**NMCP**

**NATIONAL MALARIA CONTROL PROGRAMME**

WORLD BANK

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

# GOMBE STATE MALARIA CONTROL BOOSTER PROJECT
# Impact Evaluation: Primary Health Care Facility (PHF) Survey
# 2012

**Conducted with the Support of the World Bank**

**Implementing Firm: Hanovia Medical Limited**

NAME OF STATE | CODE

NAME OF LGA | CODE

NAME OF WARD | CODE

NAME OF PRIMARY HEALTHCARE FACILITY | CODE

SEA NUMBER

| RURAL | 1 |
| PERI-URBAN | 2 |
| URBAN | 3 |

NAME OF VILLAGE

| INTERVIEWER NAME | CODE | DATE OF FIRST INTERVIEW | | |
|---|---|---|---|---|
| | | DAY | MONTH | YEAR |
| INTERVIEWER NAME | CODE | DATE OF FINAL INTERVIEW | | |
| | | DAY | MONTH | YEAR |

## CONSENT

**ENUMERATOR: READ THE FOLLOWING TEXT:**

Hello, my name is **[YOUR NAME]**. I am from **[NAME OF ORGANIZATION]**, and I would like to ask you some questions about this health facility.

**(0.01)** Are you in charge of this facility today?

| | |
|---|---|
| YES | 01 | ► (0.03) |
| NO | 02 | |

**(0.02)** Are you authorized to represent the facility?

| | |
|---|---|
| YES | 01 | |
| NO | 02 | ► **END INTERVIEW** |

**(0.03)** Do you agree to participate in this interview?

| | |
|---|---|
| YES | 01 | |
| NO | 02 | ► **END INTERVIEW** |

**(0.04)** What is your role / position in this health facility?

| | |
|---|---|
| DIRECTOR OR VICE DIRECTOR | 01 |
| HEAD OF HEALTH FACILITY | 02 |
| MEDICAL DIRECTOR | 03 |
| OTHER DOCTOR | 04 |
| ADMINISTRATOR | 05 |
| NURSE | 06 |
| OTHER (SPECIFY) | ► _____ |

**(0.05)** **GENDER OF RESPONDENT**

| | |
|---|---|
| MALE | 01 |
| FEMALE | 02 |

**(0.06)** **NAME OF RESPONDENT**

_____

**Mobile Phone #:** _____  **Email:** _____

| RESULT OF INTERVIEW | COMPLETED | 1 |
|---|---|---|
| | PARTIALLY COMPLETED | 2 |
| | REFUSAL | 3 |
| | PHF NOT PRESENT | 4 |
| | OTHER (SPECIFY) | 96 ▶ _____ |

| LANGUAGES | ENGLISH | 01 |
|---|---|---|
| | BOLEWA | 02 |
| | FULFULDU | 03 |
| | HAUSA | 04 |
| | IGBO | 05 |
| | KANURI | 06 |
| | TANGALE | 07 |
| | TERA | 08 |
| | OTHER (SPECIFY) | 96 ▶ _____ |

☐ LANGUAGE OF THE INTERVIEW

☐ RESPONDENTS' LOCAL LANGUAGE

☐ TRANSLATOR USED (1 = NEVER; 2 = SOMETIMES; 3 = ALWAYS)

**SUPERVISOR NAME** _____

| TEAM | ID |
|---|---|
| | |

| DAY | MONTH | YEAR |
|---|---|---|
| | | |

**DATA ENTRY OPERATOR** _____

| TEAM | ID |
|---|---|
| | |

| DAY | MONTH | YEAR |
|---|---|---|
| | | |

**DATA ENTRY SUPERVISOR** _____

| TEAM | ID |
|---|---|
| | |

| DAY | MONTH | YEAR |
|---|---|---|
| | | |

**GPS:** **Way Point ID** ☐☐☐

**Latitude (N):** [ ☐☐ . ☐☐☐☐ ]

**Longitude (E):** [ ☐☐ . ☐☐☐☐ ]

**COMMENTS** _____

_____

_____

## Section 1: General Information

**1.1: General Information**

**(1.01)**    TYPE OF HEALTH FACILITY

| | | | |
|---|---|---|---|
| HEALTH POST | 01 | OTHER (SPECIFY) | 96 |
| HEALTH CLINIC | 02 | ▼ | |
| PRIMARY HEALTH CARE CENTER | 03 | | |

**(1.02)**    What authority manages the facility?

| | |
|---|---|
| STATE GOVERNMENT | 01 |
| LOCAL GOVERNMENT | 02 |
| OTHER (SPECIFY) | 96 ► |

**(1.03)**    Is this funded through the MDG-DRG?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.04)**    What year was this health facility built?
       RECORD YEAR

**(1.05)**    When (month and year) was the last major renovation of the physical structure of the building?

RECORD MONTH CODE

RECORD YEAR

**(1.06)**    What time is this facility open for patient care on…
       RECORD OPENING HOURS FOR EACH PERIOD

   A.   Monday to Friday?    to      C.   Sunday?    to

   B.   Saturday?    to      D.   Public Holidays?    to

**(1.07)**    Is 24 hour emergency service available at this facility?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.08)**    What are the three major sources of funding or income for this facility?

| | |
|---|---|
| USER FEES | 01 |
| LGA GOVERNMENT | 02 |
| STATE GOVERNMENT | 03 |
| RELICIOUS ORGANIZATION | 04 |
| NGO | 05 |
| PRIVATE COMPANY | 06 |
| HEALTH INSURANCE PAYMENTS | 07 |
| OTHER (SPECIFY) | 96 ► |

DO NOT READ ANSWERS. RECORD UP TO 3 RESPONSES

1ST

2ND

3RD

**(1.09)** Can you please tell me the amount received from each of the following income sources in the last year (2011)?

READ EACH SOURCE OF FUNDING, AND RECORD AMOUNT RECEIVED

A.  User Fees

B.  LGA Government

C.  State Government

D.  
    Religious Organization

E.  NGO

F.  Private Company

G.  
    Health Insurance Payments

H.  Other

**(1.10)** What was the total income for 2011?          RECORD TOTAL INCOME.  IF ZERO, RECORD "00"

**(1.11)** I am now going to ask you about several types of expenses which are incurred while managing a health facility.

Please tell me how much, from this facility's budget, was spend on each item in 2011.

READ EACH EXPENDITURE CATEGORY, AND RECORD AMOUNT SPENT ON EACH

A.  Drugs and consumables

B.  Salary

C.  Salary bonuses

D.  Per diems

E.  Water, electricity, and gas

F.  Communications

G.  Petrol

H.  Other transport costs

I.  Outreach activities

J.  Buidling maintenance

K.  Equipment maintenance

L.  Equipment purchase

M.  Other (specify)
    ▼

**(1.12)** What was the total expenditure of this health facility in 2011?

RECORD TOTAL EXPENDITURE IN NAIRA.  IF RESPONDENT DOES NOT KNOW, PROBE FOR ESTIMATE.  OTHERWISE, RECORD "89"

**(1.13)** NOTE THE SOURCE OF THE EXPENDITURE DATA

| | | | |
|---|---|---|---|
| OFFICIAL ACCOUNTS | 01 | OTHER (SPECIFY) | 96 |
| FACILITY RECORDS | 02 | ▼ | |
| ORAL REPORT | 03 | | |

## 1.2: Facility Characteristics

**(1.14)** Is there a reception / registration room?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.15)** Is there an indoor waiting area for patients?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.16)** Is there a separate waiting room for women in the facility?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.17)** Is their air conditioning in patient areas?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.18)** Are there any observation beds?

| | | | |
|---|---|---|---|
| YES | 01 | | |
| NO | 02 | ► | **(1.20)** |

**(1.19)** How many beds are available?           RECORD NUMBER OF BEDS

**(1.20)** Are accommodations for persons on-call present?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(1.21)** For how many hours per day does the facility normally have electricity?           RECORD NUMBER OF HOURS:

**(1.22)** What is the main source of energy for lighting (i.e. which do you use the most?)

| | | | |
|---|---|---|---|
| ELECTRICITY FROM GRID (NEPA / PHCN) | 01 | TORCH | 06 |
| ELECTRICITY FROM GENERATOR | 02 | SOLAR PANEL | 07 |
| KEROSINE / PARAFFIN / GAS / OIL LAMP | 03 | OTHER (SPECIFY) | 96 |
| CANDLES | 04 | ▼ | |
| OPEN FIRE | 05 | | |

**(1.23)** What is the main source of clean water in this facility in the:     A. Dry season:     B. Rainy season:

| | | | |
|---|---|---|---|
| DIRECTLY FROM RIVER / LAKE / STREAM / DAM | 01 | | |
| PUMPED / PIPED FROM RIVER / LAKE / STREAM / DAM | 02 | | |
| UNPROTECTED WELL | 03 | BOUGHT FROM WATER VENDOR | 09 |
| PROTECTED WELL | 04 | BOTTLED / BAGGED WATER | 10 |
| BOREHOLE | 05 | RAIN WATER | 11 |
| PUBLIC TAP | 06 | OTHER (SPECIFY) | 96 |
| OWN TAP | 07 | ▼ | |
| OTHER TAP (E.G. IN NEARBY BUILDING) | 08 | | |

**(1.24)** How long, in hours and minutes, does it take to fetch water from the main source for this health facility (round trip)?

RECORD NUMBER OF MINUTES:

RECORD NUMBER OF HOURS:

**(1.25)** Last week, was this water source available for all working hours?

| | | |
|---|---|---|
| YES | 01 | ► **(1.27)** |
| NO | 02 | |

**(1.26)** Last week, how many hours was the water source available?

RECORD NUMBER OF HOURS (MAX. 168):

**(1.27)** What is the primary source for a telephone?

| | | |
|---|---|---|
| IN-FACILITY LANDLINE | 01 | ► **(1.31)** |
| IN-FACILITY MOBILE | 02 | ► **(1.31)** |
| ONE OR TWO-WAY RADIO | 03 | ► **(1.31)** |
| OUTSIDE FACILITY | 04 | |

**(1.28)** How long, in hours and minutes, does it take to reach the primary telephone source for the facility (round trip)?

RECORD NUMBER OF MINUTES:

RECORD NUMBER OF HOURS:

**(1.29)** Last week, how many hours was the telephone source available?

RECORD NUMBER OF HOURS (MAX. 168):

**(1.30)** Does this facility refer patients to other facilities?

| | | |
|---|---|---|
| YES | 01 | |
| NO | 02 | ► **(1.33)** |

**(1.31)** How far, in kilometers, is the referral facility / hospital from this facility?

RECORD DISTANCE IN KILOMETERS. IF LESS THAN 1, RECORD "00"

**(1.32)** How long, in hours and minutes, does it take to travel from this health facility to the referral health facility?

RECORD NUMBER OF MINUTES:

RECORD NUMBER OF HOURS:

**(1.33)** Does the facility have access to transportation (to pick up patients or take them to the referral facility?

| | | |
|---|---|---|
| YES | 01 | |
| NO | 02 | ► **(1.36)** |

**(1.34)** What type of transportation does the facility have access to?

READ ALL OPTIONS ALOUD, AND RECORD "YES" / "NO" FOR EACH ONE.

| | | |
|---|---|---|
| YES | 01 | |
| NO | 02 | |

A. Ambulance owned by facility

B. Ambulance owned by LGA

C. Private vehicle rented full-time

D. Private vehicle rented part-time

E. Other vehicle owned by facility

F. Private vehicles on call

G. Other (specify)
▼

**(1.35)** Last week, how many hours was the transportation available?

RECORD NUMBER OF HOURS (MAX. 168):

**(1.36)**  Does the facility have access to a functioning computer?

| | |
|---|---|
| YES | 01 |
| NO | 02 ► **NEXT SECTION** |

☐

**(1.37)**  Does the facility use the computer for any of the following:

| | |
|---|---|
| YES | 01 |
| NO | 02 |

READ ALL OPTIONS ALOUD, AND RECORD "YES" / "NO" FOR EACH ONE.

A.  Tracking or organizing medical records ☐

B.  Managing lab results ☐

C.  Billing patients ☐

D.  Tracking number of patients ☐

E.  Tracking expenditures / costs ☐

F.  Tracking drug inventory ☐

G.  Other (specify)
▼ ☐

_____

## Section 2: Administration and Management

**(2.01)** How many health facility staff meetings were held in the past 12 months?     RECORD NUMBER OF MEETINGS

**(2.02)** Has a facility workplan been developed for this year?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 ► **(2.04)** |

**(2.03)** Who was involved in setting this workplan?     READ ALL OPTIONS ALOUD, AND RECORD "YES" / "NO" FOR EACH ONE.

| | |
|---|---|
| YES | 01 |
| NO | 02 |

A. Health facility staff

B. NGO staff

C. Local government

D. Community health workers

E. Community members

F. Village / Ward Development Committee

G. Other (specify)
▼

**(2.04)** Are priority activities identified for 2012?

| | |
|---|---|
| YES | 01 |
| NO | 03 ► **(2.06)** |

**(2.05)** What are the priority activities for 2012?     **DO NOT** READ OPTIONS ALOUD. RECORD "YES" / "NO" IF MENTIONED / NOT MENTIONED.

| | |
|---|---|
| YES | 01 |
| NO | 02 |

A. PRENATAL CARE

B. INSTITUTIONAL DELIVERY

C. POST NATAL CARE

D. IMMUNIZATION

E. NUTRITION

F. IMCI

G. MALARIA

H. TB

I. HIV / AIDS

J. OTHER (SPECIFY)
▼

**(2.06)** Is there a written emergency preparedness plan?

| | |
|---|---|
| YES | 01 |
| NO | 02 ► **(2.08)** |

**(2.07)** How long ago was the emergency preparedness plan last updated?

| | |
|---|---|
| WITHIN LAST 6 MONTHS | 01 |
| WITHIN LAST YEAR | 02 |
| MORE THAN A YEAR AGO | 03 |

**(2.08)**  Is there a community group, such as a ward or village development committee, that supervises the work of this health facility?

| | |
|---|---|
| YES | 01 |
| NO | 02  ▶  **(2.11)** |

**(2.09)**  In the last  6 months, how many supervision visits were made by this group or these community members?

RECORD NUMBER OF VISITS

| | |
|---|---|
| IF ZERO | 00  ▶  **(2.11)** |

**(2.10)**  Were recommendations written in a supervision book from last supervision?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 |

**(2.11)**  Is there a community group, such as a ward or village development committee, who make formal recommendations to this health facility?

| | |
|---|---|
| YES | 01 |
| NO | 02  ▶  **(2.14)** |

**(2.12)**  In the last  6 months, how many supervision visits were made by this group or these community members?

RECORD NUMBER OF VISITS

| | |
|---|---|
| IF ZERO | 00  ▶  **(2.14)** |

**(2.13)**  Were recommendations written in a supervision book from last supervision?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 |

**(2.14)**  In the past 6 months, how many supervision visits were made by an LGA representative?

RECORD NUMBER OF VISITS

| | |
|---|---|
| IF ZERO | 00  ▶  **(2.16)** |

**(2.15)**  Were recommendations written in a supervision book from last supervision?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 |

**(2.16)**  In the past 6 months, how many supervision visits were made representatives of NGOs or other donor organizations?

RECORD NUMBER OF VISITS

| | |
|---|---|
| IF ZERO | 00  ▶  **(2.18)** |

**(2.17)**  Were recommendations written in a supervision book from last supervision?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 |

**(2.18)**  In the past 6 months, how many times did employees of this health facility make supervisory visits to community health workers or community directed distributors (CDDs)?

RECORD NUMBER OF VISITS

**(2.19)**  In the last 6 months, how many times was staff performance at this

RECORD NUMBER OF TIMES

facility <u>internally</u> assessed?

**(2.20)** In the last 6 months, how many times was staff performance at this facility <u>externally</u> assessed?

RECORD NUMBER OF TIMES

**(2.21)** Is patient opinion obtained through client surveys or other methods?

| YES | 01 | |
|---|---|---|
| NO | 02 | ▶ **(2.24)** |

**(2.22)** Is patient opinion reviewed / reported to staff?

| YES | 01 |
|---|---|
| NO | 02 |

**(2.23)** In the last 12 months, have any changes occurred as a result of patient opinion?

| YES | 01 |
|---|---|
| NO | 02 |

**(2.24)** Is there an annual budget for the health facility in the form of a written document?

| YES, SEEN | 01 | |
|---|---|---|
| YES, NOT SEEN | 02 | |
| NO | 03 | ▶ **(2.27)** |

**(2.25)** Who was involved with developing the budget?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

READ ALL OPTIONS ALOUD, AND RECORD "YES" / "NO" FOR EACH ONE.

A. Myself

B. Other health facility staff

C. NGO staff

D. Local government

E. Community health workers

F. Community members

G. Village / Ward Development Committee

H. Other (specify)
   ▼

**(2.26)** Of the people that participated, who was most important, second most important, and third most important in developing this budget?

| | |
|---|---|
| FIRST MOST IMPORTANT | 01 |
| SECOND MOST IMPORTANT | 02 |
| THIRD MOST IMPORTANT | 03 |

READ THE PERSONS MARKED "YES" ABOVE, AND MARK UP TO THREE IN ORDER OF IMPORTANCE

A. Myself

B. Other health facility staff

C. NGO staff

D. Local government

E. Community health workers

F. Community members

G. Village / Ward Development Council

H. Other (specify)

**(2.27)** I am going to read a series of statements. For each statement, please state whether you strongly disagree, disagree, agree, or strongly agree.

| | | | |
|---|---|---|---|
| STRONGLY DISAGREE | 01 | STRONGLY AGREE | 04 |
| DISAGREE | 02 | NOT APPLICABLE | 05 |
| AGREE | 03 | DON'T KNOW | 89 |

A. I have sufficient physical resources to help care for patients

B. I have sufficient human resources to help care for patients

C. I have sufficient medical ersonnel to treat the patients who come here

D. I have sufficient other professional staff to assist at this facility

E. Medical equipment and supplies are readily available

F. There is sufficient time t ocare for each patient

G. I have pharmaceuticals I want to prescribe available

| | | |
|---|---|---|
| H. | I have funds available to make improvements | |
| I. | Open positions for health staff are filled within 2 months | |
| J. | Examining room equipment is in working order | |
| K. | I have influence on the way my work unit (my facility) is managed | |
| L. | I have the ability to initiate changes in the way work is done in my unit (my facility) | |
| M. | I can set the pace of my own work | |
| N. | I am satisfied in the manner in which I receive directions from administrators | |
| O. | I am satisfied in the way in which I must report my activities | |
| P. | I have the freedom to care for patients even when they are unable to pay the fees and charges | |
| Q. | I am satisfied with the appreciation received from my superiors | |
| R. | I have my professional judgement questionned by non-physicians working in the organization | |
| S. | I am satisfied with the harmony of relationships among doctors and other staff | |
| T. | I have input into major organizational decisions | |
| U. | I am appreciated by staff in the organization | |
| V. | The physicians who work here are competent | |
| W. | The nurses who work here are competent | |
| X. | Staff are appropriately compensated for their work | |
| Y. | I am able to provide bonuses to staff at my discretion | |
| Z. | I am appropriately compensated for my work | |

## Section 3a: Human Resources

**(3.01)** Do all facility workers have written job descriptions?

| | |
|---|---|
| ALL HAVE DESCRIPTIONS | 01 |
| SOME HAVE DESCRIPTIONS | 02 |
| NONE HAVE DESCRIPTIONS | 03 |

**(3.02)** In the past 12 months, how many new staff were hired, both clinical and non-clinical?

Record number of clinical staff

Record number of non-clinical staff

**(3.03)** In the past 12 months, how many new staff were transferred to another facility, both clinical and non-clinical?

Record number of clinical staff

Record number of non-clinical staff

**(3.04)** In the past 12 months, how many new staff were transferred, both clinical and non-clinical?

Record number of clinical staff

Record number of non-clinical staff

**(3.05)** In the past 12 months, how many staff resigned, both clinical and non-clinical?

Record number of clinical staff

Record number of non-clinical staff

| For [POSITION], how many positions are… RECORD FOR EACH POSITION | (3.06) Possible? | (3.07) Filled? | (3.08) Vacant? |
|---|---|---|---|
| A. Clinical officers | | | |
| B. Doctors | | | |
| C. Midwives | | | |
| D. Nurses | | | |
| E. Environmental health offices | | | |
| F. Pharmacist and pharmacy technicans | | | |
| G. Lab tecnicians | | | |
| H. Junior CHEWS | | | |
| I. Sernior CHEWS | | | |
| J. Administrative staff | | | |
| K. Data manager | | | |
| L. Other staff | | | |

In the last 12 months, how many facility-based clinical staff, community health workers (CHWs), and community-directed distributors (CDDs) have received training in…

RECORD NUMBER FOR EACH ITEM BELOW

| | (3.09) Facility-based staff | (3.10) CHWs and CDDs |
|---|---|---|
| A. Prenatal care | | |
| B. Institutional delivery | | |
| C. Post-natal care | | |
| D. Immunization | | |
| E. Nutrition | | |
| F. IMCI | | |
| G. Malaria | | |
| H. TB | | |
| I. HIV / AIDS | | |
| J. Data management and utilization | | |
| K. Quality control | | |
| L. Other (specify) | | |

## Section 3b: Human Resources (continued)

| WORKER ID | (3.11) LIST ALL HEALTH WORKERS WORKING IN THIS FACILITY, INCLUDING THE RESPONDENT. FOR EACH HEALTH WORKER, ASK THE REMAINING QUESTIONS IN THIS SECTION. THEN MOVE ON TO THE NEXT WORKER. NAME OF HEALTH WORKER | (3.12) Is [NAME] male or female? MALE 01 FEMALE 02 | (3.13) How old is [NAME]? RECORD AGE IN YEARS | (3.14) What is [NAME]'s position in this facility? SEE CODES BELOW | (3.15) What year did [NAME] receive his / her medical degree? RECORD YEAR. IF NOT APPLICABLE, RECORD "00" | (3.16) How many years has [NAME] worked at this facility? RECORD NUMBER OF YEARS | (3.17) How many days per week does [NAME] usually work at this health facility? RECORD NUMBER OF DAYS PER WEEK | (3.18) How many hours per week does [NAME] usually work at this health facility? RECORD NUMBER OF HOURS PER WEEK | (3.19) How many hours per week does [NAME] usually spend providing medical care to patients? RECORD NUMBER OF HOURS PER WEEK | (3.20) Does [NAME] provide prenatal care directly? YES 01 NO 02 | (3.21) Does [NAME] provide curative care for children directly? YES 01 NO 02 | (3.22) Does [NAME] provide curative care for adults directly? YES 01 NO 02 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | | | | | | | | | | | | |
| 02 | | | | | | | | | | | | |
| 03 | | | | | | | | | | | | |
| 04 | | | | | | | | | | | | |
| 05 | | | | | | | | | | | | |
| 06 | | | | | | | | | | | | |
| 07 | | | | | | | | | | | | |
| 08 | | | | | | | | | | | | |
| 09 | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | |

**CODES:** (3.14)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CLINICAL OFFICER | 01 | NURSE | 04 | LAB TECHNICIAN | 07 | ADMINISTRATIVE STAFF | 10 |
| DOCTOR | 02 | ENVIRONMENTAL HEALTH OFFICER | 05 | JUNIOR CHEW | 08 | DATA MANAGER | 11 |
| MIDWIFE | 03 | PHARMACIST / PHARMACY TECH. | 06 | SENIOR CHEW | 09 | OTHER STAFF | 12 |

(3.26)

| | | | | | | |
|---|---|---|---|---|---|---|
| OFF DUTY / OFF HC | 01 | FAMILY MEMBER SICK | 04 | LATE | 07 |
| ON LEAVE | 02 | OTHER AUTHORIZED ABSENCE | 05 | OTHER (SPECIFY) | 08 ▶ _____ |
| SICK | 03 | UNAUTHORIZED ABSENCE | 06 | | |

| WORKER ID | (3.23) Does [NAME] provide VCT directly? | (3.24) Is [NAME] here today? | (3.25) What service is [NAME] providing today? | (3.26) Why is [NAME] not here today? |
|---|---|---|---|---|
| | | | PRENATAL 01 ▶<br>CHILD CARE 02 ▶<br>ADULT CARE 03 ▶ NEXT RESPONDENT<br>VCT 04 ▶<br>OTHER 96 ▶ | |
| | YES 01<br>NO 02 | YES 01<br>NO 02 ▶ (3.26) | | SEE CODES BELOW |
| 01 | | | | |
| 02 | | | | |
| 03 | | | | |
| 04 | | | | |
| 05 | | | | |
| 06 | | | | |
| 07 | | | | |
| 08 | | | | |
| 09 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |
| 15 | | | | |

## Section 4: Laboratory

**(4.01)** Is there a laboratory in this health facility?

| | |
|---|---|
| YES | 01 |
| NO | 02 ► **NEXT SECTION** |

**(4.02)** For each of the following tests, are you able to do this today, were you able to do this in the past 6 months (but not today), or are you unable to do this test?

| | |
|---|---|
| ABLE TO DO TODAY | 01 |
| ABLE TO DO IN PAST 6 MONTHS | 02 |
| UNABLE TO DO | 03 |

READ EACH TEST ALOUD AND RECORD ANSWER FOR EACH TEST

A. White cell and red cell counts

B. Malaria smears (thick and thin)

C. Malaria rapid diagnostic test

D. TB smears

E. Gram stains

F. Blood type and cross match

G. HIV testing

H. Liver function testing

I. Syphilis testing

J. Urine dipstick tests

K. Prenancy testing

L. Hepatitis B testing

M. Hepatitis C testing

N. Blood sugar

O. Stool tests for parasites

P. Stool tests for occult blood

# Section 5: Records

## 5.1: Patient Records (Malaria)

**(5.01)** Is there a malaria register to record details of patients with malaria or suspected malaria?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 ► **(5.03)** |

**(5.02)** What details are recorded in this register?

| | |
|---|---|
| RECORDED | 01 |
| NOT RECORDED | 02 |

READ EACH ITEM ALOUD AND NOTE "RECORDED" / "NOT RECORDED" FOR EACH

A. Patient name

B. Patient age

C. Patient address

D. Method of diagnosis

E. Result of diagnosis

F. Treatment

G. Result of treatment

H. Liver function testing

I. Syphilis testing

J. Urine dipstick tests

K. Pregnancy testing

## 5.2: Facility records and general HMIS

**(5.03)** What is the population of the catchment area of this health facility?

RECORD POPULATION OF CATCHMENT AREA _____

**(5.04)** During the past 1 month, how many of the following occurred in this health facility?

READ EACH ITEM ALOUD AND RECORD THE APPROPRIATE NUMBER IN EACH CASE

A. Total outpatient cases attended

B. Total malaria outpatient cases attended

C. Total inpatients admitted

D. Total inpatients admitted for malaria

E. Total number of bed-days of occupancy

F. Total number of bed-days of occupancy due to malaria

G. Total number of inpatient deaths recorded

H. Total number of inpatient deaths recorded due to malaria

I. Total number of maternal deaths recorded

J. Total number of maternal deaths recorded due to malaria

K. Total infant deaths recorded

L. Total infant deaths recorded due to malaria

**(5.05)** Does this facility have a [REGISTER / REPORT]?

| | |
|---|---|
| YES, SEEN AND COMPLETE | 01 |
| YES, SEEN AND NOT COMPLETE | 02 |
| YES, NOT SEEN | 03 |
| NO | 04 |

READ ALOUD EACH ITEM BELOW, AND RECORD ANSWER FOR EACH

| | | |
|---|---|---|
| A. | Daily patient report | |
| B. | Monthly patient report | |
| C. | Annual patient report | |
| D. | Facility status report | |
| E. | Monthly inventory report | |
| F. | Vacinnation coverage report | |
| G. | Family planning register | |
| H. | **OTHER RELEVANT REPORTS???** | |

## Section 6: Community Outreach

**(6.01)** How many community health workers (CHWs) and community-directed distributors (CDDs) are supported by this facility?

A. NUMBER OF CHWs ☐

B. NUMBER OF CDDs ☐

**(6.02)** How many community health workers (CHWs) and community-directed distributors (CDDs) are currently active in this area?

A. NUMBER OF CHWs ☐

B. NUMBER OF CDDs ☐

**(6.03)** On average, how often do CHWs and CDDs visit this facility for instruction, meetings, or training?

| | |
|---|---|
| DAILY | 01 |
| WEEKLY | 02 |
| EVERY 2 WEEKS | 03 |
| MONTHLY | 04 |
| LESS THAN ONCE A MONTH | 05 |

A. CHWs ☐

B. CDDs ☐

**(6.04)** What activities do CHWs and CDDs perform?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

DO NOT READ OPTIONS ALOUD.  RECORD "YES" / "NO" FOR EACH ITEM BELOW.

| | A. CHWs | B. CDDs |
|---|---|---|
| A. VACCINATIONS | | |
| B. AT-HOME DELIVERIES | | |
| C. VITAL REGISTRATION (BIRTHS, DEATHS) | | |
| D. DISTRIBUTION / SALE OF ACT | | |
| E. DISTRIBUTION / SALE OF OTHER ANTI-MALARIAL DRUGS | | |
| F. DIAGNOSIS OF MALARIA WITH RDT | | |
| G. DIAGNOSIS OFMALARIA | | |
| H. ILLNESS REFERRAL | | |
| I. DOTS | | |
| J. BEHAVIOR CHANGE COMMUNICATION FOR MALARIA TREATMENT / PREVENTION | | |
| K. ANTE-NATAL CARE | | |
| L. POST-NATAL CARE | | |
| M. OTHER (SPECIFY) | | |

**(6.05)**  Does this facility have a designated supervisor for CHWs and CDD?  ► (6.07)

| | |
|---|---|
| YES | 01 |
| NO | 02 |

A. CHWs ☐

B. CDDs ☐

**(6.06)**  How many CHWs and CDDs is this person responsible for?

A. NUMBER OF CHWs ☐

B. NUMBER OF CDDs ☐

**(6.07)**  In the last 6 months, did the CHW or CDD do any of the following activities?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

READ OPTIONS ALOUD.  RECORD "YES" / "NO" FOR EACH ITEM BELOW.

| | | A. CHWs | | B. CDDs |
|---|---|---|---|---|
| A. | Participate in CHW / CDD meetings | | | |
| B. | Supervision of CHW / CDD activities (obseve consultations, activities) | | | |
| C. | Replace CHW / CDD supplies | | | |
| D. | Support CHW / CDD training | | | |
| E. | Provide CHW / CDD training | | | |
| F. | Collect and compile monthly activity reports | | | |
| G. | Promote specific health programs | | | |
| H. | Bednet distribution assistance | | | |
| I. | Provide malaria treatment services | | | |
| J. | Provide malaria prevention services | | | |
| K. | General clinic assistance | | | |
| L. | No specific role | | | |
| M. | Other (specify) | | | |

**(6.08)** In what ways does the village or ward development committee support this facility?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

READ OPTIONS ALOUD.  RECORD "YES" / "NO" FOR EACH ITEM BELOW.

| | | |
|---|---|---|
| A. | Helped improve health facility (e.g. thorugh providing land, supplies to clinic) | |
| B. | Repairs to facility | |
| C. | Mobilized community to use health facility | |
| D. | Provided transport to staff for home visits | |
| E. | Gave in-kind contributions | |
| F. | Gave financial contributions | |
| G. | Improved security for the facility | |
| H. | Improved water quality | |
| I. | Improved water supply | |
| J. | Supported training of CHWs and/or CDDs | |
| K. | Support to outreach teams | |
| L. | Other (specify) | |

**(6.09)** In what ways does the community in general support this facility?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

READ OPTIONS ALOUD.  RECORD "YES" / "NO" FOR EACH ITEM BELOW.

| | | |
|---|---|---|
| A. | Helped improve health facility (e.g. thorugh providing land, supplies to clinic) | |
| B. | Repairs to facility | |
| C. | Mobilized community to use health facility | |
| D. | Provided transport to staff for home visits | |
| E. | Gave in-kind contributions | |
| F. | Gave financial contributions | |
| G. | Improved security for the facility | |
| H. | Improved water quality | |
| I. | Improved water supply | |
| J. | Supported training of CHWs and/or CDDs | |
| K. | Support to outreach teams | |
| L. | Other (specify) | |

**Section 7: Services**

I would like to ask you some questions about the health services available in this facility

| ASK ALL QUESTIONS IN THIS SECTION FOR EACH SERVICE BEFORE MOVING ON TO THE NEXT SERVICE | | (7.01) Does this facility provide [SERVICE] within the facility or as outreach? | | (7.02) How many days per week is this service offered? | (7.03) What is the price per unit charged for this service, excluding the registration fee? | | (7.04) FOR EACH SERVICE, RECORD THE TOTAL NUMBER OF PATIENTS LISTED IN THE REGISTER, BEGINNING WITH [MONTH] TO [MONTH]. RECORD FOR BOTH IN-FACILITY ("IN") AND OUTREACH ("OUT") | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | YES 01 NO 02 | | BY APPOINTMENT 08 NO SPECIFIC TIME 09 | NO PRICE 00 DON'T KNOW 89 | | NO PRICE 00 DON'T KNOW 89 | | | | | | | | | | | | |
| | | | | | | | MONTH 1 | | MONTH 2 | | MONTH 3 | | MONTH 4 | | MONTH 5 | | MONTH6 | |
| | SERVICES | In-facility | Outreach | DAYS/WEEK | PRICE IN NAIRA | UNIT | IN | OUT | IN | OUT | IN | OUT | IN | OUT | IN | OUT | IN | OUT |
| A. | Immunizations | | | | | | | | | | | | | | | | | |
| A1. | BCG | | | | | PER DOSE | | | | | | | | | | | | |
| A2. | DPT (pentavalent 1, 2, 3) | | | | | PER DOSE | | | | | | | | | | | | |
| A3. | Polio | | | | | PER DOSE | | | | | | | | | | | | |
| A4. | Measles | | | | | PER DOSE | | | | | | | | | | | | |
| A5. | Tetanus Toxoid | | | | | PER DOSE | | | | | | | | | | | | |
| B. | Curative care for children < 5 yrs | | | | | PER VISIT | | | | | | | | | | | | |
| C. | Curative care for adults | | | | | PER VISIT | | | | | | | | | | | | |
| D. | Child growth monitoring | | | | | PER VISIT | | | | | | | | | | | | |
| E. | Nutritional advice for children | | | | | PER VISIT | | | | | | | | | | | | |
| F. | Prenatal care | | | | | PER VISIT | | | | | | | | | | | | |
| G | | | | | | | | | | | | | | | | | | |
| G1. | Normal | | | | | PER DELIVERY | | | | | | | | | | | | |
| G2. | Ceasarian | | | | | PER DELIVERY | | | | | | | | | | | | |
| G3. | Assisted (forcepts, vaccuum) | | | | | PER DELIVERY | | | | | | | | | | | | |
| H. | Home delivery with skilled staff | | | | | PER DELIVERY | | | | | | | | | | | | |
| I. | Blood transfusion | | | | | PER UNIT | | | | | | | | | | | | |
| J. | Family planning/clinical | | | | | | | | | | | | | | | | | |
| J1. | Pill | | | | | PER INITIAL VISIT | | | | | | | | | | | | |
| J2. | Injection | | | | | PER VISIT | | | | | | | | | | | | |
| J3. | Implant insertion | | | | | PER INSERTION | | | | | | | | | | | | |
| J4. | Male condoms | | | | | PER VISIT | | | | | | | | | | | | |
| J5. | IUD insertion | | | | | PER INSERTION | | | | | | | | | | | | |
| J6. | Female sterilization | | | | | PER PROCEDURE | | | | | | | | | | | | |
| J7. | Male sterilization | | | | | PER PROCEDURE | | | | | | | | | | | | |
| K. | Tuberculosis diagnosis | | | | | PER NEW CASE | | | | | | | | | | | | |
| L. | Tuberculosis treatment | | | | | PER DOT | | | | | | | | | | | | |
| M. | Malaria treatment | | | | | | | | | | | | | | | | | |
| M1. | Diagnosis (micrscopy) | | | | | | | | | | | | | | | | | |
| M2. | Diagnosis (RDT) | | | | | | | | | | | | | | | | | |
| M3. | ACT | | | | | PER VISIT | | | | | | | | | | | | |
| M4. | Other anti-malarial | | | | | PER VISIT | | | | | | | | | | | | |
| M5. | IPT | | | | | PER VISIT | | | | | | | | | | | | |
| M6. | Treatment for complicated malaria | | | | | PER VISIT | | | | | | | | | | | | |
| N. | STI services | | | | | | | | | | | | | | | | | |
| N1. | Diagnosis, treatment, testing, and counseling | | | | | PER VISIT | | | | | | | | | | | | |
| O. | HIV/AIDs services | | | | | | | | | | | | | | | | | |
| O1. | VCT | | | | | PER VISIT | | | | | | | | | | | | |
| O2. | PMTCT | | | | | PER VISIT | | | | | | | | | | | | |
| O3. | ART | | | | | PER VISIT | | | | | | | | | | | | |
| P. | 24-hour emergency care | | | | | PER VISIT | | | | | | | | | | | | |
| Q. | Inpatient stay | | | | | PER DAY | | | | | | | | | | | | |
| R. | Referral to another facility (ambulance ride) | | | | | PER TRANSPORT | | | | | | | | | | | | |

## Section 8: User Fees

**(8.01)** Are user fees being collected for outpatient visits?

| | |
|---|---|
| YES | 01 |
| NO | 02 ▶ **(8.03)** |

**(8.02)** Are user fees being collected for outpatient visits?

| | |
|---|---|
| YES, PUBLICLY POSTED | 01 |
| YES, NOT POSTED | 02 |
| NO | 03 |

**(8.03)** Do patients pay for registration / consultation / doctor's fees?

| | |
|---|---|
| YES | 01 |
| NO | 02 ▶ **(8.05)** |

**(8.04)** Are written guidelines on registration fees present for outpatient visits?

| | |
|---|---|
| YES, PUBLICLY POSTED | 01 |
| YES, NOT POSTED | 02 |
| NO | 03 |

**(8.05)** Do patients pay fees for medicine

| | |
|---|---|
| YES | 01 |
| NO | 02 ▶ **(8.08)** |

**(8.06)** Are written guidelines on drug fees present for outpatient visits?

| | |
|---|---|
| YES, PUBLICLY POSTED | 01 |
| YES, NOT POSTED | 02 |
| NO | 03 |

**(8.07)** What percent of the drug cost is charged to patients, and is this of the wholesale or retail price?

| | |
|---|---|
| NOT APPLICABLE | 00 |

**A.** % of wholesale price

**B.** % of wholesale price

**(8.08)** Do patients pay fees for lab tests (e.g. lab diagnosis, x-ray)?

| | |
|---|---|
| YES | 01 |
| NO | 02 ▶ **(8.10)** |

**(8.09)** Are written guidelines on lab fees present for outpatient visits?

| | |
|---|---|
| YES, PUBLICLY POSTED | 01 |
| YES, NOT POSTED | 02 |
| NO | 03 |

**(8.10)** Do patients pay fees for supplies (e.g. dressing)?

| | |
|---|---|
| YES | 01 |
| NO | 02 ▶ **(8.13)** |

**(8.11)** Are written guidelines on supplies fees present for outpatient visits?

| | |
|---|---|
| YES, PUBLICLY POSTED | 01 |
| YES, NOT POSTED | 02 |
| NO | 03 |

**(8.12)** Who was involved in setting the fees?     READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Health facility staff

**B.** NGO staff

**C.** Local government

**D.** State government

**E.** CHWs

**F.** Village / Ward development committee

**G.** Community

**H.** Other (specify)
▼

**(8.13)** In the last 12 months, has the user fee pattern been revised, updated, or reviewed?

| | | |
|---|---|---|
| YES | 01 | |
| NO | 02 | ► **(8.15)** |

**(8.14)** Who was involved in revising the fees?     READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Health facility staff

**B.** NGO staff

**C.** Local government

**D.** State government

**E.** CHWs

**F.** Village / Ward development committee

**G.** Community

**H.** Other (specify)
▼

**(8.15)** What does the facility do with the user fees?     READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Facility infrastructure

**B.** Facility programs

**C.** Use in community

**D.** Send back to managing agency / LGA government

**F.** Staff salaries

**G.** Send back to state government

**H.** Other (specify)
▼

**(8.16)** Are there different rates for children and adults?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(8.17)** Are any of the following individuals exempt from paying fees?

READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Widows

**B.** Children under 5

**C.** Orphans

**D.** TB patients

**E.** HIV / AIDS patients

**F.** Extremely por

**G.** Physicall disabled persons

**H.** Military personnel

**I.** Pregnant women

**J.** Refugees

**K.** Other (specify)
▼

**(8.18)** Who decides whith patients are exempt from paying fees?

READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Health facility staff

**B.** NGO staff

**C.** Local government

**D.** State government

**E.** CHWs

Village / Ward development committee

**G.** Community

**H.** Other (specify)
▼

**(8.19)** Do exempt patients receive a special exemption card that allows them to receive services for free?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(8.20)** Are there some services that are free for ALL patients (for which they do NOT have to pay fees)?

READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Prenatal care

**B.** Institutional delivery

**C.** Post-natal care

**D.** Immunization

**E.** Nutrition

**F.** IMCI

**G.** Malaria

**H.** TB

**I.** HIV / AIDS

**J.** Other (specify)
▼

_____

**(8.21)** Does this facility accept health insurance payments?

| | | |
|---|---|---|
| YES | 01 | |
| NO | 02 | ► **NEXT SECTION** |

**(8.22)** What proportion or percentage of payments are covered by health insurance?

RECORD PROPORTION / PERCENTAGE

**(8.23)** Is the insurance provided by the facility (i.e. does the facility collect premiums)?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(8.24)** Who sponsors the health insurance schemes accepted by this facility?

| | | | | |
|---|---|---|---|---|
| NATIONAL HEALTH INSURANCE SCHEME | 01 | OTHER (SPECIFY) | 96 | |
| INTERNATIONAL NGO | 02 | ▼ | | |
| LOCAL NGO | 03 | | | |
| PRIVATE COMPANY | 04 | | | |
| COMMUNITY-BASED HEALTH INSURANCE | 05 | _____ | | |

**(8.25)** Do clients with health insurance pay some out of pocket fee?

| | | |
|---|---|---|
| YES | 01 | |
| NO | 02 | ► **(8.27)** |

**(8.26)** Are these fees a percentage of total charges, or a co-payment?

| | | | |
|---|---|---|---|
| PERCENTAGE OF CHARGES | 01 | EITHER, DEPENDING ON INSURANCE PLAN | 03 |
| FIXED CO-PAYMENT | 02 | | |

**(8.27)** What services are covered by the health insurance scheme?

READ ALL OPTIONS ALOUD AND RECORD "YES" / "NO" FOR EACH OPTION

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**A.** Preventive care

**B.** Immunizations

**C.** Antenatal care

**D.** Labor / delivery

**E.** Postnatal care

**F.** Child curative care

**G.** Adult curative care

**H.** Medicine

**I.** Survery

**J.** Other (specify)
▼

## Section 9: Universal Precautions

**(9.01)**  Is there a safety box or closed container present for disposal of used sharps in the room patients are seen?

| | |
|---|---|
| YES | 01 |
| NO | 02  ▶  **(9.04)** |

**(9.02)**  Is there evidence that the safety boxes or closed containers are being used properly for disposal of used sharps?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(9.03)**  Is there evidence that syringes are being disposed of WITHOUT being recapped?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(9.04)**  Does this site have a vaccination refrigerator?

| | |
|---|---|
| YES | 01 |
| NO | 02  ▶  **(9.08)** |

**(9.05)**  Is a temperature log kept?

| | |
|---|---|
| YES, SEEN | 01 |
| YES, NOT SEEN | 02 |
| NO | 03 |

**(9.06)**  In the last 30 days, how many times per day was the tempreature logged?

RECORD NUMBER OF TIMES PER DAY

**(9.07)**  In the last 30 days, how many times was the refrigerator temperature over 8 degrees Celsius or under 2 degrees Celcius?

RECORD NUMBER OF TIMES

**(9.08)**  Is there a functional incinerator for disposing of medical waste?

| | |
|---|---|
| YES | 01 |
| NO | 02  ▶  **(9.10)** |

**(9.09)**  Is there evidence that the incinerator is being used regularly?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

**(9.10)**  Is there a closed container present for disposal of other bedical waste (besides sharps) in each room where patients are seen?

| | |
|---|---|
| YES | 01 |
| NO | 02  ▶  **NEXT SECTION** |

**(9.11)**  Is there evidence that this container is being used properly for disposal of medical waste?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

## Section 10: National Protocols

**(10.01)** FOR EACH OF THE FOLLOWING, RECORD IF PROTOCOL IS PRESENT (SEEN) OR NOT PRESENT (NOT SEEN)

| | |
|---|---|
| SEEN | 01 |
| NOT SEEN | 02 |

| | | |
|---|---|---|
| **A.** | PATIENT EDUCATION MATERIALS (IEC MATERIALS) | |
| **B.** | IMCI CHART BOOK OR WALL CHART | |
| **C.** | ACUTE RESPIRATORY INFECTION (ARI) | |
| **D.** | DIAGNOSIS AND TREATMENT OF DIARRHEA | |
| **E.** | GRAPHS FOR GROWTH MONITORING | |
| **F.** | TUBERCULOSIS DIAGNOSIS AND TREATMENT | |
| **G.** | HMIS GUIDELINES | |
| **H.** | HMIS DATA | |
| **I.** | MALARIA DIAGNOSIS AND TREATMENT | |
| **J.** | IMMUNIZATION SCHEDULE | |
| **K.** | FAMILY PLANNING | |
| **L.** | ANTENATAL CARE NATIONAL STANDARDS | |
| **M.** | NEWBORN CARE NATIONAL STANDARDS | |
| **N.** | POST-PARTUM CARE NATIONAL STANDARDS | |
| **O.** | PROCEDURES MANUAL FOR INFECTION PREVENTION AND CONTROL | |
| **P.** | MANAGEMENT OF STI GUIDELINES | |
| **Q.** | NATIONAL HIV TESTING AND COUNCELING GUIDELINES | |

## Section 11. Equipment

**(11.01)** Where is the outpatient equipment located?

| | | |
|---|---|---|
| GENERAL CONSULTATION | 01 | |
| SEPARATE OUTPATIENT ROOM | 02 | |
| OTHER (SPECIFY) | 96 | ▶ _____ |

**(11.02)** FOR EACH OF THE FOLLOWING EQUIPMENT, RECORD WHETHER IT IS PRESENT AND WORKING, PRESENT BUT NOT WORKING, OR NOT PRESENT

| | |
|---|---|
| PRESENT AND WORKING | 01 |
| PRESENT AND NOT WORKING | 02 |
| NOT PRESENT | 03 |

**A.** STERILIZER

**B.** TIMER OR CLOCK WITH SECOND HAND

**C.** CHILDREN'S SCALE

**D.** HEIGHT MEASURE

**E.** ADULT SCALE

**F.** BLOOD PRESSURE INSTRUMENT

**G.** THERMOMETER

**H.** STETHOSCOPE

**I.** OTOSCOPE

**J.** SUCTION / ASPIRATING DEVICE

**K.** VISION CHART

**L.** OXYGEN TANK

**M.** AMBUBAG

**N.** INCUBAOR

**O.** DRIP STAND

**P.** FLASHLIGHT

**Q.** STRETCHER

**R.** MINOR SURGICAL INSTRUMENTS FOR PROCEDURES LIKE INCISION AND DRAINAGE AND SUTURING

**S.** ORT CORNER WITH EQUIPMENT (1 LITER CONTAINER, CUPS AND SPOONS, REHYDRATION GUIDELINES)

**(11.03)** Where is the sterilization equipment located?

| | | |
|---|---|---|
| GENERAL CONSULTATION | 01 | |
| SEPARATE STERILIZATOIN | 02 | |
| OTHER (SPECIFY) | 96 ► | |

**(11.04)** FOR EACH OF THE FOLLOWING EQUIPMENT, RECORD WHETHER IT IS PRESENT AND WORKING, PRESENT BUT NOT WORKING, OR NOT PRESENT

| | |
|---|---|
| PRESENT AND WORKING | 01 |
| PRESENT AND NOT WORKING | 02 |
| NOT PRESENT | 03 |

A.   ELECTRIC AUTOCLAVE (PRESSURE AND WET HEAD)

B.   NON-ELECTRIC AUTOCLAVE (PRESSURE AND WET HEAD)

C.   ELECTRIC DRY HEAT STERILIZER

D.   ELECTRIC BOILER OR STEAMER (NO PRESSURE)

E.   NON-ELECTRIC POT WITH COVER (STEAM BOIL)

F.   HEAT SOURCE FOR NON-ELECTRIC EQUIPMENT

G.   AUTOMATIC TIMER (MAY BE ON EQUIPMENT)

H.   TST INDICATOR STRIPS OR OTHER STERILIZATION INDICATORS

**(11.05)** Where is the lab equipment located

| | | |
|---|---|---|
| GENERAL CONSULTATION | 01 | |
| SEPARATE LABORATORY | 02 | |
| OTHER (SPECIFY) | 96 ► | |

**(11.06)** FOR EACH OF THE FOLLOWING EQUIPMENT, RECORD WHETHER IT IS PRESENT AND WORKING, PRESENT BUT NOT WORKING, OR NOT PRESENT

| | |
|---|---|
| PRESENT AND WORKING | 01 |
| PRESENT AND NOT WORKING | 02 |
| NOT PRESENT | 03 |

A.   MICROSCOPE

B.   CENTRIFUGE

C.   HEMOGLOBINOMETER

D.   REFRIGERATOR FOR STORING REGENTS

**(11.07)** Where is the vaccination equipment located

| | |
|---|---|
| GENERAL CONSULTATION | 01 |
| SEPARATE VACCINATION ROOM | 02 |
| OTHER (SPECIFY) | 96 ▶ _____ |

**(11.08)** FOR EACH OF THE FOLLOWING EQUIPMENT, RECORD WHETHER IT IS PRESENT AND WORKING, PRESENT BUT NOT WORKING, OR NOT PRESENT

| | |
|---|---|
| PRESENT AND WORKING | 01 |
| PRESENT AND NOT WORKING | 02 |
| NOT PRESENT | 03 |

**A.** MAIN VACCINE THERMOMETER

**B.** COLD BOX / VACCINE CARRIER

**C.** ICE PACKS

**D.** REFRIGERATOR

**(11.09)** Where is the antenatal equipment located

| | |
|---|---|
| GENERAL CONSULTATION | 01 |
| SEPARATE LABORATORY | 02 |
| OTHER (SPECIFY) | 96 ▶ _____ |

**(11.10)** FOR EACH OF THE FOLLOWING EQUIPMENT, RECORD WHETHER IT IS PRESENT AND WORKING, PRESENT BUT NOT WORKING, OR NOT PRESENT

| | |
|---|---|
| PRESENT AND WORKING | 01 |
| PRESENT AND NOT WORKING | 02 |
| NOT PRESENT | 03 |

**A.** FETOSCOPE

**B.** STETHOSCOPE AND BLOOD PRESSURE CUFF

**C.** TAPE MEASURE

**D.** SCALE

**(11.11)** Where is the delivery and neonatal equipment located?

| | |
|---|---|
| GENERAL CONSULTATION | 01 |
| SEPARATE OUTPATIENT ROOM | 02 |
| OTHER (SPECIFY) | 96 ▶ _____ |

☐

**(11.12)** FOR EACH OF THE FOLLOWING EQUIPMENT, RECORD WHETHER IT IS PRESENT AND WORKING, PRESENT BUT NOT WORKING, OR NOT PRESENT

| | |
|---|---|
| PRESENT AND WORKING | 01 |
| PRESENT AND NOT WORKING | 02 |
| NOT PRESENT | 03 |

**A.** DELIVERY TABLE ☐

**B.** FETOSCOPE ☐

**C.** PARTOGRAPH ☐

**D.** DELIVERY LIGHT ☐

**E.** ASPIRATOR / SUCTION BULB ☐

**F.** RESUSCIATION BAG, NEWBORN ☐

**G.** EYE DROPS OR OINTMENT FOR NEWBORN ☐

**H.** IV SETS, INCLUDING STERILIZED NEDLE AND TUBE ☐

**I.** IV FLUIDS, INCLUDING NORMAL SALINE AND RINGER LACTATE ☐

**J.** SCISSORS ☐

**K.** ONE UMBILICAL CORD CLAMP OR STERILE TAPE OR STERILE TIE ☐

**L.** SUTURING MATERIAL ☐

**M.** CLEAN TOWELS ☐

**N.** CLEAN RAZOR BLADE ☐

**O.** EXAMINATION GLOVES ☐

**P.** STERILE COTTON OR GAUZE (TO CLEAN BABY'S MOUTH AND NOSE) ☐

**Q.** HAND SOAP OR DETERGENT ☐

**R.** HAND SCRUBBING BRUSH ☐

**S.** STERILE TRAY ☐

**T.** PLASTIC OCNTAINER WITH A PLASTIC LINER TO DISPOSE THE PLACENTA ☐

**U.** PLASTIC CONTAINER WITH A PLASTICLINER FOR MEDICAL WASTE ☐

| | |
|---|---|
| **V.** STETHOSCOPE, ADULT | |
| **W.** STETHOSCOPE, PINARD FETAL | |
| **X.** SPHYGMOMANOMETER | |
| **Y.** KIDNEY BASIN | |
| **Z.** STEEL BOWL | |
| **AA.** PROTECTIVE APRON AND PLASTIC DRAW SHEET | |
| **BB.** TOURNIQUET | |
| **CC.** TWO STERILE TOWELS (ONE TO RECEIVE THE BABY, ONE FOR ACTIVE MANAGEMENT) | |
| **DD.** BABY SCALE (INFANT WEIGHING SCALE) | |
| **EE.** FORCEPS, ARTERY | |
| **FF.** FORCEPS, DRESSING | |
| **GG.** FORCEPS, URINE | |
| **HH.** NEEDLE HOLDER | |
| **II.** SYRINGES AND DISPOSABLE NEEDLES | |
| **JJ.** 16- OR 18-GAUGE NEEDLES | |
| **KK.** SPECULUM, VAGINAL | |
| **LL.** CLAMPS (HEMOSTATS) | |
| **MM.** SUCTION PUMP, HAND OR FOOT OPERATED | |
| **NN.** VACUUM EXTRACTOR | |
| **OO.** UTERINE DILATOR | |
| **PP.** CURETTE, UTERINE | |
| **QQ.** VAGINAL RETRACTOR | |
| **RR.** AMBU BAG | |
| **SS.** GUERDAL AIRWAYS - NEONATAL, CHILD, AND ADULT | |

## Section 12: Drug Storage and Availability

**(12.01)** Is there a separate pharmacy or drug storage area in the health facility?

| | |
|---|---|
| YES | 01 |
| NO | 02 ► **(12.06)** |

☐

**(12.02)** Can the doors and windows be locked to keep the drug storage area secured?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

☐

**(12.03)** Is the drug storage area clean?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

☐

**(12.04)** Are drugs protected from water and sunlight?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

☐

**(12.05)** Does the outpatient pharmacy maintain stock cards or stock register?

| | |
|---|---|
| YES | 01 |
| NO | 02 |

☐

ASK **(12.06)** AND **(12.07)** FOR EACH OF THE ITEMS BELOW.

| | (12.06) Has [ITEM] been continuously available for the past 12 months? <br><br> YES 01 <br> NO 02 ► NEXT ITEM | (12.07) For how many days has [ITEM] been out of stock? |
|---|---|---|
| **GENERAL DRUGS** | | |
| **A.** Tetracycline ophthalmic ointment | | |
| **B.** Paracetamol tabs | | |
| **C.** Amoxicillin (syrup, tabs, or capsule) | | |
| **D.** ORS packets | | |
| **E.** Iron tabs (with or without folic acid) | | |
| **FAMILY PLANNING** | | |
| **F.** Condoms | | |
| **G.** Oral contraceptive tablets | | |
| **H.** DMPA | | |
| **I.** IUD | | |

| | (12.06) Has [ITEM] been continuously available for the past 12 months?<br><br>YES 01<br>NO 02 ► NEXT ITEM | (12.07) For how many days has [ITEM] been out of stock? |
|---|---|---|
| **MALARIA** | | |
| J. ACT | | |
| K. SP / fansidar | | |
| L. Chloroquine | | |
| **TUBERCULOSIS** | | |
| M. Rifampin | | |
| N. Streptomycin | | |
| O. INH | | |
| P. Pyrazinamide | | |
| Q. Ethambutal | | |
| **EMERGENCY OBSTETRIC CARE** | | |
| R. Magnesium sulfate | | |
| S. Diazepam injection | | |
| T. Misoprostol | | |
| U. Oxytocin | | |
| **TUBERCULOSIS** | | |
| V. BCG | | |
| W. OPV | | |
| X. TT vaccine | | |
| Y. DPT/HBV tetravalent | | |
| Z. Measles | | |

## Section 12.2: Anti-Malarial Drug Availability

READ THE FOLLOWING TEXT TO THE RESPONDENT:

**I would now like to see the anti-malarial drugs you have available in this facility and to ask you some basic questions about these.**

| DRUG ID | (12.08) BRAND NAME, INCLUDING DRUG SPECIFICATION | (12.09) UNIT FORM | (12.10) DOSE | (12.11) From where do you usually procure this drug? | (12.12) What is the cost per unit at which you usually procure this drug? | (12.13) What is the cost per unit at which you usually sell this drug? | (12.14) NAFDAC No. | (12.15) EXPIRATION DATE | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | COUNTING 01 <br> PACKET / SACHET 02 <br> SYRUP 03 <br> MIXTURE 04 <br> SUSPENSION 05 <br> POWDER 06 <br> DROPS 07 <br> INJECTIONS 08 | ADULT 01 <br> CHILD 02 <br> COUNTING (ANYBODY) 03 | HEALTH FACILITY 01 <br> MARKET 02 <br> PMV ASSOCIATION 03 <br> OTHER (SPECIFY) 96 | RECORD COST IN NAIRA | RECORD COST IN NAIRA | RECORD NAFDAC NUMBER | DD | MM | YYYY |
| | Record brandname including drug specification | | | | | | | | | |
| 01 | | | | | | | | | | |
| 02 | | | | | | | | | | |
| 03 | | | | | | | | | | |
| 04 | | | | | | | | | | |
| 05 | | | | | | | | | | |
| 06 | | | | | | | | | | |
| 07 | | | | | | | | | | |
| 08 | | | | | | | | | | |
| 09 | | | | | | | | | | |
| 10 | | | | | | | | | | |
| 11 | | | | | | | | | | |
| 12 | | | | | | | | | | |
| 13 | | | | | | | | | | |
| 14 | | | | | | | | | | |
| 15 | | | | | | | | | | |

| DRUG ID | (12.16) How popular is this drug?<br><br>CUSTOMERS REQUEST VERY OFTEN  01<br><br>REQUESTED SOMETIMES  02<br><br>RARELY REQUESTED  03 | (12.17) How often do you recommend this drug?<br><br>VERY OFTEN  01<br>OFTEN  02<br>NOT OFTEN  03<br>RARELY  04<br>NEVER  05 | (12.18) How many doses of this drug do you normally dispense in a day?<br><br>RECORD NUMBER OF DOSES |
|---|---|---|---|
| 01 | | | |
| 02 | | | |
| 03 | | | |
| 04 | | | |
| 05 | | | |
| 06 | | | |
| 07 | | | |
| 08 | | | |
| 09 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |

# Section 13: Organizational Determinants

## 13.1: Organizational Citizenship and Behaviors

**(13.01)** How would you rate the following aspects of your work with colleagues?  Do you…

| | | | | |
|---|---|---|---|---|
| Strongly Disagree? | 01 | Agree | 04 |
| Disagree | 02 | Strongly Agree | 05 |
| Neither agree nor disagree | 03 | NOT APPLICABLE | 00 |

READ EACH ITEM BELOW, AND RECORD THE RESPONDENT'S ANSWER IN THE BOX PROVIDED:

A. Staff willingly share their expertise with other members

B. When disagreements occur among staff, they try to act like peacemakers and resolve the situation themselves

C. Staff willingly give their time to help each other out when someone falls behind or has difficulties with work

D. Staff discuss work issues with each other before they take action

E. Staff take steps to prevent problems arising between them

F. Staff focus on what is wrong rather than the positive side

G. Staff spend a lot of time chatting amongst themselves or complaining about work-related issues

H. My job allows me freedom in how I organize my work and the methods and approaches to use

I. I am given enough authority by my supervisors to do my job well

J. My job is a source of pride for me and my family

K. If I did not do well at work, I would feel ashamed (or badly)

L. If I were known as a bad professional, it would bring shame to me and my family

M. When changes occur in the facility, I adjust to the change rather than resisting it

N. Rapid changes are difficult for staff to cope with

O. Changes bring opportunities to make improvements in the facility

## 13.2: Organizational Culture

**(13.02)** On a scale of 1 to 10 (1 is the lowest, 10 is the highest), please rate each of the following statements:

READ EACH ITEM BELOW, AND RECORD THE RESPONDENT'S ANSWER IN THE BOX PROVIDED:

A. The staff in my facility interact in an easy manner and are like a family

G. The head of my facility relies on policies and procedures

B. My facility is a very dynamic and innovative place. People are willing to take risks to do a job well-done

H. The head of my facility pushes staff to achieve goals

C. My facility is very formal and structured. Policies and procedures are important for doing our work

I. Loyalty and tradition is very important in my family

D. In my facility, we focus on achieving daily goals and getting our work done. Relationships between staff are less important.

J. Innovation and being first to try something new is important in my family

E. The head of my facility is considered to be a mentor and a role model

K. Following procedures and rules is very important in my family

F. The head of my facility is considered to be a risk-taker and an innovator

L. Achieving results and high performance is very important in my family.

## 13.3: Leadership and Values

**(13.03)** IS RESPONDENT FACILITY MANAGER / DIRECTOR OR DEPUTY MANAGER / DIRECTOR?

| | |
|---|---|
| YES | 01 |
| NO | 02 ▶ **END INTERVIEW** |

READ TO RESPONDENT:

I will now read you a series of scenarios and possible responses that you might have.  Please select the response that most closely matches what you would do in a specific situation.  Select only one response for each question.

**(13.04)** The performance of your staff is improving.  What will you do?

| | |
|---|---|
| Stress their responsibilities and standards | 01 |
| Take no particular action | 02 |
| Give positive feedback and make staff feel involved in the achievements | 03 |
| Emphasize the importance of deadlines and tasks | 04 |

**(13.05)** Members of your staff have been unable to solve a problem over the past month, though they have been trying to address it.

| | |
|---|---|
| Call a meeting and together try to solve the problem | 01 |
| Let your staff address this problem on their own | 02 |
| Give them direction and instructions on how to solve the problem | 03 |
| Encourage the group to solve the problem on their own, and you are available when needed to discuss | 04 |

**(13.06)** You are considering a major change in how things are done in the facility.  What will you do?

| | |
|---|---|
| Collaborate with your staff to develop the needed changes | 01 |
| Announce your vision for the changes and implement a clear plan | 02 |
| Ask your staff to develop and implement their own plan for change | 03 |
| Consult with your staff, but direct the changes yourself | 04 |

**(13.07)** The performance of your staff has been falling in recent months.  What will you do?

| | |
|---|---|
| Ask your staff to rethink their direction and goals and come up with a plan together | 01 |
| Ask for suggestions from your staff on what to do, and formulate a specific plan to meet objectives | 02 |
| Redefine goals clearly and supervise whether these are being met closely | 03 |
| Allow your staff freedom to set their own goals and do not push them. | 04 |

**(13.08)** Your staff are no longer working together as an effective team.  What will you do?

| | |
|---|---|
| Discuss ideas as a group and identify how to work together | 01 |
| Let your staff work out their issues on their own | 02 |
| Act quickly and decisively to get the team back on track | 03 |
| Make yourself available to discuss any issues and support your team to work our their own problems | 04 |

## 13.4: Decision and Authority

**(13.01)** How would you rate the following aspects of your decision-making and authority.  Do you…

| | | | | |
|---|---|---|---|---|
| Strongly Disagree? | 01 | Agree | 04 |
| Disagree | 02 | Strongly Agree | 05 |
| Neither agree nor disagree | 03 | NOT APPLICABLE | 00 |

READ EACH ITEM BELOW, AND RECORD THE RESPONDENT'S ANSWER IN THE BOX PROVIDED:

A.
   I am able to allocate my facility budget according to how it is needed.  There is enough flexibility in my budget.

B.    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.

C.    The LGA-level health authorities support my decisions and actions for doing a better job in my facility.

D.    I have choice over who I hire for what tasks

E.    I have choice over what services are provided in the facility

F.    I have enough authority to obtain the resources I need (drugs, supplies, funding) to meet the needs of my job

G.    The policies and procedures for doing things are clear to me

H.    The policies and procedures for doing things are useful tools for the challenges I face in providing services and reporting on activities

I.    LGA-level health authorities provide adequate feedback to me about my job and facility performance