The Gambia

Maternal and Child Nutrition and Health Results Project

Baseline Survey Report

December 2015

WORLD BANK GROUP
Health, Nutrition & Population

Table of Contents

List of figures

List of tables

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Abbreviations and Acronyms

ANC:	Antenatal Care
BFCI	Baby Friendly Community Initiative
CAC:	Catchment Area Committee
CBOs:	Community Based Organizations
CCT:	Conditional Cash Transfer
CHN:	Community Health Nurse
CPR:	Contraceptive Prevalence Rate
CRR:	Central River Region
C-Section:	Caesarian Section
DCD:	Department of Community Development
DHS:	Demographic and Health Survey
EAs:	Enumeration Areas
FFS:	Fee-For-Service
FGD:	Focus Group Discussion
FP:	Family Planning
GBOS:	Gambia Bureau Of Statistics
GDP:	Gross Domestic Product
HMIS:	Health Management Information System
HRITF:	Health Results Initiative Trust Fund
IE:	Impact Evaluation
IUCD:	Intra-Uterine Contraceptive Device
IYCF:	Infant and Young Child Feeding
LGA:	Local Government Area
LQAS:	Lot Quality Assurance Sampling
MICS:	Multiple Indicator Cluster Survey
MCH:	Maternal and Child Health
MCNHRP:	Maternal and Child Nutrition and Health Results Project
MDG:	Millennium Development Goal
MMR:	Maternal Mortality Ratio
MoFEA:	Ministry of Finance and Economic Affairs
MoHSW:	Ministry of Health and Social Welfare
NaNA:	National Nutrition Agency
NBR-E:	North Bank Region - East
NBR-W:	North Bank Region - West
OIC:	Officer-in-charge
OPD:	Out-Patients Department
ORS:	Oral Rehydration Solution
PBF:	Performance Based Financing
PHC:	Primary Health Care
PIC:	Project Implementation Committee
PMU:	Project Management Unit
PNC:	Postnatal Care

POM:	Project Operations Manual
RAD:	Regional Agricultural Directorate
RBF:	Results Based Financing
RCH:	Reproductive and Child Health
RHD:	Regional Health Directorate
SAM:	Severe Acute Malnutrition
SBA:	Skilled Birth Attendance
SBCC:	Social and Behavior Change Communication
SEN:	State Enrolled Nurse
SRN:	State Registered Nurse
TBA:	Traditional Birth Attendant
TFR:	Total Fertility Rate
TT:	Tetanus Toxoid
U5MR:	Under-five mortality rate
URR:	Upper River Region
VAS:	Vitamin A Supplementation
VDC:	Village Development Committee
VSG:	Village Support Group
WHO:	World Health Organization

Executive Summary

The baseline survey for the impact evaluation of the Maternal and Child Nutrition and Health Results Project (MCNHRP) in The Gambia took place between November 2014 and February 2015. It covered the three regions where the original project is taking place: Central River Region (CRR), North Bank Region West (NBR-W) and Upper River Region (URR). The primary institutions involved in carrying out the baseline evaluation were: the University of Southern California, the World Bank Group, the University of The Gambia, Harvard University and the Gambia Bureau of Statistics.

Indicators of maternal and child nutrition and health in The Gambia highlight significant room for improvement, especially among people living in rural areas where poverty rates are high. The poor performance of the health service delivery system on maternal and child nutrition and health outcomes points to an operationally weak primary health care (PHC) system and inadequate linkages between communities and the health system.

Results-based financing (RBF) in the health sector has been defined as a financing mechanism where cash or non-monetary transfers are made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined service delivery or health outcomes results have been attained and verified (Brenzel 2009). In The Gambia, the MCNHRP will employ both supply-side and demand-side RBF initiatives that aim to improve efficiency, address bottlenecks and improve health system function through strategic purchasing and increased autonomy of various stakeholders in maternal and child nutrition and health. This project builds on the pilot project that was carried out in NBR-W in 2014.

The overarching objective of the impact evaluation is to assess the effectiveness of the MCNHRP's package of supply- and demand-side interventions for increasing the utilization and quality of maternal and child nutrition and health services. The baseline survey was designed to provide a cross-sectional overview of the situation at the beginning of the project period. It provides a baseline against which the impact of the project can subsequently be measured.

The overall approach for the impact evaluation is a randomized phased-in 2 x 2 design, with staggered roll-out of the supply- and demand-side interventions, with an embedded process evaluation. The mixed methods evaluation is based on a conceptual framework that details out the pathways of impact for both types of intervention. The use of qualitative methods to complement the quantitative survey methodology will allow the evaluation team to disentangle the mechanisms behind the main quantitative results and better explain the overall implementation effectiveness of the project.

This report presents the findings of the baseline survey, which constituted the first round of data collection for the impact evaluation. It provides an overview of the situation with regard to knowledge, attitudes and behaviors in relation to maternal and child nutrition and health in CRR, NBR-W and URR prior to the start of the project.

Quantitative data collection for the baseline survey included a household survey administered in 2257 households, within which questionnaires were administered to two people (head of household, mother of youngest child under age 5); facility-based surveys in 24 health facilities in which questionnaires were administered to the head of the health facility, health workers and women attending reproductive and child health (RCH) services; and community based surveys in 109 communities within which questionnaires were administered to members of the Village Development Committees (VDCs) and Village Support Groups (VSGs). Qualitative data were collected through a combination of semi-structured interviews and focus group discussions with a range of stakeholders at national, regional, health facility and community levels.

As explained in Sections 4 and 6, the data in this report should not be considered nationally representative. The resulting sample is not representative at the national or regional level for three main reasons: first, geographically, the project covered only 3 regions in the country, which are on average less developed than the regions not included. Second, within regions, surveys were only conducted in communities with existing health platforms. These communities are on average slightly larger and likely also more developed than communities without such platforms. Last, within communities, the survey targeted only women with recent births, which are not representative of the larger adult female population.

The main findings from the baseline survey, drawing from all of the above-mentioned sources, are presented in Section 5. As a result of the multiplicity of data sources, the study sample size does not remain constant in each of the tables; data sources and sample sizes are included as notes for each table. Findings are presented sequentially by topic: women's health, breastfeeding, family planning, child health, child nutrition, household health, environmental sanitation, and health system. Quantitative and qualitative data are jointly presented under each topic, with anonymized qualitative quotes used to illustrate points emerging from the data.

The findings illustrate a complex situation with regard to maternal and child nutrition and health in the three regions where the MCNHRP will operate. There is room for improvement on almost all indicators but performance often varies by region, type of health facility, literacy of the respondent and wealth quintile of the respondent. This means that a nuanced approach will be required, targeting project activities to respond to the most acute needs in different areas, building on existing strengths and striving to overcome weaknesses.

These data provide a comprehensive overview of the current state of maternal and child nutrition and health in the project area, against which it will be possible to measure change over time. The midline and endline surveys will be designed to maximize learning from this impact evaluation. The qualitative component will provide some explanatory power as to why and how change is occurring (or not).

All of the questionnaires used for data collection as well as sample interview and focus group discussion guides are included as annexes. The code tree used to guide qualitative data analysis is also an annex.

1. Introduction

1.1 Background

Health and nutrition in The Gambia

The Gambia is a small country in West Africa with a population of approximately 1.9 million (2013). The population has been growing at a fairly high rate of 3.3% per year over the last decade. The Gambia is a low-income country with average per capita Gross National Income (GNI) estimated at US$450 (World Bank 2014) which is less than a third of the sub-Saharan African average of US$1,720. In the 2013 Human Development Index, the country was ranked 165 out of 187 countries. Life expectancy at birth for the average Gambian was 59 years in 2012. Poverty in The Gambia is pervasive in spite of a noticeable decline of overall poverty rates during the last decade. The Gambia has had strong economic performance in recent years with an average annual real GDP growth rate of 6-7% during 2005-2010. However, economic growth in The Gambia has staggered in the last five years and has not been inclusive. There are large regional variations of poverty within The Gambia, with rural areas recording a substantially higher poverty head count (73.9%) compared with urban areas (32.7%).

The Gambia's performance on MDGs 1c, 4 and 5 has been mixed. While better off than the sub-Saharan African average for under-five mortality rate (U5MR) and maternal mortality ratio (MMR), The Gambia's performance is lagging behind regional peers like Ghana and Senegal. U5MR and MMR have declined since 1990, but the progress has been modest in relation with the Millennium Development Goals (MDG) 1c, 4 and 5. Data from the 2013 Demographic Health Survey (DHS) show encouraging results for child mortality with an estimated U5MR of 54 per 1,000 live births. The data from the 2013 DHS shows no change in underweight prevalence since 2000, i.e., 16% (DHS, 2013). According to the 2015 State of the World's Mothers report (Save the Children 2015), The Gambia ranks 174 out of 179 countries on the Mother's Index just above Mali, Niger, Somalia, the Democratic Republic of the Congo and the Central African Republic but behind countries like Chad, Guinea-Bissau and Cote d'Ivoire.[1] Furthermore, nutrition and health outcomes vary strongly between the rural eastern regions and urbanized western regions of The Gambia with the eastern regions making less progress on these indicators.

[1] Indicators of the 2013 Mother's Index include: (i) Lifetime risk of maternal death; (ii) Under-5 mortality rate; (iii) Expected years of formal education; (iv) Gross national income per capita; and (iv) Participation of women in national government

Maternal health indicators continue to perform poorly. The total fertility rate (TFR) appears to have increased from 5.1 in 2005 to 5.6 children per woman while the contraceptive prevalence rate (CPR) has dropped from 13% to 9%. Unmet need for family planning is estimated at 25%. The percentage of women who had skilled attendance at delivery – 57% – has remained unchanged since 2005. Ninety-nine per cent of pregnant women made at least one visit to ANC and the recommended four ANC visits were completed by 75% of women (DHS 2013). However, only 38% of women attend their first ANC visit in the first trimester, jeopardizing healthy outcomes for both mother and child. Teenage pregnancies are common, resulting in a high adolescent fertility rate of 118 per 1,000 and nearly 20% of adolescent girls age 15-19 having begun childbearing (MICS 2010). Pregnancy in adolescence raises the risk for maternal morbidity and mortality, and child malnutrition. Utilization of health services by youth is low, and few facilities offer youth-friendly reproductive health services.

The poor performance of the health service delivery system on maternal and child nutrition and health outcomes point to an operationally weakened primary health care (PHC) system and inadequate linkages between communities and the health system. In recent years, financing has been diverted from primary care to tertiary care, weakening PHC provision and resulting in part in the deterioration of health and nutrition indicators. The current health strategy is to revitalize PHC.

The limited central government spending on health has resulted in a transfer of the financial burden onto patients in the form of out-of-pocket expenditures. Total expenditure on health per capita in 2010 was US$26 and the total expenditure on health was 6% of GDP. General government expenditure on health as a percentage of total health expenditure is 51%; out-of-pocket expenditure by poor families 24%; and external resources 25%. Although the policy is to provide free basic services – in particular maternal and child health services – households pay for food, transportation and laboratory services, medicines and medical supplies where they are not available at the time of seeking care. The high poverty head count at 48.4% means that out-of-pocket health expenditures constitute a major financial burden for a substantial part of the population despite the theoretically free provision of health services by the government. This is particularly important in rural areas, where 73.9% of the population are classified as poor (GBOS 2011).

Results-based financing

Results-based financing (RBF) in the health sector has been defined as a financing mechanism where cash or non-monetary transfers are made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined service delivery or

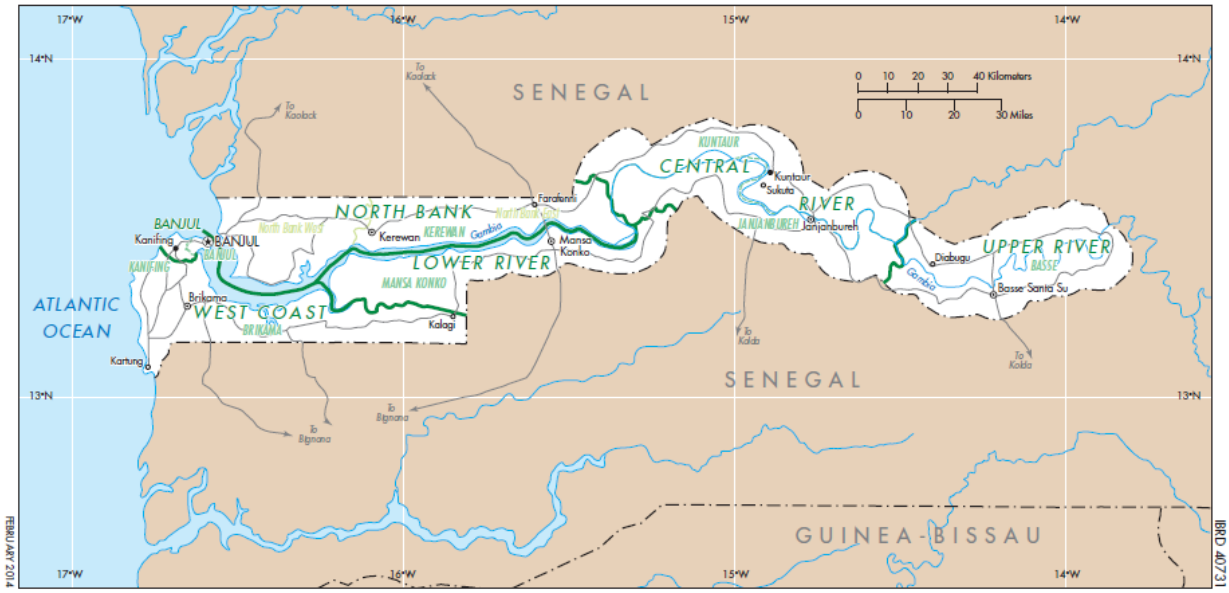
health outcomes results have been attained and verified.[2] RBF can be supply-side or demand-side initiatives that aim to improve efficiency, address bottlenecks, and improve health system function through strategic purchasing and increased autonomy of various actors in the health system. An increasing number of countries are implementing RBF approaches as an alternative to input-based financing, and many of these countries have been employing a performance-based financing (PBF) approach, a particular type of RBF in which health facilities are rewarded monetarily for producing predefined results in terms of quantity and quality of agreed services, subject to verification of those outputs by an independent party. PBF schemes have attained national coverage in Rwanda, Burundi, and Sierra Leone, and are being piloted in different sub-Saharan countries, among them: Central African Republic, Zimbabwe, Zambia, the Democratic Republic of Congo (DRC), Benin, Cameroon, Chad, and Burkina Faso.

1.2 The Maternal and Child Nutrition and Health Results Project

Overview

The development objective of this planned project is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in The Gambia. The project will be implemented in three Regions with some of the poorest performing indicators – Upper River, Central River and North Bank West Regions (Figure 1). These three Regions currently account for one third of the total population. Over the five-year period of implementation, the project is expected to reach approximately 183,000 children under five and 180,000 women aged 15-49 years, yielding a total of 363,000 direct beneficiaries of the Project. The interventions will provide support through RBF arrangements with women, Village Development Committees (VDC) and Village Support Groups (VSG), and primary health facilities.

Figure 1: Map of the regions of The Gambia



The project has recently received additional financing from the World Bank to incorporate activities relating to food security and Ebola preparedness. The project area will also be expanded to encompass Lower River Region and North Bank Region East.

The project will be implemented under the leadership of the National Nutrition Agency (NaNA) and the Ministry of Health and Social Welfare (MoHSW).

The project is composed of four components as described in Table 1. Components 1 and 2 apply RBF mechanisms to address demand- and supply-side challenges as well as social and behavioral issues for improving maternal and child health and nutrition outcomes, respectively. Component 2 also encompasses interventions to improve food and nutrition security. Component 3 strengthens overall management capacity (including monitoring and evaluation) of communities, local government and the health system to effectively engage in results-based management. Component 4 focuses on Ebola preparedness and control. Innovative aspects of this project are the combined use of RBF approaches on the demand- and supply-sides and at the community and PHC levels to improve health and nutrition outcomes.

Table 1: Summary of project components

Component 1: Community Mobilization for Social and Behavior Change	• Conditional cash transfers to communities and support groups • Conditional cash transfer to individuals • Social and behavior change communication (SBCC)
Component 2: Delivery of Community Nutrition and Primary Health Care Services	• Performance-based financing for health centers • Start-up support, including selected health care waste management measures • Health system strengthening for Ebola preparedness and control • PHC scale-up • Food security-enhanced BFCI scale-up
Component 3: Capacity Building for Service Delivery and RBF	• Capacity building • M&E, operational research and verification • Coordination and program management at all levels • Performance contracts with RHD, RAD, RBF Committee, and NaNA
Component 4: Ebola Preparedness and Control	• Social mobilization • Case management

*RHD: Regional Health Directorate; HMIS: Health Management Information System; NaNA: National Nutrition Agency

The four components outlined in the table above are further described below.

Component 1: Community mobilization for social and behavior change

This component will focus on community-based promotion of key family and community practices and health care seeking behaviors for improved maternal and child nutrition and health outcomes through:

(i) Provision of *conditional cash transfers (CCT) to communities and village support groups (VSG)* to increase demand for and utilization of health and nutrition services through counseling and timely referrals for life-saving health services

Village Development Committees (VDCs) will sign an RBF contract with the Regional Health Directorate (RHD) under which quarterly payments will be made for achieved performance on predefined community indicators:

- Proportion of Women 15-49 years who can cite at least three risk factors of pregnancy
- Proportion of Women 15-49 years who can cite at least two advantages of exclusive breastfeeding
- Proportion of mothers with children 6-23 months who cite at least 2 practices of good complementary feeding
- Proportion of children 6-23 months who consumed foods from at least 4 recommended food groups during the previous day (7 food groups: grains, roots& tubers/ legumes & nuts/dairy products/flesh foods/eggs/vitamin A rich fruits & vegetables/other fruits & vegetables)
- Proportion of women 15-49 years who consumed foods from at least 4 recommended food groups during the previous day (7 food groups: grains, roots & tubers/ legumes & nuts/dairy products/flesh foods/eggs/vitamin A rich fruits & vegetables/other fruits & vegetables)
- Proportion of women 15-49 years with improved sanitation facility in household
- Proportion of women 15-49 years with a designated hand-washing station in household where water and soap are present

Members of the PIC will verify the achievement of results through monitoring visits and reports as well as Lot Quality Assurance Sampling (LQAS). Incentives for community structures will be shared between VSGs (30%) and VDCs (70%). VDCs can use their payments for operating costs, community mobilization and community health and development activities while VSGs will divide their incentives among the members.

(ii) Provision of *CCTs to individual women* to increase demand for health and nutrition services

CCTs will be provided to women for timely antenatal care (ANC). They will receive payments for:

- First attendance at ANC during the first trimester of pregnancy
- Fulfillment of the first criterion and completion of at least three more routine ANC visits during the course of pregnancy

Use of the services will be verified by PIC members using health facility records and counter-verified by an independent verification agent. Once the data have been verified, payments will be transferred to women by the health facilities where the services were provided.

(iii) Accompanying measures aimed at promoting behavioral changes and increasing demand to improve household practices related to health and nutrition through *social and behavior change communication (SBCC)*

SBCC strategies will be implemented to accompany the other sub-components in order to have a comprehensive and sustainable approach to promoting behavioral changes and increasing demand for healthcare utilization.

All three sub-components combined are expected to improve household practices and treatment-seeking behaviors related to health and nutrition.

Component 2: Delivery of selected primary health care services

This component aims to support and incentivize the delivery of selected nutrition and health care services at primary health centers. Health centers will receive performance-based payments for the delivery of a predefined package of maternal and child health and nutrition services. A fee-for-service (FFS) mechanism which includes quantity and quality payments for a defined package of maternal and child health and nutrition services will be used. The following indicators will be incentivized:

Primary care level indicators:

- Number of women having received ANC in the 1st trimester
- Number of women having received 3 additional scheduled ANC visits
- Number or pregnant women delivering with skilled attendants
- Number of post-partum mothers being provided with a minimum of 3 PNC services within 6 weeks of delivery
- Number of referrals of women with pre-, intra- and post-partum complications
- Number of women supplied with modern methods of family planning (method-specific pricing) (new clients)
- Number of women supplied with modern methods of family planning (method-specific pricing) (repeat clients)
- Number of children 6-59 months administered VAS according to protocol
- Number of children 12-59 dewormed according to protocol
- Number of children referred for neonatal complications
- Number of children with SAM on treatment according to protocol
- Number of new outpatient visits
- Update of community registers

Secondary level indicators:

- Number of pregnancies with complications before and during delivery requiring interventions
- Number of Caesarean sections
- Number of mothers treated for postpartum complications
- Number of infants treated for neonatal complications
- Number of people provided with a permanent family planning method (tubal ligations,

vasectomy)

Some of the indicators are base indicators; others will be phased in and out.

Health centers will sign an RBF contract with the MOHSW RBF Committee and receive quarterly payments corresponding to their achieved performance based on both the quantity and quality of services. Members of the PIC will verify the achievement of quantity outputs. Inaccurate reporting will incur a reduction in the size of the incentive payment.

A quality assessment tool will be used by RHDs to assess the quality of services provided by the contracted health facilities each quarter. The tool includes a broad variety of indicators such as cleanliness, quality of recordkeeping, availability of staff and supplies etc. In addition to the assessment of quality by RHDs, community-based organizations (CBOs) will be contracted by NaNA to undertake client tracer and satisfaction surveys with a view to: (i) verify the authenticity of patients and services reported by a health facility; and (ii) capture patient feedback regarding the services they received.

The total payment will be based on verification by NaNA, RHDs and CBOs.

Health centers can use their RBF payments for material and equipment, training, consulting services and operating costs, and staff bonuses that should ultimately improve service delivery. Staff bonuses can comprise up to 40% of the total payment received by the facilities. As part of the RBF contracting cycle, each health facility should develop a business plan to guide future investments and use of RBF payments. A Catchment Area Committee (CAC) consisting of ten community members and the Officer In Charge will be specifically assigned to support facilities in the effective design and implementation of their business plans. RHDs will supervise health facilities to ensure that business plans are in place at the start of each contracting cycle.

Component 3: Capacity Building for Service Delivery and Results-Based Management

Recognizing the limited in-country capacity to implement the first two components, the third component of the pilot project was designed to ensure appropriate capacity among all stakeholders for effective implementation. This will include:

(i) strengthening of management capacity of key implementing entities including NaNA, MoHSW, MoHSW RBF Committee, service providers, VDCs, VSGs, and RHDs for effective implementation of the RBF;

(ii) monitoring and evaluation including verification of RBF activities;

(iii) project implementation including project management and coordination, fiduciary management, oversight, and communications; and

(iv) ensuring effective management and implementation support of the project by the RHDs, NaNA, RAD, and the MoHSW RBF Committee by means of performance contracts.

Capacity building will be provided through: (i) long-term technical assistance; and (ii) in-service and on-the-job training and consulting services. To the extent possible, capacity building will use in-country peer learning and south-south learning from countries with mature RBF programs. This component will also strengthen the capacity of the MOHSW in RBF, procurement and financial management.

Component 4 – Ebola Preparedness and Response

In support of the implementation of immediate actions in the National Ebola Preparedness and Response Plan, the project will specifically focus on (i) Social Mobilization (e.g. development and distribution of communication materials), (ii) Case Management (e.g. health care worker training and preparedness, provision of personal protective equipment) and (iii) Surveillance. WHO has signed an MOU with the project to implement the Social Mobilization and Case management sub-components while the surveillance sub-component will be implemented by the National Ebola Task Force under the direct supervision of the RBF Committee.

Project implementation structures

National level

The MOHSW and the National Nutrition Agency (NaNA) are the implementing partners for the MCNHRP. They have the overall responsibility for implementing the project, providing general policy directions and coordinating/liaising with the World Bank, other Ministries and stakeholders. The Project Implementation Committee (PIC) comprises representatives of the MOHSW and NaNA. It is responsible for coordinating and reviewing all aspects of project implementation. The MOHSW is the purchaser and regulator for the project. An RBF committee has been formed within the MOHSW to monitor service delivery standards and manage performance contracts within the health system. NaNA is the project's fund holder and acts as a secretariat for the PIC and the project Steering Committee.

All entities involved in the Project's implementation are overseen by the Steering Committee composed of the Ministry of Finance and Economic Affairs (MOFEA), MOHSW and NaNA. The Steering Committee meets quarterly. Its responsibilities include approving annual work plans and budgets submitted by the PIC and ensuring that proposals and budgets are in line with national priorities.

Regional level

At the regional level, the primary entities through which the project operates are the Regional Health Directorates and the Regional PIC. Each of these entities works to support the mandates described above for their national-level counterparts but with a focus at the regional level.

Community level

The main community structures involved in the project are the VDCs and VSGs with the former focused on community development activities and the latter focused on health promotion.

CACs constitute a bridge between communities and health facilities. They support and provide oversight for project-related activities within health facilities.

Health facilities' primary mandate continues to be the provision of quality health services. Under the project they also assume responsibility for implementation of business plans, appropriate recording of project-related information and paying incentives to pregnant women as appropriate.

Conceptual Framework: Theory of change and pathways of impact

RBF interventions are complex. Complexity means that in order to pinpoint how RBF programs work and ultimately impact health outcomes, there is a need for a systematic mapping of how one expects RBF to work and a need for rigorous testing of these hypotheses. This project builds on a conceptual framework that was developed for a supply-side performance based financing (PBF) intervention and provides a systematic chain of interlinked elements (Hasan et al, forthcoming). The conceptual framework integrates principles from several theories about human behavior, including theory of change, expectancy/motivation theory and social ecological theory. Theory of change helps predict the likely behavioral and organizational changes that a program should bring about, expectancy theory helps identify the conditions for behaviors to change, and social ecological theory helps embed those changes in and across each level. The social ecological model also helps provide guidance for developing successful programs in social environments. We build on this framework to also include the behavioral and organization changes expected from the demand-side community-level interventions. The framework embeds the RBF interventions in four levels: health facility, health system, community and political economy. It links the four levels through the essential strategic purchasing, whereby different actors from different levels are linked through contracts and agreements. The changes occurring within one level influence and are influenced by changes occurring in other levels, represented by the nested nature of the framework. The project maps out the hypothesized pathways of impact and, by identifying (and measuring) both intermediate and final outcome variables, it aims to answer whether the interventions have an impact, how much of an impact, and the pathways through which impact is achieved or hindered (Rawat et al 2013). The theory of change and pathways of impact for the supply- and demand-side interventions are illustrated separately in Figure 2 and Figure 3 below. The numbering in the figures indicates hypothesized direct causal links with program design features, and arrows indicate additional pathways of impact.

For the facility-based PBF intervention, *within the health facility level*, the key features of the PBF design include the five numbered elements in Figure 2 (see top left corner of health facility

level in Figure 2). Key characteristics of performance payments include their size, the frequency of payments, the extent to which they constitute additional resources, the level at which the payments are made (in this project, the performance payments made to the facility can have up to 40% allocated for individual staff members with the remaining 60% for activities delineated in the business plan), and the distribution mechanisms for payments to staff (how it is distributed among staff members). Many pay-for-performance schemes have been evaluated within the scope of expectancy theory, because achieving these behavioral attributes are critical in the implementation of a program that expects systemic changes (Marsh et al. 2011). Expectancy/motivation theory suggests that for the program to be successful, it should be designed and implemented in such a way that key behavioral attributes are achieved: understanding, expectancy, valence, buy-in and perceived fairness (see top left corner of health facility level in Figure 2).[3]

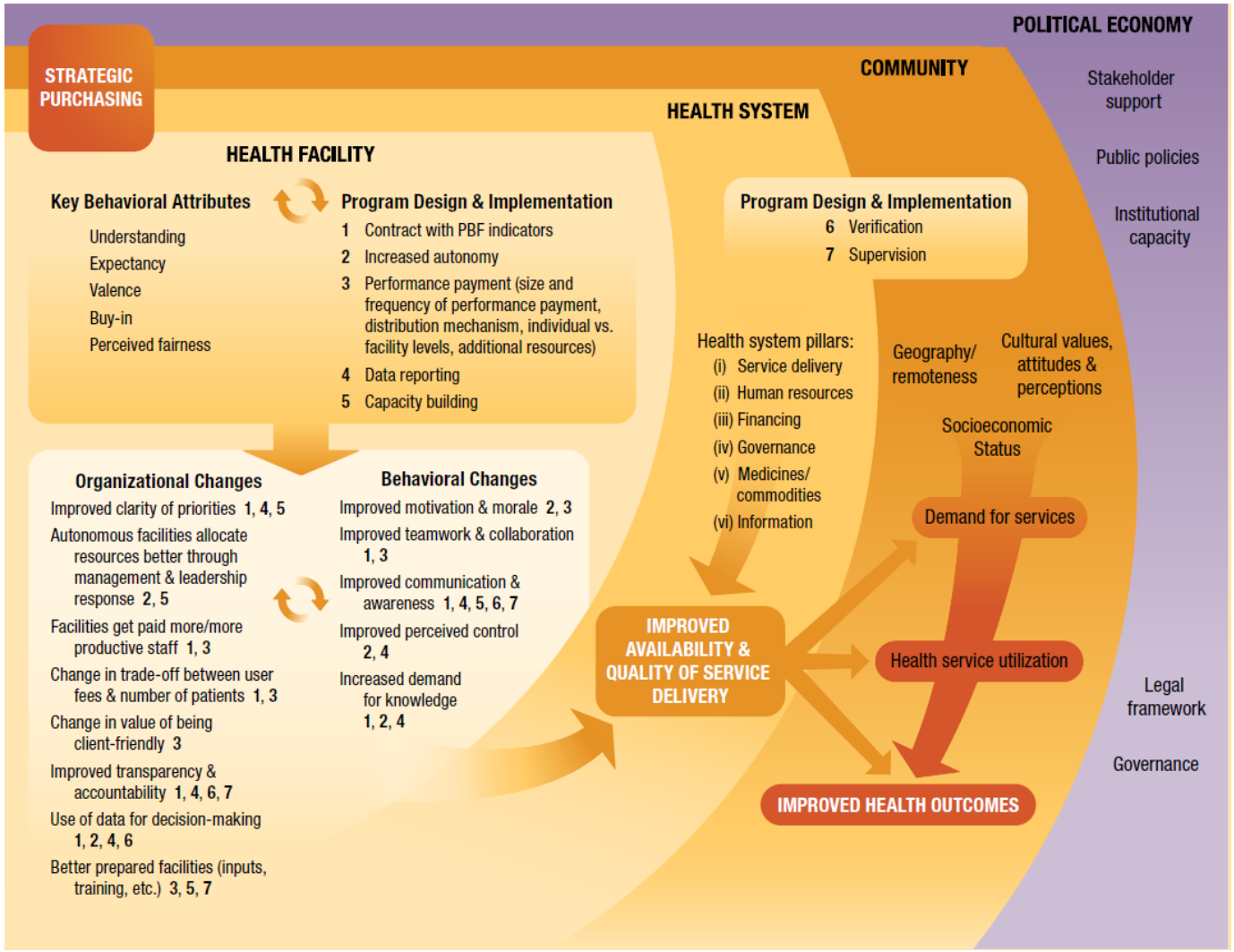
At the *health system level*, program design features of verification and supervision will impact how well the RBF is implemented at the health facility level (Figure 2). For example, Regional Health Directorates (RHDs) are responsible for supervising health facilities and NaNA for verifying results. In addition, key general health system features influence both the design and future implementation of the RBF schemes as well as the overall availability and quality of services.

At the community level, there are multiple pathways of impact. Community-level factors will influence not only the implementation of the community-level interventions but also the facility-level PBF intervention (Figure 2). For example, greater distances between the community and the nearest health facility may dampen demand for services and hinder service utilization. In addition, health facility and health system factors – such as better service quality in facilities – may also induce greater demand for service utilization.

Finally, *the political economy* exerts influence on the design and implementation of the scheme, and the implementation and results of the RBF program can also affect the political economy. For example, if there is strong support for the RBF from stakeholders at multiple levels, mobilizing sufficient support (financial and otherwise) is more likely, enhancing the likelihood of successful implementation. And conversely, implementation of an RBF pilot that achieves the expected results improves the political economy for expansion or scale-up of RBF.

[3] Understanding of the program is defined as having the knowledge of criteria by which incentives are awarded, the amount of money at stake, and the additional design features. Expectancy is the health facility staff's beliefs that they are capable of doing things that will enable them to achieve performance objectives. Valence is the belief that the incentives are sufficiently valuable or substantial to inspire the expected behavioral responses. Buy-in is the acceptance of the program and its criteria, and perceived fairness is the idea that staff believe the program design features and implementation are fair.

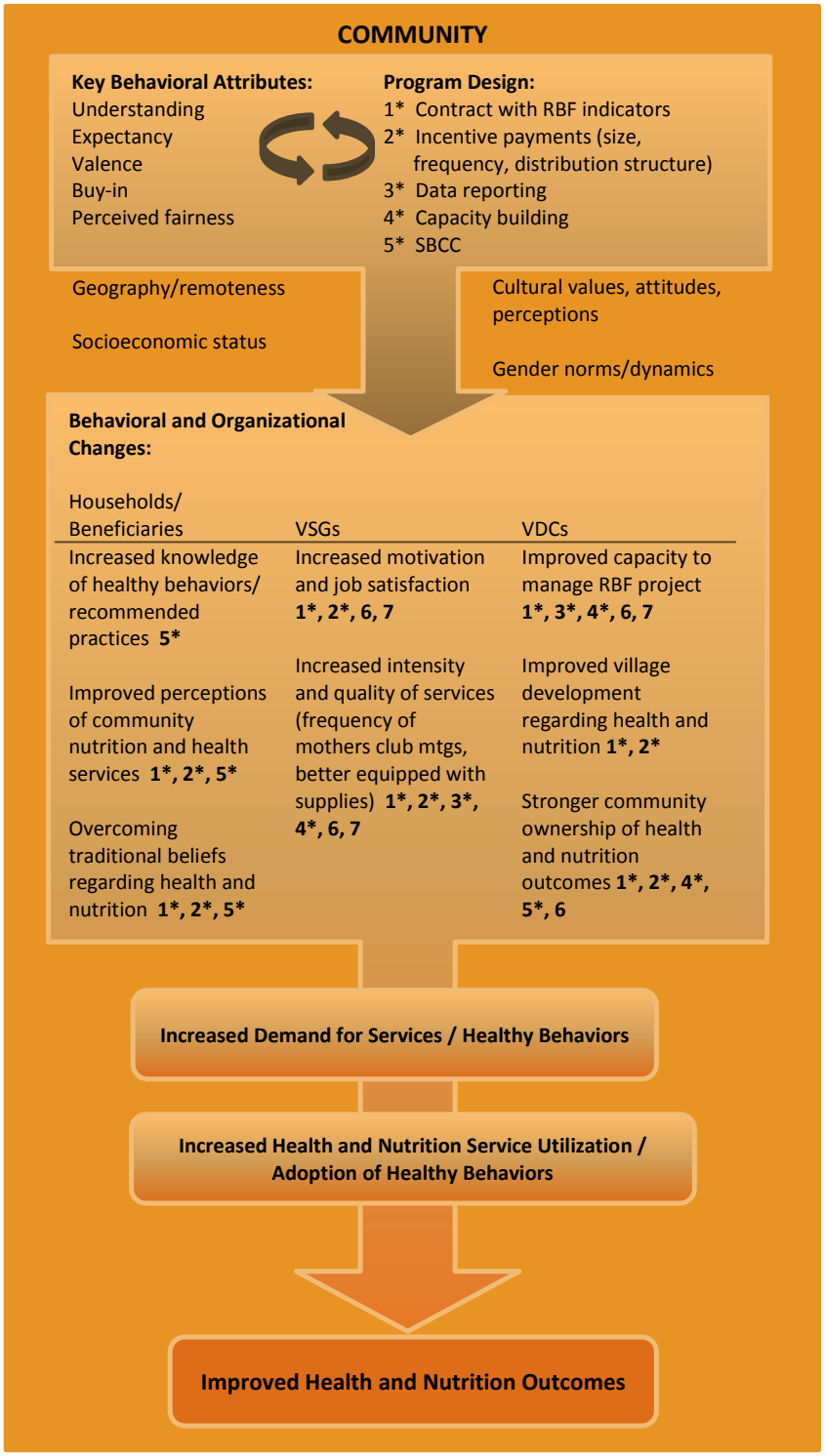
Figure 2: PBF conceptual framework for theory of change and pathways of impact



Source: Hasan et al, forthcoming

The demand-side interventions will have additional pathways of impact directly at the community level. As illustrated in Figure 3, program design elements for the demand-side interventions are designated with numbers 1 – 5. All of these elements are premised on understanding, expectancy, valence, buy-in and perceived fairness of the actors involved (primarily VDCs, VSGs and household members in the communities). With the implementation of the interventions, the project expects to see changes in behavior for these actors as well as changes at an organizational level. For community members, it expects increased knowledge of healthy behaviors, improved perceptions of community nutrition/health services, and overcoming of some traditional beliefs regarding health and nutrition. For VSGs, the project expects increased motivation and job satisfaction, increased intensity, and improved quality of services. For VDCs, it expects improved capacity to manage the RBF program, improved village development regarding health and nutrition, and greater ownership of health and nutrition outcomes. The causal links between the program design elements and expected changes are indicated by the number of the design element. These behavioral and organizational changes are expected to result in an increased demand for services and healthy behaviors, leading to increased utilization of services and improved health and nutrition outcomes.

Figure 3: Demand-side RBF conceptual framework for theory of change and pathways of impact



The community-level interventions can also have an impact on the effectiveness of the supply-side PBF. For example, cultural values that favor delivering at home pose challenges that the PBF program alone may not be able to address. However, the community-level intervention may be able to adapt these such that families then value delivering with skilled personnel over delivering at home, increasing demand for services. Thus, both supply- and demand-side interventions are hypothesized to increase demand for services and healthy behaviors, which will lead to increased utilization of services and adoption of healthy behaviors, ultimately improving health and nutrition outcomes.

2. Impact evaluation objectives

2.1 Impact evaluation objective

In collaboration with NaNA, the MOHSW, and the World Bank operational team, the evaluation team developed an evaluation and rollout design to allow rigorous assessment of the impact of the RBF interventions described above on health related outcomes. Conceptually, the key objective of the impact evaluation is to assess the effectiveness of the package of supply and demand side interventions developed for and implemented in facilities and communities as part of The Gambia MCNHRP.

2.2 Scope of the impact evaluation

The impact evaluation was designed and baseline data were collected before the project was restructured to include Ebola preparedness or received additional financing for food and nutrition security. The impact evaluation does not, therefore, include explicit attention to the activities relating to food and nutrition security or Ebola preparedness that were introduced as a result of the restructuring and additional financing. In addition, the geographical scope of the impact evaluation remains that of the original project i.e. NBR-W, CRR and URR.

2.3 Aims of the impact evaluation

The overall research question of this impact evaluation is "Does RBF improve health status and the utilization and quality of maternal and child nutrition and health services in The Gambia?" The primary research questions are grouped according to three broad categories:

Effect on nutrition and health outcomes:

Do supply- and/or demand-side interventions improve:

- Maternal and child health and nutrition outcomes (e.g. child mortality, stunting, low birth weight)?

Effect on services and adoption of behaviors:

- Quantity of service utilization (e.g. skilled birth attendance, ANC, PNC, referrals from community to facilities, VAS, deworming, SAM treatment, OPD visits, uptake of contraception)?
- Adoption of healthy behaviors (e.g. breastfeeding, hygiene and sanitation practices, knowledge of IYCF)?
- Quality of service provision?

Effect on intermediate outcomes along pathways of impact:

Do supply- and/or demand-side interventions have an effect on:

- Perceptions of seeking care?
- Staff motivation and satisfaction? VSGs and communities?
- Out of pocket payments for MCH services?
- Baby Friendly Community Initiative (BFCI) implementation?[4]

[4] BFCI provides an entry point to address the nutritional and developmental needs of both mother and child at the community-level and also addresses environmental sanitation, personal hygiene, and equity.

- Health facility infrastructure and village development?
- Linkage between communities & health facilities?
- Supervision of facilities & communities by RHDs?
- Health facility staff availability?
- Three delays for delivery care?
- Awareness/knowledge at community level?
- Data reporting and management?

A mixed methods evaluation will be conducted based on a conceptual framework that details out the pathways of impact for both interventions. This will allow the evaluation team to untangle the mechanisms behind the main quantitative results found and explain the overall implementation effectiveness of the project.

2.4 Study design

The overall approach for the impact evaluation is a randomized phased in 2 x 2 design (Figure 4). The preliminary plan for the supply-side foresees facilities in the three target regions to be enrolled in the project in two phases. In discussion with the PIC, it was decided that each phase for the supply-side roll-out will last 18 months which should provide a sufficiently long time window to allow the impact evaluation team to observe behavioral change. In total, 22 facilities will be enrolled: 13 selected facilities were enrolled in Phase I (including the 3 facilities from the pilot project), and 9 facilities will be enrolled in Phase II.

Figure 4: Study design

		Supply-side RBF: Health Facility	
		Comparison	Treatment
Demand-side RBF: Community	Comparison	A	C
	Treatment	B	D

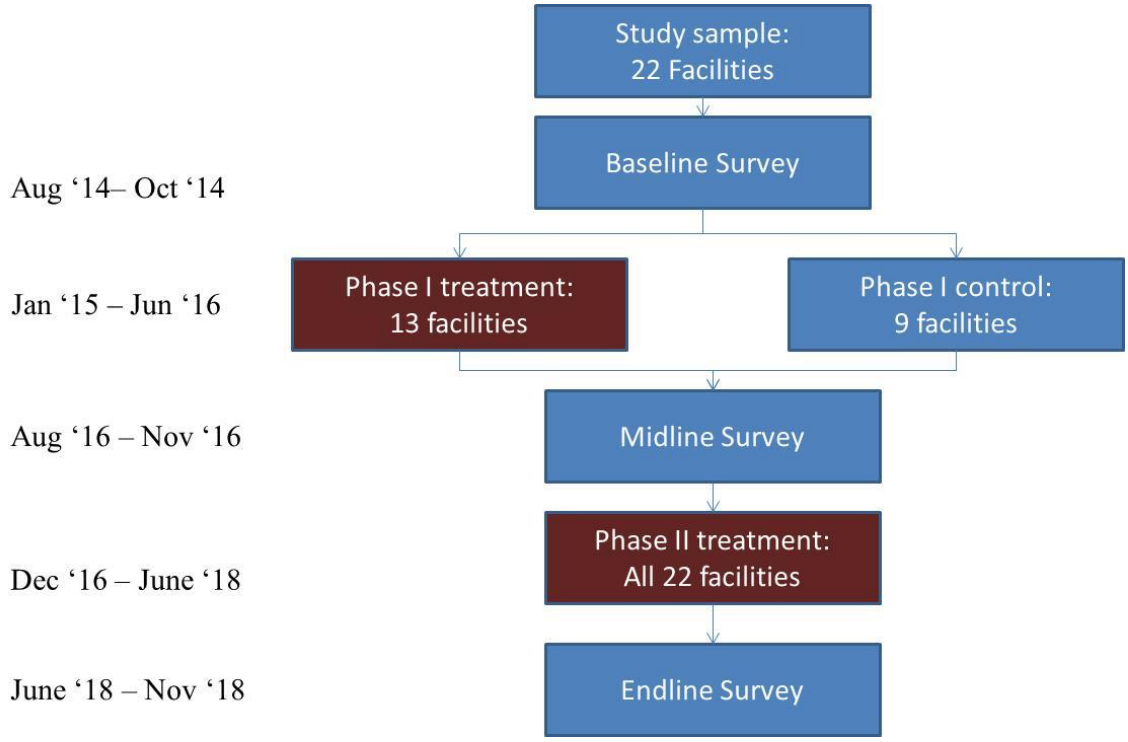
Group A: control group – receives neither the supply-side health facility nor the demand-side community RBF interventions
Group B: intervention group – receives the demand-side community RBF only
Group C: intervention group – receives the supply-side health facility RBF only
Group D: intervention group – receives both supply-side health facility and demand-side community RBF interventions

In addition to the supply-side interventions, some communities in the target regions will be enrolled in a community-based demand-side component, for which each phase will last 12 months. With an estimated target population of approximately 567,000 people we expect the

demand-side RBF intervention to work only with selected communities in each health center catchment area. There are more than 800 communities in the target areas overall; at the beginning of the project, a selection ceremony with key stakeholders (project team, Regional Governors, DCD, LGAs, MOHSW staff, RHDs) was held, during which approximately two communities were selected for the demand-side RBF in each facility catchment area (yielding a total of 50 communities). The rollout of the community incentive intervention will be spread out over 3 years; in year 1, a total of 60 communities (the 50 communities randomly selected plus the 10 pilot communities in the Jokadu district of NBR-W) will be targeted for the impact evaluation; in each of years 2 and 3 additional communities will be included. During the first year of the intervention, communities will work towards and receive payments against a given set of objectives. Objectives will be monitored (through LQAS) and rewarded on a quarterly basis in the first year. In the second year, communities will be asked to maintain the achieved targets; if they achieve this objective, a final payment is made at the end of the second year, when communities graduate from the intervention. It is important to note that the monitoring efforts will increase over time: in the first year of the intervention, a total of 60 communities will need to be monitored on a quarterly basis; in the second year, all the communities newly enrolled will need to be monitored on a quarterly basis, while 60 communities enrolled in year 1 will need to be monitored once at the end of their second year.

To measure the community-level impact of the project, three main surveys will be conducted: a baseline survey will be conducted at the beginning of the project; a midline survey approximately 18 months after project launch, and an endline survey after approximately 36 months of the project. Figure 5 summarizes the time line of the survey monitoring plan. We will have a mixed-method explanatory design with an embedded process evaluation to explore pathways of impact according to the conceptual framework outlined above.

Figure 5: Timeline for household and health facility surveys



Empirical Strategy

The principal empirical strategy for the impact evaluation is to compare changes in communities reached early by the interventions to changes observed in communities reached in later phases of the project. As outlined above, under the guidance of the MOHSW, the aim is to select 10 facilities plus the 3 facilities in the pilot for Phase I of the rollout, and the remaining 11 facilities for Phase II. In order to ensure fairness and transparency, the selection of Phase I and Phase II facilities was done in a formal public ceremony organized in cooperation with the MOHSW, where half of the facilities in each of target regions were randomly selected for Phase 1, and half of the facilities in each of the regions were selected for Phase 2. Given that the intervention will continue in the three facilities that participated in the pilot project, these three facilities were automatically part of Phase 1.

As described above, similar to the rollout of the supply-side intervention, a public ceremony was organized to select communities for the demand-side intervention. The staggered rollout of the interventions means that we will observe substantial variation in intervention exposure over the duration of the project. Figure 6 illustrates project coverage over time. The shaded areas highlight critical evaluation periods: the initial survey, which will provide baseline estimates for nutrition and health service utilization prior to the project launch (time 0 and the content of this

report). The second main period is the midline survey; the last critical time period is the time of the endline survey. The first main evaluation will happen at the time of the midline survey.

Figure 6: Number of communities under each intervention over time

Months since project started	**No Intervention**	**Demand side intervention only**	**Supply side intervention only**	**Supply side & active demand side intervention**	**Completed demand side intervention**
0	242	0	40	16	0
6	116	24	122	37	0
12	116	24	122	37	0
18	44	33	122	39	61
24	0	0	198	39	61
30	0	0	105	66	127
36	0	0	105	66	127

By the time the midline survey will be rolled out, 13 health centers will have been exposed to the facility PBF for at least 18 months; if the facility incentives affect utilization and health outcomes, we should observe that indicators in the areas targeted earlier improve more rapidly than the indicators in areas not yet reached by the facility PBF intervention. Similarly, for the demand-side interventions, a total of 127 communities will have been reached by the community RBF by the time of the midline survey; 61 communities will be in the second year of the intervention (graduation phase), while an estimated 66 communities (3 per health facility) will be in the first year of the intervention. If demand-side incentives work, we should observe more rapid improvements in Group 2 than in Group 1. We will also be able to test whether the demand-side intervention works better in combination with supply-side intervention: if it is the case, we should observe indicators in Group 4 to improve more rapidly than indicators in Group 2.

Figure 7: Number of survey areas under each intervention over time

Months since project started	**No Intervention**	**Demand side intervention only**	**Supply side intervention only**	**Supply side & active demand side intervention**	**Completed demand side intervention**
0	114	0	12	6	0
6	36	18	52	26	0
12	36	18	52	26	0
18	18	18	26	26	44
24	0	0	44	44	44
30	0	0	44	44	44
36	0	0	44	44	44

Figure 7 summarizes program coverage in the 132 enumeration areas covered by the impact evaluation. By the time of the midline survey, 18 areas will not have received any intervention at all and 18 areas will have received demand side interventions only. 26 areas will have supply side interventions only, and 26 areas will have received demand and supply side interventions. By the time of the endline, all areas will have received supply side interventions – the sample will be split evenly between supply side only, supply and active demand, as well as supply and completed demand side program.

The collection of the endline data will allow us to further assess the impact of both demand- and supply-side interventions. If it is true that these intervention packages work, we should observe larger improvements in health indicators between midline and endline for Group 1 than for Group 4, where the intervention package has stayed the same between the two surveys. The endline survey will also allow us to test whether demand side effects are persistent: if it is true that behavioral change sticks, we should observe that behaviors in communities targeted early are no different from behaviors in communities targeted in Phases II or III of the demand-side RBF intervention roll-out.

Inclusion of health facilities in the impact evaluation. All minor and major public facilities in the project regions are included for both the supply-side intervention and the evaluation – this yields 22 health centers in total (Table 2). Three of these facilities participated in the pilot project. Hospitals are for referrals only, and we have included Farafenni Hospital, which is not in the project regions, as the referral hospital for NBR-W as the regular referral hospital is inaccessible due to a ferry shutdown. There will be approximately equal number of facilities in intervention (13) and control groups (11).

Table 2: Regions and health facilities included in the project and impact evaluation (n=24)

Region	Project Health Facility	Included in IE (Yes/No)	Included in pilot (Yes/No)
North Bank Region West	1. Kerr Cherno	Yes	Yes
	2. Kuntair		
	3. Albreda		
	4. Essau Major Health Center		No
	5. Nema Kunku		
	6. Farefenni Hospital (Referral hospital for Essau)		
Central River Region	7. Bansang RCH Clinic	Yes	No
	8. Bansang Hospital		
	9. Janjanbureh		
	10. Karantaba		
	11. Brikamaba		
	12. Kudang		
	13. Dankunku		
	14. Kaur		
	15. Chamen		
	16. Kuntaur Major Health Center		
Upper River Region	17. Basse Major Health Center	Yes	No
	18. Ganbissara		
	19. Fatoto		
	20. Bajakunda		
	21. Yerobawol		
	22. Demba Kunda Koto		
	23. Koina		
	24. Diabugu		

*Private sector facilities are excluded from the interventions and the study.

2.5 Policy implications

At the national level, the close collaboration fostered by regular information exchange between the PIC, the World Bank operational team, and the IE research team will ensure that research findings can quickly be translated into adjustments to implementation as needed. Should the evaluation identify barriers to the successful implementation of the RBF interventions, weaknesses of the schemes, or unexpected negative effects on the coverage and quality of health

and nutrition services, the PIC – through NaNA and MOHSW – will be able to promptly intervene with adequate measures. The evaluation will also inform the Government and build the basis for the decisions on whether and how to expand the RBF approaches being piloted to other parts of the country.

At the international level, this study is expected to produce new evidence on the effects of both supply- and demand-side RBF interventions as well as the effect of community-level engagement on quality of and access to maternal and child health and nutrition services. The mixed methods approach adopted by the research team will be instrumental in this regard, allowing the research team not only to quantify the effects of the RBF interventions but also pathways through which such effects are produced. Furthermore, it can help identify potential barriers early on during implementation such that adjustments can be made for improved implementation. Understanding the pathways and identifying and explaining the intermediate outcomes are essential in informing relevant health policies and programs in The Gambia and elsewhere.

3. Baseline survey

The mixed-methods baseline survey was designed to collect data that could provide a cross-sectional overview of the situation at the beginning of the project period. It provides a baseline against which the impact of the project will be measured.

3.1 Baseline survey methods

Overview

As mentioned previously, the baseline survey provides a snapshot of the situation relating to maternal and child nutrition and health prior to project implementation. The methods for the baseline survey are described below. This constitutes the first round of evaluation data collection. Similar methods will be used for the midline and endline surveys.

A mix of quantitative and qualitative methods were employed for the baseline survey. The quantitative part of the evaluation relied on three main sources of data while the qualitative part of the study used both focus group discussions and key informant interviews with a wide range of stakeholders to elicit their perspectives on different issues relevant to maternal and child nutrition and health.

1. Quantitative assessments
    a. Household surveys: 2257 households, within which questionnaires were administered to two people
    b. Facility-based surveys: 24 health facilities in the study area, within which questionnaires were administered to the head of the health facility, health workers and women attending MCH services.
    c. Community-based surveys (VSGs, VDCs): 109 communities (approximately five for each facility), within which questionnaires were administered to members of the committees.
2. Qualitative assessments
    a. Focus group discussions: 27 FGDs of approximately 5-8 participants each.
    b. Key informant interviews: 20 interviews.

The various sources of data together constitute an IE with an embedded process evaluation that aims to not only answer the IE questions but also explain how the interventions are being implemented and why results are achieved (or not). The linking of the impact evaluation and process evaluation will enable a stronger explanation of results, and this overall approach is relatively novel for RBF evaluations – thus we hope to add to the evidence base in a new and more comprehensive manner.

Data collection

Quantitative data collection

A household survey targeted a random sample of women 15 and older in communities in 2259 households, and a facility survey directly targeted all 24 health facilities in the area.

For the household survey, two-stage cluster sampling was used to identify a random sample of approximately 100 households with i) at least one woman of age 15 or older and ii) at least one child under the age of five from the catchment areas of each facility. To identify these women, we first randomly selected five enumeration areas from the catchment areas of each of the 24 facilities using probability proportional to population size (based on the latest census estimates); in all selected enumeration areas, a household listing was conducted. From all eligible households listed, 20 households were selected for the survey. (We used the recent census enumeration areas as well as well-defined health facility catchment area assignment to do a mapping.). Within each household, questionnaires were administered to the head of the household and the mother of the youngest child. For the latter, the mother has to be aged at least 15 years and the child under 5 years for inclusion. During the interviews, the following information was collected:

- Household size, assets, income and poverty level
- Household member education
- Respondent education and health knowledge
- Health expenditure
- Mortality within the household
- Pregnancy history
- Health care utilization for recent births, including ANC, delivery and PNC
- Breastfeeding behaviors
- Health care utilization for children, including child health checkups, vitamin supplements and vaccines received
- Child morbidity: fever, diarrhea, and respiratory infection in the 2 weeks preceding the survey
- Child anthropometrics: height, weight and mid-upper arm circumference
- Satisfaction with health services, including distance, opening hours, attitudes, available services
- Satisfaction with community outreach activities
- Perceptions of community activities
- Perceived control/autonomy regarding if/when to seek health care

See Annex 1 for the full household survey.

The facility survey that was administered to officers in charge focused on facility services; in particular, we assessed the following variables, primarily the key behavioral attributes and intermediate outcomes:

- Key behavioral attributes (understanding, expectancy, valence, buy-in, perceived fairness)
- Staff availability and presence
- Overall conditions of facility (quality check list)
- Basic functionality: electricity, water
- Staff turnover
- Staff satisfaction and motivation
- Teamwork and collaboration
- Communication
- Awareness and clarity of priorities
- Demand for knowledge
- Perceived control/autonomy
- Transparency and accountability
- Use of data for decision making.

See Annex 2 for the full health facility survey.

Within health facilities, a survey was also administered to health workers. Below are the primary topics that were covered:

- Training
- Working hours
- Salary and other compensation
- Supervision
- Satisfaction and motivation
- Teamwork and collaboration
- MCNH knowledge
- Awareness of the MCNHRP

See Annex 3 for the full health worker survey.

Exit interviews were carried out with women attending ANC services and caregivers who had brought children under five to attend outpatient services. The main domains covered in these interviews were:

- Services received
- Satisfaction with services
- Costs incurred
- Household amenities and assets
- Use of community health services

See Annexes 4 and 5 for the surveys for women attending ANC services and caregivers of children attending under-five out-patient services, respectively.

For the household and facility surveys, the standard HRITF instruments were modified to reflect the above variables. Compared to the standard instruments, there was more emphasis on measuring the intermediate variables (e.g. organizational changes) with a heavier focus on behavioral elements (e.g. motivation, understanding, teamwork, etc.) for actors involved in order to map the pathways of impact as per the conceptual framework for each intervention.

Overall, surveys were administered to the officer in charge of each of the 24 health facilities and a total of 94 health workers working in maternal and child health services. Exit interviews were administered to 150 women attending ANC services and 160 caregivers of children aged under 5 attending out-patient services.

The community-based survey was administered to members of VSGs and VDCs focusing on the key behavioral attributes and expected intermediate outcomes:

- Key behavioral attributes (understanding, expectancy, valence, buy-in, perceived fairness)
- Knowledge of healthy behaviors/recommended practices
- Perceptions of community nutrition and health services
- Traditional beliefs regarding health and nutrition
- Motivation and job satisfaction
- Intensity and quality of services
- Capacity to manage RBF project
- Village development regarding health and nutrition
- Community ownership of health and nutrition outcomes

See Annexes 6 and 7 for the full community-based survey.

This survey was administered to 109 VDC members and 108 VSG members.

All quantitative data collection was carried out using tablet computers, with data uploaded to a 'cloud' system for verification as soon as network allowed.

Participant enrollment

Table 3 summarizes total planned and actual participant enrollment for the baseline evaluation.

Table 3: Quantitative data collection

Location	Planned # Locations	Actual # Locations	Participants	Planned # Participants/ location	Actual # Participants/ location
Households	2400	2259	Head of household	1	1
Households	2400	2259	Mother of youngest child <5	1	1
Health facilities	24	24	Officer in charge	1	1
Health facilities	24	24	Health workers	4	4
Health facilities	24	24	Women attending MCH services	8	13
Community	120	109	Village Development Committee	5	1
Community	120	108	Village Support Group	5	1

Qualitative data collection

The qualitative assessments were conducted to map the pathways of impact as illustrated in the conceptual framework (Figure 2 and Figure 3), to help provide an explanation of the quantitative results, and to allow for more in-depth exploration of topics of particular interest. A combination of focus group discussions and in-depth interviews was utilized. Table 4 shows the range of respondents who participated in focus group discussions and interviews.

During the interviews and focus group discussions, the following themes were explored, varying slightly by target group:

- Uptake of MNCH services
- MNCH-related knowledge and beliefs
- Family planning knowledge, attitudes and practices
- Availability, accessibility, acceptability and quality of health services
- Barriers to accessing services
- Work-related behaviors (Motivation & Morale, Teamwork & Collaboration, Communication, Awareness, Perceived Control, Demand for Knowledge)
- Awareness and understanding of the MCNHRP
- Key behavioral attributes (understanding, expectancy, valence, buy-in, perceived fairness)

A sample interview guide and focus group discussion guide are available in Annexes 7 and 8.

Participant enrolment

Table 4 summarizes planned and actual participant enrollment for the qualitative data collection.

Table 4: Qualitative data collection

Focus Group Discussions					
Level	**Target population**	**Planned**		**Actual**	
		Per region	**Total**	**Per region**	**Total**
National	RBF Committee		1		1
	NaNA		1		1
	Steering Committee		1		0
Regional	Regional Health Directorate		0	1	3
Health facility	Facility Staff	3	9	1	3
	Catchment Area Committee		0	1	3
Community	VDC members	2	6		0
	VSG members	2	6		0
	VDC & VSG combined		0	1-2	5
	Women	2	6	2	6
	Men	2	6	1-2	5
	Adolescent girls	2	6		0
Total			**42**		**27**
Interviews					
Level	**Target population**	**Planned**		**Actual**	
		Per region	**Total**	**Per region**	**Total**
Regional	Regional Health Directorate Directors	1	3		0
Health facility	Officer-in-charge	3	9	1	3
Community	Community Health Nurse		0	1	3
	TBA		0	1-2	5
	"Vulnerable women"[1]		0	2-4	9
	Village chiefs	2	6		0
Total			**18**		**20**

[1] No specific definition of vulnerability was followed but researchers suggested that it might encompass young women, unmarried women, widows, particularly poor women, or women who were otherwise socially isolated. Community leaders then suggested interview participants.

These numbers were designed with regional balance in mind and to ensure that saturation could be achieved (i.e. that it is unlikely that additional themes would emerge if extra interviews/FGDs were carried out). Although fewer focus group discussions and interviews were carried out than originally planned, this was deemed a more practical number given the constraints of timing for the field work. Furthermore, it was not felt that this would diminish the quality of the data.

Data analysis

Prior to the initiation of data analysis, a full analysis plan was elaborated based on the project's conceptual framework. It included details of which variables were to be included and how they should be disaggregated. Quantitative data was cleaned, merged and anonymized before analysis. Summary statistics of key outcome variables and covariates were produced and are presented here. Tests to assess statistical differences between different groups were not run so the results presented are all descriptive and any commentary on differences should not be construed as statistically-based conclusions.

For the qualitative data, a framework for analysis was developed derived initially from the project's conceptual framework and pathways of impact, and refined using themes emerging from the data. Transcripts were read several times as a process of data immersion and to understand the data in their entirety. They were then re-read specifically to identify emerging taxonomies and themes. A coding scheme that reflects the framework for analysis and additional emerging themes was applied to facilitate thematic analysis. Continuous and iterative hypothesis generation and testing throughout the analysis allowed for continual refinement of themes and ensured that the insights provided by the data could be adequately captured. Qualitative data were analyzed alongside initial findings from the quantitative baseline survey.

Data storage and access policy

Data storage

The questionnaire data has been divided into eight databases:

- The household roster where one observation corresponds to one person in each of the 2226 households
- The household survey
- The health facility main respondent survey
- The health worker survey
- The ANC exit interviews
- The Under-five services exit interviews
- The VDC survey
- The VSG survey

Anonymous data files will be created by removing the following information:

- Health facility names

- Global Positioning System (GPS) coordinates
- Community names
- Names of individuals

Anonymous files will be sent to the World Bank and the Harvard School of Public Health. The University of Southern California will store two files – one with anonymous data and one with identification but with the data removed. The two files will be able to be linked using a third file including identification and kept in a different computer, not on the server.

Qualitative transcripts have been anonymized by removing the following information:

- Health facility names
- Community names
- Names of individuals

Transcript file names are coded to indicate the type of respondent and the location of the interview/FGD. The codesheet is saved on a separate computer from the transcripts at the University of Southern California. Anonymized transcripts will be sent to the World Bank.

Data access

The impact evaluation team will work together on further analyses and publications from these data. No analyses or publications will be carried out without written approval from the PI of the impact evaluation, the World Bank project Task Team Leader (also co-PI on the impact evaluation) and the Project Coordinator of the MCNHRP.

In the event of a person external to the project requesting to use the data, a contract for data access and utilization will be created. This contract will ask the person requesting the data to:

- use the data only in the framework of the project specifically mentioned and defined in the contract
- not transmit the data to other persons
- protect data access and data confidentiality
- inform the PI and World Bank project Task Team Leader of any problems encountered when analyzing the data
- ensure that the data source is acknowledged and appropriate authorships rules are followed in the production of results and publications.

The authorships rules are as follows: Core members of impact evaluation team are co-authors of the publications and authorship has to be discussed with the PI and Task Team Leader in advance of any publications. The intellectual process which leads to publication includes 5 steps: 1/ development of the study design 2/ design of the data collection instruments and sampling procedures, 3/ study implementation, data collection and quality control, 4/ analysis and interpretation of data, 5/ drafting or editing the paper. Anyone who significantly contributed to at least two steps is a co-author. The first author is the person who coordinates the writing effort and participates in at least one of the other steps.

A full version of all published papers or conference presentations will be sent to the two responsible persons mentioned above.

Ethical review and clearance

Ethical clearance for the impact evaluation was obtained from The Gambia Government/MRC Joint Ethics Committee as well as the Ethics Review Committee of the University of Southern California.

3.2 Baseline survey report

This report presents the findings of the baseline survey, which constituted the first round of data collection for the impact evaluation. It provides an overview of the situation with regard to knowledge, attitudes and behaviors in relation to maternal and child nutrition and health in NBR-W, CRR and URR prior to the start of the project.

The next section, Section 4, provides information on the baseline survey study sample, outlining its characteristics and representativeness within The Gambia. Section 5 of the report constitutes the main findings of the baseline survey. These are presented sequentially by topic: women's health, breastfeeding, family planning, child health, child nutrition, household health, environmental sanitation, and health system. Quantitative and qualitative findings are presented jointly in each topic area. In Section 6, the validity of the study design is assessed. Finally, recommendations for survey improvement are presented in Section 7.

4. Sample characteristics and representativeness

The main objective of the survey conducted was to assess health and health services in the three of the nation's seven health regions included in the MCNHRP: NBR-W, CRR and URR. These areas cover approximately one-third of the national population, and are among the country's poorest regions with low maternal and child health service utilization rates. As outlined above, three principal types of data were collected: target population data, health facility data, and community group data. Data on the target population (households, mothers and children) were collected through a standard household questionnaire. Data on health facilities were collected through a mix of interviews with staff members and exit interviews with mothers. Data on community activities were collected through interviews with members of the VDC and VSG.

4.1 Household survey sampling and household characteristics

Because community-level interventions associated with the MCNHRP require that organizational support be in place in communities that participate in the study, only settlements with active participation in the MOHSW-implemented PHC and the NaNA-implemented Baby Friendly Community Initiative (BFCI) programs were eligible for the MCNHRP and, thus, also the survey. While all villages are eligible to participate in the BFCI in principle, PHC villages must have a community health nurse, and tend to be larger (≥ 400 people) than non-PHC villages. A total of 298 villages (750 enumeration areas) were identified that had both an active PHC system and an active BFCI.

In order to get a representative sample of households from eligible areas, 132 of these enumeration areas (EAs) – 6 EAs for each of the 22 minor or major health centers – were randomly selected for the study using population weighted proportional probability sampling.

Household definition and household selection

For sampling and interview purposes, households were defined as the core family unit of the primary female respondent. This household unit typically includes the woman herself, her children, and the father of her children. In contrast, many previous surveys in The Gambia have defined a household as the extended family unit living within a compound. The Demographic and Health Survey (DHS) defines a household as: "a […] person or group of related or unrelated persons who live together in the same dwelling unit(s) or in connected premises, who acknowledge one adult member as the head of the household, and who have common arrangements for cooking and eating". This definition (also used in the Multiple Indicator Cluster Survey (MICS) survey) includes not only the regular members of the extended household,

but may also include guests who had spent the night prior to the survey at the home. The focus on the "nuclear" family chosen for this study implies substantially smaller average household size for obvious reasons, but also somewhat lower asset holdings in cases where assets are shared within compounds but not owned by specific nuclear household members.

Given the MCNHRP's focus on maternal and child nutrition and health, only households with women and children were targeted and included in the study. The specific criterion chosen for study eligibility was the presence of at least one woman aged 15 or older who had given birth within the five years prior to the survey. While the focus on households with women of reproductive age is fairly standard in other survey programs such as the national DHS and the MICS, DHS include all women of reproductive age independent of their birth histories. The study sample analyzed in this report is restricted to women with recent births, and thus excludes (mostly young) women who have never given birth as well as those (slightly older women) who have not given birth in recent years.

For household selection, all households were listed in each EA initially; 19 households were then randomly chosen for the survey. When EAs had fewer than 19 eligible households, all households were automatically selected for the study.

Household interviews

As described above, a total of 132 EAs were selected from a total of 750 eligible EAs. Given the focus on nuclear family households, most households had only one woman with recent births. In cases where the nuclear household contained two women, the woman with the most recent birth was selected for the study. Table 5 shows the geographic distribution of EAs and households selected for the study. A total of 2,226 households and women were interviewed across 131 enumeration areas.[5] Given the larger number of minor and major health centers in URR and CRR, relatively larger numbers of households (34.3% and 41.9%, respectively) were interviewed in these two regions.

Table 5: Household Interviews by Region

Region	Number of enumeration areas selected	Number of household interviews	Percent of household interviews
CRR	53	932	41.9%
NBR-W	30	530	23.8%
URR	48	764	34.3%
Total	131	2,226	100.0%

[5] Data from one of the original 132 enumeration area was lost due to technical difficulties with one of the tablet computers being used for data collection.

Figure 8 shows the overall age distribution among household members in the sample. Given the continued high fertility rates in the country, the study population is very young, with more than 50% of household members (6586 out of 11,283 members) younger than 15 years of age.

Figure 8: Age distribution of household members

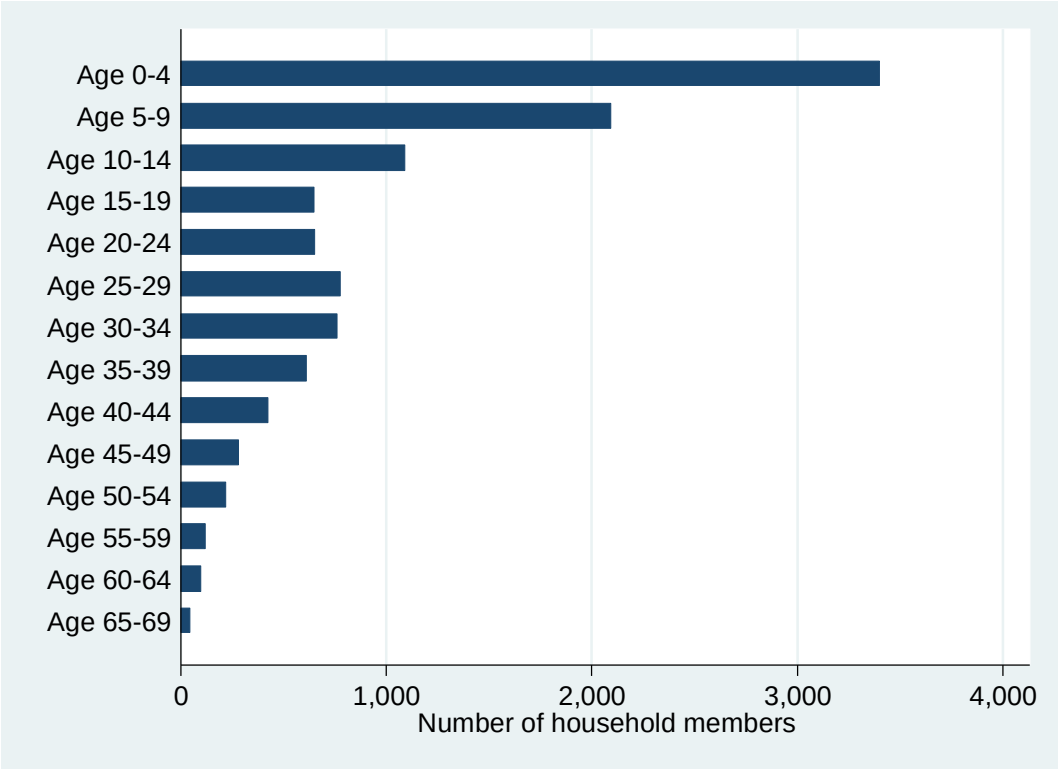


Figure 9 shows the age distribution for women interviewed in the study. Given that the primary respondent had to have a least one birth in the past five years, the age structure of respondents looks somewhat different, with women ages 25-29 being the largest group, and relatively few women under the age of 20 and over the age of 39.

Figure 9: Age distribution of women interviewed

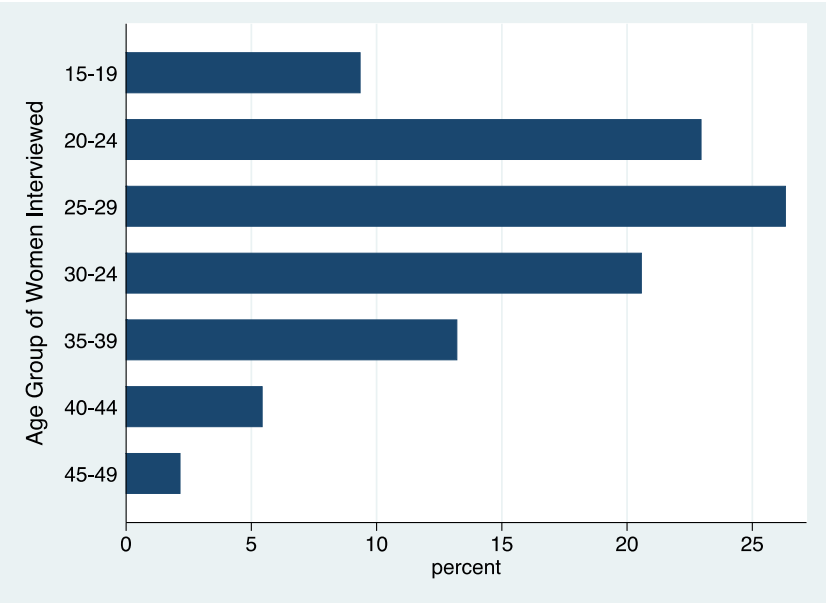


Table 6 shows literacy rates by age group; on average, only 24.9% of women are literate, with somewhat higher rates for younger women; however, even under age 20, literacy is very limited, with less than one third of women considering themselves literate.

Table 6: Literacy rate of women interviewed by age group

Age Group	Percentage Literate
15-19	30.3%
20-24	31.3%
25-29	25.8%
30-34	19.7%
35-39	22.1%
40-44	19.8%
45-49	4.2%
Total	24.9%

Table 7 summarizes the age distribution for children under five in our sample. There were 3,402 children under five in our sample, an average of slightly more than 1.5 per household. Given the focus on the most recent births, the age distribution is slightly skewed towards children under 1, who account for 31% of all children under 5 in the sample.

Table 7: Children under the age of five by one-year-age group

Age	Frequency	Percent	Cum. Percent
0	1056	31.0	31.0
1	638	18.8	49.8
2	637	18.7	68.5
3	593	17.4	85.9
4	478	14.1	100.0
Total	3402	100.0	

Table 8 shows the ethnic distribution across the three regions. The largest ethnicity overall was Madinka/Jahanka (30.8%), followed by Wolof (22.6%) and Fula/Tukulor (20.2%). Wolof was the largest group in CRR and NBR-W, while Sarahule was the largest ethnicity in URR.

Table 8: Ethnicity, head of household by region

	CRR	NBR-W	URR	All Regions	Percent of Total
Mandinka/Jahanka	293	116	277	686	30.8%
Fula/ Tukulor	238	128	84	450	20.2%
Wolof	327	174	1	502	22.6%
Jola/Karoninka	3	10	1	14	0.6%
Sarahule	64	13	387	464	20.8%
Serere	1	52	1	54	2.4%
Manjago	0	11	0	11	0.5%
Total	932	530	764	2,226	100.0%

4.2. Health facility sampling and health facility characteristics

Given the relatively small geographical area and population covered by the study, all health facilities in the target area were identified and assessed for the study. The 24 health facilities in the target area (and study sample) can be grouped into 3 categories: hospitals (2), major health centers (3) and minor health centers (19).

Health facility categories and service provision

Health facilities are categorized based on the type of health services offered and the level/cadre of the health staff within the facility. Minor health centers offer up to 70 percent of the Basic Health Care Package needs of the target population, and are supposed to have 20-40 beds per 15,000 people within their catchment area. Major health centers offer the same services as minor health centers and should additionally have an operating theater, a radiology laboratory and the

ability to perform blood transfusions among other services. Major health centers are also supposed to be staffed with medical officers and registered nurse midwives, two cadres not found in minor health centers. Hospitals offer all the services offered by minor and major health centers, but focus more on specialized care. Hospitals usually cover a population of at least 200,000 people, with 150 to 300 beds available.

Table 9 gives a breakdown of the 24 facilities according to facility type and region. There are only two hospitals – one in CRR and one for NBR-W. The AFPRC Hospital is technically in North Bank Region East, but was included in the study because it serves as the primary referral hospital for all health centers in NBR-W.

Table 9: Health facility breakdown by region and facility type

Region	Hospitals	Major health centers	Minor health centers	Total
CRR	1	1	8	10
NBR-W	1	1	4	6
URR	0	1	7	8
Total				24

Health facility staff and health worker interviews

As part of the survey, a detailed assessment of all health facilities was conducted. At the beginning of the assessment, all current health workers were listed by senior facility staff. At each facility, 4 health workers were then selected for more detailed interviews. In Kudang and Sami Karantaba only 3 staff members were present at the time of the facility visit due to ongoing staff training on maternal and neonatal health, resulting in a final sample total of 94 health worker interviews conducted across the 24 health facilities.

Table 10 provides an overview of the health workforce employed. A total of 740 health workers were listed across the 24 facilities, with nurses and midwives accounting for approximately half of total staff. The largest number of interviews were conducted with nurses (60), which includes both state enrolled nurses (SEN) and state registered nurses (SRN) (27), Community Health Nurses (18) and midwives (17).

Table 10: Health facility staff

Health Facility Cadre	Total staff members	Percent of staff members	Number of staff members interviewed	Percent of interviewed staff
Doctor or Medical officer	51	6.9	3	3.2
Nurse (SEN/SRN)	244	33.0	27	28.7
Midwife (SCM/SEM)	131	17.7	15	16.0
Public Health Officer	50	6.8	23	24.5
Nursing assistant	71	9.6	3	3.2
Lab technician	11	1.5	3	3.2
Community Health Nurse	42	5.7	18	19.1
Other, specify	140	18.9	2	2.1
Total	740	100	94	100.0

As part of the facility assessments, exit interviews were conducted with women visiting the facilities for antenatal care (ANC) visits. A total of 150 exit interviews were conducted. As Table 11 shows, a quarter of the women (38/150) interviewed for the ANC exit survey said that this was their first pregnancy, while 26 percent of the women interviewed (39/150) said that this was their first ANC visit for this pregnancy.

Table 11: ANC visit characteristics

	First pregnancy	*First ANC visit*
Region		
CRR	29.8%	31.9%
NBR-W	25.0%	27.3%
URR	22.0%	20.3%
Can read and write		
No	18.3%	26.1%
Yes	48.6%	25.7%
Wealth Quintile		
Lowest	14.3%	42.9%
Second	14.3%	35.7%
Third	42.9%	0.0%
Fourth	29.4%	35.3%
Highest	24.2%	26.3%
Total	25.3%	26.0%

Notes: Based on a total of 150 ANC exit interviews

Exit interviews were also conducted with caregivers of children under the age of five. A total of 159 such exit interviews were completed. As Table 12 shows, virtually all caregivers came to the

facility due to acute illness of their child. The most common symptom reported by parents was fever (83.6% of children), followed by cough (45.3%) and diarrhea (22%).

Table 12: Characteristics of child visits

	Child has fever	*Child has diarrhea*	*Child has cough*	*Frequency*
Region				
CRR	76.5%	19.6%	37.3%	51
NBR-W	81.8%	27.3%	45.5%	44
URR	90.6%	20.3%	51.6%	64
Household head went to school				
No	85.6%	22.1%	49.0%	104
Yes	80.0%	21.8%	38.2%	55
Household has electricity				
No	83.6%	21.8%	44.5%	110
Yes	83.7%	22.4%	46.9%	49
Total	83.6%	22.0%	45.3%	159

Notes: Based on a total of 159 exit interviews with caregivers of children under the age of 5. Data was missing for one person.

4.3 Community surveys

As mentioned above, a total of 132 enumeration areas were selected for the study. Enumeration areas typically have a population size of about 500, which means that larger settlements often have multiple enumeration areas. In each of the 109 communities or settlements in our sample, two questionnaires were administered: the VDC survey and the VSG survey. As Table 13 shows, a total of 109 VDC and a total of 108 VSG interviews were conducted. One settlement in URR (Sandi Kunda) reported not having a functioning VSG, so the VSG questionnaire was not administered.

Table 13: Community questionnaire breakdown by region

	VDC		*VSG*	
	Interviews	*Percent*	*Interviews*	*Percent*
CRR	50	45.9%	50	46.3%
NBR-W	27	24.8%	27	25.0%
URR	32	29.4%	31	28.7%
Total	109	100.0%	108	100.0%

5. Findings

5.1 Women's health

Maternal health

Maternal and neonatal complications for most recent birth

The tables below show the prevalence of complications and warning signs for women during pregnancy (Table 14), at delivery (Table 15) and after delivery (Table 16) for their most recent birth. Of the 2,208 women interviewed, 70% reported complications during their most recent pregnancy. NBR-W saw the lowest prevalence for women reporting complications with 63%, followed by URR (69%) and CRR (76%) respectively.

Ten percent of the women interviewed reported they experienced severe bleeding during pregnancy. By region, CRR had the highest proportion with 12% compared to 9% in URR and NBR-W. Women living near a facility were less likely to experience severe bleeding during pregnancy (9% compared to 13%). Women in CRR were more likely to report that the baby stopped moving (15%) and that they experienced blurred vision while pregnant (52%).

Table 14: Prevalence of antenatal and perinatal complications for most recent birth

	During Pregnancy				
	Complications during Pregnancy[1]	Severe bleeding in pregnancy	Abdominal pain in pregnancy	Baby stopped/slowed while pregnant	Blurred vision while pregnant
Region					
CRR	75.5%	11.6%	58.0%	15.2%	52.0%
NBR-W	62.6%	8.9%	46.1%	14.2%	40.1%
URR	69.1%	8.8%	51.7%	12.7%	36.9%
Female respondent is literate					
No	69.7%	10.6%	53.4%	14.8%	44.9%
Yes	71.7%	8.3%	51.8%	12.1%	41.2%
Wealth Quintile					
Lowest	73.2%	14.0%	56.5%	15.1%	46.2%
Second	72.7%	8.8%	53.5%	17.4%	52.8%
Third	66.9%	8.1%	48.0%	12.2%	40.1%
Fourth	69.6%	10.0%	51.2%	14.1%	41.7%
Highest	68.6%	9.3%	55.8%	11.7%	39.1%
Gov't Hospital or HC in village					
No	69.0%	12.5%	54.1%	9.7%	46.9%
Yes	70.6%	9.3%	52.7%	15.4%	43.1%
Total	70.2%	10.0%	53.0%	14.1%	44.0%
N	2,208	2,208	2,208	2,208	2,208

Note: All data are based on women interviewed who had attended ANC at least once (n=2,208)
[1] Complications during pregnancy include: bleeding, abdominal pain, baby slowed or stopped moving, or blurred vision. Data was not available for 18 women.

Approximately 2% of women reported having had a C-Section at delivery, with rates being lowest in URR and highest in CRR. The reported prevalence of bleeding more than normal during delivery in CRR (48%) was more than twice that in NBR-W (22%) and substantially higher than in URR (39%).

Table 15: Prevalence of complications during and after delivery for most recent birth

	C-Section[1]	Seizure at delivery*	Bleeding at delivery*	Abdominal Pain at delivery
Region				
CRR	3.4%	14.0%	48.2%	57.6%
NBR-W	2.3%	12.3%	21.7%	41.1%
URR	0.8%	10.6%	38.6%	51.5%
Female respondent is literate				
No	2.0%	12.9%	36.5%	52.7%
Yes	2.9%	11.1%	34.1%	48.2%
Wealth quintile				
Lowest	2.6%	21.7%	43.5%	55.6%
Second	2.3%	13.6%	33.3%	54.3%
Third	2.0%	7.8%	40.3%	45.5%
Fourth	2.5%	10.6%	31.8%	52.9%
Highest	1.9%	11.5%	32.0%	49.5%
Govt' hospital or HC in village				
No	2.4%	14.2%	36.6%	48.0%
Yes	2.2%	11.8%	35.5%	52.6%
Total	2.3%	12.4%	35.7%	51.5%
N	2,166	1,050	1,050	2,167

Note: Columns 1 and 4 are based on all women who delivered irrespective of the location of delivery; Columns 2 and 3 are based on 1,050 women who had delivered at a health facility.
[1] Data not available for 60 women.

Seventy-one percent of women reported at least one postpartum complication (abdominal pain, bleeding or headache), and less than one in five of these women was referred. With considerable variation by region, a third of the women surveyed reported having experienced bleeding after delivery. NBR-W had a substantially lower percentage of women who complained of bleeding after delivery (19%) compared to CRR (34%) and URR (40%). Literate mothers were less likely to report having experienced bleeding after delivery (29%) compared to illiterate mothers (34%). A woman was most likely to be referred if she lived in NBR-W (36%) and least likely to be referred if she lived in URR (12%). Approximately 11% of women reported neonatal complications (as defined by the neonate having trouble breathing). Women in NBR-W were least likely to report that their baby had trouble with breathing (5%), compared to 8% in URR and 16% in CRR.

Table 16: Post-partum and neonatal complications

	Abdominal pain after pregnancy	Bleeding after delivery	Severe. Headache after delivery	Referral among those with PP Complications[1]	Neonatal Complications[2]
Region					
CRR	57.6%	34.5%	51.8%	15.7%	15.9%
NBR-W	41.1%	19.2%	36.1%	30.5%	5.4%
URR	51.5%	40.4%	44.1%	12.2%	7.8%
		Female respondent is literate			
No	52.7%	34.2%	45.8%	16.6%	11.1%
Yes	48.2%	28.8%	44.2%	19.4%	9.1%
Wealth Quintile					
Lowest	55.6%	33.7%	47.0%	17.9%	11.7%
Second	54.3%	35.9%	48.4%	18.8%	11.8%
Third	45.5%	31.8%	42.5%	13.9%	8.6%
Fourth	52.9%	33.0%	46.2%	18.4%	9.5%
Highest	49.5%	29.6%	43.1%	16.9%	11.3%
		Gov't Hospital or HC in village			
No	48.0%	23.4%	43.8%	25.1%	4.9%
Yes	52.6%	35.6%	45.9%	15.2%	12.2%
Total	51.5%	32.8%	45.4%	17.3%	10.6%
N	**2,166**	**2167**	**2167**	**1536**	**2166**

[1] Among 1,536 women reporting postnatal complications.
[2] Neonatal complications are defined as trouble breathing. Data is not available for 60 infants.

Stillbirth and low birth weight

Data on experiences of miscarriage/abortion, stillbirths and low birthweight were collected in the household survey and are presented in Table 17 below.

Approximately 9% of women reported having experienced a miscarriage or abortion. Only 1 percent of mothers said they had a pregnancy that ended in a stillbirth. Two percent of women in CRR reported a pregnancy that ended in stillbirth, which was the highest of the three regions; with URR (1%) and NBR-W none.

Of the 2,226 women interviewed, 1,051 had their infant weighed (and were thus asked the question about birth weight). Of these weighed infants, health cards of 723 (69%) were shown to the enumerators to verify the weight of the child at birth. Given that the enumerators could verify almost 70% of the birth weights, there is good confidence in the results obtained. For the women who had their infants weighed, 11% had a baby with a low birth weight (LBW) (defined as <2.5kg). The differences in LBW by region, literacy and wealth are negligible.

Table 17: Perinatal outcomes

	Ever had a miscarriage or abortion (% of women)	Last birth ended in a stillbirth (% of women)	Low Birth Weight of <2.5kg (% of infants weighed at birth)
Region			
CRR	7.8%	1.9%	11.5%
NBR-W	7.7%	0.2%	9.7%
URR	10.6%	1.3%	10.9%
Female respondent is literate			
No	8.8%	1.6%	11.0%
Yes	8.7%	0.4%	9.9%
Wealth Quintile			
Lowest	5.7%	1.6%	13.7%
Second	8.9%	2.0%	11.7%
Third	9.5%	0.7%	11.7%
Fourth	10.4%	0.9%	9.7%
Highest	9.2%	1.3%	8.1%
Gov't Hospital or HC in village			
No	6.0%	2.2%	11.8%
Yes	9.6%	1.0%	10.3%
Total	8.8%	1.3%	10.7%
N	2,133	2,226	1,051

Note: Low birth weight estimates based on 1,051 (47.2%) of women who reported that their infant had been weighed at birth.

Understanding women's nutrition during pregnancy can help shed light on data relating to low birthweight. In focus group discussions, health workers and VDCs/VSGs described providing pregnant women with information on an appropriate diet based on locally available foods to try to ensure a balanced diet and adequate iron intake.

A range of traditional beliefs were described that might negatively affect pregnant women's nutrition. In CRR, these included: pregnant women not being allowed to eat the meat of a cow slaughtered when it was in its early months of pregnancy for fear of losing the baby she is carrying; eating clay or charcoal; and not eating bread during pregnancy for fear of the child growing large and leading to complicated labor. In URR the traditional beliefs mentioned included: women not eating roasted meat in case it makes them bleed heavily during delivery; not eating eggs or pawpaw as they might make the child dumb; and not eating too much fish as this might make the child a thief. However, some interview respondents said that these beliefs

were declining thanks to awareness creation activities and that most women strive to eat a balanced diet when pregnant.

An officer-in-charge in URR remarked that anemia was particularly high among the Fula, which he attributed to their diet, helminthic infections and lack of spacing between births. A community health nurse in a different community in URR also commented on very high prevalence of anemia among pregnant women. Poverty was acknowledged as a contributing factor to anemia as some people could not afford to eat an iron-rich diet.

Maternal and child deaths

As opposed to the other tables above, data in Table 18 are taken from the interview with the head of the health facility during which data were verified in the facility registers. Each facility was asked how many total deliveries and neonatal and maternal deaths occurred both at the facility and within the communities it serves. 'Total facility deliveries' includes spontaneous vaginal deliveries, assisted deliveries (which includes forceps and vacuum) and C-sections.

The table shows the average number of deaths (neonatal and maternal) at both facility and community levels including disaggregation by region. NBR-W has the highest number of neonatal deaths – this corresponds with the highest number on average at the community level (4.3 deaths per facility catchment area) compared to 1.0 for CRR and 1.1 for URR). At the facility level, CRR facilities have the highest average number of neonatal deaths, at 7.7 per facility. URR and NBR-W facilities have a considerably lower tally for neonatal deaths at 1.3 and 1.4 on average respectively.

There were no maternal deaths registered at the community level for CRR, but NBR-W and URR each had an average maternal death per facility catchment area of 1. As with neonatal deaths, CRR also has a higher number of maternal deaths per facility at 3.5 maternal deaths per facility. URR and NBR-W have significantly lower maternal deaths per facility at 0.9 and 0.6 maternal deaths per facility respectively.

Table 18: Neonatal and maternal deaths in health facilities and in communities

	Total facility deliveries*	Average number of neonatal deaths in facility	Average number of neonatal deaths in communities	Average number of maternal deaths in facility	Average number of maternal deaths in communities
Region					
CRR	474	7.7	1.0	3.5	0.0
NBR-W	691	1.4	4.3	0.6	1.0
URR	611	1.3	1.1	0.9	1.0
Total	574	3.8	1.9	1.8	0.6

Note: Facility deliveries – which includes vaginal deliveries, assisted deliveries (forceps and assisted) and C-sections – corresponds to 47% of total deliveries in the project area. The remaining 53% occurred within communities.
* Survey collected data on deliveries for the 3 months preceding the survey. To arrive at an annual figure, total facility deliveries for the past 3 months were multiplied by 4.

Utilization of services

Women were asked a series of questions about their experiences with maternal health care services, including utilization of antenatal, delivery, and postnatal care as well as any complications they may have had and their perceptions of the quality of the care received.

The survey findings suggest that receiving antenatal care (ANC) at least once during the pregnancy is universal in the study area, reportedly utilized by all women who provided complete information on maternal care utilization – see Table 19.[6] However, early ANC remains very low with only 8% of these women scheduling their first appointment within the first twelve weeks of their pregnancy. While still at a low level, women in URR were approximately twice as likely to report early ANC as were women in CRR or NBR-W. Sixty-eight percent of women received four or more ANC consultations.

Approximately 61% of women reported delivering in a health facility and 47% being delivered by a skilled attendant. In this study area, skilled assistance is a subset of facility-based deliveries, with some women reporting assistance by unskilled workers at facilities. Women in NBR-W were more likely to report an institutional delivery than were women in CRR or URR (72%, 52% and 62%, respectively) and were substantially more likely to report skilled attendance at their delivery (71%, versus 40% and 38%, respectively).[7]

[6] Complete information is defined as having provided information on the timing of ANC, skilled birth attendance and institutional delivery, and PNC utilization
[7] Skilled assistance at delivery is defined as the presence of a doctor, a nurse, or a midwife.

National guidelines indicate that a woman should receive her first postnatal care within 24 hours of delivery, her second visit within one week of giving birth, and a third visit within six weeks of delivery. While 72% of women reported having at least one PNC visit, only 37% received PNC within 24 hours of delivery and only 7% received the recommended three visits. Women in NBR-W were more likely to have at least one PNC visit (89% of women in NBR-W had at least one PNC visit, compared to 51% in URR). In contrast, women in URR sought PNC within 24 hours on average more than women in NBR-W (59% in URR compared to 22% in NBR-W).

Table 19: Care seeking: Use of antenatal delivery, and postnatal care

	1 or more ANC Visits	ANC within first 12 weeks	4 or more ANC Visits	Institutional Delivery	Skilled Birth Attendance	One or more PNC visit	PNC visit within 24 hours of birth	Three or more PNC visits
Region								
CRR	100%	5.5%	66.9%	52.4%	40.2%	79.1%	27.6%	6.1%
NBR-W	100%	6.9%	64.5%	72.0%	71.4%	89.2%	22.4%	10.6%
URR	100%	12.5%	71.2%	62.3%	38.1%	50.5%	58.9%	5.4%
Female respondent is literate								
No	100%	8.9%	68.3%	60.5%	44.2%	71.0%	37.8%	6.9%
Yes	100%	6.4%	66.2%	60.5%	54.8%	73.5%	35.3%	7.0%
Wealth Quintile								
Lowest	100%	9.3%	63.6%	50.5%	36.4%	76.1%	30.4%	6.9%
Second	100%	8.8%	69.9%	54.7%	37.4%	66.6%	41.9%	7.8%
Third	100%	6.9%	69.7%	62.7%	50.9%	72.5%	39.6%	6.0%
Fourth	100%	8.9%	72.1%	63.9%	48.9%	67.7%	41.2%	6.1%
Highest	100%	7.4%	63.5%	70.2%	60.5%	75.3%	32.6%	7.9%
Gov't Hospital or HC in village								
No	100%	6.2%	62.6%	51.6%	45.6%	77.7%	32.3%	7.9%
Yes	100%	8.9%	69.2%	63.0%	47.3%	69.9%	38.5%	6.7%
Total	100%	8.3%	67.8%	60.5%	46.9%	71.6%	37.2%	7.0%

Note: Based on 2,129 women who provided complete information on maternal care, defined as information on timing of ANC, skilled birth attendance, institutional delivery and number of PNC visits.

Qualitative data suggest that, across all regions, awareness was low with regard to the importance of attending PNC. Traditional Birth Attendants (TBAs) appear to play a critical role in providing PNC visiting women in their homes and helping them care for the baby until the naming ceremony. Despite this, low attendance at facility-based PNC services remains a concern.

Table 20 provides more detail on reported assistance at delivery. Nurses or midwives were the most common assistants, and were reported to attend approximately 44% of all deliveries, with TBAs assisting another 40% of the deliveries. The aggregate numbers hide substantial regional and socio-economic variation. While 71% of women in NBR-W had skilled attendance at delivery (first two columns of table 20), this was the case for only 40% and 38% of women in CRR and URR, respectively. The data indicate that the TBA plays a very important role in delivery care with TBAs assisting with the majority of deliveries in CRR (44%) and URR (48%).

Furthermore, while 60% of women in the highest socio-economic quintile had skilled attendance at delivery, only 36% of women in the lowest quintile had skilled assistance.

Table 20: Assistance at delivery

	Skilled Attendance							
	Medical Doctor	Nurse/ Midwife	CHN	TBA	Family Member	Friend/ Neighbor	No One	Other
Region								
CRR	4.2%	36.0%	3.5%	44.1%	7.8%	1.0%	2.8%	0.3%
NBR-W	2.7%	68.6%	1.0%	21.2%	3.1%	0.6%	2.2%	0.2%
URR	2.0%	36.1%	3.1%	48.3%	3.8%	0.4%	3.5%	2.3%
Female respondent is literate								
No	2.7%	41.5%	3.1%	41.3%	6.1%	0.9%	3.0%	1.1%
Yes	4.2%	50.6%	1.8%	36.6%	3.1%	0.2%	2.6%	0.6%
Wealth Quintile								
Lowest	3.8%	32.5%	2.9%	47.4%	8.6%	1.4%	2.2%	1.0%
Second	2.1%	35.3%	2.8%	46.4%	6.6%	0.7%	5.0%	0.2%
Third	3.7%	47.2%	2.8%	37.5%	5.6%	0.2%	1.4%	1.4%
Fourth	2.1%	46.8%	2.8%	38.9%	3.5%	0.5%	3.5%	1.6%
Highest	3.7%	56.7%	2.6%	30.5%	2.3%	0.7%	2.6%	0.7%
Gov't Hospital or HC in village								
No	2.3%	43.3%	3.0%	41.4%	6.4%	0.4%	2.8%	0.4%
Yes	3.3%	44.0%	2.7%	39.7%	5.0%	0.8%	3.0%	1.1%
Total	3.1%	43.8%	2.8%	40.1%	5.3%	0.7%	2.9%	1.0%

Note: Based on 2,129 women who provided complete information on maternal care, defined as information on timing of ANC, skilled birth attendance, institutional delivery and number of PNC visits.

The qualitative data revealed that the decision to seek care was usually made by the head of the household, which could lead to delays in attending the health facility if the household head was unavailable or unwilling to allow care seeking. Given the time sensitive nature of delivery, this had most impact on women's ability to attend a health facility for delivery.

Table 21 provides additional detail on preventive services received during pregnancy. Approximately 86% of women received at least one tetanus toxoid (TT) dose during their most recent pregnancy, and there were no strong regional or socioeconomic trends. There were relatively few first-time mothers in the sample, however first time mothers living in CRR were far less likely than mothers in other regions to receive at least two TT doses (36%, compared to approximately 55% in both NBR-W and URR). The use of iron supplements remains relatively low, with only slightly over a quarter (26%) of women taking iron for 90 or more days of their most recent pregnancy as recommended by national guidelines. The percentage of women receiving a full iron course in NBR-W (49%) was more than double that of women in other regions. Correct postnatal iron supplementation remains extremely rare throughout – almost no one outside of CRR received a full dose (90 days or more) of postnatal iron, and within CRR, only 4% of women received the full dose. Uptake of IPT, to prevent malaria, was generally

relatively high in the survey area, with 90% of women receiving at least one dose and 63% receiving at least two doses.

Table 21: Availability of antenatal and postnatal supplements

	Any Tetanus during pregnancy	Primagrav & 2+ TT doses	Multigrav & 1+TT dose	90+ Days Antenatal Iron	90+ Days Postnatal Iron	At least 1 dose IPT	At least two doses IPT
Region							
CRR	88.0%	36.2%	86.4%	18.5%	3.6%	87.8%	68.4%
NBR-W	85.9%	55.0%	83.4%	48.6%	0.0%	93.5%	66.1%
URR	84.4%	54.0%	82.5%	18.4%	0.3%	89.0%	54.4%
Female respondent is literate							
No	85.7%	50.6%	83.8%	24.1%	2.0%	89.7%	63.7%
Yes	87.7%	43.2%	85.7%	30.2%	0.6%	89.3%	61.2%
Wealth Quintile							
Lowest	89.2%	40.0%	87.5%	17.2%	4.3%	84.7%	62.2%
Second	85.8%	47.8%	83.8%	22.6%	1.9%	89.8%	63.0%
Third	85.6%	57.4%	83.8%	26.0%	0.2%	91.0%	60.6%
Fourth	86.4%	38.3%	84.8%	27.9%	0.9%	90.9%	60.2%
Highest	84.2%	56.5%	81.9%	34.4%	0.7%	91.4%	69.1%
Gov't Hospital or HC in village							
No	87.7%	32.4%	85.4%	42.3%	6.6%	87.9%	69.6%
Yes	85.8%	53.1%	84.0%	21.0%	0.2%	90.0%	61.2%
Total	86.2%	47.7%	84.3%	25.7%	1.6%	89.6%	63.0%
Total	**2129**	**285**	**1756**	**2127**	**2129**	**2129**	**2129**

Note: Based on 2,129 women, including 285 first-time mothers and 1,756 multigravidae mothers, who provided complete information on maternal care, defined as information on timing of ANC, skilled birth attendance, institutional delivery and number of PNC visits. Two women did not provide information on the days of iron supplementation during pregnancy, and 88 women did not provide a complete pregnancy history necessary to determine birth order.

Use of bednets during pregnancy

Women reported nearly universal household ownership of at least one bednet – 99% of households were reported to own at least one bednet with little variation between groups (Table 22). However, only 44% of households owned at least three bednets with evidence of substantial variation across regions and wealth quintiles. While 51% of households in NBR-W reported at least three bednets, the figures for CRR (46%) and URR (36%) were lower. Nearly twice the proportion of households in the highest wealth quintile (63%) owned at least three bednets compared to households in the lowest wealth quintile (33%).

Table 22: Household ownership of bednets and bednet utilization during pregnancy

	At least 1 Bednet	At least 3 Bednets	Bednet Use During Pregnancy
Region			
CRR	99.6%	45.5%	97.6%
NBR-W	98.9%	51.1%	94.9%
URR	99.1%	35.9%	97.1%
Female respondent is literate			
No	99.4%	45.0%	96.7%
Yes	98.7%	39.1%	96.9%
Wealth Quintile			
Lowest	99.3%	33.0%	95.9%
Second	99.8%	47.2%	97.5%
Third	99.3%	36.6%	97.1%
Fourth	98.9%	38.2%	96.6%
Highest	98.9%	62.6%	96.8%
Gov't Hospital or HC in village			
No	98.8%	38.7%	96.0%
Yes	99.4%	44.9%	97.0%
Total	99.2%	43.5%	96.8%
N	2,226	2,226	2,226

Note: Based on 2226 interviews done at household level

The role of TBAs

As noted above, TBAs play an important role in providing, or facilitating access to, maternal health services. TBAs in NBR-W reported referring pregnant women to the health facility for delivery in any situation where there was time to do so; TBAs escorted their clients in labor to the facility. They also reported referring women with complications pre- and post-partum. In CRR and URR, the role of TBAs appeared slightly more variable with some people reporting that TBAs still delivered women at home if they thought there were no complications and others reporting that TBAs escorted all women to the health facility for delivery. The availability of a small vehicle at some health facilities that is used to collect women in labor and take them to the facility was gratefully acknowledged by health workers and community members all of whom appreciated how much this facilitated access to the facility at the time of delivery.

Most TBAs appeared to embrace the idea of referring all women to the health facility for delivery and they did not see their role as being diminished by this.

"Q: what is the ideal role that you would like to play as the community's TBA? A: I would like my role to be strengthened so that I can help more women to deliver safely Probe: when you say

to deliver more women safely what do you mean by that? A: I mean that more women go to the health center to be delivered safely because when a woman is in labor in this community they call us the TBA first and when we go there we help them by advising them to go to the health center to deliver there and we go with them there. We tell the women that they are not supposed to deliver at home." TBA, URR

Across all regions, TBAs appeared to be held in high esteem by health workers and community members. Some health workers and community members noted that many of the TBAs are very old and that a problem of succession is emerging. Respondents suggested that if younger women are to take on this role it will be important to ensure that it is appropriately incentivized. A health facility in URR reported already providing an incentive of D200 to TBAs for every woman they bring to the facility for delivery.

Patient satisfaction with maternal health care

In general, women were satisfied with the ANC, delivery and PNC services offered by the health facility in their district (Table 23). Almost all women interviewed were willing to return for ANC in the future and would recommend the facility to a friend. Most women were willing to deliver at the facility and attend PNC in the future (90% and 85% respectively), though women in URR reported generally lower levels of satisfaction on these aspects, especially for future PNC attendance.

Table 23: Satisfaction with maternal health care

	Willingness to return for ANC for future pregnancy*	Would recommend facility to friend for ANC*	Would return to facility for future delivery**	Would recommend facility to friend for Deliver)**	Would return to facility for future PNC***	Would recommend facility to friend for PNC***
Region						
CRR	97.2%	96.5%	89.2%	89.5%	94.2%	94.7%
NBR-W	96.9%	97.5%	95.3%	96.3%	95.7%	94.5%
URR	96.4%	96.1%	84.1%	84.8%	65.3%	64.9%
Female respondent is literate						
No	96.7%	96.1%	88.8%	90.2%	83.1%	83.0%
Yes	97.5%	98.2%	92.7%	91.7%	89.4%	88.8%
Wealth Quintile						
Lowest	96.9%	96.7%	81.9%	83.8%	90.2%	90.6%
Second	96.1%	96.8%	87.6%	88.9%	80.8%	80.4%
Third	96.3%	95.7%	92.2%	92.6%	83.1%	83.1%
Fourth	97.5%	96.5%	91.1%	92.8%	81.9%	81.4%
Highest	97.5%	97.3%	93.4%	92.3%	87.4%	86.7%
Gov't Hospital or HC in village						
No	97.3%	97.1%	92.9%	93.3%	94.8%	94.2%
Yes	96.7%	96.4%	89.0%	89.8%	81.6%	81.5%
Total	96.9%	96.6%	90.0%	90.6%	84.6%	84.4%
N	2,226	2,226	1,051	1,051	2,209	2,209

* Asked of all women in household survey
** Asked of all women in household survey who gave birth at a facility
*** Based on women who received PNC

Many women, across all regions, reported having received good quality care at the health facility including during ANC and delivery. However, a few stories emerged of poor quality of care due to health worker negligence.

"The way I was received when I escorted my wife who was in labor was not in the least satisfactory to me. When I arrived with my wife in labor the staff said they were having their breakfast and didn't have time for me. I then put my wife on the bed waiting for the staff to come when my wife called me to assist her and I went to call the staff but they were still not ready with their breakfast. When my wife called for assistance I found her in full labor and she delivered in my hands… It was about one hour from the time we arrived up to the time my wife delivered in my hands before the staff attended to her. I was the one who even put her in bed as the staff didn't come because they were having their breakfast." VDC/VSG member, CRR

In focus group discussions, some women stated a preference for female health workers within MCH services, saying that they felt ashamed to have male health workers seeing their body.

Respondents were read a series of statements regarding the health facility in their district and asked to agree (1), be neutral (2) or disagree (3) with the statement. Rather than focusing on the quality of care received, these statements explored different, more specific aspects regarding the accessibility and acceptability of health services. Table 24 shows that out of the 10 questions asked, respondents agreed with 9 of the questions and were neutral on one (the area where the facility was located was safe).

Table 24: Satisfaction with ANC services

How much do you agree with the following statements on a scale from 1 to 3, where 1 means you agree and 3 means you disagree?										
	It is convenient to travel to facility	It is easy to get prescribed medicine	Registration fees are adequate	Lab fees are reasonable	Medication costs are reasonable	Transportation costs are reasonable	Waiting times are reasonable	Opening hours are adequate	The area is safe[1]	It is easy to make contact with the health workers
Region										
CRR	1.32	1.23	1.64	1.86	1.00	1.25	1.34	1.07	2.48	1.02
NBR-W	1.56	1.47	1.28	1.33	1.35	1.77	1.49	1.18	2.33	1.23
URR	1.19	1.12	1.03	1.26	1.29	,1.63	1.26	1.02	2.05	1.02
Female respondent is literate										
No	1.36	1.21	1.19	1.40	1.26	1.67	1.34	1.08	2.26	1.09
Yes	1.29	1.40	1.23	1.36	1.25	1.29	1.38	1.09	2.26	1.12
Wealth Quintile										
Lowest	1.47	1.13	1.07	1.38	1.07	1.78	1.47	1.13	2.57	1.03
Second	1.40	1.20	1.22	1.56	1.37	1.76	1.27	1.07	2.40	1.13
Third	1.33	1.37	1.22	1.33	1.00	1.29	1.17	1.03	2.17	1.15
Fourth	1.27	1.30	1.35	1.41	1.38	1.60	1.34	1.10	1.90	1.14
Highest	1.23	1.27	1.00	1.12	1.40	1.33	1.52	1.07	2.24	1.04
Total	1.34	1.25	1.19	1.39	1.26	1.59	1.35	1.08	2.26	1.10

Notes: Based on a total of 150 ANC exit interviews.

1.'Safety' was not defined so there may have been varying interpretations of the type of safety implied.

Based on the ANC Exit Interviews, women reported average wait times of 32 minutes before seeing a health staff. Women in CRR had longer wait times (44 minutes) than women in URR (28 minutes) or NBR-W (25 minutes). Forty four percent of the women interviewed said they waited too long to see a health worker.

Reasons for health facility selection for ANC

The most common reason provided for choosing a health facility for ANC was proximity to the respondent's home (78%). Another 31% of respondents said they chose to visit the facility for ANC due to either trust of providers or the quality of care offered at the facility. The options in Table 25 are not mutually exclusive, with the 150 women interviewed allowed to choose more than one reason for choosing the facility for ANC.

Table 25: Reasons for health facility selection for ANC

	What were the most important reasons for choosing this health facility today?				
	Close to home	Low cost	Trust providers/high quality care	Availability of drugs	Recommendation or referral
Region					
CRR	74.5%	12.8%	38.3%	19.1%	2.1%
NBR-W	79.5%	18.2%	36.4%	20.5%	4.5%
URR	79.7%	10.2%	25.4%	3.4%	5.1%
Female respondent is literate					
No	75.7%	15.7%	33.0%	13.0%	3.5%
Yes	85.7%	5.7%	31.4%	14.3%	5.7%
Wealth Quintile					
Lowest	71.4%	14.3%	42.9%	28.6%	0.0%
Second	78.6%	7.1%	21.4%	14.3%	0.0%
Third	85.7%	14.3%	28.6%	28.6%	0.0%
Fourth	64.7%	23.5%	41.2%	0.0%	0.0%
Highest	80.0%	13.7%	29.5%	13.7%	6.3%
Total	77.9%	14.3%	30.7%	13.6%	4.3%

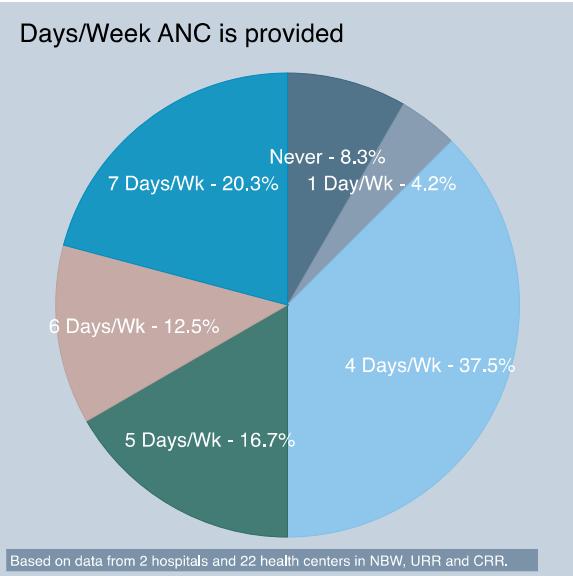
Note: based on 150 ANC exit interviews.

Availability of ANC services

Opening hours

ANC services are offered seven days per week in 20% of the health facilities visited during the survey (Figure 10). Another 13% and 17% offer services six days and 5 days per week, respectively. The most common offering of ANC services is four days per week (38%).

Figure 10: Days/Week ANC is provided



As indicated in Table 26, all except for one of the twenty-four facilities visited (96%) reported offering general care 24 hours per day, and all except for two facilities offered designated ANC and under-five care. The two facilities not offering designated ANC or child health services are hospitals that are not meant to deliver these services.

Several facilities stated that women and children could access the services anytime – seven days per week, and 10-24 hours per day. Approximately two-thirds of facilities limit the times at which these services are available, with half of the facilities reporting that ANC and child health care is available four or fewer days per week. On the days that the services are offered, most facilities provide the services between four and seven hours per day.

Table 26: Availability of ANC services

	Open 24 hours	ANC offered anytime (24 hrs)	Days per week ANC offered	ANC not available on weekend	ANC offered less than 8 hrs/day on days available
Region					
CRR	90.0%	20.0%	5.0	50.0%	70.0%
NBR-W	100%	16.7%	4.2	83.3%	83.3%
URR	100%	12.5%	4.4	75.0%	37.5%
Type of Facility					
Hospital	100%	0.0%	0.0	100%	100%
Major HC	100%	0.0%	5.0	66.7%	100%
Minor HC	94.7%	21.1%	5.0	63.2%	52.6%
Total	95.8%	16.7%	4.6	66.7%	62.5%

Notes: All statistics are based on the 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

Women reported that the RCH outreach services to the community greatly improved the accessibility and uptake of these services. However, health workers reported that a shortage of fuel often hampered the provision of outreach services.

Facility fees: ANC

Among women who completed the ANC Exit Interviews, 38% were charged fees. Substantial variation emerged between regions with 55% of women in NBR-W reporting paying a fee compared to only 17% of women in URR. Of the women who paid a fee, the average cost for the facility visit was $0.60. Approximately 26% of the women who paid a fee were charged for a laboratory fee. For these women, the average laboratory fee was $1.55.[8]

Table 27: Facilities fees (ANC)

	Percent paying any fee*	Total cost of facility visit**	Lab fee (if >0)***
Region			
CRR	48.9%	$0.34	$1.16
NBR-W	54.5%	$0.81	$1.94
URR	16.9%	$0.69	$1.40
Respondent is literate			
No	43.5%	$0.64	$1.61
Yes	20.0%	$0.36	$1.16
Wealth Quintile			
Lowest	57.1%	$0.60	$2.33
Second	35.7%	$0.70	$1.16
Third	28.6%	$0.02	-
Fourth	58.8%	$0.49	$1.16
Highest	35.8%	$0.62	$1.66
Total	38.0%	$0.60	$1.55
	150	57	15

* Data reported is based on 150 ANC exit interviews.
** Data reported is based on 57 women who reported being charged a fee. All fees originally reported in GMD and converted at 43 GMD:1US$.
*** Data reported is based on 15 women who reported being charged a lab fee. All fees originally reported in GMD and converted at 43 GMD: 1US$.

Although most health facilities reported fee waivers for pregnant women, some women reported having had to pay to attend ANC services. Among those paying any fee, there is a high reliance on out-of-pocket payments to pay the costs that are incurred. Only one of the 310 patients responding to exit interviews reported having health insurance, and respondents generally reported that expenses were paid out of the household budget or with the help of family members or friends.

[8] All fees originally reported in GMD and converted at 43 GMD: 1US$.

Barriers to care-seeking – ANC and PNC

Table 28 provides an overview of time and financial cost of traveling to a health facility for ANC visits. The average time reported by women to travel to a health facility for ANC was 34 minutes, with women in NBR-W reporting the shortest time (28 minutes) and women in CRR reporting the longest time (38 minutes). Literate women on average reported shorter travel times (25 minutes) compared to illiterate women (37 minutes). The majority of women (82%) reported that they did not pay anything for transport to the health facility.

Table 28: Time and financial costs of transport to health center (ANC)

		Transport Cost to Facility		
	Time to facility (Minutes)	$0 to Facility	$0.01-$0.93 to Facility	$0.94-$1.86 to Facility
Region				
CRR	38.3	85.1%	14.9%	0.0%
NBR-W	28.3	79.5%	20.5%	0.0%
URR	34.4	81.4%	10.2%	8.5%
Respondent is literate				
No	36.6	80.9%	14.8%	4.3%
Yes	24.9	85.7%	14.3%	0.0%
Wealth Quintile				
Lowest	26.9	100%	0.0%	0.0%
Second	52.1	71.4%	14.3%	14.3%
Third	36.4	100%	0.0%	0.0%
Fourth	64.9	64.7%	35.3%	0.0%
Highest	27.5	82.1%	14.7%	3.2%
Total	33.9	82.0%	14.7%	3.3%

Notes: based on 150 ANC exit interviews.
All costs originally reported in GMD and converted at 43 GMD:1US$.

The costs of transport to the facility, in addition to the costs of drugs that were prescribed and, in the case of referral to a higher level facility, fuel costs for the ambulance were all mentioned as barriers to accessing appropriate care.

A wide range of actors emerged in the qualitative data that help explain why timely uptake of ANC and PNC services was low in some cases.

Health workers, TBAs and VSGs all had good knowledge of danger signs during pregnancy and how to address these – either through community-based interventions such as nutrition or referral to a health facility. Women in the communities had more mixed levels of knowledge, with some women able to describe some danger signs and others unable to name a single one. Similarly, some women could clearly explain the benefits of attending ANC while other women simply stated that it was important for the health of the woman and the baby but unable to provide any further details.

Traditional beliefs around pregnancy appear to have affected women's willingness to attend ANC during the first trimester of pregnancy. Some women described traditional beliefs whereby if people reveal their pregnancy early they will miscarry (NBR-W, CRR) or become bewitched (CRR), which has impeded uptake of early ANC. Unmarried women reported wanting to hide their pregnancy due to the shame of being pregnant outside wedlock while women who were still breastfeeding from their prior pregnancy also reported delayed ANC attendance due to the shame of becoming pregnant again so quickly.

"*Women would tell you I don`t want to go to clinic early because people would know I am pregnant at the early stage of the pregnancy and others would say ok if people know that can bring the work of the devil in*." CHN, URR

While some men were described as very supportive of their wives during pregnancy, other men hampered access to ANC during early pregnancy.

"In local communities men have to decide what the women should or should not do. The husband will tell you to wait because it is very early to go and women cannot force themselves to go without seeking and getting permission. Some men are very aggressive." Community Health Nurse, CRR

Across all regions, health workers noted difficulties in persuading women to register at ANC during their first trimester of pregnancy.

"If you look at even the booking we're advocating for early booking but you will see many a time antenatal women they will come when they're in their third trimester which is defeating the purpose. " Officer-in-charge, CRR

Although some of the health facilities in NBR-W that were involved in the pilot project reported some increase in early ANC attendance they also said that there was still great room for improvement.

Women noted that many of them still concealed their pregnancy until after the first trimester was complete. There were, however, some suggestions within communities in all three regions that early ANC attendance is increasing due to the arrival of the MCNHRP.

If early ANC increases, more women should have time to attend their four scheduled ANC visits during pregnancy. But, nuanced messaging may be required to promote appropriate ANC attendance. That women should attend ANC monthly after their first visit was a very commonly

held belief among pregnant women across all three regions, which discouraged women from attending ANC during their first trimester of pregnancy.

"Q: Why won't you go to the clinic after one month of pregnancy? R5: Because if you start early, you will keep on going and coming, and it makes you tired and exhausted. We women prefer our freedom a lot, that's why we don't go that early." Woman who had delivered in the previous six months, CRR

The need for monthly ANC visits was also expressed by a VSG member in CRR and a TBA in URR even as it does not match the national protocol and it has implications for the workload of health workers. If pregnant women only attended the four scheduled ANC visits (and any required emergency visits) this workload might be reduced.

The difficulties accessing the health facility (cost, time, transportation) were noted to impede uptake of ANC and PNC services, especially the latter as women often did not feel sick at the time of their scheduled visit so they did not think it worth going to the health facility given all of the challenges involved.

Delayed access to ANC services was reported among women without a birth certificate or identification card as this documentation is required for accessing services. While some efforts are being made to overcome this, additional efforts may be required to ensure access to services for this population.

Barriers to care-seeking – Skilled delivery

Across all three regions, participants in the qualitative research were knowledgeable about why skilled attendance at delivery is important. Despite this, a range of barriers impeded women's utilization of skilled delivery services. These are examined below within the framework of the "Three Delays" model, which assesses delays in the decision to seek care, delays in reaching a health facility once that decision has been made, and delays in receiving care once at the health facility.

Delays in the decision to seek care

Some women accurately described how to approximate their due date for delivery by counting months from the last menstrual period but other women, particularly women across CRR, displayed low levels of knowledge with regard to the length of gestation and their due date for delivery:

"Q: Can a pregnant woman know when she is due for delivery? R1: Nobody can know the time, but you may know the month. Probe: How do you know the month? R1: You can know it by

counting from the period when you miss your menses, up to 9 months. Some can go up to 10 or 11 months before they deliver. There are even people who can be pregnant for 2 years and every month you see it reducing." Woman who had delivered in the previous six months, CRR

"Q. Can a pregnant woman know when she will deliver? R1: As for me when I fall in to labor in the 9 months of the pregnancy then I would know it's a boy but when it is 10 months then I know it's going to be a girl. R2: As for me, I do not give birth on the 9th month of my pregnancy. I deliver during the 10th or above. R3: I do in the 11th or 12th month." Women who had delivered in the previous six months, CRR

When women did not know when they were due to deliver, it took many of them a long time to realize that they were in active labor:

"Q: Why were you unable to deliver at the health facility? A: I was taken unaware because I didn't know that I was in active labor. It started in the night and around 5am I delivered. Probe: When you were pregnant, did you know when you were expecting to deliver? A: No I did not know." 'Vulnerable woman', NBR-W

"Stomach ache disturbs me a lot, especially after 6 months. It goes and comes as if I am due for labor and continues up to the time of delivery. Sometimes it confuses me. Also, it makes me forget that I am due for delivery until it is too late. That's why I always deliver at home." Woman who had delivered in the previous six months, CRR

As with ANC attendance above, in many places, men decided when women should go to the health facility which could cause delays affecting uptake of health facility delivery.

Delays in reaching the health facility

Across all three regions, and particularly in URR, expressed demand for health facility delivery was much higher than actual service utilization. The most frequently mentioned barrier to accessing services was the difficulty in getting to the health facility due to long distances and inadequate transport options. In one community in URR, women reported that three maternal deaths had occurred in the last year due to delays in reaching the health facility for delivery. Some communities in NBR-W noted that the horse carts purchased through the pilot project to transport women in labor to the health facility, had improved accessibility but others suggested that this was still an inadequate solution and that vehicles were required to ensure appropriate access. Ensuring access at night and during the rainy season was described as a particular challenge.

"In my village there is no health facility and most labor cases happen in the night, so far this year 4 women delivered at night and out of these 4 only one delivered at the health facility. You

cannot travel at that time of the night to this health facility you will not even have something to bring you. Most women deliver at home because of the condition of the roads and mobility. Just last week a pregnant woman was coming to the health facility but… she could not reach the facility… so she ended up delivering on the way." CAC representative, CRR

"Q. Is it easy to travel from here to the health facility for delivery? R4: It's not easy. We use carts. There are no vehicles. Probe: Horse or donkey carts? R5: Donkeys and sometimes they drop you on the way. It`s too far. R9: And when you get to the hill, you will come off the cart and walk. It's far and if you fall down there, that could also be disastrous… R1: Yes. Even the donkey driver will come down and hold the donkey firmly and you all walk behind pushing the cart till when it gets down the hill on the other side. Probe: The pregnant woman too will have to walk to climb and descend the hill? R8: Yes. That`s our major problem here." Woman who had delivered in the previous six months, CRR

Delivery on the way to the health facility was commonly reported, especially in communities that were far from a health facility. As a result of these challenges, many women preferred to deliver at home:

"If you are well and not having complications, you will prefer to deliver at home, so that you will be free from the endless struggle of trying to get to the health center on horse or donkey carts." Woman who had delivered in the previous six months, URR

Delays in receiving care at the health facility

In some cases, the need for permission from a woman's husband or father was found to further delay access to skilled delivery even once a woman arrived at the health facility.
"In this area, like other parts of the country, we have the male dominance syndrome… I had one patient who developed complications because when she was to undergo caesarian section the woman that came with her called the father who said we should not operate on his child. So we had to try and do vacuum extraction to be able to deliver the child. The child was fine but for the woman it will take time for her to regain her health because she was suffering from continuous fitting and that is going to affect the brain. She may have irreversible brain damage." Officer-in-charge, URR

In NBR-W, health workers and community members noted that delays in receiving care at the health facility have greatly reduced since the pilot project was initiated. In the other two regions, particularly in CRR, such delays were reported to still exist and were attributed to poor health worker attitudes.

"Staff attitude is a problem towards our clients." Officer-in-charge, CRR

Preference for community versus facility care among women who know of a TBA or community health nurse in their community

Table 29 below presents information collected from ANC exit interviews regarding women's preferences for seeking care in the community over a nearby health facility. Of the 140 women interviewed at ANC who knew of a CHN or TBA, 20% said they preferred to seek ANC with a CHN while 52% preferred ANC at a facility. Strong regional and literacy differences emerged for these preferences. Women in NBR-W had a very strong preference for seeking ANC at a health facility (78%) with no women reporting a preference for a CHN. Similarly, women in CRR also expressed a preference for going to a health facility (56%) over seeking ANC with a CHN (22%). In stark contrast, women in URR had a stronger preference for CHNs (43%) over health facilities (14%). In addition, literate women had a strong preference for seeking ANC at a health facility over seeing a CHN.

Thirty seven percent of women interviewed preferred delivering with a TBA compared to 52% who preferred to deliver at a health facility. As in the case of ANC, a higher proportion of women in NBR-W (79%) and CRR (62%) prefer delivering in a health facility over delivering with a TBA (18% and 19%, respectively). However, in URR, there is a strong preference among women to deliver with a TBA – 62% prefer delivering with a TBA compared to 26% who prefer a health facility. The results show that it might be more challenging to increase institutional delivery in URR compared to NBR-W and CRR.

Table 29: Preference for community vs. facility-based maternal health care

	I prefer to see Community Health Nurse for antenatal care rather than visiting a health facility			I prefer to deliver with a Traditional Birth Attendant rather than going to a health facility		
	Agree	Neither Agree nor Disagree	Disagree	Agree	Neither Agree nor Disagree	Disagree
Region						
CRR	22.2%	22.2%	55.6%	19.2%	19.2%	61.5%
NBR-W	0.0%	22.2%	77.8%	17.9%	3.6%	78.6%
URR	42.9%	42.9%	14.3%	61.5%	12.8%	25.6%
Female respondent is literate						
No	27.8%	33.3%	38.9%	38.0%	15.5%	46.5%
Yes	0.0%	14.3%	85.7%	31.8%	0.0%	68.2%
Wealth Quintile						
Lowest	0.0%	100.0%	0.0%	75.0%	0.0%	25.0%
Second	0.0%	0.0%	0.0%	57.1%	0.0%	42.9%
Third	50.0%	0.0%	50.0%	50.0%	0.0%	50.0%
Fourth	16.7%	16.7%	66.7%	33.3%	25.0%	41.7%
Highest	18.8%	31.2%	50.0%	30.5%	11.9%	57.6%
Total	20.0%	28.0%	52.0%	36.6%	11.8%	51.6%

Note: Based on 140 women interviewed for ANC exit interviews who knew about community health workers in their community.

Quality of care: Services offered during ANC

The *National Maternal Care Guidelines and Service Delivery Standards* ('*Maternal Care Guidelines*') serve as the guide for health workers regarding the provision of antenatal, intrapartum and postnatal care in The Gambia. The *Maternal Care Guidelines* state that all women attending antenatal care should receive the following services during their first visit:

a. Measure height of woman
b. Test for syphilis
c. HIV testing and Counseling
d. Administer Tetanus Toxoid

The following services should be offered at every visit including the first visit:

a. Measure weight
b. Stomach palpation
c. Take blood pressure
d. Measure uterine height
e. Measure Hemoglobin level

Women attending antenatal care can get an estimated date for delivery and schedule delivery at the facility during their first visit.

Tables 30 and 31 show the proportion of women who had received any of the ANC services listed in the *Maternal Care Guidelines* during their most recent pregnancy based on the household survey.[9] The services most consistently provided during ANC (Table 30) are weighing (98%), taking blood pressure (96%), stomach palpation (98%) and taking a blood sample (85%). In contrast, the services that were provided the least frequently were measurement of height (36%), scheduling delivery at facility (28%) and getting an estimated due date (25%). For nearly all ANC services, a higher proportion of women in NBR-W reported receiving the service compared to women in CRR and URR. This was especially true for taking height, taking a urine sample, scheduling a delivery, and getting an estimated due date. A lower proportion of illiterate women appear to receive ANC services than literate women.

[9] Administration of TT is not included here as it is covered in Table 21 above.

Table 30: Services provided during antenatal care visits

	Weighed	Height taken	BP taken	Urine sample given	Blood sample Given	Scheduled delivery	Estimated due date	Stomach palpated	Uterine height taken
Region									
CRR	98.8%	55.0%	96.0%	64.9%	85.3%	23.9%	21.5%	96.4%	73.3%
NBR-W	97.5%	76.2%	96.9%	86.9%	88.7%	44.4%	40.0%	100.0%	92.5%
URR	97.2%	13.1%	96.4%	46.3%	83.7%	25.2%	22.1%	99.0%	56.3%
Female respondent is literate									
No	97.1%	31.0%	96.1%	54.9%	83.3%	27.1%	23.6%	98.3%	66.2%
Yes	100.0%	52.0%	97.5%	71.3%	91.1%	32.2%	30.2%	99.0%	71.3%
Wealth Quintile									
Lowest	100.0%	47.3%	93.9%	62.6%	90.1%	16.8%	19.8%	99.2%	80.2%
Second	94.9%	31.2%	97.2%	60.2%	86.9%	30.7%	26.7%	96.6%	63.1%
Third	99.5%	33.5%	96.6%	56.2%	82.3%	26.6%	23.2%	99.0%	69.5%
Fourth	97.7%	32.7%	97.7%	52.7%	85.5%	30.9%	26.8%	98.6%	59.1%
Highest	96.7%	37.5%	95.7%	63.6%	82.1%	32.6%	27.2%	98.9%	69.6%
Gov't Hospital or HC in village									
No	98.1%	55.2%	98.1%	77.1%	89.5%	35.2%	40.0%	98.1%	78.1%
Yes	97.7%	33.1%	96.2%	56.1%	84.4%	27.3%	23.1%	98.5%	65.9%
Total	97.7%	35.7%	96.4%	58.5%	85.0%	28.2%	25.1%	98.5%	67.3%

Note: Based on 2,197 women interviewed in household survey who attended ANC regarding services offered during ANC visit for most recent birth.

Table 31 shows that only 21% of women interviewed reported being tested for syphilis during ANC and 19% reported having their blood type and rhesus factor assessed. Only 36% of women who attended ANC were counseled on HIV/AIDS, and of the 779 women counseled, 82% ended up being tested. An estimated 71% of women received advice on diet and 60% received advice on what to do in case of an emergency. Women in NBR-W appeared to fare better on average on provision of all of these services compared to women in CRR or URR.[10]

Table 31: Other services provided during antenatal care visits

	Tested for syphilis	Blood type and rhesus factor assessed	Given dietary advice	Given advice on what to do in case of emergency	Received HIV counseling	Tested for HIV*
Region						
CRR	19.9%	8.4%	73.3%	58.6%	32.9%	74.2%
NBR-W	40.6%	33.8%	72.5%	74.4%	52.4%	89.7%
URR	15.9%	18.9%	70.2%	56.5%	27.9%	84.2%
Female respondent is literate						
No	19.7%	16.3%	71.5%	59.8%	33.4%	81.5%
Yes	27.2%	26.7%	71.3%	61.4%	42.9%	83.9%
Wealth Quintile						
Lowest	22.1%	8.4%	75.6%	51.9%	32.2%	78.8%
Second	25.6%	15.3%	69.9%	63.1%	35.1%	81.7%
Third	23.6%	21.7%	73.9%	62.6%	39.1%	80.7%
Fourth	19.5%	21.4%	69.1%	56.8%	34.8%	87.4%
Highest	16.3%	22.3%	70.1%	64.7%	37.9%	82.5%
Gov't Hospital or HC in village						
No	28.6%	16.2%	81.0%	72.4%	27.8%	78.5%
Yes	20.4%	18.9%	70.2%	58.6%	38.1%	83.0%
Total	21.3%	18.6%	71.4%	60.2%	35.8%	82.3%

Note: 2,197 women interviewed in household survey who attended ANC regarding services offered during ANC visit for most recent birth.
* Based on 788 women who reported receiving HIV counseling.

Maternal and newborn health care workers are also supposed to advise women on what the danger signs are and the importance of seeking care as soon as a sign presents itself. The danger signs for pregnancy as listed in the *Maternal Care Guidelines* are:

a. Vaginal bleeding
b. Convulsions/fitting/unconsciousness
c. Severe headaches with or without blurred vision
d. Fever of any type

[10] While these data are self-reported, they are consonant with observation at health facilities. The tables on stocks of medicines and equipment show that frequent stockouts limited their ability to consistently perform tests, especially those related to maternal and child health.

e. Abdominal pain
f. Fast and/ difficult breathing
g. Swelling of the face, fingers or legs
h. Any other concern that the woman may have

Table 32 shows the results from the ANC exit interviews conducted at the 24 facilities and outreach clinics organized by the health facility staff regarding counseling and advice that women received. Out of the 150 women interviewed, 29% were counseled on giving birth at the facility. The data indicate a substantial degree of variation between regions from only 7% of women in URR to 36% in NBR-W and 52% in CRR receiving counseling on delivering at a health facility.

Out of the 150 women interviewed at the facility for ANC, a quarter were informed about danger signs during pregnancy by a health care worker during the current or previous ANC visits. Women in NBR-W were more likely to have discussed these with a health care worker (36%) than those in CRR (25%) or URR (17%).

Table 32: Counseling during ANC

	Percentage of women receiving counseling on delivering at health facility	Percentage of women who were informed about danger signs of pregnancy
Region		
CRR	52.3%	25.0%
NBR-W	36.2%	34.0%
URR	6.8%	16.9%
Female respondent is literate		
No	27.0%	24.3%
Yes	37.1%	25.7%
Wealth Quintile		
Lowest	14.3%	14.3%
Second	28.6%	14.3%
Third	42.9%	28.6%
Fourth	41.2%	35.3%
Highest	29.5%	25.3%
Total	29.3%	24.7%

Note: Based on 150 ANC exit interviews conducted.

Health worker knowledge: Maternal health services

This section focuses on eight interrelated tables that correspond to the health worker knowledge section of the health worker questionnaire. Health workers were asked eight questions regarding what questions they would ask or course of action they would take in a given scenario. Only health workers who were doctors (or medical officer), nurses or midwives were asked these

questions. The actions mentioned by the worker are recorded. Each table header in this section provides the question asked to the health worker regarding the course of action they would take, and each column displays the proportion of health workers who mentioned that particular response. Responses were unprompted i.e. the interviewer did not provide a list of potential courses of action for health workers to choose from: any free-listed responses were recorded.

The first scenario involved a woman who believes she is pregnant, and decides to attend the antenatal clinic for the first time. Of the 56 health workers who were interviewed, approximately 70% reported that they would ask the woman about the number of prior pregnancies and number of live births experienced (Table 33). The percentages of health workers were lower for those in URR compared to those in CRR or NBR-W. On average, 61% of health workers reported that they would ask about the number of miscarriages, stillbirths and abortions. Again, the percentage was lower for health workers in URR. Just over half of the health workers (54%) reported that they would inquire about how the last child was delivered, and only 9% reported that they would ask about tetanus immunization.

Table 33: Health worker knowledge (previous pregnancies)

What questions would you ask her about her previous pregnancies?					
	Number of prior pregnancies	Number of live births	Number Miscarriages/ stillbirths/ abortions	How last child was delivered (Natural/ Caesarian)	Tetanus-immunization
Region					
CRR	75.0%	75.0%	60.7%	50.0%	3.6%
NBR-W	78.6%	71.4%	71.4%	64.3%	7.1%
URR	50.0%	64.3%	50.0%	50.0%	21.4%
Type of health facility					
Hospital	85.7%	57.1%	71.4%	71.4%	0.0%
Major Health Center	80.0%	60.0%	60.0%	40.0%	10.0%
Minor Health Center	64.1%	76.9%	59.0%	53.8%	10.3%
All Facilities	69.6%	71.4%	60.7%	53.6%	8.9%
N	56	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

Regarding the current pregnancy, 73% of health workers reported that they would ask about the last date of menstruation, and 57% would ask about any current health problems (Table 34). Only 27% reported that they would ask about any vaginal bleeding during the current pregnancy. A very low percentage of health workers – only 5% – reported that they would ask about current medications that the woman is taking. Again, only a small proportion would ask about tetanus immunization for the current pregnancy.

Table 34: Health worker knowledge (current pregnancy)

What questions would you ask her about her current pregnancy?					
	Last Menstrual Date	Any health Problems Now?	Any Vaginal Bleeding?	Taking Medications Now?	Tetanus Immunizations?
Region					
CRR	64.3%	57.1%	28.6%	7.1%	14.3%
NBR-W	85.7%	50.0%	21.4%	7.1%	0.0%
URR	78.6%	64.3%	28.6%	0.0%	0.0%
Type of health facility					
Hospital	57.1%	42.9%	28.6%	14.3%	0.0%
Major Health Center	70.0%	30.0%	20.0%	0.0%	0.0%
Minor Health Center	76.9%	66.7%	28.2%	5.1%	10.3%
Total	73.2%	57.1%	26.8%	5.4%	7.1%
N	56	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

Taking a full medical history is an important part of quality of care, and there were mixed results based on the health worker interviews (Table 35). While 93% of health workers reported that they would ask about a history of high blood pressure, the other questions were not commonly reported. Approximately 32% and 45% of health workers, respectively, reported that they would ask about previous incidence of sexually transmitted infections (STIs) and heart disease, liver disease, malaria or goitre. Only 3% would ask about allergies to medications or blood grouping.

Table 35: Health worker knowledge (medical history)

What questions would you ask her about her medical history?					
	History of High Blood Pressure?	Any Previous STI (Including HIV)?	Any Heart disease, Liver disease, Malaria, Goitre?	Allergies to medications	Blood grouping Cross-matching
Region					
CRR	92.9%	42.9%	39.3%	3.6%	3.6%
NBR-W	100.0%	14.3%	35.7%	0.0%	7.1%
URR	85.7%	28.6%	64.3%	0.0%	0.0%
Type of health facility					
Hospital	85.7%	28.6%	28.6%	0.0%	0.0%
Major Health Center	100.0%	40.0%	60.0%	0.0%	10.0%
Minor Health Center	92.3%	30.8%	43.6%	2.6%	2.6%
Total	92.9%	32.1%	44.6%	1.8%	3.6%
N	56	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

When asked about physical examinations to be performed during ANC, the results were also mixed (Table 36). Relatively high proportions of health workers reported that they would check weight and blood pressure, palpate the abdomen, and listen to the fetal heart rate (75%, 86%, and 79% respectively). However, only half reported that they would measure the woman's height. Even lower proportions of health workers reported that they would check the woman's temperature (34%) and conduct a pelvic examination (27%). Only 16% of health workers reported that they would check the respiratory rate, check for edema or swelling or measure the uterus size.

Table 36: Health worker knowledge (physical examinations)

What Physical Examinations would you perform on her?	Height	Weight	Blood Pressure	Temperature	Respiratory Rate	Palpate Abdomen	Listen to Fetal heart rate	Pelvic Examination	Check for Edema/ Swelling	Measure Womb Size
Region										
CRR	42.9%	71.4%	85.7%	39.3%	17.9%	85.7%	64.3%	32.1%	17.9%	17.9%
NBR-W	42.9%	78.6%	85.7%	28.6%	21.4%	85.7%	64.3%	7.1%	21.4%	21.4%
URR	71.4%	78.6%	85.7%	28.6%	7.1%	57.1%	50.0%	35.7%	7.1%	7.1%
Type of health facility										
Hospital	42.9%	57.1%	85.7%	14.3%	14.3%	85.7%	71.4%	14.3%	14.3%	14.3%
Major Health Center	50.0%	70.0%	60.0%	30.0%	10.0%	100.0%	30.0%	60.0%	10.0%	10.0%
Minor Health Center	51.3%	79.5%	92.3%	38.5%	17.9%	71.8%	66.7%	20.5%	17.9%	17.9%
Total	50.0%	75.0%	85.7%	33.9%	16.1%	78.6%	60.7%	26.8%	16.1%	16.1%
N	56	56	56	56	56	56	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

When asked about laboratory investigations, only a few laboratory tests were reported by the majority of health workers (Table 37). The most common investigations health workers reported they would conduct were hemoglobin (98%) and urine protein (82%). Relatively lower proportions of health workers reported that they would test to confirm pregnancy (27%) and test for STIs (45%). Only 20% reported that they would check blood grouping for the woman. There was some variation across regions, especially for pregnancy, urine protein and STIs.

Table 37: Health worker knowledge (laboratory investigations)

What laboratory investigations would you perform on her?	Pregnancy test	Hemoglobin	Urine Protein	STI (Syphilis & Gonorrhea)	Blood grouping & Cross-matching
Region					
CRR	28.6%	96.4%	89.3%	39.3%	17.9%
NBR-W	35.7%	100.0%	64.3%	42.9%	21.4%
URR	14.3%	100.0%	85.7%	57.1%	21.4%
Type of health facility					
Hospital	42.9%	100.0%	71.4%	42.9%	14.3%
Major Health Center	30.0%	100.0%	70.0%	40.0%	40.0%
Minor Health Center	23.1%	97.4%	87.2%	46.2%	15.4%
Total	26.8%	98.2%	82.1%	44.6%	19.6%
N	56	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

Health workers were also asked what medications, supplements or treatment they would prescribe or provide to the woman (Table 38). While positive responses on iron/folic acid supplementation were very high (95%), a much lower percentage of health workers responded that they would provide IPT for malaria (68%). Even lower proportions of health workers said they would provide an insecticide treated net or tetanus toxoid (29% and 41%, respectively).

Table 38: Health worker knowledge (prescriptions)

What will you prescribe/provide to her?	Insecticide Treated Net	Iron/Folic acid supplement	Administer Tetanus toxoid	IPT for Malaria
Region				
CRR	21.4%	96.4%	42.9%	78.6%
NBR-W	14.3%	92.9%	35.7%	64.3%
URR	57.1%	92.9%	42.9%	50.0%
Type of health facility				
Hospital	28.6%	85.7%	57.1%	71.4%
Major Health Center	30.0%	100.0%	50.0%	70.0%
Minor Health Center	28.2%	94.9%	35.9%	66.7%
Total	28.6%	94.6%	41.1%	67.9%
N	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

Regarding advice that health workers would give to women, 68% of health workers reported that they would provide advice on nutrition, but only 46% specifically said they would give advice on iron/folic acid supplements. Approximately 54% of health workers reported that they would provide advice on the danger signs for which the woman should seek emergency assistance. Even lower proportions of health workers reported that they would give advice on breastfeeding (7%), contraception (9%), HIV counseling and testing (18%) and use of insecticide treated nets (21%). Notably, relatively low proportions of health workers in URR reported giving advice on nutrition, danger signs to seek help, and breastfeeding than the other regions. Overall, breastfeeding and contraception advice was the least commonly reported by health workers.

Table 39: Health worker knowledge (advice)

What kinds of advice will you give?	Nutrition	Iron/Folic acid supplements	Danger signs for emergency help*	Breast feeding	Contraception	HIV Voluntary Counseling and testing	Use of ITN
Region							
CRR	75.0%	46.4%	57.1%	7.1%	7.1%	17.9%	21.4%
NBR-W	78.6%	35.7%	64.3%	14.3%	14.3%	14.3%	21.4%
URR	42.9%	57.1%	35.7%	0.0%	7.1%	21.4%	21.4%
Type of health facility							
Hospital	71.4%	42.9%	28.6%	14.3%	14.3%	14.3%	14.3%
Major Health Center	40.0%	30.0%	60.0%	0.0%	10.0%	10.0%	30.0%
Minor Health Center	74.4%	51.3%	56.4%	7.7%	7.7%	20.5%	20.5%
Total	67.9%	46.4%	53.6%	7.1%	8.9%	17.9%	21.4%
N	56	56	56	56	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).
* No definition was provided for 'danger signs' so this was open to the interpretation of the questionnaire administrators.

In terms of follow-up actions, completing the antenatal card was reported by 68% of health workers, followed by 54% reporting that they would schedule another ANC visit, and only 25% reporting that they would schedule an institutional delivery for the woman. Quite a bit of variation existed between regions – while 93% of health workers in NBR-W reported that they would complete the antenatal card, only 50% in URR reported the same thing. In CRR, 36% of health workers reported that they would schedule an institutional delivery compared to 21% in NBR-W and only 7% in URR.

Table 40: Health worker knowledge (follow-up actions)

What follow-up actions will you take for her?			
	Complete antenatal card	Schedule another antenatal care visit	Schedule institutional delivery
Region			
CRR	50.0%	60.7%	35.7%
NBR-W	92.9%	42.9%	21.4%
URR	78.6%	50.0%	7.1%
Type of health facility			
Hospital	71.4%	57.1%	28.6%
Major Health Center	80.0%	60.0%	0.0%
Minor Health Center	64.1%	51.3%	30.8%
Total	67.9%	53.6%	25.0%
N	56	56	56

Notes: Based on 56 interviews with health workers (doctors, nurses and midwives).

Supplies, equipment and drugs: Maternal health services

Availability and stock-out of supplies for ANC

The following two tables show the availability and stock-out occurrence, respectively, of ANC supplies at the 24 health facilities. Only 38% of facilities had malaria test kits for ANC. Fewer than one in four facilities (21%) had kits to test for HIV. Even more concerning is that a very low share of health facilities (8%) had pregnancy and syphilis test kits, and only 13% had urine protein and glucose test kits.

Table 41: Availability of at least one test during ANC on the day of interview

	Malaria Test	HIV Test	Pregnancy test	Rapid Plasma Reagent (Syphilis)	Urine protein & glucose test dipstick test)
Region					
CRR	30.0%	10.0%	0.0%	0.0%	0.0%
NBR-W	0.0%	0.0%	0.0%	0.0%	0.0%
URR	75.0%	50.0%	25.0%	25.0%	37.5%
Type of facility					
Hospital	50.0%	0.0%	0.0%	0.0%	0.0%
Major Health Center	0.0%	33.3%	0.0%	0.0%	0.0%
Minor Health Center	42.1%	21.1%	10.5%	10.5%	15.8%
Total	37.5%	20.8%	8.3%	8.3%	12.5%

Notes: Availability of supplies to conduct tests for ANC at facility or outreach. Based on 24 health facility surveys; 2 hospitals, 3 major health centers and 19 minor health centers.

Stock-out of test kits was common across all facilities, which correlates with the low percentage of facilities that had these available as indicated in the previous table. All test kits had stock-out rates (for at least 1 day) of at least 65%. This is disturbing news given that although facilities do offer tests in theory, de facto, they do not have the kits in stock to run these tests for women who attend ANC. Syphilis, pregnancy and urine protein tests had the highest rates of stock-out for which more than 90% of health facilities experienced stock-outs. In fact, in NBR-W, 100% of facilities reported stock-out for all the test kits for at least one day in the previous month.

Table 42: Stock-out of ANC supplies for at least one day in last 30 days

	Malaria Kit	HIV testing kit	Pregnancy testing kit	Rapid Plasma Reagent (Syphilis)	Urine protein & glucose testing kit (dipstick test)
Region					
CRR	70.0%	90.0%	100.0%	100.0%	100.0%
NBR-W	100.0%	100.0%	100.0%	100.0%	100.0%
URR	37.5%	50.0%	75.0%	87.5%	75.0%
Type of health facility					
Hospital	50.0%	100.0%	100.0%	100.0%	100.0%
Major Health Center	100.0%	66.7%	100.0%	100.0%	100.0%
Minor Health Center	63.2%	78.9%	89.5%	94.7%	89.5%
Total	66.7%	79.2%	91.7%	95.8%	91.7%

Notes: Table shows percentage of facilities with stock-out of kits for tests for at least 1 day within past 30 days.

Availability of maternal and newborn health equipment

Table 43 shows the availability of medical supplies for maternal and newborn health services. The partograph was the only piece of equipment available in all facilities surveyed. Intravenous solutions and needles were available in virtually all facilities (92%). Newborn resuscitation kits (25%), tape measure (29%) and delivery lights (38%) were the supplies that the lowest proportion of health facilities reported having. No health facilities in URR reported having a newborn resuscitation kit.

Table 43: Availability of maternal and newborn health supplies (at least one of each)

Table 4.7.7.2.2 - Availability of maternal and newborn health supplies (at least one of each)

	Fetoscope	Blood pressure monitor	Tape measure	Adult weighing scale	Partograph	Delivery light	IV tubing	IV solution	IV needles	Syringes and disposable needles	Newborn resuscitation kit
Region											
CRR	90.0%	90.0%	20.0%	90.0%	100.0%	30.0%	70.0%	90.0%	90.0%	80.0%	40.0%
NBR-W	50.0%	50.0%	33.3%	50.0%	100.0%	50.0%	83.3%	100.0%	100.0%	100.0%	33.3%
URR	62.5%	37.5%	37.5%	50.0%	100.0%	37.5%	100.0%	87.5%	87.5%	25.0%	0.0%
Type of health facility											
Hospital	50.0%	50.0%	0.0%	50.0%	100.0%	100.0%	50.0%	50.0%	50.0%	50.0%	50.0%
Major Health Center	66.7%	66.7%	66.7%	66.7%	100.0%	33.3%	66.7%	100.0%	100.0%	66.7%	0.0%
Minor Health Center	73.7%	63.2%	26.3%	68.4%	100.0%	31.6%	89.5%	94.7%	94.7%	68.4%	26.3%
Total	70.8%	62.5%	29.2%	66.7%	100.0%	37.5%	83.3%	91.7%	91.7%	66.7%	25.0%

Note: Based on 24 health facility interviews.

Availability and stock-out of EmOC drugs

Table 44 shows the availability and stock-out of diazepam and oxytocin at the health facilities. All facilities had at least one dose of diazepam with only 4% of health facilities (all minor health centers in URR) having a stock-out within the past 30 days. The opposite is true for oxytocin with no health facility having it available at the time of the survey and all of them experiencing a stock-out in the last 30 days.

Table 44: Availability and stock-out (last 30 days) of emergency obstetric drugs in health facilities

	Diazepam Available	Diazepam Stock-out	Oxytocin Available	Oxytocin Stock-out
Region				
CRR	100.0%	0.0%	0.0%	100.0%
NBR-W	100.0%	0.0%	0.0%	100.0%
URR	100.0%	12.5%	0.0%	100.0%
Type of health facility				
Hospital	100.0%	0.0%	0.0%	100.0%
Major Health Center	100.0%	0.0%	0.0%	100.0%
Minor Health Center	100.0%	5.3%	0.0%	100.0%
Total	100.0%	4.2%	0.0%	100.0%

Notes: Based on 24 health facility interviews.

Community beliefs

Women who had used community health services, visited a CHN, or visited a TBA in the three months prior to the survey (n=644) were asked a set of questions regarding their beliefs about pregnancy, antenatal care, delivery, family planning and changes within the facility over the past year. These women were given a set of statements and asked to give their opinion about each using a Likert Scale: from Agree Strongly to Disagree Strongly. Each table has at most three questions representing the statements posed to the women.

Pregnancy-related beliefs

Women in general did not believe that working hard during pregnancy would lead to an easy delivery. On average, 65% of women disagreed somewhat or strongly with the statement that hard work keeps a woman strong and helps her have an easy delivery. A higher share of women in URR disagreed strongly with this statement (61%) compared to CRR and NBR-W. Women on average agreed that there are risks associated with every pregnancy, with 77% agreeing (strongly or somewhat) with this statement. A higher proportion of women in URR reported agreement with the statement (93%) compared to women in CRR or NBR-W.

Table 45: Pregnancy related beliefs

Percentage of women agreeing with the following statements: "Hard work during pregnancy keeps you strong and helps you to have an easy delivery"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	16.4%	18.7%	16.4%	16.4%	32.0%
NBR-W	16.4%	4.5%	23.1%	9.7%	46.3%
URR	9.5%	3.9%	5.6%	19.6%	61.4%
Total	13.4%	9.2%	13.0%	16.5%	48.0%
"There are risks associated with every pregnancy"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	50.2%	27.4%	11.2%	5.8%	5.4%
NBR-W	35.8%	4.5%	23.1%	8.2%	28.4%
URR	68.9%	24.0%	2.8%	1.8%	2.5%
Total	55.5%	21.1%	10.0%	4.5%	8.9%

Notes: Based on 644 interviews of women who had seen TBA or CHN in past 3 months

Antenatal care related beliefs

Women were asked about ANC, which is important for identifying problems, conducting necessary and timely tests to ensure a safe pregnancy and delivery and increasing interactions with health staff to share information that can help women have a healthy pregnancy and

delivery. The survey results indicate strong beliefs around ANC, especially regarding the timing of the first ANC visit (Table 46).

As noted above, one of the most common reasons for women not attending ANC within the first trimester in The Gambia is the belief that acknowledging the pregnancy early could lead to a negative outcome during or after delivery. On average, 45% of women agreed that acknowledging the pregnancy early is dangerous for the baby (32% of women agreed strongly; 12% agreed somewhat). In NBR-W, this figure was particularly high with nearly 60% of women strongly agreeing with the statement.

Nearly 77% of women agreed either strongly or somewhat that it is ok for the first ANC visit to take place during the second trimester of pregnancy, and only 14% of women disagreed with this statement. These views are antithetical to recommended guidelines that the first ANC visit should occur during the first trimester. The belief that going for ANC for the first time in the second trimester was ok was particularly strong in NBR-W and URR. When asked about avoiding early ANC to prevent people from knowing about the pregnancy, 63% of women disagreed either strongly or somewhat with the statement with only 24% of women agreeing.

Women were divided on the usefulness of ANC – while 45% of women agreed that ANC is not helpful in preventing problems during pregnancy, an equal proportion of women disagreed with the statement. These results indicate that increasing knowledge and awareness about the timing and usefulness of ANC could increase uptake of timely ANC services in improving maternal health.

Table 46: Antenatal care related beliefs

Percentage of women agreeing with the following statements: "It is dangerous for the baby if you acknowledge your pregnancy too early"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	36.4%	24.4%	16.0%	9.3%	13.8%
NBR-W	59.0%	6.7%	22.4%	1.5%	10.4%
URR	16.2%	5.3%	15.1%	12.0%	51.4%
Total	32.2%	12.3%	17.0%	8.9%	29.7%
"It is ok for a woman to go to ANC for the first time during her second trimester"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	47.6%	24.9%	13.8%	5.8%	8.0%
NBR-W	73.1%	3.0%	14.9%	0.7%	8.2%
URR	72.3%	7.7%	2.8%	7.7%	9.5%
Total	63.8%	12.7%	9.2%	5.6%	8.7%
"I would avoid going to ANC early in my pregnancy because I do not want people to know I am pregnant too soon"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	18.7%	17.3%	15.1%	17.3%	31.6%
NBR-W	18.7%	8.2%	20.1%	10.4%	42.5%
URR	9.8%	4.2%	6.7%	21.4%	57.9%
Total	14.8%	9.6%	12.4%	17.7%	45.5%
"ANC is good for identifying issues, but is not helpful to prevent problems during pregnancy"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	43.6%	22.7%	10.2%	8.4%	15.1%
NBR-W	29.1%	5.2%	18.7%	10.4%	36.6%
URR	22.1%	10.9%	6.7%	22.8%	37.5%
Total	31.1%	13.8%	10.4%	15.2%	29.5%

Notes: Based on 644 interview of women who had seen TBA or CHN in past 3 months

Delivery related beliefs

Women were also asked about beliefs related to delivery. Of the women interviewed, 67% were of the opinion that delivering at home is not safer than at a facility while 21% felt that it is safer to deliver at home. The majority of women (71%) disagreed with the statement that women who deliver at a health facility are more likely to experience complications during labor with only

18% agreeing with the statement. Agreement was most common among women in CRR where 32% of women believing that complications are more likely at a health facility. While 30% of women believe that the risks are the same whether they deliver at home or at the health facility, nearly twice the percentage of women (58%) do not share this believe.

Table 47: Delivery related beliefs

Percentage of women agreeing with the following statements: "It is safer to give birth at home than at a health facility"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	24.9%	13.3%	18.2%	17.8%	25.8%
NBR-W	15.7%	4.5%	13.4%	14.2%	52.2%
URR	6.0%	1.1%	6.4%	18.0%	68.6%
Total	14.6%	6.1%	12.0%	17.1%	50.2%
"The risks are the same whether I deliver at the facility or I deliver at home"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	4.2%	20.4%	13.8%	11.1%	20.4%
NBR-W	.2%	1.5%	20.9%	12.7%	47.8%
URR	.2%	4.9%	7.0%	27.5%	50.4%
Total	0.1%	.6%	12.3%	18.7%	39.3%
"A woman who delivers at the health facility is likely to have complications during labor"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	20.4%	1.6%	15.6%	18.2%	34.2%
NBR-W	11.2%	6.0%	11.2%	12.7%	59.0%
URR	4.2%	1.8%	9.9%	28.2%	56.0%
Total	11.4%	.1%	12.1%	21.5%	49.0%

Notes: Based on 644 interview of women who had seen TBA or CHN in past 3 months

When asked about assistance at delivery, 46% of women disagreed with the statement that they are more comfortable with the TBA than with health center staff. However, 35% of women expressed that they are more comfortable with the TBA. Nearly 62% of women agreed that it was more comfortable to deliver in a health facility compared to the previous year. Again, women in NBR-W had very strong feelings on this with 63% agreeing strongly and another 10% agreeing somewhat. When asked about the level of support received, 59% of women disagreed that they receive more support if they deliver in the community compared to at the facility.

Finally, 61% of women agreed that they receive privacy during delivery at a health facility while 24% of women disagreed.

Table 48: Delivery related beliefs (cont. 1)

Percentage of women agreeing with the following statements: "I am more comfortable with the local TBA than I am with the staff at the health center"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	22.0%	23.0%	20.0%	16.0%	19.0%
NBR-W	17.0%	7.0%	15.0%	15.0%	46.0%
URR	18.0%	14.0%	20.0%	10.0%	38.0%
Total	19.0%	16.0%	19.0%	13.0%	33.0%
"It is more comfortable to deliver in a health facility than it was one year ago"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
NBR-W	62.7%	10.4%	14.2%	4.5%	8.2%
CRR	42.7%	32.0%	12.0%	7.6%	5.8%
URR	26.8%	19.7%	46.8%	2.5%	4.2%
Total	39.8%	22.1%	27.8%	4.7%	5.6%
"A woman receives more support if she delivers in the community than in the health facility"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	25.0%	15.6%	23.7%	15.6%	20.1%
NBR-W	16.4%	5.2%	14.9%	14.9%	48.5%
URR	7.4%	6.3%	10.2%	28.1%	48.1%
Total	15.4%	9.3%	15.9%	21.0%	38.4%
"Women who deliver at health facilities receive privacy during the delivery"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	44.9%	27.1%	9.8%	6.7%	11.6%
NBR-W	64.2%	9.7%	9.7%	3.0%	13.4%
URR	33.8%	12.7%	21.5%	15.1%	16.9%
Total	44.0%	17.1%	14.9%	9.6%	14.3%

Notes: Based on 644 interview of women who had seen TBA or CHN in past 3 months

More than half of the women (56%) agreed that it is cheaper to deliver at home than at the health facility while nearly a third of the women (29%) disagreed with this statement. This was a particularly a strong belief in URR with 72% of women in URR stating that it is cheaper to deliver at home. When asked about perceived changes related to health services, 45% of women

thought that the transportation costs to give birth in a health facility were lower than the previous year while 28% did not agree with this sentiment. Women in NBR-W were in particular agreement on lower costs with 49% agreeing strongly and another 8% agreeing somewhat. Approximately 55% of women interviewed did not feel like they could easily get to a health facility if something goes wrong during a home delivery. This was particularly true for women in URR, 77% of whom felt this way.

Table 49: Delivery related beliefs (cont. 2)

Percentage of women agreeing with the following statements: "It is cheaper to give birth at home than at a health facility"	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	25.6%	26.9%	15.7%	15.7%	16.1%
NBR-W	21.6%	6.7%	20.9%	15.7%	35.1%
URR	55.2%	16.4%	12.5%	4.3%	11.7%
Total	37.8%	18.0%	15.4%	10.7%	18.2%
"The costs required to get to a health facility and giving birth is lower now than it was one year ago"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
NBR-W	48.5%	8.3%	18.9%	7.6%	16.7%
CRR	26.7%	34.7%	16.9%	7.6%	14.2%
URR	14.8%	12.0%	39.8%	16.2%	17.3%
Total	25.9%	19.2%	27.5%	11.4%	16.1%
"If I deliver at home and something goes wrong, I can easily get to the health facility"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	20.0%	27.6%	19.1%	12.4%	20.9%
NBR-W	22.6%	6.0%	26.3%	6.8%	38.3%
URR	8.2%	4.3%	10.3%	21.0%	56.2%
Total	15.3%	12.8%	16.7%	15.0%	40.1%

Notes: Based on 644 interview of women who had seen TBA or CHN in past 3 months

Women were also asked about their husband's preferences for where they deliver. While 25% of women agreed that their husbands prefer that they deliver at home (going up to 36% in CRR), 57% of women disagreed with this belief.

Table 50: Delivery related beliefs (cont. 3)

Please tell us whether you agree with the statement: "My husband prefers that I deliver at home"	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	18.7%	17.8%	17.3%	17.3%	28.9%
NBR-W	14.2%	2.2%	9.0%	11.2%	63.4%
URR	12.0%	7.7%	22.2%	12.3%	45.8%
Total	14.8%	10.1%	17.7%	13.8%	43.5%

Women in the survey generally believed that it is safer to deliver in a health facility, the level of support received from health facility staff is higher than support received delivering in the community, and there is privacy during delivery at a health facility. Most women felt that the risks are not higher at the health facility and that it would be difficult to get to the health facility if something went wrong during delivery at home. Most women also felt that their husbands did not have a preference for home delivery. However, a substantial percentage of women still felt more comfortable with the TBA compared to health facility staff, and they stated that the costs incurred with a home delivery are lower than that of a facility delivery.

Infectious disease prevalence - Childbearing women

The prevalence of infectious disease in childbearing women during the two weeks prior to the survey was extremely low in our sample (Table 51). There was no self-reported case of diarrhea and pneumonia. Approximately 3.5% of women reported cases of fever, coughing or malaria. The prevalence of coughing and fever varied slightly by region, with URR having the highest prevalence. As in the other diseases, the wealth quintile category did not show a clear pattern. The prevalence of malaria/fever for childbearing women in our data was extremely low, especially considering the survey was conducted in the middle of the peak season. This reflects recent data from the Malaria Indicator Survey, which showed that the national prevalence of malaria has declined from 4.0% in 2010/11 to 0.2% in 2014, with large decreases in prevalence noted across all regions.[11] This might be further explained by the high rate of bed net use among pregnant women as shown in Table 22; the baseline survey was conducted a few weeks after the mass distribution of bed nets nationwide by CIAM and the MOHSW.

[11] MOHSW. (2015) The Gambia Malaria Indicator Survey, 2014. Preliminary Report. *MOHSW*.

Table 51: Most commonly reported health problems in pregnancy

	Number of women reporting a health problem	Diarrhea (Childbearing Women)	Pneumonia (Childbearing Women)	Cough (Childbearing Women)	Malaria/Fever (Childbearing Women)
Region					
CRR	25	0.3%	0.0%	0.8%	1.6%
NBR-W	10	0.4%	0.0%	0.6%	1.0%
URR	49	0.4%	0.1%	2.8%	3.2%
Female respondent is literate					
No	62	0.3%	0.1%	1.3%	2.1%
Yes	22	0.5%	0.0%	1.6%	1.8%
Wealth Quintile					
Lowest	13	0.7%	0.0%	0.5%	1.9%
Second	11	0.2%	0.0%	1.1%	1.1%
Third	24	0.2%	0.2%	2.3%	2.7%
Fourth	20	0.2%	0.0%	2.1%	2.3%
Highest	16	0.5%	0.0%	1.1%	2.1%
Gov't Hospital or HC in village					
No	10	0.4%	0.2%	0.6%	0.8%
Yes	74	0.4%	0.0%	1.7%	2.4%
Total	85	0.4%	0.0%	1.5%	2.0%

Note: Based on 2195 women interviewed at the household level about their most recent pregnancy.

The average duration of illness for the women in our sample was 2.2 days - the longest duration of illness by region was in CRR (3.1) followed by NBR-W (2.0) and URR (1.8). Illiterate mothers were ill for longer durations (2.3) compared to literate mothers (2.0). The duration of illness generally fell with an increase in the wealth quintile with the lowest quintile having an average illness duration of 2.5 days falling to 2.2 days for the highest quintile. Childbearing mothers living in settlements with a health facility had longer durations of illness (2.2) compared to those in settlements without a facility (2.0).

5.2 Family planning

Uptake of family planning

Use of modern contraceptives was low, particularly in URR where only 4% of women reported using modern contraceptives. Utilization patterns suggest higher usage rates in NBR-W (27%), and as well as a socio-economic gradient to use, indicated by increasing use over wealth quintiles. Many women, particularly in URR, reported utilizing non-modern practices and commodities to delay pregnancy. Reliance on breastfeeding to prevent or delay pregnancy is particularly common in URR, where it is the dominant FP method and is utilized by 67% of all women who reported doing anything or utilizing any method to delay birth. In contrast, breastfeeding as a form of family planning was uncommon outside of URR, with women in NBR-W and CRR most likely to rely upon injectable contraceptives.

Slight caution is required when interpreting the percentages in the table below as they are based on very small numbers of respondents. Overall, 321 women reported using a family planning method, so this is the denominator for the percentages in columns three to eleven.

Table 52: Use of family planning - Detail (among users)

	Any FP Method	Use of Modern Contra-ceptive	Among women using any family planning								
			IUD	Injectable/ Depo-provera	Implants/ Norplant	Pill	Condoms	Other Modern	Breast-feeding	Withdrawal	Traditional/ Spiritual Method
Region											
CRR	12.6%	10.3%	1.0%	61.6%	2.0%	17.2%	1.0%	1.0%	1.0%	1.0%	15.2%
NBR-W	30.1%	27.1%	1.5%	62.9%	7.6%	18.2%	1.5%	0.8%	0.0%	2.3%	5.3%
URR	14.2%	3.8%	0.0%	18.1%	0.0%	8.5%	2.1%	1.1%	67.0%	1.1%	2.1%
Female respondent is literate											
No	15.4%	10.3%	0.5%	50.9%	3.2%	12.5%	1.9%	0.9%	23.1%	1.9%	5.1%
Yes	22.7%	16.7%	1.8%	46.8%	4.6%	20.2%	0.9%	0.9%	12.8%	0.9%	11.9%
Wealth Quintile											
Lowest	12.1%	9.0%	0.0%	65.9%	0.0%	9.1%	2.3%	2.3%	13.6%	0.0%	9.1%
Second	16.7%	13.3%	1.6%	55.6%	4.8%	17.5%	1.6%	0.0%	9.5%	0.0%	9.5%
Third	16.6%	9.4%	0.0%	40.3%	3.2%	12.9%	3.2%	0.0%	27.4%	4.8%	8.1%
Fourth	17.0%	8.9%	1.5%	41.5%	3.1%	6.2%	0.0%	0.0%	38.5%	1.5%	7.7%
Highest	23.5%	18.8%	1.1%	49.5%	5.5%	24.2%	1.1%	2.2%	11.0%	1.1%	4.4%
Gov't Hospital or HC in village											
No	14.9%	13.7%	1.6%	67.7%	8.1%	14.5%	0.0%	0.0%	0.0%	1.6%	6.5%
Yes	17.9%	11.4%	0.8%	45.2%	2.7%	15.2%	1.9%	1.1%	24.3%	1.5%	7.6%
Total	17.2%	11.9%	0.9%	49.5%	3.7%	15.1%	1.5%	0.9%	19.7%	1.5%	7.4%

Note: Based on 1,886 women who were not pregnant and reported having a sexual partner at the time of the survey.

Using modern family planning for birth spacing was much more acceptable than using it for limiting the number of children women had. In some communities, it was seen as shameful if a woman became pregnant while still breastfeeding her previous child and family planning could be used to avoid this shame. Overall, there was high awareness about the importance of birth spacing, usually for two years, for the health of the mother and her children.

A member of the RBF committee drew attention to how the pricing structure of incentive payments might affect the advice that health workers gave to women:

"The amount charged is very lucrative – you go to the implant, you go to the Depo, you go the IUCDs but when you come down to the pill it can take a lower amount of money probably that was why [health workers] started advocating for Jadelle and the other one." RBF Committee member

This is something that should be monitored going forward to ensure that women are given information on all appropriate family planning methods so that they can make an informed choice about which method is best for them.

Reasons for not using family planning

Not knowing how to access services can present a fundamental barrier to health care utilization. The use of and unmet need for contraceptives provides a potentially important lens into this issue. Women who reported not using contraceptives (n=1487) were asked a series of questions around this decision, including whether they approved of the practice in general and why they ultimately opted out of use (Table 53).

Overall, 40% of women did not approve of family planning, with substantial regional variation: 28% of women in CRR did not approve going up to 43% in NBR-W and 53% in URR. Women's partners' disapproval was reportedly lower, at 9% in NBR-W, 19% in URR and 20% in CRR. While knowledge of where to access contraceptives was high in NBR-W and URR, nearly 20% of women in CRR reported not knowing where to get contraceptives. Women in the lowest socioeconomic strata and women living further from health facilities were also less likely to know how to access family planning commodities.

Table 53: Reasons for not using family planning

	Woman does not approve of FP	Woman's partner does not approve of FP	Woman reports not knowing where to get FP	Other reason
Region				
CRR	28.0%	20.0%	19.0%	27.0%
NBR-W	43.0%	9.0%	1.0%	32.0%
URR	53.0%	19.0%	2.0%	20.0%
Female respondent is literate				
No	41.0%	17.0%	9.0%	25.0%
Yes	39.0%	18.0%	10.0%	27.0%
Wealth Quintile				
Lowest	33.0%	18.0%	16.0%	26.0%
Second	33.0%	18.0%	12.0%	28.0%
Third	47.0%	14.0%	4.0%	27.0%
Fourth	44.0%	16.0%	6.0%	25.0%
Highest	44.0%	19.0%	6.0%	22.0%
Gov't Hospital or HC in village				
No	22.0%	24.0%	22.0%	28.0%
Yes	46.0%	15.0%	5.0%	25.0%
Total	40.0%	17.0%	9.0%	26.0%

Notes: Based on 1,487 respondents who have never used any family planning methods.

Although Depo was a preferred method of modern family planning, a striking number of women reported side effects from this injectable contraceptive which led to discontinuation. In the qualitative data, there was a strong perceived association between modern contraceptives and severe side effects that may constitute a barrier to uptake. One woman reported that:

"*With the injection, when I started menstruating, the blood did not stop coming and that is not good for a Muslim*." Vulnerable woman, URR

Women also perceived high levels of side effects with oral contraceptive pills.

Lack of available financing was cited as a limitation to the provision of family planning services due to the cost implications of training health workers. One RHD member noted the lack of trained health workers as an impediment to the uptake of modern family planning.

"*The family planning contraceptive prevalence rate is very low, because the service providers are not trained on this and they need equipment to be able to do this*." RHD member, CRR

Across all three regions, but especially in CRR and URR, community members voiced strong opinions that family planning should only be used by married women. The prevailing view was that unmarried women, whether adolescent or widowed, should not use family planning. Unmarried women said that it was difficult for them to seek contraceptives due to prevailing

social attitudes in this area. In URR in particular, many community members associated family planning use by unmarried women with promiscuity.

A VDC/VSG member in URR was explicit about family planning only being for married women: *"We do give advice on Family Planning but for married women. It is believed here that women who are not married should not use contraceptives."*

However, shame was also associated with pregnancy and childbearing out of wedlock and a few people noted that for unmarried women who could not abstain from sex it was preferable that they use family planning rather than get pregnant.

In a focus group discussion, men in CRR explicitly stated that awareness of family planning was low in the area which hampered demand for these services and acceptability in the community.

Cultural acceptability of family planning

While nearly half of women reported being in favor of family planning use to prevent a pregnancy, only one-third of women reported thinking that their partners were in favor of using family planning. These findings contrast slightly with those presented in the previous table where women's disapproval of family planning was higher than perceived male disapproval. However, consistent with findings reported above, approval of family planning methods was especially low in URR, where only 37% of women reported approving of family planning methods and 20% reported that their partners approved. Literate women were approximately 30% more likely to approve of utilizing family planning methods, compared to women who could not read. It is noteworthy that only 18% of women approved of women under the age of 18 using family planning, with substantial variation by region and literacy.

Table 54: Cultural acceptability of family planning

	Woman approves of couples using family planning	Woman believes partner approves of family planning	Woman approves of other women under age 18 using family planning
Region			
CRR	44.7%	30.1%	17.0%
NBR-W	72.5%	54.4%	25.7%
URR	37.3%	19.6%	14.9%
Female respondent is literate			
No	45.0%	28.9%	16.7%
Yes	58.8%	41.5%	22.8%
Wealth Quintile			
Lowest	42.7%	29.3%	17.6%
Second	51.8%	36.3%	19.8%
Third	43.9%	29.9%	18.5%
Fourth	49.8%	33.0%	18.0%
Highest	54.2%	31.7%	17.4%
Gov't Hospital or HC in village			
No	50.8%	33.9%	17.3%
Yes	47.9%	31.6%	18.6%
Total	48.5%	32.1%	18.3%
	1995	**1886**	**1996**

Note: based on 1,995 women who were not pregnant and were fertile at the time of the interview. Column 2 limited to those 1,886 women who currently have a sexual partner.

In the qualitative research, many groups were reluctant to even discuss family planning and professed no knowledge of the topic nor where information or supplies could be accessed. In a community in CRR, women suggested that FGD participants lower their voices when the topic of family planning was introduced.

In two communities in CRR, there were reports of TBAs stopping distribution of contraceptive supplies due to moral judgments about the use of modern family planning:

"*We used to give the pills to the TBAs to distribute but at some point two of my TBAs complained to me about an incident in a particular village where people talked about them in the mosque for distributing pills for women not to deliver. Because of the miscommunication, the TBAs had to stop distributing the pills. Another one also had to stop because people who were not married and wanted to play around were going to her and it is not meant for them*." CHN, CRR

"*I told them to stop giving [contraceptives] to me because of its implications. You know it was not given to me for people to abuse it in the name of immoral behaviors. I am a TBA and I have to give it to people who request it and if I give it out to people who are encouraging immoral behaviors I will commit a sin*." TBA, CRR

A VDC/VSG member in URR explained that family planning use *"is happening here but in secret, though it is painful. We cannot manifest it in the open for religious reasons"*.

Table 55 below shows women's agreement with the statement "Family planning is against nature". It shows that 32% of women agreed with this statement, 34% neither agreed or disagreed, and 34% of women disagreed with this statement. Strongest disagreement was found in CRR while strongest agreement was noted in NBR-W.

Table 55: Community beliefs about family planning

Agreement with the statement: "*Family planning is against nature*"	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	15.8%	4.5%	24.1%	9.8%	45.9%
NBR-W	20.1%	19.6%	29.0%	11.6%	19.6%
URR	21.8%	8.8%	42.6%	14.4%	12.3%
Total	20.0%	11.7%	34.0%	12.5%	21.8%

Notes: Based on 644 interview of women who had seen TBA or CHN in past 3 months

Health workers described having to talk to women one-on-one about family planning and also having to engage influential figures within communities to try to help increase the acceptability of modern family planning.

Timing and intention of pregnancies

Timing and intention of current pregnancy

Seventy one percent of current pregnancies were desired at that time while 28% of respondents would have preferred their pregnancy to have happened later. Only 1% of women who were pregnant at the time of the survey did not want to ever be pregnant again. Currently pregnant women in URR were most likely to have wanted the pregnancy then, which maps closely to women in this region reporting the lowest level of contraceptive use. Mistimed pregnancies were more common in CRR and NBR-W with 30% and 34% of women in these respective regions reporting that their pregnancy was mistimed.

Table 56: Timing and intention of current pregnancies

Respondent would have liked the current pregnancy to have happened when it happened, later, or not at all?			
	When it happened	Later	Not at All
Region			
CRR	68.7%	30.3%	1.0%
NBR-W	64.3%	33.9%	1.8%
URR	83.6%	16.4%	0.0%
Female respondent is literate			
No	75.0%	25.0%	0.0%
Yes	58.7%	37.0%	4.3%
Wealth Quintile			
Lowest	72.2%	25.9%	1.9%
Second	67.4%	30.4%	2.2%
Third	73.8%	26.2%	0.0%
Fourth	70.6%	29.4%	0.0%
Highest	73.5%	26.5%	0.0%
Gov't Hospital or HC in village			
No	68.1%	31.9%	0.0%
Yes	72.4%	26.4%	1.2%
Total	71.4%	27.6%	1.0%

Note: Based on 210 women pregnant at the time of the interview.

Ideal timing of the next child

Table 57 presents the ideal timing of the next child. Looking only at women who did not approve of family planning, approximately 66% would ideally wait at least two years to have their next child, and 6% of the respondents would prefer to not have any more children at all. The differences in ideal timing of the next child were fairly small between women who approved of family planning and those who did not suggesting that approval of family planning does not impact the ideal timing of women's next child.

Table 57: Ideal timing of next child

	Among women who do not approve of family planning					Among women who approve of family planning:				
	Would not wait for next child	Would wait <2 yrs for next child	Would wait >2 yrs for next child	Does not want more children	Undecided	Would not wait for next child	Would wait <2 yrs for next child	Would wait >2 yrs for next child	Does not want more children	Does not want more children
Region										
CRR	7.6%	15.3%	64.4%	2.8%	9.8%	7.3%	15.9%	63.8%	6.5%	6.5%
NBR-W	11.8%	3.9%	72.4%	7.9%	3.9%	3.6%	4.2%	66.9%	17.9%	7.5%
URR	4.1%	9.5%	65.2%	7.5%	13.8%	3.8%	9.5%	71.5%	9.9%	5.3%
Female respondent is literate										
No	6.6%	11.7%	63.6%	6.0%	12.1%	5.5%	10.7%	64.5%	12.7%	6.6%
Yes	6.7%	10.0%	74.2%	3.3%	5.7%	4.0%	8.7%	72.5%	8.4%	6.4%
Wealth Quintile										
Lowest	8.1%	16.3%	61.1%	3.6%	10.9%	7.9%	17.0%	59.4%	9.1%	6.7%
Second	6.8%	13.5%	63.0%	6.2%	10.4%	4.9%	10.7%	66.5%	10.7%	7.3%
Third	5.8%	10.7%	65.6%	4.5%	13.4%	4.6%	7.4%	71.4%	9.7%	6.9%
Fourth	5.9%	8.3%	69.1%	5.4%	11.3%	5.9%	9.9%	68.8%	10.4%	5.0%
Highest	6.5%	7.5%	70.4%	8.1%	7.5%	2.7%	6.8%	67.7%	15.9%	6.8%
Gov't Hospital or HC in village										
No	4.5%	7.7%	78.8%	5.4%	3.6%	2.6%	4.8%	71.6%	15.3%	5.7%
Yes	7.2%	12.4%	62.1%	5.5%	12.8%	5.8%	11.8%	65.5%	10.1%	6.8%
Total	6.6%	11.4%	65.7%	5.5%	10.8%	5.1%	10.1%	66.9%	11.4%	6.5%
N	**1027**	**1027**	**1027**	**1027**	**1027**	**968**	**968**	**968**	**968**	**968**

Notes: Based on 1,995 women who were fertile at the time of the interview.

Sources of family planning information

Table 58 provides additional detail on sources of information on family planning, with facility-based health workers, community health nurses, and family/friends all prominent sources of information. Women in NBR-W named most sources of information on family planning, followed by those in CRR and then those in URR. Women could indicate multiple sources of information on family planning.

Table 58: Percentage of women having received information on family planning by source

	Health worker at Facility	Community health nurse	Other HW	Friends/Family	Women in Community	Radio/TV
Region						
CRR	64.3%	53.2%	0.1%	55.5%	0.0%	2.0%
NBR-W	88.5%	69.4%	1.7%	76.8%	0.0%	0.4%
URR	50.3%	43.7%	0.4%	40.4%	0.0%	3.4%
Female respondent is literate						
No	63.7%	53.7%	0.5%	53.8%	0.0%	2.2%
Yes	70.1%	54.1%	0.7%	60.4%	0.0%	2.0%
Wealth Quintile						
Lowest	58.6%	50.9%	0.2%	49.1%	0.0%	3.2%
Second	69.4%	60.4%	0.7%	59.6%	0.0%	2.5%
Third	65.8%	56.9%	0.7%	56.9%	0.0%	2.5%
Fourth	65.1%	50.0%	0.5%	54.7%	0.0%	1.6%
Highest	67.4%	50.8%	0.9%	56.9%	0.0%	0.9%
Gov't Hospital or HC in village						
No	68.6%	56.9%	1.0%	65.4%	0.0%	0.4%
Yes	64.3%	52.9%	0.5%	52.5%	0.0%	2.6%
Total	65.3%	53.8%	0.6%	55.4%	0.0%	2.1%

Note: Based on 2,223 women reporting.

Decision-making for family planning

Less than 13% of women reported being the main decision maker regarding family planning use, and 40% reported that the decision was shared by herself and her partner as a couple. Nearly one in four women reported that their partner had primary control over whether they used contraceptives to prevent or delay pregnancy. Some women did not see the relevance of the question to their lives as they were not using contraception or had never discussed it with their partner. Table 59 below presents data on decision making for family planning use within a couple.

Table 59: Decision making for family planning

	Woman is main decider on FP use	Partner is main decider on FP use	FP use is joint decision by couple	Spoke with partner re: FP in last 6 months
Region				
CRR	15.3%	26.6%	38.1%	21.4%
NBR-W	15.9%	28.5%	43.7%	31.0%
URR	7.1%	18.0%	40.8%	18.4%
Respondent is literate				
No	10.4%	25.5%	39.4%	22.0%
Yes	19.0%	19.8%	43.2%	24.2%
Wealth Quintile				
Lowest	16.2%	31.0%	34.0%	17.5%
Second	9.3%	27.9%	43.0%	26.5%
Third	12.0%	16.0%	48.1%	22.2%
Fourth	11.0%	23.6%	40.2%	20.7%
Highest	14.4%	21.9%	36.6%	25.8%
Gov't Hospital or HC in village				
No	13.0%	27.7%	31.8%	20.4%
Yes	12.4%	23.0%	42.8%	23.2%
Total	12.6%	24.0%	40.4%	22.6%
	1885	**1885**	**1885**	**1886**

Notes: based on 1886 women who currently have a sexual partner.

When asked about fertility intentions, many people stated that the number of children they would have was in God's hands. Children were widely viewed as gifts from God and people stated that the timing of pregnancies was "*in the hands of God*". An implication of this belief was that some women did not talk to their husbands about or even consider family planning as they felt that it was not for them to decide the number of children they should have. Within a couple, it often seemed to be the man who decided how many children they should have.

"*The man decides as he is the one who married the woman. It is his decision to make – the number of children the woman should have*." Male community member, CRR

"If a woman wants to have a certain number of children she has to discuss it with her husband and if he doesn't agree, then leave it. Some may decide not to have children even though for me I will not stop delivering if I don't have the consent of my husband." Woman who had delivered in the previous six months, NBR-W

A TBA in URR reported that many women in her community would like to use family planning but could not as their husbands would not agree to it.

A group of men in a community of "Jahankas" (a branch of the Mandinka ethnic group) in CRR joked about the very high fertility rate among their ethnic group. This was clearly a source of

pride with men stating that they benefit from their wives having many children as some of them will be likely to prosper.

Across all three regions, expressed desired fertility was high with both male and female respondents stating that women should have at least six children, and some suggesting that more children was ideal. A stated preference for sons was given as a reason for women to keep having children if they had only had female children so far. In one community, a few of the younger participants in a male focus group discussion expressed the need to limit fertility due to the needed resources to provide proper care for the children.

Family planning services supplies and equipment

Availability of family planning supplies was extremely high with the exception of the IUCD, which was not widely available (Table 60). Supplies for family planning were more likely to be available than many other medical drugs or equipment (see later in the report). All facilities interviewed had female condoms and 96% had a least one male condom, at least one dose of Depo and at least one contraceptive implant.

Table 60: Availability of family planning supplies (at least one unit)

	Male condom	Female condom	Oral contraception	Injectable (Depo)*	Implant (Jadelle)	IUCD
Region						
CRR	90.0%	100.0%	90.0%	90.0%	100.0%	20.0%
NBR-W	100.0%	100.0%	83.3%	100.0%	100.0%	0.0%
URR	100.0%	100.0%	100.0%	100.0%	87.5%	0.0%
Type of health facility						
Hospital	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%
Major Health Center	100.0%	100.0%	100.0%	100.0%	66.7%	0.0%
Minor Health Center	94.7%	100.0%	89.5%	94.7%	100.0%	10.5%
Total	95.8%	100.0%	91.7%	95.8%	95.8%	8.3%

Notes: Shows the percentage of facilities with family planning supplies
***** Depo**:** Depot Medroxyprogesterone Acetate (DMPA)

Women who participated in the qualitative research suggested that it would be useful if contraceptive supplies were available in the community as many of them had not told their husbands that they were using family planning and they could not explain to them the need to visit the health center when they needed to collect contraceptive supplies.

Despite this high availability, there was also a high rate of stock-out for these supplies (Table 61). Seventy nine percent of facilities said they ran out of female condoms at some point in the past 30 days. Stock-outs were particularly frequently reported for Depo (96%), oral contraception

(92%) and Jadelle (92%). URR reported fewer stock-outs than either NBR-W or CRR and minor health centers reported fewer stock-outs than larger health facilities.

Table 61: Stock-out of family planning supplies for at least 1 day in last 30 days

	Male condom	Female condom	Oral contraception	Injectable (Depo)	Implant (Jadelle)	IUCD
Region						
CRR	70.0%	90.0%	100.0%	100.0%	100.0%	80.0%
NBR-W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
URR	37.5%	50.0%	75.0%	87.5%	75.0%	100.0%
Type of health facility						
Hospital	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Major Health Center	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%
Minor Health Center	63.2%	78.9%	89.5%	94.7%	89.5%	89.5%
Total	66.7%	79.2%	91.7%	95.8%	91.7%	91.7%

Note: Stock-out of family planning services for at least a day of the past 30 days at facility level. Based on 24 health facility interviews.

5.3 Child health

Infectious disease prevalence

As with the prevalence of infectious diseases for childbearing women, the disease prevalence for children under five was extremely low given the period in which the survey took place (October to November). In our sample, there were 3,402 children under five, of whom 396 (11.6%) had reportedly been ill during the two weeks prior to the survey. Among those who reported having been ill during this period, 46% were reported to have had malaria/fever, 31% were reported to have had a cough/pneumonia and 12% were reported to have had diarrhea. Although there was some regional variation in illness reported, no patterns of difference were noted by respondent's literacy, wealth quintile or availability of a government health facility in the village.

Table 62: Most commonly reported health problems among children (under five) with a reported illness in the past two weeks

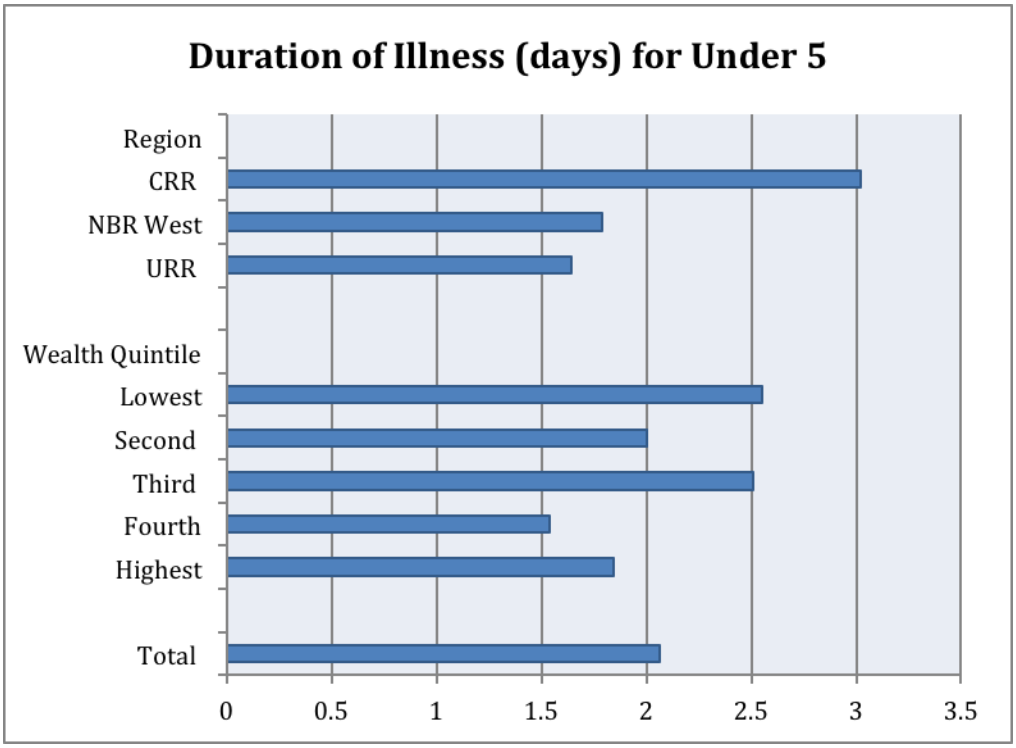
	Number of Illnesses Reported	Diarrhea (Children)	Cough/Pneumonia (Children)	Malaria/Fever (Children)
Region				
CRR	73	16.4%	34.2%	56.2%
NBR-W	110	11.8%	26.4%	50.9%
URR	212	9.9%	32.5%	40.1%
Female respondent is literate				
No	290	11.7%	30.3%	47.2%
Yes	105	11.4%	33.3%	42.9%
Wealth Quintile				
Lowest	59	11.9%	27.1%	50.8%
Second	80	5.0%	30.0%	48.7%
Third	87	17.2%	32.2%	41.4%
Fourth	90	10.0%	40.0%	47.8%
Highest	79	13.9%	24.1%	43.0%
Gov't Hospital or HC in village				
No	47	8.5%	40.4%	57.4%
Yes	348	12.1%	29.9%	44.5%
Total	396	11.6%	31.1%	46.2%

Note: Based on the 396 children under five who were ill 2 weeks prior to the survey.

The low prevalence of the above diseases, especially malaria in CRR, which is the region that has traditionally had the highest rate of malaria in the country, is surprising. Although this may be attributable to the bed net distribution exercise that had been carried out, this suggests that there may be some under-reporting of childhood illness.

The average duration of illness for children under five was around 2 days. Children in the CRR region had an average illness duration of 3 days, compared to 1.6 days in URR and 1.8 days in NBR-W. The average illness duration decreased as household wealth increased: children from the lowest quintile had an average illness duration of 2.6 days as opposed to 1.8 for the highest quintile (Figure 11).

Figure 11: Duration of illness (days) for children under 5



Health service utilization and adoption of health behaviors

Care-seeking for infectious diseases

As stated above, reported illness among children under five was very low in our sample. Out of almost 3402 children, only 46 reported having had diarrhea in the preceding two weeks. Out of these 46 children, 49% sought care. By region NBR-W had a higher proportion of care seeking for diarrhea (67%) than CRR (45%) and URR (40%). Care seeking for fever and cough followed a similar trend at the regional level. NBR-W had the highest rate of care seeking for children under five (97% and 87% respectively) followed by CRR (93% and 72%) and URR (95% and 70%).

Care seeking for malnutrition across all three regions was 34%, a figure influenced by the low rates in NBR-W (19%) and URR (13%). Almost two thirds of children under five suffering from

malnutrition in CRR were taken for care. With the exception of malnutrition, increases in wealth were associated with an increased likelihood of seeking care for children under five.

Table 63: Care seeking for children (under age five)

	Care Seeking Diarrhea	Care Seeking Cough/Pneumonia	Care Seeking Malaria/Fever	Care Seeking Malnutrition
Number of reported cases*	46	123	183	343
Region				
CRR	45.0%	72.4%	92.7%	60.7%
NBR-W	66.7%	87.0%	97.2%	18.8%
URR	40.0%	70.0%	95.4%	12.7%
Mother is Literate				
No	44.1%	74.7%	95.3%	33.3%
Yes	61.5%	71.4%	94.4%	36.1%
Wealth Quintile				
Lowest	33.3%	68.8%	90.5%	38.7%
Second	50.0%	75.0%	93.5%	46.2%
Third	50.0%	63.0%	96.2%	27.0%
Fourth	57.1%	75.7%	94.6%	29.7%
Highest	54.5%	88.9%	100.0%	29.2%
Gov't Hospital or HC in village				
No	57.1%	75.0%	100.0%	24.0%
Yes	47.5%	73.5%	94.2%	35.8%
Total	48.9%	73.8%	95.1%	34.1%

Note: Based on 3402 children under age 5 in household survey.

Timeliness of care-seeking

Table 64 below provides detail on the timeliness of care seeking for children under five. Those living in NBR-W were most likely to seek care: 84% of children sought care in NBR-W, compared to only 63% in CRR. Maternal literacy and wealth were positively associated with overall care seeking and seeking care within 24 hours of illness onset. While individuals living in villages with no nearby health facility were more likely to report ever seeking care, they were also more likely to delay care seeking.

Table 64: Care seeking: Timeliness of care seeking among children (under age five) with reported illness in past two weeks

		Among those who sought care		
	Sought care when ill	Sought care within 24 hours	Sought care within 24-48 hours	Sought care later than 48 hours
Region				
CRR	65.7%	44.8%	43.3%	11.9%
NBR-W	83.8%	52.6%	45.6%	1.8%
URR	65.8%	50.4%	36.4%	13.2%
Female respondent is literate				
No	68.8%	50.3%	39.5%	10.3%
Yes	69.8%	46.3%	43.3%	10.4%
Wealth Quintile				
Lowest	59.3%	37.5%	43.8%	18.8%
Second	69.2%	44.4%	42.6%	13.0%
Third	64.9%	52.0%	42.0%	6.0%
Fourth	72.9%	51.6%	43.5%	4.8%
Highest	76.4%	56.4%	30.9%	12.7%
Gov't Hospital or HC in village				
No	72.7%	50.0%	40.6%	9.4%
Yes	68.6%	49.3%	40.3%	10.4%
Total	69.1%	49.4%	40.3%	10.3%
N	**366**	**253**	**253**	**253**

Note: Based on 366 children under age 5 with a reported illness in the two weeks preceding the interview. Data was missing for 30 children.

Source of care

Among children for whom care was sought, minor health centers were the most frequent source of care (31%), followed by major health centers (11%) and then pharmacies (10%). Minor health centers were particularly relied upon in NBR-W with lower usage reported in CRR and URR. In CRR, major health centers were almost as frequently visited as minor health centers. Reported use of private clinics was much higher where there was no government health facility in the community (25% vs. 6%). These data are presented in Table 65.

Table 65: Source of care among children (under age five) with a reported illness in the past two weeks who sought care

	Government hospital	Major health center	Minor health center	Health post	NGO clinic	Private clinic	Pharmacy	Mobile clinic	Traditional healer	Faith-based healer	CHW	Community clinic	Home care	Other
Region														
CRR	9.0%	17.9%	19.4%	7.5%	1.5%	10.4%	13.4%	3.0%	6.0%	9.0%	0.0%	3.0%	0.0%	0.0%
NBR-W	1.8%	8.8%	59.6%	7.0%	0.0%	5.3%	3.5%	1.8%	0.0%	0.0%	5.3%	1.8%	5.3%	0.0%
URR	0.8%	7.8%	24.8%	7.0%	0.8%	8.5%	11.6%	3.1%	0.0%	14.0%	7.0%	7.0%	0.0%	7.8%
Female respondent is literate														
No	3.2%	10.8%	28.6%	7.6%	1.1%	9.7%	8.6%	1.6%	1.1%	10.3%	4.3%	5.9%	1.6%	5.4%
Yes	3.0%	10.4%	38.8%	6.0%	0.0%	4.5%	14.9%	4.5%	3.0%	7.5%	6.0%	1.5%	0.0%	0.0%
Wealth Quintile														
Lowest	3.1%	21.9%	21.9%	9.4%	3.1%	3.1%	15.6%	6.2%	3.1%	9.4%	0.0%	0.0%	0.0%	3.1%
Second	3.7%	5.6%	31.5%	9.3%	1.9%	9.3%	9.3%	3.7%	1.9%	16.7%	1.9%	3.7%	0.0%	1.9%
Third	4.0%	10.0%	36.0%	0.0%	0.0%	8.0%	12.0%	0.0%	0.0%	12.0%	8.0%	10.0%	0.0%	0.0%
Fourth	3.2%	9.7%	33.9%	9.7%	0.0%	6.5%	8.1%	3.2%	1.6%	8.1%	3.2%	4.8%	3.2%	4.8%
Highest	1.8%	10.9%	29.1%	7.3%	0.0%	12.7%	9.1%	1.8%	1.8%	1.8%	9.1%	3.6%	1.8%	9.1%
Gov't Hospital or HC in village														
No	3.1%	12.5%	28.1%	9.4%	0.0%	25.0%	0.0%	6.2%	6.2%	3.1%	0.0%	0.0%	3.1%	3.1%
Yes	3.2%	10.4%	31.7%	6.8%	0.9%	5.9%	11.8%	2.3%	0.9%	10.4%	5.4%	5.4%	0.9%	4.1%
Total	3.2%	10.7%	31.2%	7.1%	0.8%	8.3%	10.3%	2.8%	1.6%	9.5%	4.7%	4.7%	1.2%	4.0%

Note: Based on 253 children with a reported illness in the past two weeks who sought care.

Children with diarrhea who received ORS

Out of the 396 children under five who were ill within the two weeks prior to the survey, only 46 (12%) had diarrhea. Forty one percent of these children received oral rehydration solution (ORS) as part of their treatment for the diarrhea (Table 66). Children under five in URR were more likely to receive ORS when they had diarrhea (57%) than children in NBR-W (33%) or CRR (23%).

Table 66: Had diarrhea and received ORS (aged under five)

	Had diarrhea and received ORS
Region	
CRR	23.1%
NBR-W	33.3%
URR	57.1%
Mother is Literate	
No	38.2%
Yes	50.0%
Wealth Quintile	
Lowest	28.6%
Second	50.0%
Third	40.0%
Fourth	33.3%
Highest	54.5%
Gov't Hospital or HC in village	
No	25.0%
Yes	42.9%
Total	41.3%

Notes: Based on 46 morbidity episodes among children under 5 where the respondent indicated diarrhea to be the health problem.

Vaccination coverage

Approximately 90% of respondents to the household questionnaire consented to a series of questions on vaccination of their youngest child. Vaccine coverage, in general, was reported to be relatively high. Table 67 below provides an overview of vaccination coverage using a number of tracer vaccines.

The table shows completion of BCG and pentavalent vaccination, as well as initiation of rotavirus, measles and deworming. Very high coverage was reported of BCG vaccination (96%) and full pentavalent coverage (96%%), while the more recently introduced rotavirus vaccine had the lowest coverage, at 61% for at least one dose. Approximately 90% of children over the age of 6 months reported having received at least one dose of Vitamin A supplementation, however

mebendazole coverage remained low, particularly in URR where only 16% of children over the age of 1 year were reported to have received a dose of the deworming tablet. The Region with the highest coverage, CRR, had only reached 71% of children with at least one dose of Mebendazole.

Table 67: Vaccination coverage

	BCG – all children	At least 1 Rotavirus among children age 7 weeks +	All three Pentavalent doses among children age 5 months +	At least 1 measles vaccine among children 10 months +	At least 1 Vitamin A dose among children > 6 months	At least one dose of mebendazole among children > 1 year
Region						
CRR	96.1%	72.3%	97.7%	97.8%	95.2%	71.3%
NBR-W	98.9%	46.0%	98.7%	98.6%	90.5%	64.9%
URR	92.7%	57.6%	91.0%	91.7%	85.5%	15.7%
Female respondent is literate						
No	95.2%	58.6%	95.0%	95.2%	91.1%	49.1%
Yes	96.5%	65.7%	98.1%	98.6%	89.9%	61.7%
Wealth Quintile						
Lowest	95.1%	64.2%	97.2%	97.8%	94.3%	57.8%
Second	97.5%	61.6%	97.1%	97.3%	92.6%	52.9%
Third	95.0%	57.1%	93.8%	94.8%	85.3%	51.9%
Fourth	95.8%	61.3%	94.6%	94.6%	90.2%	45.5%
Highest	94.4%	58.2%	96.2%	95.6%	91.7%	53.1%
Gov't Hospital or HC in village						
No	99.0%	70.7%	98.2%	98.4%	95.9%	68.5%
Yes	94.5%	57.4%	95.0%	95.4%	89.2%	47.5%
Total	95.6%	60.5%	95.8%	96.1%	90.8%	52.4%
N	**1867**	**1666**	**1400**	**1072**	**1345**	**949**

Note: Based on 1,867 respondents who consent to provide information on vaccination of their youngest child, including 1,679 children over the age of 6 weeks, 1,400 children over the age of 5 months, 1,345 children over the age of 6 months, 1,068 children over the age of 10 months, and 949 children over the age of 12 months. Data on rotavirus is missing for 13 children and on measles is missing for 4 children.

The above table only includes data on Vitamin A supplementation of at least one dose among children older than six months. However, in the qualitative data, in both CRR and URR, uptake of Vitamin A supplementation was noted to be low among children who had completed their vaccination schedule as caregivers often stopped regularly attending health services once immunization is complete.

Use of bednets

Bednet coverage for children was virtually universal. This could be due to the bednet distribution that occurred prior to the survey. Bednet use for children under five was almost the same in all three regions and across wealth quintiles.

Table 68: Household ownership of bednets and bednet utilization by children (aged under five)

	At least 1 bednet	At least 3 bednets	Children under 5 used bednet last night
Region			
CRR	99.6%	45.5%	95.9%
NBR-W	98.9%	51.1%	95.1%
URR	99.1%	35.9%	97.2%
Mother is Literate			
No	99.4%	45.0%	96.0%
Yes	98.7%	39.1%	96.3%
Wealth Quintile			
Lowest	99.3%	33.0%	96.6%
Second	99.8%	47.2%	96.3%
Third	99.3%	36.6%	96.5%
Fourth	98.9%	38.2%	95.6%
Highest	98.9%	62.6%	95.2%
Gov't Hospital or HC in village			
No	98.8%	38.7%	95.3%
Yes	99.4%	44.9%	96.3%
Total	99.2%	43.5%	96.0%
N	2,226	2,226	3,356

Note: First two columns based on 2226 interviews done at household level
* Based on the 3356 children under 5 in our survey for whom we have information on bednet use the previous night.

Patient satisfaction with health facility services

Adults taking a child to the clinic for treatment were asked about their satisfaction with certain aspects of the facility. Respondents were asked to agree (1), be neutral (2) or disagree (3) with statements made by the interviewer. With relatively little variation by region, literacy or wealth quintile, the 154 respondents agreed that the facility was clean, and that staff were courteous, spent an adequate amount of time with them and took time to explain issues to them. Waiting times were said to be reasonable and privacy was sufficient at the facility.

Table 69: Satisfaction with health facility experience for children (aged under five)

Please tell me whether you agree or disagree with the following statements? (1 agree, 2 neither agree of disagree, 3 disagree)	Health facility is clean	Staff are courteous and respectful	Health workers explained health condition clearly	It is easy to get prescribed medicines	Waiting time is reasonable	Health facility has sufficient privacy	Health worker spent sufficient time with child
Region							
CRR	1.11	1.02	1.05	1.52	1.25	1.07	1.09
NBR-W	1.18	1.16	1.27	1.57	1.53	1.16	1.13
URR	1.10	1.20	1.46	1.35	1.55	1.11	1.09
Mother is Literate							
No	1.15	1.17	1.30	1.49	1.47	1.14	1.12
Yes	1.12	1.06	1.22	1.43	1.48	1.12	1.18
Wealth Quintile							
Lowest	1.23	1.15	1.00	1.46	1.38	1.15	1.15
Second	1.21	1.32	1.21	1.44	1.50	1.11	1.05
Third	1.19	1.12	1.44	1.46	1.58	1.28	1.31
Fourth	1.07	1.09	1.28	1.46	1.45	1.09	1.10
Highest	1.12	1.13	1.27	1.46	1.47	1.13	1.14
Total	1.14	1.14	1.28	1.47	1.47	1.13	1.14

Notes: Based on 154 exit interviews after clinic visits with children under-5. There was missing data for six caregivers who participated in the exit interviews; these are excluded here.

Reasons for health facility selection

Table 70 below gives the reason for choosing the facility for health services for a child under the age of five. The reasons given are not mutually exclusive, with respondents allowed to choose more than one reason. The most common reason for choosing the facility for the child was proximity (54%). The availability of drugs (18%) and quality of care (14%) were the second and third most common reasons for seeking care at the facility. In URR, the low cost of services was a more frequently cited reason for choosing the health facility than in CRR or NBR-W (19% vs. 8% and 7% respectively).

Table 70: Reasons for health facility selection

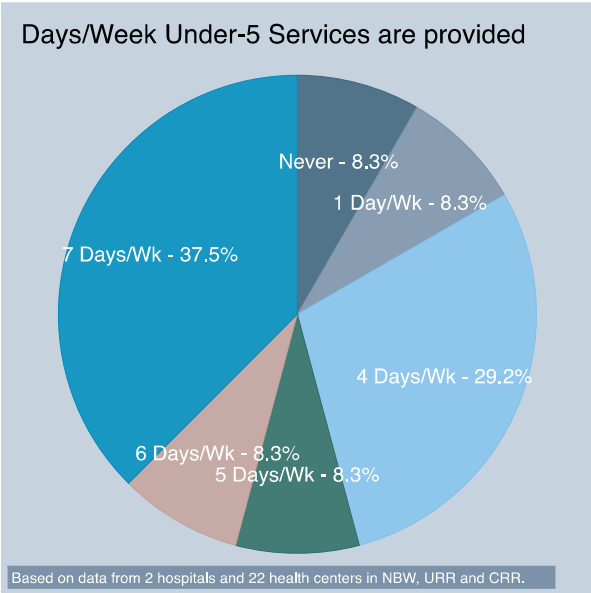
"What are the primary reasons for choosing this health facility today?"	Close to home	Low cost	Trust providers/high quality care	Availability of drugs	Recommendation or referral
Region					
CRR	48.1%	7.7%	21.2%	17.3%	3.8%
NBR-W	61.4%	6.8%	6.8%	25.0%	0.0%
URR	53.1%	18.8%	14.1%	12.5%	0.0%
Mother is Literate					
No	53.6%	11.8%	13.6%	18.2%	1.8%
Yes	55.1%	12.2%	16.3%	16.3%	0.0%
Wealth Quintile					
Lowest	0.0%	0.0%	0.0%	0.0%	0.0%
Second	61.5%	0.0%	7.7%	30.8%	0.0%
Third	47.4%	10.5%	10.5%	26.3%	5.3%
Fourth	38.5%	11.5%	26.9%	23.1%	0.0%
Highest	57.3%	14.6%	12.5%	13.5%	1.0%
Total	53.2%	12.3%	14.3%	18.2%	1.3%

Notes: Based on 154 exit interviews with caregivers of children under age five. There was missing data for six caregivers who participated in the exit interviews; these are excluded here.

Availability of child health services

Figure 12 illustrates that 8% of health facilities did not offer any child health services and a further 8% only offered these services on one day per week but the remaining 83% of facilities offered services for children under five at least four days per week, with 38% of facilities offering these services every day.

Figure 12: Days/week under-5 services are provided



While 96% of health facilities reported being open 24 hours a day, only 29% reported that services for children under the age of five were available any time. In 63% of health facilities these services were not available at the weekends and 58% reported providing these services for less than 8 hours per day.

Table 71: Availability of services for children (aged under five)

	Open 24 hours	Days per week U5 care offered	U5 care available anytime (24 hrs)	U5 care not available on weekends	U5 care available less than 8 hrs/day
Region					
CRR	90.0%	5.5	40.0%	50.0%	60.0%
NBR-W	100%	4.7	16.7%	66.7%	83.3%
URR	100%	4.0	25.0%	75.0%	37.5%
Type of Facility					
Hospital	100%	0	0.0%	100%	100%
Major HC	100%	6.0	33.3%	33.3%	66.7%
Minor HC	94.7%	5.1	31.6%	63.2%	52.6%
Total	95.8%	4.8	29.2%	62.5%	58.3%

Notes: All statistics are based on the 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

Health facility fees

Health facility costs were low, with only 8% of respondents reporting having to pay fees to attend services for children under five and the average cost of a visit being $1. This is a noticeably lower proportion of clients reported paying a fee than among women attending ANC services of whom 38% of women reported having been charged fees. (See Table 27 above.) In NBR-W, a particular low proportion of clients reported having paid a fee to attend child health services (2%) and the total cost of the visit was lower than in the other two regions.

Table 72: Health facility fees (U5)

	Percent paying any fee	Total cost of facility visit
Region		
CRR	9.6%	$0.52
NBR-W	2.3%	$0.12
URR	9.4%	$1.55
Respondent is literate		
No	7.3%	$0.98
Yes	8.2%	$1.05
Wealth Quintile		
Lowest		
Second	15.4%	$0.64
Third	5.3%	$0.58
Fourth	11.5%	$1.63
Highest	6.2%	$0.88
Total	7.5%	$1.00
	160	12

Notes: All fees originally reported in GMD and converted at 43 GMD:1US$. Data reported is based on 160 under-5 exit interviews.

Barriers to accessing child health services

Average travel time to the health facility to access child health services varied by region with the shortest times reported in URR (41 minutes) compared with 56 minutes in NBR-W and 73 minutes in CRR. Transportation costs were highest in NBR-W.

Table 73: Time and financial costs of transport to health facility (U5)

		Transport Cost to Facility		
	Time to facility (Minutes)	$0	$0.01-$0.93	$0.94-$1.86
Region				
CRR	73.1	78.8%	21.2%	0.0%
NBR-W	55.9	56.8%	40.9%	2.3%
URR	40.5	87.5%	10.9%	1.6%
Respondent is literate				
No	54.9	78.2%	20.9%	0.9%
Yes	55.8	71.4%	26.5%	2.0%
Wealth Quintile				
Lowest	--	--	--	--
Second	63.0	76.9%	23.1%	0.0%
Third	76.0	89.5%	10.5%	0.0%
Fourth	52.1	76.9%	23.1%	0.0%
Highest	53.0	72.9%	25.0%	2.1%
Total	55.2	76.2%	22.5%	1.3%

Notes: Based on 159 (column 1) and 160 (columns 2,3,4) under-five visit exit interviews: there is missing data for 1 person for the question regarding time to facility.
All costs originally reported in GMD and converted at 43 GMD:1US$.

Comparing travel time in minutes with what was reported for women attending ANC services, we find longer average travel time for ANC than for under-5 visits (average of 34 and 55 minutes, respectively). While out of pocket expenses for transportation costs were low overall, respondents were also more likely to report paying out of pocket travel expenses for accessing under-5 care than for ANC.

Preference for community vs. facility care

The results in Table 74 are similar to those presented in relation to women attending ANC services above, in that we see a preference, by the 32 women interviewed, for facility level care for under five in NBR-W and CRR whilst women in URR prefer community level care for their under fives.

Table 74: Preference for community vs. facility-based care for under-5 checkups

	"I prefer seeing a community health nurse rather than visiting a health center for under-5 checkups."		
	Agree	Neither Agree nor Disagree	Disagree
Region			
CRR	33.3%	8.3%	58.3%
NBR-W	0.0%	27.3%	72.7%
URR	55.6%	33.3%	11.1%
Mother is Literate			
No	28.6%	28.6%	42.9%
Yes	27.3%	9.1%	63.6%
Wealth Quintile			
Lowest	0.0%	0.0%	0.0%
Second	33.3%	0.0%	66.7%
Third	50.0%	33.3%	16.7%
Fourth	16.7%	33.3%	50.0%
Highest	23.5%	17.6%	58.8%
Total	28.0%	22.0%	50.0%

Note: Based on the 32 people interviewed for the under 5 exit who knew a community health worker in their community.

Given the high proportion of women in URR who preferred to attend ANC, deliver and send their children to community level healthcare, increasing the uptake of these services presents a daunting task for the project.

Health worker knowledge

Health workers were asked at what age particular vaccines should be given to an infant/child. Table 75 gives the proportion of health workers who gave the correct answer. The vaccines in question are BCG, (which should be given at birth as per the national protocols), the first dose of Pentavalent (to be given between 6 to 8 weeks) and the first measles vaccine dose (to be given between 6 and 9 months of age). The question was only asked for health workers who identified themselves as either a nurse of a doctor.

Knowledge of when vaccinations should be administered was very low among the health workers. Only 23% of the health workers knew the correct time to give the BCG vaccine. In the case of the first doses for Pentavalent and measles, the proportion of health workers who gave the correct age was 19% and 29% respectively.

Table 75: Healthcare workers can accurately state the age at which vaccinations should be provided

	BCG (at birth)	Pentavalent first dose (6-8 weeks)	Measles first dose (6-9 months)
Region			
CRR	28.9%	23.7%	47.4%
NBR-W	33.3%	45.8%	54.2%
CRR	34.4%	12.5%	18.8%
Type of health facility			
Hospital	50.0%	50.0%	87.5%
Major Health Center	25.0%	33.3%	41.7%
Minor Health Center	31.1%	21.6%	33.8%
Total	23.4%	18.8%	28.9%
N	128	128	128

Notes: Based on 128 health worker interviews. Based on health worker interviews.

Supplies and equipment

Availability of drugs for child health care

Only 8% of the health facilities had ORS (Oral Rehydration Solution) at the time of the interview, and a third had folic acid available for children. The low availability of Mebendazole, especially in URR, is also of concern. Iron tablets and Vitamin A were more likely to be available at a facility (79% and 71% respectively) although availability of iron tablets was low in NBR-W (50%).

Table 76: Availability of child supplements, ORS, antibiotics and deworming medication on the day of the survey

	Oral Rehydration Solution	Iron tablets	Folic acid	Antibiotic drug (Besides Amoxicillin)	Vitamin A	Mebendazole
Region						
CRR	10.0%	90.0%	40.0%	60.0%	70.0%	90.0%
NBR-W	0.0%	50.0%	66.7%	66.7%	83.3%	66.7%
URR	12.5%	87.5%	0.0%	62.5%	62.5%	12.5%
Type of health facility						
Hospital	0.0%	50.0%	50.0%	100.0%	0.0%	100.0%
Major Health Center	0.0%	66.7%	66.7%	100.0%	100.0%	100.0%
Minor Health Center	10.5%	84.2%	26.3%	52.6%	73.7%	47.4%
All Facilities	8.3%	79.2%	33.3%	62.5%	70.8%	58.3%

Notes: Table shows the availability of drugs for treatment of most common under five illnesses. Based on 24 health facility interviews.

The drugs least likely to be available on the day of the survey were also the drugs most likely to have experienced stock-out during the 30 days before the survey: ORS (92%) and Folic acid (71%). Patterns of drug stock-outs varied by region and type of health facility.

Table 77: Stock-out of child health drugs at facility in the last 30 days

	Oral Rehydration Solution	Iron tablets	Folic acid	Antibiotic drug (Besides Amoxicillin)	Vitamin A	Mebendazole
Region						
CRR	90.0%	10.0%	60.0%	50.0%	30.0%	10.0%
NBR-W	100.0%	66.7%	50.0%	33.3%	16.7%	33.3%
URR	87.5%	12.5%	100.0%	62.5%	37.5%	87.5%
Type of health facility						
Hospital	100.0%	50.0%	50.0%	0.0%	100.0%	0.0%
Major Health Center	100.0%	33.3%	33.3%	0.0%	0.0%	0.0%
Minor Health Center	89.5%	21.1%	78.9%	63.2%	26.3%	52.6%
Total	91.7%	25.0%	70.8%	50.0%	29.2%	41.7%

Notes: Table shows the stock-out (for at least a day) of drugs for treatment of most common illnesses among children under five over the past 30 days. Based on 24 health facility interviews.

Availability of supplies for provision of vaccination services

Out of the 24 facilities in our sample 23 (96%) had weighing scales for infants and all 24 (100%) had vaccination cards. Only two thirds of the facilities had needles and disposable syringes, with particularly low availability of these in URR (25%).

Table 78: Availability of vaccination equipment

	Weighing scale (Infants)	Functional fridge	Needles (and disposable syringes)	Vaccination card (for immunization)
Region				
CRR	90.0%	80.0%	80.0%	100.0%
NBR-W	100.0%	83.3%	100.0%	100.0%
URR	100.0%	87.5%	25.0%	100.0%
Type of health facility				
Hospital	100.0%	0.0%	50.0%	100.0%
Major Health Center	100.0%	100.0%	66.7%	100.0%
Minor Health Center	94.7%	89.5%	68.4%	100.0%
Total	95.8%	83.3%	66.7%	100.0%

Notes: Table shows percentage of facilities with equipment to perform vaccinations. Based on 24 health facilities.

Table 79 shows the availability of vaccines at the health facilities and illustrates that no more than half of the facilities had each of these vaccines in stock on the day of the survey. Overall availability of vaccines ranged from 42% (Measles and Pentavalent) to 50% (Tetanus Toxoid). Vaccine availability was consistently high in URR (88%) while, of concern, no vaccines were available in NBR-W.

Table 79: Availability of vaccines at the facility on the day of the survey

	BCG	OPV*	TT	Measles vaccine	Pentavalent	Rotavirus	Pneumococcal
Region							
CRR	40.0%	40.0%	50.0%	30.0%	30.0%	40.0%	30.0%
NBR-W	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
URR	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%
Type of health facility							
Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Major Health Center	33.3%	33.3%	66.7%	33.3%	33.3%	33.3%	33.3%
Minor Health Center	52.6%	52.6%	52.6%	47.4%	47.4%	52.6%	47.4%
Total	45.8%	45.8%	50.0%	41.7%	41.7%	45.8%	41.7%

Note: Availability of vaccines at facility level. Based on 24 health facility interviews.
* OPV: Oral Polio Vaccine

As might be expected given the low availability of vaccines, stock-outs for these drugs in the preceding 30 days were high. Seventy one percent of the facilities experienced a stock-out of BCG, the same number also experienced a stock-out of rotavirus. Stock-outs were lowest in URR and highest in NBR-W.

Table 80: Stock-out of vaccines at the facility in the last 30 days

	BCG	OPV	TT	Measles vaccine	Pentavalent	Rotavirus	Pneumococcal
Region							
CRR	70.0%	60.0%	50.0%	70.0%	70.0%	60.0%	70.0%
NBR-W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
URR	50.0%	12.5%	12.5%	37.5%	12.5%	62.5%	37.5%
Type of health facility							
Hospital	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Major Health Center	66.7%	66.7%	33.3%	66.7%	66.7%	100.0%	100.0%
Minor Health Center	68.4%	47.4%	47.4%	63.2%	52.6%	63.2%	57.9%
Total	70.8%	54.2%	50.0%	66.7%	58.3%	70.8%	66.7%

Notes: Table shows percentage of health facilities with at least one day of stock-out of vaccines in the previous 30 days. Based on 24 health facility interviews.

Health workers described how these stock-outs affected their ability to provide services:

"When you go for RCH sometimes there are no vaccines. It was just yesterday when "ROTA" [Rotavirus vaccine] came but throughout the past 3 weeks there was no ROTA. You want to work but the material is not there." Health worker, URR

With regard to supplies to facilitate the provision of vaccination outreach services, all three major health centers had ice packs and a cold box to carry vaccines, and most minor health centers also carried these supplies, with slightly lower availability of ice packs than cold boxes.

Table 81: Availability of cold box and ice packs for vaccination services

	Cold box (Vaccination carrier)	Ice packs
Region		
CRR	80.0%	80.0%
NBR-W	83.3%	83.3%
URR	100.0%	87.5%
Type of health facility		
Major Health Center	100.0%	100.0%
Minor Health Center	94.7%	89.5%
Total	87.5%	83.3%

Note: Table shows percentage of facilities with equipment to perform outreach vaccinations. Based on 22 health facilities (excluding Hospitals).

Perceived changes in child care commitments

Of the 644 women in our survey who used the services of a community health nurse, in the three months preceding the survey, 61% agreed with the statement that they now spend less time caring for a sick child than they did a year ago. The highest proportion of women who agreed strongly with this statement was in NBR-W (62%), which encompasses the area of the pilot project.

Table 82: Perceived changes in child care commitments

Do you agree with the following statement: *I spend less time caring for sick children than I did one year ago.*					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
NBR-W	62.1%	7.6%	18.2%	3.0%	9.1%
CRR	19.2%	28.1%	29.0%	8.9%	14.7%
URR	29.9%	36.3%	14.8%	6.3%	12.7%
Total	32.8%	27.5%	20.5%	6.6%	12.7%

Notes: Based on 644 household interviews of women who had seen a TBA or CHN in past 3 months

5.4 Child nutrition

Prevalence of malnutrition

The prevalence of stunting, wasting and underweight children based on anthropometry carried out at the time of the survey is given in Table 83 below. A quarter of the children can be characterized as suffering from moderate to severe stunting. As expected, CRR had the highest prevalence of moderate to severe stunting out of the 3 regions (28%), followed by URR (23%) and NBR-W (22%). The prevalence of moderate to severe stunting decreased with wealth, with 29% prevalence among children in the lowest wealth quintile dropping to 18% for the highest wealth quintile. Nearly a tenth of the children in CRR suffered from severe stunting, the highest of the three regions. URR had a severe stunting prevalence equal to the average (7%), and the lowest rate of severe stunting was in NBR-W at 6%.

Ten percent of children under the age of 5 were found to have moderate to severe wasting whilst 2% suffered from severe wasting. The prevalence of moderate to severe wasting mirrored that of severe wasting, with moderate to severe wasting being 4 to 5 times higher across all categories. In both wasting categories, CRR had the highest prevalence (12% and 3% respectively). In both URR and NBR-W, prevalence of moderate and severe wasting among children under five was 8% and 2% respectively. As with stunting, moderate to severe wasting also fell with income (from 10% among children in the lowest wealth quintile to 8% among children in the highest wealth quintile), but there was no clear pattern when it came to severe wasting.

As has been the trend, almost a quarter of children in CRR were underweight: the highest prevalence of the three regions. Prevalence rates in NBR-W and URR were lower at (17% and 18% respectively). As with stunting and wasting, prevalence of moderately underweight children decreased with wealth (from 24% to 14% between the lowest and highest wealth quintiles). Six percent of the children in the three regions were severely underweight.

No substantial differences were noted in the prevalence of malnutrition by mother’s literacy.

Table 83: Anthropometrics - Means

	Measured during this survey	Moderate to severe stunting HAZ Below -2	Severe stunting HAZ Below -3	Moderate to severe wasting WHZ Below -2	Severe wasting WHZ Below -3	Moderate to severe underweight WAZ Below -2	Severe underweight WAZ Below -3
Region							
CRR	96.5%	27.8%	8.9%	11.7%	2.7%	23.4%	7.2%
NBR-W	99.4%	22.2%	6.1%	8.2%	2.4%	17.0%	3.5%
URR	99.3%	23.0%	6.5%	8.4%	2.1%	17.6%	5.2%
Female respondent is literate							
No	98.1%	25.1%	7.6%	9.7%	2.6%	20.1%	5.8%
Yes	98.3%	24.0%	6.8%	9.8%	1.9%	19.0%	5.1%
Wealth Quintile							
Lowest	98.6%	29.0%	9.5%	11.3%	1.9%	24.1%	7.5%
Second	96.7%	26.0%	9.7%	10.3%	2.6%	21.4%	6.7%
Third	98.7%	27.2%	8.8%	10.1%	2.9%	20.6%	5.7%
Fourth	99.1%	24.2%	5.0%	9.5%	2.0%	18.9%	4.4%
Highest	97.8%	17.9%	4.1%	7.6%	2.7%	14.4%	4.0%
Gov't Hospital or HC in village							
No	98.6%	27.0%	9.4%	9.9%	2.6%	21.3%	6.6%
Yes	98.1%	24.2%	6.9%	9.7%	2.4%	19.4%	5.4%
Total	98.2%	24.8%	7.4%	9.7%	2.4%	19.8%	5.6%
N	3,387	3,325	3,325	3,325	3,325	3,325	3,325

Note: There were a total of 3,402 children under 5, with 15 unavailable. Of the 3,387 available, 62 refused to be measured. Eighty-two of the children had implausible z-scores (<-6 or >6)

Many communities, particularly in CRR and URR, reported food insecurity, attributed largely to the recent failed rains.

"We need assistance because there is hardship. The women and children need food rations. We had a failed cropping season last year and if you are hungry you cannot support your child." Woman who had delivered in the previous six months, CRR

"Also, when the family's locally produced food stuff has run out buying complementary foods for the child becomes a big problem for some. The poor rains experienced in the last cropping season resulted in a poor harvest especially rice. The result is hunger. If any assistance in the form of food rations is going to be provided, it should be done already to alleviate the suffering. We are seeking assistance." Woman who had delivered in the previous six months, CRR

"If one's crops are spoilt due to the last season's drought, they may not be able to provide sufficient food for the family as some families have already finished eating their farm products at this time of the year." VDC/VSG member, URR

Community gardens, spearheaded by VDCs, were highlighted as an important source of nutritious food within communities and where no community garden existed demand for one was high:

"The other challenge for us is improving our nutritional status by eating good foods which includes having a vegetable garden for the community. In order to get a balanced diet we need to eat enough vegetables and fruits which is lacking in this village. The problem we have is that although the women would like to start gardening, fencing and water supply is the biggest challenge for them. Those women who started their own gardening travel a long distance to get water for their plants to grow. There is no community garden." VDC/VSG member, CRR

Breastfeeding

Breastfeeding initiation and duration of breastfeeding

Table 84 provides an overview of breastfeeding behaviors in the study sample. Only 15 % of the women interviewed breastfed their child within the first hour. CRR had the highest rate of breastfeeding within the first hour (20%), followed by NBR-W (13%). Most infants (87%) were breastfed within 24 hours of birth. Women in NBR-W were most likely to engage in exclusive breastfeeding for the first six months (55%), with this falling to 43% in CRR. The median duration of breastfeeding for the three regions was 12.0 months, with women in URR reporting the shortest median duration at 9.5 months.

Table 84: Breastfeeding behavior for most recent birth

	Breastfeeding was initiated within one hour after birth	Infant was breastfed within 24 hours after birth	Exclusive breastfeeding (EBF) at 6 months*	Median duration of breastfeeding in months**
Region				
CRR	20.1%	88.0%	43.0%	13.0
NBR-W	12.8%	89.4%	55.0%	15.0
URR	9.7%	84.0%	47.0%	9.5
Female respondent is literate				
No	12.7%	86.3%	48.0%	12.0
Yes	20.9%	89.0%	58.0%	12.0
Wealth Quintile				
Lowest	12.1%	89.7%	53.0%	12.0
Second	16.4%	88.1%	53.0%	13.0
Third	10.6%	85.6%	48.0%	11.0
Fourth	16.0%	86.7%	51.0%	11.0
Highest	18.8%	84.8%	46.0%	12.0
Gov't Hospital or HC in village				
No	33.5%	88.3%	52.0%	12.0
Yes	9.3%	86.6%	49.0%	12.0
Total	14.8%	87.0%	49.0%	12.0
N	2,226	2,226	1,497	2,060

* Only women who had breastfed beyond 6 months.
** Only women who had completed breastfeeding.

In the qualitative data, the practice of exclusive breastfeeding was reported to be common across all three regions: a pattern that is not reflected in the quantitative data presented above. Respondents reported that many women had abandoned the traditional practice of giving a newborn baby "holy water" before initiating breastfeeding. While colostrum was previously discarded, women now described the importance of giving this to the baby.

In one community in NBR-W, the VDC/VSG have promoted the idea that the 'holy water' can be given to the mother and passed on to the baby through the breastmilk as a way of adapting this tradition in a way that promotes health.

Challenges remain, however, with one health worker explaining some women's desire to also give their children water to drink:

"Health seeking behavior in the past was hampered by traditional and cultural beliefs that people have towards health and disease. A good example is when exclusive breastfeeding was being promoted in the early stages. It was believed that exclusive breastfeeding can work for

Europeans who live in cold climates but not for people who live in hot climates like here. So it was a bit difficult for many mothers to accept exclusive breast feeding as the newborn not drinking water for six months will harm the child." VDC/VSG member, CRR

"*They tell you this part of the country is very hot. So how can you have a child for six months without drinking? It takes a lot of time and effort to convince them that the child does not need the water as the breast milk contains the water for the baby*." Health worker, URR

Two groups of respondents noted that exclusive breastfeeding was still not universal and that further efforts were needed in this area. Male and female community members alike described how women's domestic duties including housework, farming and child care, sometimes interfered with their ability to exclusively breastfeed. This was generally judged to be irresponsible behavior on the part of women.

Participants in NBR-W reported an increase in exclusive breastfeeding up to the age of six months since the pilot project, with concomitant health benefits noted.

"*Now we are practicing exclusive breastfeeding and this is giving our children good health, no more frequent incidence of diarrhea, vomiting and high body temperature."* Woman who had delivered in the previous six months, NBR-W

Breastfeeding knowledge

Despite these challenges promoting the adoption of healthy breastfeeding practices, general messages on the importance of early and exclusive breastfeeding appear to have reached a significant proportion of the population (Table 85). For example, despite some regional variations, knowledge of exclusive breastfeeding was relatively high, with more than 92% of mothers reporting that infants should consume only breastmilk until they reach 6 months of age. This is in stark contrast to the 49% of mothers who reported having done this (see Table 52 above). Moreover, when given more detailed follow up questions, households exhibited gaps in knowledge regarding the how this should translate into daily feeding practices. For example, 60% of mothers in NBR-W stated that infants should receive water as well as breastmilk. Altogether, 45% of women agreed that infants should receive water in addition to breastmilk. When asked about why breastfeeding is important, women's levels of knowledge were even lower: only 20% of mothers were able to list three benefits of breastmilk, unprompted.

Table 85: Breastfeeding knowledge

	Percentage of mothers who state:			
	Breastfeeding should begin within 1 hour of birth	Child should receive only breastmilk in the first six 6 months	Infant up to six months should receive water as well as breastmilk	Three advantages for child of breastfeeeding
Region				
NBR-W	77.4%	94.7%	60.2%	28.9%
CRR	69.8%	96.5%	43.3%	19.1%
URR	69.1%	87.0%	35.6%	15.2%
Female respondent is literate				
No	70.2%	92.5%	46.9%	18.7%
Yes	75.0%	93.9%	38.0%	24.1%
Wealth Quintile				
Lowest	67.0%	93.9%	42.3%	16.6%
Second	66.5%	92.6%	39.6%	16.9%
Third	73.0%	92.1%	43.6%	17.8%
Fourth	74.8%	93.5%	49.1%	21.1%
Highest	75.6%	91.9%	48.8%	28.0%
Gov't Hospital or HC in village				
No	70.2%	95.4%	43.9%	41.1%
Yes	71.7%	92.0%	44.9%	13.9%
Total	71.4%	92.8%	44.7%	20.1%

Note: Based on 2,226 women responding to the women's questionnaire.

Qualitative data suggest that messages about the importance of exclusive breastfeeding are being widely disseminated by health workers, TBAs and other VSG members.

Growth monitoring

Of the 3,387 children under five years who were included in the survey, slightly less than half had received growth monitoring (a combination of height only, weight only, height and weight both, or mid-upper arm circumference) in the six months before the survey.

Out of the roughly 3,387 children under five in our sample who were available to have their measurements taken, 47% had been measured (at least one out of height and weight) in the 6 months prior to the survey. Of the children who only had one of the two measurements, measurement of their weight (58%) was more likely than height (2%). Twenty eight percent of the children had both a height and weight measurement in the past six months. Out of the 12% of children who had a Mid Upper Arm Circumference (MUAC) measurement, 11% were moderately wasted ('Yellow') and 1% was severely wasted ('Red').

Table 86: Anthropometric monitoring and referral

	Measured in last 6 months	Measured-height only	Measured-weight only	Measured-height/weight	Measured-MUAC	Outcome-green	Outcome-yellow*	Outcome-red**	Unsure of outcome
Region									
CRR	47.6%	0.4%	34.5%	50.5%	14.5%	79.0%	13.3%	1.5%	6.1%
NBR-W	60.4%	0.2%	82.0%	14.2%	3.6%	78.3%	9.0%	1.1%	11.6%
URR	38.6%	5.4%	66.6%	10.1%	18.0%	78.2%	9.2%	0.4%	12.2%
Mother is Literate									
No	45.0%	2.1%	58.6%	27.4%	11.9%	78.7%	10.2%	1.0%	10.0%
Yes	54.3%	1.1%	55.3%	30.1%	13.5%	78.2%	12.6%	1.1%	8.1%
Wealth Quintile									
Lowest	50.8%	0.9%	42.4%	40.3%	16.4%	77.3%	11.8%	1.2%	9.7%
Second	45.8%	0.3%	55.3%	34.7%	9.7%	79.7%	12.8%	0.0%	7.5%
Third	45.7%	2.5%	61.8%	18.5%	17.2%	76.4%	9.2%	1.0%	13.4%
Fourth	48.9%	3.7%	63.3%	23.9%	9.2%	80.4%	10.4%	0.9%	8.3%
Highest	45.4%	1.6%	66.3%	22.7%	9.4%	79.0%	10.0%	2.3%	8.7%
Gov't Hospital or HC in village									
No	61.5%	0.0%	36.2%	60.2%	3.6%	89.4%	4.7%	1.3%	4.7%
Yes	43.1%	2.6%	66.7%	14.7%	16.0%	74.0%	13.5%	1.0%	11.5%
Total	47.3%	1.8%	57.7%	28.1%	12.4%	78.6%	10.9%	1.1%	9.5%
N	3,387	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600

Note: Out of 3,387 under fives in survey, 1600 had measurements taken within 6 months prior to survey.
* Outcome Yellow: Child suffering from severe acute malnutrition. Should be referred immediately
** Outcome Red: Child at risk of malnutrition. Mother of child should be counseled.

The URR RHD reported that seven VSGs in the region were spearheading community-based growth monitoring for all children under five.

Children in NBR-W were more likely than other children to have had their nutritional status checked (60%, compared to 48% in CRR and 39% in URR), as were children whose mothers were literate (54% versus 45%). Children with no nearby health facility appeared to be less likely to have their nutritional status checked, which may be because they are less likely to benefit from outreach services. Among children identified as malnourished, few were referred and the majority of those referred lived in CRR, where 61% of identified children were referred[12], compared to 19% in NBR-W and only 13% in URR. Among children referred, 42% were given nutrition rehabilitation (ranging from 34% in CRR to 69% in URR) while 33% were referred to a higher level of health facility.

Table 87: Growth monitoring and referral for acute malnutrition in last 6 months

	Nutrition Status checked in last 6 months	Identified as malnourished - Red/Yellow	Referred after identification of malnourishment	**Among children referred**	
				Given nutrition rehabilitation	Referred to higher level
Region					
CRR	47.6%	21.0%	60.7%	34.1%	41.2%
NBR-W	60.4%	21.7%	18.8%	57.9%	0.0%
URR	38.6%	21.8%	12.7%	69.2%	23.1%
Female respondent is literate					
No	45.0%	21.3%	33.3%	43.9%	29.3%
Yes	54.3%	21.8%	36.1%	37.1%	40.0%
Wealth Quintile					
Lowest	50.8%	22.7%	38.7%	31.0%	24.1%
Second	45.8%	20.3%	46.2%	56.7%	33.3%
Third	45.7%	23.6%	27.0%	40.0%	15.0%
Fourth	48.9%	19.6%	29.7%	52.6%	52.6%
Highest	45.4%	21.0%	29.2%	26.3%	42.1%
Gov't Hospital or HC in village					
No	61.5%	10.6%	24.0%	66.7%	25.0%
Yes	43.1%	26.0%	35.8%	39.0%	33.3%
Total	47.2%	21.4%	34.1%	41.9%	32.5%
N	**3387**	**1600**	**343**	**117**	**117**

Note: Among 3,387 children under the age of 5 who were measured in the previous 6 months.

With regard to the management of severe acute malnutrition, in focus group discussions RHD members noted the insufficiency of giving food supplementation only to the child who was malnourished as caregivers tended to share the supplements with other children in the household.

[12] The World Food Programme is currently providing support for addressing moderate acute malnutrition in CRR, which may have contributed to this high proportion of referrals.

Knowledge of the acceptable minimum diet

Knowledge of the acceptable minimum diet was low in the project area. Knowledge of the minimum meal frequency[13] was low (41%), albeit somewhat higher than knowledge of dietary diversity. Only 11% of mothers of children aged 6-23 months were able to describe the minimum dietary variety, which was defined as including any four of the following food categories: dairy products; foods made from grains, roots, and tubers, including porridge and fortified baby food from grains; fruits and vegetables; eggs; meat, poultry, fish; legumes and nuts.

Knowledge of appropriate variety of young children's diet was especially low in CRR. Overall, only 9% of mothers of infants aged 6-23 months were able to accurately describe both the appropriate frequency and variety of feeding of their young children, with only 4% of mothers in CRR able to do this.

Table 88: Knowledge of adequate diet among mothers of young children

	Mother knows minimum meal frequency	Mother of child 6-23 months lists correct variety	Mother of child 6-23 month knows variety and frequency of feeding
Region			
NBR-W	40.0%	21.0%	16.0%
CRR	42.0%	4.0%	4.0%
URR	41.0%	13.0%	10.0%
Mother is Literate			
No	41.0%	11.0%	8.0%
Yes	41.0%	14.0%	11.0%
Wealth Quintile			
Lowest	44.0%	7.0%	6.0%
Second	39.0%	13.0%	10.0%
Third	44.0%	12.0%	8.0%
Fourth	41.0%	12.0%	9.0%
Highest	39.0%	15.0%	11.0%
Gov't Hospital or HC in village			
No	45.0%	9.0%	6.0%
Yes	40.0%	12.0%	10.0%
Total	41.0%	11.0%	9.0%
N	**2122**	**933**	**933**

Notes: Minimum meal frequency is defined as receiving solid or semisolid food at least twice a day for breastfed infants age 6-8 months and at least 3 times a day for breastfed children age 9-23 months. For non-breastfed children age 6-23 months, minimum meal frequency is receiving solid or semisolid food or milk feeds at least 4 times a day. Column 1 based on 2,122 mothers of children of all ages; Columns 2 and 3 based on 933 mothers of children aged 6-23 months.

[13] For breastfed children, minimum meal frequency is receiving solid or semisolid food at least twice a day for infants age 6-8 months and at least 3 times a day for children age 9-23 months.

5.5 Household health

Care-seeking: Timeliness

Approximately 9% (N=940) of the population reported an illness in the two weeks preceding the survey. Of these, 368 (61%) were household residents aged five or over. Among these household members aged five or older, 68% sought care, with the highest rates of care-seeking in NBR-W and the lowest in CRR (Table 89). Among those who sought care, 41% did so within the first 24 hours of illness, including 42% of respondents in communities with a government health facility and only 33% of respondents in communities without a government health facility. Rapid care seeking was lower in NBR-W (33%) than in CRR or URR (42% and 43% respectively).

Table 89: Care seeking: Timeliness of care seeking among household members age five and older with a reported illness in the two weeks preceding the interview

		Among those who sought care		
	Sought care when ill	Sought care within 24 hours	Sought care within 24-48 hours	Sought care later than 48 hours
Region				
CRR	60.5%	42.1%	40.0%	17.9%
NBR-W	74.2%	33.3%	53.0%	13.6%
URR	69.5%	42.5%	44.9%	12.6%
Female respondent is literate				
No	67.0%	40.7%	46.1%	13.1%
Yes	69.4%	42.6%	39.7%	17.6%
Wealth Quintile				
Lowest	60.2%	32.0%	40.0%	28.0%
Second	59.0%	45.8%	40.7%	13.6%
Third	66.1%	44.9%	43.6%	11.5%
Fourth	72.6%	35.7%	54.1%	10.2%
Highest	76.9%	44.6%	42.2%	13.3%
Gov't Hospital or HC in village				
No	71.7%	32.6%	62.8%	4.7%
Yes	67.1%	41.8%	42.8%	15.4%
Total	67.6%	40.8%	45.1%	14.1%
N	**544**	**368**	**368**	**368**

Note: Based on 544 household members aged 5 or older with a reported illness in the two weeks preceding the interview.

Care seeking: Source of care

Minor health centers were the most frequent sources of care for household members aged five and older; they accounted for approximately one-third of all care sought and were used by nearly a quarter of all individuals who were ill in the previous two weeks (24%). Pharmacies accounted for 12% of all health care and were the second most common sources of care, followed by major health centers (11%). As with child health services, there was greater use of private clinics in communities with no government health facility.

Table 90: Source of care among household members age five or older with a reported illness in the past two weeks who sought care

	Government hospital	Major health center	Minor health center	Health post	NGO clinic	Private clinic	Pharmacy	Mobile clinic	Traditional healer	Faith-based healer	CHW	Community clinic	Home care	Other
Region														
CRR	11.6%	12.6%	33.7%	4.2%	1.1%	5.3%	12.6%	4.2%	2.1%	6.3%	1.1%	5.3%	0.0%	0.0%
NBR-W	3.0%	21.2%	37.9%	9.1%	0.0%	7.6%	4.5%	1.5%	4.5%	0.0%	6.1%	0.0%	1.5%	3.0%
URR	1.9%	7.7%	33.8%	3.9%	1.9%	9.2%	14.0%	0.5%	0.5%	11.1%	7.2%	1.9%	1.0%	5.3%
Female respondent is literate														
No	4.7%	10.1%	33.3%	5.4%	1.0%	8.4%	13.1%	1.3%	1.7%	8.1%	5.4%	2.7%	1.0%	3.7%
Yes	2.9%	16.2%	39.7%	2.9%	2.9%	5.9%	7.4%	2.9%	1.5%	7.4%	5.9%	1.5%	0.0%	2.9%
Wealth Quintile														
Lowest	6.0%	8.0%	44.0%	2.0%	0.0%	6.0%	8.0%	4.0%	2.0%	14.0%	2.0%	2.0%	0.0%	2.0%
Second	5.1%	5.1%	32.2%	3.4%	1.7%	10.2%	18.6%	1.7%	0.0%	8.5%	6.8%	1.7%	1.7%	3.4%
Third	6.4%	20.5%	25.6%	3.8%	2.6%	5.1%	11.5%	1.3%	1.3%	7.7%	6.4%	5.1%	0.0%	2.6%
Fourth	3.1%	10.2%	41.8%	7.1%	1.0%	6.1%	11.2%	0.0%	2.0%	6.1%	5.1%	3.1%	1.0%	2.0%
Highest	3.6%	10.8%	30.1%	6.0%	1.2%	12.0%	10.8%	2.4%	2.4%	6.0%	6.0%	0.0%	1.2%	7.2%
Gov't Hospital or HC in village														
No	7.0%	9.3%	18.6%	11.6%	2.3%	14.0%	14.0%	2.3%	2.3%	9.3%	4.7%	0.0%	0.0%	4.7%
Yes	4.3%	11.7%	36.6%	4.0%	1.2%	7.1%	11.7%	1.5%	1.5%	7.7%	5.5%	2.8%	0.9%	3.4%
Total	4.6%	11.4%	34.5%	4.9%	1.4%	7.9%	12.0%	1.6%	1.6%	7.9%	5.4%	2.4%	0.8%	3.5%

Note: Based on 368 household members with a reported illness in the past two weeks who sought care.

Satisfaction with care

Table 91 shows the opinion of the people interviewed regarding their satisfaction with the care they received from the facility when they were ill. These are the 651 people who were ill in the two weeks prior to the survey and sought care. The respondents were asked, on a scale of 1 to 4, their satisfaction with a number of services and with the health facility; with 1 being complete agreement and 4 complete disagreement with the statement.

In general, respondents expressed satisfaction with the services and the environment at the health facility, with little variation between regions or wealth quintiles. The area of least satisfaction with services across all regions and wealth quintiles was the ease with which prescribed medications could be obtained.

Table 91: Patient satisfaction with health facility experience

On a scale from 1 (complete agreement) to 4 (complete disagreement) how much do you agree with the following statements:							
	Facility hours are sufficient	Health staff are courteous	Waiting time is reasonable	Health workers spent sufficient time w patient	Easy to get prescribed medications	Had sufficient privacy	Satisfied with services
Region							
CRR	1.54	1.51	1.79	1.66	1.98	1.61	1.63
NBR-W	1.51	1.41	1.58	1.47	1.92	1.43	1.48
URR	1.68	1.60	1.98	1.74	2.54	1.68	1.76
Female respondent is literate							
No	1.62	1.57	1.85	1.71	2.33	1.65	1.72
Yes	1.57	1.44	1.83	1.54	2.06	1.48	1.52
Wealth Quintile							
Lowest	1.84	1.71	1.98	1.81	2.12	1.83	1.72
Second	1.67	1.61	1.97	1.80	2.47	1.72	1.80
Third	1.65	1.60	1.99	1.71	2.38	1.65	1.79
Fourth	1.69	1.61	1.88	1.69	2.45	1.68	1.70
Highest	1.24	1.19	1.44	1.32	1.77	1.23	1.31
Gov't Hospital or HC in village							
No	1.70	1.59	1.94	1.78	2.17	1.89	1.72
Yes	1.59	1.53	1.83	1.64	2.27	1.56	1.66
Total	1.60	1.54	1.84	1.66	2.25	1.60	1.66

Note: Based on the 651 respondents who sought care for an illness episode within the last 14 day.

Reasons for not seeking care

Tables 92 and 93 give the reasons why household members who were sick did not seek care. It is important to note that the responses were not presented as mutually exclusive choices. Out of the 940 people who were ill during the two weeks prior to the survey, 289 did not seek care at either a facility of traditional healer. Of these 289, 113 (40%) were under the age five, with the remaining 176 (60%) aged five and older. These 289 people (or, in the case of children, their caregiver) were asked reasons for not seeking care and given up to three choices from the list. The total number of choices given by the respondents was 319; giving us just over one reason per person.

By far the most common reason for not seeking care is that the respondent did not feel sick enough to warrant seeking care (32%). The second most common reason for not seeking care was cost. Almost a quarter of the reasons offered were attributed to the cost of seeking care. The higher the wealth quintile of the household, the less likely the respondent was to mention cost of care as a reason for not seeking care: 31% of respondents in the lowest quintile did not seek care due to the high cost compared with 17% of respondents in the highest wealth quintile.

Table 92: Reasons for household member not seeking care

	Not sick enough	Prefer home	Too expensive	Too far	No transport	Too busy	Long wait times
Region							
CRR	26.8%	17.5%	34.0%	21.6%	5.2%	5.2%	1.0%
NBR-W	29.4%	8.8%	26.5%	8.8%	20.6%	11.8%	0.0%
URR	35.4%	8.2%	19.0%	12.7%	12.0%	1.9%	0.0%
Female respondent is literate							
No	31.7%	12.2%	23.5%	16.1%	10.0%	4.8%	0.4%
Yes	32.2%	8.5%	30.5%	11.9%	13.6%	1.7%	0.0%
Wealth Quintile							
Lowest	38.2%	9.1%	30.9%	7.3%	3.6%	7.3%	0.0%
Second	21.5%	16.9%	33.8%	16.9%	6.2%	0.0%	0.0%
Third	38.8%	10.4%	23.9%	17.9%	19.4%	4.5%	0.0%
Fourth	25.0%	10.0%	16.7%	18.3%	15.0%	8.3%	1.7%
Highest	38.1%	9.5%	16.7%	14.3%	7.1%	0.0%	0.0%
Gov't Hospital or HC in village							
No	27.6%	24.1%	37.9%	13.8%	10.3%	6.9%	0.0%
Yes	32.3%	10.0%	23.5%	15.4%	10.8%	3.8%	0.4%
Total	31.8%	11.4%	24.9%	15.2%	10.7%	4.2%	0.3%

Note: Based on the 289 people who said they did not seek care when they fell ill.

Table 93: Reasons for household member not seeking care (cont.)

	Poor staff attitude	Poor staff knowledge	Staff absent	Inconvenient HF hours	HF out of stock	Poor quality care	Other
Region							
CRR	0.0%	0.0%	0.0%	3.1%	3.1%	3.1%	5.2%
NBR-W	2.9%	5.9%	2.9%	2.9%	0.0%	0.0%	8.8%
URR	0.0%	0.0%	1.3%	1.3%	1.3%	1.3%	29.1%
Female respondent is literate							
No	0.4%	0.4%	1.3%	2.2%	1.3%	2.2%	18.7%
Yes	0.0%	1.7%	0.0%	1.7%	3.4%	0.0%	18.6%
Wealth Quintile							
Lowest	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	12.7%
Second	0.0%	0.0%	0.0%	4.6%	4.6%	6.2%	16.9%
Third	0.0%	0.0%	0.0%	0.0%	3.0%	1.5%	13.4%
Fourth	1.7%	1.7%	1.7%	3.3%	0.0%	0.0%	30.0%
Highest	0.0%	2.4%	4.8%	0.0%	0.0%	0.0%	21.4%
Gov't Hospital or HC in village							
No	0.0%	0.0%	0.0%	3.4%	0.0%	0.0%	10.3%
Yes	0.4%	0.8%	1.2%	1.9%	1.9%	1.9%	19.6%
Total	0.3%	0.7%	1.0%	2.1%	1.7%	1.7%	18.7%

Note: Based on the 289 people who said they did not seek care when they fell ill.

5.6 Environmental sanitation

Household availability of sanitation facilities

Overall, 35% of households reported having an improved toilet, 61% reported having an unimproved toilet and approximately 4% reported having no toilet facilities. Unimproved toilet facilities, such as a pit latrine with no slab or a hanging pit latrine, remained more common than improved facilities, which include flush toilets and pit latrines with slabs. Families in URR were most likely to report improved facilities, as were families with a literate female respondent and those from upper socio-economic quintiles.

Table 94: Sanitation facilities

	Any improved toilet	Any unimproved	No toilet
Region			
CRR	26.7%	66.1%	6.3%
NBR-W	37.2%	58.7%	4.3%
URR	42.0%	57.6%	0.1%
Female respondent is literate			
No	32.5%	62.7%	4.2%
Yes	40.4%	57.5%	2.3%
Wealth Quintile			
Lowest	18.7%	69.2%	11.2%
Second	17.8%	78.2%	3.6%
Third	30.8%	66.1%	2.5%
Fourth	46.7%	52.4%	0.7%
Highest	58.3%	41.3%	0.7%
Gov't Hospital or HC in village			
No	29.4%	64.1%	6.0%
Yes	35.9%	60.6%	3.1%
Total	34.5%	61.4%	3.7%

Note: Based on 2,226 households included in the final sample.

Environmental sanitation was an area where room for improvement was noted by the qualitative research participants. Specifically, the shortage of facilities such as improved latrines was highlighted.

Household availability of handwashing facilities

Availability of handwashing facilities varied substantially across the study area, with 66% of households in URR having a handwashing station, compared to only 18% in CRR. Availability of a handwashing station, soap and clean water was consistently low and available in only 8% of households. There was a clear socio-economic gradient in the availability of handwashing facilities with, for example, nearly 50% of households in the highest quintile having a designated

area for handwashing, compared to 20% in the lowest quintile and 34% of the households in the highest quintile having soap, compared to 18% in the lowest quintile.

Table 95: Handwashing station

	HH has handwashing station	Among HH with station		Percentage of all households with handwashing station, clean water and soap
		Soap available	Clean water available	
Region				
CRR	17.7%	37.0%	96.4%	6.4%
NBR-W	28.1%	27.5%	96.6%	7.4%
URR	66.2%	17.9%	41.1%	11.0%
Female respondent is literate				
No	36.6%	21.0%	56.5%	7.3%
Yes	37.5%	30.8%	79.3%	11.0%
Wealth Quintile				
Lowest	19.6%	18.4%	64.4%	3.4%
Second	33.5%	19.0%	55.0%	6.3%
Third	37.1%	17.0%	56.4%	5.8%
Fourth	44.7%	23.1%	59.8%	9.7%
Highest	49.3%	33.6%	73.2%	15.9%
Gov't Hospital or HC in village				
No	30.8%	32.3%	89.0%	9.7%
Yes	38.6%	21.4%	56.1%	7.8%
Total	36.8%	23.5%	62.3%	8.2%
N	2,226	818	820	2,226

Note: Based on 2,226 households included in the final sample. Data on soap availability is missing for two of 820 households reporting a handwashing station.

Refuse disposal

Refuse collection remains rare or non-existent, with most families reporting throwing refuse in public space (31%), in a pit (28%) or in the yard (29%). Families in NBR-W were most likely to throw their trash in a pit, while families in URR were most likely to throw their waste into a public space.

Table 96: Refuse disposal

	Refuse Collected	Refuse Thrown in Pit	Refuse Buried	Refuse Burned	Refuse Thrown in Street/Public Space	Refuse Thrown in Yard
Region						
CRR	0.0%	36.7%	10.4%	2.3%	21.4%	28.9%
NBR-W	0.0%	41.7%	1.5%	4.3%	20.0%	30.8%
URR	0.1%	7.7%	0.4%	5.1%	51.6%	26.8%
Female respondent is literate						
No	0.1%	26.3%	4.5%	2.9%	33.8%	28.8%
Yes	0.0%	33.0%	5.9%	6.1%	24.3%	27.9%
Wealth Quintile						
Lowest	0.0%	38.9%	6.7%	2.5%	28.3%	22.7%
Second	0.0%	31.0%	5.2%	2.5%	27.6%	29.4%
Third	0.0%	24.5%	3.8%	3.1%	35.3%	30.1%
Fourth	0.0%	22.9%	4.3%	5.6%	34.2%	29.7%
Highest	0.2%	22.4%	4.3%	4.9%	31.6%	31.2%
Gov't Hospital or HC in village						
No	0.0%	55.2%	0.0%	3.4%	7.7%	33.1%
Yes	0.1%	20.0%	6.3%	3.8%	38.3%	27.3%
Total	0.0%	27.9%	4.9%	3.7%	31.4%	28.6%

Note: Based on 2,226 households included in the final sample.

5.7 Health system

Health facility infrastructure

While all but one health facility had electricity, power outages were reportedly common, with more than half of facilities having a power outage in the seven days preceding the survey (Table 97). All major health centers and the two hospitals accessed electricity from the grid, however only one-quarter of minor health centers did so. In contrast to the higher level facilities, minor health facilities frequently relied on solar (37%) and generator (32%) power.

Table 97: Electricity source

	Electric grid	Generator	Solar power	No electricity	Power outages in last 7 days
Region					
CRR	50.0%	30.0%	20.0%	0.0%	60.0%
NBR-W	33.3%	50.0%	0.0%	16.7%	40.0%
URR	37.5%	0.0%	62.5%	0.0%	62.5%
Type of Facility					
Hospital	100%	0.0%	0.0%	0.0%	50.0%
Major HC	100%	0.0%	0.0%	0.0%	33.3%
Minor HC	26.3%	31.6%	36.8%	5.3%	61.1%
Total	41.7%	25.0%	29.2%	4.2%	56.5%

Notes: Statistics are based on the 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Final column based on the 23 facilities with electricity.

All major health centers and hospitals had water piped directly into the facility. One-quarter of minor health centers relied on water piped into the yard, and another 16% used water from a protected well. Water outages were most common in URR and CRR. In all, almost two-fifths of health facilities had water outages in the seven days preceding the survey but neither of the hospitals had experienced a water outage during this period.

Table 98: Water source

	Piped into facility	Piped into yard	Protected well	Facility had water outage in last 7 days
Region				
CRR	60.0%	10.0%	30.0%	40.0%
NBR-W	100%	0.0%	0.0%	16.7%
URR	50.0%	50.0%	0.0%	50.0%
Type of Facility				
Hospital	100%	0.0%	0.0%	0.0%
Major HC	100%	0.0%	0.0%	33.3%
Minor HC	57.9%	26.3%	15.8%	42.1%
Total	66.7%	20.8%	12.5%	37.5%

Notes: Statistics are based on the 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

Two-thirds of facilities had working toilets for their patients. Availability of toilet facilities ranged from 100% in NBR-W to only 38% in URR. Among those facilities with working toilets, approximately two-thirds offered separate facilities for men and women, with the highest proportion of sex-segregated facilities available in NBR-W. Waiting rooms for patients were rare – less than 20% of health facilities offered waiting rooms – but information was not captured on 'waiting areas' that might not constitute rooms but that are designated for clients waiting to attend services. Access to other basic amenities varied at facilities. While ambulances were universally available, less than 17% of facilities had an incinerator on the property and even fewer (10%) had a telephone.

Table 99: Basic amenities at health facilities

	Facility has working toilet for patients	Facility has separate toilets for men and women	Facility has waiting room*	Facility has access to ambulance	Facility has phone	Facility has incinerator
Region						
CRR	70.0%	40.0%	10.0%	100%	10.0%	10.0%
NBR-W	100%	83.3%	16.7%	100%	0.0%	33.3%
URR	37.5%	25.0%	25.0%	100%	12.5%	12.5%
Type of Facility						
Hospital	100%	100%	50.0%	100%	50.0%	50.0%
Major HC	66.7%	66.7%	0.0%	100%	33.3%	66.7%
Minor HC	63.2%	36.8%	15.8%	100%	0.0%	5.3%
Total	66.7%	45.8%	16.7%	100%	8.3%	16.7%

* These percentages are specific to respondents being asked about "waiting rooms". Information was not captured on 'waiting areas' that might not constitute rooms but that are designated for clients waiting to attend services.

Health workers and managers from many different health facilities underscored the inadequacy of the health facility infrastructure with limited space compromising privacy and chronic under-investment in maintenance exerting a visible toll. The main inadequacies mentioned by health workers were: insufficient ward space and consultation rooms, lack of basic drugs and equipment, inadequate electricity supply, lack of incinerators, poor staff quarters, inadequate waiting areas and insufficient vehicles. From the client perspective, the most often reported shortcomings were: lack of basic drugs and equipment, inadequate electricity supply, inadequate waiting areas and insufficient vehicles for evacuations and referrals. Many respondents requested that their local health facility be upgraded so as to be able to provide a wider range of services and to be staffed by more health workers.

Facilities in NBR-W cited important improvements in health facility infrastructure thanks to the incentive money received through the pilot project, creating optimism among health workers in other regions that they too may soon be able to improve their own facilities.

"The facelift given to the health facility makes you feel happy just by looking at it." CAC member, NBR-W

Larger infrastructure problems, however, still remain in NBR-W such as issues with electricity, incinerators and additional buildings.

In one health facility, health workers were so disturbed by the state of their living quarters that they invited the researchers to visit them, stating that their accommodation was "not fit for animals to live in". This had a significant negative impact on health workers' morale.

Satisfaction with health facility infrastructure, equipment and supplies

A series of issues within the health facility was discussed with health workers and they were asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied with the current situation. Table 100 shows that, overall, health worker satisfaction with health facility infrastructure was low. Nearly half of health workers reported feeling that the quality of care was constrained by the working conditions of the facility. More than half of health workers were neutral or dissatisfied with the physical condition of the building and nearly 90% of health workers were neutral or dissatisfied with the quantity of medicine and equipment at the facility. The quality and physical condition of equipment in the health facility appeared to be a greater source of dissatisfaction than the quality of medicine available in the health facility.

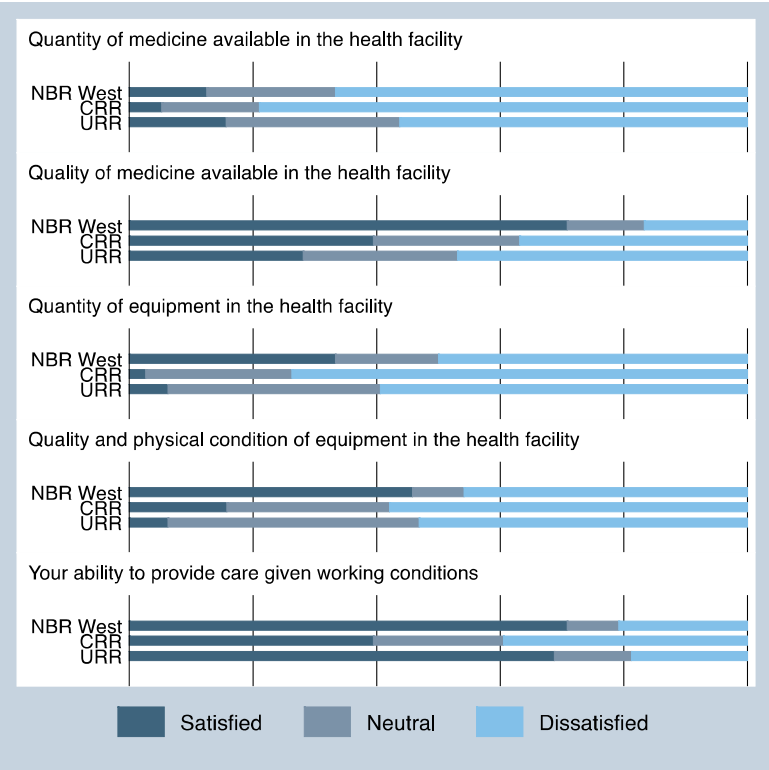
Table 100: Health worker satisfaction with infrastructure, equipment, and supplies

	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied
Quantity of medicine available in the health facility	10.6%	21.3%	68.1%
Quality of medicine available in the health facility	43.6%	21.3%	35.1%
Quantity of equipment in the health facility	11.7%	25.5%	62.8%
Quality and physical condition of equipment in the health facility	20.2%	26.6%	53.2%
Availability of other supplies in the health facility (compresses, etc.; office supplies)	21.3%	19.2%	59.6%
The physical condition of the health facility building	43.6%	19.2%	37.2%
Your ability to provide high quality of care given the current working conditions in the facility	57.5%	14.9%	27.7%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

Satisfaction with the quantity of medicine and equipment was lowest in CRR, which may help explain why health workers in CRR were most likely to feel constrained in their ability to provide high quality care (Figure 13).

Figure 13: Quantity of medicine available in health facility



Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in NBR-W, CRR and URR.

Across all regions, health workers noted a lack of basic supplies, equipment and drugs that hampered their ability to provide services.

"For us lack of materials is our problem. Sometimes you need to do something the materials are not available and some of these materials patients cannot buy them especially if we have an emergency case like Hydralazine (drug used to treat hypertension in pregnancy) is not available, catheter is not available. Sometimes it's just crazy, to be candid enough, this is just crazy. Cord scissors, no not available. We ask the women to go and buy razor blades. It's just crazy actually… it's crazy… if I want to work, I want the materials." Health worker, URR

One of the qualitative researchers noted: *"The constant stock-out of drugs and lack of basic equipment and supplies poses a challenge in the provision of quality maternal and child health services."* Health workers in all regions complained that these shortages hampered their ability to provide services, with some health workers visibly upset by this.

Shortages of basic drugs was a ubiquitous problem, with researchers in different facilities noting:

"There were only a few drugs on the drug shelves, notably IV fluids, Coartem and Paracetamol. There were no antibiotics or pediatric syrups." Qualitative researcher

When drugs were not available at the health facility, women reported having to buy drugs themselves, which was not always possible.

"Sometimes you may not have the money to buy the drugs and the pharmacy opens only on Sundays. So even if it's urgent you have to wait until on Sunday to be able to buy the medicine you need." Woman who had delivered in the previous six months, NBR-W

Similar problems were noted in other communities but sometimes there was no pharmacy at all in the community so women would have to pay a transport fare in order to reach a pharmacy, which added extra cost on top of any medication costs.

"I always go with the expectation that I will get some medicine like even Paracetamol but it doesn't materialize. The last time I went with my son who was having chest pain, but there was no medicine available. I was referred to [a different] health center to buy the drugs, what a waste of time!" Woman who had delivered in the previous six months, CRR

In some cases, only expired drugs were to be found at health facilities and at the regional store:
"The ones we have are all expired, those at the regional store are also all expired and we have stopped using them that is the vitamin A." Health worker, CRR

Quality of care was often compromised due to insufficient drug supplies.
"We presently have 300 ampoules of Pitocin that was 2 weeks ago for the whole Region. Basse has a delivery rate of nothing less than 270 patients per month. If you give 300 ampoules and tell me that it should be shared amongst 10 other health facilities, we will keep 100. We cannot play God because you don't know which woman will bleed after delivery or not. It is not easy, sometimes we have to pinch the woman on her thigh or the ear and make it look like an accident, by taking a needle and puncturing it and observe clotting time, before she delivers. You may be able to know whether she will or will not bleed. We also need this Pitocin to control post-partum hemorrhage - the major killer of our women in The Gambia. You can use up to 5 ampoules to control a cut or bleeding. So we are seriously short of life saving drugs." Health worker, URR

Health workers and community members alike noted that there were fewer drug shortages in NBR-W since the pilot project began, with this improvement attributed to the project. Officers-in-charge reported using some of the health facility incentive payments to buy drugs to supplement what they were given from regional stores. That said, even with this boost in health facility income, it was impossible for facilities to buy all of the drugs that they needed.

Stakeholders in CRR and URR voiced hopes that the MCNHRP would help address their drug shortages.

Acknowledging the importance of an adequate drug supply, there is a guideline for essential drugs for health facilities but health managers are not able to follow the guideline due to insufficient resources. The MCNHRP is designed to try to alleviate some of the pressure arising from insufficient supplies and equipment:

"R: In terms of supplies we are buying them a start up stock in terms of equipment… R: This start up capital should be used in building the quality of service delivery. For example if they need drugs they can use part of the money to buy drugs." PIC members

Many health workers lamented the lack of blood banks within their facilities noting that these created challenges in reducing maternal mortality. With some communities reluctant to donate blood they sometimes found it difficult to find blood for transfusions when needed.

Sometimes the lack of equipment led health workers to put themselves at risk in order to provide services to their patients:

"You know you have a delivery and you have to do suctioning to remove the secretion and we have no suction machine. You have to use the giving set (referring to tube of intravenous fluid giving set). The other day I had an asphyxiated baby. The nurse I was working with told me to use my mouth and the giving set to suck the secretion. I told her I cannot do it because I didn't want to use my mouth to suck the secretion out as I would swallow it so she had to do it. But then later on the following day I did it but it's just crazy. At the end of the day you put yourself at risk because you cannot also leave that baby to die. You must do it. You must suck the secretion so that the baby can breathe." Health worker, URR

Blood pressure machines, in particular, were noted to be lacking across many facilities, with a detrimental effect on the ability to provide services. Furthermore, the inability to measure blood pressure or hemoglobin during outreach services was noted as a hindrance to the provision of quality services.

While greatly appreciating the accessibility of outreach services, women across all regions expressed dissatisfaction with the availability of equipment (e.g. examination beds) and the lack of waiting areas. In CRR, in particular, many women complained about the overcrowding and insufficient seating.

In one health facility, a qualitative researcher reported: *"I was shocked not only about the state of the theatre equipment but also the poor state of cleanliness of the operating room itself where*

women are operated on. I could see stains of dry blood on the equipment trolley and layers of dust on both the equipment and anesthetic trollies." Cleanliness and upkeep of the facilities was a concern across different health facilities.

Shortages of supplies also extended to non-medical supplies with stationery and other similar supplies also reported to be hard to find.
"Could you imagine our daily activity book was full since 25th December and we just got it yesterday. Nobody can blame me for not writing my daily records I cannot take it from my salary and buy the book so if the RBF is here we can buy things like that when we need it." Health worker, CRR

A health facility in CRR reported that it received a monthly supply of 20 litres of fuel for its motorbike but that the return trip to collect the supply used up half of this fuel. Maintenance of motorbikes and other vehicles was also mentioned as a problem due to insufficient funds although some facilities indicated that Riders for Health were helping to alleviate this problem.

Referral facilities

The nearest referral facilities were, on average, 34 kilometres from health centers. At an average of 42 kilometers from the nearest hospital, facilities in CRR were furthest from referral sites, while facilities in NBR-W were closest.

Table 101: Referral facilities

	Distance to main referral facility (Km-One Way)
Region	
CRR	42.6
NBR-W	21.4
URR	32.4
Type of Facility	
Major HC	33.7
Minor HC	34.1
Total	34.0

Notes: Statistics are based on data provided by administrative staff at 22 public health centers in the North Bank West, Central River and Upper River regions.

Health workforce

Staffing

Health facility representatives were asked about the number of authorized and filled positions for several key technical roles, including doctors, medical officers, nurses, midwives, pharmacists and lab technicians. Overall, only 45% (13 of 29) of authorized positions were filled, with the greatest shortfalls found in hospitals, where, on average, 20% of positions were reported to be

filled. This compares to an average of 71% of positions filled in major health centers. CRR had the highest staffing, with 30% of positions filled, relative to 66% and 57% for NBR-W and URR, respectively.

Table 102: Staffing (Dr./MO, CO, administrator, nurse, midwife, pharmacist, lab technician)

	Average # of authorized positions	Average # of filled positions	Average proportion of positions filled
Region			
CRR	14.3	9.4	65.7%
NBR-W	58.8	17.5	29.8%
URR	23.5	13.3	56.6%
Type of Facility			
Hospital	147.5	29.5	20.0%
Major HC	42.3	30.0	70.9%
Minor HC	13.8	8.2	59.4%
Total	28.5	12.7	44.6%

Notes: Statistics are based on the 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff positions include medical doctors, medical officers, clinical officers, administrators, nurses, midwives pharmacists and lab technicians.

The data suggest very low health worker density. Estimates vary from a high of 1.4 health workers (defined as doctors, clinical officers, or nurses) per 1,000 population in NBR-W to a low of 0.5 health workers per 1,000 population in CRR. Consistent with the variance in health workforce density, case workload was highest in CRR, which had the lowest number of health workers per 1,000 population, and lowest for NBR-W, which had the highest workforce density. Health workers reported seeing nearly 34 patients per month in minor health centers and 26 patients per month in major health centers. These averages are largely driven by the number of staff per facility, rather than the number of clients – with approximately 1,120 monthly patients at minor health centers, compared to 3,450 patients in major health centers and 3,200 patients in hospitals, minor health centers have the smallest aggregate number of in- and out-patients.

Table 103: Health worker density and workload

	Number of Doctors, Clinical Officer, Nurse, Midwife/1,000 Population	Number of in- and outpatients per health worker	Number of patients seen last work day
Region			
CRR	0.5	135.5	27.5
NBR-W	1.4	61.5	13.9
URR	1.0	116.0	48.0
Type of Facility			
Major HC	1.0	102.4	25.7
Minor HC	0.9	113.0	33.8
Total	0.9	111.6	32.5
Total	22	22	68

Notes. Statistics are based on the 22 public health centers in the North Bank West, Central River and Upper River regions. Population data for the first column was provided by NaNA but was not available for the hospitals so they are excluded from these analyses. First and second column rely on data collected from administrators from 22 facilities. Staff positions include medical doctors, medical officers, clinical officers, nurses, and midwives.

An overall shortage of health workers and rapid turnover of health workers were noted as problems by health workers and community members across all regions, with a negative impact on the quality of services provided. Shortages cut across all cadres including doctors, nurses, lab technicians, pharmacists and data clerks.

Many health workers noted that, as a result, their workload was unsustainably high. This created day-to-day challenges and had an impact on the availability of services in the project area:

"The work load is too much you can see she is alone in the shift running the outpatient, labor ward and in-patient ward, one person running all these three. You will have lot of patients at the outpatient here whilst you are conducting deliveries there, so those people have to wait. In-case one of them has severe illness you don't know and you are in the in-patient ward giving medication. To be alone in the shift is very difficult." Health worker, CRR

"Most women do not attend post natal care services based on the limited number of staff then. People have started coming and we started posting some staff here now. Recently we have one midwife to stay at the facility to be attending to these antenatal mothers and another to attend to post-natal mothers. The midwife feels it is very tedious for him to be doing both antenatal and post natal services at the same time. So priority is given to antenatal." Community health nurse, CRR

Health workers also reported having ceased providing community-based birth registration services due to insufficient staffing.

Nurses pointed out that due to the staff shortages they had to take on roles that were traditionally the responsibility of doctors and they were not remunerated for this additional work. Their impression was that they worked harder and longer hours than nurses in the Kombos but for less pay. Health workers reported that they had not been able to take any time off for months as there were insufficient staff to cover all the required shifts, which negatively affected their morale.

Women in URR described receiving sub-standard care, such as being given the wrong prescription, from trainee nurses who were working unsupervised due to staff shortages.

A shortage of laboratory technicians was highlighted as a particular problem with regard to providing the recommended tests for pregnant women:

"For the past one or two years there is no lab technician or lab assistant in the facility and you will bear with me that, that is very necessary because you need to screen these mothers for certain ailments and if a qualified somebody is not available and a lab, many a times if they are referred to Farafenni, looking at the distance and the fares involved, many of them don't go. And also we are not trained on that, we many a times only do the Hb test which is never accurate. But other tests like syphilis, sickle cell, they are never done here." Officer-in-charge, CRR

The MCNHRP has a minimum staffing standard for project health facilities but this constitutes a challenge due to persistent shortages and high turnover. While RHDs reported trying to ensure this minimum staffing they sometimes felt that it was beyond their control. Project staff acknowledged this as a constraint and noted that it is the role of the RBF Committee to help ensure appropriate staffing within health facilities where the project operates.

Additional employment

Approximately 9% of health workers reported having more than one job. Outside employment in NBR-W (12%) was twice that of URR (6%), and was particularly common for employees of major health centers (17%), compared to minor health centers (6%). Overall, less than 10% of staff reported having additional income (data not shown).

Absenteeism

Forty of the ninety-four staff interviewed (43%) reported at least one absence in the two weeks preceding the survey. The mean number of days absent was highest in major health centers (2.07 days) and very few of the absences (2%) were reported to be unauthorized.

Table 104: Absenteeism

	Any absences in last 14 days	# Days absent in last 14	Absences were unauthorized
Region			
CRR	50.0%	1.8	0.0%
NBR-W	41.7%	1.6	8.3%
URR	34.4%	1.1	0.0%
Type of Facility			
Hospital	50.0%	1.4	0.0%
Major HC	50.0%	2.1	0.0%
Minor HC	40.5%	1.4	2.7%
Total	42.6%	1.5	2.1%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

Facility rosters offer an alternative way to assess absenteeism. Overall, 207 staff were listed on the roster, of whom 70 (34%) were absent from the facility on the day of the survey. Of the 70 reported absences, 43% were unauthorized. Unauthorized absences accounted for up to 64% of all absences in CRR but none of the absences in NBR-W. Comparing the two sources suggests that health workers' accounts of their own absences and whether or not they were authorized might not be entirely reliable.

Table 105: Absenteeism (cont. 1)

	% of workers absent on day of survey	% of nurses absent on day or survey	% midwives absent on day of survey	% nurse assistants absent on day of survey	% of absences that are authorized
Region					
CRR	40.9%	13.0%	24.0%	40.0%	63.9%
NBR-W	22.4%	35.3%	20.6%	16.7%	0.0%
URR	39.5%	33.3%	8.3%	33.3%	41.2%
Type of Facility					
Hospital	32.7%	12.5%	25.0%	42.9%	41.2%
Major HC	11.5%	0.0%	15.4%	0.0%	0.0%
Minor HC	38.8%	29.3%	17.6%	27.8%	46.0%
Total	33.8%	25.0%	19.7%	25.8%	42.9 %
N	207	52	71	31	70

Notes: Statistics are based on data provided by administrative staff at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Administrators reported on a total of 207 staff, including 52 nurses (Nurse Anesthetic, State Enrolled Nurse, State Registered Nurse, or Community Health Nurse), 71 midwives (Midwife, State Certified Midwife, State Enrolled Midwife or Community Health Midwife) and 31 nursing assistants, as well as 53 other cadres.

Health worker training

The proportion of health workers trained varied greatly by health topic. Most health staff (78%) were trained in handling malaria – in major health centers, this figure reached 92%. In contrast, only half the health workers were trained to deal with TB, and between one-third and one-half were trained to deal with maternal health issues, such as ANC, labor, newborn care, and delivery. Almost 11% of health workers reported having received no in-service training.

Table 106: Training (ever)

	IMCI	Malaria	TB prevention and treatment	FP	ANC	Labor	EMONC	Newborn care	PNC	Breastfeeding	Nutrition	Immunization	No in-service training
Region													
CRR	26.3%	76.3%	36.8%	28.9%	47.4%	44.7%	50.0%	42.1%	42.1%	47.4%	36.8%	28.9%	13.2%
NBR-W	16.7%	79.2%	54.2%	29.2%	16.7%	12.5%	25.0%	25.0%	8.3%	25.0%	29.2%	45.8%	8.3%
URR	43.8%	78.1%	59.4%	56.2%	56.2%	50.0%	53.1%	53.1%	40.6%	50.0%	50.0%	59.4%	9.4%
Type of Facility													
Hospital	12.5%	75.0%	50.0%	37.5%	37.5%	25.0%	37.5%	37.5%	25.0%	37.5%	25.0%	62.5%	12.5%
Major HC	25.0%	91.7%	41.7%	41.7%	50.0%	50.0%	75.0%	58.3%	33.3%	33.3%	41.7%	25.0%	0.0%
Minor HC	32.4%	75.7%	50.0%	37.8%	41.9%	37.8%	40.5%	39.2%	33.8%	44.6%	40.5%	44.6%	12.2%
Total	29.8%	77.7%	48.9%	38.3%	42.6%	38.3%	44.7%	41.5%	33.0%	42.6%	39.4%	43.6%	10.6%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

Of the 94 staff participating in the survey, 85 (90%) perceived a need for additional training, with training related to IMCI, TB, PNC and nutrition being the most in demand. Perceived need varied greatly by facility – while only 9% of major health center staff reported a need for training in ANC, twice this proportion requested training at hospitals.

Table 107: Training needs

	Any needs	IMCI	Malaria	TB prevention and treatment	FP	ANC	Labor	EMONC	Newborn care	PNC	Breastfeeding	Nutrition	Immunization
Region													
CRR	94.7%	33.3%	19.4%	41.7%	16.7%	19.4%	5.6%	13.9%	19.4%	19.4%	11.1%	22.2%	19.4%
NBR-W	91.7%	27.3%	18.2%	13.6%	27.3%	40.9%	40.9%	27.3%	36.4%	40.9%	22.7%	36.4%	9.1%
URR	84.4%	48.1%	25.9%	33.3%	37.0%	29.6%	18.5%	18.5%	25.9%	37.0%	37.0%	37.0%	18.5%
Type of Facility													
Hospital	100%	31.8%	24.2%	36.4%	25.8%	28.8%	19.7%	21.2%	24.2%	30.3%	27.3%	31.8%	18.2%
Major HC	91.7%	54.5%	0.0%	9.1%	18.2%	9.1%	0.0%	0.0%	27.3%	9.1%	0.0%	18.2%	9.1%
Minor HC	89.2%	50.0%	25.0%	25.0%	37.5%	50.0%	37.5%	25.0%	37.5%	62.5%	12.5%	37.5%	12.5%
Total	90.4%	36.5%	21.2%	31.8%	25.9%	28.2%	18.8%	18.8%	25.9%	30.6%	22.4%	30.6%	16.5%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were asked for any training needs the staff personally need for their present job. Options were not read aloud but were noted as the respondent listed them.

Demand for knowledge

While 85% of health workers reported that training was sufficient to provide the care that patients needed, the desire for additional training was apparent in the very high take up of the training opportunities that were available; more than 90% of staff reported taking advantage of opportunities that arise.

Table 108: Demand for knowledge

	Mostly	Somewhat	Rarely
My training is sufficient to give my patients the help they need.	85.1%	6.4%	8.5%
I take advantage of available training opportunities at work	91.5%	1.1%	7.5%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR.
Health workers were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Forty seven percent of health workers reported being dissatisfied with the training opportunities available to them to upgrade their skills and knowledge.

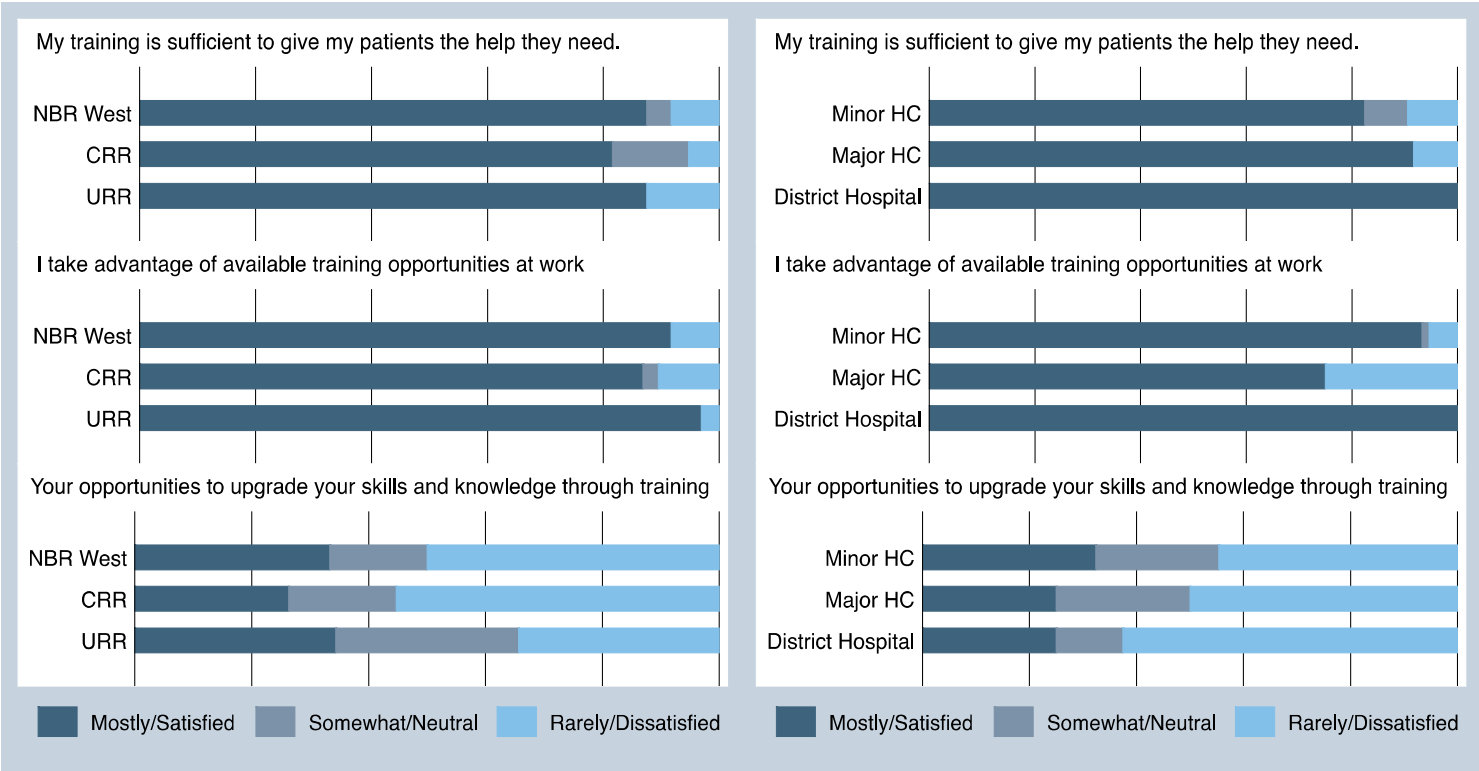
Table 109: Demand for knowledge (cont. 1)

	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied
Your opportunities to upgrade your skills and knowledge through training	30.9%	22.3%	46.8%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR.
Health workers were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

There were few regional differences in health worker attitudes towards training. However, all health workers in hospitals reported that their training was sufficient to give their patients the help they needed and that they took advantage of available training opportunities at work. Moreover, it was health workers in hospitals who reported highest dissatisfaction with the training opportunities available to them.

Figure 14: Demand for knowledge



Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. For the first 2 questions, staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never. For the final question, staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

In focus group discussions, health workers requested capacity building in a range of different areas including waste management, infection prevention and control, IMCI, data management, management, communication, fundraising, IT, financial management, monitoring and evaluation, and RBF.

One officer-in-charge in CRR was very explicit that greater attention should be given to capacity building:
"Knowledge deficit is also a problem but this I think is attitudinal. There are some nurses who benefitted from a lot of training but cannot still cope. It is not just going for training and after completion not upgrading yourself. Medicine and nursing are very dynamic fields and one must always keep abreast with new techniques and methods and not just coming to work and going home afterwards. We have mapped out a strategy that every month we should have a step down training. We have a doctor here and will take one, two topics that we feel are very pertinent to the management of our patients and then we discuss. And any time an individual goes for training, when s/he comes back, s/he should conduct a step down training." Officer-in-charge, CRR

VDCs/VSGs requested general capacity development to help them implement their community-based activities. The URR RHD noted that, given that it has been approximately 15 years since the VSGs were established, refresher training might be required to ensure adequate capacity within these groups.

One TBA requested capacity building in family planning so that she could make contraceptives available at community level and help women who experienced any side effects. Some TBAs, apparently unaware of the new MOHSW policy that redefined their role to focus on referrals for skilled delivery rather than provision of home delivery services, requested additional training in conducting deliveries.

Health worker compensation

Health workers at hospitals reported making nearly twice as much as those at health centers. The average monthly salary in The Gambia is approximately $46.50.[14] While salaries in CRR fell just below this national average, those in NBR-W and URR were well over. Minor health facility staff made, on average, slightly over the national average, while those in hospitals made more than double this average. Incentive payments for reaching monthly targets were particularly important in major health centers; incentive payments were also received by some health workers under projects supported by the Global Fund. Comparison of salaries across regions is not meaningful as there is a different mix of types of health facilities and number and cadres of health workers across the districts.

[14] GBOS and GAMJOBS. 2013. The Gambia Labor Force Survey (2012). Available online at: http://www.gbos.gov.gm/uploads/survey/LaborForce.pdf

Table 110: Health worker compensation

	Monthly salary 1 Year Ago	Current monthly salary	Incentive received last pay check
Region			
CRR	$34.23	$41.19	$5.28
NBR-W	$68.67	$73.63	$7.30
URR	$51.07	$61.42	$8.37
Type of Facility			
Hospital	$96.88	$96.81	$3.84
Major HC	$53.91	$61.02	$20.47
Minor HC	$42.07	$50.79	$4.98
Total	$48.77	$56.35	$6.86

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions.

In the qualitative data, health worker satisfaction with remuneration, including both the level of remuneration and timeliness of salary payments, was generally low.

"It's not easy, if you look at our pay scale - the government pay scale, it is very, very poor sorry to say." Health worker, URR.

Incentives

Of the 24 facilities visited, only two (8%) gave performance bonuses in 2013, and both of these facilities were in NBR-W. However, many facilities offered other incentives. Subsidized housing was the most commonly reported incentive. Of the 94 health workers interviewed, 80% received housing or housing subsidies through their work. Subsidies were somewhat more common in minor health facilities, and somewhat less common in CRR. Other common incentives included uniforms, which were given to 46% of staff, and health benefits, which were available to 31% of staff. Health benefits were reportedly given to 42% of health workers in NBR-W compared to only 19% of health workers in URR.

Table 111: Health worker incentives

	Subsidized housing	Health care benefits	Free meals	Uniform for work	Transport to work	Free schooling for children
Region						
CRR	73.7%	34.2%	5.3%	42.1%	21.1%	2.6%
NBR-W	83.3%	41.7%	16.7%	50.0%	12.5%	0.0%
URR	84.4%	18.8%	0.0%	46.9%	25.0%	0.0%
Type of Facility						
Hospital	75.0%	37.5%	0.0%	62.5%	0.0%	0.0%
Major HC	75.0%	41.7%	8.3%	41.7%	41.7%	0.0%
Minor HC	81.1%	28.4%	6.8%	44.6%	18.9%	1.4%
Total	79.8%	30.9%	6.4%	45.7%	20.2%	1.1%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the CRR, NBR-W and URR.

Satisfaction with remuneration

Remuneration was a serious concern for health workers. Only 32% of staff reported being satisfied with rewards (financial or otherwise) for hard work. Meanwhile, 81% reported dissatisfaction with their salary and 77% were dissatisfied with their benefits. Health workers with children (N=24) also reported high rates of dissatisfaction with locally available schooling; 33% of health workers with children were satisfied with schooling options compared to 54% who were dissatisfied.

Table 112: Health worker remuneration

Please tell me whether you are satisfied, neutral or unsatisfied with..	Satisfied	Neutral	Unsatisfied
..your opportunity to be rewarded for hard work, financially or otherwise.	31.9%	22.3%	45.7%
..your salary	11.7%	7.5%	80.9%
..your benefits (such as housing, travel allowance, bonus including performance bonus, etc)	6.4%	17.0%	76.6%
..living accommodations	52.1%	16.0%	31.9%
..available schooling for your children. (N=24)	33.0%	13.0%	54.0%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied. Information on available schooling was asked of 24 health workers with school-aged children.

Hospital-based health workers expressed the highest levels of satisfaction with opportunities to use their skills at work, salary and benefits (Figure 15). Staff at major health centers expressed the lowest levels of satisfaction with remuneration and no major health center staff were satisfied with their benefits.

Figure 15: Health worker satisfaction

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

Collaboration and teamwork

Most health workers felt that collaboration and teamwork was important in their facilities (Table 113). More than 90% stated that staff tried to peacefully resolve any disagreements among themselves and that they willingly helped one another when one member fell behind or had trouble. Similarly, more than 90% reported that the facility was like an extended family.

Table 113: Collaboration and teamwork

	Mostly	Somewhat	Rarely
Staff willingly share their expertise with other members.	80.9%	10.6%	8.5%
When disagreements occur among staff, they try to act like peacemakers to resolve the situation themselves.	91.5%	2.1%	6.4%
Staff willingly give their time to help each other out when someone falls behind or has difficulties with work.	92.6%	5.3%	2.1%
Staff talk to each other before taking an action that might affect them.	89.4%	7.5%	3.2%
Staff focus on what is wrong rather than the positive side.	47.9%	12.8%	39.4%
Staff spend time complaining about work-related issues.	68.1%	16.0%	16.0%
My facility is a very personal place. It is like an extended family and people share a lot with each other.	92.6%	3.2%	4.3%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

In the qualitative data, good communication was reported within health facilities with monthly meetings described as very useful.

Almost 94% of health workers were satisfied with working relationships with other facility staff. But, they were less likely to be satisfied with working relationships with Regional Health Directorates (77%) or the relationships between the facility and local traditional healers (79%).

Table 114: Collaboration and teamwork

	Satisfied	Neither Satisfied nor Unsatisfied	Unsatisfied
Working relationships with other facility staff	93.6%	4.3%	2.1%
Working relationships with the Regional Health Directorate	76.6%	13.8%	9.6%
Working relationships with management staff within the health facility	89.4%	8.5%	2.1%
The relationships between the health facility and local traditional leaders	78.7%	13.8%	7.5%
The relationships between the health facility and the catchment area/ communities	84.0%	12.8%	3.2%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

Some health workers described good teamwork within the health facility:
"The teamwork at the maternity unit is good because I just joined them newly and being a new graduate (in midwifery), practically we are not very conversant with it but then they are really helping me there. The teamwork is really good." Health worker, URR

Community health nurses reported very good working relationships with health workers, TBAs and VSGs. However, opportunities were also highlighted for improving communications with CHNs and RHDs. In NBR-W, TBAs reported good collaboration with community health nurses and facility-based health workers. TBAs described being treated with respect by health workers, being well received when they took clients there and collaborating with health workers in caring for their clients.

"When the nurses admit my client and do their checks, they will tell me to monitor her and call them when I need any help. They will then go to attend to other clients and I will call them to come when I know the birth is due. I assist the nurses during the delivery." TBA, NBR-W

Similar collaboration was described in URR. However, in CRR, TBAs reported sometimes being sent out of the delivery room by health workers who did not want them there.

Health workers in NBR-W described an increased sense of solidarity and teamwork brought about by the pilot project, which has reportedly had a positive impact on communication and morale. Collaboration with the CAC, the RHD, the VSG and the VDC was also reported to have increased. In contrast, an officer-in-charge in CRR reported "zero" collaboration with the CAC or VDC, a sentiment that was echoed by health workers in the same facility.

However, in some health facilities, a few colleagues were perceived as not doing their fair share of work:

"Some of the other thing is like co-workers' attitude like some will not relieve people early you know they will be late, they will not record the drugs that are given." Health worker, URR

This was described as detrimental to the team spirit of the workforce.

Some respondents suggested that capacity building of some stakeholders may be required in order to ensure effective teamwork and collaboration.

"Let me start by saying initially the CAC was dead because I think the whole of last year, before I came I think there was never a meeting. So you can say that the CAC is not playing any major role as far as the health facility is concerned. But like when I came, we had two meetings and some of them they may not know what is their role as far as the management of the health center is concerned." Officer-in-charge, CRR.

In some health facilities, there appeared to be a fractious relationship between the OIC and the CAC with the delineation of responsibilities (and rewards) not clear to all those involved.

However, in other facilities, this relationship seemed very functional, imbued with mutual respect.

Communication between health facilities and VDCs, as well as between VDCs and the broader community, was reportedly mixed with some communities reporting that this worked well and others noting a need to strengthen this area.

Health workers' intrinsic motivation

Table 115 shows that health workers reported feeling satisfied with the level of respect they receive in the community (94%), but satisfaction with their opportunities for promotion was much lower, with 64% reporting dissatisfaction along this metric.

Table 115: Intrinsic motivation

	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied
The level of respect you receive in the community	93.6%	6.4%	0.0%
Your opportunities for promotion	17.0%	19.2%	63.8%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

There was almost universal acknowledgement (99%) that recognition by the community of their work as a professional was important to health workers and that peer respect was important. It was also important to most health workers that patients follow their instructions (93%).

Table 116: Intrinsic motivation (cont. 1)

	Mostly	Neutral	Rarely
It is important for me that the community recognizes my work as a professional.	98.9%	1.1%	0.0%
It is important for me that my peers recognize my work as a professional.	98.9%	1.1%	0.0%
My patients follow my instructions.	92.6%	7.5%	0.0%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Most health workers reported optimism around new opportunities, with 97% expressing hope that changes in facilities create opportunities to improve health. Ninety six percent of health workers reported pride in working at their facility. While 99% reported being punctual in coming to work, approximately 15% expressed some degree of hesitancy when asked about their motivation. Of the health workers interviewed, 8% were neutral and 6% stated that they rarely felt motivated to work as hard as they can.

Table 117: Intrinsic motivation (cont. 2)

	Mostly	Somewhat	Rarely
Changes in the facility create new opportunities for us to improve health.	96.8%	1.1%	2.1%
I am proud to be working for this health facility.	95.7%	2.1%	2.1%
I am punctual about coming to work.	98.9%	1.1%	0.0%
These days, I feel motivated to work as hard as I can.	86.2%	7.5%	6.4%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Some health workers reported deriving their sense of motivation from seeing good health outcomes in their patients, especially healthy deliveries.

"For me what motivates me is caring for a mother for 9 months and then they come back to show me the baby, even if it is an at-risk woman, to help her until she delivers safely keeps me motivated." Health worker, URR

"We feel proud of it and being able to go in to these communities and giving them knowledge on basic health yeah. We are very proud of it." Community health nurse, URR

However, health workers were not immune to the challenges of their working environment. Weaknesses in the health system were described as demotivating for health workers. These ranged from the unavailability of basic drugs and equipment to dissatisfaction with staff living quarters. Health workers appeared frustrated at being constrained in the quality of care they could provide.

"In the Kombos some of these materials they are available. Why are they not available in the provinces and you know that these people they are very very poor? You post someone here, he or she wants to do something where is the materials? And whilst the person is in the Kombos the materials are there but why not here? For me that one is my frustrating part actually because am not used to this kind of things. Yeah, sometimes patients cannot buy so what can you do?" Health worker, URR

Equally, the shortage of health workers negatively affected morale as staff felt over-stretched.

Extrinsic motivation

Health workers in NBR-W reported improvements in morale and motivation due to the incentive payments received under the pilot project:

"I think the staff have been more committed now than before, because the more you work, the more incentive you earn. It has motivated the staff to work harder." Community health nurse, NBR-W

"We don't want to lose clients, the more we lose clients, the more we lose money for the facility and the more we lose our staff bonuses also. So if you think of all those things you will be careful how you talk to clients." Health worker, NBR-W

In both CRR and URR, although understanding of the MCNHRP was somewhat limited, health workers and community members alike appeared motivated to take on this new work and to ensure its success. Within CRR and URR, health managers noted that the arrival of the MCNHRP was already providing motivation for health workers and improving performance:

"With the advent of the RBF, you can see that staff are little bit more energetic and are ready to work extra hours compared to before. Because when the project was introduced everyone was aware. So there is that energy in the staff to work more because they are expecting something in return. You can see that in them because if you don't work you get less incentive. So they tend to work. That zeal is there to work and provide that data and quality services." Officer-in-charge, CRR

RHD members also highlighted the project incentive payments as a source of motivation for better fulfilling their duties:

"I can tell you there were some of these people who were not going out to supervise but right now because of this project they are going out now. Because there are some incentives tied to that supervision and there are charges if you also don't do it." RHD member

"Basically it is motivation because there are contracts which are time bound and quality, to look at quality which we are also scored against and we as RHD we don't want to be scored low. We will ensure to have a very good percentage, so that is a motivating factor to ensure that we do these things in there right way and at their right time also." RHD member

Autonomy

When asked about their workplace, health workers reported relatively high levels of autonomy (Table 118). More than 90% reported that their job allowed them both the freedom and the authority to organize and conduct their work. Similarly high levels of workers reported that their facility was dynamic and that their supervisor was willing to take risks. However, this innovative attitude appeared to be constrained when specific rules had been introduced – nearly as many health workers reported that their supervisor relied too much on policies and procedures as that

their supervisor was willing to take risks, and more than 80% of health workers agreed with both statements.

Table 118: Autonomy

	Mostly	Somewhat	Rarely
My job allows me freedom in how I organize my work and the methods and approaches to use.	92.6%	3.2%	4.3%
I am given enough authority by my supervisors to do my job well.	93.6%	3.2%	3.2%
The head of my facility is willing to innovate and take risks in order to improve things.	90.4%	4.3%	5.3%
The head of my facility relies too much on policies and procedures.	86.2%	6.4%	7.5%
My facility is very dynamic and an innovative place. People are willing to take risks to do a job well-done.	91.5%	2.1%	6.4%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

The original 5-point scale of the questions was used for more granular information, and it showed that health workers at hospitals perceived less autonomy than did staff at major or minor health facilities. Similarly, staff at hospitals were less likely to report that their supervisors were willing to innovate and take risks, and were more likely to report that their supervisors relied too heavily on policies and procedures. Nonetheless, staff at hospitals uniformly reported that their facilities were dynamic and innovative, compared to less than 80% of staff at major health centers and approximately 85% of staff at minor health centers.

The increase in autonomy that health managers hoped the project will bring was described a very motivating.

Satisfaction

Most health workers (98%) felt that that their patients trusted them, and 95% stated that they were able to complete their tasks efficiently and effectively. Health workers at smaller facilities appeared to perceive higher levels of patient trust, with all health workers at minor health centers reporting high levels of community trust. Overall, 65% of health workers would prefer to work at a different facility; this is surprising given that 96% reported feeling pride in working for the health facility (Table 117 above).

Table 119: Satisfaction

	Mostly	Somewhat	Rarely
My job makes me feel good about myself.	96.8%	2.1%	1.1%
My patients trust me.	97.9%	1.1%	1.1%
I would prefer to work somewhere else than in this facility.	64.9%	10.6%	24.5%
I complete my tasks efficiently and effectively.	94.7%	3.2%	2.1%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

While health workers reported generally high satisfaction with specific components of their job (e.g. 97% stated that their job made them feel good about themselves, and 80% were satisfied with the available opportunities to use their skills on the job), more than half of health workers felt some degree of dissatisfaction with their job. More than a third were neither satisfied nor dissatisfied, and a further 18% were dissatisfied.

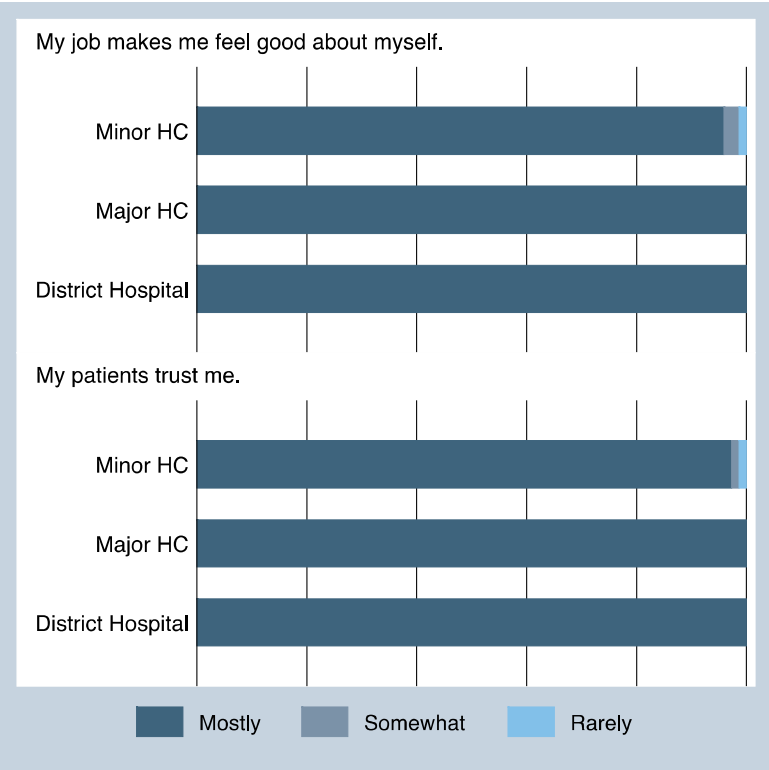
Table 120: Satisfaction (cont.)

	Satisfied	Neutral	Unsatisfied
Overall, how satisfied are you with your job?	46.8%	35.1%	18.1%
The opportunities to use your skills in your job.	79.8%	10.6%	9.6%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

The vast majority of health workers across all types of health facility reported that their job made them feel good about themselves and that their patients trusted them.

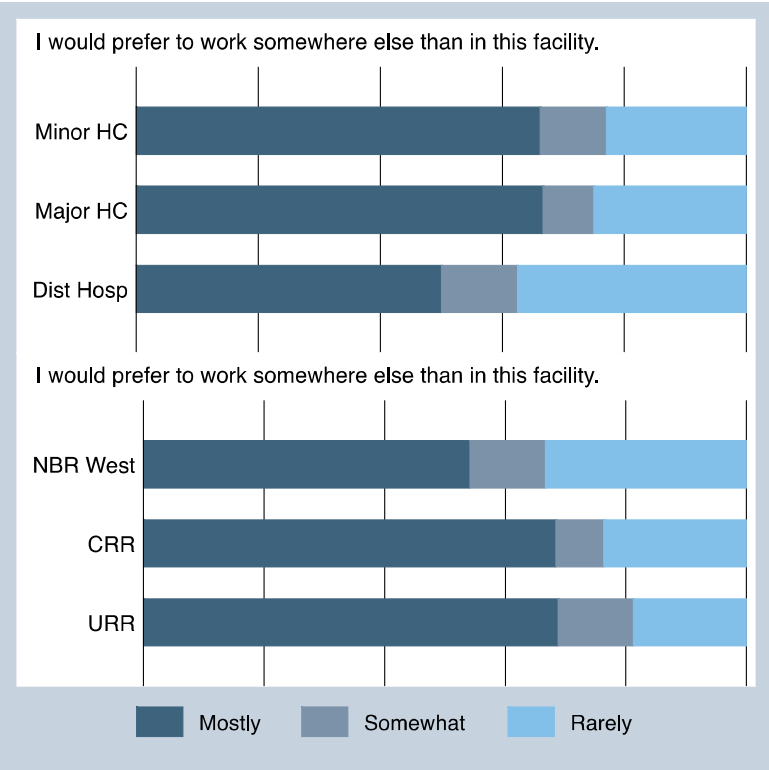
Figure 16: Health worker satisfaction



Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Health workers in hospitals were least likely to report a desire to work in a different health facility. Although a desire to work elsewhere was common, health workers in NBR-W were least likely to desire a shift – approximately 50% of staff there stated a preference for working somewhere else, compared to approximately 70% in both CRR and URR.

Figure 17: Health worker satisfaction (cont.)



Client friendliness

Health workers emphasized a client-oriented approach, and nearly all health workers reported both being friendly and polite to all clients and that it was important that clients could ask them questions. On the other hand, some health workers considered time constraints to be a barrier to consistent and appropriate client care – nearly 20% of health workers reported not having time to appropriately deal with clients.

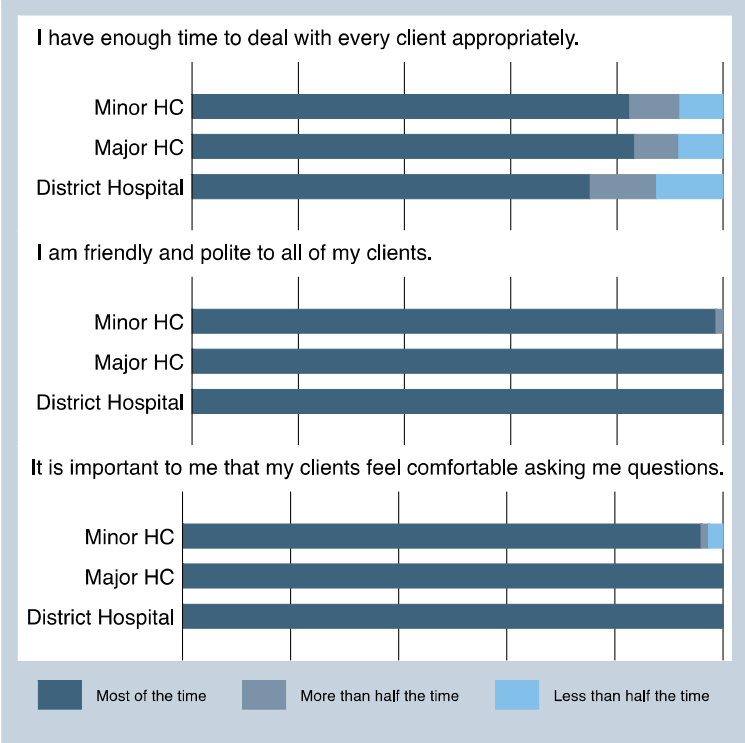
Table 121: Client friendliness

	Mostly	Somewhat	Rarely
I have enough time to deal with every client appropriately.	81.9%	9.6%	8.5%
I am friendly and polite to all of my clients.	98.9%	1.1%	0.0%
It is important to me that my clients feel comfortable asking me questions.	96.8%	1.1%	2.1%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Disaggregating these data by the type of health facility, Figure 18 below shows that the highest proportion of staff reporting not having enough time to deal with each client appropriately were in hospitals, suggesting that time constraints are greatest in this setting.

Figure 18: Client friendliness



Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Community members' perceptions of health worker attitudes was mixed with some describing positive experiences and others citing poor attitudes and neglect of patients as problems in some health facilities. A community health nurse in CRR highlighted the need for health worker attitudes to be improved: "*"Also some sort of memo [should be] written to all the staff to effect behavioral change towards pregnant women. With strict warning even if it will not be implemented, because staff need to change their attitude for the better"*.

In contrast, data from NBR-W show a perceived improvement in client friendliness since the pilot project began:

"Some [patients] told us that in the past they will sit there and nurses will be doing their own things, but now they are received from the gate, they are welcomed, given a seat, and you have a

TV to watch while waiting for your service. If you have to deliver, they put you in bed and are always beside you, talking to you, massaging you. When you deliver they give you hot water, provide hot water for you to take bath." RHD member

Women who had visited a TBA or CHN in the previous six months were asked a series of questions about how the health facility had changed compared to a year previously. Women were of the opinion that health facilities were cleaner than a year ago, with four out of five believing this to be the case. In addition, compared to a year ago, the women agreed that facility staff were friendlier and made more effort to follow up with patients, and that waiting times had decreased. Across all of these indicators the highest proportion of women voicing strong agreement with each of the statements about these health facility improvements was in NBR-W, which is where the pilot project had been operating for a year at the time of the survey.

Table 122: Health facilities

"The health facility is cleaner now than it was one year ago"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	47.6%	30.7%	9.8%	6.2%	5.8%
NBR-W	79.9%	6.7%	6.0%	1.5%	6.0%
URR	62.9%	24.7%	9.5%	1.4%	1.4%
Total	61.1%	23.1%	8.9%	3.1%	3.9%
"Health staff are friendlier and more available now than they were one year ago"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	41.9%	38.7%	9.9%	6.3%	3.2%
NBR-W	70.9%	14.2%	6.7%	1.5%	6.7%
URR	53.4%	21.9%	19.1%	3.9%	1.8%
Total	53.1%	26.1%	13.3%	4.2%	3.3%
"Health staff make more of an effort to follow up with and reach out to patients than they did one year ago"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	37.5%	33.9%	17.9%	5.4%	5.4%
NBR-W	61.9%	14.2%	15.7%	2.2%	6.0%
URR	35.9%	19.7%	32.7%	7.7%	3.9%
Total	41.9%	23.5%	24.0%	5.8%	4.8%
"In the last year waiting times at the health facility have decreased"					
	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly
Region					
CRR	29.5%	29.5%	28.6%	4.9%	7.6%
NBR-W	52.6%	12.8%	21.8%	4.5%	8.3%
URR	39.1%	26.1%	16.9%	9.2%	8.8%
Total	38.5%	24.5%	22.0%	6.7%	8.3%

Notes: Based on 644 household interviews of women who had seen a TBA or CHN in past 3 months

Results focus

Almost all health workers (97%) reported that achieving results and high performance was important in their facility, and 85% reported that personal relationships between staff was less important than achieving daily goals. A substantial proportion of health workers (85%) also reported looking at monthly statistics to see how the department was performing.

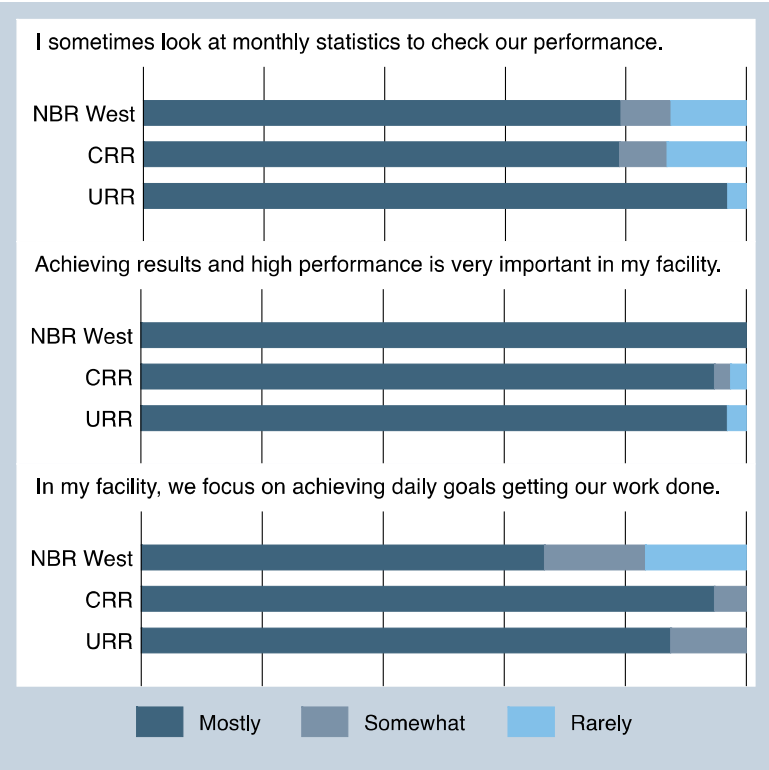
Table 123: Results focus

	Mostly	Somewhat	Rarely
Achieving results and high performance is very important in my facility.	96.8%	1.1%	2.1%
In my facility, we focus on achieving daily goals getting our work done. Relationships between staff are less important.	85.1%	10.6%	4.3%
I sometimes look at monthly statistics from my department to see how well we are performing.	85.1%	5.3%	9.6%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

When compared with CRR and NBR-W, health workers in URR appeared most likely to look at monthly statistics to check their performance. While there was little geographic variation in the reported importance of achieving results and high performance, health workers in NBR-W were substantially less likely than their colleagues elsewhere to report emphasizing daily goals over relationships between staff.

Figure 19: Health facilities performance



Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

Internal and external supervision and assessment

Information on internal and external staff reviews is provided in Table 124. The survey suggests substantial regional differences in staff reviews. Both internal and external reviews were reported to be most common in NBR-W, where 100% of facilities reported routine internal performance reviews and 83% reported external staff reviews in the twelve months preceding survey. This compares with only 50% of facilities in CRR reporting internal staff reviews, and only 38% of facilities in URR and 40% of facilities in CRR reporting external staff reviews. While all major health centers reported internal staff reviews, only one of the two hospitals included in the survey reported internal review, and neither of the hospitals reported receiving external staff reviews.

Table 124: Health worker review

	Internal review of staff performance in last 12 months	External review of staff performance in last 12 months
Region		
CRR	50.0%	40.0%
NBR-W	100%	83.3%
URR	75.0%	37.5%
Type of Facility		
Hospital	50.0%	0.0%
Major HC	100%	66.7%
Minor HC	68.4%	52.6%
Total	70.8%	50.0%

Notes: Statistics are based on administrative data provided by 22 public health centers and two public hospitals in CRR, NBR-W and URR.

Table 125 shows that staff at facilities confirmed health facility reports. Approximately 80% of staff reported having either an internal or external supervisor. Approximately two-thirds of staff had spoken to an internal supervisor about performance in the six months preceding the survey, and approximately 75% of health center staff had spoken with an external supervisor over the same period. Only half of hospital staff reported having spoken to either type of supervisor during this period.

Table 125: Supervision

	Has an internal supervisor	Spoke with internal supervisor about performance in last 6 months	Has an external supervisor	Spoke with external supervisor about performance in last 6 months
Region				
CRR	71.1%	63.2%	73.7%	68.4%
NBR-W	87.5%	66.7%	66.7%	58.3%
URR	81.2%	62.5%	93.8%	87.5%
Type of Facility				
Hospital	75.0%	50.0%	62.5%	50.0%
Minor HC	77.0%	66.2%	79.7%	74.3%
Major HC	91.7%	58.3%	83.3%	75.0%
Total	78.7%	63.8%	78.7%	72.3%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR.

Leadership and management

Health workers' reported satisfaction with the head of health facilities was high overall – 90% of health workers reported that the facility head was a mentor, and 89% reported that the head motivated staff to achieve goals.

Table 126: Leadership and management

	Mostly	Somewhat	Rarely
My immediate supervisor motivates me to achieve goals	86.2%	5.3%	8.5%
The head of my facility is a mentor and a role model.	90.4%	5.3%	4.3%
The head of my facility motivates staff to achieve goals.	89.4%	4.3%	6.4%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read a series of statements and asked if they agree most of the time, more than half of the time, less than half of the time, only rarely, or never. These response categories were re-coded to "Mostly" if staff reported the statement to be true most of the time or more than half of the time, to "Somewhat" if the statement held true less than half the time, and "Rarely" if the statement held true only rarely or never.

However, overall satisfaction with the way that their health facility was managed was lower (Table 127). More than 25% of staff were either neutral or dissatisfied with the quality of management, and nearly 20% expressed some degree of dissatisfaction with opportunities to discuss work with their immediate supervisor. Nearly a quarter were less than satisfied with the quality of internal supervision, and 41% were less than satisfied with the quality of external supervision.

Table 127: Leadership and management (cont.)

	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied
Quality of the management of the health facility by the management staff within the health facility	73.4%	14.9%	11.7%
Your opportunity to discuss work issues with your immediate supervisor	81.9%	11.7%	6.4%
Your immediate supervisor's recognition of your good work	87.2%	8.5%	4.3%
Quality of internal supervision.	75.5%	7.5%	17.0%
Quality of external supervision.	58.5%	19.2%	22.3%

Notes: Statistics are based on data provided by 94 staff members at 22 public health centers and two public hospitals in CRR, NBR-W and URR. Staff were read about a series of issues and asked if they were satisfied, neither satisfied nor unsatisfied, or unsatisfied.

TBAs and health workers alike reported deriving satisfaction from supervisors looking through their health records and providing them positive feedback.

External performance assessment

The table below gives the number of times that a health facility had an evaluation from either the RHD or the MoHSW in the twelve months preceding the survey. Of the 24 facilities, only two (8%) of the facilities had an evaluation within the past 12 months; one in CRR and another in NBR-W. Both of these facilities were minor health centers.

Table 128: External performance assessments at health facilities

	Total number of facilities	Number of facilities receiving an external performance assessment in past 12 months	Percentage of facilities receiving a performance assessment
Region			
CRR	10	1	10.0%
NBR-W	6	1	17.0%
URR	8	0	0.0%
Type of Facility			
Hospital	2	0	0.0%
Major Health Center	3	0	0.0%
Minor Health Center	19	2	11.0%
Total	24	2	8.0%

Note: Based on 24 health facility surveys.

Some RHDs reported being hampered in fulfilling their supervisory role due to transportation issues such as old vehicles and an insufficient fuel supply.

Health center management

Health center management committees

Twenty facilities reported having management committees. These committees participated in a number of different activities, with the most common ones being improving infrastructure, environmental sanitation activities, administrative support to the health facility, provision of drugs to the health facility, improving security at the facility and improving water quantity or quality. Management committees in NBR-W were reported to be particularly active.

Table 129: Management committee activities - last 12 months

	Admin support to HC	Provided new supplies/ equipment	Provided new or repaired infrastructure	Provided drugs	Provided transport to staff (for home visits)	Gave in-kind contributions	Improved security at HC	Improved water quantity or quality	Supported training for CHWs	Mobilized community or supported outreach teams	Verified MCH results	Environmental sanitation activities	IRS	Disease Screening	Data reporting for RBF	Designing, training & mobilization for RBF
Region																
CRR	28.6%	14.3%	28.6%	28.6%	0.0%	28.6%	28.6%	28.6%	0.0%	14.3%	14.3%	42.9%	28.6%	28.6%	14.3%	14.3%
NBR-W	100%	100%	83.3%	100%	33.3%	66.7%	83.3%	100%	50.0%	100s%	66.7%	100%	83.3%	33.3%	66.7%	50.0%
URR	14.3%	0.0%	71.4%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	28.6%	0.0%	0.0%	0.0%	0.0%
Type of Facility																
Hospital	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	0.0%
Major HC	66.7%	33.3%	66.7%	66.7%	0.0%	33.3%	66.7%	66.7%	0.0%	66.7%	33.3%	66.7%	66.7%	33.3%	0.0%	0.0%
Minor HC	40.0%	33.3%	60.0%	33.3%	6.7%	26.7%	33.3%	33.3%	13.3%	26.7%	20.0%	53.3%	26.7%	13.3%	26.7%	26.7%
Total	45.0%	35.0%	60.0%	40.0%	10.0%	30.0%	40.0%	40.0%	15.0%	35.0%	25.0%	55.0%	35.0%	20.0%	25.0%	20.0%

Notes: Based on data provided by administrative staff at 18 public health centers and two public hospitals in CRR, NBR-W and URR who currently have an executive committee.

Management autonomy

Facility administrators reported varying degrees of autonomy. While most reported being able to assign tasks and activities to staff, far fewer were reportedly able to allocate facility budget as desired. A substantial number of administrators reported not having sufficient authority to obtain the resources needed in their facility and not being able to choose what health services are provided at facilities. Facilities in URR reported particular difficulties in accessing drugs and supplies.

Facility administrators generally reported that policies and procedures were clear and useful for achieving work-related goals. Regional Health Management Teams (RHMTs) were generally reported to be supportive and to provide helpful feedback, with the exception of facilities in URR, where more than 60% of facilities found feedback sufficient less than half the time.

Figure 20: Facility administrators

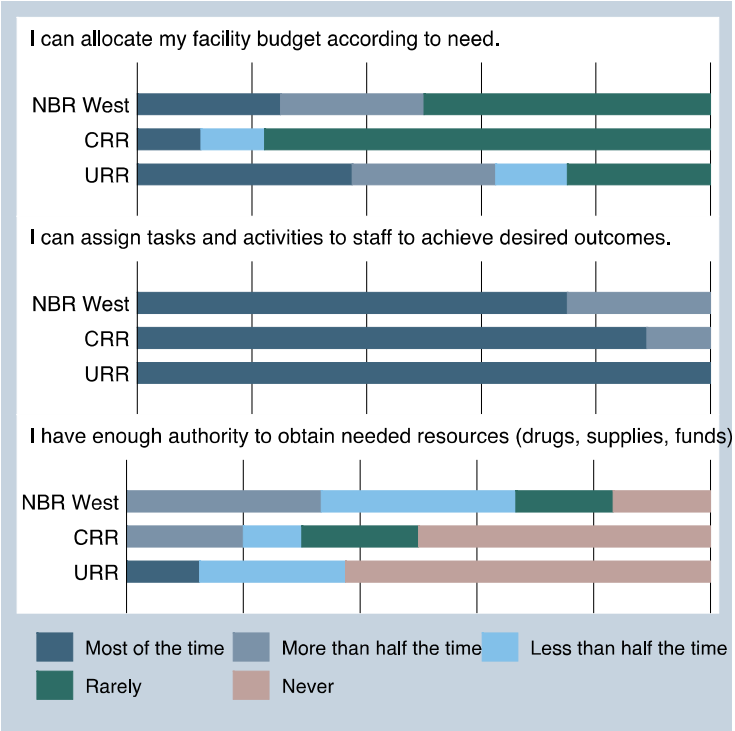


Figure 21: Facility administrators (cont. 1)

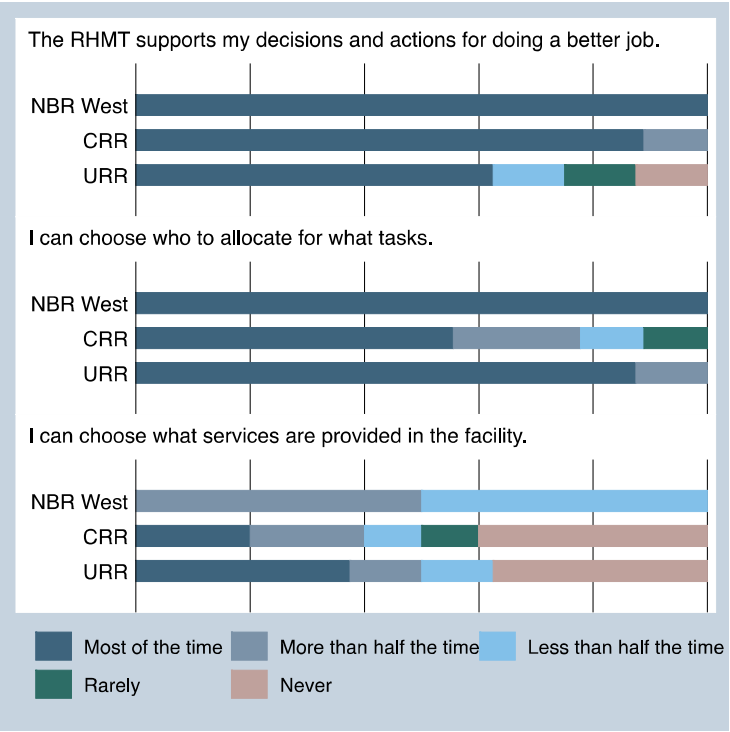
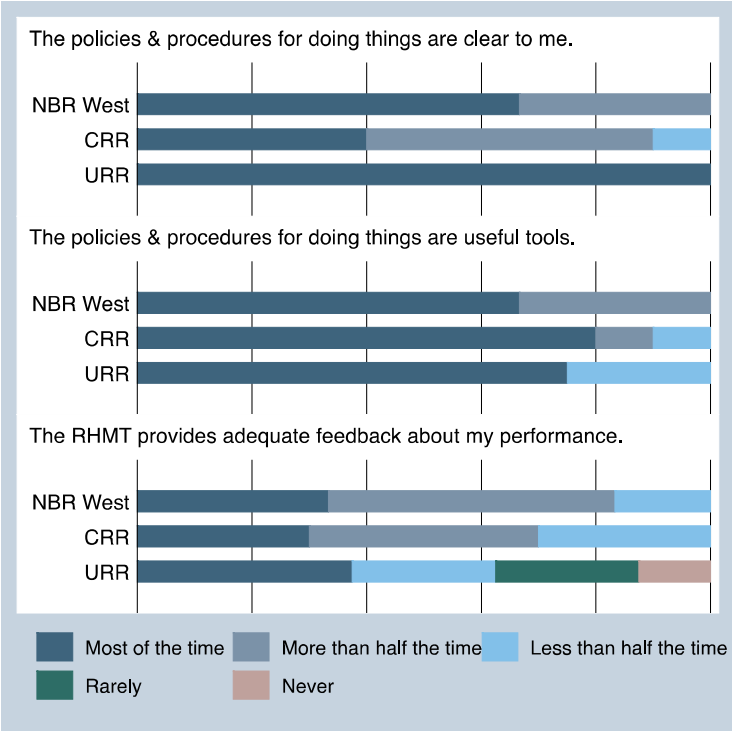


Figure 22: Facility administrators (cont. 2)



Notes: Based on data provided by facility heads at 21 public health centers and two public hospitals in CRR, NBR-W and URR who currently have an executive committee.

Both at the level of the RHD and at health facility level, respondents articulated a desire for budgetary autonomy, explaining that they were best situated to understand their own needs and as such should be able to act accordingly. PIC members also noted that an important lesson from the pilot project was empowering project participants (at community, health facility and regional levels) to make their own decisions. However, in one case the request for full autonomy appeared to be closely linked to one RHD member's desire to upgrade his house suggesting that continued oversight of budget allocation and expenditure will be important.

It will be important to work with health managers to ensure that they understand the latitude that they have under the MCNHRP while still operating within government guidelines. This seemed unclear to some health managers in CRR and URR.

"Q: What do you think can be done to improve the financial situation of the health facility? A: Well it is difficult to say because this is government facility, and there are rules and regulations as to how it should operate." Officer-in-charge, CRR

Health information

The need to ensure quality data as part of the MCNHRP appeared to be well understood by health workers and managers but not all health managers thought that their facilities were sufficiently well staffed to be able to fulfill the project's expectations.

"I need another data entry clerk as well because RBF relies heavily on data. When we have enough hands, we will be able to do the job as expected." Officer-in-charge, URR

"I think also they have to increase the number of data entry clerks. I went to outpatients yesterday and when I went there the nurse told me that they are the ones who clerk (referring to consultation) the patients, you record and you take the vital signs. In the Kombos it's a different thing. At the outpatient, you have data entry clerks stationed there on morning and on afternoon. If you want to have correct data, I think that those are the things that we should tackle." Health worker, URR

Some shortcomings in record keeping were noted across health facilities in CRR and URR.
"Probe: For us to understand, do you mean the registers that you go with on trek to enter the records of immunization, that some of your colleagues don't record the data on the register? R5: Yes exactly." Health worker, URR

"I know the data entry clerks are doing a lot of things but the workload is too much for them. I know they can do it the wrong way and that can be a problem." Health worker, URR

Health workers in NBR-W reported an increase in the time they had to spend on record keeping following the introduction of the MCNHRP. However, national level stakeholders noted that the project should greatly improve the quality of data being recorded as accurate reporting is incentivized.

Health financing

Health facility income

All major and minor health centers reported earning income in 2013, however the amount of income varied dramatically by region, from just under $500 in CRR to nearly $4,000 in NBR-W. Hospitals were omitted from analyses on health facility income (Table 130).

Catchment area population estimates were used to calculate per capita income for each health center. There was high regional variance among regions, with $0.02 per capita in CRR- and URR- facilities, compared to $0.37 per capita in NBR-W. Substantial variation also existed between facility types – minor health centers reported per capita income that was three times that reported by major health centers.

Table 130: Income at health centers (2013)

	Total reported income in 2013 (mean)	Per capita income among facilities who know catchment population
Region		
CRR	$492.19	$0.02
NBR-W	$3,953.30	$0.37
URR	$1,914.44	$0.07
Type of Facility		
Major HC	$2,100.74	$0.05
Minor HC	$1,958.56	$0.16
Total	$1,989.02	$0.14

Notes: Data is from 14 public health centers in CRR, NBR-W and URR who report their income; hospitals are not included. All income originally reported in GMD, converted at a rate of 43GMD: 1USD. Catchment area information provided by NaNA.

Most RHDs and health facilities reported an acute shortfall in funding that limited their ability to operate. Most facilities were using the government-sanctioned fees for services but some facilities appeared to be charging higher fees as a way of increasing their income.

Budgets and workplans

Budgets and workplans were most common in NBR-W, where 50% of facilities had budgets and 67% had workplans. While approximately 15%-25% of minor health centers had these documents in place, no major health centers did so. Of the seven facilities with workplans, six identified priority areas for action.

Table 131: Budget and workplans

	Budget in place	Workplan in place	Workplan identifies priority areas
Region			
CRR	10.0%	10.0%	0.0%
NBR-W	50.0%	66.7%	66.7%
URR	12.5%	25.0%	25.0%
Type of Facility			
Hospital	100%	100%	50.0%
Major HC	0.0%	0.0%	0.0%
Minor HC	15.8%	26.3%	26.3%
Total	20.8%	29.2%	25.0%

Notes: Based on data provided by facility heads at 24 public health centers and two public hospitals in CRR, NBR-W and URR.

Facility Officers in Charge and staff were universally involved in setting up work plans. Village representation, by VSGs, VDCs, CHWs, or community members was sporadic but highest in NBR-W.

Formal tracking of budgets remained weak. Few major health centers and no minor health centers were able to provide official reports on financing, with 95% of minor health centers providing oral reports of revenues.

Table 132: Source of information on income at health facilities (2013)

	Official accounts	Facility records	Oral report
Region			
CRR	10.0%	0.0%	90.0%
NBR-W	16.7%	16.7%	66.7%
URR	12.5%	0.0%	87.5%
Type of Facility			
Hospital	100%	0.0%	0.0%
Major HC	33.3%	0.0%	66.7%
Minor HC	0.0%	5.3%	94.7%
Total	12.5%	4.2%	83.3%

Notes: Statistics are based on the 22 public health centers and two public hospitals in the North Bank West, Central River and Upper River regions. Official accounts constitute the data sent to the RHD; facility reports constitute records held within the health facility; and oral reports constitute information from facility head or other respondent.

The Drug Revolving Fund (DRF) was the only source of income for most facilities that was reported in qualitative interviews, with this producing very little revenue, which was usually spent on incidental expenses.

Some health facilities reporting having no ability to procure needed items due to a near total lack of funds.

"Q: What is the current procedure and procurement in your health center? A: Zero, we don't procure because we don't have any money to procure." Officer-in-charge, CRR

Fee waivers and the burden of health care costs

Based on health facility reports, all facilities offered fee waivers to at least one group, with waivers for services for children under the age of five and pregnant women almost ubiquitous. Fee waivers for the extreme poor were, however, rare.

Table 133: Availability of fee waivers

	Pregnant women	Children under 5	Extreme Poor
Region			
CRR	100%	100%	0.0%
NBR-W	83%	100%	0.0%
URR	100%	100%	38%
Type of Facility			
Hospital	50%	100%	0.0%
Major HC	100%	100%	33%
Minor HC	100%	100%	11%
Total	95.8%	100%	12.5%

Notes: All statistics are based on the 22 public health centers and two public hospitals in CRR, NBR-W and URR.

Despite the availability of these waivers, approximately 20% of households visited in the household survey reported having a significant health expense – defined as one higher than could be afforded with the household's usual income – in the previous twelve months.

High healthcare costs were substantially more common in CRR and URR than in NBR-W, possibly due to the different socioeconomic profile of households visited in these regions. Significant expenses appear to be more heavily concentrated among households in the lower wealth quintiles, and wealth was substantially higher among households in NBR-W. Families relied on a limited number of coping strategies to deal with these high and often unexpected costs. Nearly half of all families facing high expenses borrowed money to pay these costs. Selling of household possessions and utilizing remittances were also frequently reported.

Table 134: Burden of health facility costs

	High health expenditures in last 12 months	Among households with catastrophic health expenditure, % of households reporting the following strategies to cover costs (in last 12 months)			
		Sold land to pay HC costs	Sold livestock to pay HC costs	Borrowed money to pay HC costs	Used remittances/gifts to pay HC costs
Region					
CRR	21.8%	38.9%	33.2%	39.4%	16.3%
NBR-W	7.9%	38.1%	33.3%	52.4%	19.0%
URR	24.1%	35.9%	25.0%	47.8%	17.5%
Respondent is literate					
No	20.2%	37.9%	30.5%	43.5%	15.4%
Yes	16.4%	36.3%	26.7%	47.3%	23.1%
Wealth Quintile					
Lowest	21.4%	38.9%	31.6%	42.1%	15.8%
Second	24.7%	36.4%	29.1%	47.3%	17.3%
Third	19.1%	35.3%	22.6%	48.2%	22.6%
Fourth	17.8%	36.7%	30.4%	41.8%	13.9%
Highest	13.5%	41.7%	36.7%	40.0%	15.0%
Gov't Hospital or HC in village					
No	16.9%	35.3%	30.6%	28.2%	16.5%
Yes	20.0%	38.1%	29.4%	48.3%	17.2%
Total	19.3%	37.5%	29.7%	44.3%	17.1%
	2225	**429**	**428**	**429**	**428**

Notes: Based on 2,225 households providing information on health expenditures.

Availability of supplies, drugs, equipment and services

Availability of supplies

Table 135 shows the availability of sterile gloves and cotton (or gauze) at health facilities. All six facilities in NBR-W had both sterile gloves and sterile cotton with an average quantity of 81.5 and 18.3 respectively. Availability of these supplies was much lower in CRR and URR.

Table 135: Availability of at least one unit of sterilized gloves and cotton or gauze

	Sterile gloves available*	Sterile gloves (Quantity)	Sterile cotton (or Gauze) available**	Sterile cotton (or Gauze) (Quantity)
Region				
CRR	90.0%	41.3	60.0%	15.0
NBR-W	100.0%	81.5	100.0%	18.3
URR	62.5%	56.6	50.0%	1.3
Type of health facility				
Hospital	50.0%	3.0	50.0%	20.0
Major Health Center	100.0%	74.0	66.7%	2.7
Minor Health Center	84.2%	59.3	68.4%	11.7
All Facilities	83.3%	56.5	66.7%	11.3

Note: Based on 24 health facility interviews.
* A unit refers to a pair of functioning unused sterile gloves
** One sterile gauze (or cotton bud) that is unused.

Availability of equipment

Out of the 24 health facilities, nine (38%) had at least 1 autoclave, of which 2 were the hospitals. Auto timers and TST (time, steam and temperature) indicator strips were less likely to be available at a facility (17% and 12% respectively).

Table 136: Availability of sterilization equipment

	Autoclave	Auto timer	TST Indicator
Region			
CRR	60.0%	20.0%	20.0%
NBR-W	33.3%	33.3%	0.0%
URR	12.5%	0.0%	12.5%
Type of health facility			
Hospital	100.0%	50.0%	50.0%
Major Health Center	66.7%	0.0%	33.3%
Minor Health Center	26.3%	15.8%	5.3%
Total	37.5%	16.7%	12.5%

Note: Based on 24 Health facilities surveyed. An autoclave is a sterilizer; an auto timer enables the sterilizer to be automatically turned on or off; TST indicator strips are used for routine monitoring of sterilization cycle time, steam and temperature.

All 24 facilities surveyed reported having their own vehicle for emergency transport and referral pickup of patients. Only 4 facilities, all in NBR-W, had at least a day in the week prior to the survey when the facility did not have a vehicle for transporting patients. Although all health facilities reporting having an ambulance, qualitative data suggest that this is insufficient given the catchment area each facility has to cover. For example, if an outreach clinic was being conducted there was no ambulance available for referrals or emergency transportation.

Availability of drugs

Paracetamol, Fansidar and Coartem were the three drugs that facilities were most likely to have in supply (Table 137). All facilities had at least one strip of Paracetamol and almost half of the facilities had amoxicillin in stock either in tablet or syrup form but only one quarter of facilities had Rifampin in stock at the time of the survey.

Table 137: Availability of essential medicines

	Paracetamol	Amoxicillin (Tablets/Syrup)	Coartem	Fansidar	Rifampin
Region					
CRR	100.0%	30.0%	90.0%	80.0%	30.0%
NBR-W	100.0%	50.0%	100.0%	100.0%	50.0%
URR	100.0%	62.5%	100.0%	87.5%	0.0%
Type of health facility					
Hospital	100.0%	0.0%	100.0%	50.0%	50.0%
Major Health Center	100.0%	66.7%	100.0%	66.7%	66.7%
Minor Health Center	100.0%	47.4%	94.7%	94.7%	15.8%
All Facilities	100.0%	45.8%	95.8%	87.5%	25.0%

Note: Table shows the percentage of facilities having at least one dose of the medication. Based on 24 health facility interviews.

The table on stock-outs of drugs (Table 138) reflects similar trends to the table above. Stock-outs were highest of Rifampin and Amoxicillin, and lowest of Paracetamol and Coartem. Stock-outs were lowest in NBR-W where only Amoxicillin had been out of stock in the previous 30 days.

Table 138: Stock-out of drugs in last 30 days

	Paracetamol	Amoxicillin (Tablets/Syrup)	Coartem	Fansidar	Rifampin
Region					
CRR	0.0%	80.0%	10.0%	20.0%	70.0%
NBR-W	0.0%	50.0%	0.0%	0.0%	50.0%
URR	12.5%	62.5%	0.0%	25.0%	100.0%
Type of facility					
Hospital	0.0%	100.0%	0.0%	50.0%	50.0%
Major Health Center	0.0%	33.3%	0.0%	33.3%	33.3%
Minor Health Center	5.3%	68.4%	5.3%	10.5%	84.2%
All Facilities	4.2%	66.7%	4.2%	16.7%	75.0%

Note: Table shows percentage of facilities with at least one day of stock-out in the past 30 days

Availability of laboratory services

All hospitals and major health centers reported offering the services they should be offering except for pregnancy testing. One out of the two hospitals could not offer pregnancy testing. All other facilities were able to offer pregnancy testing for women. However, a substantial proportion of minor health centers did not offer all of the laboratory services that they are meant

to offer with only 37% offering stool tests for parasites, 42% offering syphilis testing and 47% offering either hemoglobin assessment or blood sugar assessment. Assessment of regional differences is not appropriate given the different mix of levels of facilities available in each region.

Table 139: Facility ability to provide laboratory services on the day of survey

	Hemoglobin estimation	Malaria smears	HIV testing*	Syphilis testing	Urine (protein and glucose)*	Pregnancy testing	Blood sugar	Stool test for parasite
Region								
CRR	30.0%	40.0%	40.0%	30.0%	20.0%	40.0%	40.0%	20.0%
NBR-W	83.3%	83.3%	33.3%	83.3%	83.3%	66.7%	83.3%	83.3%
URR	75.0%	75.0%	62.5%	62.5%	75.0%	75.0%	62.5%	62.5%
Type of facility								
Hospital	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%
Major Health Center	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Minor Health Center	47.4%	52.6%	31.6%	42.1%	42.1%	52.6%	47.4%	36.8%
All Facilities	58.3%	62.5%	45.8%	54.2%	54.2%	58.3%	58.3%	50.0%

Notes; Table shows percentage of facilities that offer the above health services.
* Based on minimum standards, minor health centers are not required to offer HIV testing services or urine testing services

Table 140 is a continuation of the table above, giving the average number of tests run by each facility. Hemoglobin estimation was the most common test run (1,153), followed by malaria smears (706) and HIV testing (234). Stool tests for parasites were the least frequently run out of the eight tests studied, with only six stool tests having reportedly been run in the previous three months.

Table 140: Average number of lab services run by facility in past 3 months

	Hemoglobin estimation	Malaria slides	HIV testing*	Syphilis test	Urine (protein & glucose)*	Pregnancy test	Blood sugar assessment	Stool test for parasite
Region								
CRR	177	440	254	96	83	70	29	2
NBR-W	3480	1038	268	241	246	46	181	12
URR	626	788	182	55	125	64	5	5
Type of facility								
Hospital	9,033	2,974	971	194	673	164	513	14
Major HC	1,657	939	461	450	377	32	47	33
Minor HC	244	430	120	58	44	56	13	0
Total	1,153	706	233	118	138	62	59	6

Notes: Average number of tests conducted at a facility over the past 3 months.

Qualitative data highlighted that the limited hours of electricity reported as well as shortages of the necessary equipment and staff restricted the availability of laboratory services such as hemoglobin testing and urinalysis. Furthermore, although health workers encouraged women to attend the health facility early in the day, women reported having other chores to complete, such as gardening and cooking, which sometimes interfered with this. This meant that they arrived at the health facility late in the day, making it harder to complete ANC-related laboratory services that day.

6. Sample representativeness, balance and power calculations

6.1 Representativeness of the sample

The sampling strategy utilized for this survey was designed to provide a comprehensive baseline assessment of the health status, health service utilization and health service perceptions in the populations served by the 24 health facilities participating in the MCNHRP. To reach this objective, sampling was centered around the health facilities of interest, with a particular focus on communities with functioning community platforms in place which will be the target of the planned demand side interventions.

The resulting sample is not representative at the national or regional level for three main reasons: first, geographically, the project covered only 3 regions in the country, which are on average less developed than the regions not included. Second, within regions, surveys were only conducted in communities with existing health platforms. These communities are on average slightly larger and likely also more developed than communities without such platforms. Last, within communities, the survey targeted only women with recent births, which are not representative of the larger adult female population.

Table 141 compares a set of indicative indicators from the data collected in this study to the nationally representative 2013 Gambia DHS project. For the DHS, we show both the national level results, and the average outcomes reported in the three regions covered by the MCNHRP project ("in sample"). Given the focus on nuclear households in this study, households are smaller than households in the 2013 DHS, which reported an average household size of 8.2 persons compared to 5.8 in this survey. Education rates were also lower in this survey when compared to the DHS. Households in the presented study have substantially lower access to assets that indicated wealth (e.g., televisions and refrigerators), while assets that indicated relative poverty (e.g., bicycles) are somewhat more common than they are in the DHS sample. Similarly, households in the DHS sample were nearly three times as likely to have electricity and households in this sample were substantially more likely to rely on unimproved sanitation than were households in the DHS: 61%, versus 39%.

Despite the higher poverty and lower education in our sample, health service utilization is relatively high in our sample; only the use of postnatal care was substantially lower than in the DHS, and both measles vaccination and Vitamin A coverage are higher in the MCNHRP sample than in the DHS samples.

Fertility patterns appear to differ substantially between surveys. Compared to women in the DHS,

women in our sample were more likely both to use a modern method of family planning to prevent pregnancy and also to say that they desired additional children. The substantial regional variation within our survey may help to explain this – while only 4% of women in URR reported using family planning methods, nearly a quarter of women in NBR-W did so.

Nutritional indicators were fairly consistent across the surveys. Just under half of children aged less than six months were reported to be exclusively breastfed in this sample. This is largely consistent with the 2013 DHS survey (47%). Somewhat surprisingly, moderate-to-severe stunting appears stable across the two surveys. Of note, there is a clear socioeconomic gradient in malnutrition rates within the MCNRHP sample, and the relatively higher poverty of our sample may be masking temporal changes in malnutrition rates over time.

Table 141: Comparison of key indicators across surveys

Indicator	MCNHRP	DHS – 2013	
		In Sample[a]	Total
Household Overview			
Average HH Size	5.8	10.0	8.2
No Education – Head of Household	76.1%	81.9%	63.4%
Electricity	17.8%	18.4%	44.5%
Television	14.0%	22.9%	48.5%
Mobile Phone	84.5%	84.9%	90.6%
Refrigerator	3.0%	6.5%	22.7%
Bicycle	49.9%	53.8%	47.0%
Unimproved Sanitation Facility	61.0%	53.5%	39.1%
Hand washing: Water & Cleansing Agent[b]	22.4%	34.1%	61.3%
Health Service Utilization			
ANC Utilization	98.2%	99.7%	99.3%
Facility-Based Delivery Rate	60.2%	41.9%	62.6%
PNC Utilization	70.9%	68.7%	77.9%
Measles Vaccination	98.7%	93.8%	87.8%
Vitamin A Supplementation (Children 6-59 months)	85.5%	63.3%	68.7%
Fertility and Family Planning			
FP Use – Any Modern Method [c]	12.0%	1.0%	8.9%
Desire No More Children (Women 15 and Older)	8.3%	16.2%	15.2%
Nutritional Indicators			
Exclusive Breastfeeding (<6 months)	49.0%	46.4%	47.0%
Nutritional Status: Moderately or Severely Stunted (Children 24-59 months) [d]	30.8%	33.9%	25.8%

Notes: a) "In Sample" areas are DHS areas which geographically overlap with the 3 regions in the MCNHRP project. b) Among households with a hand washing station, c) Among women with birth in last five years not currently pregnant d) Among children aged 24-59 months.

6.2 Treatment randomization and sample balance

As discussed in the introductory chapters, the study conducted was designed as baseline survey for the MCNHRP project. The MCNHRP project contains two layers of interventions – a

facility-based supply side, and a community based demand side intervention. Both interventions will be rolled out to the entire project area in a staggered way; the order of the rollout was determined through a random draw. Table 142 summarizes the treatment assignments for the first phase of the project. Three of the five health facilities in NBR-W were already included in the supply side pilot project, and were automatically selected for (continued) treatment. From the remaining two facilities in NBR-W, one was randomly selected for the supply side intervention. In CRR and URR, 50% of facilities were chosen for the supply side intervention, while the remaining eight facilities will provide the control group during Phase 1. Randomization for the demand side intervention was done at the community level, with exactly two communities from each health facility catchment area randomly selected for Phase 1.

Table 142: Phase I treatment assignments

Region	*Number of facilities in pilot*	*Number of facilities with supply side intervention*	*Number of facilities without supply side intervention*	*Number of communities with demand side intervention*	*Number of communities without demand side intervention*
CRR	0	5	4	18	35
NBR-W	3	4	1	10	20
URR	0	4	4	16	32
Total	**3**	**13**	**9**	**44**	**87**

Notes: Based on a total of 22 facilities and 131 enumeration areas.

Table 143 compares baseline health service utilization indicators by treatment group. Overall, the sample seems well balanced across groups. For the supply side intervention, slightly higher rates of facility based deliveries and post-natal care utilization were found in the intervention group, but these differences were not statistically significant.

Table 143: Balance across treatment arms

	Supply side intervention			*Demand side intervention*		
Outcome	*No*	*Yes*	*Equal means test (p-value)*	*No*	*Yes*	*Equal means test (p-value)*
Any ANC	99.8%	99.8%	0.92	99.8%	99.9%	0.72
4+ ANC visits	67.6%	69.7%	0.69	67.2%	68.3%	0.70
Facility based delivery	57.8%	61.1%	0.72	60.1%	62.0%	0.74
Postnatal care visit	64.0%	70.3%	0.54	71.4%	70.1%	0.79
Uses any modern FP method	10.5%	9.1%	0.74	12.5%	12.3%	0.95
Exclusive breastfeeding for 6M	56.6%	58.8%	0.76	55.4%	55.4%	0.99

Notes: Supply side comparison is based on the 19 health centers not participating in the pilot. Demand side comparisons include all 131 enumeration areas. Standard errors for equal means test are clustered at the health facility level for the supply side intervention, and clustered at the enumeration area level for the demand side intervention.

6.3 Observed Design Effects (DEFF) and minimum detectable effects

The data collected as part of the baseline survey allows us to update the power calculations used in the original project development and project design phases. As anticipated, relatively high rates of intra-class correlation (>0.10) were found across the primary health service utilization outcomes of interest, resulting in large cross-sectional design effects, particularly when it comes to comparisons between treated and control areas for the supply side intervention. For the supply side intervention analysis, observations are clustered around the health centers, which means an average of approximately 100 households per cluster; for the demand side interventions, average cluster size is 16. In terms of the outcomes analyzed, strongest local correlations were found for post-natal care visits and facility based deliveries; both are clearly affected by local characteristics such as facility quality but also average distance to facility, local income levels and general local attitudes towards health services. Many of these factors are unlikely to change over the period between the baseline and endline surveys, and will thus be absorbed by the facility and cluster fixed effects that can be used in the later data analysis (as long as the same clusters will be assessed in subsequent survey rounds as is currently planned). The current data does not allow us to directly identify the extent to which local correlation is driven by temporary environmental factors affecting the cluster. To be conservative, we assume that at least one quarter of the total local correlation observed is driven by temporary shocks; under this assumption, anticipated longitudinal design effects vary between 1.2 (ANC and breastfeeding on the demand side) and 6.2 for supply side variation in postnatal care visits. With these assumptions, increases between 6 (family planning) and 13 (postnatal care) percentage points need to be achieved by the planned interventions to find statistically significant improvements with probability 90% or higher.

Table 144: Observed design effects and minimum detectable effect sizes

	Cross-sectional Design Effect (DEFF)		*Anticipated longitudinal DEFF*		*Minimum detectable effect sizes*	
	Supply side	*Demand side*	*Supply side*	*Demand side*	*Supply side*	*Demand side*
4+ ANC visits	5.9	1.9	2.2	1.2	0.08	0.06
Facility based delivery	14.9	6.6	4.5	2.4	0.12	0.09
Postnatal care visit	22.0	5.8	6.2	2.2	0.13	0.08
Uses any modern FP method	8.1	3.2	2.8	1.6	0.08	0.06
Exclusive breastfeeding for 6M	5.5	1.8	2.1	1.2	0.09	0.07

Notes: Cross-section DEFFs represent the empirically observed DEFF in the baseline survey. Anticipated DEFF is based on the assumption that 75% of within-cluster variation is driven by time-invariant characteristics, while 25% is driven by temporary variations in the local environment. Minimum detectable effect sizes show effect sizes needed to reach power 0.80 with alpha = 0.05 and anticipated DEFF.

7. Recommendations

Based on the experience of this baseline survey, a number of issues were identified and several lessons were learned, giving rise to a number of recommendations for the midline and endline surveys. These recommendations, which could also be useful for other HRITF-funded evaluations, are discussed below.

Questionnaire questions and skips

A full tracking of missing data was carried out and reasons underlying missing data (e.g. faulty skip patterns in the questionnaire) sought. Detailed notes have been kept on all of this and will be used to inform the midline evaluation questionnaires.

When it came to data analysis, a few questions that were included in the baseline survey were difficult to interpret e.g. "ANC is good for identifying issues, but is not helpful to prevent problems during pregnancy" (From the CHW beliefs section of the household survey); "The area is safe" (ANC exit interview); "There is a waiting room" (ANC exit interview). These questions should be rephrased before the midline evaluation to ensure that the answers can be appropriately interpreted.

Some shortcomings were noted with regard to the data collected on pre-, intra-, post-partum and neonatal complications. Some additional risk factors could be included in the midline survey, such as post-partum uterine rupture, septic umbilicus and neonatal jaundice. Furthermore, questions could be more precisely worded to help better isolate certain symptoms (e.g. severe bleeding).

The baseline survey embedded a skip pattern whereby we first asked if anyone had been sick in the preceding two weeks before asking about specific symptoms (e.g. diarrhoea, fever etc.). If respondents answered no to the filter question about being sick, the questions about specific symptoms were not asked. This yielded data that suggested very low prevalence of disease. Removing the filter question might lead to more accurate data regarding individual illnesses. However, this would affect the comparability of midline data with the baseline data as well as comparability with other World Bank Group surveys as this filter question is standard in World Bank Group questionnaires. In light of this, we might consider leaving the survey unchanged. Another option would be to maintain the filter question but remove the skip that was included for the baseline survey.

An oversight in the skip pattern early in the reproductive health section of the questionnaire meant that, in the baseline survey, pregnant women were not asked about whether or not they

approved of family planning. This skip pattern should be rectified for the midline and endline surveys to yield a larger sample size for these questions.

The baseline survey data suggest almost universal utilization of bednets. This was higher than expected. It may be useful to change how questions about bednet utilization are asked in the midline survey (although this would, again, raise questions of comparability with the baseline data).

Evaluation logistics

This baseline survey was the first time that tablets had been used for data collection in The Gambia. This presented various logistical and technical challenges. Although the use of this technology cut down post-processing time, it required much more time upfront; the time required for programming the tablets was consistently under-estimated for the baseline survey. For subsequent data collection rounds, it will be important to have the tablets fully programmed and tested (three rounds of back and forth between the programmers and the survey managers) before the training of enumerators. This will help identify problems with interpreting questions as well as with skip patterns in the questionnaire before data collection begins. Furthermore, more time should be allocated for pilot testing the questionnaires with enumerators and making necessary adjustments. While it is possible to make adjustments in the field, this requires connectivity, which was a problem at times in the baseline survey.

The use of tablets also changed the nature of data checks during implementation. The daily editing for skip patterns/logic/completion was less urgent, but it would be useful to include daily random checks of audio against entries. For the midline survey, more time should be built in at a higher level to review the data as it comes in. Someone could usefully work on the data full-time for days 2-10 downloading raw data, checking skips and ensuring that everything is working. At least one form should be returned to each team within the first week so that they know the data are being checked for inconsistencies.

It is important to have the following people on the survey team:

- Survey manager: someone who understands the whole process from designing to finalizing the questionnaire. This person should also be the contact point between the cloud and the field, responsible for ensuring that data flows are functioning as planned.
- Researcher: someone who understands the importance of every question and who can be present during the enumerators' training.
- Statistician/data analyst: someone who can do statistical programming and is responsible for performing data checks especially in the early stages of data collection.

For ease of sharing evaluation tools, the final deliverables from the survey firm should include all of the final questionnaires in both Excel and Word format.

The qualitative data collection was a very intensive process that would benefit from additional time in subsequent data collection rounds. This includes sufficient time for pilot testing the instruments and incorporating changes as appropriate. Identifying appropriate transcribers/translators was a particular challenge and delays incurred at this stage affected the timeframe for data analysis during the baseline. Ensuring appropriate capacity in these areas even before midline qualitative data are collected will be important.

Additional areas for inclusion in the midline evaluation

Through development of the project's routine monitoring tools, certain gaps have been revealed that the midline and endline evaluations can help fill. With regard to referrals from communities to health facilities, the project has been unable to verify evacuation and escort of patients (women and neonates). The midline and endline evaluations should include assessment of the proportion of referrals from the community to a health facility that are evacuated and/or escorted.

In the baseline survey it was impossible to fully assess infant and young child feeding (IYCF) as no questions were included on children's consumption of an appropriate quantity and variety of food. The midline and endline surveys should track all IYCF indicators as defined by UNICEF with appropriate food groups.

Due to the length of the baseline survey, a decision was made to only collect complete data on women's most recent birth rather than full birth histories, restricting the ability to measure and assess associated results. Given that the actual administration of the survey took less time than anticipated, it is worth considering the inclusion of questions to elicit full birth histories and additional questions on desired/wanted fertility in the midline questionnaire.

The very low acceptability of modern family planning, especially for unmarried women, warrants further exploration. Better understanding people's attitudes towards family planning might help inform targeted SBCC messaging that might resonate with local communities. This would also be an interesting topic for more in-depth qualitative exploration in the midline evaluation.

Significant changes are taking place with regard to maternal and child nutrition and health in The Gambia, some due to this project and others attributable to other efforts, including the broader legal and policy environment. The midline and endline evaluations should seek to capture information on people's ability to adapt to these changes. This could include, for example, adaptation to results-based financing rather than input-based financing, or adaptation to the new TBA policy that re-defines the role of TBAs. This should be done using both quantitative and qualitative methods.

In order to better understand patients' perception of quality of care within health facilities, questions in the exit interviews should separately address trust in health workers and quality of care, which are currently assessed jointly. Furthermore, both of these concepts should be further broken down in an effort to understand different elements of the relationship between health workers and clients as well as different aspects of quality of care. On quality of care specifically, it may be worth considering the inclusion of clinical and process quality using methods that go beyond the standard questionnaire.

During data collection, the ANC cards of all women who take part in ANC exit interviews (or whose ANC cards are reviewed for any other reason) should be checked to assess uptake of tetanus toxoid. Their cards should also be reviewed for the haemoglobin level during pregnancy as well as the total number of iron supplementation tablets they received during pregnancy and post-partum.

Areas where fewer questions might be asked

Data analysis is ongoing so although not all data have been used at this stage, it is not yet clear where it might be possible to make cuts to the questionnaires. The full dataset will, however, be reviewed before the midline questionnaires are finalized in order to identify potential areas where cuts could be made.

Annexes

Annex 1: Household questionnaire

Health Results Based Financing Impact Evaluation
THE GAMBIA
2014

HOUSEHOLD QUESTIONNAIRE

IDENTIFIER		
ENUMERATION AREA NUMBER	SETTLEMENT NAME	HOUSEHOLD NUMBER

Ethical Information Sheet

Maternal and Child Nutrition and Health Results Project

Title of Research: Impact Evaluation of the Maternal and Child Nutrition and Health Results Project

Greetings/Introduction

You are being invited to take part in a research study that is looking at the impact assessment of the Maternal and Child Nutrition and Health Results Project, also called the MCNHRP. Before you make a decision, I would like to explain the reason for the study because it is important that you understand why the research is being conducted and what it would involve. You are free to ask questions or seek for clarification if there is anything that is not clear, or if you would like more information.

Reason for the study

The Government of the Gambia is going to implement a program in North Bank West, Upper River Region and Central River Region to improve health and nutrition. This study will assess what the impact of the program has been, including offering information that can help improve implementation. The results of the study will be made available to your community.

How to take part?

You are free to participate or not in the study and you have the right to stop participating at any time without giving a reason. If you decide to take part, you will be asked to sign or thumbprint a consent form. If you decide after you have begun participation that you do not want to be included in the study, let a member of the team know, and your information will not be used.

What would happen to me if I take part?

You are invited to take part in this study. This will involve us asking questions about your family, your community and your experiences with health and nutrition. Your participation in the study will affect you in no harmful way and will not affect your rights or your family's rights.

Would my taking part in this study be kept confidential?

All information that is collected about you in the course of the study will be kept strictly confidential, and you have the right not to answer any of the questions as well as not to participate. Your personal information will only be available to the study team members and might be seen by some rightful persons from the Ethics Committee, Government authorities and sponsor.

Who has reviewed the study?

This research study has been submitted to the Research and Publication Committee, University of The Gambia and the Gambian Government/MRC Ethics Committee. It was approved by the two committees before final approval by the World Bank.

Who can I contact?

If you have any queries regarding the study you can contact Mr. Yaya S Jallow on (+220) 365 7614. If at any point you have a question, please ask the field staff or Mr. Yaya S Jallow.

ID CODE	(1.01)	(1.02)	(1.03)	(1.04)			(1.05)	(1.06)
	Please give me the names of the persons who live in your household. A HOUSEHOLD IS A PERSON OR GROUP OF PEOPLE THAT LEAVE TOGETHER AND SHARE THE SAME COOKING/CATERING ARRANGEMENT AND SLEEP IN THE SAME WRITE THE FIRST NAME AND THEN THE SURNAME START THE LIST WITH THE HEAD OF THE HOUSEHOLD	GENDER MALE 1 FEMALE 2	AGE	What is NAME's Birthday? Record "99" if Respondent Report Don't Know Date of Birth			Does NAME have Children <5 years old (if 13 or older) YES 01 NO 00	Is NAME Currently Pregnant (if 13 or older) YES 01 NO 00
	NAME	CODE	YEARS If <5 ▶ (1.04)	Day	Month	Year	CODE	CODE
01			If >13 , <50 and a woman ▶ (1.05)					
02			Otherwise ▶ NEXT					
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								

AFTER ROSTER IS COMPLETE

(1.07)
Among the women aged 15 or older, who is it that most recently gave birth? This birth could be a still birth or a live birth. We are interested in speaking with the woman with the most recent delivery, regardless of the outcome.
ROSTER LIST
CODE

1. Household Characteristics

SUBJECT: HEAD OF HOUSEHOLD

RESPONDENT: HEAD OF HOUSEHOLD OR MOST KNOWLEDGEABLE HOUSEHOLD MEMBER

(1.08)	(1.09)	(1.10)	(1.11)	(1.12)		(1.13)	(1.14)	(1.15)
What is the marital status of the head of houshold	Can the Head of Household read and write in any language?	Has the head of household ever attended school?	What is the highest school level that the head of houshold attended?	Within that school level, what was the highest grade that the head of household completed?	COMPUTER GENERATED EQUIVALENCY GRADE, BASED ON MAP	What is the religion of the head of household?	What is the ethnicity of the head of household?	What is the mother tongue of the head of household?
NEVER MARRIED 1			KINDERGARTEN 01					
MONOGAMOUSLY 2			PRIMARY/ LOWER BASIC 02					
POLYGAMOUSLY 3			UPPER BASIC 03					
DIVORCED / SEPARATED 4			HIGH SCHOOL 04			ISLAM 01	MANDINKA/JAHANKA 01	ENGLISH 01
WIDOWED 5			SENIOR SECONDARY 05			CHRISTIANITY 02	FULA/TUKOLOR 02	MANDINKA/JAHANI 02
			NON- 06			TRADITIONAL 03	WOLOF 03	WOLOF 03
			DIPLOMA/TERTIARY 07			NONE 04	JOLA/KARONINKA 04	FULA/TUKULOR 04
			UNDERGRADUATE 08	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL; OPTIONS: 1, 2, 3, 4, 5, 6, 6 LOWER, 6 UPPER, 7, 8, 9,10, 11, 12		OTHER, SPECIFY 96	05 SARAHULE	05 JOLA/KARONINKA
			MASTERS 09		WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL		SERERE 06	SERERE 06
			PHD 10				AKUL/CREOLE 07	AKU/CREOLE 07
			OTHER, SPECIFY 96				MANJAGO 08	MANJAGO 08
			DON'T KNOW -				NON-GAMBIAN 09	NON-GAMBIAN 09
							OTHER, SPECIFY 96	SARAHULE 10
	YES 01	YES 01						OTHER (SPECIFY:_ 96
	NO 00	NO 00 ▶ (1.13)						
CODE	CODE	CODE	CODE	GRADE	AUTOFILL	CODE	CODE	CODE

2 Education

	(2.01)	(2.02)	(2.03)
	How many people in this household are currently in school?	Have any of these people have an absence in the last 2 weeks because they were sick? YES 1 ▶ Next Question NO 2 ▶ Skip to Housing	How many days were missed due to illness?
	NUMBER	CODE	NUMBER

4 Housing

SUBJECT: ONE RESPONSE FOR THE HOUSEHOLD AS A WHOLE

RESPONDENT: HEAD OF HOUSEHOLD OR MOST KNOWLEDGEABLE HOUSEHOLD MEMBER

(4.01) TYPE OF DWELLING

TRADITIONAL HUT	01
IMPROVED TRADITIONAL HUT	02
DETACHED HOUSE	03
HOUSE ATTACHED TO SHOP	04
SEMI-DETACHED HOUSE	05
SERVANT QUARTERS	06
GUEST HOUSE/WING	07
HOSTEL	08
NON-RESIDENTIAL BUILDING (SCHOOL, CLASSROO	09
IMPROVISED HOUSING/ SHACK	10
OTHER, SPECIFY	96

(4.02) What is the ownership status of your dwelling?

INTERVIEWER: READ THE ALTERNATIVES TO THE RESPONDENT

Owner occupied dwelling - by Individual	01
Owner occupied dwelling - Communal/ Family	02
Rented (not tied to the job)	03
Rented (tied to the job)	04
Rent free (owned by employer)	05
Rent free (other owner)	06
Other, specify	96

(4.03) How many rooms does your dwelling have?

(INCLUDE ROOMS OUTSIDE THE MAIN DWELLING, DO NOT INCLUDE KITCHEN AND BATHROOMS)

NUMBER OF ROOMS:

(4.04) Does this household have electricity?

YES	01
NO	00

(4.05) What is the main source of energy used for cooking?

KEROSINE / PARAFFIN	01	CHARCOAL	08
GAS	02	COAL	09
ELECTRICITY FROM GRID (NAWE	03	SAWDUST	13
ELECTRICITY FROM GENERATOI	04	OTHER, SPECIFY	96
ELECTRICITY FROM SOLAR PAN	05		
WOOD	07		

(4.06) MAIN MATERIAL USED FOR FLOOR:

NATURAL FLOOR:	
EARTH/SAND	11
RUDIMENTARY FLOOR	
WOOD PLANKS	21
PALM / BAMBOO	22
FINISHED FLOOR	
CERAMIC TILES	33
CEMENT	34
PLASTIC CARPET/ELLINIUM OR OTHER CARPE	35
OTHER, SPECIFY	96

(4.07) MAIN MATERIAL USED FOR ROOF:

NATURAL ROOF:	
THATCH/PALM LEAF	12
RUDIMENTARY ROOFING	
PALM / BAMBOO	22
WOOD PLANKS	23
FINISHED ROOFING	
METAL/CORRUGATED	31
WOOD	32
CEMENT	35
ROOFING TILES	36
OTHER, SPECIFY	96

(4.08) MAIN MATERIAL USED FOR EXTERIOR WALL:

NATURAL WALLS:	
CANE/PALM/TRUNKS	12
DIRT	13
RUDIMENTARY WALLS	
BAMBOO WITH MUD	21
STONE WITH MUD	22
PLYWOOD	24
CARDBOARD	25
REUSED WOOD	26
FINISHED WALLS	
CEMENT/CEMENT BLOCKS	31
STONE WITH LIME/CEMENT	32
BRICKS	33
WOOD PLANKS/SHINGLES	35
OTHER, SPECIFY	96

4 Housing

(4.09) During the dry season, what is your household's main source for drinking water?

PIPED WATER		
PIPED INTO DWELLING	11 ►	####
PIPED INTO YARD/PLOT	12 ►	####
PIPED INTO OTHER DWELLING	13	
PUBLIC TAP/STANDPIPE	14	
TUBEWELL/BOREHOLE	21	
DUG WELL		
PROTECTED WELL	31	
UNPROTECTED WELL	32	
RAINWATER	51	
SURFACE	81	
BOTTLED WATER/ SACHET	91	
OTHER, SPECIFY	96	

How do you treat your drinking water during the rainy season? (MULITPLE POSSIBLE)

BOIL	A		
ADD BLEACH/CHLORINE	B	LET IT STAND AND SETTLE	F
STRAIN THROUGH CLOTH	C	DONT KNOW	X
WATER FILTER (CERAMIC/SAND/COM	D	OTHER, SPECIFY	Y
SOLAR	E	NONE	Z

What type of toilet facility do your household members use at home?

FLUSH OR POUR FLUSH TOILET		**PIT LATRINE**	
FLUSH TO SEPTIC TANK	12	VENTILATED IMPROVED LATRINE	21
FLUSH TO PIT LATRINE	13	PIT LATRINE WITH SLAB	22
FLUSH TO SOMEWHERE ELSE	14	PIT LATRINE WITHOUT SLAB/OPEN PIT	23
FLUSH, DON'T KNOW WHERE	15	NO FACILITY, BUSH/FIELD	61
		OTHER, SPECIFY	96

(4.10) How long does it take you to go to this source on foot?
ONE WAY ONLY, RECORD 00 IF LESS THAN 1 MINUTE MINUTES:

(4.11) How do you treat your drinking water during the dry season? (MULTIPLE POSSIBLE)

BOIL	A
ADD BLEACH/CHLORINE	B
STRAIN THROUGH CLOTH	C
WATER FILTER (CERAMIC/SAND/COMPOST, ETC)	D
SOLAR	E
LET IT STAND AND SETTLE	F
DONT KNOW	G
NONE	I
OTHER, SPECIFY	H

(4.12) During the rainy season, what is your household's main source for drinking water?

PIPED WATER		
PIPED INTO DWELLING	11 ►	####
PIPED INTO YARD/PLOT	12 ►	####
PIPED INTO OTHER DWELLING	13	
PUBLIC TAP/STANDPIPE	13	
TUBEWELL/BOREHOLE	21	
DUG WELL		
PROTECTED WELL	31	
UNPROTECTED WELL	32	
RAINWATER	51	
SURFACE WATER(RIVER/DAM/LAKE/POND/STREAM/CANAL/IRRIGA	81	
BOTTLED WATER/ SACHET	91	
OTHER, SPECIFY	96	

(4.13) How long does it take you to go to this source on foot?
ONE WAY ONLY MINUTES:

(4.16) How many other households does your household share the toilet facility with?
IF HOUSEHOLD DOES NOT SHARE, WRITE '0' NUMBER:

(4.17) How do you mainly deal with the household's refuse / rubbish?

REFUSE COLLECTED	01
THROW INTO A PIT	02
BURY	03
BURN	04
THROW ONTO STREET OR PUBLIC AREA	05
THROW INTO YARD	06
OTHER, SPECIFY	96

(4.18) What is your household's main source of energy for lighting?

KEROSINE / PARAFFIN / OIL LAMP	01	WOOD	07
GAS	02	CHARCOAL	08
ELECTRICITY FROM GRID/ NAWEC	03	CROPS OR OTHER	11
ELECTRICITY FROM GENERATOR/ DIESE	04	RECHARGEABLE/BATTERY OPERATED TORCH	13
ELECTRICITY FROM SOLAR PANEL	05	CANDLES	14
		OTHER, SPECIFY	96

(4.19) (ASK TO SEE THE HANDWASHING STATION)
INTERVIEWER: ARE YOU ABLE TO SEE THE HANDWASHING STATION?

YES	01	
NO	00 ►	(4.23)

(4.20) IS THERE SOAP AT THE HANDWASHING STATION?

YES	01
NO	00

(4.21) IS THERE A SOURCE OF CLEAN WATER AT THE HANDWASHING STATION?

YES	01
NO	00

(4.22) IS THERE A CLEAN CLOTH FOR DRYING HANDS AT HANDWASHING STATION?

YES	01
NO	00

(4.23) WHY WAS HANDWASHING STATION NOT SEEN?

NO HANDWASHING STATION	01
OTHER, SPECIFY	96

5 Household Assets

SUBJECT: ONE RESPONSE FOR THE HOUSEHOLD AS A WHOLE

RESPONDENT: HEAD OF HOUSEHOLD OR MOST KNOWLEDGEABLE HOUSEHOLD MEMBER

ID CODE OF RESPONDENT: [ ]

Part A: Durable Goods

DURABLE GOOD CODE	DURABLE GOOD	(5.01) How many [DURABLE GOOD]s does your household own? ONLY INCLUDE FUNCTIONING ASSETS IF NONE WRITE ZERO AND ► NEXT DURABLE	(5.02) If you were to sell your [DURABLE GOOD] today, how much money could you get for it? IF MORE THAN ONE, ASK FOR THE TOTAL VALUE OF ALL ITEMS
		NUMBER	DALASI
01	Radio/CD/cassette player		
02	Television		
03	Electric Clothes iron		
04	Electric stove		
05	Gas stove		
06	Paraffin lamp		
07	Bed		
08	Mattress		
09	Mosquito nets		
10	Refrigerator / freezer		
11	Sewing machine		
12	Table (for dining)		
13	Sofa		
14	Land line telephone		
15	Mobile Telephone		
16	Motorcycle		
17	Bicycle		
18	Pick UP, Truck or car		
19	Wheelbarrow		
20	Plough		
21	Hoes / axes		
22	Harrows		
23	Tractor		
24	Power Tiller		

Part B: Land Ownership and Livestock

(5.03) Does your household own the land plot on which this dwellling is built? [ ]

YES 1

NO 2 ► (5.06)

(5.04) What are the dimensions (in meters) of your land?

[ ] meters x [ ] meters ► (5.07)

IF DON'T KNOW DIMENSIONS: 99 ► (5.05)

(5.05) What is the size of this plot?

AREA UNIT: SIZE: [ ] AREA UNIT: [ ]

SQUARE METER 1 Other, describe 96

ACRE 2

rice field

Maize field

Other

(5.06) Does your household own any land (or other land besides this residence)? [ ]

YES 1

NO 2 ► (5.12)

(5.07) How many plots of land does your household own?

NUMBER: [ ]

(5.08) What are the dimensions (in meters) of the largest plot?

[ ] meters x [ ] meters ► (5.10)

IF DON'T KNOW DIMENSIONS: ► 99 (5.09)

(5.09) How much land is this largest plot?

AREA UNIT: SIZE: [ ] AREA UNIT: [ ]

SQUARE METER 1 Other, describe 96

ACRE 2

(5.10) What are the dimensions (in meters) of the next largest plot of land?

[ ] meters x [ ] meters ► (5.12)

IF DON'T KNOW DIMENSIONS: ► (5.11)

(5.11) How much land is the next largest plot of land?

AREA UNIT: SIZE: [ ] AREA UNIT: [ ]

SQUARE METER 1 Other, describe 96

ACRE 2

ANIMAL CODE	ANIMAL	(5.12) How many [ANIMAL]s does your household own? IF NONE WRITE ZERO ► NEXT ANIMAL	(5.13) If you were to sell your [ANIMAL] today, how much money could you get for it? IF MORE THAN ONE, ASK FOR THE TOTAL VALUE OF ALL ITEMS
		NUMBER	DALASI
01	Oxen		
02	Cattle		
03	Goats		
04	Sheep		
05	Pigs		
06	Poultry e.g. Chicken/ Doves/ Ducks		
07	Horse		
08	Donkey		
96	Other animals, specify		

5 Household Assets

Part C: Health Related Financial Shocks

(5.14) In the past 12 months, did your household have any health expenditures that were higher than you could afford with your usual income?

YES	1
NO	2 ► NEXT SECTION

(5.15) In the last 12 months, did anyone in your household have to sell any land, buildings, farm equipm

PROBE: Health care payments include paying for hospital bills, doctor's bills or medicines.

YES	1
NO	2 ► (5.18)

		(5.16) Did you have to sell [ASSET]? YES 1 NO 2 ► NEXT	(5.17) How much money did you get for these in total? AMOUNT IN DALASI
1	Land		
2	Buildings		
3	Farm equipment		
4	Livestock		
5	Food Reserves		
6	Other possessions		

Part C: Health Related Financial Shocks (cont.)

(5.18) In the last 12 months, did anyone in your household have to borrow money in order to pay for health care? Borrowing money is when you are expected to give the money back after some time.

PROBE: Health care payments include paying for hospital bills, doctor's bills or medicines.

YES	1
NO	2 ► (5.20)

(5.19) How much money did you borrow in total over the last 12 months?

AMOUNT IN DALASI: [ ]

(5.20) In the last 12 months, did anyone lend someone in your household animals to help you pay for health care?

PROBE: Health care payments include paying for hospital bills, doctor's bills or medicines.

YES	1
NO	2 ► (5.22)

(5.21) What is the value of the animals that you borrowed in the last 12 months?

AMOUNT IN DALASI: [ ]

If (5.18) & (5.20) are no, Skip to (5.24)

(5.22) As of today, how much money have you already paid back?

AMOUNT IN DALASI: [ ]

(5.23) As of today, how much money do you still need to pay back?

AMOUNT IN DALASI: [ ]

(5.24) In the last 12 months, did anyone in your household receive money as a gift, to help pay for health care? This includes assistance from your community to your household to help pay for bills, gifts from family outside of your household, and other gifts to help pay for health care.

YES	1
NO	2 ► (5.26)

(5.25) Of the money that you received as a gift, how much did you spend on health care?

AMOUNT IN DALASI: [ ]

(5.26) At this time, how much money do you still owe on health care bills?

WRITE ZERO IF NOTHING AMOUNT IN DALASI: [ ]

6 Other Sources of Income

SUBJECT: ONE RESPONSE FOR THE HOUSEHOLD AS A WHOLE

RESPONDENT: HEAD OF HOUSEHOLD OR MOST KNOWLEDGEABLE HOUSEHOLD MEMBER

ID CODE OF RESPONDENT

Now I would like to ask you some questions on other sources of income for your household, apart from payment for work.

Note, if multiple people earn income from a job, what is the total earning from all jobs.

		(6.01)	(6.02)	(6.03)
		In the past 12 months, did any member of your household receive income from [SOURCE OF INCOME]?	In the past 12 months, did your household receive from [SOURCE OF INCOME]?	What is the frequency of payment?
		YES 1 NO 2 ► NEXT SOURCE		Daily 01 Weekly 02 Monthly 03 Every 6 months 04 One time per season 05 OTHER_____ 96
SOURCE OF INCOME CODE	SOURCE OF INCOME		DALASI	CODE
01	Agriculture Sales from Men's Fields			
02	Agriculture Sales from Wormen's Fields			
03	Agricultural Sales from Communal or Other Fields			
04	Sales from Household Garden			
05	Primary Job/Labour Source of the head of household			
06	Remittances / gifts (in cash or in kind) from relatives, co-workers or friends within country			
07	Remittances / gifts (in cash or in kind) from relatives, co-workers or friends outside country			

7 Consumption

Part A: Monthly non-food consumption

ID CODE OF THE RESPONDENT

SUBJECT: ONE RESPONSE FOR THE HOUSEHOLD AS A WHOLE

RESPONDENT: HEAD OF HOUSEHOLD OR MOST KNOWLEDGEABLE HOUSEHOLD

NON-FOOD ITEM CODE	(7.01) Has your household purchased [NON-FOOD ITEM] during the past 30 days or received it for free?		(7.02) In the past 30 days, how much did your household spend on [NON-FOOD ITEM]? *WRITE ZERO IF NOTHING*	(7.03) In the past 30 days, what is the value of [NON-FOOD ITEM] your household received for free or against an in-kind payment? *WRITE ZERO IF NOTHING*
		YES 1		
		NO 2		
	NON-FOOD ITEM DESCRIPTION	Don't 3	DALASI	DALASI
		If No ► NEXT ITEM		
01	Public transport (to and from health facility)			
02	Health insurance			
03	Health care consultation fees, western doctors and nurses			
04	Medication and injections			
05	Laboratory fees, X-rays fees			
06	Consultation fees with traditional doctors, healers, etc.			
07	Other health related expenditures			

8 Mortality

SUBJECT: ONE RESPONSE FOR THE HOUSEHOLD AS A WHOLE
RESPONDENT: HEAD OF HOUSEHOLD OR MOST KNOWLEDGEABLE HOUSEHOLD MEMBER

(8.01) Has there been a death of any adult, child or infant living in this household in the past 12 months?

YES	1
NO	2

☐ >>PROGRAMMING PROMPT, offer condolences

(8.02) In the past 12 months, has there been any baby who cried or showed signs of life but only survived a few hours or days?

YES	1 **TREAT ANY SUCH BABY AS A DECEASED HOUSEHOLD MEMBER**
NO	2

☐

(8.03) How many household members died in the past 12 months?
IF ZERO, RECORD "0" AND ► NEXT SECTION NUMBER: ☐

Please tell me the names of those household members that passed away in the past 12 months, starting with the most recent death. RECORD MOST RECENT DEATH FIRST, FOLLOWED BY PREVIOUS DEATH

DECEASED CODE	NAME OF THE DECEASED	(8.04) What was the date of death?		(8.05) What was the gender of the deceased?	(8.06) How old was [HE/SHE] when [HE/SHE] passed away?		(8.07) What was the cause of death?	(8.08) Where did [HE/SHE] die?	(8.09) What was the relationship of the deceased to the current head of household?	(8.10) Did the person receive any medical care before passing away?
							BIRTH TRAUMA (Mother) 01			
							BIRTH TRAUMA (Infant) 02			
							CONGENITAL ANOMALIES 03			
							SICKLE CELL 04			
							MEASLES 05			
							MALARIA 06			
							MALNUTRITION 07		SPOUSE (WIFE/HUSBAND) 01	No
							DIARRHEA 08	AT HOME 01	OWN SON / DAUGHTER 02	Yes, traditional healer
							PNEUMONIA 09	IN ANOTHER 02	STEP SON/DAUGHTER 03	Yes, CHW
							TUBERCULOSIS 10	IN THE STREET 03	SON/DAUGHTER IN-LAW 04	Yes, health center
					RECORD AGE IN DAYS, MONTHS OR YEARS		ACCIDENT 12	IN A CLINIC 04	GRANDCHILD 05	Yes, hospital
							VIOLENCE 13	IN A HOSPITAL 05	BROTHER/SISTER 06	Yes, other'
							STROKE 14	OTHER: 96	PARENT 07	Specify:
					DAYS 1		CANCER 15		PARENT-IN-LAW 09	
					MONTHS 2		HEART DISEASE 16		NIECE/NEPHEW 10	
					YEARS 3		OLD AGE 17		OTHER RELATIVE 11	
				MALE 01			UNKNOWN 18		DOMESTIC HELP 12	
		Don't Know=99	**2013 2014**	FEMALE 02	**RECORD =99 IF DON'T KNOW FOR DAY AND/OR MONTH.**		OTHER, SPECIFY 96		OTHER NON-RELATIVE 13	
									OTHER, SPECIFY 96	
		MONTH	YEAR	CODE	NUMBER	CODE	CODE	CODE	CODE	CODE
01										
02										
03										
04										
05										
06										

9 Health Status and Utilization

SUBJECT:MOTHER OF THE YOUNGEST CHILD

RESPONDENT: SELF RESPONDENT; AND FOR CHILDREN UNDER 15, THE MOTHER OR PRIMARY CAREGIVER.

If Primary Caregiver not available, switch to another caregiver

ID CODE	(9.01)	(9.0A)	(9.02)	(9.03)	(9.04)			(9.05)	(9.06)	(9.07)
				DISABILITY AND CHRONIC ILLNESSES						
	Is NAME available to answer questions regarding HIS/HER health? If not, is there somebody who can answer on HIS/HER behalf?	ID CODE OF RESPONDENT (CAREGIVER OF CHILD <15 yrs, OR RESPONDENT FOR THOSE >15)	Currently, how is YOUR/[NAME]´s health in a normal day, would you say it is excellent, good, fair or poor?	Do YOU/Does [NAME} suffer from any disabilities or chronic illnesses?	What disabilities or chronic illnesses do YOU/[NAME] suffer from? RECORD UP TO 3 RESPONSES			Given YOUR/[NAME]'s health, how are YOU/[NAME] currently able to do daily activities such as work, school, etc?	Are YOU/[NAME} currently covered under a health insurance scheme?	In the last 2 weeks, have YOU/[NAME] been sick or suffering from any illness or injury, excluding disabilities or chronic illnesses?
					DISABILITIES					
					PHYSICAL DISABILITY	01				
					MENTAL DISABILITY	02				
					BLINDNESS/VISUAL IMPAIRMEN	03				
					DEAFNESS/SUMBNESS	04				
					OTHER DISABILITY	05				
					CHRONIC ILLNESS			EASILY 01		
					HEART CONDITION	06		WITH SOME 02		
					DIABETES	07		WITH MUCH 03		
					EPILEPSY	08		UNABLE TO DO 04		
					ASTHMA	09			YES 1	YES 1
	Yes, Available 1 ► (9.02)		EXCELLENT 1	YES 1	CANCER	10			NO 2	NO 2 ► (9.50)
	Not available, but someone will report for then 2 ► (9.0A)		GOOD 2	NO 2 ► (9.06)	HIV/AIDS	11				
	Not available 3 ► NEXT PERSON		FAIR 3		TUBERCULOSIS	12				
			POOR 4		HYPERTENSION	13				
		ID CODE OF CAREGIVER			OTHER CHRONIC ILLNESS	14				
					SICKLE CELL	15				
					ULCER	16				
			CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										

ACUTE ILLNESS							DIARRHEA		DIARRHEA	
(9.08)			(9.09)	(9.10)	(9.11)	(9.12)		(9.13)	(9.14)	(9.15)
What were YOU/[NAME] mainly suffering from?			How long ago did the illness start?	For how may days were YOU/[NAME] sick	In the last 2 weeks, how many days of work , school, playing, or other main activities did YOU/[NAME] miss due to poor health?	In the last 2 weeks, how many days was YOU/[NAME] confined to bed due to poor health?	SYSTEM: CHECK WHETHER YOU/[NAME] IS A CHILD UNDER AGE FIVE AND HAD DIARRHEA IN QUESTION (9.08), I.E. ANSWERED	How much was [NAME] offered to drink during this illness? Was he/she offered more than usual, about the same, less than usual, or nothing at all?	How much was [NAME] offered to eat during this illness? Was he/she offered more than usual, about the same, less than usual, or nothing at all?	Was /[NAME] given a fluid made from a special pack, called Oral Rehydration Solution (ORS), like this one?
DISEASES		**DISEASES (cont)**								
MALARIA	01	SKIN	18							
MEASLES	02	GENITO-URINARY	19							
CANCER	03	PREGNANCY / CHILDBIRTH RELATED -	20							
ANEMIA	04	HIGH RISK/PROBLEMS WITH PREGNANCY	21							
DIABETES	05	PERINATAL	22							
MALNUTRITION	06	CONGENITAL	23							
MENTAL DISORDER	07	INJURY OR	24							
NERVOUS /	08	**SYMPTOMS**								
EYE PROBLEM	09	FEVER	41		INTERVIEWER: WRITE THE ANSWER IN NUMBER OF DAYS. IF STILL ILL TODAY, RECORD 00.					INTERVIEWER: SHOW THE RESPONDENT THE PACK
EAR PROBLEM	10	ABDOMINAL PAIN	42	INTERVIEWER: WRITE THE ANSWER IN NUMBER OF DAYS						
HEART DISEASE	11	COUGH ONLY	43							
CHEST INFECTION	12	COUGH WITH DIFFICULT, FAST BREATHING	44					MORE THAN USUAL 1	MORE THAN USUAL 1	
TUBERCULOSIS	13	DIARRHEA WITHOUT BLOOD	45							
PNEUMONIA	14	DIARRHEA WITH BLOOD	46	PROMPT IF RESPONSE < 28				ABOUT THE SAME 2	ABOUT THE SAME 2	
OTHER	15	DIARRHEA AND VOMITING	47							
DIGESTIVE	16	VOMITING	48				YES 1	LESS THAN USUAL 03	LESS THAN USUAL 3	YES 1
MUSCLE / BONE	17	HEADACHE	49				NO 2 ► (9.16)			NO 2 ► (9.16)
		OTHER	96						NOTHING TO EAT 4	
1st	2nd	3rd								
CODE 1	CODE 2	CODE 3		DAYS, 0-14	DAYS, 0-14	DAYS, 0-14	CODE	CODE	CODE	CODE

SEEKING CARE					SEEKING CARE	SEEK OF CARE, PLACE		
(9.16)	(9.17)			(9.18)	(9.19)	(9.20)		(9.21)
Did YOU/[NAME] go to any health facility, health personnel or traditional healer to seek care for this illness? PROBE WHETHER PATIENT WENT TO CENTER BUT CENTER WAS CLOSED/NOT STAFFED - COUNT THIS AS A "YES"	Why didn't YOU/[NAME] go to a health facility or health personnel for care?			[ONLY IF NAME <15 years old] Who decided that [NAME] should receive care?	How long after the illness started did YOU/[NAME] first seek care?	Where did YOU/[NAME] MOST RECENTLY seek care?		IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE
	TOO EXPENSIVE		01			GOVERNMENT HOSPITAL	01	
	TOO FAR		02			GOVERNMENT MAJOR HEALTH CENTER	02	
	TOO BUSY (WORK, CHILDREN)		03			GOVERNMENT MINOR HEALTH CENTER	03	
	WASN'T SICK ENOUGH		04			GOVERNMENT HEALTH POST	04	
	FACILITY HAS POOR STRUCTURE		05			NGO CLINIC	05	
	FACILITY POORLY STOCKED		06					
	POOR STAFF ATTITUDE		07		WITHIN 24 HOURS 1	PRIVATE CLINIC	06 ► (9.22)	
	POOR STAFF KNOWLEDGE		08			PRIVATE PRACTITIONER	07 ► (9.22)	
	STAFF USUALLY ABSENT		09		BETWEEN 24 AND 2	PHARMACY	08 ► (9.22)	
	HEALTH FACILITY CLOSED		10		48 HOURS	MOBILE CLINIC/OUTREACH	09 ► (9.22)	
	NO TRANSPORTATION		11	MOTHER 1	BETWEEN 48 3	TRADITIONAL HEALER	10 ► (9.22)	
	POOR QUALITY OF CARE		12	FATHER 2	HOURS AND 1	FAITH/CHURCH HEALER	11 ► (9.22)	
	INCONVENIENT HOURS		13	HEAD OF HOUSEHOLD 3	WITHIN 2 WEEKS 4	COMMUNITY HEALTH WORKER	12 ► (9.22)	
	LONG WAITING TIMES		14	GRANDPARENT 4		COMMUNITY OWNED CLINIC	13 ► (9.22)	
	PREFER HOME CARE		15	OTHER, SPECIFY 96	WITHIN 3 WEEKS 5	SERVICE CLINIC	14 ► (9.22)	
YES 1 ► (9.18)	OTHER (SPECIFY)		16			OTHER, SPECIFY	96 ► (9.22)	
NO 2		► 0.00	96		MORE THAN 3 6 WEEKS			
	RECORD UP TO 3 ANSWERS							
	FIRST	SECOND	THIRD					
CODE	CODE 1	CODE 2	CODE 3	CODE	CODE	CODE	NAME	CODE

SEEK OF CARE, LAST VISIT						EXPENDITURES					HOSPITALIZATION			MEDICINES				
(9.30)	(9.31)	(9.32)	(9.33)	(9.34)	(9.35)	(9.36)				(9.37)	(9.38)	(9.39)	(9.40)	(9.41)	(9.42)	(9.43)	(9.44)	(9.45)
Did this health care provider administer any rapid test (such as a fingerprick to detect malaria)?	Did this health care provider order any X-rays or laboratory examinations such as urine or blood tests?	Did YOU/[NAME] have these tests done?	Did YOU/[NAME] receive results?	Did this health care provider prescribe any medicines?	Did the health worker refer you to an after hours private clinic or pharmacy?	Not including medication, in the last 2 weeks, how much did your household spend out of its own pocket for the treament of YOU/[NAME]'s illness? Specifically, how much did your household pay out of pocket for ..... READ ALOUD EACH CATEGORY				IF 9.06 IS YES: Did an employer or insurance pay for any of the provider fees, laboratory and X ray fees or transportation?	In the last 2 weeks, did YOU/[NAME] have to spend the night in a health facility or hospital to treat this illness?	Over the last 2 weeks, how many nights did YOU/[NAME] spend in the health facility or hospital?	In the last 2 weeks, how much did your household spend out of its own pocket on YOUR/[NAME]'s stay on the health facility or hospital to treat this illness? (Not including Medication)	Now I am going to ask some questions regarding medicines that YOU/[NAME] may have taken to treat this illness. In the last 2 weeks, did YOU/[NAME] take any medicines to address this PROBE FOR INJECTIONS THAT MAY HAVE BEEN ADMINISTERED	How many different kinds of medicines did YOU/[NAME] take?	Of the medications taken, how many are Traditional (Herbal)? "00" if NONE	Did YOU/[NAME] need a prescription? PROBE: A DOCTOR'S PRESCRIPTION IS A PIECE OF PAPER WHERE THE DOCTOR WRITES THE NAME OF THE MEDICATION AND HOW MUCH MEDICATION THE PATIENT HAS TO TAKE. PATIENTS CAN TAKE THIS TO A PHARMACY IN ORDER TO GET THE RIGHT	Did YOU/[NAME] receive instructions to take any medicine that you could not obtain at the facility pharmacy due to stock outs?
YES 1 NO 2	YES 1 NO 2 ► (9.34)	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2	A. Consulting Fees/ Provider Fees	B. Laboratory and X-ray Fees	C. Any other payments to the provider?	D. Transportation, including for Caregiver/ Escort	YES, EMPLOYER 01 YES, INSURANCE 02 NO 03 OTHER, SPECIFY 96	YES 1 NO 2 ► (9.41)		PROBE TO BE SURE THIS AMOUNT IS IN ADDITION TO COSTS IN (9.36)	YES 1 NO 2 ► (9.48)			YES 1 NO 2	YES 1 NO 2
CODE	CODE	CODE	CODE	CODE	CODE	DALASI	DALASI	DALASI	DALASI	CODE	CODE	NIGHTS, 1-14	DALASI	CODE	NUMBER	NUMBER	CODE	CODE

9 ID CODE 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15

9 ID CODE 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15

9 ID CODE 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15

MEDICINES			Satisfaction							MOSQUITO NETS		
(9.46)	(9.47)	(9.48)	(9.49)							(9.50)	(9.51)	(9.52)
In the last 2 weeks, how much did your household spend out of pocket in total to obtain these medications for YOU/[NAME]? PROBE TO BE SURE THIS AMOUNT IS IN ADDITION TO COSTS IN (9.36) and 9.39 IF NOTHING, RECORD ZERO	Did your employer or insurance pay for any of this medication? YES, EMPLOYER 01 YES, INSURANCE 02 NO 03 OTHER, SPECIFY 96 ► (9.49)	Why did YOU/[NAME] not take medication for the illness? TOO EXPENSIVE 01 TOO FAR 02 TOO BUSY (WORK, CHILDREN) 03 OUT OF STOCK 04 WASN'T SICK ENOUGH 05 DOESN'T HELP 06 DOESN'T LIKE SIDE EFFECTS 07 NO TRANSPORTATION 08 POOR QUALITY OF DRUGS 09 INCONVENIENT HOURS 10 LONG WAITING TIMES 11 PREFERS TRADITIONAL CARE 12 OTHER, SPECIFY 96	I'm going to read you a series of statements regarding this health facility. Please tell me if you agree, neither agree nor disagree or disagree with each statement. Some statements may not apply to your situation. Please let me know if a statement does not apply to you. AGREE 1 NEITHER AGREE NOR DISAGREE 2 DISAGREE 3 VERY SATISFIED 4 DOES NOT APPLY 5							Last night, did YOU/[NAME] sleep under a mosquito net? YES 1 NO 2 ► (9.53)	What type of net did YOU/[NAME] sleep under last night, was it a long-term treated net, a net that was treated after it was bought, or a net that has INTERVIEWER NOTE: PERMANET AND POLYNET ARE BOTH TREATED NETS TREATED 01 NOT TREATED 02 DON'T KNOW 03	Does the Mosquito net have any holes in them such that a mosquito can enter? Yes No
			A. The hours the facility is open are adequate to meet your needs.	B. The health staff are courteous and respectful.	C. The amount of time you spent waiting to be seen by a health worker was reasonable.	D. The health worker spent a sufficient amount of time with you.	E. It is easy to get medicine that health workers prescribe.	F. You had enough privacy during your visit.	G. The overall quality of services provided was satisfactory.			
DALASI	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE

CARE FOR OTHERS								(12.01)	(12.02)	(12.03)	(12.04)
	(9.53)	(9.54)			(9.55)	AUTOMATIC		Have you ever been pregnant, including pregnancies that may have ended in miscarriage, abortion or stillbirth (born dead)?	Are you pregnant now?	How many months pregnant are you?	Do you have any children to whom you have given birth who are now living with you?
THIS SECTION ONLY IF [NAME] 5 YEARS OLD OR OLDER? SEE QUESTION (1.03)	In the last 2 weeks, did YOU/[NAME] stop regular activities at any time to take care of a sick household member?	Who did YOU/[NAME] take care of? RECORD UP TO 3 PEOPLE			In the last 2 weeks, how many days of regular activities did YOU/[NAME] miss to take care of sick household members?	Is respondent a women between 15 and 49?	Interviewer Read. THANK YOU. I WILL NOW ASK YOU A FEW QUESTIONS ABOUT ANY PREGNANCIES YOU MAY HAVE HAD.				
		HEAD OF HOUSEHOLD 01									
		SPOUSE (WIFE/HUSBAND) 02									
		OWN SON / DAUGHTER 03									
		STEP SON/DAUGHTER 04									
		SON/DAUGHTER IN-LAW 05									
		GRANDCHILD 06									
		BROTHER/SISTER 07									
		PARENT / PARENT-IN-LAW 08									
		GRAND PARENT / GRAND PARENT-IN-L 09									
		NIECE/NEPHEW 09									
YES 01	YES 1	OTHER RELATIVE 10				YES ► (12.01)		YES 1	YES 1	ENTER 00 IF NOT YET ONE MONTH PREGNANT ; ENTER -99 IF DON'T	YES 1
NO 02 ► NEXT PERSON	NO 2 ► NEXT PERSON	DOMESTIC HELP / MAID 11				NO ► NEXT RESPONDENT		NO 2	NO 2 ► (12.04)		NO 2
1		OTHER NON-RELATIVE 12						► SECTION 14	NOT SURE 3 ► (12.04)		► (12.06)
2		CO-WIFE 13			ROUND UP TO THE NEXT FULL NUMBER						
								CODE	CODE	MONTHS	CODE
	CODE	CODE1	CODE2	CODE3	DAYS, 1-14						

ID CODE	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15

(12.05)		(12.06)	(12.07)		(12.08)	(12.09)		CALCULATE	(12.10)	CALCULATE	(12.11)		(12.12)	(12.13)	(12.14)		(12.15)	(12.16)	(12.17)		CALCULATE 1	
A. How many living with you?	B.	Do you have any children to whom you have given birth who are still alive but do not live with you?	A. how may living elsewhere?	B.	Have you ever given birth to a child who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	A. How many sons died?	B. How many daughters died?	PROGRAM TO SUM THE ANSWERS TO (12.05) (12.07) (12.09) ENTER TOTAL HERE. IF NONE, WRITE 00.	Please confirm the total number of children you have given birth to is… [NUMBER IN QUESTION **CALCU**]	PROGRAM CONTINUE SECTION IF THE NUMBER OF LIVE BIRTHS IN (12.10) AT LEAST ONE?	When was the last time that you gave birth to a child that was born alive?		Have you ever had a pregnancy that ended in stillbirth, that is when pregnancy has lasted at least 28 weeks but the baby dies before it is born?	How many pregnancies have ended in	When was the last time you had a stillbirth?		Have you ever had a pregnancy that ended in a miscarriage or abortion, that is when the pregnancy lasts less than 28 weeks?	How many pregnancies have ended in a miscarriage or abortion?	When was the last time you had a miscarriage or abortion?		PROGRAM TO CALCULATE IN THE LAST 72 MONTHS, DID THE WOMAN HAVE AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION? CHECK INFORMATION FROM CELLS (12.11) (12.14) (12.17)	
		YES 1 NO 2 ► (12.08)			YES 1 NO 2 ► (12.10)				YES 1 NO 2 IF NOT CORRECT, PROBE AND CORRECT AS NECESSARY	YES 1 NO 2 ► (12.12)			YES 1 NO 2 ► (12.15)				YES 1 NO 2 ► CALCULATE 1				YES 1 NO 2 ► NEXT PERSON	
NUMBER OF SONS	NUMBER OF DAUGHTERS	CODE	NUMBER OF SONS	NUMBER OF DAUGHTERS	CODE	NUMBER	NUMBER		CODE		MONTH (MM)	YEAR (YYYY)	CODE	NUMBER	MONTH (MM)	YEAR (YYYY)	CODE	NUMBER	MONTH (MM)	YEAR (YYYY)		

6	ID CODE	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15

10 Parent's Characteristics

(10.01)	(10.02)	10.02 A	(10.03)	(10.04)	(10.05)	(10.06)	
What is your marital status?	Can we ask you a few questions about your child's father?	Who is the child's father?	Can your child's father read and write in any language?	Has your child's father ever attended school?	What is the highest school level that the child's father attended?	Within that school level, what was the highest grade that the child's father completed?	COMPUTER GENERATED EQUIVALENCY GRADE, BASED ON MAP
					KINDERGARTEN 01		
					PRIMARY/ LOWER BASIC 02		
					UPPER BASIC 03		
					HIGH SCHOOL 04		
					SENIOR SECONDARY 05		
					NON-TERTIARY/VOCATIONARY 06		
		Options --> All men on the roster AND "Not on the Roster"			DIPLOMA/TERTIARY 07		
					UNDERGRADUATE 08		
					MASTERS 09		
					PHD 10		
NEVER MARRIED 1					OTHER, SPECIFY 96	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL; OPTIONS: 1, 2, 3, 4, 5, 6 LOWER, 6 UPPER, 7, 8, 9,10, 11, 12	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL
MONOGAMOUSLY MARRIED 2					DON'T KNOW - 99		
POLYGAMOUSLY MARRIED 3							
DIVORCED / SEPARATED 4	YES 01		YES 01	YES 01			
WIDOWED 5	NO 00 ► (10.07)		NO 00	NO 00 ► (10.07)			
CODE	CODE	ROSTER CODE	CODE	CODE	CODE	GRADE	AUTOFILL

(10.07)	(10.08)		(10.09)		(10.10)		(10.11)		(10.12)	
Can you read and write in any language?	Have you ever attended school?		What is the highest school level that you ever attended?		Within that school level, what was the highest grade that you completed?	COMPUTER GENERATED EQUIVALENCY GRADE, BASED ON MAP	What is the your religion?		What is your ethnicity?	
			KINDERGARTEN	01						
			PRIMARY/ LOWER BASIC	02						
			DROP							
			UPPER BASIC	04			ISLAM	01	MANDINKA/JAHANKA	01
			HIGH SCHOOL	05			CHRISTIANITY	02	FULA/TUKOLOR	02
							TRADITIONAL	03	WOLOF	03
			SENIOR SECONDARY	07			NONE	04	JOLA/KARONINKA	04
			NON-TERTIARY/VOCATIONARY	08	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL; OPTIONS: 1, 2, 3, 4, 5, 6, 6 LOWER, 6 UPPER, 7, 8, 9,10, 11, 12	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL	OTHER, SPECIFY	96	SARAHULE	05
			DIPLOMA/TERTIARY	09					SERERE	06
			UNDERGRADUATE	10					AKUL/CREOLE	07
			MASTERS	11					MANJAGO	08
			PHD	12					NON-GAMBIAN	09
			OTHER, SPECIFY	96					OTHER, SPECIFY	96
YES 01	YES 01		DON'T KNOW	- 99						
NO 00	NO 00	► (10.11)								
CODE	CODE		CODE		GRADE	AUTOFILL	CODE		CODE	

	(12.01)	(12.02)	(12.03)	(12.04)	(12.05)		(12.06)	(12.07)		(12.08)
	Have you ever been pregnant, including pregnancies that may have ended in miscarriage, abortion or stillbirth (born dead)?	Are you pregnant now?	How many months pregnant are you?	Do you have any children to whom you have given birth who are now living with you?	A. How many living with you?	B.	Do you have any children to whom you have given birth who are still alive but do not live with you?	A. how may living elsewhere?	B.	Have you ever given birth to a child who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?
Interviewer Read. Th	YES 1 NO 2 ► SECTION 14	YES 1 NO 2 ► (12.04) NOT SURE 3 ► -12.04	ENTER 00 IF NOT YET ONE MONTH PREGNANT ; ENTER -99 IF DON'T	YES 1 NO 2 ► (12.06)			YES 1 NO 2 ► (12.08)			YES 1 NO 2 ► (12.10)
	CODE	CODE	MONTHS	CODE	NUMBER OF SONS	NUMBER OF DAUGHTER	CODE	NUMBER OF	NUMBER OF	CODE
ID CODI										

(12.09)		CALCULATE	(12.10)	CALCULATE	(12.11)		(12.12)	(12.13)	(12.14)		(12.15)	(12.16)	(12.17)		CALCULATE 1
A. How many sons died?	B. How many daughters died?	PROGRAM TO SUM THE ANSWERS TO (12.05) (12.07) (12.09) ENTER TOTAL HERE. IF NONE, WRITE 00.	Please confirm the total number of children you have given birth to is… [NUMBER IN QUESTION **CALCU**] YES 1 NO 2 IF NOT CORRECT, PROBE AND CORRECT AS NECESSARY	PROGRAM CONTIN (12.10) AT LEAST ONE? YES 1 NO 2 ► (12.12)	When was the last time that you gave birth to a child that was born alive?		Have you ever had a pregnancy that ended in stillbirth, that is when pregnancy has lasted at least 28 weeks but the baby dies before it is born? YES 1 NO 2 ► (12.15)	How many pregnancies have ended in	When was the last time you had a stillbirth?		Have you ever had a pregnancy that ended in a miscarriage or abortion, that is when the pregnancy lasts less than 28 weeks? YES 1 NO 2 ► CALCULATE 1	How many pregnancies have ended in a miscarriage or abortion?	When was the last time you had a miscarriage or abortion?		PROGRAM TO CALCULATE IN THE LAST 72 MONTHS, DID THE WOMAN HAVE AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION? CHECK INFORMATION FROM CELLS -12.11 -12.14 -12.17 YES 1 NO 2 ► NEXT PERSON
NUMBER	NUMBER		CODE		MONTH (MM)	YEAR (YYYY)	CODE	NUMBE	MONTH (MM)	YEAR (YYYY)	CODE	NUMBER	MONTH (MM)	YEAR (YYYY)	

13 Maternal Care

SUBJECT: ALL WOMEN WHO HAVE BEEN PREGNANT

INTERVIEWER: LIST ALL PREGNANCIES STARTING WITH MOST RECENT. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.

RESPONDENT: SELF

ANTENATAL CARE

			-13.01	(13.02)			-13.03	-13.04	-13.05	-13.06
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO CALCULATE 1 I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	INTERVIEWER: CONFIRM TOTAL NUMBER OF LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN THE LAST 24 MONTHS.		Now I am going to ask you some questions about your last pregnancy/the previous pregnancy that ended in live birth, still birth, miscarriage or abortion. Did you consult any health care provider or traditional healer for antenatal care for this pregnancy?	Why didn't you consult any health care provider or traditional healer for antenatal care for this pregnancy? RECORD UP TO 3 REASONS.			Did you ever try to go for antenatal care but the facility staff told you to go away and come back another day?	Were you referred to the health center for ANC or delivery services by a CHW or TBA at any point during your pregnancy?	Were you accompanied to the health center for ANC or delivery services by a CHW or TBA at any point during your pregnancy?	Did the CHW or TBA help to provide transportation to the ANC visit during your pregnancy?
			FOR WOMEN WHOSE LAST PREGNANCY WAS A STILLBIRTH, MISCARRIAGE OR ABORTION, THE LAST PREGNANCY IS THE PREGNANCY THAT ENDED IN STILLBIRTH, MISCARRIAGE OR ABORTION	TOO EXPENSIVE		01				
				TOO FAR		02				
				TOO BUSY (WORK, CHILDREN)		03				
				SELF-TREATED		04				
				WAS TOO EARLY IN PREGNANCY		05				
				FACILITY HAS POOR STRUCTURE		06				
				FACILITY POORLY STOCKED		07				
				POOR STAFF ATTITUDE		08				
				POOR STAFF KNOWLEDGE		09				
				POOR QUALITY OF CARE		10				
				SERVICE NOT AVAILABLE		11				
				NO TRANSPORTATION		12				
				DID NOT NEED		13				
				INCONVENIENT HOURS		14				
				LONG WAITING TIMES		15				
			YES 1 ► (13.04)	PREFER HOME CARE		16	YES 1	YES 1	YES 1	YES 1
			NO 2	FAMILY DIDN'T WANT ME TO GO		17	NO 2	NO 2	NO 2	NO 2
				OTHER (SPECIFY)		96	► (13.22)			
		PRE		FIRST	SECOND	THIRD				
			CODE	CODE 1	CODE 2	CODE 3	CODE	CODE	CODE	CODE
		1								
		2								
		3								

ANTENATAL CARE

(13.07)				(13.08)				(13.09)	(13.10)	(13.11)			
What kind of provider did you see for antenatal care for this pregnancy?				In what kind of facility or location did you see this health care provider?				What is the name of the Health Faclity?		INTERVIEWER: ASK WOMAN TO SEE ANC CARD			
IF MORE THAN ONE PROVIDER, WRITE THE PROVIDER THAT IS HIGHEST ON THE LIST.				IF MORE THAN ONE, WRITE FACILITY CORRESPONDING TO PROVIDER IN CELL (13.07)					What is the name of your he MOVED THIS QUESTION				
MEDICAL DOCTOR	01			GOVERNMENT HOSPITAL	01				Free Entry	Card available and	01		
NURSE/MIDWIFE	02			GOVERNMENT HEALTH CENTER	02					Card available but not	02	►	(13.12)
COMMUNITY HEALTH NURSE	03	►	(13.08)	GOVERNMENT HEALTH POST	03				Don't Know = - 99	Card not available	03	►	(13.12)
LAB TECHNICIAN	04	►	(13.08)	PRIVATE HOSPITAL	04								
PHARMACIST/ DRUG SELLER	05	►	(13.08)	PRIVATE CLINIC	05								
TRADITIONAL BIRTH ATTENDANT	06	►	(13.08)	NGO CLINIC	06								
TRADITIONAL HEALER	07	►	(13.08)	PHARMACY	07	►	(13.12)						
SPIRITUAL HEALER	08	►	(13.08)	MOBILE CLINIC	08	►	(13.12)						
VILLAGE HEALTH WORKER	09	►	(13.08)	PROVIDER'S HOME	09	►	(13.12)						
OTHER (SPECIFY)	96	►	(13.08)	OWN HOME	10	►	(13.12)						
				OTHER HOME	11	►	(13.12)						
				OUTDOOR LOCATION	12	►	(13.12)						
				OTHER (SPECIFY)	96	►	(13.12)						
CODE				CODE				CODE + OTHER	CODE	CODE			

ANTENATAL CARE

(13.12)	(13.13)	(13.14)	(13.15)													(13.16)
How many months pregnant were you when you **first** received antenatal care for this pregnancy?	How many times did you receive antenatal care for this pregnancy?	How many months pregnant were you when you **last** received antenatal care for this pregnancy?	Now I would like to ask you about things that may have been done during the antenatal care visits for your last pregnancy. During those visits, was the following done during at least one visit?													INTERVIEWER CONFIRM: Is the card complete and filled out? If yes, use the card to collect the following information. If no, ask the respondent to update the information
			YES 0													
			NO 1													
			A.	B.	C.	D.	E.	F.	H.	G.	I.	J.	K.	L.	M.	
	IF ONCE, RECORD 1 AND ► (13.15)		Were you weighed?	Was your height measured?	Was your blood pressure measured?	Did you give a urine sample?	Did you give a blood sample?		Did the health worker estimate your due date?		Was your uterine height measured (this is when the provider measures your stomach using a measurement tape)?	Were you tested for Syphilis?	Did the health worker ask for your blood type and Rhesus?	Did you receive advice on the diet during your pregnancy?	Did you receive advice on what to do in case of an emergency?	What is the source of data for question (13.12) - question (13.15)?
INTERVIEWER ROUND MONTHS		INTERVIEWER ROUND MONTHS														ANC Card 01 ANC Card + Respondent 02 Respondent only 03 IF CARD AND RESPONDENT DISAGREE, ACCEPT RESPONDENT'S ANSWER
								Did you scl		Did the provider p						
MONTHS	NUMBER	MONTHS	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
									SWITCHED H AND G							
									SWITCHED H AND G							
									SWITCHED H AND G							

			AIDS, TETANUS					IRON		MALARIA								Risk Factors During Pregnancy					PREGNANCY RESULT		
-13.17	-13.18	-13.19	-13.16	(13.17)	(13.18)	-13.19	(13.20)	-13.21	(13.22)	-13.23	-13.24							-13.25	-13.26	-13.27	-13.28	-13.29	-13.3		-13.31
If you were pregnant again, would you go back to the same clinic for antenatal care?	Would you recommend this clinic to a relative or friend for their antenatal check-up?	In general, how satisfied are you with the antenatal care you received in this clinic? Would you say that you are very satisfied, somewhat satisfied, niether satisfied nor dissatisfied, somewhat dissatisfied, or very	During this pregnancy, were you offered counseling and testing for the virus that causes AIDS?	I will not ask you the result, but were you tested?	I will not ask you the result, but did you receive the	During this pregnancy, were you given an injection in the arm to prevent the baby from	How many times did you receive this shot during the pregnancy?	During this pregnancy, were you given or did you buy any iron tablets or iron syrup?	During the pregnancy, for how many days did you take the iron tablets or iron syrup?	During this pregnancy, did you take any drugs to prevent you from getting	How many doses did you take?							During this pregnancy, did you sleep under an bed net?	During this pregnancy, did you ever have any bleeding?	During this pregnancy, did you ever have severe abdominal	During this pregnancy, did the baby ever stop moving or	During this pregnancy, did you ever have blurred vision?	When did this pregnancy end?		What was the result of this pregnancy?
																							INTERVIEWER: RECORD END DATE OF PREGNANCY REGARDLESS OF RESULT (LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION). RECORD ANY MISSING ELEMENT OF THE DATE AS "-99".		BORN ALIVE, SINGLE BIRTH 1
																									BORN ALIVE, MULTIPLE BIRTH 2
																									STILL BIRTH 3
																									► (0.32)
											A.	B.	C.	D.	E.	F.	G.								MISCARRIAGE
																									► (0.32)
		Very Satisfied 1						YES 1		YES 1								YES 1	YES 1	YES 1	YES 1	YES 1			ABORTION 5
		Somewhat Satisfied 2	YES 1	YES 1	YES 1	YES 1		NO 2		NO 2								NO 2	NO 2	NO 2	NO 2	NO 2			► (0.32)
		Neither satisfied nor dissatis 3	NO 2	NO 2	NO 2	NO 2		►		►															
YES 1	YES 1	Somewhat dissatisfied 4	►	►		►		(13.23)		(13.25)															
NO 2	NO 2	Very dissatisfied 5	(13.19)	(13.19)		(13.21)					Fandisar/SP	Choloroquine	Coartem	Artemeter	Unknown Drug	Quinine	Other Known Drug, specify								
CODE	CODE	CODE	CODE	CODE	CODE	CODE	NUMBER	CODE	DAYS	DAY	DOSES	DOSES	DOSES	DOSES	DOSES	DOSES	DOSES	CODE	CODE	CODE	CODE	CODE	DAY	MONTH	YEAR	CODE

DELIVERY

(13.32) Who assisted with the delivery for this pregnancy?			(13.33) Where did you deliver?			IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.	(0.01) What is the name of the health care provider who helped with this delivery?	(0.02) Did you go directly there when you went into labor or were you referred by a CHW or TBA to this facility?	-0.03 Were you accompanied to the health center for delivery services by a CHW or TBA?	-0.04 Did the CHW or TBA help to provide transportation to HC for your delivery?	-0.05 Was the birth delivered by caesarean section, that is did they cut your belly open to take the baby out?
MEDICAL DOCTOR	01		GOVERNMENT HOSPITAL	01			Don't Know = - 99	Directly 01			
NURSE/MIDWIFE	02		GOVERNMENT CLINIC	02				Referred 02			
COMMUNITY HEALTH NURSE	03		GOVERNMENT HEALTH POST	03							
LAB TECHNICIAN	04		PRIVATE HOSPITAL	04		► (0.05)					
PHARMACIST/ DRUG SELLER	05	► (13.33)	PRIVATE CLINIC	05							
TRADITIONAL BIRTH ATTENDANT	06	► (13.33)	NGO CLINIC	06							
TRADITIONAL HEALER	07	► (13.33)	PHARMACY	07	► (0.06)						
SPIRITUAL HEALER	08	► (13.33)	MOBILE CLINIC	08	► (0.06)						
FAMILY MEMBER	09	► (13.33)	OWN HOME	09	► (0.06)				YES 1	YES 1	
FRIEND/NEIGHBOR	10	► (13.33)	ANOTHER HOME	10	► (0.06)				NO 2	NO 2	
NO ONE	11	► (13.33)	A PUBLIC PLACE	11	► (0.06)						YE 1
OTHER (SPECIFY)	96	► (13.33)	OTHER (SPECIFY)	96	► (0.06)						NC 2
CODE			CODE			CODE	CODE	CODE	CODE	CODE	CODE

(0.06) Why didn't you deliver in a formal health facility for this pregnancy? RECORD UP TO 3 REASONS.		CODE 1	CODE 2	CODE 3
TOO EXPENSIVE	01			
TOO FAR	02			
WAS TOO LATE IN DELIVERY	05			
FACILITY HAS POOR STRUCTURE	06			
FACILITY POORLY STOCKED	07			
POOR STAFF ATTITUDE	08			
POOR STAFF KNOWLEDGE	09			
POOR QUALITY OF CARE	10			
SERVICE NOT AVAILABLE	11			
NO TRANSPORTATION	12			
DID NOT NEED	13			
INCONVENIENT HOURS	14			
LONG WAITING TIME	15			
PREFER HOME DELIVERY	16			
FAMILY DIDN'T WANT ME TO GO	17			
OTHER (SPECIFY)	96			
		FIRST	SECOND	THIRD

-0.07 Was the infant(s) a boy or a girl?			-0.08 Was the infant(s) weighed at birth?			-0.09 How much did the infant weigh?		
MALE 01			YES 1			RECORD WEIGHT IN **KILOGRAMS**		
FEMALE 02			NO 2					
			► (0.15)					
A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD
CODE	CODE	CODE	CODE	CODE	CODE	KILOGRAMS	KILOGRAMS	KILOGRAMS
						__.___	__.___	__.___
						__.___	__.___	__.___
						__.___	__.___	__.___

Risk Factors diuring delivery

-0.08	-0.09	-0.1	-0.11	-0.12	-0.13
During this delivery, did you have a seizure or fit, or fall	During this delivery did you have more bleeding than is	How long were you in the active stage of labor? That is, the stage when you are actively pushing the Record Don't Know as -99	If you were pregnant again, would you go back to the same clinic for delivery?	Would you recommend this clinic to a relative or friend for delivery?	In general, how satisfied are you with the delivery care you received in this clinic? Would you say that you are very satisfied, somewhat satisfied, niether satisfied nor
YES 1	YES 1				Very Satisfied 1
NO 2	NO 2				Somewhat Satisfied 2
					Neither satisfied nor dissatis 3
			YES 1	YES 1	Somewhat dissatisfied 4
			NO 2	NO 2	Very dissatisfied 5
CODE	CODE	MINUTES	CODE	CODE	CODE

INFANT CHARACTERISTICS

-0.14			-0.15			(0.16)
CONFIRM: IS THE SOURCE FOR WEIGHT RECALL OR HEALTH CARD?			When the infant(s) was born for this pregnancy, was he/she very large, larger than average, average, smaller than average or very small?			When the infant was born, did it have any trouble breathing?
			VERY LARGE 1			
			LARGER THAN AVERAGE 2			
RECALL 1			AVERAGE 3			YES 1
HEALTH CARD 2			SMALLER THAN AVERAGE 4			NO 2
			VERY SMALL 5			
A.	B.	C.	A.	B.	C,	
FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	
CODE	CODE	CODE	CODE	CODE	CODE	CODE

FEEDING

-0.17			-0.18			(0.19)
Did you ever breastfeed the infant?			After the infant was born, how much time did it take before you started breastfeeding him/her?			Did the infant have any trouble suckling? Did it refuse to
YES 1			WRITE THE ANSWER IN HOURS			
NO 2						YES 1
► (0.24)			IF LESS THAN ONE HOURS, RECORD 00			NO 2
A.	B.	C.	A.	B.	C.	
FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOD CHILD	THIRD CHILD	
CODE	CODE	CODE	HOURS	HOURS	HOURS	CODE

-0.2			-0.21								
In the first 3 days after delivery, was the infant given anything to drink other than breast milk?			What was the infant given to drink other than breastmilk? INTERVIEWER: RECORD UP TO 3 RESPONSES.								
			MILK (OTHER THAN BREASTMIL	01	INFANT FORMULA	06					
			PLAIN WATER	02	GRIPE WATER	07					
			SUGAR/GLUCOSE WATER	03	TEA/INFUSIONS	08					
			SUGAR-SALT-WATER SOLUTION	04	HONEY	09					
			FRUIT JUICE	05	COFFEE	10					
YES 1					OTHER (SPECIFY)	96					
NO 2											
► (0.22)											
A.	B.	C.	A.			B			C		
FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD			SECOND CHILD			THIRD CHILD		
			1	2	3	1	2	3	1	2	3
CODE	CODE	CODE	CODE 1	CODE 2	CODE 3	CODE 1	CODE 2	CODE 3	CODE 1	CODE 2	CODE 3

FEEDING						Risk Factors After Delivery		
-0.22	(0.23)	(0.24)	-0.25	(0.26)	(0.27)	-0.28	-0.29	-0.3
For how many months did you breastfeed?	For how money months did you exclusively breastfeed to your baby? This means only you gave the baby only breastmilk, and no other food, water, or liquid.	Why did you not breast feed	What did you give instead of breast milk?	Did someone teach you to breast feed?	Who taught you?	After this delivery, did you have severe abdominal pain?	After this delivery did you have more bleeding than is normal?	After this delivery, did you have a severe headache?
RECORD IN MONTHS								
IF LESS THAN ONE MONTH, RECORD 00		Mother Sick 01	Milk, other than breast 01	Yes 01	Mother 01			
		Lack of milk 02	Infant Formula 02	No 02 ► (0.28)	Friend 02			
		Did not want to 03	Other, Specify 96		Mother in Law 03			
STILL BREASTFEEDING 98		Lack of knowledge 04			Traditional Birth Attendant 04			
		Not to spoil figure 05			Community Health Nurse 05			
NO SKIP	IF LESS THAN ONE MONTH, RECORD 00	Doctor Advised 06			Health Facility Staff 06			
		Other, Specify 96			Other, Specify 96			
	STILL BREASTFEEDING 98							
	► (0.26)					YES 1	YES 1	
						NO 2	NO 2	
CODE	MONTHS	CODE	CODE	CODE	CODE	CODE	CODE	CODE

POSTNATAL CARE

(0.31) After the birth/miscarriage, did a health professional or traditional birth attendant or healer check on your health?

YES	1		
NO	2	►	(0.33)

CODE

(0.32) After the birth/miscarriage, did anyone in the VSG refer you to the health clinic for a check up?

YES	1
NO	2

CODE

(0.33) How many post-natal check ups did you attend/receive in the first 6

NUMBER

(0.34) How long after the birth/miscarriage did you receive the first post-natal check?

WRITE THE ANSWER IN DAYS. IF LESS THAN A DAY, WRITE 00

DAYS

(0.35) Who checked on your health the first time?

MEDICAL DOCTOR	01		
NURSE/MIDWIFE	02		
COMMUNITY HEALTH NURSE	04	►	(0.38)
VILLAGE HEALTH WORKER	05	►	(0.38)
LAB TECHNICIAN	05	►	(0.38)
PHARMACIST/ DRUG SELLER	06	►	(0.38)
TRADITIONAL BIRTH ATTENDANT	07	►	(0.38)
TRADITIONAL HEALER	08	►	(0.38)
SPIRITUAL HEALER	09	►	(0.38)
OTHER, SPECIFY	96	►	(0.38)

CODE

POSTNATAL CARE

(0.36) Where did this check take place?

GOVERNMENT HOSPITAL	01		
GOVERNMENT CLINIC	02		
GOVERNMENT HEALTH POST	03		
PRIVATE HOSPITAL	04		
PRIVATE CLINIC	05		
NGO CLINIC	06		
PHARMACY	07	►	(0.38)
MOBILE CLINIC	08	►	(0.38)
PROVIDER'S HOME	09	►	(0.38)
OWN HOME	10	►	(0.38)
OTHER HOME	11	►	(0.38)
OUTDOOR LOCATION	12	►	(0.38)
OTHER (SPECIFY)	96	►	(0.38)

CODE

(0.37) IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.

► (0.42)

NAME | CODE

(0.38) Why didn't you have a postnatal check up in a formal health institution/personnel for this pregnancy?

TOO EXPENSIVE	01
TOO FAR	02
TOO BUSY (WORK, CHILDREN)	03
SELF-TREATED	04
DID NOT NEED	05
FACILITY HAS POOR STRUCTURE	06
FACILITY POORLY STOCKED	07
POOR STAFF ATTITUDE	08
POOR STAFF KNOWLEDGE	09
POOR QUALITY OF CARE	10
SERVICE NOT AVAILABLE	11
NO TRANSPORTATION	12
INCONVENIENT HOURS	13
LONG WAITING TIMES	14
PREFER HOME CARE	15
FAMILY DIDN'T WANT ME TO GO	16
OTHER (SPECIFY)	96

CODE 1 | CODE 2 | CODE 3

			IRON TABLETS/SYRUP			VITAMIN A						DEATH		CE IN HOU
-0.39	-0.4	-0.41	(0.42)	(0.43)	(0.44)	(0.45)		0.45 A	0.45 B	0.45 C	(0.46)	(0.47)	(0.48)
Were you referred to the health center for post natal care by a CHW or TBA at any point during your pregnancy?	Were you accompanied to the health center for postnatal care services by a CHW or TBA?	Did the CHW or TBA help to provide transportation to HC for your postnatal care?	After the birth/miscarriage, were you given or did you buy any iron tablets or iron syrup or folic acid to take?	How long after the birth/ miscarriage did you take the first iron dose?	For how many days after the birth/miscarriage did you take the iron tablets or iron syrup?	In the first two months after the birth/miscarriage, did you receive a vitamin A dose (like this)? SHOW COMMON AMPULES / CAPSULES /	INTERVIEWER: CH ► 13.84	If you had another baby, would you go back to the same clinic for postnatal care?	Would you recommend this clinic to a relative or friend for their postnatal check-up?	In general, how satisfied are you with the postnatal care you received in this clinic? Would you say that you are very satisfied, somewhat satisfied, niether satisfied nor dissatisfied, somewhat dissatisfied, or very dissatisfied?	Is the child still alive?	How old was the child when he/she died?	Is the child still living with you?
							IF LIVE BIRTH: ASK FOLLOWING QUESTIONS FOR AT LEAST FIRST CHILD, AND IF MULTIPLE BIRTHS, PROCEED TO SAME QUESTIONS FOR SECOND/THIRD CHILD IF APPLICABLE.				YES 1 ► (0.48) NO 2	INTERVIEWER: WRITE THE ANSWER IN MONTHS IF LESS THAN ONE MONTH, WRITE ZERO	YES 1 NO 2
				WRITE THE ANSWER IN DAYS		YES 1 NO 2 ► INSTRUCTIONS PRIOR TO (0.46)				Very Satisfied 1 Somewhat Satisfied 2 Neither satisfied nor dissatis 3 Somewhat dissatisfied 4 Very dissatisfied 5		► 13.84	
YES 1 NO 2 ► (0.42)	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2 ► (0.45)					YES 1 NO 2	YES 1 NO 2				
CODE	CODE	CODE	CODE	DAYS	DAYS	CODE	CODE	CODE	CODE	CODE	CODE	MONTHS	CODE

Exclusive Breastfeeding

#REF!	After delivery, when do you think is the best time to start breastfeeding?	Immediately/Within one hour after birth	01
		Within first day	02
		Within 2 days of brith	03
	(ONE ANSWER)	When the baby wants	04
		When the mother is ready	05
		Other ____	96
#REF!	Until what age do you think it's best to give only breastmilk?	0-1 month	01
		2-3 months	02
		4-5 months	03
		6 months	04
		More than 6 months	05
#REF!	If you have a baby under 6 months, what is best to feed him/her?	Breast milk only	01
		Breast milk and solid foods	02
		Breast milk and water	03
		Breast milk and animal milk	04
		Breast milk and formula	05
		Breast milk and tea	06
		Other	07
#REF!	Until what age do you think it's best to give any breastmilk?	0-1 month	01
		2-3 months	02
		4-5 months	03
		6 months	04
		6 months - 1 year	05
		1 year - 2 years	06
		More than 2 years	07
#REF!		Breast milk	01
	When a child receives both breast milk and other foods, what should the chil	Other Foods	02
#REF!	How do you know the baby needs to be fed? Would you feed them:	When the baby demands feeding	A
	INTERVIEWER: PROMPT FOR EACH:	Every time baby cries	B
	*REWORDED	At set times	D
		Other ____	E
#REF!	Why is it good for your baby to breastfeed?	Gives baby protection from disease	A
	*CHANGED WORDING	Creates bond between baby and mother	B
	Do not prompt, circle all that are mentioned	Makes the child strong and intelligent	C
		Makes the child strong and healthy	D
		It is the right food for the baby	E
		Other ____	F
#REF!	What benefits does the mother have from breastfeeding her child?	Creates a bond between mother and baby	A
		Helps to prevent anemia	B
		Helps to expel the placenta	C
		Prevents mother from getting cancer In the future	D
	Do not prompt, circle all that are mentioned	It is free	E
		It is ready to use as is	F
		Babies who are breastfed need less medical attention and are sick less often	G
		It helps the mother have faster recovery after delivery	H
		It prevents pregnancy	I
		Other ____	J

#REF!		Yes	01
	Should the baby receive the first milk that tends to be thicker and yellower th	No	00
#REF!	Do you agree that It is important to give a young baby water as well as breastmilk.	Yes	01
		No	00
#REF!	Would you breastfeed during the night? That is, after you have gone to bed?	Yes	01
		No	00
#REF!	Do you think that a mother with small breasts can produce enough milk?	Yes	01
		No	00
#REF!	Can a mother who has a young baby and who is not well fed produce enou	Yes	01
		No	00
#REF!	What do you think makes a woman have enough milk?	Giving breast milk often	A
		Breastfeeding for a long time each time	B
	Do not prompt, circle all that are mentioned	Good food	C
		Drinking before breatfeeding	D
		Free from problems	E
		Eating the right food	F
		Being or feeling strong	G
		Taking the right tea/infusion	H
		Other ____	H
#REF!	What is the most common reason for a mother to have over-full, hard, sore b	Not Breastfeeding Enough	01
		Baby belches on breast	02
		Other	03
		Don't Know	-99
#REF!	I will read to you a number of cases, Can you tell me if a woman should continue breastfeeding in each case?		
	When she is angry	Yes	01
		No	00
	When her husband is angry with her	Yes	01
		No	00
	When the woman is sick	Yes	01
		No	00
	When the baby is sick	Yes	01
		No	00
	When she has swollen and painful breasts (engorgement)	Yes	01
		No	00
	When she has cracked nipples	Yes	01
		No	00
	When she has an infection on her nipples	Yes	01
		No	00

Minimum Acceptable Diet

#REF!	What is the minimum food needed by your child?	Breastmilk	A
		Grain	B
		Roots or Tubers	C
	Do not prompt, circle all that are mentioned	Legumes or nuts	D
		Dairy Products	E
		Red Meat	F
		Fish	G
		Poultry	H
		Eggs	I
		Oils/ Fats	J
		Fruits	K
		Vegetables	L
#REF!	How often do you need to feed your youngest child?	2 times per day	01
		3 times per day	02
		4 times per day	03
		5 times per day	02
		6 or more times per day	03

SUBJECT: Woman who most recently had a live brith
RESPONDENT: SELF

		(14.01)	(14.02)	(14.03)	(14.04)	(14.05)	(14.06)	(14.07)	-14.08	(14.09)	(14.10)	(14.11)	(14.12)	-14.13
	PROGRAMMER -12.02	At the time you became pregnant, did you want to become pregnant then, did you want to be pregnant later, or did you not want to have any (more) children at all?	If you could choose for yourself, how	What is your idea	What do you think	In the next few weeks, if yo	Do you approve or	Do you approve or	Do you current	Do you think that y	In the last 6 months, how	Would you say that using contrace	Would you say that y	Are you currently do
	IS THE WOMAN	► (14.13)	WOULD NOT WAIT 1			BIG PROBLEM 1								
			LESS THAN 2 YEARS 2			SMALL PROBLEM 2					NEVER 1	MAINLY RESPONDENT 01		
			MORE THAN 2 YEARS 3			NO PROBLEM 3	APPROVE 1	APPROVE 1	YES 1	APPROVE 1	ONCE OR TWICE 2	MAINLY HUSBAND/PARTNER 02	YES 1	YES 1 ► (14.16)
			DOESN'T WANT MORE 4			CAN'T GET PREGNANT 4	DISAPPROVE 2	DISAPPROVE 2	NO 2	DISAPPROVE 2	MORE THAN TWICE 3	JOINT DECISION 04	NO 2	NO 2
	YES 1	THEN 1	HAVE NOT DECIDED YET 5						► (14.13)			OTHER, SPEFICY 96		
	NO 2	LATER 2	INFERTILE 6											
	► (14.02)	NOT AT ALL 3	► (15.01)											
ID CODE	CODE	CODE	CODE	NUMBER	NUMBER	CODE	CODE	CODE	CODE	CODE	CODE	CODE		CODE

(14.14)		-14.15	-14.16	(14.17)	-14.18	(14.19)	(14.20)			
			Which method are you currently using?							
			IF MORE THAN ONE METHOD, INDICATE THE HIGHEST M							
			TUBAL LIGATION (FEMALE 01 ► (14.20)							
Why are you currently not using any metho			VESECTOMY (MALE STERILIZATION) 02 ► (14.20)	Where did you obtain this method?			Have any of the following ever talked to you about family planning meth			
			IUD / SPIRAL 03	MEDICAL DOCTOR 01	How long have you been					
WOULD LIKE TO GET PREGNANT	01	Have you eve	INJECTABLES / DEPOPROVERA 04	NURSE/MIDWIFE 02				YES	1	
DOES NOT APPROVE	02		IMPLANTS / NORPLANT 05	COMMUNITY HEALTH NURSE 03				NO	2	
PARTNER DOES NOT APPROVE	03	► (14.20)	PILL 06	LAB TECHNICIAN 04						
FAMILY DOES NOT APPROVE	04		MALE CONDOM 07	PHARMACIST/ DRUG SELLER 05						
NOT AVAILABLE	05		FEMALE CONDOM 08	TRADITIONAL HEALER 06						
TOO EXPENSIVE	06		DIAPHRAGM 09	TRADITIONAL BIRTH ATTENDANT 07						
SCARED OF SIDE-EFFECTS	07		FOAM/JELLY 10	SPIRITUAL HEALER 08		How much did you pa				
DON'T KNOW OF ANY METHOD	08	YES 1	LACTATIONAL AMENORRHEA METHOD 11 ► (14.20)	OTHER SHOP 09	ENTER YEARS IF 12 MO					
LACTATIONAL AMENORRHEA	09	NO 2	RHYTHM / NATURAL METHOD ► (14.20) 12	FAMILY MEMBER 10						
HAD HYSTERECTOMY	10		WITHDRAWAL 13 ► (14.20)	FRIEND/NEIGHBOR 11			A	B	C	D
IS MENOPAUSAL	11		OTHER MODERN METHOD, SPECIFY 14	OTHER (SPECIFY) 12						
IS INFECUND	12		OTHER TRADITIONAL METHOD, SPECIFY 15							
OTHER (SPECIFY)	96						Health worker at	Community Healt	Friends/Family	Other (Specify)
CODE		CODE	CODE	CODE	YEARS	MONTHS	DALASI	CODE	CODE	CODE	CODE

15 Vaccination

SUBJECT: YOUNGEST CHILD OF RESPONDENT

-15.01

RESPONDENT: MOTHER OR PRIMARY CAREG [ ] CONFIRM TOTAL NUMBER OF LIVING CHILDREN 0-5 Y

(15.02)	-15.03	-15.04	-15.05	(15.05) continued	-15.06	-15.07
			INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD	INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD		
			* IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLC	* IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLOWING:		
			RECORD DAY USING 2 DIGITS DD (RANGE 01-31)	RECORD DAY USING 2 DIGITS DD (RANGE 01-31)		
			RECORD MONTH USING 2 DIGITS MM (RANGE 01-12)	RECORD MONTH USING 2 DIGITS MM (RANGE 01-12)		
			RECORD YEAR USING 2 DIGITS YY (RANGE 09-14)	RECORD YEAR USING 2 DIGITS YY (RANGE 09-14)		
		Do you have an u	RECORD ANY MISSING ELEMENT OF THE DATE AS "DK" IF DATE DOES NOT INC	RECORD ANY MISSING ELEMENT OF THE DATE AS "DK".		
RECORD			* IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN	* IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN DAY COLUMN.		
			* IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.	* IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.		
			ALL VACCINE COLUMNS SHOULD BE FILLED OUT.	ALL VACCINE COLUMNS SHOULD BE FILLED OUT.		
		IF YES, RECORD				
IMPORT I	RECORD					Has [NAME] received any vaccina
		YES, S 1				YES 1
					INTERVIEWER: Whic	NO 2
		YES, N 2	A. B. C. D. E. F.	O P Q R S V	First Dose 1	
		► (15.09)			Second Dose 2	SKIP TO NEXT CHILD
		NO 3	BCG OPV0 Measles Pneumococcal Rotavirus Vacc DPT-Hep-Hib3 (	MEASLES Dewomring first Deworming secor VITAMIN A first VITAMIN A secor Hib3 (if delivered	Third Dose 3	
		► (15.08)			Other, Specify 96	

ID CODE	ID CODE	ID CODE	CODE	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEAF	DAY MON YEAF	DAY MON YEAF	DAY MON YEAF	DAY MON YEAF	DAY MON YEAF	DAY MON YEAF	DAY MON YEAF	CODE	CODE
01																			
02																			
03																			
04																			
05																			

(15.08)	-15.09	(15.10)	-15.11	(15.12)	(15.13)	(15.14)	(15.15)	(15.16)	(15.17)	(15.18)	(15.19)	(15.20)	(15.21)	(15.22)	15.23	15.24
Did you ever have	Did [NAME] ever receiv	Did [NAME] rec	When did [NAME] receive t	Did [NAME] rece	When did [NAME] receiv	How many times	Did [NAME] receiv	How many tir	Did [NAME] receiv	Did [NAME] re	Did [NAME] ever	When was the last vitamin A sup	In the last 6 mont	Did [NAME] ever receive	When was the last mebendazole prov	In the last 6 months, how
YES 1	YES 1	YES 1	JUST AFTER 01	YES 1	JUST AFTER 01		YES 1		YES 1	BEFORE 01	YES 1	6 MONTHS AGO OR LESS 01		YES 1	6 MONTHS AGO OR LESS 01	
NO 2	NO 2	NO 2	LATER 02	NO 2	LATER 02		NO 2		NO 2	AFTER 02	NO 2	MORE THAN 6 MONTHS 02		NO 2	MORE THAN 6 MONTHS 02	
	► (15.19)			► (15.15)			► (15.17)		► (15.19)		► NEXT CHILD			► NEXT CHILD		
CODE	CODE	CODE	CODE	CODE	CODE	NUMBER	CODE	NUMBER	CODE	CODE	CODE	CODE	NUMBER	CODE	CODE	NUMBER

15

ID CODE 01 02 03 04 05

16 Height and Weight

SUBJECTS: ALL CHILDREN OF THE REPONDENT <5 YEARS OLD IN THE HOUSEHOLD.
RESPONDENT: Woman who most recently had a live birth

	(16.01)	(16.02)		(16.03)	(16.04)	(16.05)		(16.06)	(16.07)	(16.08)	(16.09)	(16.10)	(16.11)	(16.12)	(16.13)	(16.14)	(16.15)	(16.16)	(16.17)
	RECORD ID C	RECORD INDIVIDUAL'S AGE FROM SECTION 1		Did [NAME] sleep in the house last night?	In the last 6 months, was [NAME] measured to determine [NAME]'s nutritional status?	What was the date of the last measurement? INTERVIEWER: CONFIRM FROM THE CARD IF AVAILABLE*		For the last measurement, which method was used to determine [NAME]'S nutritional status?	For the last measurement, where was [NAME] measured?	What was the result of the last measurement?	Did you obtain any specialized care for [NAME]'s malnutrition after the last measurement?	Where was the care for [NAME]'s malnutrition obtained from?	Were any of the following given to take care of [NAME]'s malnutrition?	WILL YOU ALLOW US TO TAKE THE WEIGHT AND MEASUREMENTS OF [NAME]? IF YES, ENTER THE CHILD'S INFORMATION INTO ANTHROPOMETRY SHEET AND	OUTCOME OF ANTHROPOMETRY		RECORD METHOD FOR MEASURING HEIGHT	RECORD WEIGHT IN KILOGRAMS	RECORD UPPER ARM CIRCUMFERENCE IN CENTIMETERS
									GOVERNMENT HOSPITAL 01			GOVERNMENT HOSPITAL 01							
												GOVERNMENT MAJOR HEALTH CENT 02							
												GOVERNMENT MINOR HEALTH CENTE 03	READ EACH OPTION ALOUD AND RECORD YES OR NO						
									GOVERNMENT HOSPITAL 01			GOVERNMENT HEALTH POST 04		YES 01	MEASURE 01				
									GOVERNMENT CLINIC 02			NGO CLINIC 05		NO					
									GOVERNMENT HEALTH POST 03			PRIVATE CLINIC 06		2	NOT 02				
								Height only 1	PRIVATE HOSPITAL 04			PRIVATE PRACTITIONER 07			TOO ILL 03				
								Weight only 2	PRIVATE CLINIC 05			PHARMACY 08	YES 1		REFUSED 04	RECORD HEIGHT IN CEN			
								Height / Weight 3	PRIVATE HEALTH POST 06			MOBILE CLINIC/OUTREACH 09	NO 2		OTHER (S 96 ► NEXT PE				
								Mid-Upper Arm 4	PHARMACY 07			TRADITIONAL HEALER 10							
									MOBILE CLINIC 08	GREEN 1	YES 1	FAITH/CHURCH HEALER 11				CHILDREN LESS THAN 24 MONTHS SHOULD BE MEASURED LAYING			CHILDREN WITH MUAC<11.5 MUST BE IMMEDIATELY REFERRED TO NEAREST HEALTH FACILITY
				YES 1	YES 1				PROVIDER'S HOME 09	► (16.12)	NO 2	COMMUNITY HEALTH WORKER 12							
				NO 2	NO 2				OWN HOME 10	YELLOW 2	► (16.12)	COMMUNITY OWNED CLINIC 13					STANDING 01		
					► (16.12)				OTHER HOME 11	RED 3		SERVICE CLINIC 14					LYING 02		
									OUTDOOR LOCATION 12	DON'T		OTHER, SPECIFY 96							
						Don't Know = 99			OTHER (SPECIFY) 96	KNOW 4									
		A.	B.										Vitamir	Nutritio	Nutritio	Other v	Refere	Other	
ID CODE	ID CODE	YEARS	MONTH	CODE	CODE	MM	YYYY	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE			CENTIMETERS	CODE	KILOGRAMS	CENTIMETERS
01																		.		.	.
02																		.		.	.
03																		.		.	.
04																		.		.	.
05																		.		.	.

18 Community Health Worker Service Usage and Satisfaction

SUBJECTS: WOMAN WITH MOST RECENT LIVE BIRTH
RESPONDENT: SELF

	(18.01)	(18.02)	(18.03)											(18.04)						
	In the last 3 months, have you met with a community member (Community Health Nurse or a member of the Village Support Group) either in your home or in the community?		Did this person provide any of the following services? RECORD YES OR NO CODES FOR EACH SERVICE BELOW											We would like to know a bit more about your interaction with the community member talking to you. Can you tell us how						
						YES 1														
						NO 2														
															VERY UNSATISFIED 1					
															UNSATISFIED 2					
			A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.		SATISFIED 3					
				Referral to institutional delivery			Referral to child vaccination								VERY SATISFIED 4					
	YES, AT HOME 1																			
	YES, IN THE COMMUNITY 2	Was the person																		
	YES, IN BOTH HOME AND 3													A.	B.	C.	D.	E.	F.	G.
	NO 4																Their time availability to attend to you?			Them being good role models?
	► End																			
		CHN A																		
		VSG B	Referral to pre		Referral to pos			Advice on HIV	Advice on fam	Child growth n	Advice on wa	Distribution of	Information, Ed							
		Other C																		
ID CODE						Referral to Vol								Their level of kn	Them being resp	There being eno		The information t	Them being resp	
	CODE	CODES	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01																				

-18.05

We would like to know a bit more about your opinions on pregnancy and child care. For each of the following, can you tell us whether you Strongly Agree, Agree Somewhat, Neither Agree nor Disagree, Disagree Somewhat, or Strongly Disagree?

AGREE STRONGLY	1
AGREE SOMEWHAT	2
NEITHER AGREE NOR DISAGREE	3
DISAGREE SOMEWHAT	4
DISAGREE STRONGLY	5

A.	B.	C.	D.	E.	F,	G.	H.	I.	J.	K.	L.	M.	N.	O.	P.	Q.	R.	S.	T.	U.	V.	W.	X.
It is ok for a	w ANC is good f	I would avoid	It is dangerous	Hard work du	Finding transp	A woman rec	I am more cor	It is safer to gi	It is cheaper to	There are risk	The risks are	If I deliver at h	A woman wh	My husband p	The costs req	Women who c	It is more com	The health fac	Health staff are	Health staff ma	In the last yea	Family planni	I spend less ti
CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE

18 ID CODE 01

-19.01 -19.02

WRITE DOWN YOUR NOTES (IF ANY) PER RESPONDENT

Could you give me the names of the household members that have a cellpho

RECORD ID CODE AND NAME

Could you please give me the cellphone numbe

	NAME	ID CODE	CELLPHONE NUMBER

5 Could you also give us the cellphone numbers of at least two other family members, relatives, or friends of your household? If we need to contact you again and your cellphone number does not work, we would

-19.03 -19.04 -19.05

	NAME	CELLPHONE NUMBER	RELATIONSHIP TO HEAD

9

THANK THE HOUSHOLD MEMBERS (YOUR MANUAL TELLS YOU HOW TO END)

Interview Results

Main Respondent(s) of Household Questions? Record up to 2

Code

RECORD GPS Coordinates

Record GPS Coorddinates

Lat

Long

RESULT OF THE INTERVIEW:

INTERVIEW DONE	
PARTIALLY COMPLETED	01
REGISTERED PERSON REFUSED INTERVIEW	02
HOUSEHOLD MEMBERS NOT PRESENT	03
HOUSEHOLD VACATED	04
HOUSE ADDRESS NOT FOUND	05
HH HEAD / OTHER REFUSED TO ALLOW INTERVIE	06
	07
Language not spoken, Interview not conducted	
OTHER, SPECIFY: _____	08
	96

TRANSLATOR USED?

NEVER	1
SOMETIMES	2
ALWAYS	3

LANGUAGE USED

...BY THE RESPONDE

ENGLISH	01
MANDINKA	02
WOLOF	03
FULA	04
JOLA	05
SERER	6
OTHER (SPECIFY:_____)	96

Health Results Based Financing Impact Evaluation
THE GAMBIA
2014
Health Facility Questionnaire
F1 - Health Facility Assessment Questionnaire

IDENTIFIER	
HEALTH REGION	HF NUMBER

LGA NAME	LGA CODE	DISTRICT NAME	DISTRICT CODE	VILLAGE NAME	VILLAGE CODE

GPS COORDINATES OF HEALTH FACILITY	
LATITUDE (NORTH)	.
LONGITUDE (EAST)	.

NAME OF HEALTH FACILITY	LOCATION OF HEALTH FACILITY

RESULT OF THE INTERVIEW		
	INTERVIEW DONE	01
	PARTIALLY COMPLETED	02
	PERSON IN CHARGE REFUSED INTERVIEW	03
	PERSON IN CHARGE IS OUT (STAFF THAT IS PRESENT IS NOT AUTHORIZED)	04
	FACILITY IS EMPTY (NO STAFF MEMBERS)	05
	HEALTH FACILITY NOT FOUND	06
	OTHER, SPECIFY:	96

INTERVIEWER	CODE

	DAY	MONTH	YEAR
VISIT 1			
VISIT 2			
VISIT 3			

Translator Used?

NEVER	01
SOMETIMES	02
ALWAYS	03

LANGUAGE

ENGLISH	01	JOLA	05
MANDINKA	02	SERER	06
WOLOF	03	SARAHULE	7
FULA	04	OTHER, SPECIFY:	96

INTERVIEW

SUPERVISOR	CODE

DAY	MONTH	YEAR

DATA ENTRY OPERATOR	CODE

DAY	MONTH	YEAR

(1)	General Information			
(A)	General		RECORD RESPONSE	
	RESPONDENT: HEAD OF THE HEALTH FACILITY OR HIS/HER DEPUTY IF ABSENT OR UNAVAILABLE.			
(1.01)	Are you in charge of this facility today?	YES 1		CODE
		NO 2		
(1.02)	Are you authorized to represent this facility?	YES 1		CODE
		NO 2		
(1.03)	What is your job title at this facility?	Doctor or medical officer 01		CODE
		Clinical officer 02		
		Hospital administrator/ Executive director 03		
		Nurse (SEN/SRN) 04		
		Midwife (SCM/SEM) 05		
		Pharmacist 06		
		Public Health Officer 07		
		Nursing assistant 08		
		Pharmacy technician/Dispenser 09		
		Lab technologist 10		
		Lab technician 11		
		12		
		Other, specify: 96		
(1.04)	Is this facility a district hospital, a health center?	District hospital 01		CODE
		Major Health Center 02		
		Minor Health Center 03		
(1.05)	In what year was the facility commissioned? INTERVIEWER: RECORD YEAR IN YYYY FORMAT (E.G. 1941).			
(1.06)	When was the last major investment in the infrastructure? INTERVIEWER: RECORD MONTH AND YEAR. INCLUDE MAJOR PAINTING, PLUMBING, EXTENSIONS TO THE BUILDING, ETC.	a. MONTH MM		
		b. YEAR YYYY IF INVESTMENT WAS OVER MORE THAN ONE YEAR, ONLY RECORD THE MOST RECENT YEAR OF INVESTMENT		
(1.07)	Does this facility provide care round-the-clock (i.e. 24 hours)?	YES, FORMALLY/ OFFICIALLY 01 ► **(1.10)**		CODE
		YES, INFORMALLY/ IN PRACTICE 02 ► **(1.10)**		
		NO 03		
(1.08)	At what time of the day does outpatient care start? INTERVIEWER: RECORD IN MILITARY TIME THROUGHOUT. E.G. IF IT STARTS AT 7AM, RECORD 0700. IF IT STARTS AT 7PM, RECORD 1900.	a. Weekdays		
		b. Saturday		
		c. Sunday		
		d. Holidays		

(1.09)	At what time does outpatient care end? INTERVIEWER: RECORD IN MILITARY TIME THROUGHOUT. E.G. IF IT ENDS AT 7AM, RECORD 0700. IF IT ENDS AT 7PM, RECORD 1900.	a. Weekdays		
		b. Saturday		
		c. Sunday		
		d. Holidays		
(1.10)	On what days does the facility offer antenatal care clinics, and for how many hours on those days?	a. Monday		
		b. Tuesday		
		c. Wednesday		
	INTERVIEWER: FOR EACH DAY, RECORD THE NUMBER OF HOURS THE SERVICE IF OFFERED. IF SERVICE IS NOT OFFERED THAT DAY, RECORD "00".	d. Thursday		
		e. Friday		
		f. Saturday		
		g. Sunday		
(1.11)	On what days does the facility offer under 5 clinics, and for how many hours on those days?	a. Monday		
		b. Tuesday		
		c. Wednesday		
	INTERVIEWER: FOR EACH DAY, RECORD THE NUMBER OF HOURS THE SERVICE IF OFFERED. IF SERVICE IS NOT OFFERED THAT DAY, RECORD "00".	d. Thursday		
		e. Friday		
		f. Saturday		
		g. Sunday		
(1.12)	What are the three main sources of funding or income (in the sense of incoming cash) for this facility?	a. MOHSW / REGIONAL HEALTH MANAGEMENT TEAM		CODE
		b. USER FEES		
		c. DRUG SALES		
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OF THE 3 SOURCES OF FUNDING CITED BY THE RESPONDENT (AND 3 ONLY), RECORD "1"	d. FAITH BASED ORGANIZATIONS		
		e. PRIVATE COMPANY		
		f. DONOR		
		g. INSURANCE PAYMENTS		
		h. OTHER, SPECIFY:		
(1.13)	Can you please tell me the amount received from each of the following sources in 2013 in Dalasi?	a. MOHSW / REGIONAL HEALTH MANAGEMENT TEAM		
		b. USER FEES		
		c. DRUG SALES		
		d. FAITH BASED ORGANIZATIONS		
	INTERVIEWER: FOR EACH SOURCE, NOT ONLY THE 3 MAIN ONES, RECORD AMOUNT RECEIVED IN DALASI. IF ZERO, RECORD "0000".	e. PRIVATE COMPANY		
		f. DONOR		
		g. INSURANCE PAYMENTS		
		h. OTHER, SPECIFY:		

(1.14)	Can you please tell me the total amount received in 2013 in DALASI INTERVIEWER: CONFIRM THE TOTAL AMOUNT STATED MATCHES THE SUM OF AMOUNTS STATED IN (1.13). IF NOT, PROBE ON (1.13) AND ADJUST UNTIL YOU OBTAIN MATCHING AMOUNTS. IF ZERO, RECORD '0000'.	DALASI				
(1.15)	INTERVIEWER: SOURCE OF INFORMATION CONSULTED TO OBTAIN BUDGET FIGURES	OFFICIAL ACCOUNTS	01			CODE
		FACILITY RECORDS	02			
		NO SOURCE: ORAL REPORT	03			
		OTHER, SPECIFY:	96			
(1.16)	Can you please tell me whether the facility paid out any performance bonuses or salary top ups to staff in 2013, in addition to salary/regular allowances?	YES	1			CODE
		NO	2	►	**(1.19)**	
(1.17)	How much did the facility pay for performance bonuses or salary top ups to staff in 2013 in Dalasi?	DALASI				
(1.18)	Who is eligible to receive pay for performance bonuses?	All Staff	01			CODE
		All Medical Staff	02			
		All Permanent Technical Staff (eg, contract staff not eligible)	03			
		Staff performing MCH services	04			
		Staff performing deiveries	05			
		Staff providing care for Under-5's	06			
		OTHER, SPECIFY:	96			
(1.19)	INTERVIEWER: SOURCE OF INFORMATION CONSULTED TO OBTAIN RBF EXPENSE FIGURES	RBF MONITORING SYSTEM	01			CODE
		OTHER FACILITY RECORD	02			
		NO SOURCE: ORAL REPORT	03			
		OTHER, SPECIFY:	96			
(1.20)	What is the primary source of electricity?	Electrical mains/grid/NAWEC	01			CODE
		Generator	02			
		Solar	03			
		No source of electricity	04	►	**(1.23)**	
		Other, specify: _____)	96			
(1.21)	Were there any electric power outages in the last 7 days?	YES	1			CODE
		NO	2	►	**(1.23)**	
(1.22)	How many hours was electric power missing in the last 7 days?	MAXIMUM 168 HOURS				
(1.23)	What is the primary source of water?	Piped into Facility	01			CODE
		Piped into Yard/Plot	02			
		Public tap/Standpipe	03			
		Protected well	04			
		Unprotected well	05			
		Unprotected spring	06			
		Rainwater	07			
		Surface water (lake, river or stream)	08	►	**(1.27)**	
		Bottled water	09	►	**(1.25)**	
		Other, specify:	10			

(1.24)	Is this primary source of water used only by the facility, or is it shared with other users?	**ONLY FACILITY** 01		CODE
		SHARED 02		
(1.25)	In the last 7 days, was there any time when there was no water available in the facility?	YES 1		CODE
		NO 2 ► **(1.27)**		
(1.26)	In the last 7 days, for how many hours was there no water available at the facility?	MAXIMUM 168 HOURS		
(1.27)	How long does it take to fetch water from the primary source for the health facility, one way on foot in minutes? IF WATER IN FACILITY, RECORD "0".			
(1.28)	Does the health facility have phone line, whether a landline or a mobile line?	YES, LANDLINE 01 ► **(1.31)**		CODE
		YES, MOBILE 02 ► **(1.31)**		
		YES, BOTH 03 ► **(1.31)**		
		NO 04		
(1.29)	INTERVIEWER: ONLY IF ANSWER TO (1.28) WAS NO: Are there any phone services available in the community apart from the staffs' personal phone that the health facility staff can use if needed?	YES 1		CODE
		NO 2 ► **(1.33)**		
(1.30)	How long does it take to reach those phone services?	MINUTES		
(1.31)	In the last 7 days, was there any time when the facility did not have any telephone service whether landline or mobile?	YES 1		CODE
		NO 2 ► **(1.33)**		
(1.32)	How many hours was telephone out in the last 7 days?	MAXIMUM 168 HOURS		
(1.33)	Do any of the health facility staff have a mobile phone line?	YES 1		CODE
		NO 2		
(1.34)	Does this facility refer patients to other facilities?	YES 1		CODE
		NO 2 ► **(1.37)**		
(1.35)	Where does the facility refer the following: INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD THE FOLLOWING CODES: Hospital……..……1 Major Health Center…… 2 Minor Health Center……..…… 3 Other, Specify……..... 4 Do not refer……5	a. Lab tests		CODE
		b. Radiology		
		c. In-patient		
		d. Specialized care		
		e. Surgery		
		f. High Risk Pregnancy		
		g. Uncomplicated delivery		
		h. Complicated delivery		
		i. Other, specify:		
(1.36)	How far is the main referral facility from this facility one way in kilometers?	KILOMETERS		
(1.37)	Does the facility have access to any kind of transportation (to pick up patients or take them to a referral facility)?	YES 1		CODE
		NO 2 ► **(1.41)**		

(1.38)	How many working [VEHICLES] does the facility have access to? INTERVIEWER: READ OPTIONS ALOUD. FOR EACH OPTION, RECORD NUMBER OF WORKING VEHICLES AVAILABLE. IF ZERO, RECORD 00. OWNED REFERS TO OWNED BY THE FACILITY OR THE INDIVIDUAL.	a. Ambulance owned by facility		
		b. Private vehicle rented full time		
		c. Private vehicle rented part time		
		d. Other vehicle owned by facility		
		e. Private vehicles on call		
		f. Contracted vehicle on call (eg. Riders for Health)		
		g. Motorbike owned by facility		
		h. Rented motorbike		
		i. Bicycle owned by facility		
		j. Other, specify:		
(1.39)	In the last 7 days, was there any time when there was no transportation available for patients?	YES 1		CODE
		NO 2 ► **(1.41)**		
(1.40)	How many days was transportation unavailable in the last 7 days?	MAXIMUM 7 DAYS		
(1.41)	Does the facility own a functioning computer?	YES 1		CODE
		NO 2		
(B)	**Universal Precautions**		RECORD RESPONSE	
	RESPONDENT: HEAD OF THE HEALTH FACILITY OR HIS/HER DEPUTY IF ABSENT OR UNAVAILABLE.			
(1.42)	Does the facility have a general outpatient consultation room?	YES, SEEN 01		CODE
		YES, NOT SEEN 02		
		NO 03 ► **(1.46)**		
(1.43)	Is this room equipped with a safety box or closed container present for disposal of used sharps?	YES 01		CODE
		YES, NOT SEEN 02		
		NO 03		
(1.44)	Does the room have posted procedures for decontamination procedure steps?	YES 01		CODE
		YES, NOT SEEN 02		
		NO 03		
(1.45)	Does the room have a basin with a water source and soap?	YES 01		CODE
		YES, NOT SEEN 02		
		NO 03		
(1.46)	What disinfectant(s) are being used in the facility? INTERVIEWER: READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF THE DISINFECTANT IS BEING USED, "2" IF NOT.	a. Chlorhexidine (gluconate)		CODE
		b. Dakin		
		c. Sodium Hypochlorite/Chlorine solution/JIK solution		
		d. Methylated spirit		
		e. Other, specify:		
(1.47)	In the last 30 days, was there any time when the facility ran out of disinfectant(s)?	YES 1		CODE
		NO 2 ► **(1.49)**		
(1.48)	In the last 30 days for how many days was the facility out of disinfectant(s)?	DAYS		NUMBER
(1.49)	Is there a functional incinerator for disposing of medical waste?	YES, SEEN 01		CODE
		YES, NOT SEEN 02		
		NO 03		

(1.50)	What procedure is used for decontaminating medical equipment after initial use? INTERVIEWER: DO NOT READ OPTIONS ALOUD. RECORD SINGLE RESPONSE. IF SEVERAL DECONTAMINATION TECHNIQUES, RECORD MOST USED ONE.	SOAKED IN DISINFECTANT SOLUTION AND THEN BRUSH SCRUBBED WITH SOAP+WATER	01		CODE
		BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAKED IN DISINFECTANT SOLUTION	02		
		BRUSH SCRUBBED WITH SOAP AND WATER ONLY	03		
		SOAKED IN DISINFECTANT SOLUTION ONLY	04		
		CLEANED WITH SOAP & WATER	05		
		EQUIPMENT NEVER DECONTAMINATED	06		
		EQUIPMENT NEVER REUSED	07 ► **(1.52)**		
		OTHER, SPECIFY:	96		
(1.51)	What procedure is used for sterilizing medical equipment before reuse? INTERVIEWER: DO NOT READ OPTIONS ALOUD. RECORD SINGLE RESPONSE. IF SEVERAL STERILIZATION TECHNIQUES, RECORD MOST USED ONE.	DRY-HEAT STERILIZATION	01		CODE
		AUTOCLAVING	02		
		BOILING	03		
		STEAM STERILIZATION	04		
		CHEMICAL METHOD	05		
		PROCESSED OUTSIDE FACILITY	06		
		NONE	07		
		OTHER, SPECIFY:	96		
(1.52)	Is the protocol for sterilizing equipment displayed?	DISPLAYED	01		CODE
		NOT DISPLAYED	02		
(1.53)	Is there a provision for the disposal of bio medical waste?	YES	1		CODE
		NO	2 ► **(2.01)**		
(1.54)	How is biomedical waste disposed of? INTERVIEWER: DO NOT READ OPTIONS ALOUD. RECORD SINGLE RESPONSE. IF SEVERAL WASTE DISPOSAL METHODS, RECORD MOST USED ONE.	BURIED IN PIT	01		CODE
		BURNED	02		
		THROWN OUTSIDE	03		
		OUTSOURCED	04		
		OTHER, SPECIFY:	05		

(2)	**Administration and Management**		RECORD RESPONSE	
	RESPONDENT: HEAD OF THE HEALTH FACILITY OR HIS/HER DEPUTY IF ABSENT OR UNAVAILABLE.			
(2.01)	Is there a Hospital/Health Center Executive Committee for this health facility?	YES 1		CODE
		NO 2 ► **(2.08)**		
(2.02)	How many members are on this Committee?			
(2.03)	Is there a representation of any of the following on this Committee? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF YES, "2" IF NO.	a. Health facility director/head		CODE
		b. Health facility staff		
		c. Catchment Area Committees (CACs)		
		d. Community Health Workers		

		e. MOHSW/ Regional Health Management Team		
		f. Non Governmental Organization staff		
		g. Other, specify:		
(2.04)	In the last 12 months, how many Hospital/Health Center Executive Committee meetings were held?			
(2.05)	Does the facility have written records of the Hospital/Health Center Executive Committee meetings (minutes, decisions, etc.)?	YES, SEEN 1		CODE
		YES, NOT SEEN 2		
		NO 3		
(2.06)	What initiatives were taken by the Hospital/Health Center Executive Committee and implemented in the last 12 months?	a. ADMINISTRATIVE SUPPORT TO FACILITY, E.G. APPROVING PAYMENTS		CODE
		b. PROVIDED NEW SUPPLIES OR EQUIPMENT		
		c. PROVIDED NEW INFRASTRUCTURE		
		d. PROVIDED REPAIRS TO FACILITY		
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED.	e. PROVIDED DRUGS		
		f. SENSITIZATION / MOBILIZED COMMUNITY TO USE THE HEALTH FACILITY		
		g. PROVIDED TRANSPORT TO STAFF FOR HOME VISITS		
		h. GAVE IN-KIND CONTRIBUTIONS		
		i. IMPROVED SECURITY AT THE FACILITY		
		j. IMPROVED WATER QUALITY		
		k. IMPROVED WATER SUPPLY (QUANTITY)		
		l. SUPPORTED TRAINING FOR COMMUNITY HEALTH WORKERS		
		m. SUPPORTED OUTREACH TEAMS		
		n. VERIFIED HEALTH FACILITY MATERNAL AND CHILD HEALTH-RELATED RESULTS		
		o. ENVIRONMENTAL SANITATION (E.G. DESTRUCTION OF MOSQUITO BREEDING SITES)		
		p. INDOOR RESIDUAL SPRAY		
		q. SCREENING OF DISEASES		
		r. REPORTED AND COLLECTED DATA FOR RESULTS-BASED FINANCING ACTIVITIES		
		s. DESIGNED THE RESULTS-BASED FINANCING SCHEME		
		t. PARTICIPATED IN TRAINING AND AWARENESS RAISING OF THE RESULTS-BASED FINANCING SCHEME		
		u. OTHER, SPECIFY:		
(2.07)	Has a facility budget been developed for the current financial year?	YES, SEEN 1		CODE
		YES, NOT SEEN 2		
	INTERVIEWER: ASK TO SEE THE BUDGET.	NO 3		
(2.08)	Has a facility workplan been developed for the current financial year?	YES, SEEN 1		CODE
		YES, NOT SEEN 2		
	INTERVIEWER: ASK TO SEE THE WORKPLAN.	NO 3 ► **(2.11)**		

(2.09)	Who was involved in setting this workplan? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF YES, "2" IF NO.	a. Health facility director		CODE
		b. Health facility staff		
		c. Non governmental Organization staff		
		d. MOHSW/ Regional Health Management Team		
		e. Village Support Groups		
		f. Hospital/Health center executive committee		
		g. Hospital management		
		h. VDC Chairperson		
		i Community Health Workers		
		j. Community members		
		k. Health Center Committee		
		l. Other, specify:		
(2.10)	Are priority health-related activities identified in this workplan for the current financial year?	YES 1		CODE
		NO 2 ► **(2.12)**		
(2.11)	Now I will read you a list of services. For each service, please tell me whether this service is a priority or not a priority for this fiscal year. INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF YES/PRIORITY, "2" IF NO/NOT A PRIORITY.	a. Antenatal care		CODE
		b. Institutional delivery		
		c. Postnatal care		
		d. Immunization		
		e. Curative consultations		
		f. Family planning/Reproductive health		
		g. Nutrition		
		h. Integrated management of childhood illness		
		i. Malaria		
		j. Tuberculosis		
		k. HIV/AIDS		
		l. Health promotion and monitoring		
		m. Other, specify:		
(2.12)	How many health facility staff meetings were held in the last 3 months?			
(2.13)	Do all facility staff have written job descriptions?	All have work descriptions 01		CODE
		Some have work descriptions 02		
		None have work descriptions 03		
(2.14)	In the last 3 months, how many visits were made to the health facility by the Regional Health Team (RHT) for supervision or technical support? INTERVIEWER: IF ZERO, RECORD "0".			
(2.15)	In the last 3 months, how many visits were made by a central monitoring team (MOHSW) for supervision or technical assistance? INTERVIEWER: IF ZERO, RECORD "0".	-		
(2.16)	In the last 3 months, how many visits were made by the Regional Health Management Team for supervision or technical support? INTERVIEWER: IF ZERO, RECORD "0".	-		

(2.17)	In the last 3 months, how many visits were made by the local government for supervision or technical support? INTERVIEWER: IF ZERO, RECORD "0".			
(2.18)	In the last 3 months, how many visits were made by a donor for supervision or technical support? INTERVIEWER: IF ZERO, RECORD "0".			
(2.19)	In the last 3 months, how many visits were made by this health facility to Community Health Workers for supervision or technical support? INTERVIEWER: IF ZERO, RECORD "0".			
NOTE, RECALL PERIOD IS NOW 12 MONTHS				
(2.20)	In the last 12 months, how many times was the performance of staff assessed internally, that is, by persons within the facility?	IF ZERO ► **(2.22)**		
(2.21)	Is the result of this internal staff performance assessment linked to staff salary or incentive payment?	YES 1 NO 2		CODE
(2.22)	In the last 12 months, how many times was the performance of staff assessed externally, that is, by persons from outside the facility, e.g. the District (or Regional) Health Management Team?	IF ZERO ► **(2.24)**		
(2.23)	Is the result of the staff performance assessment linked to staff salary or incentive payment?	YES 1 NO 2		CODE
(2.24)	In the last 12 months, how many times was the performance of the facility as a whole assessed externally, that is, by persons from outside the facility?	IF ZERO ► **(2.26)**		
(2.25)	Is the result of the external performance assessment of the facility linked to facility financing?	YES 1 NO 2		CODE
(2.26)	Does the facility obtain information on patient opinion through client surveys, a complaint/suggestion box or another method?	YES 1 NO 2 ► **(2.29)**		CODE
(2.27)	Is there a formal mechanism to inform the staff about patient opinion ?	YES 1 NO 2		CODE
(2.28)	In the last 12 months, have any changes occurred as a result of patient opinion?	YES 1 NO 2		CODE
(2.29)	In the last 12 months, has there been a formal review of HMIS data?	YES 1 NO 2		CODE
(2.30)	In the last 12 months, has HMIS data been used to plan for service delivery?	YES 1 NO 2		CODE
(2.31)	In the last 12 months, has HMIS data been analyzed within this facility?	YES 1 ► **-3.01** NO 2		CODE
(2.32)	What has the data been used for?	Planning service delivery 01 Passed along to district, regional health teams or others 02 OTHER, SPECIFY 96		CODE

(3) Human Resources

RESPONDENT: HEAD OF HUMAN RESOURCES, HEAD OF THE FACILITY OR BEST INFORMED STAFF MEMBER

FOR EACH TYPE OF POSITION LISTED BELOW, ASK QUESTIONS (3.01) TO (3.04). IF ZERO, RECORD 0.

POSITION TYPE		(3.01) How many authorized positions are there in the facility for [POSITION TYPE]s?	(3.02) How many authorized positions for [POSITION TYPE] are currently filled?	(3.03) In the last 12 months, how many [POSITION TYPE] have left the facility permanently?	(3.04) How many [POSITION TYPE] work regularly in this facility without being in an authorized position?	(3.05) In the last 12 months, how many [POSITION TYPE] have been hired?	(3.06) Is this category of worker difficult to keep staffed? YES OR NO QUESTION YES=1 NO=2
Doctor or medical officer	a.						
Clinical officer	b.						
Hospital administrator/ Executive director	c.						
Nurse	d.						
Midwife	e.						
Pharmacist	f.						
PHO	g.						
Pharmacy technician	h.						
Pharmacy Assistant	i						
Lab technologist	j.						
Lab technician	k.						
Classified Daily Employee (CDE)	l.						
State Enrolled Nurse	m.						
State Registered Nurse	n.						
State Certified Midwife	o.						
State Enrolled Midwife	p.						
Community Health Nurse	q.						
Community Health Midwife	r.						
Nurse Attendants	s.						
Ordelies	t.						

	Other, specify:	u.						

(B)	Community Health Workers		RECORD RESPONSE	
(3.07)	How many villages are in your catchment area?			
(3.08)	How many community health posts are in your catchment area?			
(3.09)	Does the health facility catchment area have active Community Health Workers (CHWs)?	YES 1		CODE
		NO 2 ► (3.13)		
(3.10)	How many Community Health Workers are currently active in this catchment area?	a. FEMALE		
		b. MALE		
(3.11)	Is there any Community Health Worker who has stopped working in the last 12 months?	YES 1		CODE
		NO 2		
3.12.1	Have you hired any new Community Health Workers in the last 12 months?	YES 1		CODE
		NO 2 ► 3.14		
3.12.2	How many Community Health Workers did you hire in the last 12 months?			
(3.12)	How many Community Health Workers have stopped working in the last 12 months?	a. FEMALE		
		b. MALE		
(3.13)	Does the health facility have a specially designated Community Health Nurse (CHN)?	YES 1		
		NO 2 ► (4.01)		
(3.14)	How many Community Health Nurse work from this facility?			
(3.15)	In the last 3 months, did the Community Health Nurse(s) do any of the following activities?	a. Participate in Community Health Workers meetings		CODE
		b. Supervise Community Health Workers activities (observe consultations, activities)		
	INTERVIEWER: READ ALL OPTIONS ALOUD.	c. Replace Community Health Workers kits		
		d. Provide Community Health Workers training		
	YES 1	e. Support Community Health Workers training		
	NO 2	f. Collect and compile Monthly Activity Reports		
		g. Meet with VHWs at health posts		
		h. Promote specific health programs		
		i. Organize vaccination campaign(s)		

		j. Other, specify:		

(4) Staff Roster

SUBJECT: ALL STAFF MEMBERS INVOLVED IN MCH SERVICES, WHETHER TEMPORARY OR PERMANENT, STARTING WITH THE HEAD OF THE FACILITY

RESPONDENT: **HEAD OF FACILITY OR BEST INFORMED STAFF MEMBER**

	(4.01)	(4.02)	(4.03)	(4.04)	(4.05)	(4.06)	(4.07)	(4.08)	(4.09)	(4.10)	(4.11)	(4.12)	(4.13)				
	INTERVIEWER: LIST FULL NAMES OF ALL STAFF WORKING IN THE FACILITY. FOR EACH STAFF, ASK ALL THE QUESTIONS OF THIS SECTION, THEN MOVE TO NEXT STAFF.	IS [NAME] MALE OR FEMALE?	Is NAME a respondent ?	How old is [NAME]?	What is [NAME]'s position in this facility? **Clinical** Doctor or medical officer 01 Clinical officer 02 Hospital administrator/ Executive director 03 Nurse 04 Nurse Anaesthetic 05 Midwife 06 State Enrolled Nurse 07 State Registered Nurse 08 State Certified Midwife 09 State Enrolled Midwife 10 Community Health Nurse 11 Community Health Midwife 12 Ordilies 13 Nursing assistant 14 Lab technologist 15 Lab technician 16 Pharmacy Technician 17 Pharmacy Assistant 18 Pharmacist 19 PHO 20 Other clinical 21 **Non Clinical** Calssified Daily 22	Was [NAME] appointed by the central Ministry or contracted locally? Appointed 1 Contracted Locally 2	How many days per week does NAME work at this facility?	How many hours per week does [NAME] usually work at this health facility?	How many hours per week does [NAME] usually spend providing medical care directly to patients? INTERVIEWER: IF NON-CLINICAL STAFF: RECORD 00	Does [NAME] also work in a private health practice?	Is [NAME] here today?	Can you please tell me why [NAME] is not here today? ► NEXT PROVIDER OFFICIALLY OFF DUTY 01 ON SICK LEAVE 02 ON TRAINING 03 ON MATERNITY LEAVE 04 OTHER AUTHORIZED ABSENCE 05 LATE 06 UNAUTHORIZED ABSENCE 07 OTHER (SPECIFY) 96	What services is [NAME] providing today? INTERVIEWER: RECORD UP TO 5 SERVICES. IF CHILD POSTNATAL CARE COMBINED WITH CHILD PREVENTIVE CARE (E.G. VACCINATIONS), RECORD "03" FOR POSTNATAL CARE TO CHILD. PRENATAL CARE 01 DELIVERIES 02 CHILD POSTNATAL CARE 03 MOTHER POSTNATAL CARE 04 CHILD PREVENTIVE CARE 05 CHILD CURATIVE CARE 06 ADULT CURATIVE CARE 07 VOLUNTARY COUNSELING AND TESTING 08 NON-CLINICAL (ADMIN, RECEPTION, ETC) 09				
I D C O D E	FULL NAME	MALE 01 FEMALE 02	**YES 01** NO 02	YEARS			MAX 7	MAX 168	MAX 168	YES 1 NO 2	YES 1 ► **(4.13)** NO 2		A.	B.	C.	D.	E.
		CODE	CODE		CODE	CODE				CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01																	
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(5) Laboratory

RESPONDENT: LAB TECHNICIAN OR BEST INFORMED STAFF MEMBER

ID CODE OF THE RESPONDENT FROM THE STAFF ROSTER				CODE
(5.01)	Does the facility provide laboratory services?	YES 1 NO 2 ► (6.01)		

(A) Lab Tests

		(5.02)	(5.03)	(5.04)
		For the following tests, please tell me if you are able to perform them today, if you were able to perform them 3 months ago but not today, or if you simply cannot do this test (today or 3 months ago). INTERVIEWER: RECORD ONE RESPONSE FOR EACH TEST.	How many of the […] tests were conducted in the last 3 months? INTERVIEWER: IF NONE, RECORD "0". RECORD ONE RESPONSE FOR EACH TEST.	INTERVIEWER: RECORD SOURCE OF THE INFORMATION. RECORD ONE RESPONSE FOR EACH TEST.
		Able to do this test today 01		RECORDS 01
		Able to do in past 3 months but not today 02		NO RECORDS AVAILABLE, ORAL REPORT 02
		Cannot do this test, today or in past 3 months 03		
		CODE		CODE
a.	White cell and red cell counts			
b.	Hemoglobin estimation (Hematocrit)			
c.	Blood type and cross match			
d.	Malaria smears (thick and thin)/ Rapid diagnostic test			
e.	Tuberculosis smears			
f.	Gram stains			
g.	HIV testing			
h.	Hepatitis B testing			
i.	Hepatitis C testing			
j.	Syphilis testing (RPR or VDRL Test)			
k.	Urine protein & glucose test (dipstick tests)			
l.	Pregnancy testing			
m.	Blood sugar			
n.	Stool tests for parasites			
o.	Stool tests for occult blood			
p .	Liver function testing			

(B)	Lab Equipment			RECORD RESPONSE	
(5.05)	Where is the lab equipment located?	Separate laboratory	01		CODE
		Room that is also used for other activities	02		
		Other, specify:	96		
(5.06)	INTERVIEWER: RECORD QUANTITY OF EACH EQUIPMENT FUNCTIONING. RECORD ONE RESPONSE FOR EACH EQUIPMENT. RECORD 98 IF NOT FUNCTIONING OR NOT AVAILABLE.	a. Microscope			
		b. Centrifuge			
		c. Hemoglobinometer			
		d. Refrigerator for storing reagents			
(5.07)	Is there a Tuberculosis Laboratory Register? INTERVIEWER: IF YES, ASK TO SEE IT.	YES, SEEN	1		CODE
		YES, NOT SEEN	2		
		NO	3		
(5.08)	How many laboratory technicians are trained in Acid-Fast Bacilli (AFB) microscopy? INTERVIEWER: CHECK THE NUMBER DOES NOT EXCEED THE TOTAL NUMBER OF LABORATORY TECHNICIANS				

(6) Services

RESPONDENT: HEAD OF THE FACILITY OR BEST INFORMED STAFF MEMBER

(A)	Vaccination Services			RECORD RESPONSE	
(6.01)	Does this facility provide immunization services?	YES	1		CODE
		NO	2 ► (6.14)		
(6.02)	Is there a separate room or area for immunizations?	YES	1		CODE
		NO	2		
(6.03)	Are immunizations regularly given to children at the facility or in outreach activities?	Facility only	01		CODE
		Outreach only	02		
		Facility and outreach	03		
(6.04)	Is there a vaccination outreach work plan for the current year?	YES	1		CODE
		NO	2		
(6.05)	In the last 30 days, on how many days did the facility staff do vaccination outreach in the community?				
(6.06)	Does this facility have a [STORAGE METHOD] for storing vaccines?	a. Ice Lined Refrigerator (ILR)			CODE
		b. Cold Box			CODE
	INTERVIEWER: READ EACH OPTION ALOUD. FOR EACH OPTION, RECORD "1" IF THE FACILITY HAS THE CITED STORAGE METHOD, "2" IF NOT.	c. Refrigerator			CODE
		d. Vaccine Carriers			CODE

(6.07)	Is a temperature log kept? INTERVIEWER: IF YES, ASK TO SEE IT.	YES, SEEN	1		CODE
		YES, NOT SEEN	2		
		NO	3 ► **(6.11)**		
(6.08)	In the past 7 days, on how many days was the temperature logged?				
(6.09)	In the past 7 days, how many times was the temperature logged in total?				
(6.10)	In the past 7 days, how many days had a measurement of over 8^0C or under 2^0C?				
(6.11)	Are immunization cards issued to every child starting his/her immunization schedule?	YES	1		CODE
		NO	2 ► **(6.14)**		
(6.12)	After a child starts its immunization schedule, where are the immunization cards kept?	Given to caregiver to bring for next visit	01 ► **(6.14)**		CODE
		Kept at facility	02		
		One copy given to caregiver and one kept at facility	03		
		Other, specify:	96 ► **(6.14)**		
(6.13)	Could you show me some cards that belong to specific patients?	SEEN	1		CODE
		NOT SEEN	2		
(B)	**Antenatal Care Services**			RECORD RESPONSE	
(6.14)	Are antenatal services provided at this facility?	YES	1		CODE
		NO	2 ► **(6.17)**		
(6.15)	Are pregnant women seen at specific times that are separate from times allocated to other patients consultations?	YES	1		CODE
		NO	2		
(6.16)	In the last 30 days, how many days has antenatal care been available to women?	MAXIMUM 30 DAYS			
(6.17)	In the last 6 months, how many times did the facility hold meetings with Traditional Birth Attendants?				
(6.18)	In the last 6 months, on how many days did the facility staff do outreach in the community for antenatal care?				
(6.19)	In the last 6 months, were iron folate routinely prescribed? INTERVIEWER: CHECK RECORDS. IF NO RECORDS, ASK IN-CHARGE. RECORD ANSWER BASED ON WHETHER RECORDS WERE SEEN OR NOT.	RECORDS SEEN: All the time	01		CODE
		RECORDS SEEN: Sometimes	02		
		RECORDS SEEN: Seldom or never	03		
		RECORDS NOT SEEN, ORAL REPORT: All the time	04		
		RECORDS NOT SEEN, ORAL REPORT: Sometimes	05		
		RECORDS NOT SEEN, ORAL REPORT: Seldom or never	06		
(6.20)	Do women who come to the facility for antenatal care get an antenatal or maternal health card?	YES	1		CODE
		NO	2 ► **(6.23)**		

(6.21)	Where are the maternal health cards kept once issued to a mother?	Given to mother to bring for next visit	01 ► **(6.23)**		CODE
		Kept at facility	02		
		One copy given to mother and one kept at facility	03		
		Other, specify:	96 ► **(6.23)**		
(6.22)	Could you show me some cards that belong to specific patients?	SEEN	1		CODE
		NOT SEEN	2		
(C)	**Delivery and Postpartum Services**			RECORD RESPONSE	
(6.23)	Are delivery services offered by the facility, either in the facility or in the community?	YES	1		CODE
		NO	2 ► **(6.26)**		
(6.24)	Do facility staff assist with deliveries only in the facility, only in the community, or in both the facility and the community?	Only in facility	01		CODE
		Only in community	02		
		Both in facility and community	03		
(6.25)	Does this health facility have the capacity to manage emergency caesarian sections?	Can be managed now	01		CODE
		Usually, but not now	02		
		Must be referred	03		
(6.26)	Are postpartum care services offered at the facility?	YES	1		CODE
		NO	2 ► **(6.43)**		
(6.27)	Are postpartum services offered at specific hours only, during general outpatient hours, or both at specific hours and during general outpatient hours?	Specific hours only	01		CODE
		Outpatient hours only	02		
		Both specific and outpatient hours	03		
(6.28)	In the last 30 days, on how many days was postpartum care available to women?	MAXIMUM 30 DAYS			
(6.29)	In the last 6 months, how many postpartum outreach clinics were held by this facility?				
(6.30)	In the last 6 months, how many women were referred to another facility due to complications during delivery?				
(6.31)	In the last 6 months, how many women/infants were referred to another facility due to neo-natal complications?				
(6.32)	In the last 12 months, how many maternal deaths were recorded at the facility? INTERVIEWER: CHECK RECORDS.				
(6.33)	In the last 12 months, how many maternal deaths were recorded in the community (excluding those at the facility)? INTERVIEWER: CHECK RECORDS.				
(6.34)	In the last 12 months, how many stillbirths were recorded at the facility? A still birth is a baby that is born dead.INTERVIEWER: CHECK RECORDS.				
(6.35)	In the last 12 months, how many stillbirths were recorded in the community (excluding those at the facility)? INTERVIEWER: CHECK RECORDS.				
(6.36)	In the last 12 months, how many neonatal deaths were recorded at the facility? A neonatal death is when a baby is born alive but dies within 28 days. INTERVIEWER: CHECK RECORDS.				

(6.37)	In the last 12 months, how many neonatal deaths were recorded in the community (excluding those at the facility)? INTERVIEWER: CHECK RECORDS.				
(D)	**Family Planning Services**			RECORD RESPONSE	
(6.38)	Are family planning services offered by the facility, either in the facility or in the community?	YES	1		CODE
		NO	2 ► **(6.43)**		
(6.39)	Do facility staff assist with family planning only in the facility, only in the community, or in both the facility and the community?	Only in facility	01		CODE
		Only in community	02		
		Both in facility and community	03		
(6.40)	Is there a separate room for family planning services?	YES	1		CODE
		NO	2 ► **(6.43)**		
(6.41)	In the last 30 days, on how many days were family planning services available to women?	MAXIMUM 30 DAYS			
(6.42)	In the last 6 months, how many family planning outreach clinics were held by this facility?				
(E)	**Tuberculosis Services**			RECORD RESPONSE	CODE
(6.43)	What tuberculosis services does this health facility provide?	Diagnosis services only	01		
		Treatment services only	02		
		Both diagnosis and treatment services	03		
		None	04 ► **(7.01)**		CODE
(6.44)	Is there a Tuberculosis Corner in the health facility? INTERVIEWER: TUBERCULOSIS CORNER IS A PLACE IN THE FACILITY WHERE PATIENTS WITH TUBERCULOSIS ARE SEEN AND PROVIDED DRUGS.	YES	1		
		NO	2 ► **(6.46)**		
(6.45)	Who manages the Tuberculosis Corner in this health facility?	Health Facility Staff	01		CODE
		Community health worker	02		
		Classified daily employee	03		
		Other, specify:	96		CODE
(6.46)	Is there a Tuberculosis Register? IF YES, ASK TO SEE IT.	YES, SEEN	01		
		YES, NOT SEEN	02		CODE
		NO	03		
(6.47)	Is there a Suspect Tuberculosis Cases Register? IF YES, ASK TO SEE IT.	YES, SEEN	01		
		YES, NOT SEEN	02		
		NO	03		CODE
(6.48)	Do patients who come for tuberculosis treatment get a tuberculosis treatment card?	YES	1		
		NO	2 ► **(6.51)**		
(6.49)	Where are the tuberculosis treatment cards kept once issued to a patient?	Given to patient to bring for next visit	01 ► **(6.51)**		
		Kept at facility	02		
		One copy given to patient and one kept at facility	03		
		Other, specify:	96 ► **(6.51)**		
(6.50)	Could you show me some cards that belong to specific patients?	SEEN	1		CODE
		NOT SEEN	2		

(F)	Malaria Services		RECORD RESPONSE
(6.51)	In the last 6 months, how many presumptive cases of suspected malaria were seen in the facility? INTERVIEWER: CHECK RECORDS.		
(6.52)	In the last 6 months, how many laboratory confirmed cases of Plasmodium Falciparum (PF) malaria were seen in the facility? INTERVIEWER: CHECK RECORDS.		
(6.53)	In the last 6 months,how many malaria cases (any kind of malaria) were treated with Artemisinin-based Combination Therapies (ACT)? INTERVIEWER: CHECK RECORDS.		
(6.54)	Does the facility provide treatment according to the National Malaria Treatment guidelines? INTERVIEWER: IF YES, ASK TO SEE GUIDELINES.	YES, SEEN 1	
		YES, NOT SEEN 2	
		NO 3	

(7)	General Health Management Information Systems (HMIS)		RECORD RESPONSE	
	RESPONDENT: HEAD OF THE FACILITY OR BEST INFORMED STAFF MEMBER			
(7.01)	Do you have an estimate of the size of the catchment population that this facility serves, that is, the target, or total population living in the area served by this facility?	YES 1		CODE
		NO 2 ► **0.00**		
(7.02)	How many people is the catchment [POPULATION CATEGORY]?	a. Total population		
		b. Total male population		
		c. Total female population		
		d. Total female 15-49 years population, i.e. women of childbearing age		
		e. Total <5 years population		
		f. Total <1 year population		
Now I would like to see the register that shows the total number of patients attended in this facility in the last completed calendar month.				
INTERVIEWER: FOR QUESTIONS (0) TO (7.14), RECORD FOR THE LAST COMPLETED CALENDAR MONTH. FOR QUESTIONS (7.03) TO (7.09), IF SOME CATEGORIES CAN'T BE IDENTIFIED FROM REGISTER, RECORD 'DON'T KNOW' FOR THESE CATEGORIES.			Outpatients	Inpatients
	Number of **TOTAL** patients - PROGRAM GENERATE THIS FROM male AND female BELOW			
(7.03)	Number of **TOTAL** male patients			
(7.04)	Number of **TOTAL** female patients			
(7.05)	Number of **TOTAL** pregnant women			
	Number of **TOTAL** under 5 patients - PROGRAM GENERATE THIS FROM male AND female BELOW			

(7.06)	Number of **TOTAL** male under 5 patients				
(7.07)	Number of **TOTAL** female under 5 patients				

	Number of **TOTAL** under 1 patients - PROGRAM GENERATE THIS FROM male AND female BELOW				
(7.08)	Number of **TOTAL** male under 1 patients				
(7.09)	Number of **TOTAL** female under 1 patients				
(7.10)	Monthly Integrated Activity Report	SEEN, FULLY COMPLETED	1		CODE
		SEEN, NOT COMPLETE	2		
		NOT SEEN	3		
(7.11)	Facility Status Report	SEEN, FULLY COMPLETED	1		CODE
		SEEN, NOT COMPLETE	2		
		NOT SEEN	3		
(7.12)	Notifiable Disease Report	SEEN, FULLY COMPLETED	1		CODE
		SEEN, NOT COMPLETE	2		
		NOT SEEN	3		
(7.13)	Vaccination/immunization Coverage Report	SEEN, FULLY COMPLETED	1		CODE
		SEEN, NOT COMPLETE	2		
		NOT SEEN	3		
(7.14)	Family Planning Register	SEEN, FULLY COMPLETED	1		CODE
		SEEN, NOT COMPLETE	2		
		NOT SEEN	3		

(8) Health services utilization based on Health Management Information Systems (HMIS)

RESPONDENT: HEAD OF THE FACILITY OR BEST INFORMED STAFF MEMBER.

I would like to ask you some questions about the health services available.

ASK QUESTIONS (8.01) TO (8.04) FOR EACH SERVICE BEFORE MOVING TO NEXT SERVICE.	(8.01) Does this facility provide [SERVICE] within the facility and/or as outreach? INTERVIEWER: RECORD FOR BOTH FACILITY AND OUTREACH. YES 1 1; NO 2 ► NEXT. SKIP TO NEXT IF BOTH NO	(8.02) How many days per week is this service offered? INTERVIEWER: IF BY APPOINTMENT ONLY, RECORD 8; IF NOT APPLICABLE, RECORD 97	(8.03) What is the total price in dalasi charged for this type of service? INTERVIEWER: IF NO CHARGE, RECORD "0".	(8.04) INTERVIEWER: FOR EACH SERVICE, RECORD THE MONTHLY TOTAL NUMBER OF INPATIENTS (IN) AND OUTPATIENTS (OUT) LISTED IN THE REGISTER, REGARDING THE LAST 3 MONTHS PRIOR TO THE

	SERVICES	In-facility CODE	Outreach CODE	DAYS/WEEK	DALASI	UNIT	MONTH 1 IN	MONTH 1 OUT	MONTH 2 IN	MONTH 2 OUT	MONTH 3 IN	MONTH 3 OUT
	Family planning/clinical											
a.	Contraceptive pill					per initial visit						
b.	Injection					per visit						
c.	Implant insertion					per insertion						
d.	Male condoms					per visit						
e.	Intrauterine Contraceptive Device (IUCD) insert					per insertion						
f.	Female sterilization					per procedure						
g.	Male sterilization					per procedure						
	Antenatal Care											
h.	Antenatal care					per visit						
	Facility based delivery											
i.	Spontaneous Vaginal Delivery					per delivery						
j.	Ceasarian section					per delivery						
k.	Assisted (forcepts, vaccuum)					per delivery						
l.	Postnatal care					per visit						

	Immunizations											
m.	Bacille Calmette Guerin (BCG)					per dose						
n.	Pentavalent Dose 1 (DPT, Hepatitis B, Hemophilus influenzae B)					per dose						
o.	Pentavalent Dose 2 (DPT, Hepatitis B, Hemophilus influenzae B)					per dose						
p.	Pentavalent Dose 3 (DPT, Hepatitis B, Hemophilus influenzae B)					per dose						
q.	Polio Dose 1					per dose						
r.	Polio Dose 2					per dose						
s.	Polio Dose 3					per dose						
t.	Measles Dose 1 (<1 year)					per dose						
u.	Rotavirus Vaccine					per dose						
v.	Pneumococcal Vaccine					per dose						
w.	Tetanus Toxoid to pregnant women					per dose						
x.	Vitamin A Supplement					per dose						
y.	Deworming					per dose						

ASK QUESTIONS (8.01) TO (8.04) FOR EACH SERVICE BEFORE MOVING TO NEXT SERVICE.	(8.01) Does this facility provide [SERVICE] within the facility and/or as outreach? INTERVIEWER: RECORD FOR BOTH FACILITY AND OUTREACH.	(8.02) How many days per week is this service offered?	(8.03) What is the total price in Dalasi charged for this type of service? INTERVIEWER: IF NO CHARGE, RECORD "0". NOTE: IF DIFFERENT FEES FOR NATIONAL AND FOREIGN PATIENTS, LIST FEES FOR NATIONALS	(8.04) INTERVIEWER: FOR EACH SERVICE, RECORD THE MONTHLY TOTAL NUMBER OF INPATIENTS (IN) AND OUTPATIENTS (OUT) LISTED IN THE REGISTER, REGARDING THE LAST 3 MONTHS PRIOR TO THE
	YES 1 NO 2 ► NEXT **SKIP TO NEXT IF BOTH NO**	INTERVIEWER: IF BY APPOINTMENT ONLY, RECORD 8; IF NOT APPLICABLE, RECORD 97		

		In-facility	Outreach				MONTH 1		MONTH 2		MONTH 3	
	SERVICES			DAYS/WEEK	DALASI	UNIT	IN	OUT	IN	OUT	IN	OUT
		CODE	CODE									
	Curative and preventive care											
aa.	Curative care for children <5 years					per visit						
ab.	Curative care for children >5 years and adults					per visit						
ac.	Child growth monitoring and nutritional advice					per visit						
ad.	Treatment for severe acute malnutrition											
ae	Malaria treatment with Artemisinin-based Combination Therapy (ACT)					per visit						
af	Tuberculosis diagnosis					per new case						
ag	Tuberculosis treatment					per Directly Observed Therapy						
	Sexually Transmitted Infections services SPLIT THIS INTO 2											
ah	Diagnosis, testing, and counseling for STIs					per visit						
ai	Treatment for STIs					per visit						
	Emergency Services											
aj	24-hour emergency care					per visit						
ak	Inpatient stay					per day						
al	Ambulance ride to another facility for referral					per transport						

(9) User Fees			RECORD RESPONSE	
RESPONDENT: HEAD OF THE FACILITY OR BEST INFORMED STAFF MEMBER.				
(9.01)	Do patients pay for consultation or doctor's fees? CHECK QUESTION (1.12).	YES 1		CODE
		NO 2		
(9.02)	Do patients pay laboratory fees for tests?	YES 1		CODE
		NO 2		
(9.03)	Do patients pay fees for x-ray tests?	YES 1		CODE
		NO 2		
		NOT APPLICABLE, NO X-RAYS 98		
(9.04)	Do patients pay fees for supplies (e.g. compresses, syringes, etc.)?	YES 1		CODE
		NO 2		
(9.05)	Do patients pay fees for medicines?	YES 1		CODE
		NO 2 ► (9.08)		
(9.06)	What percentage of the drug cost is charged to patients? INTERVIEWER: RECORD PERCENTAGE WITHOUT "%" SIGN, AS A NUMBER. E.G. IF 5% IS CHARGED, RECORD 05. IF 80% IS CHARGED, RECORD 80.	MAXIMUM 100		
(9.07)	Is this percentage charged based on the wholesale or retail price?	Wholesale 01		CODE
		Retail 02		
(9.08)	Program to: CHECK WHETHER THE FACILITY CHARGES ANY FEES FROM (9.01), (9.02), (9.03), (9.04) and (9.05).	HAS FEES 01		CODE
		NO FEES AT ALL 02 ► (9.14)		
(9.09)	Who was involved in setting the fees? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Health facility manager/ in charge		CODE
		b. Health facility staff		
		c. Non Governmental Organization staff		
		d. Ministry of Health and Social Welfare (Headquarters)		
		e. VDC Chairmanr		
		f. Community Health Workers		
		g. Community members		
		h. RHT Health Committee		
		i. Other, specify:		
(9.10)	In the last 3 months, where did the facility direct revenue from user fees? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Facility infrastructure		CODE
		b. Facility equipment and supplies		
		c. Drugs		
		d. Facility programs		
		e. Use in community		
		f. Sent back to managing agency		
		g. Staff salaries		
		h. Staff performance bonuses		
		i. Sent back to central government		
		j. Sent back to decentralized government		
		k. Other, specify:		

(9.11)	Are any of the following individuals exempt from paying fees? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Widows		CODE
		b. Children under 5		
		c. Elderly (above 65 years)		
		d. Orphans		
		e. Tuberculosis patients		
		f. HIV/AIDS patients		
		g. Extreme poor		
		h. Physically disabled persons		
		i. Military personnel		
		j. Pregnant women		
		k. Refugees		
		l. Other, specify:		
(9.12)	Who decides which patients are exempt from paying fees? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Health facility manager/ in charge		CODE
		b. Health facility staff		
		c. Non Governmental Organization staff		
		d. Ministry of Health (Headquarters)		
		e. Community Health Worker Cooperative president / leader		
		f. Community Health Workers		
		g. Community members		
		h. Health Committee		
		i. Other, specify:		
(9.13)	Do exempt patients receive a special exemption card that allows them to receive services for free?	YES 1		CODE
		NO 2		
(9.14)	Does this facility participate in a health insurance scheme?	YES 1		CODE
		NO 2 ► **(10.01)**		
(9.15)	What type of health insurance?	Public 01		CODE
		Private 02		
		Both 03		
(9.16)	What services are covered under the health insurance scheme? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Routine well baby visits (Including vaccination)		CODE
		b. Sick child care		
		c. Adult outpatient care		
		d. Antenatal care for pregnant women		
		e. Delivery care for pregnant women		
		f. Post partum care for women and newborns		
		g. Hospital admission and inpatient care		
		h. Other, specify:		

(9.17)	Where are the funds collected through the insurance scheme allocated by the facility? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Facility infrastructure		CODE
		b. Facility equipment and supplies		
		c. Drugs		
		d. Facility programs		
		e. Use in community		
		f. Sent back to managing agency		

		g. Staff salaries		
		h. Staff performance bonuses		
		i. Sent back to central government		
		j. Sent back to decentralized government		
		k. Other, specify:		

(10) Leadership

RESPONDENT: HEAD OF THE HEALTH FACILITY ONLY

ID CODE OF THE RESPONDENT FROM THE STAFF ROSTER

In this part of the questionnaire, I would like to know what you would do in certain situations regarding the facility. I will read you a series of scenarios. For each scenario, I will read 4 possible responses that you might have. Please select the response that most closely matches what you would do in this specific situation. You can only select one response for each scenario. There are no correct or incorrect answers - we just want to know how you would approach each situation.

INTERVIEWER: EACH RESPONSE IS CODED BETWEEN 1 AND 4. RECORD APPROPRIATE CODE ACCORDING TO RESPONDENT'S RESPONSE.

	SCENARIOS	1	2	3	4	RECORD RESPONSE (RANGE 1-4)	
(10.01)	**Scenario 1: The performance of your staff is improving.**	You stress their responsibilities and standards.	You take no particular additional action.	You give positive feedback and make staff feel involved in the achievements.	You emphasize the importance of deadlines and tasks.		CODE
(10.02)	**Scenario 2: Members of your staff have been unable to solve a problem over the past month, though they have been trying to address it.**	You call a meeting and together try to solve the problem.	You let your staff address this problem on their own.	You give them direction and instructions on how to solve the problem.	You encourage the group to solve the problem on their own, and you are available when needed to discuss.		CODE
(10.03)	**Scenario 3: You are considering a major change in how things are done in the facility.**	You collaborate with your staff to develop the needed changes.	You announce your vision for the changes and implement a clear plan.	You ask your staff to develop and implement their own plan for change.	You consult with your staff, but direct the changes yourself.		
(10.04)	**Scenario 4: The performance of your staff has been falling in recent months.**	You ask your staff to rethink their direction and goals and come up with a plan together.	You ask for suggestions from your staff on what to do, and you formulate a specific plan to meet objectives.	You redefine goals clearly and supervise whether these are being met closely.	You allow your staff freedom to set their own goals and do not push them.		CODE

(10.05)	**Scenario 5: Your staff are no longer working together as an effective team.**	You discuss ideas as a group and identify how to work better together.	You let your staff work out their issues on their own.	You act quickly and decisively to get the team back on track.	You make yourself available to discuss any issues and support your team to work out their own problems.		CODE

(11) FLEXIBILITY - NAME CHANGE FOR THIS SECTION

RESPONDENT: HEAD OF THE HEALTH FACILITY ONLY

ID CODE OF THE RESPONDENT FROM THE STAFF ROSTER

In this part of the questionnaire I would like to ask you some questions regarding how work is organized and decisions are made in this facility. All answers are confidential.

I am now going to read you a series of statements about decision-making and authority in this facility. Please telll me whether you feel these are true most of the time, more than half of the time, less than half of the time, rarely or never.

RESPONSE CODE		RECORD RESPONSE
MOST OF THE TIME	1	
MORE THAN HALF OF THE TIME	2	
LESS THAN HALF OF THE TIME	3	
ONLY RARELY	4	
NEVER	5	

INTERVIEWER CONFIRM:IS HEAD OF FACILITY AVAILABLE FOR THIS INTERVEIW?		
YES	►	(11.01)
NO	►	(12.01)

(11.01)	I am able to allocate my facility budget according to how it is needed. There is enough flexibility in my budget.		CODE
(11.02)	I am able to assign tasks and activities to staff as needed to achieve the outcomes I want in the facility. There is enough flexibility to use staff to address needs.		CODE
(11.03)	The Regional Health Management Team supports my decisions and actions for doing a better job in my facility.		CODE
(11.04)	I have choice over who I allocate for what tasks.		CODE
(11.05)	I have choice over what services are provided in the facility.		CODE
(11.06)	I have enough authority to obtain the resources I need (drugs, supplies, funding) to meet the needs of my facility.		CODE
(11.07)	The policies and procedures for doing things are clear to me.		CODE

(11.08)	The policies and procedures for doing things are useful tools for the challenges I face in providing services and reporting on activities.		CODE
(11.09)	The Regional Health Management Team provides adequate feedback to me about my job and the performance of my facility.		CODE

(12) Direct Observation

INTERVIEWER: THERE IS NO RESPONDENT FOR THIS SECTION OF THE QUESTIONNAIRE. AFTER SEEKING PERMISSION, YOU SHOULD WALK AROUND THE FACILITY AND OBSERVE THE ITEMS OUTLINED IN THIS SECTION.

(A)	General			RECORD RESPONSE	
(12.01)	Is there a reception/registration room in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2		
(12.02)	Is there a waiting room in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2		
(12.03)	Is there a separate waiting room for women in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2		
(12.04)	Is there a room with auditory and visual privacy for patient consultations in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2		
(12.05)	Is there a minor surgery theater in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2		
(12.06)	Are there observation beds in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2 ► **(12.17)**		
(12.07)	INTERVIEWER: RECORD HOW MANY OBSERVATION BEDS ARE PRESENT. IF ZERO, RECORD "0".				
(12.08)	Are there separate wards for men and women in this facility? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES	1		CODE
		NO	2 ► **(12.17)**		
(12.09)	Number of beds for Men. INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.				
(12.10)	Number of beds for Women. INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.				
(12.11)	Is there a separate ward for women waiting to deliver?	YES	1		CODE
		NO	2 ► **(12.13)**		
(12.12)	INTERVIEWER: RECORD HOW MANY OBSERVATION BEDS ARE PRESENT. IF ZERO, RECORD "0".				

(12.13)	Is there a separate ward for women and infancts after giving birth?	YES 1 NO 2 ► **(12.15)**		CODE
(12.14)	INTERVIEWER: RECORD HOW MANY OBSERVATION BEDS ARE PRESENT. IF ZERO, RECORD "0".			
(12.15)	Is there a separate ward for children?	YES 1 NO 2 ► **(12.17)**		CODE
(12.16)	INTERVIEWER: RECORD HOW MANY OBSERVATION BEDS ARE PRESENT. IF ZERO, RECORD "0".			
(12.17)	Is a functional toilet facility available for patients? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES 1 NO 2		CODE
(12.18)	Are there separate toilet facilities for male and female patients? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES 1 NO 2		CODE
(12.19)	Does the facility have accommodations for health workers who are on-call during non-routine hours, e.g. night shift? INTERVIEWER: CONFIRM WITH DIRECT OBSERVATION.	YES 1 NO 2		CODE
(B)	**Posting of User Fees**		RECORD RESPONSE	
(12.20)	Is there any posting in the facility that shows the user fees for outpatient visits? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, SEEN 1 YES, NOT SEEN 2 NO 3		CODE
(12.21)	Is there any posting in the facility that shows laboratory fees for outpatients? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, PUBLICLY POSTED 01 YES, NOT POSTED 02 NO, NOT POSTED 03		CODE
(12.22)	Is there any posting in the facility that shows X-ray fees for outpatients? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, PUBLICLY POSTED 01 YES, NOT POSTED 02 NO, NOT POSTED 03		CODE
(12.23)	Is there any posting in the facility that shows supplies fees for outpatients? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, PUBLICLY POSTED 01 YES, NOT POSTED 02 NO, NOT POSTED 03		CODE

(12.24)	Is there any posting in the facility that shows the user fees for inpatient visits? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, SEEN 1 YES, NOT SEEN 2 NO, NOT POSTED 3 NOT APPLICABLE, NO X-RAYS 98		CODE

(12.25)	Is there any posting in the facility that shows laboratory fees for inpatients? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, PUBLICLY POSTED 01 YES, NOT POSTED 02 NO, NOT POSTED 03		CODE
(12.26)	Is there any posting in the facility that shows X-ray fees for inpatients? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, PUBLICLY POSTED 01 YES, NOT POSTED 02 NO, NOT POSTED 03		CODE
(12.27)	Is there any posting in the facility that shows supplies fees for inpatients? INTERVIEWER: IF YES, LOOK FOR POSTING IN FACILITY.	YES, PUBLICLY POSTED 01 YES, NOT POSTED 02 NO, NOT POSTED 03		CODE
(12.28)	Is any of the following posted publicly for patients to see? INTERVIEWER: FOR EACH DOCUMENT, ASK TO SEE THE DOCUMENTS POSTED AND RECORD ACCORDING TO THE FOLLOWING CODES: YES AND SEEN……1 YES, NOT SEEN……..…2 NO……..3	a. Inpatient capacity (Number of beds) b. Service days/hours c. Staff rotation d. Management contact e. Complaints and suggestions handling policy f. Other, specify:		CODE CODE CODE CODE CODE CODE
(C)	**National Protocols**		RECORD RESPONSE	
INTERVIEWER: ASK THE FACILITY HEAD OR BEST INFORMED STAFF MEMBER TO SEE THE CLINICAL CARE PROTOCOLS. FOR EACH OF THE FOLLOWING, RECORD IF YOU HAVE SEEN OR NOT SEEN THE PROTOCOL / GUIDELINES / MATERIALS.				
(12.29)	Patient education materials (Information and Education Campaign materials)	SEEN 1 NOT SEEN 2		CODE
(12.30)	Integrated Management of Neonatal Childhood Illness (IMNCI) chart booklet or wall chart	SEEN 1 NOT SEEN 2		CODE
(12.31)	Graphs for growth monitoring	SEEN 1 NOT SEEN 2		CODE
(12.32)	National protocol for tuberculosis diagnosis and treatment	SEEN 1 NOT SEEN 2		CODE
(12.33)	Health Management Information System (HMIS) guidelines	SEEN 1 NOT SEEN 2		CODE
(12.34)	Health Management Information System (HMIS) Data	SEEN 1 NOT SEEN 2		CODE
(12.35)	National Protocol for malaria diagnosis and treatment (not part of IMCI)	SEEN 1 NOT SEEN 2		CODE
(12.36)	National protocol for child vaccination	SEEN 1 NOT SEEN 2		CODE
(12.37)	National protocol for reproductive health/family planning	SEEN 1 NOT SEEN 2		CODE
(12.38)	National protocol for reducing unsafe abortion morbidity/mortality	SEEN 1 NOT SEEN 2		CODE
(12.39)	Antenatal Care National Standards	SEEN 1 NOT SEEN 2		CODE
(12.40)	Labor and Delivery Care	SEEN 1 NOT SEEN 2		CODE

(12.41)	Newborn Care National Standards	SEEN	1		CODE
		NOT SEEN	2		
(12.42)	Post-Partum Care National Standards	SEEN	1		CODE
		NOT SEEN	2		
(12.43)	Procedures Manual for Infection Prevention and Control	SEEN	1		CODE
		NOT SEEN	2		
(12.44)	Management of Sexually Transmitted Infections (STI) guidelines	SEEN	1		CODE
		NOT SEEN	2		
(12.45)	National HIV testing and counseling guidelines	SEEN	1		CODE
		NOT SEEN	2		
(12.46)	Prevention of mother to child transmission of HIV (PMTCT) guidelines	SEEN	1		CODE
		NOT SEEN	2		
(12.47)	HIV treatment (Antiretroviral therapy, ART) guidelines	SEEN	1		CODE
		NOT SEEN	2		
(12.48)	National list for essential drugs	SEEN	1		CODE
		NOT SEEN	2		
(12.49)	National protocol for drug procurement	SEEN	1		CODE
		NOT SEEN	2		
(12.50)	Detecting and reporting adverse drug or vaccine reaction	SEEN	1		CODE
		NOT SEEN	2		

(13) Equipment (Direct Observation)

INTERVIEWER: THERE IS NO RESPONDENT FOR THIS SECTION OF THE QUESTIONNAIRE. AFTER SEEKING PERMISSION, YOU SHOULD WALK AROUND THE FACILITY AND OBSERVE THE ITEMS OUTLINED IN THIS SECTION.

	General equipment			RECORD RESPONSE	
(13.01)	Where is the outpatient equipment located?	Separate outpatient room	01		CODE
		Room that is also used for other activities	02		
		Other, specify:	96		
(13.02)	PLEASE RECORD THE QUANTITY FOR EACH TYPE OF EQUIPMENT. RECORD 98 IF NOT FUNCTIONING OR NOT AVAILABLE			QUANTITY AVAILABLE AND FUNCTIONING	
a.	Timer or clock with seconds hand				
b.	Children's (Salter) hanging scale				
c.	Height measure				
d.	Tape measure				
e.	Adult weighing scale				
f.	Blood pressure instrument				
g.	Thermometer				
h.	Stethoscope				
i.	Fetoscope				

j.	Otoscope			
k.	Suction/aspirating device			
l.	Vision chart			
m.	Oxygen tank			
n.	Bag Valve Mask (Ambu bag)			
o.	Incubator			
p.	Drip Stand			
q.	Flashlight			
r.	Stretcher			
s.	Wheel chair			
t.	Minor surgical instruments for procedures like incision & drainage and suturing (forceps, scalpel)			
u.	Oral Rehydration Therapy (ORT) corner with equipment *(I liter container, cups and spoons and rehydration guidelines)*			
v.	Urinary Catheter			
w.	Examination table/bed			
x.	Antiseptic liquid			
	Sterilizing Equipment		RECORD RESPONSE	
(13.03)	Where is the sterilization equipment located?	Separate sterilization room 01 Room that is also used for other activities 02 Other, specify: 96		CODE
(13.04)	PLEASE RECORD THE QUANTITY FOR EACH TYPE OF EQUIPMENT. RECORD 98 IF NOT FUNCTIONING OR NOT AVAILABLE.		QUANTITY AVAILABLE AND FUNCTIONING	
a.	Electric autoclave (pressure and wet heat)			
b.	Automatic timer (MAY BE ON EQUIPMENT)			
c.	Time, Steam and Temperature (TST) Indicator strips or other sterilization indicators			

	Vaccination Equipment		RECORD RESPONSE	
(13.05)	Where is the vaccination equipment located? (VACCINATION EQUIPMENT: VACCINE FRIDGE PARRAFIN OR ELECTRIC, COLD BOX, VACCINE CARRIERS)	Separate vaccination room 01 Room that is also used for other activities 02 Other, specify: 96		CODE
(13.06)	PLEASE RECORD THE QUANTITY FOR EACH TYPE OF EQUIPMENT. RECORD 98 IF NOT FUNCTIONING OR NOT AVAILABLE		QUANTITY AVAILABLE AND FUNCTIONING	
a.	Vaccine thermometer			
b.	Cold box / Vaccine carrier			
c.	Ice packs			
d.	Refrigerator			
	Antenatal Care Equipment		RECORD RESPONSE	
(13.07)	Where is the antenatal care equipment located? (ANTENATAL CARE EQUIPMENT: FETOSCOPE, BLOOD PRESSURE INSTRUMENT, TAPE MEASURE, ADULT WEIGHING SCALE)	Separate antenatal care room 01 Room that is also used for other activities 02		CODE

		Other, specify: 96	
(13.08)	PLEASE RECORD THE QUANTITY FOR EACH TYPE OF EQUIPMENT. RECORD 98 IF NOT FUNCTIONING OR NOT AVAILABLE		QUANTITY AVAILABLE AND FUNCTIONING
a.	Examination table/bed		
b.	Fetoscope		
c.	Blood pressure instrument		
d.	Tape measure		
e.	Adult weighing scale		

Delivery and Neonatal Equipment				RECORD RESPONSE	
(13.09)	Where is the delivery and neonatal equipment located?	Separate delivery/neonatal care room	01		CODE
		Room that is also used for other activities	02		
		Other, specify:	96		
(13.10)	PLEASE RECORD THE QUANTITY FOR EACH TYPE OF EQUIPMENT. RECORD 98 IF NOT FUNCTIONING OR NOT AVAILABLE			QUANTITY AVAILABLE AND FUNCTIONING	
a.	Delivery table/bed				
b.	Partograph				
c.	Delivery light				
d.	Aspirator/suction bulb				
e.	Resuscitation bag, newborn				
f.	Eye drops or ointment for newborn				
g.	Needles				
h.	Intravenous tubing/administration sets				
i.	Intravenous solutions, including normal saline and ringer lactate				
j.	Intravenous needles or cannulas				
k.	Scissors				
l.	Umbilical cord clamp or sterile tape or sterile tie				
m.	Suturing material				
n.	Clean towels				
o.	Clean razor blade				
p.	Sterile gloves				
q.	Sterile cotton or gauze (to clean baby's mouth and nose)				
r.	Hand soap or detergent				
s.	Hand scrubbing brush				
t.	Sterile tray				
u.	Plastic container with a plastic liner to dispose the placenta				
v.	Plastic container with a plastic liner for medical waste (gauze,				
w.	Stethoscope, adult				
x.	Stethoscope, Pinard fetal				
y.	Blood pressure instrument				
z.	Kidney basin				
aa.	Steel bowl				
ab.	Protective apron and plastic draw sheet				
ac.	Tourniquet				
ad.	Two sterile towels (one to receive the baby, one for active management)				
ae.	Baby scale (infant weighing scale)				
af.	Forceps, artery				
ag.	Forceps, dressing				
ah.	Forceps, uterine				
ai.	Needle holder				
aj.	Syringes and disposable needles				
ak.	16- or 18-gauge needles				
al.	Speculum, vaginal				
am.	Clamps (hemostats)				
an.	Suction pump, hand or foot operated				
ao.	Vacuum extractor				
ap.	Uterine dilator				
aq.	Curette, uterine				
ar.	Vaginal retractor				
as.	Bag Valve Mask (Ambu bag), Adult				
at.	Guedel airways-neonatal, child, and adult				
au.	Perineal pads				
av.	Kit for caesarean sections				
aw.	Delivery kit				
ax.	Newborn resuscitation kit				

(14) Drug and Vaccine Storage and Availability

RESPONDENT: PHARMACIST, HEAD OF THE FACILITY OR BEST INFORMED STAFF MEMBER.

Now I would like to ask you some questions about drug storage and availability in this facility.

(14.01)	Do the following entities have the authority to procure drugs and equipment for this facility, ….? INTERVIEWER: READ ALL OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF YES, "2" IF NO.	a. Health facility manager/ in charge		CODE
		b. Health facility staff		
		c. Non Governmental Organization staff		
		d. Local government		
		e. National government		
		f. Community Health Worker Cooperative president / leader		
		g. Community Health Workers		
		h. Community members		
		i. Health Committee		
		j. Other, specify:		
(14.02)	Could you bring me to the place in this facility that is used to store drugs?	YES, SEEN 1		CODE
		YES, NOT SEEN 2		
		NO, THERE IS NO SUCH PLACE 3		
(14.03)	INTERVIEWER: IS THIS A SEPARATE ROOM FROM THE REST OF THE FACILITY?	YES 1		CODE
		NO 2		
(14.04)	Does this pharmacy serve only to store and dispense drugs, or does it also serve for other purposes?	Only to store and dispense drugs 01		CODE
		Also serves for other purposes 02		
(14.05)	Can the doors and windows be locked to keep the pharmacy secured?	YES 1		CODE
		NO 2		
(14.06)	INTERVIEWER: DOES THE DRUG AREA LOOK CLEAN, PARTIALLY DIRTY, OR DIRTY?	CLEAN 01		CODE
		PARTIALLY DIRTY 02		
		DIRTY 03		
(14.07)	INTERVIEWER: DO THE CEILING, WALLS, FLOORS AND WINDOWS LOOK DRY AND FREE FROM TRACES OF WATER INFILTRATION?	DRY, NO TRACES OF WATER INFILTRATION 01		CODE
		DRY BUT THERE ARE TRACES OF WATER INFILTRATION 02		
		THERE IS WETNESS / WATER 03		
(14.08)	INTERVIEWER: ARE THE WINDOWS COVERED TO KEEP THE SUNLIGHT OUT?	WINDOWS COVERED 01		CODE
		WINDOWS NOT COVERED 02		
		NO WINDOWS 03		
(14.09)	INTERVIEWER: ARE THE DRUGS KEPT ON AN ELEVATED PLATFORM?	YES 1		CODE
		NO 2		
(14.10)	Does the pharmacy maintain stock cards or stock register? INTERVIEWER: IF YES, ASK TO SEE CARDS/REGISTER.	YES, SEEN 1		CODE
		YES, NOT SEEN 2		
		NO 3		

FOR EACH DRUG, ASK QUESTIONS (14.11) THROUGH (14.15)						
		(14.11)	**(14.12)**	**(14.13)**	**(14.14)**	**(14.15)**
		What is the strength of [DRUGS] that is stocked? INTERVIIEWER RECORD "98" IFNONE IF 98 ► NEXT DRUG	How much do you charge to patients for one dose of [DRUGS] in Dalasi?	What quantity of [DRUGS] are available at this time? IF NONE, RECORD 00 and ► (14.15)	In the past 30 days, has the item been out of stock at any time? YES 1 NO 2 ►NEXT DRUG	In the past 30 days, how many days has the item been out of stock?
General Drugs						
					CODE	
a.	Tetracycline ophthalmic ointment					
b.	Paracetamol (Panadol) tabs	_____ mg				
c.	Amoxicillin (tabs or capsule)	_____ mg				
d.	Amoxicillin (syrup)					
e.	Oral Rehydration Solution (ORS) packets	1 packet				
f.	Iron tabs (with or without folic acid)	1 tab				
g.	Folic acid tabs	1 tab				
h.	Other antibiotics besides Amoxicillin	_____ mg				
i.	Vitamin A	1 capsule				
j.	Mebendazole	_____ mg				
Family Planning						
k.	Male comdoms SEPERATED MALE AND FEMALE	1 unit				
l.	Female Condoms	1 unit				
m.	Oral contraceptive tablets	28 day supply				
n.	Depot Medroxyprogesterone Acetate (DMPA)	1 unit				
o.	Implant - Jadelle	1 unit				
p	Intrauterine Contraceptive Device (IUCD)	1 unit				
Malaria						
q.	Coartem	1 tab				
r	Fansidar	1 tab				
Tuberculosis						
s.	Rifampin	_____ mg				
t.	Streptomycin	_____ mg				
u.	Isoniazid (INH)	_____ mg				
v.	Pyrazinamide	_____ mg				
w.	Ethambutal	_____ mg				
x.	Combitabs (Multidrug tabs)	1 tab				
y.	Diagnostic kits	1 kit				

HIV/AIDS -DROP						
	1st Line Regimens Antiretroviral drugs - Combination 1	_____ mg				
	1st Line Regimens Antiretroviral drugs - Combination 2	_____ mg				
	1st Line Regimens Antiretroviral drugs - Combination 3	_____ mg				
	2nd Line Regimens Antiretroviral drugs - Combination 1	_____ mg				
	2nd Line Regimens Antiretroviral drugs - Combination 2	_____ mg				
	2nd Line Regimens Antiretroviral drugs - Combination 3	_____ mg				
Emergency Obstetric Care						
aa	Magnesium Sulfate					
ab	Diazepam Injection					
ac	Misoprostol					
ad	Oxytocin					
Vaccines						
ae	Bacille Calmette-Guérin (BCG)	1 dose				
af	Oral Polio Vaccine (OPV)	1 dose				
ag	Tetanus Toxoid (TT)	1 dose				
ah	Measles vaccine					
ai	Pentavalent (DPT, Hepatitis B, Hemophilus influenzae B)					
aj	Rotavirus Vaccine	1 dose				
ak	Pneumococcal Vaccine	1 dose				
Diagnostic kits						
al	Malaria rapid diagnostic kit	1 unit				
am	HIV test kit	1 unit				
an	Pregnancy testing kit	1 unit				
ao	Rapid plasma reagin (RPR) test for syphilis	1 unit				
ap	Urine protein & glucose testing kit (dipstick test)	1 unit				

(14.16)	What do you do when this facility runs out of key drugs like Coartem, Amoxycillin etc.?	a.	INFORM FACILITY INCHARGE		CODE
		b.	CALL THE DISTRICT DRUG STORE/PHARMACY		
		c.	CALL DHMT		
		d.	BUY MEDICINES LOCALLY IN THE PRIVATE MARKET		
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF YES, "2" IF NO.	e.	SEND PATIENTS TO BUY THE MEDICINE IN THE PRIVATE MARKET		
		f.	GO TO THE CAPITAL TO BUY MEDICINES		
		g.	OTHER, SPECIFY:		

(15)	Catchment area				RECORD RESPONSE
RESPONDENT: HEAD OF THE HEALTH FACILITY OR HIS/HER DEPUTY IF ABSENT OR UNAVAILABLE.					
INTERVIEWER: CHECK THE REGISTER FROM THE FACILITY.					
(15.01)	Please provide a list of the villages that fall in the catchment area of this facility.		Name	Distance in KMs	
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		8			
		9			
		10			
		11			
		12			
		13			
		14			
		15			
		16			
		17			
		18			
		19			
		20			

THANK YOU FOR YOUR TIME

Health Results Based Financing Impact Evaluation
THE GAMBIA
2014
Health Facility Questionnaire
F2 - Health Worker Individual Questionnaire

IDENTIFIER		
HEALTH DISTRICT	HF NUMBER	HW NUMBER

LGA NAME	LGA CODE	DISTRICT NAME	DISTRICT CODE	VILLAGE NAME	VILLAGE CODE

GPS COORDINATES OF HEALTH FACILITY	
LATITUDE (NORTH)	.
LONGITUDE (EAST)	.

RESULT OF THE INTERVIEW	
INTERVIEW DONE	01
PARTIALLY COMPLETED	02
PERSON IN CHARGE REFUSED INTERVIEW	03
PERSON IN CHARGE IS OUT (STAFF THAT IS PRESENT IS NOT AUTHORIZED)	04
FACILITY IS EMPTY (NO STAFF MEMBERS)	05
HEALTH FACILITY NOT FOUND	06
OTHER, SPECIFY:	96

NAME OF HEALTH FACILITY	LOCATION OF HEALTH FACILITY
TYPE OF HEALTH FACILITY	1 Public Health Center 2 Pubic Hospital

INTERVIEWER	CODE

	DAY	MONTH	YEAR
VISIT 1			
VISIT 2			
VISIT 3			

Translator Used?		
NEVER	01	
SOMETIMES	02	
ALWAYS	03	

LANGUAGE				INTERVIEW
ENGLISH	01	FULA	04	
MADINKA	02	JOLA	05	
WOLOF	03	SERER	06	
		OTHER, SPECIFY:	96	

SUPERVISOR	CODE	DAY	MONTH	YEAR

(1)	General Information		RECORD RESPONSE	
(1.01)	May I know your name?			
(1.02)	ENTER HEALTH WORKER ID CODE FROM STAFF ROSTER IN FORM F1			
(1.03)	GENDER	MALE 01 FEMALE 02		
(1.04)	How old are you?	YEARS		
(1.05)	What is your marital status?	Single 01 ► (1.07) Married/Living together 02 Widowed 03 ► (1.07) Divorced/separated 04 ► (1.07)		CODE
(1.06)	Do you live with your spouse?	YES 1 NO 2		CODE
(1.07)	Do you have children?	YES 1 NO 2 ► (1.09)		CODE
(1.08)	How many school-going children live with you?			
(1.09)	Were you born in this district?	YES 1 NO 2		CODE
(1.10)	What type of employment contract do you have with your employer?	Permanent and pensionable 01 Short term contract (less than 6 months) 02 Fixed term contract (6 months and more) 03 Casual (no contract) 04 Volunteer 05 Other, specify: 96		CODE
(1.11)	What is the highest level of education you ever completed?	KINDERGARTEN 01 PRIMARY/ LOWER BASIC 02 UPPER BASIC 03 HIGH SCHOOL 04 SENIOR SECONDARY 05 NON-TERTIARY/VOCATIONARY 06 DIPLOMA/TERTIARY 07 UNDERGRADUATE 08 MASTERS 09 PHD 10 NONE 11 ► 1.13 OTHER, SPECIFY 96 DON'T KNOW -99		CODE
(1.12)	How many year(s) and month(s) have you been working after formal completion of your highest training? RECORD YEARS AND MONTHS. IF LESS THAN A YEAR, RECORD "0" IN YEARS AND RECORD NUMBER OF MONTHS.	a. YEARS b. MONTHS (RANGE IS 0-11)		
(1.13)	How many year(s) and month(s) have you worked as a health worker at this facility? RECORD YEARS AND MONTHS. IF LESS THAN A YEAR, RECORD "0" IN YEARS AND RECORD NUMBER OF MONTHS.	a. YEARS b. MONTHS (RANGE IS 0-11)		

(1.14)	What is your position as a health worker as designated by the Ministry of Health?	Doctor or medical officer	01		CODE
		Clinical officer	02		
		Hospital administrator/executive director	03		
		Nurse (SEN/SRN))	04		
		Midwife (SCM/SEM))	05		
		Pharmacist	06		
		PHO	07		
		Nursing assistant	08		
		Pharmacy technician/Dispenser	09		
		Lab technologist	10		
		Lab technician	11		
		Classified Daily Employee (CDE)	12		
		Other, specify:	96		
(1.15)	Are you the OIC/CEO of this facility?	YES	1		
		NO	2		
Now I am going to ask you about the services that you have provided in the past 3 months.					
(1.16)	In the past 3 months, have you done the following activities? INTERVIEWER: READ EACH OPTION ALOUD. FOR EACH OPTION, RECORD "1" IF THE HEALTH WORKER PROVIDED THE SERVICE AT LEAST ONCE IN THE PAST 3 MONTHS, "2" IF NOT. IF THE HEALTH WORKER HAS WORKED AT THE CURRENT HEALTH FACILITY FOR LESS THAN 3 MONTHS, ASK ABOUT THE SERVICES PROVIDED WITHIN THE DURATION AT THIS HEALTH FACILITY.	**a**	Supervise Community Health Worker (CHW)		CODE
		b	Supervise Traditional Birth Attendant (TBA)		
		c	Curative consultation for children		
		d	Curative consultation for adults		
		e	Family planning consultation		
		f	Antenatal care consultation (ANC)		
		g	Postnatal care consultation (PNC)		
		h	Deliveries in facility		
		i	Deliveries at home		
		j	Tuberculosis diagnosis/treatment		
		k	Vaccinations		
		l	Growth monitoring /Nutrition counselling		
		m	Malaria treatment		
	YES 1	**n**	Community Health Worker training		
	NO 2	**o**	Treatment of disability and chronic diseases		
		p	HIV/AIDS testing and counseling		
		r	HIV/AIDS treatment (Anti retroviral therapy, ART)		
		s	Male circumcision		
		t	Other, specify:		

(2)	Staff Training					
(2.01)	For each subject I mention, I would like to know the most recent time you received in-service training. Please do not include your initial medical or nursing education. INTERVIEWER: THIS TRAINING INCLUDES ONLY THE TRAINING RECEIVED AFTER UNDERGOING PROFESSIONAL EDUCATION. FOR EXAMPLE, TRAINING RECEIVED AS PART OF THE BACHELOR OF MEDICINE AND SURGERY (MBBS) OR MEDICAL DOCTOR (MD) PROGRAM SHOULD NOT BE MENTIONED HERE. READ EACH OPTION ALOUD. FOR EACH OPTION, RECORD "1"IF THE TRAINING OCCURED LESS THAN A YEAR AGO, "2" IF IT OCCURED MORE THAN A YEAR AGO, AND "3" IF THE WORKER WAS NEVER TRAINED IN THIS SPECIALTY AFTER THEIR EDUCATION. RECORD "1" OR "2" FOR UP TO 3 "OTHER" TRAINING AND SPECIFY WHICH ONES.					
		TRAINING LESS THAN 1 YEAR AGO	TRAINING MORE THAN 1 YEAR AGO	NEVER TRAINED	RECORD RESPONSE	
a	Integrated Management of Childhood Illness (IMCI)	1	2	3		CODE
b	Malaria	1	2	3		CODE
c	Tuberculosis diagnosis and treatment	1	2	3		CODE
d	Family planning	1	2	3		CODE
e	Antenatal care	1	2	3		CODE
f	Labor and delivery	1	2	3		CODE
g	Emergency Obstetric and Newborn Care	1	2	3		CODE
h	Newborn Care	1	2	3		CODE
i	Postnatal / Postpartum care	1	2	3		CODE
j	Breastfeeding	1	2	3		CODE
k	Mental Health	1	2	3		CODE
l	Nutrition and growth monitoring	1	2	3		CODE
m	HIV/AIDS testing and counseling	1	2	3		CODE
n	HIV/AIDS treatment and follow-up (Antiretroviral therapy, ART)	1	2	3		CODE
o	Prevention of mother to child transmission of HIV/AIDS (PMTCT)	1	2	3		CODE
p	Management of Sexually Transmitted Infections (STI)	1	2	3		CODE
q	Immunization / Vaccination	1	2	3		CODE
r	Adult curative care	1	2	3		CODE
s	Management and administration	1	2	3		CODE
t	Community Health / Outreach	1	2	3		CODE
u	Other, specify:	1	2	3		CODE

				RECORD RESPONSE	
(2.02)	Are there other training needs you personally feel you need for your present job?	YES	1		CODE
		NO	2 ► **(3.01)**		

(2.03)	What kind of additional training do you feel you need for your present job? INTERVIEWER: DO NOT READ EACH OPTION ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED.			RECORD RESPONSE	
		YES	NO		
a	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)	1	2		CODE
b	MALARIA	1	2		CODE
c	TUBERCULOSIS DIAGNOSIS AND TREATMENT	1	2		CODE
d	FAMILY PLANNING	1	2		CODE
e	ANTENATAL CARE	1	2		CODE
f	LABOR AND DELIVERY	1	2		CODE
g	EMERGENCY OBSTETRIC AND NEWBORN CARE	1	2		CODE
h	NEWBORN CARE	1	2		CODE
i	POSTNATAL / POSTPARTUM CARE	1	2		CODE
j	BREASTFEEDING	1	2		CODE
k	MENTAL HEALTH	1	2		CODE
l	NUTRITION AND GROWTH MONITORING	1	2		CODE
m	HIV/AIDS TESTING AND COUNSELING	1	2		CODE
n	HIV/AIDS TREATMENT AND FOLLOW-UP (ANTI RETROVIRAL THERAPY, ART)	1	2		CODE
o	PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV/AIDS (PMTCT)	1	2		CODE
p	MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI)	1	2		CODE
q	IMMUNIZATION / VACCINATION	1	2		CODE
r	ADULT CURATIVE CARE	1	2		CODE
s	MANAGEMENT AND ADMINISTRATION	1	2		CODE
t	COMMUNITY HEALTH / OUTREACH	1	2		CODE
u	OTHER, SPECIFY:	1	2		CODE

(3)	Hours and Duties		RECORD RESPONSE	
(3.01)	How many hours per week are you contracted to work at this facility? RECORD AVERAGE NUMBER OF HOURS PER WEEK.	HOURS PER WEEK		
(3.02)	We realize that health workers cannot always fulfill their duties and stick to their assigned schedules. In the last 14 days, how many days were you absent from work?	NUMBER OF DAYS IN THE LAST 14 DAYS		
(3.03)	Was this absence authorized?	YES 1 NO 2		CODE
(3.04)	During this last absence, what type of activity were you doing? INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT. MENTIONED.....1 NOT MENTIONED.....2	a. PUBLIC HOLIDAY b. I WAS SICK c. I WAS CARING FOR SICK RELATIVES d. I WAS ATTENDING ANOTHER JOB (PAID) e. I WAS ATTENDING ANOTHER JOB (UNPAID) f. I WAS CARING FOR CHILDREN g. I WAS DOING HOUSEHOLD CHORES h. I WAS TIRED FROM THE PREVIOUS DAY i. WEDDING/ FUNERAL/ CELEBRATION ETC j. OTHER, SPECIFY: k. Don't Know		CODE
(3.05)	When you are away from the facility without authorized leave, do any of the following occur? INTERVIEWER: READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a. Facility head / manager contacts you b. Your salary / allowance / bonus is reduced c. Manager discusses this with you d. Absences are reflected in your performance assessment e. Your coworkers speak to you about it f. Other, specify:		CODE
(3.06)	In comparing to 12 months ago, would you say the number of hours you work in a week have increased, decreased or remained the same?	Increased 01 Decreased 02 Remained the same 03 NA - Worked here less than 1 ye -88		CODE
(3.07)	How many individual patients did you see on your last full working day? INTERVIEWER: PLEASE DO NOT COUNT GROUP SENSITIZATION OF MOTHERS/PATIENTS	NUMBER OF PATIENTS		

(4)	Salary			RECORD RESPONSE	
(4.01)	What was your monthly net salary one year ago?(Enter NA (-88) if worked here less than 1 year)	DALASI			
(4.02)	What is your current monthly net salary ? (Enter NA (-88) if worked here less than 1 year)	DALASI			
(4.03)	How much was paid as an incentive for achieving targets In your last pay check?	DALASI			
(4.04)	Over the past 2 years, has your salary increased because of the following reasons? INTERVIEWER: READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	a.	Routine or general increase		CODE
		b.	Individual performance		CODE
		c.	Promotion		CODE
		d.	Other, specify:		CODE
(4.05)	In the last 12 months, did you receive all your due salary according to the payment schedule?	YES	1 ► **(4.12)**		CODE
		NO	2		
(4.06)	What day of the month are you supposed to receive your salary?	INTERVIEWER: ENTER A NUMBER, EG 08 OR 21. MAX 31.			
(4.07)	Last month, how many days was your salary delayed?	INTERVIEWER: ENTER A NUMBER, EG 08 OR 21. MAX 31.			
		STILL NOT RECEIVED	77 ► (4.09)		
		RECEIVED ON TIME	00		
(4.08)	Have you received your salary in totality?	YES	1		CODE
		NO	2		
(4.09)	In the last 12 months, those times that you did not receive your full salary on time, what reason was usually given for you not being paid? INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS REASON OR NOT. MENTIONED……..1 NOT MENTIONED……2	a.	LACK OF FUNDS		CODE
		b.	SYSTEMIC DELAY / ADMINISTRATIVE PROBLEM		
		c.	SALARY WITHHELD TO SERVICE OUTSTANDING DEBTS		
		d.	NON-PAYMENT WAS NOT EXPLAINED		
		e.	RELATED TO PERFORMANCE / ABSENCE		
		f.	OTHER, SPECIFY:		
(4.10)	For the last 12 months, have you received all the salary due to you, even if it was not according to the payment schedule?	YES	1 ► **(4.12)**		CODE
		NO	2		
(4.11)	How many months' salary are you currently owed regarding the past 12 months?	NUMBER OF MONTHS (RANGE IS 1-12)			

(4.12)	If you were to leave your current job,where would you go?	NGO WITHIN THE HEALTH SECTOR 01		CODE
		OUTSIDE THE COUNTRY 02		
		PRIVATE HEALTH FACILITY 03		
		FAITH BASED ORGANIZATION 04		
		NON HEALTH ORGANIZATION 05		
		GOVERNMENT FACILITY 06		
		STAY AT HOME 07		
		OTHER, SPECIFY: 96		
		DON'T KNOW - 99		
(4.13)	What would be the lowest monthly net salary you would accept to work in your preferred job?	DALASI		

(5)	**Other Compensation**			RECORD RESPONSE	
(5.01)	Do you currently receive any of the following benefits as part of your primary job?	a.	Free or subsidized housing		CODE
		b.	Health care benefits and/or medicines		CODE
		c.	Free food/meals at work		CODE
	INTERVIEWER: READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	d.	Uniform for your work		CODE
		e.	Shoes for your work		CODE
		f.	Transport between work and home		CODE
		g.	Free schooling or school subsidies for children		CODE
(5.02)	Do you currently receive a housing allowance?	YES	1		CODE
		NO	2 ► **(5.05)**		
(5.03)	How often is the housing allowance paid?	EACH DAY	01		CODE
		EACH WEEK	02		
		EACH MONTH	03		
		EVERY FOUR MONTHS	04		
		EVERY SIX MONTHS	05		
		EACH YEAR	06		
		IRREGULAR/AD HOC	07		
		OTHER, SPECIFY:	96		
(5.04)	How much was your last housing allowance in DALASI?	DALASI			
(5.05)	Do you currently receive a "Rural Hardship" allowance (for working in rural areas)?	YES	1		CODE
		NO	2 ► **(5.08)**		

(5.06)	How often is the Rural Hardship allowance paid?	EACH DAY	01		CODE
		EACH WEEK	02		
		EACH MONTH	03		
		EVERY FOUR MONTHS	04		
		EVERY SIX MONTHS	05		
		EACH YEAR	06		
		IRREGULAR/AD HOC	07		
		OTHER, SPECIFY:	96		
(5.07)	How much was your last Rural Hardship allowance in DALASI?	DALASI			
(5.08)	Do you normally receive a travel allowance for outreach activities?	YES	1		CODE
		NO	2 ► **(5.10)**		
(5.09)	In the last 3 months, how much did you receive as travel allowance for outreach activities in DALASI?	DALASI			
(5.10)	Are you eligible for a Government Pension for your work here?	YES	1		CODE
		NO	2		
(5.11)	Do you receive public health insurance for your work here?	YES	1		CODE
		NO	2 ► **(6.01)**		
(5.12)	Does your family also receive Health Insurance?	YES	1		CODE
		NO	2		

(6) Supervision (internal and external)

INTERNAL SUPERVISION

Now I would like to talk with you about supervision of your work by people who also work in this facility.				RECORD RESPONSE	
(6.01)	Within the facility, is there anyone who is responsible for supervising your work? This could include providing feedback on your performance, giving you advice, discussing your career with you?	YES	1		CODE
		NO	2 ► **(6.09)**		
(6.02)	Within the facility, who is responsible for supervising your work?	Health facility head	01		CODE
		Head of service within the facility	02		
		Other health worker in the facility	03		
		Other, specify:	96		

(6.03)	What is the position of your supervisor as designated by the Ministry of Health?	Doctor or medical officer	01		CODE
		Clinical officer	02		
		Hospital administrator/executive director	03		

		Nurse (SEN/SRN))	04		
		Nurse Anaesthetic	05		
		Midwife (SCM/SEM))	06		
		Pharmacist	07		
		Environmental health technologist	08		
		Nursing assistant	09		
		Pharmacy technician	10		
		Pharmacy Assistant	11		
		Lab technologist	12		
		Lab technician	13		
		Classified Daily Employee (CDE)	14		
		PHO	15		
		Other, specify:	96		
(6.04)	When was the last time you met with this internal supervisor to discuss your performance or your career development?	Within the past month or 30 days	01		CODE
		Within the past 2 to 3 months (31-90 days)	02		
		Within the past 4-6 months	03		
		More than 6 months ago	04		
		Never	05		
(6.05)	Within the last 12 months, have you discussed any job difficulties with your internal supervisor?	YES	1		CODE
		NO	2 ► **(6.07)**		
(6.06)	After these discussions, did you notice a lot of improvements, some improvements or no improvements?	A LOT OF IMPROVEMENTS	01		CODE
		SOME IMPROVEMENTS	02		
		NO IMPROVEMENTS	03		
(6.07)	When was the last time that your supervisor shared HMIS data on your unit's work with you?	Within the past month or 30 days	01		CODE
		Within the past 2 to 3 months (31-90 days)	02		
		Within the past 4-6 months	03		
		More than 6 months ago	04		
		Never	05 ► **(6.09)**		
(6.08)	Did anything about how you deliver services change because of looking at these data? Where there a lot of improvements, some improvements, of no change?	A LOT OF IMPROVEMENTS	01		CODE
		SOME IMPROVEMENTS	02		
		NO IMPROVEMENTS	03		

(7)	Supplemental Income			
It is common for health workers to have additional work to their primary job at the health facility. I would like to ask you questions about additional work you might be doing. Please answer the following questions with regards to your supplemental activity.			RECORD RESPONSE	
(7.01)	Do you have any other job or activity to supplement your income from this health facility?	YES 1		
		NO 2 ► **(8.01)**		CODE
(7.02)	What kind of job or activitiy is this?	a. Work in another government health facility		CODE
		b. Work in private clinic or private practice		CODE
		c. Work in a pharmacy		CODE
	INTERVIEWER: READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" FOR YES OR "2" FOR NO.	d. Work in non-health related business other than farming		CODE
		e. Farming		CODE
		f. Other, specify:		CODE
(7.03)	What is the main reason that you are doing this other job or activity?	I CANNOT MAKE ENDS MEET ON MY PRIMARY INCOME 01		CODE
		HOURLY PAY IS LUCRATIVE IN THIS SECONDARY JOB 02		
	INTERVIEWER: DO NOT READ OPTIONS ALOUD.	I CAN GAIN EXPERIENCE THAT IS NOT AVAILABLE IN MY PRIMARY JOB. 03		
		THE SECONDARY JOB HAS A BETTER ENVIRONMENT 04		
		I CAN SEE PATIENTS I COULD NOT SEE DURING WORKING HOURS 05		
		OTHER, SPECIFY: 96		
(7.04)	How long have you been doing this additional job or activity? RECORD BOTH YEARS AND MONTHS.	a. YEARS		
		b. MONTHS (RANGE IS 0-11)		
(7.05)	How many hours did you spend on this other work in the last 7 days?	HOURS IN LAST 7 DAYS		
(7.06)	How much did you earn doing this other work in the last month?	DALASI		

(9)	Health Worker Satisfaction		
In this part of the questionnaire I would like to ask you some questions regarding your satisfaction with your current job. All answers are confidential. I am going to read you a series of statements about your level of satisfaction with various aspects of your current job. For each of these aspects, please tell me whether you are satisfied, neither satisfied nor unsatisfied (indifferent), or unsatisfied.			
	RESPONSE CODE _	RECORD RESPONSE	
	SATISFIED 1		
	NEITHER SATISFIED NOR UNSATISFIED, I.E. INDIFFERENT 2		
	UNSATISFIED 3		
(9.01)	Working relationships with other facility staff		CODE
(9.02)	Working relationships with the Regional Health Team		CODE
(9.03)	Working relationships with Management staff within the health facility		CODE
(9.04)	Quality of the management of the health facility by the management staff within the health facility		CODE
(9.05)	Quantity of medicine available in the health facility		CODE
(9.06)	Quality of medicine available in the health facility		CODE
(9.07)	Quantity of equipment in the health facility		CODE
(9.08)	Quality and physical condition of equipment in the health facility		CODE
(9.09)	Availability of other supplies in the health facility (compresses, etc.; office supplies)		CODE
(9.10)	The physical condition of the health facility building		CODE
(9.11)	Your ability to provide high quality of care given the current working conditions in the facility		CODE
(9.12)	The relationships between the health facility and local traditional leaders		CODE
(9.13)	The relationships between the health facility and the catchment area/ communities		CODE
(9.14)	The level of respect you receive in the community		CODE
(9.15)	Your opportunities to upgrade your skills and knowledge through training		CODE
(9.16)	Your opportunity to discuss work issues with your immediate supervisor		CODE
(9.17)	Your immediate supervisor's recognition of your good work		CODE
(9.18)	Your opportunity to be rewarded for hard work, financially or otherwise.		CODE
(9.19)	The opportunities to use your skills in your job.		CODE
(9.20)	Your salary		CODE

(9.21)	Your benefits (such as housing, travel allowance, bonus including performance bonus, etc)		CODE
(9.22)	Your opportunities for promotion		CODE
(9.23)	Safety and security in the community		CODE
(9.24)	Living accommodations		CODE
(9.25)	Available schooling for your children. IF NO CHILDREN, WRITE "NA".		CODE
(9.26)	Quality of internal supervision.		CODE
(9.27)	Quality of external supervision.		CODE
(9.28)	Overall, how satisfied are you with your job?		CODE

(10) Personal Drive

In this part of the questionnaire I would like to talk with you about your work environment. All answers are confidential. I am going to read you a series of statements about your work with your colleagues. For each of these aspects, please tell me whether you feel these are true most of the time, more than half of the time, less than half of the time, rarely or never.

INTERVIEWER: READ EACH STATEMENT TO THE RESPONDENT AND RECORD THE RESPONSE CODE FOR EACH QUESTION. PLEASE SHOW AND ASK TO PICK OUT THE COLORED AND NUMBERED CARDS.

	RESPONSE CODE	-	**RECORD RESPONSE**	
	MOST OF THE TIME	1		
	MORE THAN HALF OF THE TIME	2		
	LESS THAN HALF OF THE TIME	3		
	ONLY RARELY	4		
	NEVER	5		
(10.01)	Staff willingly share their expertise with other members.			CODE
(10.02)	When disagreements occur among staff, they try to act like peacemakers to resolve the situation themselves.			CODE
(10.03)	Staff willingly give their time to help each other out when someone falls behind or has difficulties with work.			CODE
(10.04)	Staff talk to each other before taking an action that might affect them.			CODE
(10.05)	My immediate supervisor motivates me to achieve goals			CODE
(10.06)	Staff focus on what is wrong rather than the positive side.			CODE
(10.07)	Staff spend their time chatting amongst themselves about things that are not related to work.			CODE
(10.08)	Staff spend time complaining about work-related issues.			CODE
(10.09)	My job allows me freedom in how I organize my work and the methods and approaches to use.			CODE
(10.10)	I am given enough authority by my supervisors to do my job well.			CODE
(10.11)	It is important for me that the community recognizes my work as a professional.			CODE
(10.12)	It is important for me that my peers recognize my work as a professional.			CODE
(10.13)	Changes in the facility are easy to adjust to.			CODE
(10.14)	Rapid changes are difficult to cope with.			CODE
(10.15)	Changes in the facility create new opportunities for us to improve health.			CODE
(10.16)	My job makes me feel good about myself.			CODE

(10.17)	My patients trust me.		CODE

(10.18)	I am proud to be working for this health facility.		CODE
(10.19)	My patients follow my instructions.		CODE
(10.20)	I would prefer to work somewhere else than in this facility.		CODE
(10.21)	My training is sufficient to give my patients the help they need.		CODE
(10.22)	I complete my tasks efficiently and effectively.		CODE
(10.23)	I am punctual about coming to work.		CODE
(10.24)	These days, I feel motivated to work as hard as I can.		CODE
(10.25)	My facility is a very personal place. It is like an extended family and people share a lot with each other.		CODE
(10.26)	My facility is very dynamic and an innovative place. People are willing to take risks to do a job well-done.		CODE
(10.27)	My facility is very formal and structured. Policies and procedures are important for doing our work.		CODE
(10.28)	In my facility, we focus on achieving daily goals getting our work done. Relationships between staff are less important.		CODE
	SKIP 10.29-10.32 if 1.15 Is YES		
(10.29)	The head of my facility is a mentor and a role model.		CODE
(10.30)	The head of my facility is willing to innovate and take risks in order to improve things.		CODE
(10.31)	The head of my facility relies too much on policies and procedures.		CODE
(10.32)	The head of my facility motivates staff to achieve goals.		CODE
(10.33)	Following procedures and rules is very important in my facility.		CODE
(10.34)	Achieving results and high performance is very important in my facility.		CODE
(10.35)	I have enough time to deal with every client appropriately.		CODE
(10.36)	I am friendly and polite to all of my clients.		CODE
(10.37)	I sometimes looking at monthly statistics from my department to see how well we are performing.		CODE
(10.38)	I take advantage of avialable training opportunities at work		CODE
(10.39)	It is important to me that my clients feel comfrotable asking me questions.		CODE

CASE SCENARIOS			POTENTIAL RESPONSES	RECORD REPONSE	
(11.03)	If it were the case that too few women in the community come in for post-natal care, what would you do?	A	NOTHING. IT IS THE WOMEN'S OWN CHOICE.		CODE
		B	Nothing, there's no resources (including financial resources)		CODE
		C	ENGAGE WITH TRADITIONAL BIRTH ATTENDANTS		CODE
		D	OFFER INCENTIVE TO TRADITIONAL BIRTH ATTENDANTS		CODE
	INTERVIEWER:DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS REASON OR NOT.	E	OFFER AN IN-KIND INCENTIVE TO WOMEN WHO COME IN		CODE
		F	OFFER A CASH INCENTIVE TO WOMEN WHO COME IN		CODE
		G	ENGAGE WITH COMMUNITY HEALTH WORKERS		CODE
		H	OFFER INCENTIVE TO COMMUNITY HEALTH WORKERS		CODE
	MENTIONED….1	I	TALK TO THE COMMUNITY LEADERS AND HAVE THEM CONVINCE THE WOMEN		CODE
	NOT MENTIONED….2	J	ORGANIZE SENSITIZATION/OUTREACH ACTIVITIES		CODE
		K	TALK TO HEALTH FACILTY MANAGER		CODE
		L	OTHER, SPECIFY		CODE
(11.04)	Say that the facility does not have any means of transportation for patients in emergencies. What would you do?	A	NOTHING. THE PATIENTS AND THEIR FAMILIES HAVE TO SORT IT OUT.		CODE
		B	CONTRACT A PRIVATE PERSON/FIRM IN THE COMMUNITY WHO HAS A CAR		CODE
		C	ORGANIZE A COMMUNITY FUND RAISER TO BUY A VEHICLE		CODE
	INTERVIEWER:DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS REASON OR NOT.	D	SEEK FUNDS FROM THE GOVERNMENT TO BUY VEHICLE		CODE
		E	SEEK FUNDS FROM NGO'S TO BUY VEHICLE		CODE
		F	BUY A VEHICLE FROM THE FACILITY'S FUNDS		CODE
		G	ENCOURAGE THEM TO USE COMMUNITY BASED TRANSPORT		CODE
		H	TALK TO HEALTH FACILTY MANAGER		CODE
	MENTIONED….1	I	OTHER, SPECIFY		CODE

	NOT MENTIONED….2			

(13) Staff Knowledge

INTERVIEWER: IT IS VERY IMPORTANT THAT THE HEALTH WORKER DOES NOT SEE THE SURVEY FORM WHERE YOU ARE RECORDING HIS/HER ANSWERS. MANY OF THE OPTIONS SHOULD NOT BE READ ALOUD AND THEREFORE IT IS IMPORTANT THAT HE/SHE CANNOT SEE THEM. WHEN SPECIFIED, THE HEALTH WORKER MAY LOOK AT THE LAMINATED CASE SCENARIO CARDS. DO NOT LET THE HEALTH WORKER SEE THE CASE SCENARIO CARD AND THEN LEAVE TO TAKE CARE OF A PATIENT. LET THE HEALTH WORKER LEAVE, IF NEED BE, AFTER ASKING ALL OF THE QUESTIONS PERTAINING TO A CASE SCENARIO. DO NOT LET THE HEALTH WORKER LEAVE WITH A CASE SCENARIO AND THEN RETURN TO ANSWER QUESTIONS ABOUT THAT CASE SCENARIO; ASK THOSE CORRESPONDING QUESTIONS BEFORE HE/SHE LEAVES.

START BY READING THE FOLLOWING STATEMENT TO THE HEALTH WORKER:

The following set of questions are an assessment of your knowledge of basic disease protocols. This assessment will not affect your employment at this facility, nor does it affect your standing as a practitioner in this area. This is a tool simply to help the Ministry of Health obtain information on how to improve training of facility staff in the future. I will present you with situations that you would observe in the clinic. Please answer the questions to the best of your knowledge.

(13.01)	INTERVIEWER: IS THE HEALTH WORKER A DOCTOR OR NURSE?	YES 1			CODE
		NO 2 ► **END**			
(13.02)	At how many months and weeks of age should a child receive the following vaccines? INTERVIEWER: READ THE NAMES OF THE VACCINES	A. BCG		WEEKS	
				MONTHS	
		B. Pentavalent (DPT-Hib-Hep) first dose		WEEKS	
				MONTHS	
		C. Measles first dose		WEEKS	
				MONTHS	
(13.03)	Imagine a mother brings in her 9 month old child for routine immunization. You find the child has a fever, a red throat, and a runny nose, but no other signs of illness. Should you give the immunization?	YES 1			CODE
		NO 2			

Case Scenario 5					
I will now read a fifth case scenario.--------Mrs. Njie is 16 years old. She is 30 weeks pregnant and has attended the antenatal clinic three times. All findings were within normal limits until her last antenatal visit 1 week ago. At that visit it was found that her blood pressure was 130/90 mm Hg. Her urine was negative for protein. The fetal heart sounds were normal, the fetus was active and uterine size was consistent with dates. She has come to the clinic today, as requested, for follow-up. The main findings include: Proteinuria 2+; Blood pressure is 130/90 mm Hg; No headache, visual disturbance, upper abdominal pain, convulsions, or loss of consciousness; Fetus is active and fetal heart sounds are normal; and Uterine size is consistent with dates of pregnancy.					
PLEASE GIVE THE RESPONDENT CARD 5 WITH CASE SCENARIO 5.					
(13.08)	In giving Mrs. Njie advice about danger signs, what signs do you tell her about that mean she should go to the hospital/health center immediately, day or night, <u>without</u> waiting?	A.	VAGINAL BLEEDING		CODE
		B.	FEVER		CODE
		C.	SWOLLEN FACE, HANDS OR LEGS		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.	D.	SEVERE TIREDNESS OR BREATHLESSNESS		CODE
		E.	SEVERE HEADACHE, BLURRED VISION, LIGHTHEADEDNESS, DIZZINESS, BLACKOUT		CODE
		F.	FOUL SMELLING DISCHARGE OR FLUID FROM VAGINA		CODE
	MENTIONED……..1	G.	CONVULSIONS		CODE
	NOT MENTIONED……2	H.	ABDOMINAL PAIN		CODE
		I.	FEELS ILL		CODE
		J.	OTHER, SPECIFY		CODE

(13.10)	Unfortunately, after 20 minutes of ventilation,the baby does not start breathing or gasping?	A.	STOP RESUSCITATION MEASURES (BABY IS DEAD)		CODE
		B.	EXPLAIN TO THE MOTHER WHAT HAS HAPPENED		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.	C.	OFFER SUPPORTIVE CARE AND COMFORT TO THE MOTHER (E.G. OFFER HER THE OPPORTUNITY TO HOLD HER BABY)		CODE
		D.	RECORD THE EVENT		CODE
	MENTIONED.....1	E.	OTHER, SPECIFY		CODE
	NOT MENTIONED.....2				

COMMENTS BY INTERVIEWER

(14) Protocol-based vignettes

Now I would like to discuss some examples of situations that may happen at the health center. These situations may or may not be currently true in the health facility where you work. For each situation, I would like to know what kind of actions you would take. All answers are confidential. The first type of situation I would like to discuss with you is a prenatal care visit. I will read out the case to you and then I will ask you what you would do.

Mrs. JARJU, a married woman of 26, has recently moved into the area and comes to see you for the first time. She is obviously pregnant and reports that she has not yet received any antenatal care for this pregnancy. Please tell me what questions you would ask Mrs. JARJU, and what actions you would take.

QUESTIONS			POTENTIAL RESPONSES	RECORD REPONSE	
(14.01)	What questions would you ask Mrs Jarju about her previous pregnancies?	A	NUMBER OF PRIOR PREGNANCIES		CODE
		B	NUMBER OF LIVE BIRTHS		CODE
		C	NUMBER OF MISCARRIAGES/ STILLBIRTHS/ ABORTIONS		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE	D	ANY BLEEDING DURING PREVIOUS LABOR		CODE

	WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT. MENTIONED……..1 NOT MENTIONED……2	E	HOW WAS THE LAST CHILD DELIVERED? (NATURAL? CEASARIAN? FORCEPS?)		CODE
		F	BIRTH WEIGHT OF PREVIOUS CHILD		CODE
		G	HISTORY OF GENETIC ANOMALIES		CODE
		H	TETANUS IMMUNIZATIONS?		CODE
		I	OTHER, SPECIFY		CODE
(14.02)	What questions would you ask Mrs Jarju about her current pregnancy? INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT. MENTIONED……..1 NOT MENTIONED……2	A	LAST MENSTRUAL DATE?		CODE
		B	ANY HEALTH PROBLEMS NOW?		CODE
		C	ANY CONTRACTIONS?		CODE
		D	ANY VAGINAL BLEEDING?		CODE
		E	ANY WEIGHT LOSS / GAIN ?		CODE
		F	ANY NAUSEA OR VOMITING?		CODE
		G	TAKING MEDICATIONS NOW?		CODE
		H	TETANUS IMMUNIZATIONS?		CODE
		I	OTHER, SPECIFY		CODE
(14.03)	What questions would you ask Mrs Jarju about her medical history? INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT. MENTIONED……..1 NOT MENTIONED……2	A	ANY HISTORY OF HIGH BLOOD PRESSURE?		CODE
		B	ANY HISTORY OF DIABETES?		CODE
		C	ANY PREVIOUS STI, INCLUDING HIV?		CODE
		D	ANY PREVIOUS IUD OR CONTRACEPTIVE USE?		CODE
		E	ANY PAP SMEARS?		CODE
		F	ANY HEART DISEASE, LIVER DISEASE, MALARIA, GOITRE?		CODE
		G	FAMILY HISTORY OF HEREDITARY DISEASE?		CODE
		H	ANY ALLERGIES TO MEDICATIONS?		CODE
		I	PAST OR CURRENT SMOKER?		CODE
		J	ANY HISTORY OF ALCOHOL USE?		CODE
		K	ANY HISTORY OF ILLICIT DRUG USE?		CODE
		L	BLOOD GROUPING AND CROSS-MATCHIING		CODE

		M	OTHER, SPECIFY		CODE
(14.04)	What physical examinations would you perform on Mrs Jarju ?	A	BODY HEIGHT		CODE
		B	BODY WEIGHT		CODE
		C	BLOOD PRESSURE		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.	D	TEMPERATURE		CODE
		E	RESPIRATORY RATE		CODE
		F	PALPATE ABDOMEN		CODE
		G	LISTEN TO FETAL HEARTBEAT		CODE
		H	PELVIC EXAMINATION		CODE
	MENTIONED……..1	I	CHECK FOR EDEMA/SWELLING		CODE
	NOT MENTIONED……2	J	MEASURE SIZE OF WOMB		CODE
		K	OTHER, SPECIFY		CODE

(14.05)	What laboratory investigations would you perform on Mrs Jarju ?	A	PREGNANCY TEST		CODE
		B	HEMOGLOBIN TEST		CODE
		C	URINE TEST FOR DIABETES		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.	D	URINE PROTEIN		CODE
		E	ULTRASOUND		CODE
		F	BLOOD PLATELETS COUNT		CODE
		G	LIVER ENZYMES		CODE
		H	SERUM UREA AND CREATININE		CODE
	MENTIONED……..1	I	HIV TEST		CODE
	NOT MENTIONED……2	J	STI TEST - SYPHILLIS AND/OR GONORRHEA		CODE
		K	RUBELLA ANTIBODIES		CODE
		L	BLOOD GROUPING AND CROSS-MATCHIING		CODE
		M	OTHER, SPECIFY		CODE

(14.06)	What would you prescribe or provide to Mrs Jarju?	A	INSECTICIDE TREATED MOSQUITO NET		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.	B	IRON / FOLIC ACID SUPPLEMENTS		CODE
		C	ADMINISTER TETANUS TOXOID		
	MENTIONED……..1	D	INTERMITTENT PREVENTIVE TREATMENT FOR MALARIA		CODE
	NOT MENTIONED……2	E	OTHER, SPECIFY		CODE
(14.07)	What kind of advice would you give to Mrs Jarju?	A	NUTRITION		CODE
		B	IRON / FOLIC ACID SUPPLEMENTS		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.	C	DANGER SIGNS FOR EMERGENCY HELP		CODE
		D	BREASTFEEDING		CODE
		E	CONTRACEPTION		CODE
	MENTIONED……..1	F	HIV VOLUNTARY COUNSELING AND TESTING		CODE
		G	USE OF INSECTICIDE TREATED BEDNET		CODE
	NOT MENTIONED……2	H	OTHER, SPECIFY		CODE

Annex 4: Exit interview – ANC services

(1)	Identification			RECORD RESPONSE	
	INTERVIEWER: ASK THE FOLLOWING QUESTIONS TO THE PATIENT.				
I am going to start the interview by asking you some questions about yourself.					
(1.01)	Can you tell me how old you are?	YEARS (COMPLETED)			
(1.02)	Can you read and write?	YES	1		CODE
		NO	2		
(1.03)	What is the highest level of education that you completed, and how many years (or grades) of school have you completed within that level?	KINDERGARTEN	01		CODE
		PRIMARY/ LOWER BASIC	02		
		UPPER BASIC	03		
		HIGH SCHOOL	04		
		SENIOR SECONDARY	05		
		NON-TERTIARY/VOCATIONARY	06		
		DIPLOMA/TERTIARY	07		
		UNDERGRADUATE	08		
		MASTERS	09		
		PHD	10		
		NONE	11 ► **(1.04)**		
		OTHER, SPECIFY	96		
		DON'T KNOW	- 99		
		GRADE (NUMBER OF YEARS) COMPLETED WITHIN THAT LEVEL			
(1.04)	What is your marital status?	Single	01 ► **(2.01)**		CODE
		Married/Living together (Monogamous)	02		
		Married Polygamous	03		
		Widowed	04 ► **(2.01)**		
		Divorced/separated	05 ► **(2.01)**		
(1.05)	What is the highest level of education that your spouse / partner completed, and how many years (or grades) of school has your spouse / partner completed within that level?	KINDERGARTEN	01		CODE
		PRIMARY/ LOWER BASIC	02		
		UPPER BASIC	03		
		HIGH SCHOOL	04		
		SENIOR SECONDARY	05		
		NON-TERTIARY/VOCATIONARY	06		
		DIPLOMA/TERTIARY	07		
		UNDERGRADUATE	08		
		MASTERS	09		

		PHD 10		
		NONE 11		
		OTHER, SPECIFY 96 ► **(2.01)**		
		DON'T KNOW - 99		
		GRADE (NUMBER OF YEARS) COMPLETED WITHIN THAT LEVEL		

(2)	Treatment and counseling		RECORD RESPONSE	
(2.01)	During this visit to the health center, how many health workers provided care to you? This includes any doctors, nurses, pharmacist, lab technician, midwife, etc. who directly took care of you or provided you with advice or medicine.			
(2.02)	What is the name of the (first) health worker who provided care to you?			
(2.03)	INTERVIEWER: ENTER HEALTH WORKER ID CODE FROM THE FACILITY STAFF ROSTER			
	INTERVIEWER: CHECK IF PATIENT SAW MORE THAN ONE HEALTH WORKER	IF PATIENT SAW MORE THAN ONE PROVIDER, ASK NAMES OF ALL PROVIDERS. OTHERWISE, ► (2.10).		
(2.04)	What is the name of the second health worker who provided care to you?			
(2.05)	INTERVIEWER: ENTER HEALTH WORKER ID CODE FROM THE FACILITY STAFF ROSTER			
(2.06)	What is the name of the third health worker who provided care to you?			
(2.07)	INTERVIEWER: ENTER HEALTH WORKER ID CODE FROM THE FACILITY STAFF ROSTER			
(2.08)	What is the name of the fourth health worker who provided care to you?			
(2.09)	INTERVIEWER: ENTER HEALTH WORKER ID CODE FROM THE FACILITY STAFF ROSTER			
(2.10)	Do you have an antenatal-care card/book, or an immunization card with you today? INTERVIEWER: IF YES: ASK TO SEE THE CARD/BOOK.	Yes, card/book seen 01		CODE
		Yes, card/book not seen 02 ► **(2.15)**		
		No, card/book kept with facility 03 ► **(2.15)**		
		No card/book used 04 ► **(2.15)**		

(2.11)	INTERVIEWER: CHECK ANTENATAL-CARE CARD/BOOK, OR IMMUNIZATION CARD. INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS TOXOID.	YES, 1 TIME 01 YES, 2 OR MORE TIMES 02 NO 03		CODE

(2.12)	INTERVIEWER: HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANTENATAL CARE CARD/BOOK?	# WEEKS		
(2.13)	INTERVIEWER: DOES THE CARD/BOOK INDICATE THE CLIENT HAS RECEIVED INTERMITTENT PREVENTIVE TREATMENT (IPT) AGAINST MALARIA?	YES, 1 DOSE 01 YES, 2 DOSES 02 NO 03		CODE
(2.14)	INTERVIEWER: DOES THE CARD/BOOK MENTION THE CLIENT'S BLOOD GROUP?	YES 1 NO 2		CODE
(2.15)	How long have you been pregnant? (INTERVIEWER: RECORD MONTHS OR WEEKS)	a. WEEKS b. MONTHS		
(2.16)	Is this your first pregnancy?	YES 1 NO 2		CODE
(2.17)	Is this your first antenatal visit at this facility for this pregnancy?	YES 1 ► **(2.19)** NO 2		CODE
(2.18)	Including this visit, how many antenatal care visits have you had for this pregnancy to this health facility?			
(2.19)	How many antenatal care visits have you had for this pregnancy to other health facilities?			
(2.20)	During this visit, were you weighed?	YES 1 NO 2		CODE
(2.21)	During this visit, was your height measured?	YES 1 NO 2		CODE
(2.22)	During this visit, did someone measure your blood pressure? INTERVIEWER, EXPLAIN: This is when someone wraps a wide cloth around your arm above your	YES 1		CODE

	elbow and you feel squeezing and pressure on your arm, which is then released after some time.	NO 2		
(2.23)	During this visit, did you give a urine sample? INTERVIEWER, EXPLAIN: Did someone ask you to collect your urine in a small bottle or pot for some medical tests?	YES 1		CODE
		NO 2		

(2.24)	During this visit, did you give a blood sample? INTERVIEWER, EXPLAIN: Did someone prick your finger or your arm with a needle to collect blood for some medical tests?	YES 1		CODE
		NO 2		
(2.25)	During this visit, were you counseled on giving birth at this facility?	YES 1		CODE
		NO 2		
(2.26)	During this visit, did the provider palpate your stomach? INTERVIEWER, EXPLAIN: Did the health worker make you lie down on a table or couch and touch your stomach?	YES 1		CODE
		NO 2		
(2.27)	During this visit, did the health worker estimate your delivery or due date?	YES 1		CODE
		NO 2		
(2.28)	During this visit, was your uterine height measured? INTERVIEWER, EXPLAIN: This is when the provider measures your stomach using a measurement tape.	YES 1		CODE
		NO 2		
(2.29)	During this visit, did a health worker ask for your blood type?	YES 1		CODE
		NO 2		
(2.30)	During this visit, did a health worker give you advice on your diet (this is, what to eat and drink) during pregnancy?	YES 1		CODE
		NO 2 ► **(2.32)**		
(2.31)	What did the health worker advise you to eat during pregnancy?	a. DARK GREEN LEAFY VEGETABLES		CODE
		b. MILK		CODE
	INTERVIEWER: DO NOT CITE ANSWERS, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC	c. MEAT AND POULTRY		CODE
		d. FRUITS, VEGETABLES AND NUTS		CODE

	ANSWERS (E.G., "ANYTHING ELSE?")	e. CEREALS f. OTHER, SPECIFY:		CODE
(2.32)	During this visit, did a health worker give you iron pills, folic acid or iron with folic acid, or give you a prescription for them? INTERVIEWER: SHOW THE CLIENT AN IRON PILL, A FOLIC-ACID PILL, OR A COMBINED PILL.	YES 1 NO 2 ► **(2.36)**		CODE
(2.33)	INTERVIEWER: ASK TO SEE THE CLIENT'S IRON/FOLIC ACID/IRON WITH FOLIC ACID PILLS OR PRESCRIPTION FOR IT.	SAW PILLS 01 SAW PRESCRIPTION 02 NO PILLS OR PRESCRIPTION 03		CODE
(2.34)	During this or previous visits, has a health worker discussed with you the side effects of the iron pill?	YES 1 NO 2		CODE
(2.35)	Please tell me any side effect of the iron pill that you know of. INTERVIEWER: DO NOT CITE ANSWERS, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?")	a. NAUSEA b. BLACK STOOLS c. CONSTIPATION d. OTHER, SPECIFY:		CODE CODE CODE
(2.36)	During this visit, has a health worker given or prescribed any antimalarial pills for you? INTERVIEWER: SHOW THE CLIENT CAPSULES	YES 1 NO 2 ► **(2.38)**		CODE
(2.37)	INTERVIEWER: ASK TO SEE THE CLIENT'S ANTIMALARIAL PILLS OR PRESCRIPTION FOR IT.	SAW PILLS 01 SAW PRESCRIPTION 02 NO PILLS OR PRESCRIPTION 03		CODE
(2.38)	Do you own an Insecticide Treated Net (ITN), that is a net that has been treated with an insecticide to protect you from mosquito bites?	YES 1 NO 2 ► **(2.40)**		CODE
(2.39)	Last night, did you sleep under an insecticide treated net?	YES 1 NO 2		CODE
(2.40)	During this visit, did a health worker offer you an Insecticide Treated Net	YES 1		CODE

	free of charge?	NO	2		
(2.41)	During this visit, did a health worker offer to sell you an Insecticide Treated Net ?	YES	1		CODE
		NO	2		
(2.42)	During this visit or previous visits, has a health worker asked you whether you had ever received a tetanus toxoid injection?	YES	1		CODE
		NO	2		
(2.43)	Have you ever received a tetanus toxoid injection, including one you may have received today?	YES	1		CODE
		NO	2 ► **(2.45)**		

(2.33)	INTERVIEWER: ASK TO SEE THE CLIENT'S IRON/FOLIC ACID/IRON WITH FOLIC ACID PILLS OR PRESCRIPTION FOR IT.	SAW PILLS	01		CODE
		SAW PRESCRIPTION	02		
		NO PILLS OR PRESCRIPTION	03		
(2.34)	During this or previous visits, has a health worker discussed with you the side effects of the iron pill?	YES	1		CODE
		NO	2		
(2.35)	Please tell me any side effect of the iron pill that you know of. INTERVIEWER: DO NOT CITE ANSWERS, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?")	a. NAUSEA			CODE
		b. BLACK STOOLS			CODE
		c. CONSTIPATION			CODE
		d. OTHER, SPECIFY:			
(2.36)	During this visit, has a health worker given or prescribed any antimalarial pills for you? INTERVIEWER: SHOW THE CLIENT CAPSULES	YES	1		CODE
		NO	2 ► **(2.38)**		
(2.37)	INTERVIEWER: ASK TO SEE THE CLIENT'S ANTIMALARIAL PILLS OR PRESCRIPTION FOR IT.	SAW PILLS	01		CODE
		SAW PRESCRIPTION	02		
		NO PILLS OR PRESCRIPTION	03		
(2.38)	Do you own an Insecticide Treated Net (ITN), that is a net that has been treated with an insecticide to protect you from mosquito bites?	YES	1		CODE
		NO	2 ► **(2.40)**		
(2.39)	Last night, did you sleep under an insecticide treated net?	YES	1		CODE
		NO	2		

(2.40)	During this visit, did a health worker offer you an Insecticide Treated Net free of charge?	YES 1		CODE
		NO 2		
(2.41)	During this visit, did a health worker offer to sell you an Insecticide Treated Net ?	YES 1		CODE
		NO 2		
(2.42)	During this visit or previous visits, has a health worker asked you whether you had ever received a tetanus toxoid injection?	YES 1		CODE
		NO 2		
(2.43)	Have you ever received a tetanus toxoid injection, including one you may have received today?	YES 1		CODE
		NO 2 ► **(2.45)**		

(2.44)	Including any Tetanus Toxoid injection you received today, how many times in total during your lifetime have you received a Tetanus Toxoid injection? (INTERVIEWER: INJECTION MAY HAVE BEEN RECEIVED EITHER AT THIS FACILITY OR ELSEWHERE.)			
(2.45)	During this visit or previous visits, has a health worker talked with you about any signs of complications (danger signs) that should warn you of problems with the pregnancy?	Yes, during this visit 01		CODE
		Yes, during previous visit 02		
		No 03 ► **(2.49)**		
(2.46)	Please tell me any signs of complications (danger signs) during pregnancy that you know of. INTERVIEWER: DO NOT CITE ANSWERS, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?")	a. ANY VAGINAL BLEEDING		CODE
		b. FEVER		CODE
		c. SWOLLEN FACE, HANDS OR LEGS		CODE
		d. TIREDNESS OR BREATHLESSNESS		CODE
		e. SEVERE HEADACHE		CODE
		f. BLURRED VISION		CODE
		g. CONVULSIONS		CODE
		h. LIGHTHEADEDNESS/DIZZINESS/BLACKOUT		CODE
		i. SEVERE PAIN IN LOWER BELLY		CODE
		j. BABY STOPS MOVING OR REDUCED FETAL MOVEMENT		CODE
		k. BAG OF WATER BREAKS OR LEAKS		CODE
		l. DIFFICULTY BREATHING		CODE
		m. FOUL SMELLING DISCHARGE OR FLUID FROM VAGINA		CODE
		n. OTHER, SPECIFY:		

(2.47)	What did the health worker advise you to do if you experience any of the warning signs during pregnancy? INTERVIEWER: DO NOT CITE ANSWERS, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?")	a. SEEK CARE AT FACILITY		CODE
		b. DECREASE ACTIVITY		CODE
		c. CHANGE DIET		CODE
		d. OTHER, SPECIFY:		CODE
(2.48)	During this visit, did the health worker talk counsel you about delivering your baby in the health facility?	YES 1		CODE
		NO 2		

(2.49)	During this visit, did a health worker talk with you about using family planning after the birth of your baby?	YES 1		CODE
		NO 2 ► **(3.01)**		
(2.50)	During this visit, did the health worker discuss with you any specific method of family planning?	YES 1		CODE
		NO 2 ► **(3.01)**		
(2.51)	Which family planning methods did the health worker discuss? INTERVIEWER: DO NOT CITE ANSWERS, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?")	a. FEMALE STERILIZATION		CODE
		b. MALE STERILIZATION		CODE
		c. CONTRACEPTIVE PILL		CODE
		d. INTRAUTERINE DEVICE (IUD)		CODE
		e. INJECTABLE CONTRACEPTIVES		CODE
		f. IMPLANTS		CODE
		g. MALE CONDOMS		CODE
		h. FEMALE CONDOMS		CODE
		i. DIAPHRAGM		CODE
		j. FOAM / JELLY		CODE
		k. LACTATIONAL AMENORRHEA		CODE
		l. RHYTHM METHOD		CODE
		m. WITHDRAWAL		CODE

(3)	**Patient travel and expenditure**		RECORD RESPONSE	
(3.01)	How far is your household from this health facility?	KILOMETERS		
(3.02)	How long did it take you to reach this health facility from home today, <u>one way</u> in minutes?	MINUTES		
(3.03)	What was your primary mode of transportation today? (<u>One way</u>)	By foot 01 ► **(3.05)**		
		Bicycle 02 ► **(3.05)**		CODE

		Horse/ Donkey/Other Animal 03		
		Private car 04		
		Public car/bus including taxi 05		
		Private motorcycle 06		
		Other (Specify:_____) 96		
(3.04)	How much did it cost in DALASI for you to travel to the health facility today, one way?	DALASI		
(3.05)	How long did you wait in the health facility before being seen in consultation by the health worker?	MINUTES		
(3.06)	Do you think the time you spent waiting was too long?	YES 1		CODE
		NO 2		

(3.07)	How long did you spend with the doctor, nurse or other practitioner during the consultation?	MINUTES		
(3.08)	Do you think the time you spent with the worker was enough?	YES 1		CODE
		NO 2		
(3.09)	Did you have to pay a registration, consultation or doctor's fee?	YES 1		CODE
		NO 2 ► **(3.11)**		
(3.10)	How much did you pay for this in DALASI ?	DALASI		
(3.11)	Was a laboratory test done?	YES 1		CODE
		NO 2 ► **(3.13)**		
(3.12)	How much was paid in DALASI for this?	DALASI		
(3.13)	Was an ultrasound done?	YES 1		CODE
		NO 2 ► **(3.15)**		
(3.14)	How much was paid in DALASI for this?	DALASI		
(3.15)	Were medicines dispensed to you today?	YES 1		CODE
		NO 2 ► **(3.17)**		
(3.16)	How much was paid in DALASI for this?	DALASI		
(3.17)	How much was spent in total in DALASI at the facility for this visit, not including transportation costs?	DALASI IF ZERO ► **(3.19)**		
(3.18)	Where did the money come from that was used to pay for health care today?	a. SAVINGS OR REGULAR HOUSEHOLD BUDGET		CODE
		b. HEALTH INSURANCE		CODE

	INTERVIEWER: DO NOT READ OPTIONS ALOUD, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?") MENTIONED…….1 NOT MENTIONED..2	c. SELLING HOUSEHOLD POSSESSIONS		CODE
		d. MORTGAGING OR SELLING LAND OR REAL ESTATE		CODE
		e. FROM A FRIEND OR RELATIVE		CODE
		f. FROM SOMEONE OTHER THAN FAMILY AND FRIENDS		CODE
		g. OTHER, SPECIFY:		CODE
(3.19)	Are you currently covered under a health insurance scheme?	YES 1		CODE
		NO 2 ► **(4.01)**		
(3.20)	What type of health insurance is this? Is it Public, Private or both?	Public 01		CODE
		Private 02		
		Both 03		

(3.21)	In the last 12 months, how many months have you been enrolled in the insurance scheme that covers you now?	MONTHS. MAXIMUM 12.		

(4)	**Patient satisfaction**			RECORD RESPONSE	
(4.01)	What was the **most important** reason you chose this health facility today instead of a different source of care? INTERVIEWER: DO NOT READ OPTIONS ALOUD. ONLY ONE ANSWER IS ALLOWED.	LOCATION CLOSE TO HOME	01		CODE
		LOW COST	02		
		TRUST IN PROVIDERS / HIGH QUALITY CARE	03		
		AVAILABILITY OF DRUGS	04		
		AVAILABILITY OF FEMALE PROVIDER	05		
		AVAILABILITY OF MALE PROVIDER	06		
		RECOMMENDATION OR REFERRAL	07		
		OTHER, SPECIFY:	96		
(4.02)	What was the **next most important** reason you chose this health facility today instead of a different source of care, if there is any other reason?	NO OTHER REASON	01		CODE
		LOCATION CLOSE TO HOME	02		
		LOW COST	03		
		TRUST IN PROVIDERS / HIGH QUALITY CARE	04		
		AVAILABILITY OF DRUGS	05		

	INTERVIEWER: DO NOT READ OPTIONS ALOUD. ONLY ONE ANSWER IS ALLOWED.	AVAILABILITY OF FEMALE PROVIDER	06	
		AVAILABILITY OF MALE PROVIDER	07	
		RECOMMENDATION OR REFERRAL	08	
		OTHER, SPECIFY:	96	

I'm going to read you a series of statements regarding this health facility. Please tell me if you agree, neither agree nor disagree, or disagree with each statement. Some statements may not apply to your situation. Please let me know if a statement does not apply to you.

INTERVIEWER: READ EACH STATEMENT TO THE RESPONDENT AND RECORD THE RESPONSE CODE FOR EACH QUESTION. PLEASE SHOW AND ASK TO PICK OUT THE COLORED AND NUMBERED CARDS WITH RESPONSE CODES

		Agree	**Neither agree nor disagree**	**Disagree**	**Not applicable**	RECORD RESPONSE	
(4.03)	It is convenient to travel from your house to the health facility.	1	2	3	4		CODE
(4.04)	The health facility is clean.	1	2	3	4		CODE
(4.05)	The health staff are courteous and respectful.	1	2	3	4		CODE
(4.06)	The health workers did a good job of explaining your condition.	1	2	3	4		CODE
(4.07)	It is easy to get medicine that health workers prescribe.	1	2	3	4		CODE
(4.08)	The registration fees of this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.09)	The lab fees of this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.10)	The medication fees of this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.11)	The transport fees for this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.12)	The amount of time you spent waiting to be seen by a health worker was reasonable.	1	2	3	4		CODE
(4.13)	You had enough privacy during your consultation.	1	2	3	4		CODE

(4.14)	The health worker spent a sufficient amount of time with you.	1	2	3	4		CODE
(4.15)	The hours the facility is open are adequate to meet your needs.	1	2	3	4		CODE
(4.16)	The overall quality of services provided was satisfactory.	1	2	3	4		CODE
(4.17)	The Health staff treated you with care and compassion	1	2	3	4		CODE

		Agree	**Neither agree nor disagree**	**Disagree**	**Not applicable**	RECORD RESPONSE	
(4.18)	a. The health workers in this facility provide good quality prenatal care.	1	2	3	4		CODE
(4.19)	b. The health workers in this facility provide good quality delivery services.	1	2	3	4		CODE

(5)	**Security and Trust**	

I'm going to read you a series of statements regarding security and trust in this health facility. Please respond to the statements as you did above by confirming if you agree, neither agree nor disagree, or disagree with each statement. Some statements may not apply to your situation. Please let me know if a statement does not apply to you.

INTERVIEWER: READ EACH STATEMENT TO THE RESPONDENT AND RECORD THE RESPONSE CODE FOR EACH QUESTION.

		Agree	**Neither agree nor disagree**	**Disagree**	**Not applicable**	RECORD RESPONSE	
(5.01)	The area around the health facility is not safe and it makes it difficult for the people in the community to use available health services	1	2	3	4		CODE
(5.02)	The health workers in this facility are extremely thorough and careful.	1	2	3	4		CODE
(5.03)	You trust in the skills and abilities of the health workers of this facility.	1	2	3	4		CODE
(5.04)	You completely trust the health worker's decisions about medical treatments in this facility.	1	2	3	4		CODE
(5.05)	The health workers in this facility are very friendly and approachable.	1	2	3	4		CODE

(5.06)	The health workers in this facility are easy to make contact with.	1	2	3	4		CODE
(5.07)	The health workers in this facility care about your health just as much or more than you do.	1	2	3	4		CODE
(5.08)	The health workers in this facility act differently toward rich people than toward poor people.	1	2	3	4		CODE
(5.09)	The health workers in this facility act the same towards all patients.	1	2	3	4		CODE
(5.10)	You trust the health workers to keep your medical information confidential	1	2	3	4		CODE
(5.11)	All in all, you trust the health workers completely in this health facility.	1	2	3	4		CODE

(6)	**Questions about the household (continued)**		
(6.09)	How many [ASSET]s does your household own? ONLY INCLUDE FUNCTIONING ASSETS. IF ZERO, RECORD ZERO AND GO TO NEXT ASSET.	RECORD RESPONSE	
a	Radio/CD/cassette player?		CODE
b	Television?		CODE
c	Clothes iron?		CODE
d	Electric stove?		CODE
e	Gas stove?		CODE
f	Paraffin lamp?		CODE
g	Bed?		CODE
h	Mattress?		CODE
i	Refrigerator / freezer?		CODE
j	Sewing machine?		CODE
k	Table? (for dining?)		CODE
l	Sofa?		CODE
m	Land line telephone?		CODE
n	Mobile / Telephone?		CODE
o	Motorcycle?		CODE
p	Bicycle?		CODE
q	Truck or car?		CODE
r	Wheelbarrow?		CODE
s	Plough?		CODE

t	Hoes / harrows / axes ?		CODE
(6.10)		**(6.10)**	
	ANIMAL	How many [ANIMAL]s does your household own? INTERVIEWER: IF ZERO, **RECORD "0".**	
a	Oxen?		CODE
b	Cattle?		CODE
c	Goats?		CODE
d	Sheep?		CODE
e	Pigs?		CODE
f	Poultry?		CODE
g	Game?		CODE
h	Donkey?		CODE
i	Horse?		CODE
j	Other, specify:		CODE

(7)	**Community Health Nurse**			RECORD RESPONSE	
(7.01)	Do you know of any community health nurses (CHW) in your community?	YES	1		CODE
		NO	2 ► **(8.01)**		
(7.02)	Do you have both male and female Community Health Nurse in your community?	Male CHN only	01		CODE
		Female CHN only	02		
		Both Male and Female	03		
(7.03)	In the last month, has any community health nurse provided services to you while you were in the health post?	YES	1		CODE
		NO	2		
(7.04)	In the last month, has any community health nurse provided services to you while you were in your own home?	YES	1		CODE
		NO	2		
(7.05)	In the last month, has any community health nurse provided services to you while you were elsewhere in your community?	YES	1		CODE
		NO	2		
(7.06)	INTERVIEWER: CHECK THE PREVIOUS 3 QUESTIONS TO SEE WHETHER RESPONDENT HAS USED SERVICES IN THE LAST MONTH	YES	1		CODE
		NO	2 ► **(7.08)**		
(7.07)	What services did the CHN provide you?	a. PROVIDE IRON / FOLIC ACID TABLETS			CODE
		b. PROVIDE TETANUS TOXOID IMMUNIZATION			CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED.	c. PROVIDE PREVENTIVE ANTIMALARIAL PILLS			CODE
		d. INFORMATION ON DANGER SIGNS DURING PREGNANCY			CODE

	e. ADVICE ON EXCLUSIVE BREASTFEEDING			CODE
	f. HEALTH EDUCATION OR PROMOTION			CODE
	g. REFERRAL TO HEALTH FACILITY			CODE
	h. OTHER, SPECIFY:			

I'm going to read you three statements in relation to work done by the Community Health workers. Please indicate if you agree, neither agree nor disagree, or disagree with each statement.

		Agree	Neither agree nor disagree	Disagree	RECORD RESPONSE	
(7.08)	Community Health Nurses provide a valuable service in my community.	1	2	3		CODE
(7.09)	Community Health Nurse(s) provide good quality service in my community	1	2	3		CODE
(7.10)	I prefer to visit a Community Health Nurse rather than to come into the facility.	1	2	3		CODE

(8)	**Traditional Birth Attendant**			RECORD RESPONSE	
(8.01)	Do you know of any traditional birth attendant (TBA) in your community?	Yes	1		CODE
		No	2 ► **END**		
(8.02)	Have you used Traditional Birth Attendant services in the last month, either in your own home, in the community or in the health post?	Yes, at own home	01		CODE
		Yes, at health post	02		
		Yes, in the community	03		
		Yes, both at home and in the health post	04		
		Yes, both at home and in the community	05		
		Yes, both in the health post and in the community	06		
		Yes, both at home, in the health post and the community	07		
		No	08 ► **(8.04)**		
(8.03)	What services did the TBA provide you?	a. IDENTIFY YOUR PREGNANCY			CODE
		b. BRING YOU FOR ANTENATAL CHECKUP			CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED.	c. INFORMATION ON DANGER SIGNS DURING PREGNANCY			CODE
		d. ESCORT TO HEALTH FACILITY FOR DELIVERY			CODE
		e. HEALTH EDUCATION OR PROMOTION			CODE
		f. ADVICE ON EXCLUSIVE BREASTFEEDING			CODE
		g. PROVIDE VITAMIN A SUPPLEMENTATION			
		h. OTHER, SPECIFY:			CODE

I'm going to read you three statements in relation to work done by the Traditional Birth Attendant (TBA). Please indicate if you agree, neither agree nor disagree, or disagree with each statement.

		Agree	Neither agree nor disagree	Disagree	RECORD RESPONSE	
(8.04)	Traditional Birth Attendants provide a valuable service in my community.	1	2	3		CODE
(8.05)	Traditional Birth Attendants provide good quality service in my community.	1	2	3		CODE
(8.06)	I prefer to deliver with a Traditional Birth Attendant rather than at the health facility.	1	2	3		CODE

THANK YOU FOR YOUR TIME

Annex 5: Exit interview – U5 services

(1)	Identification			RECORD RESPONSE	
	INTERVIEWER: ASK THE FOLLOWING QUESTIONS TO THE CAREGIVER				
(1.01)	Gender of respondent	MALE	01		CODE
		FEMALE	02		
(1.02)	Is it the first time the child is brought to this facility for this illness or this purpose of the visit?	YES	1		CODE
		NO	2		
(1.03)	What is the child's sex?	MALE	01		CODE
		FEMALE	02		
(1.04)	What is the child's date of birth? (Refer to the Infant Wellness Card - IWC)	Day _____ Month_____ Year___		► (1.06)	
		Don't Know	- 99	► (1.05)	
(1.05)	What is the age of the child? INTERVIEWER: ENTER COMPLETED YEARS AND MONTHS. IF THE CHILD'S AGE IS MORE THAN 4 YEARS AND 11 MONTHS, STOP THE OBSERVATION AND MOVE TO THE NEXT SAMPLED CHILD.	a. YEARS (COMPLETED. RANGE IS 0 TO 4)			
		b. MONTHS (COMPLETED. RANGE IS 0 TO 11)			
(1.06)	How are you related to the child?	Mother	01		CODE
		Father	02		
		Female caregiver (including other family member)	03		
		Male caregiver (including other family member)	04		
		Other, specify:	96		
(1.07)	Can you read and write? (Any WrittenLanguage)	Yes	1		CODE
		No	2		
(1.08)	What is the highest level of education that you completed, and how many years (or grades) of school have you completed within that level?	KINDERGARTEN	01		CODE
		PRIMARY/ LOWER BASIC	02		
		UPPER BASIC	03		
		HIGH SCHOOL	04		
		SENIOR SECONDARY	05		
		NON-TERTIARY/VOCATIONARY	06		
		DIPLOMA/TERTIARY	07		
		UNDERGRADUATE	08		
		MASTERS	09		
		PHD	10		
		NONE	11 ► (1.09)		

		OTHER, SPECIFY	96	
		DON'T KNOW	- 99	
		GRADE (NUMBER OF YEARS) WITHIN THAT LEVEL		

(1.09)	What is your marital status?	Single	01 ► **(2.01)**		CODE
		Monogamously Married	02		
		Polygamously Married	03		
		Widowed	04 ► **(2.01)**		
		Divorced/separated	05 ► **(2.01)**		
(1.10)	What is the highest level of education that your spouse / partner completed, and how many years (or grades) of school has your spouse / partner completed within that level?	KINDERGARTEN	01		CODE
		PRIMARY/ LOWER BASIC	02		
		UPPER BASIC	03		
		HIGH SCHOOL	04		
		SENIOR SECONDARY	05		
		NON-TERTIARY/VOCATIONARY	06		
		DIPLOMA/TERTIARY	07		
		UNDERGRADUATE	08		
		MASTERS	09		
		PHD	10		
		NONE	11 ► **(2.01)**		
		OTHER, SPECIFY	96		
		DON'T KNOW	- 99		
		GRADE (NUMBER OF YEARS) WITHIN THAT LEVEL			

(2)	**Treatment and counseling**			RECORD RESPONSE	
INTERVIEWER: INTRODUCE THIS SECTION WITH "Now I would like to ask you some questions about this visit to the health center."					
(2.01)	What is the purpose of the child's visit to the health center today? INTERVIEWER: RECORD "1" IF PURPOSE APPLIES AND "2" OTHERWISE.	a	Vaccination/Immunization ► **(2.04)**		CODE
		b	Child growth monitoring ► **(2.04)**		CODE
		c	Well baby check-up ► **(2.04)**		CODE
		d	Child illness		CODE
(2.02)	How long ago in days did this illness start?	NUMBER OF DAYS			
(2.03)	What were the symptoms that led you to bring the child to the health facility today?	a	DIARRHEA		CODE
		b	FEVER		CODE
		c	COUGH/DIFFICULTY BREATHING		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD; FOR EACH OPTION, RECORD "1" IF MENTIONED OR '2" IF NOT MENTIONED.	d	SKIN INFECTION/ PUS WOUND		CODE
		e	TONSILLITIS/ SORE THROAT		CODE
		f	OTITIS MEDIA/ PAIN IN EAR		CODE
		g	INJURY		CODE
	MENTIONED……..1 NOT MENTIONED…..2	h	OTHER, SPECIFY:		
(2.04)	Did you come to this facility on your own, or based on a referral from another facility, or	Came directly on own	01		CODE

	based on a referral from a community health worker?	Referred by health worker in another facility 02		
		Referred by a community health worker 03		
(2.05)	Did someone in the health facility ask the age of the child?	YES 1		CODE
		NO 2		

(2.06)	Did someone in the health facility weigh the child?	YES 1		CODE
		NO 2		
(2.07)	Did someone in the health facility measure the height of the child?	YES 1		CODE
		NO 2		
(2.08)	Did someone in the health facility plot weight or height against a growth chart?	YES 1		CODE
		NO 2		
		DON'T KNOW -99		
(2.09)	Did the health worker physically examine the child?	YES 1		CODE
		NO 2		
(2.10)	At this visit, did the health worker also tell you that there was something wrong with the child?	YES 1		CODE
		NO 2 ► **(2.26)**		
(2.11)	What did the health worker say was wrong with the child?	a DON'T KNOW		CODE
		b MALARIA		CODE
		c FEVER		CODE
		d MEASLES		CODE
		e DEHYDRATION		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED OR '2" IF NOT MENTIONED.	f VIRAL INFECTION/FLU		CODE
		g DIARRHEA		CODE
		h DYSENTERY/ BLOODY DIARRHEA		CODE
	MENTIONED…….1	I COLD/ UPPER RESPIRATORY INFECTION		CODE
	NOT MENTIONED…..2	j PNEUMONIA		CODE
		k MALNUTRITION		CODE
		l PARASITIC INFECTIONS		CODE
		m OTHER, SPECIFY:		
(2.12)	Did the health worker tell you things to do at home to help treat the child's illness?	YES 1		CODE
		NO 2 ► **(2.14)**		
(2.13)	What did the health worker tell you to do?	a GIVE MORE FLUIDS		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED OR '2" IF NOT MENTIONED.	b CONTINUE OR INCREASE FEEDINGS AND/OR BREASTFEEDING		CODE
		c TEPID (slightly warm) BATHS FOR FEVER		CODE
		d KEEP THE CHILD WARM		CODE

	MENTIONED……..…1 NOT MENTIONED…..2	e	AVOID GIVING MEDICATIONS OTHER THAN THOSE PRESCRIBED TODAY		CODE
		f	OTHER, SPECIFY:		
(2.14)	Did the health worker tell you to bring the child back if the child's condition becomes worse?		YES 1		CODE
			NO 2 ► **(2.16)**		

(2.15)	From the advice given to you by the health worker, how will you know if the child should be brought back?	a	FEVER DOES NOT GO AWAY AFTER CERTAIN TIME		CODE
		b	FEVER DEVELOPS		CODE
		c	CHILD IS UNABLE TO DRINK OR IS DRINKING POORLY		CODE
		d	CHANGE IN CONSCIOUSNESS		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED OR '2" IF NOT MENTIONED.	e	DIARRHEA PERSISTS		CODE
		f	BLOOD APPEARS IN THE STOOL		CODE
		g	CHILD DEVELOPS RAPID OR DIFFICULT BREATHING		CODE
		h	CHILD BECOMES SICKER FOR ANY REASON		CODE
	MENTIONED…….1	I	NEW SYMPTOMS DEVELOP		CODE
	NOT MENTIONED…..2	j	OTHER, SPECIFY:		
(2.16)	Did the child receive any medicine or prescriptions today from the health facility?	Received medicine at health facility 01			CODE
		Received prescription to get outside the health facility 02			
		Received neither medicine nor prescription at the health facility 03 ► **(2.25)**			
(2.17)	In total, how many medications were given or prescribed to the child?				
	INTERVIEWER: CHECK ANSWER FROM (2.16). IF ANSWER=01 ► (2.19). IF ANSWER=02 ► (2.18).				
(2.18)	What medicines were prescribed? INTERVIEWER: CHECK ON THE MEDICINES ON THE PRESCRIPTION FOR CONFIRMATION.	1.			
		2.			
		3.			
		4.			
		5.			
(2.19)	What medicines were given at the facility? INTERVIEWER: CHECK ON THE MEDICINES GIVEN FOR CONFIRMATION.	1.			
		2.			
		3			

	► (2.21)	4.		
		5.		
(2.20)	Were there any medicines that you were unable to get because the pharmacy did not have them in stock	YES 1 NO 2		CODE
(2.21)	How long does it take you to travel from this health facility to the location (pharmacy) where you get the prescribed medicine using your usual mode of transportation? (One way. IF IN FACILTY, RECORD 0)	MINUTES		
(2.22)	How much does it cost you to get from the facility to the pharmacy, one way?	DALASI		
(2.23)	Did the health worker thoroughly explain how to take the medicines?	YES 1 NO 2		CODE
(2.24)	Did the health worker(s) tell you about possible adverse reactions (side effects) that the given/prescribed medicine might have?	YES 1 NO 2		CODE
(2.25)	Did the health worker give you a specific date to bring the child back to the health facility for a follow-up visit?	YES 1 NO 2		CODE
(2.26)	Is the child immunization card available?	YES 1 NO 2 ► **(2.28)**		CODE
(2.27)	**INTERVIEWER: CHECK CHILD'S IMMUNIZATION STATUS.**			
	RECORD "01" FOR RECEIVED AND "02" FOR NOT RECEIVED.	**RECEIVED**	**NOT RECEIVED**	RECORD RESPONSE
A	BCG	01	02	CODE
B	Pentavalent DTP/Hep B/Hib 1	01	02	CODE
C	Pentavalent DTP/Hep B/Hib 2	01	02	CODE
D	Pentavalent DTP/Hep B/Hib 3	01	02	CODE
E	Pentavalent DTP/Hep B/Hib 4	01	02	CODE
F	Rotavirus	01	02	CODE
G	Yellow Fever	01	02	CODE
H	OPV0	01	02	CODE
I	OPV1	01	02	CODE
J	OPV2	01	02	CODE
K	OPV3	01	02	CODE
L	OPV4	01	02	CODE
M	OPV5	01	02	CODE
N	Pneumococcal Vaccine	01	02	CODE
O	Rotaviris	01	02	CODE
P	Measles	01	02	CODE
Q	Vitamin A	01	02	CODE
R	Deworming	01	02	CODE
(2.28)	Did your child receive an immunization today?	YES 1 NO 2		CODE

(2.29)	Following the last immunization the child received (whether today or in the past), does the child need to receive more immunization(s)?	YES 1		CODE
		NO 2 ► **(2.31)**		
(2.30)	What is the date of return for the child's next immunization? INTERVIEWER: IF CARD AVAILABLE, CHECK CARD. IF NOT OR IF NO INFORMATION ON THE CARD, ASK CAREGIVER.	a. DAY (DD)		
		b. MONTH (MM)		
		c. YEAR (YYYY)		
(2.31)	Did the health worker ask you to bring back the child to receive immunization another day?	YES 1		CODE
		NO 2 ► **(3.01)**		
(2.32)	When did the health worker ask you to bring the child back?	a. MONTH (MM)		
		b. YEAR (YYYY)		

(3)	**Patient travel and expenditure**		RECORD RESPONSE	
(3.01)	How far is your household from this health facility in kilometers **(One way)**? Enter 99 if Don't Know	Kilometers		
(3.02)	How long did it take you/the patient to reach this health facility from home today? (**One way**)	MINUTES		
(3.03)	What was your primary mode of transportation today? (**One way**)	By foot 01 ► **(3.05)**		CODE
		Bicycle 02 ► **(3.05)**		
		Horse/ Donkey or Other Animal 03		
		Private car 04		
		Public car/bus including taxi 05		
		Private motorcycle 06		
		Other, specify: 96		
(3.04)	How much did it cost in Dalasi for you/the patient to travel to the health facility today? **(One way)**	DALASI		
(3.05)	How long did you/the patient wait in the health facility before being seen in consultation by the health worker?	MINUTES		
(3.06)	Do you think the time you spent waiting was too long?	YES 1		CODE
		NO 2		
(3.07)	How long did you/the patient spend with the doctor or nurse during the consultation?	MINUTES		
(3.08)	Do you think the time you spent with the worker was enough?	YES 1		CODE

		NO 2		
(3.09)	Was a registration/ consultation/ doctor fee charged?	YES 1 NO 2 ► **(3.11)**		CODE
(3.10)	How much was paid in Dalasi for this?	DALASI		
(3.11)	Was a laboratory test done?	YES 1 NO 2 ► **(3.13)**		CODE
(3.12)	How much was paid in Dalasi for this?	DALASI		
(3.13)	Was an x-ray done?	YES 1 NO 2 ► **(3.15)**		CODE

(3.14)	How much was paid in Dalasi for this?	DALASI		
(3.15)	Were medicines dispensed to you at the pharmacy in the health center?	YES 1 NO 2 ► **(3.17)**		CODE
(3.16)	How much was paid in Dalasi for this?	DALASI		
(3.17)	How much was spent in total in DALASI at the facility for this visit, not including transportation costs? INTERVIEWER: CHECK TO SEE IF THE TOTAL MATCHES THE AMOUNTS GIVEN. IF NOTHING WAS PAID ► (3.19).	DALASI		
(3.18)	Where did the money come from that was used to pay for health care today? INTERVIEWER: DO NOT READ OPTIONS ALOUD, BUT FOR EACH OPTION RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS (E.G., "ANYTHING ELSE?") MENTIONED…….1 NOT MENTIONED..2	a. SAVINGS OR REGULAR HOUSEHOLD BUDGET		CODE
		b. HEALTH INSURANCE		CODE
		c. SELLING HOUSEHOLD POSSESSIONS		CODE
		d. MORTGAGING OR SELLING LAND OR REAL ESTATE		CODE
		e. FROM A FRIEND OR RELATIVE		CODE
		f. FROM SOMEONE OTHER THAN FAMILY AND FRIENDS		CODE
		g. OTHER, SPECIFY:		
(3.19)	Is the child covered under a health insurance scheme?	YES 1 NO 2 ► **(4.01)**		CODE
(3.20)	What type of health insurance is this? Is it Public, Private or both?	Public 01 Private 02 Both 03		CODE
(3.21)	In the last 12 months, how many months has the household been enrolled in the insurance scheme?	MONTHS		

(4)	Patient satisfaction			RECORD RESPONSE	
(4.01)	What was the **most important** reason you chose this health facility today instead of a different source of care? INTERVIEWER: DO NOT READ OPTIONS ALOUD. ONLY ONE ANSWER IS ALLOWED.	LOCATION CLOSE TO HOME	01		CODE
		LOW COST	02		
		TRUST IN PROVIDERS / HIGH QUALITY CARE	03		
		AVAILABILITY OF DRUGS	04		
		AVAILABILITY OF FEMALE PROVIDER	05		
		AVAILABILITY OF MALE PROVIDER	06		
		RECOMMENDATION OR REFERRAL	07		
		OTHER, SPECIFY:	96		
(4.02)	What was the next most important reason you chose this health facility today instead of a different source of care? INTERVIEWER: DO NOT READ OPTIONS ALOUD. ONLY ONE ANSWER IS ALLOWED.	No other reason	01		CODE
		Location close to home	02		
		Low cost	03		
		Trust in providers/ high quality care	04		
		Availability of drugs	05		
		Availability of female provider	06		
		Availability of male provider	07		
		Recommendation or referral	08		
		Other, specify:	96		

(4)	Patient satisfaction (continued)						
I'm going to read you a series of statements regarding this health facility. Please tell me if you agree, neither agree nor disagree or disagree with each statement. Some statements may not apply to your situation. Please let me know if a statement does not apply to you.							
INTERVIEWER: READ EACH STATEMENT TO THE RESPONDENT AND RECORD THE RESPONSE CODE FOR EACH QUESTION. SHOW AND ASK TO PICK OUT THE COLORED AND NUMBERED CARDS WITH RESPONSE CODES.							
		Agree	**Neither agree nor disagree**	**Disagree**	**Not applicable**	RECORD RESPONSE	

(4.03)	It is convenient to travel from your house to the health facility.	1	2	3	4		CODE
(4.04)	The health facility is clean.	1	2	3	4		CODE
(4.05)	The health staff are courteous and respectful.	1	2	3	4		CODE
(4.06)	The health workers did a good job of explaining your child's condition.	1	2	3	4		CODE
(4.07)	It is easy to get medicine that health workers prescribe.	1	2	3	4		CODE
(4.08)	The registration fees of this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.09)	The lab fees of this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.10)	The medication fees of this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.11)	The transport fees for this visit to the health facility were reasonable.	1	2	3	4		CODE
(4.12)	The amount of time you spent waiting to be seen by a health worker was reasonable.	1	2	3	4		CODE
(4.13)	You had enough privacy during your visit.	1	2	3	4		CODE
(4.14)	The health worker spent a sufficient amount of time with you.	1	2	3	4		CODE
(4.15)	The hours the facility is open are adequate to meet your needs.	1	2	3	4		CODE
(4.16)	The overall quality of services provided was satisfactory.	1	2	3	4		CODE
(4.17)	The health workers treated you with care and compassion.	1	2	3	4		CODE
(4.18)	The health workers provide good quality child health services.	1	2	3	4		CODE
(4.19)	The health workers provide good antenatal health services.	1	2	3	4		CODE
(4.20)	The health workers provide good quality delivery services.	1	2	3	4		CODE

(5)	**Security and Trust**					
I'm going to read you a series of statements regarding security and trust in this health facility. Please respond to the statements as you did above by confirming if you agree, neither agree nor disagree,or disagree with each statement. Some of these statements may not apply to you. Please tell me if any of those statements does not apply to you.						
INTERVIEWER: READ EACH STATEMENT TO THE RESPONDENT AND RECORD THE RESPONSE CODE FOR EACH QUESTION. SHOW AND ASK TO PICK OUT THE COLORED AND NUMBERED CARDS WITH RESPONSE CODES.						
		Agree	**Neither agree nor disagree**	**Disagree**	**Not applicable**	RECORD RESPONSE

(5.01)	The area around the health facility is not safe and it makes it difficult for the people in the community to use available health services	1	2	3	4		CODE
(5.02)	The health workers in this facility are extremely thorough and careful.	1	2	3	4		CODE
(5.03)	You trust in the skills and abilities of the health workers of this facility.	1	2	3	4		CODE
(5.04)	You completely trust the health worker's decisions about medical treatments in this facility.	1	2	3	4		CODE
(5.05)	The health workers in this facility are very friendly and approachable.	1	2	3	4		CODE
(5.06)	The health workers in this facility are easy to make contact with.	1	2	3	4		CODE
(5.07)	The health workers in this facility care about your child's health just as much or more than you do.	1	2	3	4		CODE
(5.08)	The health workers in this facility act differently toward rich people than toward poor people.	1	2	3	4		CODE
(5.09)	All in all, you trust the health workers completely in this health facility.	1	2	3	4		CODE

(6)	**Questions about the household**			RECORD RESPONSE	
(6.01)	Does your household own any land, including land where you have a house?	YES	1		CODE
		NO	2 ► **(6.03)**		
		DON'T KNOW	99 ► **(6.03)**		
(6.02)	If you were to sell the land you own, how much in DALASI do you think you would receive for it?	DALASI			
(6.03)	MAIN MATERIAL USED FOR FLOOR:				CODE
		NATURAL FLOOR:			
		EARTH/SAND	11		
		DUNG	12		
		RUDIMENTARY FLOOR			
		WOOD PLANKS	21		
		PALM / BAMBOO	22		
		FINISHED FLOOR			
		VINYL/ASPHALT STRIPS	31		
		CERAMIC TILES	32		
		CEMNET	33		
		OTHER, SPECIFY	96		

(6.04)	MAIN MATERIAL USED FOR ROOF:			CODE
		NATURAL ROOF:		
		NO ROOF 11		
		THATCH/PALM LEAF 12		
		RUDIMENTARY ROOFING		
		RUSTIC MAT 21		
		PALM / BAMBOO 22		
		WOOD PLANKS 23		
		FINISHED ROOFING		
		METAL/CORRUGATE 31		
		WOOD 32		
		CALAMINE/CEMENT FIBER 33		
		CEMENT 34		
		ROOFING TILES 35		
		OTHER, SPECIFY 96		
(6.05)	MAIN MATERIAL USED FOR EXTERIOR WALL:			CODE
		NATURAL WALLS:		
		CANE/PALM/TRUNKS 12		
		DIRT 13		
		RUDIMENTARY WALLS		
		BAMBOO WITH MUD 21		
		STONE WITH MUD 22		
		PLYWOOD 23		
		REUSED WOOD 24		
		FINISHED WALLS		
		CEMENT 31		
		STONE WITH LIME/CEMENT 32		
		BRICKS 33		
		WOOD PLANKS/SHINGLES 34		
		OTHER, SPECIFY 96		

(6.06)	How many rooms does your household have, Including rooms outside the main dwelling, not counting the kitchen and bathrooms? INTERVIEWER: DO NOT COUNT KITCHEN AND BATHROOM.			
(6.07)	How many people live in your household? INTERVIEWER: WRITE THE TOTAL NUMBER IN EACH CATEGORY.	a. Men 18 years and older		
		b. Women 18 years and older		
		c. Children & adolescents between 6 & 17 years		
		d. Children 5 years and below		
		e. Total		
(6.08)	Does your household have electricity?	YES 1		
		NO 2		CODE

(7) Household assets

		(7.01)	
	ASSET	How many [ASSET]s does your household own? INTERVIEWER: ONLY INCLUDE FUNCTIONING ASSETS. IF ZERO, RECORD "0".	
a	Radio/CD/cassette player?		CODE
b	Television?		CODE
c	Clothes iron?		CODE
d	Electric stove?		CODE
e	Gas stove?		CODE
f	Paraffin lamp?		CODE
g	Bed?		CODE
h	Mattress?		CODE
i	Refrigerator / freezer?		CODE
j	Sewing machine?		CODE
k	Table? (for dining?)		CODE
l	Sofa?		CODE
m	Land line telephone?		CODE
n	Mobile / Telephone?		CODE
o	Motorcycle?		CODE
p	Bicycle?		CODE
q	Truck or car?		CODE
r	Wheelbarrow?		CODE
s	Plough?		CODE
t	Hoes / harrows / axes ?		CODE
		(7.02)	
	ANIMAL	How many [ANIMAL]s does your household own? INTERVIEWER: IF ZERO, RECORD "0".	
a	Oxen?		CODE
b	Cattle?		
c	Goats?		CODE
d	Sheep?		CODE
e	Pigs?		CODE

f	Poultry?		CODE
g	Game?		CODE
h	Donkey?		CODE
i	Horse?		CODE
j	Other, specify:		CODE

(8)	Community Health Nurse			RECORD RESPONSE	
(8.01)	Do you know of any community health nurses (CHN) in your community?	Yes	1		CODE
		No	2 ► **END**		
(8.02)	Do you have both male and female Community Health Nurses in your community?	Male CHN only	01		CODE
		Female CHNonly	02		
		Both Male and Female	03		
(8.03)	Have you used Community Health Nurse services in the last month, either in your own home, in the community or in the health post?	Yes, at own home	01		CODE
		Yes, at health post	02		
		Yes, in the community	03		
		Yes, both at home and in the health post	04		
		Yes, both at home and in the community	05		
		Yes, both in the health post and in the community	06		
		Yes, both at home, in the health post and the community	07		
		No	08 ► **(8.05)**		

(8.04)	What services did the Community Health Nurse provide you?	a. PROVIDE IRON / FOLIC ACID TABLETS		CODE
		b. PROVIDE TETANUS TOXOID IMMUNIZATION		CODE
		c. PROVIDE VITAMIN A		
		d. PROVIDE PREVENTIVE ANTIMALARIAL PILLS		CODE
	INTERVIEWER: DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, RECORD "1" IF MENTIONED, "2" IF NOT MENTIONED.	e. INFORMATION ON DANGER SIGNS DURING PREGNANCY		CODE
		f. ADVICE ON EXCLUSIVE BREASTFEEDING		CODE
		g. HEALTH EDUCATION OR PROMOTION		CODE
		h. REFERRAL TO HEALTH FACILITY		CODE
		i. OTHER, SPECIFY:		
I'm going to read you three statements in relation to work done by the Community Health Nurses Please indicate if you agree, neither agree nor disagree, or disagree with each statement.				

INTERVIEWER: READ EACH STATEMENT TO THE RESPONDENT AND RECORD THE RESPONSE CODE FOR EACH QUESTION. SHOW AND ASK TO PICK OUT THE COLORED AND NUMBERED CARDS WITH RESPONSE CODES.

		Agree	Neither agree nor disagree	Disagree	RECORD RESPONSE	
(8.05)	Community Health Nurses provide a valuable service in my community.	01	02	03		CODE
(8.06)	Community Health Nurses provide good quality service in my community.	01	02	03		CODE
(8.07)	I prefer to see a Community Health Nurses rather than come to the health facility.	01	02	03		CODE

THANK YOU FOR YOUR TIME

Annex 6 Village Development Committee questionnaire

Health Results Based Financing
The Gambia
2014

COMMUNITY QUESTIONNAIRE

IDENTIFIER	
EA NUMBER	VILLAGE CODE

Ethical Information Sheet

Maternal and Child Nutrition and Health Results Project

Title of Research: Impact Evaluation of the Maternal and Child Nutrition and Health Results Project

Greetings/Introduction

You are being invited to take part in a research study that is looking at the impact assessment of the Maternal and Child Nutrition and Health Results Project, also called the MCNHRP. Before you make a decision, I would like to explain the reason for the study because it is important that you understand why the research is being conducted and what it would involve. You are free to ask questions or seek for clarification if there is anything that is not clear, or if you would like more information.

Reason for the study

The Government of the Gambia is going to implement a program in North Bank West, Upper River Region and Central River Region to improve health and nutrition. This study will assess what the impact of the program has been, including offering information that can help improve implementation.

How to take part?

You are free to participate or not in the study and you have the right to stop participating at any time without giving a reason. If you decide to take part, you will be asked to sign or thumbprint a consent form. If you decide after you have begun participation that you do not want to be included in the study, let a member of the team know, and your information will not be used.

What would happen to me if I take part?

You are invited to take part in this study. This will involve us asking questions about your community, your role in the community and information related to your community's health and nutrition. Your participation in the study will affect you in no harmful way.

Would my taking part in this study be kept confidential?

All information that is collected about you in the course of the study will be kept strictly confidential, and you have the right not to answer any of the questions as well as not to participate. Your personal information will only be available to the study team members and might be seen by some rightful persons from the Ethics Committee, Government authorities and sponsor.

Who has reviewed the study?

This research study has been submitted to the Research and Publication Committee, University of The Gambia and the Gambian Government/MRC Ethics Committee. It was approved by the two committees before final approval by the World Bank.

Who can I contact?

If you have any queries regarding the study you can contact Mr. Yaya S Jallow on (+220) 365 7614. If at any point you have a question, please ask the field staff or Mr. Yaya S Jallow.

Do you agree to participate and answer the following survey questions?

Yes I agree ☐
Not agreed ☐ ► END
Withdrawn ☐ ► END

Section 1: Direct Observation

NOTE TO SURVEYOR, TYPICALLY MEANS 75 PERCENT

(1.01) DO THE CHILDREN (UNDER 12 YEARS OLD) IN THIS COMMUNITY TYPICALLY WEAR SHOES (FOOT WEAR)?

YES	01
NO	02

(1.02) DO THE ADULTS (12 YEARS AND OLDER) IN THIS COMMUNITY TYPICALLY WEAR SHOES (FOOT WEAR)?

YES	01
NO	02

(1.03) DO THE HOUSES IN THIS COMMUNITY TYPICALLY HAVE GLASS IN THEIR WINDOWS?

YES	01
NO	02

(1.04) ARE THE HOUSE SURROUNDINGS IN THIS COMMUNITY SWEPT CLEAN?

YES	01
NO	02

(1.05) WHAT MATERIAL IS MOST COMMONLY USED FOR THE FLOORS IN HOUSES IN THIS COMMUNITY?

NATURAL FLOOR:	11
EARTH/SAND	12
DUNG	
RUDIMENTARY FLOOR	21
WOOD PLANKS	22
PALM / BAMBOO	
FINISHED FLOOR	31
CERAMIC TILES	34
CEMENT	35
PLASTIC/ELLINEUM OR OTHI	36
◄ OTHER, SPECIFY	96

FLOORS

(1.06) WHAT MATERIAL IS MOST COMMONLY USED FOR FOR THE ROOFS FOR HOUSES IN THIS COMMUNITY?

NATURAL ROOF:	
THATCH/PALM LEAF	12
RUDIMENTARY ROOFING	
RUSTIC MAT	21
PALM / BAMBOO	22
WOOD PLANKS	23
FINISHED ROOFING	
CORRUGATED/ METAL	31
WOOD	32
CALAMINE/CEMENT FIBER	33
CEMENT	35
ROOFING TILES	36
◄ OTHER, SPECIFY	96

ROOFS

(1.07) WHAT MATERIAL IS MOST COMMONLY USED FOR THE OUTSIDE WALLS OF THE HOUSES IN THIS COMMUNITY?

NATURAL WALLS:	
CANE/PALM/TRUNKS	12
DIRT/MUD	13
RUDIMENTARY WALLS	
BAMBOO WITH MUD	21
STONE WITH MUD	22
PLYWOOD	24
REUSED WOOD	26
FINISHED WALLS	
CEMENT	31
STONE WITH LIME/CEMENT	32
BRICKS	33
WOOD PLANKS/SHINGLES	35
◄ OTHER, SPECIFY	96

WALLS

(1.08) ARE THERE PILES OF EXPOSED GARBAGE VISIBLE ALONG THE ROADS/STREETS/PATHS?

YES	01
NO	02

(1.09) ARE ANIMAL DROPPINGS VISIBLE IN THE COMMUNITY?

YES	01
NO	02

(1.10) ARE THERE OBSTRUCTED SEWERS, GUTTERS, OR CANALS IN THIS VILLAGE?

YES	01
NO	02

(1.11) ARE THERE STANDING STAGNANT POOLS OF WATER (DO NOT INCLUDE MARSHES, LAKES, OR PONDS) IN THIS COMMUNITY?

YES	01
NO	02

(1.12) ARE THERE ANY LARGE LIVESTOCK VISIBLE ROAMING AROUND THE HOUSES?

YES	01
NO	02

(1.13) IN GENERAL, HOW CLEAN DO YOU THINK THIS VILLAGE IS COMPARED TO OTHER VILLAGES IN THE AREA?

MUCH DIRTIER	01
DIRTIER	02
ABOUT THE SAME	03
CLEANER	04
MUCH CLEANER	05

(1.14) WHAT IS THE TOPOGRAPHY OF THIS COMMUNITY?

INLAND PLAINS	01
RIVERSIDE/COASTAL	02
◄ OTHER (SPECIFY)	96

_____

Section 2: Informant Background

You will administer this questionnaire to the head of the Village Development Committee (VDC), or, if not available, the deputy head

(2.01)	(2.02)	(2.03)	(2.04)	(2.05)	(2.06)	(2.07)	(2.08)	(2.09)	(2.10)		(2.11)
What is your position in the community? (MULITPLE Choose from list below:	What is your current position in the VDC?	Please record gender.	How old are you? ***(enter years)***	For how many years have you lived in this community?	What is the highest level of education you have completed?	For this level, what is the highest class completed?	What is your marital status	How many years have you been a member of the VDC? (years)	How many male and female members does the VDC currenlty have?		How many times per month does the VDC come together
CHAIRPERSON A	Head 01	MALE 01			KINDERGARTEN 01		Single 01				
SPOUSE TO VILLAGE HEAD B	Other 02	FEMALE 02			PRIMARY/ LOWER BASIC 02		Married 02				
SCHOOL HEADTEACHER C					UPPER BASIC 03		Widowed 03				
TEACHER D					HIGH SCHOOL 04		Divorced 04				
AGRICULTURAL E					SENIOR SECONDARY 05						
RELIGIOUS LEADER F					NON- 06						
MERCHANT/BUSINESS G					DIPLOMA/TERTIARY 07						
HEALTH WORKER H					UNDERGRADUATE 08						
NGO WORKER I					MASTERS 09						
OTHER (SPECIFY) J					PHD 10						
					NONE 11 ▶ (2.08)						
					OTHER, SPECIFY 96 ▶ (2.08)						
					DON'T KNOW -99 ▶ (2.08)						
CODES	CODE	CODE	YEARS	YEARS	CODE	LEVEL	CODE	YEARS	MALES	FEMALES	NUMBER

(2.12)	(2.13)	(2.14)	(2.15)								(2.16)
In the past week, how many hours have members of the VDC spent on average on community activities?	How much money did the VDC receive last year for community activities	How is resource allocation decided by the VDC?	Does the VDC currently supervise any of the following activities? YES 1 NO 2								Do members of the VDC committee receive any money for being on this No 0 Yes 1
		Head 01 Consensus 02 Vote 03 Other, Specify 96	A. Cleaning	B. Builing a road	C. Building a health facility	D. Buidling a school	E, Building latrines	F. Electricity	G. Other infrastructure	H. Heatlh and Nutrition Promotion	
HOURS	DALASI	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE

Section 3: Community Demographics

You will administer this questionnaire to the head of the Village Development Committee (VDC), or, if not available, the deputy head

(3.01) How many households are there in this community? NUMBER OF HOUSEHOLDS: [ ]

(3.02) How many people live in this community? NUMBER OF PEOPLE: [ ]

(3.03) What are the most common religions practised by residents of this community?

RECORD UP TO THREE

MUSLIM/ISLAM	01	1st [ ]
CHRISTIAN	02	
TRADITIONAL	03	2nd [ ]
◄ OTHER (SPECIFY)	96	
		3rd [ ]

(3.04) What is the PERCENTAGE of households that practice these religions?

1st % OF HOUSEHOLDS [ ]
2nd % OF HOUSEHOLDS [ ]
3rd % OF HOUSEHOLDS [ ]

(3.05) What are the most common languages spoken in their homes by residents of this community?

RECORD UP TO THREE

MANDINKA	01	1st [ ]
WOLOF	02	
FULA	03	2nd [ ]
JOLA	04	
SERER	05	3rd [ ]
SARAHULE	06	
MANJAGO	07	
◄ OTHER (SPECIFY)	96	

(3.06) What is the PERCENTAGE of households that speak each of these languages in this community?

1st % OF HOUSEHOLDS [ ]
2nd % OF HOUSEHOLDS [ ]
3rd % OF HOUSEHOLDS [ ]

(3.07) What is the main ethnic group in this community?

RECORD UP TO THREE

MANDINKA	01	1st [ ]
WOLOF	02	
FULA	03	2nd [ ]
JOLA	04	
SERERS	05	3rd [ ]
SARAHULE	06	
MANJAGO	07	
◄ OTHER	96	

(3.08) What is the PERCENTAGE of households in the community that belongs to each of these ethnic groups?

1st % OF HOUSEHOLDS [ ]
2nd % OF HOUSEHOLDS [ ]
3rd % OF HOUSEHOLDS [ ]

Section 4: Access to Basic Services and Community Characteristics

(4.01) What is the most common type of road surface in this community?

TAR / TARMAC (PAVED)	01 ►	(4.04)
GRAVEL	02	
DUST	03	
_____ ◄ OTHER (SPECIFY)	96	

(4.02) How far is it to the nearest paved (tar / tarmac) road?
RECORD TO NEAREST .25 OF KILOMETER. RECORD "0" IF VILLAGE IS ON THE ROAD OR LESS THAN .25 KM FROM ROAD. KM:

(4.03) Do vehicles pass on the main road in this commmunity throughout the year?

YES	01
NO	02

(4.04) During the past 12 months, how many months was the main road passable by horse or donkey cart?

YES	01
NO	02

(4.05) During the past 12 months, how many months was the main road passable by car?
NUMBER OF MONTHS:

(4.06) During the past 12 months, how many months was the main road passable by heavy vehicles (4WD, lo
NUMBER OF MONTHS:

(4.07) Do light trucks and public transport (buses, minibuses or taxis) stop in this community?

YES	01
NO	02

(4.08) How difficult is it to travel to and from this village?

VERY DIFFICULT	01
DIFFICULT	02
A LITTLE DIFFICULT	03
EASY	04

(4.09) Are boats an important means of transportation in this community?

YES	01	
NO	02 ►	(4.11)

(4.10) For how many months last year could motorboats travel on the main waterway?
NUMBER OF MONTHS:

(4.11) How far is it to the nearest major urban center ONE WAY?
KM:

(4.12) What is the cost of the total fare to go by public transport from here to the nearest urban center ONE WAY?
DALASI:

(4.13) What is the main source of drinking water for residents of this community during the **dry / wet** season?

PIPED WATER	
PIPED INTO DWELLING	11
PIPED INTO YARD/PLOT	12
PUBLIC TAP/STANDPIPE	13
TUBEWELL/BOREHOLE	21
DUG WELL	
PROTECTED WELL	31
UNPROTECTED WELL	32
WATER FROM SPRING	
PROTECTED SPRING	41
UNPROTECTED SPRING	42
RAINWATER	51
SURFACE WATER(RIVER/DAM/L	81
BOTTLED WATER	91
_____ ◄ OTHER, SPECIFY	96

DRY SEASON:

WET SEASON:

Section 4: Access to Basic Services and Community Characteristics

(4.14) What are the most common types of toilet that households in this community have?
RECORD UP TO THREE

FLUSH OR POUR FLUSH TOILET		
FLUSH TO SEPTIC TANK	12	
FLUSH TO PIT LATRINE	13	1st
FLUSH TO SOMEWHERE ELSE	14	
FLUSH, DON'T KNOW WHERE	15	
PIT LATRINE		2nd
VENTILATED IMPROVED LATRINE	21	
PIT LATRINE WITH SLAB	22	3rd
PIT LATRINE WITHOUT SLAB/OPE	23	
NO FACILITY/BUSH/FIELD	61	
OTHER, SPECIFY	96	

(4.15) What PERCENTAGE of households in this community use each type of toilet?

% OF HOUSEHOLDS 1st: ____ % OF HOUSEHOLDS 2nd: ____ % OF HOUSEHOLDS 3rd: ____

(4.16) What PERCENTAGE of households in this community have electricity?

% OF HOUSEHOLDS: ____

(4.17) For how many hours each day do these households normally have electricity?

NUMBER OF HOURS: ____

(4.18) How do most households in this community dispose off their refuse/rubbish?
RECORD UP TO THREE

REFUSE COLLECTED	01	1st
PIT	02	
BURY	03	2nd
BURN	04	
NOTHING	05	3rd
OTHER	96	

(4.19) What is the nearest body of water to this community?

STREAM	01
RIVER	02
POND	03
LAKE	04
SWAMP	05
MARSH	06
OTHER	96

(4.20) How far from the community is this body of water?

KM: ____

(4.21) For how many months each year does this body of water contain water?

NUMBER OF MONTHS: ____

(4.22) In the last 12 months, did it rain more than normal, normal or less than normal?

MUCH MORE THAN NORMAL	01
MORE THAN NORMAL	02
NORMAL	03
LESS THAN NORMAL	04
MUCH LESS THAN NORMAL	05

(4.23) In the last 12 months, was the temperature higher, the same or lower than normal?

MUCH HIGHER THAN USUAL	01
SOMEWHAT HIGHER THAN USUAL	02
ABOUT THE SAME	03
SOMEWHAT LOWER THAN USUAL	04
MUCH LOWER THAN USUAL	05

(4.24) In the last 12 months, did it rain more than earier, on time or later than normal?

MUCH EARLIER THAN NORMAL	01
SOMEWHAT EARLIER THAN NOR	02
ON TIME	03
SOMEWHAT LATER THAN NORM	04
MUCH LATER THAN NORMAL	05

Section 4: Access to Basic Services and Community Characteristics

You will administer this questionnaire to the head of the Village Development Committee (VDC), or, if not available, the deputy head

FACILITY NUMBER	FACILITY DESCRIPTION	(4.25) Is there a [FACILITY] in or near your community?	(4.26) How far from your community is the nearest [FACILITY]?	(4.27) In what year was the nearest [FACILITY] established?	(4.28) Which organization helped with the nearest [FACILITY]'s construction/establishment? NOTE: This is outside assistance, and should not include government	(4.29) What type of help did the organization provide?					(4.30) Did the community contribute towards the construction/establishment of the nearest [FACILITY]?
		YES 1 ► (4.27) NO 2			01 02 03 04 05 06 07 08 96	YES 1 NO 2 A LABOR	B MATERIALS	C CASH	D REHABILITATION	E CONSTRUCTION	YES 1 NO 2 ► (4.33)
		CODE	KM	YYYY	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01	Primary School Classrooms										
02	Junior Secondary School Classrooms										
03	Senior Secondary School Classrooms										
04	Govt. Hospital										
05	Govt. Health Center										
06	Govt. Health Post										
07	Private Clinic										
08	Private Health Center										
09	Private Health Post										
10	Pharmacy										
11	Drug Store										

Section 4: Access to Basic Services and Community Characteristics

(4.31) **What is the name of the nearest health center?**

FACILITY NUMBER	(4.32)				(4.33)	(4.34)	(4.35)			(4.36)	(4.37)	(4.38)				
	What did the community contribute to the construction/establishment of the nearest [FACILITY]?				How many people work in the nearest [FACILITY]?	How many people does the nearest [FACILITY] serve?	Can you purchase any of the following at the [HEALTH FACILITY]?			How often is Coartem available at the [FACILITY]?	How often are rapid diagnostic tests (RDTs) for malaria available at the [FACILITY]?	Are any of the following working at the [FACILITY]?				
	YES 1						YES 1			ALWAYS 1	ALWAYS 1	YES 1				
	NO 2						NO 2			SOMETIMES 2	SOMETIMES 2	NO 2				
	A.	B.	C.	D.			A.	B.	C.	NEVER 3	NEVER 3	A.	B.	C.	D.	E.
	LABOR	MATERIALS	CASH	OTHER			PARACETAMOL	COARTEM	FANSIDAR			DOCTOR	NURSE	MIDWIFE	PUBLIC HEALTH OFFICER	LAB TECHNICIAN
	CODE	CODE	CODE	CODE	NUMBER	NUMBER	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01																

Section 5: Social Capital and Community Empowerment

ID GROUP		(5.01)	(5.02)	(5.03)	(5.04)
	Are there any ..[GROUP]s.. active in this community? YES 1 NO 2 ► NEXT ITEM		How many members does … have? [RECORD THE MOST ACTIVE]	In what year was … started?	How frequenly do you meet with this group montly?
		CODE	NUMBER	YYYY	NUMBER
01	Neighbourhood Health Committee				
02	Women's Club/ Mothers Support				
03	Credit Club				
04	Peer Educators Club				
05	Football Club				
06	Agricultural Committee				
07	Youth Club				
08	Village Support Groups				
09					
96	Other (Specify)				

ID ACTIVITY	(5.05) In this community, can women…… YES 1 NO 2	
1	Purchase Land	
2	Inherit Land	
3	Sell Land	
4	Leave Land as a Bequest when they die?	

Do individuals in this community trace their descent through their father, their mother, or are both kinds of descent traced? (PATRILINEAL OR MATRILINEAL)

MOTHER	01
FATHER	02
BOTH	03
◄ OTHER (SPECIFY)	96

How is the village headman of this community chosen?

ELECTED	01
APPOINTED BY ELDERS	02
APPOINTED BY COMMITTEE	03
APPOINTED BY GOVERNEMN	04
INHERITED	05
◄ OTHER (SPECIFY)	96

(5.08) Who participates in deciding which community development project is to take place within this community?

RECORD UP TO 3

GOVERNMENT	01
CHIEF / HEADMAN	02
COMMUNITY	03
NGO FINANCING PROJECT	04
VDC	05
VSG	06
◄ OTHER	96

(5.09) Do community leaders hold regular meetings with the households?

YES	1
NO	2

(5.10) How often do community leaders hold meetings?

TWICE A MONTH	01	TWICE A YEAR	05
ONCE A MONTH	02	ONCE A YEAR	06
ONCE IN TWO MONTHS	03	IRREGULARLY	07
ONCE IN THREE MONTHS	04	NEVER	08

(5.11) About how many people attend?

RECORD NAME AND NUMBER OF PEOPLE FOR EACH VILLAGE

NB.	A.- VILLAGE NAME	B.- NUMBER OF PEOPLE
1		
2		
3		
4		
5		
6		
7		
8		

Section 6: Economic Activities

You will administer this questionnaire to the head of the Village Development Committee (VDC), or best informed respondent

(6.01) What activities are the most important sources of livelihood for individuals in this community?

RECORD UP TO THREE

WAGE EMPLOYMENT	01	
RUNNING A BUSINESS / SELF-EMPLOYED	02	1st
FARMING	03	
FISHING	04	
CHARCOAL / FIREWOOD	05	2nd
BEE KEEPING	06	
PIECEWORK (Eg Carpentry or Seamstress where	07	
◄ OTHER (SPECIFY)	96	3rd

(6.02) Do people in this community leave temporarily during certain times of the year to look for work elsewhere?

YES	1	
NO	2	► (6.05)

(6.03) In the past 12 months, FROM what percentage of households in this community have members left temporarily to look for work elsewhere?

NUMBER OF HOUSEHOLDS:

(6.04) Where do most of them go?

RURAL AREAS	1
URBAN AREAS	2
OUTSIDE THE GAMBIA	3

(6.05) Do people from outside of this community come to work temporarily in this community during certain times of the year?

YES	1	
NO	2	► (7.08)

(6.06) In the past 12 months, how many people came into this community to work temporarily?

NUMBER OF PEOPLE:

(6.07) Where do most of them come from?

RURAL AREAS	1
URBAN AREAS	2
OUTSIDE THE GAMBIA	3

(6.08) Do any households grow crops or keep livestock in this community?

YES	1	
NO	2	► (7.01)

(6.09) What PERCENTAGE of households grow crops in this community?

% OF HOUSEHOLDS:

(6.10) What PERCENTAGE of households keep goats in this community?

% OF HOUSEHOLDS:

(6.11) What PERCENTAGE of households keep sheep in this community?

% OF HOUSEHOLDS:

(6.12) What PERCENTAGE of households keep cattle in this community?

% OF HOUSEHOLDS:

(6.13) Are there any groups in this coimmunity that are poorer than average?

WIDOWS	1
SINGLE MOTHERS	2
ELDERLY	3
OTHER, SPECIFY	96

(6.14) In general, do you think that people in this village are poorer, wealthier or the same as other villages in the area?

POORER	1
THE SAME	2
WEALTHIER	3

(6.15) In general, do you think that people in this village are poorer, wealthier or the same as they were 5 years ago?

POORER	1
THE SAME	2
WEALTHIER	3

Section 7: External Shocks

I would now like us to talk about the important events that have taken place in this community in the past 10 years, i.e. since 2004, including any events that have occurred this year. We are specifically interested in events that have changed the well-being of people in this community for better or for worse. Examples of events that might have made people worse off are disease epidemcis, crop failures, natural disasters, price fluctuations, or the loss of key social services. Examples of events that may have made people better off are new schools or medical facilities, new employment opportunities, or the construction of a new road.

SHOCK NUMBER	SHOCK DESCRIPTION	(7.01) Has … taken place / been constructed in this community in the past 10 years? YES 1 NO 2 ► NEXT ITEM	(7.02) How many times in the past 10 years has……taken place?	(7.03) In which year did … last occur?	(7.04) What percentage of housholds in the community were affected by …?
		CODE	NUMBER OF TIMES	YEAR	0-100
01	Drought				
02	Flood				
03	Crop Disease/pests				
04	Livestock Disease				
05	Human Epidemic Disease				
06	Sharp Changes in Prices				
07	Massive Job Layoffs				
08	Loss of Key Social Services				
09	New Health Facility or Major Improvement to Old Facility				
10	New School or Major Improvement to Old School				
11	New Road or Major Improvement to Old Road				
12	New Employment Opportunity				
13	Closure of a health facility				
96	Other (Specify)				

Section 8: Community Programs

NOTE: BEDNETS AND INSECTICIDE TREATED NETS ARE MATERIALS AND NOT MEDICAL SUPPLIES

PROGRAM NUMBER	(8.01) Please list all the names and codes for community programs in your community for the past 3 years (including activities organized by the VDCS and activities organized by others)		(8.02) When did the program start?		(8.03) When did the program end?		(8.04) Did the program provide:					(8.05) How frequently was the program/assistance distributed?	(8.06) What percentage of the population received benefits from this program?	(8.07) Did you coordinated with the VSG on this activity?	(8.08) Do men directly benefit from this project?	(8.09) Do women directly benefit from this project?	(8.10) Do children under the age of 5 directly benefit from this project?	(8.11) Do children aged 5-12 directly benefit from this project?	(8.12) Do adolescents aged 12-16 directly benefit from this project?	(8.13) Do adolescents aged 17-45 directly benefit from this project?	(8.14) Do unmarried women directly benefit from this project?	(8.15) Was this program organized by the VDC?	(8.16) If no, who was organizing it?	(8.17) How satisfied with the quality of the program are you? Are you very satified, somewhat satisfied, neither satsified nor dissatisfied, somewhat dissatisfied or very dissatisfied?
	NUTRITION																							
	Maternal Nutrition	11																						
	Exclusive Breastfeeding	12																						
	Complementary Feeding	13																						
	Anemia Control	14																						
	Community and/or Kitchen Gardens	15																						
	REPRODUCTIVE HEALTH CARE																							
	Antenatal Care	21																						
	Delivery Care	22																						
	Postnatal Care	23																						
	Family Planning Care	24																						
	MALARIA/INSECTICIDE TREATED NETS	30																						
	OTHER HEALTH AND NUTRTION	40												YES 01	YES 01	YES 01	YES 01	YES 01	YES 01	YES 01	YES 01			
	HYGIENE				IF CONTINUING,									NO 00	NO 00	NO 00	NO 00	NO 00	NO 00	NO 00	NO 00			
	Handwashing behavior	51			WRITE "9888" IN YEAR		YES 1					EVERY MONTH 01												
	Community Cleaning	52					NO 2					EVERY 3 MONTHS 02										YES 1		Very Satisfied 01
	Fecal Disposal	53					A.-	B.-	C.-	D.-	E.-	EVERY 6 MONTHS 03										NO 2 ► ####	Name of organization	Somewhat satisfied 02
	Latrines	54										EVERY 12 MONTHS 04												Neither satisfied nor 03
	Housing Updates	61										ONE TIME ONLY 05												Somewhat dissatisfied 03
	Water Supplie and Treatment	62										OTHER 96												Very dissatisfied 05
	Credit and Financing	63																						
	OTHER (SPECIFY)	96																						
	PROGRAM NAME	CODE	MONTH	YEAR	MONTH	YEAR	CODE	CODE	CODE	CODE	CODE	CODE	PERCENTAGE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	NAME	CODE
01																								
02																								
03																								
04																								
05																								
06																								
07																								
08																								
09																								
10																								
11																								
12																								

Section 9: Prices

PART A: FOOD AND FUEL:

QUESTIONS SHOULD BE ANSWERED BY KEY INFORMATS AND MARKET/SHOP/KANTING-BA TRADERS

(9.01) What is the price of.....?

		PRICE IN LOCAL CURENCY
A	1 KG Rice	
B	1 Loaf of Bread	
C	1 KG of Maize/ Grain	
D	1 Chicken	

		PRICE IN LOCAL CURENCY
E	1 KG of Fresh Groundnuts	
F	1 KG of Cassava Tubes	
G	1 KG of Dry Fish	
H	1 KG of Sugar	

		PRICE IN LOCAL CURENCY
I	1 Litre Cooking Oil	
J	1 KG of Salt	
K	1 Litre of Milk	
L	1 Litre of Petrol	

PART B: EDUCATION

QUESTIONS SHOULD BE ANSWERED BY KEY INFORMATS, TEACHERS AND OTHER EDUCATION WORKERS

FACILITY NUMBER	TYPE OF FACILITY	(9.02) What is the price of ...? [PER PUPIL, PER YEAR] RECORD PRICE IN CURRENCY					
		A	B	C	D	E	F
		School Fees	Parent ASSN. Fees and Levies (PTA)	Boarding Fees	Text Books	Uniforms	Other Spending on Education
1	Preschool/Kindergarden						
2	Primary						
3	Junior Secondary						
4	Senior Secondary						
5	Other (Specify)						

Section 10: Costs of RBF project

(10.01) Are you aware of the RBF activities in your community?

YES 1
NO 2 ► END

(10.02) In the past year, did any community members volunteer time for RBF activities?

YES 1
NO 2

(10.03) How many volunteers were there in the past year?

NUMBER:

(10.04) Did the community make any donations for the RBF intervention last year?

YES 1
NO 2

(10.05) What type of donation did the community make for the RBF intervention?

READ EACH ALOUD:

YES 1
NO 2

a	Construction of a building/facility	
b	Transportation	
c	Supplies	
d	Drama or materials for awareness raising	
e	Other	

(10.06) What was the approximate value of these donations in the past year (12 Months)?

VALUE IN LOCAL CURRENCY:

ASK THE FOLLOWING QUESTIONS TO THE INDIVIDUALS IN THE COMMUNITY THAT HAVE VOLUNTEERED FOR RBF ACTIVITES:

COMMUNITY MEMBER ID	(11.01) INTERVIEWER: LIST ALL COMMUNITY MEMBERS WHO VOLUNTEERED TO SUPPORT THE RBF LAST YEAR (12 MONTHS). ASK EACH QUESTION TO EACH MEMBER.	(11.02) Is [NAME] male or female?	(11.03) What is your primary employment?	(11.04) Were you ever paid a stipend for your work with the RBF intervention in the past year?	(11.05) How much was the stipend?	(11.06) Did you ever receive an in-kind gift for your work with the RBF intervention?	(11.07) What would you say was the approximate value of the gift you received?	##### In your opinion, was this a meaningful amount of money/compensation? That is, did it make it easier for	(11.09) Do you spend time on the verification system for the RBF scheme?	(11.10) What percent of time in the past month did you spend on RBF verification, reporting, data management and feedback?	(11.11) How many hours per week do you usually spend verifying results for the RBF scheme?		(11.12) Do you spend time on data entry, analysis, and reporting for the RBF scheme?	(11.13) How many hours per week do you usually spend on data entry, analysis, and reporting for the RBF scheme?		(11.14) Do you spend time raising awareness of the community for the RBF scheme?	(11.15) How many hours per week do you usually spend raising awareness of the community on the RBF scheme?		(11.16) Do you spend more time now on outreach services because of the RBF scheme?	(11.17) In your opinion, have communications about the RBF been clear and understandable?	(11.18) Do you feel like you understand the goals of the RBF?	(11.19) Were you involved in setting the RBF targets for your community?	(11.20) Do you know what the maximum amount the village could receive if it meets 100% of its	(11.21) Do you know what the viillage's RBF targets are?	(11.22) Do you think that these targets focus on the most important health priorities in the village?	(11.23) Do you think that the targets are possible to reach with enough hard work and effort?	##### Do you think the targets are driven by personal behavior and impossible to
		MALE 1 FEMALE 2	NONE/UNMPLOY 1 HOUSEHOLD 2 FARMING 3 CONSTRUCTION 4 CLERICAL 5 GOVERNMENT 6 PROFESSIONAL 7 OTHER 8	YES 1 NO 2 ► (11.06)		YES 1 NO 2 ► (11.09)		YES 1 NO 2	YES 1 NO 2 ► (11.12)				YES 1 NO 2 ► (11.14)			YES 1 NO 2 ► (11.16)			YES 1 NO 2	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2 ► END	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2
	NAME	CODE	CODE	CODE	DALASI	CODE	DALASI	CODE	CODE	ERCENTAG	HOURS	MINUTES	CODE	HOURS	MINUTE	CODE	HOURS	MINUTE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01																											
02																											
03																											
04																											
05																											
06																											
07																											
08																											
09																											
10																											

Interview Results

RESULT OF THE INTERVIEW:

INTERVIEW DONE	
PARTIALLY COMPLETED	01
REGISTERED PERSON REFUSED INTERVIEW	02
HOUSEHOLD MEMBERS NOT PRESENT	03
HOUSEHOLD VACATED	04
HOUSE ADDRESS NOT FOUND	05
HH HEAD / OTHER REFUSED TO ALLOW INTER	06
	07
Language not spoken, Interview not	
OTHER, SPECIFY: _____	08
	96

TRANSLATOR USED?

NEVER	1
SOMETIMES	2
ALWAYS	3

RECORD GPS Coordinates

Record GPS Coorddinates

Lat

Long

LANGUAGE USED

...BY THE RESPONDENT?

ENGLISH	01
MANDINKA	02
WOLOF	03
FULA	04
JOLA	05
SERER	6
OTHER (SPECIFY:_____)	96

Annex 7: Village Support Group questionnaire

Health Results Based Financing

The Gambia

2014

IDENTIFIER			
REGION	DISTRICT	LOCALITY	FACILITY

Village Support Group Questionnaire

INTERVIEWER AND VISITS

CODE:

RESULT OF THE INTERVIEW:

INTERVIEW DONE	01
PARTIALLY COMPLETED	02
REGISTERED PERSON REFUSED INTERVIEW	03
OTHER (SPECIFY: _____)	96

LANGUAGE USED:

Translator Used?

NEVER	1
SOMETIMES	2
ALWAYS	3

Language

ENGLISH	01
MANDINKA	02
WOLOF	03
FULA	04
JOLA	05
SERER	06
SARAHULE	07
OTHER (SPECIFY:_____	96

Mandinka, Wolof, Fula, Serer, Krio

Section 1: Informant Background

You will administer this questionnaire to the head of the Village Support Group (VSG), or, if not available, a senior member

	(1.01)	(1.02)	(1.03)	(1.04)	(1.05)	(1.06)		(1.07)	(1.08)	(1.09)	(1.10)		(1.11)	(1.12)	(1.13)	(1.14)
	What is your position in the community? MULTIPLE POSSIBLE Choose from list below:	What is your role in the VSG?	Please record gender.	How old are you? ***(enter years)***	For how many years have you lived in this community?	What is the highest level of education you have completed?		For this level, what is the highest class?	What is your marital status	How many years have you been a member of the VSG? (years -- if less than 1 year, enter 00)	How many male and female members does the VSG currenlty have?		Has any member left the VSG in the last 6 months?	How many members have left?	Why do you think this person left?	In the past month, how many meetings have the member of the VSG had?
	HEADMAN/WOMAN A SPOUSE TO HEADMAN/WOMAN B SCHOOL HEADTEACHER D TEACHER E AGRICULTURAL EXTENSION F RELIGIOUS LEADER G MERCHANT/BUSINESS H HEALTH WORKER I NGO WORKER J OTHER (SPECIFY) K	Senior Member # Junior member # Head of VSG # Other # (SPECIFY)	MALE 01 FEMAL 02			KINDERGARTEN 01 PRIMARY/LOWER BASIC 02 UPPER BASIC 03 HIGH SCHOOL 04 SENIOR SECONDARY 05 NON-TERTIARY/VOCATIONAF 06 DIPLOMA/TERTIARY 07 UNDERGRADUATE 08 MASTERS 09 PHD 10 NONE 11 ▶ 1.08 OTHER, SPECIFY 96 DON'T KNOW -99			Single # Married # Co-habitatin # Widowed # Divorced #				Ye 1 No 0 ▶ (1.14)		To meet committee need (eg 01 Health reasons (eg, sick, elde 02 The committee was too much 03 Too busy with other commitments 04 Relocated 05 Other, Specify 96	
	CODES	CODE	CODE	YEARS	YEARS	CODE		LEVEL	CODE	YEARS	MALES	FEMALES	CODE	NUMBER	CODE	MEETINGS

(1.15)	(1.16)	(1.17)	(1.18)	(1.19)	(1.20)	(1.21)	(1.22)	(1.23)	(1.24)	(1.25)	(1.26)	(1.27)	(1.28)	(1.29)	(1.30)	(1.31)	(1.32)	(1.33)	(1.34)
Are minutes available from the most	How many members attended the last meeting? {SURVEYOR: CHECK MEETING NOTES IF AVAILABLE}	In the past month, how many activities has the VSG helped to organize?	How many VSG members helped to organize and run the last activity?	In the past week, how many hours per day have VSG members spent on average on community activities?	Does the VSG have more work now than it did at this time last	Have VSG members received any compensation in kind or in cash for their activities in the past year?	How much income has the VSG received?	How does the VSG decide how money will be allocated?	Would you say that this amount of compensation is a meaningful amount? That is, does it make it easier for VSG members to afford daily needs?	Do you feel like the VSG members are appropriately rewarded for their work?	How happy would you say current VSG members are with their work?	Do you feel like you understand the goals of this VSG?	Are these goals clearly defined with targets (eg, targets for the year or each month)?	Do you feel like the goals of the committee can be achieved given hard work & resources? Or do you think that the goals depend on behaviors that are out of your	Do you feel like you have the resources you need to achieve these goals?	Has this village entered into a contract for maternal and child health and nutrition results?	Do you feel like you understand the goals of this contract?	Are these goals clearly defined with targets (eg, targets for the year or each month)?	Do you feel like the goals of the contract can be achieved given hard work & resources? Or do you think that the goals depend on behaviors that are out of your
Yes 01 No 00					Yes 01 No 00	Yes 01 No 00 ▶		Chair Decides 01 Consensus 02 Vote 03 Other 04	Yes 01 No 00	Yes 1 No 0	Extremely happy 01 Quite happy 02 03 Mostly satisfied Somewhat dissatis 04 Quite unhappy 05	Yes 01 No 00 ▶ ####	Yes 01 No 00	Can be 01 Beyond 00	Yes 01 No 00	Yes 01 No 00 ▶ ####	Yes 01 No 00	Yes 01 No 00	Can be 01 Beyond 00
CODE	NUMBER	EVENTS	NUMBER	HOURS	CODE	CODE	DALASI	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE

Section 3: VSG Activities

Instructions: Ask respondent to list all the activities the VSG is currently doing in the community

(3.01)	CODE	(3.02)	(3.03)	(3.04)	(3.05)	(3.06)	(3.07)	(3.08)	(3.09)	(3.10)	(3.11)	(3.12)	(3.13)	(3.14)	(3.15)
Please list all the activities VSG members currentiv do in the communitv		Since when have you been doing this activity?	How frequently do you organize activities?	What percentage of households benefits from this program? In addition to receiving goods, people may benefit from increased knowledge or awareness of an issue.	Did you coordinated with the VDC on this activity?	Do men directly benefit from this project?	Do women directly benefit from this project?	Do children under the age of 5 directly benefit from this project?	Do children aged 5-12 directly benefit from this project?	Do adolescents aged 12-16 directly benefit from this project?	Do adolescents aged 17-45 directly benefit from this project?	Do unmarried women directly benefit from this project?	What sorts of activities do you do for this project?	How many VSG members are currently participating in this activity?	Would you say that the quality of this activity is very strong, strong, ok, weak, or very weak?
NUTRITION															
Maternal Nutrition	11														
Exclusive Breastfeeding	12														
Complementary Feeding	13														
Anemia Control	14														
Community and/or Kitchen Gardens	15														
REPRODUCTIVE HEALTH CARE															
Antenatal Care	21														
Delivery Care	22														
Postnatal Care	23														
Family Planning Care	24														
MALARIA/INSECTICIDE TREATED	30														
OTHER HEALTH AND NUTRTION	40		EVERY DAY 01		YES 01	YES 01	YES 01	YES 01	YES 01	YES 01	YES 01	YES 01			
HYGIENE			A FEW DAYS PER WEEK 02		NO 00	NO 00	NO 00	NO 00	NO 00	NO 00	NO 00	NO 00	HOME VISIT 1		
Handwashing behavior	51		ONCE PER WEEK 03										COMMUNITY MEETINGS 2		Very Strong 01
Community Cleaning	52		ONCE OR TWICE PER MONTH 04										INDIVIDUAL COUNSELING 3		Strong 02
Fecal Disposal	53		EVERY FEW MONTHS 05										ORGANIZE DRAMAS/TOWN 4		OK 03
Latrines	54		OTHER 96												Weak 04
OTHER (SPECIFY)	96														Very weak 05

PROGRAM NUMBER

	ACTIVITY NAME	CODE	CODE 2	CODE3	CODE	CODE	CODE	CODE	MONT	YEAR	CODE	PERCENT										CODE	NUMBER	CODE
01																								
02																								
03																								
04																								
05																								
06																								
07																								
08																								
09																								
10																								
11																								
12																								

CALCULATE	(3.16)	(3.17)	(3.18)	(3.19)	(3.20)	(3.21)	(3.22)	(3.23)	(3.24)	CALCULATE	(3.25)	(3.26)	(3.27)
IF 1.31 IS NO ► END	How many women were referred for antenatal care the last month?	How many women were escorted for antenatal care in the last month?	For how many women did you arrange transportation to antenatal care in the last month?	How many women were referred for delivery care the last month?	How many women were escorted for delivery care in the last month?	For how many women did you arrange transportation to delivery care in the last month?	How many women were referred for post natal care care the last month?	How many women were escorted for post natal care in the last month?	For how many women did you arrange transportation to post natal care in the last month?	PROGRAMMER: IF No Community Meetings (2.13), (3.25) IF No Home Visits (2.13), SKIP (3.26) IF No Referrals (2.16-2.24), SKIP (3.27)	Approximately what proportion of VSG time is spent preparting for and facilitating community meetings?	Approximately what proportion of VSG time is spent preparting for and making home visits?	Approximately what proportion of VSG time is spent identtifying and referring women to the health clinics for reproductive health services?
	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER		PERCENTAGE	PERCENTAGE	PERCENTAGE

9 Health Status and Utilization

SUBJECT: MOTHER OF THE YOUNGEST CHILD

RESPONDENT: SELF RESPONDENT; AND FOR CHILDREN UNDER 15, THE MOTHER OR PRIMARY CAREGIVER.

If Primary Caregiver not available, switch to another caregiver

ID CODE	(9.01) Is NAME available to answer questions regarding HIS/HER health? If not, is there somebody who can answer on HIS/HER behalf?	(9.0A) ID CODE OF RESPONDENT (CAREGIVER OF CHILD <15 yrs, OR RESPONDENT FOR THOSE >15)	(9.02) Currently, how is YOUR/[NAME]´s health in a normal day, would you say it is excellent, good, fair or poor?	(9.03) Do YOU/Does [NAME} suffer from any disabilities or chronic illnesses?	(9.04) What disabilities or chronic illnesses do YOU/[NAME] suffer from? RECORD UP TO 3 RESPONSES			(9.05) Given YOUR/[NAME]'s health, how are YOU/[NAME] currently able to do daily activities such as work, school, etc?	(9.06) Are YOU/[NAME} currently covered under a health insurance scheme?	(9.07) In the last 2 weeks, have YOU/[NAME] been sick or suffering from any illness or injury, excluding disabilities or chronic illnesses?
				DISABILITY AND CHRONIC ILLNESSES						
	Yes, Available 1 ► (9.02) Not available, but someone will report for then 2 ► (9.0A) Not available 3 ► NEXT PERSON	ID CODE OF CAREGIVER	EXCELLENT 1 GOOD 2 FAIR 3 POOR 4	YES 1 NO 2 ► (9.06)	**DISABILITIES** PHYSICAL DISABILITY 01 MENTAL DISABILITY 02 BLINDNESS/VISUAL IMPAIRMEN 03 DEAFNESS/SUMBNESS 04 OTHER DISABILITY 05 **CHRONIC ILLNESS** HEART CONDITION 06 DIABETES 07 EPILEPSY 08 ASTHMA 09 CANCER 10 HIV/AIDS 11 TUBERCULOSIS 12 HYPERTENSION 13 OTHER CHRONIC ILLNESS 14 SICKLE CELL 15 ULCER 16			EASILY 01 WITH SOME 02 WITH MUCH 03 UNABLE TO DO 04	YES 1 NO 2	YES 1 NO 2 ► (9.50)
			CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										

ACUTE ILLNESS							DIARRHEA		DIARRHEA	
(9.08)			(9.09)	(9.10)	(9.11)	(9.12)		(9.13)	(9.14)	(9.15)
What were YOU/[NAME] mainly suffering from?			How long ago did the illness start?	For how may days were YOU/[NAME] sick	In the last 2 weeks, how many days of work , school, playing, or other main activities did YOU/[NAME] miss due to poor health?	In the last 2 weeks, how many days was YOU/[NAME] confined to bed due to poor health?	SYSTEM: CHECK WHETHER YOU/[NAME] IS A CHILD UNDER AGE FIVE AND HAD DIARRHEA IN QUESTION (9.08), I.E. ANSWERED	How much was [NAME] offered to drink during this illness? Was he/she offered more than usual, about the same, less than usual, or nothing at all?	How much was [NAME] offered to eat during this illness? Was he/she offered more than usual, about the same, less than usual, or nothing at all?	Was /[NAME] given a fluid made from a special pack, called Oral Rehydration Solution (ORS), like this one?
DISEASES		**DISEASES (cont)**								
MALARIA	01	SKIN	18							
MEASLES	02	GENITO-URINARY	19							
CANCER	03	PREGNANCY / CHILDBIRTH RELATED -	20							
ANEMIA	04	HIGH RISK/PROBLEMS WITH PREGNANCY	21							
DIABETES	05	PERINATAL	22							
MALNUTRITION	06	CONGENITAL	23							
MENTAL DISORDER	07	INJURY OR	24							
NERVOUS /	08	**SYMPTOMS**								
EYE PROBLEM	09	FEVER	41		INTERVIEWER: WRITE THE ANSWER IN NUMBER OF DAYS. IF STILL ILL TODAY, RECORD 00.					INTERVIEWER: SHOW THE RESPONDENT THE PACK
EAR PROBLEM	10	ABDOMINAL PAIN	42	INTERVIEWER: WRITE THE ANSWER IN NUMBER OF DAYS						
HEART DISEASE	11	COUGH ONLY	43							
CHEST INFECTION	12	COUGH WITH DIFFICULT, FAST BREATHING	44					MORE THAN USUAL 1	MORE THAN USUAL 1	
TUBERCULOSIS	13	DIARRHEA WITHOUT BLOOD	45							
PNEUMONIA	14	DIARRHEA WITH BLOOD	46	PROMPT IF RESPONSE < 28				ABOUT THE SAME 2	ABOUT THE SAME 2	
OTHER	15	DIARRHEA AND VOMITING	47							
DIGESTIVE	16	VOMITING	48				YES 1	LESS THAN USUAL 03	LESS THAN USUAL 3	YES 1
MUSCLE / BONE	17	HEADACHE	49				NO 2 ► (9.16)			NO 2 ► (9.16)
		OTHER	96						NOTHING TO EAT 4	
1st	2nd	3rd								
CODE 1	CODE 2	CODE 3		DAYS, 0-14	DAYS, 0-14	DAYS, 0-14	CODE	CODE	CODE	CODE

SEEKING CARE					SEEKING CARE	SEEK OF CARE, PLACE		
(9.16)	(9.17)			(9.18)	(9.19)	(9.20)		(9.21)
Did YOU/[NAME] go to any health facility, health personnel or traditional healer to seek care for this illness? PROBE WHETHER PATIENT WENT TO CENTER BUT CENTER WAS CLOSED/NOT STAFFED - COUNT THIS AS A "YES"	Why didn't YOU/[NAME] go to a health facility or health personnel for care?			[ONLY IF NAME <15 years old] Who decided that [NAME] should receive care?	How long after the illness started did YOU/[NAME] first seek care?	Where did YOU/[NAME] MOST RECENTLY seek care?		IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE
	TOO EXPENSIVE 01					GOVERNMENT HOSPITAL 01		
	TOO FAR 02					GOVERNMENT MAJOR HEALTH CENTER 02		
	TOO BUSY (WORK, CHILDREN) 03					GOVERNMENT MINOR HEALTH CENTER 03		
	WASN'T SICK ENOUGH 04					GOVERNMENT HEALTH POST 04		
	FACILITY HAS POOR STRUCTURE 05					NGO CLINIC 05		
	FACILITY POORLY STOCKED 06							
	POOR STAFF ATTITUDE 07				WITHIN 24 HOURS 1	PRIVATE CLINIC 06 ► **(9.22)**		
	POOR STAFF KNOWLEDGE 08					PRIVATE PRACTITIONER 07 ► **(9.22)**		
	STAFF USUALLY ABSENT 09				BETWEEN 24 AND 48 HOURS 2	PHARMACY 08 ► **(9.22)**		
	HEALTH FACILITY CLOSED 10					MOBILE CLINIC/OUTREACH 09 ► **(9.22)**		
	NO TRANSPORTATION 11			MOTHER 1	BETWEEN 48 HOURS AND 1 3	TRADITIONAL HEALER 10 ► **(9.22)**		
	POOR QUALITY OF CARE 12			FATHER 2		FAITH/CHURCH HEALER 11 ► **(9.22)**		
	INCONVENIENT HOURS 13			HEAD OF HOUSEHOLD 3	WITHIN 2 WEEKS 4	COMMUNITY HEALTH WORKER 12 ► **(9.22)**		
	LONG WAITING TIMES 14			GRANDPARENT 4		COMMUNITY OWNED CLINIC 13 ► **(9.22)**		
	PREFER HOME CARE 15			OTHER, SPECIFY 96	WITHIN 3 WEEKS 5	SERVICE CLINIC 14 ► **(9.22)**		
YES 1 ► (9.18)	OTHER (SPECIFY) 16					OTHER, SPECIFY 96 ► **(9.22)**		
NO 2		► 0.00	96		MORE THAN 3 WEEKS 6			
	RECORD UP TO 3 ANSWERS							
	FIRST	SECOND	THIRD					
CODE	CODE 1	CODE 2	CODE 3	CODE	CODE	CODE	NAME	CODE

	SEEK OF CARE, LAST VISIT		SEEK OF CARE, LAST VISIT					
(9.22)	(9.23)	(9.24)	(9.25)	(9.26)		(9.27)	(9.28)	(9.29)
How did YOU/[NAME] travel to the facility?	For the last visit, how much time did it take to travel to the health care provider?	For the last visit, did YOU/[NAME] have a direct interaction with a health worker?	Why did YOU/[NAME] not have a direct interaction with a health worker?	For the last visit, how much time did YOU/[NAME] wait to be seen by a health worker?		For the last visit, who attended YOU/[NAME]?	Did this health care provider ask questions about how YOU/[NAME] was feeling or the symptoms that YOU/[NAME] had?	Did this health care provider do any physical exams on YOU/[NAME] such as taking blood pressure, listening to the heart, etc?
	INTERVIEWER: WRITE THE ANSWER IN MINUTES		NO HEALTH WORKER PRESENT 01	INTERVIEWER: WRITE THE ANSWER IN MINUTES		MEDICAL DOCTOR 01		
			HEALTH WORKER TOO BUSY 02			NURSE/MIDWIFE 02		
			HEALTH WORKER NOT SEEING PATIENTS 03			VILLAGE HEALTH WORKER 03		
			HEALTH WORKER REFUSED 04			LAB TECHNICIAN 04		
			NO FEMALE HEALTH WORKER 05			PHARMACIST/ DRUG SELLER 05		
			NO MALE HEALTH WORKER 06			TRADITIONAL BIRTH ATTENDANT 06		
By foot 01			HEALTH WORKER NOT QUALIFIED 07			TRADITIONAL HEALER 07 ► (9.36)		
Bicycle 02			WAITING TIME TOO LONG 08 ► (9.26)			SPIRITUAL HEALER 08 ► (9.36)		
Horse/ Donkey or Other Animal 03			PATIENT ARRIVED LATE 09			OTHER, SPECIFY 96		
Private car 04	ONE WAY ONLY		COULD NOT AFFORD FEE 10				YES 1	YES 1
Public car/bus 05			OTHER, SPECIFY: _____ 96				NO 2	NO 2
Private motorcycle 06								
A Motorbike Taxi 07		YES 1 ► (9.26)						
Other, specify: 96		NO 2	► (9.41)	If "WAIT TIME TOO LONG" in 9.2 ####				
CODE	MINUTES	CODE	CODE	HOURS	MINUTES	CODE	CODE	CODE

SEEK OF CARE, LAST VISIT						EXPENDITURES					HOSPITALIZATION			MEDICINES				
(9.30)	(9.31)	(9.32)	(9.33)	(9.34)	(9.35)	(9.36)				(9.37)	(9.38)	(9.39)	(9.40)	(9.41)	(9.42)	(9.43)	(9.44)	(9.45)
Did this health care provider administer any rapid test (such as a fingerprick to detect malaria)?	Did this health care provider order any X-rays or laboratory examinations such as urine or blood tests?	Did YOU/[NAME] have these tests done?	Did YOU/[NAME] receive results?	Did this health care provider prescribe any medicines?	Did the health worker refer you to an after hours private clinic or pharmacy?	Not including medication, in the last 2 weeks, how much did your household spend out of its own pocket for the treament of YOU/[NAME]'s illness? Specifically, how much did your household pay out of pocket for ..... READ ALOUD EACH CATEGORY				IF 9.06 IS YES: Did an employer or insurance pay for any of the provider fees, laboratory and X ray fees or transportation?	In the last 2 weeks, did YOU/[NAME] have to spend the night in a health facility or hospital to treat this illness?	Over the last 2 weeks, how many nights did YOU/[NAME] spend in the health facility or hospital?	In the last 2 weeks, how much did your household spend out of its own pocket on YOUR/[NAME]'s stay on the health facility or hospital to treat this illness? (Not including Medication) PROBE TO BE SURE THIS AMOUNT IS IN ADDITION TO COSTS IN (9.36)	Now I am going to ask some questions regarding medicines that YOU/[NAME] may have taken to treat this illness. In the last 2 weeks, did YOU/[NAME] take any medicines to address this PROBE FOR INJECTIONS THAT MAY HAVE BEEN ADMINISTERED	How many different kinds of medicines did YOU/[NAME] take?	Of the medicines taken, how many are Traditional (Herbal)? "00" if NONE	Did YOU/[NAME] need a prescription? PROBE: A DOCTOR'S PRESCRIPTION IS A PIECE OF PAPER WHERE THE DOCTOR WRITES THE NAME OF THE MEDICATION AND HOW MUCH MEDICATION THE PATIENT HAS TO TAKE. PATIENTS CAN TAKE THIS TO A PHARMARCY IN ORDER TO GET THE RIGHT	Did YOU/[NAME] receive instructions to take any medicine that you could not obtain at the facility pharmacy due to stock outs?
										YES, EMPLOYER 01				YES 1				
						A.	B.	C.	D.	YES, INSURANCE 02				NO 2 ► (9.48)				
YES 1	YES 1	YES 1	YES 1	YES 1	YES 1	Consulting Fees/ Provider Fees	Laboratory and X-ray Fees	Any other payments to the provider?	Transportation, including for Caregiver/ Escort	NO 03	YES 1						YES 1	YES 1
NO 2	NO 2 ► (9.34)	NO 2	NO 2	NO 2	NO 2					OTHER, SPECIFY 96	NO 2 ► (9.41)						NO 2	NO 2
CODE	CODE	CODE	CODE	CODE	CODE	DALASI	DALASI	DALASI	DALASI	CODE	CODE	NIGHTS, 1-14	DALASI	CODE	NUMBER	NUMBER	CODE	CODE

6	ID CODE	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15

MEDICINES			Satisfaction							MOSQUITO NETS		
(9.46)	(9.47)	(9.48)	(9.49)							(9.50)	(9.51)	(9.52)
In the last 2 weeks, how much did your household spend out of pocket in total to obtain these medications for YOU/[NAME]? PROBE TO BE SURE THIS AMOUNT IS IN ADDITION TO COSTS IN (9.36) and 9.39 IF NOTHING, RECORD ZERO	Did your employer or insurance pay for any of this medication? YES, EMPLOYER 01 YES, INSURANCE 02 NO 03 OTHER, SPECIFY 96 ► (9.49)	Why did YOU/[NAME] not take medication for the illness? TOO EXPENSIVE 01 TOO FAR 02 TOO BUSY (WORK, CHILDREN) 03 OUT OF STOCK 04 WASN'T SICK ENOUGH 05 DOESN'T HELP 06 DOESN'T LIKE SIDE EFFECTS 07 NO TRANSPORTATION 08 POOR QUALITY OF DRUGS 09 INCONVENIENT HOURS 10 LONG WAITING TIMES 11 PREFERS TRADITIONAL CARE 12 OTHER, SPECIFY 96	I'm going to read you a series of statements regarding this health facility. Please tell me if you agree, neither agree nor disagree or disagree with each statement. Some statements may not apply to your situation. Please let me know if a statement does not apply to you. AGREE 1 NEITHER AGREE NOR DISAGREE 2 DISAGREE 3 VERY SATISFIED 4 DOES NOT APPLY 5							Last night, did YOU/[NAME] sleep under a mosquito net? YES 1 NO 2 ► (9.53)	What type of net did YOU/[NAME] sleep under last night, was it a long-term treated net, a net that was treated after it was bought, or a net that has INTERVIEWER NOTE: PERMANET AND POLYNET ARE BOTH TREATED NETS TREATED 01 NOT TREATED 02 DON'T KNOW 03	Does the Mosquito net have any holes in them such that a mosquito can enter? Yes No
			A. The hours the facility is open are adequate to meet your needs.	B. The health staff are courteous and respectful.	C. The amount of time you spent waiting to be seen by a health worker was reasonable.	D. The health worker spent a sufficient amount of time with you.	E. It is easy to get medicine that health workers prescribe.	F. You had enough privacy during your visit.	G. The overall quality of services provided was satisfactory.			
DALASI	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE

	CARE FOR OTHERS								(12.01)	(12.02)	(12.03)	(12.04)
	(9.53)	(9.54)			(9.55)	AUTOMATIC			Have you ever been pregnant, including pregnancies that may have ended in miscarriage, abortion or stillbirth (born dead)?	Are you pregnant now?	How many months pregnant are you?	Do you have any children to whom you have given birth who are now living with you?
THIS SECTION ONLY IF [NAME] 5 YEARS OLD OR OLDER? SEE QUESTION (1.03)	In the last 2 weeks, did YOU/[NAME] stop regular activities at any time to take care of a sick household member?	Who did YOU/[NAME] take care of? RECORD UP TO 3 PEOPLE			In the last 2 weeks, how many days of regular activities did YOU/[NAME] miss to take care of sick household members?	Is respondent a women between 15 and 49?	Interviewer Read. THANK YOU. I WILL NOW ASK YOU A FEW QUESTIONS ABOUT ANY PREGNANCIES YOU MAY HAVE HAD.					
		HEAD OF HOUSEHOLD 01										
		SPOUSE (WIFE/HUSBAND) 02										
		OWN SON / DAUGHTER 03										
		STEP SON/DAUGHTER 04										
		SON/DAUGHTER IN-LAW 05										
		GRANDCHILD 06										
		BROTHER/SISTER 07										
		PARENT / PARENT-IN-LAW 08										
		GRAND PARENT / GRAND PARENT-IN-L 09										
		NIECE/NEPHEW 09										
YES 01	YES 1	OTHER RELATIVE 10				YES ► (12.01)		YES 1	YES 1		ENTER 00 IF NOT YET ONE MONTH PREGNANT; ENTER -99 IF DON'T	YES 1
NO 02 ► NEXT PERSON	NO 2 ► NEXT PERSON	DOMESTIC HELP / MAID 11				NO ► NEXT RESPONDENT		NO 2 ► SECTION 14	NO 2 ► (12.04)			NO 2 ► (12.06)
1		OTHER NON-RELATIVE 12							NOT SURE 3 ► (12.04)			
2		CO-WIFE 13			ROUND UP TO THE NEXT FULL NUMBER							
								CODE	CODE		MONTHS	CODE
	CODE	CODE1	CODE2	CODE3	DAYS, 1-14							

(12.05) A. How many living with you?	(12.05) B.	(12.06) Do you have any children to whom you have given birth who are still alive but do not live with you?	(12.07) A. how may living elsewhere?	(12.07) B.	(12.08) Have you ever given birth to a child who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	(12.09) A. How many sons died?	(12.09) B. How many daughters died?	CALCULATE PROGRAM TO SUM THE ANSWERS TO (12.05) (12.07) (12.09) ENTER TOTAL HERE. IF NONE, WRITE 00.	(12.10) Please confirm the total number of children you have given birth to is… [NUMBER IN QUESTION **CALCU**] YES 1 NO 2 IF NOT CORRECT, PROBE AND CORRECT AS NECESSARY	CALCULATE PROGRAM CONTINUE SECTION IF THE NUMBER OF LIVE BIRTHS IN (12.10) AT LEAST ONE?	(12.11) When was the last time that you gave birth to a child that was born alive?		(12.12) Have you ever had a pregnancy that ended in stillbirth, that is when pregnancy has lasted at least 28 weeks but the baby dies before it is born?	(12.13) How many pregnancies have ended in	(12.14) When was the last time you had a stillbirth?		(12.15) Have you ever had a pregnancy that ended in a miscarriage or abortion, that is when the pregnancy lasts less than 28 weeks?	(12.16) How many pregnancies have ended in a miscarriage or abortion?	(12.17) When was the last time you had a miscarriage or abortion?		CALCULATE 1 PROGRAM TO CALCULATE IN THE LAST 72 MONTHS, DID THE WOMAN HAVE AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION? CHECK INFORMATION FROM CELLS (12.11) (12.14) (12.17) YES 1 NO 2 ► NEXT PERSON
		YES 1 NO 2 ► (12.08)			YES 1 NO 2 ► (12.10)					YES 1 NO 2 ► (12.12)			YES 1 NO 2 ► (12.15)				YES 1 NO 2 ► CALCULATE 1				
NUMBER OF SONS	NUMBER OF DAUGHTERS	CODE	NUMBER OF SONS	NUMBER OF DAUGHTERS	CODE	NUMBER	NUMBER		CODE		MONTH (MM)	YEAR (YYYY)	CODE	NUMBER	MONTH (MM)	YEAR (YYYY)	CODE	NUMBER	MONTH (MM)	YEAR (YYYY)		

9	ID CODE	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15

10 Parent's Characteristics

(10.01)	(10.02)	10.02 A	(10.03)	(10.04)	(10.05)	(10.06)	
What is your marital status?	Can we ask you a few questions about your child's father?	Who is the child's father?	Can your child's father read and write in any language?	Has your child's father ever attended school?	What is the highest school level that the child's father attended?	Within that school level, what was the highest grade that the child's father completed?	COMPUTER GENERATED EQUIVALENCY GRADE, BASED ON MAP
					KINDERGARTEN 01		
					PRIMARY/ LOWER BASIC 02		
					UPPER BASIC 03		
					HIGH SCHOOL 04		
					SENIOR SECONDARY 05		
					NON-TERTIARY/VOCATIONARY 06		
		Options --> All men on the roster AND "Not on the Roster"			DIPLOMA/TERTIARY 07		
					UNDERGRADUATE 08		
					MASTERS 09		
					PHD 10		
NEVER MARRIED 1					OTHER, SPECIFY 96	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL; OPTIONS: 1, 2, 3, 4, 5, 6, 6 LOWER, 6 UPPER, 7, 8, 9,10, 11, 12	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL
MONOGAMOUSLY MARRIED 2					DON'T KNOW - 99		
POLYGAMOUSLY MARRIED 3							
DIVORCED / SEPARATED 4	YES 01		YES 01	YES 01			
WIDOWED 5	NO 00 ► (10.07)		NO 00	NO 00 ► (10.07)			
CODE	CODE	ROSTER CODE	CODE	CODE	CODE	GRADE	AUTOFILL

(10.07)	(10.08)		(10.09)		(10.10)		(10.11)		(10.12)	
Can you read and write in any language?	Have you ever attended school?		What is the highest school level that you ever attended?		Within that school level, what was the highest grade that you completed?	COMPUTER GENERATED EQUIVALENCY GRADE, BASED ON MAP	What is the your religion?		What is your ethnicity?	
			KINDERGARTEN	01						
			PRIMARY/ LOWER BASIC	02						
			DROP							
			UPPER BASIC	04			ISLAM	01	MANDINKA/JAHANKA	01
			HIGH SCHOOL	05			CHRISTIANITY	02	FULA/TUKOLOR	02
							TRADITIONAL	03	WOLOF	03
			SENIOR SECONDARY	07			NONE	04	JOLA/KARONINKA	04
			NON-TERTIARY/VOCATIONARY	08	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL; OPTIONS: 1, 2, 3, 4, 5, 6, 6 LOWER, 6 UPPER, 7, 8, 9,10, 11, 12	WRITE 0 IF NO GRADE WAS COMPLETED WITHIN THAT LEVEL	OTHER, SPECIFY	96	SARAHULE	05
			DIPLOMA/TERTIARY	09					SERERE	06
			UNDERGRADUATE	10					AKUL/CREOLE	07
			MASTERS	11					MANJAGO	08
			PHD	12					NON-GAMBIAN	09
			OTHER, SPECIFY	96					OTHER, SPECIFY	96
YES 01	YES 01		DON'T KNOW	- 99						
NO 00	NO 00	► (10.11)								
CODE	CODE		CODE		GRADE	AUTOFILL	CODE		CODE	

	(12.01)	(12.02)	(12.03)	(12.04)	(12.05)		(12.06)	(12.07)		(12.08)
	Have you ever been pregnant, including pregnancies that may have ended in miscarriage, abortion or stillbirth (born dead)?	Are you pregnant now?	How many months pregnant are you?	Do you have any children to whom you have given birth who are now living with you?	A. How many living with you?	B.	Do you have any children to whom you have given birth who are still alive but do not live with you?	A. how may living elsewhere?	B.	Have you ever given birth to a child who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?
Interviewer Read. Th	YES 1 NO 2 ► SECTION 14	YES 1 NO 2 ► (12.04) NOT SURE 3 ► -12.04	ENTER 00 IF NOT YET ONE MONTH PREGNANT ; ENTER -99 IF DON'T	YES 1 NO 2 ► (12.06)			YES 1 NO 2 ► (12.08)			YES 1 NO 2 ► (12.10)
	CODE	CODE	MONTHS	CODE	NUMBER OF SONS	NUMBER OF DAUGHTER	CODE	NUMBER OF	NUMBER OF	CODE
ID CODI										

(12.09) A. How many sons died?	(12.09) B. How many daughters died?	CALCULATE	(12.10)	CALCULATE	(12.11)	(12.12)	(12.13)	(12.14)	(12.15)	(12.16)	(12.17)	CALCULATE 1
		PROGRAM TO SUM THE ANSWERS TO (12.05) (12.07) (12.09) ENTER TOTAL HERE. IF NONE, WRITE 00.	Please confirm the total number of children you have given birth to is… [NUMBER IN QUESTION **CALCU**] YES 1 NO 2 IF NOT CORRECT, PROBE AND CORRECT AS NECESSARY	PROGRAM CONTIN (12.10) AT LEAST ONE? YES 1 NO 2 ► (12.12)	When was the last time that you gave birth to a child that was born alive?	Have you ever had a pregnancy that ended in stillbirth, that is when pregnancy has lasted at least 28 weeks but the baby dies before it is born? YES 1 NO 2 ► (12.15)	How many pregnancies have ended in	When was the last time you had a stillbirth?	Have you ever had a pregnancy that ended in a miscarriage or abortion, that is when the pregnancy lasts less than 28 weeks? YES 1 NO 2 ► CALCULATE 1	How many pregnancies have ended in a miscarriage or abortion?	When was the last time you had a miscarriage or abortion?	PROGRAM TO CALCULATE IN THE LAST 72 MONTHS, DID THE WOMAN HAVE AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION? CHECK INFORMATION FROM CELLS -12.11 -12.14 -12.17 YES 1 NO 2 ► NEXT PERSON
NUMBER	NUMBER		CODE		MONTH (MM) YEAR (YYYY)	CODE	NUMBE	MONTH (MM) YEAR (YYYY)	CODE	NUMBER	MONTH (MM) YEAR (YYYY)	

13 Maternal Care

SUBJECT: ALL WOMEN WHO HAVE BEEN PREGNANT

INTERVIEWER: LIST ALL PREGNANCIES STARTING WITH MOST RECENT. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.

RESPONDENT: SELF

ANTENATAL CARE

			-13.01	(13.02)			-13.03	-13.04	-13.05	-13.06
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO CALCULATE 1 I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	INTERVIEWER: CONFIRM TOTAL NUMBER OF LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN THE LAST 24 MONTHS.		Now I am going to ask you some questions about your last pregnancy/the previous pregnancy that ended in live birth, still birth, miscarriage or abortion. Did you consult any health care provider or traditional healer for antenatal care for this pregnancy?	Why didn't you consult any health care provider or traditional healer for antenatal care for this pregnancy? RECORD UP TO 3 REASONS.			Did you ever try to go for antenatal care but the facility staff told you to go away and come back another day?	Were you referred to the health center for ANC or delivery services by a CHW or TBA at any point during your pregnancy?	Were you accompanied to the health center for ANC or delivery services by a CHW or TBA at any point during your pregnancy?	Did the CHW or TBA help to provide transportation to the ANC visit during your pregnancy?
				TOO EXPENSIVE		01				
				TOO FAR		02				
				TOO BUSY (WORK, CHILDREN)		03				
				SELF-TREATED		04				
				WAS TOO EARLY IN PREGNANCY		05				
			FOR WOMEN WHOSE LAST PREGNANCY WAS A STILLBIRTH, MISCARRIAGE OR ABORTION, THE LAST PREGNANCY IS THE PREGNANCY THAT ENDED IN STILLBIRTH, MISCARRIAGE OR ABORTION	FACILITY HAS POOR STRUCTURE		06				
				FACILITY POORLY STOCKED		07				
				POOR STAFF ATTITUDE		08				
				POOR STAFF KNOWLEDGE		09				
				POOR QUALITY OF CARE		10				
				SERVICE NOT AVAILABLE		11				
				NO TRANSPORTATION		12				
				DID NOT NEED		13				
				INCONVENIENT HOURS		14				
				LONG WAITING TIMES		15				
			YES 1 ► (13.04)	PREFER HOME CARE		16	YES 1	YES 1	YES 1	YES 1
			NO 2	FAMILY DIDN'T WANT ME TO GO		17	NO 2	NO 2	NO 2	NO 2
				OTHER (SPECIFY)		96	► (13.22)			
		PRE		FIRST	SECOND	THIRD				
			CODE	CODE 1	CODE 2	CODE 3	CODE	CODE	CODE	CODE
		1								
		2								
		3								

ANTENATAL CARE

(13.07)			(13.08)			(13.09)	(13.10)	(13.11)		
What kind of provider did you see for antenatal care for this pregnancy?			In what kind of facility or location did you see this health care provider?			What is the name of the Health Faclity?		INTERVIEWER: ASK WOMAN TO SEE ANC CARD		
IF MORE THAN ONE PROVIDER, WRITE THE PROVIDER THAT IS HIGHEST ON THE LIST.			IF MORE THAN ONE, WRITE FACILITY CORRESPONDING TO PROVIDER IN CELL (13.07)				What is the name of your he MOVED THIS QUESTION			
MEDICAL DOCTOR	01		GOVERNMENT HOSPITAL	01			Free Entry	Card available and	01	
NURSE/MIDWIFE	02		GOVERNMENT HEALTH CENTER	02				Card available but not	02 ►	(13.12)
COMMUNITY HEALTH NURSE	03 ►	(13.08)	GOVERNMENT HEALTH POST	03			Don't Know = - 99	Card not available	03 ►	(13.12)
LAB TECHNICIAN	04 ►	(13.08)	PRIVATE HOSPITAL	04						
PHARMACIST/ DRUG SELLER	05 ►	(13.08)	PRIVATE CLINIC	05						
TRADITIONAL BIRTH ATTENDANT	06 ►	(13.08)	NGO CLINIC	06						
TRADITIONAL HEALER	07 ►	(13.08)	PHARMACY	07 ►	(13.12)					
SPIRITUAL HEALER	08 ►	(13.08)	MOBILE CLINIC	08 ►	(13.12)					
VILLAGE HEALTH WORKER	09 ►	(13.08)	PROVIDER'S HOME	09 ►	(13.12)					
OTHER (SPECIFY)	96 ►	(13.08)	OWN HOME	10 ►	(13.12)					
			OTHER HOME	11 ►	(13.12)					
			OUTDOOR LOCATION	12 ►	(13.12)					
			OTHER (SPECIFY)	96 ►	(13.12)					
CODE			CODE			CODE + OTHER	CODE	CODE		

ANTENATAL CARE

(13.12)	(13.13)	(13.14)	(13.15)													(13.16)
How many months pregnant were you when you **first** received antenatal care for this pregnancy?	How many times did you receive antenatal care for this pregnancy?	How many months pregnant were you when you **last** received antenatal care for this pregnancy?	Now I would like to ask you about things that may have been done during at least one visit?													INTERVIEWER CONFIRM: Is the card complete and filled out? If yes, use the card to collect the following information. If no, ask the respondent to update the information
				YES 0												
				NO 1												
			A.	B.	C.	D.	E.	F.	H.	G.	I.	J.	K.	L.	M.	
	IF ONCE, RECORD 1 AND ► (13.15)		Were you weighed?	Was your height measured?	Was your blood pressure measured?	Did you give a urine sample?	Did you give a blood sample?		Did the health worker estimate your due date?		Was your uterine height measured (this is when the provider measures your stomach using a measurement tape)?	Were you tested for Syphilis?	Did the health worker ask for your blood type and Rhesus?	Did you receive advice on the diet during your pregnancy?	Did you receive advice on what to do in case of an emergency?	What is the source of data for question (13.12) - question (13.15)?
INTERVIEWER ROUND MONTHS		INTERVIEWER ROUND MONTHS														ANC Card 01 ANC Card + Respondent 02 Respondent only 03 IF CARD AND RESPONDENT DISAGREE, ACCEPT RESPONDENT'S ANSWER
								Did you sc		Did the provider p						
MONTHS	NUMBER	MONTHS	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
									SWITCHED H AND G							
									SWITCHED H AND G							
									SWITCHED H AND G							

			AIDS, TETANUS					IRON		MALARIA								Risk Factors During Pregnancy					PREGNANCY RESULT			
-13.17	-13.18	-13.19	-13.16	(13.17)	(13.18)	-13.19	(13.20)	-13.21	(13.22)	-13.23	-13.24							-13.25	-13.26	-13.27	-13.28	-13.29	-13.3			-13.31
If you were pregnant again, would you go back to the same clinic for antenatal care?	Would you recommend this clinic to a relative or friend for their antenatal check-up?	In general, how satisfied are you with the antenatal care you received in this clinic? Would you say that you are very satisfied, somewhat satisfied, niether satisfied nor dissatisfied, somewhat dissatisfied, or very	During this pregnancy, were you offered counseling and testing for the virus that causes AIDS?	I will not ask you the result, but were you tested?	I will not ask you the result, but did you receive the	During this pregnancy, were you given an injection in the arm to prevent the baby from	How many times did you receive this shot during the pregnancy?	During this pregnancy, were you given or did you buy any iron tablets or iron syrup?	During the pregnancy, for how many days did you take the iron tablets or iron syrup?	During this pregnancy, did you take any drugs to prevent you from getting	How many doses did you take?							During this pregnancy, did you sleep under an bed net?	During this pregnancy, did you ever have any bleeding?	During this pregnancy, did you ever have severe abdominal	During this pregnancy, did the baby ever stop moving or	During this pregnancy, did you ever have blurred vision?	When did this pregnancy end?			What was the result of this pregnancy?
											A.	B.	C.	D.	E.	F.	G.						INTERVIEWER: RECORD END DATE OF PREGNANCY REGARDLESS OF RESULT (LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION). RECORD ANY MISSING ELEMENT OF THE DATE AS "-99".			BORN ALIVE, SINGLE BIRTH 1
																										BORN ALIVE, MULTIPLE BIRTH 2
																										STILL BIRTH 3
																										► (0.32)
											Fandisar/SP	Choloroquine	Coartem	Artemeter	Unknown Drug	Quinine	Other Known Drug, specify									MISCARRIAGE
																										► (0.32)
		Very Satisfied 1						YES 1		YES 1								YES 1	YES 1	YES 1	YES 1	YES 1				ABORTION 5
		Somewhat Satisfied 2	YES 1	YES 1	YES 1	YES 1		NO 2		NO 2								NO 2	NO 2	NO 2	NO 2	NO 2				► (0.32)
		Neither satisfied nor dissatis 3	NO 2	NO 2	NO 2	NO 2		►		►																
YES 1	YES 1	Somewhat dissatisfied 4	►	►		►		(13.23)		(13.25)																
NO 2	NO 2	Very dissatisfied 5	(13.19)	(13.19)		(13.21)																				
CODE	CODE	CODE	CODE	CODE	CODE	CODE	NUMBER	CODE	DAYS	DAY	DOSES	DOSES	DOSES	DOSES	DOSES	DOSES	DOSES	CODE	CODE	CODE	CODE	CODE	DAY	MONTH	YEAR	CODE

DELIVERY

(13.32) Who assisted with the delivery for this pregnancy?			(13.33) Where did you deliver?			IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.	(0.01) What is the name of the health care provider who helped with this delivery?	(0.02) Did you go directly there when you went into labor or were you referred by a CHW or TBA to this facility?	-0.03 Were you accompanied to the health center for delivery services by a CHW or TBA?	-0.04 Did the CHW or TBA help to provide transportation to HC for your delivery?	-0.05 Was the birth delivered by caesarean section, that is did they cut your belly open to take the baby out?
MEDICAL DOCTOR	01		GOVERNMENT HOSPITAL	01			Don't Know = - 99	Directly 01			
NURSE/MIDWIFE	02		GOVERNMENT CLINIC	02				Referred 02			
COMMUNITY HEALTH NURSE	03		GOVERNMENT HEALTH POST	03							
LAB TECHNICIAN	04		PRIVATE HOSPITAL	04		► (0.05)					
PHARMACIST/ DRUG SELLER	05	► (13.33)	PRIVATE CLINIC	05							
TRADITIONAL BIRTH ATTENDANT	06	► (13.33)	NGO CLINIC	06							
TRADITIONAL HEALER	07	► (13.33)	PHARMACY	07	► (0.06)						
SPIRITUAL HEALER	08	► (13.33)	MOBILE CLINIC	08	► (0.06)						
FAMILY MEMBER	09	► (13.33)	OWN HOME	09	► (0.06)				YES 1	YES 1	
FRIEND/NEIGHBOR	10	► (13.33)	ANOTHER HOME	10	► (0.06)				NO 2	NO 2	
NO ONE	11	► (13.33)	A PUBLIC PLACE	11	► (0.06)						YE 1
OTHER (SPECIFY)	96	► (13.33)	OTHER (SPECIFY)	96	► (0.06)						NC 2
CODE			CODE			CODE	CODE	CODE	CODE	CODE	CODE

(0.06) Why didn't you deliver in a formal health facility for this pregnancy? RECORD UP TO 3 REASONS.		FIRST	SECOND	THIRD
TOO EXPENSIVE	01			
TOO FAR	02			
WAS TOO LATE IN DELIVERY	05			
FACILITY HAS POOR STRUCTURE	06			
FACILITY POORLY STOCKED	07			
POOR STAFF ATTITUDE	08			
POOR STAFF KNOWLEDGE	09			
POOR QUALITY OF CARE	10			
SERVICE NOT AVAILABLE	11			
NO TRANSPORTATION	12			
DID NOT NEED	13			
INCONVENIENT HOURS	14			
LONG WAITING TIME	15			
PREFER HOME DELIVERY	16			
FAMILY DIDN'T WANT ME TO GO	17			
OTHER (SPECIFY)	96			
		CODE 1	CODE 2	CODE 3

-0.07 Was the infant(s) a boy or a girl?		-0.08 Was the infant(s) weighed at birth?		-0.09 How much did the infant weigh?
MALE	01	YES	1	RECORD WEIGHT IN **KILOGRAMS**
FEMALE	02	NO	2	
		►	(0.15)	

	A.	B.	C.	A.	B.	C.	A.	B.	C.
	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD
CODE	CODE	CODE	CODE	CODE	CODE	CODE	KILOGRAMS	KILOGRAMS	KILOGRAMS
							__.__	__.__	__.__
							__.__	__.__	__.__
							__.__	__.__	__.__

Risk Factors diuring delivery						INFANT CHARACTERISTICS							FEEDING											
-0.08	-0.09	-0.1	-0.11	-0.12	-0.13	-0.14			-0.15			(0.16)	-0.17			-0.18			(0.19)	-0.2			-0.21	
During this delivery, did you have a seizure or fit, or fall	During this delivery did you have more bleeding than is	How long were you in the active stage of labor? That is, the stage when you are actively pushing the Record Don't Know as -99	If you were pregnant again, would you go back to the same clinic for delivery?	Would you recommend this clinic to a relative or friend for delivery?	In general, how satisfied are you with the delivery care you received in this clinic? Would you say that you are very satisfied, somewhat satisfied, niether satisfied nor	CONFIRM: IS THE SOURCE FOR WEIGHT RECALL OR HEALTH CARD?			When the infant(s) was born for this pregnancy, was he/she very large, larger than average, average, smaller than average or very small?			When the infant was born, did it have any trouble breathing?	Did you ever breastfeed the infant?			After the infant was born, how much time did it take before you started breastfeeding him/her?			Did the infant have any trouble suckling? Did it refuse to	In the first 3 days after delivery, was the infant given anything to drink other than breast milk?			What was the infant given to drink other than breastmilk?								
									VERY LARGE 1							WRITE THE ANSWER IN HOURS							INTERVIEWER: RECORD UP TO 3 RESPONSES.								
									LARGER THAN AVERAGE 2				YES 1										MILK (OTHER THAN BREASTMIL 01			INFANT FORMULA 06					
						RECALL 1			AVERAGE 3			YES 1	NO 2						YES 1	YES 1			PLAIN WATER 02			GRIPE WATER 07					
						HEALTH CARD 2			SMALLER THAN AVERAGE 4			NO 2	► (0.24)			IF LESS THAN ONE HOURS, RECORD 00			NO 2	NO 2			SUGAR/GLUCOSE WATER 03			TEA/INFUSIONS 08					
									VERY SMALL 5											► (0.22)			SUGAR-SALT-WATER SOLUTION 04			HONEY 09					
																							FRUIT JUICE 05			COFFEE 10					
																										OTHER (SPECIFY) 96					
						A.	B.	C.	A.	B.	C,		A.	B.	C.	A.	B.	C.		A.	B.	C.	A.			B			C		
						FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD		FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOD CHILD	THIRD CHILD		FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD			SECOND CHILD			THIRD CHILD		
YES 1	YES 1				Very Satisfied 1																										
NO 2	NO 2				Somewhat Satisfied 2																										
					Neither satisfied nor dissatis 3																										
			YES 1	YES 1	Somewhat dissatisfied 4																										
			NO 2	NO 2	Very dissatisfied 5																										
																							1	2	3	1	2	3	1	2	3
CODE	CODE	MINUTES	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	HOURS	HOURS	HOURS	CODE	CODE	CODE	CODE	CODE 1	CODE 2	CODE 3	CODE 1	CODE 2	CODE 3	CODE 1	CODE 2	CODE 3

FEEDING						Risk Factors After Delivery		
-0.22	(0.23)	(0.24)	-0.25	(0.26)	(0.27)	-0.28	-0.29	-0.3
For how many months did you breastfeed?	For how money months did you exclusively breastfeed to your baby? This means only you gave the baby only breastmilk, and no other food, water, or liquid.	Why did you not breast feed	What did you give instead of breast milk?	Did someone teach you to breast feed?	IWho taught you?	After this delivery, did you have severe abdominal pain?	After this delivery did you have more bleeding than is normal?	After this delivery, did you have a severe headache?
RECORD IN MONTHS								
IF LESS THAN ONE MONTH, RECORD 00		Mother Sick 01	Milk, other than breast 01	Yes 01	Mother 01			
		Lack of milk 02	Infant Formula 02	No 02 ► (0.28)	Friend 02			
		Did not want to 03	Other, Specify 96		Mother in Law 03			
STILL BREASTFEEDING 98		Lack of knowledge 04			Traditional Birth Attendant 04			
		Not to spoil figure 05			Community Health Nurse 05			
NO SKIP	IF LESS THAN ONE MONTH, RECORD 00	Doctor Advised 06			Health Facility Staff 06			
		Other, Specify 96			Other, Specify 96			
	STILL BREASTFEEDING 98							
	► (0.26)					YES 1	YES 1	
						NO 2	NO 2	
CODE	MONTHS	CODE	CODE	CODE	CODE	CODE	CODE	CODE

	POSTNATAL CARE				POSTNATAL CARE		
(0.31)	(0.32)	(0.33)	(0.34)	(0.35)	(0.36)	(0.37)	(0.38)
After the birth/miscarriage, did a health professional or traditional birth attendant or healer check on your health?	After the birth/miscarriage, did anyone in the VSG refer you to the health clinic for a check up?	How many post-natal check ups did you attend/receive in the first 6	How long after the birth/miscarriage did you receive the first post-natal check?	Who checked on your health the first time?	Where did this check take place?	IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.	Why didn't you have a postnatal check up in a formal health institution/personnel for this pregnancy?
					GOVERNMENT HOSPITAL 01		TOO EXPENSIVE 01
					GOVERNMENT CLINIC 02		TOO FAR 02
				MEDICAL DOCTOR 01	GOVERNMENT HEALTH POST 03		TOO BUSY (WORK, CHILDREN) 03
				NURSE/MIDWIFE 02	PRIVATE HOSPITAL 04		SELF-TREATED 04
				COMMUNITY HEALTH NURSE 04 ► (0.38)	PRIVATE CLINIC 05		DID NOT NEED 05
				VILLAGE HEALTH WORKER 05 ► (0.38)	NGO CLINIC 06		FACILITY HAS POOR STRUCTURE 06
			WRITE THE ANSWER IN DAYS. IF LESS THAN A DAY, WRITE 00	LAB TECHNICIAN 05 ► (0.38)	PHARMACY 07 ► (0.38)	► (0.42)	FACILITY POORLY STOCKED 07
				PHARMACIST/ DRUG SELLER 06 ► (0.38)	MOBILE CLINIC 08 ► (0.38)		POOR STAFF ATTITUDE 08
				TRADITIONAL BIRTH ATTENDANT 07 ► (0.38)	PROVIDER'S HOME 09 ► (0.38)		POOR STAFF KNOWLEDGE 09
				TRADITIONAL HEALER 08 ► (0.38)	OWN HOME 10 ► (0.38)		POOR QUALITY OF CARE 10
				SPIRITUAL HEALER 09 ► (0.38)	OTHER HOME 11 ► (0.38)		SERVICE NOT AVAILABLE 11
YES 1	YES 1			OTHER, SPECIFY 96 ► (0.38)	OUTDOOR LOCATION 12 ► (0.38)		NO TRANSPORTATION 12
NO 2 ► (0.33)	NO 2				OTHER (SPECIFY) 96 ► (0.38)		INCONVENIENT HOURS 13
							LONG WAITING TIMES 14
							PREFER HOME CARE 15
							FAMILY DIDN'T WANT ME TO GO 16
							OTHER (SPECIFY) 96
CODE	CODE	NUMBER	DAYS	CODE	CODE	NAME / CODE	CODE 1 / CODE 2 / CODE 3

			IRON TABLETS/SYRUP			VITAMIN A					DEATH		CE IN HOU
-0.39	-0.4	-0.41	(0.42)	(0.43)	(0.44)	(0.45)		0.45 A	0.45 B	0.45 C	(0.46)	(0.47)	(0.48)
Were you referred to the health center for post natal care by a CHW or TBA at any point during your pregnancy?	Were you accompanied to the health center for postnatal care services by a CHW or TBA?	Did the CHW or TBA help to provide transportation to HC for your postnatal care?	After the birth/miscarriage, were you given or did you buy any iron tablets or iron syrup or folic acid to take?	How long after the birth/ miscarriage did you take the first iron dose?	For how many days after the birth/miscarriage did you take the iron tablets or iron syrup?	In the first two months after the birth/miscarriage, did you receive a vitamin A dose (like this)? SHOW COMMON AMPULES / CAPSULES /	INTERVIEWER: CH ► 13.84	If you had another baby, would you go back to the same clinic for postnatal care?	Would you recommend this clinic to a relative or friend for their postnatal check-up?	In general, how satisfied are you with the postnatal care you received in this clinic? Would you say that you are very satisfied, somewhat satisfied, niether satisfied nor dissatisfied, somewhat dissatisfied, or very dissatisfied?	Is the child still alive?	How old was the child when he/she died?	Is the child still living with you?
							IF LIVE BIRTH: ASK FOLLOWING QUESTIONS FOR AT LEAST FIRST CHILD, AND IF MULTIPLE BIRTHS, PROCEED TO SAME QUESTIONS FOR SECOND/THIRD CHILD IF APPLICABLE.				YES 1 ► (0.48) NO 2	INTERVIEWER: WRITE THE ANSWER IN MONTHS IF LESS THAN ONE MONTH, WRITE ZERO	YES 1 NO 2
				WRITE THE ANSWER IN DAYS		YES 1 NO 2 ► INSTRUCTIONS PRIOR TO (0.46)				Very Satisfied 1 Somewhat Satisfied 2 Neither satisfied nor dissatis 3 Somewhat dissatisfied 4 Very dissatisfied 5		► 13.84	
YES 1 NO 2 ► (0.42)	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2 ► (0.45)					YES 1 NO 2	YES 1 NO 2				
CODE	CODE	CODE	CODE	DAYS	DAYS	CODE	CODE	CODE	CODE	CODE	CODE	MONTHS	CODE

Exclusive Breastfeeding

#REF!	After delivery, when do you think is the best time to start breastfeeding?	Immediately/Within one hour after birth	01
		Within first day	02
		Within 2 days of brith	03
	(ONE ANSWER)	When the baby wants	04
		When the mother is ready	05
		Other ____	96
#REF!	Until what age do you think it's best to give only breastmilk?	0-1 month	01
		2-3 months	02
		4-5 months	03
		6 months	04
		More than 6 months	05
#REF!	If you have a baby under 6 months, what is best to feed him/her?	Breast milk only	01
		Breast milk and solid foods	02
		Breast milk and water	03
		Breast milk and animal milk	04
		Breast milk and formula	05
		Breast milk and tea	06
		Other	07
#REF!	Until what age do you think it's best to give any breastmilk?	0-1 month	01
		2-3 months	02
		4-5 months	03
		6 months	04
		6 months - 1 year	05
		1 year - 2 years	06
		More than 2 years	07
#REF!		Breast milk	01
	When a child receives both breast milk and other foods, what should the chil	Other Foods	02
#REF!	How do you know the baby needs to be fed? Would you feed them:	When the baby demands feeding	A
	INTERVIEWER: PROMPT FOR EACH:	Every time baby cries	B
	*REWORDED	At set times	D
		Other ____	E
#REF!	Why is it good for your baby to breastfeed?	Gives baby protection from disease	A
	*CHANGED WORDING	Creates bond between baby and mother	B
	Do not prompt, circle all that are mentioned	Makes the child strong and intelligent	C
		Makes the child strong and healthy	D
		It is the right food for the baby	E
		Other ____	F
#REF!	What benefits does the mother have from breastfeeding her child?	Creates a bond between mother and baby	A
		Helps to prevent anemia	B
		Helps to expel the placenta	C
		Prevents mother from getting cancer In the future	D
	Do not prompt, circle all that are mentioned	It is free	E
		It is ready to use as is	F
		Babies who are breastfed need less medical attention and are sick less often	G
		It helps the mother have faster recovery after delivery	H
		It prevents pregnancy	I
		Other ____	J

#REF!		Yes	01
	Should the baby receive the first milk that tends to be thicker and yellower th	No	00
#REF!	Do you agree that It is important to give a young baby water as well as breastmilk.	Yes	01
		No	00
#REF!	Would you breastfeed during the night? That is, after you have gone to bed?	Yes	01
		No	00
#REF!	Do you think that a mother with small breasts can produce enough milk?	Yes	01
		No	00
#REF!	Can a mother who has a young baby and who is not well fed produce enou	Yes	01
		No	00
#REF!	What do you think makes a woman have enough milk?	Giving breast milk often	A
		Breastfeeding for a long time each time	B
	Do not prompt, circle all that are mentioned	Good food	C
		Drinking before breatfeeding	D
		Free from problems	E
		Eating the right food	F
		Being or feeling strong	G
		Taking the right tea/infusion	H
		Other ____	H
#REF!	What is the most common reason for a mother to have over-full, hard, sore b	Not Breastfeeding Enough	01
		Baby belches on breast	02
		Other	03
		Don't Know	-99
#REF!	I will read to you a number of cases, Can you tell me if a woman should continue breastfeeding in each case?		
	When she is angry	Yes	01
		No	00
	When her husband is angry with her	Yes	01
		No	00
	When the woman is sick	Yes	01
		No	00
	When the baby is sick	Yes	01
		No	00
	When she has swollen and painful breasts (engorgement)	Yes	01
		No	00
	When she has cracked nipples	Yes	01
		No	00
	When she has an infection on her nipples	Yes	01
		No	00

Minimum Acceptable Diet

#REF!	What is the minimum food needed by your child?	Breastmilk	A
		Grain	B
		Roots or Tubers	C
	Do not prompt, circle all that are mentioned	Legumes or nuts	D
		Dairy Products	E
		Red Meat	F
		Fish	G
		Poultry	H
		Eggs	I
		Oils/ Fats	J
		Fruits	K
		Vegetables	L
#REF!	How often do you need to feed your youngest child?	2 times per day	01
		3 times per day	02
		4 times per day	03
		5 times per day	02
		6 or more times per day	03

SUBJECT: Woman who most recently had a live brith
RESPONDENT: SELF

		(14.01)	(14.02)	(14.03)	(14.04)	(14.05)	(14.06)	(14.07)	-14.08	(14.09)	(14.10)	(14.11)	(14.12)	-14.13
	PROGRAMMER -12.02	At the time you became pregnant, did you want to become pregnant then, did you want to be pregnant later, or did you not want to have any (more) children at all?		What is your idea	What do you think									
	IS THE WOMAN		If you could choose for yourself, how			In the next few weeks, if yo							Would you say that y	
							Do you approve or	Do you approve or	Do you current	Do you think that y	In the last 6 months, how	Would you say that using contrace		Are you currently d
		► (14.13)	WOULD NOT WAIT 1			BIG PROBLEM 1								
			LESS THAN 2 YEARS 2			SMALL PROBLEM 2					NEVER 1	MAINLY RESPONDENT 01		
			MORE THAN 2 YEARS 3			NO PROBLEM 3	APPROVE 1	APPROVE 1	YES 1	APPROVE 1	ONCE OR TWICE 2	MAINLY HUSBAND/PARTNER 02	YES 1	YES 1 ► (14.16)
			DOESN'T WANT MORE 4			CAN'T GET PREGNANT 4	DISAPPROVE 2	DISAPPROVE 2	NO 2	DISAPPROVE 2	MORE THAN TWICE 3	JOINT DECISION 04	NO 2	NO 2
	YES 1	THEN 1	HAVE NOT DECIDED YET 5						► (14.13)			OTHER, SPEFICY 96		
	NO 2	LATER 2	INFERTILE 6											
	► (14.02)	NOT AT ALL 3	► (15.01)											
ID CODE	CODE	CODE	CODE	NUMBER	NUMBER	CODE	CODE	CODE	CODE	CODE	CODE	CODE		CODE

(14.14)		-14.15	-14.16	(14.17)		-14.18	(14.19)	(14.20)			
			Which method are you currently using?								
			IF MORE THAN ONE METHOD, INDICATE THE HIGHEST M								
			TUBAL LIGATION (FEMALE 01 ► (14.20)								
Why are you currently not using any metho			VESECTOMY (MALE STERILIZATION) 02 ► (14.20)	Where did you obtain this method?				Have any of the following ever talked to you about family planning meth			
			IUD / SPIRAL 03	MEDICAL DOCTOR	01	How long have you been					
WOULD LIKE TO GET PREGNANT	01	Have you eve	INJECTABLES / DEPOPROVERA 04	NURSE/MIDWIFE	02				YES	1	
DOES NOT APPROVE	02		IMPLANTS / NORPLANT 05	COMMUNITY HEALTH NURSE	03				NO	2	
PARTNER DOES NOT APPROVE	03	► (14.20)	PILL 06	LAB TECHNICIAN	04						
FAMILY DOES NOT APPROVE	04		MALE CONDOM 07	PHARMACIST/ DRUG SELLER	05						
NOT AVAILABLE	05		FEMALE CONDOM 08	TRADITIONAL HEALER	06						
TOO EXPENSIVE	06		DIAPHRAGM 09	TRADITIONAL BIRTH ATTENDANT	07						
SCARED OF SIDE-EFFECTS	07		FOAM/JELLY 10	SPIRITUAL HEALER	08		How much did you pa				
DON'T KNOW OF ANY METHOD	08	YES 1	LACTATIONAL AMENORRHEA METHOD 11 ► (14.20)	OTHER SHOP	09	ENTER YEARS IF 12 MO					
LACTATIONAL AMENORRHEA	09	NO 2	RHYTHM / NATURAL METHOD 12 ► (14.20)	FAMILY MEMBER	10						
HAD HYSTERECTOMY	10		WITHDRAWAL 13 ► (14.20)	FRIEND/NEIGHBOR	11			A	B	C	D
IS MENOPAUSAL	11		OTHER MODERN METHOD, SPECIFY 14	OTHER (SPECIFY)	12						
IS INFECUND	12		OTHER TRADITIONAL METHOD, SPECIFY 15								
OTHER (SPECIFY)	96							Health worker at	Community Health	Friends/Family	Other (Specify)
CODE		CODE	CODE	CODE		YEARS	MONTHS	DALASI	CODE	CODE	CODE	CODE

15 Vaccination

SUBJECT: YOUNGEST CHILD OF RESPONDENT

-15.01

RESPONDENT: MOTHER OR PRIMARY CAREG [ ] CONFIRM TOTAL NUMBER OF LIVING CHILDREN 0-5 Y

(15.02)	-15.03	-15.04	-15.05	(15.05) continued	-15.06	-15.07
			INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD	INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD		
			* IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLO	* IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLOWING:		
			RECORD DAY USING 2 DIGITS DD (RANGE 01-31)	RECORD DAY USING 2 DIGITS DD (RANGE 01-31)		
			RECORD MONTH USING 2 DIGITS MM (RANGE 01-12)	RECORD MONTH USING 2 DIGITS MM (RANGE 01-12)		
			RECORD YEAR USING 2 DIGITS YY (RANGE 09-14)	RECORD YEAR USING 2 DIGITS YY (RANGE 09-14)		
		Do you have an u	RECORD ANY MISSING ELEMENT OF THE DATE AS "DK" IF DATE DOES NOT INC	RECORD ANY MISSING ELEMENT OF THE DATE AS "DK".		
RECORD			* IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN	* IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN DAY COLUMN.		
			* IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.	* IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.		
			ALL VACCINE COLUMNS SHOULD BE FILLED OUT.	ALL VACCINE COLUMNS SHOULD BE FILLED OUT.		
		IF YES, RECORD				
IMPORT I	RECORD					Has [NAME] received any vaccina
		YES, S 1				YES 1
					INTERVIEWER: Whic	NO 2
		YES, N 2	A. B. C. D. E. F.	O P Q R S V	First Dose 1	
		► (15.09)			Second Dose 2	SKIP TO NEXT CHILD
		NO 3	BCG OPV0 Measles Pneumococcal Rotavirus Vacc DPT-Hep-Hlb3 (	MEASLES Dewomring first Deworming secor VITAMIN A first VITAMIN A secor Hib3 (if delivered	Third Dose 3	
		► (15.08)			Other, Specify 96	

ID CODE	ID CODE	ID CODE	CODE	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	DAY MON YEA	CODE	CODE
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(15.08)		(15.09)	(15.10)		(15.11)	(15.12)		(15.13)		(15.14)	(15.15)		(15.16)	(15.17)		(15.18)		(15.19)		(15.20)		(15.21)	(15.22)		(15.23)		15.24
Did you ever have																											
		Did [NAME] ever receiv			When did [NAME] receive t		Did [NAME] rece	When did [NAME] receiv			Did [NAME] receiv		How many tir							When was the last vitamin A sup					When was the last mebendazole prov		In the last 6 months, how
										How many times												In the last 6 mont	Did [NAME] ever receive				
			Did [NAME] rec											Did [NAME] receiv		Did [NAME] re		Did [NAME] ever									
YES	1	YES 1	YES	1	JUST AFTER	01	YES	1	JUST AFTER	01		YES	1		YES	1	BEFORE	01	YES	1	6 MONTHS AGO OR LESS	01		YES	1	6 MONTHS AGO OR LESS	01	
NO	2	NO 2	NO	2	LATER	02	NO	2	LATER	02		NO	2		NO	2	AFTER	02	NO	2	MORE THAN 6 MONTHS	02		NO	2	MORE THAN 6 MONTHS	02	
		► (15.19)					► (15.15)					► (15.17)			► (15.19)									► NEXT CHILD				
																			► NEXT CHILD									
CODE		CODE	CODE		CODE	CODE		CODE		NUMBER	CODE		NUMBER	CODE		CODE		CODE		CODE		NUMBER	CODE		CODE		NUMBER

15 ID CODE: 01 02 03 04 05

16 Height and Weight

SUBJECTS: ALL CHILDREN OF THE REPONDENT <5 YEARS OLD IN THE HOUSEHOLD.
RESPONDENT: Woman who most recently had a live birth

	(16.01)	(16.02)		(16.03)	(16.04)	(16.05)		(16.06)	(16.07)		(16.08)		(16.09)	(16.10)		(16.11)					(16.12)	(16.13)		(16.14)	(16.15)	(16.16)	(16.17)
	RECORD ID C	RECORD INDIVIDUAL'S AGE FROM SECTION 1		Did [NAME] sleep in the house last night?	In the last 6 months, was [NAME] measured to determine [NAME]'s nutritional status?	What was the date of the last measurement? INTERVIEWER: CONFIRM FROM THE CARD IF AVAILABLE"		For the last measurement, which method was used to determine [NAME]'S nutritional status?	For the last measurement, where was [NAME] measured?		What was the result of the last measurement?		Did you obtain any specialized care for [NAME]'s malnutrition after the last measurement?	Where was the care for [NAME]'s malnutrition obtained from?		Were any of the following given to take care of [NAME]'s malnutrition?					WILL YOU ALLOW US TO TAKE THE WEIGHT AND MEASUREMENTS OF [NAME]? IF YES, ENTER THE CHILD'S INFORMATION INTO ANTHROPOMETRY SHEET AND	OUTCOME OF ANTHROPOMETRY		RECORD HEIGHT IN CEN	RECORD METHOD FOR MEASURING HEIGHT	RECORD WEIGHT IN KILOGRAMS	RECORD UPPER ARM CIRCUMFERENCE IN CENTIMETERS
														GOVERNMENT HOSPITAL	01												
														GOVERNMENT MAJOR HEALTH CENTI	02												
														GOVERNMENT MINOR HEALTH CENTE	03	READ EACH OPTION ALOUD AND RECORD YES OR NO											
									GOVERNMENT HOSPITAL	01				GOVERNMENT HEALTH POST	04						YES	01	MEASURI	01				
									GOVERNMENT CLINIC	02				NGO CLINIC	05						NO							
									GOVERNMENT HEALTH POST	03				PRIVATE CLINIC	06							2	NOT	02				
								Height only	1	PRIVATE HOSPITAL	04			PRIVATE PRACTITIONER	07								TOO ILL	03				
								Weight only	2	PRIVATE CLINIC	05			PHARMACY	08		YES	1					REFUSED	04	RECORD HEIGHT IN CEN			
								Height / Weight	3	PRIVATE HEALTH POST	06			MOBILE CLINIC/OUTREACH	09		NO	2					OTHER (S	96 ►	NEXT PER			
								Mid-Upper Arm	4	PHARMACY	07			TRADITIONAL HEALER	10												
										MOBILE CLINIC	08	GREEN	1	YES	1	FAITH/CHURCH HEALER	11								CHILDREN LESS THAN 24 MONTHS SHOULD BE MEASURED LAYING			CHILDREN WITH MUAC<11.5 MUST BE IMMEDIATELY REFERRED TO NEAREST HEALTH FACILITY
				YES	1	YES	1			PROVIDER'S HOME	09	► (16.12)		NO	2	COMMUNITY HEALTH WORKER	12										
				NO	2	NO	2			OWN HOME	10	YELLOW	2	► (16.12)		COMMUNITY OWNED CLINIC	13								STANDING	01	
						► (16.12)				OTHER HOME	11	RED	3			SERVICE CLINIC	14								LYING	02	
										OUTDOOR LOCATION	12	DON'T				OTHER, SPECIFY	96										
						Don't Know = 99				OTHER (SPECIFY)	96	KNOW	4														
		A.	B.													Vitamir	Nutritio	Nutritio	Other v	Refere	Other						
ID CODE	ID CODE	YEARS	MONTH	CODE	CODE	MM	YYYY	CODE	CODE		CODE		CODE	CODE		CODE	CODE	CODE	CODE	CODE	CODE	CODE		CENTIMETERS	CODE	KILOGRAMS	CENTIMETERS
01																								.		.	.
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18 Community Health Worker Service Usage and Satisfaction

SUBJECTS: WOMAN WITH MOST RECENT LIVE BIRTH
RESPONDENT: SELF

	(18.01)	(18.02)	(18.03)											(18.04)						
	In the last 3 months, have you met with a community member (Community Health Nurse or a member of the Village Support Group) either in your home or in the community?		Did this person provide any of the following services? RECORD YES OR NO CODES FOR EACH SERVICE BELOW											We would like to know a bit more about your interaction with the community member talking to you. Can you tell us how						
						YES 1														
						NO 2														
																VERY UNSATISFIED 1				
																UNSATISFIED 2				
			A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.			SATISFIED 3				
																VERY SATISFIED 4				
	YES, AT HOME 1			Referral to institutional delivery			Referral to child vaccination													
	YES, IN THE COMMUNITY 2	Was the perso																		
	YES, IN BOTH HOME AND 3													A.	B.	C.	D.	E.	F.	G.
	NO 4																Their time availability to attend to you?			Them being good role models?
	► End																			
		CHN A																		
		VSG B	Referral to pre		Referral to pos			Advice on HIV	Advice on fam	Child growth n	Advice on wa	Distribution of	Information, Ed							
		Other C																		
ID CODE						Referral to Vol								Their level of kn	Them being resp	There being eno		The information t	Them being resp	
	CODE	CODES	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE
01																				

-18.05

We would like to know a bit more about your opinions on pregnancy and child care. For each of the following, can you tell us whether you Strongly Agree, Agree Somewhat, Neither Agree nor Disagree, Disagree Somewhat, or Strongly Disagree?

AGREE STRONGLY	1
AGREE SOMEWHAT	2
NEITHER AGREE NOR DISAGREE	3
DISAGREE SOMEWHAT	4
DISAGREE STRONGLY	5

A.	B.	C.	D.	E.	F,	G.	H.	I.	J.	K.	L.	M.	N.	O.	P.	Q.	R.	S.	T.	U.	V.	W.	X.
									It is cheaper to														
											The risks are			My husband p			It is more com						
								It is safer to gi								Women who d		The health fac					
It is ok for a v	ANC is good f	I would avoid	It is dangerous	Hard work dur	Finding transp	A woman rece	I am more con			There are risk		If I deliver at h	A woman whe		The costs req				Health staff are	Health staff ma	In the last yea	Family plannin	I spend less ti
CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE	CODE

-19.01 -19.02

Could you give me the names of the household members that have a cellpho

RECORD ID CODE AND NAME

Could you please give me the cellphone numbe

	NAME	ID CODE	CELLPHONE NUMBER

Could you also give us the cellphone numbers of at least two other family members, relatives, or friends of your household? If we need to contact you again and your cellphone number does not work, we would

-19.03 -19.04 -19.05

	NAME	CELLPHONE NUMBER	RELATIONSHIP TO HEAD

THANK THE HOUSHOLD MEMBERS (YOUR MANUAL TELLS YOU HOW TO END)

Interview notes

PLEASE WRITE DOWN YOUR NOTES (IF ANY) PER RESPONDENT

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

Interview Results

Main Respondent(s) of Household Questions? Record up to 2

Code

RECORD GPS Coordinates

Record GPS Coorddinates

Lat Long

RESULT OF THE INTERVIEW:

INTERVIEW DONE	
PARTIALLY COMPLETED	01
REGISTERED PERSON REFUSED INTERVIEW	02
HOUSEHOLD MEMBERS NOT PRESENT	03
HOUSEHOLD VACATED	04
HOUSE ADDRESS NOT FOUND	05
HH HEAD / OTHER REFUSED TO ALLOW INTERVIE	06
	07
Language not spoken, Interview not conducted	
OTHER, SPECIFY: _____	08
	96

TRANSLATOR USED?

NEVER	1
SOMETIMES	2
ALWAYS	3

LANGUAGE USED

...BY THE RESPONDE

ENGLISH	01
MANDINKA	02
WOLOF	03
FULA	04
JOLA	05
SERER	6
OTHER (SPECIFY:_____)	96

Annex 8: Sample interview guide

In-depth Interview Guide for Health Facility Managers
Maternal and Child Nutrition and Health Results Based Financing
Baseline Evaluation

Serial #: **District:**

Health facility Name:

Key Informant Age:

Key Informant Gender:

Key Informant Qualification:

Key Informant Experience (Years):

Date: **Start time:** **End time:**

Instructions for Interviewer

1. This guide should help you to initiate and carry forward the interview.
2. It should flow like a normal conversation rather than a usual questions-answers session.
3. Inform the participant you are going to record the session. They should agree to be recorded before you can proceed. Anyone who objects should be replaced. Reasons for refusing to participate should be recorded.
4. The questions need not be followed chronologically. But, before completing the discussion, please make sure that all the points in the guide have been covered.
5. The participant should be comfortable and in a mood to sit with you for about 60 minutes at least. If this is not possible, please request for another schedule.
6. Start the discussion by talking about general things related to work and life. You may use traditional ice-breaking conversations.
7. All participants should be health workers managing a health facility in the project area.

Goal Statement and Informed Consent

MoH and NaNA are jointly conducting a baseline evaluation for the Results-Based Financing (RBF) project, assisted by the World Bank. The specific purpose of this interview with you is to gather your perception and experiences on the current functioning of MCH services within your health facility as well as the links with other community structures. We have selected you for this discussion as you are within a health facility that will fall within the project area for this work. Your personal identity will not be revealed to any

individual/organization, nor will be reported in any documents. The information you are sharing will be solely used for the betterment of the program, especially improving the design and implementation of RBF in health facilities and community. You are free to refuse answering any questions and withdraw at any time from this discussion.
Are you willing to participate in this discussion: Yes/ No
Can I record this discussion in an audio format? Yes/ No.

Introduction

1. How long have you been working in this facility? What is your role in this facility?
2. Can you give a brief description of the maternal and child nutrition and health services offered within this facility?

Staff and Training

3. How is the overall staffing in MCH services? *[probe: availability, shortage, what needs to be done more, major challenges/opportunities for improvement etc.]*
4. What about workload, working hours, hours of operation and patient load? *[probe: any changes brought in, why and why not these changes, what more needs to be done? Which component of MCH gives the maximum workload?]*
5. How is the current level of staff motivation, job satisfaction and performance *[probe separately for each aspect: Have you noticed any changes in any of these recently? why and why not these changes? What more needs to be done in this regard?]*
6. How is the teamwork and staff communication within facility and with higher authorities? *[probe: what have you done to improve these? challenges? How else might this be improved?]* How often do you meet up with your staff? Do you think it might be useful to meet with them more often? What do you discuss when you meet?
7. Have the staff in MCH services received any training to help them fulfill their responsibilities? If yes, *[probe: when, where, how long, topic of training]* How useful did the staff find this training? What can be done to conduct more training and improve its quality and usefulness? If staff were not trained, what was the reason?
8. Is there any recent change in the skills and knowledge of staff? If yes, please specify? What caused these changes? *[probe: managing pregnancy complications, SBA, family planning services etc.]*

Infrastructure

9. Do you think that this facility's infrastructure is adequate? *[probe: toilets, consultation rooms, no. of beds, in-patient facility, waiting rooms, drug storage facility, VCT etc.]*
10. What improvements would you like to see in these areas?

Drugs/Supplies/Equipment

11. What is the current availability of drugs, supplies and equipment within MCH services? Have there been any stock-outs in the last six months? What were the effects on utilization of services and patients?

12. Has any equipment been broken during the last six months? What were the effects on the utilization of services and patients? Did you make any new purchase or repair any machine?
13. What is the current procedure of procurement in your facility?
14. What are the procurement challenges? What have you done for improving the current system? What else needs to be done?

Service quality

15. Do you think that the quality of MCH services could be improved? *[probe: provider behaviour, waiting time, time spent with patients, client satisfaction etc.]* How could this be improved?

Clients and community

16. What is your overall sense of health seeking behaviour for MCH services e.g. timeliness and utilization of ANC, delivery and PNC services*? [probe: what could you do to increase demand for services? What are the challenges in trying to do this?]*
17. How do you assess patient satisfaction with these services? What is the current level of patient satisfaction with these services? How might it be improved?
18. What are your user fees policies within MCH services? Do mothers pay for drugs, supplies etc? All the time? If not, when do women pay and when do they not be? What do you do when women cannot afford to pay these fees?

Service delivery targets

19. How do you monitor your health facility's performance in MCH services? *[probe: do you get support from RHT's office?]* . Can you elaborate on this?
20. Do you set specific health services delivery targets? If so, what is the process for setting these targets? How often do you achieve these targets? *[probe: which target was easy to achieve, which was difficult, why?]* What happens when you do not achieve the targets?

Overall performance

21. How do you think your facility has performed during the last quarter? Why*? Can you give an example? [probe: three reasons for performance and non-performance]*
22. Do you have a business plan? Can you explain the processes of its design, revision and approval*? [probe: stakeholders involved, timeline, challenges and opportunities]* . What are your key objectives/aims when you design your business plan? *[probe: revenue generation, improving delivery status, quality of care etc.]*
23. What activities in your operational plan were you able to implement and not implement effectively? Why?
24. What are some of the best performing indicators in your facility? Why do you think this is?
25. What are some of the worst performing indicators in your facility? Why do you think this is?

Health Management Information System (HMIS) and Verification

26. Can you please explain the process and frequency of HMIS entry? Do you think that these processes might be improved? If so, how?
27. Is there any internal and external verification of this information? If so, who does this and how does it work?
28. What is the current feedback mechanism in your facility? Who gives you feedback on the performance of facility? How often? How is the efficiency and transparency in this regard?

Revenue generation

29. How does your facility generate revenue? What are the different sources that you receive money from?
30. Does the income that you receive cover the operating costs of your facility? If so, is there a surplus? If not, how do you address the funding shortfall?
31. What do you think could be done to improve the financial situation of the health facility?
32. If you had additional funds, how would you allocate these? *[Probe: Salary top-ups? Equipment and supplies? Building renovation?]*

Management/Supervision and Support

33. What are the current financial management procedures of the facility *[probe: auditing, timeliness, reporting, verification etc.]* How could these be improved?
34. How is the CAC involved in the decision making process of your facility?
35. How do you collaborate with VDCs?
36. How do you collaborate with VSGs?

RBF project

37. Have you heard about the Results-Based Financing (or RBF) project?
38. Can you describe the overall objectives of this project? Are any of these objectives more or less important?
39. To what extent to the objectives match your priorities within the health facility?
40. What will your specific responsibilities be in this project? *[probe: indicators incentivized, roles etc]*
41. Do you feel well positioned to take on these responsibilities? Is there any training or support that you think would help you fulfill this work?
42. What opportunities will the project bring for you? What makes you most excited about this project?
43. What are your recommendations for more effective implementation of the project?

Wrap up

44. Is there anything else relevant to your work or the RBF project that you'd like to tell me about?

Annex 9: Sample focus group discussion guide

Focus Group Discussion Guide for Women who have delivered in the last 6 months
Maternal and Child Nutrition and Health Results Based Financing
Impact Evaluation Baseline

Serial #: **District:**

Number of participants: **Age range:**

Community:

Date: **Start time:** **End time:**

Instructions for Facilitator

- This guide should help you to initiate and carry forward the discussion.
- It should flow like a normal discussion rather than a questions-answers session.
- Inform the participant you would like to record the session. They should agree to be recorded before you can proceed. Anyone who objects should be replaced. Reasons for refusal to participate should be recorded.
- The questions need not be followed chronologically. But, before completing the discussion, please make sure that all the points in the guide have been covered.
- The participant should be comfortable and in a mood to sit with you for about 60 minutes at least. If this is not possible, please request for another schedule.
- Start the discussion by talking about general things related to work and life. You may use traditional ice-breaking conversations.
- All participants should be women in the study communities who have delivered in the last 6 months.

Goal Statement and **Informed Consent**

MoH and NaNA are jointly conducting a process evaluation of the Results-Based Financing (RBF) pilot project, assisted by the World Bank. The specific purpose of this discussion is to ascertain women's perception and experiences around maternal and child nutrition and health. We have selected you for this discussion because you have delivered a baby in the last six months. Your personal identity will not be revealed to any individual/organization, nor reported in any documents. The information you are sharing will be solely used for the betterment of the program, especially improving the program benefits to the community. You are free to refuse answering any questions and withdraw at any time from this discussion.
Are you willing to participate in this discussion: Yes/ No
Can I record this discussion in an audio format? Yes/ No

Introduction

1. Have you heard about the results based financing project in this community?

a. What does the project aim to do?

ANC

2. Do all women attend ANC during pregnancy?
   a. Why do you think it is important for women to attend ANC when they're pregnant?
3. When do women usually first attend ANC during pregnancy (i.e. how far into pregnancy)?
4. Why do women choose to attend ANC at that time?
   a. What are the factors that make women wait or want to attend ANC?
5. Is it easy to go to ANC?
   a. Why (not)?
   b. What things make it easy/hard?
   c. If hard, how do women overcome these barriers?
6. How many times do women attend ANC after the first visit?
   a. Why?
7. Is it useful to attend ANC all of these times?
   a. Why (not)?
   b. What do women like best about going to ANC?
   c. What do women like least about it?

TBA

8. Do women also see a TBA during pregnancy?
   a. Why (not)?

If woman do see a TBA:

9. What advice and services does the TBA provide? [Probe: ANC, delivery, PNC?]
10. Does the TBA refer women to the health facility at any stage?
    a. If so, what for? When (e.g. during pregnancy, for delivery, post-natally)?
    b. Do they refer all women or only some? If not all, which women are referred? If only 'high risk' women referred: what do you mean by "high risk"?
    c. Do women then go to the health facility? If not, why not?

Risks

11. Are there any risks involved in pregnancy?
    a. If so, what are the risks?
    b. How can they be avoided?
    c. Who can recognize these risks?

Delivery

12. Do women know when they were expecting to deliver? How?
13. Do women deliver at the health facility?
    a. Why (not)?
    b. Is it easy to get to the health facility? Why (not)?
14. Do most women deliver where they had planned to i.e. if they want to deliver at a health facility do they actually deliver there?
    a. If no, why do women end up delivering elsewhere?
15. Does anyone else advise women on where to deliver? What do they advise? Do women follow this advice?

16. If health facility delivery is desired, when do women decide to go to the health facility for delivery? In active labour already? With contractions how far apart? Why?
17. How is the quality of care for delivery?
    a. Are the health workers friendly?
    b. Do you think they did everything they can to make women comfortable and to look after the baby?
    c. What could they do differently to improve the experience for you?

Pregnancy

18. When do women first tell people that they are pregnant?
    a. Why do they wait until this time to tell them?
19. Whom do they usually tell first? And then?
20. In general, how are pregnant women viewed in this community?
21. Is this any different for adolescent pregnant women? Or unmarried pregnant women? Or widowed pregnant women? How is it different? How do people show this? What impact do you think this has on these groups of pregnant women?

Family planning

22. How many children do women usually have? Is that number changing over time or does it stay about the same?
23. Who decides how many children to have – women? Their husbands? Both together? Someone else?
24. How long should women wait to get pregnant again after they have had a child? Why?
25. Is it ok for women to use family planning methods to help achieve this spacing between children? Why (not)?
26. What family planning methods do you know about?
    a. Where did you hear about them?
    b. Which methods do you think are most popular in this community?
    c. Are there any particular methods that are ok? Or not ok? Why?
27. Have you ever attended the health facility for family planning services?
    a. If not, why not?
28. Have you ever used any methods of family planning?
    a. If so, which ones? Why? Where you happy with using this method? Why (not)?
    b. If not, would you ever consider using any of these methods? Why (not)? Which methods would you consider (if any)?
29. In general, is it ok for adolescent/unmarried/widowed women to use family planning? Why (not)?
30. Do you discuss family planning with anyone?
    a. How do you make decisions about whether or not to use family planning?

Wrap-up

31. Is there anything else about any of the topics that we have touched on today that you would like to tell me about that you think it would be useful for me to know?

Annex 10: Code tree for qualitative data analysis

I. COMMUNITY AND HEALTH FACILITIES

Key Behavioral Attributes

- Understanding of the project
- Expectancy
- Valence
- Buy-In
- Perceived Fairness

Behavior

- Motivation & Morale
- Teamwork & Collaboration
- Communication
- Awareness
- Perceived Control
- Demand for Knowledge

Program Design

- Supervision
- Recommendations moving forward

Program Implementation

- Distribution of Incentives
    - Health Facilities
    - Community
    - Individuals
- Expenditure of Incentives
    - Health Facilities
    - Community
    - Individuals
- Workload

Availability of Services

Quality of Services

- OPD visits
- ANC visits
- Skilled delivery
- PNC visits
- Treatment for complications (delivery, post-partum, neonate)
- Deworming
- Caesarean section
- Modern Family Planning
- Nutrition services (health facility and community-based)
- Community health services

SES

Gender norms/dynamics
TBAs
Family planning
Food security
Political Economy

- Stakeholder support
- Public Policies
- Institutional Capacity
- Legal Framework
- Governance

II. COMMUNITY

Behavioral and Organizational Changes

- Knowledge of maternal and child health
- Expressed demand for health services
    - OPD visits
    - ANC 1st visit < 3 months
    - Number of ANC visits
    - Skilled delivery
    - Home/TBA delivery
    - PNC visits
    - Modern family planning
    - Traditional family planning
    - Deworming
- Expressed demand for nutrition services
    - VAS
    - Management of SAM
- Demand for healthy behavior
    - Environmental Hygiene Criteria:
        - Handwashing with soap and water
        - Latrine use
- Utilization of health services
    - OPD visits
    - ANC 1st visit < 3 months
    - Number of ANC visits
    - Skilled delivery
    - Home/TBA delivery
    - Caesarean section
    - PNC visits
    - Treatment for complications (delivery, post-partum, neonate)
    - Modern family planning
    - Traditional family planning
    - Deworming
- Utilization of nutrition services
    - Vitamin A supplementation

    - SAM treatment
- Adoption of Healthy Behaviors
    - Handwashing with soap and water
    - Latrine use
    - Exclusive breastfeeding to 6 months
    - Birth spacing

Accessibility

- Barriers to accessing services
    - Geography/transport
    - Financial
    - Traditional beliefs regarding care seeking

Social support

Health and nutrition impacts of non-utilization of services

In households and amongst beneficiaries

- Knowledge of healthy behaviors and recommended practices
    - Advantages of breast feeding
    - Descriptions of minimum acceptable diet
    - Healthy pregnancy and associated risk factors
    - Facility delivery
    - Post-partum and post-natal care practices
    - Family planning and birth spacing
- Traditional beliefs regarding health
    - Traditional beliefs regarding pregnancy
    - Traditional beliefs regarding delivery
    - Traditional beliefs regarding family planning
- Traditional beliefs regarding nutrition

VSGs & VDCs

- Motivation
- Job satisfaction
- Capacity and knowledge
    - VDC capacity to manage RBF
- Intensity of services
    - Frequency of mothers club meetings
    - Frequency of village meetings
- Quality of community health services
    - Better equipped with supplies
    - TBA services
    - TBA referrals, evacuations or escorts
- Village development regarding health
- Village development regarding nutrition
- Community ownership of health activities and outcomes
- Community ownership of nutrition activities and outcomes

III. HEALTH FACILITIES

Health System Pillars

- Service Delivery

    - Infrastructure
- Health Workforce
- Financing
- Governance
- Medicines/Commodities
- Information

Program Design and Implementation

- Contract with PBF indicators
    - Autonomy
        - Allocating resources
        - Management and Leadership Response
- Data Reporting
    - Verification
- Capacity Building
- Sustainability