

Comparison of Results of the FASTR Health Facility Phone Survey to an In-Person Spot Check Visit in Senegal

Viviane Azais¹, Samba Cor Sarr², Zeyni El Abidine Sy², Abdoulaye Diallo², Babacar Gueye², Abib Ndiaye², Fanding Badji², Ibrahima Ndiaye², Pape Ibrahima Ndour², Oumar Dieng¹, Wanying Li¹, Leenisha Marks¹, Ashley Sheffel¹, Biram Ndiaye¹, Peter Hansen¹, Rachel Neill¹

Key Messages

- Rapid phone surveys can provide a cost-effective and flexible alternative to traditional in-person surveys to facilitate timely health sector decision-making.
- The Global Financing Facility for Women, Children, and Adolescents' (GFF) FASTR rapid health facility phone survey assesses the performance of primary health care facilities, with the first data collection round in Senegal conducted in May 2024.
- To evaluate the concurrence of estimates derived from phone surveys compared to in-person surveys, in-person "spot check" assessments were performed in a sub-sample of interviewed facilities, with results from the infrastructure and supplies modules compared across phone and in-person data collection modalities.
- The findings indicated an average agreement rate of 74% for infrastructure indicators and 87% for medical supplies, highlighting the potential of phone surveys to efficiently capture many key health facility indicators. Indicators with lower concurrence were often more complex, multi-part questions.
- This study highlights the importance of careful phone survey design to enhance data accuracy while providing a positive signal for health facility phone surveys as a complementary tool to in-person methods particularly when timely, low-cost data is required for decision making.

Affiliations: ¹ Global Financing Facility for Women, Children, and Adolescents, Washington DC, USA; ² Ministry of Health and Social Action, Dakar, Senegal.

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INTRODUCTION

Phone surveys can serve as a rapid and cost-efficient complement to traditional in-person surveys, enabling quicker data collection for inform timely programmatic and policy decisions. The Global Financing Facility for Women, Children, and Adolescents (GFF) has developed the Frequent Assessments and Systems Tools for Resilience (FASTR) rapid-cycle health facility phone survey to rapidly assess the availability, readiness, and functionality of primary health care (PHC) facilities, with a specific focus on reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services. The FASTR health facility phone survey is designed to complement existing in-person comprehensive surveys and provides timely and cost-effective insights from PHC facilities for high priority indicators.

The consistency of health facility data collected by mobile phone compared to in-person data collection and enumerator observation remains underexplored. We conducted a rapid spot check exercise to assess the level of agreement between data collected by the FASTR rapid-cycle health facility phone survey compared to in-person item verification at health facilities in Dakar and Thies, Senegal from March to May 2024. Comparing the results from phone and in-person survey modalities provides a useful signal on the consistency of phone survey data collection for key health facility survey indicators and can support continued iteration and improvement of FASTR's health facility phone survey instrument.

Objectives

This spot check exercise had two primary objectives. The first objective was to assess and quantify the level of agreement between the FASTR rapid-cycle health facility phone survey and a corresponding in-person health facility survey instrument and enumerator verification developed for this assessment. The second objective was to use the results of the study to refine the design of the FASTR rapid-cycle health facility phone survey questionnaire and enhance the accuracy of the data collected.

The outcomes of the study should not be considered a fully generalizable statistical analysis of consistency across phone and in-person data collection, but rather should be interpreted in the context of incorporating rapid learning and quality improvement exercises into FASTR survey implementation.

METHODS

Spot check survey questionnaires

Two questionnaires were used to collect data: (1) the FASTR rapid-cycle health facility phone survey's infrastructure and medical supplies modules and (2) an in-person survey instrument adapted based on the phone survey but fit for in-person administration and item verification.

The in-person survey expanded on the phone survey by breaking down questions into more detailed components to enable in-person verification of each aspect of the indicators defined in the phone survey. For example, a single phone survey question about "functional toilets on the facility premises" was split into two separate questions for the in-person assessment: one about whether the toilets are functional and another about their location on the premises. Similarly, for broad categories of medical supplies, such as "long-acting reversible contraception methods," the in-person survey broke these categories down into specific components like "implant," "IUD – non-hormonal," and "IUD – hormonal" which an enumerator could verify. This approach aimed to provide more granular information about the presence or absence of each tracer item in the in-person survey, enabling both a comparison with the phone survey results and deeper analysis of the key drivers behind any differences observed.

Data collection

Timeline and sample

Data collection took place between March 25 and May 7, 2024. A sample of 43 health facilities were selected for the in-person spot checks, representing approximately 11% of the 400 PHC facilities that participated in the phone survey. To minimize implementation costs, facilities were purposively selected from the Dakar (25 facilities) and Thies (18 facilities) regions. Since the FASTR rapid-cycle health facility phone survey is part of the Senegalese Ministry of Health and Social Action's routine monitoring and evaluation activities, no Institutional Review Board approval was required. Informed consent was obtained from all survey respondents prior to the interviews.

Study participants

The primary respondent for both the FASTR phone survey and the in-person spot checks was the health facility manager. Additional respondents were involved in the spot check survey as questions were asked of the most knowledgeable person at the facility, particularly during in-person item verification. For example, the pharmacist and/or person in charge of vaccination often answered questions related to medical supplies and equipment.

Data collection procedures

The in-person spot checks occurred, on average, four days after the phone interview at each facility, with a range of one to eight days between the phone call and the visit. To avoid respondent bias during phone interviews, facilities sampled for the in-person spot checks were not informed of this selection in advance of the phone survey but instead were contacted within one day after the phone interviews to arrange a convenient time for the in-person visit. Additionally, a different team of enumerators was used to perform the in-person checks to avoid the possibility of recall bias from the enumerator.

Data analysis

Our primary objective was to evaluate the level of agreement between responses obtained via phone surveys and in-person surveys. To do so, we matched facilities selected from the phone survey 1:1 with the in-person spot check sample and analyzed each survey indicator using three metrics:

- Simple percent agreement represents the overall proportion of responses where both phone and in-person surveys yielded the same response. 80% agreement is often considered the benchmark in interrater reliability studies [1]. We considered 70% percent agreement or above to be a reasonable benchmark for adequate agreement between the phone and in-person modalities, as we are interpreting the phone survey results as signals and are therefore not expecting nor attempting to achieve perfect equivalence with in-person results.
- Cohen's Kappa provides a more nuanced understanding by estimating the agreement beyond what could be attributed to random coincidence. Kappa values range from -1 to 1, with higher values indicating greater agreement after adjusting for chance; almost perfect agreement is above 0.90, strong agreement is 0.80 to 0.90, moderate agreement is 0.60 to 0.79, weak agreement is 0.40 to 0.59, .39 to .21 is minimal, and below .2 as no agreement [1].
- Prevalence adjusted and bias adjusted kappa (PABAK) [2], a variation of Cohen's Kappa that adjusts for the prevalence of certain responses and potential biases in the data, to ensure that our agreement measures are robust and not overly affected by imbalances in response categories or any systematic biases present in the survey data.

Due to the small sample of purposively selected facilities, Cohen's Kappa and the PABAK were not considered our primary measures of agreement; however, calculating these provides a useful signal on how the phone survey performed compared to the in-person item verification. Each of the three metrics was calculated separately for each survey indicator. The average percentage agreement per module was determined by averaging the indicator-specific agreements within each module for a summary measure.

The analysis also delved deeper into variables exhibiting low percent agreement. We formulated hypotheses to explain possible drivers behind the observed low agreement (e.g., wording nuances, respondent and enumerator interpretations, the influence of physical verification processes) and

adjusted the analysis in various ways to explore how these adjustments impacted the percent agreement.

FINDINGS

Percentage agreement and Kappa estimates

The average percentage agreement for the infrastructure items was 74% (Table 1) with 50% of the indicators above the 70% percent agreement benchmark. The indicators for electricity and the location of facility water source achieved perfect agreement (100%), and access to an emergency vehicle and the functionality of the emergency vehicle had high agreement rates (93%) and substantial Kappa values, indicating consistent responses. Conversely, indicators like hand sanitizing at toilets and points of care (65%), menstrual facilities in female toilets (63%), room with visual and/or auditory privacy (63%), patient-only toilet (58%), availability of a waiting room to isolate patients with contagious disease symptoms (58%), waste management method (53%), and the existence of a cleaning protocol (49%) demonstrated lower agreement rates and Kappa values.

Table 1 | Infrastructure Indicators Results (N=43 facilities)

| Indicator | Percent agreement | Cohen's Kappa | Prevalence adjusted and bias adjusted kappa | Phone survey result | Spot checks result |
|----------------------------------------------------------------------------|-------------------|---------------|---------------------------------------------|---------------------|--------------------|
| Main electricity source | 100% | -.** | -.** | 100% | 100% |
| Water source is located on the facility premises | 100% | -.** | -.** | 100% | 100% |
| Access to an emergency vehicle | 93% | 0.84 | 0.86 | 33% | 30% |
| Emergency vehicle is functional | 93% | 0.89 | 0.91 | 30% | 30% |
| Main water source | 91% | 0.00 | 0.88 | -.* | -.* |
| Staff-only toilet (that is improved, private, accessible, and functional) | 86% | 0.44 | 0.72 | 93% | 79% |
| Main toilet type | 72% | 0.49 | 0.65 | -.* | -.* |
| Female-only toilet (that is improved, private, accessible, and functional) | 70% | 0.23 | 0.40 | 28% | 26% |

Table 1 | Infrastructure Indicators Results (N=43 facilities)

| | | | | | |
|-----------------------------------------------------------------------------|-----|------|-------|-----|-----|
| Hand sanitizing at toilets and points of care | 65% | 0.26 | 0.30 | 60% | 63% |
| Patient isolation ward | 65% | 0.27 | 0.30 | 44% | 33% |
| Menstrual hygiene facilities in female toilet | 63% | 0.48 | 0.63 | 26% | 21% |
| Room with visual and/or auditory privacy | 63% | 0.21 | 0.44 | _* | _* |
| Patient-only toilet (that is improved, private, accessible, and functional) | 58% | 0.15 | 0.16 | 93% | 51% |
| Waiting room for patients with contagious disease symptoms | 58% | 0.05 | 0.16 | 35% | 30% |
| Waste management method | 53% | 0.29 | 0.47 | _* | _* |
| Existence of a cleaning protocol | 49% | 0.10 | -0.02 | 67% | 30% |

Notes: Categorical indicator results that are not percentages are not displayed in the results table and are labeled with an asterisk (-*). Indicators with too few rating categories, and therefore unable to calculate Kappa, are marked with double asterisks (-**).

Overall, the medical supplies indicators (Table 2) performed better than the infrastructure indicators, with an average percent agreement of 87%. 95% of the indicators exceeding the 70% percent agreement benchmark. Several indicators, including blood pressure monitors, gloves, and long-acting reversible contraceptive methods (e.g. IUD), achieved perfect agreement (100%) and high Kappa values, indicating strong consistency between phone surveys and spot checks. Indicators such as zinc sulfate (67%) and chlorhexidine (60%) had lower agreement rates, highlighting areas where survey mode may result in differing responses.

Table 2 | Medical Supplies Indicators Results (N=43 facilities)

| Indicator | Percent agreement | Cohen's Kappa | Prevalence adjusted and bias adjusted kappa | Phone survey result | Spot checks result |
|----------------------------------------------|-------------------|---------------|---------------------------------------------|---------------------|--------------------|
| Blood pressure monitor | 100% | _** | _** | 100% | 100% |
| Glove | 100% | _** | _** | 100% | 100% |
| Long-acting reversible contraceptive methods | 100% | 1.00 | 1.00 | 77% | 77% |

Table 2 | Medical Supplies Indicators Results (N=43 facilities)

| | | | | | |
|-------------------------------------------------------------|-----|------|------|------|-----|
| Thermometer | 98% | 0.00 | 0.95 | 100% | 98% |
| Blood glucose test | 98% | 0.00 | 0.95 | 100% | 98% |
| MMR vaccine | 98% | 0.95 | 0.95 | 63% | 65% |
| BCG vaccine | 98% | 0.95 | 0.95 | 65% | 63% |
| Polio vaccine | 98% | 0.95 | 0.95 | 63% | 65% |
| Speculum | 95% | 0.77 | 0.91 | 88% | 88% |
| HIV diagnostic test | 95% | 0.88 | 0.91 | 77% | 72% |
| Penta vaccine | 95% | 0.90 | 0.91 | 65% | 65% |
| Children weighing scale | 93% | 0.73 | 0.86 | 88% | 81% |
| Urine test strip | 93% | 0.54 | 0.86 | 95% | 88% |
| Malaria diagnostic test | 93% | 0.73 | 0.86 | 88% | 81% |
| Short-acting reversible contraceptive methods | 93% | 0.80 | 0.86 | 74% | 81% |
| PCV vaccine | 93% | 0.85 | 0.86 | 63% | 60% |
| Refrigerator | 91% | 0.61 | 0.81 | 86% | 86% |
| Pregnancy test (urine) | 91% | 0.56 | 0.81 | 93% | 84% |
| Oxytocin or other uterotonic | 91% | 0.80 | 0.81 | 63% | 63% |
| Antihypertensive drugs | 91% | 0.72 | 0.81 | 81% | 77% |
| Antimalarial drugs | 91% | 0.74 | 0.81 | 79% | 74% |
| HPV vaccine | 91% | 0.81 | 0.81 | 63% | 58% |
| Syphilis diagnostic test | 88% | 0.73 | 0.77 | 70% | 67% |
| Children height chart | 86% | 0.44 | 0.72 | 93% | 79% |
| Amoxicillin | 86% | 0.61 | 0.72 | 79% | 74% |
| Vitamin A | 86% | 0.70 | 0.72 | 63% | 63% |
| Covid-19 vaccine | 86% | 0.72 | 0.72 | 51% | 42% |
| Protective gown | 84% | 0.16 | 0.67 | 95% | 84% |
| Oral rehydration solution | 84% | 0.67 | 0.67 | 67% | 51% |
| Pap smear equipment | 81% | 0.61 | 0.63 | 67% | 58% |
| Protective eyewear | 81% | 0.58 | 0.63 | 67% | 67% |
| Anti-asthmatics | 81% | 0.56 | 0.63 | 70% | 70% |
| Folic acid and iron | 79% | 0.56 | 0.58 | 67% | 56% |
| Magnesium sulfate | 77% | 0.54 | 0.53 | 51% | 47% |
| Ready-to-use therapeutic foods | 77% | 0.52 | 0.53 | 58% | 58% |
| Oxygen delivery device | 74% | 0.49 | 0.49 | 51% | 40% |
| Metformin, insulin injection, or another hypoglycemic agent | 74% | 0.48 | 0.49 | 44% | 47% |

Table 2 | Medical Supplies Indicators Results (N=43 facilities)

| | | | | | |
|------------------------------------------|-----|------|------|-----|-----|
| Medical or surgical mask | 72% | 0.13 | 0.44 | 91% | 72% |
| Respiratory protection mask N95, FFP2 | 70% | 0.20 | 0.40 | 81% | 70% |
| Zinc sulfate | 67% | 0.38 | 0.35 | 63% | 40% |
| Chlorhexidine | 60% | 0.22 | 0.21 | 51% | 16% |

Notes: Categorical indicator results that are not percentages are not displayed in the results table and are labeled with an asterisk (*). Indicators with too few rating categories, and therefore unable to calculate Kappa, are marked with double asterisks (**).

Investigation of low percentage agreement

For indicators with an agreement rate below 70%, we conducted a deeper investigation and provided hypotheses for the driving factors behind each indicator below.

Infrastructure indicators

Hand sanitizing at toilets and all points of care (65% agreement): The phone survey question may be too aggregated for respondents to accurately answer the question. This question was also challenging to replicate in-person for enumerator verification due to the difficulty for enumerators to identify all available toilets and points of care at the facilities, which could impact the results. However, while the individual facility matches had a 65% agreement, the total result across the two surveys was very similar (60% of facilities in the phone survey compared to 63% of facilities in the in-person survey), resulting in the same interpretation of results for this indicator.

Menstrual hygiene facilities in female-only toilets (63% agreement): Given that a considerable proportion of respondents are male (44%), there may be a tendency for them to default to “no” when unsure of the answer. When we disaggregate the results by gender, we find a much higher agreement among female respondents (71%) than among male respondents (53%) for this question, suggesting that male phone respondents may have been unsure of the response without physical verification.

Room with visual and/or auditory privacy (63% agreement): There are several possible reasons. First, this is a multiple-choice question with subtle differences between the answer options, which may be challenging for respondents to distinguish during phone interviews (the four options being: auditory and visual privacy, visual privacy only, auditory privacy only, and no room for privacy). In the in-person survey, enumerators were required to observe the room directly as opposed to relying on respondent recall, which likely enhanced their ability to accurately assess the type of privacy. Secondly, enumerators in the phone survey were not given a definition of privacy to reduce survey length, whereas in-person enumerators were given a detailed definition to facilitate the enumerator verification, which may have

introduced inconsistency in the responses. If we simplify this to a yes/no question considering any privacy available, the percentage agreement increases to 84%.

Isolation ward (65% agreement) and waiting room for respiratory patients (58% agreement): Like the room with auditory and visual privacy, the current phrasing of these questions might impact consistency against the in-person verification. Additionally, the similarity between these two questions in the survey resulted in an 84% overlap in responses, indicating that respondents may struggle to distinguish between isolation wards and waiting rooms and/or that the definitions may not be clear to respondents and/or enumerators.

Patient-only toilet (that is improved, private, accessible, and functional) (58% agreement): The privacy condition of the patient-only toilet (compared to improved, accessible, and functional) was the significant factor behind the low agreement. Phone survey respondents overestimated the availability of a toilet that met the full definition compared to in-person verification. If we exclude the privacy condition, the agreement increases to 93%.

Waste management (53% agreement): This categorical indicator is quite complex, featuring 10 answer choices such as “incineration in an incinerator, with the incinerator operational and with fuel on the day of the investigation,” “open burning on flat land (without protection),” and “dispose of without burning on flat ground or open pit (without protection).” Given that answer choices are not read aloud in the phone survey, it is possible that the respondent may not have provided sufficient detail for the enumerators to categorize responses in a consistent manner over the phone due to the many response options and nuances between them.

Cleaning protocol (49% agreement): The phone survey overrepresented the presence of cleaning protocols compared to the in-person results. The low percent agreement could stem from respondents being familiar with the protocols, while spot check enumerators may have faced challenges in locating the physical copy of the protocol/guidelines.

Summary of revised infrastructure indicators

The results of the experimentation with indicator definitions are outlined in Table 3. The average percent agreement of infrastructure indicators increased from 74% to 81%. In summary, improving the simplicity of response options and removing privacy conditions from toilets enhanced indicator agreements considerably in most, but not all, cases.

Table 3 | Infrastructure indicators: Results with modified definitions (N=43 facilities)

| Indicator | Recommended modifications | Original Percent Agreement | Percent Agreement with recommended modifications | Prevalence adjusted and bias adjusted kappa |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------|----------------------------------------------------|
| Patient-only toilet (improved, private, accessible and functional) | Remove privacy from the definition | 58% | 93% | 0.86 |
| Staff-only toilet (improved, private, accessible and functional) | Remove privacy from the definition | 86% | 91% | 0.81 |
| Female-only toilet (improved, private, accessible and functional) | Remove privacy from the definition | 70% | 72% | 0.44 |
| Main toilet type | Re-categorize as a binary variable: improved vs. not improved toilet | 72% | 100% | -.** |
| Main water source | Re-categorize as a binary variable: improved vs. not improved water source | 91% | 100% | -.** |
| Waste management method | Re-categorize as a binary variable: safe waste management, unsafe, and other | 53% | 65% | 0.30 |
| Room with visual and/or auditory privacy | Re-categorize as a binary variable: any type of private room available versus no private room available | 63% | 84% | 0.67 |

Table 3 | Infrastructure indicators: Results with modified definitions (N=43 facilities)

| | | | | |
|---------------------------------------------------|-------------------------------------------------------------------------------|-----|-----------------------------------------------------|------|
| Hand sanitizing at toilets and all points of care | Consider 'present' if any hand sanitizing station was located at the facility | 65% | Definition adjustment doesn't improve the agreement | 0.21 |
|---------------------------------------------------|-------------------------------------------------------------------------------|-----|-----------------------------------------------------|------|

Notes: Categorical indicator results that are not percentages are not displayed in the results table and are labeled with an asterisk (-*). Indicators with too few rating categories, and therefore unable to calculate Kappa, are marked with double asterisks (-**).

Medical Supplies Indicators

Zinc Sulfate (67% agreement): The phone survey results overestimated the availability of zinc sulphate compared to the in-person verification. The lower agreement rate for this item could stem from potential respondent confusion regarding its various formulations – either in the phone survey or in the in-person survey (if enumerators struggled to verify the presence of the item). To enhance clarity and agreement, we would consider specifying that the indicator includes both syrup or tablet formulations and specifying the population for the medication (e.g., children or adults).

Chlorhexidine (60% agreement): The phone survey results overestimated the availability of chlorhexidine compared to the in-person verification. This tracer is included in the survey as a newborn care tracer (due to its use for umbilical cord care); however, previous FASTR survey experience from Vietnam and Burkina Faso showed that this item was rarely available at PHC facilities in those settings, and the item also had a low prevalence in Senegal. The low stock of chlorhexidine in several settings invalidates a key assumption in the selection of essential medicine tracers for the phone survey, which is to limit the essential medicines tracer list to frequently utilized and commonly available medications to improve respondent recall.

DISCUSSION AND CONCLUSION

Strengths and limitations

Key strengths of this study were several measures taken to reduce bias in the results, including the close time between phone survey administration and the in-person survey and item verification, that phone survey respondents were blinded in their knowledge of the subsequent in-person spot check, and that different enumerators conducted the different data collection efforts, eliminating the possibility of enumerators recalling the phone survey responses.

Several factors constrain the interpretation of the study findings including a small and non-representative purposive sample constrained to Dakar and Thies regions, different enumerator training sessions which could have resulted in different interpretations of questions across the two sets of enumerators, the use of a new survey instrument for the in-person spot check, and the conduct of the phone survey during a health worker strike which resulted in a higher-than-average number of refusals and the use of replacement facilities.

Implications for health facility phone surveys

Despite a small sample and purposive size limiting the generalizability of the findings, this study provides a positive signal for the ability of phone surveys to capture critical health facility indicators in Senegal and likely similar sub-Saharan African countries. The findings also provide practical insights into how to construct questions for phone survey implementation. Aggregated questions, complex answer choices, lack of clear definitions, and subjective interpretations were identified as key issues affecting the accuracy of the phone survey modality. Modifications to simplify questions, re-categorize variables, and provide clearer definitions significantly improved agreement rates.

The findings also underscore that phone and in-person survey modalities often reflect different perspectives on the same indicators. The phone modality reflects the perspective of the respondent (the facility manager) while the in-person assessment reflects the perspective of the external enumerator (and relies heavily on enumerators correctly identifying survey items at the facility). Where there are differences between the two, it does not necessarily mean that the external person's perspective is always valid, and the in-charge's perspective is invalid. Future research on this topic would benefit from in-depth cognitive testing and examination of bias introduced both from the perspective of the facility manager and the enumerator conducting in-person verification.

This study is part of a larger ongoing effort from the GFF on how to optimize considerations of surveys cost, timeliness, and precision to better align RMNCAH-N and PHC data with real-world decision-making needs. Findings will inform continued improvements of the FASTR rapid-cycle health facility phone survey questionnaire and will inform future survey studies comparing the FASTR phone survey instrument to existing gold standard comprehensive in-person survey instruments.

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ABOUT THE GFF'S FREQUENT ASSESSMENTS AND SYSTEMS TOOLS FOR RESILIENCE (FASTR) RAPID-CYCLE ANALYTICS AND DATA USE INITIATIVE

The GFF supports country-led efforts to improve the timely use of data for decision-making, ultimately leading to stronger primary healthcare (PHC) systems and better reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes. This set of initiatives and technical support is referred to as Frequent Assessments and System Tools for Resilience (FASTR). FASTR's technical approaches enable countries to use rapid-cycle analytics for strengthening PHC systems and improving RMNCAH-N outcomes through the timely and high-frequency analysis and use of data. For more information on the GFF's FASTR initiative, visit our [website](#) and the [FASTR Resource Repository](#).

Contact us at fastr@worldbank.org.

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International Bank for Reconstruction and Development

Global Financing Facility for Women, Children, and Adolescents

1818 H Street NW, Washington D.C. 20433

<https://www.globalfinancingfacility.org/>