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| **SECTION-A: FACILITY IDENTIFICATION** | | | **SKIP** |
| 1 | Quality Assurance office Name |  |  |
| 2 | Form number | **This will be auto generated and will be hidden from the data collector.** |  |
| 3 | Date of visit |  |  |
| 4 | Latitude (**Example: 24.861462**) |  |  |
| 5 | Longitude (**Example: 67.009939**) |  |  |
| x6 | Province | 1. Baluchistan 2. Punjab 3. Sindh |  |
| 7 | District | 1. Jafferabad 2. Labella 3. Naseerabad 4. Muzaffargarh 5. Rahimyar Khan 6. Badin 7. Sanghar 8. Qamber Shahdadkot |  |
| 8 | Taluka/Tehsil | 1. **Name of Tehsils from selected district will appear in drop down.** |  |
| 9 | Union Council | **Name of Union Councils from selected Tehsil will appear in drop down.** |  |
| 10 | Health Facility type | 1. Public Health Facility 2. Private Health Facility |  |
| 11 | Health Facility | 1. Urban 2. Rural |  |
| 12 | Health Facility DHIS ID / Private Provider ID | **This will be auto generated** |  |
| 13 | Health Facility Name | **Select from the dropdown list** |  |
| 14 | Is catchment area of this health facility defined? | 1. Yes 2. No |  |
| 15 | What is the source of recorded population? | 1. Facility Record 2. Verbally (estimated) |  |
| 16 | Catchment Population of Health Facility | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(6 digit numeric)** |  |
| 17 | Health Facility level | 1. District Head Quarter (**DHQ**) Hospital 2. Taluka/Tehsil Head Quarter (**THQ**) Hospital 3. Specialized Teaching Institute / Tertiary Care Hospital 4. Rural Health Center (**RHC**) 5. Basic Health Unit (**BHU**) 6. Mother and Child Health (**MCHC**) Center 7. Civil/Government Dispensary (**CD/GD**) 8. Maternity Home 9. Private Hospital (Where inpatient care is provided) 10. Private Clinic (Only OPD services) |  |
| 18 | Managing Authority of Health Facility | Government / Public………………………………1  Government Contractualized……………….…2 NGO / Not for Profit………………………….……3 Private for Profit…………………………………….4  Others (specify) …………………………………….96 | SKIP 19 IF 18 IS NOT 2 |
| 19 | Name of Government Contractualized | P.P.H.I……………………………………………………1  P.H.F.M.C………………………………………………2  INDUS……………………………………………………3  I.H.S………………………………………………………4  HANDS………………………………………………….5  MERF…………………………………..……………….6  M.S.F…………………………………………..……….7  Other (Health Facility)…………………………..96 |  |
| 20 | Health Facility service provision | Outpatient……………………………………………..1  Inpatient………………………………………………..2 |  |
| 21 | How many days in a week this health facility is operational? | Number of days **(Limit is 07)** |  |
| 22 | How many hours in a day this health facility is Operational? | 4 hours…………………………………………………..1  6 hours…………………………………………………..2  8 hours…………………………………………………..3  12 hours…………………………………………………4  24 hours…………………………………………………5 |  |

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| **SECTION-B: INPATIENT & OBSERVATION BEDS** | | | **SKIP** |
| 1 | Does This Facility routinely provide Inpatient Care? (Day care observation) | YES…………………………………………………..1  NO…………………………………………………..2 |  |
| 2 | Does this facility have beds for overnight observations? | YES…………………………………………………..1  NO…………………………………………………..2 | (Skip 3, 4, 5 if 2 is No) |
| 3 | Excluding delivery Bed (Delivery table and OT table) how many overnight inpatient beds in total does this facility have for adults? | #\_\_\_\_\_\_\_ **(Limit is 400)** |  |
| 4 | Excluding delivery Bed (Delivery table and OT table) how many overnight inpatient beds in total does this facility have for Children? | #\_\_\_\_\_\_\_ **(Limit is 400)** |  |
| 5 | Of the overnight/inpatient beds in the facility how many are dedicated maternity beds? This not include Labor room and OT beds | #\_\_\_\_\_\_\_ **(Limit is 400)** |  |

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| **SECTION-C: STAFFING (NUMBERS & THEIR CAPACITY) (This section should skip from private provider)** | | | | | | | |
| Please tell me how many staff with each of the following qualifications is currently sanctioned, appointed and vacant to this facility. Please count each staff member only once, on the basis of the highest technical or professional qualification. Also mentioned # of part time staff among appointed and availability of staff on day of survey against appointed. | | | | | | | |
| 1 | Qualification Category of Staff | Sanctioned | Appointed | Vacant | # of Part Time Staff | Availability of Staff on Day of Survey | SKIP |
|  | HINT\*\*\* |  |  | Vacant=(Sanctioned-Appointed) | Not greater than appointed staff | Not greater than appointed staff |  |
| 1A | Generalist (Non Specialist Medical Doctors) |  |  |  |  |  |  |
| 1B | Specialist Medical Doctors (Overall) |  |  |  |  |  |  |
| 1C | Non Physician Clinicians / Para Medical Professionals (Dispenser, MTs, OTTs) |  |  |  |  |  |  |
| 1D | Nursing Professionals |  |  |  |  |  |  |
| 1E | Midwifery Professionals |  |  |  |  |  |  |
| 1F | Pharmacists |  |  |  |  |  |  |
| 1G | Laboratory and Radiology Technician |  |  |  |  |  |  |
| 1H | Community / Lady Health Workers |  |  |  |  |  |  |
| 1I | Gynecologist **\*\*** These are not greater then B |  |  |  |  |  |  |
| 1J | Pediatrician  **\*\*** These are not greater then B |  |  |  |  |  |  |
| 1K | Anesthetist  **\*\*** These are not greater then B |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| 2 | List of Trained Facility Staff currently posted (\*\*Add all participants name one by one and record all required information) | | | | |
| S. No. | Training Name | Training By AKU | | Duration of Service at This Facility | |
| Yes | No | Month | Year |
| 2A |  |  |  |  |  |
| 2B |  |  |  |  |  |
| 2C |  |  |  |  |  |
| 2D |  |  |  |  |  |

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| 3 | Any Staff available who was trained by AKU or and other | YES…………………………………………………..1  NO…………………………………………………..2 | | If no skip 4 | |
| 4 | List of Trained Transferred out Staff (\*\*Add all participants name one by one and record all required information who were trained) | | | | |
| S. No | Training Name | Training By AKU | | Duration of Service at This Facility | |
| Yes | No | Month | Year |
| 4A |  |  |  |  |  |
| 4B |  |  |  |  |  |
| 4C |  |  |  |  |  |
| 4D |  |  |  |  |  |

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| **SECTION-D: INFRASTRUCTURE** | | | |
| D1 | **COMMUNICATIONS** | | SKIP |
| 1 | Does this facility have a functioning land line telephone? | YES………………………………..1  NO………………………………..2 |  |
| 2 | Does this facility have a functioning mobile telephone? | YES………………………………..1  NO………………………………..2 |  |
| D2 | **AMBULANCE/TRANSPORT FOR EMERGENCIES** | | |
| 1 | Does this facility have a functional ambulance or other vehicle for emergency transportation for clients that is stationed at this facility or operates from this facility | YES………………………………..1  NO………………………………..2 |  |
| 2 | Does this facility have access to an ambulance or other vehicle for emergency transport for clients that is stationed at another facility or that operates from another facility in near proximity | YES………………………………..1  NO………………………………..2 |  |
| 3 | Is fuel for the ambulance or other emergency vehicle available today? (Enter response by observing) | YES………………………………..1  NO………………………………..2 | IF 1 & 2 IS YES 3 SHOULD BE ASKED |

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| D3 | **POWER SUPPLY** | |  |
| 1 | What is the facility’s main source of electricity? | Central supply of electricity (e.g. National or community grid) ………………………….…..1  Generator (fuel or battery operated generator) …………………………………………………………2  Solar system……………………………………..3  Uninterruptible Power Source……….…4 |  |
| 2 | Other than the main or primary source, what is the secondary or backup source of electricity? | Central supply of electricity (e.g. National or community grid) ……………………………….1  Generator (fuel or battery operated generator) ……………………………….…………………………2  Solar system……………………………….………3  Uninterruptible Power Source……………4  No secondary source available……………5 |  |
| 3 | On the day of visit, is secondary source functional? | YES………………………………..1  NO………………………………..2 |  |
| 4 | During the past 7 days, was electricity available at all times from the main or any backup source when the facility was open for services? | Always available (no Interruptions) ……………1  Often available (interruptions of less than 2 hours per day) ……………………………………………2  Sometimes available (frequent or prolonged interruptions of more than 2 hours per day) ……………………………………………………………………3 |  |

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| D4 | **BASIC CLIENT AMENITIES** | |  |
| 1 | What is the primary source of water for the facility at this time? | Public tap water 1  Rainwater collection 2  Cart /small tank/drum 3  Tanker truck 4  RO Plant 4  No water source 5 |  |
| 2 | What is the secondary source of water for the facility at this time? | Public tap water 1  Rainwater collection 2  Cart /small tank/drum 3  Tanker truck 4  RO Plant 5  No water source 6 |  |
| 3 | Is water available from this source on facility premises? | Yes, inside the facility 1  Yes, within the ground of the facility 2  No, outside the facility grounds 3 |  |
| 4 | Is there a toilet (latrine) on premises in functioning conditionthat is accessible for general outpatient client use? | Yes, gender separated toilets 1  Yes, common toilets for all patients 2  No, toilet is available…………………………..3 |  |

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| D5 | **INFECTION CONTROL** | | | | | | |  |
| 1 | Does this facility have any guidelines on standard precautions for infection prevention? If yes, ask to see the document | Yes, observed 1  Yes, reported not seen 2  No 3 | | | | | |  |
| 2 | Please tell me if the following items used for processing of equipment for reuse are available and functional in the facility today. | | | | | | |  |
|  | Item | Availability | | | Functionality | | | If no Skip Functionality |
| 2A | Electric autoclave (pressure & wet heat) | Yes | No | Qty | Yes | No | Qty |  |
| 2B | Non-electric autoclave (Functioning through Gas) |  |  |  |  |  |  |  |
| 2C | Electric boiler or steamer (no pressure) |  |  |  |  |  |  |  |
| 2D | Non-electric pot with cover for boiling/steam |  |  |  |  |  |  |  |
| 3 | Please tell me if the following resources/supplies used for infection control are available in the general outpatient area of this facility today | | | | | | |  |
| 3A | Clean running water (piped, bucket with tap, or pour pitcher) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3B | Hand-washing soap/liquid soap | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3C | Alcohol based hand rub | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3D | Disposable latex gloves | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3E | Waste receptacle (pedal bin) with lid and plastic bin liner | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3F | Sharps container ("safety box") | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3G | Environmental disinfectant (e.g., chlorine, alcohol) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3H | Disposable syringes with disposable needles | YES………………………………..1  NO………………………………..2 | | | | | |  |

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| D6 | **HEALTH CARE WASTE MANAGEMENT** | |  |
| 1 | The health facility has leak proof, covered, labeled waste bins available in every treatment areas as per main 04 categories | |  |
| 1A | Sharps | YES………………………………..1  NO………………………………..2 |  |
| 1B | Non Sharps Infectious Waste | YES………………………………..1  NO………………………………..2 |  |
| 1C | General non-infectious waste | YES………………………………..1  NO………………………………..2 |  |
| 1D | Anatomical Waste/Infectious | YES………………………………..1  NO………………………………..2 |  |
| 2 | Is the Facility having Incinerator? | YES………………………………..1  NO………………………………..2 |  |
| 3 | Is the incinerator functional today? | YES………………………………..1  NO………………………………..2 |  |
| 4 | Is fuel for the incinerator available today? | YES………………………………..1  NO………………………………..2 |  |
| 5 | How does this facility **finally** dispose all four kinds of facility waste category sharps, non-sharps infectious, general non-infectious and Anatomical waste? | Burn waste through Incinerator within Facility 1  Burning of waste on flat ground without protection within facility 2  Burning of waste in protected PIT within facility 3  Burning of waste in unprotected PIT within facility 4  Dumping of waste on flat ground without protection within facility 5  Dumping of waste in protected PIT within facility 5  Dumping of waste in unprotected PIT within facility 6  Facility Waste disposed outside the facility in covered container 7  Facility Waste disposed outside the facility unprotected…………………………………………8 |  |

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| D7 | **SUPERVISION** | | |  |
| 1 | What is that Mechanism Called? | M&E Team 1  Internal Facility Audit / Quality Team 2  Health Care Commission Team Visit 3  Other (Specify) 96 | |  |
| 2 | Who Visited Usually? | Deputy Commissioner 1  Medical Superintendent 2  CEO Health / DHO Health 3  Provincial Technical Team 4  Health Care Commission Officer 5  Others (Specify) 96 | |  |
| 3 | When was the last time this facility received a supervision visit from the higher level (DHMT or other)? | This month 1  In the last 3 months 2  More than 3 months ago 3  Don’t know 96 | |  |
| 4 | During the supervision visit, did the supervisor assess the following? | | | Skip this question and sub sections for private health |
| 4A | Pharmacy (drug stock out records) | | YES………………………………..1  NO………………………………..2 |  |
| 4B | Pharmacy (expiry and available drug records) | | YES………………………………..1  NO………………………………..2 |  |
| 4C | Availability of Staff (As per Facility Need) | | YES………………………………..1  NO………………………………..2 |  |
| 4D | Training of Staff (As per Facility Need) | | YES………………………………..1  NO………………………………..2 |  |
| 4E | Data Completeness, Data Quality, Timely Reporting to Data | | YES………………………………..1  NO………………………………..2 |  |

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| D8 | **BASIC OUTPATIENT EQUIPMENT** | | | |  |
| 1 | Please tell me if the following basic equipment and supplies used in the provision of client services are available and functional in this facility today | Available | | Functioning Quantity | If not available Functioning Quantity would be disabled |
| Yes Observed | Not Available | Quantity |  |
| 1A | Adult weighing scale |  |  |  |  |
| 1B | Child weighing scale- 250 gram gradation |  |  |  |  |
| 1C | Infant weighing scale – 100 gram gradation |  |  |  |  |
| 1D | Measuring tape / Height board / Stadiometre |  |  |  |  |
| 1E | Thermometer |  |  |  |  |
| 1F | Stethoscope |  |  |  |  |
| 1G | Blood pressure apparatus with stethoscope  (Either digital or manual) |  |  |  |  |
| 1H | Light source (flashlight acceptable) |  |  |  |  |
| 1I | Pulse Oximeter |  |  |  |  |
| 1J | ARI Timer |  |  |  |  |

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| **SECTION-E: AVAILABLE SERVICES** | | | |
| E1 | **FAMILY PLANNING SERVICES** | | SKIP |
| 1 | Does this facility offer family planning services? | YES………………………………..1  NO………………………………..2 | IF no go to E2 |
| Ask to be shown the location in the facility where family planning services are provided. Find the person most knowledgeable about family planning services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | |
| 2 | Does this facility provide or prescribe any of the following modern methods of family planning: | |  |
| 2A | Combined oral contraceptive pills | YES………………………………..1  NO………………………………..2 |  |
| 2B | Progestin-only contraceptive pills | YES………………………………..1  NO………………………………..2 |  |
| 2C | Combined estrogen progesterone injectable contraceptives | YES………………………………..1  NO………………………………..2 |  |
| 2D | Progestin-only injectable contraceptives | YES………………………………..1  NO………………………………..2 |  |
| 2E | Male condoms | YES………………………………..1  NO………………………………..2 |  |
| 2F | Intrauterine contraceptive device (IUCD) | YES………………………………..1  NO………………………………..2 |  |
| 2G | Implants | YES………………………………..1  NO………………………………..2 |  |
| 2H | Emergency contraceptive pills (ECPs) | YES………………………………..1  NO………………………………..2 |  |
| 2I | Male sterilization (Vasectomy) | YES………………………………..1  NO………………………………..2 |  |
| 2J | Female sterilization (Tubal Ligation) | YES………………………………..1  NO………………………………..2 |  |
| 3 | Please tell me if the following documents are available in the facility today: If available, ask to see the document | |  |
| 3A | National family planning guidelines | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 3B | Any family planning check-lists and/or job- aids | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 4 | **Have you or any provider(s) of family planning services are trained:** | |  |
| 4A | Received any family planning training in the last two years? | YES………………………………..1  NO………………………………..2 |  |
| 4B | Received any training in adolescent sexual and reproductive health in the last two years? | YES………………………………..1  NO………………………………..2 |  |
| 4C | What Was the Name of Training or Content of Training? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 4D | What was the duration of that Training? | Two Days………………………………..……………….1  Two- Three Days………………………………..……2  Three- Four Days………………………………..…..3  Four-Five Days………………………………..………4 |  |
| 4E | What was the Organization Name Who Conduct those Training? | AKU………………………………..……………….………1  Other (Specify) ………………………..……………96 |  |

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| E2 | **ANTENATAL CARE SERVICES** | |  |
| 1 | Does this facility offer antenatal care (ANC) services? | YES………………………………..1  NO………………………………..2 | IF no go to E3 |
| Ask to be shown the location in the facility where family planning services are provided. Find the person most knowledgeable about family planning services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | |
| **2** | **Do ANC providers provide any of the following services to pregnant women as part of routine ANC services?** | |  |
| 2A | Iron supplementation | YES………………………………..1  NO………………………………..2 |  |
| 2B | Folic acid supplementation | YES………………………………..1  NO………………………………..2 |  |
| 2C | Intermittent preventive treatment in pregnancy (IPTp) for malaria | YES………………………………..1  NO………………………………..2 |  |
| 2D | Tetanus toxoid immunization | YES………………………………..1  NO………………………………..2 |  |
| 2E | Monitoring for hypertensive disorder of pregnancy | YES………………………………..1  NO………………………………..2 |  |
| 2F | Offers diagnostic laboratory tests as per FANC package | YES………………………………..1  NO………………………………..2 |  |
| **3** | **Please tell me if the following documents are available in the facility today:**  **If available, ask to see the document** | |  |
| 3A | Any ANC check-lists and/or job-aids | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 3B | IPTp guidelines, check-lists and/or job-aids (including wall charts) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| **4** | **Have you or any provider(s) of ANC services trained in following:** | |  |
| 4A | Received any ANC training in the last two years? | YES………………………………..1  NO………………………………..2 |  |
| 4B | What Was the Name of Training or Content of Training? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 4C | What was the duration of that Training? | Two Days………………………………..……………….1  Two- Three Days………………………………..……2  Three- Four Days………………………………..…..3  Four-Five Days………………………………..………4 |  |
| 4D | What was the Organization Name Who Conduct those Training? | AKU………………………………..……………….………1  Other (Specify) ………………………..……………96 |  |

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| E3 | **OBSTETRIC AND NEWBORN CARE SERVICES** | | | | | | |  |
| 1 | Does this facility offer delivery (including normal delivery, basic emergency obstetric care) and/or newborn care services? | YES………………………………..1  NO………………………………..2 | | | | | | If no then go to E4 |
| Ask to be shown the location in the facility where obstetric and newborn care services are provided. Find the person most knowledgeable about obstetric and newborn care services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | | | | | | |
| **2** | **Please tell me if the following routine interventions are carried out by providers of delivery services in this facility:** | | | | | | |  |
| 2A | Administration of oxytocin injection immediately after birth to all women for the prevention of post-partum hemorrhage (AMTSL) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 2B | Monitoring and management of labour using partograph | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 2C | Immediate and exclusive breastfeeding | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 2D | Hygienic cord care (cut with sterile item and apply disinfectant to tip and stump, and no application of other substances) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 2E | Thermal protection (drying baby immediately after birth and wrapping) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| **3** | **Please tell me if any of the following interventions for the management of complications during and after pregnancy and childbirth have been carried out in the last 12 months by providers of delivery services as part of their work in this facility.** | | | | | | |  |
| 3A | Parenteral administration of antibiotics (IV or IM) for mothers | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3B | Parenteral administration of oxytocic for treatment of post-partum hemorrhage (IV or IM) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3C | Parenteral administration of magnesium Sulphate for management of preeclampsia and Eclampsia (IV or IM) | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3D | Assisted vaginal delivery | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3E | Manual removal of placenta | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3F | Removal of retained products of conception | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3G | Neonatal resuscitation with bag and mask | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3H | Caesarean section | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3I | Blood transfusion | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3J | Antibiotics for preterm or prolonged PROM (premature rupture of membranes) to prevent infection | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3K | Corticosteroids in preterm labor | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3L | KMC (Kangaroo mother care) for premature/very small babies | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3M | Application of CHX gel on umbilical stump to newborn | YES………………………………..1  NO………………………………..2 | | | | | |  |
| 3N | Injectable antibiotics for neonatal sepsis | YES………………………………..1  NO………………………………..2 | | | | | |  |
| **4** | **Are the following documents available in the facility today:**  **If available, ask to see the document** | | | | | | |  |
| 4A | Any national guidelines for essential childbirth care (PCPNC) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 4B | Any check-lists and/or job-aids for Essential childbirth care (PCPNC or others) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 4C | Any national guidelines for essential newborn care (ECSB or ECEB) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 4D | Any national guidelines for Helping Baby Breath (HBB) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| **5** | **Regarding BEmONC Training;** | | | | | | |  |
| 5A | Received training in newborn resuscitation (HBB) using the newborn bag and mask in the last two years | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training………………………………..…………………2  No Training………………………………..……………3 | | | | | |  |
| 5B | Apart from newborn resuscitation, received training in essential childbirth care in the last two years (BEmONC Training on PCPNC Guideline) | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training………………………………..…………………2  No Training………………………………..……………3 | | | | | |  |
| 5C | Apart from receiving training in HBB & BEmONC, received training in helping baby survive including KMC guideline | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training………………………………..…………………2  No Training………………………………..……………3 | | | | | |  |
| 5D | What was the duration of that Training? | Two Days………………………………..……………….1  Three Days……….………………………………..……2  Four Days…………………….……………………..…..3  Five Days……………………………….………..………4 | | | | | |  |
| 5E | What was the Organization Name Who Conduct those Training? | AKU………………………………..……………….………1  Other (Specify) ………………………..……………96 | | | | | |  |
| **06** | **I would like to know if the following basic equipment items are available in this service area (Labor Room) today. For each equipment or item, please tell me if it is available today and functioning.**  **Ask to see the items** | | | | | | |  |
| S. No | ITEMS | **Available**  **(Observed)** | | | **Functionality**  **(Observed)** | | | If not available skip Qty and Functionality |
| **Yes** | **No** | **Qty** | **Yes** | **No** | **Qty** |  |
| 6A | Examination light (flashlight ok) |  |  |  |  |  |  |  |
| 6B | Delivery Instruments Kits |  |  |  |  |  |  |  |
| 6C | Vacuum Extractor |  |  |  |  |  |  |  |
| 6D | MVA Instruments |  |  |  |  |  |  |  |
| 6E | D&E Instrument Kit |  |  |  |  |  |  |  |
| 6F | Disposable latex gloves |  |  |  |  |  |  |  |
| 6G | Delivery bed |  |  |  |  |  |  |  |
| 6H | Resuscitation table with heat source |  |  |  |  |  |  |  |
| 6I | Newborn bag and mask size 1 for term babies |  |  |  |  |  |  |  |
| 6J | Newborn bag and mask size 0 for pre-term babies |  |  |  |  |  |  |  |
| 6K | Electric suction pump (for suction apparatus) |  |  |  |  |  |  |  |
| 6L | Suction bulb, single use |  |  |  |  |  |  |  |
| 6M | Suction bulb, sterilizable multi-use |  |  |  |  |  |  |  |
| 6N | Infant weighting scale |  |  |  |  |  |  |  |
| 6O | Blood pressure apparatus (may be digital or manual sphygmomanometer with stethoscope) |  |  |  |  |  |  |  |
| 6P | Clean running water (piped, bucket with tap, or pour pitcher) |  |  |  |  |  |  |  |
| 6Q | Hand-washing soap/liquid soap |  |  |  |  |  |  |  |
| 6R | Alcohol based hand rub |  |  |  |  |  |  |  |
|  | | | | | | | | |
| **07** | Does this facility stock any medicines for emergency obstetric care in this service site? | YES………………………………..1  NO………………………………..2 | | | | | |  |
| **08** | The facility or on call 24 hours a day (including Weekends and on public holidays)? | YES………………………………..1  NO………………………………..2 | | | | | |  |

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| E4 | **IMMUNIZATION** | |  |
| 1 | Does this facility offer immunization services? | YES………………………………..1  NO………………………………..2 | If no then go to E5 |
| Ask to be shown the location in the facility where immunization services are provided. Find the Person most  Knowledgeable about immunization services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | |
| 2 | Is this facility providing immunization services today? | YES………………………………..1  NO………………………………..2 |  |
| **3** | **Does this facility provide any of the following immunization services in the facility only, as outreach at fixed post only, or both?**  **\*Vaccines schedule should be specified as part of country adaptation** | |  |
| 3A | Birth doses (HepB-0, BCG, OPV-0) | Both in the facility and as outreach……1  In Facility Only……………………………….…..2  In Out Reach Only………………………………3  Service Not Offered……………………….……4 |  |
| 3B | Infant Vaccines (under 1 year) | Both in the facility and as outreach……1  In Facility Only……………………………….…..2  In Out Reach Only………………………………3  Service Not Offered……………………….……4 |  |
| 3C | Adolescent/adult vaccines (Tetanus) | Both in the facility and as outreach……1  In Facility Only……………………………….…..2  In Out Reach Only………………………………3  Service Not Offered……………………….……4 |  |
|  | | | |
| 4 | How often does this facility offer routine full child immunization services at the facility? | Daily……………………………….…………1  Weekly……………………………….…….2  Monthly……………………………….…..3  Quarterly……………………………….…4 |  |
| 5 | How often does this facility offer routine full child immunization services as outreach? | Daily……………………………….…………1  Weekly……………………………….…….2  Monthly……………………………….…..3  Quarterly……………………………….…4 |  |
| 6 | Do you have the national guidelines for routine child immunization available in this facility today?  If available, ask to see the document  \*National guideline should be specified as part of country adaptation | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 7 | Have you or any provider(s) of immunization service delivery received any training in any of the following child immunization services in the last two years?  If yes: Pease specify if it was through formal training or supportive supervision | |  |
| 7A | Immunization service delivery (Immunization in practice (IIP) or any similar) | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training…………………………………………………..2  No Training………………………………..……………3 |  |
| 7B | Vaccine management/handling and cold chain | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training…………………………………………………..2  No Training………………………………..……………3 |  |
| 7C | Data reporting and monitoring of service delivery (e.g. Data Quality Self-Assessment (DQS)) | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training…………………………………………………..2  No Training………………………………..……………3 |  |
| 7D | Training on new vaccine\* prior to introduction  \* New vaccine should be specified as part of country adaptation | Yes, Formal Training………………………………..1  Yes, Supportive Supervision or On The Job Training…………………………………………………..2  No Training………………………………..……………3 |  |
| 8 | What was the duration of that Training? | Two Days………………………………..……………….1  Three Days……….………………………………..……2  Four Days…………………….……………………..…..3  Five Days……………………………….………..………4 |  |
| 9 | What was the Organization Name Who Conduct those Training? | AKU………………………………..……………….………1  Other (Specify) ………………………..……………96 |  |
| 10 | I would like to know if the following items for immunization supplies are available in this service area today. For each item, please tell me if it is available today. Ask to see the items | |  |
| 10A | Auto-disable syringes | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 10B | Sharps container/safety box | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 10C | Vaccine carrier(s)/cold box | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 10D | Set of ice packs for vaccine carriers  (Note: 4-5 ice packs make one set) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 10E | Immunization cards (or child health booklet) | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 10F | Official immunization tally sheets or integrated tally sheet | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 11 | Does this facility have a refrigerator available and functioning for the storage of vaccines? | Available and functional…………………1  Available not functional………………….2  Available don’t know if functioning..3  Not available………………………………….4 |  |
| 12 | What type of energy source is used for the vaccine refrigerator? | Central supply of electricity (e.g. National or community grid) ………………….………….1  Generator (fuel or battery operated generator) ………………………………….……….2  Solar system………………………………….…….3  Uninterruptible Power Source………………4 |  |
| 13 | Does this energy source supply power to the refrigerator for 24 hours a day and for 7 days in the week? | YES………………………………..1  NO………………………………..2 |  |
| 14 | Is the temperature of the refrigerator monitored twice daily?  If yes: please ask to see the log used to record the temperature | Yes, log Observed………………………………..1  Yes, log Reported but not seen……………2  No……………………………………..……………….3 |  |
| 15 | Has the temperature log been completed for the last 30 days?  Please review log and check for completeness (temperature recorded 2 times / day during the last 30 days) | Yes ………………………………..1  Yes, Partially……..……………2  No….……………..……………….3 |  |
| 16 | Has the temperature been out of the range 2 to 8 oC inclusive in the last 30 days?  **Please check the temperature record and verify the temperature for the last 30 working days in order to answer the question** | Observed in range….……………..………………1  Reported in range but not seen….………..2  Out of range….……………..……………………….3  Record not available….……………..…………..4 |  |

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| E5 | **CESAREAN SECTION** | |  |
| 1 | Does this facility offer any surgical services (including minor surgery such as suturing, circumcision, wound debridement, etc.), or caesarean section? | YES………………………………..1  NO………………………………..2 | If no then go to E6 |
| Ask to be shown the location in the facility where surgical services are provided. Find the person most knowledgeable about surgical services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | |
| 2 | Please tell me if this facility provides the following services: | |  |
| 2A | Incision and drainage of abscesses | YES………………………………..1  NO………………………………..2 |  |
| 2B | Wound debridement | YES………………………………..1  NO………………………………..2 |  |
| 2C | Male circumcision | YES………………………………..1  NO………………………………..2 |  |
| 2D | Tubal ligation | YES………………………………..1  NO………………………………..2 |  |
| 2E | Vasectomy | YES………………………………..1  NO………………………………..2 |  |
| 2F | Dilatation & Curettage | YES………………………………..1  NO………………………………..2 |  |
| 2G | Obstetric fistula repair | YES………………………………..1  NO………………………………..2 |  |
| 2H | Episiotomy, cervical and vaginal laceration repair | YES………………………………..1  NO………………………………..2 |  |
| 2I | Laparotomy (uterine rupture, ectopic pregnancy, acute abdomen, intestinal obstruction, perforation, injuries) | YES………………………………..1  NO………………………………..2 |  |
| 3 | Do you have materials on Integrated Management of Emergency and Essential Surgical care (IMEESC) (e.g. best practices, protocols, etc.) available in this facility today?  **If available, ask to see the document** | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 4 | Have you or any provider(s) of basic surgical services received any training in IMEESC in the last two years? | YES………………………………..1  NO………………………………..2 |  |
| 5 | Do you have the national guidelines for Comprehensive Emergency Obstetric Care (CEmONC) available in this facility today | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 |  |
| 6 | Have you or any provider(s) of delivery service received any training in | YES………………………………..1  NO………………………………..2 |  |
| 7 | Does this facility have a health professional who can perform caesarean section (Gynecologist) 24/7 through on call on public holidays as well? | YES………………………………..1  NO………………………………..2 |  |
| 8 | Does this facility have anesthetist 24/7 through on call on public holidays as well? | YES………………………………..1  NO………………………………..2 |  |
| 9 | Does this facility have OT Technician 24/7 through on call on public holidays as well? | YES………………………………..1  NO………………………………..2 |  |

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| E6 | **BLOOD TRANSFUSION** | |  |
| 1 | Does this facility offer blood transfusion services? | YES………………………………..1  NO………………………………..2 | IF NO GO TO E7 |
| Ask to be shown the location in the facility where blood is collected, processed, tested, stored, or handled prior to transfusion. Find the person most knowledgeable about blood transfusion services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | |
| 2 | Does this facility obtain blood from a national or regional blood center? | YES………………………………..1  NO………………………………..2 |  |
| 3 | Does this facility obtain ANY blood from sources other than the national or regional blood center? | YES………………………………..1  NO………………………………..2 |  |
| 4 | Does any place in this facility do blood screening for infectious diseases prior to transfusion? | YES………………………………..1  NO………………………………..2 |  |
| 5 | Please tell me if the blood that is transfused in the facility is "always", "Sometimes”, “rarely”, or "never" screened for any of the following infectious diseases. | |  |
| 5A | HIV | Always………………………………..1  Sometimes………………………….2  Rarely……………………………….…3  Never………………………………….4 |  |
| 5B | Syphilis | Always………………………………..1  Sometimes………………………….2  Rarely……………………………….…3  Never………………………………….4 |  |
| 5C | Hepatitis B | Always………………………………..1  Sometimes………………………….2  Rarely……………………………….…3  Never………………………………….4 |  |
| 5D | Hepatitis C | Always………………………………..1  Sometimes………………………….2  Rarely……………………………….…3  Never………………………………….4 |  |
| 6 | Does this facility have a refrigerator available and functioning in this service area for the storage of blood? | Available and functional 1  Available not functional 2  Available don’t know if  Functioning 3  Not available 4 |  |
| 7 | Is the temperature of the refrigerator monitored at least once every 24 hours?  If yes: please ask to see the log used to record the temperature | Yes, log Observed………………………………..1  Yes, log Reported but not seen……………2  No……………………………………..……………….3 |  |
| 8 | Has the temperature been out of the range 2  To 6 oC inclusive in the last 30 days?  Please check the temperature record and verify the temperature for the last 30 working days in order to answer the question | Yes 1  Yes, partially 2  No 3 |  |
| 9 | Has the temperature been out of the range 2-6OC inclusive in the last 30 days? | Observed in range 1  Reported in range but not seen 2  Out of range 3  Record not available 4 |  |
| 10 | Do you have any guidelines on the appropriate use of blood and safe transfusion practices? | Yes, observed 1  Yes, reported not seen 2  No 3 |  |
| 11 | Have any provider(s) of blood transfusion services received any training in the appropriate use of blood and safe transfusion practices in the last two years? | Yes 1  No 2 |  |

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| E7 | **CHILD PREVENTATIVE, CURATIVE, & NUTRITION CARE SERVICES UNDER 05 YEAR** | | | | | | | SKIP |
| 1 | Does this facility offer preventative and curative care services for children under 5? | Yes 1  No………………………………………………………2 | | | | | | IF NO GO TO E8 |
| Ask to be shown the location in the facility where child preventative and curative care services are provided. Find the person most knowledgeable about child preventative and curative care services in the facility. Introduce yourself, explain the purpose of the survey and ask the following questions. | | | | | | | | |
| 2 | Please tell me if this facility provides the following services: | | | | | | |  |
| 2A | Diagnose and/or treat child malnutrition | Yes 1  No………………………………………………………2 | | | | | |  |
| 2B | Provide vitamin A supplementation | Yes 1  No………………………………………………………2 | | | | | |  |
| 2C | Provide iron supplementation | Yes 1  No………………………………………………………2 | | | | | |  |
| 2D | Provide ORS to children with diarrhea | Yes 1  No………………………………………………………2 | | | | | |  |
| 2E | Provide zinc supplementation to children with diarrhea | Yes 1  No………………………………………………………2 | | | | | |  |
| 2F | Child growth monitoring | Yes 1  No………………………………………………………2 | | | | | |  |
| 2G | Treatment of pneumonia | Yes 1  No………………………………………………………2 | | | | | |  |
| 2H | Administration of amoxicillin for the treatment of pneumonia in children | Yes 1  No………………………………………………………2 | | | | | |  |
| 2I | Treatment of malaria in children | Yes 1  No………………………………………………………2 | | | | | |  |
| 2J | Treatment of malnourished child with RUTF as OTP | Yes 1  No………………………………………………………2 | | | | | |  |
| 2K | Treatment of malnourished child with Fortified dry rations as SFP | Yes 1  No………………………………………………………2 | | | | | |  |
| 2L | Inpatient care of malnourished child at Therapeutic feeding center | Yes 1  No………………………………………………………2 | | | | | |  |
| 3 | Please tell me if the following documents are available in the facility today:  If available, ask to see the document | | | | | | |  |
| 3A | IMCI guidelines for the diagnosis and management of childhood illnesses | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 3B | National guidelines for growth monitoring | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 3C | Any check-lists and/or job-aids for IMNCI | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 3D | Any check-lists and/or job-aids for Oral Therapeutic Program (RUTF), Supplementary feeding program (Fortified Rations), and inpatient care | Yes, Observed………………………………..1  Yes, Reported but not seen……………2  No………………………………..……………….3 | | | | | |  |
| 4 | Have you or any provider(s): | | | | | | |  |
| 4A | Of curative care services for sick children received any training in the Integrated Management of Childhood Illnesses (IMCI) in the last two years? | Yes 1  No………………………………………………………2 | | | | | |  |
| 4B | Of growth monitoring services for children received any training in growth monitoring in the last two years? | Yes 1  No………………………………………………………2 | | | | | |  |
| 4C | Of curative care services for sick children received any training in the community based management of acute malnutrition (CMAM) in the last two years? | Yes 1  No………………………………………………………2 | | | | | |  |
| 4D | Of curative care services for sick children received any training in OTP, SFP and inpatient care for malnourished children in the last two years? | Yes 1  No………………………………………………………2 | | | | | |  |
| 4E | What Was the Name of Training or Content of Training? | NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| 4F | What was the duration of that Training? | 2 Days 1  3 Days 2  4 Days 3  5 or More Days……………………………………..4 | | | | | |  |
| 4G | What was the Organization Name Who Conduct those Training? | AKU……………………………………………………….1  Other (Specify)……………………………………..96 | | | | | |  |
| 5 | Please tell me if the following basic equipment items are available and functional in this service area today.  Ask to see the items | **Available**  **(Observed)** | | | **Functionality**  **(Observed)** | | | If not available skip Qty and Functionality |
| **Yes** | **No** | **Qty** | **Yes** | **No** | **Qty** |
| 5A | Length / Height measuring equipment |  |  |  |  |  |  |  |
| 5B | Growth charts |  |  |  |  |  |  |  |
| 5C | MUAC Tapes |  |  |  |  |  |  |  |
| 5D | ARI Timer |  |  |  |  |  |  |  |
| 5E | Pulse Oximeter |  |  |  |  |  |  |  |

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| E8 | **COMMUNICABLE & NON COMMUNICABLE DISEASES** | | SKIP |
| 1 | Does this facility offer HIV counseling and testing services? | Yes 1  No 2 |  |
| 2 | Does this facility offer HIV & AIDS care and support services, including treatment of opportunistic infections and provisions of Palliative care? | Yes 1  No 2 |  |
| 3 | Does this facility offer diagnosis or treatment of STIs other than HIV? | Yes 1  No 2 |  |
| 4 | Does this facility offer diagnosis, treatment prescription, or treatment follow-up of tuberculosis? | Yes 1  No 2 |  |
| 5 | Does this facility offer diagnosis or treatment of malaria? | Yes 1  No 2 |  |
| 6 | Does this facility offer diagnosis or management of non-communicable diseases? | Yes 1  No 2 |  |
| 7 | Do providers in this facility diagnose and/or manage diabetes in patients? | Yes 1  No 2 |  |
| 8 | Do providers in this facility diagnose and/or manage cardiovascular diseases such as hypertension & CVDs in patients? | Yes 1  No 2 |  |
| 9 | Do providers in this facility diagnose and/or manage chronic obstructed pulmonary diseases COPDs in patients? | Yes 1  No 2 |  |
| 10 | Do providers in this facility diagnose and/or manage arthritis in patients? | Yes 1  No 2 |  |
| 11 | Do providers in this facility diagnose and/or manage Osteoporosis in patients? | Yes 1  No 2 |  |
| 12 | Do providers in this facility diagnose and/or manage Any Cancers in patients? | Yes 1  No 2 |  |
| 13 | Do providers in this facility diagnose and/or manage Any Injuries / Road Traffic Accidents & Others in patients? | Yes 1  No 2 |  |
| 14 | Do providers in this facility diagnose and/or manage Anxiety, Depression, Epilepsy and other mental / psychotic health problems in patients? | Yes 1  No 2 |  |

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| **SECTION-F: DIAGNOSTICS**  I would like to know if the following diagnostic tests and associated equipment are available today in this facility.  **This section will not be collected from private health facilities** | | | | | | | | |
| F1 | **CLINICAL CHEMISTRY** | | | | | | |  |
| 1 | Does this facility do blood glucose tests using a glucometer?  IF YES: Ask onsite or offsite. | Yes 1  No……………………………………………………….2 | | | | | | If no go to 2 |
|  | I would like to know if the following equipment items for glucose testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 1A | Glucometer |  |  |  |  |  |  |  |
| 1B | Glucometer test strips (with valid expiration date) |  |  |  |  |  |  |  |
| 2 | Does this facility do urine chemical testing using dipsticks? |  | | | | | |  |
| 3 | Does this facility do urine protein dipstick tests? | Yes 1  No……………………………………………………….2 | | | | | |  |
| 4 | Does this facility do urine glucose dipstick tests? | Yes 1  No……………………………………………………….2 | | | | | |  |
| 5 | Does this facility do urine ketone dipstick tests? | Yes 1  No……………………………………………………….2 | | | | | | IF NO GO TO 6 |
|  | I would like to know if the following equipment items for urine dipstick testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 5A | Dipsticks for urine protein (with valid expiration date) |  |  |  |  |  |  |  |
| 5B | Dipsticks for urine glucose (with valid expiration date) |  |  |  |  |  |  |  |
| 5C | Dipsticks for urine ketones (with valid expiration date) |  |  |  |  |  |  |  |
| 6 | Does this facility do urine rapid tests for pregnancy? | Yes 1  No 2 | | | | | | IF NO GO TO 7 |
|  | I would like to know if the following equipment items for urine pregnancy testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 6A | Urine pregnancy test kit (with valid expiration date) |  |  |  |  |  |  |  |
| 7 | Does this facility do ALT or Creatanine testing? | Yes 1  No 2 | | | | | |  |
| 8 | Does this facility do liver function tests? | Yes 1  No 2 | | | | | |  |
| 9 | Does this facility do renal function tests? | Yes 1  No 2 | | | | | |  |
| 10 | Does this facility do serum electrolyte testing? | Yes 1  No 2 | | | | | | If no go to F2 |
|  | If “Yes” for any test above, then I would like to know if the following equipment items and reagents for liver and kidney function testing and serum electrolyte testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | |  |
| Yes | No | Qty | Yes | No | Qty | IF NO SKIP QTY AND FUNCTIONING |
| 10A | Blood chemistry analyzer |  |  |  |  |  |  |  |
| 10B | Centrifuge |  |  |  |  |  |  |  |
| 10C | Specific assay kit- liver function test |  |  |  |  |  |  |  |
| 10D | Specific assay kit- renal function test |  |  |  |  |  |  |  |
| 10E | Specific assay kit- serum electrolyte test |  |  |  |  |  |  |  |

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| F2 | **HEMATOLOGY** | | | | | | | SKIP |
| 1 | Does this facility do haemoglobin testing? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 2 |
|  | I would like to know if the following equipment items for haemoglobin testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 1A | Colorimeter or hemoglobin meter |  |  |  |  |  |  |  |
| 1B | Hemo Cue |  |  |  |  |  |  |  |
| 2 | Does this facility do full blood count and differential testing? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 3 |
|  | I would like to know if the following equipment items and reagents for full blood count testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 2A | Hematology analyzer (for total lymphocyte count, full blood count, platelet count) |  |  |  |  |  |  |  |
| 2B | Stains for full blood count and differential blood counts |  |  |  |  |  |  |  |
| 3 | Does this facility do CD4 count (absolute and percentage) testing? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to F3 |
|  | I would like to know if the following equipment items for CD4 testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 3A | CD4 counter |  |  |  |  |  |  |  |
| 3B | Specific assay kit- CD4 test |  |  |  |  |  |  |  |

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| F3 | **PARASITOLOGY** | | | | | | | SKIP |
| 1 | Does this facility do malaria rapid diagnostic testing? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 02 |
|  | I would like to know if the following equipment items for malaria RDTs are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 1A | Malaria rapid diagnostic kit (with valid expiration date) |  |  |  |  |  |  |  |
| 2 | Does this facility do malaria smear tests? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 604 |
|  | I would like to know if the following equipment items for malaria smear tests are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 2A | Wright-Giemsa stain or other acceptable malarial stain (e.g. Field Stain A and B) |  |  |  |  |  |  |  |

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| F4 | **BACTERIOLOGY** | | | | | | | SKIP |
| 1 | Does this facility do Ziehl-Neelson testing for TB (AFB)? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 02 |
|  | I would like to know if the following equipment items for Ziehl-Neelson testing for TB are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 1A | Fluorescence microscope (FM) |  |  |  |  |  |  |  |
| 1B | Simple Microscope |  |  |  |  |  |  |  |
| 1C | Ziehl-Neelson stain |  |  |  |  |  |  |  |
| 2 | Does this facility do rapid syphilis testing? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 03 |
|  | I would like to know if the following equipment items for rapid syphilis testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 2A | Syphilis rapid test kit (with valid expiration date) |  |  |  |  |  |  |  |
| 3 | Does this facility do syphilis serology testing? | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 04 |
|  | I would like to know if the following reagents for syphilis serology testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 3A | Specific assay kit- syphilis serology |  |  |  |  |  |  |  |
| 4 | Does this facility do gram stain testing? IF YES: Ask onsite or offsite. | Yes 1  No.……………………………………………………...2 | | | | | | If no go to 701 |
|  | I would like to know if the following reagents for gram stain testing are available and functional today or not available or not functioning today. | **Available** | | | **Functioning** | | | IF NO SKIP QTY AND FUNCTIONING |
| Yes | No | Qty | Yes | No | Qty |
| 4A | Gram stains |  |  |  |  |  |  |  |

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| **SECTION-G: COMMODITIES & SUPPLIES** | | | |
| G1 | **SUPPLY CHAIN MANAGMENT** | | SKIP |
| 1 | Who is the principal person responsible for managing the ordering of medical supplies at this facility? | Nurse.…………………………………………1  Clinical officer.…………………………...2  Pharmacy technician.…………………3  Pharmacy assistant.……………………4  Pharmacist.…………………………………5  Medical assistant.………………………6  Other (specify) .…………………………96 |  |
| 2 | Which of the following mechanisms is used to determine this facility’s resupply quantities?   1. The facility itself (pull distribution system) 2. A higher-level facility (push distribution system) | Yes No  Yes No |  |
| 3 | How are the facility’s resupply quantities determined? | Formula (any calculation) .……………………1  Don’t know.……………………..…………………..2  Other (Specify) .…………………………………..96 |  |
| 4 | What is the replenishment mechanism for the medicine? | Weekly………………………………………………1  Fortnightly…………………………………………2  Monthly ……………………………………………3  Quarterly…………………………………………..4  Bi-annual…………………………………………..5  Annually……………………………………………6  On need basis……………………………………7 |  |
| 5 | When is the next replenishment cycle due? | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  DD MM YYYY |  |
| 6 | What is the main source of your routine pharmaceutical commodity supplies? By this I mean who is the direct supplier to your facility? | Provincial medical stores……………………1  Joint medical stores……………………………2  Ngo/donors………………………………………..3  Private sources…………………………………..4  Other (specify) …………………………………96 |  |
| 7 | How are your commodity supplies from the main supplier to this facility? | Supplier delivers to facility…………………1  Facility must arrange delivery to  Facility……………………………………………….2  Other (specify)…………………………………96 |  |
| 8 |  | |  |
| 8A | Local supplier delivers | Yes 1  No.……………………………………………………...2 |  |
| 8B | Higher level delivers | Yes 1  No.……………………………………………………...2 |  |
| 8C | This facility collects | Yes 1  No.……………………………………………………...2 |  |
| 9 | For the most recent order, how long did it take between ordering and receiving products? | Less than 2 weeks………………………1  2 weeks to 1 month……………………2  Between 1 and 2 months……………3  More than 2 months……………………4 |  |
| 10 | How long the medicine usually last once replenished? | \_\_\_\_\_\_ DAY(S)  \_\_\_\_\_\_ MONTH(S)  \_\_\_\_\_\_ Year(s) |  |
| 11 | Are there other mechanisms for medicine supply? | Yes 1  No.……………………………………………………...2 |  |
| 12 | What are the other mechanisms for medicine supply? | NGO.……………………………………………………..1  Donation (Philanthropist)..…………………….2  Other (Specify) .……………….……………………3 |  |
| 13 | Does this facility record equipment in a stock register? | Yes 1  No.……………………………………………………...2 |  |
| 14 | If yes, ask to see the register to check if it is maintained? | Yes Maintained Regularly…………………..1  Yes maintained Irregularly…………………2  No the register is not maintained……….3 |  |
| 15 | Does this facility record drug in a stock register? Ask to see the register to check if it is maintained? | Yes Maintained Regularly…………………..1  Yes maintained Irregularly…………………2  No the register is not maintained……….3 |  |
| 16 | Does this facility follow essential drug list to stock/restock drugs? | Yes 1  No.……………………………………………………...2 |  |
| 17 | Are these medicines supplied to patients from this facility free of cost? | Yes, all of them…………………………………1  Yes, Only for Emergency patients……..2  Yes, Only Emergency medicines……….3  Partially…………………………………………….4  No…………………………………………………….5 |  |

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| G2 | **PROTECTION FROM ENVOIRMENT** | |  |
| 01 | Are the Drugs properly Shelved?  Observe | Yes Observed…………………………………….1  Yes, reported but not observed…………2  No……………………………………………………..3 |  |
| 02 | Are the medicines protected from water?  Observe | Yes Observed…………………………………….1  Yes, reported but not observed…………2  No……………………………………………………..3 |  |
| 03 | Is the temperature maintained where the drugs are stored?  If yes record the temperature currently maintained/mentioned | Yes ………………………………………….1  No……………………………………………2  Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 04 | Are the medicines protected from the sun?  Observe | Yes Observed…………………………………….1  Yes, reported but not observed…………2  No……………………………………………………..3 |  |
| 05 | Is the room clean of evidence of rodents (bats, rats) or pests (roaches, etc)? | Yes ………………………………………….1  No……………………………………………2 |  |
| 06 | Is the storage room well ventilated? | Yes ………………………………………….1  No……………………………………………2 |  |
| 07 | Are the medicines organized according to date of Expiration ("first expire, first out")? | Yes, all medicines…………………….1  Yes, only some medicines………..2  No……………………………………………3 |  |
| 08 | What system does this facility use to monitor the amount of medicines received, the amount issued, and the amount present today?  Ask To See The System And Record Observation | Computer System Updated Daily……….1  Ledger/Stock Card Updated Daily………2  Computer System Not Updated Daily, But There Is Daily Record Of Distributed Vaccines……………………………………………3  Ledger/Stock Card Not Updated Daily, But There Is Daily Record Of Distributed Medicines…………………………………………4  Any Other System…………………………….5 |  |

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| G3 | **CONSUMPTION ASSESSMENT** | | | | | |  |
| 1 | Enter the three review months that will be used during this assessment. | | | | | |  |
| 1A | MONTH-1 | | MONTH [\_\_][\_\_] YEAR [\_\_][\_\_][\_\_][\_\_] | | | |  |
| 1B | MONTH-2 | | MONTH [\_\_][\_\_] YEAR [\_\_][\_\_][\_\_][\_\_] | | | |  |
| 1C | MONTH-3 | | MONTH [\_\_][\_\_] YEAR [\_\_][\_\_][\_\_][\_\_] | | | |  |
| 2 | Review the SOURCE DOCUMENT used to compile and summarize information for monthly reporting (i.e., stock register, tally sheet) for following indicators for 3 months | | Received | Issued | Discarded | Balance |  |
| 2A | MONTH-1 | 1CHT7UK.OL./87Y7 |  |  |  |  |  |
| Low osmolality oral rehydration salts in sachet |  |  |  |  |  |
| Zinc Sulphate 20mg dispersible tablets/syrup |  |  |  |  |  |
| Folic acid tablets |  |  |  |  |  |
| Ferrous Sulphate tablets |  |  |  |  |  |
| Amoxicillin Dispersible tablet / syrup250 mg |  |  |  |  |  |
| Tetanus Toxoid Vaccine |  |  |  |  |  |
| 2B | MONTH-2 | Misoprostol tablets 200 mcg |  |  |  |  |  |
| Low osmolality oral rehydration salts in sachet |  |  |  |  |  |
| Zinc Sulphate 20mg dispersible tablets/syrup |  |  |  |  |  |
| Folic acid tablets |  |  |  |  |  |
| Ferrous Sulphate tablets |  |  |  |  |  |
| Amoxicillin Dispersible tablet / syrup250 mg |  |  |  |  |  |
| Tetanus Toxoid Vaccine |  |  |  |  |  |
| 2C | MONTH-3 | Misoprostol tablets 200 mcg |  |  |  |  |  |
| Low osmolality oral rehydration salts in sachet |  |  |  |  |  |
| Zinc Sulphate 20mg dispersible tablets/syrup |  |  |  |  |  |
| Folic acid tablets |  |  |  |  |  |
| Ferrous Sulphate tablets |  |  |  |  |  |
| Amoxicillin Dispersible tablet / syrup250 mg |  |  |  |  |  |
| Tetanus Toxoid Vaccine |  |  |  |  |  |

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| G4 | **Medicine, Vaccine and Commodities** | | | | | | | | |  |
| 1 | **MNCH Very Essential Medicines List** | Availability of M/C/V at facility | | Stock Out in Past 03 Months | | Stock Out Days(If Yes in Previous Column) | | Provider Prescribe the Same | |  |
| YES | NO | YES | NO | DD | MM | YES | NO |
| 1 | Misoprostol tablets 200 mcg |  | |  | |  | |  | |  |
| 2 | Oxytocin injection10 IU in 1‐ml |  | |  | |  | |  | |  |
| 3 | Cold Chain for Injection Oxytocin (Syntocinon) is maintaining? | Yes ………………………………………….1  No……………………………………………2 | | | | | | | |  |
| 4 | Sodium chloride infusion0.9 % |  | |  | |  | |  | |  |
| 5 | Sodium lactate ringer's lactate infusion1000ml |  | |  | |  | |  | |  |
| 6 | Dextrose infusion5 & 10% |  | |  | |  | |  | |  |
| 7 | Magnesium Sulphate injection500mg/ml (*Eclampsia only*) |  | |  | |  | |  | |  |
| 8 | Diazepam\* (Injection 10mg) |  | |  | |  | |  | |  |
| 9 | Diazepam\* (rectal gel/solution5 mg/ml in 0.5 ml,2 ml, 4 ml tubes) |  | |  | |  | |  | |  |
| 10 | Hydralazine\* (hydrochloride) Tablet 25 and 50 mg |  | |  | |  | |  | |  |
| 11 | Hydralazine\* (hydrochloride) injection powder for injection 20 mg |  | |  | |  | |  | |  |
| 12 | Methyldopa tablet 250 mg; 500 mg |  | |  | |  | |  | |  |
| 13 | Low osmolality oral rehydration salts  dry mixture (low osmolality formula) in sachet |  | |  | |  | |  | |  |
| 14 | Zinc sulphate scored dispersible tablets/syrup 20 mg |  | |  | |  | |  | |  |
| 15 | Vitamin A capsules 500,000; 100,000IU; 200,000IU |  | |  | |  | |  | |  |
| 16 | Vitamin K1\* (phytonadione) injection 10 mg |  | |  | |  | |  | |  |
| 17 | Paracetamol (syrup 120 mg / 5 ml) |  | |  | |  | |  | |  |
| 18 | Paracetamol tablets 500 mg |  | |  | |  | |  | |  |
| 19 | Paracetamol Injection 150 mg / ml |  | |  | |  | |  | |  |
| 20 | Paracetamol suppository 100 mg |  | |  | |  | |  | |  |
| 21 | Chlorhexidine gluconate (7.1%) gel equivalent to 4 % chlorhexidine |  | |  | |  | |  | |  |
| 22 | Ferrous salt + folic acid tablets  (equivalent to 60 mg iron + 400 mcg folic acid) |  | |  | |  | |  | |  |
| 23 | Mebendazole tablets chewable100 mg *(Adults only* |  | |  | |  | |  | |  |
| 24 | Mebendazole syrup100 mg per 5 ml |  | |  | |  | |  | |  |
| 25 | Salbutamol  tablets2 & 4 mg |  | |  | |  | |  | |  |
| 26 | Salbutamol  syrup2 mg per 5 ml |  | |  | |  | |  | |  |
| 27 | Salbutamol  solution 5 mg / ml |  | |  | |  | |  | |  |
| 28 | Chlorpheniramine maleate tablets 4 mg |  | |  | |  | |  | |  |
| 29 | Chlorpheniramine maleate syrup 2 mg per 5 ml |  | |  | |  | |  | |  |
| 30 | Chlorpheniramine maleate injection4 mg (as disodium salt) in 1‐ml |  | |  | |  | |  | |  |
| 31 | Chlorpheniramine maleate tablet 0.5 mg |  | |  | |  | |  | |  |
| 32 | Dexamethasone (disodium phosphate) injection 10 mg /ml |  | |  | |  | |  | |  |
| 33 | Dexamethasone (disodium phosphate) tablet 0.5 mg |  | |  | |  | |  | |  |
| 34 | Ampicillin  (as sodium salt) Injection 250 mg |  | |  | |  | |  | |  |
| 35 | Ampicillin  (as sodium salt) Syrup 125 & 250 mg / 5 ml |  | |  | |  | |  | |  |
| 36 | Ampicillin  (as sodium salt) Capsules 250; 500 mg |  | |  | |  | |  | |  |
| 37 | Ceftriaxone injection 250 mg; 500; 1 gm |  | |  | |  | |  | |  |
| 38 | Metronidazole Infusion 5 mg / ml in 100‐ml |  | |  | |  | |  | |  |
| 39 | Metronidazole Tablet 200; 400 mg |  | |  | |  | |  | |  |
| 40 | Metronidazole Syrup 200 mg / 5 ml |  | |  | |  | |  | |  |
| 41 | Gentamycin injection 40 mg; 80 mg |  | |  | |  | |  | |  |
| 42 | Amoxicillin Injection 250 mg; 500 mg |  | |  | |  | |  | |  |
| 43 | Amoxicillin Dispersible tablet / capsule 500 mg; 250 mg |  | |  | |  | |  | |  |
| 44 | Amoxicillin Syrup 125 mg; 250 mg / 5 ml |  | |  | |  | |  | |  |

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| 2 | **VACCINES** | Availability of M/C/V at facility | | | Stock Out in Past 03 Months | | | Stock Out Days(If Yes in Previous Column) | | | Provider Prescribe the Same | | |  |
| YES | NO | | YES | NO | | DD | MM | | YES | | NO |
| 1 | BCG Vaccine |  | | |  | | |  | | |  | | |  |
| 2 | Pentavalent Vaccine (DPT+HBV+HIB) |  | | |  | | |  | | |  | | |  |
| 3 | Measles Vaccine |  | | |  | | |  | | |  | | |  |
| 4 | Polio Vaccine (OPV/IPV) |  | | |  | | |  | | |  | | |  |
| 5 | Pneumococcal Vaccine |  | | |  | | |  | | |  | | |  |
| 6 | Tetanus Toxoid |  | | |  | | |  | | |  | | |  |
| 7 | Rota Virus Vaccine |  | | |  | | |  | | |  | | |  |
| 8 | Anti-Rabies Vaccine (PVRV) Single Dose Vial |  | | |  | | |  | | |  | | |  |
| 9 | Anti-Snake Venum Serum |  | | |  | | |  | | |  | | |  |
| 10 | Typhoid Conjugate Vaccine |  | | |  | | |  | | |  | | |  |
| 3 | **EMERGENCY TRAY** | Availability of M/C/V at facility | | | Stock Out in Past 03 Months | | | Stock Out Days(If Yes in Previous Column) | | | Provider Prescribe the Same | | |  |
| YES | | NO | YES | | NO | DD | | MM | YES | NO | |
| 1 | Injection Tranexamic Acid 250MG/5ML (10) |  | | |  | | |  | | |  | | |  |
| 2 | Injection Atropine 1MG/IML (10) |  | | |  | | |  | | |  | | |  |
| 3 | Injection Adrenaline 0.1MG/1ML (10) |  | | |  | | |  | | |  | | |  |
| 4 | Injection Diazepam 5 MG/ML (10) |  | | |  | | |  | | |  | | |  |
| 5 | Injection Diclofenac Sodium 25MG/ML (10) |  | | |  | | |  | | |  | | |  |
| 6 | Injection Hydrocortisone sodium 100 MG (10) |  | | |  | | |  | | |  | | |  |
| 7 | Injection Lidocaine 2% W/V (5) |  | | |  | | |  | | |  | | |  |
| 8 | Water for injection 5 ML (5) |  | | |  | | |  | | |  | | |  |
| 9 | Injection ringer lactate 1000 ML (10) |  | | |  | | |  | | |  | | |  |
| 10 | Injection Normal Saline 500 ML (10) |  | | |  | | |  | | |  | | |  |
| 11 | Injection Glucose / Dextrose 25% 25ml ampoule (2) |  | | |  | | |  | | |  | | |  |
| 12 | Glyceryl Trinitrate Sublingual 500 MCG (50) |  | | |  | | |  | | |  | | |  |
| 13 | Isosorbide dinitrate Sublingual 5 MG (10) |  | | |  | | |  | | |  | | |  |
| 14 | Lidocaine GEL (1) |  | | |  | | |  | | |  | | |  |
| 15 | Cotton Roll 500 GMS (1) |  | | |  | | |  | | |  | | |  |
| 16 | Compression bandage (5) |  | | |  | | |  | | |  | | |  |
| 17 | D/S 1 CC, 5 CC, 10 CC (10 each) |  | | |  | | |  | | |  | | |  |
| 18 | IV set (20) |  | | |  | | |  | | |  | | |  |
| 19 | IV Cannula18G, 20G, 22G, 24G (20) |  | | |  | | |  | | |  | | |  |
| 20 | Silk Sutures Sterile Packs0, 1/0, 2/0 (10) |  | | |  | | |  | | |  | | |  |
| 21 | ETT 3 mm, 3.5 mm, 4 mm, 7.5 mm, 8mm (10) |  | | |  | | |  | | |  | | |  |
| 22 | Foleys catheter all sizes 10 F to 28 F (12) |  | | |  | | |  | | |  | | |  |
| 23 | NG Tube 14-18 For, infant/child: 10-14 Fr (10) |  | | |  | | |  | | |  | | |  |
| 24 | Injection MgSO4 2ml ampules (20) |  | | |  | | |  | | |  | | |  |
| 25 | Injection Dobutamine 50mg/ml (5) |  | | |  | | |  | | |  | | |  |
| 26 | Injection Furosemide 10mg/ml (10) |  | | |  | | |  | | |  | | |  |
| 27 | Injection Calcium Gluconate 100mg/ml in 10ml (10) |  | | |  | | |  | | |  | | |  |

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| 4 | **REPRODUCTIVE COMMODITIES** | Availability of M/C/V at facility | | Stock Out in Past 03 Months | | Stock Out Days(If Yes in Previous Column) | | Provider Prescribe the Same | |  |
| YES | NO | YES | NO | DD | MM | YES | NO |
| 1 | Condoms |  | |  | |  | |  | |  |
| 2 | COCs |  | |  | |  | |  | |  |
| 3 | POPs |  | |  | |  | |  | |  |
| 4 | Injectable |  | |  | |  | |  | |  |
| 5 | IUCDs |  | |  | |  | |  | |  |
| 6 | Implants |  | |  | |  | |  | |  |

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| **SECTION-H: RECORDING AND REPORTING OF DATA**  **This whole section will not be collected from private health facilities** | | | |
| H1 | **ASSESSMENT REVIEW MONTHS** | |  |
| 1 | Enter the three review months that will be used during this assessment. | |  |
| 1A | Month 1 | MONTH YEAR |  |
| 1B | Month 2 | MONTH YEAR |  |
| 1C | Month 3 | MONTH YEAR |  |
| 2 | **HUMAN RESOURCES FOR DATA ASSESSMENT** | |  |
| 1 | Is there a designated person to enter data/compile reports from the different units in the same health facility?  Please Write name and designation of all persons. | Yes ………………………………………….1  No……………………………………………2 |  |
| 2 | Is there a designated person to review the quality of compiled data prior to submission to the next level, e.g., to districts, to regional offices, to the central DHIS, etc.?  Please Write name and designation of all persons. | Yes…………………………………………………..1  Partly (the data are reviewed but no one is designated with the responsibility)…………………………………2  Not at all…………………………………………3 |  |
| 3 | Are designated staff trained in: | |  |
| 3A | Data entry/compilation? | Yes (staff have received training in the past two years)……………………………………..1  Mostly (all staff have received training but not in the past two years)……………….2  Partly (some staff have received training)………………………………………………..3  Not at all……………………………………………….4 |  |
| 3B | Data quality review or data quality check? | Yes (staff have received training in the past two years)……………………………………..1  Mostly (all staff have received training but not in the past two years)……………….2  Partly (some staff have received training)………………………………………………..3  Not at all……………………………………………….4 |  |

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| 3 | **INDICATOR DEFINITIONS AND REPORTING GUIDELINES** | | | | | | |  |
| 1 | Does the health facility have standard written definitions for the following indicators?  (Recommended indicators; adapt for the country, as necessary) | | | | | | |  |
|  | **List of Indicators** | **Are these indicators recorded and reported by this facility?** | | **Are Facility Staff aware about standard definition of each indicator?** | | **Is the HF staff report correctly as per standard definition?** | |  |
| **YES** | **NO** | **YES** | **NO** | **YES** | **NO** |
| 1A | ANC – 1 visit |  |  |  |  |  |  |  |
| 1B | ANC Revisits (2/3/4 or more) |  |  |  |  |  |  |  |
| 1C | ANC-1 women with Hb <10 g/dl |  |  |  |  |  |  |  |
| 1D | PNC-1 visits |  |  |  |  |  |  |  |
| 1E | PNC Revisits (2/3/4 or more) |  |  |  |  |  |  |  |
| 1F | Spontaneous Vaginal Delivery |  |  |  |  |  |  |  |
| 1G | Assisted Vaginal Deliveries |  |  |  |  |  |  |  |
| 1H | Stillbirths in the facility |  |  |  |  |  |  |  |
| 1I | IUDs (Intra Uterine Death) in the facility |  |  |  |  |  |  |  |
| 1J | Newborns with birth asphyxia |  |  |  |  |  |  |  |
| 1K | Newborns successfully resuscitated |  |  |  |  |  |  |  |
| 1L | Pneumonia <05 |  |  |  |  |  |  |  |
| 1M | Diarrhea <05 |  |  |  |  |  |  |  |

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| 4 | **DATA COMPLETENESS** | |  |
| 1 | If the source registers and/or monthly reports are not completely filled in, what are the possible reasons for the missing data? | Storage or archiving problems………………………….1  Staffing issues…………………………………………………..2  Not understanding the data element(s)……………3  Presence of other vertical reporting requirements……………………………………………………4  Other (specify)…………………………………………………96 |  |

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| 5 | **DISCREPANCIES** | |  |
| 1 | If there was a discrepancy observed between the main source document and the monthly reports, what are the reasons for the discrepancy? | Data entry errors………………………………………………1  Arithmetic errors………………………………………………2  Information from all source documents not compiled correctly…………………………………………….3  Other (specif)……………………………………………….96 |  |

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| 6 | **REPORT TIMELINESS** | |  |
| 1 | Is there a deadline for submission of the monthly DHIS report by the health facilities? | Yes ………………………………………….1  No……………………………………………2 |  |
| 1A | If yes, what is the deadline? | DATE [\_] [\_] |  |
| 2 | Does the health facility record the dates of submission of monthly DHIS reports to the district | Yes ………………………………………….1  No……………………………………………2 |  |
| 3 | If yes, are the DHIS monthly reports submitted on time (before or on the deadline)?  (REVIEW THE RECORDS AND CHECK THE DATES OF SUBMISSION FOR THE THREE REVIEW MONTHS) | |  |
| 3A | MONTH-1 | Yes ………………………………………….1  No……………………………………………2 |  |
| 3B | MONTH-2 | Yes ………………………………………….1  No……………………………………………2 |  |
| 3C | MONTH-3 | Yes ………………………………………….1  No……………………………………………2 |  |

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| 7 | **DATA PROCESSING AND ANALYSIS** | |  |
| 1 | Ask relevant staff in the health facility office to show up-to-date (i.e., not more than one year old) reports, documents, and/or displays that contain the following. The assessor should record the observations accordingly. | |  |
| 1A | Aggregated/summary DHIS report within the past three months. **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 1B | Demographic data on the catchment population of the health facility for calculating coverage’s. **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 1C | Indicators (e.g., Penta3 coverage, ANC coverage and others) calculated for the health facility catchment area within the past three months. **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 1D | Comparisons between health facility and district/national targets. **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 1E | Comparisons of data over time, i.e., monitoring trends (e.g., for ANC, Penta3). **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 1F | Comparisons of sex-disaggregated data (e.g., for Penta3, Pneumonia, Diarrhea and others).**(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 1G | Comparisons of service coverage (e.g., ANC, TT immunization, SBA). **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |

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| 8 | **INFORMATION USE GUIDELINES AND STRATEGIC DOCUMENTS** | |  |
| 1 | Are there written national/provincial guidelines on DHIS information display and use at health facilities? (OBSERVE) | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 2 | Does the health facility have copies of the national/district strategic plans, health facility annual plans, and/or health facility performance targets? (OBSERVE) | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |

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| 9 | **DATA VISUALIZATION** | |  |
| 1 | Does the health facility prepare data visuals (graphs, tables, maps, etc.) showing achievements toward targets (indicators, geographic and/or temporal trends, and situation data)? (OBSERVE) | Yes, paper or electronic copies of data visuals observed at the health facility…………………………………………………..1  No…………………………………………………………2 |  |
| 2 | If yes, what type of information is captured in the data visuals? (OBSERVE) | |  |
| 2A | Maternal health care | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 2B | Neonate and child health care (other than EPI) | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 2C | Top causes of morbidity and mortality | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |

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| 10 | **FEEDBACK TO HEALTH FACILITIES** | |  |
| 1 | Did the health facility receive feedback reports from the district office / MOH based on DHIS information in the past three months?  (OBSERVE THE REPORT AND CHECK THE DATE) | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 2 | If yes, indicate the types of feedback reports: | |  |
| 2A | Feedback on data quality (including data accuracy, reporting timeliness, and/or report completeness) **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |
| 2B | Feedback on service performance based on reported DHIS data (e.g., appreciation/acknowledgement of good performance; resource allocation/mobilization) **(OBSERVE)** | Yes Observed………………………………………….1  No……………………………..……………………………2 |  |

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| 11 | **ROUTINE DECISION-MAKING FORUMS AND PROCESSES AT THE HEALTH FACILITY** | |  |
| 1 | Does the health facility have a performance monitoring or management team? | Yes ………………………………………….1  No……………………………………………2 |  |
| 2 | Does the health facility have routine team meetings for performance monitoring and/or management? | Yes ………………………………………….1  No……………………………………………2 | IF NO GO TO 111 |
| 3 | If yes, how often are the performance review/management meetings supposed to take place? | Weekly…………………………………….1  Monthly…………………………………..2  Quarterly…………………………………3  Biannually……………………………….4  Annually………………………………….5  No schedule……………………………6 |  |
| 4 | How many times did the performance monitoring/ management meetings take place during the past three months? | More than four times…………………..1  Four times……………………………………2  Three times………………………………….3  Two times…………………………………….4  One time………………………………………5  Not once………………………………………6 |  |
| 5 | Were minutes of performance monitoring/management meetings maintained for the three review months of to ? | Yes ………………………………………….1  No……………………………………………2 |  |
| 6 | If yes, please check the performance monitoring/management meeting records for the selected months and determine if the following topics were discussed: | |  |
| 7 | Did they have discussions on DHIS management, such as data quality, completeness, or timeliness of reporting? | Yes ………………………………………….1  No……………………………………………2 |  |

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| 12 | **ANNUAL PLANNING** | |  |
| 1 | Does the health facility have an annual plan for the current year? | Yes ………………………………………….1  No……………………………………………2 |  |
| 2 | If yes, does that annual plan use data from the DHIS for problem identification and/or target setting? | Yes ………………………………………….1  No……………………………………………2 | IF NO GO TO 121 |
| 3 | Does the annual plan contain activities and/or targets related to improving or addressing any of the following? |  |  |
| 3A | Coverage of services like ANC, delivery, EPI or TB | Yes ………………………………………….1  No……………………………………………2 |  |
| 3B | Hospital/health center performance | Yes ………………………………………….1  No……………………………………………2 |  |
| 3C | Diseases (e.g., top ten diseases) | Yes ………………………………………….1  No……………………………………………2 |  |
| 3D | Emerging issues/epidemics | Yes ………………………………………….1  No……………………………………………2 |  |
| 3E | Commodity stock out | Yes ………………………………………….1  No……………………………………………2 |  |
| 3F | Human resource management | Yes ………………………………………….1  No……………………………………………2 |  |
| 3G | Gender disparity in health services coverage | Yes ………………………………………….1  No……………………………………………2 |  |

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| 13 | **SUPERVISION BY THE DISTRICT** | |  |
| 1 | How many times did the district supervisor visit your health facility over the past three months? | More than four times……………………………1  Four times…………………………………………….2  Three times…………………………………………..3  Two times……………………………………………..4  One time……………………………………………….5  Not once……………………………………………….6 |  |
| 2 | Did the supervisor check the data quality? | Yes ………………………………………….1  No……………………………………………2 |  |
| 3 | During the visit, did the district supervisor discuss your health facility’s performance based on the DHIS information? | Yes ………………………………………….1  No……………………………………………2 |  |

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| 14 | **FACILITY CHECKLIST: EQUIPMENT INVENTORY AND CONDITION FOR DATA RECORDING & REPORTING** | | |  |
| 1 | Please verify if the following equipment or type of service is available in the facility or office. | **Total quantity**  (If none, enter 0) | **Total quantity that are in working condition**  (If none, enter 0) |  |
| 1A | Laptop computer |  |  |  |
| 1B | Desktop computer |  |  |  |
| 1C | Printers |  |  |  |
| 1D | Modems |  |  |  |
| 1E | Calculator |  |  |  |

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| 15 | **AVAILABILITY OF REGISTERS/FORMS** | | | | | | | | |  |
| 1 | **Type of records, tally sheets, or reports**  Please enter the name of the records, tally sheets, or reporting forms that are used at the facility/office level in this column | **Is the tool available?** | | **Is the tool a standard DHIS tool?** | | **Have you run out of this form in the past six months?** | | **If yes, for how long were you out of stock?** | |  |
| YES | NO | YES | NO | YES | NO | YES | NO |
| 1A | Immunization cards (or child health booklet) |  |  |  |  |  |  |  |  |  |
| 1B | OPD Registers |  |  |  |  |  |  |  |  |  |
| 1C | Maternal Health Register |  |  |  |  |  |  |  |  |  |
| 1D | Obs/Gynae OPD Registers |  |  |  |  |  |  |  |  |  |
| 1E | Obstetric Register |  |  |  |  |  |  |  |  |  |
| 1F | Pediatric OPD Register |  |  |  |  |  |  |  |  |  |
| 1G | Indoor Register |  |  |  |  |  |  |  |  |  |
| 1H | EPI Health Register |  |  |  |  |  |  |  |  |  |
| 1I | Stock and Supplies Management Registers for Medicines, vaccines, contraceptive |  |  |  |  |  |  |  |  |  |
| 1J | IMNCI case investigation forms for children’s |  |  |  |  |  |  |  |  |  |
| 1K | Partograph book |  |  |  |  |  |  |  |  |  |
| 1L | Inpatient Record Files |  |  |  |  |  |  |  |  |  |
| 1M | ANC card |  |  |  |  |  |  |  |  |  |
| 1N | Birth Certificate |  |  |  |  |  |  |  |  |  |
| 1O | FP Register |  |  |  |  |  |  |  |  |  |
| 1P | FP Cards |  |  |  |  |  |  |  |  |  |
| 1Q | Monthly Report (Blank Forms) |  |  |  |  |  |  |  |  |  |
| 1R | R&R tool for Tuberculosis |  |  |  |  |  |  |  |  |  |
| 1S | R&R tool for Malaria |  |  |  |  |  |  |  |  |  |
| 1T | R&R tool for HIV |  |  |  |  |  |  |  |  |  |
| 1U | R&R tool for Nutrition Services |  |  |  |  |  |  |  |  |  |
| 1V | R&R tool for Notifiable Diseases |  |  |  |  |  |  |  |  |  |
| 1W | R&R tool for Non Communicable Diseases (Diabetes, Hypertension, CVDs, Osteoporosis, Cancers and Others) |  |  |  |  |  |  |  |  |  |
| 1X | Registers for Equipment & Capital Assets |  |  |  |  |  |  |  |  |  |
| 1Y | Registers for Vital Events (Birth & Death  Registration) |  |  |  |  |  |  |  |  |  |
| 1Z | Registers for Financial & HR Information |  |  |  |  |  |  |  |  |  |

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| 16 | **RECORDING AND REPORTING OF DATA (Section only for Private Health Facilities)** | |  |
| 1 | Do you record daily OPD / IPD data of clients or patient visiting your clinic or hospital? | Yes ………………………………………….1  No……………………………………………2 | IF NO SKIP 2, 3, 4 |
| 2 | How do you record that information? | Paper based registers…………………..… …1  Electronically collect through mobile applications………………………………………..2  On prescription paper only…………………3  Others (Specify)………………………………….96 |  |
| 3 | What type of registers you used for paper based entries? | PPMIS registers given by AKU…………………1  Registers provided by other NGOs………….2  Simple registers……………………………………..3  Others (Specify)…………………………………….96 |  |
| 4 | Is there a designated person to enter data/compile reports from the different units in the same clinic or hospital?  If Yes, Please Write name and designation of all persons. | Yes, we have a Person……………………………1  No, we don’t have any Person……………….2 |  |
| 5 | What are the main reasons for not recording data of clients or patient visiting your clinic or hospital?  **(Select Multiple responses)** | Lack of human resource………………………..1  Lack of recording and reporting toolS……2  Doesn’t feel need to data collection……..3  Increased work load / OPD clients………..4  Fear of Income Tax / FBR………………………5  Other (Specify)……………………………………..96 |  |

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|  | **SECTION-I: CLIENT / PATIENT’S SATISFACTION** | |  |
|  | Public HF: This Whole section will repeat for 06 clients of same facility with Different Type (03 Maternal & 03 Peads).  Private HF: This Whole section will repeat for 03 clients of same facility with Different Type i.e. 03 Maternal & 03 Peads as per our thematic district. | |  |
| 1 | Consent Obtained from Patient / Relative? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 2 | Date and Time of Interview | DATE:  [\_] [\_] - [\_] [\_] - [\_] [\_][\_] [\_]  TIME:  [\_] [\_]-[\_] [\_]-[\_] [\_] |  |
| 3 | Who is the respondent? | Patient…………………………………………………1  Family member/friend…………………………2 |  |
| 4 | How are you related to the patient? | Mother 1  Father 2  Female caretaker 3  Male caretaker…………………………………….4 |  |
| 5 | Patients Gender | Male 1  Female…………………………………………………2 |  |
| 6 | Patient age | Years |\_\_\_|\_\_\_| Months |\_\_\_|\_\_\_| |  |
| 7 | Can the patient read and write? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 8 | Type of patient | Pediatric 1  Maternity 2 | IF 1🡪9  2🡪10 |
| 9 | CHILD HEALTH | |  |
| 9A | Health worker asks about nature of complaint? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9B | Nature of the primary complaint | Diarrhea…………………………………………………….1  Cough/difficulty breathing…………………………2 |  |
| 9C | Is the duration of the primary complaint asked? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9D | Does the health worker ask whether child is able to drink or breastfeed? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9E | Does the health worker ask whether child vomits everything he/she has taken? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9F | Does the health worker ask whether child has lethargy or a change in level of consciousness? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9G | Does the health worker check about convulsions? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9H | Does the health worker ask for previous treatment for the same condition, before coming to the health facility? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9I | Does the health worker ask about diarrhea? | Yes, but diarrhea not present…………………….1  Yes, and diarrhea was present…………………..2  No, did not ask about diarrhea………………….3 |  |
| 9J | If diarrhea present does the health worker ask about following;  **Circle all that apply** | Asked how long………………………………………….1  Asked about blood……………………………………..2  Checked skin pinch……………………………………..3  Checked Sunken Eyes………………………………….4  None of the above………………………………………5 |  |
| 9K | Does the health worker ask about coughing or difficult breathing? | Yes, but cough/difficult breathing not present…………………………………………………1  Yes, and cough/difficult breathing was present…………………………………………………2  No, did not ask about cough/difficult breathing……………………………………………..3 |  |
| 9L | If cough or difficult breathing present does the health worker ask about following;  **Circle all that apply** | Asked how long……………………………………1  Listen stridor or wheezing……………………2  Checked breathing rate……………………….3 |  |
| 9M | Does the HCP tell mother/caretaker the name of the disease? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9N | Does the HCP explain about the disease, its causes and/or course? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9O | Does the HCP explain what the mother/caretaker should do at home for the child? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 9P | If yes, what did the health worker say?  Circle all that apply | Give more fluids………………………………….1  Continue or increase feedings and/or breast feeding…………………………………….2  Give medicine…………………………………….3  Tepid baths for fever………………………….4  Keep the child warm………………………….5  Avoid giving medications other than those prescribed………………………………………….6 |  |
| 9Q | Does the HCP tell mother/caretaker when child is to return for a scheduled check-up (return visit)? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10 | MATERNAL HEALTH | |  |
| 10A | Does the health worker receives and treats you respectfully | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10B | Does the health worker explains to you about the 04 WHO-recommended schedule of ANC visits (1st visit: <16 weeks, 2nd visit: 24–28 weeks, 3rd visit: 30–32 weeks, 4th visit: 36–38 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10C | Does the health worker takes a FANC history from you and screen danger signs during pregnancy | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10D | Does the health worker calculates the estimated date of your delivery | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10E | Does the health worker measures yours vital signs (blood pressure, temperature, pulse and respiration) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10F | Does the health worker measures fundal height (after 12 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10G | Does the health worker listens to fetal heart sounds (after 20 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10H | Does the health worker determines fetal lie and presentation (after 36 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10I | Does the health worker requests laboratory tests according to the FANC package (Hepatitis B & C, HIV, Haemoglobin, Urine DR, Random blood sugar, Blood Group and Rh Factor) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10J | Does the health worker gives immunization to you (2 doses of Tetanus Toxoid) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 10K | Does the health worker prescribe you iron and calcium supplements and folic acid | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 11 | HEALTH FACILITY QUALITY INDICATORS FOR ALL | |  |
| 11A | How satisfied are you with the wait times at this hospital? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |
| 11B | Do you have to buy any medicine for your treatment from outside? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |
| 11C | How satisfied are you with the hospital cleanliness? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |
| 11D | How satisfied are you with the cleanliness of the toilets? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |
| 11E | If you or someone in your family is sick in the future, how likely are you to return to this hospital? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |
| 11F | How satisfied are you with your doctor’s explanation of the cause of your illness? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |
| 11G | How satisfied are you with your doctor’s explanation of your treatment? | Very Satisfied………………………………………..1  Satisfied………………………………………………..2  Dissatisfied……………………………………………3  Very Dissatisfied……………………………………4 |  |

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|  | **SECTION-J: QUALITY ASSESSMENT OF HEALTH CARE PROVIDER AT FACILITY** | |  |
| J1 | **Focused Antenatal Care** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No |  |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | The provider receives and treats the pregnant woman cordially and respectfully | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | Provider Explains to the women about the 04 WHO-recommended schedule of ANC visits (1st visit: <16 weeks, 2nd visit: 24–28 weeks, 3rd visit: 30–32 weeks, 4th visit: 36–38 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | The provider takes a FANC history, including screening for danger signs (Convulsions, Loss of consciousness, severe headache, blurred vision, respiratory difficulty, fever, severe abdominal pain, and vaginal bleeding) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | Provider calculates the estimated date of delivery according to her last menstrual period at her first antenatal visit and documents it | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | Measures vital signs (blood pressure, temperature, pulse and respiration) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | Measures fundal height (after 12 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | Listens to fetal heart sounds (after 20 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1H | Determines fetal lie and presentation (after 36 weeks) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1I | The provider requests diagnostic tests according to the FANC package   1. Basic: Blood group and Rh factor, hemoglobin, blood glucose, urine analysis for proteinuria, Hepatitis B & C, HIV. 2. Specific: Ultrasounds if needed | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1J | The provider gives immunization according to national guideline (2 doses of TT among pregnant women) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1K | The provider gives Iron and calcium supplements and folic acid | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1L | Give Mebandazole 500mg to every woman once in 6 months.  **Do not give in first trimester.** | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1M | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | Staff is not trained on guideline…………..1  Staff is not adequately skill to conduct the proper assessment……………………………..2  Supplies are not available…………………..3  Equipment’s are not available………..4  Increased Work load / Shortage of Time………………………………………………5  Staff don’t consider this thing important……………………………………..6  Other……………………………………………96 |  |

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| J2 | **Delivery and Post Natal** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No | **Skip this section for Private HF of Child Health Districts** |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | All women in labor are monitored with a partograph that is complete and accurate and manages properly. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | AMTSL is performed for all women during Childbirth | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | If oxytocin is the uterotonics used for AMTSL at this facility, is reliable refrigeration available and used for oxytocin storage? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | Thoroughly dries every baby, stimulates baby and covers baby’s head immediatel | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | Delays cord cutting until pulsation stops (2–3 minutes) and applies CHX to the cord stump | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | Encourages mother to start breastfeeding within one hour of delivery | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | Staff is not trained on guideline…………..1  Staff is not adequately skill to conduct the proper assessment……………………………..2  Supplies are not available…………………..3  Equipment’s are not available……….…..4  Increased Work load / Shortage of Time………………………………………….………5  Staff don’t consider this thing important……………………………………..…..6  Other…………………………………………..……96 |  |

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| J3 | **Essential Newborn Care** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No | **Skip this section for Private HF of Child Health Districts** |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | Wipe the mouth and nose with gauze, when head is delivered | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | Place the baby on clean dry towel or blanket on the mothers abdomen | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | Note the time of birth and sex of baby, and inform mothers | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | Record weight of the baby in record register and inform mother | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | Wipes the eyes and face and thoroughly dry the baby | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | Stimulates the baby while drying by rubbing up and down along the baby’s spine with the heel of the palm | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | Assess the baby’s breathing while drying and stimulating | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1H | If the baby is not crying or breathing well within 30 second of birth, clamp and cut the cord immediately and start resuscitation. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1I | Remove the wet cloth and place the baby skin to skin on the mother’s chest | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1J | Cover the baby with a clean dry cloth including the head. Use a baby cap to cover head of newborn | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1K | Wait for 2-3 minutes after birth or until the cord ceases to pulsate, whichever comes first, before clamping and cutting the cord. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1L | Tie the cord when the mother and baby are stable and after completing AMTSL. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1M | Tie the cord with a ligature or place the disposable cord clamp, if available, 2 fingers (2-3 cm) from the abdomen, making sure the tie is firmly applied with two or three knots. Check for bleeding; if present, retie the cord. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1N | Apply chlorhexadine gel on the cord, taking care to apply it on the base of the cord. Inform mother about applying same gel for 07 days | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1O | Instill eye drops (tetracycline or erythromycin), one drop in each eye. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1P | Place an identification band, preferably two (one on the wrist and the other on the ankle of the baby). Noting the name of the mother and that of the father (where available), the sex of the baby, and date and time of the delivery. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1Q | Keep the baby warm, ideally by keeping him/her in skin-to-skin contact on the mother’s chest. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1R | In case of a Cesarean section or if the mother is ill, wrap the baby well and cover the head. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1S | Check the baby’s axillary temperature with a thermometer | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1T | Administer Inj. Vitamin K to the newborn and explain to the mother that an injection will be required to prevent hemorrhage in the baby. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1U | Support the mother in breastfeeding her baby within one hour of birth and before their transfer out of the delivery room. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1V | Monitor and record baby’s breathing, temperature after every 15 minutes for 2 hours, than every 30 minutes for 1 hour, and then every 1 hour for 3 hours. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1W | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | Staff is not trained on guideline…………..1  Staff is not adequately skill to conduct the proper assessment……………………………..2  Supplies are not available…………………..3  Equipment’s are not available…….……..4  Increased Work load / Shortage of Time………………………………………………..…5  Staff don’t consider this thing important…………………………………………..6  Other…………………………………………………96 |  |

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| J4 | **Verify for Following Steps: History and General Danger Sign Assessment as per IMNCI** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No | **Skip this section for Private HF of Maternal & Newborn Health Districts** |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | Ask age of child from his / her mother and record properly. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | Ask or observe gender of child from his / her mother and record properly. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | Ask if she has received care from another caregiver during this complaint. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | Assessed height, and weight of child | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | Assessed nutritional status of child using MUAC tape | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | Ask from women about presenting complaint of Child | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | Ask about the duration of presenting complaint of Child | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1H | Ask whether child is able to drink or breastfeed? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1I | Ask whether child vomits everything he/she has taken? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1J | Checks whether child has lethargy or a change in level of consciousness? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1K | Ask about convulsions | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1L | Ask about the child vomits everything he / she has taken | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1M | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | Staff is not trained on guideline…………..1  Staff is not adequately skill to conduct the proper assessment……………………………..2  Supplies are not available…………………..3  Equipment’s are not available…….……..4  Increased Work load / Shortage of Time………………………………………………..…5  Staff don’t consider this thing important…………………………………………..6  Other…………………………………………………96 |  |

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| J5 | **Verify for Following Steps: Pneumonia as per IMNCI** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No | **Skip this section for Private HF of Maternal & Newborn Health Districts** |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | ASK: Does the child have cough or difficult breathing? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | ASK: For how long child have cough or difficult breathing? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | LOOK: Does the child have fast breathing? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | Count Child’s breathing with help from ARI Timer | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | LOOK: for chest in drawing | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | LOOK and LISTEN for Stridor | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | LOOK and LISTEN for wheezing | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1H | Classify Cough and Difficult Breathing Properly | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1I | Identify Pneumonia through Fast Breathing and Chest Indrowing | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1J | Treat “Severe Pneumonia or Very Severe Disease” Through First dose of appropriate antibiotics or urgent referral | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1K | Treat “Pneumonia” Through oral amoxicillin for 5 days and If wheezing (even if it disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1L | Treat “Cough or Cold” Through soothing throat remedies and If wheezing (even if it disappeared after rapidly acting bronchodilator) give an inhaled bronchodilator for 5 days | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1M | If coughing for more than 2 weeks or if having recurrent wheezing, refer for assessment for TB or asthma | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1N | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | Staff is not trained on guideline…………..1  Staff is not adequately skill to conduct the proper assessment……………………………..2  Supplies are not available…………………..3  Equipment’s are not available…….……..4  Increased Work load / Shortage of Time………………………………………………..…5  Staff don’t consider this thing important…………………………………………..6  Other…………………………………………………96 |  |

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| J6 | **Verify for Following Steps: Diarrhea as per IMNCI** | |  |
|  | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No | **Skip this section for Private HF of Maternal & Newborn Health Districts** |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | ASK: Does the child have diarrhea? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | ASK: For how long does the child have diarrhea? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | ASK: Is there blood in the stool? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | LOOK at the child's general condition. Is the child lethargic or unconscious? Restless and irritable? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | LOOK For Sunken Eyes | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | OFFER the child fluid. Is the child not able to drink or drinking poorly? Drinking eagerly, thirsty? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | PINCH the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly? | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1H | Classify Diarrhea according to level of dehydration and duration properly | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1I | Identify dehydration level and identify appropriate treatment (Plans A, B, and C for giving fluids and food, Giving ORS for dehydration, Zinc supplementation, Ciprofloxacin for dysentery) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1J | PLAN A – treat diarrhea at home | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1K | PLAN B – treat SOME DEHYDRATION with low osmolality oral rehydration salts (ORS) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1L | PLAN C – treat SEVERE DEHYDRATION quickly with intravenous (IV) fluids | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1M | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | Staff is not trained on guideline…………..1  Staff is not adequately skill to conduct the proper assessment……………………………..2  Supplies are not available…………………..3  Equipment’s are not available…….……..4  Increased Work load / Shortage of Time………………………………………………..…5  Staff don’t consider this thing important…………………………………………..6  Other…………………………………………………96 |  |

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| J7 | **Verify for Following Steps: Counsel the Mother and Follow Up Care Provision as per IMNCI** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No | **Skip this section for Private HF of Maternal & Newborn Health Districts** |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | Provide advice and counseling about hygiene of child | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | Provide advice and counseling about rest and activity of child | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | Encourage the woman to ask questions, and be sure that she understands what is being said. | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | Provide advice on follow up after 3 or 5 days (As per condition of child and classification of disease) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | Check the child’s Immunization Status | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | Give the Child vaccine on this visit IF NEEDED | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** |  |  |

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| J8 | **Verify for Following Steps: Communication, Respect and Confidentiality** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No |  |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | The provider maintain privacy around the time, and patients confidentiality is respected | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | The provider not mis treat any client such as verbal abuse / discrimination / neglect or denial of services | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | The provider gave right to informed choices in the services they receive to the patient | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | The provider clearly explained reason for intervention / outcome | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | The provider deliver clear and accurate information to the patient and their attendant | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | The provider give IEC Material to visiting patient for strengthening his / her understanding | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1G | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | No IEC material is available………………….1  Increased workload / Shortage of time…………………………………………………….2  No separate space is available for counseling / maintaining confidentiality…………………………………….3  Partition curtains are not available……..4 |  |

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| J9 | **Referral and Linkages** | |  |
| 1 | Please enter the Name and Designation of HCP to whom you observe for this section. | Name  Designation  Provider Trained by AKU? Yes / No |  |
|  | Verify by direct observation or by role play or by reviewing medical record | |  |
| 1A | The provider receive patients from community through LHW referral (Referral In) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1B | Referral slips are appropriately placed safe in a box for referral In patients | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1C | The provider appropriately assessed before referral, and Refer is made without delay (Referral Out) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1D | The provider referred within or between health facilities with appropriate information exchange (For referral out patients, Referral Note, is given to patient and entry in facility documentation) | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1E | An up to date list of networking facilities in the same geographical area that provide referral care to clients should pasted on wall | Yes ……………………………………….…………….1  No……………………………………….………………2 |  |
| 1F | If you find “No” for any of the above statement then what is the reason;  **(Multiple answers can be select)** | This is LHW Uncovered facility…………….1  Referral slips are not available for “refer out” patients / clients………………………….2  Referral box is not available for “refer in” patients / clients…………………………………3  Community visit facility by themselves, LHW not refer them……………………………4  No register available to record refer out patient record…………………………………….5 |  |

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| **SECTION A: DISTRICT AND PROVINCIAL AUTHORITIES INFORMATION**  **(Should Completed By District Managers)** | | |
| **1 MASTER TRAINER LIST** | | |
| 1 | Province | Baluchistan  Punjab  Sindh |
| 2 | District | Jafferabad  Labella  Naseerabad  Muzaffergarh  Rahim Yar Khan  Badin  Sanghar  Qamber Shahdadkot |
| 3 | Taluka/Tehsil | **Name of Tehsils from selected district will appear in drop down.** |
| 4 | Details of Master Trainer **(\*\*Add all participants name one by one and record all required information who trained in 2018 cycle of AKU)** | Name of Trainer  Designation of trainer  Facility of trainer  Currently posted in same facility: Y/N  Duration of service in same facility: Months / Years  Transferred to Other Facility: Y/N  If Yes, then what |
| 5 | Details of Master Trainer **(\*\*Add all participants name one by one and record all required information who need to be train in 2020 cycle of AKU)** | Name of Trainer  Designation of trainer  Facility of trainer  Currently posted in same facility: Y/N  Duration of service in same facility: Months / Years  Transferred to Other Facility: Y/N  Duration of transferred from facility: Months / Years |
| **2 TRANSFER & POSTING DETAILS OF DISTRICT AUTHORITIES (Since January 2017 till Date)** | | |
| 1 | Details of CEO Health **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| 2 | Details of DM IRMNCH **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| 3 | Details of DM PHFMC (Punjab) **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| 4 | Details of DC LHW Program **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| 5 | Details of DC LHW Program **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| 6 | Details of DC IHS Sindh **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| 7 | Details of DM PPHI (Sindh & Baluchistan) **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  District:  From Month with Year:  To Month with Year: |
| **3 TRANSFER & POSTING DETAILS OF PROVINCIAL AUTHORITIES (Since January 2017 till Date)** | | |
| 1 | DG Health Services **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  Province:  From Month with Year:  To Month with Year: |
| 2 | Program Director MNCH / IRMNCH **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  Province:  From Month with Year:  To Month with Year: |
| 3 | Program Director EPI **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  Province:  From Month with Year:  To Month with Year: |
| 4 | Program Director Lady Health Worker Program **(\*\*Add all participants name one by one and record all required information from January 2017 till date)** | Name:  Designation:  Province:  From Month with Year:  To Month with Year: |