MINISTRY OF HEALTH AND SOCIAL WELFARE-LIBERIA
NATIONAL MALARIA CONTROL PROGRAMME
Assessing Health Worker Performance on Malaria Case Management
FORM 1: OBSERVATION OF OUTPATIENT CONSULTATIONS

1. Facility Identification

County: _____

District: _____

Town/Community _____

Name of the facility: _____

Type of health facility: 1=Hospital
2=Health Center
3=Clinic
4=Other(s):
_____Specify)

Operating authority: 1=Government
2=NGO - Supported
3=Mission
4=Private
5=Other(s):
_____(Specify)

County code ....

District code ....

Town/Community code

Facility code

Facility type code ....

Operating Authority code ....

2. Health Worker Information

Health Worker category: 1=Doctor
2=Physician Assistant
3=Nurse
4=Midwife

5=Dispenser

6=Nurse Aide

7=Other(s)

(Specify)_____

Code for Health Worker should be the same as the one used for the Health Worker interview.

HW category code......................

Health Worker Code.............

3. Information About Observation

Date:
_____

Age of the patient (ask at the end of consultation)

Sex of the patient (1=male; 2=female)

Name of Observer: _____

Time observation started: _____

Signature_____

Client code (serial number): _____

Day.....................................

Month ....

Year.........................

Age (in years).......................

Age (in months) ....

Sex of patient ....

Observer code…

Hour.....................................

Minutes................................

Client code ....

QUESTIONNAIRE CODE

3. Observation of Outpatient Consultation

BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE PATIENT/CHILD'S CARETAKER. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT HERE TO BE CONSULTED DURING THE SESSION.

BE AS DISCREET AS POSSIBLE DURING THE ASSESSMENT. DO NOT TAKE PART IN THE INTERACTION BETWEEN THE PROVIDER AND THE PATIENT/CHILD'S CARETAKER. TRY TO SIT ON ONE SIDE OF THE ROOM, WHERE YOU WILL OBSERVE AND HEAR THE INTERACTION BETWEEN THE PROVIDER AND THE PATIENT/CHILD'S CARETAKER.

FOR EACH OF THE ITEMS BELOW, CIRCLE THE ANSWER THAT BEST EXPRESSES YOUR ASSESSMENT OF WHAT HAPPENED DURING THE INTERACTION.

READ TO HEALTH WORKER: Hello. I am representing the Ministry of Health and Social Welfare. We are carrying out a survey of health facilities that provide outpatient consultation to patients, with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this patient in order to better understand how health care is provided in this facility.

Any information I collect will be completely confidential. If, at any point, you would prefer that I leave, please feel free to tell me.

Do you have any questions for me? Do I have your permission to be present at this consultation?

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100a	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES.. 1 NO... 2	→ STOP

READ TO PATIENT/CARETAKER: Hello. I am representing the Ministry of Health and Social Welfare. We are carrying out a survey of health facilities that provide outpatient services to patients. I would like to observe this consultation in order to better understand how health care is provided.

Any information I collect will be kept completely confidential and will not affect the level of care you receive here, now or in the future. If, at any point, you would prefer that I leave, please feel free to tell me.

After the consultation, my colleague would like to talk with you about your experience here today.

Do you have any questions for me? Do I have your permission to be present at this consultation?

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100b	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PATIENT/CARETAKER.	YES.. 1 NO... 2	→STOP

100. Health Worker's Interaction With Patients

NO.	QUESTIONS	YES	NO	DON'T KNOW	N/A
101	Record whether a health worker **asked** about or whether the patient/caretaker **mentioned** any of the following:				
01	Fever or body hotness	1	2	8	9
02	Cough or difficult breathing...	1	2	8	9
03	Diarrhea	1	2	8	9
04	Vomiting..	1	2	8	9
05	Duration of the fever…………………………………………………	1	2	8	9
06	Ear problem	1	2	8	9
07	Other symptoms……………………………………………… (Specify)	1	2	8	
08	Treatment at home before coming to health facility………………	1	2	8	9
09	Treatment at any other health facility before coming to health facility	1	2	8	9
10	Patient's age………………………………………………..	1	2	8	9

QUESTIONNAIRE CODE ☐☐☐☐☐☐

102	Record whether a health worker **asked** about or whether the caretaker **mentioned** any of the following **danger signs.**	YES	NO	DON'T KNOW	N/A
01	Change in behavior or altered consciousness	1	2	8	9
02	History of convulsions during current illness	1	2	8	9
03	Reduced output of urine	1	2	8	9
04	Dark urine…………………………………………………………	1	2	8	9
05	Spontaneous bleeding	1	2	8	9
06	Prostration/lethargy..	1	2	8	9
07	Persistent vomiting	1	2	8	9
08	Inability to drink/breastfeed	1	2	8	9

103	RECORD WHETHER A PROVIDER **PERFORMED** ANY OF THE FOLLOWING **PHYSICAL EXAMINATIONS**	YES	NO	DON'T KNOW	N/A
01	Take patient's temperature by thermometer.................................	1	2	8	
02	Feel the patient for fever or body hotness	1	2	8	
03	Count respiration (breaths)...	1	2	8	9
04	Check skin turgor for dehydration (pinch abdominal skin)	1	2	8	9
05	Check whether child is able to drink/breastfeed	1	2	8	9
06	Check for neck stiffness	1	2	8	9
07	Check for pallor by looking at palms...	1	2	8	
08	Check for pallor by looking at conjunctiva or mouth	1	2	8	
09	Weigh the patient	1	2	8	
10	Refer the patient for laboratory confirmation (microscopy or Rapid Diagnostic Test)..	1	2	8	

104	DOES THE HEALTH WORKER DIAGNOSE MALARIA?	1	2	8	9
105	DOES THE HEALTH WORKER PRESCRIBE AN APPROPRIATE ANTIMALARIAL DRUG IN ACCORDANCE WITH NATIONAL GUIDELINES? (ACT=1ST LINE, ORAL QUININE=2ND LINE)	1	2	8	9
106	DOES THE HEALTH WORKER PRESCRIBE THE APPROPRIATE DOSAGE?	1	2	8	9

107	RECORD WHETHER THE HEALTH WORKER DID ANY OF THE FOLLOWING WHEN **COUNSELING** THE PATIENT/CARETAKER	YES	NO	DON'T KNOW	N/A
01	Tell the patient/caretaker about the illness(es)	1	2	8	
02	Explain how to administer oral treatment(s)...................................	1	2	8	9
03	Give the 1st dose of oral treatment(s) in the health facility	1	2	8	9
04	Check whether caretaker knows how to give oral treatment(s) at home...	1	2	8	9
05	Advise of antipyretic in case of high fever....................................	1	2	8	9
06	Advise to drink and eat more	1	2	8	
07	Tell the mother to give sponge bath to reduce fever	1	2	8	
08	Describe signs or symptoms warranting for _immediate return_ to a health facility	1	2	8	
09	Advise on the use of insecticide treated nets	1	2	8	
10	Advise on where to obtain the insecticide treated nets	1	2	8	
11	Check whether caretaker has any questions	1	2	8	

QUESTIONNAIRE CODE

108	RECORD THE OUTCOME OF THE CONSULTATION. [THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED]	PATIENT SENT HOME ....1 PATIENT REFERRED WITHIN FACILITY ....2 PATIENT ADMITTED......................3 PATIENT REFERRED TO ANOTHER FACILITY ....4 DON'T KNOW 8	
109	RECORD TIME CONSULTATION HAS ENDED.	HOUR MINUTES	

200. Classification and Treatment

THE FOLLOWING INFORMATION SHOULD BE OBTAINED FROM THE HEALTH WORKER AFTER THE CONSULTATION HAS ENDED AND THE CARETAKER HAS LEFT THE ROOM. EXPLAIN TO THE HEALTH WORKER THAT YOU WILL ASK ABOUT HIS/HER DIAGNOSIS (CLASSIFICATION) AND WHAT TREATMENTS OR ADVICE HE/SHE PROVIDES.

201	Does your diagnosis (classification) for the patient with regard to this illness include malaria?	YES... 1 NO.. 2 DON'T KNOW 8	→ 208 → 203
202	With regard to malaria, did you classify the condition as severe malaria or uncomplicated malaria?	SEVERE MALARIA........................ 1 UNCOMPLICATED MALARIA ...... 2 WAITING LAB RESULTS .... 3 DON'T KNOW 8	
203	Did you advise the caretaker to be immediately referred or admitted?	YES... 1 NO.. 2	→ 206
204	Did you give any pre-referral treatment?	YES... 1 NO.. 2	→ 207
205	What pre-referral treatment did you give?	INJECTABLE ANTIMALARIAL...... 1 INJECTABLE ANTIBIOTIC .... 2 BOTH .... 3 NONE OF ABOVE 4	
206	Did you give or prescribe any antimalarial treatment(s)	YES... 1 NO.. 2	→ 210
207	What **antimalarial** did you give/prescribe for the patient?	CHLOROQUINE .... 1 SP (FANSIDAR)............................ 2 QUININE .... 3 AS + AQ....................................... 4 OTHER(S): _____ 6 (SPECIFY)	
208	Have you had any in-service training in malaria case management in last 2 years	YES……………………………… 1 NO……………………………… 2	
209	**If diagnosis was malaria**, was the patient adequately managed according to the national policy? (i.e Patient was treated with AS & AQ or Oral Quinine).	YES………………………….. 1 NO……………………………. 2	
210	What is the time interval (hours) between onset of first symptom and presentation to health facility?	WITHIN 24 HOURS…………….. 1 WITHIN 48 HOURS…………….. 2 ABOVE 48 HOURS ……………. 3	

QUESTIONNAIRE CODE

211	**Observer's comments:**

QUESTIONNAIRE CODE

MINISTRY OF HEALTH AND SOCIAL WELFARE-LIBERIA
NATIONAL MALARIA CONTROL PROGRAMME
Assessing Health Worker Performance on Malaria Case Management
FORM 2:   Exit Interview for Patient/Caretaker of Sick Child

1. Facility Identification

County: _____

District: _____

Town/Community: _____

Name of the facility: _____

County code.............................. ☐☐

District code .... ☐☐☐☐

Town/Community code ☐☐☐

Facility code ☐☐☐

Facility type .... ☐☐

Type of health facility:	1=Hospital
	2=Health Center
	3=Clinic
	4=Other(s):

_____(Specify)

Operating authority:	1=Government
	2=NGO – Supported
	3=Mission
	4= Private
	5=Other(s):

_____(specify)

OPERATING AUTHORITY......... ☐☐

2. Information About Interview

Date:

DAY...................................... ☐☐

MONTH................................ ☐☐

YEAR .... ☐☐☐☐

Name of interviewer:_____

INTERVIEWER CODE .... ☐☐

Client code*: _____

CLIENT CODE...................... ☐☐

Client Code (number) should be the same as the one used for Observation of Outpatient Consultation

Sex of the patient/caretaker
(1=Male; 2=Female)

SEX OF PATIENT/
   CARETAKER .... ☐

* Client code should be the same code in Form 1 (observation of out patient consultation)

QUESTIONNAIRE CODE ☐☐☐☐☐☐

3. Information About Visit

INTRODUCE YOURSELF TO THE CLIENT.

Hello. I am from the Ministry of Health and Social Welfare. As my colleague told you earlier, we are collecting some information regarding the quality of services that you have received today in this facility. All the information you give me will be kept strictly confidential, and the care that you receive at this facility in the future will not be affected by your participation or nonparticipation. You may refuse to answer any of the questions, and you may stop the interview at anytime.

Do you have any questions for me now? Do you agree to participate?

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	May I begin the interview?	CLIENT AGREES .... 1 CLIENT REFUSES 2	→STOP
101 01 02 03	Did you bring this child to the facility today because of any of the following problems: Cough or difficult breathing Diarrhea Fever/body hotness at home	YES NO COUGH OR DIFFICULT BREATHING........................ 1 2 DIARRHEA .... 1 2 FEVER/BODY HOTNESS ... 1 2	
102	For what other reason(s) did you bring this child to this health facility today? CIRCLE ALL ITEMS THE RESPONDENT MENTIONS. PROBE: Anything else?	EYE PROBLEMS............................. A SKIN PROBLEMS............................B INJURY .... C OTHER _____ W (SPECIFY)	
103	Have you brought this child to this facility before for this same type of sickness?	YES.. 1 NO.. 2 DON'T KNOW 8	→105 →105
104	IF YES to 103 How long ago was that?	WITHIN THE PAST WEEK............ 1 WITHIN THE PAST MONTH .... 2 MORE THAN 1 MONTH AGO .... 3 DON'T KNOW.............................. 8	
105	How many days ago did the illness for which you brought this child here begin? IF LESS THAN 1 DAY, WRITE "00" IN THE BOXED CELLS.	DAYS AGO .... ☐☐ DON'T KNOW...........8	
106	Did the health worker tell you what illness this child has?	YES.. 1 NO.. 2 DON'T KNOW.............................. 8	→108 →108
107	What illness(s) did he/she tell you? CIRCLE ALL ITEMS THE RESPONDENT MENTIONS.	MALARIA .... A COUGH OR DIFFICULT BREATHING.............................B DIARRHEA ....C OTHER _____W (SPECIFY)	
108	Did the health worker tell you about any signs or symptoms you may see for which you must *immediately bring* the child back? IF NECESSARY, PROBE.	YES.. 1 NO.. 2 DON'T KNOW.............................. 8	

QUESTIONNAIRE CODE ☐☐☐☐☐☐

NO.	QUESTIONS		CODING CLASSIFICATION	GO TO

109	What signs and symptoms would make you bring the child back immediately to a health facility?
	
	CIRCLE ALL SYMPTOMS MENTIONED
	
	PROBE BY ASKING WHAT ELSE?
			GETS SICKER..............................A
			UNABLE TO DRINK ....B
			IN 2 DAYS IF FEVER
			   PERSISTS C
			PERSISTENT VOMITING ....D
			CONVULSIONS...........................E
			OTHER_____ W
			       (SPECIFY)
			DON'T KNOW..............................Z	

110	Did the provider give or prescribe any medicines for the child to take at home?		YES... 1 NO.. 2	→201

111	ASK TO SEE ALL MEDICATIONS THAT THE CARETAKER RECEIVED.
	CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.
			HAS ALL MEDS............................ 1
			HAS SOME MEDS, SOME
			   PRESCRIPTIONS..................... 2
			NO MEDICATIONS SEEN, HAS
			   PRESCRIPTIONS ONLY.......... 3	

112	IS THERE ANY ANTIMALARIAL DRUG AMONG THE PRESCRIPTIONS SHOWN TO YOU?		YES... 1 NO.. 2 DON'T KNOW................................ 8	→201 →201
113	WHICH ANTIMALARIAL DRUG(S) WAS GIVEN/PRESCRIBED TO THE PATIENT?		CHLOROQUINE ....A (SP)FANSIDAR.............................B QUININE ....C AS + AQ……………………………. D OTHER _____ W (SPECIFY)	→201 →201
114	CHECK 113: "QUININE" CIRCLED [ ] ↓		"QUININE" NOT CIRCLED [ ]	→ 119
115	How many tablets/teaspoons of this medicine will you give at a time?		TABLETS/TEASPOONS .... [ ] FOR 9 OR MORE ENTER "9"	
116	How many times a day will you give this medicine?		TIMES .... [ ] FOR 6 OR MORE ENTER "6"	
117	For how long?		DAYS .... [ ] FOR 8OR MORE DAYS ENTER "8"	
118	Is the mother /caretaker able to tell how to take quinine correctly?		YES... 1 NO.. 2 DON'T KNOW................................ 8	
*119	Check 113: AS + AQ CIRCLED [ ] ↓		AS + AQ Not circled [ ]	___124
120	How many tablets of this medicine will you give at a time?		Tablets…………………………… [ ] For 9 or more enter "9"	
121	How many times a day will you give this medicine?		Time………………………… [ ] For 6 or more enter "6"	
122	For how long?		Days…………………………… [ ] For 8 or more days enter "8"	
123	Is the mother/caretaker able to tell how to take AS + AQ correctly?		Yes…………………………………1 No…………………………………..2 Don't know…………………………8	
124	CHECK 113: "OTHER" CIRCLED [ ] ↓		"OTHER" NOT CIRCLED [ ]	→201

QUESTIONNAIRE CODE [ ][ ][ ][ ][ ]

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
125	How many tablets/teaspoons of this medicine will you give at a time? CIRCLE "TABLETS" IF TABLETS WERE GIVEN OR "TEASPOONS" IF SYRUP WAS GIVEN	TABLETS/TEASPOONS .... □ FOR 9 OR MORE ENTER "9"	
126	How many times a day will you give this medicine?	TIMES .... □ FOR 6 OR MORE ENTER "6"	
127	For how long?	DAYS .... □ FOR 8 OR MORE DAYS ENTER "8"	
128	IS THE MOTHER/CARETAKER ABLE TO TELL HOW TO TAKE (NAME OF MEDICINE) CORRECTLY?	YES... 1 NO... 2 DON'T KNOW................................ 8	
129	Did a health worker at the facility explain to you how to give these medicines at home?	YES... 1 NO... 2 DON'T KNOW................................ 8	
130	Was the child given a dose of any of these medications here at the facility already?	YES..1 NO ....2 DON'T KNOW 8	

200. Information About Client's Satisfaction

201	NOW I AM GOING TO ASK YOU SOME QUESTIONS ABOUT THE SERVICES YOU RECEIVED TODAY. I WOULD LIKE TO HAVE YOUR HONEST OPINION ABOUT THE THINGS THAT WE WILL TALK ABOUT. THIS INFORMATION WILL HELP US TO IMPROVE THE HEALTH SERVICES.		
*01	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES.............. □□□ SAW PROVIDER IMMEDIATELY ..000 DON'T KNOW.................................998	
202	**Interviewer's comments:**		

QUESTIONNAIRE CODE □□□□□□

MINISTRY OF HEALTH AND SOCIAL WELFARE-LIBERIA
NATIONAL MALARIA CONTROL PROGRAMME
Assessing Health Worker Performance on Malaria Case Management

FORM 3:	Health Worker Interview

1. Facility Identification

County: _____

County code.. ☐☐

District : _____

District code... ☐☐☐

Town/Community: _____

Town/Community code ☐☐☐

Name of the facility: _____

Facility code…………………………… ☐☐☐

Type of health facility: 1=Hospital
2=Health Center
3=Clinic
4=Other(s): _____(Specify)

Facility type... ☐☐

Operating authority:

1 = Government
2 = NGO – Supported
3 = Mission
4 = Private
5= Other(s):_____ (Specify)

Operating authority .... ☐

2. Health Worker Information

Health Worker category:

1=Doctor
2=Phisician Assistant
3=Nurse
4=Midwife
5= Dispenser
6 = Nurse Aide
7 = Other(s)
(Specify)_____

HW CATEGORY .... ☐

Sex of Health Worker: 1 = Male; 2 = Female

SEX OF HEALTH WORKER.................. ☐

Health Worker Code: _____

HW CODE .... ☐☐

Health Worker Code (number) should be the same as the one used for Observation of Outpatient Consultation

Date: _____

DAY .... ☐☐
MONTH... ☐☐
YEAR.. ☐☐

Name of the interviewer: _____

INTERVIEWER CODE .... ☐☐

Health Worker Interview

INTRODUCE YOURSELF TO THE HEALTH WORKER.

Hello. I am representing the Ministry of Health and Social Welfare. We are carrying out a survey of health facilities that provide services to patients, with the goal of finding ways to improve service delivery. I would like to ask you some questions about this subject.

This information is completely confidential. You may choose to stop the interview at any time.

Do you have any questions for me at this time? Do you agree to participate?

100. Health Worker's Training and Experience

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	May I continue?	YES... 1 NO 2	➜STOP
101	What year did you start working in this facility?	YEAR .... ⬜⬜⬜⬜	
102	Now I would like to ask you some questions about your educational background. What was the highest level of education attained?	PRIMARY…………………1 SECONDARY…………….2 POST-SECONDARY………………..3 CLASS ATTAINED……….. ⬜⬜	
103	What is your current technical qualification?	DOCTOR ....1 PHISICIAN ASSISTANT ....2 NURSE (PN/RN)…………………………….3 MIDWIFE ....4 LPN……………………………………….5 NURSE AIDE……………………………. 6 OTHER _____ 7	
104	What year did you graduate with this qualification?	YEAR .... ⬜⬜⬜⬜	
105	How many years of study were required for this qualification (AFTER COMPLETING THE BASIC EDUCATION DESCRIBED IN Q102)? IF LESS THAN 1 YEAR, WRITE "00" IN THE BOXED CELLS FOR YEARS AND INDICATE THE NUMBER OF MONTHS.	YEARS .... ⬜⬜ MONTHS .... ⬜⬜	

QUESTIONNAIRE CODE ⬜⬜⬜⬜⬜

200. **Service Provision**

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	Do you personally provide outpatient health care services?	YES ....1 NO 2	→Stop
202	How many years have you been providing this kind of health service? IF LESS THAN 1 YEAR, WRITE "00" IN THE BOXED CELLS.	YEARS .... ☐☐	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
203	ASK THE FOLLOWING QUESTIONS FOR EACH SPECIFIC SUBJECT: Have you ever received any in-service training in [SUBJECT]? IF YES: Which year did you receive the training?		(A)	(B)	
			YES NO	YEAR	
01	Malaria case management	MAL Rx...............	1 2 →02	☐☐	
02	Vector control (net treatment or re-treatment)	VECTOR.............	1 2 →03	☐☐	
03	Integrated Management of Childhood Illness (IMCI)	IMCI	1 2 →04	☐☐	
04	EPI/cold chain	EPI.....................	1 2 →05	☐☐	
05	Nutrition/micronutrient deficiencies	NUTRITION	1 2 →06	☐☐	
06	HIV/AIDS	HIV/AIDS	1 2 →07	☐☐	
07	Tuberculosis	Tuberculosis	1 2	☐☐	
08	Other: _____ (SPECIFY)	OTHER	1 2 →301	☐☐	

300. **Supervision**

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	In the last 6 months, have you had a supervisor, either someone from within this facility, or from outside the facility, speak with you about your work or observe your work?	YES.. 1 NO 2	→401
302	How many times in the last 6 months has your work been supervised?	NUMBER OF TIMES .... ☐☐	

NO.	QUESTIONS	CODING CLASSIFICATION			
303	What did your supervisor do the last time he/she supervised you?		YES	NO	DK
01	Check your records/reports	CHECK RECORD......	1	2	3
02	Observe your work	OBSERVE	1	2	3
03	Provide feedback on your performance	FEEDBACK	1	2	3
04	Provide updates on administrative or technical issues related to your work	UPDATES..................	1	2	3
05	Discuss problems you have encountered	DISCUSS...................	1	2	3
06	Anything else: _____ (SPECIFY)	OTHER			3
			1	2	

400. Health Worker's Opinion

| 401 | What are the three most important issues you feel need to be addressed for you to improve your work?

CIRCLE ALL WHAT THE HEALTH WORKER MENTIONS

IF FEWER THAN THREE ISSUES ARE MENTIONED, PROBE. | MORE STAFF..A
TREAT STAFF BETTER ....B
PAY BETTER C
MORE TRAINING...............................D
MORE FEEDBACK ON
   STAFF PERFORMANCE ....E
MORE/BETTER EQUIPMENT
   OR SUPPLIES...................................F
EMERGENCY TRANSPORT
   FOR PATIENTS...............................G
 BETTER PHYSICAL
ENVIRONMENT ....H
BETTER SECURITY I
ACCOMMODATION……………………J
COMMUNICATION……………………..K
OTHER _____ W
              (SPECIFY) | |

402
Interviewer's comments:

MINISTRY OF HEALTH AND SOCIAL WELFARE - LIBERIA
National Malaria Control Programme
Assessing Health Worker Performance on Malaria Case Management

Form 4:   facility inventory

1. Facility Identification

County: _____

District: _____

Town/Community: _____

Name of the facility: _____

Type of health facility: 1=Hospital
2=Health Center
3=Clinic
4=Other(s): _____ (specify)

Operating authority: 1=Government
2=NGO – Supported
3=Mission
4= Private
5==Other(s): _____Specify

County code............................. ☐☐

District code .... ☐☐☐

Town/Community code ☐☐☐

Facility code.................... ☐☐☐

Facility type code .... ☐

Operating authority .... ☐

2. Information About Interview

Date: _____

Name of the interviewer:_____

DAY..................................... ☐☐

MONTH................................ ☐☐

YEAR .... ☐☐☐☐

INTERVIEWER CODE .... ☐☐

Number of other questionnaires for this facility completed and checked:

OBSERVATIONS .... ☐☐

EXIT INTERVIEWS .... ☐☐

HW INTERVIEWS .... ☐☐

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3. INFORMATION ABOUT VISIT

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	INTRODUCE YOURSELF TO THE IN-CHARGE OF THE FACILITY IF YOU HAVE NOT DONE SO ALREADY Now we are in the final stage of our information collection. I will ask you few general questions about staffing and equipments and supplies for your facility. I may need to interview another staff who is responsible for a particular service that you may not be to able to provide up-to-date information, i.e., pharmacy. Any questions?		
101	May I begin the interview?	IN-CHARGE AGREES...................................... 1 IN-CHARGE REFUSES.................................. 2	→STOP
200	**GENERAL INFORMATION ABOUT THE FACILITY**		
201	How many days per week is this facility open?	DAYS SERVICE OPEN .... ☐	
202 01 02 03 04	Does this facility provide child health services? Does this facility provide ANC services? Does this facility provide EPI services? Does this facility provide IPT services? Does this facility provide ITNs? (Insecticides Treated Nets)	YES=1 NO= 2 YES =1 NO=2 YES = 1 NO = 2 YES = 1 NO = 2 YES = 1 NO = 2	
203	How many days per week are child health services provided?	DAYS OF CHILD H. SERVICES.......... ☐	
204	Does this facility provide Malaria Case Management?	Yes = 1 No = 2	
205	Does this facility provide malaria microscopy ?	Yes = 1 No = 2	
206	Does this facility provide haemologbin measurement?	Yes = 1 No = 2	
207	Does this facility provide lumbar puncture (CSF)?	Yes = 1 No = 2	
208	Does the facility have VCT services for HIV?	Yes = 1 No = 2	
209	Does the facility have a full copy of the National Malaria Treatment guidelines?	Yes = 1 No = 2	
210	Does the facility have a full copy of the IMCI guidelines?	Yes = 1 No = 2	
211	Does the facility implement a programme of community based activities?	Yes = 1 No = 2	
212	Does the facility make provision for people who cannot pay for services?	Yes = 1 No = 2	
213	Approximately what proportion of patients did you exempt in the last 12 months?	0 - 20 = 1, 21 – 40 = 2, 41- 60 = 3, 61 and above = 4	
214	Does the facility have a functioning laboratory (a working microscope or RDT (rapid diagnostic test)?	Yes = 1 No = 2	
215	Does the facility have an established system for quality control of malaria slides read?	Yes = 1 No = 2	
216 01 02 03	Are blood smears taken for severe cases of malaria For under fives For other age groups For pregnant women	Yes = 1 No = 2 Yes = 1 No=2 Yes = 1 No=2 Yes=1 No=2	
217	Is there a standard list of antimalarial drugs according to the national guidelines for the facility?	Yes = 1 No = 2	

QUESTIONNAIRE CODE ☐☐☐☐☐

	Staffing	(A) DOCTOR	(B) PA	(C) NURSE (PN/RN)	(D) MIDWIFE	(E) LPN	(F) Nurse Aides	(G) Other
301	What type of health workers are involved in malaria case management and what type of in-service training they have received?							
01	Total number of health workers assigned to facility........							
02	Number assigned to OPD (children & adults).................							
03	Number managing patients present today......................							
04	Number working on malaria prevention measures							
05	Number trained in IMCI..							
06	Number trained in malaria case management...............							

400. MEDICAL SUPPLIES AND EQUIPMENTS

401	Does the facility have the following equipment and materials?		
01	Functioning adult scale?	YES ....1 NO...2	
02	Functioning baby scale?	YES ....1 NO...2	
03	Functioning body thermometer?	YES ....1 NO...2	
04	Functioning watch with second hand or timing device?	YES ....1 NO...2	
05	Equipments to mix ORS (cups, spoons, and jars)?	COMPLETE SET ....1 INCOMPLETE SET..................................2 NONE 3	
06	Source of safe drinking water?	YES ....1 NO...2	
07	Stock cards/drug logbook?	YES ....1 NO...2	
08	Child immunization cards (Under five card)?	YES ....1 NO...2	
09	IMCI chart booklet/wall charts?	YES ....1 NO...2	
10	Malaria diagnosis and treatment guidelines in OPD?	YES…………………………………………1 NO…………………………………………2	
11	Health Education materials on malaria prevention and control displayed in OPD?	YES…………………………………………1 NO…………………………………………2	
402	Does facility have needles and syringes appropriate for immunization (auto-destruct)?	YES ....1 NO...2	→404
403	Are these syringes and needles single or multiple use?	SINGLE USE .... 1 MULTIPLE USE 2	
404	Does this facility have a functioning sterilizer, cooker or stove?	YES ....1 NO...2	
405	Does the facility have a functioning fridge?	YES ....1 NO...2	→410
406	Does the facility have ice packs, vaccine carriers and cold box(es)?	YES ....1 NO...2	
406a	Does the facility have vaccine carriers?	YES…………………………………………1 NO…………………………………………2	
406b	Does the facility have cold box(es)?	YES…………………………………………1 NO…………………………………………2	
407	Does the facility have safety boxes?	YES…………………………………………1 NO…………………………………………2	
408	Does the facility have a medical waste disposal sites?	Incinerator………………………………A Burning sites………………………………B	

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409	Does the facility have the following vaccines in stock?		YES	NO	
01	BCG ?		BCG 1	2	
02	OPV?		OPV 1	2	
03	DPT?		DPT........................1	2	
04	Measles?		MEASLES 1	2	
05	TT?		TT............................1	2	
06	Yellow fever?		Yellow Fever……….1	2	

410	DRUG AVAILABILITY, STOCKOUTS AND EXPIRY DATES.	(A) Does this facility have these drugs in stock on the day of the survey?			(B) Were there any stock outs of these drugs in this facility continuously for 1 week in the last 3 months?			(C) Were any of the in-stock drugs expired?			
		YES, OBSERVED	YES, REPORTED	NOT AVAIL-ABLE	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW	
01	ORS packets?.........................	1	2	3	1	2	3	1	2	3	
02	Cotrimoxazole?........................	1	2	3	1	2	3	1	2	3	
03	Amoxicilline?...........................	1	2	3	1	2	3	1	2	3	
04	Chloroquine?	1	2	3	1	2	3	1	2	3	
05	Quinine?	1	2	3	1	2	3	1	2	3	
06	SP (Fansidar)	1	2	3	1	2	3	1	2	3	
07	AS + AQ	1	2	3	1	2	3	1	2	3	
08	Coartem	1	2	3	1	2	3	1	2	3	
09	Vitamin A capsules	1	2	3	1	2	3	1	2	3	
10	Iron tablets?............................	1	2	3	1	2	3	1	2	3	
11	Mebendazole/albendazole?....	1	2	3	1	2	3	1	2	3	
12	Diazepam…………….……...	1	2	3	1	2	3	1	2	3	
13	Paracetamol…………………...	1	2	3	1	2	3	1	2	3	

411	Does the facility have the following injectable drugs available the day of visit?	(A) Does this facility have these drugs in stock on the day of the survey?			(B) Were there any stock outs of these drugs in this facility within past 3 months?			(C) Were any of the in-stock drugs expired?			
		YES, OBSERVED	YES, REPORTED	NOT AVAILABLE	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW	
01	Benzylpenicillin?	1	2	3	1	2	3	1	2	3	
02	Quinine IM/IV?	1	2	3	1	2	3	1	2	3	
03	Chloroquine IM?	1	2	3	1	2	3	1	2	3	
04	Arthemeter IM?………………..	1	2	3	1	2	3	1	2	3	
05	Chloramphenicol IM?............	1	2	3	1	2	3	1	2	3	
06	Gentamycin IM?.....................	1	2	3	1	2	3	1	2	3	
07	Water for injections?.............	1	2	3	1	2	3	1	2	3	
08	Dextrose 5%, 10%, 50%IV fluids?	1	2	3	1	2	3	1	2	3	
		1	2	3	1	2	3	1	2	3	
09	Diazepam IM?	1	2	3	1	2	3	1	2	3	

412	Does this facility use malaria microscopy as a diagnostic tool?	YES 1	
		NO...2	→414
		DON'T KNOW 3	→414

413	Are following equipment, reagents and supplies available in this facility on the day of visit?	YES, OBSERVED	YES, REPORTED	NOT AVAILABLE	
01	Functioning microscope	1	2	3	
02	Giemsa stock...	1	2	3	
03	Slides...	1	2	3	
04	Tally counters	1	2	3	
05	Zyline	1	2	3	
06	Timer	1	2	3	
07	Slide boxes.…………………………………………	1	2	3	
08	Racks.……………………………………………	1	2	3	
09	Lancets.…………………………………………	1	2	3	
414	Does this facility use Rapid Diagnostic Test (RDT) kits?	YES..1 NO..2 DON'T KNOW..3			→500 →500
415	Are there any unexpired RDT kits in stock?	YES, OBSERVED .... 1 YES, REPORTED .... 2 NO.. 3			
416	Where did facility get antimalarials?	NMCP/NDS.…………………………………………1 NDS.…………………………………………………2 Pharmacy.…………………………………………3 NGO.………………………………………………4 Other.………………………………………………5 (Specify)_____			
417	Was antimalaria bought or given at no cost?	Bought.…………………………………………………1 Given at no cost.………………………………………2			
500	**RECORD KEEPING**				
	PLEASE CIRCLE ALL THE ITEMS THAT ARE INCLUDED IN THE REGISTER.				
501	Is the outpatient register correctly filled in *(name, sex, age and diagnosis)?*	YES……………………1 NO……………………2			
502	Is the inpatient register correctly filled *(name, sex, age, weight, temperature, provisional & final diagnosis, treatment, investigations, date of admission & discharge, outcome)?*	YES……………………1 NO……………………… 2			
503	Is the register/medication cards/log book/ledger (for pharmacy) correctly filled out *(name of drugs, expiratory dates, minimum stock level, and current stock level)?*	YES……………………1 NO……………………2			
504	Are there health summary tables/graphs displayed in OPD?	YES……………………1 NO……………………2			
505	What is the total number of visits to the health facility for outpatient services during the previous month?	TOTAL VISITS			
506	How many of these visits were from confirmed and unconfirmed malaria?				
01	Confirmed malaria cases?	CONFIRMED			
02	Unconfirmed malaria cases?	UNCONFIRMED			
507	How many of these malaria cases were of patient under five years of age, and five years and above?				
01*	Under five cases?	< 5 CASES....................			
02*	Five years and above cases?	=> 5 CASES.....................			
508	Do you carry out ITN activities in this health facility?	YES……………………1 NO…………… 2			STOP
509	What type of ITN activities do you carry out? PLEASE PROBE AND RECORD ALL MENTIONED	PROMOTION.…………………………………A DISTRIBUTION TO U5 & PREGNANT WOMEN.……………………………………B RE-TREATMENT.…………………….……C OTHER(S).……………………………….…D			

510	Where do you get your ITNs from	NMCP/NDS…………A UNICEF………………B NGOs…………………C. (Specify)_____ Other(s)………………D	
511	How many insecticide treated nets (ITNs) were distributed from this facility during the past 12 months?	ITNs.................................	☐☐☐☐☐☐
512	How many insecticide treated nets (ITNs) were re-treated by staff of this facility during the past 12 months?	RE-TREATED NETS.........	☐☐☐☐☐☐

513 Interviewer's Remarks:

<div style="border:1px solid black; height:250px;"></div>

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MINISTRY OF HEALTH AND SOCIAL WELFARE – LIBERIA
NATIONAL MALARIA CONTROL PROGRAMME
Assessing Malaria morbidity and mortality in OPD and IPD

Form 5:   Malaria morbidity and mortality
1. Facility Identification

County: _____

Name of the facility: _____

District: _____

Town/Community: _____

Type of health facility: 1=Hospital
2=Health Center
3=Clinic
4=Other: _____ (Specify)

Operating authority: 1=Government
2=NGO – Supported
3=Mission
4=Private
5=Other: _____ (Specify)

COUNTY CODE

FACILITY CODE

District code:

Town/Community code:

FACILITY TYPE Code ....

OPERATING AUTHORITY ....

Review the OPD and IPD registers over the past 12 months (1st August 2004 – 31st July 2005) and record the total number of:

OUTPATIENT MORBIDITY									
CHILDREN UNDER 5 YRS			AGE 5 YRS & ABOVE (Excluding pregnant women)			PREGNANT WOMEN			
No. Seen (all diseases)	No. with Clinical diagnosis of malaria	No. with a diagnosis of malaria lab-confirmed	No. Seen (all diseases)	No. with Clinical diagnosis of malaria	No. with a diagnosis of malaria lab-confirmed	No. Seen (all diseases)	No. with Clinical diagnosis of malaria	No. with a diagnosis of malaria lab-confirmed	No. antenatal record reviewed	No. with correctly prescribed Intermittent Preventive Treatment (IPT)

INPATIENT MORBIDITY								
CHILDREN UNDER 5 YRS			AGE 5 YRS & ABOVE (Excluding pregnant women)			PREGNANT WOMEN		
No. admitted (all diseases)	No. with Clinical diagnosis of malaria	No. with a diagnosis of malaria lab-confirmed	No. admitted (all diseases)	No. with Clinical diagnosis of malaria	No. with a diagnosis of malaria lab-confirmed	No. admitted (all diseases)	No. with Clinical diagnosis of malaria	No. with a diagnosis of malaria lab-confirmed

MORTALITY DATA									
CHILDREN UNDER 5 YRS				AGE 5 YRS & ABOVE (Excluding pregnant women)			PREGNANT WOMEN		
No. of Deaths (all diseases)	No. of deaths with a clinical diagnosis of Malaria	No. of deaths with lab confirmed Malaria diagnosis	No of deaths with a diagnosis of Anaemia	No. of Deaths (all diseases)	No of deaths with a clinical diagnosis of Malaria	No. of deaths with confirmed Malaria diagnosis	No. of Deaths (all diseases)	No of deaths with a diagnosis of Malaria	No. of deaths with confirmed Malaria diagnosis