and source of utilities and other physical structures.
- Questions on equipment can capture the availability of items such as syringes and stethoscopes or more specialized medical equipment such as ultrasound and MRI machines. In the Caribbean, these questions

revealed that private providers had specialty equipment not available in the public sector that had been overlooked in favor of sending patients overseas.

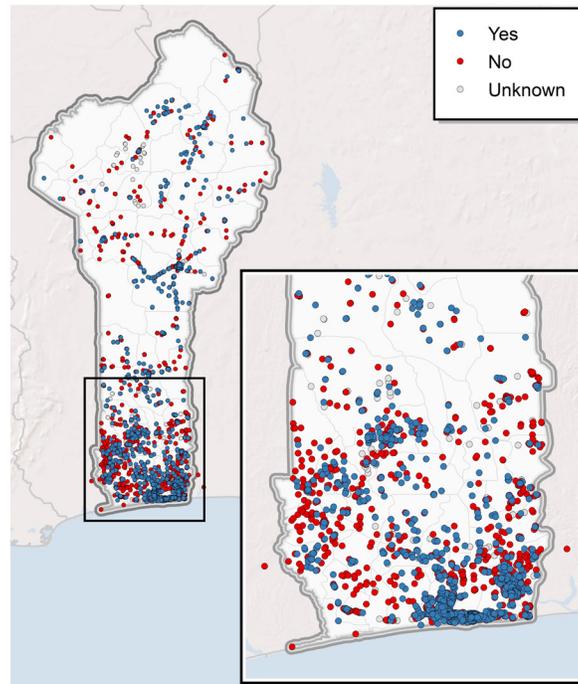
- Personnel information sheds light on the size, type, and quality of human resources available. At the provider level, it can reveal a provider's specific services, employment history, and education. At the facility level, it can capture the number of personnel by provider type and number of personnel trained or capable of providing a specialized service such as HIV or family planning counseling.
- Health service statistics and patient volume data by health service type can provide information on the demand for specific health services in the private sector. Figure 3 shows the locations of private facilities offering reproductive health and family planning services in Benin.

Figure 2. Density of private facilities by department in Benin



The figure shows significant variation in where facilities are located, with facilities heavily concentrated in the south.

Figure 3. Private facilities offering reproductive health and family planning services in Benin



The census revealed that these services are disproportionately concentrated in the southeast and urban areas and that additional research into the barriers to operating private health businesses in certain areas may be warranted.

Revenue and expense data, including pricing, facility revenue, facility expenses, loan history and practices, record keeping and reporting, can provide useful information about a facility's operations, management practices, and financial viability. More specifically, cost of services data can offer insights into the financial resources required to provide health services to a facility's catchment population. Record keeping variables, including the existence and types of systems for financial recording, reporting of medicines and product purchases, and sales and client volume, provide information on the types of managerial systems in place that affect the efficiency of the facility's operations.

Quality measures are obtained through observable factors such as physical infrastructure, availability and type of equipment, number of health personnel, number and types of services, or a combination of these factors. While data on structural inputs are easy to collect, this approach is limited to describing the physical quality of a health facility. Another approach is to capture information on less

Helpful hint: Gathering sensitive data

Gathering financial data can be difficult because this information is often viewed as private. SHOPS's experience in Nigeria revealed that respondents were willing to share information on revenue, but were reluctant to share expense data. Financial questions should be treated with sensitivity and asked toward the end of a survey, if at all, to avoid the risk of offending respondents and potentially limiting future partnership opportunities.

observable factors, such as provider competencies, provider-patient interaction, and patient satisfaction with health services. To get this information, questions can be asked about patient wait times, total time spent in counseling with a provider, whether a patient would recommend a provider to others, and the overall level of patient satisfaction

with a visit. Answering these questions requires use of more costly data collection methods such as quizzes, clinical vignettes, direct observation, mystery client surveys, or exit interviews. Despite the cost, the methods produce a more complete picture of a health facility's capacity to provide for its catchment areas by offering insight into the actual patient experience and whether a patient receives

necessary health services. These methods also provide valuable information on provider training gaps and needs (Annex C provides more information on methods to measure quality). SHOPS's census approach in Nigeria included the use of mystery client surveys to measure the quality of family planning surveys in Lagos.

Strengthening private sector family planning services in Nigeria

In Nigeria, SHOPS is working to strengthen the capacity of private sector providers in six states to offer family planning, reproductive health, and maternal and child health services through business training, family planning training, and access to finance interventions. While government agencies and insurance companies maintain lists of private health facilities, these lists are inaccurate and only include basic details. Without sufficient data, the project found it difficult to set targets, design appropriate interventions, and identify specific facilities to target for each intervention. In 2012, SHOPS conducted a private health facility census in the six states to fill the data gap. In addition to basic facility information, SHOPS collected extensive data on facility business practices and the quality of family planning counseling services for a subset of facilities in Lagos.

The table displays results from mystery client surveys conducted at 965 facilities in Lagos. It shows the percentage of time the provider asked each of the listed basic family planning questions.

Results from family planning mystery client survey in Lagos, 2012

Category	Question	% of time question asked
Background	Your age?	54
	Are you married?	57
	How long have you been married?	6
	Do you have children?	92
Ask client her preferences	Do you want to have more children in the future?	77
	Does your partner support you in family planning?	48
	Are there any family planning methods that you are currently using or have used before?	53
	Which family planning method would you prefer?	60
	Are there any family planning methods which you don't wish to use?	10
	Are there any family planning methods which your husband/partner doesn't wish to use?	13
Rule out pregnancy	Are you pregnant?	18
	When was your last menstrual period?	67
	Have you had unprotected sex since your last menstrual period?	28
Check for contra-indications	Do you have any major health problems?	25
	Are you taking any medications currently or periodically?	9
	Are you allergic to any drugs?	9
	Do you have heavy periods?	22

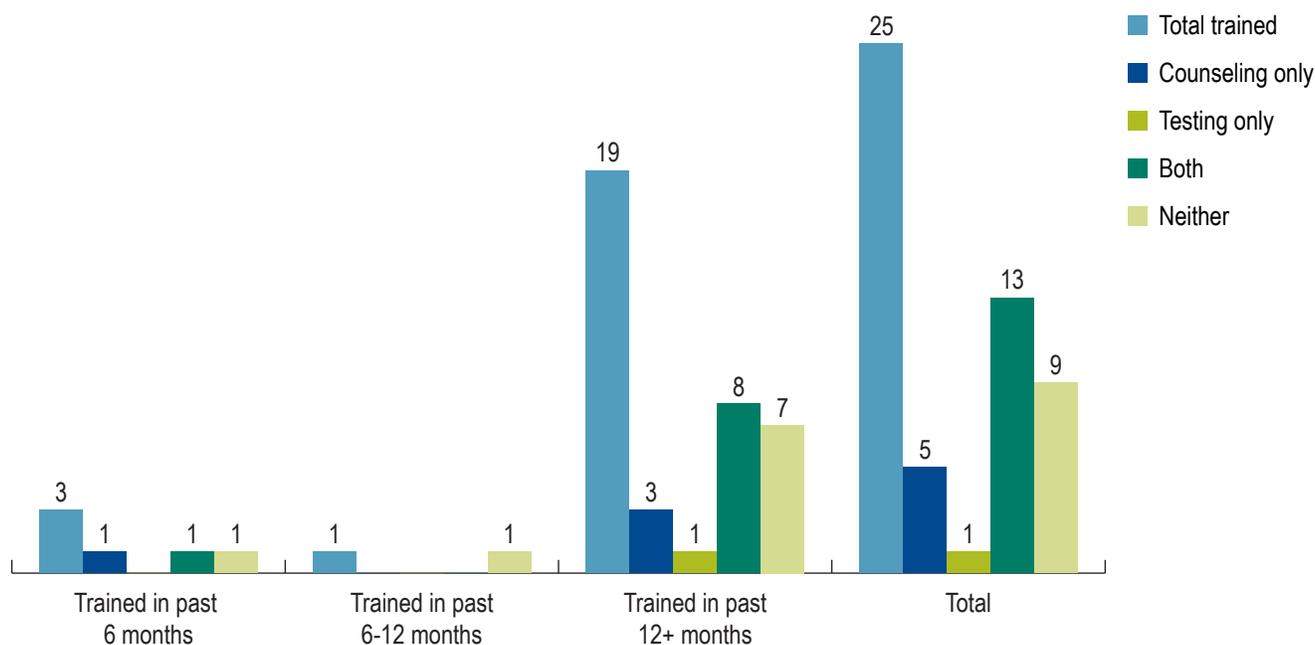
The survey found that providers often failed to ask key questions necessary to gauge the mystery client's preferences for contraceptive methods. However, providers were generally responsive to patient needs and provided more information on long-acting methods than other methods, which was in line with the mystery client's profile. Data from the census have allowed the SHOPS team in Nigeria to better set program targets and identify specific facilities to include in their family planning training intervention.

The full report, *A Census of Private Health Facilities in Six States of Nigeria*, may be accessed at shopsproject.org.

Other data can be included in a census to respond to specific questions or areas of interest. For example, data may be collected on the stock of pharmaceuticals to measure the prevalence of stockouts. It can also help identify dispensing patterns and whether a pharmacy needs additional training or resources to carry pharmaceuticals that adhere to standard treatment protocols. Dual practice indicators can provide insight into the human resources available within the private sector and interaction between the private and public health sector at the provider level. Provider training history can be captured to identify gaps in provider

knowledge and better inform future programming. For example, Figure 4 shows the distribution of facilities with providers who have received training in and/or are providing HIV counseling and/or testing services in St. Kitts and Nevis. The findings revealed that many private providers had not been trained within the year the census was conducted and that three providers were offering counseling and/or testing services without any formal training. Based on these findings, the National AIDS Program increased private provider access to government training on appropriate HIV counseling and testing protocols.

Figure 4. Facilities training and/or providing HIV counseling and/or testing services in St. Kitts and Nevis, 2012



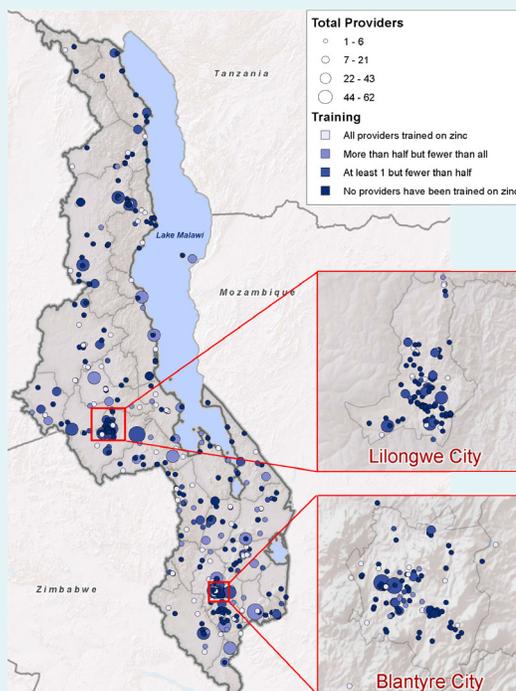
Using census data to target training on the use of zinc as a treatment for childhood diarrhea in Malawi

Diarrhea is a major risk to children's health in Malawi. According to the 2010 DHS, 17.5 percent of all children under 5 had experienced an episode of diarrhea in the two weeks preceding the survey. Scientific evidence shows that zinc, when taken in combination with oral rehydration salts (ORS), can reduce the length and severity of diarrhea episodes among children. In 2004, UNICEF and the WHO revised their guidelines for the management of pediatric diarrhea to recommend use of zinc along with ORS for uncomplicated diarrhea. In 2012, the Malawi Ministry of Health adopted the revised guidelines. Many public providers subsequently received training on ORS and zinc through USAID's Support for Service Delivery Integration project. The vast majority of private providers did not have access to that training and no information existed on which private providers had received training and which had not.

In 2012, SHOPS launched a program to fill this gap by training private providers on the use of ORS and zinc for childhood diarrhea management. A private health facility census was conducted prior to launch and included questions to determine prior participation in training on diarrhea management and desired topics for future technical and business training opportunities. The figure shows all private health facilities located during the census along with the proportion of health providers at each facility who had received training on ORS and zinc at the time of the survey.

Analysis revealed that a large proportion of facilities in Malawi's most densely populated areas had few, if any, providers trained on ORS and zinc. It allowed SHOPS to target zinc training where the need was greatest, and to directly contact all facilities targeted to receive training using contact details gathered during the census.

The *Malawi Private Health Sector Mapping Report* may be accessed at shopsproject.org.



Step 6: Conduct the Census

Once variables have been selected and instruments developed, data collection can begin. The approach to data collection can take many forms. In the Caribbean, the number of private providers was so limited that a single individual could gather data from all private health facilities in a two-week period. In countries like Namibia, with larger populations of private providers and a vast landscape, data collection firms should be employed to ensure that data are gathered in a timely and efficient manner. These firms should be vetted and selected well

in advance of data collection in order to prevent implementation delays. Depending on the type of information being collected, it may also be important to require the research firm to hire data collectors who already have some familiarity with the medical field. In Namibia, information on specialized medical equipment was collected, which required extensive training of data collectors who were unfamiliar with the equipment. The time and cost required to sufficiently train data collectors on census instruments, objectives, and methodology should be considered when designing the approach.

The most difficult part of conducting a private health facility census is actually locating the facilities. Private facility lists are often available from government oversight agencies and professional associations who keep track of their members. While usually inaccurate or incomplete, they provide a useful starting point and should be requested as early as possible. Once lists have been obtained, they should be merged, and duplicate facilities removed, to generate a master list. There should also be a clear method for merging this interim master list with data from the census so that, after the census has been conducted, the accuracy of the final list can be assessed. Doing so has the dual benefit of ensuring that as many facilities are located as possible and that stakeholders have access to the most comprehensive and accurate data on the private health sector.

Locating additional facilities is often a simple task in sparsely populated rural areas; residents have few options and are likely to be aware of all the private health facilities in the area. In dense urban areas, locating additional facilities is much more challenging. There are several ways in which data collectors may identify additional facilities during the data collection process. One is snowball sampling whereby surveyed health care providers are asked

Helpful hint: Gathering data from private providers

Gathering data at private health facilities is often more difficult than at public ones. Private providers may not be required to regularly report to the government and may be reluctant to provide information to data collectors, especially true for data on revenue and expenses. Private providers are also operating their own business—time away from patients is money lost. A clearly written consent form and plan to collect data before and after regular business hours can help mitigate these constraints.

to identify other providers not included on existing facility lists. If using a data collection firm, training should include showing photos of different types of health facilities and tips for identifying private provider facilities that are not well marked. Another approach is a methodical walk-through of targeted areas (Annex D provides more information on SHOPS's methodology for identifying overlooked facilities in densely populated areas).



Kathryn Banke

Data collectors are trained on census instruments in Benin.

Data collection in Namibia

In Namibia, SHOPS identified specific categories of private health facilities to target in the census, including consulting rooms, hospitals, pharmacies, pathology and radiology laboratories, ambulance services, mobile clinics, and medical suppliers. The Namibian Association of Medical Aid Funds registry served as the basis for developing a master facility list. SHOPS then developed four tailored survey instruments to collect data from each major health category, and selected a private research firm through a competitive process to conduct local data collection with SHOPS oversight. Data collectors conducted an intensive search on foot in major cities such as Windhoek to identify any facilities not included in the association's registry. The team also reviewed online medical listings and Telecom Namibia's 2013–2014 telephone directory to identify additional facilities. SHOPS supplemented these efforts with the snowball methodology.

Step 7: Validate and Disseminate Findings

Once data collection is complete, findings are generally compiled into a report and the data is shared with stakeholders in a user-friendly repository. Ideally, the results should be part of a larger multisectoral event to discuss key findings and how to use the data. Dissemination events provide a unique opportunity to validate findings and modify the final product to best meet the needs of users.

In the Caribbean, all census data were compiled into a Microsoft Access database with a series of prepopulated reports. Stakeholder feedback revealed that the original platform design limited usability; it required a Microsoft Access software license and was not readily available to practitioners or potential patients. To promote greater sustainability and use of census findings, SHOPS transferred the national registries to web-based platforms linked to Ministry of Health websites.



H. Amanda Lynch-Foster, USAID

USAID Mission Director Daniel Smolka and U.S. Ambassador Dr. Larry Palmer with St. Kitts and Nevis' Minister of Health Marcella Liburd and Permanent Secretary in the Ministry of Health Andrew Skeritt attend the census handover event in St. Kitts.

Dissemination events also provide an opportunity to discuss how to use census findings to collaboratively strengthen health outcomes. For example, SHOPS gathered over 240 key stakeholders, including the USAID/Nigeria Mission Director, Ministry of Health representatives, private providers, and implementing

partners, to share census results in Nigeria. SHOPS presented on the number of providers operating in six states and the types of services they provided. Participants then discussed challenges currently facing private health providers, such as the quality of private services, unregistered private providers, competition of small clinics with larger hospitals, and ability to access financing for capital improvements. During these discussions, both USAID and the Ministry of Health committed to working together to address these challenges and strengthen the private sector to reach national health goals and objectives.

Step 8: Maintain Census Data

Ideally, census data should be routinely monitored and maintained to ensure sustained use. Stakeholders are less likely to value, and subsequently utilize, a resource that contains inaccurate or out-of-date data. In practice, the maintenance process can be arduous and time-consuming. Some private practitioners may have reasons to stay off a monitored list, including fear the government will use it to levy additional taxes. For those who wish to be included in the list, a great deal of time and effort is required to regularly validate or add new information, especially if it is for multiple facilities across a wide geographic area. Depending on the level of stakeholder engagement, it may be important to first gauge the interest, feasibility, and cost implications of developing and maintaining a dynamic facility list.

Step 9: Ongoing Technical Assistance

Following data dissemination, a best practice is to regularly communicate and provide ongoing technical assistance to census data “owners.” At a minimum, these efforts should include detailed training on data collection instruments and methodologies and proper data maintenance techniques. This training should be accompanied by a user manual for necessary refresher training. If possible, efforts should also be made to ensure that data are available to health association representatives for dissemination to members, and that a mechanism is in place to validate new facility data. The latter activity could involve a two- or three-person multisectoral team, including the Ministry of Health census data owner, meeting regularly to update the information and disseminate revisions to appropriate stakeholders.



Private pharmacy in St. Kitts and Nevis.

Kylie Graff

COST CONSIDERATIONS

The cost of completing a private facility census depends on the level of effort needed to identify, locate, and gather information from the facilities within the targeted location. A comprehensive census of all private health facilities in a country will certainly be more time consuming and costly than one focused on providers of a specific health service in a specific state or region. The size and location of facilities within the target area also affects the cost. Small, informal facilities are often difficult to locate, but getting the owner's time for an interview is relatively easy. Larger facilities are easier to find, but their staff are busier, and multiple visits may be required to collect all the necessary data. Identifying rural facilities and collecting their information is generally easy because there are relatively few facilities and most are well known to residents. In densely populated urban areas that rely heavily on informal providers, community members are unlikely to know of all local facilities, making identification and data collection more time-consuming and costly. In fact, a comprehensive private health facility census may be prohibitively expensive in extremely large and dense cities. Still, a comprehensive census is often worth the time and expense—most are feasible and cost only two to three times that of a sample survey, while providing much more data.

Census designers must also consider the cost implications of census output formats. A dynamic web-based database that allows continual updating of census information will be considerably more expensive and time consuming to maintain and use—in terms of sustained stakeholder engagement and technical assistance—than creating a static database that provides a snapshot of facility location and attributes at the time of data collection. However, the dynamic platform may be more useful in the long term.

CONCLUSION

The private health sector is increasingly recognized as a vital component of the health system in most low- and middle-income countries, with the capacity to play a large role in improving health indicators. One of the major barriers to leveraging the private sector is a lack of information on its size, scope, and capacity. A private facility census can help fill this gap by gathering detailed data on all private sector resources for health within a target area or for a specific health condition. Drawing on SHOPS's experiences in eight countries in sub-Saharan Africa and the Caribbean, this primer provides practical advice to potential donors on the methodology, potential benefits, and cost implication of carrying out a private facility census. The country examples demonstrate how census data can be used and how a census can be designed to answer context-specific questions. Insights gained from these censuses have resulted in better informed program design and implementation. This, in turn, has allowed stakeholders to not only better understand the private sector's composition, but to clearly identify areas for greater private sector engagement, strengthen private provider capacity, and more easily conduct future research on the private health sector.

Annexes



ANNEX A: BENIN CENSUS AT A GLANCE



All 77 communes canvassed

3,174 private facilities mapped

6,217 private providers interviewed

-  55% of facilities are rural
-  52% of facilities are in the South: Ouémé, Littoral, Atlantique, and Mono departments
-  77% of facilities offer at least one maternal/child health service
-  22% of facilities offer voluntary testing and counseling for HIV and AIDS
-  66% of facilities have access to electricity
-  16% of facilities are affiliated with an NGO or other organization
-  33% of registered facilities received an accreditation visit in the past 6 months
-  8% of facilities accept medical insurance
-  4% of facilities stock antiretroviral drugs
-  27% of facilities offer oral contraceptives
-  66% of facilities cite a shortage of medical equipment/supplies as a barrier to growth
-  54% of providers are registered to practice health care in Benin
-  7 clients, on average, are seen per facility each day
-  8.7 years is the average time a provider has worked in the private sector
-  49% of providers are medical aides
-  8% of providers work both in the private and public sector
-  20% of providers have been trained in diarrhea treatment with ORS protocols
-  53% of providers choose malaria treatment updates as a top priority for clinical training
-  48% of providers choose quality assurance systems as a priority for supportive training

ANNEX B: ONLINE HEALTH FACILITY SURVEYS

Source	Title
Demographic and Health Surveys	Service Provision Assessment
World Bank Group	General Provider Facility Questionnaire
World Bank Group	Quality of Medical Care Research in Public and Private Sectors
World Health Organization (maternal, newborn, and adolescent health)	Health Facility Survey: Tool to evaluate the quality of care delivered to sick children attending outpatient facilities
RAND	The Indonesia Family Life Survey
RAND	Matlab Health and Socio-Economic Survey (MHSS)
MEASURE Evaluation	Uganda Delivery of Improved Services for Health (DISH) Facility Survey 2002

ANNEX C: DATA COLLECTION METHODS FOR MEASURING QUALITY

The table below describes each data collection method, and gives the advantages and limitations of each method.

Data collection method	Description	Advantages	Disadvantages
Written quiz	Tests providers' knowledge on health diagnoses and treatments	<ul style="list-style-type: none"> • Relatively straightforward method to collect data on provider knowledge • Most useful for testing knowledge soon after information dissemination 	<ul style="list-style-type: none"> • Does not provide information on providers' actual behavior at point of care • Does not measure providers' long-term retention of knowledge
Clinical vignette	Assesses providers' skills by presenting a hypothetical scenario and assessing how the provider responds	<ul style="list-style-type: none"> • Allows assessment of providers' behavior and knowledge in a clinical setting 	<ul style="list-style-type: none"> • Difficult to execute with busy private providers who are unwilling to give proper consultation to a hypothetical situation • Requires data collectors to undergo considerable training in order to record provider responses accurately
Direct observation	Assesses providers' skills in a clinical setting by directly observing providers' interaction with clients	<ul style="list-style-type: none"> • Allows assessment of providers' behavior and knowledge in a clinical setting 	<ul style="list-style-type: none"> • Potentially inaccurate assessment as providers might adjust their behavior in the presence of an external observer • Requires time-intensive training of observers
Mystery client survey	Has a surveyor pretend to be a patient with a specific condition or medical need and interact with the provider like a normal patient but following a standard script. After exiting the facility, the surveyor and a second surveyor complete a form containing questions about the experience	<ul style="list-style-type: none"> • Provides accurate assessment of providers' behavior and knowledge in clinical setting 	<ul style="list-style-type: none"> • Requires extensive training of data collectors and data collectors must be prepared for multiple scenarios • Requires a second surveyor to wait outside and help the first surveyor record data • Captures only one aspect of quality for a particular type of health service
Exit surveys	Measures patient satisfaction after patient receives care from provider	<ul style="list-style-type: none"> • Provides information on quality from the perspective of the health care recipient 	<ul style="list-style-type: none"> • Results can be highly subjective as responses are influenced by individual expectations and needs • Patients may be unwilling to provide negative reviews of their providers

ANNEX D: FINDING OVERLOOKED FACILITIES IN DENSELY POPULATED AREAS

Regardless of the effort devoted to locating additional facilities not included in original lists, a portion of private health facilities in more populated areas will likely be overlooked by data collectors. The process below was used in Lagos, Nigeria, and revealed that 15 percent of all private health facilities were overlooked during the initial census. While many were smaller facilities, such as pharmacies, additional hospitals were also identified. A more intensive search was conducted in randomly selected areas to help estimate the number of facilities overlooked during the initial census via the four-step process described below.

Step 1: Divide the Selected Area into Smaller Areas

First, divide the area into smaller geographic areas to allow for improved precision in facility identification. The individual geographic areas must be small enough for a data collector to walk through every street within a reasonable amount of time (maximum of two days). If clear geographic divisions of sufficiently small size do not exist, it may be necessary to demarcate new divisions for the search. This is a difficult task that requires advanced GIS skills.

Step 2: Randomly Select a Subset of Smaller Areas

The next step is to randomly select a portion of the identified geographic areas. A survey expert could be employed to design a strategy for randomly selecting geographic areas that ensures the results are sufficiently representative of the population.

Step 3: Perform Street-by-Street Walk-Throughs in Randomly Selected Areas

Once areas have been selected, perform intensive street-by-street walk-throughs to search for private health facilities not found during the initial census. It may be helpful to provide data collectors with maps that clearly demarcate the boundaries of their selected area and the locations of facilities that have already been located. These maps can be created using GIS software or Google Maps.

Step 4: Use Search Findings to Augment and Adjust Census Findings

Committing resources to an intensive search for missed facilities has several potential benefits. First, the findings can be used to draw conclusions about the total number of private health facilities missed during the initial survey. They can also be used to generate more accurate estimates of private facility use. For example, an intensive search might reveal that approximately 20 percent of all facilities were missed and, among these, the average number of patients was 10 fewer than among facilities in the initial census. This suggests that estimates of the average number of patients in a catchment area should be reduced by two (20 percent of 10).

REFERENCES

- Das, Jishnu, Jeffery Hammer, and Kenneth Leonard. 2008. "The Quality of Medical Advice in Low-Income Countries." *Journal of Economic Perspectives* 22(2).
- Glick, Peter. 2007. *Are Client Satisfaction Surveys Useful? Evidence from Matched Facility and Household Data in Madagascar*. Ithaca NY: Cornell University.
- Center for Global Development. 2009. *Partnerships with the Private Sector in Health. What the International Community Can Do to Strengthen Health Systems in Developing Countries. Final Report of the Private Sector Advisory Facility Working Group*. Washington, DC: Center for Global Development.
- Institut National de la Statistique et de l'Analyse Économique (INSAE) et ICF International. 2013. *Enquête Démographique et de Santé du Bénin 2011-2012*. Calverton, Maryland, USA: INSAE et ICF International.
- Leonard, K.L., G. Mliga, and D.H. Mariam. 2000. "Bypassing Health Centers in Tanzania: Revealed Preference for Quality." *Journal of African Economies* 11(4).
- Leonard, K. and M.C. Masatu. 2006. "Outpatient process quality evaluation and the Hawthorne Effect." *Social Science & Medicine* 63(9).
- Lidelow, M. and A. Wagstaff. 2003. *Health Facility Surveys: An Introduction*. Policy Research Working Paper 2953. Washington, DC: World Bank.
- Peabody, J.W., J. Luck, P. Glassman, T.R. Dresselhaus, and M. Lee. 2000. "Comparison of vignettes, standardized patients, and chart abstraction: a prospective validation study of 3 methods of measuring quality." *Journal of American Medical Association* 283(13): 1715-22.
- Peabody J.W., J. Luck, P. Glassman, S. Jain, J. Hansen, M. Spell, and M. Lee. 2004. "Measuring the quality of physician practice by using clinical vignettes: a prospective validation study." *Annals of Internal Medicine* 141(10): 771-80.
- Thomas, Eric J., and Laura A. Peterson. 2003. "Measuring Errors and Adverse Events in Health Care." *Journal of General Internal Medicine* 18(1): 61-67.
- Veloski, J., S. Tai, A.S. Evans, and D.B. Nash. 2005. "Clinical vignette-based surveys: a tool for assessing physician practice variation." *AM J Med Qual.* 20(3): 151-7.
- World Health Organization. 2006. *Improving Data Quality: A Guide for Developing Countries*. Manila, Philippines: Regional Office of the Western Pacific.

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