

NIGERIAQUAL  
PROGRAM MANAGEMENT AUDIT FORM

A. FACILITY DETAILS	B. LEVEL (CHECK ONE)	OWNERSHIP
1 Review period <input style="width: 50px;" type="text"/> to <input style="width: 50px;" type="text"/>	1 <input type="checkbox"/> Primary health centre	1 <input type="checkbox"/> Public
2 Name of interviewee _____	2 <input type="checkbox"/> Secondary health facility	2 <input type="checkbox"/> Private
3 Designation _____	3 <input type="checkbox"/> Tertiary hospital (FMC)	3 <input type="checkbox"/> Faith-based
4 Implementing partner _____	4 <input type="checkbox"/> Tertiary hospital (Teaching hospital)	
5 Facility name _____		
6 State _____		
7 LGA _____		
8 Name of assessor _____		
9 Date of assessment _____		

C. ORGANIZATIONAL STRUCTURES AND STRATEGIC PLANNING			
1 Does this organization have a mission statement? <i>Yes=[1], No=[0]</i>	2 Does this organization have an organogram? (if yes, please ask to see) <i>Yes=[1], No=[0]</i>	3 Are all key positions in the organizations chart filled by staff? <i>Yes=[1], No=[0]</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4 Is there a presence of documented annual operational plan approved by the board, State or Federal government? <i>Yes=[1], No=[0]</i>	5 Was the annual operational plan available and sighted? <i>Yes=[1], No=[0]</i>	6 Are HIV activities integrated into this plan? <i>Yes=[1], No=[0]</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7 Does the organization regularly evaluate its progress in implementing the annual operational plan? <i>Yes=[1], No=[0]</i>	8 How many activities were planned in the last 6 months? <i>score : 1 point</i>	9 How many of these activities were implemented? <i>score=activities implemented/activities planned (maximum score=1)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	

D. STAFFING AND PERSONNEL			
1 Are continuous professional training and education for staff adequately supported? <i>Yes=[1], No=[0]</i>	2 What is the total number of full-time staff in your organization? <i>score: 1 point</i>	3 What is the number of full-time staff who have received training in the past one year? <i>score= staff with training/total number of staff (maximum score =1)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	

**E. DATA MANAGEMENT AND SECURITY**

1 Are data on organization outcomes routinely collected and used to monitor the quality of service delivery?  Yes  No

*Yes={1}, No={0}*

2 Is there a dedicated department or person responsible for management information systems?  Yes  No

*Yes={1}, No={0}*

3 Does your organization have automated systems to capture patient health information data?  Yes  No

*Yes={1}, No={0}*

4 Does your organization use the HMIS forms?  Yes  No

*Yes={1}, No={0}*

5 How many HMIS forms have been completed in the last 6 months?

*( total number of HMIS forms completed in the last 6 months /6, max. score: 1 point)*

6 What are the dates of submission for the last 3 reports?

*[score: 1 point each for report (s) submitted on time, 0 for report(s) not submitted on time]*

7 Are there adequate processes in place to protect organization information? (clinical, financial and administrative)  Yes  No

*Yes={1}, No={0}*

8 Is there dependable power to ensure system security options are continually operable?  Yes  No

*Yes={1}, No={0}*

9 Is there reliable internet access and system security to transmit data reports?  Yes  No

*Yes={1}, No={0}*