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**Health Facility Assessment Tool**

**MISP Process Evaluation**

**Date:**

**Name of evaluator:**

**IDENTIFICATION INFORMATION**

|  |  |  |
| --- | --- | --- |
| **ID1: Facility Name** | **ID2: District Name** | **ID3: Region Name** |
| ID4 | Type of facility***(Circle one)***   | National hospital ....................................... 1Regional hospital ....................................... 2District hospital ....................................... 3 Maternity ..................................... 4Primary Health Care Center (PHCC) .........................5Primary Health Care Unit (PHCU) ........................6Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_0 |
| ID5 | Type of operating agency ***(Circle one)***  | Government.........................................1Private .......................................2NGO.........................................3Religious Mission..........................................4Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_0 |
| ID6 | Population in the catchment area of this facility ***(Insert number)*** |  Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

| **A.**  **GENERAL INFORMATION** |
| --- |
| **No.** | **Question** | **Response** |
| A1 | Was the facility open at the time you arrived?**[arrival time should be after 8am, depending on the local context] (*Observe*)** | Yes...................................1No...................................2Do not know ............................99 |
| A2 | Is there a sign posted stating the times when the facility is open? **(*Observe*)** | Yes...................................1No...................................2Do not know ............................99 |
| A3 | Is the facility open during evenings or weekends? | Yes...................................1No...................................2Do not know ............................99 |
| A4 | Have you informed the community about the reproductive health (RH) services available at this facility? | Yes...................................1No...................................2Do not know ............................99 |
| A6 | Does the facility have services for the RH needs of adolescents? | Yes...................................1No...................................2Do not know ............................99 |
| A7 | Can adolescents receive RH services at the facilities without consent of their parents? | Yes...................................1No...................................2Do not know ............................99 |
| A8 | Does this health facility address specific access needs of people with physical disabilities and other impairments (vision, hearing, speech, mental?) | Yes...................................1No............2 **🡪 SKIP TO B1**Do not know ...........99 **🡪 SKIP TO B1** |
| A9 | How does the facility address these needs? ***(Circle all that apply)*** |  Wide entrance....................... 1  Wooden ramps.......................2 Translators, (sign language) ....3 Other (specify).........................4  |

**INSTRUCTIONS:** Upon entering the facility, please answer questions A1 and A2 based on your observation. The remaining questions in this section should be asked of the respondent.**INSTRUCTIONS:** “Now I would like to ask you some basic questions about the facility itself.” Be sure to **observe** as well as ask questions of the respondent.

| **B. FACILITY & SECURITY** |
| --- |
| **No.** | **Question** | **Response** |
| B1 | How many beds are available for patients in this facility (in all departments)?  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| B2 | Does this facility have power? **(*Ask respondent and observe)*** | Yes...................................1No...................................2Do not know ............................99 |
| B3 | What is the source of power for this facility? ***(Circle all that apply)*** | Power lines.................................1 Solar.................................2 Generator................................3Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4Do not know ............................99 |
| B4 | Is there adequate external lighting at the facility? (Entrance, latrines, corridors etc.) **(*Ask respondent and observe)*** | Yes...................................1No...................................2Do not know ............................99 |
| B5 | Is there a security guard at the health facility? **(*Ask respondent and observe*)** | Yes...................................1No...................................2Do not know ............................99 |
| B6 | Can you turn on the lights at any time of day or night as needed (e.g., to handle a delivery during the night)? | Yes...................................1No...................................2Do not know ............................99 |
| B7 | Does this facility have clean water? | Yes...................................1No...................................2Do not know ............................99 |
| B8 | How is the facility’s water supplied? ***(Circle all that apply & probe for all sources)*** | Inside plumbing (external source) …………. 1Inside plumbing (inside facility) ………….. 2 Outdoor pump…………… 3Outdoor protected well……………. 4Rainwater catchment……………. 5 Water delivery……………. 6Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_7 Do not know ............................99 |
| B9 | Is the system for water functioning any time of day or night as needed? | Yes...................................1No...................................2Do not know ............................99 |
| B10 | Does this health facility have latrines? **(*Ask respondent and observe*)** | Yes...................................1No..........2 **🡪 SKIP TO B13**Do not know .......99 **🡪 SKIP TO B13** |
| B11 | Are the latrines sex segregated latrines at the health facilities?**(*Ask respondent and observe*)** | Yes...................................1No...................................2Do not know ............................99 |
| B12 | Do the latrines at the health facilities lock from the inside? **(*Ask respondent and observe*)** | Yes...................................1No...................................2Do not know ............................99 |
| B13 | Do health facilities have a private secure exam room for survivors of sexual violence? **(*Ask respondent and observe*)** | Yes...................................1No...................................2Do not know ............................99 |

| **C. TRANSPORT AND COMMUNICATIONS** |
| --- |
| **No.** | **Question** | **Response** |
| C1 | What are the types of functioning communications systems available in this facility? **(*Circle all that apply)*** | Land telephone(s)……………. 1 Mobile phones ………….. 2Radio….………………….3Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4None….5Do not know……….99 |
| C2 | Is there a functional transport system for referral to and from this health facility (to and from community or other facilities)? | Yes...................................1No............2 **🡪 SKIP TO C4**Do not know .........99 **🡪 SKIP TO C5** |
| C3 | What are the types of transport systems available? (**Then** **🡪 SKIP TO C5)*****(Circle all that apply)*** | Ambulance ……………1Motor vehicle …………. 2Boat …………………….3Bicycle …………………. 4Animal drawn cart …………… 5Stretcher …………………. 6Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7**🡪 SKIP TO C5** |
| C4 | (If no) Please explain why.*(****Write your response in the box)*** |  |
| C5 | Is there a referral protocol available at the health facility? (e.g., to a facility with basic emergency obstetric care (EmOC), comprehensive EmOC, assisted deliveries, etc) | Yes...................................1No...................................2Do not know ............................99 |
| C6 | How far is the nearest referral hospital within the setting (camp, urban, IDP or other setting)? **(Enter distance in kilometers and/or hours)** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**INSTRUCTIONS:** “Now, I would like to ask you some basic questions about availability of transport and communications.” **INSTRUCTIONS**: “Now, I would like to ask you about the human resource situation at this facility.”

| **D. HUMAN RESOURCES** |
| --- |
| **No.**  | **Question** | **Response** |
| D1 | What types of skilled medical staff are available at this facility for Reproductive Health (RH) Services? ***(Circle all that apply)*** | Obstetrician/Gynecologist ………… 1 Pediatrician ………………. 2 General medical doctor ………… 3 Nurse midwife ………. 4 General nurse ………… 5 Medical assistant/Clinical officer ……... 6 TBA (supervised by facility midwife) … 7 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8Do not know…………….99 |
| D2 | Are your staffing needs adequate? | Yes............1**🡪 SKIP TO D4**No...................................2Do not know ........99 **🡪 SKIP TO D4** |
| D3 | (If no) Please explain why.*(****Write your response in the box)*** |  |
| D4 | Does the facility have 24/7 coverage by skilled medical staff? | Yes...................................1No...................................2Do not know ............................99 |
| D5 | What staff are physically present Monday to Sunday during night-time hours?***(Circle all that apply)*** | Obstetrician/Gynecologist ………… 1 Pediatrician ………………. 2 General medical doctor ………… 3 Nurse midwife ………. 4 General nurse ………… 5 Medical assistant/Clinical officer ……... 6 TBA (supervised by facility midwife) … 7 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8Do not know…………….99 |

**INSTRUCTIONS: “**Now, I would like to ask you some questions about the health of mothers and their newborn children.”

| **E. PREVENTION OF EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY** |
| --- |
| **No.**  | **Question** | **Response** |
| E1 | Are normal deliveries performed in this facility?  | Yes............1 **🡪 SKIP TO E3**No...................................2Do not know ........99 **🡪 SKIP TO E3** |
| E2 | (If no) What is the main reason that this service is not being provided? | Training issues………… 1 Supplies/equipment issues………… 2 Management issues………… 3 Not authorized to provide ………… 4 No indication…………. 5 No clients …………... 6Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_7Do not know…………………...99  |
| E3 | What staff *currently* perform normal deliveries in this facility? | General medical doctor …………. 1 Nurse midwife …………2  Nurse ………….3 Clinical officer……… 4 Medical assistant …………5 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6Do not know…………………...99  |
| E5 | Who receives clean delivery kits distributed from this facility?***(Circle all that apply)***  | Visibly pregnant women ………...1Community skilled birth attendants………... 2TBAs………... 3We do not distribute clean delivery kits…... 4Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5Do not know…………………...99 |
| E6 | How many clean delivery kits have been distributed in the past three months?  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E7 | What are the signal functions of basic emergency obstetric care provided at this facility? ***(Circle all that apply)*** | Parenteral antibiotics ………... 1 Parenteral uterotonic drugs (oxytocin)………. 2 Parenteral anticonvulsant drugs………... 3Manual removal of retained products of conception using appropriate technology…… 4Manual removal of placenta………... 5Assisted vaginal delivery (vacuum of forceps delivery).. 6Newborn resuscitation………… 7Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8Do not know…………………...99 |
| E8 | For the signal functions (services) not provided, what are the main reasons? ***(Circle all that apply)*** | Training issues………... 1 Supplies/equipment issues………… 2 Management issues………… 3 Not authorized to provide………… 4 No indication/No clients…………. 5Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6Do not know…………………...99  |
| E9 | Is Misoprostol used for post-partum hemorrhage in this facility? | Yes...................................1No...................................2Do not know ............................99 |
| E10 | Is at least one provider trained to perform the following elements of newborn care: ***(READ LIST & circle all that apply)*** | * Encourage breastfeeding (early and exclusive)……..1
* Newborn infection management (Including injections & antibiotics)… 2
* Thermal care (including immediate drying and skin-to-skin care)………………………………….. 3
* Sterile cord cutting and appropriate cord care ……4
* Kangaroo care for low birth weight…………… 5
* Special delivery care practices for preventing mother to-child transmission of HIV ...……………….6
 |
| E11 | What are the elements of newborn care provided at this facility?***(READ LIST & circle all that apply)*** | * Thermal protection (delayed bath, drying, skin-to-skin contact)…...1
* Prevention of infection (cleanliness, hygienic cord cutting and care, eye care) ….………………………………2
* Management of newborn sepsis….3
* Management of low birth weight/preterm babies…..4
* Newborn resuscitation ……….…….5
* Counseling for immediate & exclusive breastfeeding.6
* Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_66
* NONE ...………………………………...7
* Do not know…………………...99
 |
| E12 | What is the main reason that essential newborn care services have not been provided?  | Training issues…………. 1 Supplies/equipment issues…………. 2 Management issues………… 3 Not authorized to provide………... 4 No indication/No clients………... 5 Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6Do not know…………………...99 |
| E13 | Are cesarean deliveries performed at this facility?  | Yes...........1 **🡪 SKIP TO E15**No...................................2Do not know .......99 **🡪 SKIP TO E15** |
| E14 | What is the main reason that cesarean deliveries are not provided? | Training issues…………. 1 Supplies/equipment issues…………. 2 Management issues………… 3 Not authorized to provide………... 4 No indication/No clients………... 5 Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6Do not know…………………...99 |
| E15 | Have you heard of any maternal deaths in this setting (camp, urban settlements, etc)?  | Yes...................................1No..........2 **🡪 SKIP TO E17**Do not know .......99 **🡪 SKIP TO E17** |
| E16 |  (If yes) How many in the last 30 days?  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E17 | How many newborns have been referred or admitted in this facility for the following conditions in the last 30 days? | Neonatal sepsis:\_\_\_\_\_\_\_\_\_Low birth weight/preterm:\_\_\_\_\_\_\_\_Birth asphyxia:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E18 | Have you heard of newborn deaths in this setting?  | Yes...................................1No..........2 **🡪 SKIP TO E20**Do not know .......99 **🡪 SKIP TO E20** |
| E19 | (If yes) How many deaths in the last 3 months?  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**INSTRUCTIONS:** “In this section, I will ask questions about abortion and post-abortion care.”

|  |
| --- |
| **SECTION E CONTINUED: COMPREHENSIVE ABORTION CARE SERVICES** |
| **No.**  | **Question** | **Response** |
| E20 | What types of abortion care services are available at this facility? ***(Circle all that apply)*** | Treatment of retained products……………. 1 Counselling……………. 2 Post-abortion family planning.…. 3Reproductive health and other health services……………. 4 Community/provider partnerships…………. 5 Safe abortion care……………. 6 NONE available……………. 7 **🡪 SKIP TO E23** Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_8 Do not know …………………...99 **🡪 SKIP TO E23** |
| E21 | What methods are used for post-abortion care? | Medical abortion ……………...1 Electric/manual vacuum aspiration ………….2 Dilatation & Curettage (D&C)/Dilatation & Evacuation (D&E) …………… 3 None available……………. 4Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5Do not know………………...99 |
| E22 | What are the methods used for safe abortion care? | Medical abortion ……………...1 Electric/manual vacuum aspiration ………….2 Dilatation & Curettage (D&C)/Dilatation & Evacuation (D&E) …………… 3 None available……………. 4Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5Do not know………………...99 |
| E23 | What are the main reasons that abortion services are not provided at this facility? | Training issues…………. 1 Supplies/equipment issues…………. 2 Management issues………… 3 Not authorized to provide………... 4 No indication/No clients………... 5 Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6Do not know…………………...99 |
| E24 | Have you heard of maternal deaths due to abortions in this setting?  | Yes...................................1No...........2 **🡪 SKIP TO F1**Do not know ........99 **🡪 SKIP TO F1** |
| E25 | (If yes) How many deaths have in the last 30 days?  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**INSTRUCTIONS:** “In this section, I will ask questions about care for survivors of sexual violence.”

| **F. PREVENTION AND RESPONSE TO SEXUAL VIOLENCE** |
| --- |
| **No** | **Question** | **Response** |
| F1 | Is clinical care for survivors of sexual violence provided in this facility? | Yes.............1**🡪 SKIP TO F3**No...................................2Do not know ............................99 |
| F2 | (If no) What are the main reasons why each service is not provided? (**Then 🡪 SKIP TO F3)*****(Circle all that apply)*** | Training issues…………. 1 Supplies/equipment issues…………. 2 Management issues………… 3 Not authorized to provide………... 4 No indication/No clients………... 5 Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6Do not know…………………...99 **SKIP TO F3** |
| F3 | (If **F1** is yes) Which services are provided?***(Circle all that apply)*** | Confidential history and examination……… 1Forensic evidence collection………… 2 Provision of PEP within 72 hours………… 3 Provision of emergency contraception within 120 hours…………. 4 Provision of antibiotics to prevent STIs….…… 5 Psychosocial counselling …….6 Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7Do not know…………….99 |
| F4 | Has this facility informed the community of services available for care of survivors of sexual assault? | Yes...................................1No............2 **🡪 SKIP TO F6**Do not know .........99 **🡪 SKIP TO F6** |
| F5 | (If yes) What information was communicated? | The location of services…………... 1 The benefits of clinical care…………... 2 The hours of service................ 3Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4   |
| F6 | Have you heard of incidents of sexual violence in this setting (camps, urban resettlement, etc)? | Yes...................................1No............2 **🡪 SKIP TO F8**Do not know ........99 **🡪 SKIP TO F8** |
| F7 | (If yes) How many did you see in the last 30 days? ***(INSERT # in the box)***  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| F8 | Have any survivors of sexual assault presented themselves to the facilities during the last three months? | Yes...................................1No..........2 **🡪 SKIP TO F11**Do not know .......99 **🡪 SKIP TO F11** |
| F9 | (If yes) How many presented to the facility within the last three months? ***(INSERT # in the box)***  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| F10 | In the last three months, how many sexual violence survivors accessed the health facility for care **within five days** of assault? ***(INSERT # in the box)***  | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| F11 | Is at least one provider trained to provide the following elements of care for survivors of sexual violence: ***(READ LIST & Circle all that apply****)* |  Confidential history and examination………. 1 Forensic evidence collection ………...2 Provision of PEP………… 3 Provision of emergency contraception…… 4 Provision of antibiotics to prevent STIs……. 5 Psychosocial counseling………... 6 Care of child survivors………… 7None……8  |
| F12 | Are there Standard Operating Procedures in place for referral of survivors of sexual violence? | Yes...................................1No...................................2Do not know ............................99 |
| F13 | Has this facility referred at least one survivor of sexual violence for any of these services: (psychological, legal, social)? | Yes...................................1No...................................2Do not know ............................99 |

**INSTRUCTIONS:** “In this section, I will ask questions about standard precautions and the prevention of HIV.”

| **G. STANDARD PRECAUTIONS & PREVENTION OF HIV** |
| --- |
| **No.** | **Question** | **Response** |
| G1 | Does this facility have a protocol for standard precautions? | Yes...................................1No...........2 **🡪 SKIP TO G5**Do not know ........99 **🡪 SKIP TO G5** |
| G2 | (If yes) Are the protocols posted on the wall where they are visible? | Yes...................................1No...................................2Do not know ............................99 |
| G3 | Is the use of protocols monitored to ensure appropriate application? | Yes...................................1No...................................2Do not know ............................99 |
| G4 | How are the protocols monitored? | Supervisor using checklist…………. 1Peer review using checklist ………….2Both a & b ...………….3Do not know…………... 99 |
| G5 | How does this facility sterilize its equipment?***(Circle all that apply)*** | Autoclave…………… 1 Hot air sterilizer…………… 2 Steam sterilizer (electric)…………… 3 Steam sterilizer/pressure cooker (non-electric)…4 High-level disinfection ………….5 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6Do not know…………………….99 |
| G6 | Is blood transfusion performed in this facility?  | Yes...................................1No...........2 **🡪 SKIP TO G8**Do not know.......99 **🡪 SKIP TO G13** |
| G7 | (If yes) What is the source of the blood supply? **(Then 🡪 SKIP TO G9)** | Blood comes from an external blood bank………1 Blood comes from facility blood bank……...2Blood is collected from family or friends as needed (live transfusion) …………………3  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4**(Now SKIP TO G9)** |
| G8 | (If **G6** is no) What are the main reasons that this service is not provided? **(Then 🡪 SKIP TO G13)*****(Circle all that apply)*** | Training issues………… 1 Supplies / equipment issues …………2 Management issues………… 3 Not authorized to provide………… 4 No indication/no clients…………. 5 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6Do not know…………….99 **(Now SKIP TO G13)**  |
| G9 | Is there a protocol for safe and rational blood transfusion?  | Yes...................................1No.........2 **🡪 SKIP TO G11**Do not know ......99 **🡪 SKIP TO G11** |
| G10 | Is the rational blood transfusion protocol monitored to ensure its application during transfusions?  | Yes...................................1No...................................2Do not know ............................99 |
| G11 | What transfusion transmissible diseases are blood screened for?  | HIV…………. 1 Syphilis…………... 2 Hepatitis B…………... 3 Hepatitis C…………... 4 Malaria…………… 5Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6Do not know…………………...99  |
| G13 | How is solid medical waste disposed in this facility?***(Circle all that apply)*** | Pit latrine…………… 1Waste pit ……………. 2Burned/incinerated…………… 3Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4Do not know………99 **🡪 SKIP TO G16**  |
| G14 | Is the waste disposal site at least 50m away from any water source? | Yes...................................1No...................................2Do not know ............................99 |
| G15 | Are sharps disposal bins/boxes used in this facility? | Yes...................................1No...................................2Do not know ............................99 |
| G16 | Does this facility have post occupational exposure treatment for staff? | Yes...................................1No...................................2Do not know ............................99 |
| G17 | (If yes) Which post occupational exposure treatment does this facility provide to staff? ***(Circle all that apply)*** | Post Exposure Prophylaxis (PEP)…………. 1 Hep B vaccines…………. 2Hep B immunoglobulin ……………3Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4 |
| G18 | Does the health facility have adequate supplies to practice standard precautions? | Yes.........1 **🡪 SKIP TO G20**No...................................2Do not know .......99 **🡪 SKIP TO G20** |
| G19 | (If no) List the supplies that are inadequate. ***(Please list the supplies in the box)*** |  |
| G20 | Are free condoms (male and/or female) readily available? | Yes.........1 **🡪 SKIP TO H1**No...................................2Do not know ......99 **🡪 SKIP TO H1** |
| G21 | (If no) Explain why.***(Please write response in box)*** |  |

**INSTRUCTIONS:** “In this section, I will ask questions about planning for comprehensive reproductive health service provision.”

| **H. PLANNING FOR COMPREHENSIVE RH SERVICES INTEGRATED INTO PRIMARY HEALTH CARE** |
| --- |
| **No.** | **Question** | **Response** |
| H1 | Where do you get your reproductive health supplies? ***(Please write the supplier in the box)***  |  |
| H2 | Is the supply distribution chain reliable? | Yes...........1 **🡪 SKIP TO H4**No...................................2Do not know .......99 **🡪 SKIP TO H4** |
| H3 |  (If no) Please explain why.***(Please write response in the box)*** |  |
| H4 | Do you keep a reliable commodities’ register for reproductive health supplies? | Yes...................................1No...................................2Do not know ............................99 |
| H5 | Does the pharmacy in this facility keep reproductive health supplies?  | Yes...................................1No...................................2Do not know ............................99 |
| H6 | Does this facility have adequate reproductive health supplies?  | Yes...................................1No...................................2Do not know ............................99 |
| H7 | Please explain your answer (to H6). |  |
| H8 | Does this facility collect data on the following MISP indicators:***(Prompt and circle all that apply)*** | Number of reported rape cases………… 1Coverage of HIV rapid tests for safe blood transfusion ………….2 Condom distribution…………. 3 Clean delivery kits distribution…………… 4 Availability of clinical management of rape survivors…………. 5 Other RH indicators (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6 |

| 1. **ADDITIONAL REPRODUCTIVE HEALTH SERVICES**
 |
| --- |
| **No** | **Question** | **Response** |
| **CONTRACEPTION** |
| I1 | What contraceptive services are available to meet demand at this facility?***(Circle all that apply)*** |   Male condoms……… 1  Female condoms ………2Oral contraceptive pills…………... 3 Emergency contraceptive…………. 4 IUDs ………...5 Injectable contraceptives…………. 6Implants…………….7 None available…………... 8 **🡪 SKIP TO I4** Other specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_9Do not know…...99 **🡪 SKIP TO I4**  |
| I2 | Please provide the number of women supplied with each method over the last one month ***(Please write number next to each method)***  |   Male condoms……… 1\_\_\_\_\_\_\_  Female condoms ………2\_\_\_\_\_\_\_Oral contraceptive pills…………... 3\_\_\_\_\_\_\_ Emergency contraceptive…………. 4\_\_\_\_\_\_\_ IUDs ………...5\_\_\_\_\_\_\_ Injectable contraceptives…………. 6\_\_\_\_\_\_\_Implants…………….7\_\_\_\_\_\_\_ None available…………... 8 Other specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_9\_\_\_\_\_Do not know…...99 |
| **AVAILABILITY OF ANTI-RETROVIRAL DRUGS** |
| I4 | Are anti-retrovirals (ARVs) available for continuing users? | Yes...................................1No.............2 **🡪 SKIP TO I8** Do not know ............................99 |
| I5 | Are there ARV treatment protocols for continuing users? | Yes...................................1No...................................2Do not know ............................99 |
| I6 | Is there a referral system for ARVs for continuing users including persons living with HIV & PMTCT? | Yes...................................1No.............2 **🡪 SKIP TO I8** Do not know .........99 **🡪 SKIP TO I8**  |
| I7 | (If yes) Where are they referred to? ***(Please write name of facility)*** | Referral Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| I8 | Are anti-retrovirals given to **mothers** in maternity / labor ward (PMTCT)? | Yes...................................1No...................................2Do not know ............................99 |
| I9 | Are anti-retrovirals given to **newborns** in maternity / labor ward (PMTCT)? | Yes...................................1No...................................2Do not know ............................99 |
| **SYNDROMIC MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS** |
| I10 | Is syndromic diagnosis and management of sexually transmitted infections provided?  | Yes...................................1No..........2 **🡪 SKIP TO I15** Do not know ....99 **🡪 SKIP TO I15**  |
| I11 | (Ifyes) What types of protocols are you following?***(Circle all that apply)*** | MoH protocol…………. 1WHO protocol ………….2None available ………….3Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4 |
| I12 | Do you have sufficient supplies for syndromic management of STIs? | Yes...........1 **🡪 SKIP TO I14** No...................................2Do not know .....99 **🡪 SKIP TO I14**  |
| I13 | (If no) Please explain:***(Please write response in the box)*** |  |
| I14 | How many patients received syndromic treatment or STIs in the last three months?  | Number of patients: \_\_\_\_\_\_\_\_\_\_ |
| **CULTURALLY APPRORIATE MENSTRUAL MATERIALS** |
| I15 | Does the facility typically receive any menstrual hygiene supplies? | Yes...................................1No...................................2Do not know ............................99 |
| I16 | Have menstrual hygiene supplies been distributed at this health facility in the last three months?  | Yes...................................1No.........2 **🡪 SKIP TO END** Do not know ....99**🡪 SKIP TO END**  |
| I17 | (If yes) To whom are they distributed?***(Please circle all that apply)*** | Women of RH age & adolescent girls……… 1Post-natal women………. 2Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3 |

**Feedback Form**

Please use this page as an opportunity to provide feedback on this tool. Consider introduction, length of time taken, wording and relevancy of questions, challenges with any questions, missing data, cultural sensitivity, changes made to questions during the pilot, form structure as well as other issues you would like to raise. Please be as specific and detailed as possible and feel free to add more pages. Please also write any edits on the tool itself. Scan and send all feedback to Sandra Krause at sandrak@wrcommission.org.