

**AFRICAN POPULATION AND HEALTH RESEARCH CENTRE - PARTNERSHIP FOR A HEALTHY NAIROBI
SERVICE PROVISION ASSESSMENT STUDY - Midwives/Nurses Tool**

SECTION 1. INTRODUCTION AND CONSENT

INTERVIEWER'S CODE

001 RESPONDENT'S FULL NAME _____

002 DATE OF BIRTH (MM/YYYY)

003 SEX (*Observe and fill in the box appropriately*) **F=Female, M=Male**

004 DATE INTERVIEW COMPLETED (DD/MM/YYYY)

Hello. My name is _____. I am here on behalf of the Partnership for a Healthy Nairobi - which is a joint initiative between the African Population & Health Research Centre, the Ministry of Health, City Council of Nairobi, Population Council, AMREF Kenya and Jhpiego. We are conducting a study to assist the government in knowing more about health services that are used by people in this community. I will be asking you questions about your past and present work. The information that you provide will be used by the Partnership for a Healthy Nairobi to understand the availability of resources for health in this community. Your name will not appear in any reports that are published. However your name and contact details will be kept in a confidential database at APHRC for use in future in case we need to contact you. You may refuse to answer any question you choose to or choose to stop the interview at any time. Have you understood? Do you have any questions? Do I have your permission to proceed?

005 RESPONDENT AGREES TO BE INTERVIEWED..... 1
RESPONDENT REFUSES TO BE INTERVIEWED 2 → **FILL QN 008, THANK THE RESPONDENT & END THE INTERVIEW**

RESPONDENT'S SIGNATURE (Put date if respondent refuses to sign)

006 RESPONDENT SIGNS..... 01 007 START TIME (24 HOUR)
RESPONDENT REFUSES TO SIGN.....02

008 RESULT CODES:
1 =COMPLETED '2 : RESPONDENT NOT AVAILABLE 3 =PARTIALLY COMPLETED
4 = REFUSED 5 =OTHER _____

009 EDITED BY TL(CODE): DATE
D D M M Y Y Y Y

TL SIGNATURE:

RESPONDENT'S DETAILS

101 SUB-LOCATION WHERE RESPONDENT RESIDES _____

102 VILLAGE OF RESIDENCE _____

103 Tel No.
IF NONE/REFUSED RECORD 9999999999

104 EMAIL ADDRESS (BLOCK LETTERS) _____
IF NO EMAIL ADDRESS, RECORD "NONE"

- 105** What is your level of training? (Probe to inquire the formal trainings that the respondent has done)
- Enrolled Nurse 01
 - Enrolled Midwife 02
 - Enrolled Community Nurse..... 03
 - CIRCLE** Enrolled Community Midwife..... 04
 - ALL THAT** Clinical Officer 05
 - APPLY** Registered Nurse 06
 - Registered Midwife 07
 - Registered Nurse Midwife 08
 - Registered community health nurse 09
 - Registered community Midwife 10
 - CHW'S (includes TBAs) 11
 - OTHER (specify) _____

- 106** Are you:
- Retired 01
 - Resigned 02
 - Never employer 03
 - Soon-to-retire (within one year) 04
 - Licensed private practitioner 05
 - OTHER (Specify) _____ 06

- 107** Are you currently
- Practicing in a private facility..... 01
 - Practicing self-employed..... 02
 - Non-practicing and unemployed... 03
 - Non-practicing but employed elsewhere 04

FW: IF CHW'S THANK THE RESPONDENT AND END THE INTERVIEW

What is the latest qualification?

108 When did you qualify as _____ (Training in Qn. 105) ? (MM/YYYY)

109 FW: CHECK 106, IF ANSWER IS 04 OR 05, SKIP TO 110, ELSE ASK:

When did you retire/resign from the Public Service? (MM/YYYY)

110 Have you ever worked in maternity unit post registration/enrollment? Yes..... 1
 No..... 2 → **112**

111 For how long after registration did you work in a maternity unit - taking all periods together?
1= Never worked in maternity 2=Less than six months 3= 6 to 12 months 4= More than 12 months

112 Do you hold a current practice licence? Yes..... **(FW: ASK TO SEE LICENCE)** Licence seen..... 1
 No..... → **113** No license seen..... 2

113 Are you currently linked to any health facility? Yes..... 1
 No..... 2 → **115**

114 To which health facility are you linked? **(FW: WRITE IN BLOCK LETTERS)**

115 How far is it from your residence to the nearest health facility? 5 KMS OR LESS..... 01
 5 - 10 KMS 02
 MORE THAN 10 KMS 03
 DON'T KNOW/NOT SURE 09
(Try to get an estimate if respondent does not know distance in actual kms)

116 What health services do you offer in this community? **CIRCLE ALL THAT APPLY, PROBE; ANY OTHER?**

ANTENATAL SERVICES A
 DELIVERY SERVICES IN THE CLINIC B
 DELIVERY SERVICES AT HOME C
 MATERNAL/CHILD HEALTH D
 FAMILY PLANNING E
 POSTNATAL SERVICES F
 OTHER REPRODUCTIVE HEALTH SERVICES G
 CURATIVE SERVICES FOR ADULTS AND OLDER CHILDREN H
 CURATIVE SERVICES FOR CHILDREN UNDER 5YRS I
 OTHER(SPECIFY) _____ J
 NONE K → **201**

117 Which services do community members mostly seek from you?

ANTENATAL SERVICES A
 DELIVERY SERVICES IN THE CLINIC B
 DELIVERY SERVICES AT HOME C
 MATERNAL/CHILD HEALTH D
 FAMILY PLANNING E
 POSTNATAL SERVICES F
 OTHER REPRODUCTIVE HEALTH SERVICES G
 CURATIVE SERVICES FOR ADULTS AND OLDER CHILDREN H
 CURATIVE SERVICES FOR CHILDREN UNDER 5YRS I
 OTHER(SPECIFY) _____ J
 NONE K

CIRCLE ALL THAT APPLY

118 How many clients do you serve in a month? (For ALL the services that you offer)

Less than 10 01
 10 to 50 02
 51 to 100 03
 Over 100 04
 DK/DON'T KEEP RECORDS 09

SECTION 2 - WILLINGNESS TO PARTICIPATE IN PHN ACTIVITIES

201 Have you ever heard of service guidelines? Yes.....1
 No.....2 → Go to 203

202 When was the last time you had training in any service guidelines?
 (DD/MM/YYYY) **IF NEVER, RECORD 99999999 AND SKIP TO 203**
 (Service guidelines include IMCI, EMOC, FANC, infection control etc...)

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203 Would you like to attend any training in service guidelines? Yes..... 1
 No..... 2

204 Would you like to attend training for any of the following ?

	YES	NO	ALREADY TRAINED
01 Integrated management of childhood illness (IMCI)?	1	2	9
02 Adolescent sexual and reproductive health (ASRH)?	1	2	9
03 Delivery care ('safe motherhood'/life saving skills)?	1	2	9
04 Integrated management of adult illness (IMAI)?	1	2	9
05 Family planning?	1	2	9
06 Diagnosis and treatment (management) of STIs?	1	2	9

	YES	NO	ALREADY TRAINED	
07 Diagnosis and treatment (management) of malaria?	1	2	9	
08 Diagnosis and treatment (management) of tuberculosis?	1	2	9	
09 Management of MultiDrug-Resistant TB (MDR-TB)?	1	2	9	
10 HIV/AIDS opportunistic infection treatment and care?	1	2	9	
11 HIV/AIDS counselling and testing?	1	2	9	
12 HIV/AIDS counselling only ?	1	2	9	
13 HIV testing including HIV rapid testing?	1	2	9	
14 Prevention of mother to child transmission (PMTCT)?	1	2	9	
15 Infection control/standard precautions for handling blood and other bodily fluids?	1	2	9	
16 Management of TB/HIV co-infection?	1	2	9	
17 Drug and supplies management?	1	2	9	
18 Health management information system (HMIS) training?	1	2	9	
19 Post-Exposure Prophylaxis (PEP)?	1	2	9	
20 Other guidelines you would like training in: SPECIFY 1 _____	1	2	9	
SPECIFY 2 _____	1	2	9	
SPECIFY 3 _____	1	2	9	
205 Would you be interested/willing to join the PARTNERSHIP FOR A HEALTHY NAIROBI to improve the health services being offered in this community? FW: EXPLAIN WHAT THE PARTNERSHIP FOR A HEALTHY NAIROBI IS ABOUT	Yes.....	1	No.....	2
206 In what ways do you expect to participate in the PHN? FW: DO NOT READ RESPONSES PROBE: HOW ELSE? CIRCLE ALL THAT APPLY	Offering emergency curative services in the community	A	Offering non-emergency curative services in the community	B
	Follow up of patients seen at other health facilities	C	Referral of patients to other health facilities	D
	Conducting home visits	E	Offering emergency obstetric services	F
	Offering preventive services (e.g. ANC, Immunisation, FP)	G	Other (specify) _____	H
	Other (specify) _____	I		
207 In what ways do you expect to benefit by joining the PHN? FW: DO NOT READ RESPONSES PROBE: HOW ELSE? CIRCLE ALL THAT APPLY	Training opportunities	B	Employment opportunities	C
	Networking opportunities	D	Allowances	E
	Support to obtain drugs and supplies from MoH	F	Support to obtain equipment	G
	Financial support	H	Other (specify) _____	I
	Other (specify) _____	J		

208 What is your opinion about Public-Private partnerships where government works with private health service providers and vice versa?

END THE INTERVIEW BY THANKING THE RESPONDENT

SECTION 3 - ENDINGS AND INTERVIEWER'S OBSERVATIONS

301 RECORD THE TIME AT END OF INTERVIEW
(USE THE 24 HOUR-FORMAT)

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302 INTERVIEWER'S OBSERVATIONS - TO BE FILLED IN AFTER COMPLETING THE INTERVIEW

303 COMMENTS ON SPECIFIC QUESTIONS:

304 ANY OTHER COMMENTS:

305 TEAM LEADER'S OBSERVATIONS

NAME OF THE TEAM LEADER: _____

DATE: (DDMMYYYY)

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