# EmONC Needs Assessment

## MODULE 1: IDENTIFICATION OF FACILITY AND INFRASTRUCTURE

## SECTION 1: INTERVIEW INFORMATION

***INSTRUCTIONS**: The supervisor should complete this section as soon as the team arrives at the facility and before interviewing the facility officer in charge. Copy the Unique Facility Identifier (UFI) onto each page of Modules 1 through 9 before the team begins to collect data.*

| **Team Number** | **Facility Number** | **Unique Facility Identifier (UFI)** |
|---|---|---|
| \|___\|___\| | \|___\|___\| Sequential number beginning with 01 | \|___\|___\|___\|___\| 2-digit Team Number + 2-digit Facility Number |

| **Facility Name** | |
|---|---|
| | |
| **Region/Province** | **District** |
| | |
| **Region/Province Code** | **District Code** |
| \|___\|___\| | \|___\|___\|___\| |

*The UFI should be entered into the GPS unit when marking the coordinates in the device. The coordinates must also be entered below. Take the GPS reading at the front gate of the facility.*

| **Geographic Coordinates** | |
|---|---|
| Latitude (decimal degrees) | Longitude (decimal degrees) |
| N \|___\|___\| º\|___\|___\|' \|___\|___\|.\|___\|" | E \|_0_\|___\|___\| º\|___\|___\|' \|___\|___\|.\|___\|" |
| Elevation | Accuracy reading |
| \|___\|___\|___\|___\| meters | ± \|___\|___\| meters |

***INSTRUCTIONS:***

*This Module includes five sections to be completed from the staff members of the facility. You should separate the sections and ask for assistance for:*

- *Part A from the In charge of the institution (Director, Medical Superintendent, Medical office in charge)*
- *Part B from the in charge of the Labour room (Ward sister/ Nurse in charge)*
- *Part C from the in charge of the NICU/SCBU (Ward sister/ Nurse in charge)*
- *Part D from the in charge of the Operating Theatre (Ward sister/ Nurse in charge)*
- *Part E from the in charge of ambulance services and who went in the ambulance last (Nursing Officer / Medical officer)*

*If the person indicated above is not available, seek someone else who can help you answer the questions for each section.*

## PART A – INCHARGE OF THE INSTITUTION

### SECTION 2: FACILITY IDENTIFICATION INFORMATION

**Interviewer Name** _____ **Date** (d/m/y): ___ / ___ / ___

***INSTRUCTIONS**: Direct these questions to the officer in charge of the institution.*

| No. | Item | Response |
|---|---|---|
| 1 | Type of facility<br><br>(*Circle one)* | Teaching Hospital ……..…….…….. 1<br>Provincial Hospital ……..…….. 2<br>District General Hospital A ……..……..…… 3<br>District General Hospital B ……..……..…… 4<br>Type A Base Hospital ……...…. 5<br>Type B Base Hospital ……...…. 6<br>Divisional Hospital Type A ……...…. 7<br>Divisional Hospital Type B ……...…. 8<br>Divisional Hospital Type C ……...…. 9<br>Primary Medical Care Unit ……..……... 10<br>Other (specify):_____ 11 |

## SECTION 3: GENERAL

I'd like to ask you a few questions about the facility's overall capacity and infrastructure.

| No. | Item | Response | Remarks |
|---|---|---|---|
| 2 | How many obstetric wards / units are there in the institution? *(write number)* | \|___\|___\| | |
| 3 | How many labour rooms are available at the institution? | One for the institution……...1<br>One for each unit ……2<br>Two for each unit ……3<br>Other _____ 4 | *(write number)*<br>\|___\|___\| |
| 4 | How many beds are available for patients in this facility (total in all departments)? *(write number)* | \|___\|___\|___\|___\| | |
| 5 | How many of the total number of beds are dedicated exclusively to obstetric patients?*(write number)* | Total: \|___\|___\|___\|<br>Antenatal side: \|___\|___\|___\|<br>Postnatal side: \|___\|___\|___\| | |
| 6 | How many deliveries were performed by the institution for 2010 | \|___\|___\|___\|___\| | |
| 7 | Do you have a Neonatal Intensive Care Unit (NICU) in the facility? | Yes …….. 1<br>No ……...…. 0 | If 'Yes' please fill part C |
| 8 | Do you have a Special Care Baby Unit (SCBU) in the facility? | Yes …….. 1<br>No ……...…. 0 | If 'Yes' please fill part C |
| 9 | Do you have a Mother Baby Center (MBC) in the facility? | Yes …….. 1<br>No ……...…. 0 | If 'Yes' please fill part C |
| 10 | Do you have a Lactation Management Center (LMC) in the facility? | Yes …….. 1<br>No ……...…. 0 | If 'Yes' please fill part C |
| 11 | Does this facility have electricity?<br>*(If irregular, circle 1 for "yes")* | Yes …….. 1<br>No ……...…. 0 | If 'NO', skip to 20 |
| 12 | What is the primary source of electricity? *(circle one)* | Power lines (grid) …… 1<br>Generator …… 2<br>Other (specify) ……..... 3<br>_____ | |

| No. | Item | Response | Remarks |
|---|---|---|---|
| 13 | Is the electricity functioning (at the moment of this interview)? | Yes …….. 1<br>No ……...…. 0 | |
| 14 | In the last month, how many days were you without electricity?*(write number)* | \|___\|___\| | |
| 15 | Is there a functioning back-up generator available with continuous fuel supply? | Yes …….. 1<br>No ……...…. 0 | If 'NO', skip to 20 |
| 16 | How does the generator switch on? | Auto …… 1<br>Manually ……. 0 | If 'Manually' skip to 18 |
| 17 | On the last instance there was a power failure did the generator switch on automatically? | Yes …….. 1<br>No ……...…. 0 | Skip to 20 |
| 18 | Do you have a dedicated staff to switch on the generator in an event of emergency? | Yes …….. 1<br>No ……...…. 0 | |
| 19 | Is there a separate generator for the units? | Yes …….. 1<br>No ……...…. 0 | |
| 20 | What is the primary source of water?<br>*(circle one)* | Piped water …….. 1<br>Hand pump …….. 2<br>Well …… 3<br>River ……... 4<br>Other (specify) …… 5<br>_____ | |
| 21 | Does this facility have sufficient water for functions such as infection prevention (hand washing, cleaning equipment and environment), patient and staff use, etc.? | Yes …….. 1<br>No ……...…. 0 | |
| 22 | Are you regularly carrying out water testing in your institution? | Yes …….. 1<br>No ……...…. 0 | |
| 23 | Is there a water supply at the time of the interview? – (to be observed) | Yes …….. 1<br>No ……...…. 0 | |
| 24 | Do you have a continuous supply of water? (24/7) | Yes …….. 1<br>No ……...…. 0 | |
| 25 | In the last month, how many days were you without water? | \|___\|___\| | |

| No. | Item | Response | | Remarks |
|---|---|---|---|---|
| 26 | We'd like to know about some of the basic services provided at this facility. Some services we ask about in greater detail in other questionnaires. But there are some services that we do not ask about elsewhere. Does the facility provide:<br>*(read each item)* | | | |
| | | Yes | No | |
| | a. Antenatal care | 1 | 0 | |
| | b. Postnatal care | 1 | 0 | |
| | c. Treatment or repair of obstetric fistula | 1 | 0 | |
| | d. Cervical screening (pap smear) | 1 | 0 | |
| | e. Testing and treatment for sexually transmitted infections (STI) | 1 | 0 | |
| | f. Family Planning Clinic | 1 | 0 | |
| | g. Well Baby Clinic | 1 | 0 | |
| | h. Organized health promotion activities | 1 | 0 | |
| | i. Health Education unit | 1 | 0 | |
| | j. Infection Control Unit | 1 | 0 | |
| | k. Blood transfusion service | 1 | 0 | |
| | l. laboratory | 1 | 0 | |
| 27 | Does the facility carry out maternal death audits or case reviews on a routine basis? | Yes ..... 1<br>No .....0<br>Never had a death .....9 | | |

## SECTION 4: TRANSPORTATION AND COMMUNICATION

The next few questions I'd like to ask you in relation to communication and transportation to facilitate referral.

### Communications to facilitate referral

| No. | Item | Response | Remarks |
|---|---|---|---|
| 28 | Do you have land phones at the facility? | Yes …….. 1<br>No ……...… 0 | If 'No' skip to 31 |
| 29 | Is it available 24/7? | Yes …….. 1<br>No ……...… 0 | |
| 30 | Do you have direct dialing facility in separate units? | Yes …….. 1<br>No ……...… 0 | |
| 31 | Do you get cell phone signal at this facility? | Yes …….. 1<br>No ……...… 0 | If 'NO' skip to 34 |
| 32 | Do people use private cell phones to contact persons in this facility? | Yes …….. 1<br>No ……...… 0 | |
| 33 | Is it a policy in this facility to reimburse staff who uses their cell phones for work-related calls? | Yes …….. 1<br>No ……...… 0 | |

Now I'm going to ask you about the modes of transportation available for emergency referral. Please indicate the number available in each of the categories. If it is '0' skip to 54. If there is an ambulance please complete part E.

### Transport

| No. | Item | Available and functional | Available but not functional | Total No. available |
|---|---|---|---|---|
| 34 | Ambulance facility | \|___\|___\| | \|___\|___\| | \|___\|___\| |
| 35 | Motor vehicle | \|___\|___\| | \|___\|___\| | \|___\|___\| |
| 36 | Other (please specify): _____ | \|___\|___\| | \|___\|___\| | \|___\|___\| |

| No. | Item | Response | Remarks |
|---|---|---|---|
| 37 | Is there an available source of maintenance / repair for vehicles when necessary? | Yes …….. 1<br>No ……...…. 0 | |
| 38 | Are there funds available **today** for maintenance or repair if they were needed? | Yes …….. 1<br>No ……...…. 0 | |
| 39 | Is sufficient fuel available **today** to transport women and newborns if needed to the next station? | Yes …….. 1<br>No ……...…. 0 | |
| 40 | Are there adequate number of ambulance drivers to provide 24/7 cover? | Yes …….. 1<br>No ……...…. 0 | |
| 41 | During the past 3 months was there a day / days when no driver was available? | Yes …….. 1<br>No ……...…. 0 | |
| 42 | Do you get a replacement vehicle when the ambulance is under repair? | Yes …….. 1<br>No ……...…. 0 | If NO, skip to 45 |
| 43 | Is it full time or as when a transfer has to be done? | Full time ……. 1<br>When required …… 0 | |
| 44 | If when required how long does it take on average to reach the institution once requested? | _____ minutes | |
| 45 | Within the last 3 months was the facility without an ambulance in **working condition** at any time? | Yes …….. 1<br>No ……...…. 0 | If NO, skip to 51 |
| 46 | If so when? *(Write the date)* | _____ | |
| 47 | If so for how long? *(Write the duration)* | _____ | |
| 48 | If so why? *(Write the reason)* | _____<br>_____ | |
| 49 | What arrangements were available at that time (When the ambulance was not available)? | _____<br>_____ | |

| No. | Item | Response | Remarks |
|---|---|---|---|
| 50 | How many times was an ambulance needed for obstetric emergencies during this time? *(Write no from Records)* | \|___\|___\| | |
| 51 | How many times was an ambulance needed for neonatal emergencies during this time? *(Write no from Records)* | \|___\|___\| | |
| 52 | Is it hospital policy to reimburse money used for transporting patients in the event private transport has to be used? | Yes …….. 1<br>No ……...…. 0 | If NO, skip to 54 |
| 53 | Is there a dedicated fund line available for such reimbursement? | Yes …….. 1<br>No ……...…. 0 | |
| 54 | On average how long does it take for the reimbursement? *(Write duration)* | \|___\|___\| *days* | |

**General referral**

| No. | Item | Response | Remarks |
|---|---|---|---|
| 55 | Do you have a practice of verifying service availability at the receiving station before transfer? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | |
| 56 | Do you have a practice of informing receiving station / institution before transfer? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | If 'No' skip to 58 |
| 57 | Who is the responsible person in this institution delegated the responsibility of informing? | Doctor …….. 1<br>Nurse …… 2<br>Other _____ 9 | |
| 58 | Does this facility have an identified/agreed policy on transfer plans/protocols? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | If 'No' skip to 60 |
| 59 | If 'Yes' what is it? | _____<br>_____ | |

| No. | Item | Response | Remarks |
|---|---|---|---|
| 60 | What is the nearest next level hospital? | _____<br>_____ | |
| 61 | How long does it take to get to that nearest next level hospital?<br>*(Record time in minutes)* | \|___\|___\|___\| minutes | |
| 62 | Do you have an identified referral hospital with specialized obstetric care? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | If 'No' skip to 65 |
| 63 | What is the name of that hospital? | _____<br>_____ | |
| 64 | How long does it take to get to the identified referral hospital with specialized obstetric care?<br>*(Record time in minutes)* | \|___\|___\|___\| minutes | |
| 65 | Do you have an identified referral hospital with specialized neonatal care? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | If 'No' skip to 67 |
| 66 | What is the name of that hospital? | _____<br>_____ | |
| 67 | If the patient needs ICU care, what is your closest institution with ICU care? | _____<br>_____ | |
| 68 | How long does it take to reach there?<br>*(Record time in minutes)* | \|___\|___\|___\| minutes | |
| 69 | Do you have an identified referral hospital with ventilator care for newborns? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | If 'No' skip to 72 |
| 70 | How long does it take to get to the identified referral hospital with ventilator care for newborns?<br>*(Record time in minutes)* | \|___\|___\|___\| minutes | |

| No. | Item | Response | Remarks |
|---|---|---|---|
| 71 | What is the name of the identified referral hospital with ventilator care for newborns? | _____<br>_____ | |
| 72 | If a neonate needs ICU care, what is your closest institution with ICU care? | _____<br>_____ | |
| 73 | How long does it take to reach there?<br>*(Record time in minutes)* | \|___\|___\|___\| minutes | |
| 74 | Do you have a practice of sending an appropriate staff member with every transfer referral? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | |
| 75 | In the past 3 months have you refused an admission to your hospital? | Yes (after stabilizing) 1<br>Yes (without stabilizing) 2<br>No 0<br>Not applicable. …….. 9 | |
| 76 | In the past 3 months have you refused an admission transferred to your hospital? | Yes ……... 1<br>No …… 0<br>Not applicable …….. 9 | |
| 77 | What is the reason for that? | No doctor …… …… 1<br>No staff ……... 2<br>No facilities …… 3<br>Other _____ 4 | |
| 78 | What is the policy for an emergency transfer | Ask the patient to go by himself …… 1<br>Transfer by the hospital ….. 2 | |

| Comments |
|---|
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