FORMATTING DATE: 20 Apr 2022
ENGLISH LANGUAGE: 20 Apr 2022

THE DHS PROGRAM

SERVICE PROVISION ASSESSMENT SURVEY

[COUNTRY AND YEAR]

INVENTORY QUESTIONNAIRE

FACILITY IDENTIFICATION

001 NAME OF FACILITY _____

002 LOCATION OF FACILITY (TOWN/CITY/VILLAGE) _____

003 REGION . . . . . [ ][ ]

004 DISTRICT . . . . . [ ][ ][ ]

005 FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

006 TYPE OF FACILITY (COUNTRY SPECIFIC)

- FACILITY TYPE 1 1
- FACILITY TYPE 2 2
- FACILITY TYPE 3 3
- FACILITY TYPE 4 4
- FACILITY TYPE 5 5
- FACILITY TYPE 6 6
- FACILITY TYPE 7 7
- FACILITY TYPE 8 8
- FACILITY TYPE 9 9

007 MANAGING AUTHORITY (OWNERSHIP)

- GOVERNMENT/PUBLIC 1
- NGO/PRIVATE NOT-FOR-PROFIT 2
- PRIVATE-FOR-PROFIT 3
- MISSION/FAITH-BASED 4

008 URBAN/RURAL

- URBAN 1
- RURAL 2

009 INPATIENT AND OUTPATIENT SERVICE PROVISION

- BOTH INPATIENT AND OUTPATIENT 1
- ONLY INPATIENT 2
- ONLY OUTPATIENT 3

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY [ ][ ]
				MONTH [ ][ ]
				YEAR [ ][ ][ ][ ]
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER [ ][ ][ ][ ]
RESULT	_____	_____	_____	RESULT [ ][ ]

RESULT CODES (LAST VISIT):

1 = FACILITY COMPLETED
2 = FACILITY RESPONDENTS NOT AVAILABLE
3 = POSTPONED / PARTIALLY COMPLETED
4 = FACILITY REFUSED
5 = FACILITY CLOSED / NOT YET FUNCTIONAL
6 = OTHER (SPECIFY) _____

TOTAL NUMBER OF PROVIDER INTERVIEWS AND OBSERVATIONS

		TOTAL # CLIENT VISITS
TOTAL NUMBER OF PROVIDERS INTERVIEWED		
TOTAL NUMBER OF ANC OBSERVATIONS		
TOTAL NUMBER OF FAMILY PLANNING OBSERVATIONS		
TOTAL NUMBER OF SICK CHILD OBSERVATIONS		
TOTAL NUMBER OF PROVIDERS FOR NEONATAL RESUSCITATION		

FACILITY GEOGRAPHIC COORDINATES

010	WAYPOINT NAME (FACILITY NUMBER)	WAYPOINT
011	ELEVATION	ELEVATION
012	LATITUDE	N/S a DEGREES/DECI b c
013	LONGITUDE	E/W a DEGREES/DECI b c
014	ACCURACY	ACCURACY

LANGUAGE OF QUESTIONNAIRE** 0 1 | LANGUAGE OF INTERVIEW** | NATIVE LANGUAGE OF RESPONDENT** | TRANSLATOR USED (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:

01 ENGLISH	03 LANGUAGE 3	05 LANGUAGE 5
02 LANGUAGE 2	04 LANGUAGE 4	06 LANGUAGE 6

TEAM	TEAM SUPERVISOR	
NUMBER	NAME NUMBER	

CONSENT

FIND THE MANAGER, THE PERSON IN-CHARGE OF THE FACILITY, OR THE MOST SENIOR HEALTH WORKER RESPONSIBLE FOR CLIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:

Hello. My name is _____. I am working with [NAME OF ORGANIZATION] in collaboration with the Ministry of Health conducting a survey of health facilities all over [NAME OF COUNTRY]. The information we collect will help the government with planning and finding ways to improve the delivery of services.

Your facility was selected for the survey. I would like to ask you questions about various health services. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information. We anticipate that the time required from an individual respondent to complete data collection from a service site may take from 5 to 10 minutes, depending on how busy each separate site is.

The information acquired during this survey may be used by the Ministry of Health or other organizations to improve services, or for research on health services. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. Neither your name nor the names of any other health workers who participate in this study will be included in the dataset or in any report; however, there is a small chance the facility can be identified. Still, we are asking for your help in order to collect this information.

Participation in the survey is voluntary, you may refuse to answer any question or choose to stop the interview at any time. There is no penalty for refusing to participate, however, your experience and views are important, and we hope you will agree to participate in the survey and answer the questions, which will benefit the services you provide and the nation. In case you need more information about the survey, you may contact the person listed on this card.

GIVE CARD WITH CONTACT INFORMATION

Do you have any questions? May I begin the interview now?

INTERVIEWER'S SIGNATURE

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 2 | |

	RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 ↓	RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 → END
100	RECORD THE TIME THE INTERVIEW STARTED USE 24 HOURS FORMAT	HOURS . . . . . | | MINUTES . . . . . | |

EXPLAIN TO THE RESPONDENT AT THE START OF THIS INTERVIEW THAT THERE ARE QUESTIONS ON MANAGEMENT MEETINGS AND QUALITY MANAGEMENT ACTIVITIES THAT REQUIRE LOOKING AT RECORDS OF THOSE MEETINGS AND ACTIVITIES. IT WILL THEREFORE BE HELPFUL IF RECORDS PERTAINING TO MANAGEMENT MEETINGS AND QUALITY MANAGEMENT ACTIVITIES ARE GATHERED, IF THEY ARE NOT READILY AVAILABLE AT THE LOCATION WHERE YOU ARE CONDUCTING THE INTERVIEW.

EXPLAIN ALSO THAT THERE IS A SUBSECTION ON HEALTH STATISTICS (NUMBER OF OUTPATIENT VISITS AND INPATIENT DISCHARGES) FOR THE IMMEDIATE PAST ONE COMPLETE MONTH. IT WILL BE HELPFUL TO ALSO START GATHERING SUCH INFORMATION IF INFORMATION IS NOT READILY AVAILABLE WHERE THE INTERVIEW IS BEING CONDUCTED.

NOTE!!!!

THANK THE RESPONDENT AT THE END OF EACH SECTION OR SUBSECTION BEFORE PROCEDING TO THE NEXT DATA COLLECTION POINT

102	Does this facility offer any of the following client services? In other words, is there any location in this facility where clients can receive any of the following services:	YES	NO	DONE
01	Child vaccination services, either at the facility or as outreach.	1	2	☐
02	Growth monitoring services, either at the facility or as outreach	1	2	☐
03	Curative care services for children under age 5, either at the facility or as outreach	1	2	☐
04	Any family planning services-- including modern methods, fertility awareness methods (natural family planning), male or female surgical sterilization	1	2	☐ ☐
05	Antenatal care (ANC) services	1	2	☐
06	Services for the prevention of mother-to-child transmission of HIV, either with ANC or delivery services	1	2	☐
07	Normal delivery	1	2	☐
08	Care and/or referral services for victims of gender-based violence (GBV)	1	2	☐
09	Post abortion care (PAC) services	1	2	☐
10	Diagnosis or treatment of malaria	1	2	☐
11	Diagnosis or treatment of STIs, excluding HIV	1	2	☐
12	Diagnosis, treatment prescription or treatment follow-up for TB	1	2	☐
13	HIV testing and counseling services	1	2	☐
14	HIV/AIDS antiretroviral prescription or antiretroviral treatment follow-up services	1	2	☐
15	HIV/AIDS care and treatment services, including treatment of opportunistic infections and provision of palliative care	1	2	☐
16	Diagnosis or management of non-communicable diseases, specifically diabetes, cardiovascular diseases, and chronic respiratory conditions in adults	1	2	☐
17	Screening for breast cancer	1	2	☐
18	Screening for cervical cancer	1	2	☐
19	Minor surgical services, such as incision and drainage of abscesses and suturing of lacerations that do not require the use of a theatre	1	2	
20	Cesarean delivery (Cesarean section)	1	2	☐

21	Laboratory diagnostic services, including any rapid diagnostic testing	1	2	
22	Blood transfusion services	1	2	

INPATIENT SERVICES

110	Does this facility routinely provide in-patient care?	YES . . . . . 1 NO 2	→ 112
111	Does this facility have beds for overnight observation?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION ←	
112	Excluding any delivery and/or maternity beds, how many overnight or in-patient beds in total does this facility have? Please count beds for both adults and children.	# OF OVERNIGHT/ INPATIENT BEDS DON'T KNOW 998	

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

SECTION 2: GENERAL INFORMATION

PROCESSING OF INSTRUMENTS

200	I have a few questions about how surgical instruments, such as speculums, forceps, and other metal equipment are processed for re-use in this facility. Are instruments that are used in the facility processed (i.e., sterilized or high-level disinfected) for re-use?	YES . . . . . 1 NO 2	→ 210
201	Is the final processing done in this facility, outside this facility, or both?	ONLY IN THIS FACILITY . . . . . 1 BOTH IN THIS FACILITY AND OUTSIDE . . . . . 2 ONLY AT AN OUTSIDE FACILITY 3	

STORAGE OF MEDICINES

210	Does this facility store any medicines (including ARVs), vaccines or contraceptive commodities?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION ←	
211	**CHECK Q102.04** FAMILY PLANNING SERVICES AVAILABLE ↓ NO FAMILY PLANNING SERVICES → NEXT SECTION		
212	Are contraceptive commodities generally stored in the family planning service area, or are they stored in a common area with other medicines?	STORED IN FP SERVICE AREA . . . . . 1 STORED WITH OTHER MEDICINES . . 2 FP COMMODITIES NOT STOCKED 3	
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

MODULE 2: GENERAL SERVICE READINESS

SECTION 3: INFRASTRUCTURE

24-HOUR STAFF COVERAGE

300 **(FN1)**	Is there a health care worker present at the facility at all times, or officially on call for the facility at all times (24 hours a day and 7 days per week) for emergencies? Specifically, I am referring to emergency medicine specialists, general medicine specialists, other specialist doctors, nurses, and midwives [ADD COUNTRY SPECIFIC CLINICAL CARE CADRES PROVIDING EMERGENCY SERVICES].	YES . . . . . 1 NO 2	

COMMUNICATION

310	Does this facility have a land line telephone that is available to call outside at all times client services are offered? CLARIFY THAT IF FACILITY OFFERS 24-HOUR EMERGENCY SERVICES, THEN THIS REFERS TO 24-HOUR AVAILABILITY.	YES . . . . . 1 NO 2	→ 312
311	Is it functioning? ACCEPT REPORTED RESPONSE	YES . . . . . 1 NO 2	
312	Does this facility have a cellular telephone or a private cellular phone that is supported by the facility?	YES . . . . . 1 NO 2	→ 314
313	Is it functioning? ACCEPT REPORTED RESPONSE	YES . . . . . 1 NO 2	
314	Is there access to email or internet via computer, mobile phone, or any other device within the facility? ACCEPT REPORTED RESPONSE.	YES . . . . . 1 NO 2	

SOURCE OF WATER

320	What is the most commonly used source of water for the facility at this time?	PIPED INTO FACILITY . . . . . 01 PIPED ONTO FACILITY GROUNDS . . 02 PUBLIC TAP/STANDPIPE . . . . . 03 TUBEWELL/BOREHOLE . . . . . 04 PROTECTED DUG WELL . . . . . 05 UNPROTECTED DUG WELL . . . . . 06 PROTECTED SPRING . . . . . 07 UNPROTECTED SPRING . . . . . 08 RAINWATER . . . . . 09 BOTTLED WATER . . . . . 10 CART W/SMALL TANK/DRUM . . . . . 11 TANKER TRUCK . . . . . 12 SURFACE WATER . . . . . 13 OTHER (SPECIFY) _____ 96 DON'T KNOW . . . . . 98 NO WATER SOURCE 00	→ 322 → 322 → 322 → 322

321	Is the water outlet from this water supply available onsite, within 500 meters, or beyond 500 meters of the facility? REPORTED RESPONSE IS ACCEPTABLE ONSITE MEANS WITHIN THE BUILDING OR FACILITY GROUNDS. THIS QUESTION REFERS TO THE LOCATION FROM WHERE THE WATER IS ACCESSED FOR USE IN THE HEALTH FACILITY (E.G. TAP, BOREHOLE), RATHER THAN THE SOURCE WHERE IT ORIGINATES	ONSITE . . . . . 1 WITHIN 500M OF FACILITY . . . . . 2 BEYOND 500M OF FACILITY 3	
322	Is water available from *that source* at the time of the survey? OBSERVE THAT WATER IS AVAILABLE FROM SOURCE OR IN THE FACILITY ON THE DAY OF THE VISIT. E.G., CHECK THAT TAPS OR HAND PUMPS DELIVER WATER	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

POWER SUPPLY

330	Is this facility connected to the national electricity grid?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
331	Does this facility have other sources of electricity, such as a generator or solar system?	YES. . . . . 1 NO OTHER SOURCE. 2	→ 339
332	What other sources of electricity does this facility have? PROBE FOR ANSWERS AND CIRCLE ALL THAT APPLY	FUEL-OPERATED GENERATOR . . . . . A BATTERY-OPERATED GENERATOR . . B SOLAR SYSTEM . . . . . C OTHER X	
333	**CHECK Q332** GENERATOR USED (EITHER "A" OR "B" CIRCLED) ↓ GENERATOR NOT USED (NEITHER "A" NOR "B" CIRCLED) → 336		
334	Is the generator functional? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 336
335	Is fuel (or a charged battery) available today for the generator? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
336	**CHECK Q332** SOLAR SYSTEM USED ("C" CIRCLED) ↓ SOLAR SYSTEM NOT USED ("C" NOT CIRCLED) → 339		

337	Is the solar system functional? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 340
338	Is there charged battery storage today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 340
339	**CHECK Q330 AND Q331** FACILITY HAS ANY POWER SOURCE ("1" CIRCLED IN EITHER Q330 OR Q331) ↓ FACILITY HAS NO POWER SOURCE ("1" NOT CIRCLED IN EITHER Q330 OR Q331) → NEXT SECTION		
340	During the past 7 days, was electricity (excluding any back-up generator) available during the times when the facility was open for services, or was it ever interrupted for more than 2 hours at a time? CONSIDER ELECTRICITY TO BE ALWAYS AVAILABLE IF INTERRUPTED FOR LESS THAN 2 HOURS AT A TIME.	ALWAYS AVAILABLE . . . . . 1 SOMETIMES INTERRUPTED . . . . . 2 DON'T KNOW 8	
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

SECTION 3: INFRASTRUCTURE: FOOTNOTES

(FN1) Add country specific clinical care cadres providing emergency services.

SECTION 4: MANAGEMENT

STAFFING

400 (FN1)

Please tell me how many staff in each of the following occupational categories are currently assigned to, employed by, or seconded to this facility. I am interested in the highest occupational category (such as nurse or doctor) regardless of the person's actual assignments or duties.

For doctors, I would like to know how many are part-time. For other occupational categories, I would like to know only the total number, regardless of whether they are full-time or part-time.

	OCCUPATIONAL CATEGORIES (COUNTRY SPECIFIC)	(A) ASSIGNED, EMPLOYED, OR SECONDED	(B) PART TIME
01	GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS ASK: How many of them are part time?		
02	SPECIALISTS MEDICAL DOCTORS [INCLUDING ANESTHESIOLOGISTS & PATHOLOGISTS] ASK: How many of them are part time?		
03	ASSISTANT MEDICAL OFFICER		
04	CLINICAL OFFICER		
05	ASSISTANT CLINICAL OFFICER		
06	ANESTHETIST		
07	MIDWIVES		
08	REGISTERED NURSE (INCLUDING NURSING OFFICERS)		
09	ENROLLED NURSE (INCLUDING TRAINED NURSES AND PUBLIC HEALTH NURSE)		
10	NURSE ASSISTANT/ATTENDANT		
11	PHARMACIST		
12	PHARMACEUTICAL TECHNICIAN		
13	PHARMACEUTICAL ASSISTANT		

14	LABORATORY SCIENTIST		
15	LABORATORY TECHNOLOGIST		
16	LABORATORY TECHNICIAN		
17	LABORATORY ASSISTANT		
18	NUTRITIONIST		
19	OTHER		
20	SUM THE NUMBER OF STAFF REPORTED. VERIFY AND CORRECT THE TOTALS		

401	**CHECK Q102.07** NORMAL DELIVERY SERVICES AVAILABLE NO NORMAL DELIVERY SERVICES → 410		
402	How many staff in this facility provide normal delivery services?		
403	How many staff in this facility provide newborn care services, that is caring for newborns immediately after birth?		

MANAGEMENT MEETINGS

	NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES LOOKING AT RECORDS OF MEETINGS. IT WILL THEREFORE BE HELPFUL IF SUCH RECORDS ARE GATHERED BEFORE PROCEEDING WITH THE INTERVIEW		
410	Does this facility have routine facility management meetings?	YES . . . . . 1 NO 2	→ 412
411	How frequently do these facility management meetings take place?	MONTHLY OR MORE FREQUENTLY . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS FREQUENT THAN EVERY 6 MO . . 4 DON'T KNOW 8	
412	Are there any routine meetings about facility activities or management issues that include both facility staff and community / community committee members?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 420
413	How frequently are routine meetings held with both facility staff and community / community committee members?	MONTHLY OR MORE FREQUENTL` . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS FREQUENT THAN EVERY 6 MO . . 4 DON'T KNOW 8	→ 420
414	Is an official record of the meetings with both facility staff and community members maintained?	YES . . . . . 1 NO, RECORDS NOT MAINTAINED . . . 2	→ 420

415	May I see the records or minutes from the most recent meeting that took place within the last 6 months?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

CLIENT OPINION AND FEEDBACK

420	Does this facility have any system to solicit clients' opinions about the health facility or its services?	YES . . . . . 1 NO 2	→ 430
421	Please tell me all the methods that this facility uses to solicit client opinion. DO NOT READ RESPONSE OPTIONS CIRCLE ALL METHODS MENTIONED AND PROBE. ASK: Any more?	SUGGESTION BOX . . . . . A CLIENT SURVEY FORM . . . . . B CLIENT INTERVIEW FORM . . . . . C OFFICIAL MEETING WITH COMMUNITY LEADERS . . . . . D INFORMAL DISCUSSION WITH CLIENTS OR THE COMMUNITY . . . E EMAIL FROM CLIENTS/COMMUNITY F FACILITY'S WEBSITE . . . . . G LETTERS FROM CLIENTS/ COMMUNITY . . . . . H OTHER_____ X DON'T KNOW . . . . . Z	→ 430
422	Is there a procedure for reviewing or reporting on clients' opinion?	YES . . . . . 1 NO PROCEDURE . . . . . 2 DON'T KNOW 8	→ 430
423	May I see a report on the review of client opinion, or any document on such a review?	OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 REPORTS NEVER COMPILED 3	

QUALITY MANAGEMENT

	NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES LOOKING AT RECORDS OF QUALITY MANAGEMENT ACTIVITIES. IT WILL THEREFORE BE HELPFUL IF SUCH RECORDS ARE GATHERED BEFORE PROCEEDING WITH THE INTERVIEW.		
430	Does this facility have Quality Improvement team(s) responsible for quality management in this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
431	Does this facility routinely carry out quality management activities? An example may be facility-wide review of mortality, or periodic audit of registers.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 440
432	Is there an official record of any quality management activities carried out during the past year?	YES . . . . . 1 NO, RECORDS NOT MAINTAINED . . . 2	→ 434
433	May I see a record of any quality management activity? A REPORT OR MINUTES OF A QUALITY MANAGEMENT MEETING, A SUPERVISORY CHECKLIST, A MORTALITY REVIEW, AN AUDIT OF RECORDS OR REGISTERS ARE ALL ACCEPTABLE. CHECK DATE OF THE LATEST MEETING, REVIEW, AUDIT, OR OTHER ACTIVITY.	OBSERVED, LATEST MEETING WITHIN THE PREVIOUS YEAR . . . 1 OBSERVED, LATEST MEETING BEFORE THE PREVIOUS YEAR . 2 REPORTED, NOT SEEN 3	

434	**CHECK Q102.03** CURATIVE CARE SERVICES AVAILABLE NO CURATIVE CARE SERVICES → 440		
435	Does this facility routinely carry out quality management activities, specifically for curative services for children? An example may be facility-wide review of pediatric mortality, or periodic audit of pediatric registers.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW . . . . . 8 → 440	
436	When was the last time this facility conducted quality management activities, specifically for curative services for children? Was it within the past 6 months or more than 6 months ago?	WITHIN THE PAST 6 MONTHS . . . . . 1 MORE THAN 6 MONTHS AGO 2	

EXTERNAL SUPERVISION

440	Does this facility receive any external supervision, e.g., from the district, regional, zonal or national office?	YES . . . . . 1 NO . . . . . 2 → 450	
441	When was the last time a supervisor from outside this facility came here on a supervisory visit? Was it within the past 6 months or more than 6 months ago?	WITHIN THE PAST 6 MONTHS . . . . . 1 MORE THAN 6 MONTHS AGO . . . . . 2 → 450	

442	The last time during the past 6 months that a supervisor from outside the facility visited, did he or she do any of the following:	YES	NO	DON'T KNOW	
01	Use a checklist to assess the quality of available health services data	1	2	8	
02	Discuss health workers' clinical skills based on available health services data	1	2	8	
03	Discuss health workers' interpersonal skills	1	2	8	
04	Help the facility make any decisions based on available health services data	1	2	8	

HMIS

	FIND THE PERSON RESPONSIBLE FOR HEALTH INFORMATION SYSTEMS. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH QUESTIONS IN THIS SUBSECTION		
450	Does this facility have a system in place to regularly collect health services data?	YES . . . . . 1 NO 2	
451	Does this facility regularly compile any reports containing health services information?	YES . . . . . 1 NO . . . . . 2 → 454	
452	How frequently are these reports compiled?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MO . . . 4	
453	May I see a copy of the most recent report?	RECORD OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

454	Does this facility have a designated person, such as a data manager, who is responsible for health services data collection and management in this facility?	YES . . . . . 1 NO DEDICATED PERSON 2	
455	Does this facility have a designated person, such as a data manager, who is responsible for surveillance of any infectious diseases?	YES . . . . . 1 NO DEDICATED PERSON 2	
456	**CHECK Q102.07** NORMAL DELIVERY SERVICES AVAILABLE ☐ ↓	NO NORMAL DELIVERY SERVICES AVAILABLE ☐ →	460
457	Does this facility have standard operating procedures for registration or notification of neonatal deaths and stillbirths?	YES, BOTH NEONATAL DEATHS AND STILL BIRHTS . . . . . 1 YES, ONLY NEONATAL DEATHS . . . 2 YES, ONLY STILLBIRHTS . . . . . 3 NEITHER . . 4	

SERVICE STATISTICS

	NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES THAT SOME STATISTICS ARE GATHERED, IF SUCH INFORMATION IS NOT READILY AVAILABLE AT THE LOCATION WHERE THE INTERVIEW IS BEING CONDUCTED.		
460	Now, I would like to ask about service statistics in the last completed calendar month in this facility. The last completed calendar month refers to [MONTH]. IF INTERVIEW DATE IS 15TH OF THE MONTH OR LATER, THE COMPLETED CALENDAR MONTH IS THE PREVIOUS MONTH. IF INTERVIEW DATE IS EARLIER THAN 15TH OF THE MONTH, THE COMPLETE CALENDAR MONTH IS THE MONTH BEFORE THE PREVIOUS MONTH.		
461	How many outpatient client visits were made to this facility in the last completed calendar month [MONTH] for both adults and children?	# OF CLIENT VISITS ☐☐☐☐☐ DON'T KNOW 99998	
462	**CHECK Q102.03** CURATIVE CARE SERVICES FOR CHILDREN UNDER-5 AVAILABLE ☐ ↓	NO CURATIVE CARE SERVICES FOR CHILDREN UNDER-5 AVAILABLE ☐ →	464
463	How many sick-child care visits were made to this facility in the last completed calendar month [MONTH]?	# OF CLIENT VISITS ☐☐☐☐☐ DON'T KNOW 99998	
464	**CHECK Q102.04** FAMILY PLANNING SERVICES AVAILABLE ☐ ↓	NO FAMILY PLANNING SERVICES AVAILABLE ☐ →	466
465	How many family planning client visits were made to this facility in the last completed calendar month [MONTH]?	# OF CLIENT VISITS ☐☐☐☐☐ DON'T KNOW 99998	
466	**CHECK Q102.05** ANTENATAL CARE SERVICES AVAILABLE ☐ ↓	NO ANTENATAL CARE SERVICES AVAILABLE ☐ →	468
467	How many antenatal care client visits were made to this facility in the last completed calendar month [MONTH]?	# OF CLIENT VISITS ☐☐☐☐☐ DON'T KNOW 99998	
468	**CHECK Q102.07** NORMAL DELIVERY SERVICES AVAILABLE ☐ ↓	NO NORMAL DELIVERY SERVICES AVAILABLE ☐ →	480

469	How many deliveries took place at this facility in the last completed calendar month [MONTH]?	# OF DELIVERIES ☐☐☐☐☐ DON'T KNOW 99998	

TRANSPORT FOR EMERGENCIES

480	Does this facility have a functional ambulance or other vehicle for emergency transportation for clients that is stationed at this facility and that operates from this facility? FUNCTIONAL AMBULANCE MEANS THE VEHICLE HAS NO MECHANICAL PROBLEM AND HAS FUEL AVAILABLE.	YES . . . . . 1 NO 2	

EMERGENCY PREPAREDNESS

490	Does this facility have a written plan for natural disaster emergency?	YES . . . . . 1 NO 2	→ 492
491	May I see the plan? AN ACCEPTABLE DOCUMENT MAY INCLUDE ACTIONS PLANS FOR RISK COMMUNICATIONS, MANAGEMENT OF RESOURCES, OR OPERATIONAL PROCEDURES TO MANAGE PATIENTS.	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
492	Does this facility have a written plan for public health emergency?	YES . . . . . 1 NO 2	→ 494
493	May I see the plan? AN ACCEPTABLE DOCUMENT MAY INCLUDE ACTIONS PLANS FOR RISK COMMUNICATIONS, MANAGEMENT OF RESOURCES, OR OPERATIONAL PROCEDURES TO MANAGE PATIENTS.	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
494	In the past 12 months, has this facility conducted any emergency preparedness and response mock drills, simulation exercise, or tabletop exercise for natural disasters or infectious disease outbreaks?	YES . . . . . 1 NO 2	
495	Does this facility have designated site to quarantine patients with suspected contagious disease?	YES . . . . . 1 NO 2	
496	Does this facility have designated site to isolate patients with confirmed contagious disease?	YES . . . . . 1 NO 2	
497	Does this facility have stockpile of essential medicines set aside for any emergency?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION ←	
498	Where does this facility store the stockpile?	MAIN LOCATION WHERE MEDICINES AND OTHER SUPPLIES ARE STORED . 1 NEXT SECTION ← ELSEWHERE ONSITE . . . . . 2 OFFSITE . . . . . 3 NEXT SECTION ←	

499	May I see the stockpile? THE STOCKPILE IS RESERVED EXCLUSIVELY FOR EMERGENCY. INTERVIEWERS DO NOT NEED TO REVIEW ITS CONTENTS.	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

SECTION 4: MANAGEMENT: FOOTNOTES

(FN1) Adapt occupational categories according to the local health system

SECTION 5: GENDER BASED VIOLENCE CARE

500	**CHECK Q102.08** GBV SERVICES AVAILABLE IN FACILITY ☐ GBV SERVICES NOT AVAILABLE IN FACILITY ☐ → NEXT SECTION		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE GENDER BASED VIOLENCE CARE SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT GENDER BASED VIOLENCE CARE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
501	How many days in a week are gender-based violence care services offered at this facility?	NUMBER OF DAYS/WEEK ☐☐	
502	**CHECK Q300** YES, 24-HR STAFF ☐ NO 24-HOUR STAFF ☐ → 504		
503	How many hours a day are gender-based violence care services offered at this facility?	NUMBER OF HOURS/DAY ☐☐	
504	**CHECK Q501 AND Q503** NOT OFFERED FOR 24 HOURS PER DAY AND 7 DAYS PER WEEK ☐ OFFERED FOR 24 HOURS AND 7 DAYS ☐ → 506		
505	Does this facility help patients to access alternative facilities that provide GBV care during off-hours, by giving names and information of specific facilities?	YES . . . . . 1 NO 2	
506 (FN1)	Following questions about providing services to patients who visit this facility for gender based violence care.	YES / NO	
01	Does this facility require GBV patients to report to the police?	1 / 2	
02	Does this facility have medico-legal forms?	1 / 2	
03	Does this facility eliminate fees for the GBV care such as examination or laboratory cost? [PER COUNTRY POLICY]	1 / 2 → 05	
04	Does this facility charge reduced fees for the GBV care? [PER COUNTRY POLICY]	1 / 2	
05	Does this facility maintain patient privacy during triage/intake process?	1 / 2	
06	Does this facility prioritize patients who have experienced sexual assault over other patients to ensure they receive care and support as soon as possible?	1 / 2	
07	Does this facility provide GBV care to all, regardless of their sex, gender identity, sexual orientation, marital status, age, disability, race, ethnicity, and religion?	1 / 2	

507	Following questions are about providing services to patients who visit this facility for reasons other than gender based violence care.	YES	NO	
01	Do providers in this facility ask about intimate-partner violence or sexual violence, if patients present with common signs and symptoms for intimate partner violence or sexual violence?	1	2	
02	Does this facility have guidelines to ask about intimate partner violence or sexual violence?	1	2	
03	Does this facility have a policy to conduct clinical enquiry about intimate partner violence or sexual violence routinely among all patients seeking certain services such as antenatal care and family planning?	1	2 → 509	
508	Following questions are about conducting routine clinical enquiry about GBV.	YES	NO	
01	Does this facility have a protocol to conduct routine clinical enquiry about GBV?	1	2	
02	Does this facility have a questionnaire, with standard questions where providers can document responses?	1	2	
03	Does this facility offer first-line support to victims of GBV? FIRST-LINE SUPPORT IS THE IMMEDIATE CARE GIVEN TO A GBV SURVIVOR UPON FIRST CONTACT WITH THE HEALTH OR CRIMINAL JUSTICE SYSTEM.	1	2	
04	Does the facility ensure private setting and confidentiality when conducting routine enquiry about GBV?	1	2	
05	Does this facility have a system for referrals or linkages to other services for victims of GBV if they are identified from the routine enquiry about GBV?	1	2	
509	Following questions are about training staff for GBV care and screening. In the past 12 months, has this facility provided training or training opportunities elsewhere on the following topics?	YES	NO	
01	How to ask about intimate partner violence or sexual violence, if patient presents with common signs and symptoms for such violence	1	2	
02	How to conduct routine enquiry about gender based violence or GBV	1	2	
	THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

SECTION 5: GENDER BASED VIOLENCE CARE(GBV): FOOTNOTES

(FN1) 506 (03-04) fees should be adapted accoding the country specific GBV policy and guidelines

SECTION 6: INFECTION PREVENTION AND CONTROL

GUIDELINES AND MONITORING

FIND THE PERSON RESPONSIBLE FOR INFECTION PREVENTION AND CONTROL IN THE FACILITY. INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH THE QUESTIONS

600	Does this facility have any programs or systems for infection prevention and control?	YES . . . . . 1 NO 2			
601	Does this facility have any guidelines on infection prevention and control?	YES . . . . . 1 NO GUIDELINE AVAILABLE 2			→ 603
602	I would like to know what IPC topics are covered in the guidelines. May I see the guideline? CHECK EACH OF THE FOLLOWING TOPICS ARE INCLUDED	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	STANDARD PRECAUTIONS	1	2	3	
02	TRANSMISSION BASED PRECAUTIONS	1	2	3	
03	DECONTAMINATION OF MEDICAL DEVICES	1	2	3	
04	HEALTH WORKER PROTECTION	1	2	3	
05	ASEPTIC TECHNIQUE	1	2	3	
06	TRIAGE OF PATIENTS WITH SUSPECTED INFECTION	1	2	3	
603	Does this facility routinely monitor infection prevention and control?	YES . . . . . 1 NO 2			→ 606
604	How often is the monitoring done?	MONTHLY OR MORE FREQUENTLY . . . . . 1 ONCE EVERY 2-3 MONTHS . . . . 2 LESS FREQ. THAN EVERY 3 MONTHS . . . . . 3 DON'T KNOW 8			
605	Are any of the following topics monitored?	YES	NO	DON'T KNOW	
01	Condition and functionality of water, sanitation, and hygiene	1	2	8	
02	Condition and functionality of medical waste management infrastructure	1	2	8	
03	Quality and quantity of available IPC supplies and equipment	1	2	8	
04	Staff compliance with critical IPC practices such as hand hygiene, routine cleaning and disinfection	1	2	8	
606	Does this facility have designated staff for facility cleaning?	YES . . . . . 1 NO 2			→ 610

607	Have the designated staff for cleaning received training for environmental cleaning? Environmental cleaning is cleaning and disinfection of environmental surfaces such as chairs and surfaces of noncritical patient care equipment such as IV poles - when needed, according to risk level.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

PROCESSING OF INSTRUMENTS FOR REUSE

610	**CHECK Q201** EQUIPMENT PROCESSED IN THE FACILITY (1 or 2 CIRCLED) ☐ NO (3 CIRCLED) ☐ → 620	

ASK TO BE SHOWN THE MAIN LOCATION WHERE SURGICAL INSTRUMENTS ARE PROCESSED/STERILIZED IN THE FACILITY FOR REUSE. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROCESSING OF SURGICAL INSTRUMENTS IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND PROCEED.

611 ASK IF EACH OF THE INDICATED ITEMS BELOW IS USED BY THE FACILITY AND AVAILABLE. IF AVAILABLE, ASK TO SEE IT. ASK IF IT IS FUNCTIONING OR NOT.

Do you use [METHOD] in facility?
IF YES, ASK: "May I see it?"
THEN "Is it functioning?"

	ITEM	(A) USE AND AVAILABILITY			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT USED	YES	NO	DON'T KNOW
01	ELECTRIC AUTOCLAVE (PRESSURE & WET HEAT)	1 → B	2 → B	3 → 02	1	2	8
02	NON-ELECTRIC AUTOCLAVE (PRESSURE & WET HEAT)	1 → B	2 → B	3 → 03	1	2	8
03	ELECTRIC DRY HEAT STERILIZER	1 → B	2 → B	3 → 04	1	2	8
04	HEAT SOURCE FOR NON-ELECTRIC EQUIPMENT (STOVE OR COOKER)	1 → B	2 → B	3 → 05	1	2	8
05	ANY CHEMICALS FOR CHEMICAL HLD	1 → B	2 → B	3			

FIND THE PERSON RESPONSIBLE FOR WASTE MANAGEMENT ACTIVITIES IN THE FACILITY. INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH THE QUESTIONS.

620	Now I would like to ask you a few questions about waste management practices for sharps waste, such as needles or blades. How does this facility finally dispose of sharps waste (e.g., filled sharps boxes)? PROBE TO ARRIVE AT CORRECT RESPONSE IF ANY OF THE RESPONSES 02 - 09 TAKE PLACE OUTSIDE THE FACILITY, THEN THE CORRECT RESPONSE TO CIRCLE WILL BE IN THE CATEGORY OF "REMOVE OFFSITE" PREMISES MEANS THE BUILDING OR FACILITY GROUNDS. IF MORE THAN ONE APPLIES, SELECT THE METHOD USED MOST OFTEN.	**BURN IN INCINERATOR:** TWO-CHAMBER INDUSTRIAL (800-1000+°C) . . . . . 02 ONE-CHAMBER DRUM/BRICK . . . . . 03 → 622 **OPEN BURNING** FLAT GROUND-NO PROTECTION . . . . . 04 PIT OR PROTECTED GROUND . . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION . . . . . 06 COVERED PIT OR PIT LATRINE . . . . . 07 OPEN PIT-NO PROTECTION . . . . . 08 PROTECTED GROUND OR PIT . . . . . 09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT . . . . . 11 → 622 STORED UNPROTECTED . . . . . 12 OTHER (SPECIFY)_____ 96 NEVER HAVE SHARPS WASTE 95	
621	Does this facility treat sharps waste using autoclave or medical waste microwave before final dispose?	YES . . . . . 1 NO 2	
622	Now I would like to ask you a few questions about waste management practices for medical waste other than sharps, such as used bandages. How does this facility finally dispose of medical waste other than sharps boxes? PROBE TO ARRIVE AT CORRECT RESPONSE IF ANY OF THE RESPONSES 02 - 09 TAKE PLACE OUTSIDE THE FACILITY, THEN THE CORRECT RESPONSE TO CIRCLE WILL BE IN THE CATEGORY OF "REMOVE OFFSITE" PREMISES MEANS THE BUILDING OR FACILITY GROUNDS. IF MORE THAN ONE APPLIES, SELECT THE METHOD USED MOST OFTEN.	SAME AS FOR SHARP ITEMS . . . . . 01 **BURN IN INCINERATOR:** TWO-CHAMBER INDUSTRIAL (800-1000+°C) . . . . . 02 ONE-CHAMBER DRUM/BRICK . . . . . 03 → 624 **OPEN BURNING** FLAT GROUND-NO PROTECTION . . . . . 04 PIT OR PROTECTED GROUND . . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION . . . . . 06 COVERED PIT OR PIT LATRINE . . . . . 07 OPEN PIT-NO PROTECTION . . . . . 08 PROTECTED GROUND OR PIT . . . . . 09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT . . . . . 11 → 624 STORED UNPROTECTED . . . . . 12 OTHER (SPECIFY)_____ 96 NEVER HAVE MEDICAL WASTE 95	
623	Does this facility treat medical waste using autoclave or medical waste microwave before final dispose?	YES . . . . . 1 NO 2	

624	**CHECK Q620 AND Q622** INCINERATOR USED (EITHER "2" OR "3" CIRCLED) ↓ INCINERATOR NOT USED (NEITHER "2" NOR "3" CIRCLED) → 630		
625	ASK TO BE SHOWN THE INCINERATOR	INCINERATOR OBSERVED . . . . . 1 INCINERATOR REPORTED, NOT SEEN 2	
626	Is the incinerator functional today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 630
627	Is fuel available today for the incinerator? ACCEPT REPORTED RESPONSE	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

CLIENT LATRINE

630	Is there a toilet (latrine) in functioning condition that is available for general outpatient client use? IF YES, ASK TO SEE THE CLIENT TOILET AND INDICATE THE TYPE. THIS MUST BE TOILET FACILITIES FOR THE MAIN OUTPATIENT SERVICE AREA. IF MORE THAN ONE TYPE OF TOILET IS USED, THE MOST COMMON TYPE OF TOILET/LATRINE IN THE OUTPATIENT SERVICE AREA SHOULD BE SELECTED.	**FLUSH OR POUR FLUSH TOILET** FLUSH TO PIPED SEWER SYSTEM . . . . 11 FLUSH TO SEPTIC TANK . . . . . 12 FLUSH TO PIT LATRINE . . . . . 13 FLUSH TO SOMEWHERE ELSE . . . . . 14 FLUSH, DON'T KNOW WHERE . . . . . 15 **PIT LATRINE** VENTILATED IMPROVED PIT LATRINE . . 21 PIT LATRINE WITH SLAB . . . . . 22 PIT LATRINE WITHOUT SLAB/OPEN PIT . . 23 COMPOSTING TOILET . . . . . 31 BUCKET TOILET . . . . . 41 HANGING TOILET / HANGING LATRINE . . . . 51 NO FUNCTIONING FACILITY/BUSH/FIELD . . 61 OTHER (SPECIFY) _____ 96	

631	CIRCLE ANY OBSERVED CONDITION. IF NONE IS OBSERVED, CIRCLE "Y"	
01	TOILET IS AVAILABLE ONSITE . . . . . A ONSITE MEANS WITHIN THE BUILDING OR FACILITY GROUNDS.	
02	TOILET IS FUNCTIONAL . . . . . B FUNCTIONING CONDITION MEANS IT CAN BE USED. FOR EXAMPLE, WATER IS AVAILABLE FOR FLUSH TOILETS AND HOLE OR PIT IS NOT BLOCKED FOR PIT LATRINE.	
03	DOOR IS UNLOCKED WHEN NOT IN USE OR KEY IS AVAILABLE C	
04	DOOR CAN BE LOCKED INSIDE . . . . . D	
05	WALLS AROUND TOILET ALLOWS PRIVACY . . . . . E	
06	EXCLUSIVE FEMALE TOILET IS AVAILABLE . . . . . F	
07	GENDER-NEUTRAL ROOM WITH A SINGLE TOILET AVAILABLE . . . . . G	
08	WATER IS AVAILABLE IN A PRIVATE SPACE FOR WASHING . . . . . H	
09	WATER IS AVAILABLE WITHIN 5 METERS OF TOILET I	
10	SOAP IS AVAILABLE IN A PRIVATE SPACE FOR WASHING . . . . . J	
11	SOAP IS AVAILABLE WITHIN 5 METERS OF TOILET . . . . . K	
12	BIN WITH LID IS AVAILABLE FOR DISPOSAL OF USED MENSTRUAL HYGIENE PRODUCTS IN A PRIVATE SPACE L	
13	TOILET IS ACCESSIBLE FOR PEOPLE WITH LIMITED MOBILITY . . . . . M A TOILET CAN BE CONSIDERED ACCESSIBLE FOR PEOPLE WITH LIMITED MOBILITY IF IT MEETS RELEVANT NATIONAL OR LOCAL STANDARDS. IN THE ABSENCE OF SUCH STANDARDS, IT SHOULD MEET THE FOLLOWING CONDITIONS: CAN BE ACCESSED WITHOUT STAIRS OR STEPS; HANDRAILS FOR SUPPORT ARE ATTACHED EITHER TO THE FLOOR OR SIDEWALLS; THE DOOR IS AT LEAST 80 CM WIDE, AND THE DOOR HANDLE AND SEAT ARE WITHIN REACH OF PEOPLE USING WHEELCHAIRS OR CRUTCHES/STICKS.	
14	NONE OF THE ABOVE . . . . . Y	

632	**CHECK Q631** EXCLUSIVE FEMALE TOILET OR GENDER NEUTRAL TOILET NOT AVAILABLE (NEITHER "F" NOR "G" CIRCLED) ☐ ↓ EXCLUSIVE FEMALE TOILET OR GENDER NEUTRAL TOILET AVAILABLE (EITHER "F" OR "G" CIRCLED) ☐ → 634		
633	Is there a toilet (latrine) available for female clients in this facility?	YES . . . . . 1 NO 2	
634	**CHECK Q631** ACCESSIBLE TOILET NOT AVAILABLE ("M" NOT CIRCLED) ☐ ↓ ACCESSIBLE TOILET AVAILABLE ("M" CIRCLED) ☐ → 636		
635	Is there a toilet (latrine) available for people with limited mobility in this facility?	YES . . . . . 1 NO 2	
636	Is there a toilet (latrine) reserved for the exclusive use of staff?	YES . . . . . 1 NO 2	
	THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.		

SECTION 7: BASIC SUPPLIES - CLIENT EXAMINATION ROOM CLIENT WAITING AREA

AT THIS POINT TELL YOUR RESPONDENT THAT YOU WOULD LIKE TO SEE SOME BASIC SUPPLIES AND EQUIPMENT USED IN THE PROVISION OF CLIENT SERVICES. YOU WOULD LIKE TO SEE IF THESE SUPPLIES AND EQUIPMENT ARE AVAILABLE IN THE GENERAL OUTPATIENT AREA. IF YOU ARE NOT IN THE GENERAL OUTPATIENT AREA, ASK TO BE TAKEN TO THE GENERAL OUTPATIENT AREA.

BASIC SUPPLIES AND EQUIPMENT

700	I would like to know if the following items are available today in the main service area and are functioning. ASK TO SEE ITEMS.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1→ B	2 → B	3	1	2	8
02	STADIOMETER (OR HEIGHT ROD) FOR MEASURING HEIGHT	1→ B	2 → B	3	1	2	8
03	MEASURING TAPE (GENERAL USE) (1 MILLIMETER GRADATION)	1	2	3			
04	THERMOMETER	1→ B	2 → B	3	1	2	8
05	STETHOSCOPE	1→ B	2 → B	3	1	2	8
06	DIGITAL BP APPARATUS	1→ B	2 → B	3	1 ┐ 08 ┘	2	8
07	MANUAL BP APPARATUS	1→ B	2 → B	3	1	2	8
08	SELF-INFLATING BAG AND MASK [ADULT]	1→ B	2 → B	3	1	2	8
09	SELF-INFLATING BAG AND MASK [PEDIATRIC]	1→ B	2 → B	3	1	2	8
10	SPACERS FOR INHALERS	1	2	3			
11	PEAK FLOW METERS	1→ B	2 → B	3	1	2	8
12	PULSE OXIMETER	1→ B	2 → B	3	1	2	8
13	OXYGEN CONCENTRATORS	1→ B	2 → B	3	1	2	8
14	FILLED OXYGEN CYLINDER	1→ B	2 → B	3	1	2	8
15	OXYGEN DISTRIBUTION SYSTEM	1→ B	2 → B	3	1	2	8
16	OXYGEN ANALYZER	1→ B	2 → B	3	1	2	8
17	PRESSURE REGULATOR	1→ B	2 → B	3	1	2	8
18	CYLINDER GAUGES	1→ B	2 → B	3	1	2	8
19	HUMIDIFIERS	1→ B	2 → B	3	1	2	8

20	LOW FLOW METERS	1→ B	2 → B	3	1	2	8
21	NASAL CATHETER	1	2	3			
22	OXYGEN MASKS [ADULT]	1	2	3			
23	OXYGEN MASKS [PEDIATRIC]	1	2	3			
24	NASAL PRONGS/CANNULA	1	2	3			

CLIENT EXAMINATION ROOM

AT THIS POINT ASK TO BE SHOWN THE ROOM OR AREA IN THE GENERAL OUTPATIENT AREA WHERE MOST CLIENT SERVICES ARE OFFERED. OBSERVE THE CONDITION UNDER WHICH MOST CLIENT EXAMINATION TAKE PLACE. INDICATE IF THE FOLLOWING ITEMS ARE AVAILABLE IN THE ROOM OR AREA. ASK TO BE SHOWN ITEMS THAT YOU DO NOT SEE

710	STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 ┐ 06 ┘	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	MEDICAL MASKS	1	2	3
09	RESPIRATOR	1	2	3
10	GOWNS	1	2	3
11	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
12	STANDARD PRECAUTIONS GUIDELINES FOR INFECTION CONTROL	1	2	3

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

SECTION 8: DIAGNOSTICS

800	**CHECK Q102.21** DIAGNOSTIC SERVICES AVAILABLE IN FACILITY ↓ NO DIAGNOSTIC SERVICES → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE MAIN LABORATORY OR LOCATION IN THE FACILITY WHERE MOST TESTING IS DONE TO START DATA COLLECTION. INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF THE SURVEY. FOR EACH OF THE TEST OF INTEREST, ASK AND GO TO THE MAIN LOCATION IN THE FACILITY WHERE THE INFORMATION WILL BE AVAILABLE. IF INFORMATION IS NOT IN THAT LOCATION ASK IF IT IS ANYWHERE ELSE IN THE FACILITY AND GO THERE TO COMPLETE THE QUESTIONNAIRE.

HEMATOLOGY

801	Does this facility do any hemoglobin testing on site (i.e. in the facility)?	YES . . . . . 1 NO . . . . . 2 → 810								
802	Please tell me if: A) Any of the following hemoglobin test equipment is used in this facility, B) All items needed for the test are available, and C) Equipment is in working order	(A) USED		(B) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(C) IS THE ITEM IN WORKING ORDER OR UNEXPIRED?			
		YES	NO	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	HEMATOLOGY ANALYZER (for total lymphocyte count, full blood count, platelet count, etc.)	1 → B	2 → 02	1 → C	2 → C	3 → 02	1	2	8	
02	HEMOCUE	1 → B	2 → 04	1 → C	2 → C	3 → 04	1	2	8	
03	MICROCUVETTE (with valid expiration date)			1	2	3				
04	COLORIMETER OR HEMOGLOBINOMETER	1 → B	2	1 → C	2 → C	3	1	2	8	
803	Do you have a training manual, poster or other job aid for anemia testing?	YES . . . . . 1 NO . . . . . 2 → 810								
804	May I see the training manual, poster or other job aid for anemia testing?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2								

CLINICAL CHEMISTRY

810	Does this facility do any blood glucose testing in the facility?	YES . . . . . 1 NO . . . . . 2 → 812								
811	Please tell me if: A) Any of the following blood glucose test equipment is used in this facility B) It is available, and C) It is in working order	(A) USED		(B) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(C) IS THE ITEM IN WORKING ORDER OR UNEXPIRED?			
		YES	NO	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	GLUCOMETER	1 → B	2 → 812	1 → C	2 → C	3 → 812	1	2	8	
02	GLUCOMETER TEST STRIPS			1 → C	2 → C	3	1	2	8	
812	Does this facility do any ***urine chemistry testing*** using dipsticks and/or urine pregnancy test on site?	YES . . . . . 1 NO . . . . . 2 → 820								
813	Please tell me if any of the following dipstick test is done (or used) in this location. If done or used, I will like to see one. IF DONE/USED ASK TO SEE IT AND NOTE IF VALID/UNEXPIRED	(A) USED		(B) OBSERVED AVAILABLE						
		YES	NO	AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED, NOT SEEN	NORMALLY AVAILABLE, NOT TODAY			
01	DIP STICKS FOR URINE PROTEIN	1 → B	2 → 02	1	2	3	4			
02	DIP STICKS FOR URINE GLUCOSE	1 → B	2 → 03	1	2	3	4			
03	DIP STICKS FOR BACTERIA (NITRITE OR LEUKOCYTES)	1 → B	2 → 820	1	2	3	4			

PARASITOLOGY/BACTERIOLOGY

820	Please tell me if: A) Any of the following equipment is used in the facility B) It is available, and C) It is in working order	(A) EQUIPMENT / TEST USED		(B) EQUIPMENT / ALL ITEMS FOR TEST AVAILABLE?			(C) IS THE ITEM IN WORKING ORDER?		
		YES	NO	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE, NOT TODAY	YES	NO	DON'T KNOW
01	LIGHT MICROSCOPE	1 → B	2 → 02	1 → C	2 → C	3 → 02	1	2	8
02	MICROSCOPE WITH ELECTRIC LIGHT SOURCE	1 → B	2 → 03	1 → C	2 → C	3 → 03	1	2	8
03	REFRIGERATOR IN LAB AREA	1 → B	2 → 04	1 → C	2 → C	3 → 04	1	2	8

04	INCUBATOR	1 → B	2 → 05	1 → C	2 → C	3 → 05	1	2	8
05	TEST TUBES	1 → B	2 → 06	1	2	3			
06	CULTURE MEDIUM	1 → B	2 → 07	1	2	3			
07	GLASS SLIDES AND COVERS	1 → B	2 → 821	1	2	3			

821	Does this facility do any MALARIA tests (microscopy or mRDT) on site, i.e., in the facility?	YES . . . . . 1 NO 2	→ 830
822	Do you use malaria rapid diagnostic test to diagnose malaria at this laboratory/service site?	YES . . . . . 1 NO 2	→ 826
823	May I see a sample malaria rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN 3 NONE AVAILABLE TODAY 4	
824	Do you have a training manual, poster or other job aid for using malaria rapid diagnostic test?	YES . . . . . 1 NO 2	→ 826
825	May I see the training manual, poster or other job aid for using malaria rapid diagnostic test?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

		(A) EQUIPMENT / TEST USED		(B) EQUIPMENT / ALL ITEMS FOR TEST AVAILABLE?					
826	Please tell me if: A) Any of the following malaria tests or equipment is used in the facility B) All items needed for the test are available	YES	NO	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE, NOT TODAY			
01	GIEMSA STAIN	1 → B	2 → 02	1	2	3			
02	FIELD STAIN	1 → B	2 → 03	1	2	3			
03	ACRIDINE ORANGE (AO microscope, and Acridine orange stain)	1 → B	2 → 830	1	2	3			

830	Does this facility perform diagnostic X-rays, ultrasound, or computerized tomography? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED AND SPEAK WITH THE MOST KNOWLEDGEABLE PERSON.	YES. . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE AREA ←	

831	Please tell me: A) If any of the following imaging equipment is used in the facility B) if it is available today, and C) if it is functioning today	(A) EQUIPMENT USED		(B) EQUIPMENT AVAILABLE?			(C) IS THE ITEM IN WORKING ORDER?		
		YES	NO	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE, NOT TODAY	YES	NO	DON'T KNOW
01	DIGITAL X-RAY MACHINE NOT REQUIRING FILM	1 → B	2 → 02	1 → C	2 → C	3 → 02	1	2	8
02	X-RAY MACHINE	1 → B	2 → 04	1 → C	2 → C	3 → 03	1	2	8
03	UNEXPIRED FILM FOR X-RAY			1	2	3			
04	ULTRASOUND SYSTEM / MACHINE	1 → B	2 → 05	1 → C	2 → C	3 → 05	1	2	8
05	CT SCAN	1 → B	2 → NEXT SECTION	1 → C	2 → C	3 → NEXT SECTION	1	2	8

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

SECTION 9: MEDICINES AND COMMODITIES

900	**CHECK Q210** FACILITY STORES MEDICINES ☐ ↓ FACILITY STORES NO MEDICINES ☐ → NEXT SECTION	

SECTION 9.1: GENERAL MEDICINES AND SUPPLY ITEMS

ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE MEDICINES AND OTHER SUPPLIES ARE STORED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT STORAGE AND MANAGEMENT OF MEDICINES AND SUPPLIES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS

I would like to know if the following medicines are available today in this facility. If any of the medicines I mention is stored in another location in the facility, please tell me where in the facility it is stored so I can go there to verify.

ANTIBIOTICS

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
901	Are any of the following antibiotics available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	AMOXICILLIN TABLET/CAPSULE (Bacterial infections in adults)	1	2	3	4	5
02	AMOXICILLIN SYRUP/SUSPENSION OR DISPERSIBLE PEDIATRIC-DOSED TABLETS (Oral antibiotics for children)	1	2	3	4	5
03	AMOXICILIN/CLAVULINATE (AUGMENTIN) TABS (broad spectrum antibiotics)	1	2	3	4	5
04	AMPICILLIN (POWDER) INJECTION (Broad spectrum antibiotic)	1	2	3	4	5
05	AZITHROMYCIN TABS/CAPS (antibiotic)	1	2	3	4	5
06	AZITHROMYCIN SYR/SUSPENSION (antibiotic)	1	2	3	4	5
07	BENZATHINE BENZYLPENICILLIN (POWDER) FOR INJECTION	1	2	3	4	5
08	CEFOTAXIME	1	2	3	4	5
09	CEFTRIAXONE INJECTION (Injectable antibiotic)	1	2	3	4	5
10	CEPHALEXINE TABLET/CAPSULE	1	2	3	4	5
11	CEPHALEXINE SYR/SUSPENSION	1	2	3	4	5
12	CIPROFLOXACIN (2nd-line oral antibiotic)	1	2	3	4	5
13	CLOXACILLIN	1	2	3	4	5
14	CO-TRIMOXAZOLE (TABS) (Oral antibiotics-adult formation)	1	2	3	4	5

15	CO-TRIMOXAZOLE SUSPENSION OR DISPERSIBLE PEDIATRIC-DOSED TABLET (Oral antibiotics for children)	1	2	3	4	5
16	GENTAMYCIN INJECTION (Broad spectrum injectable antibiotic)	1	2	3	4	5
17	PENICILLIN INJECTION (Broad spectrum injectable antibiotic)	1	2	3	4	5

MEDICINES FOR WORM INFECTIONS

902	Are any of the following medicines for the treatment of worm infections available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	ALBENDAZOLE	1	2	3	4	5
02	MEBENDAZOLE	1	2	3	4	5

MEDICINES FOR NON-COMMUNICABLE DISEASES

903	Are any of the following medicines for the management of non-communicable diseases available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	AMLODIPINE TABLETS (CCB for high blood pressure)	1	2	3	4	5
02	ATENOLOL (Beta-blocker, Angina/hypertension)	1	2	3	4	5
03	BECLOMETHASONE INHALER	1	2	3	4	5
04	DEXAMETHASONE INJECTION	1	2	3	4	5
05	DEXAMETHASONE SYRUP/TABLETS	1	2	3	4	5
06	DIAZEPAM INJECTION (Anxiety/muscle relaxant/anticonvulsant)	1	2	3	4	5
07	ENALAPRIL CAPSULE/TABLET (A.C.E Inhibitor)	1	2	3	4	5
08	EPINEPHRINE INJECTION	1	2	3	4	5
09	THIAZIDE DIURETIC	1	2	3	4	5
10	GLIBENCLAMIDE (Oral treatment for type-2 diabetes)	1	2	3	4	5
11	GLUCOSE INJECTABLE SOLUTION	1	2	3	4	5
12	HYDROCORTISONE	1	2	3	4	5

13	INSULIN INJECTIONS (Diabetes)	1	2	3	4	5
14	METFORMIN TABLETS	1	2	3	4	5
15	PREDNISOLONE	1	2	3	4	5
16	SALBUTAMOL INHALER (Bronchospasms/Chronic asthma)	1	2	3	4	5
17	SALBUTAMOL INJECTION	1	2	3	4	5
18	ASPIRIN CAPSULES/TABLETS	1	2	3	4	5

ANTIMALARIAL MEDICINES(FN1)

ACT ANTIMALARIAL MEDICINES (Q904.01 - Q904.06) PART MUST BE ADAPTED BASED ON FIRST-LINE ANTIMALARIAL MEDICINES IN THE COUNTRY

904	Are any of the following antimalarial medicines available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	ARTEMISININ COMBINATION THERAPY: ARTEMETHER + LUMEFRANTRINE	1	2	3	4	5
02	ARTEMISININ COMBINATION THERAPY: ARTEMISININ + NAPTHOQUINE	1	2	3	4	5
03	ARTEMISININ COMBINATION THERAPY: DIHYDROARTEMISININ + PIPERAQUINE	1	2	3	4	5
04	ARTEMISININ COMBINATION THERAPY: ARTESUNATE + AMODIAQUINE	1	2	3	4	5
05	ARTEMISININ COMBINATION THERAPY: ARTESUNATE + MEFLOQUINE	1	2	3	4	5
06	ARTEMISININ COMBINATION THERAPY: OTHER	1	2	3	4	5
07	ARTEMETHER INJECTION	1	2	3	4	5
08	SULFADOXINE + PYRIMETHAMINE (SP)	1	2	3	4	5
09	QUININE TABLETS	1	2	3	4	5
10	QUININE INJECTION	1	2	3	4	5
11	ARTESUNATE INJECTABLE	1	2	3	4	5
12	ARTESUNATE SUPPOSITORIES / RECTAL ARTESUNATE	1	2	3	4	5
13	CHLOROQUINE	1	2	3	4	5
14	AMODIAQUINE	1	2	3	4	5

FEVER REDUCING AND PAIN MEDICINES

905	Are any of the following OTHER medicines available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	PARACETAMOL TABLETS	1	2	3	4	5
02	PARACETAMOL SYRUP OR DISPERSIBLE PEDIATRIC-DOZED TABLETS	1	2	3	4	5
03	MORPHINE INJECTION	1	2	3	4	5

MATERNAL AND CHILD HEALTH (FN2)

906	Are any of the following medicines for maternal and child health available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	CALCIUM GLUCONATE INJECTION	1	2	3	4	5
02	FOLIC ACID TABLETS [COUNTRY SPECIFIC ADULT DOSE]	1	2	3	4	5
03	IRON TABLETS [COUNTRY SPECIFIC ADULT DOSE]	1	2	3	4	5
04	IRON TABLETS [COUNTRY SPECIFIC PEDIATRIC DOSE]	1	2	3	4	5
05	IRON SYRUP	1	2	3	4	5
06	IRON + FOLIC ACID COMBINATION TABLET	1	2	3	4	5
07	[PER COUNTRY GUIDELINES] CALCIUM TABLET [COUNTRY SPECIFIC ADULT DOSE]	1	2	3	4	5
08	[PER COUNTRY GUIDELINES] ANTENATAL MULTIPLE MICRONUTRIENT SUPPLEMENTS [COUNTRY SPECIFIC ANTENATAL DOSE]	1	2	3	4	5
09	MAGNESIUM SULPHATE INJECTION	1	2	3	4	5
10	MISOPROSTOL TABLETS/CAPSULES	1	2	3	4	5
11	OXYTOCIN OR OTHER INJECTABLE UTEROTONIC	1	2	3	4	5
12	TETANUS TOXOID VACCINE	1	2	3	4	5
13	ORAL REHYDRATION SALTS (ORS) SACHETS	1	2	3	4	5

14	LOW OSMOLALITY ORAL REHYDRATION SALTS (ORS) SACHETS	1	2	3	4	5
15	VITAMIN A CAPSULES [COUNTRY SPECIFIC PEDIATRIC DOSE]	1	2	3	4	5
16	ZINC TABLETS	1	2	3	4	5
17	BUDESONIDE INHALATION (AEROSOL)	1	2	3	4	5
18	AMODIAQUINE	1	2	3	4	5
19	PHENOBARBITONE INJECTION	1	2	3	4	5
20	DOPAMINE INJECTION	1	2	3	4	5
21	CORTICOSTEROID	1	2	3	4	5

INTRAVENOUS FLUIDS

907	Are any of the following intravenous fluids available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	NORMAL SALINE / SODIUM CHLORIDE INJECTABLE SOLUTION	1	2	3	4	5
02	RINGERS LACTATE	1	2	3	4	5
03	5% DEXTROSE - NORMAL SALINE	1	2	3	4	5

STORAGE CONDITION: ANTIBIOTICS & GENERAL MEDICINES

908	OBSERVE THE PLACE WHERE THE MEDICINES ASSESSED SO FAR ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS	YES	NO
01	ARE THE MEDICINES OFF THE FLOOR?	1	2
02	ARE THE MEDICINES PROTECTED FROM WATER?	1	2
03	ARE THE MEDICINES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2
909	ARE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expired, first out")?	YES, ALL MEDICINES . . . . . 1 YES, ONLY SOME MEDICINES . . . . . 2 NO 3	

910	What system does this facility use to monitor the amount of medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY . . . . . 1 LEDGER/STOCK CARD UPDATED DAILY . . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES . . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES . . . . . 4 OTHER SYSTEM (SPECIFY) _____ 8	

SUPPLY ITEMS

911	Do you have the following supply items available in the facility/location today?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	INFUSION SET FOR IV SOLUTION	1	2	3
02	PEDIATRIC INFUSION SET FOR IV SOLUTION	1	2	3
03	CANULA FOR ADMINISTERING IV FLUIDS	1	2	3
04	CANULA FOR ADMINISTERING IV FLUIDS - 22/24 G	1	2	3
05	LATEX GLOVES	1	2	3
06	ALCOHOL-BASED HAND RUB	1	2	3
07	HAND WASHING SOAP	1	2	3
08	DISINFECTING SOLUTION	1	2	3
09	INSECTICIDE TREATED MOSQUITO NETS AND/OR ITN VOUCHERS	1	2	3

SECTION 9.2: CONTRACEPTIVE COMMODITIES

920	**CHECK Q212** CONTRACEPTIVES STORED WITH OTHER MEDICINES IN COMMON LOCATION (RESPONSE 2 CIRCLED) ↓ CONTRACEPTIVES STORED IN FP SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY (RESPONSE 1 OR 3 CIRCLED) → 930	

921	Are any of the following CONTRACEPTIVE commodities available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	COMBINED ORAL CONTRACEPTIVE PILLS	1	2	3	4	5
02	PROGESTIN-ONLY CONTRACEPTIVE PILLS	1	2	3	4	5
03	COMBINED INJECTABLE CONTRACEPTIVES	1	2	3	4	5
04	PROJESTIN-ONLY INJECTABLE CONTRACEPTIVES - INTRAMUSCULAR (DMPA-IM)	1	2	3	4	5

05	[PER COUNTRY GUIDELINES] PROJESTIN-ONLY INJECTABLE CONTRACEPTIVES - SUBCUTANEOUS (DMPA-SC)	1	2	3	4	5
06	MALE CONDOMS	1	2	3	4	5
07	FEMALE CONDOMS	1	2	3	4	5
08	INTRAUTERINE CONTRACEPTIVE DEVICE	1	2	3	4	5
09	IMPLANT	1	2	3	4	5
10	EMERGENCY CONTRACEPTIVE PILLS (E.G., PROSTINOL 2)	1	2	3	4	5
11	CYCLE BEADS FOR STANDARD DAYS METHOD	1	2	3	4	5

922	PRESENTLY INTERVIEWING IN PHARMACY ☐ → PRESENTLY INTERVIEWING IN FAMILY PLANNING SERVICE AREA ☐ → THANK THE RESPONDENT IN THE FP SERVICE AREA PROCEED TO NEXT SECTION OR SERVICE SITE	

SECTION 9.3: STOCKPILE OF MEDICINES RESERVED FOR EMERGENCY

930	**CHECK Q498** STOCKPILE FOR EMERGENCY IS STORED IN THE MAIN LOCATION WHERE MEDICINES ARE STORED (RESPONSE 1 CIRCLED) ☐ ↓ STOCKPILE FOR EMERGENCY IS STORED AT ELSEWHERE ONSITE OR AT AN OFFSITE LOCATION (RESPONSE 2 OR 3 CIRCLED) ☐ → THANK THE RESPONDENT AND CONTINUE TO NEXT SECTION OR SERVICE SITE		
931	May I see stockpile of essential medicines that is set aside for emergency situations such as natural THE STOCKPILE IS RESERVED EXCLUSIVELY FOR EMERGENCY AND DIFFERENT FROM MEDICINES STORED FOR TYPICAL USE. INTERVIEWERS DO NOT NEED TO REVIEW ITS CONTENTS	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE

SECTION 9: MEDICINES AND COMMODITIES :FOOTNOTES

(FN1) Q904: Coding categories to be developed locally and revised based on the pretest. All antimalarials commonly used in the country should be included in the response categories. Common brand names for medicine, such as Coartem, Malaron, Artemether–Lumefantrine or Artesunate–Amodiaquine, should be added to the response categries for Artemisinin-based combination treatments (ACTs) as appropriate.

(2) Coding categories for a single or combined formulation of iron, folate, calcium, micronutrient supplements to be developed locally and revised based on the pretest.

MODULE 3: SERVICE-SPECIFIC READINESS

SECTION 10: CHILD VACCINATION

1000 **(FN1)**	**CHECK Q102.01** CHILD VACCINATION SERVICES AVAILABLE ☐ ↓ NO CHILD VACCINATION SERVICES AVAILABLE ☐ → 1006	

ASK TO BE SHOWN THE MAIN LOCATION WHERE CHILD VACCINATION SERVICES ARE PROVIDED IN THE FACILITY. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT CHILD VACCINATION SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

1001 Now I would like to ask you specifically about vaccination services for children under 5 years. For each of the following services, please tell me whether the service is offered by this facility either at your facility or through outreach.

	CHILD VACCINATION SERVICE	(A) AT FACILITY		(B) THROUGH OUTREACH	
		YES	NO	YES	NO
01	Routine DPT+HepB+Hib (i.e., pentavalent)	1	2	1	2
02	Routine polio vaccination	1	2	1	2
03	Routine measles vaccination	1	2	1	2
04	BCG vaccination	1	2	1	2
05	Pneumococcal vaccination (pneumonia vaccine)	1	2	1	2
06	Rotavirus vaccination	1	2	1	2

1002	Do you have the national guidelines for child vaccinations available in this service area today?	YES . . . . . 1 NO 2	→ 1004
1003	May I see the guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 1006
1004	Do you have any other guidelines for child vaccinations available in this service area today?	YES . . . . . 1 NO 2	→ 1006
1005	May I see the other guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1006	Does this facility offer HPV vaccine to adolescents?	YES . . . . . 1 NO 2	→ 1011
1007	Do you have the HPV vaccination guidelines available at this service area today?	YES . . . . . 1 NO 2	→ 1009
1008	May I see the national HPV vaccination guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 1011
1009	Do you have any other guidelines on HPV vaccination available at this service area today?	YES . . . . . 1 NO 2	→ 1011

1010	May I see the other guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1011	Does this facility routinely store any vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided?	ROUTINELY STORE VACCINES . . . . . 1 STORES NO VACCINES . . . . . 2 NEXT SECTION OR SERVICE SITE	
1012	ASK TO BE TAKEN TO THE AREA WHERE VACCINES ARE STORED. ASK TO SEE THE VACCINE REFRIGERATOR.	REFRIGERATOR OBSERVED . . . . . 1 REFRIGERATOR NOT OBSERVED . . . . . 2 NEXT SECTION OR SERVICE SITE	
1013	What type of temperature monitoring device is used for monitoring temperature in the vaccine service refrigerator?	THERMOMETER ONLY . . . . . 1 FREEZE TAG ONLY . . . . . 2 BOTH THERMOMETER AND FREEZE TAG . . 3	
1014	Do you maintain a cold-chain temperature monitoring chart?	YES . . . . . 1 NO 2	→ 1017
1015	May I see the cold-chain temperature monitoring chart?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 1017
1016	CHECK WHETHER THE TEMPERATURE RECORD WAS COMPLETED TWICE DAILY FOR EACH OF THE PAST 30 DAYS, INCLUDING WEEKENDS AND PUBLIC HOLIDAYS.	YES, COMPLETED . . . . . 1 NO, NOT COMPLETED 2	

1017	Please tell me if each of the following vaccines is available in the facility today. If available, I would like to see it. IF AVAILABLE, CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED, VVM CHANGED, NOT FROZEN)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED, NOT SEEN	NOT AVAILABLE TODAY / DK	NEVER AVAILABLE
01	DPT+HepB+Hib (PENTAVALENT)	1	2	3	4	5
02	ORAL POLIO VACCINE	1	2	3	4	5
03	[PER COUNTRY GUIDELINES] INACTIVATED POLIO VACCINE	1	2	3	4	5
04	MEASLES VACCINE AND DILUENT	1	2	3	4	5
05	BCG VACCINE AND DILUENT	1	2	3	4	5
06	PNEUMOCOCCAL CONJUGATE VACCINE	1	2	3	4	5
07	ROTAVIRUS VACCINE	1	2	3	4	5

1018	**CHECK Q1006** HPV VACCINE IS PROVIDED ↓	HPV VACCINE IS NOT PROVIDED →	1020

1019	[PER COUNTRY GUIDELINES] Is HPV vaccine and diluent available in the facility today? If available, I would like to see it.	AT LEAST ONE VALID ..... 1 AVAILABLE, NONE VALID ..... 2 REPORTED, NOT SEEN ..... 3 NOT AVAILABLE TODAY / DK ..... 4 NEVER AVAILABLE 5	
1020	**CHECK Q1013** THERMOMETER (RESPONSE 1 OR 3 CIRCLED) ☐ ↓ FREEZE TAG ONLY (RESPONSE 2 CIRCLED) ☐ → 1023		
1021	CHECK THE THERMOMETER. WHAT IS THE TEMPERATURE IN THE VACCINE REFRIGERATOR?	BETWEEN +2 AND +8 DEGREES ..... 1 ABOVE +8 DEGREES ..... 2 BELOW +2 DEGREES ..... 3 THERMOMETER NOT FUNCTIONAL ..... 4 THERMOMETER NOT AVAILABLE 5	
1022	**CHECK Q1013** THERMOMETER AND FREEZE TAG (RESPONSE 3 CIRCLED) ☐ ↓ THERMOMETER ONLY (RESPONSE 1 CIRCLED) ☐ → 1024		
1023	CHECK THE FREEZE TAG. WHAT IS THE STATUS DISPLAYED ON THE FREEZE TAG IN THE VACCINE REFRIGERATOR?	GOOD ..... 1 ALARM ..... 2 FREEZE TAG NOT FUNCTIONAL 3	
1024	Does this facility routinely offer vitamin A supplementation during vaccination for children?	YES ..... 1 NO 2	
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

SECTION 10: CHILD VACCINATION:FOOTNOTES

(FN1) Adapt according to the country child vaccination program. Inactivated Polio Vaccine(IPV) and Human Papilloma Virus(HPV) vaccines should be removed in countries that don't have a program for the HPV and IPV

SECTION 11: CHILD CURATIVE CARE SERVICES

1100	**CHECK Q102.03** CURATIVE CARE SERVICES AVAILABLE ↓ NO CURATIVE CARE SERVICES → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CURATIVE CARE SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT CURATIVE CARE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

	1101 Please tell me if providers in this facility provide the following services as part of sick-child care	YES	NO
01	Assess and/or treat child malnutrition	1	2
02	Provide vitamin A supplementation to children	1	2
03	Provide iron supplementation to children	1	2
04	Provide zinc supplementation to children	1	2

1102 **(FN1)**	Do providers of services for sick children in this facility follow the Integrated management of childhood Illness (IMCI) guidelines in the provision of services to children under 5 years?	YES . . . . . 1 NO 2	
1103 **(FN1)**	Do you have the IMCI guidelines (chart booklet) for the diagnosis and management of childhood illnesses available in this service area today?	YES . . . . . 1 NO 2	→ 1105
1104 **(FN1)**	May I see the IMCI guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 1107
1105	Do you have any (other) guidelines for the diagnosis and management of childhood illnesses available in this service site today?	YES . . . . . 1 NO 2	→ 1107
1106	May I see the other guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

	1107 I would like to know if the following items are available in this service area. I would like to see them. For equipment and instruments, I would like to know if they are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	CHILD WEIGHING SCALE (100 GRAM GRADATION)	1 → B	2 → B	3 → 02	1	2	8
02	INFANT WEIGHING SCALE (10 GRAM GRADATION)	1 → B	2 → B	3 → 03	1	2	8
03	HEIGHT BOARD	1 → B	2 → B	3 → 04	1	2	8

04	LENGTH BOARD	1 → B	2 → B	3 → 05	1	2	8	
05	MID UPPER ARM CIRCUMFERENCE (MUAC) MEASURING TAPE FOR CHILDREN	1	2	3				
06	MEASURING TAPE (GENERAL USE) (1 MILLIMETER GRADATION)	1	2	3				
07	GROWTH CHARTS	1	2	3				
08	THERMOMETER	1 → B	2 → B	3 → 09	1	2	8	
09	STETHOSCOPE	1 → B	2 → B	3 → 10	1	2	8	
10	PULSE OXIMETER	1 → B	2 → B	3 → 11	1	2	8	
11	TIMER OR WATCH WITH SECONDS HAND	1 → B	2 → B	3 → 12	1 → 13	2 → 13	8	
12	OTHER DEVICE (E.G., CELL PHONE) THAT CAN MEASURE SECONDS	1 → B	2 → B	3 → 13	1	2	8	
13	CALIBRATED 1/2 OR 1-LITER MEASURING JAR FOR ORS	1	2	3				
14	CUP AND SPOON	1	2	3				
15	ORS PACKETS OR SACHETS	1	2	3				
16	LOW OSMOLALITY ORS PACKETS OR SACHETS	1	2	3				
17	READY TO USE THERAPEUTIC FOODS (RUTF)	1	2	3				

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

SECTION 11: CHILD CURATIVE CARE SERVICES: FOOTNOTES

(FN1) Change the Integrated management of childhood illness (IMCI) according to the country specific adaptation of the IMCI guidelines, for example to the Integrated Management of Newborn & Childhood Illnesses (IMNCI), or Integrated Management of Neonatal and Childhood

SECTION 12: CHILD GROWTH MONITORING SERVICES

1200	**CHECK Q102.02** GROWTH MONITORING SERVICES AVAILABLE ↓ NO GROWTH MONITORING SERVICES → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE MAIN LOCATION WHERE GROWTH MONITORING SERVICES ARE PROVIDED IN THE FACILITY. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT GROWTH MONITORING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1201	Does this facility provide growth monitoring services at this facility or through outreach?	ONLY AT THIS FACILITY . . . . . 1 ONLY THROUGH OUTREACH . . . . . 2 BOTH AT THIS FACILITY AND THROUGH OUTREACH 3	
1202	Does this facility assess for wasting or acute malnutrition?	YES . . . . . 1 NO 2	→ 1207
1203	**CHECK Q1201** GROWTH MONITORING BOTH AT THIS FACILITY AND THROUGH OUTREACH ↓ GROWTH MONITORING ONLY AT THIS FACILITY OR ONLY THROUGH OUTREACH →		1205
1204	Is assessing for wasting or acute malnutrition done both at this facility and through outreach?	ONLY AT THIS FACILITY . . . . . 1 ONLY THROUGH OUTREACH . . . . . 2 BOTH AT THIS FACILITY AND THROUGH OUTREACH 3	
1205	Do you have any guidelines for the diagnosis and management of malnutrition available in this service site today? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO GUIDELINE AVAILABLE 2	→ 1207
1206	May I see the guidelines for the diagnosis and management of malnutrition?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1207	Do you have any guidelines for growth monitoring available in this service area today? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO GUIDELINE AVAILABLE 2	→ 1209
1208	May I see the guidelines for growth monitoring?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1209	IS GROWTH MONITORING OFFERED IN THE SAME ROOM OR AREA WITH CHILD CURATIVE CARE SERVICES? DIFFERENT ROOM OR AREA ↓ SAME ROOM OR AREA → NEXT SECTION OR SERVICE SITE		

1210	I would like to know if the following items are available in this service area. I would like to see them. For equipment and instruments, I would like to know if they are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	WEIGHING SCALE (100 GRAM GRADATION)	1 → B	2 → B	3 → 02	1	2	8
02	INFANT WEIGHING SCALE (10 GRAM GRADATION)	1 → B	2 → B	3 → 03	1	2	8
03	HEIGHT BOARD	1 → B	2 → B	3 → 04	1	2	8
04	LENGTH BOARD	1 → B	2 → B	3 → 05	1	2	8
05	MID UPPER ARM CIRCUMFERENCE (MUAC) MEASURING TAPE FOR CHILDREN	1	2	3			
06	MEASURING TAPE (GENERAL USE) (1 MILLIMETER GRADATION)	1	2	3			
07	GROWTH CHARTS	1	2	3			

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

1300	**CHECK Q102.04** FAMILY PLANNING SERVICES ☐ → ↓ NO FAMILY PLANNING SERVICES ☐ → ↓ NEXT SECTION OR SERVICE SITE ←	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE FAMILY PLANNING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT FAMILY PLANNING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

	Does this facility provide (i.e., stock the commodity) or prescribe, counsel or refer clients for any of the following modern methods of family planning:	PROVIDE - STOCK THE COMMODITY	PRESCRIBE, COUNSEL, OR REFER	NO
01	COMBINED ORAL CONTRACEPTIVE PILLS	1	2	3
02	PROGESTIN-ONLY CONTRACEPTIVE PILLS	1	2	3
03	COMBINED INJECTABLE CONTRACEPTIVES	1	2	3
04	PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES - IM (DMPA-IM)	1	2	3
05	**[PER COUNTRY GUIDELINE] (FN1)** PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES - SC (DMPA-SC)	1	2	3
06	MALE CONDOMS	1	2	3
07	FEMALE CONDOMS	1	2	3
08	INTRAUTERINE CONTRACEPTIVE DEVICE (IUD)	1	2	3
09	IMPLANT	1	2	3
10	EMERGENCY CONTRACEPTIVE PILLS (E.G., PROSTINOL 2)	1	2	3
11	CYCLE BEADS FOR STANDARD DAYS METHOD	1	2	3
12	COUNSEL CLIENTS ON PERIODIC ABSTINENCE		2	3
13	VASECTOMY (MALE STERILIZATION)	1	2	3
14	TUBAL LIGATION (FEMALE STERILIZATION)	1	2	3
15	OTHER METHODS (E.G., SPERMICIDE OR DIAPHRAGM)	1	2	3

1302	Do you have the national family planning guidelines available at this service area today?	YES . . . . . 1 NO . . . . . 2 →	1304
1303	May I see the national family planning guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 →	1306
1304	Do you have any other guidelines on family planning available at this service area today?	YES . . . . . 1 NO . . . . . 2 →	1306
1305	May I see the other guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

1306	Does this facility have a system whereby certain observations and parameters are routinely carried out on family planning clients before the consultation takes place? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE.	YES . . . . . 1 NO 2	→ 1308

1307	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely done for all family planning clients?	ACTIVITY OBSERVED	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY DONE	DON'T KNOW
01	Weighing of clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8

1308	Do family planning providers in this facility routinely diagnose and treat STIs, or are STIs clients referred to another provider or location for STI diagnosis and treatment? PROBE TO ARRIVE AT THE RIGHT ANSWER	ROUTINELY DIAGNOSE AND TREAT STIs . . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATMENT . . . . . 2 REFER ELSEWHERE IN FACILITY FOR DIAGNOSIS AND TREATMENT . . 3 REFER OUTSIDE FACILITY FOR DIAGNOSIS & TREATMENT . . . . 4 NO DIAGNOSIS / TREATMENT / REFERRAL 5	
1309	Do providers of family planning conduct HIV testing from this service site?	YES . . . . . 1 NO 2	→ 1320
1310	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN . . 3 NOT AVAILABLE TODAY 4	

EQUIPMENT AND SUPPLIES

1320	IS THIS THE SAME LOCATION AS THE OUTPATIENT SERVICE SITE?	YES, OUTPATIENT SERVICE SITE . . 1 NO, DIFFERENT LOCATION 2	→ 1321.04

		(A) AVAILABLE			(B) FUNCTIONING		
1321	I would like to know if the following items are available in this service area today and are functioning	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	DIGITAL BP APPARATUS	1 → B	2 → B	3 → 02	1 → 04	2	8
02	MANUAL BP APPARATUS	1 → B	2 → B	3 → 03	1	2	8
03	STETHOSCOPE	1 → B	2 → B	3 → 04	1	2	8

04	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → B	2 → B	3 → 05	1	2	8	
05	EXAMINATION BED OR COUCH	1	2	3				
06	SAMPLE OF FP METHODS	1	2	3				
07	OTHER FP-SPECIFIC VISUAL AIDS [E.G., FLIP CHARTS, LEAFLETS]	1	2	3				
08	PELVIC MODEL FOR IUCD	1	2	3				
09	MODEL FOR SHOWING CONDOM USE	1	2	3				

1330 **CHECK Q212**

FP COMMODITIES STORED IN OTHER LOCATION OR NOT STOCKED (RESPONSE 1 NOT CIRCLED) → THANK YOUR RESPONDENT NEXT SECTION OR SERVICE SITE

FP COMMODITIES STORED IN FP SERVICE AREA (RESPONSE 1 CIRCLED) → 921

(FN1) Q1301(05):Verify country program and adapt as per country needs or specific injectable. For example, in countries with a Sayna Press program, you may specify "DMPA-SC/ Sayana Press "

1400	**CHECK Q102.05** ANC SERVICES AVAILABLE IN FACILITY ☐ ↓ ANC SERVICES NOT AVAILABLE IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE ANTENATAL CARE SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT ANTENATAL CARE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

1401	Do ANC providers provide any of the following services to pregnant women as part of routine ANC?	YES	NO
01	Iron supplementation	1	2
02	Folic acid supplementation	1	2
03	Iron + folic acid combination tablet	1	2
04	Malaria testing	1	2
05	Intermittent preventive treatment (IPT) for malaria	1	2
06	Tetanus toxoid vaccination	1	2

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			
1402	Do ANC providers in this facility provide any of the following tests from this site to pregnant women as part of ANC? IF YES, ASK TO SEE THE TEST KIT OR EQUIPMENT. IF TEST NOT DONE IN ANC, PROBE TO DETERMINE IF THE TEST IS DONE ELSEWHERE IN THE FACILITY CHECK TO SEE IF AT LEAST ONE TEST KIT OF EACH TEST IS VALID/UNEXPIRED	AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NONE AVAILABLE TODAY	NO, OR NEVER AVAILABLE	AVAILABLE ELSEWHERE IN FACILITY
01	HIV RAPID DIAGNOSTIC TEST	1	2	3	4	5	6
02	URINE PROTEIN TEST	1	2	3	4	5	6
03	URINE GLUCOSE TEST	1	2	3	4	5	6
04	ANY RAPID TEST FOR HEMOGLOBIN	1	2	3	4	5	6
05	SYPHILIS RAPID DIAGNOSTIC TEST	1	2	3	4	5	6

1403	As part of ANC services, please tell me if providers in this facility provide the following services to ANC clients	YES	NO
01	Counseling on recommended minimum of 8 ANC visits for each pregnancy	1	2
02	Counseling about healthy eating and physical activity during pregancy	1	2
03	Counseling on birth preparedness or preparation for delivery	1	2
04	Counseling about postpartum family planning	1	2
05	Counseling about HIV/AIDS	1	2
06	Counseling about use of ITNs to prevent mosquito bites and malaria	1	2
07	Counseling about breastfeeding	1	2
08	Counseling about newborn care	1	2
09	Counseling on postnatal care visits	1	2

1404	Do ANC providers in this facility routinely diagnose and treat STIs, or are STI clients referred to another provider or location for diagnosis and treatment?	ROUTINELY DIAGNOSE AND TREAT STIs . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATMENT . . . . . 2 REFER ELSEWHERE IN FACILITY FOR DIAGNOSIS AND TREATMENT . . . . . 3 REFER OUTSIDE FACILITY FOR DIAGNOSIS AND TREATMENT . . . . . 4 NO DIAGNOSIS / TREATMENT / REFERRAL 5	
1405	Do you have the national ANC guidelines available in this service area today?	YES . . . . . 1 NO 2	→ 1407
1406	May I see the national ANC guidelines? ACCEPTABLE IF PART OF OTHER GUIDELINES	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 1409
1407	Do you have any other ANC guidelines available in this service area today?	YES . . . . . 1 NO 2	→ 1409
1408	May I see the other guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1409	Do you have IPTp guidelines available in this service area?	YES . . . . . 1 NO 2	→ 1411
1410	May I see the IPTp guidelines? ACCEPTABLE IF PART OF OTHER GUIDELINES	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1411	Do you have guidelines on micronutrient supplementation during pregnancy available in this service area?	YES . . . . . 1 NO 2	→ 1420
1412	May I see the guidelines on micronutrient supplementation during pregnancy?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

1420	IS THIS THE SAME LOCATION AS THE OUTPATIENT SERVICE SITE?	YES, OUTPATIENT SERVICE SITE . . . . . 1 NO, DIFFERENT LOCATION . . . . . 2 →					→ 1421.06
1421	I would like to know if the following items are available in this service area and are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	DIGITAL BP APPARATUS	1 → B	2 → B	3 → 02	1	2	8
02	MANUAL BP APPARATUS	1 → B	2 → B	3 → 03	1	2	8
03	STETHOSCOPE	1 → B	2 → B	3 → 04	1	2	8
04	MEASURING TAPE (GENERAL USE) (1 MILLIMETER GRADATION)	1 → B	2 → B	3 → 05			
05	ADULT WEIGHING SCALE	1 → B	2 → B	3 → 06	1	2	8
06	FETAL STETHOSCOPE/PINNARD	1 → B	2 → B	3	1	2	8

1422 **(FN1)**	Please tell me if any of the following medicines are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NO, OR NEVER AVAILABLE
01	IRON TABLETS (INDIVIDUAL TABLETS) [COUNTRY SPECIFIC ADULT DOSE]	1	2	3	4	5
02	FOLIC ACID TABLETS (INDIVIDUAL TABLETS) [COUNTRY SPECIFIC ADULT DOSE]	1	2	3	4	5
03	COMBINED IRON AND FOLIC ACID TABLETS	1	2	3	4	5
04	**[PER COUNTRY GUIDELINES]** CALCIUM TABLET [COUNTRY SPECIFIC ADULT DOSE]	1	2	3	4	5
05	**[PER COUNTRY GUIDELINES]** ANTENATAL MULTIPLE MICRONUTRIENT SUPPLEMENTS [COUNTRY SPECIFIC ANTENATAL DOSE]	1	2	3	4	5
06	SP FOR IPTp	1	2	3	4	5
07	TETANUS TOXOID VACCINE	1	2	3	4	5
08	INSECTICIDE TREATED BEDNETS (ITNs) AND/OR ITN VOUCHERS	1	2	3	4	5

1423	IN THE SERVICE OR WAITING AREA, HAVE YOU SEEN OPENLY DISPLAYED BREASTMILK SUBSTITUTES AND RELATED PRODUCTS, POSTERS IDEALIZING THE USE OF BREASTMILK SUBSTITUTES, FEEDING BOTTLES OR NIPPLES? NOTE: FEEDING CUPS ARE PERMITTABLE. IF ONLY FEEDING CUPS ARE VISIBLE, CIRCLE CODE 'X' FOR 'NONE DISPLAYED'	FORMULA MARKETING POSTERS DISPLAYED . . . . . A INFANT FURMULA BOXES/CANS DISPLAYED . . . . . B FEEDING BOTTLES DISPLAYED . . . . . C NIPPLES DISPLAYED . . . . . D NONE DISPLAYED X	
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

SECTION 14: ANTENATAL CARE: FOOTNOTES

(FN1) Coding categories for a single or combined formulation of iron, folate, calcium, micronutrient supplements to be developed locally and revised based on the pretest.

SECTION 15: PMTCT OF HIV INFECTION

1500	**CHECK Q102.06** PMTCT SERVICES OFFERED IN FACILITY ☐ NO PMTCT SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE	

CAUTION!!!
THIS SECTION SHOULD BE COMPLETED ONLY AFTER COMPLETING THE ANC SECTION

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE PMTCT SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF PMTCT SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

1501	As part of PMTCT services, please tell me if providers in this facility provide the following services to clients.	YES	NO
01	Provide HIV counseling and testing services to pregnant women. This includes testing done outside this location but results provided to client here	1	2
02	Provide HIV testing services to infants born to hiv positive women. This includes testing done outside this location but results provided to client here. for example, blood collected here as DBS but testing done elsewhere	1	2
03	Provide ART treatment initiation for HIV positive pregnant women	1	2
04	Provide ARV prophylaxis to newborns of HIV positive women	1	2
05	Provide infant and young child feeding counseling for PMTCT, including exclusive breastfeeding and lactation	1	2
06	Provide nutritional counseling for HIV positive pregnant women and their infants	1	2
07	Provide family planning counseling to HIV positive pregnant women	1	2
08	Provide cervical cancer screening to PMTCT patients	1	2

1502	**CHECK Q1501.01** HIV COUNSELING AND TESTING FOR PREGNANT WOMEN ☐ NO HIV COUNSELING AND TESTING FOR PREGNANT WOMEN ☐ → NEXT SECTION OR SERVICE SITE	

1503	IS THIS THE SAME LOCATION AS THE ANC SERVICE SITE?	YES, ANC SERVICE SITE . . . . . 1 NEXT SECTION OR SERVICE SITE ☐ NO, DIFFERENT LOCATION 2	
1504	Is HIV rapid diagnostic testing available from this service site?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE ☐	
1505	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN . . . . . 3 NOT AVAILABLE TODAY 4	

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

1600	**CHECK Q102.07** NORMAL DELIVERY AVAILABLE ↓ NORMAL DELIVERY NOT AVAILABLE → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE NORMAL DELIVERY SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT DELIVERY SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

SIGNAL FUNCTIONS

1601	Please tell me if any of the following interventions have ever been carried out by providers as part of their work in this facility, and if so, whether the intervention has been carried out at least once during the past 3 months.	(A) EVER PROVIDED IN FACILITY			(B) PROVIDED IN PAST 3 MONTHS		
		YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
01	PARENTERAL ADMINISTRATION OF ANTIBIOTICS (IV OR IM)	1 → B	2 → 02	8 → 02	1	2	8
02	PARENTERAL ADMINISTRATION OF OXYTOCIC (IV OR IM)	1 → B	2 → 03	8 → 03	1	2	8
03	PARENTERAL ADMINISTRATION OF ANTICONVULSANT FOR HYPERTENSIVE DISORDERS OF PREGNANCY (IV OR IM)	1 → B	2 → 04	8 → 04	1	2	8
04	ASSISTED VAGINAL DELIVERY USING INSTRUMENT SUCH AS FORCEPS OR A SUCTION DEVICE	1 → B	2 → 05	8 → 05	1	2	8
05	MANUAL REMOVAL OF PLACENTA	1 → B	2 → 06	8 → 06	1	2	8
06	REMOVAL OF RETAINED PRODUCTS (E.G., MANUAL VACUUM EXTRACTION, DILATION AND CURETTAGE)	1 → B	2 → 07	8 → 07	1	2	8
07	NEONATAL RESUSCITATION	1 → B	2 → 08	8 → 08	1	2	8
08	KANGAROO MOTHER CARE FOR LOW BIRTH WEIGHT BABIES **NOTE: THIS IS NOT A SIGNAL FUNCTION**	1 → B	2 → 08	8 → 08	1	2	8
09	CORTICOSTEROIDS FOR PRE-TERM LABOR **NOTE: THIS IS NOT A SIGNAL FUNCTION**	1 → B	2 → 10	8 → 10	1	2	8
10	CESAREAN DELIVERY	1 → B	2 → 11	8 → 11	1	2	8
11	BLOOD TRANSFUSION	1 → B	2 → 1603	8 → 1603	1	2	8

1602	Has blood transfusion been done in this facility in a context of delivery during the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 3	
1603	Do you have the national guidelines for BEmONC available in this service site?	YES . . . . . 1 NO 2	→ 1605
1604	May I see the guidelines for BEmONC ?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1605	Do you have the national guidelines for CEmONC? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1607
1606	May I see the national guidelines for CEmONC?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1607	Do you have guidelines on management of pre-term labor? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1609
1608	May I see the guidelines on management of pre-term labor?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1609	Do providers of delivery services in this facility use partograph to monitor labor and delivery?	YES . . . . . 1 NO USE OF PARTOGRAPH 2	→ 1611
1610	Are partographs used routinely (for all cases) or selectively (only for some cases) to monitor labor and delivery in this facility?	ROUTINELY . . . . . 1 SELECTIVELY 2	
1611 **(FN1)**	[PER COUNTRY GUIDELINES] Do providers of delivery services in this facility use Labour Care Guide (LCG) to monitor labor and delivery?	YES . . . . . 1 NO USE OF LABOUR CARE GUIDE . . . . 2 DON'T KNOW 8	→ 1613
1612	Is LCG used routinely (for all cases) or selectively (only for some cases) to monitor labor and delivery in this facility?	ROUTINELY . . . . . 1 SELECTIVELY 2	
1613	Do you have guidelines on routine care of newborns immediately after birth, including breastfeeding? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1615
1614	May I see the guidelines on routine care of newborns immediately after birth?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1615	Do you have guidelines on care of preterm and small babies immediately after birth? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1617
1616	May I see the guidelines on care of preterm and small babies immediately after birth?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

1617	Does the facility conduct regular reviews of maternal deaths or “near-misses”?	BOTH DEATHS AND NEAR MISSES . . 1 ONLY DEATHS . . . . . 2 ONLY NEAR MISSES . . . . . 3 NO 4	
1618	Does the facility conduct regular reviews of newborn deaths or “near-misses”?	BOTH DEATHS AND NEAR MISSES . . 1 ONLY DEATHS . . . . . 2 ONLY NEAR MISSES . . . . . 3 NO 4	

EQUIPMENT AND SUPPLIES FOR ROUTINE DELIVERIES

1620	I would like to know if the following items are available in this delivery area and are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON’T KNOW
01	INCUBATOR	1 → B	2 → B	3 → 02	1	2	8
02	OTHER EXTERNAL HEAT SOURCE	1 → B	2 → B	3 → 03	1	2	8
03	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → B	2 → B	3 → 04	1	2	8
04	SUCTION BULB OR PENGUIN SUCKER	1 → B	2 → B	3 → 06	1	2	8
05	MANUAL VACUUM EXTRACTOR (FOR VACUUM-ASSISTED DELIVERY)	1 → B	2 → B	3 → 06	1	2	8
06	VACUUM ASPIRATION KIT OR D&C KIT	1 → B	2 → B	3 → 07	1	2	8
07	NEONATAL SIZE SELF INFLATING BAG	1 → B	2 → B	3 → 08	1	2	8
08	NEWBORN MASK SIZE 0	1 → B	2 → B	3 → 09	1	2	8
09	NEWBORN MASK SIZE 1	1 → B	2 → B	3 → 10	1	2	8
10	NEWBORN WEIGHING SCALE (10 GRAM GRADATION)	1 → B	2 → B	3 → 11	1	2	8
11	FETAL STETHOSCOPE	1 → B	2 → B	3 → 12	1	2	8
12	DIGITAL BLOOD PRESSURE APPARATUS	1 → B	2 → B	3 → 13	1	2	8
13	MANUAL BLOOD PRESSURE MACHINE	1 → B	2 → B	3 → 14	1	2	8
14	STETHOSCOPE	1 → B	2 → B	3 → 15	1	2	8

15	PULSE OXIMETER	1 → B	2 → B	3 → 16	1	2	8
16	OXYGEN CONCENTRATORS	1 → B	2 → B	3 → 17	1	2	8
17	FILLED OXYGEN CYLINDER	1 → B	2 → B	3 → 18	1	2	8
18	OXYGEN DISTRIBUTION SYSTEM	1 → B	2 → B	3 → 19	1	2	8
19	OXYGEN ANALYZER	1 → B	2 → B	3 → 20	1	2	8
20	PRESSURE REGULATOR	1 → B	2 → B	3 → 21	1	2	8
21	CYLINDER GAUGES	1 → B	2 → B	3 → 22	1	2	8
22	HUMIDIFIERS	1 → B	2 → B	3 → 23	1	2	8
23	LOW FLOW METERS	1 → B	2 → B	3 → 24	1	2	8
24	NASAL CATHETER	1 → B	2 → B	3 → 25	1	2	8
25	OXYGEN MASKS	1 → B	2 → B	3 → 26	1	2	8
26	NASAL PRONGS/CANNULA FOR ADULTS	1 → B	2 → B	3 → 27	1	2	8
27	NASAL PRONGS/CANNULA FOR NEWBORNS	1 → B	2 → B	3 → 28	1	2	8
28	AIR-OXYGEN BLENDERS	1 → B	2 → B	3 → 1621	1	2	8

1621	Do you have any of the following items? If yes, I would like to see them.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	DELIVERY PACK	1 → 07	2	3
02	CORD CLAMP	1	2	3
03	EPISIOTOMY SCISSORS	1	2	3
04	SCISSORS OR BLADE TO CUT CORD	1	2	3
05	SUTURE MATERIAL WITH NEEDLE	1	2	3
06	NEEDLE HOLDER	1	2	3
07	SPECULUM	1	2	3

08	FORCEPS (LARGE)	1	2	3
09	FORCEPS (MEDIUM)	1	2	3
10	BLANK PARTOGRAPH OR LABOR CARE GUIDE	1	2	3
1622	Does this facility routinely observe any of the following postpartum or newborns related practices?	YES	NO	DON'T KNOW
01	Placing newborn to the abdomen (Skin to Skin)	1	2	8
02	Drying and wrapping newborns to keep them warm	1	2	8
03	Initiation of breastfeeding within the first hour	1	2	8
04	Routine, complete (head-to-toe) examination of newborn	1	2	8
05	Suction of the newborn by means of catheter	1	2	8
06	Suction of the newborn by means of suction bulb or penguin sucker	1	2	8
07	Weigh the newborn immediately	1	2	8
08	Administer Vitamin K to newborn	1	2	8

09	Apply Tetracycline eye ointment to both eyes	1	2	8
10	Give full bath (immerse newborn in water) shortly (i.e., within a few minutes/hours) after birth	1	2	8
11	Give the newborn prelacteal liquids	1	2	8
12	Give the newborn OPV (oral polio vaccine/ polio zero vaccine) prior to discharge	1	2	8
13	Give the newborn BCG prior to discharge	1	2	8

1623	Does this facility routinely give free sample of formula to mothers and families when they return home after delivery?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1624	Does this facility provide counseling on post partum family planning before women return home after delivery?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
1625	Please tell me if any of the following medicines or items are available at this service site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY / DK	NO, OR NEVER AVAILABLE
01	TETRACYCLINE EYE OINTMENT FOR NEWBORN	1	2	3	4	5
02	INJECTABLE ANTIBIOTIC (E.G., CEFTRIAXONE, AMPICILLIN, GENTAMICIN)	1	2	3	4	5
03	OXYTOCIN	1	2	3	4	5
04	TRANEXAMIC ACID	1	2	3	4	5
05	MISOPROSTOL	1	2	3	4	5
06	MAGNESIUM SULPHATE	1	2	3	4	5
07	DIAZEPAM	1	2	3	4	5
08	ANTIHYPERTENSIVES (E.G. ALPHA METHYLDOPA, HYDRALAZINE, LABETOLOL)	1	2	3	4	5
09	IV SOLUTION (RINGER LACTATE) WITH INFUSION SET	1	2	3	4	5
10	SKIN DISINFECTANT (OTHER THAN CHLORHEXIDINE)	1	2	3	4	5
11	7.1% CHLORHEXIDINE DIGLUCONATE AQUEOUS SOLUTION OR GEL	1	2	3	4	5

1626	Does this facility allow birth companions to be present during labor and delivery?	YES . . . . . 1 NO 2	

PMTCT DURING LABOR AND DELIVERY

1630	Do you provide or offer any PMTCT service at this service site for women who come in to deliver?	YES . . . . . 1 NO 2	
1631	Do providers of delivery services conduct HIV testing from this service site?	YES . . . . . 1 NO 2	→ 1650
1632	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN . . . . 3 NOT AVAILABLE TODAY 4	

STANDARD PRECAUTIONS

1650	STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	MEDICAL MASKS	1	2	3
09	GOWNS	1	2	3
10	RESPIRATOR	1	2	3
11	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
12	STANDARD PRECAUTIONS GUIDELINES FOR INFECTION CONTROL	1	2	3

THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.

SECTION 16: DELIVERY AND NEWBORN CARE: FOOTNOTES

(FN1) Only include if a country has accepted new WHO Labour Care Guide that is the new generation partograph. If a country includes both the old type partograph and the new generation partograph, retain both items. Remove this question in countries that do not have a nationally accepted WHO WHO Labor Guide that is the new generation partograph.

SECTION 17: POST ABORTION CARE

1700	**CHECK Q102.09** PAC SERVICES AVAILABLE IN FACILITY ↓ PAC SERVICES NOT AVAILABLE IN FACILITY → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE POST ABORTION CARE SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT POST ABORTION CARE SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1701	Do you have the national post abortion care guidelines available at this service area today?	YES . . . . . 1 NO 2	→ 1703
1702	May I see the national post abortion care guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 1705
1703	Do you have any other guidelines on family planning available at this service area today?	YES . . . . . 1 NO 2	→ 1705
1704	May I see the other guidelines?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1705	After providing post abortion care, does this facility provide family planning counselling on the same day before women leave the facility?	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE ←	
1706	Is the counseling provided in the same location where post abortion care is provided?	YES . . . . . 1 NO 2	
	THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.		

SECTION 18: OTHER REPRODUCTIVE AND WOMEN'S HEALTH

1800	**CHECK Q102.17 AND Q102.18** BREAST OR CERVICAL CANCER SCREENING SERVICES AVAILABLE IN FACILITY ☐ ↓ BREAST OR CERVICAL CANCER SCREENING SERVICES NOT AVAILABLE IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE BREAST OR CERVICAL CANCER SCREENING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT THE CANCER SCREENING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1801	Does this facility offer diagnostic services for breast cancer?	YES . . . . . 1 NO 2	→ 1804
1802	Does this facility have staff who are trained to administer breast examination?	YES . . . . . 1 NO 2	
1803	Does this facility conduct mammography on-site or make referrals for mammography?	CONDUCT MAMMOGRAPHY . . . . . 1 MAMMOGRAPHY REFERRALS . . . . . 2 NEITHER 3	
1804	Does this facility offer diagnostic services for cervical cancer?	YES . . . . . 1 NO 2	→ 1806
1805	Does this facility have staff who are trained to conduct pap smear test?	YES . . . . . 1 NO 2	
1806	Does this facility offer treatment services for cervical cancer such as cryotherapy or thermal ablation?	YES . . . . . 1 NO 2	
	THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.		

SECTION 19: MALARIA

1900	**CHECK Q102.10 AND Q102.03** CURATIVE CARE SERVICES OR MALARIA SERVICES AVAILABLE CURATIVE CARE SERVICES OR MALARIA SERVICES NOT AVAILABLE → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH MALARIA ARE SEEN.FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF MALARIA SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1901	Do providers in this facility diagnose malaria?	YES . . . . . 1 NO 2	→ 1910
1902	Do providers in this facility use blood tests to verify the diagnosis of malaria, either by microscopy or mRDT?	YES . . . . . 1 NO 2	→ 1910
1903	Do providers use blood test to verify the diagnosis of malaria for all suspected cases always, or only sometimes?	ALWAYS . . . . . 1 ONLY SOMETIMES 2	
1904	Does this facility have a trained microscopist who can conduct microscopy diagnostic test for malaria?	YES . . . . . 1 NO 2	
1905	Do providers use malaria rapid diagnostic test (mRDT) to diagnose malaria at this service site?	YES . . . . . 1 NO 2	→ 1907
1906	May I see a sample malaria RDT kit? CHECK THAT AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN . . . . 3 NONE AVAILABLE TODAY 4	
1907	Do you have a training manual, poster or other job aid for using malaria rapid diagnostic test?	YES . . . . . 1 NO 2	→ 1909
1908	May I see the training manual, poster or other job aid for using malaria rapid diagnostic test?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
1909	Does this facility offer pre-consultation malaria testing for children presenting with fever?	YES, SOMETIMES BEFORE CONSULTATION . . . . . 1 NO, ALWAYS AFTER CONSULTATION . . 2	
1910	Do providers in this facility prescribe treatment for uncomplicated malaria?	YES . . . . . 1 NO 2	
1911	Do providers in this facility prescribe treatment for, or manage severe malaria?	YES . . . . . 1 NO, REFER ALL CASES OF SEVERE MALARIA 2	
1912	Do you have the national guidelines for the diagnosis and treatment of malaria available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1914
1913	May I see the national guidelines for the diagnosis and treatment of malaria?	OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 → NEXT SECTION OR SERVICE SITE	

1914	Do you have any other guidelines for the diagnosis and treatment of malaria in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE ←	
1915	May I see the other guidelines for the diagnosis and treatment of malaria?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.			

2000	**CHECK Q102.11** STI SERVICE OFFERED →	STI SERVICE NOT OFFERED → NEXT SECTION OR SERVICE SITE	
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE STI SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF STI SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2001	Do providers in this facility make diagnosis that a client has a sexually transmitted infection (STI)?	YES . . . . . 1 NO 2	
2002	Do providers in this facility prescribe treatment for STIs?	YES . . . . . 1 NO 2	
2003	**CHECK Q2001 AND Q2002** RESPONSE "1" CIRCLED IN EITHER Q2001 OR Q2002 →	RESPONSE "1" NOT CIRCLED IN EITHER Q2001 OR Q2002 → NEXT SECTION OR SERVICE SITE	
2004	Are STI clients seen by this service ever referred for HIV counseling and testing, or offered the service from this service site?	YES . . . . . 1 NO 2	→ 2008
2005	Are STI clients seen by this service routinely referred for HIV counseling and testing or offered the service from this service site? Or only if they are suspected to be infected with HIV?	ROUTINELY REFERRED OR OFFERED SERVICE . . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV INFECTED 2	
2006	Do STI service providers in this facility provide HIV testing from this service site?	YES . . . . . 1 NO 2	→ 2008
2007	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN . . . . 3 NONE AVAILABLE TODAY 4	
2008	Do you have the national guidelines for the diagnosis and treatment of STIs available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 2010
2009	May I see the national guidelines for the diagnosis and treatment of STIs?	OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 NEXT SECTION OR SERVICE SITE ←	
2010	Do you have any other guidelines for the diagnosis and treatment of STIs available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO . . . . . 2 NEXT SECTION OR SERVICE SITE ←	
2011	May I see the other guidelines for the diagnosis and treatment of STIs?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
	THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.		

2100	**CHECK Q102.12** TB SERVICES OFFERED IN FACILITY NO TB SERVICES IN FACILITY → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE TB SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF TB SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		

TB DIAGNOSIS

2101	Do providers in this facility make diagnosis that a client has tuberculosis?	YES . . . . . 1 NO 2	

TB TREATMENT

2102	Do providers in this facility prescribe treatment for TB or manage patients who are on TB treatment?	YES . . . . . 1 NO 2	
2103	**CHECK Q2101 AND Q2102** TB DIAGNOSIS OR TREATMENT IN FACILITY (RESPONSE "1" CIRCLED IN EITHER Q2101 OR Q2102) NO TB DIAGNOSIS OR TREATMENT IN FACILITY (RESPONSE "1" NOT CIRCLED IN EITHER Q2101 OR Q2102) → NEXT SECTION OR SERVICE SITE		
2104	Is HIV rapid diagnostic testing available from this service site?	YES . . . . . 1 NO . . . . . 2 → NEXT SECTION OR SERVICE SITE	
2105	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID . . . . . 1 OBSERVED, NONE VALID . . . . . 2 REPORTED AVAILABLE, NOT SEEN . . . . 3 NOT AVAILABLE TODAY 4	
	THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.		

SECTION 22: HIV/AIDS

HIV TESTING

2200	**CHECK Q102.13** HIV TESTING AVAILABLE IN FACILITY ☐ NO HIV TESTING SERVICES IN FACILITY ☐ → 2220		
	ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV COUNSELING AND TESTING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV COUNSELING & TESTING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2201	Do staff working in this facility have access to HIV post-exposure prophylaxis, i.e., PEP?	YES . . . . . 1 NO 2	→ 2204
2202	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? MAY BE PART OF ANOTHER DOCUMENT	YES . . . . . 1 NO 2	→ 2204
2203	May I see the protocols or guidelines on PEP?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
2204	Does this facility provide voluntary medical male circumcision to patients who tested HIV negative?	YES . . . . . 1 NO 2	
2205	Does this facility provide pre-exposure prophylaxis (PrEP) to patients who tested HIV negative?	YES . . . . . 1 NO 2	
2206	Does this facility provide post-exposure prophylaxis (PEP) to victims of sexual violence?	YES . . . . . 1 NO 2	

HIV TREATMENT

2220	**CHECK Q102.14** HIV TREATMENT SERVICES OFFERED IN FACILITY ☐ NO HIV TREATMENT SERVICES IN FACILITY ☐ → 2240		
	ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV TREATMENT SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV TREATMENT SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2221	Do providers in this facility prescribe antiretroviral therapy (ART)?	YES . . . . . 1 NO 2	
2222	Do providers in this facility provide treatment follow-up services for persons on ART, including providing community-based services?	YES . . . . . 1 NO 2	
2223	**CHECK Q102.13** NO HIV TESTING SERVICES IN FACILITY ☐ HIV TESTING SERVICES IN FACILITY (Q2201-Q2206 asked) ☐ → 2240		
2224	Do staff working in this facility have access to HIV post-exposure prophylaxis, i.e., PEP?	YES . . . . . 1 NO 2	→ 2227

2225	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? MAY BE PART OF ANOTHER DOCUMENT	YES . . . . . 1 NO 2	→ 2227
2226	May I see the protocols or guidelines on PEP?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	
2227	Does this facility provide voluntary medical male circumcision to patients who tested HIV negative?	YES . . . . . 1 NO 2	
2228	Does this facility provide pre-exposure prophylaxis (PrEP) to patients who tested HIV negative?	YES . . . . . 1 NO 2	
2229	Does this facility provide post-exposure prophylaxis (PEP) to victims of sexual violence?	YES . . . . . 1 NO 2	

HIV CARE AND TREATMENT

2240	**CHECK Q102.15** HIV CARE AND TREATMENT SERVICES AVAILABLE IN FACILITY ☐ ☐ NO HIV CARE AND TREATMENT SERVICES IN FACILITY → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV CARE AND SUPPORT SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV CARE AND SUPPORT SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

		YES	NO	DON'T KNOW
2241	Please tell me if providers in this facility provide the following services for HIV/AIDS clients:			
01	Prescribe treatment for any opportunistic infections or symptoms related to HIV/AIDS. This includes treating topical fungal infections.	1	2	8
02	Provide systemic intravenous treatment of specific fungal infections such as cryptococcal meningitis	1	2	8
03	Provide treatment for Kaposi's sarcoma	1	2	8
04	Provide or prescribe palliative care for patients, such as symptom or pain management, or nursing care for the terminally ill, or severely debilitated clients	1	2	8
05	Provide Nutrition Assessment, Counseling, and Support (NACS) services	1	2	8
06	Care for pediatric HIV/AIDS patients	1	2	8
07	Prescribe or provide preventive treatment for TB (INH + Pyridoxine prophylaxis)	1	2	8
08	Primary preventive treatment for opportunistic infections, such as Cotrimoxazole preventive treatment (CPT)	1	2	8
09	Family planning counseling and/or services	1	2	8
10	Provide condoms for preventing further transmission of HIV	1	2	8
11	Provide mental health screening	1	2	8
12	Provide Hepatitis C screening	1	2	8

13	Provide Hepatitis C treatment	1	2	8	
14	Provide cervical cancer screening for HIV positive women	1	2	8	
2242	Is there a system for routinely screening and testing HIV-positive clients for TB?	YES . . . . . 1 NO SYSTEM 2 2244			
2243	May I see the system, or evidence of such a system?	SYSTEM OR REGISTER OBSERVED . . . . . 1 SYSTEM OR REGISTER REPORTED, NOT SEEN 2			
2244	**CHECK Q102.13 AND Q102.14** NEITHER HIV TESTING NOR ART SERVICES IN FACILITY HIV TESTING OR ART SERVICES IN FACILITY (Q2201-Q2206 or Q2224-Q2229 asked) NEXT SECTION OR SERVICE SITE				
2245	Do staff working in this facility have access to HIV post-exposure prophylaxis, i.e., PEP?	YES . . . . . 1 NO 2			→ 2248
2246	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? MAY BE PART OF ANOTHER DOCUMENT	YES . . . . . 1 NO 2			→ 2248
2247	May I see the protocols or guidelines on PEP?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2			
2248	Does this facility provide voluntary medical male circumcision to patients who tested HIV negative?	YES . . . . . 1 NO 2			
2249	Does this facility provide pre-exposure prophylaxis (PrEP) to patients who tested HIV negative?	YES . . . . . 1 NO 2			
2250	Does this facility provide post-exposure prophylaxis (PEP) to victims of sexual violence?	YES . . . . . 1 NO 2			
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.					

SECTION 23: NON-COMMUNICABLE DISEASES

2300	**CHECK Q102.16** CHRONIC DISEASE SERVICES AVAILABLE FROM FACILITY CHRONIC DISEASE SERVICES NOT AVAILABLE FROM FACILITY → NEXT SECTION OR SERVICE SITE	

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH NON-COMMUNICABLE OR CHRONIC CONDITIONS SUCH AS DIABETES AND CARDIOVASCULAR DISEASES ARE SEEN. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF SUCH SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

DIABETES

2301	Do providers in this facility diagnose and/or manage diabetes?	YES, DIAGNOSE ONLY . . . . . 1 YES, MANAGEMENT ONLY . . . . . 2 YES, DIAGNOSE AND MANAGEMENT . . . . . 3 NO 4	→ 2310
2302	Do you have the national guidelines for the diagnosis and management of diabetes available in this service area?	YES . . . . . 1 NO 2	→ 2304
2303	May I see the national guidelines for the diagnosis and management of diabetes?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 2310
2304	Do you have any other guidelines for the diagnosis and management of diabetes available in this service area?	YES . . . . . 1 NO 2	→ 2310
2305	May I see the other guidelines for the diagnosis and management of diabetes?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

CARDIO-VASCULAR DISEASES

2310	Do providers in this facility diagnose and/or manage cardiovascular diseases in patients?	YES, DIAGNOSE ONLY . . . . . 1 YES, MANAGEMENT ONLY . . . . . 2 YES, DIAGNOSE AND MANAGEMENT . . . . . 3 NO 4	→ 2320
2311	Do you have the national guidelines for the diagnosis and management of cardio-vascular diseases available in this service area?	YES . . . . . 1 NO 2	→ 2313
2312	May I see the national guidelines for the diagnosis and management of cardio-vascular diseases?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 2320
2313	Do you have any other guidelines for the diagnosis and management of cardio-vascular diseases available in this service area?	YES . . . . . 1 NO 2	→ 2320
2314	May I see the other guidelines for the diagnosis and management of cardio-vascular diseases?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

RESPIRATORY

2320	Do providers in this facility diagnose and/or manage chronic respiratory diseases such as COPD in patients?	YES, DIAGNOSE ONLY . . . . . 1 YES, MANAGEMENT ONLY . . . . . 2 YES, DIAGNOSE AND MANAGEMENT . . . . . 3 NO 4	→ 2330
2321	Do you have the national guidelines for the diagnosis and management of chronic respiratory diseases available in this service area?	YES . . . . . 1 NO 2	→ 2323
2322	May I see the national guidelines for the diagnosis and management of chronic respiratory diseases?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	→ 2330
2323	Do you have any other guidelines for the diagnosis and/ management of chronic respiratory diseases available in this service area?	YES . . . . . 1 NO 2	→ 2330
2324	May I see the other guidelines for the diagnosis and management of chronic respiratory diseases?	OBSERVED . . . . . 1 REPORTED, NOT SEEN 2	

BASIC SUPPLIES AND EQUIPMENT

2330	IS THIS AREA SAME WITH THE GENERAL OUTPATIENT AREA THAT WAS ASSESSED?	SAME WITH THE OUTPATIENT SITE . . . . . 1 NEXT SECTION OR SERVICE AREA ← DIFFERENT FROM THE OUTPATIENT SITI 2	

2331	I would like to know if the following items are available today in the main service area and are functioning ASK TO SEE ITEMS.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1 → B	2 → B	3 → 02	1	2	8
02	STADIOMETER [OR HEIGHT ROD] FOR MEASURING HEIGHT	1 → B	2 → B	3 → 03	1	2	8
03	MEASURING TAPE (GENERAL USE) (1 MILLIMETER GRADATION)	1	2	3			
04	THERMOMETER	1 → B	2 → B	3 → 05	1	2	8
05	DIGITAL BP APPARATUS	1 → B	2 → B	3 → 07	1 → 07	2	8
06	MANUAL BP APPARATUS	1 → B	2 → B	3 → 07	1	2	8
07	STETHOSCOPE	1 → B	2 → B	3 → 08	1	2	8
08	SELF-INFLATING BAG AND MASK [ADULT]	1 → B	2 → B	3 → 09	1	2	8

09	SELF-INFLATING BAG AND MASK [PEDIATRIC]	1 → B	2 → B	3 → 10	1	2	8
10	MICRONEBULIZER	1 → B	2 → B	3 → 11	1	2	8
11	SPACERS FOR INHALERS	1	2	3			
12	PEAK FLOW METERS	1 → B	2 → B	3 → 13	1	2	8
13	PULSE OXIMETER	1 → B	2 → B	3 → 14	1	2	8
14	OXYGEN CONCENTRATORS	1 → B	2 → B	3 → 15	1	2	8
15	FILLED OXYGEN CYLINDER	1 → B	2 → B	3 → 16	1	2	8
16	OXYGEN DISTRIBUTION SYSTEM	1 → B	2 → B	3	1	2	8
THANK YOUR RESPONDENT FOR THEIR TIME AND HELP. PROCEED TO THE NEXT DATA COLLECTION SITE.							

SECTION 24: CESAREAN DELIVERY

2400	**CHECK Q102.20** CESAREAN SECTION DONE IN FACILITY ☐ → CESAREAN DELIVERY NOT DONE IN FACILITY ☐ → 2500		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CESAREAN DELIVERIES ARE DONE. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF SUCH SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2401	Does the facility have a health worker who can perform Cesarean delivery (section) present at the facility or on call 24 hours a day (including weekends and on public holidays)?	YES . . . . . 1 NO 2	
2402	Does this facility have an anesthetist present in the facility or on call 24 hours a day (including weekends and on public holidays)?	YES . . . . . 1 NO 2	
2403	Have Cesarean deliveries been performed in this facility during the past 3 months?	YES . . . . . 1 NO 2	
2404	Has blood transfusion been done in this facility in a context of cesarean delivery during the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 3	
	THANK YOUR RESPONDENT. PROCEED TO THE FINAL SUMMARY SECTION.		

2500	IN ANY OF THE SERVICE OR WAITING AREAS THROUGHOUT THE ASSESSMENT, HAVE YOU SEEN OPENLY DISPLAYED BREASTMILK SUBSTITUTES AND RELATED PRODUCTS, POSTERS IDEALIZING THE USE OF BREASTMILK SUBSTITUTES, FEEDING BOTTLES OR NIPPLES? NOTE: FEEDING CUPS ARE PERMITTABLE. IF ONLY FEEDING CUPS ARE VISIBLE, CIRCLE CODE 'X' FOR 'NONE DISPLAYED'	FORMULA MARKETING POSTERS DISPLAYED . . . . . A INFANT FURMULA BOXES/CANS DISPLAYED . . . . . B FEEDING BOTTLES DISPLAYE . C NIPPLES DISPLAYE . . . . . D NONE DISPLAYEI X
2501	RECORD THE INTERVIEW END TIME	HOURS . . . . . MINUTES . . . . .

END OF INTERVIEW

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR: _____ DATE: _____

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY
HEALTH WORKER'S INTERVIEW QUESTIONNAIRE

[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FACILITY IDENTIFICATION

QTYPE: H W I

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

PROVIDER SEX: (1=MALE; 2=FEMALE) . . . . . [ ]

PROVIDER STATUS: (1=ASSIGNED; 2=SECONDED) . . . . . [ ]

INTERVIEWER'S VISIT

DATE . . . . . DAY [ ][ ]
MONTH [ ][ ]
YEAR [ ][ ][ ][ ]

INTERVIEWER'S NAME _____

INTERVIEWER'S NUMBER: [ ][ ][ ][ ]

OBSERVATIONS AND SIMULATIONS ASSOCIATED WITH PROVIDER

NUMBER OF ANC OBSERVATIONS ASSOCIATED WITH PROVIDER . . . . . [ ]

NUMBER OF FP OBSERVATIONS ASSOCIATED WITH PROVIDER . . . . . [ ]

NUMBER OF SICK CHILD OBSERVATIONS ASSOCIATED WITH PROVIDER . . . . . [ ]

NUMBER OF NEWBORN RESUSCITATION SIMULATIONS ASSOCIATED WITH PROVIDER . . . . . [ ]

PREVIOUS INTERVIEW ASSOCIATED WITH PROVIDER

CHECK IF PROVIDER WAS PREVIOUSLY INTERVIEWED IN ANOTHER FACILITY.

IF YES, RECORD NAME AND FACILITY NUMBER WHERE HE/ SHE WAS INTERVIEWED

YES, PREVIOUSLY INTERVIEWED 1
(RECORD NAME AND FACILITY NUMBER)

NAME OF FACILITY

NUMBER OF FACILITY [ ][ ][ ][ ][ ] → **END**

NO, NOT PREVIOUSLY INTERVIEWED 2
GOTO CONSENT AND INTRODUCTION

LANGUAGE OF QUESTIONNAIRE** [ ][ ]
LANGUAGE OF INTERVIEW** [ ][ ]
NATIVE LANGUAGE OF RESPONDENT** [ ][ ]
TRANSLATOR USED (YES = 1, NO = 2) [ ]

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH
02 LANGUAGE 2
03 LANGUAGE 3
04 LANGUAGE 4
05 LANGUAGE 5
06 LANGUAGE 6

TEAM NUMBER [ ][ ]

TEAM SUPERVISOR NAME _____ NUMBER [ ][ ][ ][ ]

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY

HEALTH WORKER INTERVIEW

INTRODUCTION AND CONSENT

READ THE FOLLOWING CONSENT STATEMENT

Good day. My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

Your facility was selected to participate in this study. We will be asking you several questions about the types of services that you personally provide, as well as questions about the training you have received. The questions usually take about 20-30 minutes.

All information you give will be confidential and will not be shared with anyone other than members of our survey team. The information you provide us may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that the facility can be identified. Participation in the survey is voluntary, you may refuse to answer any question or choose to stop the interview at any time. There is no penalty for refusing to participate, however, your experience and views are important and we hope you will collaborate with the study.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your facility manager.

Do you have any questions?

May I begin the interview now?

SIGNATURE OF INTERVIEWER _____

DATE

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 2 |

RESPONDENT AGREES TO BE INTERVIEWED . . 1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 → END

1. EDUCATION AND EXPERIENCE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME	HOURS		| MINUTES			
102	What is your current occupational category or qualification? For example, are you a registered nurse, or generalist medical doctor or a specialist medical doctor? [LIST WILL BE COUNTRY SPECIFIC - MUST BE EXTENSIVE, WITH NO NEED FOR "OTHER"]	GENERALIST MEDICAL DOCTOR . . . . . 01 SPECIALIST MEDICAL DOCTOR . . . . . 02 ASSISTANT MEDICAL OFFICER . . . . . 03 CLINICAL OFFICER . . . . . 04 ASSISTANT CLINICAL OFFICER . . . . . 05 REGISTERED NURSE . . . . . 07 ENROLLED NURSE . . . . . 08 NURSE ASSISTANT/ATTENDANT . . . . . 09 MIDWIFE . . . . . 10 LABORATORY SCIENTIST . . . . . 11 LABORATORY TECHNOLOGIST . . . . . 12 LABORATORY TECHNICIAN . . . . . 13 LABORATORY ASSISTANT . . . . . 14 OTHER CLINICAL STAFF NOT LISTED ABOVE . . . . . 96 SPECIFY _____ NO TECHNICAL QUALIFICATION/ NON CLINICAL STAFF 95	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
103	What year did you graduate (or complete studies) with this qualification? IF NO TECHNICAL QUALIFICATION (102=95), ASK: What year did you complete any basic training for your current occupational category?	YEAR	
104	In what year did you start working in this facility?	YEAR	
105	How long have you worked in the current capacity/ position?	MONTHS . . . . . YEARS	
106	Have you received any dose of the COVID-19 vaccination?	YES . . . . . 1 NO . . . . . 2 REFUSED TO ANSWER 3	
107	Are you a manager or in-charge for any clinical services?	YES . . . . . 1 NO 2	

2. GENERAL TRAINING

			YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	
200	I would like to ask you a few questions about in-service training you have received related to your work. In-service training refers to training you have received related to your work since you started working. I will start with some general topics. Note that the training topics I will mention may have been covered as stand alone trainings, or they may have been covered under another training topic. Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES, ASK: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?					
01	Standard precautions, including hand hygiene, cleaning and disinfection, waste management, needle stick and sharp injury prevention?	01 STANDARD PRECAUTIONS	1	2	3	
02	Any specific training related to injection safety practices or safe injection practices?	02 INJECTION SAFETY	1	2	3	
03	Health Management Information Systems (HMIS) or reporting requirements for any service?	03 HMIS	1	2	3	
04	How to care and/or refer victims of gender-based violence(GBV)?	04 GBV VICTIMS CARE/ REFERRAL	1	2	3	
05	Use of personal protective equipment (PPE) to prevent infection at work?	05 PPE USE	1	2	3	
06	Triage and isolation of patients with suspected or confirmed infectious diseases?	06 TRIAGE/ ISOLATION	1	2	3	
07	Anemia assessment, diagnosis, and treatment?	07 ANEMIA ASSESMENT DIAGNOSIS/ TREATMENT . .	1	2	3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	CHECK [Q102] FOR PROVIDER OCCUPATIONAL CATEGORY / QUALIFICATION CODE [11, 12, 13 OR 14, 96] NOT CIRCLED ☐ CODE [11, 12, 13 OR 14] (i.e., LABORATORY-RELATED) CIRCLED ☐ → 700 CODE '95' CIRCLED ☐ → END		
	I will now ask you a few questions about services you personally provide in your current position in this facility and any in-service training, training updates, or refresher trainings you may have received related to that service. Please remember we are talking about services you provide in your current position in this facility. The training topics I will mention may have been covered as a stand-alone training, or covered as part of another training topic.		

MALARIA

202	In your current position, and as a part of your work for this facility, do you personally diagnose and/or treat malaria?	YES . . . . . 1 NO 2				
203	Have you received any in-service training, training updates, or refresher trainings on topics related to diagnosis and/or treatment of malaria?	YES . . . . . 1 NO 2				→ 205
204	Have you received on the job mentorship, or onsite job training related to diagnosis and/or treatment of malaria?	YES . . . . . 1 NO 2				→ 206
205	Have you received any in-service training, training updates, or refresher trainings in any of the following topics [READ TOPIC]: IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO TRAINING OR UPDATES	
01	Diagnosis of malaria, including through on the job mentorship, or onsite job training?	01 DIAGNOSING MALARIA	1	2	3	
02	Malaria rapid diagnostic test (mRDT), including through on the job mentorship, or onsite job training?	02 MALARIA RDT	1	2	3	
03	Malaria microscopy, including through on the job mentorship, or onsite job training?	03 MALARIA MICROSCOPY	1	2	3	
04	Case management / treatment of malaria, including through on the job mentorship, or onsite job training?	04 TREATMENT MALARIA	1	2	3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

DIABETES

206	In your current position, and as a part of your work for this facility, do you personally diagnose and/or manage diabetes?	YES . . . . . 1 NO 2	
207	Have you received any in-service training, training updates, or refresher training on topics specific to the diagnosis and/or management of diabetes? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

CARDIO-VASCULAR DISEASES

208	In your current position, and as a part of your work for this facility, do you personally diagnose and/or manage cardio-vascular diseases?	YES . . . . . 1 NO 2	
209	Have you received any in-service training, training updates, or refresher training on the diagnosis and/or management of cardio-vascular diseases? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

CHRONIC RESPIRATORY DISEASES

210	In your current position, and as a part of your work for this facility, do you personally diagnose and/or manage chronic respiratory conditions such as chronic obstructive pulmonary disease (COPD)?	YES . . . . . 1 NO 2	
211	Have you received any in-service training, training updates, or refresher training on the diagnosis and/or management of chronic respiratory diseases? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

BREAST CANCER AND CERVICAL CANCER

212	In your current position, and as part of your work for this facility, do you personally provide any reproductive cancer screening, diagnosis and/or treatment services, that is for breast cancer and/or cervical cancer?	YES . . . . . 1 NO 2				
213	Have you received any in-service training, training updates, or refresher training on topics related to breast cancer and/or cervical cancer services?	YES . . . . . 1 NO 2				→ 300
214	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	
01	Clinical breast examinations?	01 BREAST EXAM . .	1	2	3	
02	Mammography?	02 MAMMOGRAM . .	1	2	3	
03	Cytology based screening such as the Papanicolaou (“Pap”) smear or liquid-based cytology to screen for cervical cancer?	03 PAP SMEAR OR LBC . .	1	2	3	
04	The HPV testing to screen for cervical cancer?	04 HPV TEST . .	1	2	3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
05	Visual inspection with acetic acid (VIA) to inspect the cervix for visual signs suspicious for cancer or pre-cancer?	05 VIA TEST . . 1 2 3	
06	Cryotherapy, or thermal ablation also called cold coagulation or thermal coagulation for treatment of cervical intraepithelial neoplasia?	06 CRYOTHERAPY OR THERMAL ABLATION . . 1 2 3	

3. CHILD HEALTH SERVICES

300	In your current position, and as a part of your work for this facility, do you personally provide any child vaccination services?	YES . . . . . 1 NO 2				
301	In your current position, and as a part of your work for this facility, do you personally provide any child growth monitoring services?	YES . . . . . 1 NO 2				
302	In your current position, and as a part of your work for this facility, do you personally provide any child curative care services (includes inpatient, outpatient, emergency/triage, malaria, tuberculosis and HIV)?	YES . . . . . 1 NO 2				
303	Have you received any in-service training, training updates, or refresher training on topics related to child health or childhood illnesses?	YES . . . . . 1 NO 2				→ 305
304	Have you received any in-service training or training updates in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	
01	Expanded progamme on immunization (EPI) or cold chain monitoring?	01 EPI OR COLD CHAIN MONITORING	1	2	3	
02 **(FN1)**	Integrated management of childhood illness (IMCI)?	02 IMCI	1	2	3	
03	Diagnosis and/or treatment of acute respiratory infections?	03 DIAGNOSIS AND/OR TREATMENT OF ARI . .	1	2	3	
04	Diagnosis and/or treatment of diarrhea?	04 DIAGNOSIS AND/ OR TREATMENT OF DIARRHEA	1	2	3	
05	Nutritional assessment of child growth and/or screening for acute malnutrition?	05 NUTRITIONAL ASSESSMENT	1	2	3	
06	Assessment and/or treatment of micronutrient deficiencies in children?	06 MICRONUTRIENT DEFICIENCIES	1	2	3	
07	Breastfeeding?	07 BREASTFEEDING	1	2	3	
08	Complementary feeding in infants?	08 COMPLEMENTARY FEEDING IN INFANTS	1	2	3	
09	Pediatric HIV/AIDS?	09 PEDIATRIC HIV/AIDS	1	2	3	
10	Pediatric ART?	10 PEDIATRIC ART	1	2	3	
11	Pediatric emergency triage?	11 PEDIATRI C TRIAGE	1	2	3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
305	CHECK 205 MALARIA TRAINING NOT ASKED ☐ ↓ ANY CODE '1','2' OR '3' CIRCLED ☐ → 400		

NO.	QUESTIONS AND FILTERS			YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO TRAINING OR UPDATES	SKIP
306	Have you received any in-service training, training updates, or refresher training in any of the following topics related to malaria [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?						
01	Diagnosis of malaria, including through on the job mentorship, or onsite job training?	01	DIAGNOSING MALARIA . .	1	2	3	
02	Malaria rapid diagnostic test (mRDT), including through on the job mentorship, or onsite job training?	02	MALARIA RDT . .	1	2	3	
03	Malaria microscopy, including through on the job mentorship, or onsite job training?	03	MALARIA MICROSCOPY . .	1	2	3	
04	Case management / treatment of malaria, including through on the job mentorship, or onsite job training?	04	TREATMENT OF MALARIA . .	1	2	3	

4. FAMILY PLANNING SERVICES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
400	In your current position, and as a part of your work for this facility, do you personally provide any family planning services?	YES . . . . . 1 NO 2	
401	Have you received any in-service training, training updates, or refresher training on topics related to family planning?	YES . . . . . 1 NO . . . . . 2 → 500	

NO.	QUESTIONS AND FILTERS			YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	SKIP
402	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?						
01	General counseling for family planning?	01	GENERAL COUNSELING . .	1	2	3	
02	IUD insertion and/or removal?	02	IUD INSERTION/ . .	1	2	3	
03	Implant insertion and/or removal?	03	IMPLANT INSERT/ REMOVAL . .	1	2	3	
04 **(FN02)**	Injectable administration and counseling?	04	INJECTABLE . .	1	2	3	
05	Performing sterilization?	05	STERILIZATION . .	1	2	3	
06	Counseling on family planning side effects and how to manage them?	06	FP SIDE EFFECTS . .	1	2	3	
07	Family planning for HIV positive women?	07	FP FOR HIV POSITIVE WOMEN . .	1	2	3	
08	Lactation Amenorhhea Method (LAM)	08	LAM	1	2	3	
09	Post-partum family planning counseling?	09	POST-PARTUM FP . .	1	2	3	
10	Post-abortion family planning counseling?	10	POST-ABORTION FP COUNSELING . .	1	2	3	

5. MATERNAL HEALTH SERVICES

ANC - PNC - PMTCT

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
500	In your current position, and as a part of your work for this facility, do you personally provide any antenatal care or postnatal care services? IF YES, PROBE AND INDICATE WHICH SERVICES ARE PROVIDED	YES, ANTENATAL . . . . . 1 YES, POSTNATAL . . . . . 2 YES, BOTH . . . . . 3 NO, NEITHER 4	
501	Have you received any in-service training, training updates, or refresher training on topics related to antenatal care or postnatal care?	YES . . . . . 1 NO 2	→ 503
502	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS / YES, OVER 24 MONTHS AGO / NO IN-SERVICE TRAINING OR UPDATES	
01	ANC screening (e.g., blood pressure, urine glucose, and protein)?	01 ANC SCREENING . . 1 2 3	
02	Counseling for ANC (e.g., nutrition, FP, and newborn care)?	02 ANC COUNSELING . . 1 2 3	
03	Micronutrient supplementation of pregnant women, such as iron and folic acid containing supplements, multiple micronutrient supplements, calcium, and others?	03 MICRONUTRIENT SUPPLEMENTATION OF PREGNANT WOMEN . . 1 2 3	
04	Post-abortion family planning counseling?	04 POST-ABORTION FP COUNSELING . . 1 2 3	
503	Do you personally provide any services that are specifically geared toward preventing mother-to-child transmission of HIV?	YES . . . . . 1 NO 2	
504	Have you received any in-service training, training updates, or refresher training on topics related to prevention of mother-to-child transmission (PMTCT) of HIV? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

DELIVERY SERVICES

505	In your current position, and as a part of your work for this facility, do you personally provide delivery services? By that I mean conducting the actual delivery of newborns?	YES . . . . . 1 NO 2	→ 510
506	During the past 6 months, approximately how many deliveries have you conducted as the main provider (include deliveries conducted for private practice and for facility)?	TOTAL DELIVERIES	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
507	When was the last time you used a partograph?	NEVER . . . . . 0 WITHIN PAST WEEK . . . . . 1 WITHIN PAST MONTH . . . . . 2 WITHIN PAST 6 MONTHS . . . . . 3 OVER 6 MONTHS AGO 4	
508 **(FN3)**	Have you used a WHO Labour Care Guide that is the new generation partograph?	YES . . . . . 1 NO 2	→ 510
509 **(FN3)**	When was the last time you used a WHO Labour Care Guide that is the new generation partograph?	WITHIN PAST WEEK . . . . . 1 WITHIN PAST MONTH . . . . . 2 WITHIN PAST 6 MONTHS . . . . . 3 OVER 6 MONTHS AGO 4	
510	Have you received any in-service training, training updates, or refresher training on topics related to delivery care?	YES . . . . . 1 NO 2	→ 512

511	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	
01	Integrated Management of Pregnancy and Childbirth (IMPAC)?	01 IMPAC	1	2	3	
02	Comprehensive Emergency Obstetric and Newborn Care (CEmONC)?	02 CEmONC	1	2	3	
03	Routine care for labor and normal vaginal delivery?	03 CARE NORMAL VAGINAL L&D . . .	1	2	3	
04	Active Management of Third Stage of Labor (AMTSL)?	04 AMTSL	1	2	3	
05	Basic Emergency obstetric and Newborn care (BEmONC)/Life saving skills (LSS) - in general?	05 BEmONC/LSS	1	2	3	
06	Post abortion care?	06 POST ABORTION CARE . .	1	2	3	
07	Special delivery care practices for preventing mother-to-child transmission of HIV?	07 DELIVERY CARE FOR PMTCT	1	2	3	

NEWBORN CARE SERVICES

512	In your current position, and as a part of your work for this facility, do you personally provide care for the newborn?	YES . . . . . 1 NO 2	
513	Have you received any in-service training, training updates, or refresher training on topics related to newborn care?	YES . . . . . 1 NO 2	→ 515
514	Have you received any in-service training, training updates, or refresher training on essential newborn care? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	TRAINING ON IPTP-EXCLUSIVE BF-NEONATAL RESUSCITATION		
515	CHECK Q 202, 302 AND 500: IF PERSONALLY PROVIDES MALARIA CARE THAT IS CODE '1' CIRCLED IN 202, AND/ OR CHILD CURATIVE CARE THAT IS CODE '1' CIRCLED IN 302, AND /OR ANC THAT IS CODE '1' CIRCLED IN 500 YES, PROVIDES MALARIA CARE, AND /OR ANC, AND/OR CHILD CARE ☐ NO ☐ →		517
516	Have you received any in-service training, training updates, or refresher training related to Intermittent preventive treatment of malaria during pregnancy, including through on the job mentorship, or onsite job training? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	
517	CHECK Q 500, 505, 512: IF PERSONALLY PROVIDES ANTENATAL CARE, POSTNATAL CARE OR BOTH THAT IS CODE '1' OR '2' OR '3' IS CIRCLED IN 500, AND/ OR DELIVERY CARE THAT IS CODE '1' CIRCLED IN 505, AND/ OR NEWBORN CARE THAT IS CODE '1' CIRCLED IN 512 YES, PROVIDES ANC AND/OR PNC AND/OR DELIVERY CARE AND /OR NEWBORN CARE ☐ NO ☐ →		519
518	Have you received any in-service training, training updates, or refresher training related to early and exclusive breastfeeding? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	
519	CHECK Q 505 AND 512: IF PERSONALLY PROVIDES DELIVERY CARE THAT IS CODE '1' CIRCLED IN 505, AND/ OR NEWBORN CARE THAT IS CODE '1' CIRCLED IN 512 YES, PROVIDES DELIVERY CARE AND /OR NEWBORN CARE ☐ NO ☐ →		600
520	Have you received any in-service training, training updates, or refresher training related to neonatal resuscitation using bag and mask? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

6. SEXUALLY TRANSMITTED INFECTIONS - TB - HIV/AIDS

SEXUALLY TRANSMITTED INFECTIONS

600	In your current position, and as part of your work for this facility, do you personally provide any STI services?	YES . . . . . 1 NO 2	
601	Have you received any in-service training, training updates, or refresher training related to diagnosing and treating sexually transmitted infections (STIs)? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

TUBERCULOSIS (TB)

602	In your current position, and as part of your work for this facility, do you personally provide any TB screening, diagnostic or management services?	YES . . . . . 1 NO 2	
603	In your current position, and as a part of your work for this facility, do you personally provide diagnosis of TB based on sputum tests using an AFB smear microscopy and or a TB diagnostic algorithm?	YES . . . . . 1 NO 2	
604	In your current position, and as a part of your work for this facility, do you personally provide treatment prescription for TB?	YES . . . . . 1 NO 2	
605	In your current position, and as a part of your work for this facility, do you personally provide management of TB-HIV co-infection?	YES . . . . . 1 NO 2	
606	Have you received any in-service training, training updates, or refresher training on topics related to TB services?	YES . . . . . 1 NO 2	→ 608

			YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	
607	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?					
01	Screening for TB infection or TB disease:					
	a) Mantoux tuberculin skin test	01a) TUBERCULIN SKIN TEST . .	1	2	3	
	b) The whole blood tests based on interferon-gamma release assays (IGRAs)	01b) BLOOD IGRA . .	1	2	3	
	c) Mtb antigen-based skin tests (TBST)	01c) TBST	1	2	3	
	d) Molecular WHO-recommended rapid diagnostic tests(mWRDs), alone or in combination	01d) TB mWRDs . .	1	2	3	
	e) Chest radiography such as X-ray	01e) CHEST X-RAY . .	1	2	3	
	f) The WHO-recommended four-symptom screen (W4SS), comprising screening for a current cough, fever, night sweats or weight loss.	01f) FOUR SYMPTOM SCREEN . .	1	2	3	
02	Diagnosis of TB based on a sputum microscopy?	02 MICROSCOPY . .	1	2	3	
03	Diagnosis of TB based on a TB diagnostic algorithm?	03 ALGORITHM . .	1	2	3	
04	Treatment prescription for TB?	04 TB TREATMENT . .	1	2	3	
05	Management of TB-HIV co-infection?	05 TB-HIV MANAGEMENT . .	1	2	3	

HIV/AIDS SERVICES

608	In your current position, and as part of your work for this facility, do you personally provide any HIV/AIDS services?	YES . . . . . 1 NO 2	
609	In your current position, and as a part of your work for this facility, do you personally provide HIV testing and counseling?	YES . . . . . 1 NO 2	
610	In your current position, and as a part of your work for this facility, do you personally provide HIV care and treatment including ART?	YES . . . . . 1 NO 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
611	In your current position, and as a part of your work for this facility, do you personally provide post-exposure prophylaxis (PEP) services?	YES . . . . . 1 NO 2	
612	Have you received any in-service training, training updates, or refresher training on topics related to HIV/AIDS services?	YES . . . . . 1 NO 2	→ 700
613	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS / YES, OVER 24 MONTHS AGO / NO IN-SERVICE TRAINING OR UPDATES	
01	HIV testing and counseling?	01 HIV TESTING & COUNSELING 1 2 3	
02	HIV care and treatment including ART?	02 HIV CARE AND TREATMENT 1 2 3	
03	Post-exposure prophylaxis (PEP) services?	03 PEP 1 2 3	

7. DIAGNOSTIC SERVICES

700	In your current position, and as a part of your work for this facility, do you personally conduct laboratory tests including rapid diagnostic tests? CIRCLE 'NO' IF THE PROVIDER ONLY COLLECTS SPECIMENS.	YES . . . . . 1 NO 2	→ 706
701	Please tell me if you personally conduct any of the following laboratory tests as part of your work in this facility	YES / NO	
01	Microscopic examining of sputum for diagnosing TB?	01 SPUTUM MICROSCOPY . . . . . '1 '2	
02	Any other TB screening or diagnostics tests?	02 OTHER TB SCREENING OR DIAGNOSTIC TESTS . . . . . '1 '2	
03	HIV rapid testing?	03 HIV RDT . . . . . '1 '2	
04	Any other HIV test, such as PCR, ELISA, or Western Blot?	04 OTHER HIV TEST . . . . . '1 '2	
05	Hematology testing, such as anemia testing?	05 ANEMIA . . . . . '1 '2	
06	Malaria microscopy?	06 MALARIA MICROSCOPY . . . . . '1 '2	
07	Malaria rapid diagnostic test (mRDT)?	07 MALARIA RDT . . . . . '1 '2	
08	Cytology based screening such as the Papanicolaou (“Pap”) smear or liquid-based cytology to screen for cervical cancer?	08 PAP SMEAR OR LBC . . . . . '1 '2	
09	The HPV testing to screen for cervical cancer?	09 HPV TESTING . . . . . '1 '2	
10	Syphilis rapid diagnostic test?	10 SYPHILIS RDT . . . . . '1 '2	
11	Any other Syphilis test, such as the rapid plasma reagin (RPR) or venereal disease research laboratory (VDRL)?	11 OTHER SYPHILIS TEST RPR/VDRL . . . . . '1 '2	
12	Urine tests including dipstick and 24-hour for proteinuria?	12 URINE TEST . . . . . '1 '2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES				SKIP
702	Have you received any in-service training, training updates, or refresher training on topics related to the tests you conduct?	YES . . . . . 1 NO . . . . . 2 → 704				
703	Have you received any in-service training, training updates, or refresher training in any of the following topics [READ TOPIC] IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES	
01	a) Mantoux tuberculin skin test for TB screening	01a) TUBERCULIN SKIN TEST . .	1	2	3	
	b) The whole blood tests based on interferon-gamma release assays (IGRAs) for TB screening	01b) BLOOD IGRA . .	1	2	3	
	c) Mtb antigen-based skin tests (TBST) for TB screening	01c) TBST	1	2	3	
	d) Molecular WHO-recommended TB rapid diagnostic tests(mWRDs), alone or in combination	01d) TB mWRDs . .	1	2	3	
	e) Chest radiography such as X-ray for TB screening	01e) CHEST X-RAY . .	1	2	3	
	f) Microscopic examination of sputum for diagnosing TB	01f) TB MICROSCOPY	1	2	3	
02	HIV rapid diagnostic test (HIV RDT)?	02 HIV	1	2	3	
03	Other HIV test, such as PCR, ELISA, or Western Blot?	03 OTHER HIV TEST	1	2	3	
04	Anemia testing?	04 ANEMIA TEST	1	2	3	
05	Malaria microscopy, including through on the job mentorship, or onsite job training?	05 MALARIA MICROSCOPY	1	2	3	
06	Malaria rapid diagnostic test (mRDT), including through on the job mentorship, or onsite job training?	06 MALARIA RDT	1	2	3	
07	Cytology based screening such as the Papanicolaou (“Pap”) smear or liquid-based cytology to screen for cervical cancer?	07 PAP SMEAR OR LBC	1	2	3	
08	The HPV testing to screen for cervical cancer?	08 HPV TESTING	1	2	3	
09	Syphilis rapid diagnostic test?	09 SYPHILIS RDT	1	2	3	
10	Any other Syphilis test, such as the rapid plasma reagin (RPR) or venereal disease research laboratory (VDRL)?	10 OTHER SYPHILIS TEST RPR/VDRL	1	2	3	
11	Urine tests including dipstick and 24-hour for proteinuria?	11 URINE TEST	1	2	3	
704	Have you received on the job mentorship, or onsite job training related to malaria microscopy? IF YES: Was the on the job mentorship, or onsite job training on malaria microscopy within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3				
705	Have you received on the job mentorship, or onsite job training related to malaria rapid diagnostic test (mRDT)? IF YES: Was the on the job mentorship, or onsite job training on malaria rapid diagnostic test within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3				
706	CHECK Q 302, 500, 503, 608: IF PERSONALLY PROVIDES CHILD CURATIVE CARE THAT IS CODE '1' CIRCLED IN 302, AND/ OR ANC THAT IS CODE '1' CIRCLED IN 500, AND/ OR PMTCT CARE THAT IS CODE '1' CIRCLED IN 503, AND /OR HIV/AIDS CARE THAT IS CODE'1' YES, PROVIDES CHILD CURATIVE CARE AND/OR ANC, AND/OR PMTCT AND /OR HIV/AIDS CARE ☐ ↓ NO ☐ → 800					

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
707	Have you received any in-service training, training updates, or refresher training related to anemia testing, point of care or in a laboratory? IF YES: Was the training, training update, or refresher training within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS . . . . . 1 YES, OVER 24 MONTHS AGO . . . . . 2 NO TRAINING OR UPDATES 3	

8. WORKING CONDITIONS IN FACILITY

800	Now I want to ask you a few more questions about your work in this facility. In an average week, how many hours do you work in this facility? IF WEEKS ARE NOT CONSISTENT, ASK THE RESPONDENT TO AVERAGE OUT HOW MANY HOURS PER MONTH AND THEN DIVIDE THIS BY 4.	AVERAGE HOURS PER WEEK WORKING IN THIS FACILITY				
801	Now I would like to ask you some questions about supervision you have personally received. This supervision may have been from a supervisor either from this facility or outside the facility. Do you receive technical support or supervision in your work? IF YES, ASK: When was the most recent time?	YES, IN THE LAST 3 MONTHS . . . . . 1 YES, IN THE LAST 4-6 MONTHS . . . . . 2 YES, IN THE LAST 7-12 MONTHS . . . . . 3 YES, MORE THAN 12 MONTHS AGO . . . . . 4 NO 5				→ 804
802	How many times in the past six months has your work been supervised?	NUMBER OF TIMES . . . . . EVERY DAY 96				
803	The last time you were personally supervised, did your supervisor do any of the following:		YES	NO	DON'T KNOW	
01	Check your records or reports?	01 CHECKED RECORD	1	2	8	
02	Observe your work?	02 OBSERVED WORK	1	2	8	
03	Provide any feedback (either positive or negative) on your performance?	03 FEEDBACK	1	2 → 05	8 → 05	
04	Give you verbal or written feedback that you were doing your work well?	04 VERBAL PRAISE	1	2	8	
05	Provide updates on administrative or technical issues related to your work?	05 UPDATES	1	2	8	
06	Discuss problems you have encountered?	06 PROBLEMS	1	2	8	
07	Discuss clinical skills?	07 CLINICAL SKILLS	1	2	8	
08	Discuss interpersonal skills?	08 INTERPERSONAL	1	2	8	
804	Do you have a written job description of your current job or position in this facility? IF YES, ASK: May I see it?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3				
805	Are there any opportunities for promotion in your current job?	YES . . . . . 1 NO . . . . . 2 UNCERTAIN/ DON'T KNOW 8				
806	Have you ever been offered any continued professional development opportunities in this facility to facilitate your professional development or move up to career advancement? IF YES, ASK: When was the most recent time?	YES, IN THE LAST 6 MONTHS . . . . . 1 YES, IN THE LAST 7-12 MONTHS . . . . . 2 YES, MORE THAN 12 MONTHS AGO . . . . . 3 NO 4				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
807	Do you think that you have equal treatment and opportunities as your colleagues of the opposite sex a) in terms of training? b) in terms of professional advancement? c) in terms of preferred geographic posts? d) in terms of time off? e) in terms of work schedule?	YES / NO / DON'T KNOW a) TRAINING . . . . . 1 2 8 b) ADVANCEMENT . . . . . 1 2 8 c) GEOGRAPHIC POST . . . . . 1 2 8 d) TIME OFF . . . . . 1 2 8 e) WORK SCHEDULE 1 2 8	
808	Are you paid salary for the work you do in your current position at this facility or are you not paid at all?	YES PAID SALARY . . . . . 1 NOT PAID 2	→ 810
809	When was the last time you received your salary for the work you do in this facility?	PAID WITHIN THE LAST 6 MONTHS . . . . . 1 PAID IN LAST 7-12 MONTHS . . . . . 2 PAID IN MORE THAN 12 MONTHS AGO 3	
810	While working in your current position at this facility, have you received any monetary salary supplement for the work you do? IF YES, PROBE: When was the last time you received a monetary salary supplement?	YES, WITHIN THE LAST 6 MONTHS . . . . . 1 YES, IN THE LAST 7-12 MONTHS . . . . . 2 YES, MORE THAN 12 MONTHS AGO . . . . . 3 NO/ NEVER 4	→ 812
811	Which types of monetary salary supplements did you receive, if any? PROBE: Anything else?	MONTHLY OR DAILY SALARY SUPPLEMENT . . . . . A PERDIEM WHEN ATTENDING TRAINING . . . . . B DUTY ALLOWANCE . . . . . C PAYMENT FOR EXTRA ACTIVITIES (NOT ROUTINELY PROVIDED) . . . . . D OTHER _____ (SPECIFY) . . . . . X NONE . . . . . Y	
812	While working in your current position at this facility, have you received any non-monetary incentives for the work you do? IF YES, ASK: When was the most recent time?	YES, IN THE LAST 6 MONTHS . . . . . 1 YES, IN THE LAST 7-12 MONTHS . . . . . 2 YES, MORE THAN 12 MONTHS AGO . . . . . 3 NO/ NEVER 4	→ 814
813	What non-monetary incentives have you received? PROBE: Anything else?	TIME OFF / VACATIONS . . . . . A UNIFORMS, BACKPACKS, CAPS, ETC. . . . . B DISCOUNT MEDICINES, FREE TICKETS FOR CARE, VOUCHERS, ETC. . . . . C TRAINING . . . . . D FOOD RATION / MEALS . . . . . E SUBSIDIZED HOUSING . . . . . F NONE . . . . . Y	
814	CHECK Q 202, 302, 701 IF DIAGNOSING AND/OR TREATING MALARIA THAT IS CODE '1' CIRCLED IN 202, AND /OR PROVIDES CHILD CURATIVE CARE CODE '1' CIRCLED IN 302, AND /OR CONDUCTS MALARIA LABORATORY TESTS: MALARIA MICROSCOPY CODE '1' CIRCLED IN 701(05), AND/OR MALARIA RAPID DIAGNOSTIC TEST CODE '1' CIRCLED IN 701(06) YES, PROVIDES MALARIA CARE, AND/OR CHILD CARE AND/OR MALARIA LAB TEST ☐ ↓ NO ☐ →		817
815	In the last 24 months, has someone provided supportive supervision as part of your malaria specific work in this facility? This supportive supervision may have been from a supervisor outside the facility.	YES . . . . . 1 NO . . . . . 2 UNCERTAIN/ DON'T KNOW 8	→ 817

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
816	In the last 24 months, how many supportive supervision visits did you have? FOR DON'T KNOW OR UNCERTAIN, CIRCLE 98	NUMBER OF TIMES . . . . . [ ][ ] UNCERTAIN/ DON'T KNOW 98	
817	Now I would like to talk about your time working in this facility. Would you say that you are very satisfied, satisfied, not satisfied, or very dissatisfied about working here?	VERY SATISFIED . . . . . 1 SATISFIED . . . . . 2 NOT SATISFIED . . . . . 3 VERY DISSATISFIED 4	
818	Among the various things related to your working situation that you would like to see improved, can you tell me the three that you think would most improve your ability to provide good quality of care services? Please rank them in order of importance, with 1 being the most important. DO NOT READ CHOICES TO YOUR RESPONDENT ENTER LETTER CORRESPONDING WITH THE 1ST MENTIONED INTO THE 1ST BOX, AND REPEAT WITH THE 2ND AND 3RD. IF THE PROVIDER ONLY MENTIONS 1 OR 2 ITEMS THEN PUT "Y" IN THE REMAINING BOX/ES. DO NOT LEAVE ANY BOX EMPTY. THERE MUST BE 3 ENTRY.	MORE SUPPORT FROM SUPERVISOR . . . . . A MORE KNOWLEDGE / UPDATES TRAINING . . . . . B MORE SUPPLIES/STOCK . . . . . C BETTER QUALITY EQUIPMENT/SUPPLIES . . . . . D LESS WORKLOAD (i.e. MORE STAFF) . . . . . E BETTER WORKING HOURS / FLEXIBLE TIMES . . . . . F MORE INCENTIVES (SALARY,PROMOTION, HOLIDAYS) . . . . . G TRANSPORTATION FOR REFERRAL PATIENTS . . . . . H PROVIDING ART . . . . . I PROVIDING PEP . . . . . J INCREASED SECURITY . . . . . K BETTER FACILITY INFRASTRUCTURE . . . . . L MORE AUTONOMY / INDEPENDENCE . . . . . M EMOTIONAL SUPPORT FOR STAFF (COUNSELING / SOCIAL ACTIVITIES) . . . . . N OTHER BOX 1 _____ (SPECIFY) . . . . . V OTHER BOX 2 _____ (SPECIFY) . . . . . W OTHER BOX 3 _____ (SPECIFY) . . . . . X NO PROBLEM . . . . . Y RANKING [ ][ ][ ] BOX 1 BOX 2 BOX 3	.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
819	CHECK FOR PRESENCE OF OTHERS: DO NOT CONTINUE UNTIL PRIVACY IS ENSURED. PRIVACY OBTAINED 1 ↓ PRIVACY NOT POSSIBLE 2 → 825		
820	READ TO THE RESPONDENT: Now I would like to ask you questions about some other important aspects of your work. You may find some of these questions very personal. However, your answers are crucial for helping to understand the condition of health providers in [COUNTRY]. Let me assure you that your answers are completely confidential and will not be told to anyone and no one else in your health facility will know that you were asked these questions. If I ask you any question you don't want to answer, just let me know and I will go on to the next question.		
821	At any time during your work in this health facility, did any staff member a) Slap you? b) Hit or punch you? c) Physically threaten you? d) Physically mistreat or harm you in any other way?	YES NO a) SLAP . . . . . 1 2 b) HIT OR PUNCH . . . . . 1 2 c) PHYSICALLY THREATEN . . . . . 1 2 d) OTHER PHYSICAL HARM 1 2	
822	At any time during your work in this health facility, did any staff member a) Shout at you? b) Say or do something to humiliate you? c) Verbally threaten you? d) Verbally mistreat you in any other way?	YES NO a) SHOUT . . . . . 1 2 b) HUMILIATE . . . . . 1 2 c) VERBALLY THREATEN . . . . . 1 2 d) OTHER VERBAL MISTREATMENT 1 2	
823	At any time during your work in this health facility, did any patient or patient's family members a) Slap you? b) Hit or punch you? c) Physically threaten you? d) Physically mistreat or harm you in any other way?	YES NO a) SLAP . . . . . 1 2 b) HIT OR PUNCH . . . . . 1 2 c) PHYSICALLY THREATEN . . . . . 1 2 d) OTHER PHYSICAL HARM 1 2	
824	At any time during your work in this health facility, did any patient or patient's family members a) Shout at you? b) Say or do something to humiliate you? c) Verbally threaten you? d) Verbally mistreat you in any other way?	YES NO a) SHOUT . . . . . 1 2 b) HUMILIATE . . . . . 1 2 c) VERBALLY THREATEN . . . . . 1 2 d) OTHER VERBAL MISTREATMENT 1 2	
825	RECORD THE TIME	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
	THANK THE RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT		

HEALTH WORKER INTERVIEW. FOOTNOTES

(FN1) Change the Integrated management of childhood illness (IMCI) according to the country specific adaptation of the IMCI guidelines, for example to the Integrated Management of Newborn & Childhood Illnesses (IMNCI), or Integrated Management of Neonatal and Childhood Illness (IMNCI) as appropriate

(FN2) Adapt as per country needs or specific injectable. For example, in countries with a Sayna Press program, you may specify "DMPA-SC/ Sayana Press administration and counseling?"

(FN3) Only include if a country has accepted new WHO Labour Care Guide that is the new generation partograph. If a country includes both the old type partograph and the new generation partograph, retain both items. Remove this question in countries that do not have a nationally accepted WHO Labor Guide that is the new generation partograph.

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY
OBSERVATION OF ANTENATAL CARE CONSULTATION

[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FACILITY IDENTIFICATION

QTYPE [O][A][N]

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

PROVIDER INFORMATION

PROVIDER QUALIFICATION CATEGORY:

PROVIDER TYPE 1	01
PROVIDER TYPE 2	02
PROVIDER TYPE 3	03
PROVIDER TYPE 4	04
PROVIDER TYPE 5	05
PROVIDER TYPE 6	06
PROVIDER TYPE 7	07
PROVIDER TYPE 8	08
PROVIDER TYPE 9	09
OTHER TYPE	96

PROVIDER CATEGORY . . . . . [ ][ ]

SEX OF PROVIDER: (1=MALE; 2=FEMALE)

SEX OF PROVIDER . . . . . [ ]

INFORMATION ABOUT OBSERVATION

DATE . . . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [2][0][2][ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** [0][1]

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED [ ] (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:

01 ENGLISH	03 LANGUAGE 3	05 LANGUAGE 5
02 LANGUAGE 2	04 LANGUAGE 4	06 LANGUAGE 6

TEAM

[ ][ ]
NUMBER

TEAM SUPERVISOR

_____ [ ][ ][ ][ ]
NAME NUMBER

OBSERVATION OF ANTENATAL CARE CONSULTATION			
NO.	QUESTIONS	CODING CATEGORIES	GO TO

BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.

INTRODUCTION AND PROVIDER CONSENT

READ THE FOLLOWING CONSENT STATEMENT TO THE PROVIDER

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

Your facility was selected to participate in this study. We will be observing your consultation with this client in order to understand how ANC services are provided in this facility. At the end of the consultation, we will ask you questions about the types of services that you provided. The observation usually takes about 15-20 minutes.

Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the names of your clients participating in this study will be included in the dataset or in any report; however, there is a small chance that the facility can be identified. Still, we are asking for your help to ensure that the information we collect is accurate.

Participation in the survey is voluntary. You may refuse to answer any question, or you can ask me to leave at any point, if you feel uncomfortable. There is no penalty for refusing to participate, however, we hope you won't mind our observing your consultation.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your facility manager.

Do you have any questions?

Do I have your permission to be present at this consultation?

SIGNATURE OF INTERVIEWER _____

DATE

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 2 | |

PROVIDER AGREES TO BE OBSERVED . . 1 ↓

PROVIDER DOES NOT AGREE TO BE OBSERVED . . . . . 2 → END

101	CLIENT CONSENT READ THE FOLLOWING CONSENT STATEMENT TO THE CLIENT Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY]. This facility was selected to participate in the study. I would like to be present while you are receiving services today in order to understand how ANC services are provided in this facility. The observation usually takes about 15-20 minutes. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services. Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. There is no penalty for refusing to participate, however, we hope you won't mind our observing the consultation. After the consultation, my colleague would like to talk with you about your experience here today. In case you need more information about the survey, you may contact the in-charge manager of this health facility. Do you have any questions for me at this time? Do I have your permission to be present at this consultation? SIGNATURE OF INTERVIEWER _____ CLIENT AGREES TO BE OBSERVED . . 1 ↓ CLIENT DOES NOT AGREE TO BE OBSERVED . . . . . 2 → END		
102	RECORD THE TIME THE OBSERVATION STARTED USE 24 HOURS FORMAT	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
FOR EACH OF THE GROUPS THAT FOLLOW, CIRCLE ANY ACTION TAKEN BY THE PROVIDER OR THE CLIENT. IF NO ACTION IN THE GROUP IS OBSERVED, CIRCLE "Y" FOR EACH GROUP AT THE END OF THE OBSERVATION.			

CLIENT HISTORY

104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:		
01	CLIENT'S AGE	A	
02	MEDICATIONS THE CLIENT IS TAKING	B	
03	DATE CLIENT'S LAST MENSTRUAL PERIOD BEGAN	C	
04	NUMBER OF PRIOR PREGNANCIES CLIENT HAS HAD	D	
05	HIV STATUS **(FN1)**	E	
06	NONE OF THE ABOVE	Y	

COMPLICATIONS OR ADVERSE OUTCOMES OF PRIOR PREGNANCIES

105	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:		
01	PRIOR STILLBIRTH(S)	A	
02	PRIOR PRETERM BIRTH(S)	B	
03	INFANT(S) WHO DIED IN THE FIRST WEEK OF LIFE	C	
04	HEAVY BLEEDING, DURING OR AFTER DELIVERY	D	
05	PREVIOUS INSTRUMENT ASSISTED DELIVERY (USE OF VENTOUSE/VACUUM, OR FORCEPS)	E	
06	PREVIOUS CAESAREAN SECTION	F	
07	PREVIOUS SPONTANEOUS ABORTIONS	G	
08	PREVIOUS MULTIPLE PREGNANCIES	H	
09	PREVIOUS PROLONGED LABOR	I	
10	PREVIOUS GESTATIONAL (ALSO KNOWN AS PREGNANCY-INDUCED) HYPERTENSION, CHRONIC HYPERTENSION, OR SYMPTOMS OF PREGNANCY-INDUCED HYPERTENSION (SEVERE HEADACHE AND BLURRED VISION)	J	
11	PREVIOUS CHRONIC OR GESTATIONAL DIABETES (HIGH BLOOD SUGAR	K	
12	PREVIOUS PREGNANCY RELATED CONVULSIONS	L	
13	HIGH FEVER OR INFECTION DURING PRIOR PREGNANCY/PREGNANCIES OR SOON AFTER DELIVERY	M	
14	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES		GO TO
	POTENTIAL DANGER SIGNS OF CURRENT PREGNANCY			
106	IN **COLUMN A**, RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY. IN **COLUMN B**, RECORD WHETHER THE PROVIDER COUNSELLED ON THE DANGER SIGNS.	(A) PROVIDER ASKED ABOUT OR CLIENT MENTIONED	(B) PROVIDER COUNSELLED	
01	VAGINAL BLEEDING	A	A	
02	FEVER	B	B	
03	HEADACHE OR BLURRED VISION	C	C	
04	SWOLLEN FACE OR HANDS OR EXTREMITIES	D	D	
05	TIREDNESS OR BREATHLESSNESS	E	E	
06	FETAL MOVEMENT (LOSS OF, EXCESSIVE)	F	F	
07	PERSISTENT COUGH FOR 2 WEEKS OR LONGER	G	G	
08	FREQUENT AND PAINFUL URINATION	H	H	
09	FOUL SMELLING VAGINAL DISCHARGE	I	I	
10	ANY OTHER SYMPTOMS OR PROBLEMS THE CLIENT THINKS MIGHT BE RELATED TO THIS PREGNANCY	J	J	
11	NONE OF THE ABOVE	Y	Y	
107	RECORD WHETHER PROVIDER ADVISED ANY OF THESE COURSES OF ACTION IF CLIENT EXPERIENCED ANY OF THESE DANGER SIGNS	SEEK CARE AT A FACILITY . . . . . A REFERRAL TO SPECIALIST PROVIDER . . . . . B INITIATION OF MEDICATION . . . . . C REEVALUATION/FOLLOW-UP VISIT WITHIN SHORT TIME PERIOD . . . . . D OTHER _____ X PROVIDER DID NOT ADVISE . . . . . Y		

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

PHYSICAL EXAMINATION

108	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:		
01	TOOK THE CLIENT'S BLOOD PRESSURE , WITH ARM ABOVE OR BELOW HEART LE\	A	
02	TOOK THE CLIENT'S BLOOD PRESSURE WITH ARM AT HEART LEVEL	B	
03	WEIGHED THE CLIEN`	C	
04	TOOK CLIENT'S HEIGHT	D	
05	AUSCULTATED THE CLIENT'S HEART	E	
06	AUSCULTATED THE CLIENT'S LUNGS	F	
07	CHECKED CONJUNCTIVA/PALMS/NAILS FOR ANEMIA	G	
08	EXAMINED LEGS/FEET/HANDS FOR EDEMA	H	
09	PALPATED THE CLIENT'S ABDOMEN FOR FETAL PRESENTATION	I	
10	AUSCULTATED THE CLIENT'S ABDOMEN FOR FETAL HEARTBEAT	J	
11	CONDUCTED AN ULTRASOUND/REFER CLIENT FOR ULTRASOUND/LOOK AT RECENT ULTRASOUND REPOR1.	K	
12	MEASURED FUNDAL HEIGHT USING TAPE MEASURE	L	
13	NONE OF THE ABOVE	Y	

ROUTINE TESTS

109	RECORD WHETHER THE PROVIDER A) ASKED ABOUT, B) PERFORMED OR, C) REFERRED THE CLIENT FOR THE FOLLOWING TESTS:	(A) PROVIDER ASKED	(B) PROVIDER PERFORMED	(C) PROVIDER REFERRED	(D) NO ACTION TAKEN	
01	HEMOGLOBIN TEST	A	B	C	Y	
02	BLOOD GROUPING	A	B	C	Y	
03	ANY URINE TEST	A	B	C	Y	
04	SYPHILIS TEST	A	B	C	Y	
05	BLOOD COUNT	A	B	C	Y	
06	ROUTINE HIV TEST	A	B	C	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

MAINTAINING A HEALTHY PREGNANCY

110	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT MAINTAINING A HEALTHY PREGNANCY		
01	DISCUSSED QUANTITY OF FOOD TO EAT DURING THE PREGNANCY	A	
02	DISCUSSED TYPES OF FOOD TO EAT DURING THE PREGNANCY	B	
03	DISCUSSED STAYING PHYSICALLY ACTIVE DURING THE PREGNANCY	C	
04	DISCUSSED THE AMOUNT OF WEIGHT TO GAIN DURING THE PREGNANCY	D	
05	INFORMED THE CLIENT ABOUT THE PROGRESS OF THE PREGNANCY	E	
06	DISCUSSED THE IMPORTANCE OF FREQUENT ANC VISITS **(FI**	F	
07	NONE OF THE ABOVE	Y	

IRON/ FOLATE SUPPLEMENTATION

111	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	PRESCRIBED OR GAVE IRON PILLS AND FOLIC ACID	A	
02	EXPLAINED THE PURPOSE OF IRON AND FOLIC ACID	B	
03	EXPLAINED HOW TO TAKE IRON AND FOLIC ACID PILLS	C	
04	EXPLAINED SIDE EFFECTS OF IRON AND FOLIC ACID PILLS	D	
05	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

CALCIUM SUPPLEMENTS (FN3)

112	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	PRESCRIBED OR GAVE CALCIUM SUPPLEMENTS	A	
02	EXPLAINED THE PURPOSE OF CALCIUM SUPPLEMENTS	B	
03	EXPLAINED HOW TO TAKE CALCIUM SUPPLEMENTS	C	
04	EXPLAINED SIDE EFFECTS OF CALCIUM SUPPLEMENTS	D	
05	NONE OF THE ABOVE	Y	

MULTIPLE MICRONUTRIENT SUPPLEMENTS (FN3)

113	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	PRESCRIBED OR GAVE MULTIPLE MICRONUTRIENT SUPPLEMENTS	A	
02	EXPLAINED THE PURPOSE OF MULTIPLE MICRONUTRIENT SUPPLEMENTS	B	
03	EXPLAINED HOW TO TAKE MULTIPLE MICRONUTRIENT SUPPLEMENTS	C	
04	EXPLAINED SIDE EFFECTS OF MULTIPLE MICRONUTRIENT SUPPLEMENTS	D	
05	NONE OF THE ABOVE	Y	

MALARIA

114	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	GAVE/PRESCRIBED MALARIA PROPHYLAXIS MEDICINE (SP) TO CLIENT DURING THE CONSULTATION	A	
02	EXPLAINED THE PURPOSE OF THE PREVENTIVE TREATMENT WITH ANTI-MALARIA MEDICINE	B	
03	EXPLAINED HOW TO TAKE THE ANTI-MALARIA MEDICINE	C	
04	EXPLAINED POSSIBLE SIDE EFFECTS OF THE ANTI-MALARIA MEDICINE	D	
05	PROVIDED ITN TO CLIENT AS PART OF CONSULTATION OR INSTRUCTED CLIENT WHERE TO OBTAIN ITN	E	
06	EXPLICITLY EXPLAINED IMPORTANCE OF USING ITN TO CLIENT	F	
07	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

PREPARATION FOR DELIVERY

115	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:		
01	ASKED THE CLIENT WHERE SHE WILL DELIVER	A	
02	ADVISED THE CLIENT TO PREPARE FOR DELIVERY (E.G. SET ASIDE MONEY, ARRANGE FOR EMERGENCY TRANSPORTATION)	B	
03	ADVISED THE CLIENT TO USE A SKILLED HEALTH WORKER FOR DELIVERY	C	
04	ADVISE THE CLIENT WHAT ITEMS TO HAVE IN HANDS IN CASE OF EMERGENCY AND IT'S IMPORTANCE (E.G., BLADE)	D	
05	ADVISED THE CLIENT TO DELIVER AT A HEALTH FACILITY	E	
06	NONE OF THE ABOVE	Y	

NEWBORN AND POSTPARTUM CARE

116	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT NEWBORN OR POSTPARTUM CARE IN ANY OF THE FOLLOWING WAYS:		
01	DISCUSSED CARE FOR THE NEWBORN (I.E., WARMTH, HYGIENE, AND CORD CARE)	A	
02	DISCUSSED IMPORTANCE OF VACCINATION FOR THE NEWBORN	B	
03	DISCUSSED FAMILY PLANNING OPTIONS FOR AFTER DELIVERY	C	
04	DISCUSSED THE IMPORTANCE OF POSTNATAL CARE ATTENDANCE	D	
05	NONE OF THE ABOVE	Y	

BREASTFEEDING

117	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT BREASTFEEDING IN ANY OF THE FOLLOWING WAYS:		
01	DISCUSSED THE IMPORTANCE OF BREASTFEEDING	A	
02	DISCUSSED EARLY INITIATION OF BREASTFEEDING	B	
03	DISCUSSED EXCLUSIVE BREASTFEEDING UNTIL 6 MONTHS OF AGE	C	
04	DISCUSSED WHERE CLIENT COULD GET HELP FOR BREASTFEEDING	D	
05	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

ADDITIONAL PROVIDER ACTIONS

118	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:		
01	LOOKED AT CLIENT'S HEALTH CARD AT ANY TIME BEFORE BEGINNING THE CONSULTATION, WHILE COLLECTING INFORMATION OR WHILE EXAMINING THE CLIENT	A	
02	WROTE ON THE CLIENT'S HEALTH CARD	B	
03	ASKED IF THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS	C	
04	ASKED PERMISSION BEFORE CARRYING OUT ANY EXAMS OR PROCEDURES	D	
05	EXPLAINED WHY THEY WERE CARRYING OUT ANY EXAMS OR PROCEDURES	E	
06	EXPLAINED THE FINDINGS OF ANY EXAMS OR CONSULTATIONS	F	
07	EXPLAINED WHY THERE WERE GIVING OUT ANY MEDICINE	G	
08	USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING	H	
09	WASHED HANDS BEFORE AND AFTER ANY PROCEDURE	I	
10	ADVISED THE CLIENT WHEN TO RETURN FOR HER NEXT ANC VISIT	J	
11	NONE OF THE ABOVE	Y	

QUESTIONS TO PROVIDER

AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS:			
119	How many weeks pregnant is the client?	WEEKS OF PREGNANCY ☐☐	
120	How many antenatal care visits has the client had at **this facility for this pregnancy**?	NUMBER OF VISITS ☐☐	
121	Has the client visited other facilities **for this pregnancy** before coming to this facility?	YES 1 NO 2 DON'T KNOW 8	→ 124
122	How many antenatal care visits has the client had at other facilities for this pregnancy?	NUMBER OF VISITS ☐☐	
123	Was the client referred from another facility for ANC care at this facility?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
124	Has the client had a previous pregnancy, regardless of the duration or outcome of that pregnancy, or is this the client's first pregnancy?	FIRST PREGNANCY . . . . . 1 NOT FIRST PREGNANCY . . . . . 2 DON'T KNOW 8	
125	Is this client's pregnancy high-risk ?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
126	Were any client measurements taken by you or another health care provider before the consultation today, for example during group counseling or while the client was waiting? IF 'YES", ASK "Which measurements?"	HEIGHT . . . . . A WEIGHT . . . . . B BLOOD PRESSURE . . . . . C TEMPERATURE . . . . . D OTHER: _____ . . . . . E NONE . . . . . Y	
127	RECORD THE TIME THE OBSERVATION ENDED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
	THANK THE SERVICE PROVIDER AND THE CLIENT AND MOVE TO THE NEXT DATA COLLECTION POINT		
	Interviewer's comments:		

(FN1) ONLY INCLUDE IF THIS IS INCLUDED IN COUNTRY-SPECIFIC GUIDELINES
(FN2) CAN BE ADAPTED TO A SPECIFIC NUMBER ACCORDING TO COUNTRY GUIDELINES
(FN3) INCLUDE THIS SECTION ONLY IF PART OF COUNTRY GUIDELINES

OBSERVATION OF ANTENATAL CARE CONSULTATION: FOOTNOTES

(FN1) Only include if this is included in country-specific guidelines

(FN2) Can be adapted to a specific number according to country guidelines

(FN3) Include this section [MULTIPLE MICRONUTRIENT SUPPLEMENTS 113(01-05)] only if part of country guidelines

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY
OBSERVATION OF FAMILY PLANNING CONSULTATION

[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FACILITY IDENTIFICATION

QTYPE F P O

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

PROVIDER INFORMATION

PROVIDER QUALIFICATION CATEGORY:
PROVIDER TYPE 1 01
PROVIDER TYPE 2 02
PROVIDER TYPE 3 03
PROVIDER TYPE 4 04
PROVIDER TYPE 5 05
PROVIDER TYPE 6 06
PROVIDER TYPE 7 07
PROVIDER TYPE 8 08
PROVIDER TYPE 9 09
OTHER TYPE 96

PROVIDER CATEGORY . . . . . [ ][ ]

SEX OF PROVIDER: (1=MALE; 2=FEMALE)

SEX OF PROVIDER . . . . . [ ]

INFORMATION ABOUT OBSERVATION

DATE: . . . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 2 [ ]

INTERVIEWER'S NAME:_____

INTERVIEWER'S NUMBER . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** 0 1

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED [ ] (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH
02 LANGUAGE 2
03 LANGUAGE 3
04 LANGUAGE 4
05 LANGUAGE 5
06 LANGUAGE 6

TEAM

[ ][ ]
NUMBER

TEAM SUPERVISOR

_____
NAME

[ ][ ][ ][ ]
NUMBER

OBSERVATION OF FAMILY PLANNING CONSULTATION

NO.	QUESTIONS	CODING CATEGORIES	GO TO

BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.

INTRODUCTION AND PROVIDER CONSENT

READ THE FOLLOWING CONSENT STATEMENT TO THE PROVIDER

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

Your facility was selected to participate in this study. We will be observing your consultation with this client in order to understand how family planning services are provided in this facility. At the end of the consultation, we will ask you questions about the types of services that you provided. The observation usually takes about 15-20 minutes.

Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the names of your clients participating in this study will be included in the dataset or in any report; however, there is a small chance that the facility can be identified. Still, we are asking for your help to ensure that the information we collect is accurate.

Participation in the survey is voluntary. You may refuse to answer any question, or you can ask me to leave at any point, if you feel uncomfortable. There is no penalty for refusing to participate, however, we hope you won't mind our observing your consultation.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your facility manager.

Do you have any questions?

Do I have your permission to be present at this consultation?

SIGNATURE OF INTERVIEWER _____ DATE

DAY				
MONTH				
YEAR	2	0	2	

PROVIDER AGREES TO BE OBSERVED . . 1 ↓

PROVIDER DOES NOT AGREE TO BE OBSERVED . . . . . 2 → END

100	CLIENT CONSENT READ THE FOLLOWING CONSENT STATEMENT TO THE CLIENT Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY]. This facility was selected to participate in the study. I would like to be present while you are receiving services today in order to understand how family planning services are provided in this facility. The observation usually takes about 15-20 minutes. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services. Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. There is no penalty for refusing to participate, however, we hope you won't mind our observing the consultation. After the consultation, my colleague would like to talk with you about your experience here today. In case you need more information about the survey, you may contact the in-charge manager of this health facility. Do you have any questions for me at this time? Do I have your permission to be present at this consultation? SIGNATURE OF INTERVIEWER _____ CLIENT AGREES TO BE OBSERVED . . 1 ↓ CLIENT DOES NOT AGREE TO BE OBSERVED . . . . . 2 → END		
101	RECORD THE TIME THE OBSERVATION STARTED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
102	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	

CLIENT HISTORY AND REPRODUCTIVE INTENTION

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
103	INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:		
01	AGE OF CLIENT	A	
02	LAST MENSTRUAL PERIOD (ASSESS IF CURRENTLY PREGNANT)	B	
03	NUMBER OF LIVING CHILDREN	C	
04	LAST DELIVERY DATE OR AGE OF YOUNGEST CHILD	D	
05	BREASTFEEDING STATUS	E	
06	REGULARITY OF MENSTRUAL CYCLE	F	
07	DESIRE FOR A CHILD OR MORE CHILDREN	G	
08	DESIRED TIMING FOR BIRTH OF NEXT CHILD	H	
09	NONE OF THE ABOVE	Y	

PHYSICAL EXAMINATION AND RISK FACTOR ASSESSMENT

104	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS:		
01	TOOK THE CLIENT'S BLOOD PRESSURE	A	
02	WEIGHED THE CLIENT	B	
03	ASKED THE CLIENT ABOUT HER SMOKING HABITS	C	
04	ASKED THE CLIENT ABOUT SYMPTOMS OF STIs (E.G., ABNORMAL VAGINAL/URETHRAL DISCHARGE)	D	
05	ASKED THE CLIENT ABOUT ANY CHRONIC ILLNESSES (HEART DISEASE, DIABETES, HYPERTENSION, LIVER DISEASE, OR BREAST CANCER)	E	
06	ASKED THE CLIENT ABOUT ANY MEDICATION THAT SHE CURRENTLY TAKES	F	
07	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

SEXUALLY TRANSMITTED INFECTIONS

105	RECORD WHETHER THE PROVIDER DISCUSSED ANY OF THE FOLLOWING ISSUES RELATED TO SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV		
01	CLIENT'S PERCEIVED RISK OF STIs/HIV	A	
02	USE OF CONDOMS TO PREVENT STIs/HIV	B	
03	USING CONDOMS ALONG WITH ANOTHER METHOD (DUAL METHOD) TO PREVENT BOTH PREGNANCY AND STIs/HIV	C	
04	NONE OF THE ABOVE	Y	

CONTRACEPTIVE COUNSELING

106	RECORD WHETHER THE PROVIDER OR CLIENT DID ANY OF THE FOLLOWING:		
01	PROVIDER ASKED OR CLIENT TOLD ABOUT HISTORY OF FAMILY PLANNING USE	A	
02	PROVIDER ASKED OR CLIENT TOLD ABOUT CONCERNS OR PROBLEMS WITH METHODS USED IN THE PAST	B	
03	PROVIDER ASKED OR CLIENT TOLD ABOUT IF SHE USES ANY METHODS CURRENTLY	C	
04	PROVIDER ASKED IF SHE HAD QUESTIONS OR CONCERNS REGARDING THE METHOD SHE CURRENTLY USES, IF SHE USES ANY METHODS	D	
05	CLIENT TOLD ABOUT CONCERNS ABOUT METHOD, OR ASKED QUESTIONS ABOUT METHOD, INCLUDING POSSIBLE SIDE EFFECTS OF METHOD	E	
06	PROVIDER ASKED CLIENT IF SHE HAS A PREFERRED METHOD OR METHOD OF CHOICE	F	
07	PROVIDER ASKED CLIENT IF SHE HAS ANY QUESTIONS	G	
08	PROVIDER AND CLIENT TALKED SWITCHING IF SHE WANTS TO STOP USING A METHOD	H	
09	PROVIDER AND CLIENT TALKED ABOUT TWO OR MORE METHODS	I	
10	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

PRIVACY/CONFIDENTIALITY

107	RECORD WHETHER THE PROVIDER TOOK ANY OF THE FOLLOWING STEPS TO ASSURE THE CLIENT OF PRIVACY:		
01	ENSURED VISUAL PRIVACY	A	
02	ENSURED AUDITORY PRIVACY	B	
03	ASSURED THE CLIENT VERBALLY OF CONFIDENTIALITY	C	
04	NONE OF THE ABOVE	Y	

METHODS PROVIDED, PRESCRIBED, OR DISCUSSED

108	**VERIFY** METHOD WITH PROVIDER AND INDICATE WHICH METHOD(S) WERE EITHER PROVIDED, PRESCRIBED, OR DISCUSSED DURING THIS VISIT. FOR EXAMPLE, IF CONDOMS WERE EITHER PRESCRIBED OR PROVIDED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS. IF OTHER METHOD(S) WAS DISCUSSED, IN ADDITION, CIRCLE THAT METHOD(S) IN COLUMN C. "DISCUSSION" REFERS TO PROVISION OF SOME INFORMATION ABOUT THE METHOD SUCH AS HOW THE METHOD WORKS, WHAT SIDE EFFECTS MAY OCCUR, OR COMPARISON AGAINST METHODS PRESCRIBED OR PROVIDED. IF CLIENT IS CONTINUING, CLIENT WHO RECEIVED REFILLS FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUD DURING THIS VISIT, CIRCLE THE METHOD THAT WAS REPLENISHED IN COLUMN B. **CAUTION**! AT LEAST ONE RESPONSE MUST BE REPORTED FOR EACH OF THE COLUMNS IF NO METHOD IS PRESCRIBED, THEN "Y" SHOULD BE CIRCLED IN COLUMN "A".

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES			GO TO
	METHOD	(A)	(B)	(C)	
		PRESCRIBED TO BE FILLED OUTSIDE THE FACILITY	PROVIDED TO CLIENT IN THE FACILITY	DISCUSSED	
01	COMBINED ORAL PILL	A	A	A	
02	PROGESTIN-ONLY ORAL PILL	B	B	B	
03	ORAL PILL (TYPE UNSPECIFIED)	C	C	C	
04	COMBINED INJECTABLE (MONTHLY)	D	D	D	
05	PROGESTIN-ONLY INJECTABLE (2 OR 3-MONTHLY) INTRAMUSCULAR (DMPA-IM) . .	E	E	E	
06	[PER COUNTRY GUIDELINES] **(FN1)** PROGESTIN-ONLY INJECTABLE (2 OR 3-MONTHLY) SUBCUTANEOUS (DMPA-SC)	F	F	F	
07	MALE CONDOM	G	G	G	
08	FEMALE CONDOM	H	H	H	
09	IUD	I	I	I	
10	IMPLANT	J	J	J	
11	EMERGENCY CONTRACEPTIVE PILL	K	K	K	
12	FERTILITY AWARENESS METHODS SUCH AS STANDARD DAYS METHOD, CYCLE BEADS, OR PERIODIC ABSTINENCE	L	L	L	
13	VASECTOMY (MALE STERILIZATION)	M	M	M	
14	TUBAL LIGATION (FEMALE STERILIZATIO . .	N	N	N	
15	LACTATIONAL AMENORRHEA METHOD . .	O	O	O	
16	SPERMICIDE	P	P	P	
17	DIAPHRAGM	Q	Q	Q	
18	OTHER	X	X	X	
19	NO METHOD	Y	Y	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

METHOD USE - FOR PRESCRIBED OR PROVIDED METHODS

	CIRCLE THE APPROPRIATE LETTERS TO INDICATE IF THE INFORMATION UNDER EACH RELEVANT SECTION WAS DISCUSSED OR SHARED WITH THE CLIENT. IF MULTIPLE METHODS ARE PROVIDED OR PRESCRIBED, CIRCLE THE APPROPRIATE LETTERS AS LONG AS THE INFORMATION IS DISCUSSED FOR ANY OF THE METHODS.		
109	CHECK Q109 COLUMNS 'A' AND' B'. ARE ANY LETTERS OTHER THAN 'Y' CIRCLED? YES ☐ NO ☐ → 111		
110	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:		
01	DISCUSSED WHETHER METHOD PROTECTS AGAINST STIs, INCLUDING HIV	A	
02	DISCUSSED WHEN THE METHOD BECOMES EFFECTIVE TO PREVENT PREGNANCY	B	
03	DISCUSSED HOW LONG THE METHOD IS EFFECTIVE TO PREVENT PREGNANCY	C	
04	DISCUSSED IF AND HOW LONG IT TAKES FERTILITY TO RETURN AFTER STOP TAKING/USING THE METHOD	D	
05	EXPLAINED HOW TO USE THE METHOD OR WHEN TO TAKE THE METHOD	E	
06	DISCUSSED WHAT TO DO IF FORGET TO TAKE THE METHOD ON TIME FOR PILLS/ INJECTABLES	F	
07	DISCUSSED A RETURN VISIT TO RESUPPLY THE METHOD FOR PILLS, INJECTABLES, OR CONDOMS	G	
08	DISCUSSED A RETURN VISIT TO CHECK THE METHOD FOR IUD	H	
09	DISCUSSED A RETURN VISIT TO CHECK PREGNANCY STATUS FOR EMERGENCY CONTRACEPTIVES (EC)	I	
10	DISCUSSED WHAT TO DO IF CLIENTS WANT TO STOP USING OR REMOVE THE METHOD	J	
11	DISCUSSED CLIENTS COULD SWITCH TO DIFFERENT METHODS IF A SELECTED METHOD IS NOT SUITABLE AFTER TRYING IT	K	
12	NONE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

SIDE EFFECTS OR HEALTH RISKS - FOR PRESCRIBED OR PROVIDED METHODS

CIRCLE THE APPROPRIATE LETTERS TO INDICATE IF THE INFORMATION UNDER EACH RELEVANT SECTION WAS DISCUSSED OR SHARED WITH THE CLIENT. IF MULTIPLE METHODS ARE PROVIDED OR PRESCRIBED, CIRCLE THE APPROPRIATE LETTERS AS LONG AS THE INFORMATION IS DISCUSSED FOR ANY OF THE METHODS.

111	CHECK Q109 COLUMNS 'A' AND' B'. IS 'A', 'B', OR 'C' CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ →		113
112	**PILLS**		
01	BLEEDING CHANGES ARE COMMON SIDE EFFECTS	A	
02	POSSIBLE OTHER SIDE EFFECTS CAN OCCUR SUCH AS HEADACHES, DIZZINESS, AND BREAST TENDERNESS	B	
03	SIDE EFFECTS ARE NOT SIGNS OF ILLNESS	C	
04	MOST SIDE EFFECTS USUALLY BECOME LESS OR STOP WITHIN THE FIRST FEW MONTHS	D	
05	WHAT TO DO TO MANAGE IRREGULAR BLEEDING SUCH AS TAKING PILLS REGULARLY	E	
06	THE CLIENT CAN COME BACK IF SIDE EFFECTS BOTHER HER OR IF SHE HAS OTHER CONCERNS	F	
07	FOR COMBINED ORAL PILL, BLOOD CLOT IS A VERY RARE HEALTH RISK	G	
08	NONE OF THE ABOVE	Y	
113	CHECK Q109 COLUMNS 'A' AND'B'. IS 'D','E', OR 'F' CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ →		115
114	**INJECTIONS**		
01	BLEEDING CHANGES ARE COMMON SIDE EFFECTS	A	
02	POSSIBLE OTHER SIDE EFFECTS CAN OCCUR SUCH AS WEIGHT GAIN, HEADACHES, AND DIZZINESS . .	B	
03	SIDE EFFECTS ARE NOT SIGNS OF ILLNESS	C	
04	MOST SIDE EFFECTS USUALLY BECOME LESS OR STOP WITHIN THE FIRST FEW MONTHS	D	
05	THE CLIENT CAN COME BACK IF SIDE EFFECTS BOTHER HER OR IF SHE HAS OTHER CONCERNS	E	
06	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
115	CHECK Q109 COLUMNS A AND B. IS "I" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ →		117
116	**IUD**		
01	BLEEDING CHANGES ARE COMMON SIDE EFFECTS	A	
02	POSSIBLE OTHER SIDE EFFECTS CAN OCCUR SUCH AS MORE CRAMPS DURING MONTHLY BLEEDING, ACNE, HEADACHES, AND BREAST TENDERNESS AND PAIN	B	
03	SIDE EFFECTS ARE NOT SIGNS OF ILLNESS	C	
04	MOST SIDE EFFECTS USUALLY BECOME LESS OR STOP WITHIN THE FIRST FEW MONTHS	D	
05	THE CLIENT CAN COME BACK IF SIDE EFFECTS BOTHER HER OR IF SHE HAS OTHER CONCERNS	E	
06	PELVIC INFLAMMATORY DISEASE IS A RARE HEALTH RISK IF THE CLIENT HAS STIs AT THE TIME OF INSERTION	F	
07	NONE OF THE ABOVE	Y	
117	CHECK Q109 COLUMNS 'A' AND 'B'. Is CODE 'J' CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ →		119
118	**IMPLANT**		
01	BLEEDING CHANGES ARE COMMON SIDE EFFECTS	A	
02	POSSIBLE OTHER SIDE EFFECTS CAN OCCUR SUCH AS HEADACHES, ABDOMINAL PAIN, AND BREAST TENDERNESS	B	
03	SIDE EFFECTS ARE NOT SIGNS OF ILLNESS	C	
04	MOST SIDE EFFECTS USUALLY BECOME LESS OR STOP WITHIN THE FIRST YEAR	D	
05	THE CLIENT CAN COME BACK IF SIDE EFFECTS BOTHER HER OR IF SHE HAS OTHER CONCERNS	E	
06	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
119	CHECK Q109 COLUMNS 'A' AND 'B'. IS CODE 'M' OR 'N' CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ → 121		
120	**MALE OR FEMALE STERILIZATION**		
01	PROCEDURE INTENDED TO BE PERMANENT . . . . . A		
02	NONE OF THE ABOVE . . . . . Y		

ADDITIONAL PROVIDER ACTIONS

121	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:		
01	LOOKED AT CLIENT'S HEALTH CARD AT ANY TIME BEFORE BEGINNING THE CONSULTATION, WHILE COLLECTING INFORMATION OR WHILE EXAMINING THE CLIENT . . . . . A		
02	WROTE ON THE CLIENT'S HEALTH CARD . . . . . B		
03	USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING C		
04	WASHED HANDS BEFORE AND AFTER ANY PROCEDURE SUCH AS PELVIC EXAM, INSERTING IMPLANT . . . . . D		
05	ASKED IF THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS . . . . . E		
06	ASKED PERMISSION BEFORE CARRYING OUT ANY EXAMS OR PROCEDURES . . . . . F		
07	EXPLAINED WHY THEY WERE CARRYING OUT ANY EXAMS OR PROCEDURES . . . . . G		
08	EXPLAINED THE FINDINGS OF ANY EXAMS OR CONSULTATIONS . . . . . H		
09	NONE OF THE ABOVE . . . . . Y		

QUESTIONS TO PROVIDER

AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS:			
200	Has this client ever visited this facility for family planning services?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
201	Has this client ever been pregnant?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
202	What was the client's family planning status at the beginning of this consultation?	CURRENT USER . . . . . 1 NOT CURRENT USER BUT EVER USED IN THE PAST . . . . . 2 NOT CURRENT USER AND NEVER USED IN THE PAST . . . . . 3 NOT DETERMINED 8	→ 205

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
203	What was the client's main reason for the visit? (FOR CURRENT USER)	RESUPPLY/ROUTINE FOLLOW-UP . . . . . 1 DISCUSS PROBLEM WITH METHOD . . . . . 2 DESIRE TO CHANGE METHOD . . . . . 3 DESIRE TO DISCONTINUE FF . . . . . 4 DISCUSS OTHER PROBLEM . . 5	
204	What was the outcome of the visit? (FOR CURRENT USER)	CONTINUED WITH CURRENT METHOD . . . . . 1 SWITCHED METHOD . . . . . 2 PLANNED METHOD SWITCH NOT RECEIVED TODAY CONTINUED USE OF CURRENT METHOD . . . . . 3 PLANNED METHOD SWITCH NOT RECEIVED TODAY DISCONTINUED CURRENT METHOD . . . . . 4 DECIDED TO STOP USING FP METHODS 5	→206
205	What was the outcome of the visit? (FOR NON CURRENT USER)	ACCEPTED TO START METHOD . . . . . 1 DID NOT DECIDE ON METHOD 2	
206	RECORD THE TIME THE OBSERVATION ENDED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
	THANK THE SERVICE PROVIDER AND THE CLIENT AND MOVE TO THE NEXT DATA COLLECTION POINT.		
	Interviewer's comments:		

OBSERVATION OF FAMILY PLANNING CONSULTATION: FOOTNOTES

(FN1) Verify country program and adapt as per country needs or specific injectable. For example, in countries with a Sayna Press program, you may specify "DMPA-SC/ Sayana Press "

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY
OBSERVATION OF SICK CHILD CONSULTATION

[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FACILITY IDENTIFICATION

QTYPE . . . . . O S C

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

PROVIDER INFORMATION

PROVIDER QUALIFICATION CATEGORY:

PROVIDER TYPE 1	01
PROVIDER TYPE 2	02
PROVIDER TYPE 3	03
PROVIDER TYPE 4	04
PROVIDER TYPE 5	05
PROVIDER TYPE 6	06
PROVIDER TYPE 7	07
PROVIDER TYPE 8	08
PROVIDER TYPE 9	09
OTHER TYPE	96

SEX OF PROVIDER: (1=MALE; 2=FEMALE)

PROVIDER CATEGORY . . . . . [ ][ ]

SEX OF PROVIDER . . . . . [ ]

INFORMATION ABOUT OBSERVATION

DATE . . . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 2 [ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** 0 1

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED [ ] (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:

01 ENGLISH	03 LANGUAGE 3	05 LANGUAGE 5
02 LANGUAGE 2	04 LANGUAGE 4	06 LANGUAGE 6

TEAM

[ ][ ]
NUMBER

TEAM SUPERVISOR

_____
NAME

[ ][ ][ ][ ]
NUMBER

OBSERVATION OF SICK CHILD CONSULTATION

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.		

INTRODUCTION AND PROVIDER CONSENT

READ THE FOLLOWING CONSENT STATEMENT TO THE PROVIDER

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

Your facility was selected to participate in this study. We will be observing your consultation with this client in order to understand how services for sick children are provided in this facility. At the end of the consultation, we will ask you questions about the types of services that you provided. The observation usually takes about 15-20 minutes.

Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the names of your clients participating in this study will be included in the dataset or in any report; however, there is a small chance that the facility can be identified. Still, we are asking for your help to ensure that the information we collect is accurate.

Participation in the survey is voluntary. You may refuse to answer any question, or you can ask me to leave at any point, if you feel uncomfortable. There is no penalty for refusing to participate, however, we hope you won't mind our observing your consultation.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your facility manager.
Do you have any questions?

Do I have your permission to be present at this consultation?

SIGNATURE OF INTERVIEWER _____

DATE

DAY				
MONTH				
YEAR	2	0	2	

PROVIDER AGREES TO BE OBSERVED . . 1 ↓

PROVIDER DOES NOT AGREE TO BE OBSERVED . . . . . 2 → END

101	CLIENT CONSENT READ THE FOLLOWING CONSENT STATEMENT TO THE CLIENT Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY]. This facility was selected to participate in the study. I would like to be present while you are receiving services today in order to understand how sick child services are provided in this facility. The observation usually takes about 15-20 minutes. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services. Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. There is no penalty for refusing to participate, however, we hope you won't mind our observing the consultation. After the consultation, my colleague would like to talk with you about your experience here today. In case you need more information about the survey, you may contact the in-charge manager of this health facility. Do you have any questions for me at this time? Do I have your permission to be present at this consultation? SIGNATURE OF INTERVIEWER _____ CLIENT AGREES TO BE OBSERVED . . 1 ↓ CLIENT DOES NOT AGREE TO BE OBSERVED . . 2 → END		
102	RECORD THE TIME THE OBSERVATION STARTED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	
104	RECORD SEX OF THE CHILD. CONFIRM SEX OF CHILD WITH THE PROVIDER	MALE . . . . . 1 FEMALE 2	

5. PROVIDER INTERACTION WITH CARETAKER AND CHILD

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
	FOR EACH OF THE GROUPS THAT FOLLOW, CIRCLE ANY ACTIONS TAKEN BY THE PROVIDER OR THE CLIENT. IF NO ACTION IN THE GROUP IS TAKEN, CIRCLE "Y" FOR EACH GROUP AT THE END OF THE OBSERVATION		

CLIENT HISTORY

105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING MAIN SYMPTOMS:		
01	FEVER	A	
02	COUGH OR DIFFICULT BREATHING (E.G., FAST BREATHING OR CHEST IN-DRAWING)	B	
03	DIARRHEA	C	
04	NONE OF THE ABOVE	Y	
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING GENERAL DANGER SIGNS:		
01	CHILD IS UNABLE TO DRINK OR BREASTFEED	A	
02	CHILD VOMITS EVERYTHING	B	
03	CHILD HAS HAD CONVULSIONS WITH THIS ILLNESS	C	
04	CHILD HAS HAD LETHARGY. IF CHILD IS ASLEEP, TRIED TO ROUSE CHILD	D	
05	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

PHYSICAL EXAMS

107	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS ON THE SICK CHILD:		
01	TOOK CHILD'S TEMPERATURE BY THERMOMETER	A	
02	FELT THE CHILD FOR FEVER OR BODY HOTNESS	B	
03	COUNTED RESPIRATION (BREATHS) FOR 60 SECONDS	C	
04	AUSCULTATED CHILD (LISTEN TO CHEST WITH STETHOSCOPE) OR COUNTED PULSE	D	
05	CHECKED SPO2 USING PULSE OXIMETRY	E	
06	CHECKED SKIN TURGOR FOR DEHYDRATION (E.G., PINCH ABDOMINAL SKIN)	F	
07	CHECKED FOR PALLOR BY LOOKING AT PALMS	G	
08	CHECKED FOR PALLOR BY LOOKING AT CONJUNCTIVA	H	
09	CHECKED FOR PALLOR BY LOOKING AT NAILS	I	
10	UNDRESSED CHILD TO EXAMINE (UP TO SHOULDERS/DOWN TO ANKLES)	J	
11	PRESSED BOTH FEET TO CHECK FOR EDEMA	K	
12	WEIGHED THE CHILD	L	
13	MEASURED THE CHILD HEIGHT/LENGTH	M	
14	PLOTTED WEIGHT ON GROWTH CHART	N	
15	PLOTTED HEIGHT/LENGTH ON GROWTH CHART	O	
16	CHECKED FOR ENLARGED LYMPH NODES IN 2 OR MORE OF THE FOLLOWING SITES: NECK, AXILLAE, GROIN	P	
17	MEASURED MID-UPPER ARM CIRCUMFERENCE (OR MUAC)	Q	
18	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

OTHER ASSESSMENTS

108	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH BY DOING ANY OF THE FOLLOWING:		
01	OFFERED THE CHILD SOMETHING TO DRINK OR ASKED THE MOTHER TO PUT THE CHILD TO THE BREAST	A	
02	MENTIONED THE CHILD'S WEIGHT OR GROWTH TO THE CARETAKER, OR DISCUSSED GROWTH CHAR	B	
03	ASKED IF CHILD RECEIVED VITAMIN A WITHIN THE PAST 6 MONTHS	C	
04	ASKED IF CHILD RECEIVED MEBENDAZOLE WITHIN THE PAST 6 MONTHS	E	
05	NONE OF THE ABOVE	Y	

COUNSELING OF CARETAKER

109	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING:		
01	PROVIDED GENERAL INFORMATION ABOUT FEEDING OR BREASTFEEDING THE CHILD EVEN WHEN NOT SICK	A	
02	TOLD THE CARETAKER TO GIVE EXTRA FLUIDS TO THE CHILD DURING THIS ILLNESS	B	
03	TOLD THE CARETAKER TO CONTINUE FEEDING SOLID FOOD TO THE CHILD DURING THIS ILLNESS	C	
04	TOLD THE CARETAKER TO CONTINUE BREASTFEEDING THE CHILD DURING THIS ILLNESS	D	
05	TOLD THE CARETAKER WHAT ILLNESS(ES) THE CHILD HAS	E	
06	DESCRIBED SIGNS AND/OR SYMPTOMS IN THE CHILD FOR WHICH TO IMMEDIATELY BRING CHILD BACK	F	
07	ASKED IF THE CARETAKER HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS	G	
08	ASKED PERMISSION BEFORE CARRYING OUT ANY EXAMS OR PROCEDURES	H	
09	EXPLAINED TO CARETAKER WHY THEY WERE CARRYING OUT EXAMINATIONS OR PROCEDURES	I	
10	EXPLAINED THE FINDINGS OF ANY EXAMS OR CONSULTATIONS	J	
11	EXPLAINED WHY THEY WERE GIVING THE CHILD ANY MEDICINE	K	
12	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

ADDITIONAL COUNSELING

110	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING. THIS REFERS ONLY TO COUSELING TO BE APPLIED AFTER THE VISIT OR MEDICINES THAT THE CARETAKER WILL GIVE TO THE SICK CHILD AT HOME AND DOES NOT INCLUDE START DOSES OR ONE TIME MEDICINES GIVEN TO THE CHILD DURING THE VISIT (E.G., ORS OR PAIN MEDICINE) FOR URGENT TREATMENT OF SYMPTOMS.		
01	PRESCRIBED OR PROVIDED ORAL MEDICATIONS DURING OR AFTER CONSULTATION	A	
02	EXPLAINED HOW TO ADMINISTER ORAL TREATMENT(S)	B	
03	DISCUSS FOLLOW-UP VISIT FOR THE SICK CHILD	C	
04	NONE OF THE ABOVE	Y	

REFERRALS AND ADMISSIONS

111	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:		
01	RECOMMEND THAT CHILD BE HOSPITALIZED URGENTLY (I.E., ADMITTED TO THE HOSPITAL OR REFERRED TO ANOTHER HOSPITAL)	A	
02	REFERRED CHILD TO ANOTHER PROVIDER WITHIN FACILITY FOR OTHER CARE	B	
03	REFERRED CHILD TO A NUTRITION CENTER	C	
04	REFERRED CHILD FOR A LABORATORY TEST WITHIN FACILITY	D	
05	REFERRED CHILD FOR A LABORATORY TEST OUTSIDE FACILITY	E	
06	EXPLAINED THE REASON FOR (ANY) REFERRAL	F	
07	GAVE REFERRAL SLIP TO CARETAKER	G	
08	GAVE PRE-REFERRAL TREATMENT TO CHILD FOR DIAGNOSED CONDITION	H	
09	EXPLAINED WHERE (OR TO WHOM) TO GO	I	
10	EXPLAINED WHEN TO GO FOR REFERRAL	J	
11	NONE OF THE ABOVE	Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

ADDITIONAL PROVIDER ACTIONS

112	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING: (THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED)	
01	LOOKED AT THE CHILD'S IMMUNIZATION CARD OR ASKED CARETAKER ABOUT CHILD VACCINATION HISTORY . . . . . A	
02	LOOKED AT THE CHILD'S HEALTH CARD EITHER BEFORE BEGINNING THE CONSULTATION, OR WHILE COLLECTING INFORMATION FROM THE CARETAKER, OR WHILE EXAMINING THE CHILD . . . . . B THIS ITEM MAY BE EITHER THE VACCINATION CARD OR OTHER HEALTH CARD	
03	WROTE ON THE CHILD'S HEALTH CARD C	
04	USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING . . . . . D	
05	WASHED HANDS BEFORE AND AFTER ANY PROCEDURE . . . . . E	
06	NONE OF THE ABOVE . . . . . Y	

6. QUESTIONS TO PROVIDER

AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS:

200	What was the outcome of this consultation? READ EACH OUTCOME OPTION AND CIRCLE CODE '1' IF YES, OR CODE '2' FOR NO.	YES NO	
	a) Treated and sent home	a) TREATED/SENT HOME . . . 1 2	
	b) Child referred to provider, same facility	b) REFERRED TO PROVIDER SAME FACILITY 1 2	
	c) Child admitted, same facility	c) ADMITTED SAME FACILITY 1 2	
	d) Child sent to lab for testing	d) SENT TO LAB FOR TESTING 1 2	
	e) Child referred to other facility	e) REFERRED TO OTHER FACILITY 1 2	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

DIAGNOSIS

	ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS FOR THE SICK CHILD. FOR ANY DIAGNOSIS, CIRCLE THE DIAGNOSIS MADE.		
	DIAGNOSIS (OR MAIN SYMPTOM, IF NO DIAGNOSIS)		
201	DEHYDRATION	SEVERE DEHYDRATION . . . . . 1 SOME DEHYDRATION . . . . . 2 NONE OF THE ABOVE / NO DEHYDRATION 3	
202	RESPIRATORY SYSTEM	PNEUMONIA / BRONCHOPNEUMONIA . . . . . A UPPER RESPIRATORY INFECTION (URI) / ACUTE RESPIRATORY ILLNESS (ARI) . . . . . B OTHER COUGH AND RESPIRATORY ILLNESS . . . . . C NONE OF THE ABOVE . . . . . Y	
203	DIGESTIVE SYSTEM / INTESTINAL	DIARRHEA . . . . . A DYSENTERY . . . . . B OTHER GASTROINTESTINAL TRACT INFECTION . . . . . C NONE OF THE ABOVE . . . . . Y	
204	MALARIA	MALARIA (UNCOMPLICATED) . . . . . 1 MALARIA (SEVERE) . . . . . 2 NONE OF THE ABOVE 3	
205	FEVER, MEASLES, AND OTHER INFECTIONS	FEVER OF UNKNOWN ORIGIN . . . . . A POSSIBLE SERIOUS BACTERIAL INFECTION (PSBI) . . . . . B MEASLES . . . . . C OTHER INFECTIONS . . . . . D NONE OF THE ABOVE . . . . . Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
206	OTHER DIAGNOSIS	ABSESS . . . . . A EAR INFECTION . . . . . B THROAT INFECTION . . . . . C ANEMIA . . . . . D MODERATE ACUTE MALNUTRITION (MAM) . . . . . E SEVERE ACUTE MALNUTRITION (SAM) . . . . . F OTHER DIAGNOSIS _____ . . . . . X (SPECIFY) NO OTHER DIAGNOSIS . . . . . Y	

ADDITIONAL QUESTIONS ON PHYSICAL EXAMINATION AND TEST RESULTS

207	Is this (NAME)'s first visit to this facility for this illness, or is this a follow-up visit?	FIRST VISIT . . . . . 1 FOLLOW-UP . . . . . 2 DON'T KNOW 8	
208	What is (NAME)'s date of birth?	DAY . . . . . [ ][ ] MONTH . . . . . [ ][ ] YEAR . . . . . [2][0][ ][ ]	
209	Did (NAME) receive Vitamin A within the past 6 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
210	Did (NAME) receive Medendazole within the past 6 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
211	You checked (NAME) palms for a pallor today. Did you find that (NAME) had a palmar pallor?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
212	Did you or other healthcare provider in this facility test/request a hemoglobin test for (NAME)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 215

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
213	Is (NAME)'s hemoglobin result available?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 215
214	What is (NAME)'s hemoglobin concentration level? RECORD HEMOGLOBIN CONCENTRATION LEVEL IN BOXES IN G/DL in 00.0 FORMAT, ADD PRECEEDING "0" IN THE FIRST BOX IF HB LEVEL IS LESS THAN 10.0 G/DL, FOR EXAMPLE 09.9 G/DL	G/DL ☐☐.☐ DECLINED TO ANSWER . . . . . 99.5 DON'T KNOW 99.8	
215	Has [NAME] had a fever with this illness [DIAGNOSIS IN 201, 202, 203, 204, 205, 206] or any time in the past two days?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
216	Have you or other healthcare provider in this facility measured (NAME)'s temperature today?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 218
217	What is (NAME)'s body temperature? RECORD BODY TEMPERATURE IN BOXES IN THE UNIT DEGREES CELSIUS (°C) in 00.0 FORMAT.	DEGREES CELSIUS ☐☐.☐ DECLINED TO ANSWER . . . . . 99.5 DON'T KNOW 99.8	
218	Did (NAME) have a malaria rapid diagnostic test (RDT) done anywhere in this facility before coming into this consultation room to see you today?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 221
219	Did you see, or did the caretaker show you (NAME)'s malaria RDT result as part of this consultation?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 221
220	What is (NAME)'s result of the malaria RDT test?	POSITIVE . . . . . 1 NEGATIVE . . . . . 2 DON'T KNOW 8	
221	Were any child measurements taken by you or another health care provider before the consultation today, for example during group counseling or while (NAME) was waiting? IF 'YES", ASK "Which measurements?"	WEIGHT . . . . . A HEIGHT . . . . . B TEMPERATURE . . . . . C OTHER: _____ . . . . . D (SPECIFY) NONE . . . . . Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
222	CHECK 105, 204, 205, 211, 215: IF CHILD HAD A FEVER (CODE 'A' IS CIRCLED IN 105 (01)), WAS DIAGNOSED WITH ANY MALARIA (CODE '1' OR CODE '2' IS CIRCLED IN 204) AND / OR WITH A FEVER (CODE 'A-D' IS CIRCLED IN 205) AND / OR FOUND WITH PALMAR PALLOR (CODE '1' IS CIRCLED IN 211), AND /OR HAD A FEVER WITH DIAGNOSED ILLNESS OR IN THE PAST TWO DAYS(CODE '1' IS CIRCLED IN 215) YES, DIAGNOSED WITH ANY MALARIA AND / OR ANY FEVER AND / OR PALMAR PALLOR ☐ OTHER ☐		229
223	(NAME) had fever and/or was diagnosed with (DIAGNOSIS FROM 204, 205, AND/OR 211), did you or other healthcare provider perform/request a mRDT test to confirm malaria?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	226
224	Is (NAME)'s malaria rapid diagnostic test (mRDT) result available?	YES, AT THE PROVIDER SITE . . . . . 1 YES, AT THE LABORATORY . . . . . 2 NO . . . . . 3 DON'T KNOW 8	226
225	What is (NAME)'s result of the mRDT test?	POSITIVE . . . . . 1 NEGATIVE . . . . . 2 DON'T KNOW 8	
226	(NAME) had fever and/or was diagnosed with (DIAGNOSIS FROM 204, 205, AND/OR 211), did you or other healthcare provider perform/request a malaria microscopy to confirm malaria?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	229
227	Is (NAME)'s malaria microscopy result available?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	229
228	What is (NAME)'s result of the malaria microscopy?	POSITIVE . . . . . 1 NEGATIVE . . . . . 2 DON'T KNOW 8	
229	Did you **vaccinate** the child during this visit or refer the child for vaccination today other than for vitamin A supplementation? IF NO, ASK: Why not?	YES, VACCINATED CHILD . . . . . 1 YES, REFERRED . . . . . 2 NOT DUE FOR VACCINATION . . . . . 3 VACCINE NOT AVAILABLE . . . . . 4 CHILD TOO SICK . . . . . 5 NOT DAY FOR VACCINATION . . . . . 6 DID NOT CHECK FOR VACCINATION . . 7 VACCINATION COMPLETED 8	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO

TREATMENT

ASK ABOUT THE TREATMENT THAT WAS EITHER PRESCRIBED OR PROVIDED. PROMPT IF NECESSARY.			
230	Did you prescribe any treatment today for this child? IF YES, CIRCLE ALL TREATMENTS THAT WERE PRESCRIBED OR PROVIDED TO CHILD IN THE FOLLOWING QUESTIONS	YES . . . . . 1 NO 2	→ 236
231	GENERAL TREATMENT	BENZYL PENICILLIN INJECTION . . . . . A GENTAMYCINE INJECTION . . . . . B CEFTRIAXONE INJECTION . . . . . C AMPICILLINE INJECTION . . . . . D OTHER ANTIBIOTIC INJECTION . . . . . E OTHER INJECTION . . . . . F CO-TRIMOXAZOLE TABLET/SYRUP . . . . . G AMOXICILLIN SYRUP . . . . . H AMOXICILLIN DISPERSIBLE TABLETS . . . . . I CIPROFLOXACINE TABLETS . . . . . J AZITHROMYCIN TABLETS . . . . . K OTHER ANTIBIOTIC TABLET/SYRUP . . L PARACETAMOL . . . . . M OTHER FEVER REDUCING MEDICINI . . N ZINC . . . . . O IRON . . . . . P VITAMINS (OTHER THAN VITAMIN A) . . . . . Q MEBENDAZOLE (IF NOT GIVEN FOR LAST 6 MONTHS) . . . . . R COUGH SYRUPS/OTHER MEDICATION . . . . . S NONE OF THE ABOVE . . . . . Y	

NO.	QUESTIONS / OBSERVATIONS	CODING CATEGORIES	GO TO
232	MALARIA	INJECTABLE QUININE . . . . . A INJECTABLE ARTEMETHER . . . . . B INJECTABLE ARTESUNATE . . . . . C OTHER INJECTABLE ANTIMALARIAL (E.G., FANSIDAR) . . . . . D SUPPOSITORY ARTESUNATE . . . . . E ARTEMISININ COMBINATION THERAPY (ACT) (COUNTRY-SPECIFIC BRAND FIRST LINE TREATMENT) . . . . . F ORAL FANSIDAR (SP) . . . . . G ORAL CHLOROQUINE . . . . . H ORAL AMODIAQUINE . . . . . I ORAL QUININE . . . . . J OTHER ORAL ANTIMALARIAL . . . . . K NONE OF THE ABOVE . . . . . Y	
233	DEHYDRATION	HOME ORT (PLAN A) . . . . . A INITIAL ORT IN FACILITY (4 HOURS - PLAN B) . . . . . B INTRAVENOUS FLUIDS (PLAN C) . . . . . C HOME ORT (PLAN A) WITH ZINC . . . . . D NONE OF THE ABOVE . . . . . Y	
234 **(FN1)**	MALNUTRITION *(PER COUNTRY-SPECIFIC GUIDELINES)*	READY-TO-USE THERAPEUTIC FOOD (RUTF) . . . . . A F-75 FEEDING FORMULA . . . . . B F-100 FEEDING FORMULA . . . . . C ANY OTHER TREATMENT _____ . . . . . X (SPECIFY) NONE OF THE ABOVE . . . . . Y	
235	OTHER TREATMENT & ADVICE	VITAMIN A (MAY ALSO BE FOR IMMUNIZATION) . . . . . A FEEDING SOLID FOODS . . . . . B FEEDING EXTRA LIQUIDS . . . . . C CONTINUED BREASTFEEDING . . . . . D ANY OTHER TREATMENT _____ . . . . . X (SPECIFY) NONE OF THE ABOVE . . . . . Y	
236	RECORD THE TIME THE OBSERVATION ENDED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	

THANK THE SERVICE PROVIDER AND THE CLIENT AND MOVE TO THE NEXT DATA COLLECTION POINT.

Interviewer's comments:

(FN1) Adapt using the country specific names of a therapeutic food or supplemental food used or formulated for the country that could be in a form of a multiple micronutrient powder, ready to use therapeutic foods, and ready to use supplemental foods. Make sure the food is used as a therapeutic food to treat malnutrition in children under age 5.

FORMATTING DATE: 27 April 2022
ENGLISH LANGUAGE: 27 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

ANTENATAL CARE CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

QTYPE . . . . . E A C

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

INFORMATION ABOUT INTERVIEW

DATE . . . . . DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 2 [ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF ESTIONNAIRE** [ ][ ]

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED (YES = 1, NO = 2) [ ]

LANGUAGE OF ESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH 03 LANGUAGE 05 LANGUAGE
02 LANGUAGE 04 LANGUAGE 06 LANGUAGE

TEAM NUMBER [ ][ ]

TEAM SUPERVISOR NAME _____ NUMBER [ ][ ][ ][ ]

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY

ANTENATAL CARE EXIT INTERVIEW

INTRODUCTION AND CONSENT

READ THE FOLLOWING CONSENT STATEMENT

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

This facility was selected to participate in the study. I would like to ask you some questions about your experiences here today to better understand how ANC services are provided in this facility. These questions usually take about 10-15 minutes.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this interview is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this interview may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that the decision to participate in this interview is completely voluntary and that your decision will not affect the services you receive. If at any point you would prefer to end the interview please feel free to tell me. There is no penalty for refusing to participate, however, we hope you will choose to participate.

In case you need more information about the survey, you may contact the in-charge manager of this health facility.

Do you have any questions for me at this time?

Do I have your permission to interview you?

SIGNATURE OF INTERVIEWER _____

DATE

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 2 | |

CLIENT AGREES TO BE INTERVIEWED . . 1 ↓

CLIENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 → END

1. INFORMATION ABOUT VISIT - ANTENATAL CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
101	RECORD THE TIME THE INTERVIEW STARTED. USE 24-HOUR FORMAT.	HOURS . . . . . | | MINUTES . . . . . | |	
102	What time did you arrive at the facility today? IF CLIENT DOESN'T KNOW THE EXACT TIME, ASK HER TO APPROXIMATE. IF SHE CAN'T GIVE AN APPROXIMATE TIME, USE 'DON'T KNOW'.	HOURS . . . . . | | MINUTES . . . . . | | DON'T KNOW 9998	
103	What time did you see the provider? IF SHE DOESN'T KNOW THE EXACT TIME, ASK HER TO APPROXIMATE. IF SHE CAN'T GIVE AN APPROXIMATE TIME, USE 'DON'T KNOW'.	HOURS . . . . . | | MINUTES . . . . . | | DON'T KNOW 9998	
104	Do you have an antenatal care card/book, or a vaccination card or TT card with you today? IF YES: ASK TO SEE THE CARD/BOOK.	YES . . . . . 1 NO, CARD KEPT WITH FACILITY . . . . . 2 NO, LEFT CARD/BOOK AT HOME . . . . . 3 NO CARD/BOOK USED AT THIS FACILITY 4	→108
105	CHECK THE ANC CARD, BOOK, OR TT CARD OR VACCINATION CARD. INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS TOXOID.	YES, 1 TIME . . . . . 1 YES, 2 TIMES . . . . . 2 YES, 3 OR MORE TIMES . . . . . 3 NO RECORD 4	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
106	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD, OR BOOK?	# OF WEEKS ..... [ ][ ] NOT AVAILABLE 95	
107	DOES THE CARD INDICATE THE CLIENT HAS RECEIVED IPT? IF YES INDICATE NUMBER OF DOSES	YES, 1 DOSE ..... 1 YES, 2 DOSES ..... 2 YES, 3 DOSES ..... 3 YES, 4 DOSES ..... 4 NO 5	
108 **(FN1)**	Have you received any doses of the COVID19 vaccine? [COUNTRY SPECIFIC] IF YES: How many doses?	YES, 1 DOSE ..... 1 YES, 2 OR MORE DOSES ..... 2 NO 3	
109	Have you ever been pregnant, regardless of the duration or outcome, or is this your first pregnancy?	FIRST PREGNANCY ..... 1 NOT FIRST PREGNANCY 2	
110	Is this your first antenatal visit at this facility for this pregnancy? IF THIS IS NOT THE 1ST VISIT, ASK: How many times have you visited this antenatal clinic for this pregnancy?	FIRST VISIT ..... 00 # OF VISITS ..... [ ][ ]	
111	Have you had antenatal care at any other facilities for this pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 113 → 113
112	How many antenatal care visits have you had at other health facilities?	# OF VISITS ..... [ ][ ]	
	A provider may have talked with you about things to do in preparation for delivery. One of those things is having enough money to pay for transportation or any unplanned costs of delivery.		
113	Do you have money set aside for the delivery? IF YES, ASK: Do you think you have enough?	YES, ENOUGH ..... 1 YES, BUT NOT ENOUGH ..... 2 NO 3	
114	Have you decided where you will go for the delivery of your baby? IF YES PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY OR AT HOME	AT THIS HEALTH FACILITY ..... 1 OTHER HEALTH FACILITY ..... 2 AT HOME ..... 3 AT TBA's HOME ..... 4 OTHER LOCATION_____ ..... 6 NO/DON'T KNOW 8	→ 201 → 116 → 201
115	What is the main reason you do not plan to deliver at **this** facility? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON	INCONVENIENT OPERATING ..... 01 LOCATION (ACCESS OR TRANSPORTATION) ..... 02 BAD REPUTATION ..... 03 BAD PREVIOUS EXPERIENCE AT THE FACILITY ..... 04 NO MEDICINE ..... 05 PREFERS TO REMAIN ..... 06 IT IS MORE EXPENSIVE ..... 07 WAS REFERRED TO OTHER FACILITY ..... 08 FACILITY DOESN'T PROVIDE DELIVERY SERVICES ..... 09 OTHER_____ ..... 96 DON'T KNOW 98	→ 201
116	What is the main reason you do not plan to deliver at a facility? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON	INCONVENIENT OPERATING ..... 01 LOCATION (ACCESS OR TRANSPORTATION) ..... 02 DELIVERING AT FACILITY IS UNECESSARY FOR CHILDBIRTH ..... 03 BAD PREVIOUS EXPERIENCE AT HEALTH FACILITIES ..... 04 AFRAID OF BEING CUT ..... 05 LACK OF PRIVACY AT FACILITIES ..... 06 COST ..... 07 LACK OF SUPPORTIVE ATTENDANCE AT FACILITY ..... 08 OTHERS MADE THE DECISION FOR ..... 09 OTHER_____ ..... 96 DON'T KNOW 98	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP

2. ANTENATAL EXPERIENCE OF CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your antenatal care. Now I am going to ask you about specific services that you received in your antenatal care visit today. I know some of these are difficult to remember, so it is ok if you don't remember, but do try to tell me what you remember as it will be very useful in checking the quality of antenatal care provided in the facilities around here.		
201	Thinking about your antenatal care visit today:		
01	Did you feel the doctors, nurses or other staff treated you with respect? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
02	Did you feel the doctors, nurses or other staff treated you in a friendly manner? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
03	Did you feel you could discuss your problems with the doctors, nurses or other providers, without others not involved in your care overhearing your conversations? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
04	Did you feel you understood the purpose of any tests you were asked to do? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT HAVE ANY TESTS, CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
05	Did you feel you understood the purpose of any medicines you were given? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT HAVE ANY MEDICINES, CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
06	Did you feel you could ask the doctors, nurses or other staff at the facility any questions you had? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
07	Did the doctors, nurses or other staff at the facility ask you if you had any questions ? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
08	Did you feel the health facility environment, including the washrooms were clean? IF YES, PROBE : Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
09	Did you feel that during private exams (such as vaginal exams) that occurred during your consultation, no other clients or patients at the facility could see you? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT HAVE ANY PRIVATE EXAMS, CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
10	Did the doctors, nurses, or other health care providers involve you in decisions about your care? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT MAKE ANY DECISIONS, CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
11	Would you say you were treated differently because of any personal attribute, like your age, marital status, number of children, your education, wealth, or something like that? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
12	Did you feel like you were treated roughly, for instance were you pushed, beaten, slapped, pinched, physically restrained or gagged, or physically mistreated in any other way? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
13	Did you feel the doctors, nurses or other healthcare providers shouted at you, scolded you, insulted, threatened, talked to you rudely, or verbally mistreated you in any other way? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	

3. ACCESS TO CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your antenatal care experience. Now I am going to ask you a few questions about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		
301	Was the time you waited to see a provider a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
302	Were the hours of service at this facility, that is when the facility opens and closes, a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
303	Were the number of days services are available to you at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM ..... 1 YES, MINOR PROBLEM ..... 2 NO, NOT A PROBLEM ..... 3 DON'T KNOW 8	
304	Was the cost for services or treatments at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM ..... 1 YES, MINOR PROBLEM ..... 2 NO, NOT A PROBLEM ..... 3 DON'T KNOW 8	
305	Is this the closest health facility to your home?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 401 → 401
306	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS ..... 01 BAD REPUTATION ..... 02 DON'T LIKE PERSONNEL ..... 03 NO MEDICINE ..... 04 PREFERS TO REMAIN ANONYMOUS ..... 05 IT IS MORE EXPENSIVE ..... 06 WAS REFERRED ..... 07 SERVICE NOT OFFERED AT FACILITY NEAREST TO HOME ..... 08 OTHER ..... 96 DON'T KNOW 98	

4. ANTENATAL CLIENT PERSONAL CHARACTERISTICS

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
Thank you for answering my questions about your experience at this facility. My final questions are about yourself.			
401	How old were you at your last birthday?	AGE IN YEARS ..... [ ][ ] DON'T KNOW 98	
402	Have you ever attended school?	YES ..... 1 NO 2	→ 404
403 **(FN2)**	What is the highest level of school you attended: primary, secondary or higher? [COUNTRY SPECIFIC]	PRIMARY ..... 1 SECONDARY ..... 2 HIGHER 3	
404	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED ..... 1 YES, LIVING WITH A MAN ..... 2 NO, NOT IN UNION 3	
405	RECORD THE TIME THE INTERVIEW ENDED	HOURS ..... [ ][ ] MINUTES ..... [ ][ ]	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

ANTENATAL CARE CLIENT EXIT INTERVIEW: FOOTNOTES

(FN1) Revise the name and required dosage of the COVID-19 vaccine according to the local health guidelines

(FN2) Revise according to the local educational system

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

EARLY POSTNATAL CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

QTYPE . . . . . E P C

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

INFORMATION ABOUT INTERVIEW

DATE . . . . . DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 2 [ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** [ ][ ]

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED (YES = 1, NO = 2) [ ]

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH 03 LANGUAGE 05 LANGUAGE
02 LANGUAGE 04 LANGUAGE 06 LANGUAGE

TEAM NUMBER [ ][ ]

TEAM SUPERVISOR NAME _____ NUMBER [ ][ ][ ][ ]

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

EARLY POSTNATAL CARE EXIT INTERVIEW

INTRODUCTION AND CONSENT

READ THE FOLLOWING CONSENT STATEMENT

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

This facility was selected to participate in the study. I would like to ask you some questions about your experiences here today to better understand how delivery services are provided in this facility. These questions usually take about 10-15 minutes.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this interview is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this interview may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that the decision to participate in this interview is completely voluntary and that your decision will not affect the services you receive. If at any point you would prefer to end the interview please feel free to tell me. There is no penalty for refusing to participate, however, we hope you will choose to participate.

In case you need more information about the survey, you may contact the in-charge manager of this health facility.

Do you have any questions for me at this time?

Do I have your permission interview you?

SIGNATURE OF INTERVIEWER _____

DATE

DAY				
MONTH				
YEAR	2	0	2	

CLIENT AGREES TO BE INTERVIEWED . . 1 ↓

CLIENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 → END

1. INFORMATION ABOUT DELIVERY

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
101	RECORD THE TIME THE INTERVIEW STARTED. USE 24-HOUR FORMAT	HOURS . . . . . ☐☐ MINUTES . . . . . ☐☐	
102	Did you plan to deliver your baby in this facility?	YES . . . . . 1 NO, HAD PROBLEM DURING DELIVERY AT HOME . . . . . 2 NO, CAME AFTER A DELIVERY AT HOME . . . . . 3 NO, OTHER REASON 4	→ 106
103	Did you plan to deliver your baby at another health facility?	YES . . . . . 1 NO 2	→ 105
104	What was the main reason you did not plan to deliver at a facility? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING . . . . . 01 LOCATION (ACCESS OR TRANSPORTATION) . . . . . 02 DELIVERING AT FACILITY IS UNECESSARY FOR CHILDBIRTH . . . 03 BAD PREVIOUS EXPERIENCE AT HEALTH FACILITIES . . . . . 04 AFRAID OF BEING CUT . . . . . 05 LACK OF PRIVACY AT FACILITIES . . . . . 06 COST . . . . . 07 LACK OF SUPPORTIVE ATTENDANCE AT FACILITY . . . . . 08 OTHERS MADE THE DECISION FOR ME . . . . . 09 OTHER . . . . . 96 DON'T KNOW 98	→ 106
105	What was the main reason you did not plan to deliver at this facility? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING . . . . . 01 LOCATION (ACCESS OR TRANSPORTATION) . . . . . 02 BAD REPUTATION . . . . . 03 BAD PREVIOUS EXPERIENCE AT THIS FACILITY . . . . . 04 FACILITY DOES NOT HAVE MEDICINE . . . . . 05 PREFERS REMAIN ANONYMOUS . . . . . 06 IT IS MORE EXPENSIVE . . . . . 07 WAS REFERRED TO OTHER FACILITY . . . . . 08 OTHER . . . . . 96 DON'T KNOW 98	
106	What day and month was your baby born?	DAY . . . . . ☐☐ MONTH . . . . . ☐☐	
107	What time was your baby born? IF WOMAN DOES NOT KNOW THE HOUR AND MINUTE OF BIRTH, PROBE FOR AT LEAST THE HOUR AND NOTE 00 FOR MINUTES	HOURS . . . . . ☐☐ MINUTES . . . . . ☐☐	

NO.	QUESTIONS	CODING CLASSIFICATION				SKIP
108	Now I am going to ask you some questions about how you were treated during your time at this facility for childbirth. During (labor/child birth/after birth) did you want to have someone outside of facility staff, such as a family member or friend in the room to support you?" IF YES, ASK: "Were you able to have that person with you during (labor/child birth/after birth)?"	(A) WANTED		(B) HAD		
		YES	NO	YES	NO	
	1) During labor	1→ B	2→ 108b	1	2	
	2) During childbirth	1→ B	2→ 108c	1	2	
	3) After birth until the time of discharge	1→ B	2→ 109	1	2	
109	After your baby was born, were you and your baby separated for more than one hour at any one time?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8				
110	After your baby was born, did your baby receive any other liquids or foods other than breast milk?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8				
111	Before you were discharged from the facility for this delivery, did any health care provider in this facility talk with you about taking care of yourself and/or your baby after delivery?	YES . . . . . 1 NO 2				→ 201
112	What topics did the provider talk with you about? READ EACH TOPIC AND RECORD THE CLIENT'S ANSWER					
				YES	NO	
	a) Using family planning after the birth of your baby to prevent unwanted pregnancy or to space your next birth	a) USING FAMILY PLANNING AFTER THE BIRTH . .		1	2	
	b) Exclusive breastfeeding, that is not giving your baby any fluids or food in addition to breast milk	b) EXCLUSIVE BREASTFEEDING		1	2	
	c) Where to access breastfeeding support in the community	c) ACCESS BREASTFEEDING SUPPORT		1	2	
	d) Signs that the baby has had enough to eat	d) SIGNS ENOUGH TO EAT		1	2	
	e) Signs that the baby is hungry	e) SIGNS THAT THE BABY IS HUNGRY		1	2	
	f) Dangers of using feeding bottles, teats, and pacifiers	f) DANGERS OF BOTTLES, TEATS, PACIFIERS		1	2	
	g) Nutrition, or what is good for you to be eating after having your baby	g) NUTRITION FOR YOU		1	2	
	h) The importance of taking iron folic acid tablets after having your baby	h) FOLIC ACID TABLETS AFTER BIRTH		1	2	
	i) What to do if you feel sad or depressed after giving birth	i) WHAT TO DO IF SAD OR DEPRESSED		1	2	
	j) Signs and symptoms for mother to check for which you must immediately come back to the facility	j) CHECK SIGNS/SYMPTOMS FOR MOTHER		1	2	
	k) Signs and symptoms for the baby to check for which you must immediately bring the baby back	k) CHECK SIGNS/SYMPTOMS FOR BABY		1	2	
	l) Registering the birth of your baby	l) REGISTERING THE BIRTH		1	2	
	m) Vaccinating your baby	m) VACCINATING YOUR BABY		1	2	
	n) How to engage and play with your baby	n) ENGAGE AND PLAY WITH YOUR BABY		1	2	
	o) When to visit a health facility to check the health for you and the baby after discharge	o) WHEN TO VISIT A HEALTH FACILITY TO CHECK . . .		1	2	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	2. DELIVERY EXPERIENCE OF CARE		
NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your delivery. Now I am going to ask you some more questions about specific aspects of your delivery experience. I know some of these are difficult to remember, so it is ok if you don't remember, but do try to tell me what you remember as it will be very useful in checking the quality of labor and delivery care provided in this facility.		
201	Did the doctors, nurses or other healthcare providers call you by your name? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
202	Did the doctors, nurses or other staff treat you with respect? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
203	Did the doctors, nurses or other staff at the facility treat you in a friendly manner? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
204	During examinations in the labor room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
205	Did you feel like the doctors, nurses or other staff at the facility involved you in decisions about your care? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT MAKE ANY DECISIONS: CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
206	Did the doctors, nurses or other staff at the facility ask your permission/consent before doing examinations and procedures on you? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
207	During the delivery, did you feel like you were able to be in the position of your choice? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
208	Did the doctors and nurses explain to you why they were carrying out examinations or procedures? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
209	Did the doctors and nurses explain to you why they were giving you any medicine? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT RECEIVE ANY MEDICINE: CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
210	Did you feel you could ask the doctors, nurses or other staff at the facility any questions you had? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
211	Did the doctors and nurses at the facility talk to you about how you were feeling? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
212	When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
213	Did you feel the doctors, nurses or other staff at the facility took the best care of you? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
214	Did you feel the health facility environment, including the washrooms were clean? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
215	Would you say you were treated differently because of any personal attribute, like your age, marital status, number of children, your education, wealth, or something like that? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
216	Did you feel like you were treated roughly, for instance were you pushed, beaten, slapped, pinched, physically restrained or gagged, or physically mistreated in any other way? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
217	Did you feel the doctors, nurses or other healthcare providers shouted at you, scolded you, insulted, threatened, talked to you rudely, or verbally mistreated you in any other way? IF YES, PROBE: Would you say this was all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	3. ACCESS TO CARE		
NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your delivery experience. Now I am going to ask you a few questions about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		
301	Was the time you waited to see a provider a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
302	Were the hours of service at this facility, that is when the facility opens and closes, a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
303	Were the number of days services are available to you at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
304	Was the cost for services or treatments at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
305	Is this the closest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 401 → 401
306	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . . . . 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . . 06 WAS REFERRED . . . . . 07 SERVICE NOT OFFERED AT FACILITY NEAREST TO HOME . . . . . 08 OTHER . . . . . 96 DON'T KNOW 98	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP

4. DELIVERY CLIENT PERSONAL CHARACTERISTICS

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your experience at this facility. My final questions are about yourself.		
401	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW 98	
402	Have you ever attended school?	YES . . . . . 1 NO 2	→ 404
403 **(FN1)**	What is the highest level of school you attended: primary, secondary or higher? [COUNTRY SPECIFIC]	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
404	How many times have you given birth, before this delivery? IF NONE WRITE 00. PROBE: PLEASE INCLUDE STILLBIRTHS OR ANY CHILDREN WHO WERE BORN ALIVE BUT LATER DIED.	NUMBER OF BIRTHS . . . . . [ ][ ]	
405	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED . . . . . 1 YES, LIVING WITH A MAN . . . . . 2 NO, NOT IN UNION 3	
406	RECORD THE TIME THE INTERVIEW ENDED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
	Interviewer's comments:		

EARLY POSTNATAL CLIENT EXIT INTERVIEW: FOOTNOTES

(FN1) Revise according to the local educational system

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY

FAMILY PLANNING CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

QTYPE . . . . . E F P

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

INFORMATION ABOUT INTERVIEW

DATE:. . . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 2 [ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** [ ][ ]

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED (YES = 1, NO = 2) [ ]

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH 03 LANGUAGE 05 LANGUAGE
02 LANGUAGE 04 LANGUAGE 06 LANGUAGE

TEAM NUMBER [ ][ ]

TEAM SUPERVISOR NAME _____ NUMBER [ ][ ][ ][ ]

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

FAMILY PLANNING CLIENT EXIT INTERVIEW

INTRODUCTION AND CONSENT

READ THE FOLLOWING CONSENT STATEMENT

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

This facility was selected to participate in the study. I would like to ask you some questions about your experiences here today to better understand how family planning services are provided in this facility. These questions usually take about 10-15 minutes.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this interview is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this interview may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that the decision to participate in this interview is completely voluntary and that your decision will not affect the services you receive. If at any point you would prefer to end the interview please feel free to tell me. There is no penalty for refusing to participate, however, we hope you will choose to participate.

In case you need more information about the survey, you may contact the incharge manager of this health facility.

Do you have any questions for me at this time?

Do I have your permission interview you?

SIGNATURE OF INTERVIEWER _____

DATE

DAY				
MONTH				
YEAR	2	0	2	

CLIENT AGREES TO BE INTERVIEWED . . 1 ↓

CLIENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 → END

1. INFORMATION ABOUT FAMILY PLANNING VISIT

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
101	RECORD THE TIME THE INTERVIEW STARTED. USE 24-HOUR FORMAT.	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
102	What time did you arrive at the facility today? IF CLIENT DOESN'T KNOW THE EXACT TIME, ASK HER TO APPROXIMATE. IF SHE CAN'T GIVE AN APPROXIMATE TIME, USE 'DON'T KNOW'.	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ] DON'T KNOW 9998	
103	What time did you see the provider? IF SHE DOESN'T KNOW THE EXACT TIME, ASK HER TO APPROXIMATE. IF SHE CAN'T GIVE AN APPROXIMATE TIME, USE 'DON'T KNOW'.	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ] DON'T KNOW 9998	
104	Before coming to this facility today, were you taking any steps or using any methods to prevent a pregnancy?	YES . . . . . 1 NO 2	→ 110
105	What method were you (last) using? PROBE	COMBINED ORAL PILL . . . . . A PROGESTIN-ONLY ORAL PILL . . . . . B ORAL PILL (TYPE UNSPECIFIED) . . . . . C COMBINED INJECTABLE (MONTHLY) . . . . . D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY) INTRAMUSCULAR (DMPA-IM) . . . . . E PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY) SUBCUTANEOUS (DMPA-SC) . . . . . F MALE CONDOM . . . . . G FEMALE CONDOM . . . . . H IUC . . . . . I IMPLANT . . . . . J EMERGENCY CONTRACEPTIVE PILL . . . . . K FERTILITY AWARENESS METHODS SUCH AS STANDARD DAYS METHOD (SDM) . . . . . L MALE STERILIZATION (VASECTOMY) . . . . . M FEMALE STERILIZATION (TUBAL LIGATION) . . . . . N LACTATIONAL AMENORRHEA . . . . . O SPERMICIDE . . . . . P DIAPHRAGM . . . . . Q OTHER_____ X	
106	Have you been having (did you have) any problems with the method?	YES . . . . . 1 NO 2	
107	What was the outcome of this visit—did you decide to continue (restart) the same method or to switch methods?	CONTINUE WITH OR RESTART SAME METHOD . . . . . 1 SWITCH METHOD . . . . . 2 STOP USING METHOD (DUE TO PROBLEMS . . . . . 3 STOP USING METHOD (ELECTIVE-NO PROBLEMS) 4	→ 201
108	Had you thought about switching methods before you came here today?	YES . . . . . 1 NO 2	→ 113
109	Had you thought about what family planning method you wanted to switch to before you came here today?	YES . . . . . 1 NO 2	→ 112 → 113
110	Had you thought about starting to use a method of family planning before you came here today?	YES . . . . . 1 NO 2	→ 113
111	Had you thought about what family planning method you wanted to use before you came here today?	YES . . . . . 1 NO 2	→ 113

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
112	What method or methods were you thinking about? IF WOMAN MENTIONS MULTIPLE METHODS, CIRCLE AS MANY AS SHE MENTIONS	COMBINED ORAL PILL . . . . . A PROGESTIN-ONLY ORAL PILL . . . . . B ORAL PILL (TYPE UNSPECIFIED) . . . . . C COMBINED INJECTABLE (MONTHLY) . . . . . D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY) INTRAMUSCULAR (DMPA-IM) . . . . . E PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY) SUBCUTANEOUS (DMPA-SC) . . . . . F MALE CONDOM . . . . . G FEMALE CONDOM . . . . . H IUD . . . . . I IMPLANT . . . . . J EMERGENCY CONTRACEPTIVE PILL . . . . . K FERTILITY AWARENESS METHODS SUCH AS STANDARD DAYS METHOD (SDM) . . . . . L MALE STERILIZATION (VASECTOMY) . . . . . M FEMALE STERILIZATION (TUBAL LIGATION) . . . . . N LACTATIONAL AMENORRHEA . . . . . O SPERMICIDE . . . . . P DIAPHRAGM . . . . . Q OTHER_____ X	
113	What family planning method did you either receive or get a prescription or referral for? CIRCLE ALL METHODS THE CLIENT HAS A PRESCRIPTION OR A REFERRAL (PRES), OR RECEIVED IN FACILITY (REC). IF THE CLIENT IS CONTINUING WITH A PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION OR REFERRAL DURING THIS VISIT, CIRCLE "Y" CHECK PACKET OR PRESCRIPTION TO CONFIRM TYPE OF PILL OR INJECTION	PRE-SCRIBED / RECE-IVED COMBINED ORAL PILL . . . . . A A PROGESTIN-ONLY ORAL PILL . . . . . B B ORAL PILL (TYPE UNSPECIFIED) . . . . . C C COMBINED INJECTABLE (MONTHLY) . . . . . D D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY) INTRAMUSCULAR (DMPA-IM) . . . . . E E PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY) SUBCUTANEOUS (DMPA-SC) . . . . . F F MALE CONDOM . . . . . G G FEMALE CONDOM . . . . . H H IUD . . . . . I I IMPLANT . . . . . J J EMERGENCY CONTRACEPTIVE PILL . . . . . K K FERTILITY AWARENESS METHODS SUCH AS STANDARD DAYS METHOD (SDM) . . . . . L L MALE STERILIZATION (VASECTOMY) . . . . . M M FEMALE STERILIZATION (TUBAL LIGATION) . . . . . N N LACTATIONAL AMENORRHEA . . . . . O O SPERMICIDE . . . . . P P DIAPHRAGM . . . . . Q Q OTHER_____ X X CONTINUING WITH METHOD IN Q104 . . . . . Y Y NO METHOD . . . . . Z Z	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP

2. FAMILY PLANNING EXPERIENCE OF CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
201	Thank you for answering my questions about your family planning consultation. Now I am going to ask you about specific services that you received in your family planning visit today. I know some of these are difficult to remember, so it is ok if you don't remember, but do try to tell me what you remember as it will be very useful in checking the quality of family planning provided in the facilities around here. During your consultation today, did the provider:		
01	Ask about whether you would like to have a/nother child?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
02	Ask about when you would like to have a/another child?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
03	Ask about your previous family planning experience?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
04	Ask about your family planning method preference?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
05	Talk about possible side effects or problems with the method you selected?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
06	Tell you what to do if you experience any side effects or problems with the method you selected?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
07	Talk about warning signs associated with the method you selected?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
08	Talk about the possibility of switching to another method if the method you selected was not suitable?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
202	Did you feel that during your consultation, no other clients or patients at the facility could see you? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
203	Did you feel you could discuss your problems with the doctors, nurses or other providers, without others not involved in your care overhearing your conversations? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
204	Did the doctors, nurses or other staff treat you with respect? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
205	Did the doctors, nurses or other staff at the facility treat you in a friendly manner? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
206	Did you feel the health facility environment, including the washrooms were clean? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
207	Did you feel you could ask the doctors, nurses or other staff at the facility any questions you had? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
208	Did you feel like the doctors, nurses or other staff at the facility involved you in decisions about your care? IF YES, PROBE: Would you say all the time, most of the time, or a few times? IF CLIENT SAYS THEY DID NOT MAKE ANY DECISIONS: CIRCLE 9	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER . . . . . 8 NOT APPLICABLE 9	
209	Would you say you were treated differently because of any personal attribute, like your age, marital status, number of children, your education, wealth, or something like that? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
210	Did you feel like you were treated roughly, for instance were you pushed, beaten, slapped, pinched, physically restrained or gagged, or physically mistreated in any other way? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
211	Did you feel the doctors, nurses or other healthcare providers shouted at you, scolded you, insulted, threatened or talked to you rudely? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
212	Did you feel that you received all of the information you wanted to know about your options for contraceptive methods? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	
213	During your consultation today, did the provider strongly recommend one method over others? IF YES, PROBE: Would you say all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . . . 1 YES, MOST OF THE TIME . . . . . 2 YES, A FEW TIMES . . . . . 3 NO, NEVER . . . . . 4 DON'T KNOW/CAN'T REMEMBER 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP

3. ACCESS TO CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your family planning visit. Now I am going to ask you a few questions about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		
301	Was the time you waited to see a provider a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
302	Were the hours of service at this facility, that is when the facility opens and closes, a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
303	Were the number of days services are available to you at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
304	Was the cost for services or treatments at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . . . 1 YES, MINOR PROBLEM . . . . . 2 NO, NOT A PROBLEM . . . . . 3 DON'T KNOW 8	
305	Is this the closest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 401 → 401
306	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . . . . 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . . 06 WAS REFERRED . . . . . 07 SERVICE NOT OFFERED AT FACILITY NEAREST TO HOME . . . . . 08 OTHER . . . . . 96 DON'T KNOW 98	

4. FAMILY PLANNING CLIENT CHARACTERISTICS

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your experience at this facility. My final questions are about yourself.		
401	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW 98	
402	Have you ever attended school?	YES . . . . . 1 NO 2	→ 404
403 **(FN1)**	What is the highest level of school you attended: primary, secondary or higher? [COUNTRY SPECIFIC]	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
404	How many times have you been pregnant? IF NONE, ENTER "00"	NUMBER OF PREGNANCIES . . . . . [ ][ ]	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
405	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED . . . . . 1 YES, LIVING WITH A MAN . . . . . 2 NO, NOT IN UNION 3	
406	RECORD THE TIME THE INTERVIEW ENDED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

FAMILY PLANNING CLIENT EXIT INTERVIEW: FOOTNOTES

(FN1) Adapt according to the local educational categories

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

SICK CHILD CARETAKER EXIT INTERVIEW

FACILITY IDENTIFICATION

QTYPE . . . . . E S C

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]. . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM]. . . . . [ ][ ][ ]

INFORMATION ABOUT INTERVIEW

DATE . . . . . DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . 2 0 2 [ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF ESTIONNAIRE** [ ][ ]

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED (YES = 1, NO = 2) [ ]

LANGUAGE OF ESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH 03 LANGUAGE 05 LANGUAGE
02 LANGUAGE 04 LANGUAGE 06 LANGUAGE

TEAM NUMBER [ ][ ]

TEAM SUPERVISOR NAME _____ NUMBER [ ][ ][ ][ ]

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

SICK CHILD CARETAKER EXIT INTERVIEW

INTRODUCTION AND CONSENT

READ THE FOLLOWING CONSENT STATEMENT

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

This facility was selected to participate in the study. I would like to ask you some questions about your experiences here today to better understand how sick child services are provided in this facility. These questions usually take about 10-15 minutes.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this interview is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this interview may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor your child's name or the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that the decision to participate in this interview is completely voluntary and that your decision will not affect the services you receive. If at any point you would prefer to end the interview please feel free to tell me. There is no penalty for refusing to participate, however, we hope you will choose to participate.

In case you need more information about the survey, you may contact the in-charge manager of this health facility.

Do you have any questions for me at this time?

Do I have your permission interview you?

SIGNATURE OF INTERVIEWER _____

DATE

DAY				
MONTH				
YEAR	2	0	2	

CLIENT AGREES TO BE INTERVIEWED . . 1 ↓

CLIENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 → END

1. INFORMATION ABOUT SICK CHILD VISIT

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
101	RECORD THE TIME THE INTERVIEW STARTED. USE 24-HOUR FORMAT.	HOURS ☐☐ MINUTES ☐☐	
102	What is the name of the sick child?	NAME _____	
103	What time did you arrive at the facility today? IF THEY DON'T KNOW THE EXACT TIME, ASK THEM TO APPROXIMATE. IF THEY CAN'T GIVE AN APPROXIMATE TIME, USE 'DON'T KNOW'.	HOURS ☐☐ MINUTES ☐☐ DON'T KNOW 9998	
104	What time did you see the provider? IF THEY DON'T KNOW THE EXACT TIME, ASK THEM TO APPROXIMATE. IF THEY CAN'T GIVE AN APPROXIMATE TIME, USE 'DON'T KNOW'.	HOURS ☐☐ MINUTES ☐☐ DON'T KNOW 9998	
105	What month and year was (NAME) born?	MONTH ☐☐ DON'T KNOW MONTH . . . . . 98 YEAR ☐☐☐☐ DON'T KNOW YEAR 9998	
	PREVIOUS VISITS FOR CURRENT ILLNESS		
106	Has (NAME) been brought to see a health provider or traditional healer before for this same illness ? IF YES, ASK: Whom did you see and where?	YES, THIS FACILITY . . . . . A YES, DIFFERENT FACILITY . . . . . B YES, TRADITIONAL HEALER . . . . . C SAW NO ONE . . . . . Y	
107	CHECK Q106 FOR PREVIOUS HEALTH PROVIDER VISITS CODE 'B' CIRCLED ☐ ↓	CODE 'B' NOT CIRCLED ☐ → 109	
108	Was (NAME) referred to this facility from the other provider at the different facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
109	CHECK Q106 FOR PREVIOUS HEALTH PROVIDER VISITS CODE 'A' CIRCLED ☐ ↓	CODE 'A' NOT CIRCLED ☐ → 111	
110	When did you first bring (NAME) to this facility for this same illness?	WITHIN THE PAST WEEK . . . . . 1 WITHIN THE PAST 2-4 WEEKS . . . . . 2 MORE THAN 4 WEEKS AGO . . . . . 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	INFORMATION PROVIDED TO CARETAKER		
111	Did the provider tell you what illness (NAME) has?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
112	What would you do if (NAME) does not get completely better or becomes worse?	RETURN TO FACILITY . . . 1 GO TO OTHER FACILITY . . . 2 GO TO OTHER HEALTH WORKER OR /PHARMACY . . . 3 GO TO TRADITIONAL HEALER . . . 4 NOTHING, JUST WAIT . . . 5 DON'T KNOW . . . 8	
113	Did the provider tell you about any signs or symptoms you may see for which you must immediately bring the child back to a health facility? IF YES, ASK: Can you tell me what these are? IF NECESSARY, PROBE: Were there any serious symptoms or danger signs for which you were told to bring (NAME) back immediately?	FEVER . . . A BREATHING PROBLEMS . . . B BECOMES SICKER . . . C BLOOD IN STOOL . . . D VOMITING . . . E POOR/NOT EATING . . . F POOR/NOT DRINKING . . . G CONVULSION . . . H OTHER _____ (SPECIFY) . . . X NO, NONE . . . Y DON'T KNOW . . . Z	
	TREATMENT AND CARETAKER COMFORT LEVEL		
114	Did the provider give or prescribe any medicines for (NAME) to take at home?	YES, GAVE MEDS . . . 1 YES, GAVE PRESCRIPTION . . . 2 GAVE MEDS AND PRESCRIPTIOI . . . 3 NO . . . 4	→ 119
115	May I see all medications that (NAME) received and any prescriptions that have not yet been filled? CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.	HAS ALL MEDICATIONS . . . 1 HAS SOME MEDS, SOME UNFILLED . . . 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY . . . 3	
116 **(FN1)**	CIRCLE IF THE CHILD RECEIVED OR WAS PRESCRIBED ANY OF THESE MEDICATIONS CIRCLE ALL THAT IS APPLIED NOTE: FIRST LINE MALARIA TREATMENT WILL BE ADAPTED FOR EACH COUNTRY USING LOCAL BRAND NAME FOR ACT	**ANTIMALARIAL MEDICINE** ARTEMISININ COMBINATION THERAPY (ACT) . . . A SP/FANSIDAR . . . B CHLOROQUINE . . . C AMODIAQUINE . . . D QUININE PILLS . . . E INJECTION/IV . . . F ARTESUNATE RECTAL . . . G INJECTION/IV . . . H OTHER ANTIMALARIAL _____ (SPECIFY) . . . I **ANTIBIOTIC DRUGS** PILL/SYRUP . . . J INJECTION/IV . . . K **OTHER DRUGS** ASPIRIN . . . L ACETAMINOPHEN . . . M IBUPROFEN . . . N ORS . . . O ZINC . . . P OTHER _____ (SPECIFY) . . . X DON'T KNOW . . . Z	
117	Do you know the reason that the provider gave this treatment for (NAME)?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
118	Do you feel comfortable that you know how much of each medication to give (NAME) each day and for how many days to give it? IF “2” OR “8” SEND CLIENT BACK TO PROVIDER AT THE END OF THE INTERVIEW	YES . . . . . 1 NO . . . . . 2 DON’T KNOW 8	
119	What did the provider tell you about feeding solid foods to (NAME) during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . . 3 GIVE NOTHING/DON’T FEED . . . . . 4 DIDN’T DISCUSS . . . . . 6 NOT CERTAIN/CAN'T REMEMBEF 8	
120	What did the provider tell you about giving fluids (or breast milk, if the child is breastfed) to (NAME) during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . . 3 GIVE NOTHING/DON’T FEED . . . . . 4 DIDN’T DISCUSS . . . . . 6 DON’T KNOW/CAN'T REMEMBER 8	
	OUTCOME		
121	What was the outcome of this consultation? READ EACH OUTOME OPTION AND CIRCLE CODE '1' IF YES, OR CODE '2' FOR NO. a) Treated and sent home b) Child referred to provider, same facility c) Child admitted, same facility d) Child sent to lab for testing e) Child referred to other facility	YES NO a) TREATED AND SENT HOME . . . . . 1 2 b) CHILD REFERRED TO PROVIDER, SAME FACILITY . . 1 2 c) CHILD ADMITTED, SAME FACILITY . . . . . 1 2 d) CHILD SENT TO LAB FOR TESTING . . . . . 1 2 e) CHILD REFERRED TO OTHER FACILITY 1 2	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP

2. SICK CHILD EXPERIENCE OF CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about the care [NAME] received today. Now I am going to ask you about specific services that your child received in this visit to the health facility today. I know some of these are difficult to remember, so it is ok if you don't remember, but do try to tell me what you remember as it will be very useful in checking the quality of sick child care provided in the facilities around here.		
201	Thinking about your visit with [NAME] today, did you feel the doctors, nurses or other staff treated you and [NAME] with respect? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	
202	Thinking about your visit with [NAME] today, did you feel the doctors, nurses or other staff treated you and [NAME] in a friendly manner? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	
203	Thinking about your visit with [NAME] today, did you feel you could discuss your problems with the doctors, nurses or other providers, without others not involved in your care overhearing your conversations? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	
204	Thinking about your visit with [NAME] today, did you feel that during your consultation, no other clients or patients in the facility could see you? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	
205	Thinking about your visit with [NAME] today, would you say you were treated poorly because of any personal attribute, like your age, marital status, number of children, your education, wealth, or something like that? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	
206	Thinking about your visit with [NAME] today, did you feel you understood the purpose of any tests you were asked to do? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times? IF CLIENT SAYS THEY DIDN'T HAVE ANY TESTS, CIRCLE 9	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER ..... 8 NOT APPLICABLE 9	
207	Thinking about your visit with [NAME] today, did you feel you understood the purpose of any medicines you were given? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times? IF CLIENT SAYS THEY WEREN'T GIVEN ANY MEDICINES, CIRCLE 9	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER ..... 8 NOT APPLICABLE 9	
208	Thinking about your visit with [NAME] today, did you feel you could ask the doctors, nurses or other staff at the facility any questions you had? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	
209	Thinking about your visit with [NAME] today, did you feel the health facility environment, including the washrooms were clean? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME ..... 1 YES, MOST OF THE TIME ..... 2 YES, A FEW TIMES ..... 3 NO, NEVER ..... 4 DON'T KNOW/CAN'T REMEMBER 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
210	Thinking about your visit with [NAME] today, did the doctors, nurses, or other health care providers involve you in decisions about [NAME'S] care? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times? IF CLIENT SAYS THEY DIDN'T MAKE ANY DECISIONS, CIRCLE 9	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8 NOT APPLICABLE . . . 9	
211	Thinking about your visit with [NAME] today, did you feel you were able to discuss any problems or concerns you had with the health staff? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
212	Thinking about your visit with [NAME] today, did you feel your concerns were taken seriously by the health staff? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
213	Thinking about your visit with [NAME] today, did you feel like you or [NAME] were treated roughly, for instance were you pushed, beaten, slapped, pinched, physically restrained or gagged, or physically mistreated in any other way? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	
214	Thinking about your visit with [NAME] today, did you feel the doctors, nurses or other healthcare providers shouted at you, scolded you, insulted, threatened or talked to you rudely? IF YES, ASK: Would you say you were treated with respect all the time, most of the time, or a few times?	YES, ALL OF THE TIME . . . 1 YES, MOST OF THE TIME . . . 2 YES, A FEW TIMES . . . 3 NO, NEVER . . . 4 DON'T KNOW/CAN'T REMEMBER . . . 8	

3. ACCESS TO CARE

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
	Thank you for answering my questions about your child's health care experience. Now I am going to ask you a few questions about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.		
301	Was the time you waited to see a provider a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . 1 YES, MINOR PROBLEM . . . 2 NO, NOT A PROBLEM . . . 3 DON'T KNOW . . . 8	
302	Were the hours of service at this facility, that is when the facility opens and closes, a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . 1 YES, MINOR PROBLEM . . . 2 NO, NOT A PROBLEM . . . 3 DON'T KNOW . . . 8	
303	Were the number of days services are available to you at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . 1 YES, MINOR PROBLEM . . . 2 NO, NOT A PROBLEM . . . 3 DON'T KNOW . . . 8	
304	Was the cost for services or treatments at this facility a problem? IF YES, PROBE: Would you say this was a major problem or a minor problem?	YES, MAJOR PROBLEM . . . 1 YES, MINOR PROBLEM . . . 2 NO, NOT A PROBLEM . . . 3 DON'T KNOW . . . 8	

NO.	QUESTIONS	CODING CLASSIFICATION	SKIP
305	Is this the closest health facility to your home?	YES . . . . . 1 → 401 NO . . . . . 2 DON'T KNOW . . . . . 8 → 401	
306	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . . . . 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . . 06 WAS REFERRED . . . . . 07 SERVICE NOT OFFERED AT FACILITY NEAREST TO HOME . . . . . 08 OTHER . . . . . 96 DON'T KNOW 98	

4. SICK CHILD CLIENT PERSONAL CHARACTERISTICS

NO.	QUESTIONS	CODING CLASSIFICATION	
	Thank you for answering my questions about your experience at this facility. My final questions are about yourself.		
401	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW 98	
402	Have you ever attended school?	YES . . . . . 1 NO . . . . . 2 → 404	
403 **(FN2)**	What is the highest level of school you attended: primary, secondary or higher? [COUNTRY SPECIFIC]	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
404	Are you currently married or living together with a man/woman as if married?	YES, CURRENTLY MARRIED . . . . . 1 YES, LIVING WITH A MAN/WOMAN . . . . . 2 NO, NOT IN UNION 3	
405	RECORD THE TIME THE INTERVIEW ENDED	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

SICK CHILD CARETAKER EXIT INTERVIEW: FOOTNOTES

(FN1) Coding categories to be developed locally and revised based on the pretest. All antimalarials commonly used in the country should be included in the response categories. Common brand names for medicine, such as Coartem, Malaron, Artemether–Lumefantrine or Artesunate–Amodiaquine, should be added to the response categries for Artemisinin-based combination treatments (ACTs) as appropriate.

(FN2) Revise according to the local educational system

FORMATTING DATE: 20 April 2022
ENGLISH LANGUAGE: 20 April 2022

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT SURVEY
SIMULATION OF NEWBORN RESUSCITATION

[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FACILITY IDENTIFICATION

QTYPE [S][N][R]

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

CHECK INVENTORY 102(07) CODE 1(YES) CIRCLED: FACILITY PROVIDES NORMAL DELIVERY AND NEWBORN CARE SERVICES

YES, FACILITY PROVIDES NORMAL DELIVERY& NEWBORN CARE SERVICES 102(07) CODE [1] CIRCLED [ ] → [ ] END

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

PROVIDER INFORMATION

PROVIDER QUALIFICATION CATEGORY:

PROVIDER TYPE 1	01
PROVIDER TYPE 2	02
PROVIDER TYPE 3	03
PROVIDER TYPE 4	04
PROVIDER TYPE 5	05
PROVIDER TYPE 6	06
PROVIDER TYPE 7	07
PROVIDER TYPE 8	08
PROVIDER TYPE 9	09
OTHER TYPE	96

PROVIDER CATEGORY . . . . . [ ][ ]

SEX OF PROVIDER: (1=MALE; 2=FEMALE)

SEX OF PROVIDER . . . . . [ ]

INFORMATION ABOUT SIMULATION

DATE . . . . . .

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [2][0][2][ ]

INTERVIEWER'S NAME: _____

INTERVIEWER'S NUMBEF . . . . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** [0][1]

LANGUAGE OF INTERVIEW** [ ][ ]

NATIVE LANGUAGE OF RESPONDENT** [ ][ ]

TRANSLATOR USED [ ] (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:

01 ENGLISH	03 LANGUAGE 3	05 LANGUAGE 5
02 LANGUAGE 2	04 LANGUAGE 4	06 LANGUAGE 6

TEAM

[ ][ ]
NUMBER

TEAM SUPERVISOR

_____ [ ][ ][ ][ ]
NAME NUMBER

NEWBORN RESUSCITATION SIMULATION QUESTIONNAIRE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
100	WAS THIS PROVIDER INTERVIEWED WITH THE HEALTH WORKER QUESTIONNAIRE?	YES . . . . . 1 NO 2	→ NR01
101	In your current position, and as a part of your work for this facility, do you personally conduct the actual delivery of newborns, or provide care for the newborn?	YES . . . . . 1 NO 2	→ 102 → NR11
NR01	CHECK HEALTH WORKER INTERVIEW [Q505] FOR A PROVIDER OF DELIVERY SERVICES; CHECK [Q512] FOR A PROVIDER OF NEWBORN CARE SERVICES YES, CODE 505 [1] AND/ OR CODE 512 [1] CIRCLED ↓ OTHER ☐		→ NR11
102	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THE NEWBORN RESUSCITATION SIMULATION?	YES . . . . . 1 ← GO TO 103 THE NEWBORN RESUSCITATION CONSENT NO 2	→ NR11
103	**NEWBORN RESUSCITATION SIMULATION INFORMATION AND CONSENT** BEFORE OBSERVING THE NEWBORN RESUSCITATION SIMULATION, OBTAIN PERMISSION FROM THE SERVICE PROVIDER. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. Hello. I am [OBSERVER]. I am representing the [IMPLEMENTING ORG]. We are conducting a study of health facilities in [COUNTRY] with the goal of finding ways to improve the delivery of services. In case you need more information about the survey, you may contact the person listed on the card that has already been given to your facility manager. I would like to ask you to demonstrate a simulated management of the baby that does not breathe at birth in order to understand how delivery and newborn care services are provided in this facility. The simulation usually takes about 5-10 minutes. Information from this simulation is confidential. Your name will not be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; your name will not be entered in any database;however, there is a small chance that the facility can be identified later. Participation in the simulation is voluntary, you may refuse to answer any question or choose to stop the simulation at any time. There is no penalty for refusing to participate, however, your experience and views are important, and we hope you will agree to participate in the simulation. Do you have any questions for me? Do I have your permission to conduct the simulation? SIGNATURE OF _____ DATE DAY . . . . . ☐☐ MONTH . . . . . ☐☐ YEAR . . . . 2 0 2 ☐ RESPONDENT AGREES TO CONDUCT SIMULATION . . 1 ↓ REFUSE 2		→ NR11
104	RECORD THE TIME USE 24 HOURS FORMAT	HOURS . . . . . ☐☐ MINUTES . . . . . ☐☐	

NEWBORN RESUSCITATION SIMULATION QUESTIONNAIRE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
NR02	You said that you personally deliver or provide care for the newborn. Do you personally conduct only delivery of newborns, or only provide care for the newborn, or both delivery and newborn care services?	YES, DELIVERY ONLY . . . . . 1 YES, NEWBORN CARE . . . . . 2 YES, BOTH . . . . . 3 NO, NONE OF THEM . . . . . 8 → PROBE AND RECONCILE WITH NR01 OR 101	
	NOTE TO THE INTERVIEWER: NEWBORN RESUSCITATION SIMULATION IS USED TO DETERMINE WHETHER RESPONDENTS KNOW THE ESSENTIAL STEPS TO HELP A BABY BREATHE. READ THE CASE SCENARIO ALOUD TO THE PARTICIPANT. PROVIDE THE PROMPTS SHOWN IN CAPITAL LETTERS, AND ASK THE QUESTION SHOWN IN SENTENCE CASE. INDICATE THE BABY'S RESPONSE TO THE PARTICIPANT'S ACTIONS USING THE NEONATAL SIMULATOR OR WORDS IF USING A MANNEQUIN[a]. FOR EXAMPLE, WHEN THE PARTICIPANTS EVALUATE CRYING, SHOW THAT THE BABY IS NOT CRYING WITH A SIMULATOR. SAY THAT THE BABY IS NOT CRYING IF USING A MANNEQUIN. AS YOU OBSERVE THE RESPONDENT, CIRCLE THE CODE "1" FOR OBSERVED ACTION "DONE" , OR CODE 2 FOR "NOT DONE" FOR EACH ACTIVITY. APART FROM GIVING THESE PROMPTS, KEEP SILENT DURING THE EVALUATION. FINDINGS ARE NOT REPORTED BACK TO THE RESPONDENT.		
NR03 (1)	Now I would like to ask you to demonstrate a simulated management of the newborn. I am going to read a role play case. Please listen carefully, and then show me the actions you would take. I will indicate the baby's responses, but I will provide no other feedback. You are called to assist at the birth of 34 week (7-1/2 months) gestation baby. You have identified a helper, prepared an area for ventilation, washed your hands, and checked your equipment. The baby is born, and the amniotic fluid is clear. Show how you will care for the baby.		
	a) DRIES THOROUGHLY	DONE / NOT DONE a) 1 2	
	b) REMOVES WET CLOTH	b) 1 2	
NR04 (1)	PROMPT: SHOW THE BABY IS NOT CRYING. SAY: You do not see or hear secretions in the baby's mouth or nose.	DONE / NOT DONE	
	a) RECOGNIZES BABY IS NOT CRYING	a) 1 2	
	b)* STIMULATES BREATHING BY RUBBING THE BACK	**b)*** 1 2	

NEWBORN RESUSCITATION SIMULATION QUESTIONNAIRE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
NR05 (1)	PROMPT: SHOW THE BABY IS NOT BREATHING. a) RECOGNIZES BABY IS NOT BREATHING b) CUTS CORD AND MOVES TO AREA FOR VENTILATION OR POSITIONS BY MOTHER FOR VENTILATION c) VENTILATES WITH BAG AND MASK WITHIN THE GOLDEN MINUTE (AT ____SECONDS) **d)* ACHIEVES A FIRM SEAL AS DEMONSTRATED BY CHEST MOVEMENT** e) TIME OF EFFECTIVE VENTILATION (CHEST MOVING GENTLY AT _____ SECONDS) **f)* VENTILATES AT 40 BREATHS/MINUTE (30-50 ACCEPTABLE)** **g)* EVALUATES FOR BREATHING OR CHEST MOVEMENT**	DONE / NOT DONE a) . . . . . 1 2 b) . . . . . 1 2 c) . . . . . 1 2 SECONDS ☐☐ **d)*** . . . . . 1 2 e) SECONDS ☐☐ **f)*** . . . . . 1 2 **g)*** 1 2	
NR06 (1)	PROMPT: SHOW THE BABY IS NOT BREATHING. a) RECOGNIZES BABY IS NOT BREATHING b) CALLS FOR HELP c) CONTINUES VENTILATION	DONE / NOT DONE a) . . . . . 1 2 b) . . . . . 1 2 c) 1 2	
NR07 (1)	PROMPT, SAY: Please show what to do if the chest is not moving with ventilation. AFTER ONE OR MORE STEPS TO IMPROVE VENTILATION, SAY: The chest is moving now. a)* **REAPPLIES MASK** b)* **REPOSITIONS HEAD** c) CLEARS SECRETIONS FROM THE MOUTH AND NOSE AS NEEDED d) OPENS MOUTH SLIGHTLY e) SQUEEZES BAG HARDER	DONE / NOT DONE **a)*** . . . . . 1 2 **b)*** . . . . . 1 2 c) . . . . . 1 2 d) . . . . . 1 2 e) 1 2	
NR08 (1)	PROMPT: SHOW THE BABY IS NOT BREATHING a) RECOGNIZES BABY IS NOT BREATHING b) CONTINUES VENTILATION	DONE / NOT DONE a) . . . . . 1 2 b) 1 2	
NR09 (1)	PROMPT: AFTER 3 MINUTES SHOW THE BABY IS BREATHING a) RECOGNIZES BABY IS BREATHING b) STOPS VENTILATION c) PROVIDES CLOSE OBSERVATION FOR THE BABY AND COMMUNICATES WITH THE MOTHER	DONE / NOT DONE a) . . . . . 1 2 b) . . . . . 1 2 c) 1 2	

NEWBORN RESUSCITATION SIMULATION QUESTIONNAIRE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
NR10 (4)	FOR EACH ACTION LISTED IN 'a' THROUGH 'd', CIRCLE '1' DONE IF THE ACTION IS TAKEN BY THE PROVIDER. IF NO ACTION IN THE GROUP IS TAKEN, CIRCLE '2' NOT DONE, RESPECTIVELY AS OBSERVED a) SLAPPING NEWBORN b) HOLDING NEWBORN HEAD DOWN c) MILKING THE NEWBORN'S CHEST OR SQUEEZING THE NEWBORN'S RIBS d) PUMPING OF LEGS	DONE / NOT DONE a) . . . . . 1 2 b) . . . . . 1 2 c) . . . . . 1 2 d) 1 2	
NR11	RECORD THE TIME	HOURS . . . . . [ ][ ] MINUTES . . . . . [ ][ ]	

FINDINGS ARE NOT REPORTED BACK TO THE RESPONDENT.
THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT

Interviewer's comments:

	FOR DATA PROCESSING (2,3)		
NR12 ('2,3)	CHECK NR03-NR09: ANY CODE CIRCLED? YES ☐ ↓ NO ☐ → END		
NR13 (1,2,3)	SUM ALL ANSWERS TO NR03 - NR09, AND ENTER TOTAL WITH CODE "1" (DONE) CIRCLED. IF NONE, RECORD "00"	TOTAL DONE . . . . . [ ][ ]	
NR14 (1,2,3)	SUM ANSWERS TO QUESTIONS MARKED WITH AN ASTERISK(*) NR04(b) + NR05(d) +NR05(f) +NR05(g) +NR07(a) +NR07(b) WITH CODE "1"(DONE) CIRCLED, AND ENTER TOTAL. IF NONE, RECORD "0"	TOTAL DONE . . . . . [ ]	
NR15 '('3)	CHECK NR13 FOR TOTAL DONE, AND NR14 FOR TOTAL DONE, AND INDICATE STATUS **PASSED:** NR13= 17 **AND** NR14= 6 17 CORRECT OF 23, AND " DONE" MUST BE OBSERVED FOR THE ITEMS MARKED WITH AN ASTERISK(*)	PASSED . . . . . 1 OTHER 2	

NEWBORN RESUSCITATION SIMULATION: FOOTNOTES

[a] Decision about whether USING THE NEONATAL SIMULATOR OR A MANNEQUIN will be made during the tool development, could be also a country specific

1. Adapted from THE HEPLING BABY BREATH, OBJECTIVE STRUCTURED CLINICAL EXAMINATIONS (OSCE- B) TOOL

See the training Video:

Welcome | AAP

NRP | AAP

2. Score computation is based on the original OSCE- B tool. Scoring results are not reported back to the respondent. Scoring is automated by the CAPI program after results are entered into a data file.
3. Delete NR12-15 if the scoring is automated by CAPI program
4. Question NR10 (harmful practices) is Not part of the original OSCE- B tool, and is not used in the scoring