

TRAINING MANUAL FOR CONDUCTING THE
SERVICE PROVISION ASSESSMENT
(SPA)

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I OVERVIEW OF DATA COLLECTION PROCEDURES¹

1. INTRODUCTION

The objective of the Service Provision Assessment (SPA) is to collect information on the delivery of health services in {COUNTRY}. The SPA examines the supply side of the health care, providing an assessment of the readiness of facilities to provide good quality health services. The priority health services included in the SPA are: (1) child health promotion and treatment of childhood illnesses; (2) maternity care (antenatal, delivery, postpartum, and newborn); (3) family planning services; and (4) services for the prevention and management of sexually transmitted infections (STIs) and HIV/AIDS.

Information from the SPA will help health program and policy makers when prioritizing interventions to increase the provision of quality health services.

A. Survey Organization

The SPA is being undertaken jointly by the [IMPLEMENTING ORGANIZATION(S)], with technical assistance from Macro International, under the MEASURE DHS+ Project. The study is being funded by the United States Agency for International Development [AND OTHER FUNDING AGENCIES].

B. Survey Objectives

The primary objectives of SPA are:

To describe the preparedness of private and government clinics in [COUNTRY] to provide good quality child, maternal, and reproductive health services;

To identify gaps in the support services, resources, or the process used in providing client services that may impact the ability of facilities to provide quality services;

To describe the process used in providing child, maternal, and reproductive health services and the extent to which accepted standards for good quality service provision are followed;

To provide comparisons on findings between regions in [COUNTRY] and, at a national level, between facilities run by different operating authorities (i.e., governmental or private); and

¹ Instructions for organization the survey and interviewer instructions draw extensively from: 1) QIQ A User's Guide for Monitoring Quality of Care (Measure Evaluation 02/01); 2) *Interviewer's Manual: For use with Model 'A' Questionnaire for High Prevalence Countries*, (Macro International, 1997); 3) Training Manual for the Kenya Service Provision Assessment (Macro International 2000).

To describe the extent to which clients understand what they must do to follow-up on the service received so that the best health outcome is achieved.

C. Spa Sample

The facilities included in the survey are a sample of all of the facilities that offer delivery services, or outpatient child, maternal, or reproductive health services in [COUNTRY]. This sample has been carefully selected to ensure that the survey results can be analyzed separately for each region in the country. The sample has also been selected so that the facilities operating under different operating authority (e.g. government, private for profit, non-governmental not-for-profit) can be compared at a national level. To ensure that the sample adequately represents the actual situation at health facilities in the country, it is very important that you find and visit all of the facilities that have been selected for the SPA in the geographic area(s) to which your team will be assigned.

D. Spa Data Collection Instruments

The SPA involves a number of data collection instruments designed to provide comprehensive information on the delivery of services in the four priority areas. These data collection instruments include the following:

■ *Facility Inventory.* The facility inventory is designed to obtain information on the preparedness to provide each of the priority services. The inventory collects information on the availability of specific items (including their location and functional status), components of support systems (e.g., logistics, maintenance, management), and facility infrastructure, including the service delivery environment. The resources assessed are those required to provide service at an internationally accepted standard. The support services are those that are commonly acknowledged as essential management tools for maintaining health services.

■ *Provider Interview.* Health service providers are interviewed for information on their qualifications (training, experience, continued education), supervision they have received, and perceptions of the service delivery environment.

Observation Protocols. Protocols have been designed for observing consultations for sick children, and antenatal care, family planning, and STI clients. These protocols assess the extent to which service providers adhere to service delivery standards based on internationally accepted components for good service delivery. The process used when conducting specific procedures, physical examinations, and the content of information exchanged between the provider and client (history, symptoms, and advice) are components of the observation.

Exit Interviews: The exit interviews are conducted with clients who's consultations you have observed. They have been designed to assess the client's understanding of the consultation/ examination, as well as recall of instructions received for treatment or preventive behaviors. Recall of key messages increases the likelihood that clients will be able to successfully follow treatment or perform the preventive behaviors that optimize healthy outcomes. The client's perception of the service delivery environment is also assessed.

E. Spa Field Staff Training

A total of [NUMBER] teams will conduct the SPA. Typically, each team will include a team leader and two additional interviewer-observers. We have recruited more health care providers to participate in the SPA training course than are needed to do the work. At the end of the course, we will be selecting the best qualified among you to participate in the survey. If you are selected to work in the survey, you may be working on the SPA for up to [DURATION] months after the completion of this training.

During the survey training course, you will be instructed how to identify the appropriate respondents at each facility and how to fill in questionnaires correctly. You will also conduct practice interviews with other trainees, MOH staff, and other health service providers. You will be given periodic tests, homework, and the questionnaires that you complete will be edited to check for completeness and accuracy.

Study the contents of this manual carefully, since this will reduce the amount of time needed for training and will improve your chances of being selected.

F. Survey Regulations

In order to ensure the success of the SPA, the following survey regulations have been established and will be strictly enforced.

Every survey staff position is vital to the success of the survey. Therefore, your presence is required for each day of the training and fieldwork. Except for illnesses, any person who is tardy or absent during any part of the training or any part of the fieldwork (whether it is a whole day or part of a day) without prior approval may be dismissed from the survey.

The selection of the survey team members is competitive; it is based on performance, ability, and testing results during the training. Therefore any person found offering assistance to or receiving assistance from another person during tests will be dismissed.

Throughout the survey training and the fieldwork period, you are representing the [NAME OF SURVEY ORGANIZATION]. Your conduct must be professional and

your behavior must be congenial when dealing with the public. You must always be aware of the fact that we are only able to do our work with the good will and cooperation of the people we interview. Therefore, any team member who is consistently overly aggressive, abrupt, or disrespectful to others may be dismissed from the survey team.

For the survey to succeed, each team must work closely together. Any team member who, in the judgment of the Survey Manager, is a disruptive influence on the team may be asked to transfer to another team or may be dismissed.

It is critical that the data gathered during the fieldwork be both consistent and accurate. Field staff may be dismissed at any time during the fieldwork if the quality of their work is inadequate.

Vehicles and gasoline are provided for the survey for official use only. Any person using a vehicle for an unauthorized personal reason will be dismissed.

SPA data are confidential. Under no circumstances should confidential information be passed on to third parties. Persons breaking these rules, and therefore, the confidence placed in them by SPA respondents, will be dismissed.

2. PLANNING THE SPA FIELDWORK

The following describes in detail the activities that are involved in planning the SPA fieldwork. In most cases, the team leader will have the chief responsibility for planning field activities.

A. Fieldwork Schedule

The Survey Manager will assign each team a list of facilities to be visited for data collection. The list will include the name and location (including street address) of the facility as well as the facility identification information required in the SPA questionnaires (see Example 1).

Example 1 Facility Identification Information for SPA Questionnaire

Facility Inventory Questionnaire	
FACILITY IDENTIFICATION	
Name of the facility _____	
Facility Location _____	FACILITY CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Code of the facility	FACILITY TYPE <input type="text"/>
Type of Health Facility *: (1 = Referral hospital; 2 = Hospital; 3= Health center; 4 = Health post; 6 = Other _____)	OPERATING AUTHORITY <input type="text"/> <input type="text"/>
Operating Authority*: 10= Government; 20 = Non-governmental organization 30 = Private for profit 96 = Other _____	

If the information is available, the list may include the name of the person in-charge at the facility, telephone numbers or other information on how to contact the facility, and the hours during which the facility is open and/or various services offered. The Survey Manager also will provide the team with a map showing the location (or approximate location) of all of the facilities on their list (see Example 2).

The team leader will work with other members of the team including the driver and senior staff of the SPA to prepare a schedule for the visits to the facilities assigned to his/her team. Because of the high costs for fuel, the schedule will be

designed to minimize 'doubling back', thereby increasing the cost-effectiveness of the survey and decreasing the distances the team is required to travel.

In developing the schedule, the team leader must take into account the location of each of the facilities as well as the localities where the team will likely be staying overnight. The team generally will need to arrive at a facility on or before

Example 2 Facility Map

the official opening hours, therefore, the lodgings that the team will use each night must be within a reasonable distance of the facility that is to be visited on the next day.

The team leader must provide a copy of the visit schedule to the Survey Manager prior to beginning fieldwork. It is likely that there will be changes in the visit schedule during the course of the fieldwork, and it is the team leader's responsibility to keep the senior survey staff updated on the team's schedule.

B. Advance Contact With Authorities/Facilities

Generally, the Survey Manager or another senior member of the team will have notified appropriate authorities of the nature and purpose of the SPA in advance of the fieldwork. It is best if an official letter from the managing authority for the facilities being surveyed be sent to the regional or district offices for that organization. Each team should also have a copy of the letter to show at facilities if necessary. In addition, prior to visiting facilities in a specific region or district, each SPA team should contact regional or district offices of the operating authorities for those facilities to be visited. Such contacts can facilitate cooperation with the study by the facility staff as well as provide pertinent information such as hours of operation, times when specific services are offered, and so forth, that is helpful when scheduling facility visits. Finally, if possible, the team leader should directly contact (by phone or radio) each facility a few days in advance of the actual date of the planned visit. This contact may decrease the probability of essential respondents or services not being available the day of the visit as well as facilitate cooperation from facility staff.

C. Logistical Arrangements

Prior to departure for fieldwork, the team leader must ensure that the team has all of the sampling materials, questionnaires and other materials (pens, clipboards, briefcases, interviewer guides, and other supplies) necessary to complete its assignment. The team leader must also have introductory letters from the Ministry of Health as well as other organizations whose facilities will be visited during the survey.

The team leader will be responsible for all transport arrangements. If the team has its own vehicle and driver, this will include confirming that any maintenance activities are complete and that coupons (or cash) are available for fuel purchases and maintenance. The team leader also may be required to make/confirm accommodation reservations for the team during the fieldwork

Throughout the fieldwork, the team leader is responsible for ensuring that the team has adequate equipment and supplies and, with the assistance of the driver, for ensuring that the maintenance schedule for the vehicle is followed and for dealing with unexpected problems with the vehicle. In particular, the team

leader must make sure that the team has a sufficient number of each of the SPA questionnaires at all times.

3. ORGANIZATION OF ACTIVITIES DURING FACILITY VISIT

There are a number of general procedures to be followed by a SPA team during a visit to a survey facility. These procedures are outlined in the following sections, along with general tips for interviewing respondents, instructions for recording responses in the questionnaires, and ensuring quality in the data collection process. Subsequent sections of the manual provide detailed instructions for completing each of the SPA instruments.

A. Verifying Facility Identification

The hospitals, clinics, and other health facilities included in this survey have been specifically selected to meet special sample criteria. Every attempt should be made to conduct the SPA data collection at the selected facilities.

The team leader is responsible for making sure that the team visits all of the facilities that his/her team is assigned during the SPA. If after contacting local authorities, you cannot locate a facility or are not sure about whether a facility that you have found is actually in the SPA sample, contact the Survey Manager. If a facility included in the team's assignment has closed, the team leader should also contact the Survey Manager.

Finally, no facility not listed in the sample should be visited and interviewed unless specifically approved by a Survey Manager.

B. Gaining Permission for the Survey

The SPA team will be visiting facilities that are operated by the government and those that are operated privately. The private facilities must give permission for the survey to be conducted on their premises. Private facilities may be less willing to participate if they fear the survey will result in negative findings or that conducting the survey will interfere with service provision. Prior notification of the survey, either from the main office of the operating authority, or if it is an independent facility, from one of the government sponsors of the survey, will help pave the way for agreement to participate. The private facility may be especially concerned about the confidentiality of the survey results. You may provide reassurance that results will only be provided in an aggregate manner (grouping facilities) so that no one facility can be identified with any particular findings.

Although officially the government facilities are obligated to allow the survey, the results will be much better if the staff at the facility agree willingly to cooperate with the survey.

The initial impression you give to the facility staff will be important to gaining their willing cooperation with the survey. At all times the staff at the facility must be treated with respect and politeness. Upon arrival at each facility, the team leader will ask to see the person in charge. If the official “in-charge” is not present the day of the survey, they must ask to see the person acting “in-charge” for the day. The team leader will introduce the survey team and explain the purpose of the visit and the activities that are a part of the survey. At this time, the introductory letters from the relevant organization and the letters explaining the survey and giving the team authorization to visit facilities will be given to the in-charge.

An example of an introduction upon arrival would be:

“Good day. My name is _____. My colleagues and I are representatives of the Ministry of Health. We are conducting a survey of facilities that provide child or reproductive health services. We are visiting hospitals and clinics throughout the country and your facility was selected, by chance, to be included in the survey. [IF RELEVANT, ADD: As you might be aware, the [OTHER ORGANIZATIONS] have been collaborating with us to ensure that this survey is representative of all providers of these health services].

As a part of the survey, we are collecting information on the types of equipment and supplies that are available in facilities and the training of staff who provide services. We would like to observe some of the services as they are provided and to talk with clients after they complete their visit to your facility.

All of the information that is collected from this facility will be strictly confidential. We will not be referring to individual facilities in our report, but rather are looking at the overall picture for all facilities of the same type.

The purpose of this survey is to provide information to health planners and organizations representing health workers regarding the current situation for health care provision for children, and maternity and reproductive health services. This information will be used to develop the most appropriate programs for improving these health services in [COUNTRY].

Do you have any questions thus far?

May we proceed?

If you are refused an interview in the facility and nothing you say can make the in-charge reconsider, contact the Survey Manager, and provide the name of the facility, it’s operating authority, and location. The Survey Manager will make every attempt to contact appropriate persons who can help to convince the health facility staff to allow the interview.

C. Organizing Data Collection at a Facility

At the start of the facility visit, the Team Leader will discuss with the in-charge or other knowledgeable person the organization of the service delivery system for the specific services included in the SPA. It is important to determine at the start of your visit where the relevant services are being provided and where medications and supplies are stored. It is also important to determine the times and locations where consultations for the various priority services are held in order to plan the logistics for the observation and for client interviews components of the SPA.

The Team Leader is responsible for working out a plan for completing all components of the SPA at a sampled facility. The Team Leader should discuss the plan with the in-charge. It may be helpful to meet with relevant supervisors (at large facilities) and other staff who may be requested to allow interviews and observations during the team's visit. For a small facility this may be relatively easy since most services are in the same general area. For larger facilities, this may involve different departments.

At this time, you must plan which staff will be interviewed so that the in-charge can ensure they remain available. All providers who are observed should be interviewed. For facilities with 8 or fewer service delivery staff, all should be interviewed. For facilities with more than 8 service delivery staff, a list should be made by service and qualification, and a systematic, proportional selection of up to 8 staff members made. The selection must include all observed providers and at least one of the most senior level health care provider assigned to the facility (e.g. doctor). Appendix 2 provides detailed instructions on how to select providers for interview. We wish to interview persons who actually provide client consultation services. Staff who have more than one duty (e.g. manager plus consultation duties) are to be included in the list of potential staff for interview. Staff who have no client consultation duties (e.g. laboratory or pharmacy workers, full-time managers) are not to be included in the list of potential staff for interview.

Observation will be the most difficult module to complete a sample for, so priority should be given to this component. If it is the time when clients are present, the team leader should arrange for the observer to go to the first area where observations will take place while the other interviewer is placed for exit interviews. Depending on how frequently the eligible clients arrive for observation, the inventory and staff interviews may be conducted in between clients. Appendix 3 provides detailed information on selection the clients for observation.

4. TIPS FOR CONDUCTING INTERVIEWS/OBSERVATIONS

The following are some general rules in conducting interviews or observations at a facility. Specific procedures for completing each of the SPA questionnaires are described in detail in Sections II-IV.

■ *Encourage respondents to cooperate by your approach*

The quality of the information you collect will depend to a large extent on the attitude of both the health providers and clients. Therefore, the interaction between yourself and all respondents is very important. All respondents should be treated respectfully and politely. The respondents should know that you appreciate their cooperation and the time they are taking to help make the survey successful.

If the respondent feels that the information is important and that you are sympathetic to their situation, they will be more straightforward with responses and will be more likely to answer questions to the best of their ability. If they feel pressured to respond, or feel that the interview is a burden, they may not carefully think about responses.

■ *Make sure you ask the questions exactly as they are written in the questionnaire*

Always ask questions using the exact wording found in the SPA instrument. Speak slowly and clearly so that the people/person you are interviewing will have no difficulty in hearing or understanding the question. At times, you may need to repeat the question in order to be sure the respondent(s) understand(s) it. In those cases, do not paraphrase the question but repeat it exactly as it is written. If, after you have repeated a question, the respondent(s) still do(es) not understand it, you may have to restate the question. Be very careful when you change the wording, however, that you do not alter the meaning of the original question.

■ *Be straightforward*

There are many questions in the survey where you are asking about the availability of items, and then asking to see them. Providers will be more cooperative if they know beforehand what to expect. If you ask questions and then later ask to see items, people may think you are trying to trick them, or “checking up” on their answer.

In order to have the greatest amount of cooperation, always tell the respondent what is coming. For example:

“Now I am going to ask you if you have various types of equipment or supplies, if they are in working order, and after answering about all of them, I will need to see the items so that I can completely fill in this questionnaire.”

■ *Never suggest answers to the respondents*

If the respondents' answer is not relevant to a question, do not prompt them by saying something like “I suppose you mean that...Is that right?” In many cases, the informants will agree with your interpretation of their answer, even when that is not what they meant. Rather, in most cases, you should probe in such a manner that the informants themselves come up with the relevant answer, e.g.,

“Can you explain a little more?”

“There is no hurry. Take a moment to think about it”.

Specific questions for which it may be necessary to provide additional clarification will be discussed in the detailed instructions for completing the SPA questionnaires. Even in these cases, you should provide only the minimum information required for an appropriate response. Except when specifically instructed (e.g. when asking the client about their thoughts on the facility during the client interview), never read out the list of coded answers to the respondents, even if they have trouble in answering the question.

■ *Ask all applicable questions*

In most cases, you will ask questions in the sequence in which they appear in the questionnaire. However, because the organization of facilities often differ, you may find that to complete one module you have to talk to more than one respondent, or go to different areas of the facility. It is up to you to ensure that when sections are skipped because the information must be collected from a different informant or location, that those sections are completed before your departure.

■ *Handle hesitant respondents tactfully*

There may be situations where the respondents simply say “We don't know”, give an irrelevant answer, act very bored or detached, contradict something they have already said, or refuse to answer the question. In these cases you must try to re-interest them in the conversation. For example, if you sense that they are growing restless, reassure them that there are not many more questions and that the government is very interested in what they say about the services or about their facility.

If the informants are giving irrelevant or elaborate answers (or complaining about something), do not stop them abruptly or rudely, but listen to what they have to say. Then try to steer them gently back to the original question. You can also

write down what they say and tell them that it is duly noted. A good atmosphere must be maintained throughout the interview. The best atmosphere for an interview is one in which the respondents see the interviewer as a friendly, sympathetic, and responsive person who cares about them.

■ *Never let the survey interfere with the health workers' ability to see patients*

If the health worker you need to see is busy with a client, wait until that visit is completed before approaching the health worker. Wait until there are no clients around or until there is a qualified person to show you around for completing the inventory and staff interview modules.

■ *Offer no opinions or advice on specific facility practices or patient care issues*

If you are asked a question that you think requires your medical opinion or advice, simply respond that you are here to collect information to provide an overview of the (whatever health service is involved) services, and you are interested in the systems and practices at this facility. Explaining this and then simply stating "I'm not in a position to provide any advice or opinions" may be sufficient. Questions requiring this response are most likely to arise during the observation and the client interview components. If the client has a specific question, you may refer them back to the provider for clarification of the issue in concern.

If you observe what you consider to be wrong practices, make a note on the questionnaire, but, again, make no comment or intervention. Remember, the purpose of the survey is to collect information that will help to improve the health services overall. If you intervene with one health worker or with one client this may bias further results and prevent you from observing the true practices and facility characteristics which might need to be addressed for the health system as a whole.

■ *Never raise expectations of immediate changes in the situation of the staff or facility*

Do not raise expectations that that you can immediately assist with solving problems that the staff or clients raise as problems. You are going to provide information to decision makers and health planners and administrators, but any changes as a result of the survey will most likely occur over an extended period of time, and be gradual in implementation. If clients or staff complain about the poor state of repair of the facility, equipment, or supplies or other problems, provide a neutral or non-judgmental response (e.g., "I know these things are difficult").

II COMPLETING THE SPA QUESTIONNAIRES

The information that you collect in the field will eventually be entered into a data file using computers in the central office in [LOCATION]. At that point, it is very difficult to correct for errors or omissions in the questionnaires. Consequently it is very important that you correctly record the answers the respondent gives and follow all special instructions in the questionnaire

1. RECORDING THE RESPONSES

In the SPA, all questionnaires are to be completed using pens with blue ink. Blue ink is used because it can be distinguished from the black ink in which the questionnaires are printed. Never use red or green ink in recording responses since these colors are reversed for supervisory staff to use in correcting the questionnaires in the office and field, respectively.


The procedures for recording responses will vary according to the type of question; there are three types of questions in the SPA questionnaires: (1) pre-coded questions, (2) questions requiring a numeric response, and (3) open-ended questions.

Never leave a response blank! A blank is recorded as "missing information" because it is not known if you asked the question or not. If a response is negative, the negative response must be circled.

A. Pre-coded Questions

The responses to pre-coded questions are listed in the questionnaire. To record a respondent's answer, circle the number (code) that corresponds to the reply. Make sure that each circle surrounds only a single number.

Example where only one response is correct

108	Does this facility have a formal system for reviewing management or administrative issues?	YES..... NO2 DON'T KNOW8	 →112 →112
-----	--	--	---

Sometimes there can be more than one response. In this case, these codes will be letters (e.g. A) rather than numbers. Be sure to circle all the appropriate responses.

Example where more than one response may be correct

112	Does this facility have any system for determining client opinion about the health facility or services? IF YES, CIRCLE ALL METHODS FOR ELICITING CLIENT OPINIONS THAT ARE USED	SUGGESTION BOX <input type="radio"/> CLIENT SURVEY FORM B CLIENT INTERVIEW C OTHER W (SPECIFY) NO CLIENT FEEDBACK Y DON'T KNOW Z
-----	---	--

In some cases, a pre-coded question will include an “other” category. The “other” code should be circled when the answer is different from any of the pre-coded responses listed for the question. When you circle the code “other” for a particular question, write the answer in the space provided. If you need more room, use the margins or the comments section on the page and write, “see note in comments section.”

Example of response using OTHER

221	What type of injection equipment is used during routine immunization sessions at this facility?	SINGLE USE 1 STERILIZABLE 2 OTHER <u>injection gun</u> 6 (SPECIFY)
-----	---	---

Sometimes responses to particular questions must be entered in response grid (table). When recording a response in one of these grids, be sure that you are entering the answer in the proper row and column.

Examples of response grid

222	ITEMS REQUIRED TO PROVIDE IMMUNIZATION SERVICES	OBSERVED IN ROOM OR ADJACENT	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED
<input type="radio"/>	Sharps box for needles	1	2	3	8
<input type="radio"/>	5 or more disposable (unused)/sterilizable: 1 ml syringes, AND 5 or more 3 ml syringes with 22 gauge needles?	1	2	3	8
<input type="radio"/>	C) Hand-washing items (soap, towel)?	1	2	3	8

B. Numeric Questions

For many questions in the SPA, a numeric response is appropriate and should be entered in the available boxes.

Example of response needing numeric response

429	How long does it take, using this form of transportation, to get to the nearest referral facility? (NOTE: IF CALL ELSEWHERE TO OBTAIN VEHICLE, RECORD AVERAGE TIME FROM CALL TO PATIENT ARRIVAL AT REFERRAL FACILITY)	MINUTES <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> DON'T KNOW 998			

Whenever respondents do not know the answer to a numeric question, for a response that has two boxes record '98', for a response having more than two boxes record nines with the last digit being an '8'. For a response with only one number response box, record an '8'.

Example of “DON’T KNOW” answer for question requiring a numeric response

429	How long does it take, using this form of transportation, to get to the nearest referral facility? (NOTE: IF CALL ELSEWHERE TO OBTAIN VEHICLE, RECORD AVERAGE TIME FROM CALL TO PATIENT ARRIVAL AT REFERRAL FACILITY)	MINUTES	<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>				
		DON'T KNOW	998				

C. Correcting Mistakes

If you make a mistake entering an answer or the respondent changes their reply, put two horizontal lines through the incorrect response. Do not try to erase an answer.

Example of corrected response

221	What type of injection equipment is used during routine immunization sessions at this facility?	SINGLE USE STERILIZABLE 2 OTHER <u>injection gun</u> 6 (SPECIFY)
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Remember that if there are two responses for a particular question that requires only one response, it may be impossible later, when the data are being coded, to determine which is the correct answer.

D. Following Instructions

The SPA questionnaires include a series of instructions for the interviewers. It is important that you follow the instructions included in the questionnaire consistently.

Skip instructions

The questionnaire is set up to avoid as much redundancy as possible and ask only appropriate questions given a situation. ARROWS are also used throughout the questionnaires to give directions about the next question to ask (i.e., 'to skip to'). It is very important to follow these skips for they will make the questionnaire much shorter and thus increase the cooperation of the respondents. Skips enable the interviewer to collect the necessary information in as an efficient manner as possible.

Example of response indicating a “skip”

200	Indicate any of the following child health services which are offered through the facility either during outreach activities or at the facility.	CURATIVE CARE..... A WELL CHILD GROWTH MONITORING B IMMUNIZATION C NO CHILD HEALTH SERVICES... Y	→300
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Written instructions

Throughout the SPA questionnaires, there are written instructions to help you remember important directions for collecting and recording information. These instructions appear in **BOLD-FACED CAPITAL LETTERS**. Pay attention to the instructions since they are there to help you complete the questionnaire as accurately and completely as possible.

Example of written instructions

ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.

III ENSURING QUALITY

All members of the SPA team are responsible for ensuring that the data that is collected at each facility is as accurate and comprehensive as possible. Each interviewer-observers is responsible for:

Checking that questionnaires you have filled are complete at the end of each provider or client interview or observation, ensuring that all answers are clear and reasonable, and that your handwriting is legible.

If questions are omitted or there appear to be errors, you must return to the original respondent(s) if possible. Apologize, explain that you made an error, and ask the question again.

- Take particular care in recording information when you are observing consultations since it is not permissible (possible) to complete omitted items later in the day based on recall.

- Notify the team leader whenever there are problems in completing the daily assignment, e.g., in observing the target number of consultations or completing interviews with health providers.

The team leader has the overall responsibility for the quality of the work of the team in the field. The team leader must:

Monitor the activities of the team during the course of each day's activities. In particular, the team leader must ensure that team members are conducting the observation and exit interviews in an organized manner that will yield the appropriate number of completed instruments by the end of the day's activities.

Attend one or two client-provider consultations with each interviewer-observer during each week and independently complete a questionnaire for each consultation that is jointly observed. Immediately afterwards, compare the questionnaire that the interviewer-observer completed with the one that the team leader filled in. Discuss any differences with the interviewer-observer.

Check all questionnaires received at the end of the day to ensure that all items are completed and skip patterns are followed. In particular, check that the observation, health worker and exit interview questionnaires include all of the appropriate identification information that will be needed to link the data from these questionnaires.

Feedback information to the team members on any problems observed in the completed questionnaires, and discuss with the staff any problems they have encountered.

Maintain regular contact with the central office. Feedback information on any problems with staff performance or aspects of the survey. Promptly notify the central office of any changes in the visit schedule initially prepared.

Prepare a packet of questionnaires at the end of the visit to each facility for return to the central office. Make sure that the correct totals of health provider, observation and exit interviews are shown on the cover of the facility inventory.

IV QUESTIONNAIRES

1. FACILITY INVENTORY

A. Overview of the Inventory Questionnaire

The facility inventory is designed to collect information on the availability of basic equipment, supplies, and medications and on the functioning of certain key systems (e.g., record-keeping, supervision, etc.). The inventory questionnaire includes:

- (1) Cover Page
- (2) General Information
- (3) Vaccine Logistic System
- (4) Child Health Services
- (4) Family Planning Services
- (5) Antenatal Care Services
- (6) Delivery Care Services
- (7) STI and HIV/AIDS Services
- (8) Laboratory Diagnostics
- (9) Availability of Contraceptive Supplies
- (10) Availability of Essential Medicines and Supplies for Providing Child Health, Maternal Health and STI and HIV/AIDS Services

Begin the interview with the in-charge at the facility or the most senior health staff person responsible for outpatient services who is available at the time of your visit. Discuss with this key informant the type of information that you are seeking, before beginning the inventory interview. Explain that you will first be asking general questions about the facility. Then, you will want to go to where specific services are offered and actually look at equipment, supplies, and drugs. The specific services you are interested in are Child Health, Family Planning, Maternal Health (including deliveries), treatment of Sexually Transmitted Infections, and treatment and/or management of clients with HIV/AIDS. You will also want to see the facility's laboratory (if applicable) and the place(s) drugs and other supplies are stored.

B. General Procedures for Completing the Inventory

Detailed instructions for completing each of section of the inventory are included below. However, there are some general points that should be taken into account in completing the various parts of the facility inventory:

- 1) Interview the most appropriate respondent: Some responses require specific knowledge about the service. The in-charge or one respondent, may not know the answers to some of these questions. For any question where the response is "DON'T KNOW" you should ask if there is someone else available

who might know the response for the information you are seeking, and only accept “DON'T KNOW” if there is no one who works with that specific service who can provide the answer.

2) Flexibility. You should first complete the GENERAL INFORMATION (Section 1). After that, you may need to be flexible in how you administer the inventory. For example, if a facility is small or service delivery is integrated, there may only one informant and most of the observation will be done in one location. On the other hand, in large facilities, you may need to visit several separate locations within the facility and interview more than one informant in order to obtain all of information required for completing the inventory. In such cases, try to complete inventory sections 2-6 in whatever order makes the most efficient use of time and service provision schedules.

If you interview more than one respondent, make sure that you take the time to inform each respondent about the purpose of the study and that you obtain their consent for the interview.

3) Multiple interviewers. In general, one member of the SPA team (usually the Team Leader) will responsible for completing the facility inventory. However, in some instances, it may be necessary to assign sections of the inventory to more than one person on the SPA team. In such cases, the team members should record responses if at all possible in the same questionnaire. If a second inventory questionnaire must be used for some sections, make sure that the facility identification information is included on both questionnaires. Write at the top of the cover sheet of each of the inventory questionnaires which sections have been completed in each of the questionnaires and attach the two questionnaires together. Never copy sections from one questionnaire to another since this may introduce errors.

4) Observing versus reporting. In the inventory, you will often be recording information on the presence of equipment, drugs, supplies and other items required for the delivery of the priority services. The following criteria are to be used for classifying the presence of the item:

“1” for “OBSERVED”: The item has been seen in the service provision area or an immediately adjacent room, where it can easily be used. If the service is not being provided the day of the visit, the inventory item may be stored in a location further away. If staff report that the item is brought to the service delivery area at the time services are provided the correct response is “2” for “REPORTED AVAILABLE”.

NOTE: In smaller Health Centers or Midwives Clinics many rooms are near each other (e.g. within less than a one minute walk to go from room to room) and it is reasonable to assume that equipment can be shared between the various rooms. You will need to assess if it is likely that the equipment is

frequently needed in more than one room at the same time. If there is one provider this is not usually going to occur. If there are several providers and several busy services (e.g. Family Planning and ANC are offered by different providers at the same time) then two blood pressure gauges would be required and “observed” would only be a valid response for the service that has the blood pressure equipment.

“2” for “REPORTED AVAILABLE” The staff report the item is located in the facility or immediately adjacent, where it can easily be used, but for some reason. (e.g., key to cabinet is missing or room is locked?), the interviewer cannot observe the item.

“3” for “NOT AVAILABLE”: The item is reported either to not be within a reasonable proximity, or is not available. If the item is “NOT AVAILABLE” verify that the staff is not reporting “not available” when the item is present, but non-functioning. If the item is available but is not functioning, it will be marked as “1” “OBSERVED” OR “2” “REPORTED AVAILABLE” and then subsequently marked as “NOT FUNCTIONING”. The program implication of having equipment that is not functioning is different than for when the equipment does not exist.

“8” for “NOT DETERMINED”: The respondent is not certain if the item is available or not and you cannot verify this (e.g. the place where the item might be is locked and cannot be accessed at the time of the survey and the respondent does not know about the item).

For some “OBSERVED” or “REPORTED AVAILABLE” items, you also will need to determine if the item is functioning at the time of your visit. For these cases use the following criteria:

“1” “YES”. You observe that the item is in working order or where it is not reasonable to ask to see the equipment function (e.g. a generator) the staff indicates that it is functional.

“2” “NO”. The item does not function of the staff indicates that it is not in working order.

“8” for “NOT DETERMINED”: The respondent is not certain if the item is in working condition or not, and you cannot verify the functioning condition (e.g. the place where the item might be is locked and cannot be accessed at the time of the survey and the respondent does not know about the item).

It is very important that you make every effort to see the items and when called for, that you verify that an item is in working order. It is possible that in a few instances, it will not be feasible for you to see an item and, as noted above, allowance has been made for recording whether an informant indicates that the item is available in such instances. However, the goal is for you to ‘observe’ the

items not simply to 'report on' their availability. If facility informants appear reluctant to show you items or become impatient with the number of items that you must check on, you may need both tact and persistence in making sure that you see the items.

5) Definitions applicable across service areas:

Routine: There are many questions where it is asked if an activity is routinely conducted, or routinely provided, etc. Routine means that this occurs for essentially all clients using that service. If an activity is only provided if "the client has a symptom" or "if there is a special circumstance" this is not routine.

Infection prevention:

In all service delivery areas, the facility is assessed to determine if conditions to minimize infection are present. These include conditions under which hand-washing by the health care provider, between seeing different clients, could reasonably be expected, and a secure box in which sharp items which may be contaminated with HIV or Hepatitis or other blood-borne infections can be securely disposed. The same criteria should be used for each service when assessing these items:

a) Hand-washing items (soap and towel): Use the same criteria described above for OBSERVED; REPORTED AVAILABLE; NOT AVAILABLE; NOT DETERMINED.

b) Water: If the water is not piped into the room where services are delivered, there should be water in a container so that hands can be washed. If there is no water in the container and the explanation is that services are not being provided at the time of the survey but water is normally brought when services are being provided you may mark "2" for "REPORTED AVAILABLE". If services are being provided at the time of the survey, and there is no water, the correct response is "3" for "NOT AVAILABLE", even if the respondent indicates that water is normally available. It can reasonably be assumed that a health provider does not walk more than a room away between client consultations to wash hands, so if water is not available in the service delivery room or an immediately adjacent room, the correct response is "NOT AVAILABLE".

c) Sharps Box: The secure container in which needles or sharp items can be safely disposed has different names and shapes. For the SPA, this is referred to as a "Sharps Container". To qualify as a sharps container, it must be made of a substance that a needle does not readily penetrate (e.g. hard cardboard) with a sealed lid that has only a small opening to allow the sharp object to be placed inside. The container is used for placing sharp items, such as blades and needles. None of the following, which are often found in health facilities, qualify as a sharps container: an opened topped box, a plastic lined

trash bin where the plastic bag is later removed, an open basin or bowl where used needles are placed for later disposal.

6) Examination rooms:

In addition to the above, the following items are assessed in the examination room, for all reproductive health services:

a) Spotlight Source: It must be possible to aim the light so that the cervix can be visualized during a pelvic examination. Overhead lights and lanterns do not count. Check to see that the light source is functional the day of the survey.

b) Table and stool for gynecologic examination: A firm bed or table can also be the examination table so long as the woman can be positioned so that the examiner can sit comfortably for using a speculum and observe the perineal area. For some facilities there may be one room where all pelvic examinations are conducted. If the respondent for the service being inventoried indicates that clients go there if a pelvic examination is necessary, this room should be assessed for the inventory. If you have not already seen the examination area, you must go to verify the existence and condition of the equipment.

c) Clean gloves: These may be reused gloves if they have been disinfected using High Level Disinfecting procedures and are stored in a clean location where they are not easily contaminated. The use of powder on the inside of the gloves is acceptable. Cleaned, disinfected gloves must be stored in a clean location (e.g. box which has a closed lid). If the gloves are hanging over items that are not clean, for drying, or where persons walking by can brush against them, this is not accepted. Clean gloves dispensed new from a box of clean gloves (e.g. 100/box single gloves) are acceptable.

d) Decontamination solution: Verify that there is a container in the room or immediately adjacent with a chlorine base solution into which non-disposable used clinical examination items (e.g. speculum; scalpel handle; etc.) are put to soak prior to cleaning. An empty bucket does not count .

C. Detailed Instructions for Completing the Inventory

COVER SHEET

Name of facility: Copy from sample list

Facility location: Write the most complete address possible for the facility.

Facility code: Refer to sample list with pre-assigned code number

Type of facility: (country-specific definitions may be required)

- 1) A Referral Hospital is a 2nd line hospital (usually Regional or teaching hospital). There are lower level hospitals that refer complicated patients to the referral hospital.
- 2) A Hospital refers to a facility that routinely admits patients for overnight treatment. This is the first-line for routine care of overnight patients..
- 3) A Health Center may have overnight beds, but these are for emergency, the facility does not plan or have staff for routine overnight patients. It has staff assigned on a permanent basis and primarily provides outpatient services. It may be the managing facility for health posts and for village level outreach services.
- 4) A Health Post may be a static facility in a village, or may be an outreach site. It usually has few, if any permanent staff and limited services. The staff are usually supervised by staff from a Health Center.

Verify the facility type that was provided to you on the sample list with the in-charge. If there is a discrepancy, enter the code that you believe is appropriate based on the discussion with the in-charge and note the reasons for making the change in the Notes section at the end of the Inventory questionnaire.

Operating authority: This is the type of organization that manages the facility and provides the primary supervision. If the staff are hired by the government, but the managers of the facility are non-governmental, such as a religious organization or an other non-governmental organization (NGO), the operating authority is the NGO or religious organization. Verify the operating authority that was provided to you on the sample list with the in-charge. If the operating authority indicated on the sample list is different than what the in-charge states, write a note and enter the appropriate code.

GPS Reading and waypoint: Record information as per instructions in Appendix 1.

Number of questionnaires completed at facility: The team leader should complete this when the work at the facility is completed. Ensure that there is a completed questionnaire for every interview and observation indicated.

Date :

Interviewer code: Record the identity number assigned to the interviewer filling the inventory section.

SECTION 1: GENERAL INFORMATION

100-100b CONSENT TO INTERVIEW

If you have not already explained the purposes of the survey to the individual that you will be interviewing, read the description of the survey at this time and confirm that the individual is willing to answer your questions.

101-103 SERVICE AVAILABILITY

101 Days of service: This refers to the number of days the facility offers normal curative services. If the facility officially closes or only provides emergency services on some days (e.g. when outreach activities are conducted), then these are not “days of service”.

102 Trained health provider 24 hours: Health provider present at all times means on-site and on duty to see walk-in patients. If only emergency care is provided after normal working hours, but this is by a trained provider on duty and on site, this counts as a 24 hours trained health provider on duty.

103 Trained health provider on-call after hours: If trained health providers have official duty, but can leave the premises, and there is either a sign or another staff member who knows where to locate them, they are on-call. If specific staff are not assigned either duty or on-call 24 hours, the answer is “NO”. Verify that there is an on-call or duty roster. The response “2” “YES, SCHEDULE NOT SEEN” applies where the respondent verifies that there is an assigned staff member after-hours but either the schedule cannot be found, or the staff clarify that (most often due to a small number of staff) they make the arrangement internally for who will be “on-call” or “on-duty” each night. Unofficial arrangements where it is explained that the health provider lives nearby so “people know they can call” if they need help is not duty or on-call and the correct response is “NO”. This is because the person has no official obligation to remain nearby, and could feasibly leave the area and not be available when needed.

104 STAFFING

This information provides general information on the level of service that can be provided through the outpatient services by describing the qualification of service providers. Ask about all staff who are permanently assigned to the outpatient department, regardless of what service they provide. The in-charge should have a staff list that indicates the staffing pattern. Any staff that provide services during outreach should be counted here if they are under the management and supervision of the facility. Public Health staff assigned to the facility, who provide

any of the maternal, child, or reproductive health services either at the facility or through outreach should also be counted. If there are other categories of health provider staff, write down the qualification and numbers in the "OTHER" category. If social workers are assigned to the outpatient clinic to routinely provide counseling for outpatient clients (e.g. such as HIV/AIDS clients and their families) write them in "OTHER".

For the staff, indicate the highest level of professional qualification achieved, regardless of their initial training. For example, MA's who were originally trained as nurses will be classified as MAs. Physicians who were originally trained as MAs or Nurses will be classified as physicians.

We are not looking for the position of the person, or for the type of work they do, but rather the technical qualification. Thus, even the most senior of nursing supervisors should be placed either as a "Professional Nurse" or "Professional Midwife" depending on her technical qualification. A midwife who is not working in antenatal or delivery services, but rather is working in a service that does not use midwifery, is still classified as a midwife since this is her technical qualification. Specialist doctors would be included as "Medical Doctor" regardless of their specialty. *Staff may only be counted once.*

105 CATCHMENT AREA

The catchment area is an official assignment of population the facility is responsible for. This is the basis for determining potential immunization and maternity service needs.

If the staff are certain that the clinic does not have a specific area for which it has (or has assumed) responsibility for serving (e.g. many private clinics have not defined catchment areas for the population they serve) the answer is "0" "NO CATCHMENT AREA".

Referral hospitals and district hospitals often do not have their own catchment area for outpatient services (such as immunization or antenatal care), but rather, include all the catchment areas of health centers that refer to their facility. In these cases, the answer is "0" "NO CATCHMENT AREA".

106-107 INPATIENT SERVICES

106 Inpatient services: This refers to services where patient care is provided on an inpatient basis. If the facility does not plan staffing or services for admitting patients, but does have some beds for overnight stays in lieu of referring, the answer should be no inpatient services but yes overnight beds (Question 107).

107 Overnight observation: Often health centers have several beds where patients can be observed or receive treatment overnight instead of being sent home or referred to another facility. These would frequently be people

receiving intravenous fluids for dehydration and weakness, or deliveries. The facility does not routinely use these beds and most often patients don't stay more than one day.

108-111 MANAGEMENT

108-111 Facility management system: This refers to an established system for considering management or administrative issues. These may be meetings to discuss scheduling or other day-to-day issues or may be meetings to discuss broader management issues such as financing issues, utilization issues, plans for health related campaigns, etc. These must, however, be regularly scheduled meetings with specific staff having defined areas of responsibility. If there are several different types of management meetings, indicate the frequency for the one that addresses the day to day issues. Note: Morning report where night shift hands over to day shift is NOT a management meeting.

111 Routine community participation: Community members would usually not attend management meetings where day-to-day schedules were discussed, but would be included in more general issues for resolving major problems (financial, repair of building, etc.) for the facility. The correct response is "YES" if community members routinely are informed of such meetings and routinely send representatives. Community members refer to any persons who are not employed by the facility and who are representing the client interests. If community members only occasionally attend meetings, the correct response is "NO".

112-114 CLIENT OPINION

112 Obtaining client opinion: This must be a routine system with some formal structure.

113 Report on opinion: This should indicate that the facility collects and reviews opinions or feedback in some way that could be used to prioritize items of importance. A list, report, or minutes from a meeting where the client feedback is routinely discussed is sufficient.

114 Changes based on opinion: Examples of the type of changes implemented might be changing the day of the week or hours a service is offered, improving the waiting area, or any other changes that were made because clients either suggested the changes, or complained about a problem related to the changes. A "YES" answer with no specifying what change was made is not acceptable.

115-117 QUALITY OF CARE

115-115a Quality assurance activities: There must be some routine system for monitoring and addressing issues related to quality of care. Common activities include medical record audits, using supervisory checklists that include

issues related to care of clients, a supervisor observing consultations, or meetings to discuss problems related to client care or to discuss issues related to trends in Health Information System data which reflects the type of client being seen. This must be a routine activity and must related directly to care of clients rather than management issues (115). These types of activities may be utilized by specific services and not be facility wide (115a). This might occur when a specific organization is working with the service, either at the national or the facility level, and has introduced the quality assurance activities for that service. If all services are responsible for the quality assurance activities, "THROUGHOUT FACILITY" is the correct response, even though it may be implemented within each service separately.

For Quality Assurance to be conducted, there must be an established standard against which quality is measured and there must be some systematic means whereby results are assessed and interventions to rectify problems are developed. Quality assurance activities must be differentiated from basic supervision. Supervisors who use checklists against which they assess components of service delivery (e.g. are the registers in order, are the listed equipment and supplies present) may be conducting quality assurance activities if there is a means by which the checklists are evaluated and interventions developed. An inventory list for items that should be present in a service delivery area is not a quality assurance tool unless the results are periodically reviewed and problems are addressed.

116 Form for monitoring quality: Ask to see the form(s) used for monitoring or a report from meetings where quality of care issues were raised. a) A supervisory checklist for health system looks for such things as presence of equipment and supplies, completeness of HIS records, and other process indicators. b) A supervisory checklist for health service provision will indicate specific content for patient assessment, treatment, or consultation. This will often be used for observing care provision. c) Staff/service internal system for identifying and addressing quality of care issues refers to a process. There should be minutes from meetings that indicate such activities as identification of problems, steps taken to resolve the problems, etc. d) Facility-wide review of mortality refers to a structured system for reviewing the care of each client who dies. There will normally be a committee established for this purpose. e) Medical record/register audit refers to checking medical records for the presence of specific items of information. These may be simply presence or absence, or may be more detailed to assess if protocols were followed. f) Quality assurance committee refers to an organized group that has regular meetings to discuss findings from quality assurance activities. COPE (Client Oriented Provider Efficiency) refers to self-assessment activities at the clinical level. G) This refers to any management or supervisory teams responsible for more than one facility who also are responsible for quality assurance activities described in 115. A report indicating quality assurance activities should be sought for this question.

117 Responsible for quality: Indicate the various persons who look at the results from quality assurance activities and who are responsible for developing interventions to improve quality of care. There may be several levels at which quality assurance activities are conducted and reviewed. There may be quality assurance responsibilities within a facility, as well as at a higher level, by persons external to the facility (e.g. district supervisors or managers). a) Individual service provision staff: This implies that staff have a system for identifying service delivery/quality of care problems and for then developing approaches to rectify the problems. b) Individual supervisors may be the in-charges of different services, Persons external to facility may be district supervisory, or a technical supervisory persons relevant to a specific service. c) For the management committee to apply for this question, it must be responsible for routinely reviewing quality issues as well as carrying out routine management activities. A management committee external to the facility may be a district or zonal management team. d) Quality assurance committee refers to a committee developed specifically to monitor quality issues. e) Quality assurance staff refers to persons assigned specifically to monitor quality. These may be medical record auditors, or service supervisors, etc. who provide reports to either a Quality Committee or a Management Committee.

118-119 CHARGING FOR SERVICES

118 Routine charging for curative services: The point of interest is whether people must pay out-of-pocket for the consultation when they use curative services. Facilities may charge a one time fee for providing a client health card (A). If the charge for the consultation is the same for all clients, this is defined as a fixed fee for each consultation (B). The fixed fee may include medications and tests or these may be charged separately. If medications and tests are included in the one consultation fee, then (D) should not be circled, if they are charged separately, (D) should also be circled. If the fixed fee varies depending on the diagnosis, the correct response is (C). This may include medications and tests or these may be charged separately (D). If a pre-pay scheme exists (either tickets, insurance, etc) this should be indicated in question 119. Where there is a fixed fee (either B or C) for the initial visit, but not for follow-up visits for the same illness, or if there is a lesser fixed fee for the follow-up visit, the response B or C (whichever is applicable) still applies.

119 Community/Client financial support: Any type of pre-pay program (insurance; purchase tickets for a certain number of services); or official program for reimbursing subsidized costs for poor clients such as special funds managed external to the facility (equity funds) or exemption/discount schemes administered by the facility are considered community/client financial support. An exemption scheme is not community or client financial support, if there is no specific program where the costs for the exempted client are subsequently reimbursed. This question should be adapted so that country-specific programs are included in the coded responses.

120-121 SUPERVISION

120 Supervisory visit: If a manager visited the facility for a purpose other than supervision (e.g. an official visit to bring guests) where the work of the facility or official health issues related to the facility were not addressed, this is not considered a supervisory visit. Often there is a register or logbook for recording supervisory visits. If staff cannot readily remember the most recent supervisory visit, ask if there is a supervisory register with this information.

121 Supervision activities: The supervisor may have checked any section of the facility, or may have asked to see management or administration books. The supervisor may have discussed issues with any of the staff or have gone to one service to observe staff.

122-122a REFERRAL FOLLOW-UP

This refers to a piece of paper or letter that tells that the client is being referred from this facility. It usually will note the client name and information on why the client is being referred. If there is a register where clients who are referred are listed, but no paper is sent with them for the referral, the correct response is "NO". If this is the referral facility and clients are never referred elsewhere, the correct response is "REFERRAL FACILITY". Check the form to ensure that there is a section where information on the referred client (e.g. diagnosis, symptoms, reason for referral) is to be written.

If the referral form is a non-structured note written on letterhead, the correct response is "3" "NO FORM USED".

123-130 FACILITY RESOURCES

123-124 Electricity. This refers to a wired source of electricity. A battery that powers a single light bulb does not count; facility generator power does not count. Solar power source is acceptable.

125-128 WATER

125 Current water source: Normal source of water is the origin of water used by the facility at the time of the survey. If water is kept in tanks, Veronica tap buckets or basins, you must ask where the water comes from. Indicate the most common source of water the day of the visit. If no water is available on the day of visit, ask about the most common source during the past month. No source of water means that the facility never has water in the facility.

126 Water source location: On-site is on the grounds or inside the facility.

127 Seasonal water source: If there is a normal source of water at any time during the year but availability varies with the season, indicate "YES".

128 Water for use in examination areas: This refers to how the water is actually provided for use in examination/consultation areas in the facility on the day of the survey. If there is a water pipe or pump outside the facility and water is taken into the facility and used from another container, the answer is “2” bucket or basin. *Example: The facility has piped water that is not functioning today. They normally use the veronica bucket, but you notice the veronica bucket is seen in in-patient, but not outpatient areas. In the outpatient area you see a basin with water. The correct response is “2” “BUCKET OR BASIN”.*

129-130 CLIENT COMFORT

129 Waiting area: Interviewer must observe the location. If patients commonly choose to wait outside (e.g. under trees) but there is a location where they could wait and be protected from rain and sun, this is a “YES” answer. However, if there is no designated waiting area that they could use, the correct response is “NO”.

130 Latrine: Interviewer must observe the latrine. If it is stopped up, it does not function. If the latrine is locked and the key is not available, or the latrine is only for staff, the answer is “NO”.

131-132 EMERGENCY COMMUNICATION

131 Emergency communication: The emergency communication would be used to call emergency transportation, or to receive treatment advice from other health providers. Check to see that the phone or short-wave radio is functioning at the time of the survey.

132 Distance for emergency communication: Probe for the distance and availability to ensure that routinely the source of communication is easily accessible for an emergency.

133-134 EQUIPMENT MAINTENENCE

There may be some types of equipment that could be classified as either major or small (e.g. some foot operated suction machines). We are looking for a general system, so we are not concerned about how to classify individual pieces of equipment. There will always be equipment, however, that clearly is in the “major” or “small” category. The following questions refer to systems for maintaining those.

133 Major equipment: Major equipment is most often mechanized and requires some sort of routine maintenance to function well. Examples are electric autoclaves, x-ray machines, generators, etc. This question refers to some routine schedule for preventive services (cleaning, or checking) for major pieces of equipment. On-site staff refers to staff who are assigned to the facility who have been trained in maintenance. Outside support may be health systems staff or other persons who routinely visit the facility to conduct maintenance activities. If the system only provides maintenance when there is a problem, then the

correct response is “NO REGULAR PROGRAM”. If the facility does not have major equipment requiring routine maintenance, the correct response is “4” “NO ROUTINE MAINTENENCE”.

134 Small equipment: Small equipment refers to such things as stethoscopes, hemostats, blood pressure cuffs, etc, which are reasonably priced to replace or often are easily repaired. If more than one system is used for maintaining small equipment, circle all that apply. If sometimes the methods indicated are used, but there is no established system then the correct response is “NO SYSTEM”.

135-136 GENERATOR AND FUEL

If there is a generator, ask to see it and check that it is in working order. You can accept the word of the respondent. If the respondent does not know if the generator functions or not, ask if there is someone else who would know. Also ask to see fuel to ensure that it is present at the time of the visit.

137-146 STERILIZING/DISINFECTION PROCEDURES

When checking the equipment for sterilization and high-level disinfection, ask to speak with a person who actually conducts the sterilization, or with someone responsible for supervising this activity.

137-138 Sterilization/disinfection of methods: Often the system and equipment for sterilizing syringes and needles is different from that used for other medical equipment. Thus it is necessary to ask about them separately.

139 Dry heat sterilizer: This is most often operated by electricity. If there is no electricity at the time of the visit, the equipment is not in working order.

140 Autoclave: The autoclave sterilizes by steam and under pressure. Ask to make sure the pressure component works. You can take the word of the staff if the item is not being used at the time. If the autoclave is electric and there is no electricity at the time of the visit, the equipment is not in working order.

141 TST Indicator strips: This is a special tape which is used to seal packages before sterilization and which changes color (most often white lines turn black) when the package has been exposed to the heat a sufficient length of time.

142 Pot for Steam/boil disinfecting: The pot which is used for both systems must have a lid. Steam sterilization places cleaned items on a rack over boiling water, boiling places them directly in the water.

143 Heat source: The source for the heat (either electricity or gas) for the autoclave, dry heat, or steam/boil system (whichever system is used) must

be available and functioning the day of the survey. You must observe the heat source and fuel, if fuel is used.

144 Timer This must be a timer which can be set to indicate when the appropriate amount of time has passed. A watch or clock are not sufficient unless they can be set to indicate (e.g. buzz or ring) when a certain amount of time has passed. Some sterilizers and autoclaves have built-in timers where either a sound is made, or the equipment automatically shuts off when the correct amount of time has passed. These may count as the timer if the equipment with the built in timer is that used for sterilization.

145 Time for processing items: Unless routinely involved in sterilization and disinfection processing of equipment, facility staff will often not know how long items are processed. Thus it is important that the information be collected from someone who normally carries out these procedures. We are looking specifically for how many minutes AFTER the correct temperature/boil is reached that the items remain exposed to heat.

There may be two purposes for the chemical disinfectant. For some facilities, this is used only for decontamination. After soaking, items are subsequently boiled, steamed, or sterilized (D). If soaking in the chemical disinfectant is the final process prior to storing equipment for use, the response to (E) applies. Ask for the name of the chemical disinfectant used and for the percent solution that is mixed for both disinfection and (if applicable) for chemical High Level Disinfection. If there is a common chemical disinfectant used in the country, add this as a pre-coded country-specific response.

146 Storage of sterilized/High Level Disinfected equipment: Check for each of the indicated storage conditions. There may be a central storage room, or the equipment may be stored where specific services are offered. If there is no equipment that has been sterilized/disinfected and is stored, ready for use, then the correct response is "DON'T KNOW".

147-148 DISPOSAL OF HAZARDESS MATERIALS

This question refers specifically to contaminated or potentially dangerous items that are being disposed of. This does not refer to items that will be reused. The types of items we are referring to are those contaminated by blood or infection (e.g. bandages), intravenous tubing or bottles, etc. There should be no needles, syringes, old IV bottles or tubing, or other waste from medical materials lying in the open. Some facilities may have a location where contaminated waste materials are placed prior to processing for destruction. In this case the waste may be visible, but must be protected. "Protected" refers to some barrier that prevents people or animals from getting to the waste materials. Be certain to go to the site where the materials are disposed to determine if the waste is visible and if visible, whether it is protected or not.

149 GENERAL CLEANLINESS

If most of the facility is swept, even if there are odd bits of paper or trash which might have been recently dropped, the correct response can be "FACILITY CLEAN" if the overall situation is one of a facility which is basically swept and clean.

If there are counters, tables, beds with blood or other sources of contamination which have not been wiped between patients, the correct response is "FACILITY NOT CLEAN"

SECTION 2a: VACCINE LOGISTIC SYSTEM

200 ELIGIBILITY

If immunization services are ever provided either at the facility or as an outreach activity from the facility, this section must be completed. This question refers to any immunization services, whether provided by the facility staff or by others who routinely come to the facility to provide the services.

200a-200b Consent: Consent is required if the person providing the information is different than the in-charge with whom you originally spoke. Even if the in-charge takes you to the service provision area and introduces you, you must explain to the staff member who is showing you around and answering questions that you have to read the brief statement as a part of the survey, and then read the consent statement.

201-211 VACCINE COLD STORAGE

201 Routine storage of vaccines: Routinely storing implies that vaccines are usually stored at the facility in a refrigerator or cold box. If the facility collects vaccines and stores them overnight for use the next day or two only, this is counted as "PICKS UP VACCINES". It is important to determine if maternity centers store tetanus toxoid vaccine, even if children's immunizations are provided under the public health system. If ANY vaccines are stored at the facility the "1" "STORES SOME VACCINES" is the correct response. If no vaccines are ever stored at the facility, then the correct response is "2" "STORES NO VACCINES".

202-203 Vaccine storage equipment: You must see the indicated items and verify that they are present and functioning (if applicable). If there is no working thermometer in the storage equipment, circle "NO THERMOMETER".

204-205 Temperature chart for vaccine storage: If ONLY today's temperature is missing, this can still be a "YES", as they may not yet have checked the temperature and recorded for the day.

206-219 VACCINE AVAILABILITY AND LOGISTIC SYSTEM

206 Inventory: The inventory should indicate the amount and date of each vaccine when received, when disbursed, and the existing balance. Supply receipts are not an inventory. The inventory may consist of stock cards, or a notebook.

207a-207b Monitoring of expiry dates and stock for vaccines: Check to see if each indicated vaccine is available. There must be at least one of the item with a valid expiry date. Look for expiry dates on all vaccines. Count each full (not opened) vial and indicate if the amount written in the inventory is the same as

that found in the storeroom. There may be opened vials that have already been excluded from the inventory but are still in the icebox. This is acceptable.

208 First-expire/first-out storage: Check for all vaccines to see that items with the closest expiry date are in the front, and later expiry dates in the back of the storage area. If items are not organized by type of vaccine then the correct response is “NO”. If all of each type of vaccine have the same expiry date or if there are no expiry dates, the correct answer is “8” “DON’T KNOW”.

209 Vaccine ordering system: “Determine own need” means that the system allows the facility to adjust the supply to the need, and that the facility determines what amount of each vaccine to request. “Determined elsewhere” means that persons outside of the facility (e.g. District Management Team”) determine the supply for the facility. If public health staff have a routine schedule for visiting the facility to provide immunizations, and they bring vaccines with them at that time, they determine the amount of vaccine so the correct response is “2” “NEED DETERMINED ELSEWHERE”. There may be facilities where both systems apply (e.g. a maternity center where the facility orders and stores tetanus toxoid, but the public health staff visit on a fixed schedule to provide child immunization services. *If “BOTH” IS THE CORRECT RESPONSE, YOU MUST ASK QUESTIONS 210 AND 211-212.*

210 Basis for orders determined elsewhere: “AMOUNT BASED ON ACTIVITY LEVEL” means that the amount of vaccines provided is determined by persons outside of the facility, based on service statistic information submitted by the facility. “STANDARD FIXED SUPPLY”, means the same amount arrives each order, regardless of utilization statistics. Staff may note that the amount of vaccines supplied has been changed over time, but if the amount is not revised at least quarterly, and is not linked to service statistics, then the answer is that the facility receives a “standard fixed supply”.

211-212 Basis for orders determined by facility: Probe to determine which response best describes the basis for determining how much of each vaccine to order and which response best describes how the facility decides when to place an order. If more than one method is used for deciding how much or when to order, circle all that apply.

213 Reliability of ordering and supply system:
“ALWAYS” means exactly that- the order is always complete.
“SOMETIMES” means that occasionally the order is not complete.
“NEVER” implies that almost every supply of vaccines is not provided according to the ordering procedure.

Many times the response is “I order and the district gives me what they have”. You must probe to find out specifically, whether they “ALWAYS” get what they order, whether “SOMETIMES” enough of the vaccine ordered is not available so

they do not get their total order, or whether essentially “NEVER” the quantities received are the same as the quantity ordered. *Note: Receiving items that were not ordered counts as not getting the complete order.*

If some extraordinary circumstance affected the supply during the previous 3 months (e.g. a rare, one-time national shortage of one vaccine for several weeks or months which resulted in several consecutive orders being short supplied; an emergency event which disrupted supply and which the staff certify has not occurred during the previous several years), write a note on the questionnaire to explain, but still provide the answer which is relevant.

Accept the health worker response to this question.

214-215 Public Health Immunization Service to non-government clinics: These questions refer most often to government public health staff who bring vaccines and provide the immunization services at facilities on a routine basis. If there is another system for routinely providing immunizations, the responses may require adaptation.

216-218 **EQUIPMENT AND SUPPLIES**

216 Vaccine carriers: The answer refers to vaccine carriers which are in a sufficient condition to maintain the cold chain during outreach sessions.

217 Ice Packs: Indicate if there are 4-5 ice packs (1 set) for vaccine carriers, or if the facility must purchase ice when necessary. “NO” indicates that there is no means to maintain the cold chain.

218 Injection system: For single-use, both the needle and the syringe are thrown away after each use. Sterilizable equipment are glass syringes and steel needles. These must be cleaned and sterilized after each use. If by chance, single use, plastic syringes are being used more than once, write a note on the questionnaire under “OTHER”.

SECTION 2b: CHILD HEALTH SERVICES

219 ELIGIBILITY FOR SURVEY

219a Child health services: Indicate if any services are offered to children below the age of 5 years either at the facility or on an outreach basis from the facility.

219b-219c Consent: Consent is required if the person providing the information is different than the in-charge with whom you originally spoke. Even if the in-charge takes you to the service provision area and introduces you, you must explain to the staff member who is showing you around and answering questions that you have to read the brief statement as a part of the survey, and then read the consent statement.

220 Number of days services provided: This should indicate the total number of days per week that each of the listed services are provided AT THE FACILITY. This means that any person or caretaker arriving at the facility during normal working hours for that day could receive the service and would not be told to return another day.

221a-228 IMMUNIZATION SERVICES

221b Outreach Immunization services: This refers to outreach activities (routinely scheduled visits to mobile service sites or villages) where the immunization services are routinely provided. If the only times immunizations are provided outside of the facility are as a part of special campaigns (National or sub-national immunization days or Polio immunization days) the correct response is "NO".

222 Immunization services today: The answer is "YES" if any client or caretaker of a sick child who walks in and requests or requires the service can receive it on this day, even if it is not a special clinic day for the service.

223 Routine charge for immunization: This question is looking for routine charges for receiving immunization services. The point of interest is whether people must pay out-of-pocket when receiving immunizations. Facilities may charge one time to provide a client health card or immunization card (A), they may have a fixed fee for each session, regardless of what or how many vaccinations the child receives (the fee may cover the vaccines, maintaining the cold chain, other costs associated with the vaccine service) (B), or they may have a variable fee depending on the vaccine provided (e.g. some facilities charge for the syringe and needle for injectable vaccines but not for oral vaccines) (C). If there is a special fee structure/pre-pay system implemented in the country (e.g. an annual fee for all well child health services, including vaccines) the responses to this question should be country-specific to allow this response.

224 Supplies for immunization: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

Go to the room where immunizations are normally provided. If there is no special room, or it is only an immunization room on certain days of the week, then the equipment may be locked in a storage cabinet elsewhere. Ask to open the cabinet where the items are locked away, to verify their presence.

b and c) If another size of needle and/or syringe is standard in the country, (1/2 ml syringes are becoming more common) the responses should be adapted. What is important is that the equipment for providing BCG as well as DPT and measles vaccines are available.

f) Individual child immunization cards may come in different forms. These are cards upon which the individual child's immunizations are recorded and which are given to the caretaker to keep. In many countries the Road to Health card is used.

g) Immunization tally sheets/register may come in different forms, depending on the country. Check to see what the national requirement is for the Health Information System reports. There must be some form of register where every immunization is recorded according to number and type, where they can easily be added for reporting.

225-228 CLIENT INFORMATION

225 DPT dropout rate: The DPT dropout rate is a calculation of the difference between the children who receive the first dose of DPT and those who complete the series of 3 DPT injections.

226 Target population: The facility must have an estimate of the number of eligible children for immunizations. The number is most often a percentage of the total population for the catchment area, but may also be a fixed number provided by the health authorities.

227 Measles coverage: The coverage rate is the proportion of the target population that has received the measles immunization. It is calculated as an annual rate.

228 Source of information: Target populations and coverage rates should not be calculated at the time of the survey. Rather, the facility should show their records where they routinely calculate this information to monitor their service. This may be on quarterly reports or the prior annual report. Some facilities display graphs and tables of such information on the walls. If they have graphs of coverage that are as recent as the last completed year, then these figures can be used. If they do not have this, then the answer is "DON'T KNOW".

229-241 SICK CHILD CONSULTATION

Any consultations services for sick children count for this section (service need not be provided through a special clinic).

230 Equipment and supplies: Go to the room where consultations for sick children are normally provided. If there is no special room, or it is only a consultation room on certain days of the week, then the equipment may be locked in a storage cabinet elsewhere.

a-b) Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

c) Infant scale: If the facility has a digital or balance scale upon which the provider or mother stands and holds the infant, this counts as an infant scale. An infant scale may also be a balance scale or a hanging scale which is calibrated in 100 gram intervals. The normal child scale with $\frac{1}{4}$ kilogram gradation is not sufficiently sensitive for an infant scale but is acceptable for the child scale. A normal dial bathroom scale does not count for the infant scale.

d) Child scale: If the facility has a digital or balance scale upon which the mother stands and holds the child, this counts as a child scale. An child scale may also be a balance scale or a hanging scale which is calibrated with at least 250 gm ($\frac{1}{4}$ kilogram) gradation. A normal dial bathroom scale does not count for the child scale.

e) Thermometer: Make sure the thermometer is present and functioning.

f) Timer/watch with second hand: This is used to count the respiratory rate of children with cough or difficult breathing. A timer is specially made (often provided by UNICEF) to measure one minute, for counting respiratory rate. A health provider's personal wrist-watch or a wall clock with a second hand are also acceptable.

g and h) ORS Supplies: These items are to use when giving ORS to an ill child at the facility and for teaching the caretaker. Any type of container appropriate for mixing ORS is sufficient.

231 Protocols/Teaching materials:

a) Medical protocols: These may be books, or other pamphlets which specifically focus on diagnosis and treatment of child illness. The protocols or guidelines must be written. A wall chart for general patient/caretaker education (e.g. a poster which talks about diarrhea and ORS) does not count as a protocol.

b) IMCI Chart Booklet is a specific booklet given to those health workers who attend IMCI training. IMCI wall charts are similar to the chart booklet except that they are designed to be fixed on the consultation room walls. If the facility has complete wall charts by no chart booklet, this still counts as having IMCI charts.

c) Visual aids for teaching caretaker refer to any flip charts/picture books/other visual aids which can be used to teach the caretaker about child care issues such as disease prevention and good health practices, or about identifying signs of severe illness, etc. Inclusion of country-specific protocols and teaching materials may be desired.

232 Routine charge for sick child consultation: The point of interest is whether people must pay out-of-pocket for the consultation when they use curative services. Facilities may charge a one time fee for providing a client health card (A). If the charge for the consultation is the same for all clients, this is defined as a fixed fee for each consultation (B). The fixed fee may include medications and tests or these may be charged separately. If medications and tests are included in the one consultation fee, then (D) should not be circled, if they are charged separately, (D) should also be circled. If the fixed fee varies depending on the diagnosis, the correct response is (C). This may include medications and tests or these may be charged separately (D). Where there is a fixed fee (either B or C) for the initial visit, but not for follow-up visits for the same illness, or if there is a lesser fixed fee for the follow-up visit, the response B or C (whichever is applicable) still applies. [Q responses revised]

233-234 Routine collection of information for consultation: Many facilities register sick children and then take specific measurements (e.g. temperature or weight) prior to sending the child for consultation. Ask if this system operates at the facility, and if yes, go to see where the system is implemented. Observe a few children receiving the routine services to see if they all have their weight and/or temperature taken, and if all are asked for their immunization card or questioned about their immunization status. Indicate which procedures you see being conducted prior to consultation. If sick child services are not being provided the day of the visit, but the respondent claims this system normally operates, you may indicate "REPORTED" for each relevant response. If sick child consultation services are being provided the day of the visit, but you do not see these services being provided routinely for all sick children, the correct response will be "NOT DONE ROUTINELY" even if the respondent indicates that they normally are provided.

235 First dose oral medication: The IMCI protocol is for a child to receive the first dose of their oral medication at the health facility. If this is a practice at the facility, but is not given by the consulting health provider, it may be a service provided by a health staff after the consultation, or by pharmacy staff. Ask if this occurs anywhere other than the consultation room, and if yes, go to see if the service is being routinely provided on the day of the visit. Use the same criteria indicated in question 233-234 for determining how to respond.
Note: Frequently an immediate dose of paracetamol is provided to children with fever. This does not correspond to a routine system for providing the first dose.

We want to know if essentially every child who is prescribed oral medications receives the first dose prior to leaving the facility.

236 Immunizations for sick children: If the sick child can receive needed vaccines on the same day as the consultation even if immunization clinic is not operating, the correct response is “YES”.

237-239 CLIENT INFORMATION:

237 Register for sick child clients: If the register does not have printed headings with the information to be recorded, it should be reviewed to see that it specifically identifies children under five (by age) and their diagnosis. In some cases the register may combine adults and children. As long as the age and diagnosis are indicated for each individual consultation this is sufficient.

238 Most recent entry: This refers to the most recent entry for a child below 5 years of age. Count the day of the survey as “day 1” when counting the prior 7 days.

239 Annual child service statistics: The information should be taken from monthly, quarterly, or an annual report. If the information is not available in a summary form at minimum by month, count the most recent completed month and indicate 1 month of data in 239a.

240 Child health cards: These are cards or records where the history of an individual child is recorded and there are notes on each illness. Some facilities use individual exercise books or folders to record the outcome of each visit (e.g. diagnosis and treatment). These keep a running history of the child’s health events and prior treatments and allow the health provider to make a more informed assessment of the child’s health problem. The “Road to Health” or another immunization card does not count unless there is space for notes regarding illness consultation and the facility indicates that this is used routinely as the child health card where the health workers are expected to write comments when the child is seen for illness. You may have to ask several questions to ascertain whether these cards are used as child health records or only for preventive health activities (growth monitoring, immunization information, vitamin-A distribution).

241 Blood test to verify malaria: Many facilities in malaria endemic areas make a presumptive diagnosis of malaria based on symptoms. While this is acceptable where staff qualifications, supplies, and funds are an issue, this may result in missing the true cause of illness. Microscopic checking of a blood smear to validate the diagnosis is preferable, when possible.

SECTION 3. FAMILY PLANNING SERVICES

300-301 ELIGIBILITY FOR SURVEY

300 Family planning services: The answer is “YES” if any family planning services are provided from the facility, even if there is no special clinic for family planning. If there are different areas where family planning services are offered (e.g. maternity, consultation area, family planning clinic) go to the area where the largest number of family planning clients are seen.

301 Consent: Consent is required if the person providing the information is different than the in-charge with whom you originally spoke. Even if the in-charge takes you to the service provision area and introduces you, you must explain to the staff member who is showing you around and answering questions that you have to read the brief statement as a part of the survey, and then read the consent statement.

302-306 FAMILY PLANNING SERVICE AVAILABILITY

302 Days of service availability: This refers to family planning services offered at the facility itself, and means that the client could come during normal working hours for that day and would not be told to return another day, but rather, would receive the necessary family planning service.

303 Family planning services today: The answer is yes if any client who walks in and requests or requires the service can receive it on this day, even if it is not a special clinic day for the service.

304 Routine charge for family planning consultation: The point of interest is whether people must pay out-of-pocket for family planning services. Facilities may charge one time to provide a client health or family planning card (A), they may have a fixed fee for each consultation visit regardless of method choice (B), or they may have a fixed fee that varies depending on the method choice (C). If the fixed fee varies depending on whether it is the first visit or follow up visit for the client, the response (B or C) still applies. If clients are charged separately depending on the method or tests received, (D) also applies.

305 Method availability: Ask for each method listed.

d) The 2-3 monthly injectable (DMPA): This is a progesterone only method. The most common names are DepoProvera (every 3 months), or noristerat (every 2 months).

e) The monthly injectable: This is a combined progesterone and estrogen method. Common names are cyclofem/cycloprovera or mesigyna/norigynon.

k) The emergency contraceptive pill: This is a regime of pills that can be taken after method failure or unprotected sex to prevent pregnancy. Common names are Levonorgestrel and Preven. Some providers also use a high dose (e.g. 50mg estrogen) family planning pill.

306 Other contraceptive methods: Answer “YES” only if the service is provided at the facility. If the client is referred elsewhere for the method, the correct response is “NO”.

307-308 Routine collection of information for consultation: Many facilities register the client and collect information prior to the consultation (e.g. blood pressure or weight). Ask if this system operates at the facility, and go to see where this system is implemented. Observe a few clients receiving the routine services to see if they all have their weight and/or blood pressure or other measures that were reported as routinely measured, actually taken. Indicate which procedures you see being conducted prior to consultation. If family planning services are not being provided the day of the visit, but the respondent claims this system normally operates, you may indicate “REPORTED” for each relevant response. If family planning services are being provided the day of the visit, but you do not see these services being provided as a routine system, the correct response will be “NOT DONE ROUTINELY” even if the respondent indicates that they normally are provided.

309 Family planning consultation environment: This refers to where the client history, discussion of side-effects or method choice occur. It may be the same room where examinations occur or may be a different room. Indicate the degree of privacy offered to the client.

310a-310b Visual aids for teaching and educating clients: Check for each of the items and subjects indicated, using the same criteria as that described in section 1B of the Overview of the Facility Inventory. Visual aids may include flip charts, flash cards, or posters so long as they impart a message related to the topic (e.g. a poster advocating condoms to prevent transmission of STIs or HIV/AIDS counts).

310c Protocols and guidelines: Many facilities have one large “Reproductive Health” Protocol which covers family planning, STIs and maternity. If a copy of the protocol is not in the service delivery area, it can be assumed that it is not easily accessible for utilization, even if a copy is elsewhere in the facility. Inclusion of country-specific protocols and teaching materials may be desired.

311-314 CLIENT INFORMATION

311 Register for family planning clients: If the register headings are not printed, it should be reviewed to see that it specifically identifies family planning clients, the method being used, and indicates whether the client is new or continuing.

312 Most recent entry: This may refer to any client seen for family planning services, whether a contraceptive user or not. Count the day of the survey as “day 1” when counting the prior 7 days.

313-313a Client caseload: This refers to all family planning visits (both new and continuing clients). The information should be taken from monthly, quarterly, or an annual report. If the information is not available in a summary form at minimum by month, count the most recent completed month and indicate 1 month of data in 313a.

314 Individual client cards: These are individual cards for each family planning user, and follow the history of the client while using contraception. Information kept this way allows the provider to provide better consultation, as the total history and prior complications or method changes are indicated.

315 STI Treatment: If the same staff who provide the family planning services also diagnose and treat STIs for FP clients, there is a better probability of compliance than if the client has to go to another provider in another location in the facility. If the respondent indicates that STI cases are referred sometimes and treat sometimes (e.g. if the Doctor is present, I refer...if the clinic is open I refer, otherwise I provide treatment), the correct response is "REFERS".

316-325 EXAMINATION OF FAMILY PLANNING CLIENTS

Go to the room where family planning services are normally provided. If there is no special room, or family planning services are only offered on certain days of the week, then the equipment may be locked in a storage cabinet elsewhere.

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

316 Same examination room: Often there is one examination room for obstetric/gynecologic examinations. If the room has already been assessed for another service (e.g. all items in questions 317-318 were previously evaluated), the interviewer must indicate under which service in the questionnaire the responses are marked, and then skip to question 319.

317 Family planning examination room environment: This refers to where the physical examination occurs. It may be the same room where consultations occur or may be a different room. Indicate the degree of privacy offered to the client.

318 Examination room facilities: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

319-325 Equipment for providing specific family planning methods:

319 Common equipment:

c) Weighing scale: May be a bathroom scale. If the procedure for the facility is to take vital signs (blood pressure; weight; etc.) in another location, such as the

registration area, the availability of the scale may be assessed at that service delivery location.

320-321 Equipment specific to IUD or Norplant:

a) Sterile gloves: These will most often be new gloves, each pair packaged individually. Reused, sterilized gloves are acceptable as long as they are stored either in a closed autoclave package or else in a closed sterile container. Verify that they were processed and stored properly for ensuring sterility.

322-323 Equipment for IUD:

b) Sponge holding forceps: These may be found separate or in IUD or Minor Surgery kits. If equipment is stated to be available in either the IUD or Minor Surgical Kit, and a sterile kit is shown, this may be accepted. You do not need to unwrap the kit to see the equipment.

c-e) These items are most often found in an IUD kit. If the IUD kit is sterile and it is stated that the equipment is in the kit, this may be accepted.

324-325 Materials for Norplant:

c-e) Artery forceps may be separate or in a Minor Surgery Kit. If the Minor Surgery Kit is sterile and it is stated that the equipment is in the kit, this may be accepted.

SECTION 4a MATERNAL HEALTH: MATERNITY CARE

400-401 ELIGIBILITY FOR SURVEY

400 Antenatal and postpartum services: These services are offered outpatient and may be either at the facility or on an outreach basis. If antenatal/postpartum services are offered in different clinics or areas of the facility (e.g. maternity and consultation area, consultant physician office) go to the area where the largest number of routine antenatal clients are seen, when completing this section.

401-402 Consent: Consent is required if the person providing the information is different than the in-charge with whom you originally spoke. Even if the in-charge takes you to the service provision area and introduces you, you must explain to the staff member who is showing you around and answering questions that you have to read the brief statement as a part of the survey, and then read the consent statement.

403-406 ANTENATAL (ANC) SERVICE AVAILABILITY

403 Days of service availability: This refers to ANC services offered at the facility itself, and means that the client could come during normal working hours for that day and would not be told to return another day, but rather, would receive the necessary ANC check and service.

404 Antenatal care services today: The answer is yes if any client who walks in and requests or requires the service can receive it on this day, even if it is not a special clinic day for the service.

405 Routine charge for antenatal care: The point of interest is whether people must pay out-of-pocket for ANC services. Facilities may charge one time to provide a client health or ANC card (A) and they may have a fixed fee for each consultation visit for ANC (B). If the fixed fee varies depending on whether it is the first visit or follow up visit for the client, the response (B) still applies. If there is a special fee that covers all ANC (it is the same fee regardless of how many ANC visits a woman makes) then (C) applies. (B) and (C) may include medications and tests or may not. If clients are charged separately for medications or tests received, then (D) also applies. [Q responses changed]

406-407 Routine collection of information for consultation: Many facilities register the client and collect information prior to the actual consultation (e.g. measuring blood pressure or weight). Ask if this system is used at the facility. If yes, go to see where this system is implemented. Observe a few clients receiving the routine services to see if they all have their weight and/or blood pressure or other measures that were reported as routinely measured, actually taken. Indicate which procedures you see being conducted prior to consultation. If ANC services are not being provided the day of the visit, but the respondent claims this system normally operates, you may indicate "REPORTED" for each

relevant response. If ANC services are being provided the day of the visit, but you do not see these services being provided as a routine system, the correct response will be 'NOT DONE ROUTINELY' even if the respondent indicates that they normally are provided.

408-410 ANC CLINICAL SERVICES

The facility must report that the ANC standards indicate that the service or test indicated is routinely offered to each ANC client at least once, and that the indicated test or service is routinely available on days that ANC services are provided. The answer can be YES even if the client has to go to another part of the facility to receive the diagnosis/medication or prescription/ or test. If the service is only available at special times, not coordinated with antenatal service timing, then it is not routinely offered to pregnant women. (e.g. a private facility that arranges for the government to provide tetanus toxoid at the facility once a month, when ANC services are provided daily, is not considered to be routinely offering tetanus toxoid).

408 Routine laboratory tests: Ask about each test. For each test where the answer is "YES", the interviewer must verify that the equipment and supplies required to provide that test (listed in section 6 of the Inventory questionnaire) are available either at the site where ANC is provided, or in a laboratory. If the response is that the test is only conducted if someone is symptomatic, but that the test is available, the correct response is "NO". If the client is referred to an external laboratory for the examination, the correct response is "NO". If the facility takes the specimen, but sends the specimen outside the facility for the laboratory examination, the correct response is "YES".

409 ANC treatment and services:

a) Tetanus toxoid (TT): If the client is informed to return another day for the TT, the correct response is "NO".

b) Antimalarial treatment: If offered only to women with symptoms, the correct response is "NO".

c) Family planning counseling: The health worker must indicate that the issue of family planning (for either birth spacing or prevention of another pregnancy) is one that is routinely raised at least once during ANC for all clients, and not only for multipara women.

d) Voluntary counseling and testing for HIV/AIDS: The health worker must indicate that all women attending ANC are informed of this service and it's availability.

410 STI Treatment: If the same staff who provide the ANC services also diagnose and treat STIs for ANC clients, there is a better probability of compliance than if the client has to go to another provider in another location in

the facility. If the respondent indicates that STI cases are referred sometimes and treat sometimes (e.g. if the Doctor is present, I refer...if the clinic is open I refer, otherwise I provide treatment), the correct response is “REFERS”.

411-417 CLIENT INFORMATION

411a Register for ANC clients: If the register headings are not printed, it should be reviewed to see that it specifically identifies antenatal care clients, and indicates whether it is a first or a follow-up visit.

411b Most recent entry: This may be either a first or follow-up visit. Count the day of the survey as “day 1” when counting the prior 7 days.

411c-411d Client caseload: This includes all ANC visits (first visits plus follow-up visits). Some facilities will not have information available for a full 12 months, so in 412a, indicate the number of months reflected in the data. The information should be taken from monthly, quarterly, or an annual report. If the information is not available in a summary form at minimum by month, count the most recent completed month and indicate 1 month of data in 411d.

412a Register for Post Partum clients: This may be in the ANC register or may be separate. If the register headings are not printed, it should be reviewed to see that it specifically identifies the number of days postpartum, and whether there were any complications in the postpartum period or not.

412b Most recent entry: This may be either a first or follow-up visit. Count the day of the survey as “day 1” when counting the prior 7 days.

412c-412d Client caseload: This includes all postpartum visits (first visits plus follow-up visits). Some facilities will not have information available for a full 12 months, so in 412a, indicate the number of months reflected in the data. The information should be taken from monthly, quarterly, or an annual report. If the information is not available in a summary form at minimum by month, count the most recent completed month and indicate 1 month of data in 412d

413 Expected annual deliveries: The facility must have a catchment area to be able to provide this information. They should either rapidly be able to take the catchment area and calculate the expected births, or should have expected births noted somewhere. The interviewer should not assist with this or the subsequent calculations.

414-415 ANC coverage: ANC coverage rate should not be calculated at the time of the survey. Rather, the facility should show their records where they routinely calculate this information to monitor their service. This may be part of an annual report. If the facility has a wall chart or graph that indicates ANC coverage

for the previous year or more recently, this is acceptable. If they do not have any of these, then the answer is “DON'T KNOW”.

416 Individual client records: Individual ANC cards refer to some individual record for the woman. Usually this will be a special card where all information relating to a pregnancy, labor, and delivery is written. It may, however, be a personal health card that includes the health history of the woman, upon which the ANC information is being written, if the facility routinely provides individual health cards to all clients. An individual record or card provides a more complete history of the woman and allows the health worker to provide more thorough assessments and care.

417-421 EXAMINATION OF ANC CLIENTS

Go to the room where ANC examinations services are normally provided. If there is no special room, or ANC services are only offered on certain days of the week, then the equipment may be locked in a storage cabinet elsewhere.

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

417 Same examination room: Often there is one examination room for obstetric/gynecologic examinations. If the room has already been assessed for another service (e.g. all items in questions 418-419 were previously evaluated), the interviewer must indicate under which service in the questionnaire the responses are marked, and then skip to question 420.

418 ANC examination room environment: This refers to where the physical examination occurs. It may be the same room where consultations occur or may be a different room. Indicate the degree of privacy offered to the client.

419 Examination room facilities: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

420 Equipment for ANC and Postpartum examinations:

e) Infant scale: If the facility has a digital or balance scale upon which the provider or mother stands and holds the infant, this counts as an infant scale. An infant scale may also be a balance scale or a hanging scale which is calibrated in 100 gram intervals. The normal child scale with ¼ kilogram gradation is not sufficiently sensitive for an infant scale. A normal dial bathroom scale does not count for the infant scale.

421 Protocols/educational materials:

a) Any protocols or guidelines for providing antenatal care, including management of women at high-risk women or with complications. Many facilities have one large “Reproductive Health” Protocol which covers family planning,

STIs and maternity. If a copy of the protocol is not in the service delivery area, it can be assumed that it is not easily accessible for utilization, even if a copy is elsewhere in the facility.

b) Any teaching materials (posters; flipcharts; booklets) that are focused toward the pregnant woman and explain normal labor or complications or antenatal care or complications of pregnancy or what to do for delivery.

Inclusion of country-specific protocols and teaching materials may be desired.

422-423 TRADITIONAL BIRTH ATTENDANTS

422 Formal relationship: This refers to some official relationship where the TBAs and providers meet at some routine interval, and information is shared. The types of activities frequently a part of these programs include TBAs submitting reports of births attended, periodic meetings for training/information sharing between the provider and the TBAs, and/or some form of community acknowledgement that the TBA is affiliated with a facility. If the provider reports that “sometimes TBAs refer women if there are complications” or “sometimes we provide training” but there is no specific program this does not count. There must be some official assignment of responsibility to the facility staff for working with TBAs.

423 Documentation of activity with TBA: Any documentation (minutes from meetings, signature sheets, schedule of visits, etc) of formal contact with the TBAs is acceptable.

424-429 EMERGENCY TRANSPORTATION

424 Transportation from home to facility: This refers to emergency transportation to go from home to the facility. If a combination of methods is commonly used to transport one person (e.g. people carry the person to the main road and from there they come by vehicle) circle “D” “COMBINATION OF ABOVE”. “COMBINATION” only refers to a combination for one woman. If many people use one method and many use another, circle both methods that are commonly used. If most people use one method and a few use another (e.g. most people go to the main road by animal and then use a motor vehicle, but a few people are carried to the facility) you must circle the most common method (in this case “D” “COMBINATION OF THE ABOVE”).

425 Facility Emergency transportation: This may be any system that is a part of the facility services. It may be anything from an ambulance, planned rented vehicles, or even paying for rental of public transport vehicles. If the family of the woman must make all arrangements and pay all costs, the facility has no emergency transportation system.

426 Description of emergency transportation system:

a) Emergency only: Ambulance or other type of vehicle which is used solely for emergency transportation. It may be used for services other than delivery.

b) Multi-use-vehicle: This may be a vehicle which is used for transporting staff, or for purposes other than emergency patient transportation, but must be based at the facility during hours of operation.

c) Emergency vehicle from other facility: This would be a vehicle based at the referral facility that will pick up and transport the emergency case when called.

d) Rental/hire when needed: This means that when needed the vehicle must be identified and transportation negotiated at that time, but the facility helps to negotiate the rental and helps pay the cost.

427 Functional status of vehicle: If Emergency only or multi-use vehicle were marked in question 426, you must ask to see the vehicle and confirm that it is present and in working condition (you may accept the word if the staff regarding functioning condition).

428 Client arranged transport from facility to referral facility: This question refers to moving from the survey facility to a referral facility, where the client must make all arrangements without facility assistance. Use the same instructions as for question 424.

429 Time for referral: This refers to the method indicated in question 426 or 428. If a vehicle must come from the referral facility to pick up the client, the travel time from when the vehicle is requested until the client arrives (e.g. round-trip time) must be indicated. If there is a large difference in time between the wet and dry season, indicate the normal time for the day of the survey.

SECTION 4b. MATERNAL HEALTH: DELIVERY AND NEWBORN CARE

430-431b ELIGIBILITY FOR SURVEY

The answer is “YES” if the facility staff provide home delivery service in an official capacity (e.g. not as “private practice”) even if the facility does not have capacity for facility deliveries or if the facility will conduct normal deliveries even if it does not routinely plan for facility deliveries.

431a-431b Consent: Consent is required if the person providing the information is different than the in-charge with whom you originally spoke. Even if the in-charge takes you to the service provision area and introduces you, you must explain to the staff member who is showing you around and answering questions that you have to read the brief statement as a part of the survey, and then read the consent statement.

432-433 DELIVERY SERVICES

432 Routine charge for normal deliveries: The point of interest is whether people must pay out-of-pocket for delivery services. Facilities may have a fixed fee for the delivery (A) and they may have a fixed fee for maternity services that includes ANC and delivery (B). (A) and (B) may include medications and tests or may not. If clients are charged separately for medications or tests received, then (C) also applies.

433 24 hour services: This may be a non-midwife, but must be some level of trained health provider (assistant nurse is acceptable) so long as they are considered competent to conduct deliveries. You may accept the word of the health worker regarding this answer.

On-call must be an officially assigned duty where the health worker is obligated to be available and reachable within a reasonable proximity of the facility. If specific staff are not assigned either duty or on-call 24 hours, the answer is “NO”. Check for an on-call or duty roster. If there is no duty roster, there is no 24-hour duty. Unofficial arrangements where it is explained that the health provider lives nearby so “people know they can call” if they need help is not duty or on-call and the correct response is “NO”.

433a Qualification of delivery staff: This refers to all deliveries in the facility, whether during normal hours or after hours. Secondary level staff may be locally defined, but generally refer to qualified nurse or higher level of training.

434-437 CLIENT INFORMATION

434 Register for delivery clients: The register should include at minimum, information on the birth outcome for the mother and the infant. The register is for facility deliveries. If home deliveries are officially conducted by the facility, birth information must also be included for these.

434a Most recent entry: This may be either a facility or home delivery, as long as it was conducted by a facility health worker as a part of their official duties (e.g. not private practice). Count the day of the survey as “day 1” when counting the prior 30 days.

435-435a Client caseload: This includes all deliveries conducted both in the facility and home deliveries conducted by facility health staff as a part of their official duties. Some facilities will not have information available for a full 12 months, so in 435a, indicate the number of months reflected in the data.

436-437 Delivery coverage: Delivery coverage rate should not be calculated at the time of the survey. Rather, the facility should show their records where they routinely calculate this information to monitor their service. This may be part of an annual report. If the facility has a wall chart or graph that indicates delivery coverage for the previous year or more recently, this is acceptable. If they do not have any of these, then the answer is “DON’T KNOW”.

438-440 HOME DELIVERY SERVICES

438 Home deliveries: This question refers to an established policy AND PRACTICE of the midwives being available to go to homes for deliveries if called. If home deliveries are private practice cases this does not count.

439-440 Home delivery equipment and supplies: Ask to see the bag and check to see that the items mentioned are all included. The bag should have the items inside, and be ready to be taken immediately should a case for home delivery arise. It is not required that the items be sterile when you are observing, but they must be in the bag. If items are in a sterile packet and the respondent indicates they are present, this is sufficient. It is not necessary to open the sterile packet.

441-446 DELIVERY ROOM EQUIPMENT AND SUPPLIES

Go to the room where normal deliveries are conducted.

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

441 Same examination room: If the delivery room has already been assessed for another service (e.g. all items in question 442-443 were previously evaluated), the interviewer must indicate under which service in the questionnaire the responses are marked, and then skip to question 444.

442 Delivery room environment: This refers to where normal deliveries occur. Indicate the degree of privacy offered to the client.

443 Delivery room facilities: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

444 Other equipment for Delivery

- a) 24 hour functioning light source: May be any light source for use at night (includes lantern, battery operated light).
- b) Skin antiseptic: is for cleaning the perineal area.
- c-d) Intravenous solutions with infusion sets: For emergency support or providing line through which oxytocic medications may be provided.
- e) Injectable ergometrine: For postpartum bleeding. The oxytocic medications may be adapted to the country protocols.
- f) Syringes and needles: For giving medications.
- g) Suture material with needle: Any suture is sufficient.
- h) Sterile scissors/blade: May be in a sterile pack or closed sterile container. If the respondent can show the sterile pack or container, this is acceptable.
- i) Needle holder: To use with the suture needle.

445 Supplies for baby:

- a) Bag and Mask: For providing respiratory support. Must be infant size.
- b) Resuscitation table for baby: This should be a firm table at a reasonable height for the Health Worker to provide necessary care to the newborn.
- c) Heat source: Either an incubator, or another source of external heat (other than blankets), primarily for premature newborns.
- d) Baby scale: This should be a balance scale and should be in the deliver room or immediately adjacent.
- e) Mucous extractor: May be a squeeze bulb or other suction apparatus.
- f) Cord ties: Item to tie off umbilical cord stub attached to infant.

446 Protocols:

- a) Guidelines: Any protocols or guidelines for labor and delivery including management of complications. Many facilities have one large "Reproductive Health" Protocol which covers family planning, STIs and maternity. If a copy of the protocol is not in the service delivery area, it can be assumed that it is not easily accessible for utilization, even if a copy is elsewhere in the facility. Inclusion of country-specific protocols and teaching materials may be desired.
- b) Partographs: Blank forms.

447-454 **ROUTINE POSTPARTUM AND NEWBORN CARE**

Routinely means that this is a part of the protocol for postpartum newborn. Accept the word of the respondent for the correct answer. If the respondent does not know the answer to these questions, ask to find a staff member who does know the answers.

447 Rooming in: This refers to having the newborn remain in the same room with the mother.

448 Vitamin A: This refers to providing one high dose (200,000iu) capsule of vitamin A to the mother after birth. This not only replenishes her supply in case she is vitamin A depleted, but ensures that adequate amounts of vitamin A are available to the newborn in the breast milk.

449 Suction with catheter: This would be most often using a foot or electric power source for suction. Suctioning a newborn with a catheter is rarely appropriate, except in an emergency situation. The hard catheter and suction may cause injury to an infant.

450 Weigh newborn: The infant should be weighed immediately after within a few minutes of birth, after the health of the newborn is ensured.

451 Pre-lactates: Often facilities routinely provide a water solution to newborns until the maternal milk is considered sufficient. This practice is not needed and may result in illness for the newborn.

452 Oral Polio Vaccine-dose 0: This is encouraged to increase the probability that the child will be fully immunized and to decrease the chance of contracting polio.

453 Administer BCG injection: This is encouraged to increase the probability that the child will be fully immunized and even if not, to ensure that the child has received the level of protections against tuberculosis that is possible with the vaccine.

454 Bathe newborn: This refers to immersing the infant in water. If the facility only routinely sponges the infant off, the correct response is "NO".

COMPLICATED DELIVERIES (455-465)

455-458 Other Obstetric Equipment: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory. Ask to see relevant equipment. We are looking for any equipment used to assist deliveries or to remove retained products of conceptions. The most commonly used equipment is listed, however, country-specific adaptation may be required.

459 Blood transfusion: A blood bank provides capacity to store blood before surgery. If the facility has blood storage capacity, even if there is no blood present, the correct response is “1”. Transfusion but no blood bank implies that if a transfusion is required, a donor will be found for the particular case.

460 Review of maternal and newborn urgent delivery cases: Ask the informant to describe the system of reviews and ensure that there is a routine system where there is a clear criteria for which types of cases are reviewed, and a specified procedure for review, including who participates in the review. The participants may be internal to the facility or external. If the system is informal consulting among the doctors or health workers, the correct response is “NO”.

461 Ever C-Section: The correct response is “YES” if emergency caesarean sections are ever conducted, even if the facility normally does not provide delivery services.

462 Equipment for caesarean section:
Go to the room where caesarean sections are conducted.

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

a) Operating table: This may be any type of hard surface table which is a height reasonable for performing surgery, and which has a surface which can be wiped with disinfectant.

b) Operating light: This refers to high intensity electric operating light which can be positioned over the patient.

c) Scrub area: This MUST be adjacent to the surgical area. If there is not running water, at minimum the water storage must include two buckets, one for washing and one for rinsing.

d) Sterilized equipment: Equipment should be packed in a sterile pack with autoclave tape indicating it has been sterilized. It is acceptable, however, if the equipment is stored in a covered container that is sterile and has a cover that clasps shut.

463 Staff trained in caesarean section: Staff for caesarean section: In some cases staff other than physicians may be trained to conduct emergency caesarean sections. This is acceptable, depending on country standards. On-call must be an officially assigned duty (ask to see the on-call duty roster) where the health worker is obligated to be available and reachable within a reasonable proximity (no more than 30 minutes travel time) of the facility.

464-464a Number of C-sections: Indicate the number of months the data represents in question 464a.

465 Date of most recent C-section: You must verify the date in a register or report. If the facility does not have a record that indicates the exact date, the correct response is "9998" for "DON'T KNOW". Do not accept an estimate for how long ago the last c-section was conducted.

SECTION 5. STI/HIV/AIDS SERVICES

500-501 ELIGIBILITY FOR SURVEY

The answer is “YES” if any services for Sexually Transmitted Infections or HIV/AIDS are provided from the facility, even if there is no special clinic for these services. If there are different areas where these services are offered (e.g. consultation area, family planning clinic) go first to the area where the largest number of STI clients are seen.

501-501a Consent: Consent is required if the person providing the information is different than the in-charge with whom you originally spoke with. Even if the in-charge takes you to the service provision area and introduces you, explain to the staff member who is showing you around and answering questions that you have to read the brief statement as a part of the survey, and then read the consent statement.

502-506 STI SERVICES

502 STI services: Any services for treatment or prevention of STIs is a “YES”, even if there is no special clinic for this service.

502a STI services today: The answer is yes if any client who walks in and requests or requires the service can receive it on this day, even if it is not a special clinic day for the service.

503 Service setting: This question is looking for where the routine, first visit client with the major complaint being STI symptoms, would be diagnosed and seen. If the STI client is first seen in outpatient, but upon suspicion of STI is referred to a special clinic, then the correct response is “SPECIAL CLINIC”.

503a Days of service availability: This refers to STI services offered at the facility itself, and means that the client could come during normal working hours for that day and would not be told to return another day, but rather, would receive the necessary diagnostic and treatment interventions.

503b Routine charge for STI services: The point of interest is whether people must pay out-of-pocket for the consultation when they use curative services. Facilities may charge a one time fee for providing a client health card (A). If the charge for the consultation is the same for all clients, this is defined as a fixed fee for each consultation (B). The fixed fee may include medications and tests or these may be charged separately. If medications and tests are included in the one consultation fee, then (D) should not be circled, if they are charged separately, (D) should also be circled. If the fixed fee varies depending on the diagnosis, the correct response is (C). This may include medications and tests or these may be charged separately (D).

504 Diagnostic standards: Syndromic refers specifically to following the diagnostic and treatment decision algorithms from the “Syndromic Approach”. Etiologic diagnosis requires laboratory verification. Clinical diagnosis is a less structured approach than “syndromic”. Clinical diagnosis assumes that providers approach each set of symptoms and findings uniquely, use their personal assessment and their knowledge to decide the diagnosis and treatment that is appropriate.

505a Confidentiality: The protocol must be written and may either be an information paper for clients, or an instruction to health workers describing the policy for the facility and what they are to inform clients. Ask to see a copy of the protocol. If there is a notice posted in a client waiting or consultation area that specifies that confidentiality is assured, this is acceptable.

505b Informed Consent: The protocol must be written and may either be an information paper for clients, or an instruction to health workers describing the policy for the facility and what they are to inform clients. Ask to see a copy of the protocol.

506 Partner notification: Active partner notification or follow-up refers to the facility notifying potentially infected persons, either through a letter or through public health workers. This answer is still valid if the permission of the client is required to notify partners. Passive partner notification refers to asking the client about potentially infected persons and requesting the client to notify these persons and ask them to come for services.

506a Active partner notification documentation: For an efficient active notification program there must be some list of persons to be notified and an indication of the outcome (e.g. client not found; client notified and tested; etc.).

507-509b CLIENT INFORMATION:

507 STI register: This may be a part of the consultation register for ill adults. At minimum it must mention a diagnosis and treatment. For the register, a diagnosis of pelvic inflammatory diseases (PID) or STI is sufficient.

507a STI diagnosis: This should indicate a specific diagnosis for the STI, not simply “infection”, “discharge”, PID, or STI.

508 Most recent entry: This includes both new and follow-up clients. Count the day of the survey as “day 1” when counting the prior 7 days.

509-509a Client caseload: This includes **BOTH** new and follow-up clients. Some facilities will not have information available for a full 12 months, so in 509a, indicate the number of months reflected in the data. The information should be taken from monthly, quarterly, or an annual report. If the information is not

available in a summary form at minimum by month, count the most recent completed month and indicate 1 month of data in 509a.

509b Official reports: These would be official reports that are submitted to the government or public health department which allow the health system to monitor the incidence and types of STIs being diagnosed. The type of STI means the specific diagnosis (e.g. syphilis, gonorrhea).

510-512 STI CONSULTATION

510 STI consultation environment: This refers to where the client history and counseling occurs. It may be the same room where examinations occur or may be a different room. Indicate the degree of privacy offered to the client.

511 Availability of resources for client education: Check for each of the items and subjects indicated, using the same criteria as that described in section 1B of the Overview of the Facility Inventory. Inclusion of country-specific materials may be desired.

512 Service delivery protocols:

a) Clinical guidelines: These should indicate diagnostic laboratory examinations required for the suspected STI client. Inclusion of country specific protocols may be desired.

b) Guidelines for syndromic approach: This is a guideline that may be in a chart or wall poster form. It provides diagnostic trees for decision making based on client symptoms and history.

c) Guidelines for diagnosing HIV/AIDS: Either protocols for suspecting diagnosis or more complete instructions regarding laboratory examinations.

d) Guidelines for treating HIV/AIDS: This would include medical protocols for HIV/AIDSs including management of opportunistic infections. Inclusion of country specific protocols may be desired.

Many facilities have one large “Reproductive Health” Protocol which covers family planning, STIs and maternity. If a copy of the protocol is not in the service delivery area, it can be assumed that it is not easily accessible for utilization, even if a copy is elsewhere in the facility. Verify that each of the above topics is covered by the protocol prior to indicating availability.

513-517 EXAMINATION OF STI CLIENTS

Go to the room where STI examination services are normally provided. If there is no special room, or STI services are only offered on certain days of the week, then the equipment may be locked in a storage cabinet elsewhere.

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

513 Same examination room: Often there is one examination room for obstetric/gynecologic examinations. If the room has already been assessed for another service (e.g. all items in questions 513-514 were previously evaluated), the interviewer must indicate under which service in the questionnaire the responses are marked, and then skip to question 515.

514 STI examination room environment: This refers to where the physical examination occurs. It may be the same room where consultations occur or may be a different room. Indicate the degree of privacy offered to the client.

515 Examination room facilities: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

516 Equipment for STI examinations
Swab sticks refer to sticks with cotton on the end which are used to swab a sample of discharge for laboratory examination.

517 **HIV/AIDS SERVICES**
This includes any official program related to AIDs. This might include voluntary testing, home care, or management of opportunistic infections in HIV/AIDS clients as well as services specifically treating the HIV virus.

518-520 **VOLUNTARY COUNSELING AND TESTING (VCT)**
This service is provided to any person who wishes to be tested for HIV/AIDS, with or without symptoms.

520 Frequency of referrals: For the various services, indicate the frequency with which the referral is made. These may be referrals within the facility, or external to the facility. For "SOMETIMES" to be a correct response, the referrals should be made for at least an estimated half of the clients. Question 536 will look for documentation of referrals.

521-524 **VCT CLIENT INFORMATION**

521 Client register: This refers ONLY to VCT clients. It should indicate the date and result of the test.

522 Most recent entry: This includes both new and follow-up clients. Count the day of the survey as "day 1" when counting the prior 7 days.

523-523a Client caseload: This includes ONLY new clients. Some facilities will not have information available for a full 12 months, so in 523a, indicate the number of months reflected in the data.

524-538 **SPECIFIC HIV/AIDS SERVICES**

525 Services and service delivery environment: Indicate the status for each service listed.

526-526a Anti-retroviral therapy statistics: This figure should indicate each client only once. If only the data for number of treatments (where one client may be counted several times) then the correct response is "DON'T KNOW". Some facilities will not have information available for a full 12 months, so in 526a, indicate the number of months reflected in the data.

527-528 **CONSULTATION FOR HIV/AIDS**

527 HIV/AIDS consultation environment: This refers to where the client history and counseling occurs. It may be the same room where examinations occur or may be a different room. Indicate the degree of privacy offered to the client.

528a Availability of resources for client education: Check for each of the items and subjects indicated, using the same criteria as that described in section 1B of the Overview of the Facility Inventory. Inclusion of country specific materials may be desired.

528b Service delivery protocols: Use the guidelines used for question 512.

529-531 **EXAMINATION OF HIV/AIDS CLIENTS**

Go to the room where HIV/AIDS clients examination services are normally provided. If there is no special room, or HIV/AIDS services are only offered on certain days of the week, then the equipment may be locked in a storage cabinet elsewhere.

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

530 HIV/AIDS client examination room environment: This refers to where the physical examination occurs. It may be the same room where consultations occur or may be a different room. Indicate the degree of privacy offered to the client.

531 Examination room facilities: Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

532 **PROTOCOLS**

532a Confidentiality: The protocol must be written and may either be an information paper for clients, or an instruction to health workers describing the

policy for the facility and what they are to inform clients. Ask to see a copy of the protocol.

532b Informed Consent: The protocol must be written and may either be an information paper for clients, or an instruction to health workers describing the policy for the facility and what they are to inform clients. Ask to see a copy of the protocol.

532c Referral Protocols: The protocols or guidelines must be written procedures for staff to follow depending on the assessed needs for the clients.

532d Guidelines for treating HIV/AIDS: These protocols or guidelines may indicate how to provide anti-retroviral treatment, or might be protocols for managing opportunistic infections.

533-535 CLIENT INFORMATION

533 Client register: This refers to HIV/AIDS patients, not VCT clients. It should indicate the diagnosis, what treatment the patient received.

534 Most recent entry: This includes both new and follow-up clients. Count the day of the survey as “day 1” when counting the prior 7 days.

535-535a Client caseload: This includes **BOTH** new and follow-up clients. Some facilities will not have information available for a full 12 months, so in 523a, indicate the number of months reflected in the data.

536-538 FOLLOW UP OF HIV+ CLIENTS

536 Referral follow-up: There should be some official mechanism for tracking clients who have been referred for services with some record kept. Even if a facility provides almost all required interventions, they often still must refer for some social or home services. If they never refer because they are the referral facility, then the correct response is “REFERRAL FACILITY”.

537 List of support services for referral of clients: One facility can rarely offer all services required by patients who have HIV/AIDS. In order to ensure that the patients are systematically told about available support services and how to avail themselves of the services, a facility should have a list of the service available and contact information to use as a reference.

538 Formal partnership: Ask for some indication of the formal partnership with organizations providing support services for Persons living with HIV/AIDS (PLHA). This might include referral forms, specific days staff come to the facility to meet with families, etc. This may be any social support network that works to assist persons living with and caring for HIV/AIDS infected persons.

Ask specifically about each listed test. If the test is conducted at the facility, you must check the laboratory component of section 6 of the SPA Inventory.

If the service location collects the specimen and sends it to a laboratory in the same facility, the answer is "CONDUCTS TEST".

"COLLECTS SPECIMEN" implies that the specimen is tested at another facility.

"SEND CLIENT ELSEWHERE" implies that the client must go to a different facility. If the client is referred to the laboratory within the same facility to receive the test, the response is "CONDUCTS TEST".

- a) The most common test for syphilis is a blood test (VDRL).
- b) Gonorrhea is most often tested using a microscopic examination of a smear.
- d) There are various blood tests for HIV/AIDs.
- e) CD4 count is a blood test that measures the lymphocyte T-cell (CD4) value. T cells are necessary for immune responses. They are destroyed by HIV/AIDS, making patients with low levels highly susceptible to opportunistic infections. A patient who is having a good response to anti-retroviral therapy will show an increase in CD4 count. It is used sometimes for presumptive diagnosis, and often to monitor the progress of AIDS clients and their response to therapy.
- f) Viral load is a blood test for an indicator of the HIV virus. High levels are significantly related to risk of opportunistic infections and death. It is used to monitor response to anti-retroviral and other therapy for HIV/AIDS.

SECTION 6. LABORATORY DIAGNOSTICS

Complete this section using the same criteria as that described in section 1B of the Overview of the Facility Inventory.

The indicated equipment and reagents may be in the laboratory, or may be in another location, depending on where the test is conducted. If it has been indicated that the facility does provide the test and you cannot find the indicated supplies, be sure to ask if it is conducted elsewhere (e.g. in the service provision area) to ensure that you have checked the appropriate location.

SECTION 7. CONTRACEPTIVE AVAILABILITY AND LOGISTIC SYSTEM

Contraceptive supplies may be stored at the family planning service location or may be stored in the same location as other medications and supplies. Go first to where stock is stored and then, only if not available there, check for availability of the method in the family planning service location.

700 Inventory: The inventory should indicate the amount and date of each method when received and when disbursed. *Note: A record of all receipts for supplies is not an inventory.*

700-709 Monitoring of expiry dates and stock for contraceptives:

(a) Expiry date and availability: Check to see if each contraceptive method (701-709) is available. Look for expiry dates on the items indicated in the questionnaire (701, 704, 706) and also indicate if they are arranged with the earliest expiry date at the front and latest expiry date at the back (700a). If all of each type of contraceptive method have the same expiry date, or if there is no expiry date, the correct response is "DON'T KNOW".

Note: For facilities where the contraceptive methods are stored in a different location than where family planning services are provided: If there is no stock of a method in the store, but the method is present in the service delivery area, the inventory should indicate a balance of "0", but you may indicate the method was available. Go to where the method is available and check expiry dates.

(b) Stock and Inventory the Same: Count each full (not opened) vial/box/packet of the methods indicated on the questionnaire (701, 704,706) and indicate if the amount written in the inventory is the same as that found in the storeroom. There may be opened boxes or packets that have already been excluded from the inventory but are still in the storeroom. This is acceptable.

710 First-expire/first-out storage: Check for all indicated methods (oral pill w/ estrogen (701); injectable progesterone (3 monthly injectable) (704) ; male condom (706) to see that items with the closest expiry date are in the front, and later expiry dates in the back of the storage area. If items are not neatly placed by method, or if items remain in large quantity boxes WHERE THEY ARE MIXED WITH OTHER ITEMS, then the correct response is "NO". Multiple packets/vials of an individual item may remain in a box, as long as the box is stored off the ground and in some recognizable order.

711-714 STORAGE CONDITIONS

Look around the area where methods are stored. Observe in corners, around windows, around the edges of the ceiling.

712 Water: Respond no if you see water stains on walls, standing water, or holes or cracks in the roof. If methods are in a box on the floor, the correct response is “NO”.

713 Sunlight: Respond No if there are openings in the room where the sun can penetrate.

714 Pests: Pests include rats, bats, etc. Respond no if there is evidence of feces or urine, holes in boxes caused by pests, or partially consumed products.

715-728 CONTRACEPTIVE LOGISTIC SYSTEM

715 “Determine own need”: This means that the system allows the facility to adjust the supply to the need, and that the facility determines what amount of each method to request. “Determined elsewhere” means that persons outside of the facility (e.g. District Management Team” determine the supply for the facility.

716 Basis for orders determined elsewhere: “AMOUNT BASED ON ACTIVITY LEVEL” means that the amount of each method provided is determined by persons outside of the facility, based on service statistic information submitted by the facility. “STANDARD FIXED SUPPLY”, means the same amount arrives each order, regardless of utilization statistics. Staff may note that the amount of a method supplied has been changed over time, but if the amount is not revised at least quarterly, and is not linked to service statistics, then the answer is that the facility receives a “standard fixed supply”.

717-718 Basis for orders determined by facility: Probe to determine which response best describes the basis for determining how much of each method to order and which response best describes how the facility decides when to place an order. If more than one method is used for deciding how much or when to order, circle all that apply.

719 Reliability of ordering and supply system:

“ALWAYS” means exactly that- the order is always complete.

“SOMETIMES” means that occasionally the order is not complete.

“NEVER” implies that almost every supply of contraceptive methods is not provided according to the ordering procedure.

Many times the response is “I order and the district gives me what they have”. You must probe to find out specifically, whether they “ALWAYS” get what they order, whether “SOMETIMES” enough of the method ordered is not available so they do not get their total order, or whether essentially “NEVER” the quantities received are the same as the quantity ordered. *Note: Receiving items that were not ordered counts as not getting the complete order.*

If some extraordinary circumstance affected the supply during the previous 3 months (e.g. a rare, one-time national shortage of one method for several weeks or months which resulted in several consecutive orders being short supplied; an emergency event which disrupted supply and which the staff certify has not occurred during the previous several years), write a note on the questionnaire to explain, but still provide the answer which is relevant.

If the health worker is confident in the response to this question, accept their response. If uncertain, you may probe some to help them think, or ask to see order sheets and stock cards (if available) where you can easily compare the order and the received supplies.

SECTION 8. ESSENTIAL MEDICATIONS AND LOGISTIC SYSTEM

800-897 MEDICINE AVAILABILITY AND LOGISTIC SYSTEM

800 Inventory: The inventory should indicate the amount and date of each vaccine when received and when disbursed. *Note: A record of all receipts for supplies is not an inventory.*

801-889 Monitoring of expiry dates and stock for medicines:

(a) Expiry date and availability: Check to see if each medicine (801-887) is available and that there is at least one vial/bottle/packet/tin of the medicine with a valid expiry date. Look at expiry dates for all stock of the items indicated in the questionnaire and also indicate if they are arranged with the earliest expiry date at the front and latest expiry date at the back (800a). If any item has no expiry date, the correct response is "DON'T KNOW".

If special medications (e.g. emergency obstetric drugs) are only stored in the service delivery area, go there to verify availability.

Note: For facilities where the indicated medication is stored in a different location than where services are provided: If there is no stock of the medication in the store, but the medication is present in the service delivery area, the inventory should indicate a balance of "0", but you may indicate the medication was available. Go to where the medication is available and check expiry dates.

(b) Stock and Inventory the Same: Count each full (not opened) vial/box/packet of the medications indicated on the questionnaire and indicate if the amount written in the inventory is the same as that found in the storeroom. There may be opened boxes or packets that have already been excluded from the inventory but are still in the storeroom. This is acceptable.

889 First-expire/first-out storage: Check all indicated medicines to see that items with the closest expiry date are in the front, and later expiry dates in the back of the storage area. If items are not neatly placed by medicine, or if items remain in large quantity boxes WHERE THEY ARE MIXED WITH OTHER ITEMS, then the correct response is "NO". (Multiple packets/vials of an individual item may remain in a box, as long as the box is stored off the ground and in some recognizable order.

890-892 STORAGE CONDITIONS

Look around the area where medicines are stored. Observe in corners, around windows, around the edges of the ceiling.

890 Water: Respond no if you see water stains on walls, standing water, or holes or cracks in the roof. If medicines are stored in a box on the floor the correct response is “NO”.

891 Sunlight: Respond No if there are openings in the room where the sun can penetrate.

892 Pests: Pests include rats, bats, etc. Respond no if there is evidence of feces or urine, holes in boxes caused by pests, or partially consumed products.

893-897 MEDICINE LOGISTIC SYSTEM

893 “Determine own need”: This means that the system allows the facility to adjust the supply to the need, and that the facility determines what amount of each medicine to request. “Determined elsewhere” means that persons outside of the facility (e.g. District Management Team” determine the supply for the facility.

894 Basis for orders determined elsewhere: “AMOUNT BASED ON ACTIVITY LEVEL” means that the amount of each medicine provided is determined by persons outside of the facility, based on service statistic information submitted by the facility. “STANDARD FIXED SUPPLY”, means the same amount arrives each order, regardless of utilization statistics. Staff may note that the amount of a medicine supplied has been changed over time, but if the amount is not revised at least quarterly, and is not linked to service statistics, then the answer is that the facility receives a “standard fixed supply”.

895-896 Basis for orders determined by facility: Probe to determine which response best describes the basis for determining how much of each medicine to order and which response best describes how the facility decides when to place an order. If more than one method is used for deciding how much or when to order, circle all that apply.

897 Reliability of ordering and supply system:

“ALWAYS” means exactly that- the order is always complete.

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If some extraordinary circumstance affected the supply during the previous 3 months (e.g. a rare, one-time national shortage of one method for several weeks or months which resulted in several consecutive orders being short supplied; an emergency event which disrupted supply and which the staff certify has not occurred during the previous several years), write a note on the questionnaire to explain, but still provide the answer which is relevant.

If the health worker is confident in the response to this question, accept their response. If uncertain, you may probe some to help them think, or ask to see order sheets and stock cards (if available) where you can easily compare the order and the received supplies.

SECTION 9. CENTRAL STOCK OF ESSENTIAL SUPPLIES

These supplies have already been assessed for their presence in the relevant service delivery areas. In this section, we are looking for whether the facility has a stock of supplies that are commonly needed across services. If the supply is only available in each service delivery area but there is no general stock, the correct response for this section is “NO”.

902 Sterile gloves come individually packaged and are marked “sterile”. If the gloves are reused and are centrally sterilized, they should be wrapped in a sterile package. If there are no sterile gloves in a central location, but you are told they are in the service delivery areas, circle “ND” for “NOT DETERMINED”. The presence of sterile gloves is also assessed separately for each particular service during the inventory for that service.

903 Clean gloves most often come in a box where the gloves are not individually packaged and the box is labeled either “clean” or “not sterile”. If the gloves are reused and are centrally cleaned, the gloves may be stored in a covered, dry container. If there are no clean gloves in a central location, but you are told they are in the service delivery areas, circle “ND” for “NOT DETERMINED”. The presence of clean gloves is also assessed for each particular service during the inventory for that service.

2. PROVIDER INTERVIEW

A. Overview of the Provider Interview

The Provider Interview is designed to collect information about the training and qualifications of different service providers. It is divided into specific service areas that will be answered for each service where the individual provider works. The provider questionnaire includes:

- (1) Cover Page
- (2) Provider Training and Experience
- (3) Experience and in-service training for:
 - a) Child Health Care
 - b) Family Planning
 - c) Antenatal care
 - d) Delivery services
 - e) Newborn care
 - f) STI services
 - g) HIV/AIDS services
- (4) Experience being supervised
- (5) Provider Opinion

You will want to provide the names of the providers selected for the interview (Appendix 2 provides methodology for selection of providers to be interviewed) to the in-charge so that arrangements can be made for when they will be interviewed. This may be in-between client observations (if there are few observations) or may be at the end of the day after client consultations are complete. The timing will depend on how busy the facility is, and the schedule of the provider.

B. General Procedures for Completing the Provider Interview

All attempts should be made to conduct this interview in a private location where only the interviewer and the staff member are present and can hear the conversation. A private room that provides visual as well as auditory privacy is best. If a supervisor or other staff member wants to be present or keeps coming into the interview area, politely but firmly explain that this interview must be conducted without others present so that the health worker does not become shy or nervous about responding. Experience has shown that when two providers are sitting together and one is being interviewed, the more vocal of the two frequently volunteers a response even if that is not the person being interviewed. Ensure that the supervisors and other staff understand that this interview is not a test, and also does not ask any questions about specific staff, supervisors, or specific situations associated with this specific health facility. Rather, the information is being gathered to provide an overview of the work and experience of staff working in facilities of this same type across the country.

C. Detailed Instructions for Completing the Provider Interview

COVER SHEET

Although most of the information is the same as that on the Inventory Questionnaire, it should be completed again. This is to minimize errors in data entry.

Name of facility: Copy from sample list

Facility location: Write the most complete address possible for the facility.

Facility code: Refer to sample list with pre-assigned code number

Type of facility:

A Referral Hospital is a 2nd line hospital (usually Regional or teaching hospital). A Hospital refers to a facility that routinely admits patients for overnight treatment. A Health Center may have overnight beds, but these are for emergency, the facility does not plan or have staff for routine overnight patients. A Health Post may be a static facility in a village, or may be an outreach site. It would usually have few staff and limited services and the staff would usually be supervised by staff from a Health Center.

Verify with the in-charge the facility type that is stated beside the name of the facility on the sample list. If there is a discrepancy, enter the code that you believe is appropriate based on the discussion with the in-charge and note the reasons for making the change in the Notes section at the end of the Inventory questionnaire.

Operating authority: This is the type of organization that manages the facility and provides the primary supervision. Thus, if the staff are hired by the government, but management is provided by a religious organization or NGO, the operating authority is the NGO or religious organization. Verify with the in-charge that the operating authority that is stated beside the name of the facility on the sample list. If you find that the type of facility indicated on the sample list is different than what the in-charge states, write a note and enter the appropriate code.

PROVIDER INFORMATION

Provider category: Health Worker Category: The highest level of professional training the staff member has achieved.

Sex of provider:

Provider code: All health workers who are interviewed will be assigned a code number by the Team Leader. One provider will have the same code number for the Health Worker Interview and Observation Questionnaire.

INFORMATION ABOUT INTERVIEW:

Interviewer code: Record the number of the interviewer conducting the Provider Interview.

Time interview started: Ensure that the time the interview starts is recorded immediately before asking for permission for the interview.

100 CONSENT

Before reading the statement, take a moment or two to have a relaxed discussion with the health worker. Make sure that the health worker knows that

- a) the information will not be linked in any way to the name
- b) the information is not to evaluate any particular health worker, but rather to provide a picture of the experience and training of the people who are working in health facilities.

Then, if there are no questions, read the permission statement.
If the health worker refuses the interview, notify the Team Leader.

101-105 TRAINING AND EXPERIENCE

101 Year began work in this facility: If the health worker does not remember the year, help him/her figure this out by using major events in the history of the country (e.g. were you working here the year _____ became President?) or else ask if you may ask the in-charge for this information. If the Health Worker has changed position since starting at the facility (e.g. a nurse who returned to school to become a medical assistant (MA)) record the year the health worker first began working at the facility.

102 Basic education: This refers to years of basic schooling prior to university or technical training.

103 Technical qualification: This refers to the highest level of technical qualification and not to the position the provider holds. If a staff originally trained as a nurse, but then returned to school and is now a midwife or a medical assistant, midwife or MA is the correct response. If the staff member received additional training but did not change their official qualification (e.g. a nurse who receives some midwifery training, but is not recognized officially as a midwife) "Nurse" is the correct response). If there is some question, ask about registration, or official title at the facility to determine the appropriate qualification. A nurse or doctor who is an instructor, or a manager, has the technical qualification of "nurse" or "doctor".

104 Year of Graduation: This refers to the most recent qualification.

105 Years of study for qualification: This refers to successfully completed years of study. If a provider had to repeat a year (e.g. they failed to pass) this counts as one, not two years, of study. If the physician was required to complete 4 years of university prior to 3 years of medical school, the response is 7 years. If a prior degree allowed the staff to study a shorter period of time for their final qualification (e.g. if a nurse originally studied 4 years and then an additional two years to become an MA, the correct response would be 6 years, even if someone without a prior qualification becomes an MA in 4 years. The years of studying does not include short courses or continuing education courses that were not required for the official qualification of the health worker.

Training requirements change over time, so the standard required at the time of the survey may not be the same as that required when the staff member received their qualification. We are interested in the years of study the interviewed staff member successfully completed.

201-203 CHILD HEALTH CARE

201 Eligibility: This refers to participating in any activities related to well or sick child health services. Activities such as providing client education or conducting registration where child health indicators (temperature or weight) are collected, count as “PROVIDING CHILD HEALTH SERVICES”. If child health services are not the primary service the health worker provides, but they occasionally provide this service, then the correct response is “YES”. If the health worker previously provided child health services, but no longer has any responsibilities in this area, the correct response is “NO”.

202 Years providing service: This refers to participating in any activity related to child health services. Thus, if a nurse previously provided well child services, but changed to consultations for sick children, the sum of the time the nurse provided any child health services is the correct response.

203 In-service training: This refers to any training related to the indicated topics. The training may have been provided by organizations external to the organization for which the health worker is employed. *Country-specific in-service training courses may be of interest and should be added to the interview. These specific training courses may also meet the general topic areas for in-service training.*

301-303 FAMILY PLANNING

301 Eligibility: This refers to participating in any activities related to family planning services. If the health worker primarily works in another service such as antenatal care or consultation for sick adults, but also provides family planning services, whether providing advice and consultation on methods or

side-effects of methods, or actually prescribing or renewing a prescription for a method, the answer is “YES”). If the staff primarily collects registration information (e.g. history, blood pressure, weight) and then refers the client to another provider for actual consultation, the correct response is “YES”. If family planning is not the primary service the health worker provides, but they are sometimes asked to provide this service, filling in when the service is busy or when staff are absent, then the correct response is “YES”. If the health worker previously had some responsibilities for providing family planning services, but no longer has any responsibilities in this area, the correct response is “NO”.

302 Years providing service: This refers to participating in any activity related to family planning services. Thus, if a nurse previously provided antenatal care that included advising about family planning, and then began working in the family planning clinic, the sum of the time the nurse provided any family planning services is the correct response.

303 In-service training: This refers to any training related to the indicated topics. The training may have been provided by organizations external to the organization for which the health worker is employed. *Country-specific in-service training courses may be of interest and should be added to the interview. These specific training courses may also meet the general topic areas for in-service training.*

401-408 MATERNAL HEALTH

401 Eligibility: This refers to participating in any activity related to antenatal care. If the health worker primarily provides another service, such as consultation for sick adults, but when a pregnant client arrives and the antenatal care clinic is closed they provide the antenatal care, the correct response is “YES”. If the staff primarily collects registration information (e.g. history, blood pressure, weight) and then refers the client to another provider for actual consultation, the correct response is “YES”, since the provider is still involved with the provision of antenatal care. If antenatal care is not the primary service the health worker provides, but they are sometimes asked to provide this service, filling in when the service is busy or when staff are absent, then the correct response is “YES”. If the health worker previously had some responsibilities for providing antenatal care services, but no longer has any responsibilities in this area, the correct response is “NO”.

402 Years providing service: This refers to participating in any activity related to antenatal care services. Thus, if a nurse previously provided consultation for ill patients which included providing antenatal care at times, and then changed to working in the antenatal care clinic, the sum of the time the nurse provided any antenatal care services is the correct response.

403 In-service training: This refers to any training related to the indicated topics. The training may have been provided by organizations external

to the organization for which the health worker is employed. *Country-specific in-service training courses may be of interest and should be added to the interview. These specific training courses may also meet the general topic areas for in-service training.*

404 Delivery services: This refers specifically to being the primary delivery service provider. If staff ever conduct deliveries in their capacity as a staff at the facility (e.g. a staff may be primarily responsible for antenatal care, and only provide delivery services on-call then the answer is “YES”). If delivery care is not the normal or primary service the health worker provides, but they are sometimes asked to provide this service, filling in when the service is busy or when staff are absent, then the correct response is “YES”. If the health worker previously had some responsibilities for providing delivery care, but no longer has any responsibilities in this area, the correct response is “NO”.

405 Years providing service: This refers to the total number of years the staff has conducted deliveries regardless of the employment status at the time.

406 In-service training: This refers to any training related to the indicated topics. The training may have been provided by organizations external to the organization for which the health worker is employed. *Country-specific in-service training courses may be of interest and should be added to the interview. These specific training courses may also meet the general topic areas for in-service training.*

407 Number of assisted deliveries: This refers specifically to the total number of deliveries where the health worker was the primary birth attendant. This does not refer to number of clients cared for during labor or postpartum.

408 Partograph: Record use of partograph by the health worker.

409-412 NEWBORN AND/OR POSTPARTUM CARE

409 Eligibility: This refers to anyone who provides delivery services as well as those persons who might have specific responsibilities for newborns or care of the postpartum woman. Even if this is not a primary responsibility at this facility, if the health worker occasionally is required to conduct or assist at deliveries and to provide newborn or postpartum care, the correct response is “YES”. If the health worker previously had some responsibilities for providing newborn or postpartum care, but no longer has any responsibilities in this area, the correct response is “NO”.

410 Years providing service: This refers to providing any care for newborns or postpartum, women regardless of whether this was a full-time responsibility or periodic responsibility.

411 In-service training: This refers to any training related to the indicated topics. The training may have been provided by organizations external to the organization for which the health worker is employed. *Country-specific in-service training courses may be of interest and should be added to the interview. These specific training courses may also meet the general topic areas for in-service training.*

501-508 STI'S/HIV/AIDS

501 Eligibility: This refers to providing any services related to STIs whether in a special clinic, or another location (e.g. adult consultations, family planning clinics, antenatal care clinic). Even if this is not the primary responsibility of the health worker at this facility, if the health worker occasionally is required to provide diagnosis and treatment for STIs, the correct response is "YES". If the health worker previously had some responsibilities for providing STIs services but no longer has any responsibilities in this area, the correct response is "NO".

502 Years providing service: This refers to accumulated time providing counseling or treatment for STIs regardless of whether this was a full-time responsibility or periodic responsibility.

503 Eligibility: This refers to providing any services related to diagnosis, treatment, or counseling for suspect or diagnosed HIV/AIDS clients, whether in a special clinic, or another location (e.g. adult consultations, social services, etc.). Even if this is not the primary responsibility of the health worker at this facility, if the health worker occasionally is required to provide services for HIV/AIDS positive clients, the answer is "YES". If the health worker previously had some responsibilities for providing services for HIV/AIDS positive clients but no longer has any responsibilities in this area, the correct response is "NO".

504 Specific services: Circle all responses relevant to the type of care for HIV/AIDS clients the provider currently provides.

505 Years providing service: This refers to all time where there was any responsibility for providing services related to HIV/AIDS.

507 Pre-service (basic) training: This refers to any training related to the indicated topics that was provided as a part of the basic training the provider received prior to beginning service provision.

508 In-service training: This refers to any training related to the indicated topics. The training may have been provided by organizations external to the organization for which the health worker is employed. *Country-specific in-service training courses may be of interest and should be added to the interview.*

These specific training courses may also meet the general topic areas for in-service training.

601-603 SUPERVISION

601 Personal supervision: In this section, we are looking for supervision of the work of this particular health worker. If a supervisor came and a staff meeting was held where general issues were discussed, this does not count as supervision in this instance. The supervisor must have spoken with the health worker personally, or checked the register books or observed/discussed the work of the health worker. Attending in-service education provided by a supervisor also does not count as a "YES" unless this was provided specifically because of an identified need for upgrading skills for the health worker.

602 Number of personal supervisions: If the staff cannot remember, ask if there is a supervisor register signed when supervisors visit the facility. If yes, use this to help remind the health worker about supervision.

603 Supervisor activities: If the health worker cannot initially describe the activities of the supervisor you may probe using the list of possible supervision activities. For each activity circle the appropriate response.

a) Checking records and reports refers to looking at specific information this health worker is responsible for. This usually entails looking through patient register books or individual patient forms to see if they are appropriately completed, or to assess the information written and subsequent diagnosis and treatment.

b) The supervisor may use a checklist, or may sit in during a consultation.

c) Feedback on performance should be related to the individual health worker. If a supervisor comments on the documentation in the records and reports, comments on the care provided to a client, or comments on the work environment which the health worker is responsible for, the correct response is "YES". A superficial visit to a department with general comments to the staff does not count as a supervisory visit and also does not count as "feedback on performance". If the supervisor stopped and specifically spoke with the staff member about issues or problems, the answer is "YES" for the relevant question (603 answer c,d, or e).

d) Updates on administrative or technical issues might have been through personal discussion, or the provider might have attended a meeting called by the supervisor where administrative issues were discussed or technical aspects of the work such as changes in policies might have been discussed.

701 HEALTH WORKER OPINION

Do not provide any specific answers for this question. If the health worker cannot initially think of any response, you may provide general probes such as “surely there must be some issues where you would like to see changes made, or that you have thought of as problems which make your work less satisfying/prevent better patient care/etc.

Thank the health worker and reassure them again that the information they provided is confidential and will not be associated with their name when analyzed. Record the time.

703 COMMENTS

Write any comments which you think might be relevant when analyzing this information. For example, if you feel that the question and response did not capture the real situation (e.g. if numerous people interrupted the interview), or there is some special circumstance related to the health worker that might affect the interpretation of responses (e.g. if the particular health worker has just returned to work after an extended absence for training, maternity, or sick leave).

3. ORGANIZING THE OBSERVATION AND EXIT INTERVIEWS

A. Arranging the Interviewers

You will be observing consultations for the following types of clients:

- a) Children below 5 years of age who are ill. A child who has solely an injury or skin disease should not be selected.
- b) Family planning clients, both new and returning clients.
- c) Antenatal clients, both new and returning clients.
- d) Persons having symptoms of sexually transmitted infections.

In many facilities the client flow is as follows:

- 1) The client is registered by one provider.
- 2) A different provider takes various measurements (temperature, weight, blood pressure)
- 3) A third provider sees the client and discusses the symptoms, problems, advises. **THIS IS THE CONSULTATION, SO THIS IS THE PROVIDER AND THE INTERACTION YOU MUST OBSERVE.** The consultation is considered the interaction where questions are asked, advice given, and prescriptions are written. The provider being observed is the provider who gives the consultation service.
- 4) The provider may send the client to another location for laboratory tests, may refer the client to another provider, or may admit the client to the facility. Your observation ends at this point. The exceptions are where a procedure is conducted by another provider as a part of the consultation. For example if the antenatal client abdominal palpation is conducted by a different provider, you must still follow the client to observe the palpation. If an examination or procedure is conducted for the STI or FP client, you must follow the client to observe the procedure or examination.
- 5) After the client has completed all activities and is prepared to depart the facility, a member of your team will conduct the exit interview.

B. Specific issues for observations

Often the consultations for children and adults with STIs are in the same out patient service area. If this is the case, you must speak with the in-charge for that area to determine the best system for identifying eligible cases as they are seen. The interviewer in charge of observation must be ready to begin observations as soon as the service begins to see eligible clients.

Antenatal and family planning clients are often seen by different staff in different areas of a facility.

In a small facility determining how the observer will identify eligible clients will be relatively simple. In a busy facility, however, the different service areas may not be immediately next to each other and the observer will have to move between service areas of the facility.

Most often, the rarest eligible clients (and thus, the clients you will give priority to observing, when they arrive) are new family planning clients and clients for sexually transmitted infections.

The methodology for sampling for Observations is described in Appendix 3.

C. Exit Interview

At the close of the observation, the observer should ask the client if s/he will agree to participate in an interview. Explain that as a part of the facility survey it is important to talk to some of the clients and that it will only take a few minutes. If yes, provide the client with some means of identification that includes the Client Code (this system should be determined prior to beginning observations) as eligible for the Exit Interview. Providing the client with a blank exit interview (with the consent and client ID completed) may be a practical way to ensure that the client ID is consistent for the observation and exit interview. Explain where the client will find the interviewer. This should be near the final service location for the facility (usually the pharmacy). If possible a facility staff may be able to help direct the client to the exit interviewer. The pharmacy dispenser may be able to assist. Remember, it is essential that the same Client Code be placed on the Observation and the Exit Interview questionnaires so that the information can be linked.

4. OBSERVATIONS OF SERVICE DELIVERY

A. Overview of the Observation questionnaires

The purpose of observing the client-provider interaction is to gain a picture of the actual procedures that are carried out and the information sharing which occur during a specific consultation. This provides us some indication of the quality of services provided for the type of client being observed.

Observers for the delivery of health services should be persons who have both training, and experience, in providing the type of service being observed. In almost all cases this requires that the observer have, at minimum, a nursing or midwifery background. The observer must have excellent listening skills and have the ability to pay attention to detail during the observation. Whenever possible, observers should not be assigned to health workers who they know, and definitely should not be assigned to health workers who they supervise. The familiarity increases the potential for bias in the service provider and the observer responses.

The observations record whether the provider carries out client assessments or examinations in compliance with standards for the service being provided, as well as whether the information sharing between the client and the provider include elements identified as those important for quality of care. The questionnaires include the following components:

- (1) Cover Page
- (2) Client history
- (3) Examination of the client
- (4) Treatments provided
- (5) Elements of client counseling and education

The content of the observation questionnaire should not be shared with the provider. If the health worker knows what specific items you are to record during the consultation, this may influence the behavior, and bias the results. If the provider asks, you may simply indicate respond that it is a guideline for you, as the observer, so that you do not forget what happens during the consultation.

B. General Procedures for Completing the Observations

Client eligibility: The Team Leader (TL) should discuss with the in-charge and the provider the types of cases that will be observed and decide upon a system for identifying eligible clients. This is particularly important in facilities where there are multiple service delivery sites and multiple providers.

If, despite being selected, it appears the client does not meet the eligibility criteria for the service observation, verify eligibility with the team leader. If the client

clearly does not meet the criteria, or the TL verifies the client is not eligible, write a note on the questionnaire explaining why this is so and submit this questionnaire with completed ones. If the eligibility is questionable and it is not possible to confirm with the TL, continue the observation but write a note in the comment section at the end to explain why the client may not be eligible.

2) Consent: Prior to observing any consultation, the consent of both the provider and the client is required. The in-charge (or someone from the facility who is designated by the in-charge) should introduce you to the provider(s) who will be observed, or, if it is a large department, to the person in charge of the department. If more than one provider will be observed in a department it would be easiest (if possible) if the observation component is explained to all at the same time and a general consent sought from each. Ensure that if the facility uses different providers for the specific procedures to be observed, that consent is received from these providers as well. Circumstances may arise where a provider who has given general consent for observation feels an observation should be curtailed or is not appropriate (e.g. the provider needs sensitive information or needs permission for an examination and believes the client is not providing it because of the presence of the observer). Ensure that the provider knows that even with the general consent s/he may request that you not observe some individual cases.

Consent will be more likely if the provider is assured that this is in no way an evaluation of the provider, and that the information from the observation will only be used in an aggregate manner (e.g. describing characteristics of the particular service provision in facilities of this type). Explain that you will be taking a few notes during the consultation. Do not mention that you are observing for specific practices or the sharing of specific information between the provider and the client. Specifically mention to the provider that s/he should care for the client as if you were not there, and that you are not suppose to say anything or talk with the provider or client during the observation.

When obtaining the consent from the client, explain that you are a health professional, and that this observation is a part of a national survey of health facilities. Explain that the purpose of observing the consultation is to have a better understanding of the service provision system. Reassure the client that no personal information that is shared between the provider and the client is being collected, and that all personal client information will remain strictly confidential. Mention that you will be sitting near the service location to observe, but that you won't be talking or participating in any way in the service provision. It is important that the client be encouraged to allow the observation, but also that they do understand that they can refuse the observation if they wish.

The approach for obtaining the consent of the client should be discussed prior to beginning observations. It may be most appropriate that consent is obtained in the waiting area by an interviewer responsible for identifying eligible clients, or it

may be more appropriate for the provider to request the consent, if the provider is familiar with the client.

3) Observer behavior:

The observer should be discreet when noting down an observation.

Seat yourself near enough so that you can hear any discussion between the provider and the client, but so that you are not in direct eye-contact with either. The presence of the observer will influence the interaction between the client and provider by making both more self-conscious and aware of what they are saying and doing. To decrease this influence, try to sit and behave in a manner to minimize any attention being drawn to you. Keep the expression on your face pleasant, and neutral and do not say anything or indicate approval or disapproval of the consultation by your expression. This is particularly important if you see or hear things that you think are not correct.

c) It is important that during the observation you remain as unobtrusive as possible to minimize the influence your presence has on the quality of the consultation. Observers should avoid any actions that might distract the provider or the client. Thus, the observers should avoid clicking pens, shuffling pagers, making eye contact with the provider or client, speaking, or doing anything that may disrupt the interaction. If at any time during the session the observer is clearly distracting the provider or the client, or if the client asks the observer to leave, the observer should politely withdraw.

d) If there is a situation where you feel that for the safety of the client you must intervene, wait until after the consultation is completed, if it does not increase the risk to the patient. Then ask to speak with the health worker for a moment, and leave the area where the client is, to discuss the matter. Make a note on the questionnaire if this occurred.

4) Familiarity with the questionnaire: The observation questionnaires are designed so that the observer circles numbers or letters, or fills in a box to describe what is seen. Because there is no fixed order for each consultation, the observer must be familiar with the observation questionnaires so that whenever a particular action is carried out or issue discussed, s/he knows exactly where to mark the questionnaire.

5) Issues for accurate recording for the observation: Activities recorded as observed or unobserved may change as the session progresses. For example, a client may at first seem only to want “information and/or counseling” about family planning, but may decide to accept a family planning method for a first time, or the client may have come for follow-up on a method, and decide to switch methods. In a like manner, an action may occur out of sequence. For example, clients may be sent to a laboratory for tests prior to or at the end of a consultation. Also some information may be shared in an informal manner, such as a casual mention that “my child is eating well despite being sick”. For these reasons, the observer must be alert, watch the body language of the client and

the provider, listen to the tone of voice, and observe non-verbal communication such as a nod or shake of the head.

It is essential that the observer only mark what the observer herself sees or hears. Thus it is essential that she pay close attention to all discussion between the provider and the client. There will be activities that are on the observation checklist that will not be conducted because the items are not appropriate for the particular client. *Please note: A “NO” response is not necessarily bad. If the observed visit is a follow-up visit for an antenatal or family planning client, and the provider still asks “first visit” client history questions, this is actually not good care. This means either the provider did not look at the client health card, or the client does not have a health card, or the appropriate information was never documented on the health card.* Information from the health card must never be used to fill in the observation questionnaire. ONLY RECORD WHAT YOU SEE AND WHAT YOU HEAR.

The observer should circle the « YES » responses for observed events during the consultations and immediately upon completion of the consultation, circle the “NO” responses. A non-filled response indicates missing or unknown information and is not acceptable. After observing many interactions it becomes difficult to differentiate which client or provider a certain action or conversation is associated with. For this reason, at the end of each session, prior to the next observation, make sure that all items on the observation check list are complete.

Consistency is important to ensure the quality of the information. Discuss any situations that arise where it was difficult to determine the correct response so that as much as possible, the observers use the same criteria for interpreting events into responses on the questionnaires.

C. Definitions applicable across all observation service areas

Although most of the information on the cover sheet is the same as that on the Inventory Questionnaire, it should be completed again. This is to minimize errors in data entry.

Name of facility: Copy from sample list

Facility location: Write the most complete address possible for the facility.

Facility code: Refer to sample list with pre-assigned code number

Type of facility:

a) Referral Hospital is a 2nd line hospital (usually Regional or teaching hospital).
b) Hospital refers to a facility that routinely admits patients for overnight treatment. c) Health Center may have overnight beds, but these are for emergency, the facility does not plan or have staff for routine overnight patients.
c) Health Post may be a static facility in a village, or may be an outreach site. It would usually have few staff and limited services and the staff would usually be supervised by staff from a Health Center.

Verify with the in-charge the facility type that is stated beside the name of the facility on the sample list. If there is a discrepancy, enter the code that you believe is appropriate based on the discussion with the in-charge and note the reasons for making the change in the Notes section at the end of the Inventory questionnaire.

Operating authority: This is the type of organization that manages the facility and provides the primary supervision. Thus, if the staff are government, but management is a religious organization or NGO, the operating authority is the NGO or religious organization. Verify with the in-charge the Operating Authority that is stated beside the name of the facility on the sample list. If you find that the Type of Facility indicated on the sample list is different than what the in-charge states, write a note and enter the appropriate code.

PROVIDER INFORMATION

Provider category: Health Worker Category: The highest level of professional training the staff member has achieved.

Provider code: One provider will have the same code number for the Health Worker Interview and the Observation Questionnaire. Prior to leaving the facility, ensure that this Provider has been requested to participate in the Provider interview.

INFORMATION ABOUT INTERVIEW

Interviewer code: Record the number of the interviewer conducting the Observation.

Client code: Assign the Client Code according to the system explained during training. Ensure that this same Client Code is also used for the Exit Interview, if the caretaker/Client is interviewed.

Time interview started: Ensure that the time the interview starts is recorded immediately before asking for permission for the interview.

100 Provider consent: Explain the observation component of the survey to the Provider in the manner described during training. Then read the consent statement in the Questionnaire to the Provider. During subsequent observations

with the same Provider, it is sufficient to simply ask if it's ok to remain for the next consultation.

100b Client/Caretaker consent: Explain the observation component of the survey to the client/caretaker, or else ask the Provider to explain, in the manner described during training. Then read the consent statement in the questionnaire to the client/caretaker.

After receiving both consents, the observer should be seated near enough to hear the consultation and to see all actions, but also back enough that the client and provider will not be distracted or easily make eye contact. LISTEN AND OBSERVE. There are specific subjects that should come up during the consultation. It does not matter if the provider or the client raises the topic.

Physical Examination: In many facilities parts of the physical examination (e.g. measurements of weight, temperature, blood pressure) are taken by a different provider and at a different location than by the consulting provider. If the observer does not actually see the examinations being conducted for the client being observed, she cannot mark "YES" for the questions in the Observation Questionnaire. The information that these measures are taken prior to the observation will be collected during the Inventory section of the survey.

NOTE: If the system is such that a different provider takes various measurements (weight, temperatures, etc) before the consultations and the location is such that the observer actually sees the client being measured, "YES" may then be marked for those physical examination activities indicated in the questionnaire.

Looks at Health card: Where there is an individual health card, the Provider should look at the card (for past history, or for measurements taken in the facility prior to the consultation) either prior to or while talking with the caretaker. This may be the child's Road to Health Card, the pre-printed Antenatal or Family Planning card, or may be the general health card used by the facility. The main criteria is that the card provide a running history of health events and provider services for the same client, over time.

Visual aids:

The visual aids can address any issues related to service delivery. You must see these being used with the caretaker or client whose consultation is being observed.

Writes on health card:

This refers specifically to writing on an individual health card such as that described above. The observer should be able to identify that an individual health card is being used and notes on this illness or treatment prescribed written. This does not refer to plotting weight and does not refer to filling in a register.

C1. Detailed Instructions for Completing the Observation of Sick Child

100d Visit type: This refers to whether this is the first visit to this health facility for this illness, or if this is a follow-up visit. This information helps us to understand what information and procedures are relevant to this particular consultation.

101-104 ASSESSMENT OF THE SICK CHILD

101 Major symptoms: Each of the major symptoms (cough, diarrhea, and fever) should be assessed, regardless of the complaint(s). For example, if a child was brought in for a cough, the Provider should ask the caretaker whether the sick child has diarrhea and fever also. The principle of the IMCI approach is to ensure that a complete assessment of the illness(es) is made. If the Provider stops assessing when one symptom is found to be positive, the integrated management process is not complete.

Listen to the discussion between the provider and the caretaker for questions, comments, or discussion about the child's respiratory status, diarrhea, fever or body hotness.

102 General danger signs: After establishing the presence or absence of major symptoms, the provider must assess for general danger signs (GDS). General danger signs include being unable to eat or breastfeed, vomiting everything, and convulsions during the current illness.

The questions about eating or drinking, and vomiting, may be related. The issues being assessed are whether the child is taking anything by mouth and whether any of what the child takes stays inside. Comments on changes in breast feeding or eating habits, any comment which may indicate the child eats some, but less, the child vomits "sometimes" all provide information which clarifies if the child is eating or drinking at all, or vomiting everything or not. A convulsion may be referred to by symptoms or a local term. It does not matter whether it is a reported incident that occurred at home, or it took place in the facility on the day of the consultation. If at any time during the consultation, the provider asks, or the client mentions something to clarify the child's status with these symptoms and the current sickness, circle yes for the relevant topic. If the topic is not addressed, circle no. If uncertain if something said counts or not, write a note with the comments in question so that you can discuss the question with the team leader. It is important that the decisions for what counts and what does not count when the discussion is vague, be consistent for all observations. Therefore, when decisions about what is a "yes" or "no" for the different topics are made, these should be shared between the teams so that each time this arises the same decision (yes or no) is made. On the other hand, if you remain uncertain after discussion with the team, or did not hear or see how the provider performed a task, circle "8" ("DON'T KNOW").

103 Physical examination: Watch for each component of the physical examination. In some facilities, all sick children are weighed and temperature taken (and sometimes respirations) during registration or at another location, prior to seeing the main provider. If this is the situation in this facility, this will be indicated in the inventory section of the SPA.

If these services are provided by the observed provider, the following should be considered:

- a) Counting respirations should be obvious as the provider must be quiet and observe the child breathing and should show some indication of measuring time.
- b) Checking for dehydration must be specific where the abdomen is pinched to observe the skin turgor. Use the following points when deciding whether the provider checked the skin turgor. If the provider performed a skin pinch, but you think s/he did it incorrectly, circle "NO" but write a note on the remarks section on the questionnaire.

The child should be placed on the examination table, flat on his/her back. The arms should be at the sides and the legs straight. The pinch site should be halfway between the umbilicus and the side of the abdomen. The provider should not use fingertips when performing the pinch as this will cause pain. In addition, the skin fold of the pinch should be vertical (in line up and down with the child's body).

- c) Checking for pallor by checking the palms or the conjunctiva, again, must be a specific act. If the Provider turns the palms upward and looks at them or compare the color with that of the provider of the caretaker, this would count as a "yes". When checking the conjunctiva or mouth, the Provider should pull down the lower lid for the eye or specifically be looking into the mouth. Without a specific action, it's unlikely anemia was checked for.
- d) If the child is weighed with the main provider, you should be able to see the weight being plotted on the card. In some facilities this is conducted prior to the consultation. If this is the case, this will be assessed in the inventory component of the SPA.

104 Other assessments:

- a) This Observation is intended to confirm whether a child is unable to drink or breastfeed, one of the signs of severe dehydration (lethargy or unconsciousness). The child is not able to drink if s/he cannot take the fluid in the mouth and swallow it, or in case of young infants, the child may not be able to suck or swallow. It may also tell us whether the child is thirsty, one of the signs of dehydration. Thus, if the mother breast feeds (or attempts to breast feed) during the consultation, circle "1" for yes. Also, if the Provider offers the child something to drink, or gives a dose of medicine and the child takes the liquid,

circle “1” for yes. If anything is swallowed by the child during the consultation, circle 1 for yes.

b) The Provider should inquire as to the normal feeding practices when the child is not ill. Such inquiries include: frequency of breast feeding (in children <2 years of age), whether the child takes complementary foods, type of food, and frequency.

c) The Provider should inquire as to the feeding practices during this illness. The discussion may be what was eaten “today”. This may involve inquiring whether the child is eating/drinking more or less than normal.

d) Weight: The Provider would observe the Growth Card (“Road to Health” most often) and might comment that the child is doing fine, or might mention that the child needs to be fed more, without actually mentioning the weight. If, after observing the card some discussion which relates to weight and growth takes place, “1” for yes may be circled.

e) Immunization: Observe the actions of the Provider. Often the immunization information is included on the growth chart. Observe whether the Provider looks at the immunization section, or if the immunization card was not brought to the consultation, if the Provider asks the caretaker about the numbers of different vaccines which the child has received.

105-109 CONSULTATION AND TREATMENT

105 Advice:

a) General feeding recommendations during sickness and health: This would include general comments which indicate that current practices are good, or comments indicating that at a certain age the caretaker should begin adding nutrients (specifying certain types of food) or increasing the number of meals per day to keep the child healthy; or that a child of this age needs to be fed actively to be healthy, etc. In IMCI settings, providers should use the “Food Box” to give individual feeding advice.

b and c) Extra fluids and food: All sick children must be given extra fluids- including breast milk- and food. The Providers are expected to advise caretakers to increase fluids and continue feeding during the illness. If the child is exclusively breast fed, and the Provider advises the caretaker to encourage breastfeeding more frequently during this illness, “1” for yes may be circled. If the caretaker mentions giving extra fluids or still feeding the child during the illness, the Provider should make some comment indicating this is good. Or else the caretaker should specifically comment on encouraging fluids and food, encourage the caretaker to give more of the foods the child will take, etc.

d) The Provider should indicate to the caretaker either the name of the illness, or the general type of illness and whether it is serious or not (e.g.

indicating that the child has a serious breathing problem, without specifically stating “pneumonia” may still count as a “YES”).

e) Signs and symptoms for IMMEDIATE return: The signs and symptoms that may be mentioned will vary according to the current symptoms and the illness. For any sick child, however, the Provider must advise the caretaker to immediately bring the child if s/he is not able to drink or breastfeed, becomes sicker, or develops a fever. Other warning signs that warrant immediate return are fast breathing, difficult breathing, blood in stool, and drinking poorly. Any one of these would be sufficient for a “YES”. There may be other warning signs that may vary depending on the classification of the current illness. If the caretaker is told another emergency care location to go to with certain symptoms, this would also count as a “YES”.

106 Referral of client elsewhere: Listen for if the provider explains to the caretaker or the child why the child is being sent to another health worker or the type of laboratory test. A simple explanation that “we want to check your blood to see why you have fever” is sufficient. It is not necessary to give the technical name of the test.

107 Medications:

a) Explanation: the Provider should explain how frequently and how much of each medication to give the child, for each which is provided or prescribed. If the Provider states “the pharmacist will explain this” the response is “2” for “NO”.

b) Providing the first dose: This is not applicable if no oral medication were prescribed. If uncertain whether oral medications were prescribed or not, the answer is “2” for “NO” (since it is certain the Provider did not provide the first dose). *Note: This refers to the first dose of prescribed medications. Giving emergency ORS or paracetamol for acutely symptomatic children is not considered giving the first dose.*

108 Visual aids:

The visual aids can address any issues related to child health or illness. You must see these being used with the caretaker of the child whose consultation is being observed.

109 Child health card:

Write on child’s card: This refers specifically to writing on an individual child health card. This may be the “Road to Health” or growth card, if there is a section where each individual child illness is commented on. The observer should be able to identify that an individual child health card is being used and notes on this illness or treatment prescribed written. This does not refer to plotting weight and does not refer to filling in a register. If no individual child card is used to record illnesses, “3” “NO CHILD HEALTH CARD USED” is the appropriate response.

109 Outcome: This refers to the final disposition of the child from this sick child service. If the child is seriously ill, the Provider may not take time to diagnose, but may immediately refer the child to a higher level facility or admit the child. If the child is sent to a higher skilled Provider within the facility for outpatient diagnosis and treatment, this is still considered a referral.

201-203B CLASSIFICATION AND TREATMENT FOR THE SICK CHILD
This section assesses whether the Provider followed IMCI protocols based on findings during the assessment of the child.

The observer should ask the Provider the specific question listed for each symptom. Even if the observer thinks that the response is obvious, the opinion of the provider is what we are seeking, not the opinion of the observer. Thus the question must be asked.

For example: Ask “Did you think the child had any problem with coughing or difficulty breathing? “ If yes, then ask “What is your classification/diagnosis for the cough?”. If the provider does not give an answer relevant to those in the questionnaire, write the exact word/phrase of his/her classification in “other” coding, and circle “X”. For example, if the provider tells you his/her classification/diagnosis for cough or difficult breathing is upper respiratory tract infection (URTI), you should write “URTI” under “OTHER”, and circle “X”.

Then ask about the medications which were prescribed or given, and circle the correct response.

Probe in a similar manner for the questions on diarrhea/dehydration and on fever.

C2. Detailed Instructions for Completing the Observation of Family Planning Client

101-103 ASSESSMENT OF CLIENT

101 Previous contact: We are looking for previous contact for services from this family planning clinic. If the client has had previous contact with the provider, the provider may or may not discuss all of the items in the session. Where integrated health services are provided, the client may have had contact for other services (such as curative or immunization). This does not count as "contact". If either the client or the provider states (directly or indirectly) that they have had previous contact, mark the correct box. If you are unable to ascertain if they have had previous contact mark "not determined". Indirect comments that indicate previous contact might refer to a previous appointment, or knowledge about a previous problem or issue related to a family planning method.

102 Reproductive history: These questions may not be asked if this is a follow-up visit. The information on the subject may also be discussed without a direct question or statement being made by the provider or the client. The observer must listen carefully to see if any of these issues arise during conversation.

- a) **Age**: The client may either state her date of birth or her age as a number. It is not important if her exact age is mentioned. If approximate age is discussed during the session, this is a "YES".
- b) **Number of living children**: The provider may ask the client how many children s/he has, or the topic may arise naturally when discussing a suitable contraceptive method. A client with children living in a different household is still considered to have living children.
- c) **Last delivery**: Either the approximate date the woman last gave birth, the approximate date of her last pregnancy termination, or the age of the youngest child (if the child was the last delivery) are acceptable.
- d) **Pregnancy complications**: Questions about specific or general complications with previous pregnancies, that might indicate a health risk from pregnancy and thus a need for highly effective contraceptive methods.
- e) **Current pregnancy status**: Specific questions to ascertain if the client is (or could possibly be) pregnant now or not. Any indication that the client is menstruating indicates she is not pregnant.
- f) **Desire for more children**: If the client has no children, mark if the question of whether s/he wants any children or not is discussed.

- g) Timing of next child: Mark “8” for “NOT APPLICABLE” if the client indicated a desire for no more children.
- h) Breastfeeding status: Any discussion of current breastfeeding practices.
- i) Regularity of menstrual cycle: Did the provider question the woman regarding regularity?

103 Health/physical exam:

If measurements (blood pressure and weight) are taken by a provider different than the one providing the consultation services, the observer may mark “YES” if she sees the measurements being taken on this client. If she does not see this, the information will be captured in the Inventory Questionnaire that the facility does routinely collect the measurements prior to the consultation.

- d) Symptoms of STIs: The provider would normally ask about symptoms such as abnormal discharge or painful urination.
- e) Chronic illness: The provider might ask about specific chronic illnesses or a general question about health problems. Questions might be asked about heart problems, blood pressure problems, diabetes, and respiratory illness.

Note: Where pre-printed family planning client cards are used much of this information is on the cards. The observer must not collect any of the observation information from the cards. The only source of information for the observation is what the observer sees and hears herself.

104-109 CONSULTATION AND TREATMENT

104 Counseling:

- a) Visual privacy: This may be achieved with a screen, a curtain, or a private room. If people walk in and out of the private area, this is not achieving visual privacy.
- b) Auditory privacy: This is achieved if the discussion between the client and the provider cannot be overheard. Visual privacy achieved with a curtain or screen may not provide auditory privacy if people are located near the barrier.
- c) Confidentiality: The provider should explicitly indicate that all issues discussed are confidential between the provider and the client.
- d) Encourage questions: This may include asking explicitly if the client has questions as well as general comments verifying if the client understands issues which were discussed.

Partner characteristics: This topic address potentially sensitive topics. As a result, both the provider and the client may discuss these issues indirectly or in a

subtle manner. Be sure to pay attention to subtle cues that indicate that these topics have been addressed.

e) Partner attitude toward FP: Any discussion related to whether the partner has any opinions on the method, side effects, or anything else which indicates that there has been consideration of the partner opinion with regards to the method, Even if the response is that the client does not want the partner to know or has not yet discussed this with the partner, this is still recorded as “YES” as the issue has been addressed.

f) Partner status: Discussion of specific issues related to the partner (multiple partners; partner having multiple partners; frequency of partner absence) which may affect counseling about which method to use, would count as “YES”.

g) STIs: Risk of STIs should be discussed with all clients, regardless of personal or partner characteristics. This may include characteristics which make someone at higher risk for an STI, information on HIV transmission, information on of symptoms of STIs.

h and i) Condoms: The role of condoms in preventing transmission of STIs should be discussed with all clients regardless of personal or partner characteristics. If the client is using another method, the provider should still encourage condoms as a second method.

105 Method used: Indicate which method(s) the client was prescribed at the end of the visit.

106 Method specific information: There are specific examinations and information required to safely prescribe or continuously use different methods of family planning. Some of these issues would be discussed generally, prior to discussion of a method, and some only once a method is determined. For all method(s) prescribed/provided indicate if the items related to that method(s) were discussed.

107 Individual client record: Where there is an individual health or family planning card, the Provider should look at the card (for past history, or for measurements taken in the facility prior to the consultation) either prior to or while talking with the client.

108 Visual aids: The visual aids can address any issues related to family planning, or related topics (e.g. STIs or HIV/AIDS). You must see these being used for the client whose consultation is being observed.

109 Return visit: This may be a specific date, or may be instructions to the client to go to a registration department to establish a return date, or

providing the client with information on when they should make another appointment or return.

201-205a ELIGIBILITY FOR OBSERVATION:

201 Procedure conducted: Indicate which procedure, if any, was carried out.

202-205 Provider consent and information: Complete this information only if the provider conducting the procedure is different from the provider conducting the screening and counseling.

206-209 OBSERVATION OF PROCEDURES

The following definitions apply for all procedures:

Visual Privacy: The client should be screened from view by others. This may be achieved in a private room, or using a curtain or screen. If persons, including other Providers came in the area during the procedure, the client did not have visual privacy.

Auditory Privacy: A normal conversation between the client and provider should not be overheard. If the privacy is achieved using a screen or curtain, ensure that people are not sitting or remaining near enough on the other side to overhear conversations.

Wash Hands: For all procedures the provider should wash their hands with soap prior to beginning the examination/procedure with the client. This includes washing the hands prior to gloving. They should then also wash their hands with soap AFTER removing gloves.

Wipe contaminated surfaces: The table where equipment was placed as well as the examination table (if there is no individual paper or cloth cover) should be wiped with a chlorine solution immediately after this client leaves. If it is left for someone else to do later, the correct response is "NO".

Decontaminate: The speculum, scalpel blade, and other reuseable items which may have come in contact with vaginal secretions or blood must be placed in a chlorine bleach solution immediately upon completion of the procedure. If items are left on a table, or in a dry basin for someone else to remove, the correct response is "NO".

206 Pelvic Examination:

3) Prepare Instruments: When the exam starts, all the equipment should be within easy reach of the provider. If the provider must leave the client to get an instrument or supplies, mark "NO".

5) Instruments: The instruments should either be in a sealed cloth with tape indicating autoclave, or stored in a metal box with a clasped lid. If the speculum or other equipment is sitting in a solution, or stored in an open container, the correct response is “NO”.

6) Gloves: The gloves should either be one-time used clean gloves which the observer sees the provider pulling from the box, or disinfected gloves which are stored in a closed container with a clasp.

7-9) Procedures: Observe and listen. To inspect the external genitalia there must be full exposure.

10) Inspect cervix: For a “YES” response, this speculum must be in place and a spotlight aimed inside the inserted speculum.

11) Bimanual exam: A bimanual exam is conducted with fingers from one hand inside the vagina, and the other hand used to palpate the uterus from the abdomen.

207 IUD Insertion:

3) Reconfirm method: Prior to beginning any procedures, the provider should at some point mention that the client is going to have an IUD inserted so that it is clear the client understands that this is the procedure she is to undergo.

4) Instruments: The instruments should either be in a sealed cloth with tape indicating autoclave, or stored in a metal box with a clasped lid. If any of the instruments are sitting in a solution, or stored in an open container, the correct response is “NO”.

6) Sterile gloves : Sterile gloves are either in a one pair per packet sealed packet, or if reused, the observer must verify that HLD procedures including storage were carried out. Clean gloves taken out of a bulk-single glove box are not sterile.

7) Speculum exam: This must include using a spotlight to look inside the speculum. The procedure must be conducted prior to the bimanual examination.

8) Bimanual exam: A bimanual exam is conducted with fingers from one hand inside the vagina, and the other hand used to palpate the uterus from the abdomen.

9) Visualize cervix during cleaning: For a “YES” response, this speculum must be in place, a swab with disinfecting solution must have been inserted for cleaning the cervix, and a spotlight aimed inside the inserted speculum after the cleaning.

- 10) Tenaculum: The tenaculum is inserted through the speculum prior to inserting the actual IUD.
- 11) Sound the Uterus: The uterine sound is inserted after the tenaculum, and then is removed after evaluating depth.
- 12) No touch technique: The IUD will be placed inside an inserter barrel using sterile technique. The IUD should not be removed from the insertion tube before placing it in the uterus.
- 14) Wait: The client should be made comfortable either lying down or sitting and should remain at least 15 minutes after insertion.

208 Injection Method:

- 1-3) Verification: If the person who gives the injection is the same person who consulted with the client, the correct response is “YES” for each of these issues which was verified during the consultation. If the injection is provided by another person, that person must verify that the client is aware that the injection is for contraception, and that the client is certain she is not pregnant or that the injection is being provided at the correct time.
- 5) Sterile needle and syringe: Verify that needle and syringe are either new (with the packets opened in front of the client and observer) or else sterilized (removed from a sterile, dry, clasp-closed metal box) opened in front of the observer.
- 6) Remove needle: If there is a needle in the vial, or the provider leaves the needle in the vial, the correct response is “NO”. It is often a (very poor) practice to leave the needle in the vial to prevent having to poke the rubber each time an injection is provided. This leaves a direct opening for contamination.
- 7) Sir/Mix: The provider should ensure that the solution is mixed by tipping the vial back and forth or gently shaking and then looking (to see that the solution is mixed).
- 8) Injection site preparation: A cotton swab or gauze with alcohol (or sterile water) should be used to clean the area where the injection will be given. The site must be left for 15-30 seconds so that it dries before injection.
- 9) Draw back plunger: The observer will see the provider insert the needle and then stabilize the syringe while briefly withdrawing. This is to ensure that the needle is not inserted into a vein. If there is no indication of hesitation between inserting the needle and pushing the medication, the plunger was not drawn back.

10) No massage: The provider may gently wipe the injection site to remove blood or liquid, but if the site is rubbed firmly, the correct response is “NO”.

11) Disposal of needles: The needle must be put into a sharps box and the syringe either in a decontamination solution or thrown away.

209 Norplant:

1) Verify: If the same provider verified non pregnancy during consultation this is acceptable. If the provider inserting the Norplant is a different person, this provider must verify with the client that she is not pregnant prior to commencing the procedure.

4-5) Instruments: The instruments should either be in a sealed cloth with tape indicating autoclave, a sealed manufacturers package, or stored in a metal box with a clasped lid. If any of the instruments are sitting in a solution, or stored in an open container, the correct response is “NO”. The instruments should be laid out on a sterile cloth, using sterile technique.

7) Sterile gloves: Sterile gloves are either in a one pair per packet sealed packet, or if re-used, the observer must verify that HLD procedures including storage were carried out. Clean gloves taken out of a bulk-single glove box are not sterile.

8) Clean skin: The skin where the incision will be made should be cleaned with an antiseptic and allowed to dry.

9) Local anesthetic: The anesthetic will be injected at the insertion site. Several minutes should be allowed between giving the anesthetic and inserting the norplant. The norplant insertion should only be mildly uncomfortable. If the client indicates moderate or severe pain, the correct response to this question will be “NO”.

10) Individual Card: Observe that the woman is provided a card and that the provider has indicated to her the written date when the implant is completed.

11) Incision care: The provider must give some explanation to the client about how long the bandage should remain, and how to care for the site until the incision is completely healed.

12) Disposal of sharp items: The blade from the scalpel must be put into a sharps box.

301-307 FAMILY PLANNING STATUS

301-306 Client status: The correct response to these questions may become apparent at various times during the course of the consultation and examination.

302 Principal reason: If it is time for re-supply or routine follow-up, but the client also has a problem with the method, most often the principal reason (the reason she came today and not previously or later) for the visit will be “1” “FOR RE-SUPPLY”.

307 Write on client card: This refers specifically to writing on an individual client card. This may be a special family planning card or a more general client health card/chart. The observer should be able to identify that an individual card is being used and notes on this consultation are written.

C3. Detailed Instructions for Completing the Observation of Antenatal Care Client

101-104 ASSESSMENT OF CLIENT

101a Visit status

Whether or not this is the first visit for this pregnancy is important for analysis purposes. Many items in the history and counseling only are asked or occur once during the pregnancy. Most often this is during the first antenatal visit.

101b Prior pregnancy: Whether or not this is the first pregnancy (regardless of whether a prior pregnancy spontaneously aborted or not) for this woman is important for analysis purposes. Many items in the history are not applicable if the client has not previously been pregnancy.

102 Client history:

a) Age: The client may either state her date of birth or her age as a number. It is not important if her exact age is mentioned. If approximate age is discussed during the session, this is sufficient for "YES".

b) The Provider should try to determine the exact date. If the woman does not know exactly, but the Provider attempts through various questions to determine an estimated date, even to the week, this is sufficient for "YES".

c) Number of prior pregnancies: The provider may determine this in different ways. If the information gathered includes the number of living children, any stillbirths, miscarriages, or abortions this is sufficient for "YES".

d) Prior stillbirths: The provider may ask about a child who dies in the womb or who never takes a breath.

e) Infant death first week: The provider may ask about any child who took even one breath before dying.

f) Prior history of heavy bleeding: This may be determined through general questions on complications or problems. If the client mentions bleeding so much she needed a blood transfusion, or required treatment for bleeding, this is sufficient for "YES". If there is no mention of bleeding when asked generally about complications or problems, the Provider must specifically ask about bleeding for this to be marked "YES".

g) Previous assisted delivery: If the client does not mention this, the Provider must specifically ask about difficulty delivering and use of equipment such as the ventous, forceps, or c-section.

103 Symptoms this pregnancy: Each of these questions should specifically either be queried by the Provider or mentioned by the client. A general question on problems is not sufficient for “YES”.

- a) Bleeding: Each ANC visit the client should be asked specifically about any spotting or bleeding.
- b) Current medications: Usually this would be asked only the first visit.
- c) Baby movement: If movement of the baby is mentioned at any time (including the Provider noticing this while palpating the abdomen) this is sufficient for “YES”. If the client specifically mentions that she has not yet felt the baby move, this is also sufficient for “YES”.
- d) Other problems: The Provider should encourage the woman to describe any worries or symptoms related to the pregnancy.

104 Physical examination: If measurements (blood pressure and weight) are taken by a provider different than the one providing the consultation services, the observer may mark “YES” if she sees the measurements being taken on this client. If she does not see this, the information will be captured in the Inventory Questionnaire that the facility does routinely collect the measurements prior to the consultation.

- b) and c) The client must be lying flat for either of these examinations to take place.
- d) and e) These tests must be specifically mentioned for a “YES” response.
- f) Individual client record: Where there is an individual health or family planning card, the Provider should look at the card (for past history, or for measurements taken in the facility prior to the consultation) either prior to or while talking with the client.

Note: Where pre-printed antenatal care client cards are used much of this information is on the cards. The observer must not collect any of the observation information from the cards. The only source of information for the observation is what the observer sees and hears herself.

105-113 CONSULTATION AND TREATMENT

105 Iron tablets: If the Provider indicates that the client has already received iron and ascertains that she still has a supply, this is sufficient for “YES” for 105a.

106 Tetanus Toxoid: If this is not the first visit, the Provider may ask the woman if she received the tetanus toxoid as prescribed previously. If the

Provider or woman indicate that either tetanus toxoid has already been received twice during this pregnancy, or else a booster injection has been received during this pregnancy (in addition to prior tetanus toxoid injections), this is sufficient for "YES".

107 Anti Malaria medication: Most often Chloroquin or Fansidar (sulphadoxine/ pyrimethamine).

108 Advice:

c) Information on progress of pregnancy: This may be any general comments indicating the Provider's assessment of the pregnancy.

109 Plans for delivery: Any indication that these issues have been discussed previously (e.g. "Have you selected who will conduct your home delivery?"; "Have you already purchased the items we spoke about previously, that you will need for the delivery?") are sufficient for "YES".

113 Visual aids: The visual aids can address any issues related to pregnancy, childbirth, care of the newborn.

114 Write on client card: This refers specifically to writing on an individual client card. This may be a special antenatal care card or a more general client health card/chart. The observer should be able to identify that an individual card is being used and notes on this consultation are written.

C4. Detailed Instructions for Completing the Observation of STI Client

101-109 ASSESSMENT OF CLIENT

101 Confidentiality: At some point during the consultation, the provider should explicitly reassure the client that any information shared during the consultations and any diagnoses are confidential and will not be discussed or shared outside of the facility setting.

102 Consultation:

- a) Symptoms: The provider might just ask for general symptoms. Specific questions which might be asked include questions about such symptoms as discharge, asking to describe the discharge; abdominal pain; pain with urination.
- b) How long: Quantifying how long the symptoms have been present.
- c) Recent sexual contacts: This may be a sensitive question so may be asked indirectly or alluded to.
- e) Relationship status: This also may be a sensitive question and, again, the observer should listen to see if there are indirect allusions or questions relating to the client or partner having multiple or high risk partners.

103-104 Examination of external genitalia:

e) The provider should fully expose the external genitalia. A female client should be lying down, a male client would be exposed from the waist to the knees. Follow the same instructions and definitions as those in Family Planning Observation (Question 206).

105-106 Pelvic examination:

Follow the same instructions and definitions as those in Family Planning Observation (Question 206).

107-108 Laboratory Tests: Indicate which types of tests were discussed with the client.

109 Informed Consent for Laboratory Tests: If the provider suggested a laboratory test, indicate if it was mentioned that this was for a sexually transmitted infection (either by the name, or more generally as a sexual infection). If a specimen was taken (most often a specimen of discharge) with no discussion that it was being taken or for what reason) the correct response is "NO". If simply "infection" was mentioned this does not count as an informed consent.

110-117 CONSULTATION AND TREATMENT

110 Diagnosis: It is not necessary that the exact name of the diagnosis be provided, so long as it is explained that it is a disease transmitted through sex.

111-112 Treatment: The provider must explicitly mention that the full course of medications must be completed, even if the client feels well.

113 Partner notification: The client may have been told to bring the partner or may have been asked if they wanted the facility to contact the partner.

114 Follow-up date: This can either be a specific appointment, or instruction to return after ____ many days.

115 Visual aids: The visual aids can address any issues related to STI transmission, symptoms, or prevention including HIV/AIDS or use of condoms. You must see these being used for the client whose consultation is being observed.

116 HIV/AIDS: The provider must have explicitly mentioned HIV/AIDS.

117 Counseling on prevention: Demonstration of how to put on a condom would include using some visual aid or model.

118 Write on client card: This refers specifically to writing on an individual client card. This may be a general client health card/chart. The observer should be able to identify that an individual card is being used and notes on this consultation are written.

5. CLIENT EXIT INTERVIEWS

A. Overview of the Exit Interview questionnaires

The Exit Interview questionnaires are designed to collect information, from the client perspective, about the client-provider interactions in each of the designated services. These are:

- (1) Exit Interview for the caretaker for sick child
- (2) Exit Interview of antenatal care client
- (3) Exit Interview of family planning client
- (4) Exit Interview of STI client

The exit interview ascertains the client perception of information shared and advice received. It also collects information on the opinion of the client about common areas of complaint when receiving services. The questionnaires include the following components:

- (1) Cover Page
- (2) Client history
- (3) Understanding of examinations, treatments, and advice received
- (4) Client satisfaction
- (5) Personal Characteristics of the client

B. General Procedures for Completing the Exit Interviews

The exit interviews will be conducted with all observed clients. The location for conducting the exit interview should be quiet and provide auditory privacy. There should be a seat for the interviewer and the for the client. The exit interview will be conducted after the client has completed all steps at the facility.

- 1) Definitions applicable across all exit interviews:

FACE SHEET

Follow the same instructions as those for the Observation modules.

201-305 CLIENT SATISFACTION AND PERSONAL INFORMATION

201 Waiting time: If more than one hour you may have to estimate. Probe to try to come the most reasonable estimate if uncertain. "DON'T KNOW" should only be used if a reasonable estimate cannot be made. Reasonable estimate refers to within 30 minutes if the wait was at least more than 1 hour.

202 Opinions of Client

Read each item and if the client cannot respond readily, probe a bit to help understand whether the issue existed at all (if it was not an issue at all “NO” is the correct response); if it seriously concerned the client (“BIG”), or if the client noticed, but it did not greatly concern him/her (“SMALL”).

203 Pre-pay: This would include any official status for exemptions or discounted prices. Country-specific adaptations may be required.

204 Total amount paid: You may have to assist in adding if money was paid in different locations. Specifically ask about any tips or extra payments which were made unofficially. These should be added as well.

205 Prior visit: This question will help us to understand responses.

301 Age: If uncertain, make a reasonable estimate based on known events in the country. Don't know is only appropriate if the age cannot be estimated within 5 years.

302-304 Schooling: These questions will contribute to the understanding of the responses.

C1. Detailed Instructions for Completing the Exit interview for the Caretaker of the Sick Child

COVER SHEET

Sex of caretaker: The sex of the caretaker will be used to see evaluate differences in counseling for caretakers of different sex.

101 Name of child: Write the name the family calls the child, and in subsequent questions refer to the child by name, as a courtesy and to help make the interview more personal.

102-102a Age: Determine the child's age either by birth date or age in months. Over two years of age, the months are less important. If the caretaker is uncertain of the child's age, attempt to figure out the age using seasonal or country events (e.g. "was the child born before or after the beginning of the last rainy season").

103-104 Primary symptoms(s): The objective is to determine if the child had symptoms which are critical in following the IMCI diagnostic and treatment protocols. Circle "1" for "YES" for any symptoms indicated in 103 or 104 which the child had.

105-107 VISIT FOR SAME SICKNESS:

105 Prior visit same sickness: This question refers to the current episode of sickness and to this specific facility. If the child had the same symptoms previously and was cured, and now has the sickness again, the response is "2" or "NO". This may help us to understanding the observation component since the provider may respond differently if this is a follow-up visit, or a return because the child is not responding to earlier treatment.

106 Time of visit: The day of the interview counts as day # 0. A reasonable estimate is sufficient. "DON'T KNOW" is only the correct response if the caretaker cannot provide any reasonable estimate.

107 Days ago sickness started: The day of the interview counts as day number "0". You may need to probe to help the respondent. "DON'T KNOW" is only the correct response if the caretaker cannot provide any reasonable estimate.

108-111 WHAT CARETAKER REMEMBERS PROVIDER EXPLAINING:
The responses to the following questions refer to the perception of the caretaker. People sometimes forget events when asked about them outside of the specific context or if they were preoccupied during the consultation, but with probes can be reminded. Unless indicated, never read the possible responses that are written, but rather attempt to probe more generally.

108 Name of illness: The caretaker does not need to know the medical name. If the caretaker is uncertain, probe for whether the provider explained anything about the illness. If the caretaker explains s/he was told the child has “severe lung illness” or something similar, this is sufficient for “YES” IF the caretaker indicates s/he considers that s/he was told what the illness was. If the caretaker explains something like “I think there’s a problem with the lungs, but the provider didn’t say anything” the correct response will be “NO”.

109 Action if child not better: If the caretaker says s/he doesn’t know, give general probes to elicit some response. E.g. “yes, but supposing the fever continues, would you try to get another treatment? If yes, from who or from where?”

110-111 Provider advice: For this question, if the caretaker does not know, probe in general for symptoms the provider said to return for, but do not read any of the specific responses. You might ask “were you told if after a certain time there was still any symptom you should come back? If yes, what symptoms did the provider tell you about.

112-116 MEDICINES

112-113 Prescribed medicines: The interview should take place after the caretaker has collected any medicines from the pharmacy or received any injections. Ask to see all medicines that are with the caretaker, and ask to see any prescriptions that have not yet been filled.

114 Explain about medicines: If the caretaker is uncertain, probe for whether the pharmacy explained how many and how often each medicine is to be taken.

115 Knowledge about giving medicines: Accept the response of the caretaker.

116 First dose: This refers to oral medications, including oral rehydration solution, that were prescribed for home treatment. If the child received an injection at the facility, this does not count.

117-120 PREVENTIVE INTERVENTIONS

For the below, it may be necessary to probe to remind the caretaker how the questions might have been addressed during the consultation.

117-118 Normal feeding patterns: Probe specifically to ascertain if any breast milk, any supplemental liquids for breast milk, or any solid food are provided if the caretaker does not mention these. Asking this question prior to asking if the provider asked about normal feeding patterns may help the caretaker remember. If the caretaker cannot remember or is uncertain, probe

specifically for whether the provider asked any questions about the child's eating when not sick.

119-120 Weighing: If weighing is carried out prior to seeing the provider for the illness, the explanation might have occurred there. A probe might include asking if the caretaker was told that the child is growing big; or is big or small for the age; or some comment similar to this.

121 Feeding during this illness: If not mentioned, probe specifically to ascertain if the child is eating more, the same, or less than normal.

122-123 Advice on feeding: If the caretaker cannot remember or is uncertain, probe in general, without reading the written responses. For example "The provider didn't mention anything about feeding/providing breast milk while your child is sick"?

124-128 IMMUNIZATION

125 Immunization today: It may be necessary to clarify whether an injection or OPV was a treatment or an immunization. If there is a question, this may be clarified by probing what the provider or person giving the drops/injection said it was for; or by clarifying where in the facility the drops/injection was provided (if the facility provides immunizations in a different location than treatments), or by asking to see the health card (even if the immunization card is not present).

C2. Detailed Instructions for Completing the Exit Interview with the Family Planning Client

101-103 CLIENT FAMILY PLANNING HISTORY

101 Current status: If the client indicates yes, but had stopped because of a problem, the correct response is “NO”.

102 Past six months: If the client hesitates, probe. Even one time attempting rhythm or using a condom counts as a “YES”.

103 Last use: If the client has indicated trying different methods, clarify that you are interested in which method was used the very last time a method was used.

104-106 PROVIDER

104 Provider ask: If the response is “NO” probe to ensure that the provider did not ask in other ways (e.g. have you had any problems with bleeding; is there any problem with side effects; etc). If the client is not having problems s/he might forget that the provider attempted to elicit any issues with the method and immediately respond “NO”.

106 Advice from provider: If the advice was that the problem would resolve, or not to worry, this is sufficient for a “YES” response.

107-113 METHOD CHOICE

107 Visit outcome: “3” is the correct response if the client left without planning to utilize a method.

108 Decision prior to visit: Even if the decision was to stop a method and not to continue family planning prior to the visit, the correct response will be “YES”.

109 Decision for new method: This question is for clients who have not used a method during the prior 6 months.

112 Methods discussed: After the response, probe (without mentioning specific methods) to ensure that all methods which were discussed are mentioned.

113 Method received: After the initial response, probe to ensure that if two methods were decided upon (e.g. natural plus spermicide) that both have been mentioned. REC indicates that the client actually has the method in hand (or inserted for IUD) at the time of the interview. PRES may include having an appointment to return for IUD, diaphragm fitting, sterilization, or other method. Even if continuing with the prior method where supplies were not required (e.g. the client came to check on the IUD which remained inserted) probe to ensure

that no second method (e.g. condom) was received or prescribed as well during this visit.

116 Client understanding: For the method(s) the client is using/will use, ask the indicated question. If necessary, probe to clarify the answer of the client.

C3. Detailed Instructions for Completing the Exit Interview with the Antenatal Care Client

103,106 Give/prescribe medication: These medicines may not be provided at each visit, but should be provided during some antenatal visit. If the client is unsure, probe about a medication to make the blood stronger (iron) and show her the pill; probe about the medicine for malaria and show her the pill.

104,107 Explanation about medications: Even if only prescribed, or provided during a previous visit, we want to know if the client remembers a provider explaining how to take the medicines.

109-114 Advice: For each question, if the client expresses uncertainty, probe trying to remind her of discussions which might have occurred with the provider. Use general probes related to the subject. Do not use the specific answers provided in the questionnaire.

115-116 Plan for where to deliver: The responses should be adapted to reflect common practices in the country.

117-118 Preparation: Even if the plan is for a facility delivery, the provider may have advised to have a plan for transportation, or to have basic delivery supplies in case the woman does not reach the facility in time for delivery.

C4. Detailed Instructions for Completing the Exit Interview with STI Clients

This interview may be very sensitive and embarrassing for both the client and the interviewer. It is important that the interviewer be matter of fact and comfortable when discussing with the client. It is suggested that during training, specific attention be given to play-acting this interview so the interviewers can become more comfortable with the subject matter and to help the group of interviewers to develop culturally appropriate probes which do not suggest a specific answer to the client.

101 Diagnosis: This does not need to be a medical terminology but can be a description “e.g. YES, I HAVE AN INFECTION”. The client does not need to indicate it is sexually transmitted for a “YES”, simply that there is an infection and that the provider did mention this.

104 How long take medications: If the client does not understand the question or is uncertain, clarify with general questions such as- how will you decide when to stop taking this medicine?

107 Offer AIDS test: If the client is uncertain, probe about any tests discussed and what the client understood they were for, before responding “NO”.

108 Ever used condom: If the client is uncertain, probe for “even once”.

109 Thoughts about condoms: These questions apply even if the client has never used condoms. If never used before, ask if s/he thinks this would be a problem. If the client is embarrassed or says don’t know, probe using comments such as “PEOPLE DON’T ALL FEEL THE SAME. FOR SOME PEOPLE, THEY ARE EMBARRASSED TO BUY CONDOMS AND IT’S A SERIOUS/BIG ISSUE THAT MAY EVEN KEEP THEM FROM BUYING THEM, FOR OTHER PEOPLE THEY MAY BE EMBARRASSED, BUT IT’S NOT SUCH A BIG ISSUE, AND THEY WILL GO AHEAD WITHOUT TOO MUCH CONCERN. AND FOR SOME PEOPLE, BUYING CONDOMS DOESN’T EMBARRASS THEM AT ALL. WHAT DO YOU THINK IS THE SITUATION FOR YOU?”

6. MODULE: DOCUMENTATION OF HEALTH CARE PROVISION

General Instructions for Completing Data Collection on Documentation of Health Care Provision

It is important to discuss the system for recording client information with the in-charge of each facility. The most common type of records are:

- 1) A facility register book, often kept by service (e.g. child health, antenatal care, etc.). This often has headings for each column that indicate the information to be recorded.
- 2) Individual client records kept by the facility.
- 3) Individual client records kept by the client.

If individual client records are used, these are to be the source of data. If client records remain with the client, collect the information during the exit interview. If client records remain at the facility, discuss with the provider whether s/he completes documentation immediately upon completion of the consultation or if it is later in the day. If it is immediately upon completion of the consultation, ask to see the record immediately after the client departs or ask for the record to be set aside and pencil the client ID number on it so that the information can be collected later, as a part of the observation.

If there is only a facility register, the data should be collected as a part of the inventory for each service. Go to the page for the same day of the week the previous week. Select the first 10 eligible clients (or every xth client if there are more than 20 clients so that a total of 10 eligibles are systematically assessed). Indicate for each client whether the relevant information for that service was noted or not.

II DEFINITIONS FOR DATA ITEMS

- 1 Age of client: The birth date might be written in the first note in the record, or the age should be indicated today.
- 2 Date of visit: Must be today's date (for register information, the date one week prior to today).
- 3 Relevant history:

Sick child: Any note, written today, that mentions prior sickness or prior problem.

Family planning: The items requested may be recorded during the first visit for FP. If this is the first visit, these items should be noted today.

Antenatal care: History of complications may be indicated by note stating history or no history of excessive bleeding; early labor; prolonged labor, etc. or a note indicating the problem. This is either in the first note for this pregnancy or in this note, if this is the first visit. If tetanus toxoid or malaria prophylaxis is prescribed today, this counts as a “YES” for “indication of status”.

STI client: Any note, written today, indicating risk factors such as partner characteristics, prior history of problem, etc. If this is a follow-up visit, the relevant history should be noted in the note for the previous visit.

4 Symptoms today:

Sick child: Description of symptoms/ reason for visit: This may be physical symptoms (fever, pain, cough) or other complaints (not eating, crying more than usual, child is not active)

Family Planning: A note indicating “no problem” or “no complaints” is acceptable. Otherwise a note should indicate problems. If there is no mention one way or the other, the correct response is “NO”. Notes about menstrual problems, itching or discharge from genital area, etc. might be noted.

Antenatal Care: A note indicating “no problem” or “no Complaints” is acceptable. Otherwise a note should indicate problems. If there is no mention one way or the other, the correct response is “NO”.

STI client: Description of symptoms/ reason for visit: This should be physical symptoms (fever, abdominal pain, vaginal or penile discharge, rash or other skin condition). If a note indicates that the client has no symptoms but came for testing, this is acceptable.

5 Description of PHYSICAL FINDINGS for today:

Sick Child: Examples: Any description such as “lung sounds” or description of findings from palpation of abdomen, assessment of dehydration, muscle tone, etc. indicating a physical assessment.

Any mention of nutrition/nutritional status THIS VISIT: This can be any note, whether simply noting the child is not eating; is eating well; was advised to take more fluids; etc. Or any comment about being under or over weight.

Family planning: Examples: Description of findings from pelvic examination, description of incision site from norplant, genital discharge.

Antenatal care: Examples: description from palpating abdomen (fetal position, fundal height), edema, conjunctival assessment of anemia, etc. Any note indicating blood pressure abnormalities.

STI client: Examples: Description of findings from pelvic examination, description of skin rash, genital discharge, description of findings from palpating abdomen.

6 MEASUREMENTS today: Actual numbers indicating the sign was measured. If the weight of the sick child is on a “Road to Health” card and the number is graphed, this is accepted.

7 DIAGNOSIS: The name of the illness should be written. “Probable _____” (e.g. probable malaria) is acceptable. Listing a symptom as the diagnosis (e.g. “fever” , “respiratory distress”) “diarrhea” (unless it specifies something like “simple watery diarrhea”), pain, STI) is not acceptable.

8 TREATMENT: The name of the medication, strength (e.g. 250 mg tabs), and the amount (how much for how long) must be written [example: Cotrim 250mg tabs 3x/day (or tid) for 7 days]

9 INSTRUCTIONS FOR RETURNING: Any written note that the client was instructed to return if certain symptoms persist or become worse; or that the client was instructed to return in a certain number of days/months.

Appendix 1 Instructions for Using the Geographic Positioning System

MEASURE DHS+ GPS Data Collection

To record the position of a facility

1. Go near the facility, and stand in an open area, as far away from buildings and trees as possible while staying close to the facility.
2. Press the start/stop button (the red button immediately below the GOTO button). This action will turn on the GPS receiver and display the welcome screen, the country database screen and then, after a short delay, the satellite page. Sometimes the unit will beep while it is initializing; you can ignore these messages; it will auto-initialize by itself.
3. Hold the GPS receiver away from your body or, if possible, place it on a flat, elevated surface.
4. Wait until the position page is displayed; this should take 1-3 minutes. (While you are waiting, you can change the datum, coordinate system and unit of measurement as outlined above.)
5. When the position page is displayed, press the MARK button. This action will display the mark position page.
6. Use the direction pad to select the AVERAGE? option at the bottom of the screen and then press the enter button.
7. Use the direction pad to highlight the waypoint's name and then press the enter button. This action will display the waypoint's name in edit mode. Change the waypoint's name to the facility number for the facility you are in. Press the enter button.
Hold the unit steady and wait for 5 minutes while the GPS unit averages. If necessary press PAGE to get back to the position page. Record the altitude from the position page on the paper form.
After 5 minutes, if necessary press PAGE to get back to the position page. Use the direction pad to highlight the SAVE? option at the bottom of the screen. Press the page button 3 times. This action will display the main menu page. Select the waypoint list option from the main menu and press the enter button. This action will display the waypoint list page. Select the number of the waypoint that you just marked and press the enter button. This action will display the waypoint page. Record the latitude and longitude on the facility form. The position of the facility has now been recorded.

Hold down the start/stop button for 3 seconds. This action will turn off the GPS receiver.

Appendix 2 Sampling Methodology for Providers

A maximum of 8 health service providers will be interviewed. The providers will be selected from a list of all service providers who are present the day of the survey (see Appendix 2.1).

Selecting providers for interview:

At the beginning of the day, the team leader should ask the in-charge to list all providers who are present the day of the survey. The providers in question are those who provide consultation services for the priority services (sick-child, sexually transmitted diseases, HIV/AIDS if different providers see these clients, Family planning, antenatal care, and delivery services). If the ANC providers also conduct deliveries in the facility (some facilities rotate staff between the delivery wards and out-patient services) then the list need only include the ANC providers. If there are no delivery service providers on the list of out-patient service providers, then the delivery service providers who are on duty at the facility need to be listed. List the providers by qualification and service, if the services are separate (such as in large facilities). If services are combined (e.g. sick child and STI) simply list the providers for that combined service, by qualification. Give each provider on the list a unique number. This is the number to be used for "Provider Code" on both the Provider Interview, and for each observed client of that provider. Circle the number for each provider that is interviewed.

The selection priority for providers is as follows:

All observed providers

A randomly selected health worker from the priority services, where client consultations were not observed. This includes delivery, plus any other service (sick child, STI, HIV/AIDS if the providers are different from those included in other services, FP, and ANC) where no client consultation was observed.

3) If the sum of providers from the first two criteria does not equal 8, the remaining providers will be selected randomly (using lottery) with the priority being 1) an additional provider from Outpatient services (or where sick children are observed), 2) an additional provider from antenatal care services, 3) If this does not result in 8 interviews, the next provider should be selected from outpatient services (or where STI clients are served), and then FP, etc.

Appendix 2.1

Sample list for Provider Interview

FACILITY CODE _____

DATE _____

LIST ALL PROVIDERS PRESENT DAY OF SURVEY. SELECT ALL OBSERVED PROVIDERS FOR INTERVIEW. IF PROVIDER WORKS IN SEVERAL SERVICES, LIST THEM UNDER THEIR PRIMARY SERVICE AREA. IN SMALL FACILITIES IF THE PROVIDERS PROVIDE ALL SERVICES, SIMPLY LIST THEM UNDER OUTPATIENT CARE.

SL	QUALIFICATION	NAME	CHECK COLUMN IF PROVIDER WAS OBSERVED WITH A CLIENT
Service: Outpatient Care (if sick child and STI services are offered in different clinic areas, list staff separately for each service)			
1	Doctor		
2	Doctor		
3	Medical Assistant		
4	Nurse		
5			
6			
7			
Service: Antenatal Care			
8	Midwife		
9	Midwife		
10	Nurse		
11			
12			
Service: Family Planning			
13	Etc.		
14			
15			
16			
17			
Service: Delivery Care			
18			
19			
20			
21			
22			

CIRCLE SERIAL NUMBER FOR PROVIDER CHOSEN FOR INTERVIEW

Appendix 3 Sampling Methodology for Observations

The goal is to observe a maximum of 15 clients for each service, dividing the observations between service providers at any given service. A maximum of 5 client observations for any given provider for one service is sufficient. Thus, if there is only one provider for antenatal care, then the maximum clients for ANC will be 5. If there are two providers seeing ANC clients, then the maximum client observations for ANC would be 10. For most facilities, this maximum number of clients will not be reached because of lack of time or lack of clients. To increase the numbers of observations at large facilities (e.g. outpatient departments associated with district hospitals), two days will be allocated. For most facilities, however, teams will only be present for one day. If there are more clients than the team can observe, an effort must be made to divide the observed clients between the four types of eligible clients (sick child, STI client, family planning, and antenatal care).

Selecting the clients for observation:

Client should be screened for eligibility in the waiting area and taken on a first come basis with the following exceptions:

For prenatal and family planning, if there are waiting clients, you should determine who are first and who are follow-up clients. Taking them in order they will be seen (they are usually registered) you can select the sample at an approximate ratio of 2 new clients for every 1 follow-up client. If there are not waiting clients, observe the clients as they arrive as you will not know how many clients to expect so a sample cannot be selected.

If there are two or more providers, the team leader can ask the person in charge of the service to ensure that eligible clients are go to each of the providers. Where there is one observer, the observer would see who the first eligible client is, complete the observation, and then check on the next eligible client and request that if it will not create a problem that the next eligible client go to the other provider.

In order to properly analyze the data, it is necessary that a list of all eligible clients who attend the facility on the observation day be collected (see Appendix 3.1-3.4). This will allow us to describe how representative the service operation was the day of the survey, using average number of clients on service days as the indicator. The in-charge should be asked to ensure that the list is completed and the team leader must ensure that the data is collected prior to departing from the facility. The provider may be asked to complete the list as s/he sees clients, or, if the required information is listed in a register in an easily retrievable manner, the information can be collected from registers. The team must ensure that the data is collected from all relevant registers (some facilities have a different register for each provider seeing sick patients). The data forms (3.1-3.4) must be included in the envelope with the questionnaires from the facility.

Analysis will be conducted two ways. One analysis will focus on the facility as the unit of observation. For this, we will indicate the proportion of observed clients in that facility where the data item in question was observed or not. This will provide an overview of processes followed within each facility.

The second analysis will focus on the client as the unit of observation, weighting the data for the observations from each facility using client population statistics. The weighting factor will be determined using total clients (e.g. children below 5 years of age who received sick child care; total number of antenatal clients, total number of family planning clients, total number of STI clients) during the prior 12 months (or the number of months for which data is available) and dividing this by the average number of service days during the months for which data is available.

Appendix 3.1

Sample List for Sick Child Observation

FACILITY CODE _____

DATE _____

SL	NAME	AGE (MONTHS)	SYMPTOM	
			SICK	INJURY
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				

CIRCLE SERIAL NUMBER FOR CLIENTS CHOSEN FOR OBSERVATION

Appendix 3.2

**Sample List for Family Planning Client
Observation**

FACILITY CODE _____

DATE

SL	NAME	FIRST VISIT	FOLLOW UP
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

CIRCLE SERIAL NUMBER FOR CLIENTS CHOSEN FOR OBSERVATION

Appendix 3.3

Sample List for Antenatal Care Client Observation

FACILITY CODE _____

DATE _____

SL	NAME	FIRST VISIT	FOLLOW-UP
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

CIRCLE SERIAL NUMBER FOR CLIENTS CHOSEN FOR OBSERVATION

Appendix 3.4

Sample List for STI Client Observation

FACILITY CODE _____

DATE _____

SL	NAME	SEX	SYMPTOM
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

CIRCLE SERIAL NUMBER FOR CLIENTS CHOSEN FOR OBSERVATION