Primary Health Care Initiatives: A Survey of Primary Health Care Facilities

Primary Health Care Initiatives (PHCI) Project
Contract No. 278-C-00-99-00059-00
Abt. Associates Inc.

Team Number: Date: ___/__/00__ Time: ___:___
dd mm yy

PART ONE:

SECTION 1: GENERAL HEALTH CENTER INFORMATION

For the questions with a square to their left, please verify that this information is correct and check the square. If the information is correct, go on to the next question. If the information is incorrect, write in the correct information on the line provided.

1.1. Name of respondent _____

1.2. Position / Title of respondent _____

1.3. Health center name: _____

1.4. Health center ID number: _____

1.5. General Health Directorate (Governorate): _____

1.6. Health Directorate: _____

1.7. Name of PHC Director: _____
(fill in name)

1.8. PHC phone number 1: _____
(fill in phone number if not printed)

1.9. PHC phone number 2: _____
(fill in phone number OR 0 if there is none)

1.10. Location*(street / location)*: _____

(city / village) _____

1.11. Mailing Address: _____

1.12. GPS Location:

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Use the GPS unit to answer the following question.

1.12.1. Top Number on GPS Unit: _____ _____ _____ _____
direction degrees minutes seconds

1.12.2. Bottom Number of GPS Unit: _____ _____ _____ _____
direction degrees minutes seconds

SECTION 2: HEALTH SERVICES AVAILABLE AT THIS PHC

Circle Yes or No indicating whether this service is available or not at this PHC.

(circle only one)
1 2

2.1. General Practice…… **Yes / No**
2.2. MCH……. **Yes / No**
2.2.1. Home Visits……. **Yes / No**
2.2.2. Home Births……. **Yes / No**
2.2.3. Vaccination / Immunization.……. **Yes / No**
2.2.4. Family Planning……. **Yes / No**
-If yes:
2.2.4.1. IUD…… **Yes / No**
2.2.4.2. Injectables……... **Yes / No**
2.2.4.3. Pills……. **Yes / No**
2.2.4.4. Counseling…….. **Yes / No**
2.2.4.5. Condoms……. **Yes / No**
2.2.4.6 Patches ……. **Yes / No**
2.3. Specialty Services…… **Yes / No**
-If yes:
2.3.1. Internal Medicine……. **Yes / No**
2.3.2. Obstetrics / Gynecology…….. **Yes / No**
2.3.3. Pediatrics……. **Yes / No**
2.3.4. Dermatology…… **Yes / No**
2.3.5. Ear Nose and Throat…… **Yes / No**
2.3.6. Ophthalmology…… **Yes / No**
2.3.7. Surgery…… **Yes / No**
2.3.8. Orthopedics……. **Yes / No**
2.3.9. Family Medicine……. **Yes / No**
2.3.10.Radiology…… **Yes / No**
2.4. Dental……... **Yes / No**
2.5. Emergency…… **Yes / No**
2.6 Health Inspection……. **Yes / No**
2.7. Health Promotion/ Education……... **Yes / No**
2.8. Laboratory…… **Yes / No**
2.9. Pharmacy……. **Yes / No**
2.10. School Health…… **Yes / No**

SECTION 3: UTILIZATION

Answer the following questions based upon the MONTHLY REPORT FOR THE CENTER FOR THE MONTH OF MAY 2000 that is submitted to the Health Directorate.

3.1. What was the total number of **physician patients** in this PHC for May 2000?

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No. of visits	Source of info

3.2. What was the total number of **dental patients** in this PHC for May 2000?

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No. of visits	Source of info

3.3. What was the total number of **nursing patients** in this PHC for May 2000?

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No. of visits	Source of info

3.4. What was the total number of **MCH child patients** in this PHC for May 2000?

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No. of visits	Source of info

3.5. What was the total number of **MCH maternity patients** in this PHC for May 2000?

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No. of visits	Source of info

3.6. What was the total number of **MCH family planning patients** in this PHC for May 2000?

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No. of visits	Source of info

3.7. What was the total number of **MCH child vaccination patients** in this PHC for May 2000?

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No. of visits	Source of info

3.8. What was the total number of **MCH maternity vaccination patients** in this PHC for May 2000?

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No. of visits	Source of info

SECTION 4: STAFFING

Write in the number of each category of staff that work in this PHC 6 days per week, working full days (FULL TIME) or less than 6 days per week or working part days (PART TIME). Each staff should only be counted once.

4.1. STAFF	**Number of staff who work FULL TIME (6 days per week / fully days) at this PHC**	**Number of staff who work PART TIME (less than 6 days per week or part days) at this PHC**
4.1.1. Specialist		
4.1.2. General Physician		
4.1.3. Qualified Resident		
4.1.4. Dentist		
4.1.5. Dental Technician		
4.1.6. Pharmacist		
4.1.7. Pharmacy Assistant		
4.1.8. Staff Nurse		
4.1.9. Midwife		
4.1.10. Practical Nurse*		
4.1.11. Assistant Nurse		
4.1.12. Lab Technician		
4.1.13. Lab Technician Asst.		
4.1.14. X-Ray Technician		
4.1.15. X-Ray Technician Asst.		
4.1.16. Clerk		
4.1.17. Telephone Operator		
4.1.18. Health Inspector		
4.1.19. Accountant		
4.1.20. Driver		
4.1.21. Security		
4.1.22. Maintenance Technician		
4.1.23. Maid		
4.1.24. Other: _____ *(specify)*		

**Practical Nurses are defined by having at least 18 months of formal training. Assistant Nurses have less than 18 months of formal training. A Staff Nurse will have a baccalaureate, associate, or diploma in Nursing.*

SECTION 5: OUTREACH

(Outreach is defined as health care activities that occur outside of the PHC.)
Circle the appropriate answer to each question. If the answer is Yes, write answers in the blanks provided.

(circle only one)

5.1. Does this PHC organize and conduct outreach activities? **Yes / No / Do not know**
1 2 3

-If yes, list up to four outreach activities that were performed in the past 6 months?

5.1.1. _____ 5.1.3. _____

5.1.2. _____ 5.1.4. _____

SECTION 6: REFERRAL

6.1. When patients need a specialist, to what type of health facility do you refer most of these patients?

1 ☐ MOH Comprehensive Health Center (CHC)
2 ☐ MOH Hospital
3 ☐ Royal Medical Service Health Center
4 ☐ Royal Medical Service Hospital
5 ☐ Private Health Care Provider
6 ☐ Private Hospital
7 ☐ Other:_____
(specify)

6.2. How far is the nearest private primary health care provider from this PHC?
_____ Km

6.3. How far is the nearest MOH comprehensive health care facility (CHC) from this PHC?
_____Km

6.4. How far is the nearest MOH hospital from this PHC? _____ Km

6.5. How far is the nearest RMS hospital from this PHC? _____ Km

6.6. How far is the nearest private hospital from this PHC? _____ Km

SECTION 7: QUALITY

Circle the appropriate answer to each question. If the answer is Yes, write answers in the blanks provided.

(A stockout is defined as not having one item (piece of equipment / consumable / drug) in this center that is usually available at a PHC.)

7.1. Has there been a stockout of medical equipment / instruments in the last 3 months?

(circle only one)

Yes / No / Do not know

1 2 3

-If yes, list up to four items of missing equipment/ instruments.

7.1.1._____ 7.1.3. _____

7.1.2._____ 7.1.4. _____

7.1.5. Does the Director expect to receive any of the missing medical equipment / instruments in the next 3 months?

(circle only one)

Yes / No/ Do not know

1 2 3

7.2. Has there been a stockout of medical consumables in the last 3 months?

(circle only one)

Yes / No/ Do not know

1 2 3

-If yes, list up to four types of missing medical consumables.

7.2.1. _____ 7.2.3. _____

7.2.2. _____ 7.2.4. _____

7.3. Has there been a shortage of drugs in the last 3 months?

(circle only one)

Yes / No/ Do not know

1 2 3

-If yes, list up to four types of missing drugs.

7.3.1. _____ 7.3.3. _____

7.3.2. _____ 7.3.4. _____

SECTION 8: BARRIERS TO QUALITY CARE

8.1. What are the 2 largest problems the staff at this PHC face during their work?

8.1.1. _____

8.1.2. _____

8.2. What are the 2 largest barriers to the improvement of people's health in Jordan?

8.2.1. _____

8.2.2. _____

SECTION 9: TRAINING OF THE PHC DIRECTOR

9.1. What year did you graduate from medical school? _____
(fill in year)

9.2. How many years have you worked in this PHC? _____
(fill in years)

9.3. In the last 3 years, have you received any additional formal training? *(circle only one)*
Yes / No
1 2

IF NO, PLEASE SKIP TO QUESTION 9.7

9.4. What was the subject of your most recent training? _____
(fill in subject)

9.5. How was this training conducted?

(check only one square)
1 ☐ Work-Shop
2 ☐ Formal on the job training
3 ☐ Study tour
4 ☐ Certificate from mini course
5 ☐ Degree
6 ☐ Other: _____
(specify)

9.6. Who conducted this training?

(check only one square)

1 ☐ Pharmaceutical Company
2 ☐ Government / MOH
3 ☐ Professional Association
4 ☐ Other: _____
(specify)
5 ☐ Not Applicable

9.7. In what area would you like additional training? _____
(fill in subject)

SECTION 10: VEHICLES

10.1. Number of MOH vehicles available all day, 6 days a week for this PHC facility? _____

10.2. Number of these vehicles used as an ambulance. _____

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SECTION 11: MEDICAL EQUIPMENT AND FURNITURE

A physician should assist the surveyor to complete the following chart.

Equipment present at this facility	**Total Number**	**Number that are Functional**	**Number that are NOT Functional**
11.1.1. Autoclave			
11.1.2. Boiling Sterilizer			
11.1.3. Heat Sterilizer			
11.1.4 Blood Centrifuge			
11.1.5. Refrigerator			
11.1.6. Thermometer in Refrigerator			
11.1.7. Sphygmomanometer (blood Pressure instrument)			
11.1.8. Syringe and needle disposal unit			
11.1.9. Biohazard Materials Disposal Unit			
11.1.10. Vaginal speculum			
- 11.1.11. Tenaculum			
11.1.12. Ring Forcep			
11.1.13. Uterine Sound			
11.1.14. Microscope			
1.1.15. Urine Centrifuge			
11.1.16. Needle Holder			
11.1.17. Forcep			
11.1.18. Scissors			
11.1.19. Hemostat Clamp			
11.1.20. Oxygen cylinder			
11.1.21. Infant Scale			
11.1.22. Adult Scale			
11.1.23. Infant Height Measure			
11.1.24. Child Height Measure			
11.1.25. Fetal Doppler Stethoscope			
11.1.26. Otoscope / Ophthalmoscop			
11.1.27. Suction Equipment			
11.1.28. ECG Machine			
11.1.29. Cardiac Monitor			
11.1.30. Cardiac Defibrillator			
11.1.31. Ultrasound Machine			
11.1.32. X-ray Machine			
11.1.33. Fluoroscope			
11.1.34. Water Bath			
11.1.35. Eye Chart			
11.1.36. Stove			
11.1.37. TV			
11.1.38. VCR			

11.2. Fill in the table with the correct number, condition and type of the components listed below. Do not fill in the black portions.

***Condition Scale: 3 (New, Functional but needs very simple cosmetic repair)**
2 (Partially functioning and in need repair)
1 (Not functional at all)
0 (Not found)

	Number *(write in the number)*	Condition* *(circle the condition)*	Type *(circle the type)*
11.2.1. Fan		0 1 2 3	
11.2.2. Air Conditioning Unit		0 1 2 3	Split / Window *1 2*
11.2.3. Drinking Fountain		0 1 2 3	
11.2.4. Waste Container		0 1 2 3	
11.2.5. Toilet		0 1 2 3	Eastern / Western *1 2*
11.2.6. Sink		0 1 2 3	Separate / Part of Counter *1 2*
11.2.7. Counter (Lab/Pharmacy)		0 1 2 3	
11.2.8. Table (NOT EXAM)		0 1 2 3	
11.2.9. Exam Table		0 1 2 3	With Stirrups /Without Stirrups *1 2*
11.2.10. Privacy Curtain		0 1 2 3	
11.2.11. Desk		0 1 2 3	
11.2.12. Chair		0 1 2 3	
11.2.13. Stool (Chair with no hands)		0 1 2 3	
11.2.14. Bench		0 1 2 3	
11.2.15. Goose Neck Lamp		0 1 2 3	
11.2.16. Instrument Trolley		0 1 2 3	
11.2.17. Instrument Supply Cabinet		0 1 2 3	
11.2.18. Other_____		0 1 2 3	

SECTION 12: EXTERIOR EVALUATION

Fill in the following chart based on your evaluation of the structures, equipment, and systems listed. Do not fill in the black spaces. See Annex I for a detailed list of conditions.

***Condition Scale: 5 (Fully functional)**
4 (In need of minor repair)
3 (Partially functioning and in need of significant repair)
2 (In need of major repair)
1 (Not functional or missing)

	Available *(**circle** yes or no)*	**Number** *(**write** in the number)*	**Condition *** *(**circle** the condition)*	**Type** *(**circle** the type)*	**Size** *(**write** in specified measurement)*
12.1.Perimeter Wall	YES / NO *1 2*		1 2 3 4 5	Fence / Wall *1 2*	_____ *(Linear Meters)*
12.2.Landscaping	YES / NO *1 2*		1 2 3 4 5		
12.3 External Sign	YES / NO *1 2*		1 2 3 4 5		
12.4. Facade	YES / NO *1 2*		1 2 3 4 5		
12.5. Handicap Access	YES / NO *1 2*		1 2 3 4 5		
12.6. Main Road	YES / NO *1 2*		1 2 3 4 5	Asphalt / Dirt *1 2*	
12.7.Parking Spaces	YES / NO *1 2*		1 2 3 4 5	Asphalt / Dirt / Cement *1 2 3*	_____ *(Square Meters)*
12.8. Sewage	YES / NO *1 2*		1 2 3 4 5	Main / Septic *1 2*	_____ *(Septic System Cubic Meters)*
12.9. Municipal Garbage Container	YES / NO *1 2*		1 2 3 4 5		
12.10. PHC Garbage Container	YES / NO *1 2*		1 2 3 4 5	Enclosed / Open *1 2*	_____ *(Cubic Meters)*
12.11. Incinerator	YES / NO *1 2*		1 2 3 4 5		_____ *(Cubic Meters)*
12.12. Flag Pole	YES / NO *1 2*		1 2 3 4 5		
12.13. Roofing	YES/ NO *1 2*		1 2 3 4 5	Cement/Zinc *1 2*	
12.14. Water Tank	YES/NO *1 2* NA *3*		1 2 3 4 5	Roof / Ground/Shared *1 2 3*	_____ *(Cubic Meters)*

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PART TWO:

SECTION 13: MEASUREMENTS

Use the measuring tape / electronic measuring device provided in your kit to calculate the areas below.

1.3.1. Number of floors of the center's building .

_____

(fill in number)

132.1. Floor area (Basement): _____ *SqM*
(fill in sq. meters)

13.2.2. Floor area (Ground Floor): _____ *SqM*
(fill in sq. meters or 0 if there is none)

13.2.3. Floor area (floor 1): _____ *SqM*
(fill in sq. meters or 0 if there is none)

13.2.3. Floor area (floor 2): _____ *SqM*
(fill in sq. meters or 0 if there is none)

13.2.3. Floor area (floor 3): _____ *SqM*
(fill in sq. meters or 0 if there is none)

13.3. Estimated distance from front of building to edge of property _____ *M*
13.4. Estimated distance from side 1 of building to edge of property _____ *M*
13.5. Estimated distance from back of building to edge of property _____ *M*
13.6. Estimated distance from side 2 of building to edge of property _____ *M*

SECTION 14: FLOOR AND SITE PLAN SKETCH

Freehand sketch the floor(s) and site plan. The sketch must include dimensions, doors, windows, and stairs. Use the scaled graph paper from your survey kit. Each floor must be labeled indicating its location in the building. Additionally, each room in the PHC must be numbered to correspond with the room evaluation forms. On the side of the floor plan, list the room numbers with the room function. Finally, make note on the floor plan where each photograph was taken.

**Note: If the PHC is one of the 5 MOH floor plans, use the floor plans supplied in the survey kit and make any changes directly to that form. Number each room and make note of where any photographs were taken. Attach that floor plan to the survey instead of a freehand sketch.*

SECTION 15: INTERIOR EVALUATION

Fill in the following chart based on your evaluation of the structures, equipment, and systems listed. Do not fill in the black spaces. See Annex I for a detailed list of conditions.

***Condition Scale: 5 (Fully functional)**
4 (In need of minor repair)
3 (Partially functioning and in need of significant repair)
2 (In need of major repair)
1 (Not functional or missing)

	Available *(**circle** yes or no)*	**Number** *(**write** in the number)*	**Condition *** *(**circle** the condition)*	**Type** *(**circle** the type)*	**Size** *(**write** in specified measurement)*
15.1. Cold Water	YES/NO *1 2*		1 5		
15.2. Hot Water	YES/NO *1 2*		1 5	Gas / Oil / Diesel / Solar *1 2 3 4* Kerosene / Electrical *5 6*	
15.3. Electricity	YES/NO *1 2*		1 2 3 4 5		
15.4. Fuse Box	YES/NO *1 2*		1 2 3 4 5		_____ *(Total Amps)*
15.5. Emergency Generator	YES/NO *1 2*		1 2 3 4 5		_____ *(Volts)*
15.6. On site step down transformer	YES/NO *1 2*		1 2 3 4 5		
15.7. Central Heating	YES/NO *1 2*		1 2 3 4 5	Gas / Oil / Diesel / Solar *1 2 3 4* Kerosene / Electrical *5 6*	
15.8. Central Cooling	YES/NO *1 2*		1 2 3 4 5		
15.9. Central Ventilation	YES/NO *1 2*		1 2 3 4 5		
15.10. Boiler	YES/NO/NA *1 2 3*		1 2 3 4 5	Shared *1*	
15.11. Fuel Tank	YES/NO/NA *1 2 3*		1 2 3 4 5	Gas / Oil / Diesel/Solar *1 2 3 4* Kerosene / Electrical *5 6* Shared *7*	_____ *(Cubic Meters)*
15.12. Fire Extinguisher	YES/NO *1 2*		1 2 3 4 5		

SECTION 16: ROOM EVALUATION

Use the forms provided in the survey kit to evaluate every room in the PHC. Follow the directions provided on the form. Use a separate form for each room. Match each room evaluation with the floor plan number. Write this number on the room evaluation form. Attach the room evaluation forms to the survey with the clips provided in the survey kit.

SECTION 17: ARCHITECT / ENGINEER'S OPINION

17.1. In your opinion what are the 2 largest architectural / engineering issues facing this clinic?

17.1.1. _____

17.1.2. _____

SECTION 16: ROOM EVALUATION

Use this form to evaluate each room in this PHC. Fill one form for each room in this PHC.

16.1.1. Fill in the room number from the floor plan: _____

16.1.2. Circle the type of room / space that you are evaluating:

General / Administrative	*Exam Rooms*	*Ancillary Services*	*Utility / Storage*
Waiting Room *1* Records Room *2* Switchboard Room *3* Doctor's Office (*No Exam) 4* Accounting Room *5*	GP *6* MCH *7* Dental *8* Emergency *9*	Laboratory *10* Pharmacy *11* X-Ray Room *12*	Storage Room *13* Boiler Room *14* Generator Room *15* Basement *16*
Spaces	*Other*		
Corridor *17* Staircase *18*	Kitchen *19* Toilet *20* Other:_____ *21* *(specify)*		

16.2. Calculate the **Total Area** of the room you are evaluating.
Use the electronic measuring device provided in your survey kit to determine the total area.

Total Room Area: **_____ SqM**
(in square meters)

16.3. Fill in the table with the correct number, condition and type of the components listed below. Do not fill in the black portions.

***Condition Scale: 5 (Fully functional)**
4 (In need of minor repair)
3 (Partially functioning and in need of significant repair)
2 (In need of major repair)
1 (Not functional or missing)

	Number *(write in the number)*	Condition* *(circle the condition – worst case if multiple)*	Type *(circle the type)*
16.3.1. Sign on door / window		1 2 3 4 5	
16.3.2. Door		1 2 3 4 5	Wood / Metal / Aluminum *1 2 3*
16.3.3. Interior walls (Permanent)		1 2 3 4 5	
16.3.4. Interior walls (Partition)		1 2 3 4 5	
16.3.5. Floor		1 2 3 4 5	Cement / Terrazzo / PVC / Stone *1 2 3 4* Wood / Marble / Ceramic *5 6 7*
16.3.6. Ceiling		1 2 3 4 5	False / Cement/Zinc *1 2 3*
16.3.7. Window		1 2 3 4 5	Aluminum / Steel / Wood *1 2 3*
16.3.8. Light		1 2 3 4 5	
16.3.9. Electrical outlet		1 2 3 4 5	

ANNEX I

CONDITION SCALE

Score of 5 (Fully functional)
If the structure / equipment / system is operating well and has no problems and is adequate for the Primary health care center then it will receive a score of 5.

Some examples of a 5 score are:
- The heating system heats the building as originally intended, has no maintenance needs, and is adequate for the work of the primary health care center.
- The walls are well painted with no holes or cracks.
- The equipment works well and does not need repair.
- Electricity is continuous.

Score of 4 (In need of minor repair)
If minor repairs less than 20% are required to bring the structure / equipment / system into good operating standards, but the structure/ equipment / system is currently functioning then a score of 4 should be given.

Some examples of a 4 score are:
- The septic tank system is inadequate due to use / the capacity is less than is required and requires frequent collection.
- The floor need a few tiles replaced but is otherwise adequate.
- The walls have some cracks, which can be remedied with plastering and paint.
- The doors simply need paint or replacement of minor hardware.

Score of 3 (Partially functioning and in need of significant repair)
If repairs of between 20% to 40% the structure / equipment / system are required and the system can no longer function adequately for the health center's activity's, then a score of 3 should be given.

Some examples of a 3 score are:
- The main road needs resurfacing.
- The windows are missing panes.
- Major leaks are experienced.
- Major cracks are found in the walls, doors or floors.
- The building experiences regular power outages.

Score of 2 (In need of major repair)
If the structure / equipment / system is deteriorating due to negligence, and major repair required, then a score of 2 should be given.

Some examples of a 2 score are:
- The transformer needs replacement due to insufficient capacity.
- The water supply is erratic.
- The roof leaks or is not structurally sound.
- Major cracks are found and reinforcement is exposed.
- The building experiences frequent electrical short circuits.

Score of 1 (Not functioning or missing)
If the structure / equipment / system is missing / nonfunctioning / or cannot be used safely, then a score of 1 should be given.

Some examples of a 1 score are:
- Equipment is missing / broken
- Light fixtures are not working
- Doors are missing