QUESTIONNAIRES AND SUPPORTING DOCUMENTS

Appendix **C**

Inventory Questionnaire

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

2013 MALAWI SERVICE PROVISION ASSESSMENT SURVEY

INVENTORY QUESTIONNAIRE

FACILITY IDENTIFICATION

001 NAME OF FACILITY _____

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

003 REGION . . . . . ☐☐

003A ZONE . . . . . ☐☐

004 DISTRICT . . . . . ☐☐☐

005 FACILITY NUMBER . . . . . ☐☐☐☐☐

006 TYPE OF FACILITY (COUNTRY SPECIFIC)

CENTRAL HOSPITAL	01
DISTRICT HOSPITAL	02
RURAL / COMMUNITY HOSPITAL	03
OTHER HOSPITAL	04
HEALTH CENTRE	05
MATERNITY	06
DISPENSARY	07
CLINIC	08
HEALTH POST	09

007 MANAGING AUTHORITY (OWNERSHIP)

GOVERNMENT/PUBLIC	1
CHRISTIAN HEALTH ASSOCIATION OF MALAWI (CHAM)	2
PRIVATE-FOR-PROFIT	3
MISSION/FAITH-BASED (OTHER THAN CHAM)	4
NGO	5
COMPANY	6

008 URBAN/RURAL

URBAN	1
RURAL	2

009 INPATIENT ONLY

YES	1
NO	2

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐
INTERVIEWER NAME	_____	_____	_____	INT. CODE ☐☐☐
RESULT	_____	_____	_____	RESULT ☐

RESULT CODES (LAST VISIT):
1 = FACILITY COMPLETED
2 = FACILITY RESPONDENTS NOT AVAILABLE
3 = POSTPONED / PARTIALLY COMPLETED
4 = FACILITY REFUSED
5= FACILITY CLOSED / NOT YET OPERATIONAL
6 = OTHER _____
(SPECIFY)

TOTAL NUMBER OF PROVIDER INTERVIEWS AND OBSERVATIONS, TOTAL # OF CLIENT VISITS

		TOTAL # CLIENT VISITS
TOTAL NUMBER OF PROVIDERS INTERVIEWED		
TOTAL NUMBER OF ANC OBSERVATIONS		
TOTAL NUMBER OF FAMILY PLANNING OBSERVATIONS		
TOTAL NUMBER OF SICK CHILD OBSERVATIONS		
TOTAL NUMBER OF DELIVERY OBSERVATIONS		

FACILITY GEOGRAPHIC COORDINATES

SET DEFAULT SETTINGS FOR GPS UNIT

- SET COORDINATE SYSTEM TO LATITUDE / LONGITUDE
- SET COORDINATE FORMAT TO DECIMAL DEGREE
- SET DATUM TO WGS84

STAND IN A LOCATION AT THE ENTRANCE OF THE FACILITY WITH PLAIN VIEW OF THE SKY

1 TURN GPS MACHINE ON AND WAIT UNTIL SATELITE PAGE CHANGES TO "POSITION"

2 WAIT 5 MINUTES

3 PRESS "MARK"

4 HIGHLIGHT "WAYPOINT NUMBER" AND PRESS "ENTER"

5 ENTER X-DIGIT FACILITY CODE / FACILITY NUMBER

6 HIGHLIGHT "SAVE" AND PRESS "ENTER"

7 PAGE TO MAIN MENU, HIGHLIGHT "WAYPOINT LIST" AND PRESS "ENTER"

8 HIGHLIGHT YOUR WAYPOINT

9 COPY INFORMATION FROM WAYPOINT LIST PAGE

10 WRITE ELEVATION [ALTITUDE]

BE SURE TO COPY THE WAYPOINT NAME FROM THE WAYPOINT LIST PAGE TO VERIFY THAT YOU ARE ENTERING THE CORRECT WAYPOINT INFORMATION ON THE DATA FORM

010	WAYPOINT NAME (FACILITY NUMBER)	WAYPOINT NAME
011	ELEVATION	ELEVATION . . . . .
012	LATITUDE	N/S . . . . . a DEGREES/DECIM b - c
013	LONGITUDE	E/W . . . . . a DEGREES/DECIM b - c

CONSENT

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

Good day! My name is _____. We are here on behalf of the Ministry of Health conducting a survey of health facilities to assist the government in knowing more about health services in Malawi

Now I will read a statement explaining the study.

Your facility was selected to participate in this study. We will be asking you questions about various health services. Information collected about your facility during this study may be used by the [MOH], organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor the names of any other health workers who participate in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help in order to collect this information.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will benefit the services you provide and the nation.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

_____

INTERVIEWER'S SIGNATURE INDICATING CONSENT OBTAINED

		2 0 1	
DAY	MONTH	YEAR	

100	May I begin the interview?	YES . . . . . 1 NO 2	→ STOP
101	INTERVIEW START TIME	HOURS : MINUTES	

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

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

NOTE!!!!

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

MODULE 1: GENERAL INFORMATION AND SERVICE AVAILABILITY

SECTION 1: GENERAL SERVICE AVAILABILITY AND INPATIENT SERVICES

SERVICE AVAILABILITY

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

INPATIENT SERVICES

110	Does this facility routinely provide in-patient care?	YES. . . . . 1 NO. 2	→ 112
111	Does this facility have beds for overnight observation?	YES. . . . . 1 NO. 2	→ 200
112	Excluding any delivery and/or maternity beds, how many ***(overnight)*** **or** ***(in-patient)*** beds in total does this facility have, both for adults and children?	# OF OVERNIGHT/ INPATIENT BEDS . . . . . ☐☐☐ DON'T KNOW 998	

SECTION 2: GENERAL FILTER QUESTIONS

PROCESSING OF EQUIPMENT

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

STORAGE OF MEDICINES

210	Does this facility store any medicines (including ARVs), vaccines or family planning commodities? PROBE	YES. . . . . 1 FACILITIES STOCKS NO MEDICINES. . . 2 →	300
211	**CHECK Q102.04** FAMILY PLANNING SERVICES AVAILABLE ☐	NO FAMILY PLANNING SERVICES ☐ →	213
212	Are contraceptive commodities generally stored in the family planning service area, or are they stored in a common area with other medicines?	STORED IN FP SERVICE AREA. . . . . 1 STORED WITH OTHER MEDICINES. . . . 2 FP COMMODITIES NOT STOCKED. 3	
213	**CHECK Q102.10** TUBERCULOSIS SERVICES AVAILABLE ☐	NO TUBERCULOSIS SERVICES ☐ →	215
214	Are medicines for the treatment of TB generally stored in the TB service area or are they stored in a common area with other medicines?	STORED IN TB SERVICE AREA. . . . . 1 STORED WITH OTHER MEDICINES. . . . 2 TB MEDICINES NOT STOCKED. 3	
215	**CHECK Q102.12 AND Q102.06** ARV TREATMENT OR PMTCT SERVICES AVAILABLE ☐	NEITHER ARV TREATMENT NOR PMTCT SERVICES ☐ →	300
216	Are antiretroviral (ARV) medicines generally stored in the ARV treatment service area, in the PMTCT service area, or are they stored in a common area with other medicines?	STORED IN ART SERVICE AREA. . . . . 1 STORED WITH OTHER MEDICINES. . . . . 2 ARV MEDICINES NOT STOCKED. . . . . 3 STORED IN PMTCT SERVICE AREA. . . . . 4 STORED IN ART AND PMTCT SERVICE AREA 5	

MODULE 2: GENERAL SERVICE READINESS

SECTION 3: 24-HOUR STAFF COVERAGE - INFRASTRUCTURE EXTERNAL SUPERVISION - USER FEES - SOURCES OF REVENUE

24-HOUR STAFF COVERAGE

300	Is there a health care worker present at the facility at all times, or officially on call for the facility at all times (24 hours a day) for emergencies?	YES, 24-HR STAFF. . . . . 1 NO 24-HOUR STAFF. 2	→ 310
301	Is there a duty schedule or call list for 24-hour staff coverage?	YES . . . . . 1 DUTY SCHEDULE NOT MAINTAINED. . . 2	→ 310
302	May I see the duty schedule or call list for 24-hour staff coverage?	SCHEDULE OBSERVED. . . . . 1 SCHEDULE REPORTED NOT SEEN. . . . 2	

COMMUNICATION

310	Does this facility have a ***land line telephone*** that is available to call outside at all times client services are offered? CLARIFY THAT IF FACILITY OFFERS 24-HOUR EMERGENCY SERVICES, THEN THIS REFERS TO 24-HOUR AVAILABILITY.	YES . . . . . 1 NO. 2	→ 313
311	May I see the land line telephone?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
312	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	→ 319
313	Does this facility have a ***cellular telephone or a private cellular phone*** that is supported by the facility?	YES . . . . . 1 NO. 2	→ 316
314	May I see either the facility-owned cellular phone or the private cellular phone that is supported by the facility?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
315	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	→ 319
316	Does this facility have a ***short-wave radio*** for radio calls?	YES . . . . . 1 NO. 2	→ 319
317	May I see the short-wave radio?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
318	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	
319	Does this facility have ***a computer?***	YES. . . . . 1 NO. 2	→ 322
320	May I see the computer?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
321	Is it functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2	
322	Is there access to email or internet via computer and/or mobile phone within the facility? ACCEPT REPORTED RESPONSE.	YES. . . . . 1 NO. 2	→ 330
323	Is the email or internet routinely available for ***at least 2 hours*** on days that client services are offered? ACCEPT REPORTED RESPONSE.	YES. . . . . 1 NO. 2	

SOURCE OF WATER

330	What is the *most commonly used* source of water for the facility *at this time?* OBSERVE THAT WATER IS AVAILABLE FROM SOURCE OR IN THE FACILITY ON THE DAY OF THE VISIT. E.G., CHECK THAT THE PIPE IS FUNCTIONING.	PIPED INTO FACILITY. . . . . 01 PIPED ONTO FACILITY GROUNDS. . . . . 02 PUBLIC TAP/STANDPIPE. . . . . 03 TUBEWELL/BOREHOLE . . . . . 04 PROTECTED DUG WELL. . . . . 05 UNPROTECTED DUG WELL. . . . . 06 PROTECTED SPRING . . . . . 07 UNPROTECTED SPRING. . . . . 08 RAINWATER . . . . . 09 BOTTLED WATER . . . . . 10 CART W/SMALL TANK/DRUM . . . . . 11 TANKER TRUCK . . . . . 12 SURFACE WATER (RIVER/DAM/LAKE/POND). . . . . 13 OTHER (SPECIFY)_____ 96 DON'T KNOW . . . . . 98 NO WATER SOURCE 00	→ 332 → 332 → 332 → 340
331	Is water outlet from this source available onsite, within 500 meters of the facility, or beyond 500M of facility? REPORTED RESPONSE IS ACCEPTABLE	ONSITE. . . . . 1 WITHIN 500M OF FACILITY. . . . . 2 BEYOND 500M OF FACILITY. 3	
332	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES. . . . . 1 NO. 2	

POWER SUPPLY

340	Is this facility connected to the central supply electricity grid?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 342
341	During the past 7 days, was electricity (excluding any back-up generator) available during the times when the facility was open for services, or was it ever interrupted ***for more than 2 hours at a time?*** CONSIDER ELECTRICITY TO BE ALWAYS AVAILABLE IF INTERUPTED FOR LESS THAN 2 HOURS AT A TIME.	ALWAYS AVAILABLE. . . . . 1 SOMETIMES INTERRUPTED. . . . . 2 DON'T KNOW. 8	
342	Does this facility have other sources of electricity, such as a generator or solar system?	YES. . . . . 1 NO OTHER SOURCE. 2	→ 350
343	What other sources of electricity does this facility have? PROBE FOR ANSWERS AND CIRCLE ALL THAT APPLY	FUEL-OPERATED GENERATOR. . . . . A BATTERY-OPERATED GENERATOR. . . . B SOLAR SYSTEM. . . . . C BATTERY-OPERATED INVERTOR. . . . . D	
344	**CHECK Q343** GENERATOR OR INVERTOR USED (EITHER "A" OR "B" OR "D" CIRCLED) ↓	GENERATOR NOT USED (NEITHER "A" NOR "B" NOR "D" CIRCLED)	→ 350
345	Is the generator functional? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 350
346	Is fuel (or a charged battery) available today for the generator? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

EXTERNAL SUPERVISION

350	Does this facility receive any external supervision, e.g., from the district, zonal, regional or national office?	YES. . . . . 1 NO. 2	→ 360
351	When was the last time a supervisor from outside this facility came here on a supervisory visit? Was it within the past 3 months, within the past 6 months, or more than 6 months ago?	WITHIN THE PAST 3 MONTHS . . . . . 1 WITHIN THE PAST 6 MONTHS . . . . . 2 MORE THAN 6 MONTHS AGO. 3	→ 360

		YES	NO	DON'T KNOW
352	The last time during the past 3 months that a supervisor from outside the facility visited, did he or she do any of the following:			
01	Use a checklist to assess the quality of available health services data?	1	2	8
02	Discuss performance of the facility based on available health services data?	1	2	8
03	Help the facility make any decisions based on available health services data?	1	2	8
03A	Provide any type of feedback, written or verbal?	1	2	8

USER FEES

360	Does this facility have any ***routine user-fees or charges*** for client services, including charges for health passports or registration?	YES. . . . . 1 NO. 2	→ 370
361	Does the facility charge a fixed fee that covers all services that a client receives, or are there separate fees for different components of the services provided by the facility? PROBE.	FIXED FEE COVERING ALL SERVICES . . . . . 1 NO, CHARGE FEE FOR SEPARATE ITEMS. . . 2	→ 363
362	Does this facility have a fee for the following items: READ OUT EACH RESPONSE CATEGORY AND CIRCLE APPROPRIATELY	YES NO	
01	CLIENT HEALTH PASSPORT	1 2	
02	REGISTRATION	1 2	
03	CONSULTATION.	1 2	
04	MEDICINES OTHER THAN ANTIRETROVIRAL MEDICINES (ARVs) .	1 2	
05	VACCINES	1 2	
06	CONTRACEPTIVE COMMODITIES.	1 2	
07	NORMAL DELIVERIES	1 2	
08	SYRINGES AND NEEDLES.	1 2	
09	CESAREAN SECTION	1 2	
10	HIV DIAGNOSTIC TEST	1 2	
11	MALARIA RAPID DIAGNOSTIC TEST	1 2	
12	MALARIA MICROSCOPY	1 2	
13	OTHER LABORATORY TESTS	1 2	
14	ARV FOR TREATMENT	1 2	
15	ARV FOR PMTCT.	1 2	
16	MINOR SURGICAL PROCEDURES.	1 2	
16A	BLOOD TRANSFUSION SERVICES	1 2	
16B	CATERING SERVICES (FOOD FOR PATIENTS)	1 2	
16C	WARD ACCOMODATION (INPATIENT STAY)	1 2	
363	Are the official fees posted or displayed so that the client can easily see them?	YES. . . . . 1 NO POSTED FEES. 2	→ 365
364	May I see the posted fees? REVIEW THE POSTED FEES AGAINST THE LIST OF ITEMS IN Q632 TO DETERMINE IF ALL FEES ARE POSTED	OBSERVED, ALL FEES POSTED. . . . . 1 OBSERVED, SOME BUT NOT ALL FEES. 2	
365	What is the procedure if a client is unable to pay for any of the fees associated with health care provided in this facility? CIRCLE ALL THAT APPLY. PROBE TO ARRIVE AT APPROPRIATE RESPONSE	FEE EXEMPTED/DISCOUNTED, NO PAYMENT EXPECTED. . . . . A FEE EXEMPTED/DISCOUNTED, PAYMENT EXPECTED LATER. . . . . B SERVICE NOT PROVIDED, ASKED TO COME BACK WHEN ABLE TO PAY. . C ACCEPT PAYMENT IN-KIND. . . . . D OTHER_____ X	

SOURCES OF REVENUE

370	Now, I would like to ask about the sources of revenue or funding for this facility. Tell me if the facility received any revenue or funding from any of the listed resources during the 2012-2013 financial year. If **someone else** is more appropriate to provide financial information, please feel free to invite that person or refer me to that person. CIRCLE ALL THAT APPLY. PROBE FOR EACH. [will be country-specific list]	MINISTRY OF HEALTH. . . . . A OTHER PUBLIC MINISTRIES. . . . . B MEDICAL SCHEMES (INSURANCE). . . . . C SOCIAL SECURITY FUND. . . . . D REIMBURSEMENT BY EMPLOYER. . . . . E GOVT. CONTRIBUTION TO PRIVATE. . . F DONOR AGENCIES/NGOs. . . . . G FAITH-BASED. . . . . H COMMUNITY PROGRAMS. . . . . I NONE. . . . . Y OTHER_____ X	

SECTION 4: STAFFING - MANAGEMENT - CLIENT OPINION QUALITY ASSURANCE - TRANSPORT - HMIS AND HEALTH STATISTICS

STAFFING

400 Please tell me how many staff in each of the following ***occupational categories*** are currently ***assigned to, employed by, or seconded to*** this facility, whether full time or part-time. I am interested in the highest occupational category (such as nurse or doctor) regardless of the person's actual assignments or duties. For doctors, I would like to know how many are part-time in this facility.

	OCCUPATIONAL CATEGORIES	(a) **ASSIGNED, EMPLOYED, OR SECONDED**	(b) **PART TIME**
01	GENERALIST [NON-SPECIALIST] MEDICAL DOCTORS		
02	SPECIALISTS MEDICAL DOCTORS [INCLUDING ANESTHESIOLOGISTS & PATHOLOGISTS]		
03	CLINICAL OFFICER (DEGREE LEVEL)		
04	CLINICAL TECHNICIAN (DIPLOMA)		
05	MEDICAL ASSISTANT		
06	ANESTHETIST		
07	REGISTERED NURSE (BSN)		
08	REGISTERED NURSE MIDWIFE (BSN)		
09	REGISTERED PSYCHIATRIC NURSE		
10	REGISTERED NURSE WITH DIPLOMA		
11	ENROLLED NURSE		
12	COMMUNITY HEALTH NURSE		
13	ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN		
14	ENROLLED NURSE MIDWIFE		
15	PHARMACIST		
16	PHARMACY TECHNOLOGIST		
17	PHARMACY TECHNICIAN		
18	PHARMACY ASSISTANT		
19	LABORATORY TECHNOLOGIST / SCIENTIST		
20	LABORATORY TECHNICIAN		
21	LABORATORY ASSISTANT		
22	RADIOGRAPHER		
23	DENTAL THERAPIST / TECHNICIAN		
24	ENVIRONMENTAL HEALTH OFFICER		
25	HEALTH SURVEILLANCE ASSISTANTS (HSA)		
26	HTC COUNSELORS (NON-HSA)		
27	SUM THE NUMBER OF STAFF REPORTED. VERIFY AND CORRECT THE TOTALS.		

MANAGEMENT MEETINGS

NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES LOOKING AT RECORDS OF MEETINGS. IT WILL THEREFORE BE HELPFUL IF SUCH RECORDS ARE GATHERED BEFORE PROCEEDING WITH THE INTERVEIW.

410	Does this facility have routine facility management meetings?	YES. . . . . 1 NO 2	→417
411	How frequently do these facility management meetings take place?	MONTHLY OR MORE FREQUENTLY. . . . . 1 ONCE EVERY 2-3 MONTHS. . . . . 2 ONCE EVERY 4-6 MONTHS. . . . . 3 LESS FREQ. THAN EVERY 6 MONTHS. . . . . 4 DON'T KNOW. 8	→417
412	Does the facility maintain official records of facility management meetings?	YES. . . . . 1 NO, RECORDS NOT MAINTAINED 2	→417
413	May I see the records or minutes from the most recent meeting that took place within the last 6 months?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	→417
414	REVIEW THE RECORDS OR MINUTES OF THE MOST RECENT MEETING NO OLDER THAN 6 MONTHS AND CIRCLE THE LETTER FOR ANY OF THE LISTED TOPICS THAT ARE MENTIONED IN THE REPORT.	RHIS DATA QUALITY. . . . . A RHIS REPORTING. . . . . B TIMELINESS OF RHIS REPORTING. . . . . C QUALITY OF SERVICES. . . . . D CLIENT UTILIZATION. . . . . E DISEASE DATA. . . . . F EMPLOYMENT CONDITIONS (E.G., SALARIES, DUTY SCHEDULES). . . . . G FINANCES OR BUDGET. . . . . H OTHER _____ X NONE OF THE ABOVE. . . . . Y	→417
415	Did the facility make any decisions based on what was discussed at the last meeting and covered in this report?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→417
416	Has the facility taken any follow-up action regarding the decisions made during the last meeting?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
417	Are there any *routine* meetings about facility activities or management issues that include both facility staff and community members?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→430
418	How frequently are routine meetings held with both facility staff and community members?	MONTHLY OR LESS FREQUENTLY. . . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS. . . . . 3 LESS FREQ. THAN EVERY 6 MONTHS. . . . . 4 DON'T KNOW. 8	→430
419	Is an official record of the meetings with both facility staff and community members maintained?	YES. . . . . 1 NO, RECORDS NOT MAINTAINED 2	→430
420	May I see the records or minutes from the most recent meeting that took place within the last 6 months?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

CLIENT OPINION AND FEEDBACK

430	Does this facility have any system for determining clients' opinions about the health facility or its services?	YES. . . . . 1 NO 2	→440
431	Please tell me all the methods that this facility uses to elicit client opinion CIRCLE ALL METHODS MENTIONED AND PROBE: ANY MORE?	SUGGESTION BOX. . . . . A CLIENT SURVEY FORM. . . . . B CLIENT INTERVIEW FORM. . . . . C OFFICIAL MEETIING WITH COMMUNITY LEADERS. . . . . D INFORMAL DISCUSSION WITH CLIENTS OR THE COMMUNITY. . . . . E EMAIL. . . . . F FACILITY'S WEBSITE. . . . . G LETTERS FROM CLIENTS/COMMUNITY. . . . . H OMBUDSMAN . . . . . I OTHER_____ X DON'T KNOW. . . . . Z	→440
432	Is there a procedure for reviewing or reporting on clients' opinion? IF YES, ASK TO SEE A REPORT OR FORM ON WHICH DATA ARE COMPILED OR DISCUSSION IS REPORTED	YES . . . . . 1 NO PROCEDURE . . . . . 2 DON'T KNOW. 8	→ 440
433	May I see a report on the review of client opinion, or any document on such a review?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 REPORTS NOT COMPILED 3	

QUALITY ASSURANCE

NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES LOOKING AT RECORDS OF QUALITY ASSURANCE ACTIVITIES. IT WILL THEREFORE BE HELPFUL IF SUCH RECORDS ARE GATHERED BEFORE PROCEEDING WITH THE INTERVEIW.

440	Does this facility routinely carry out quality assurance activities? An example may be facility-wide review of mortality, or periodic audit of registers.	YES. . . . . 1 NO . . . . . 2 DON'T KNOW 8	→450
441	Is there an official record of any quality assurance activities carried out during the past year?	YES. . . . . 1 NO, RECORDS NOT MAINTAINED 2	→450
442	May I see a record of any quality assurance activity? A REPORT OR MINUTES OF A QA MEETING, A SUPERVISORY CHECKLIST, A MORTALITY REVIEW, AN AUDIT OF RECORDS OR REGISTERS ARE ALL ACCEPTABLE.	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	

TRANSPORT FOR EMERGENCIES

450	Does this facility have a ***functional ambulance*** or other vehicle for emergency transportation for clients that is stationed at this facility and that operates from this facility?	YES. . . . . 1 NO. 2	→452
451	May I see the ambulance (or other vehicle)?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	→ 453
452	Does this facility have access to an ambulance or other vehicle for emergency transportation for clients that is stationed at another facility or that operates from another facility?	YES. . . . . 1 NO. 2	→ 460
453	Is fuel available today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

HMIS

FIND THE PERSON RESPONSIBLE FOR HEALTH INFORMATION SYSTEMS. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE ASSESSMENT BEFORE PROCEEDING WITH QUESTIONS IN THIS SUBSECTION

460	Does this facility have a system in place to regularly collect health services data?	YES. . . . . 1 NO. 2	
461	Does this facility regularly compile any reports containing health services information?	YES. . . . . 1 NO. 2	→464
462	How frequently are these reports compiled?	MONTHLY OR MORE OFTEN. . . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS. . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS. 4	
463	May I see a copy of the most recent report?	RECORD OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
463A	Are any of the compiled reports submitted to someone or to an office outside of this facility?	YES. . . . . 1 NO. 2	→464
463B	How frequently are any of the compiled reports submitted to someone or to an office outside of this facility?	MONTHLY OR MORE OFTEN. . . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS. . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS. 4	
463C	To whom are the reports sent?	DISTRICT LEVEL. . . . . A ZONAL LEVEL. . . . . B REGIONAL LEVEL. . . . . C NATIONAL LEVEL. . . . . D DONOR AGENCY. . . . . E OTHER: _____ X (SPECIFY)	
463D	When you send the reports to the [DISTRICT / ZONAL / NATIONAL / DONOR AGENCY] do you receive any feedback?	YES. . . . . 1 NEVER RECEIVE 2	
464	Does this facility have a designated person, such as a data manager, who is responsible for health services data in this facility?	YES. . . . . 1 NO DEDICATED PERSON. 2	→470
465	Who is responsible for health services data in this facility? PROBE TO DETERMINE WHO THIS PERSON IS	DATA MANAGER/HMIS PERSON. . . . . 1 FACILITY IN-CHARGE. . . . . 2 OTHER SERVICE PROVIDER. 3	

HEALTH STATISTICS

NOTIFY THE RESPONDENT THAT THIS SUBSECTION REQUIRES THAT SOME STATISTICS ARE GATHERED, IF SUCH INFORMATION IS NOT READILY AVAILABLE AT THE LOCATION WHERE THE INTERVIEW IS BEING CONDUCTED.

470	**CHECK Q110** INPATIENT CARE SERVICES AVAILABLE ☐	NO INPATIENT CARE SERVICES ☐ → 472	
471	How many ***live*** discharges were made in the last completed calendar month [MONTH], for all conditions, both for adults and children?	# OF DISCHARGES ☐☐☐☐ DON'T KNOW. 9998	
472	How many outpatient client visits were made to this facility in the last completed calendar month [MONTH] for both adults and children?	# OF CLIENT VISITS ☐☐☐☐ DON'T KNOW. 9998	

SECTION 5: PROCESSING OF EQUIPMENT FOR REUSE

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

500 **CHECK Q201** ARE ANY EQUIPMENT PROCESSED IN THE FACILITY?

YES (CODES 1 or 2 CIRCLED) ↓

NO (CODE 3 CIRCLED) → GO TO NEXT SECTION OR SERVICE SITE

501 ASK IF EACH OF THE INDICATED ITEMS BELOW IS USED BY THE FACILITY AND AVAILABLE. IF AVAILABLE, ASK TO SEE IT. ASK IF IT IS FUNCTIONING OR NOT
FOR EXAMPLE: "Do you use [METHOD] in facility?" IF YES, ASK: "May I see it?" THEN "Is it functioning?"

	ITEM	(A) USE AND AVAILABILITY: OBSERVED	(A) USE AND AVAILABILITY: REPORTED NOT SEEN	(A) USE AND AVAILABILITY: NOT USED	(B) FUNCTIONING: YES	(B) FUNCTIONING: NO	(B) FUNCTIONING: DON'T KNOW
01	ELECTRIC AUTOCLAVE (PRESSURE & WET HEAT)	1→ b	2→ b	3 ┐ 2 ↵	1	2	8
02	NON-ELECTRIC AUTOCLAVE (PRESSURE & WET HEAT)	1→ b	2→ b	3 ┐ 3 ↵	1	2	8
03	ELECTRIC DRY HEAT STERILIZER	1→ b	2→ b	3 ┐ 4 ↵	1	2	8
04	ELECTRIC BOILER OR STEAMER (NO PRESSURE)	1→ b	2→ b	3 ┐ 5 ↵	1	2	8
05	NON-ELECTRIC POT WITH COVER FOR BOILING/STEAM	1	2	3 ┐ 7 ↵			
06	HEAT SOURCE FOR NON-ELECTRIC EQUIPMENT (STOVE OR COOKER)	1→ b	2→ b	3 ┐ 7 ↵	1	2	8
07	AUTOMATIC TIMER (MAY BE ON EQUIPMENT)	1→ b	2→ b	3 ┐ 8 ↵	1	2	8
08	TST INDICATOR STRIPS/OTHER ITEM THAT INDICATES PROCESS IS COMPLETE	1	2	3			
09	ANY CHEMICALS FOR CHEMICAL HLD	1	2	3			

502 CHECK **Q501.** FOR EACH OF THE FOLLOWING METHODS OF STERILIZATION/HIGH LEVEL DISINFECTION THAT IS USED IN THE FACILITY, ASK YOUR RESPONDENT AND INDICATE THE PROCESSING DETAILS, INCLUDING PROCESSING TIME, RECOMMENDED PRESSURE, ETC.

		(1) AUTOCLAVE (steam with pressure)	(2) DRY HEAT STERILIZATION	(3) BOILING (HLD)	(4) STEAM HIGH LEVEL DISINFECTION (HLD)	(5) CHEMICAL HIGH LEVEL DISINFECTION (HLD)
A	Method	USED . . . . . 1 NOT USED . . 2 → 2	USED . . . . . 1 NOT USED . . 2 → 3	USED . . . . . 1 NOT USED . . . . . 2 → 4	USED . . . . . 1 NOT USED . . 2 → 5	USED . . . . . 1 NOT USED . . 2 →503
B	Temperature (centigrade)	TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW 998	TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW 998			
C	Pressure	PRESS-URE ☐☐☐ AUTOMATIC 666 DON'T KNOW 998 → 1E				
D	Units of pressure	UNITS OF PRESSURE: KG/SQ CM . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . . 3 MILLIMETER HG . . 4 DON'T KNOW. 8				
E	What is the duration in minutes when **equipment is not wrapped in cloth** for [METHOD]?	MINUTES ☐☐☐ AUTOMATIC . . . . 666 NOT USED. . . . . 995 DON'T KNOW 998	MINUTES ☐☐☐ AUTOMATIC . . . . . 666 DON'T KNOW 998	MINUTES ☐☐☐ DON'T KNOW 998	MINUTES ☐☐☐ DON'T KNOW 998	MINUTES ☐☐☐ DON'T KNOW. . . .998
F	What is the duration in minutes when **equipment is wrapped in cloth** for autoclave?	MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . . . 666 NOT USED. . . . . 995 DON'T KNOW 998				
G	Chemical disinfectant used					ALCOHOL. . . . . 01 BETADINE . . . . . 02 CHLORINE. . . . . 03 CIDEX . . . . . 04 FORMALDEHYDE. . 05 GLUTERALDEHYDE 06 DON'T KNOW. 98

503 Does this facility have any guidelines on final processing or sterilization of equipment?
YES. 1
NO . . . . . 2 → NEXT SECTION

504 May I see the guidelines on processing or sterilization of equipment?

HAND-WRITTEN GUIDELINES POSTED ON WALLS IN AREA WHERE EQUIPMENT IS PROCESSED OR STERILIZED IS ACCEPTABLE

OBSERVED 1
REPORTED NOT SEEN. 2

SECTION 6: HEALTH CARE WASTE MANAGEMENT AND CLIENT LATRINE

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

600	Now I would like to ask you a few questions about waste management practices for sharps waste, such as needles or blades. How does this facility ***finally*** dispose of ***sharps waste*** (e.g., filled sharps boxes)? PROBE TO ARRIVE AT CORRECT RESPONSE **NOTE!** IF ANY OF THE RESPONSES **02 - 09** TAKE PLACE OUTSIDE THE FACILITY, THEN THE CORRECT RESPONSE TO CIRCLE WILL BE IN THE CATEGORY OF "REMOVE OFFSITE"	**BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+°C). . . . . .02 1-CHAMBER DRUM/BRICK. . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION. . . . . 04 PIT OR PROTECTED GROUND. . . . . .05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION. . . . . 06 COVERED PIT OR PIT LATRINE. . . . . .07 OPEN PIT-NO PROTECTION. . . . . .08 PROTECTED GROUND OR PIT. . . . . .09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER. . . . . .10 STORED IN OTHER PROTECTED ENVIRONMENT. . . . . .11 STORED UNPROTECTED. . . . . .12 **OTHER**_____ 96 (SPECIFY) NEVER HAVE SHARPS WASTE 95	
601	Now I would like to ask you a few questions about waste management practices for medical waste other than sharps, such as used bandages How does this facility ***finally*** dispose of ***medical waste*** other than sharps boxes? PROBE TO ARRIVE AT CORRECT RESPONSE **NOTE!** IF ANY OF THE RESPONSES **02 - 09** TAKE PLACE OUTSIDE THE FACILITY, THEN THE CORRECT RESPONSE TO CIRCLE WILL BE IN THE CATEGORY OF "REMOVE OFFSITE"	SAME AS FOR SHARP ITEMS. . . . . 01 **BURN IN INCINERATOR:** 2-CHAMBER INDUSTRIAL (800-1000+°C). . . . . 02 1-CHAMBER DRUM/BRICK. . . . . 03 **OPEN BURNING** FLAT GROUND-NO PROTECTION. . . . . 04 PIT OR PROTECTED GROUND. . . . . 05 **DUMP WITHOUT BURNING** FLAT GROUND-NO PROTECTION. . . . . 06 COVERED PIT OR PIT LATRINE. . . . . 07 OPEN PIT-NO PROTECTION. . . . . 08 PROTECTED GROUND OR PIT. . . . . 09 **REMOVE OFFSITE** STORED IN COVERED CONTAINER. . . . . 10 STORED IN OTHER PROTECTED ENVIRONMENT. . . . . 11 STORED UNPROTECTED. . . . . 12 **OTHER** _____ 96 (SPECIFY) NEVER HAVE OTHER MEDICAL WASTE. 95	
602	**CHECK Q600** FACILITY-BASED WASTE DISPOSAL OR WASTE REMOVED OFFSITE (ANY CODE OTHER THAN "95" CIRCLED) ☐↓ NEITHER FACILITY-BASED WASTE DISPOSAL NOR REMOVAL OFFSITE (CODE "95" CIRCLED) ☐ → 604		
603	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF SHARPS WASTE AND INDICATE THE CONDITION OBSERVED. IF SHARPS WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE IT IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF SITE NOT INSPECTED, CIRCLE '8'.	NO WASTE VISIBLE. . . . . 1 WASTE VISIBLE, BUT PROTECTED AREA. . . . . 2 WASTE VISIBLE, ***NOT*** PROTECTED. . . . . 3 WASTE SITE NOT INSPECTED. 8	
604	**CHECK Q601.** FACILITY-BASED WASTE DISPOSAL OR WASTE REMOVED OFFSITE (ANY CODE "02" TO "96" CIRCLED) ☐↓ NEITHER FACILITY-BASED WASTE DISPOSAL NOR REMOVAL OFFSITE (CODE "01" OR "95" CIRCLED) ☐ → 606		
605	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF MEDICAL WASTE AND INDICATE THE CONDITION OBSERVED. IF MEDICAL WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE IT IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF SITE NOT INSPECTED, CIRCLE '8'.	NO WASTE VISIBLE. . . . . 1 WASTE VISIBLE, BUT PROTECTED AREA. . . . . 2 WASTE VISIBLE, ***NOT*** PROTECTED. . . . . 3 WASTE SITE NOT INSPECTED. 8	

606	**CHECK Q600 AND Q601** INCINERATOR USED (EITHER "2" OR "3" CIRCLED)	INCINERATOR NOT USED (NEITHER "2" NOR "3" CIRCLED)	→ 610
607	ASK TO BE SHOWN THE INCINERATOR	INCINERATOR OBSERVED. . . . . 1 INCINERATOR REPORTED NOT SEEN. 2	
608	Is the incinerator functional today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES 1 NO. . . . . 2 DON'T KNOW. 8	→ 610
609	Is fuel available today for the incinerator? ACCEPT REPORTED RESPONSE	YES . . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
610	Do you have any guidelines on health care waste management available in this service area? This may be part of the infection prevention guideline or protocol.	YES. . . . . 1 NO GUIDELINE AVAILABLE. 2	→ 620
611	May I see the guidelines on health care waste management?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

CLIENT LATRINE

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

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

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

BASIC SUPPLIES AND EQUIPMENT

700	I would like to know if the following items are available today in the main service area and are functioning ASK TO SEE ITEMS.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1→b	2→b	3	1	2	8
02	CHILD WEIGHING SCALE [250 GRAM GRADATION]	1→b	2→b	3	1	2	8
03	INFANT WEIGHING SCALE [100 GRAM GRADATION]	1→b	2→b	3	1	2	8
04	STADIOMETER (OR HEIGHT ROD) FOR MEASURING HEIGHT	1→b	2→b	3	1	2	8
05	MEASURING TAPE [FOR HEAD CIRCUMFERENCE]	1	2	3			
06	THERMOMETER	1→b	2→b	3	1	2	8
07	STETHOSCOPE	1→b	2→b	3	1	2	8
08	DIGITAL BP APPARATUS	1→b	2→b	3	1	2	8
09	MANUAL BP APPARATUS	1→b	2→b	3	1	2	8
10	LIGHT SOURCE (FLASHLIGHT ACCEPTABLE)	1→b	2→b	3	1	2	8
11	SELF-INFLATING BAG AND MASK [ADULT]	1→b	2→b	3	1	2	8
12	SELF-INFLATING BAG AND MASK [PEDIATRIC]	1→b	2→b	3	1	2	8
13	MICRONEBULIZER	1→b	2→b	3	1	2	8
14	SPACERS FOR INHALERS	1	2	3			
15	PEAK FLOW METERS	1→b	2→b	3	1	2	8
16	PULSE OXIMETER	1→b	2→b	3	1	2	8
17	OXYGEN CONCENTRATORS	1→b	2→b	3	1	2	8
18	FILLED OXYGEN CYLINDER	1→b	2→b	3	1	2	8
19	OXYGEN DISTRIBUTION SYSTEM	1→b	2→b	3	1	2	8
20	INTRAVENOUS INFUSION KITS - ADULT	1	2	3			
21	INTRAVENOUS INFUSION KITS - PEDIATRIC	1	2	3			
21A	TROLLEY	1→b	2→b	3	1	2	8
21B	WHEEL CHAIR	1→b	2→b	3	1	2	8

CLIENT EXAMINATION ROOM

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

710	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3
711	DESCRIBE THE SETTING OF THE ROOM OR SERVICE AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4		

CLIENT WAITING AREA

720	Is there a waiting area for clients where they ***are protected from the sun and rain?*** ASK TO SEE THE CLIENT WAITING AREA. MUST BE THE WAITINGAREA IN THE MAIN OUTPATIENT SERVICE AREA.	YES. . . . . 1 NO PROTECTED CLIENT WAITING AREA 2	

SECTION 8: DIAGNOSTICS

800	**CHECK Q102.17** DIAGNOSTIC SERVICES AVAILABLE IN FACILITY ☐ NO DIAGNOSTIC SERVICES ☐ GO TO NEXT SECTION OR SERVICE SITE	

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

HEMATOLOGY

801	Does this facility do any hemoglobin testing on site, i.e. in the facility?			YES . . . . . 1 NO 2					→ 803	
802	Please tell me if: **a)** Any of the following hemoglobin test equipment is used in this facility, **b)** All items needed for the test are available, and **c)** Equipment is in working order	**(a) USED**		**(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER/UNEXPIRED**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	Hematology analyzer (for total lymphocyte count, full blood count, platelet count, etc.)	1→b	2→02	1→c	2→c	3→02	1	2	8	
02	HemoCue	1→b	2→04	1→c	2→c	3→04	1	2	8	
03	Microcuvette (with valid expiration date)			1	2	3				
04	Colorimeter or hemoglobinometer	1→b	2→07	1→c	2→c	3→07	1	2	8	
05	Drabkin's solution (for colorimeter and hemoglobinometer)			1	2	3				
06	Pipette (for measuring blood volume)	1→b	2→07	1	2	3				
07	Litmus paper for hemoglobin test (with valid expiration date)	1→b	2→803	1	2	3	1	2	8	
803	Does this facility do CD4 testing?			YES. . . . . 1 NO. 2					→ 806	
804	Please tell me if: **a)** Any of the following CD4 test equipment or assay is used in this facility, **b)** Equipment or items needed for the test are available, and **c)** Equipment is in working order	**(a) USED**		**(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER/UNEXPIRED**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	Flow cytometer analyzer e.g., FACS count machine	1→b	2→03	1→c	2→c	3→03	1	2	8	
02	Reagent kits for flow cytometer analyzer			1	2	3				
03	Fluorescent catridge / PIMA analyzer	1→b	2→05	1→c	2→c	3→05	1	2	8	
04	Catridges for fluorescent catridge analyzer			1	2	3				
05	Rapid CD4 test strips	1→b	2→806	1→c	2→c	3→806	1	2	8	

HIV TESTING

806	Does this facility conduct any HIV tests, including HIV RDT, either in the facility or through referral?	YES. . . . . 1 NO. 2	→ 827
807	Is HIV rapid diagnostic testing available from this service site?	YES. . . . . 1 NO. 2	→ 809
808	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
809	Do you use filter paper to collect dried blood spots (DBS) at this site for HIV diagnosis?	YES. . . . . 1 NO. 2	→ 811
810	May I see a sample DBS filter paper card? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	

811	Please tell me if: **a)** Any of the following HIV test or test equipment is used in this facility, **b)** All items needed for the test are available, and **c)** Equipment is in working order	**(a) EQUIPMENT USED/ TEST CONDUCTED**		**(b) ARE ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ELISA/EIA scanner/reader	1 → b	2 → 03	1 → c	2 → c	3 → 02	1	2	8
02	Washer for ELISA scanner/reader	1 → b	2 → 03	1 → c	2 → c	3 → 03	1	2	8
03	Dynabeads with vortex mixer	1 → b	2 → 04	1 → c	2 → c	3 → 04	1	2	8
04	Western Blot test assay	1 → b	2 → 05	1	2	3			
05	PCR for viral load	1 → b	2 → 06	1 → c	2 → c	3 → 06	1	2	8
06	PCR for DNA-EID	1 → b	2 → 812	1 → c	2 → c	3 → 812	1	2	8

812	Do you have any written guidelines on how to conduct HIV test (may be manufacturers instructions, SOP, etc.)	YES. . . . . 1 NO. 2	→ 814
813	May I see the guidelines, instructions or SOP?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
814	Do you have written guidelines on confidentiality and disclosure of HIV test results MAY BE PART OF ANOTHER GUIDELINE	YES. . . . . 1 NO. 2	→ 816
815	May I see the guidelines on confidentiality and disclosure of HIV results?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	
816	Do you have other guidelines relevant to HIV/AIDS or related services	YES. . . . . 1 NO. 2	→ 818
817	May I see the other HIV/AIDS-related guidelines?	OBSERVED . . . . . 1 REPORTED NOT SEEN. 2	

818	Is there an established system for external quality control for the HIV tests conducted by this laboratory?	YES. . . . . 1 NO. 2	→823
819	What system of external quality control for HIV tests is used in this laboratory? PROBE FOR SYSTEM USED. CIRCLE ALL THAT APPLY	PROFICIENCY PANEL. . . . . A EXTERNAL INSPECTION/ OBSERVATION OF TECHNIQUE. . . . . B BLOOD SENT OUTSIDE FOR RETESTING. . C OTHER_____ X	
820	Is there a record of the results from the external quality check?	YES. . . . . 1 NO. 2	→823
821	May I see the records or results from the external quality check?	OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2	→823
822	WHAT IS THE MOST RECENT ERROR RATE RECORDED BY THE EXTERNAL QUALITY CONTROL, ACCORDING TO THE REGISTER	PERCENT ERROR RATE . . . . . ☐☐ NOT AVAILABLE. 95	
823	Do you send blood outside the facility for HIV diagnostic testing?	YES. . . . . 1 NO. 2	→827
824	For which HIV diagnostic test do you send blood outside? PROBE	ELISA/EIA. . . . . A WESTERN BLOT. . . . . B PCR FOR EID. . . . . C RAPID TESTING. . . . . D OTHER. X	
825	Do you maintain records of test result of HIV tests that are conducted outside of this facility?	YES. . . . . 1 NO. 2	→826A
826	May I see records of recent HIV tests conducted outside this facility?	OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2	
826A	Do you send blood outside the facility for viral load testing?	YES. . . . . 1 NO. 2	→827
826B	Do you maintain records of viral load tests that are conducted outside of this facility?	YES. . . . . 1 NO. 2	→827
826C	May I see records of recent viral load tests conducted outside this facility?	OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2	

STANDARD PRECAUTIONS

ASSESS THE HIV TESTING AREA (OR GENERAL LAB AREA IF NO HIV TESTING) FOR THE FOLLOWING ITEMS. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU.

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

CLINICAL CHEMISTRY

830	Does this facility do any blood glucose testing in the facility?	YES . . . . . 1 NO . . . . . 2 → 832								
831	Please tell me if: **a)** Any of the following blood glucose test equipment is used in this facility **b)** Equipment is available, and **c)** Equipment is in working order	**(a) USED**		**(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER/UNEXPIRED**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW	
01	Glucometer	1→b 2 832		1→c	2→c	3 02	1	2	8	
02	Glucometer test strips			1→c	2→c	3 832	1	2	8	
832	Does this facility do any ***liver function tests*** (such as ALT & AST) or ***renal function tests*** (such as serum creatinine) on site?	YES. . . . . 1 NO. . . . . 2 → 836								
833	Does this facility have a blood chemistry analyzer that provides serum creatinine, LFTs and glucose?	YES. . . . . 1 NO. . . . . 2 → 836								
834	May I see the blood chemistry analyzer?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2								
835	Is the blood chemistry analyzer functioning? ACCEPT REPORTED RESPONSE	YES. . . . . 1 NO. 2								
836	Does this facility do any ***urine chemistry testing*** using dipsticks and/or ***urine pregnancy test*** on site?	YES. . . . . 1 NO. . . . . 2 → 838								
837	Please tell me if any of the following dipstick is used in this location. If used, I will like to see one. IF USED ASK TO SEE IT AND NOTE IF VALID/UNEXPIRED	**(A) USED**		**(B) OBSERVED AVAILABLE**						
		Yes	No	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY			
01	Dip sticks for urine protein	1→b	2 02	1	2	3	4			
02	Dip sticks for urine glucose	1→b	2 03	1	2	3	4			
03	Urine pregnancy test	1→b	2 838	1	2	3	4			
838	Do you ever send ***blood or urine*** outside the facility for blood chemistries, LFTs, urinalysis or pregnancy tests?	YES. . . . . 1 NO. . . . . 2 → 840								
839	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE	(A) SEND SPECIMEN OUTSIDE FOR TEST		(B) RECORD OF TEST RESULTS OBSERVED						
		YES	NO	YES	NO					
01	Blood chemistries (e.g. glucose, sodium, potassium etc.)	1→b	2 02	1	2					
02	Liver Function Test (LFT)	1→b	2 03	1	2					
03	Urinalysis	1→b	2 04	1	2					
04	Pregnancy test	1→b	2 840	1	2					

PARASITOLOGY/BACTERIOLOGY

840	Please tell me if: **a)** Any of the following **EQUIPMENT** is used in the facility **b)** Is available, and **c)** Equipment is functioning	(a) **EQUIPMENT/ TEST USED**		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			(c) **IS THE ITEM IN WORKING ORDER?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	LIGHT MICROSCOPE	1→b	2 → 02	1→c	2→c	3 → 02	1	2	8
02	ELECTRON MICROSCOPE	1→b	2 → 03	1→c	2→c	3 → 03	1	2	8
03	REFRIGERATOR IN LAB AREA	1→b	2 → 04	1→c	2→c	3 → 04	1	2	8
04	INCUBATOR	1→b	2 → 05	1→c	2→c	3 → 05	1	2	8
05	TEST TUBES	1→b	2 → 06	1	2	3			
06	CENTRIFUGE FOR CSF MICROSCOPY	1→b	2 → 07	1→c	2→c	3 → 7	1	2	8
07	CULTURE MEDIUM	1→b	2 → 08	1	2	3			
08	GLASS SLIDES AND COVERS	1→b	2 → 841	1	2	3			

841	Does this facility do any **MALARIA** tests (microscopy or RDT) on site, i.e., in this facility?	YES. . . . . 1 NO. 2	→848
842	Do you use malaria rapid diagnostic test to diagnose malaria at this laboratory/service site?	YES. . . . . 1 NO. 2	→847
843	May I see a sample malaria rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
844	OBSERVE OR ASK THE BRAND OR TYPE OF MALARIA RDT KIT COUNTRY-SPECIFIC	PARACHECK. . . . . A CARE START. . . . . B FIRST RESPONSE. . . . . C SD BIOLINE. . . . . D	
845	Do you have a training manual, poster or other job aid for using malaria rapid diagnostic test?	YES . . . . . 1 NO 2	→ 847
846	May I see the training manual, poster or other job aid for using malaria rapid diagnostic test?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

847	Please tell me if: **a)** Any of the following malaria tests or equipment is used in the facility **b)** All items needed for the test are available	(a) EQUIPMENT/ TEST USED		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY
01	GIEMSA STAIN	1→b	2 → 02	1	2	3
02	FIELD STAIN	1→b	2 → 03	1	2	3
03	ACRIDINE ORANGE (AO microscope, and Acridine orange stain)	1→b	2 → 848	1	2	3

848	Does this facility do any **GRAM STAINING?**				YES. . . . . 1 NO. 2		→ 850
849	Please tell me if the following are used and are available today.	(a) **USED**		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY	
01	Crystal violet or Gentian violet	1 → b	2 → 02	1	2	3	
02	Lugol's iodine / Lugol's solution	1 → b	2 → 03	1	2	3	
03	Acetone or Acetone alcohol	1 → b	2 → 04	1	2	3	
04	Neutral red, carbol fuchsin, or other counter stain	1 → b	2 → 850	1	2	3	
850	Do you ever send any specimen outside for ***Gram staining***, ***India Ink staining, malaria testing*** or for culture?				YES. . . . . 1 NO. 2		→ 852
851	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE			(A) SEND SPECIMEN OUTSIDE FOR TEST		(B) RECORD OF TEST RESULTS OBSERVED	
				YES	NO	YES	NO
01	Gram stain			1 → b	2 → 02	1	2
02	India ink stain			1 → b	2 → 03	1	2
03	Malaria			1 → b	2 → 04	1	2
04	Specimen for culture			1 → b	2 → 852	1	2
852	Does this facility do **STOOL MICROSCOPY?**				YES. . . . . 1 NO. 2		→ 854
853	Please tell me if the following are used and are available today.	(a) **USED**		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY	
01	Formal saline (for concentration method)	1 → b	2 → 02	1	2	3	
02	Normal saline (for direct microscopy)	1 → b	2 → 03	1	2	3	
03	Lugol's iodine / Lugol's solution	1 → b	2 → 854	1	2	3	

SYPHILIS

854	Does this facility do any **syphilis** testing on site, i.e., in the facility?	YES. . . . . 1 NO. 2	→ 859
855	Do you use syphilis rapid diagnostic test to diagnose syphilis at this service site?	YES. . . . . 1 NO. 2	→ 857
856	May I see a sample syphilis rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
857	Other than syphilis RDT, does this facility conduct any other syphilis testing in the facility?	YES. . . . . 1 NO. 2	→ 859

858	Please tell me if: **a)** Any of the following syphilis test or test equipment is used in this facility, **b)** All items needed for the test are available, and **c)** Equipment is in working order	**(a) TEST CONDUCTED**		**(b) ARE ALL ITEMS FOR TEST AVAILABLE?**			**(c) IS THE ITEM IN WORKING ORDER?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	VDRL	1 → b	2 → 02	1	2	3			
02	PCR for STIs (CTN)	1 → b	2 → 03	1	2	3			
03	Rotator or shaker			1 → c	2 → c	3 → 04	1	2	3
04	Rapid plasma reagin test (RPR)	1 → b	2 → 859	1	2	3 → 859			

CHLAMYDIA

859	Does this facility do any **chlamydia** testing on site, i.e., in the facility?	YES. . . . . 1 NO 2	→ 861

860	Please tell me if: **a)** Any of the following chlamydia test, test equipment, or stain is used in the facility; **b)** All items needed for the test are available, and	**(a) TEST CONDUCTED**		**(b) ARE ALL ITEMS FOR TEST AVAILABLE?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	Geimsa stain	1 → b	2 → 02	1	2	3
02	PCR for CHLAMYDIA	1 → b	2 → 861	1	2	3

TUBERCULOSIS

861	Does this facility do any **TB** tests on site**?**					YES. . . . . 1 NO. 2				→ 865
862	Please tell me IF: **a)** Any of the following TB tests or equipment is used in the facility **b)** All items needed for the test are available **c)** Equipment is functioning	(a) EQUIPMENT/ TEST USED		(b) **EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			(c) **IS THE ITEM IN WORKING ORDER?**			
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW	
01	Ziehl-Neelson test for AFB	1	2 → 05							
02	Carbol-Fuchsin	1 → b	2 → 03	1	2	3				
03	Sulphuric Acid (20 - 25% concentration) or Acid Alcohol	1 → b	2 → 04	1	2	3				
04	Methylene Blue	1 → b	2 → 05	1	2	3				
05	Fluorescence Microscope (FM)	1 → b	2 → 06	1 → c	2 → c	3 → 06	1	2	8	
06	Culture / growth medium (e.g., MGIT 960)	1 → b	2 → 07	1	2	3				
07	Biosafety hood / cabinet	1 → b	2 → 863	1	2	3				
863	Do you use TB rapid diagnostic test to diagnose TB at this laboratory/service site?					YES. . . . . 1 NO. 2				→865
864	May I see a sample TB rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID					OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4				
865	Do you maintain any sputum containers at this service site for collecting sputum specimen?					YES. . . . . 1 NO. 2				→867
866	May I see a sample sputum container?					OBSERVED . . . . . 1 REPORTED, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4				
867	Does this laboratory send sputum outside the facility for TB testing?					YES. . . . . 1 NO . . . . . 2 DON'T KNOW. 8				→870
868	Do you maintain records of result of sputum tests conducted elsewhere?					YES. . . . . 1 NO. 2				→870
869	May I see the record or register?					OBSERVED . . . . . 1 REPORTED, NOT SEEN. 2				
870	Is there a system for quality control (either internal or external) for the TB sputum smears assessed in this laboratory?					YES. . . . . 1 NO 2				→880
871	Please tell me which type of Quality Control practice is followed by this facility. PROBE TO DETERMINE WHICH TYPE OF QUALTY CONTROL IS USED					INTERNAL QC ONLY. . . . . 1 EXTERNAL QC ONLY. . . . . 2 INTERNAL & EXTERNAL QC. . . . . 3 SEND SLIDE FOR RE-READING. . . . . 4 OTHER_____ 6 (SPECIFY)				
872	Are records maintained of the results from the quality control (internal or external) procedures?					YES. . . . . 1 NO. 2				→880
873	Are records maintained for the internal QC procedures, the external QC procedures, or for both internal and external QC procedures?					RECORDS FOR IQC ONLY. . . . . 1 RECORDS FOR EQC ONLY. . . . . 2 RECORDS FOR BOTH INTERNAL AND EXTERNAL QC PROCEDURES. 3				

DIAGNOSTIC IMAGING

880	Does this facility perform diagnostic X-rays, ultrasound, or computerized tomography? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED AND SPEAK WITH THE MOST KNOWLEDGEABLE PERSON.	YES. . . . . 1 NO . . . . . 2 **SKIP TO NEXT SECTION**								
881	Please tell me if: **a)** If any of the following imaging equipment is used in the facility **b**) if it is available today, and **c)** if it is functioning today	(a) EQUIPMENT USED		(b) **EQUIPMENT AVAILABLE?**			(c) **IS THE ITEM IN WORKING ORDER?**		
		Yes	No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	DIGITAL X-RAY MACHINE NOT REQUIRING FILM	1→b	2 → 02	1→c	2→c	3 → 02	1	2	8
02	X-RAY MACHINE	1→b	2 → 04	1→c	2→c	3 → 03	1	2	8
03	UNEXPIRED FILM FOR X-RAY			1	2	3 → 04			
04	ULTRASOUND SYSTEM / MACHINE	1→b	2 → 05	1→c	2→c	3 → 05	1	2	8
05	CT SCAN	1→b	2 → **NEXT SECTION**	1→c	2→c	3 → **SKIP TO NEXT SECTION**	1 →	2 →	8 → **ALL SKIP TO NEXT SECTION**
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE								

SECTION 9: MEDICINES AND COMMODITIES

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

SECTION 9.1: GENERAL MEDICINES AND SUPPLY ITEMS

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

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

ANTIBIOTICS

	Are any of the following ***antibiotics*** available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	AMOXICILLIN TABLET/CAPSULE (Bacterial infections in adults)	1	2	3	4	5
02	AMOXICILLIN SYRUP/SUSPENSION (Oral antibiotics for children)	1	2	3	4	5
03	AMOXICILIN/CLAVULINATE (AUGMENTIN) TABS (broad spectrum antibiotics)	1	2	3	4	5
04	AMPICILLIN (POWDER) INJECTION (Broad spectrum antibiotic)	1	2	3	4	5
05	AZITHROMYCIN TABS/CAPS (antibiotic)	1	2	3	4	5
06	AZITHROMYCIN SYR/SUSPENSION (antibiotic)	1	2	3	4	5
07	BENZATHINE BENZYLPENICILLIN (POWDER) FOR INJECTION	1	2	3	4	5
08	CEFIXIME TABS/CAPS (antibiotic)	1	2	3	4	5
09	CEFTRIAXONE INJECTION (Injectable antibiotic)	1	2	3	4	5
10	CIPROFLOXACIN (2nd-line oral antibiotic)	1	2	3	4	5
11	CO-TRIMOXAZOLE (TABS) (Oral antibiotics-adult formation)	1	2	3	4	5
12	CO-TRIMOXAZOLE SUSPENSION (Oral antibiotics for children)	1	2	3	4	5
13	DOXYCYCLINE TABS/CAPS [Broad spectrum antibiotic]	1	2	3	4	5
14	ERYTHROMYCIN [Broad spectrum antibiotic, oral tabs]	1	2	3	4	5
15	ERYTHROMYCIN [oral suspension]	1	2	3	4	5
16	GENTAMYCIN INJECTION (Broad spectrum injectable antibiotic)	1	2	3	4	5
17	METRONIDAZOLE TABLETS [antibiotic/amebecide/antiprotozoal]	1	2	3	4	5
18	METRONIDAZOLE INJECTION	1	2	3	4	5
19	PENICILLIN INJECTION (Broad spectrum injectable antibiotic)	1	2	3	4	5
20	TETRACYCLINE [Broad spectrum antibiotic, oral caps]	1	2	3	4	5
21	TETRACYCLINE EYE OINTMENT	1	2	3	4	5
22	OTHER ANTIBIOTIC EYE OINTMENT FOR NEWBORN	1	2	3	4	5
22A	AMOXICILLIN DISPERSIBLE PEDIATRIC-DOSED TABLETS	1	2	3	4	5
22B	CO-TRIMOXAZOLE DISPERSIBLE PEDIATRIC-DOSED	1	2	3	4	5
22C	PENICILLIN TABLETS	1	2	3	4	5

MEDICINES FOR WORM INFESTATION

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

MEDICINES FOR NON-COMMUNICABLE DISEASES

903	Are any of the following medicines for the management of **non-communicable diseases** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	AMITRIPTYLINE (Depression)	1	2	3	4	5
02	AMLODIPINE TABLETS (CCB for high blood pressure)	1	2	3	4	5
03	ATENOLOL (Beta-blocker, Angina/hypertension)	1	2	3	4	5
04	BECLOMETHASONE INHALER	1	2	3	4	5
05	BETAMETHASONE INJECTION	1	2	3	4	5
06	CAPTOPRIL / LISINOPRIL (Vaso-dilatation, cardiac hypertension)	1	2	3	4	5
07	DEXAMETHASONE INJECTION	1	2	3	4	5
08	DIAZEPAM INJECTION (Anxiety/muscle relaxant/anticonvulsant)	1	2	3	4	5
09	ENALAPRIL CAPSULE/TABLET (A.C.E INHIBITOR)	1	2	3	4	5
10	OTHER A.C.E INHIBITOR	1	2	3	4	5
11	EPINEPHRINE / ADRENALINE INJECTION	1	2	3	4	5
12	FUROSEMIDE (DIURETIC)	1	2	3	4	5
13	THIAZIDE DIURETIC	1	2	3	4	5
14	GLIBENCLAMIDE (Oral treatment for type-2 diabetes)	1	2	3	4	5
15	GLUCOSE INJECTABLE SOLUTION, 10% OR 50%	1	2	3	4	5
16	HEPARIN INJECTION	1	2	3	4	5
17	HYDROCORTISONE INJECTION	1	2	3	4	5
18	INSULIN INJECTIONS - LENTE [DIABETES]	1	2	3	4	5
19	ISOSORBIDE DINITRATE	1	2	3	4	5
20	METFORMIN TABLETS	1	2	3	4	5
21	NIFEDIPINE TABLETS/CAPSULES (CCB for high blood pressure)	1	2	3	4	5
22	OMEPRAZOLE / CIMETIDINE (Gastro-esophageal reflux)	1	2	3	4	5
23	PREDNISOLONE	1	2	3	4	5
24	SALBUTAMOL INHALER (Bronchospasms/Chronic asthma)	1	2	3	4	5
25	SIMVASTATIN / ATOVASTATIN (High cholesterol)	1	2	3	4	5
25A	INSULIN INJECTIONS - ACTRAPID [DIABETES]	1	2	3	4	5
25B	SALBUTAMOL TABLETS (Bronchospasms/Chronic asthma)	1	2	3	4	5

ANTI-FUNGAL MEDICINES

904	Are any of the following **anti-fungal medicines** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	FLUCONAZOLE	1	2	3	4	5
02	MICONAZOLE VAGINAL PESSARIES	1	2	3	4	5
03	MICONAZOLE CREAM	1	2	3	4	5
04	NYSTATIN ORAL SUSPENSION	1	2	3	4	5
05	NYSTATIN VAGINAL PESSARIES/CREAM	1	2	3	4	5
05A	GRISEOFULVIN TABS	1	2	3	4	5
05B	KETAKONAZOL INJECTABLE	1	2	3	4	5

ANTIMALARIAL MEDICINES

905	Are any of the following **antimalarial** medicines available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	ARTEMETHER LUMEFRANTRINE (LA): 6 TABLETS/PACK	1	2	3	4	5
02	ARTEMETHER LUMEFRANTRINE (LA): 12 TABLETS/PACK	1	2	3	4	5
03	ARTEMETHER LUMEFRANTRINE (LA): 18 TABLETS/PACK	1	2	3	4	5
04	ARTEMETHER LUMEFRANTRINE (LA): 24 TABLETS/PACK	1	2	3	4	5
05	FANSIDAR / SP [SULFADOXINE + PYRIMETHAMINE] TABS	1	2	3	4	5
06	QUININE TABLETS	1	2	3	4	5
07	QUININE INJECTION	1	2	3	4	5
08	INJECTABLE ARTESUNATE	1	2	3	4	5
09	ARTESUNATE SUPPOSITORIES / RECTAL ARTESUNATE	1	2	3	4	5
10	OTHER ANTI-MALARIAL MEDICINE	1	2	3	4	5
10A	ARTEMETER - AMODIAQUINE (ASAQ) 25mg/67.5mg	1	2	3	4	5
10B	ARTEMETER - AMODIAQUINE (ASAQ) 50mg/135mg	1	2	3	4	5
10C	ARTEMETER - AMODIAQUINE (ASAQ) 100mg/270mg	1	2	3	4	5

MATERNAL AND CHILD HEALTH

906	Are any of the following medicines for **maternal health** available in the facility/location today?	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
	CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	CALCIUM GLUCONATE INJECTION	1	2	3	4	5
02	FOLIC ACID TABLETS	1	2	3	4	5
03	IRON TABLETS	1	2	3	4	5
04	IRON + FOLIC ACID COMBINATION TABLET	1	2	3	4	5
05	MAGNESIUM SUPHATE INJECTION	1	2	3	4	5
06	MISOPROSTOL TABLETS/CAPSULES	1	2	3	4	5
07	OXYTOCIN OR OTHER INJECTABLE UTEROTONIC	1	2	3	4	5
08	TETANUS TOXOID VACCINE	1	2	3	4	5
09	ORAL REHYDRATION SALTS (ORS) SACHETS	1	2	3	4	5
10	VITAMIIN A CAPSULES	1	2	3	4	5
11	ZINC TABLETS	1	2	3	4	5
11A	HYDRALIZINE INJECTION	1	2	3	4	5

INTRAVENOUS FLUIDS

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

FEVER REDUCING AND PAIN MEDICINES

908	Are any of the following **OTHER medicines** available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	DICLOFENAC TABLETS (Strong oral pain medicine)	1	2	3	4	5
02	PARACETAMOL TABLETS	1	2	3	4	5
03	PARACETAMOL SYRUP	1	2	3	4	5
03A	DICLOFENAC SUPPOSITORIES (Strong pain medicine)	1	2	3	4	5
03B	ASPIRIN TABLETS	1	2	3	4	5
03C	BRUFEN TABLETS	1	2	3	4	5
03D	CODEINE TABLETS (Strong oral pain medicine)	1	2	3	4	5
03E	INDOMETHACIN CAPSULES (NSAID, fever reducer, pain medicine)	1	2	3	4	5
03F	MORPHINE TABLETS	1	2	3	4	5
03G	MORPHINE INJECTION	1	2	3	4	5
03H	LIQUID MORPHINE OR MORPHINE SYRUP/SUSPENSION	1	2	3	4	5
03I	PARACETAMOL SUPPOSITORIES	1	2	3	4	5
03J	PETHIDINE INJECTION	1	2	3	4	5

STORAGE CONDITION: ANTIBIOTICS & GENERAL MEDICINES

909	OBSERVE THE PLACE WHERE THE MEDICINES ASSESSED SO FAR ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS.	YES	NO
01	ARE THE MEDICINES OFF THE FLOOR?	1	2
02	ARE THE MEDICINES PROTECTED FROM WATER	1	2
03	ARE THE MEDICINES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

910	ARE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")?	YES, ALL MEDICINES. . . . . 1 YES, ONLY SOME MEDICINES. . . . . 2 NO. 3	
911	What system does this facility use to monitor the amount of medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 4 OTHER SYSTEM _____ 6 (SPECIFY)	

SUPPLY ITEMS

912	Do you have the following supply items available in the facility/location today?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
02	INFUSION SET FOR IV SOLUTION	1	2	3
03	CANULA FOR ADMINISTERING IV FLUIDS (24G)	1	2	3
04	LATEX GLOVES	1	2	3
05	ALCOHOL-BASED HAND RUB	1	2	3
06	HAND WASHING SOAP	1	2	3
07	DISINFECTING SOLUTION	1	2	3
08	INSECTICIDE TREATED MOSQUITO NETS (ITNs) OR LONG LASTING INSECTICIDE NETS (LLINs)	1	2	3
08A	GAUZE	1	2	3
08B	CANULA FOR ADMINISTERING IV FLUIDS (23G)	1	2	3
08C	CANULA FOR ADMINISTERING IV FLUIDS (22G)	1	2	3
08D	CANULA FOR ADMINISTERING IV FLUIDS (21G)	1	2	3

SECTION 9.2: CONTRACEPTIVE COMMODITIES

920	**CHECK Q212** CONTRACEPTIVES STORED WITH OTHER MEDICINES IN COMMON LOCATION **(RESPONSE 2 CIRCLED)** ☐ ↓ CONTRACEPTIVES STORED IN FP SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY **(RESPONSE 1 OR 3 CIRCLED)** ☐ ↓ PROCEED TO NEXT SECTION **(TB MEDS?)** ←	

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
921	Are any of the following **CONTRACEPTIVE commodities** available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	COMBINED ORAL CONTRACEPTIVE PILLS	1	2	3	4	5
02	PROGESTIN-ONLY CONTRACEPTIVE PILLS	1	2	3	4	5
03	COMBINED INJECTABLE CONTRACEPTIVES	1	2	3	4	5
04	PROJESTIN-ONLY INJECTABLE CONTRACEPTIVES (DEPO-PROVERA)	1	2	3	4	5
05	MALE CONDOMS	1	2	3	4	5
06	FEMALE CONDOMS	1	2	3	4	5
07	INTRAUTERINE CONTRACEPTIVE DEVICE	1	2	3	4	5
08	IMPLANT (JADELLE OR IMPLANON)	1	2	3	4	5
09	EMERGENCY CONTRACEPTIVE PILLS (PROSTINOL 2)	1	2	3	4	5
10	CYCLE BEADS FOR STANDARD DAYS METHOD	1	2	3	4	5

STORAGE CONDITION - CONTRACEPTIVE COMMODITIES

922	OBSERVE THE LOCATION WHERE CONTRACEPTIVE COMMODITIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS	YES	NO
01	ARE THE COMMODITIES OFF THE FLOOR?	1	2
02	ARE THE COMMODITIES PROTECTED FROM WATER	1	2
03	ARE THE COMMODITIES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

923	ARE THE CONTRACEPTIVE COMMODITIES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")	YES, ALL COMMODITIES. . . . . 1 NOT ALL COMMODITIES. . . . . 2 NO. 3	
924	What type of system does this facility use to monitor the amount of contraceptive commodities received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED COMMODITIES. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED COMMODITIES. . . . . 4 OTHER SYSTEM _____ (SPECIFY) 6	
925	PRESENTLY INTERVIEWING IN PHARMACY ☐ ↓ PROCEED TO NEXT SECTION OR SERVICE SITE ← PRESENTLY INTERVIEWING IN FAMILY PLANNING SERVICE AREA ☐ ↓ THANK THE RESPONDENT IN THE FP SERVICE AREA AND CONTINUE TO NEXT SECTION OR SERVICE SITE ←		

SECTION 9.3: ANTI-TB DRUGS

930	**CHECK Q214** ANTI-TB MEDICINES STORED WITH OTHER MEDICINES IN COMMON LOCATION **(RESPONSE 2 CIRCLED)** ☐ ↓ ANTI-TB MEDICINES STORED IN TB SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY **(RESPONSE 1 OR 3 CIRCLED)** ☐ ↓ PROCEED TO NEXT SECTION **(ARV MEDS?)** ←	

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
931	Are any of the following TB medicines available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	ETHAMBUTOL TABS	1	2	3	4	5
02	ISONIAZID TABS	1	2	3	4	5
03	PYRAZINAMIDE	1	2	3	4	5
04	RIFAMPICIN	1	2	3	4	5
05	ISONIAZID + RIFAMPICIN	1	2	3	4	5
06	ISONIAZID + ETHAMBUTOL (EH) (2FDC)	1	2	3	4	5
07	ISONIAZID + RIFAMPICIN + PYRAZINAMIDE (RHZ) (3FDC)	1	2	3	4	5
08	ISONIAZID + RIFAMPICIN + ETHAMBUTOL (RHE) (3FDC)	1	2	3	4	5
09	ISONIAZID + RIFAMPICIN + PYRAZINAMIDE + ETHAMBUTOL (4FDC)	1	2	3	4	5
10	STREPTOMYCIN INJECTABLE	1	2	3	4	5

STORAGE CONDITION: ANTI-TB MEDICINES

932	OBSERVE THE PLACE WHERE THE TB MEDICINES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS.	YES	NO
01	ARE THE MEDICINES OFF THE FLOOR?	1	2
02	ARE THE MEDICINES PROTECTED FROM WATER	1	2
03	ARE THE MEDICINES PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

933	ARE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")?	YES, ALL MEDICINES. . . . . 1 YES, ONLY SOME MEDICINES. . . . . 2 NO. 3	
934	What system does this facility use to monitor the amount of medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES. . . . . 4 OTHER SYSTEM _____ 6 (SPECIFY)	
935	PRESENTLY INTERVIEWING IN PHARMACY ☐ ↓ PROCEED TO NEXT SECTION OR SERVICE SITE ← PRESENTLY INTERVIEWING IN TB SERVICE AREA ☐ ↓ THANK THE RESPONDENT IN THE TB SERVICE AREA AND CONTINUE TO NEXT SECTION OR SERVICE SITE ←		

SECTION 9.4: ANTIRETROVIRAL MEDICINES

940	**CHECK Q216** ARV MEDICINES STORED WITH OTHER MEDICINES IN COMMON LOCATION **(RESPONSE 2 CIRCLED)** ☐ → ↓ ARV MEDICINES STORED IN ART SERVICE AREA OR NOT STOCKED AT ALL IN FACILITY **(RESPONSE 1 OR 3 CIRCLED)** ☐ → ↓ PROCEED TO NEXT SECTION **(ARV MEDS?)**					
941	Are any of the following Nucleoside Reverse Transcriptase Inhibitor (NTRI) ARVs available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	ZIDOVUDINE (ZDV, AZT) TABLETS	1	2	3	4	5
02	ZIDOVUDINE (ZDV, AZT) SYRUP / DISPERSIBLE PEDIATRIC TABS	1	2	3	4	5
03	ABACAVIR (ABC) TABLETS	1	2	3	4	5
04	DIDANOSINE (ddI) TABLETS	1	2	3	4	5
05	LAMIVUDINE (3TC) TABLETS	1	2	3	4	5
06	LAMIVUDINE (3TC) SYRUP	1	2	3	4	5
07	STAVUDINE 30 (D4T)	1	2	3	4	5
08	STAVUDINE SYRUP	1	2	3	4	5
09	TENOFOVIR DISOPROXIL FUMARATE (TDF)	1	2	3	4	5
10	EMTRICITABINE (FTC)	1	2	3	4	5
942	Are any of the following **Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI)** ARVs available in the facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	NEVIRAPINE (NVP) TABLETS	1	2	3	4	5
02	NEVIRAPINE (NVP) SYRUP	1	2	3	4	5
03	EFAVIRENZ (EFV) TABLETS/CAPSULES	1	2	3	4	5
04	EFAVIRENZ (EFV) SYRUP	1	2	3	4	5
05	DELAVIRDINE (DLV)	1	2	3	4	5

943	Are any of the following **Protease Inhibitor** ARVs available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	LOPINAVIR (LPV)	1	2	3	4	5
02	INDINAVIR (IDV)	1	2	3	4	5
03	NELFINAVIR (NFV)	1	2	3	4	5
04	SAQUINAVIR (SQV)	1	2	3	4	5
05	RITONAVIR (RTV)	1	2	3	4	5
06	ATAZANAVIR (ATV)	1	2	3	4	5
07	FOSAMPRENAVIER (FPV)	1	2	3	4	5
08	TIPRANAVIR (TPV)	1	2	3	4	5
09	DARUNAVIR (DRV)	1	2	3	4	5

944	Are any of the following **Fusion Inhibitor or Combined ARVs** available in this facility/location today? CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	ENFUVIRDITE (T-20)	1	2	3	4	5
02	STAVUDINE + LAMIVUDINE [D4T + 3TC]	1	2	3	4	5
03	STAVUDINE + LAMIVUDINE + NEVIRAPINE [D4T + 3TC + NVP]	1	2	3	4	5
04	ZIDOVUDINE + LAMIVUDINE [AZT + 3TC]	1	2	3	4	5
05	ZIDOVUDINE + LAMIVUDINE + ABACAVIR [AZT + 3TC + ABC]	1	2	3	4	5
06	ZIDOVUDINE + LAMIVUDINE + NEVIRAPINE [AZT + 3TC + NVP]	1	2	3	4	5
07	TENOFOVIR + EMTRICITABINE [TDF + FTC]	1	2	3	4	5
08	TENOFOVIR + LAMIVUDINE [TDF + 3TC]	1	2	3	4	5
09	LAMIVUDINE (3TC) + EFAVIRENZ (EFV) + TENAFOVIR (TDF)	1	2	3	4	5
10	TENOFOVIR + EMTRICITABINE + EFAVIRENZ [TDF + FTC + EFV]	1	2	3	4	5
11	LOPINAVIR + RITONAVIR [LPV + RTV]	1	2	3	4	5
12	ATAZANIVIR + RITONAVIR [ATV + RTV]	1	2	3	4	5

STORAGE CONDITION - ARV MEDICINES

945	OBSERVE THE LOCATION WHERE ARVs ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING STORAGE CONDITIONS	YES	NO
01	ARE THE ARVs OFF THE FLOOR?	1	2
02	ARE THE ARVs PROTECTED FROM WATER	1	2
03	ARE THE ARVs PROTECTED FROM THE SUN?	1	2
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)?	1	2
05	IS THE STORAGE ROOM WELL VENTILATED?	1	2

946	ARE THE ARVS ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out")	YES, ALL MEDICINES. . . . . 1 YES, ONLY SOME MEDICINES. . . . . 2 NO. 3	
947	What system does this facility use to monitor the amount of ARV medicines received, the amount issued, and the amount present today? ASK TO SEE THE SYSTEM AND RECORD OBSERVATION	COMPUTER SYSTEM UPDATED DAILY. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 COMPUTER SYSTEM NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED ARVS. . . . . 3 LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED ARVS. . . . . 4 OTHER SYSTEM _____ 6 (SPECIFY)	
948	PRESENTLY INTERVIEWING IN PHARMACY ☐ PROCEED TO NEXT SECTION OR SERVICE SITE ←	PRESENTLY INTERVIEWING IN ART SERVICE AREA ☐ THANK THE RESPONDENT IN THE ART SERVICE AREA AND CONTINUE TO NEXT SECTION OR SERVICE SITE ←	

MODULE 3: SERVICE-SPECIFIC READINESS

CHILD HEALTH SERVICES

SECTION 10: CHILD VACCINATION

1000	**CHECK Q102.01** CHILD VACCINATION SERVICES AVAILABLE ☐ NO CHILD VACCINATION SERVICES ☐ → NEXT SECTION OR SERVICE SITE	

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

1001 Now I would like to ask you specifically about vaccination services for children under 5 years. For each of the following services, please tell me whether the service is offered by your facility, and if so, *how many days* per month the service is provided *at the facility, and how many days per month as outreach, if any.*

	CHILD VACCINATION SERVICE (USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH
01	Routine DPT+HepB+HiB (i.e., pentavalent)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
02	Routine polio vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
03	Routine measles vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
04	BCG vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
04A	Pneumococcal vaccination (pneumonia vaccine)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
04B	Rotavirus vaccination	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐

1002	Do you have the ***national guidelines*** for child vaccinations available in this service area today? i.e., the poster, booklet, or the childe health passport?	YES . . . . . 1 NO 2	→ 1004
1003	May I see the guidelines / booklet, or child health passport?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1006
1004	Do you have ***any other guidelines*** for child vaccinations available in this service area today?	YES . . . . . 1 NO 2	→ 1006
1005	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

1006	ASK YOUR RESPONDENT TO SHOW YOU ITEMS REQUIRED FOR VACCINATION SERVICES	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	Blank/unused individual child vaccination card or health passport	1	2	3	
02	Under-1 registers	1	2	3	
03	Monthly vaccination performance forms	1	2	3	
03A	Daily temperature recording and stock management tool	1	2	3	
03B	Adverse events following immunization reporting form	1	2	3	

1007	Does this facility routinely store any vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided?	ROUTINELY STORE VACCINES. . . . . 1 STORES NO VACCINES. 2	→ 1014
1008	ASK TO BE TAKEN TO THE AREA WHERE VACCINES ARE STORED. ASK TO SEE THE VACCINE REFRIGERATOR OR FREEZER.	REFRIGERATOR OBSERVED. . . . . 1 REFRIGERATOR NOT OBSERVED. 2	→ 1014
1009	Do you maintain a cold-chain temperature-monitoring chart?	YES. . . . . 1 NO 2	→ 1012
1010	May I see the cold-chain temperature monitoring chart?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1012
1011	CHECK WHETHER THE TEMPERATURE RECORD WAS COMPLETED TWICE DAILY FOR EACH OF THE PAST 30 DAYS, INCLUDING WEEKENDS AND PUBLIC HOLIDAYS.	YES, COMPLETED . . . . . 1 NO, NOT COMPLETED 2	

1012	Please tell me if each of the following vaccines is available in the facility today. If available, I would like to see it. IF AVAILABLE, CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	DPT+HepB+HiB [PENTAVALENT]	1	2	3	4	5
02	ORAL POLIO VACCINE	1	2	3	4	5
03	MEASLES VACCINE AND DILUENT	1	2	3	4	5
04	BCG VACCINE AND DILUENT	1	2	3	4	5
04A	PNEUMOCOCCAL CONJUGATE VACCINE (PCV 13)	1	2	3	4	5
04B	ROTAVIRUS VACCINE	1	2	3	4	5

1013	WHAT IS THE TEMPERATURE IN THE VACCINE REFRIGERATOR?	BETWEEN +2 AND +8 DEGREES. . . . . 1 ABOVE +8 DEGREES. . . . . 2 BELOW +2 DEGREES. . . . . 3 THERMOMETER NOT FUNCTIONAL. 4	
1014	How many vaccine carriers do you have? ASK TO SEE THE VACCINE CARRIERS. REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT IS ACCEPTABLE.	ONE. . . . . 1 TWO OR MORE SETS. . . . . 2 NONE. 3	→ 1015A
1015	How many sets of ice packs do you have? ASK TO SEE THE ICE PACKS. REPORTED RESPONSEACCEPTABLE **NOTE: 4-5 ICE PACKS MAKE ONE SET**	ONE SET. . . . . 1 TWO OR MORE SETS. . . . . 2 NO ICE PACKS, USE PURCHASED ICE. . . . . 3 NO ICE PACKS. 4	
1015A	How many cold boxes do you have? ASK TO SEE THE COLD BOXES. REPORTED RESPONSEACCEPTABLE	# OF COLD BOXES ☐☐☐ DON'T KNOW. 998	

STANDARD PRECAUTIONS

1050	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1051	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1052	DESCRIBE THE SETTING OF THE CHILD VACCINATION SERVICE DELIVERY ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 11: CHILD GROWTH MONITORING SERVICES

1100	**CHECK Q102.02**	GROWTH MONITORING SERVICES AVAILABLE ☐ → NO GROWTH MONITORING SERVICES ☐ → NEXT SECTION OR SERVICE SITE	

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

1101	Please tell me the number of days per month that growth monitoring services are offered in this facility, and the number of days per month as outreach, if any. USE A 4-WEEK MONTH TO CALCULATE # OF DAYS		(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH
01	Child growth monitoring		# OF DAYS ☐☐	# OF DAYS 00=NO SERVICE ☐☐
1102	Do you have any guidelines for growth monitoring available in this service area today?		YES. . . . . 1 NO GUIDELINE AVAILABLE. 2	→ 1103A
1103	May I see the guidelines for growth monitoring?		OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1103A	Do you have any guidelines for diagnosing and/or managing malnutrition? This may be part of another guideline.		YES. . . . . 1 NO GUIDELINE AVAILABLE. 2	→1104
1103B	May I see the guidelines for diagnosing and/or managing malnutrition?		OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

		(A) AVAILABLE			(B) FUNCTIONING		
1104	I would like to know if the following items are available in this service area and are functioning. I would like to see them.	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	CHILD WEIGHING SCALE (250GRAM GRADATION)	1 →b	2 →b	3 → 02	1	2	8
02	INFANT WEIGHING SCALE (100 GRAM GRADATION)	1 →b	2 →b	3 → 03	1	2	8
03	HEIGHT OR LENGTH BOARD	1 →b	2 →b	3 → 04	1	2	8
04	TAPE FOR MEASURING HEAD CIRCUMFERENCE	1	2	3			
05	GROWTH CHARTS	1	2	3			
05A	TALLY SHEET	1	2	3			

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 12: CHILD CURATIVE CARE SERVICES

1200	**CHECK Q102.03** CURATIVE CARE SERVICES AVAILABLE ☐ ↓ NO CURATIVE CARE SERVICES ☐ ↓ NEXT SECTION OR SERVICE SITE ←	

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

		(a) # OF DAYS PER MONTH SERVICE IS PROVIDED AT FACILITY	(b) # OF DAYS PER MONTH SERVICE IS PROVIDED THROUGH OUTREACH (VILLAGE LEVEL) ACTIVITIES
1201	Please tell me the number of days per month that consultations or curative care for children under 5 are offered in this facility, and the number of days per month as outreach, if any. USE A 4-WEEK MONTH TO CALCULATE # OF DAYS		
01	Consultation or curative care services for sick children	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐

		YES	NO
1202	Please tell me if providers of child health services in this facility provide the following services		
01	DIAGNOSE AND/OR TREAT CHILD MALNUTRITION	1	2
02	PROVIDE VITAMIN A SUPPLEMENTATION TO CHILDREN	1	2
03	PROVIDE IRON SUPPLEMENTATION TO CHILDREN	1	2
04	PROVIDE ZINC SUPPLEMENTATION TO CHILDREN	1	2

1203	Do providers of services for sick children in this facility follow the IMCI strategy in the provision of services to children under 5 years?	YES . . . 1 NO . . . 2	
1204	Do you have the ***IMCI guidelines*** for the diagnosis and management of childhood illnesses available in this service area today? i.e., the IMCI chart booklet?	YES . . . 1 NO . . . 2	→ 1206
1205	May I see the IMCI chart booklet?	OBSERVED . . . 1 REPORTED NOT SEEN . . . 2	→ 1208
1206	Do you have ***any (other) guidelines*** for the diagnosis and management of childhood illnesses available in this service site today?	YES . . . 1 NO . . . 2	→ 1208
1207	May I see the other guidelines?	OBSERVED . . . 1 REPORTED NOT SEEN . . . 2	
1208	Does this facility have a system whereby certain observations and parameters are routinely carried out on sick children before the consultation for the presenting illness? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE BEFORE THE CONSULTATION	YES . . . 1 NO . . . 2	→ 1210

1209	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely conducted for all sick children?	ACTIVITY OBSERVED	ACTIVITY REPORTED NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing the child	1	2	3	8
02	Plotting child's weight on graph	1	2	3	8
03	Taking child's temperature	1	2	3	8
04	Assessing child's vaccination status	1	2	3	8
05	Providing group health education	1	2	3	8
06	Administer fever-reducing medicines and/or sponge for fever	1	2	3	8
07	Triaging of sick children, i.e., prioritizing sick children based on the severity of their condition	1	2	3	8
07A	Routine malaria rapid diagnostic testing for children under 5 years presenting with fever before they are seen by the clinician	1	2	3	8

1210	I would like to know if the following items are available in this service area and are functioning. I would like to see them THESE ITEMS MAY BE IN AN ORT CORNER	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	CHILD WEIGHING SCALE (250GRAM GRADATION)	1 →b	2 →b	3 ↵02	1	2	8
02	INFANT WEIGHING SCALE (100 GRAM GRADATION)	1 →b	2 →b	3 ↵03	1	2	8
03	THERMOMETER	1 →b	2 →b	3 ↵04	1	2	8
04	STETHOSCOPE	1 →b	2 →b	3 ↵05	1	2	8
05	Timer or watch with seconds hand	1 →b	2 →b	3 ↵06	1	2	8
06	Staff has watch with seconds hand or other device (e.g., cell phone) that can measure seconds	1	2	3			
07	Calibrated 1/2 or 1-liter measuring jar for ORS	1	2	3			
08	Cup and spoon	1	2	3			
09	ORS PACKETS OR SACHETS	1	2	3			
10	At least 3 buckets (for cleaning used cups)	1	2	3			
11	Examination Table/Bed	1	2	3			
1211	Please tell me if you have any of the following materials. IF YES, ASK TO SEE						
02	IMCI mother's cards or health passport	1	2	3			
03	Other visual aids for teaching caretakers	1	2	3			
1212	Are individual health records (i.e., health passport, child welfare card or other) for sick children maintained at this service site?	YES . . . . . 1 NO 2					→ 1250
1213	May I see an unused copy of the individual records or health passport?	OBSERVED . . . . . 1 REPORTED NOT SEEN 2					

STANDARD PRECAUTIONS

1250	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051]. . . . . 12 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	NEXT SECTION / SERVICE SITE

1251	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1252	DESCRIBE THE SETTING OF THE SICK CHILD SERVICE DELIVERY ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 13: FAMILY PLANNING

1300	**CHECK Q102.04** FAMILY PLANNING SERVICES ☐ ↓ NO FAMILY PLANNING SERVICES ☐ → NEXT SECTION OR SERVICE SITE				
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE FAMILY PLANING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT FAMILY PLANNING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.				
1301	How many days in a month are family planning services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS ☐☐			
1302	Does this facility ***provide*** (i.e., stock the commodity) or ***prescribe, counsel or refer clients for*** any of the following modern methods of family planning:	PROVIDE (STOCK THE COMMODITY)	PRESCRIBE/ COUNSEL, OR REFER	NO	
01	COMBINED ORAL CONTRACEPTIVE PILLS	1	2	3	
02	PROGESTIN-ONLY CONTRACEPTIVE PILLS	1	2	3	
03	COMBINED INJECTABLE CONTRACEPTIVES	1	2	3	
04	PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES (DEPO)	1	2	3	
05	MALE CONDOMS	1	2	3	
06	FEMALE CONDOMS	1	2	3	
07	INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)	1	2	3	
08	IMPLANT (JADELLE OR IMPLANON)	1	2	3	
09	EMERGENCY CONTRACEPTIVE PILLS (PROSTINOL 2)	1	2	3	
10	CYCLE BEADS FOR STANDARD DAYS METHOD	1	2	3	
11	COUNSEL CLIENTS ON PERIODIC ABSTINENCE		2	3	
12	VASECTOMY (MALE STERILIZATION)	1	2	3	
13	TUBAL LIGATION (FEMALE STERILIZATION)	1	2	3	
14	OTHER METHODS (E.G., SPERMICIDE OR DIAGPHRAGM)	1	2	3	
1303	Do you have the ***sexual and reproductive health (SRH) guidelines*** available at this service area today?	YES. . . . . 1 NO. 2			→ 1305
1304	May I see the SRH guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2			→ 1307
1305	Do you have ***any other guidelines*** on family planning available at this service area today?	YES. . . . . 1 NO. 2			→ 1307
1306	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2			
1307	Are individual records or cards maintained at this service site for family planning clients?	YES. . . . . 1 NO. 2			→ 1309
1308	May I see a blank copy of the individual records or card?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2			

1309	Does this facility have a system whereby certain observations and parameters are routinely carried out on family planning clients before the consultation takes place? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE.	YES. . . . . 1 NO. 2	→ 1311

1310	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely done for all family planning clients?	ACTIVITY OBSERVED	ACTIVITY REPORTED NOT SEEN	ACTIVITY NOT ROUTINELY DONE	DON'T KNOW
01	Weighing of clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8

1311	Do family planning providers in this facility routinely diagnose and treat STIs, or are STIs clients referred to another provider or location for STI diagnosis and treatment?	ROUTINELY DIAGNOSE AND TREAT STIs. . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATM 2 REFER ELSEWHERE IN FACILITY FOR DIAG & TRE 3 REFER OUTSIDE FACILITY FOR DIAG & TREATMEN 4 NO DIAGNOSIS / TREATMENT / REFERRAL. 5	
1312	Do providers of family planning conduct HIV testing from this service site?	YES. . . . . 1 NO. 2	→ 1314
1313	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	

EQUIPMENT AND SUPPLIES

		(A) AVAILABLE			(B) FUNCTIONING		
1314	I would like to know if the following items are available in this service area today and are functioning	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	DIGITAL BP APPARATUS	1 → b	2 → b	3 → 02	1	2	8
02	MANUAL BP APPARATUS	1 → b	2 → b	3 → 03	1	2	8
03	STETHOSCOPE	1 → b	2 → b	3 → 04	1	2	8
04	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → b	2 → b	3 → 05	1	2	8
05	EXAMINATION BED OR COUCH	1	2	3			
06	SAMPLE OF FP METHODS	1	2	3			
07	OTHER FP-SPECIFIC VISUAL AIDS [E.G., FLIP CHARTS, LEAFLETS]	1	2	3			
08	PELVIC MODEL FOR IUCD	1	2	3			
09	MODEL FOR SHOWING MALE CONDOM USE	1	2	3			
09A	MODEL FOR SHOWING FEMALE CONDOM USE	1	2	3			

1315	**CHECK Q1302.07 & Q1302.08.** IUCD OR IMPLANT PROVIDED IN FACILITY ☐		NEITHER IUCD NOR IMPLANT PROVIDED IN FACILITY ☐ →		1321
	ASK TO BE TAKEN TO THE ROOM OR LOCATION WHERE IUCDs AND/OR IMPLANTS ARE INSERTED OR REMOVED				
1316	Please show me the following items for the provision of IUCD or Implant methods:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	STERILE GLOVES	1	2	3	
02	ANTISEPTIC SOLUTION	1	2	3	
03	SPONGE HOLDING FORCEPS	1	2	3	
04	STERILE GAUZE PAD OR COTTON WOOL	1	2	3	
1317	**CHECK Q1302.07** IUCD PROVIDED IN FACILITY ☐		IUCD NOT PROVIDED IN FACILITY ☐ →		1319
1318	Please show me the following items for the provision of IUCD:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	VAGINAL SPECULUM - SMALL	1	2	3	
02	VAGINAL SPECULUM - MEDIUM	1	2	3	
03	VAGINAL SPECULUM - LARGE	1	2	3	
04	TENACULA (VOLSELLUM FORCEPS)	1	2	3	
05	UTERINE SOUND	1	2	3	
1319	**CHECK Q1302.08.** IMPLANT PROVIDED IN FACILITY ☐		IMPLANT NOT PROVIDED IN FACILITY ☐ →		1321
1320	Please show me the following items for the provision of Implant:	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	LOCAL ANESTHETIC	1	2	3	
02	STERILE SYRINGE AND NEEDLE	1	2	3	
03	CANULA AND TROCHAR FOR INSERTING IMPLANT	1	2	3	
04	SEALED IMPLANT PACK	1	2	3	
05	SCAPEL WITH BLADE	1	2	3	
06	MINOR SURGERY KIT (E.G., ARTERY FORCEPS)	1	2	3	
1321	Where are equipment such as specula or forceps that are used in the provision of family planning services processed for re-use?	FP SERVICE SITE. . . . . 1 CENTRAL LOCATION IN FACILITY. . . . . 2 BOTH LOCATIONS. . . . . 3 NO EQUIPMENT PROCESSED IN FACILITY. 4			→ 1350 → 1350
1322	What is the final processing method used for family planning equipment at this service site? PROBE FOR ALL METHODS USED	AUTOCLAVE. . . . . A DRY HEAT STERILIZATION. . . . . B SOAK IN CHLORINE SOLUTION. . . . . C BOIL OR STEAM. . . . . D WASH WITH SOAP AND WATER. . . . . E SOAK IN OTHER CHEMICAL SOLUTION. . . . F			

STANDARD PRECAUTIONS

1350	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051]. . . . . 12 CHILD CURATIVE CARE [Q1251] . . . . . 13 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	→1353

1351	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1352	DESCRIBE THE SETTING OF THE FP SERVICE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	
1353	**CHECK Q212** FP COMMODITIES STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 1 NOT CIRCLED)** ↓	FP COMMODITIES STORED IN FP SERVICE AREA **(RESPONSE 1 CIRCLED)** →	921

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 14: ANTENATAL CARE

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

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

1401	How many days in a month are antenatal care services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS ☐☐	

1402	Do ANC providers provide any of the following services to pregnant women as part of routine ANC?	YES	NO	
01	IRON SUPPLEMENTATION	1	2	
02	FOLIC ACID SUPPLEMENTATION	1	2	
03	INTERMITTENT PREVENTIVE TREATMENT (IPT) FOR MALARIA	1	2	
04	TETANUS TOXOID VACCINATION	1	2	

1403	**CHECK Q1402.04** TT VACCINATION PROVIDED ☐ ↓ TT VACCINATION NOT PROVIDED ☐ →		1406
1404	Is tetanus toxoid vaccination available on all days that ANC services are available in this facility?	YES. . . . . 1 NOT ALL ANC DAYS. 2	→ 1406
1405	How many days each week are tetanus toxoid vaccinations available at this facility?	DAYS PER WEEK. . . . . ☐☐ LESS OFTEN THAN ONCE/WEEK. 0	

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED			
1406	Do ANC providers in this facility provide any of the following **tests** from this site to pregnant women as part of ANC? IF YES, ASK TO SEE THE TEST KIT OR EQUIPMENT. IF TEST NOT DONE IN ANC, PROBE TO DETERMINE IF THE TEST IS DONE ELSEWHERE IN THE FACILITY CHECK TO SEE IF AT LEAST ONE TEST KIT OF EACH TEST IS VALID/UNEXPIRED	AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORETED AVAILABLE NOT SEEN	NONE AVAILABLE TODAY	NO, OR NEVER AVAILABLE	AVAILABLE ELSEWHERE IN FACILITY
01	HIV RAPID DIAGNOSTIC TEST	1	2	3	4	5	6
02	URINE PROTEIN TEST	1	2	3	4	5	6
03	URINE GLUCOSE TEST	1	2	3	4	5	6
04	ANY RAPID TEST FOR HEMOGLOBIN	1	2	3	4	5	6
05	SYPHILIS RAPID DIAGNOSTIC TEST	1	2	3	4	5	6

1407	As part of ANC services, please tell me if providers in this facility provide the following services to ANC clients	YES	NO
01	COUNSELING ON RECOMMENDED MINIMUM OF 4 ANC VISITS FOR EACH PREGNANCY	1	2
02	COUNSELING ON BIRTH PREPAREDNESS OR PREPARATION FOR DELIVERY	1	2
03	COUNSELING ABOUT FAMILY PLANNING	1	2
04	COUNSELING ABOUT HIV/AIDS	1	2
05	COUNSELING ABOUT USE OF ITNs TO PREVENT MOSQUITO BITES AND MALARIA	1	2
06	COUNSELING ABOUT BREASTFEEDING	1	2
07	COUNSELING ABOUT NEWBORN CARE	1	2
08	COUNSELING ON POSTNATAL CARE VISITS	1	2

1408	Do ANC providers in this facility routinely diagnose and treat STIs, or are STI clients referred to another provider or location for diagnosis and treatment?	ROUTINELY DIAGNOSE AND TREAT STIs. . . . . 1 DIAGNOSE BUT REFER ELSEWHERE FOR TREATME 2 REFER ELSEWHERE IN FACILITY FOR DIAG & TREA 3 REFER OUTSIDE FACILITY FOR DIAG & TREATMENT 4 NO DIAGNOSIS / TREATMENT / REFERRAL. 5	
1409	Do you have the *Sexual and Reproductive Health (SRH)* ***guidelines*** available in this service area today?	YES. . . . . 1 NO. 2	→ 1411
1410	May I see the **SRH** guidelines? ACCEPTABLE IF PART OF OTHER GUIDELINES	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1413
1411	Do you have ***any other ANC guidelines*** available in this service area today?	YES. . . . . 1 NO. 2	→ 1413
1412	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1413	Do you have ***IPT guidelines*** available in this service area? This may be part of another guideline	YES. . . . . 1 NO. 2	→ 1415
1414	May I see the IPT guidelines? ACCEPTABLE IF PART OF OTHER GUIDELINES	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1415	Do you have visual aids for client education on subjects related to pregnancy or antenatal care available in this service area today?	YES. . . . . 1 NO. 2	→ 1417
1416	May I see the visual aids for client education?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1417	Are individual client health passports, health cards or records for ANC and PNC clients maintained at this service site?	YES. . . . . 1 NO. 2	→ 1419
1418	May I see a blank copy of the client health passport, health card or records?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1419	Does this facility have a system whereby observation or parameters for ANC clients are routinely carried out before the consultation? IF YES, ASK TO SEE THE PLACE WHERE THESE ACTIVITIES TAKE PLACE.	YES. . . . . 1 NO. 2	→ 1421

1420	OBSERVE IF THE BELOW ACTIVITIES ARE BEING DONE ROUTINELY. IF YOU DO NOT SEE AN ACTIVITY, ASK: Is [ACTIVITY YOU DO NOT SEE] routinely done for all antenatal care clients?	ACTIVITY OBSERVED	ACTIVITY REPORTED NOT SEEN	ACTIVITY NOT ROUTINELY DONE	DON'T KNOW
01	Weighing of clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8
04	Urine test for protein	1	2	3	8
05	Blood test for anemia	1	2	3	8
06	Malaria rapid diagnostic testing	1	2	3	8
07	HIV testing and counseling (HTC) for pregnant women	1	2	3	8
07A	Syphilis RDT	1	2	3	8
07B	Collection of blood sample for syphilis testing (VDRL) in laboratory	1	2	3	8

EQUIPMENT AND SUPPLIES FOR ROUTINE ANC

1421	I would like to know if the following items are available in this service area and are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	DIGITAL BP APPARATUS	1 → b	2 → b	3 → 02	1	2	8
02	MANUAL BP APPARATUS	1 → b	2 → b	3 → 03	1	2	8
03	STETHOSCOPE	1 → b	2 → b	3 → 04	1	2	8
04	EXAMINATION LIGHT (FLASHLIGHT OK)	1 → b	2 → b	3 → 05	1	2	8
05	FETAL STETHOSCOPE	1 → b	2 → b	3 → 06	1	2	
06	ADULT WEIGHING SCALE	1 → b	2 → b	3 → 07	1	2	8
07	EXAMINATION BED OR COUCH	1	2	3			
07A	TAPE MEASURE FOR FUNDAL HEIGHT	1	2	3			
07B	HEIGHT BOARD	1	2	3			

1422	Please tell me if any of the following medicines or commodities are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NO, OR NEVER AVAILABLE
01	IRON TABLETS (INDIVIDUAL TABLETS)	1	2	3	4	5
02	FOLIC ACID TABLETS (INDIVIDUAL TABLETS)	1	2	3	4	5
03	COMBINED IRON AND FOLIC ACID TABLETS	1	2	3	4	5
04	SP / FANSIDAR FOR IPTp	1	2	3	4	5
05	TETANUS TOXOID VACCINE	1	2	3	4	5
06	INSECTICIDE-TREATED MOSQUITO BED NET (ITN) / LLINs	1	2	3	4	5
06A	ALBENDAZOLE TABLETS	1	2	3	4	5

STANDARD PRECAUTIONS

1450	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051]. . . . . 12 CHILD CURATIVE CARE [Q1251] . . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 PMTCT [Q1551]. . . . . 16 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1451	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1452	DESCRIBE THE SETTING OF THE ANC SERVICE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 15: PMTCT OF HIV INFECTION

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

CAUTION!!!

THIS SECTION SHOULD BE COMPLETED ONLY AFTER COMPLETING THE ANC SECTION

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

1501	As part of PMTCT services, please tell me if providers in this facility provide the following services to clients	YES	NO
01	PROVIDE HIV TESTING AND COUNSELING (HTC) SERVICES TO PREGNANT WOMEN INCLUDES TESTING DONE OUTSIDE THIS FACILITY BUT RESULTS PROVIDED TO CLIENT HERE	1	2
02	PROVIDE HIV TESTING SERVICES TO INFANTS BORN TO HIV POSITIVE WOMEN. THIS INCLUDES TESTING DONE OUTSIDE THIS LOCATION BUT RESULTS PROVIDED TO CLIENT HERE. FOR EXAMPLE, BLOOD COLLECTED HERE AS DBS BUT TESTING DONE ELSEWHERE	1	2
03	PROVIDE ARV PROPHYLAXIS TO HIV POSITIVE PREGNANT WOMEN	1	2
04	PROVIDE ARV PROPHYLAXIS TO NEWBORNS OF HIV POSITIVE WOMEN	1	2
05	PROVIDE INFANT AND YOUNG CHILD FEEDING COUNSELING FOR PMTCT	1	2
06	PROVIDE NUTRITIONAL COUNSELING FOR HIV POSITIVE PREGNANT WOMEN AND THEIR INFANTS	1	2
07	PROVIDE FAMILY PLANNING COUNSELING TO HIV POSITIVE PREGNANT WOMEN	1	2

1502	**CHECK Q1501.01** HIV TESTING AND COUNSELING FOR PREGNANT WOMEN ☐ ↓	NO HIV TESTING AND COUNSELING FOR PREGNANT WOMEN ☐ →	1506
1503	IS THIS THE SAME LOCATION AS THE ANC SERVICE SITE?	YES, ANC SERVICE SITE. . . . . 1 NO, DIFFERENT LOCATION. 2	→ 1506
1504	Is HIV rapid diagnostic testing available from this service site?	YES. . . . . 1 NO. 2	→ 1506
1505	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1506	**CHECK Q1501.02** INFANT HIV COUNSELING AND TESTING ☐ ↓	NO INFANT HIV COUNSELING AND TESTING ☐ →	1508A
1507	Do providers use filter paper to collect dried blood spots (DBS) for HIV diagnosis in infants at this service site?	YES. . . . . 1 NO. 2	→ 1508A
1508	May I see sample DBS filter paper cards? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1508A	**CHECK Q1501.03** ARV PROPHYLAXIS FOR HIV POSITIVE PREGNANT WOMEN ☐ ↓	NO ARV PROPHYLAXIS FOR HIV POSITIVE PREGNANT WOMEN ☐ →	1509
1508B	What PMTCT prophylaxis regimen does this facility use in the provision of ARV prophylaxis to HIV positive pregnant women?	REGIMEN 5A (OPTION B+). . . . . 1 REGIMEN 1A. . . . . 2 REGIMEN 2A. . . . . 3 REGIMEN 3A. . . . . 4 REGIMEN 4A. 5	

1509	Do you have the ***Malawi Integrated Guidelines for providing HIV services*** available in this service area?	YES. . . . . 1 NO. 2	→ 1511
1510	May I see the guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1513
1511	Do you have ***any other guidelines*** for PMTCT available in this service area?	YES. . . . . 1 NO. 2	→ 1513
1512	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1513	Do you have guidelines for ***infant and young child feeding counseling*** available in this service area? NOTE: THIS IS COVERED IN THE MALAWI INTEGRATED GUIDELINES FOR PROVIDING HIV SERVICES	YES. . . . . 1 NO. 2	→ 1515
1514	May I see the guidelines for infant and young child feeding and counseling? THIS IS PART OF THE INTEGRATED GUIDELINE FOR PROVIDING HIV SERVICES	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1515	Do you stock any ARVs for PMTCT in this service area?	YES. . . . . 1 NO. 2	→ 1550

1516	Please tell me if any of the following antiretroviral medicines are available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NO, OR NEVER AVAILABLE
01	ZIDOVUDINE (AZT) TABS	1	2	3	4	5
02	NEVIRAPINE (NVP) TABS	1	2	3	4	5
03	LAMIVUDINE (3TC) TABS	1	2	3	4	5
04	LOPINAVIR (LPV/r) TABS	1	2	3	4	5
05	ABACAVIR (ABC) TABS	1	2	3	4	5
06	EFAVIRENZ (EFV) TABS	1	2	3	4	5
07	TENAFOVIR DISOPROXIL FUMARATE (TDF) TABS	1	2	3	4	5
08	EMTRICITABINE (FTC)	1	2	3	4	5
09	ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC)	1	2	3	4	5
10	NEVIRAPINE (NVP) SYRUP	1	2	3	4	5
11	ZIDOVUDINE (AZT) SYRUP / PEDIATRIC DISPERSIBLE TABS	1	2	3	4	5
12	LAMIVUDINE (3TC) + EFAVIRENZ (EFV) + TENAFOVIR (TDF) [5A]	1	2	3	4	5

STANDARD PRECAUTIONS

1550	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 DELIVERY [Q1651]. . . . . 17 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1551	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1552	ASK TO SEE ROOM OR AREA WHERE PMTCT SERVICES ARE PROVIDED DESCRIBE THE SETTING OF THE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 16: DELIVERY AND NEWBORN CARE

1600	**CHECK Q102.07** NORMAL DELIVERY SERVICES AVAILABLE ↓ NORMAL DELIVERY SERVICES NOT AVAILABLE → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE NORMAL DELIVERY SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT DELIVERY SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1601	Is a person skilled in conducting deliveries present at the facility or on call at all times (24 hours a day), including weekends, to provide delivery care?	YES . . . 1 NO . . . 2	→ 1604
1602	Is there a duty schedule or call list for 24-hr 24-hr staff assignment?	YES . . . 1 NO . . . 2	→ 1604
1603	May I see the duty schedule or call list for 24-HR staff assignment?	OBSERVED . . . 1 REPORTED, NOT SEEN . . . 2	

SIGNAL FUNCTIONS

1604	Please tell me if any of the following interventions have ever been carried out by providers as part of their work in this facility, and if so, whether the intervention has been carried out at least once during the past 3 months.	(A) EVER PROVIDED IN FACILITY			(B) PROVIDED IN PAST 3 MONTHS		
		YES	NO	DK	YES	NO	DK
01	PARENTERAL ADMINISTRATION OF ANTIBIOTICS (IV OR IM)	1 → b	2 → 02	8 → 02	1	2	8
02	PARENTERAL ADMINISTRATION OF OXYTOCIC (IV OR IM)	1 → b	2 → 03	8 → 03	1	2	8
03	PARENTERAL ADMINISTRATION OF ANTICONVULSANT FOR HYPERTENSIVE DISORDERS OF PREGNANCY (IV OR IM)	1 → b	2 → 04	8 → 04	1	2	8
04	ASSISTED VAGINAL DELIVERY	1 → b	2 → 05	8 → 05	1	2	8
05	MANUAL REMOVAL OF PLACENTA	1 → b	2 → 06	8 → 06	1	2	8
06	REMOVAL OF RETAINED PRODUCTS OF CONCEPTION	1 → b	2 → 07	8 → 07	1	2	8
07	NEONATAL RESUSCITATION	1 → b	2 → 08	8 → 08	1	2	8
08	CORTICOSTEROIDS FOR PRE-TERM LABOR (NOT SIGNAL FUNCTION)	1 → b	2 → 1605	8 → 1605	1	2	8

1605	Do you have the national guidelines for Integrated Management of pregnancy and childbirth (IMPAC) available in this service site?	YES . . . 1 NO . . . 2	→ 1606A
1606	May I see the guidelines for Integrated Management of pregnancy and childbirth?	OBSERVED . . . 1 REPORTED NOT SEEN . . . 2	
1606A	Do you have the ***national guidelines for Basic emergency obstetric care*** (BEmOC)? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . 1 NO . . . 2	→ 1607
1606B	May I see the national guidelines on BEmOC?	OBSERVED . . . 1 REPORTED NOT SEEN . . . 2	
1607	Do you have the ***national guidelines for comprehensive emergency obstetric care*** (CEmOC)? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . 1 NO . . . 2	→ 1609
1608	May I see the national guidelines on CEmOC?	OBSERVED . . . 1 REPORTED NOT SEEN . . . 2	

1609	Do you have guidelines or protocols on management of pre-term labor? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES. . . . . 1 NO. 2	→ 1611
1610	May I see the guidelines or protocols on management of pre-term labor?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1611	Does this facility practice Kangaroo Mother Care for low birth weight babies?	YES. . . . . 1 NO. 2	→ 1613
1612	Is there a separate room or space for Kangaroo Mother Care or is it integrated into the main postnatal ward?	YES, SEPARATE ROOM. . . . . 1 YES, INTEGRATED 2	
1613	Do providers of delivery services in this facility use partographs to monitor labor and delivery?	YES. . . . . 1 NO USE OF PARTOGRAPH. 2	→ 1615
1614	Are partographs used routinely (for all cases) or selectively (only for some cases) to monitor labor and delivery in this facility?	ROUTINELY. . . . . 1 SELECTIVELY. 2	
1615	How many dedicated maternity beds are available in this facility?	# OF DEDICATED MATERNITY BEDS. . . . ☐☐☐ DON'T KNOW 998	
1616	How many dedicated delivery beds are available in this facility?	# OF DEDICATED DELIVERY BEDS. . . . ☐☐☐ DON'T KNOW. 998	
1617	Does the facility conduct regular reviews of maternal or newborn deaths or “near-misses”?	YES. . . . . 1 NO, DOES NOT PARTICIPATE. 2	→ 1622
1618	Are reviews done for mothers only, newborns only, or for both mothers and newborns?	FOR MOTHERS ONLY. . . . . 1 FOR NEWBORNS ONLY. . . . . 2 FOR BOTH MOTHERS AND NEWBORNS. . . . 3	→ 1621
1619	How often are reviews of <u>maternal deaths</u> or <u>"near misses"</u> carried out?	EVERY: ☐☐ WEEKS ONLY WHEN CASE OCCURS. . . . . 53 DON'T KNOW. 98	
1620	**CHECK Q1618:** RESPONSE "3" CIRCLED ☐↓ RESPONSE "3" NOT CIRCLED ☐→		1622
1621	How often are reviews of <u>newborn deaths</u> or <u>"near misses"</u> carried out?	EVERY: ☐☐ WEEKS ONLY WHEN CASE OCCURS. . . . . 53 ALWAYS WITH MATERNAL REVIEWS. . . . . 95 DON'T KNOW. 98	

EQUIPMENT AND SUPPLIES FOR ROUTINE DELIVERIES

1622	I would like to know if the following items are available in this delivery area and are functioning.	(A) AVAILABLE			(B) FUNCTIONING		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	INCUBATOR	1→b	2→b	3 → 02	1	2	8
02	OTHER EXTERNAL HEAT SOURCE	1→b	2→b	3 → 03	1	2	8
03	EXAMINATION LIGHT (FLASHLIGHT OK)	1→b	2→b	3 → 04	1	2	8
04	SUCTION APPARATUS WITH CATHETER	1→b	2→b	3 → 05	1	2	8
05	SUCTION BULB	1→b	2→b	3 → 06	1	2	8
06	MANUAL VACUUM EXTRACTOR	1→b	2→b	3 → 07	1	2	8
07	VACUUM ASPIRATION KIT OR D&C KIT	1→b	2→b	3 → 08	1	2	8
08	NEWBORN BAG & MASK	1→b	2→b	3 → 09	1	2	8
09	THERMOMETER	1→b	2→b	3 → 10	1	2	8
10	THERMOMETER FOR LOW-BODY TEMPERATURE	1→b	2→b	3 → 11	1	2	8
11	INFANT SCALE	1→b	2→b	3 → 12	1	2	8
12	FETAL STETHOSCOPE	1→b	2→b	3 → 12A	1	2	8
13	DIGITAL BP APPARATUS	1→b	2→b	3 → 13	1	2	8
14	MANUAL BP APPARATUS	1→b	2→b	3 → 14	1	2	8
15	STETHOSCOPE	1→b	2→b	3 → 14A	1	2	8
15A	OXYGEN CONCENTRATOR	1→b	2→b	3 → 1623	1	2	8

1623	Do you have any of the following items? If yes, I would like to see them	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	DELIVERY BED	1	2	3
02	DELIVERY PACK	1	2	3
03	CORD CLAMP	1	2	3
04	SPECULUM	1	2	3
05	EPISIOTOMY SCISSORS	1	2	3
06	SCISSORS OR BLADE TO CUT CORD	1	2	3
07	SUTURE MATERIAL WITH NEEDLE	1	2	3
08	NEEDLE HOLDER	1	2	3
09	FORCEPS (LARGE)	1	2	3
10	FORCEPS (MEDIUM)	1	2	3
11	SWAB HOLDER	1	2	3
12	BLANK PARTOGRAPH	1	2	3

1624	Does this facility ***routinely*** observe any of the following practices postpartum or related to newborns?	YES	NO	DON'T KNOW
01	Delivery to the abdomen (Skin to Skin)	1	2	8
02	Drying and wrapping newborns to keep them warm	1	2	8
03	Initiation of breastfeeding within the first hour	1	2	8
04	Routine, complete (head-to-toe) examination of newborn before discharge	1	2	8
05	Suction the newborn by means of catheter	1	2	8
06	Suction the newborn by means of a suction bulb	1	2	8
07	Weigh the newborn immediately	1	2	8
08	Administer Vitamin K to newborn	1	2	8
09	Apply Tetracycline eye ointment to both eyes	1	2	8
10	Give full bath (immerse newborn in water) shortly (i.e., within a few minutes/hours) after birth	1	2	8
11	Give the newborn prelacteal liquids	1	2	8
12	Give the newborn OPV prior to discharge	1	2	8
13	Give the newborn BCG prior to discharge	1	2	8

1625	Please tell me if any of the following medicines or items are available at this service site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NO, OR NEVER AVAILABLE
01	TETRACYCLINE EYE OINTMENT FOR NEWBORN	1	2	3	4	5
02	INJECTABLE ANTIBIOTIC (E.G., CEFTRIAXONE)	1	2	3	4	5
03	INJECTABLE UTEROTONIC (E.G., OXYTOCIN)	1	2	3	4	5
04	MAGNESIUM SULPHATE	1	2	3	4	5
05	INJECTABLE DIAZEPAM	1	2	3	4	5
06	IV SOLUTION (PLASMA EXPANDERS) WITH INFUSION SET	1	2	3	4	5
07	SKIN DISINFECTANT (OTHER THAN CHLORHEXIDINE)	1	2	3	4	5
08	4% CHORHEXIDINE SOLUTION (UMBILICAL CORD CLEANSING)	1	2	3	4	5
09	HYDRALAZINE INJECTION	1	2	3	4	5

PMTCT DURING LABOR AND DELIVERY

1626	Do you provide or offer any PMTCT service at this service site for women who come in to deliver?	YES. . . . . 1 NO. 2	
1627	Do providers of delivery services conduct HIV testing from this service site?	YES. . . . . 1 NO. 2	→ 1629
1628	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1629	Do you stock any ARVs for PMTCT in this service area?	YES. . . . . 1 NO. 2	→ 1650

		(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
1630	Please tell me if any of the following antiretroviral medicines for PMTCT are available at this service site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	AT LEAST ONE VALID	AVAILABLE NON VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NO, OR NEVER AVAILABLE
01	ZIDOVUDINE (AZT) TABS	1	2	3	4	5
02	NEVIRAPINE (NVP) TABS	1	2	3	4	5
03	LAMIVUDINE (3TC) TABS	1	2	3	4	5
04	LOPINAVIR (LPV/r) TABS	1	2	3	4	5
05	ABACAVIR (ABC) TABS	1	2	3	4	5
06	EFAVIRENZ (EFV) TABS	1	2	3	4	5
07	TENAFOVIR DISOPROXIL FUMARATE (TDF) TABS	1	2	3	4	5
08	EMTRICITABINE (FTC)	1	2	3	4	5
09	ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC)	1	2	3	4	5
10	NEVIRAPINE (NVP) SYRUP	1	2	3	4	5
11	ZIDOVUDINE (AZT) SYRUP	1	2	3	4	5
12	LAMIVUDINE (3TC) + EFAVIRENZ (EFV) + TENAFOVIR (TDF)	1	2	3	4	5

STANDARD PRECAUTIONS

1650	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 STI SERVICES [Q1851] . . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. . . . . 31 → NEXT SECTION / SERVICE SITE

1651	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE-USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1652	DESCRIBE THE SETTING OF THE DELIVERY SERVICE ROOM OR AREA.	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 17: MALARIA

1700	**CHECK Q102.08:** MALARIA SERVICES AVAILABLE ☐ NO MALARIA SERVICES ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE CLIENTS WITH MALARIA ARE SEEN. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF MALARIA SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1701	How many days in a month are malaria services available in this facility? [USE A 4-WEEK MONTH TO CALCULATE DAYS]	DAYS/MONTH . . . . . ☐☐	
1702	Do providers in this facility diagnose malaria?	YES . . . . . 1 NO 2	→ 1710
1703	Do providers in this facility use blood tests (i.e., microscopy or RDT) to verify the diagnosis of malaria?	YES. . . . . 1 NO 2	→ 1710
1704	Do providers use blood test to verify the diagnosis of malaria for all suspected cases (always), or only sometimes?	ALWAYS. . . . . 1 ONLY SOMETIMES. 2	
1705	Do providers use malaria rapid diagnostic test to diagnose malaria at this service site?	YES . . . . . 1 NO 2	→ 1710
1706	May I see a sample malaria RDT kit? CHECK THAT AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1707	OBSERVE OR ASK THE BRAND OR TYPE OF MALARIA RDT KIT	PARACHECK. . . . . A CARE START. . . . . B FIRST RESPONSE. . . . . C SD BIOLINE. . . . . D	
1708	Do you have a training manual, poster or other job aid for using malaria rapid diagnostic test?	YES . . . . . 1 NO 2	→ 1710
1709	May I see the training manual, poster or other job aid for using malaria rapid diagnostic test?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1710	Do providers in this facility prescribe treatment for malaria?	YES . . . . . 1 NO 2	
1711	Do you have the ***national guidelines*** for the diagnosis and treatment of malaria available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1713
1712	May I see the national guidelines for the diagnosis and treatment of malaria?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 **NEXT SECTION OR SERVICE SITE**	
1713	Do you have any other guidelines for the diagnosis and treatment of malaria in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO . . . . . 2 **NEXT SECTION OR SERVICE SITE**	
1714	May I see the other guidelines for the diagnosis and treatment of malaria?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
	THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.		

SECTION 18: SEXUALLY TRANSMITTED INFECTIONS

1800	**CHECK Q102.09** STI SERVICE OFFERED ☐ → (continue) STI SERVICE NOT OFFERED ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE STI SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF STI SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1801	How many days in a month are STI services available in this facility? [USE A 4-WEEK MONTH TO CALCULATE DAYS]	DAYS/MONTH . . . . . ☐☐	
1802	Do providers in this facility make diagnosis that a client has a sexually transmitted infection (STI)?	YES. . . . . 1 NO. 2	→ 1804
1803	How are diagnoses of STIs made in this facility?	SYNDROMIC APPROACH ONLY. . . . . 1 ETIOLOGIC (LAB) ONLY. . . . . 2 BOTH SYNDROMIC AND ETIOLOGIC. 3	
1804	Do providers in this facility prescribe treatment for STIs?	YES. . . . . 1 NO 2	
1805	**CHECK Q1802 AND Q1804** RESPONSE "1" CIRCLED IN EITHER Q1802 OR Q1804 OR BOTH ☐ → (continue) RESPONSE "1" CIRCLED IN NEITHER Q1802 NOR Q1804 ☐ → NEXT SECTION OR SERVICE SITE		
1806	Are STI clients seen by this service ever referred for HIV testing and counseling (HTC) services, or offered the service from this service site?	YES. . . . . 1 NO 2	→ 1810
1807	Are STI clients seen by this service routinely referred for, or offered HIV testing and counseling (HTC) services, or they are referred/offered only if they are suspected to be infected with HIV?	ROUTINELY REFERRED OR OFFERED SERVICE. . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV INFECTED. . . . 2	
1808	Do STI service providers in this facility provide HIV testing from this service site?	YES. . . . . 1 NO 2	→ 1810
1809	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1810	Do you have the ***national guidelines*** for the diagnosis and treatment of STIs available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1812
1811	May I see the national guidelines for the diagnosis and treatment of STIs?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 1814
1812	Do you have any other guidelines for the diagnosis and treatment of STIs available in this service area? ACCEPTABLE IF PART OF ANOTHER GUIDELINE.	YES . . . . . 1 NO 2	→ 1814
1813	May I see the other guidelines for the diagnosis and treatment of STIs?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	
1814	Does the facility normally perform partner notification for sexually transmitted infections?	YES. . . . . 1 NO PARTNER NOTIFICATION. 2	→ 1816
1815	Is the notification ever active (where the facility makes contact with the partner) or is it only passive (where the facility asks the clients to inform or bring their partners)?	ALWAYS ACTIVE . . . . . 1 SOMETIMES ACTIVE. . . . . 2 ONLY PASSIVE. 3	
1816	Are individual client health passports or booklets used?	YES. . . . . 1 NO. 2	→ 1818
1817	May I see a copy of the client health passport? It could either be a used or and unused copy.	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

1818	ASK TO SEE EACH OF THE FOLLOWING ITEMS, AND ASSESS IF THE ITEM IS IN THE ROOM WHERE COUNSELING OR EXAMINATION OF STI CLIENTS TAKES PLACE OR AN IMMEDIATELY ADJACENT ROOM.				
	VISUAL AIDS FOR TEACHING CLIENT:	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	About STIs	1	2	3	8
02	About HIV/AIDS	1	2	3	8
03	About cervical cancer	1	2	3	8
04	Posters on STIs (MAY INCLUDE HIV/AIDS)	1	2	3	8
05	Posters on HIV/AIDS	1	2	3	8
06	Model to demonstrate use of male condom	1	2	3	8
07	Model to demonstrate use of female condom	1	2	3	8
	INFORMATION FOR CLIENT TO TAKE HOME				
08	About STIs	1	2	3	8
09	About HIV/AIDS	1	2	3	8
10	About cervical cancer	1	2	3	8
11	IEC materials on male condoms	1	2	3	8
12	IEC materials on female condoms	1	2	3	8
13	Male condoms that can be given to the client	1	2	3	8
14	Female condoms that can be given to the client	1	2	3	8

STANDARD PRECAUTIONS

1850	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	NEXT SECTION / SERVICE SITE

1851	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER.	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES AND NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1852	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 19: TUBERCULOSIS

1900	**CHECK Q102.10** TB SERVICES OFFERED IN FACILITY ☐ NO TB SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE TB SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF TB SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
1901	How many days in a month are tuberculosis services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS / MONTH ☐☐	

TB DIAGNOSIS

1902	Do providers in this facility make diagnosis that a client has tuberculosis?	YES. . . . 1 NO 2	→1904
1903	What is the most common method used by providers in this facility for diagnosing TB? PROBE TO DETERMINE METHOD USED.	SPUTUM SMEAR ONLY. . . . 1 X-RAY ONLY. . . . 2 EITHER SPUTUM OR X-RAY. . . . 3 BOTH SPUTUM AND X-RAY. . . . 4 CLINICAL SYMPTOMS ONLY. . . . 5	
1904	Do providers in this facility ever refer clients outside this facility for TB diagnosis?	YES. . . . 1 NO 2	→1908
1905	Does this facility have an agreement with a referral site for TB test results to be returned to the facility either directly or through the client?	YES. . . . 1 NO. . . . 2	
1906	Is there a record/register of clients who are referred for TB diagnosis?	YES . . . . 1 REGISTER NOT KEPT. . . . 2	→1908
1907	May I see the records or register of clients referred for TB testing? CHECK THE RECORDS TO SEE TB DIAGNOSIS RESULTS ARE RECORDED	REGISTER SEEN (PAPER) . . . . 1 REGISTER SEEN (ELECTRONIC). . . . 2 REGISTER SEEN, BOTH PAPER AND ELECTRONI 3 REGISTER REPORTED, NOT SEEN. . . . 4	

TB TREATMENT

1908	Do providers in this facility prescribe treatment for TB or manage patients who are on TB treatment?	YES. . . . 1 NO. . . . 2	→1910
1909	What treatment regimen or approach is followed by providers in this facility for *newly diagnosed* TB? PROBE TO ARRIVE AT CORRECT RESPONSE	DIRECT OBSERVE 2M, FU 4M. . . . 1 DIRECT OBSERVE 6M. . . . 2 FOLLOW UP CLIENTS ONLY AFTER FIRST 2M DIRECT OBSERVATION ELSEWHERE. . . . 3 DIAGNOSE AND TREAT WHILE INPATIENT DISCHARGE ELSEWHERE FOR F/UP. . . . 4 PROVIDE FULL TREATMENT, WITH NO ROUTINE DIRECT OBSERVATION PHASE. . . . 5 DIAGNOSE, PRESCRIBE/PROVIDE MEDICINES ONLY, NO F/UP. . . . 6 DIAGNOSE ONLY, NO TREATMENT OR PRESCRIPTION OF MEDICINE. . . . 7	
1910	**CHECK Q1902 AND Q1908** TB DIAGNOSIS OR TREATMENT IN FACILITY ☐ NO TB DIAGNOSIS OR TREATMENT IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
1911	Does this facility have a system for testing TB patients for HIV infection?	YES. . . . 1 NO SYSTEM. . . . 2	→1913
1912	May I see the system, or evidence of such a system? THE SYSTEM MAY BE IN THE FORM OF A REGISTER	SYSTEM OR REGISTER OBSERVED. . . . 1 SYSTEM OR REGISTER REPORTED, NOT SEEN. . . . 2	

1913	Is HIV rapid diagnostic testing available from this service site?	YES. . . . . 1 NO 2	→1915
1914	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
1915	Do you have the ***national TB guidelines*** for the diagnosis and treatment of TB available in this service area? i.e., the National TB control program manual 2012?	YES . . . . . 1 NO 2	→1917
1916	May I see the national guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1917	Do you have any guidelines for the management of HIV and TB co-infection available in this service area? THIS MAY BE PART OF OTHER GUIDELINE	YES . . . . . 1 NO 2	→1919
1918	May I see the guidelines for the management of HIV and TB co-infection?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1919	Do you have any guidelines related to MDR-TB treatment available in this service area? THIS MAY BE PART OF OTHER GUIDELINE	YES . . . . . 1 NO 2	→1921
1920	May I see the guidelines on treatment of MDR-TB?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
1921	**CHECK Q1903** RESPONSES 1, 3 OR 4 CIRCLED ↓	RESPONSES 1, 3 OR 4 NOT CIRCLED →	1950
1922	Do you maintain any sputum containers at this service site for collecting sputum specimen?	YES . . . . . 1 NO 2	→1950
1923	May I see a sputum container?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	

STANDARD PRECAUTIONS

1950	ASSESS THE TB ROOM OR AREA FOR THE ITEMS . LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	→**1953**

1951	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER.	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES, OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

1952	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	
1953	**CHECK Q214** TB MEDS STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 1 NOT CIRCLED)** ↓ TB MEDICINES STORED IN TB SERVICE AREA **(RESPONSE 1 CIRCLED)** → 931		

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 20: HIV TESTING

2000	**CHECK Q102.11** HIV TESTING AVAILABLE IN FACILITY ☐ NO HIV TESTING SERVICES IN FACILITY ☐ → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV COUNSELING AND TESTING SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV COUNSELING & TESTING SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2001	How many days in a month are HIV testing services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE # OF DAYS	NUMBER OF DAYS. . . . . ☐☐	
2002	When a provider wants a client to receive an HIV test, or when a client agrees to an HIV test, what is the procedure that is followed? In other words, what are the possible options for the client to receive the test? AFTER RESPONSE IS PROVIDED, PROBE FOR ANY OTHER PROCEDURES USED FOR PROVIDING THE HIV TEST. CIRCLE ALL THAT APPLY	HIV RAPID TEST THIS SERVICE SITE. . . . . A BLOOD DRAWN HERE, SENT TO LAB IN FACILITY. . . . . B CLIENT SENT TO OTHER SITE IN FACILITY. . . . . C CLIENT SENT TO LAB IN FACILITY. . . . . D CLIENT SENT TO EXTERNAL SITE. . . . . E BLOOD DRAWN HERE SENT TO EXTERNAL SITE . . . . . F	
2003	**CHECK Q2002** HIV RAPID TESTING THIS SERVICE SITE ("A" CIRCLED) ☐ NO HIV RAPID TESTING AT THIS SERVICE SITE ("A" NOT CIRCLED) ☐		→ 2005
2004	May I see a sample HIV rapid diagnostic test (RDT) kit? CHECK TO SEE IF AT LEAST ONE IS VALID	OBSERVED, AT LEAST 1 VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED AVAILABLE, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
2005	Is an individual client chart/record/card maintained for clients who receive services through this service site? (e.g., health passport) This refers to any system, where individual information about a client is recorded so that a record of all care and services is available in one document?	YES. . . . . 1 NO INDIVIDUAL CLIENT CHART/RECORD. 2	→ 2007
2006	May I see a copy of the individual client chart or record?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2007	Do you have the ***national HIV testing and counseling (HTC) guidelines*** available in this service area?	YES. . . . . 1 NO 2	→ 2009
2008	May I see the national guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	→ 2011
2009	Do you have ***any other guidelines*** on HIV testing available in this service area?	YES. . . . . 1 NO 2	→ 2011
2010	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2011	Do staff working in this facility have access to HIV post-exposure prophylaxis?	YES. . . . . 1 NO. 2	
2012	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? MAY BE PART OF ANOTHER DOCUMENT	YES. . . . . 1 NO. 2	→ 2014
2013	May I see the protocols or guidelines on PEP?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2014	**CHECK Q2002** BLOOD DRAWN THIS SERVICE SITE ("A" OR "B" OR "F" CIRCLED) ☐ NO BLOOD DRAWN THIS SERVICE SITE (NEITHER "A" NOR "B" NOR "F" CIRCLED) ☐		→ 2052

STANDARD PRECAUTIONS

2050	ASSESS THE HIV COUNSELING AND TESTING ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 NCD [Q2351]. . . . . 22 MINOR SURGERY [Q2451]. . . . . 23 → 2053 NOT PREVIOUSLY SEEN. 31	

2051	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER.	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

2052	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	
2053	Do you have condoms available in this service site to give to clients receiving HIV testing and counseling (HTC) services?	YES. . . . . 1 NO . . . . . 2 → 2055	
2054	May I see some of the condoms?	OBSERVED, AT LEAST ONE VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	
2055	**CHECK Q2002** EXTERNAL HIV TESTING (EITHER "E" OR "F" CIRCLED) ↓ NO EXTERNAL HIV TESTING (NEITHER "E" NOR "F" CIRCLED) → **NEXT SECTION OR SERVICE SITE**		
2056	Does this facility have an agreement with the referral site for HIV tests that test results will be returned to the facility, usually directly or through the client?	YES. . . . . 1 NO AGREEMENT . . . . . 2 → **NEXT SECTION OR SERVICE SITE**	
2057	May I see some evidence of the agreement?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 21: HIV TREATMENT

2100	**CHECK Q102.12** HIV TREATMENT SERVICES OFFERED IN FACILITY ↓ NO HIV TREATMENT SERVICES IN FACILITY → NEXT SECTION OR SERVICE SITE		
	ASK TO BE SHOWN THE MAIN LOCATION IN THE FACILITY WHERE HIV TREATMENT SERVICES ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT HIV TREATMENT SERVICES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.		
2101	Do providers in this facility prescribe ART?	YES. . . . . 1 NO. 2	
2102	Do providers in this facility provide treatment follow-up services for persons on ART, including providing community-based services?	YES. . . . . 1 NO. 2	
2102A	Do providers from another facility use this facility as an outreach site for antiretroviral therapy (ART), including ART prescription and/or ART follow-up services?	YES. . . . . 1 NO. 2	
2103	**CHECK Q2101 AND Q2102 AND Q2102A** RESPONSE "1" CIRCLED IN Q2101 OR Q2102 OR Q2102A ↓ RESPONSE "1" NOT CIRCLED IN Q2101 OR Q2102 OR Q2102A → NEXT SECTION OR SERVICE SITE		
2104	Do you have the *National ART guidelines* available in this service area? i.e., the Malawi Integrated Guidelines for providing HIV services, 2011?	YES. . . . . 1 NO. 2	→2106
2105	May I see the guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	→2108
2106	Do you have *any other ART guidelines* available in this service area?	YES. . . . . 1 NO. 2	→2108
2107	May I see the other ART guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	

PRE-ART BASELINE TESTS

2108 For each of the following tests, please tell me if it is conducted as ***baseline*** routinely, selectively, or never, ***before starting*** a client on ART.

	TEST	BASELINE TEST CONDUCTED			
		ROUTINELY	SELECTIVELY	NO/NEVER	DK
01	Hemoglobin/hematocrit	1	2	3	8
02	Full blood count (Hemogram)	1	2	3	8
03	CD4 T Cell count	1	2	3	8
04	HIV RNA Viral load	1	2	3	8
05	Pregnancy test for women	1	2	3	8
06	Renal function tests (serum creatinine and U&E)	1	2	3	8
07	Urinalysis	1	2	3	8
08	Liver function tests	1	2	3	8
09	TB sputum test	1	2	3	8
10	Hepatitis B	1	2	3	8
11	Chest X-ray	1	2	3	8
12	Any other routine tests _____ (SPECIFY)	1	2	3	8

TESTS TO MONITOR CLIENTS ON ART

2109 For each of the following tests, please tell me if a ***follow-up test*** is conducted routinely, selectively, or never ***while the client is on*** ART **(i.e., for monitoring)**.

	TEST	FOLLOW-UP TEST CONDUCTED			
		ROUTINELY	SELECTIVELY	NO/NEVER	DK
01	Hemoglobin/hematocrit	1	2	3	8
02	Full blood count	1	2	3	8
03	CD4 T Cell count	1	2	3	8
04	HIV RNA Viral load	1	2	3	8
05	Pregnancy test for women	1	2	3	8
06	Renal function tests (serum creatinine and U&E)	1	2	3	8
07	Urinalysis	1	2	3	8
08	Liver function tests	1	2	3	8
09	TB sputum test	1	2	3	8
10	Hepatitis B	1	2	3	8
11	Chest X-ray	1	2	3	8
12	Any other routine tests _____ (SPECIFY)	1	2	3	8

2110 **CHECK Q216**

ARV MEDICINES STORED IN OTHER LOCATION OR NOT STOCKED **(RESPONSE 1 OR 5 NOT CIRCLED)** ☐

ARV MEDICINES STORED IN ART SERVICE AREA **(RESPONSE 1 OR 5 CIRCLED)** ☐ → 941

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 22: HIV CARE AND SUPPORT

2200	**CHECK Q102.13** HIV CARE AND SUPPORT SERVICES AVAILABLE IN FACILITY ↓ NO HIV CARE AND SUPPORT SERVICES IN FACILITY → NEXT SECTION OR SERVICE SITE	

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

	Please tell me if providers in this facility provide the following services for HIV/AIDS clients:	YES	NO	DON'T KNOW
01	Prescribe treatment for any opportunistic infections or symptoms related to HIV/AIDS? This includes treating topical fungal infections.	1	2	8
02	Provide systemic intravenous treatment of specific fungal infections such as cryptococcal meningitis	1	2	8
03	Provide treatment for Kaposi's sarcoma	1	2	8
04	Provide or prescribe palliative care for patients, such as symptom or pain management, or nursing care for the terminally ill, or severely debilitated clients	1	2	8
05	Provide nutritional rehabilitation services? i.e., client education and provision of nutritional supplements	1	2	8
06	Prescribe or provide fortified protein supplementation (FPS / RUTF), e.g., Chiponde	1	2	8
07	Care for pediatric HIV/AIDS patients	1	2	8
08	Prescribe or provide preventive treatment for TB (INH + Pyridoxine)	1	2	8
09	Primary preventive treatment for opportunistic infections, such as Cotrimoxazole preventive treatment (CPT)	1	2	8
10	Provide or prescribe micronutrient supplementation, such as vitamins or iron	1	2	8
11	General family planning counseling and/or services	1	2	8
12	Provide condoms for preventing further transmission of HIV	1	2	8
12A	Depo-Provera as integrated family planning services	1	2	8

2202	Is there a system for routinely screening and testing HIV-positive clients for TB?	YES. . . . . 1 NO SYSTEM. 2	→2204
2203	May I see the system, or evidence of such a system?	SYSTEM OR REGISTER OBSERVED. . . . . 1 SYSTEM OR REGISTER REPORTED, NOT SEEN. 2	
2204	Do you have the national guidelines for the clinical management of HIV in children and adults available in this service area?	YES. . . . . 1 NO. 2	→2206
2205	May I see the national guidelines for the clinical management of HIV in children and adults?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	→2208
2206	Do you have any guidelines for palliative care available in this service area?	YES. . . . . 1 NO. 2	→2208
2207	May I see the other guidelines?	OBSERVED. . . . . 1 REPORTED, NOT SEEN. 2	
2208	Do you have condoms available in this service site to give to clients receiving services?	YES. . . . . 1 NO. . . . . 2 **NEXT SECTION** ←	
2209	May I see some condoms?	OBSERVED, AT LEAST ONE VALID. . . . . 1 OBSERVED, NONE VALID. . . . . 2 REPORTED, NOT SEEN. . . . . 3 NONE AVAILABLE TODAY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 23: NON-COMMUNICABLE DISEASES

2300	**CHECK Q102.14** CHRONIC DISEASE SERVICES AVAILABLE FROM FACILITY ☐ →	CHRONIC DISEASE SERVICES NOT AVAILABLE FROM FACILITY ☐ → NEXT SECTION OR SERVICE SITE	

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

DIABETES

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

CARDIO-VASCULAR DISEASES

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

RESPIRATORY

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

BASIC SUPPLIES AND EQUIPMENT

2330	ASSESS THE ROOM OR AREA FOR THE BASIC SUPPLIES AND EQUIPMENT LISTED BELOW. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION SECTION (Q700). . . . . 1 NOT PREVIOUSLY SEEN. 2	→ 2350

		(A) AVAILABLE			(B) FUNCTIONING		
2331	I would like to know if the following items are available today in the main service area and are functioning ASK TO SEE ITEMS.	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ADULT WEIGHING SCALE	1 → b	2 → b	3 → 02	1	2	8
02	CHILD WEIGHING SCALE [250 GRAM GRADATION]	1 → b	2 → b	3 → 03	1	2	8
03	INFANT WEIGHING SCALE [100 GRAM GRADATION]	1 → b	2 → b	3 → 04	1	2	8
04	STADIOMETER [OR HEIGHT ROD] FOR MEASURING HEIGHT	1 → b	2 → b	3 → 05	1	2	8
05	MEASURING TAPE [FOR CIRCUMFERENCE]	1	2	3			
06	THERMOMETER	1 → b	2 → b	3 → 07	1	2	8
07	STETHOSCOPE	1 → b	2 → b	3 → 08	1	2	8
08	DIGITAL BP APPARATUS	1 → b	2 → b	3 → 09	1	2	8
09	MANUAL BP APPARATUS	1 → b	2 → b	3 → 10	1	2	8
10	LIGHT SOURCE (FLASHLIGHT ACCPTABLE)	1 → b	2 → b	3 → 11	1	2	8
11	SELF-INFLATING BAG AND MASK [ADULT]	1 → b	2 → b	3 → 12	1	2	8
12	SELF-INFLATING BAG AND MASK [PEDIATRIC]	1 → b	2 → b	3 → 13	1	2	8
13	MICRONEBULIZER	1 → b	2 → b	3 → 14	1	2	8
14	SPACERS FOR INHALERS	1	2	3			
15	PEAK FLOW METERS	1 → b	2 → b	3 → 16	1	2	8
16	PULSE OXIMETER	1 → b	2 → b	3 → 17	1	2	8
17	OXYGEN CONCENTRATORS	1 → b	2 → b	3 → 18	1	2	8
18	FILLED OXYGEN CYLINDER	1 → b	2 → b	3 → 19	1	2	8
19	OXYGEN DISTRIBUTION SYSTEM	1 → b	2 → b	3 → 20	1	2	8
20	INTRAVENOUS INFUSION KITS - ADULT	1	2	3			
21	INTRAVENOUS INFUSION KITS - PEDIATRIC	1	2	3			

CLIENT EXAMINATION ROOM

2350	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 MINOR SURGERY [Q2451]. . . . . 23 NOT PREVIOUSLY SEEN. 31	NEXT SECTION / SERVICE SITE

2351	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGS WITH NEEDLES, OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

2352	DESCRIBE THE SETTING OF THE ROOM OR SERVICE AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 24: MINOR SURGICAL SERVICES

2400	**CHECK Q102.15** MINOR SURGERY AVAILABLE ↓ MINOR SURGERY NOT AVAILABLE → NEXT SECTION OR SERVICE SITE	

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

ASK TO SEE THE ROOM OR AREA WHERE MINOR SURGERIES TAKE PLACE AND ASK TO SEE THE ITEMS BELOW

2401	Please tell me if the following equipment are available at this site today and is functioning. I would like to see them	(A) AVAILABLE			(B) FUNCTIONING/UNEXPIRED		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	NEEDLE HOLDER	1 → b	2 → b	3 → 02	1	2	8
02	SCAPEL HANDLE WITH BLADE	1 → b	2 → b	3 → 03	1	2	8
03	RETRACTOR	1 → b	2 → b	3 → 04	1	2	8
04	SURGICAL SCISSORS	1 → b	2 → b	3 → 05	1	2	8
05	NASOGASTRIC TUBE (10-16G)	1 → b	2 → b	3 → 06	1	2	8
06	TORNIQUET	1 → b	2 → b	3 → 2402	1	2	8

2402	Please tell me if any of the following materials or medicines is available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE, NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	ABSORBABLE SUTURE MATERIAL	1	2	3	4	5
02	NON-ABSORBABLE SUTURE MATERIAL	1	2	3	4	5
03	SKIN DISINFECTANT	1	2	3	4	5
04	LIDOCAINE / LIGNOCAINE INJECTION	1	2	3	4	5
05	KETAMINE INJECTION	1	2	3	4	5

2403	Do you have guidelines on Integrated management of emergency and essential surgical care (IMEESC)?	YES . . . . . 1 NO . . . . . 2 →	2450
2404	May I see the guidelines on Integrated management of emergency and essential surgical care?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

STANDARD PRECAUTIONS

2450	ASSESS THE ROOM OR AREA FOR THE ITEMS LISTED BELOW. FOR ITEMS THAT YOU DO NOT SEE, ASK YOUR RESPONDENT TO SHOW THEM TO YOU. IF THE SAME ROOM OR AREA HAS ALREADY BEEN ASSESSED, INDICATE WHERE THE DATA ARE RECORDED	GENERAL INFORMATION [Q710]. . . . . 11 CHILD VACCINATION [Q1051] . . . . . 12 CHILD CURATIVE CARE [Q1251]. . . . . 13 FAMILY PLANNING [Q1351]. . . . . 14 ANTENATAL CARE [Q1451]. . . . . 15 PMTCT [Q1551]. . . . . 16 DELIVERY SERVICES [Q1651]. . . . . 17 STI [Q1851]. . . . . 18 TUBERCULOSIS [Q1951]. . . . . 19 HIV TESTING [Q2051]. . . . . 21 NCD [Q2351]. . . . . 22 NOT PREVIOUSLY SEEN. 31	NEXT SECTION / SERVICE SITE

2451	**STANDARD PRECAUTIONS AND CONDITIONS FOR CLIENT EXAMINATION**	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED, BUCKET WITH TAP OR POUR PITCHER)	1	2	3
02	HAND-WASHING SOAP (MAY BE LIQUID SOAP)	1	2	3
03	ALCOHOL-BASED HAND RUB	1	2	3
04	WASTE RECEPTACLE (PEDAL BIN) WITH LID AND PLASTIC BIN LINER.	1 → 06	2	3
05	OTHER WASTE RECEPTACLE	1	2	3
06	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
07	DISPOSABLE LATEX GLOVES	1	2	3
08	DISINFECTANT [E.G., CHLORINE, HIBITANE, ALCOHOL]	1	2	3
09	SINGLE USE STANDARD DISPOSABLE SYRINGES WITH NEEDLES, OR OR AUTO-DESTRUCT SYRINGES WITH NEEDLES	1	2	3
10	MEDICAL MASKS	1	2	3
11	GOWNS OR DISPOSABLE APRONS	1	2	3
12	EYE PROTECTION [GOGGLES OR FACE PROTECTION]	1	2	3
13	GUIDELINES FOR STANDARD PRECAUTIONS	1	2	3
13A	EXAMINATION BED OR COUCH	1	2	3

2452	DESCRIBE THE SETTING OF THE ROOM OR AREA	PRIVATE ROOM. . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY. . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 NO PRIVACY. 4	

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 25: CESAREAN SECTION

2500	**CHECK Q102.16** CESAREAN SECTION DONE IN FACILITY →	CESAREAN SECTION **NOT** DONE IN FACILITY → NEXT SECTION OR SERVICE SITE	

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

2501	Does the facility have a health worker who can perform Cesarean section present at the facility or on call 24 hours a day (including weekends and on public holidays)?	YES. . . . . 1 NO. 2	→ 2504
2502	Is there a duty schedule or call list for 24-hr staff assignment?	YES. . . . . 1 24-HOUR DUTY SCHEDULE NOT MAINTAINED. . . 2	→ 2504
2503	May I see the duty schedule or call list for 24-HR staff assignment?	SCHEDULE OBSERVED. . . . . 1 SCHEDULE REPORTED, NOT SEEN. 2	
2504	Does this facility have an anesthetist present in the facility or on call 24 hours a day (including weekends and on public holidays?)	YES. . . . . 1 NO. 2	→ 2507
2505	Is there a duty schedule or call list?	YES. . . . . 1 24-HOUR DUTY SCHEDULE NOT MAINTAINED. . . 2	→ 2507
2506	May I see the duty schedule or call list?	SCHEDULE OBSERVED. . . . . 1 SCHEDULE REPORTED, NOT SEEN. 2	
2507	Has Cesarean section been performed in this facility during the past 3 months?	YES. . . . . 1 NO. 2	

ASK TO SEE THE ROOM OR AREA WHERE CESAREAN SECTIONS ARE DONE AND ASK TO SEE THE ITEMS BELOW

2510	Please tell me if the following equipment are available at this site today and is functioning. I would like to see them	(A) AVAILABLE			(B) FUNCTIONING/UNEXPIRED		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ANESTHESIA MACHINE	1 → b	2 → b	3 → 02	1	2	8
02	TUBINGS AND CONNECTORS (TO CONNECT ENDOTRACHEAL TUBE)	1 → b	2 → b	3 → 03	1	2	8
03	OROPHARYNGEAL AIRWAY (ADULT)	1 → b	2 → b	3 → 04	1	2	8
04	OROPHARYNGEAL AIRWAY (PEDIATRIC)	1 → b	2 → b	3 → 05	1	2	8
05	MAGILLS FORCEPS - ADULT	1 → b	2 → b	3 → 06	1	2	8
06	MAGILLS FORCEPS - PEDIATRIC	1 → b	2 → b	3 → 07	1	2	8
07	ENDOTRACHEAL TUBE CUFFED SIZES 3.0 - 5.0	1 → b	2 → b	3 → 08	1	2	8
08	ENDOTRACHEAL TUBE CUFFED SIZES 5.5 - 9.0	1 → b	2 → b	3 → 09	1	2	8
09	INTUBATING STYLET	1 → b	2 → b	3 → 10	1	2	8
10	SPINAL NEEDLE	1 → b	2 → b	3 → **NEXT SECTION / SERVICE SITE**	1	2	8

THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.

SECTION 26: BLOOD TYPING AND COMPATIBILITY TESTING

2600	**CHECK Q102.18** BLOOD TYPING SERVICES AVAILABLE FROM FACILITY ☐ BLOOD TYPING SERVICES NOT AVAILABLE FROM FACILITY ☐ NEXT SECTION OR SERVICE SITE					
2601	Please tell me if any of the following reagents or equipment is available at this services site today. I would like to see them. CHECK TO SEE IF AT LEAST ONE IS VALID (NOT EXPIRED)	(A) OBSERVED AVAILABLE		(B) NOT OBSERVED		
		AT LEAST ONE VALID	AVAILABLE NONE VALID	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE
01	Anti-A Reagent (with valid expiration date)	1	2	3	4	5
02	Anti-B Reagent (with valid expiration date)	1	2	3	4	5
03	Anti-D Reagent (with valid expiration date)	1	2	3	4	5
04	COOMB'S REAGENT (valid expiration date)	1	2	3	4	5

SECTION 27: BLOOD TRANSFUSION SERVICES

2700	**CHECK Q102.19** BLOOD TRANSFUSION AVAILABLE FROM FACILITY ↓ BLOOD TRANSFUSION NOT AVAILABLE FROM FACILITY → NEXT SECTION OR SERVICE SITE		

ASK TO BE SHOWN THE LOCATION IN THE FACILITY WHERE BLOOD IS COLLECTED, STORED, PROCESSED OR HANDLED PRIOR TO TRANSFUSION. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT PROVISION OF BLOOD TRANSFUSION SERVICES IN THE FACILITY INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY AND ASK THE FOLLOWING QUESTIONS.

2701	What is the source of the blood that is transfused in this facility? PROBE FOR A COMPLETE LIST OF SOURCES OF BLOOD.	NATIONAL BLOOD BANK (MBTS). . . . . A RELATIVES DONATING DIRECTLY. . . . . C OTHER_____ X (SPECIFY)	
2702	Has blood transfusion been done in this facility in an obstetric context (i.e., for maternal care) during the past 3 months?	YES. . . . . 1 NO. 2	

SCREENING FOR INFECTIOUS DISEASES

2710	Is blood that is transfused in this facility screened, ***either in this facility or externally,*** for any infectious diseases prior to transfusion?	YES. . . . . 1 NO. 2	→ 2720
2711	Is the blood that is transfused screened only in the facility, only at an external facility, or both?	ONLY IN THIS FACILITY. . . . . 1 ONLY AT AN EXTERNAL FACILITY. . . . . 2 BOTH INTERNALLY AND EXTERNALLY. 3	

2712	Is the blood that is transfused in the facility screened, ***either in this facility or externally,*** for any of the following infectious diseases? IF YES, ASK: Is the blood "always", "sometimes", or "rarely" screened?	ALWAYS	SOMETIMES	RARELY	NO
01	HIV	1	2	3	4
02	SYPHILIS	1	2	3	4
03	HEPATITIS B	1	2	3	4
04	HEPATITIS C	1	2	3	4
05	MALARIA	1	2	3	4

2713	Do you ever send blood sample outside the facility for screening for any of the tests mentioned above?	YES. . . . . 1 NO. 2			→ 2720
2714	For which of the following tests do you send blood sample outside the facility for screening? ASK TO SEE DOCUMENTATION	(A) SEND SPECIMEN OUT YES	 NO	(B) RECORD OF OUTSIDE TEST YES	 NO
01	HIV	1 → b	2 → 02	1	2
02	SYPHILIS	1 → b	2 → 03	1	2
03	HEPATITIS B	1 → b	2 → 04	1	2
04	HEPATITIS C	1 → b	2 → 05	1	2
05	MALARIA	1 → b	2 → 2720	1	2

BLOOD STORAGE

2720	Has the facility run out of blood for more than one day anytime during the past 3 months?	YES. . . . . 1 NO. 2	
2721	Is there a blood bank fridge or other refrigerator available for blood storage in this service area?	YES. . . . . 1 NO. 2	→ 2724
2722	May I see the blood bank fridge or other refrigerator?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	→ 2724
2723	WHAT IS THE TEMPERATURE IN THE BLOOD BANK FRIDGE OR OTHER REFRIGERATOR?	BETWEEN +2 AND +6 DEGREES. . . . . 1 ABOVE +6 DEGREES. . . . . 2 BELOW +2 DEGREES. . . . . 3 THERMOMETER NOT FUNCTIONAL. 4	
2724	Do you have any guidelines on the appropriate use of blood and safe transfusion practices?	YES. . . . . 1 NO. . . . . 2 NEXT SECTION OR SERVICE SITE	
2725	May I see the guidelines on appropriate use of blood and safe blood transfusion?	OBSERVED. . . . . 1 REPORTED NOT SEEN. 2	

SECTION 30: GENERAL FACILITY LEVEL CLEANLINESS

3000	ASSESS GENERAL CLEANLINESS / CONDITIONS OF FACILITY		YES	NO
01	**FLOOR:** SWEPT, NO OBVIOUS DIRT OR WASTE		1	2
02	**COUNTERS/TABLES/CHAIRS:** WIPED CLEAN- NO OBVIOUS DUST OR WASTE		1	2
03	NEEDLES, SHARPS OUTSIDE SHARPS BOX		1	2
04	SHARPS BOX OVERFLOWING OR TORN/PIERCED		1	2
05	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED		1	2
06	**WALLS:** SIGNIFICANT DAMAGE		1	2
07	**DOORS:** SIGNIFICANT DAMAGE		1	2
08	**CEILING:** WATER STAINS OR DAMAGE		1	2
	INTERVIEW END TIME			
	THANK YOUR RESPONDENT AND MOVE TO YOUR NEXT DATA COLLECTION POINT IF DIFFERENT FROM CURRENT LOCATION.			

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR: _____ DATE: _____

Health Worker Interview Questionnaire

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

HEALTH WORKER INTERVIEW

Facility Number: | | | | | |

Provider SERIAL Number: | | | **[FROM STAFF LISTING FORM]**

Provider Sex: (1=MALE; 2=FEMALE) |

Provider Status: (1=Assigned; 2=Seconded) |

Interviewer Code: | | |

Number of ANC Observations Associated with Provider. . . . . . |

Number of FP Observations Associated with Provider. . . . . . |

Number of Sick Child Observations Associated with Provider. . . . . . |

Number of Delivery Observations Associated with Provider. . . . . . |

INDICATE IF PROVIDER WAS PREVIOUSLY INTERVIEWED IN ANOTHER FACILITY. IF YES, RECORD NAME AND FACILITY NUMBER WHERE HE/SHE WAS INTERVIEWED

YES, PREVIOUSLY INTERVIEWED **1**

_____ NAME & NUMBER OF FACILITY | | | | | | → **END**

NO, NOT PREVIOUSLY INTERVIEWED **2**

READ THE FOLLOWING CONSENT FORM

Good day! My name is _____. We are here on behalf of the Ministry of Health conducting a study to assist the government in knowing more about health services in Malawi.
Now I will read a statement explaining the study.

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

The information you provide us may be used by the MOH, other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of the respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will collaborate with the study.
Do you have any questions about the study? Do I have your agreement to proceed?

_____ Interviewer's signature

				2	0	1	
DAY		MONTH		YEAR			

SIGNATURE OF INTERVIEWER INDICATES INFORMED CONSENT WAS PROVIDED.

101	May I begin the interview now?	YES. . . . . 1 NO. 2	→ **END**

1. EDUCATION AND EXPERIENCE

102	I would like to ask you some questions about your educational background. How many years of education have you completed in total, starting from your primary, secondary and further education?	YEARS.	
103	What is your current occupational category or qualification? For example, are you a registered nurse, or generalist medical doctor or a specialist medical doctor?	GENERALIST MEDICAL DOCTOR. . . . . 01 SPECIALIST MEDICAL DOCTOR . . . . . 02 CLINICAL OFFICER (DEGREE LEVEL). . . . . 03 CLINICAL TECHNICIAN (DIPLOMA) . . . . . 04 MEDICAL ASSISTANT. . . . . 05 REGISTERED NURSE (BSN). . . . . 07 REGISTERED NURSE MIDWIFE (BSN). . . . . 08 REGISTERED PSYCHIATRIC NURSE . . . . . 09 REGISTERED NURSE WITH DIPLOMA. . . . . 10 ENROLLED NURSE. . . . . 11 COMMUNITY HEALTH NURSE. . . . . 12 ENROLLED MIDWIFE/NURSE MIDWIFE TECHNICIAN. . . . . 13 ENROLLED NURSE MIDWIFE. . . . . 14 LABORATORY TECHNOLOGIST / SCIENTIST. . . . . 19 LABORATORY TECHNICIAN. . . . . 20 LABORATORY ASSISTANT. . . . . 21 ENVIRONMENTAL HEALTH OFFICER. . . . . 24 HEALTH SURVEILLANCE ASSISTANT. . . . . 25 HIV TESTING AND COUNSELING (HTC) COUNSELORS. . . . . 26 NO TECHNICAL QUALIFICATION / ATTENDANT. . . . . 95 OTHER_____ 96	
104	What year did you graduate (or complete) with this qualification? IF NO TECHNICAL QUALIFICATION (103=95), ASK: What year did you complete any basic training for your current occupational category?	YEAR	
105	In what year did you start working in this facility?	YEAR	
106	Have you received any dose of Hepatitis B vaccine? IF YES, ASK: How many doses have you received so far?	NO. . . . . 0 YES, 1 DOSE. . . . . 1 YES, 2 DOSES. . . . . 2 YES, 3 OR MORE DOSES. . . . . 3 CAN'T REMEMBER/DK. 8	→ 108
107	Did you receive any of the vaccination as part of your services in this facility?	YES. . . . . 1 NO. 2	
108	Are you a manager or in-charge for any clinical services?	YES. . . . . 1 NO. 2	

2. GENERAL TRAINING / MALARIA / NON-COMMUNICABLE DISEASES

200	First I want to ask you about some general training courses. Have you received any ***in-service training, training update or refresher*** in any of the following topics [READ TOPIC]. The training or training update, or refresher may have been a component of another training. IF YES, ASK: Was the ***in-service training, training update or refresher*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Standard precautions, including hand hygiene, cleaning and disinfection, waste management, needle stick and sharp injury prevention?	1	2	3
02	Any specific training related to injection safety practices?	1	2	3
03	Health Management Information Systems (HMIS) or reporting requirements for any service?	1	2	3
04	Confidentiality and rights to non-discrimination practices for people living with HIV/AIDS	1	2	3

201	**CHECK Q103 FOR PROVIDER OCCUPATIONAL CATEGORY / QUALIFICATION** CODE 19, 20 OR 21 (i.e., LABORATORY-RELATED) CIRCLED → 700 CODE 19, 20 OR 21 **NOT** CIRCLED		
	I will now ask you a few questions about services you **personally** provide ***in your current position in this facility*** and any ***in-service training or training updates*** you may have received related to that service. Please remember we are talking about **services you provide in your current position in this facility.**		
202	In your **current** position, and as a part of your work for this facility, do you personally provide any services that are designed to be ***youth friendly or adolescent friendly?*** i.e., designed with the specific aim to encourage youth or adolescent utilization?	YES. . . . . 1 NO. 2	
203	Have you received any ***in-service training or training updates*** on topics specific to youth or adolescent friendly services? The training or training update may have been a component of another training. IF YES: Was the training or training update within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS. . . . . 1 YES, OVER 24 MONTHS AGO. . . . . 2 NO TRAINING OR UPDATES. 3	

MALARIA

204	In your **current** position, and as a part of your work for this facility, do you personally diagnose and/or treat malaria?	YES. . . . . 1 NO. 2	
205	Have you received any in-service training or training updates on topics related to diagnosis and/or treatment of malaria?	YES. . . . . 1 NO. . . . . 2 → 207	

206	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	DIAGNOSING MALARIA IN ADULTS	1	2	3
02	DIAGNOSING MALARIA IN CHILDREN	1	2	3
03	HOW TO PERFORM MALARIA RAPID DIAGNOSTIC TEST	1	2	3
04	CASE MANAGEMENT / TREATMENT OF MALARIA IN ADULTS	1	2	3
05	CASE MANAGEMENT / TREATMENT OF MALARIA DURING PREGNANCY	1	2	3
06	INTERMITTENT PREVENTIVE TREATMENT OF MALARIA IN PREGNANCY	1	2	3
07	CASE MANAGEMENT / TREATMENT OF MALARIA IN CHILDREN	1	2	3

DIABETES

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

CARDIO-VASCULAR DISEASES

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

CHRONIC RESPIRATORY DISEASES

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

3. CHILD HEALTH SERVICES

300	In your **current** position, and as a part of your work for this facility, do you personally provide any **child vaccination** services?	YES. . . . . 1 NO. 2	
301	In your **current** position, and as a part of your work for this facility, do you personally provide any **child growth monitoring** services?	YES. . . . . 1 NO. 2	
302	In your **current** position, and as a part of your work for this facility, do you personally provide any **child curative care** services?	YES. . . . . 1 NO. 2	
303	Have you received any ***in-service training or training updates*** on topics related to child health or childhood illness?	YES . . . . . 1 NO 2	→ 400

304	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	EPI OR COLD CHAIN MONITORING	1	2	3
02	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES	1	2	3
03	DIAGNOSIS OF MALARIA IN CHILDREN	1	2	3
04	HOW TO PERFORM MALARIA RAPID DIAGNOSTIC TEST			
05	CASE MANAGEMENT / TREATMENT OF MALARIA IN CHILDREN	1	2	3
06	DIAGNOSIS AND/OR TREATMENT OF ACUTE RESPIRATORY INFECTIONS	1	2	3
07	DIAGNOSIS AND/OR TREATMENT OF DIARRHEA			
08	MICRONUTRIENT DEFICIENCIES AND/OR NUTRITIONAL ASSESSMENT	1	2	3
09	BREASTFEEDING	1	2	3
10	COMPLIMENTARY FEEDING IN INFANTS	1	2	3
11	PEDIATRIC HIV/AIDS	1	2	3
12	PEDIATRIC ART	1	2	3
13	OTHER ON CHILD HEALTH (SPECIFY)_____	1	2	3

4. FAMILY PLANNING SERVICES

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

403	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	GENERAL COUNSELING FOR FAMILY PLANNING	1	2	3
02	IUCD INSERTION AND/OR REMOVAL	1	2	3
03	IMPLANT INSERTION AND/OR REMOVAL	1	2	3
04	PERFORMING VASECTOMY	1	2	3
05	PERFORMING TUBAL LIGATION	1	2	3
06	CLINICAL MANAGEMENT OF FP METHODS, INCLUDING MANAGING SIDE EFFECTS	1	2	3
07	FAMILY PLANNING FOR HIV POSITIVE WOMEN	1	2	3
08	POST-PARTUM FAMILY PLANNING	1	2	3
09	OTHER ON FAMILY PLANNING (SPECIFY)_____	1	2	3

5. MATERNAL HEALTH SERVICES

ANC - PNC - PMTCT

500	In your **current** position, and as a part of your work for this facility, do you personally provide any **antenatal care or postnatal care** services? IF YES, PROBE AND INDICATE WHICH SERVICES ARE PROVIDED	YES, ANTENATAL. . . . . 1 YES, POSTNATAL. . . . . 2 YES, BOTH. . . . . 3 NO, NEITHER. 4			
501	Have you received any ***in-service training or training updates*** on topics related to antenatal care or postnatal care?	YES. . . . . 1 NO. 2			→503
502	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	ANC screening (e.g., blood pressure, urine glucose and protein)?		1	2	3
02	Counseling for ANC (e.g., nutrition, FP and newborn care)?		1	2	3
03	Complications of pregnancy and their management?		1	2	3
04	Nutritional assessment of the pregnant woman, such as Body Mass Index calculation and Mid-Upper Arm circumference measurement?		1	2	3
05	Intermittent preventive treatment of malaria in pregnancy (IPTp)		1	2	3
503	Do you ***personally*** provide any services that are specifically geared toward preventing mother-to-child transmission of HIV? IF YES, ASK: Which specific services do you provide? INDICATE WHICH OF THE LISTED SERVICES ARE PROVIDED AND PROBE: Anything else?	PREVENTIVE COUNSELING. . . . . A HIV TEST COUNSELING. . . . . B CONDUCT HIV TEST. . . . . C PROVIDE ARV TO MOTHER. . . . . D PROVIDE ARV TO INFANT. . . . . E NO PMTCT SERVICES. . . . . Y			
504	Have you received any ***in-service training or training updates*** on topics related to maternal and/or newborn health and HIV/AIDS?	YES. . . . . 1 NO. 2			→506
505	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC]? The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?		YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Prevention of mother-to-child transmission (PMTCT) of HIV?		1	2	3
02	Newborn nutrition counseling of mother with HIV?		1	2	3
03	Infant and young child feeding?		1	2	3
04	Modified obstetric practices as relates to HIV? (e.g., not rupturing membrane during labor)		1	2	3
05	Antiretroviral prophylactic treatment for prevention of mother to child transmission of HIV?		1	2	3

DELIVERY SERVICES

506	In your **current** position, and as a part of your work for this facility, do you personally provide **delivery services**? By that I mean conducting the actual delivery of newborns?	YES. . . . . 1 NO. 2	→ 509
507	During the past 6 months, approximately how many deliveries have you conducted as the ***main provider (include deliveries conducted for private practice and for facility)?***	TOTAL DELIVERIES ☐☐☐	
508	When was the last time you used a partograph?	NEVER. . . . . 0 WITHIN PAST WEEK. . . . . 1 WITHIN PAST MONTH. . . . . 2 WITHIN PAST 6 MONTHS. . . . . 3 OVER 6 MONTHS AGO. 4	
509	Have you received any ***in-service training or training updates*** on topics related to delivery care?	YES. . . . . 1 NO. 2	→ 511

510	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Integrated Management of Pregnancy and Childbirth (IMPAC)?	1	2	3
02	Comprehensive Emergency Obstetric Care (CEmOC)?	1	2	3
03	Routine care for labor and normal vaginal delivery?	1	2	3
04	Active Management of Third Stage of Labor (AMTSL)?	1	2	3
05	Emergency obstetric care (EmOC)/Life saving skills (LSS) - in general?	1	2	3
06	Post abortion care?	1	2	3
07	Special delivery care practices for preventing mother-to-child transmission of HIV?	1	2	3

NEWBORN CARE SERVICES

511	In your **current** position, and as a part of your work for this facility, do you personally provide care for the newborn?	YES. . . . . 1 NO. 2	
512	Have you received any ***in-service training or training updates*** on topics related to newborn care?	YES. . . . . 1 NO. 2	→ 600

513	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Neonatal resuscitation using bag and mask	1	2	3
02	***Early*** and e***xclusive*** breastfeeding	1	2	3
03	Newborn infection management (including injectable antibiotics)	1	2	3
04	Thermal care (including immediate drying and skin-to-skin care)	1	2	3
05	Sterile cord cutting and appropriate cord care	1	2	3
06	Kangaroo Mother Care (KMC) for low birth weight babies	1	2	3

6. SEXUALLY TRANSMITTED INFECTIONS - TB - HIV/AIDS

SEXUALLY TRANSMITTED INFECTIONS

600	In your current position, and as part of your work for this facility, do you personally provide any STI services?	YES. . . . . 1 NO. 2	
601	Have you received any ***in-service training or training updates*** on topics related to STI services?	YES. . . . . 1 NO. 2	→603

602	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Diagnosing and treating sexually transmitted infections (STIs)	1	2	3
02	The syndromic management for STIs	1	2	3
03	Drug resistance to STI treatment medications	1	2	3

TUBERCULOSIS

		Do you provide [READ SERVICE]? (a)		Have you received training or training update on [SERVICE]? IF YES, within 24 months or over? (b)		
603	Now I will ask if you provide certain TB-related services. For each service, regardless of whether you currently provide it, I will also ask if you have received related ***in-service training or training updates.*** Remember, the training or training update may have been a component of another training. READ THE QUESTIONS FROM COLUMNS A AND B	YES	NO	YES, WITHIN 24 MONTHS	YES, OVER 24 MONTHS	NO TRAINING
01	Diagnosis of tuberculosis based on sputum tests or analysis	1	2	1	2	3
02	Diagnosis of tuberculosis based on clinical symptoms	1	2	1	2	3
03	Treatment prescription for tuberculosis	1	2	1	2	3
04	Treatment follow-up services for tuberculosis	1	2	1	2	3
05	Direct Observation Treatment Short-course (DOTS) strategy	1	2	1	2	3
06	Management of TB - HIV co-infection	1	2	1	2	3
07	Management of MDR-TB or identification of need for referral	1	2	1	2	3

HIV/AIDS SERVICES

		Do you provide [READ SERVICE]? (a)		Have you received training or training update on [SERVICE]? IF YES, within 24 months or over? (b)		
604	Now I will ask if you provide certain HIV-related services. For each service, regardless of whether you currently provide it, I will also ask if you have received related ***in-service training or training updates*** . Remember, the training or training update may have been a component of another training. READ THE QUESTIONS FROM COLUMNS A AND B	YES	NO	YES, WITHIN 24 MONTHS	YES, OVER 24 MONTHS	NO TRAINING
01	Provide counseling related to HIV testing	1	2	1	2	3
02	Conduct the HIV test	1	2	1	2	3
03	Provide any services related to PMTCT	1	2	1	2	3
04	Provide any palliative care services	1	2	1	2	3
05	Provide any ART services, including prescription, counseling, or follow-up	1	2	1	2	3
06	Provide any preventive treatment for opportunistic infections (OIs) such as TB and pneumonia	1	2	1	2	3
07	Provide pediatric AIDS care	1	2	1	2	3
08	Provide HIV/AIDS home-based care	1	2	1	2	3
09	Provide post-exposure prophylaxis (PEP) services	1	2	1	2	3
09A	Early Infant Diagnosis (EID) of HIV	1	2	1	2	3
09B	STI and voluntary male circumcision	1	2	1	2	3

7. DIAGNOSTIC SERVICES

700	In your **current** position, and as a part of your work for this facility, do you personally conduct laboratory tests? CIRCLE 'NO' IF THE PROVIDER ONLY COLLECTS SPECIMENS.	YES. . . . . 1 NO. 2	→ 800

701	Please tell me if you personally conduct any of the following tests as part of your work in this facility	YES	NO
01	Microscopic examination of sputum for diagnosing tuberculosis	1	2
02	HIV rapid testing	1	2
03	Any other HIV test, such as PCR, ELISA, or Western Blot	1	2
04	Hematology testing, such as hemoglobin testing	1	2
05	CD4 testing	1	2
06	Malaria microscopy	1	2
07	Malaria rapid diagnostic test (RDT)	1	2

702	Have you received any ***in-service training or training updates*** on topics related to the different diagnostic tests you conduct?	YES. . . . . 1 NO. 2	→ 800

703	Have you received any ***in-service training or training updates*** in any of the following topics [READ TOPIC] The training or training update may have been a component of another training IF YES: Was the ***training or training update*** within the past 24 months or more than 24 months ago?	YES, WITHIN PAST 24 MONTHS	YES, OVER 24 MONTHS AGO	NO IN-SERVICE TRAINING OR UPDATES
01	Microscopic examination of sputum for diagnosing tuberculosis	1	2	3
02	HIV testing	1	2	3
03	CD4 testing	1	2	3
04	Blood screening for HIV prior to transfusion?	1	2	3
05	Blood screening for Hepatitis B prior to transfusion?	1	2	3
06	Tests for monitoring ART such as TLC and serum creatinine.	1	2	3
07	Malaria microscopy	1	2	3
08	Malaria rapid diagnostic test (RDT)	1	2	3

8. WORKING CONDITIONS IN FACILITY

800	Now I want to ask you a few more questions about your work in this facility. In an average week, how many hours do you work in this facility? IF WEEKS ARE NOT CONSISTENT, ASK THE RESPONDENT TO AVERAGE OUT HOW MANY HOURS PER MONTH AND THEN DIVIDE THIS BY 4.	AVERAGE HOURS PER WEEK WORKING IN THIS FACILITY ☐☐	
801	Now I would like to ask you some questions about supervision you have personally received. This supervision may have been from a supervisor either in this facility, or from outside the facility. Do you receive technical support or supervision in your work? IF YES, ASK: When was the most recent time?	YES, IN THE PAST 3 MONTHS. . . . . 1 YES, IN THE PAST 4-6 MONTHS. . . . . 2 YES, IN THE PAST 7-12 MONTHS. . . . . 3 YES, MORE THAN 12 MONTHS AGO. . . . . 4 NO. . . . . 5 → 804	
802	How many times in the past six months has your work been supervised?	NUMBER OF TIMES. . . . . ☐☐ EVERY DAY. . . . . '96	
803	The last time you were personally supervised, did your supervisor do any of the following:	YES NO DK	
01	Check your records or reports?	CHECKED RECORD 1 2 8	
02	Observe your work?	OBSERVED WORK 1 2 8	
03	Provide any feedback (either positive or negative) on your performance?	FEEDBACK/PERFORMANCE APPRAISAL 1 2 (05) 8 (05)	
04	Give you verbal or written feedback that you were doing your work well?	VERBAL PRAISE 1 2 8	
05	Provide updates on administrative or technical issues related to your work?	PROVIDED UPDATES 1 2 8	
06	Discuss problems you have encountered?	DISCUSSED PROBLEMS 1 2 8	
804	Do you have a written job description of your current job or position in this facility? IF YES, ASK: May I see it?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	
805	Are there any opportunities for promotion in your current job?	YES. . . . . 1 NO. . . . . 2 UNCERTAIN/DON'T KNOW. 8	
806	Which type(s) of salary supplement do you receive, if any? PROBE: Anything else?	MONTHLY OR DAILY SALARY SUPPLEMENT. . . . . A PERDIEM WHEN ATTENDING TRAINING. . . . . B DUTY ALLOWANCE. . . . . C PAYMENT FOR EXTRA ACTIVITIES / OVERTIME (NOT ROUTINELY PROVIDED). . . . . D OTHER _____ (SPECIFY) X NONE. . . . . Y	
807	In your current position, what non-monetary incentives have you received for the work you do, if any? PROBE: Anything else? (SPECIFY)	TIME OFF / VACATIONS . . . . . A UNIFORMS, BACKPACKS, CAPS, etc.. . . . . B DISCOUNT MEDICINES, FREE TICKETS FOR CARE, VOUCHERS, etc. . . . . C TRAINING. . . . . D FOOD RATION / MEALS. . . . . E SUBSIDIZED HOUSING . . . . . F OTHER_____ (SPECIFY) X NONE . . . . . Y	

808	Among the various things related to your working situation that you would like to see improved, can you tell me the three that you think would most improve your ability to provide good quality of care services? Please rank them in order of importance, with 1 being the most important. ENTER THE LETTER CORRESPONDING WITH THE 1ST MENTIONED INTO THE 1ST BOX, AND REPEAT WITH THE 2ND AND 3RD. IF THE PROVIDER ONLY MENTIONS 1 OR 2 ITEMS THEN LEAVE THE REMAINING BOX/ES EMPTY. THERE MUST BE AT LEAST ONE ENTRY. DO NOT READ CHOICES TO RESPONDENT	MORE SUPPORT FROM SUPERVISOR. . . . . A MORE KNOWLEDGE / UPDATES TRAINING. . . . . B MORE SUPPLIES/STOCK. . . . . C BETTER QUALITY EQUIPMENT/ SUPPLIES. . . . . D LESS WORKLOAD (i.e. MORE STAFF). . . . . E BETTER WORKING HOURS / FLEXIBLE TIMES. . . . . F MORE INCENTIVES (SALARY, PROMOTION, HOLIDAYS). . . . . G TRANSPORTATION FOR REFERRAL PATIENTS. . . . . H PROVIDING ART. . . . . I PROVIDING PEP. . . . . J INCREASED SECURITY. . . . . K BETTER FACILITY INFRASTRUCTURE. . . . . L MORE AUTONOMY / INDEPENDENCE. . . . . M EMOTIONAL SUPPORT FOR STAFF (COUNSELING / SOCIAL ACTIVITIES). . . . . N OTHER. X	RANKING [ ] [ ] [ ]
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT	

Observation and Exit Interview Questionnaires

Sample List for ANTENATAL CARE Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY #

TOTAL # OF ANC CLIENTS ON DAY OF VISIT FOR ALL PROVIDERS

USE THIS FORM TO LIST ANC CLIENTS SELECTED FOR ANC OBSERVATION FOR PROVIDER #1

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
101			
102			
103			
104			
105			
106			
107			
108			
109			
110			
111			
112			
113			
114			
115			
116			
117			
118			
119			
120			
121			
122			
123			
124			
125			

Sample List for ANTENATAL CARE Observation

Date | | | | | **2** | **0** | **1** | | DAY MONTH YEAR

					FACILITY #

USE THIS FORM TO LIST ANC CLIENTS SELECTED FOR ANC OBSERVATION FOR PROVIDER #2

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
126			
127			
128			
129			
130			
131			
132			
133			
134			
135			
136			
137			
138			
139			
140			
141			
142			
143			
144			
145			
146			
147			
148			
149			
150			

Sample List for ANTENATAL CARE Observation

Date | | | | | **2** | **0** | **1** | | DAY MONTH YEAR

					FACILITY #

USE THIS FORM TO LIST ANC CLIENTS SELECTED FOR ANC OBSERVATION FOR PROVIDER #3

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
151			
152			
153			
154			
155			
156			
157			
158			
159			
160			
161			
162			
163			
164			
165			
166			
167			
168			
169			
170			
171			
172			
173			
174			
175			

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

OBSERVATION OF ANC CONSULTATION

1. Facility Identification

QTYPE | O | A | N |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

2. Provider Information

Provider Qualification Category:	
GENERALIST [NON-SPECIALIST] MEDICAL DOCTOR	01
SPECIALISTS MEDICAL DOCTOR	02
CLINICAL OFFICER (DEGREE LEVEL)	03
CLINICAL TECHNICIAN (DIPLOMA)	04
MEDICAL ASSISTANT	05
REGISTERED NURSE (BSN)	07
REGISTERED NURSE MIDWIFE (BSN)	08
REGISTERED PSYCHIATRIC NURSE	09
REGISTERED NURSE WITH DIPLOMA	10
ENROLLED NURSE	11
COMMUNITY HEALTH NURSE	12
ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN	13
ENROLLED NURSE MIDWIFE	14
ENVIRONMENTAL HEALTH OFFICER	24
HEALTH SURVEILLANCE ASSISTANTS (HSA)	25
HTC COUNSELORS (NON-HSA)	26

PROVIDER QUALIF. CATEGORY | | |

SEX OF PROVIDER: (1=Male; 2=Female)	SEX OF PROVIDER . . . . . | |
PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]	PROVIDER SL NUMBER . . . . . | |

3. Information About Observation

Date:	DAY . . . . . | | MONTH . . . . . | | YEAR . . . . . | 2 | 0 | 1 | |
Name of the observer: _____	INTERVIEWER/OBSERVER CODE | | | |
Client code:	CLIENT CODE . . . . . | | | |

4. Observation of Antenatal-Care Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

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

READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing the Ministry of Health
We are conducting a study of health facilities in Malawi with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how ANC services are provided in this facility.

Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database.

Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation.

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

Interviewer's signature
(Indicates respondent's willingness to participate)

DAY	MONTH	YEAR
		2 0 1

100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**

READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health
We are conducting a study of health services in Malawi. I would like to be present while you are receiving services today in order to understand how ANC services are provided in this facility.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me.

After the consultation, my colleague would like to talk with you about your experience here today.
Do you have any questions for me at this time? Do I have your permission to be present at this consultation?

Interviewer's signature
(Indicates respondent's willingness to participate)

101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED	:	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	

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

CLIENT HISTORY

104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:	
01	Client's age	A
02	Medications the client is taking	B
03	Date client's last menstrual period began	C
04	Number of prior pregnancies client has had	D
05	None of the above	Y

ASPECTS OF PRIOR PREGNANCIES

105	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:	
01	Prior stillbirth(s)	A
02	Infant(s) who died in the first week of life	B
03	Heavy bleeding, during or after delivery	C
04	Previous assisted delivery (caesarean section, ventouse, or forceps)	D
05	Previous spontaneous abortions	E
06	Previous multiple pregnancies	F
07	Previous prolonged labor	G
08	Previous pregnancy-induced hypertension	H
09	Previous pregnancy related convulsions	I
10	High fever or infection during prior pregnancy/pregnancies	J
11	None of the above	Y

DANGER SIGNS OF CURRENT PREGNANCY

106	IN **COLUMN A**, RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY. IN **COLUMN B**, RECORD WHETHER THE PROVIDER COUNSELLED ON THE DANGER SIGNS	(A) PROVIDER ASKED ABOUT OR CLIENT MENTIONED	(B) PROVIDER COUNSELLED
01	Vaginal bleeding	A	A
02	Fever	B	B
03	Headache or blurred vision	C	C
04	Swollen face or hands	D	D
05	Tiredness or breathlessness	E	E
06	Fetal movement (loss of, excessive, normal)	F	F
07	Cough or difficulty breathing for 3 weeks or longer	G	G
08	Any other symptoms or problems the client thinks might be related to this pregnancy	H	H
09	None of the above	Y	Y

NO.	QUESTION / OBSERVATIONS	CODES

PHYSICAL EXAMINATION

107	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:	
01	Take the client's blood pressure	A
02	Weigh the client	B
03	Examine conjunctiva/palms for anemia	C
04	Examine legs/feet/hands for edema	D
05	Examine for swollen glands	E
06	Palpate the client's abdomen for fetal presentation	F
07	Palpate the client's abdomen for fundal height	G
08	Listen to the client's abdomen for fetal heartbeat	H
09	Conduct an ultrasound/refer client for ultrasound/look at recent ultrasound report	I
10	Examine the client's breasts	J
11	Conduct vaginal examination/exam of perineal area	K
12	Measure fundal height using tape measure	L
12A	Check the client's height	M
13	None of the above	Y

ROUTINE TESTS

108	RECORD WHETHER THE PROVIDER A) ASKED ABOUT, B) PERFORMED OR, C) REFERRED THE CLIENT FOR THE FOLLOWING TESTS	(A) PROVIDER ASKED	(B) PROVIDER PERFORMED	(C) PROVIDER REFERRED	(D) NO ACTION TAKEN
01	Anemia test	A	B	C	Y
02	Blood grouping	A	B	C	Y
03	Any urine test	A	B	C	Y
04	Syphilis test	A	B	C	Y

HIV TESTING AND COUNSELING (HTC)

109	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:	
01	Asked if the client knew her HIV status or discussed with the client her HIV status	A
02	Provide counseling related to HIV test	B
03	Refer for counseling related to HIV test	C
04	Perform HIV test	D
05	Refer for HIV test	E
06	None of the above	Y

MAINTAINING A HEALTHY PREGNANCY

110	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT PREPARATIONS	
01	Discussed nutrition (i.e., quantity or quality of food to eat) during the pregnancy	A
02	Informed the client about the progress of the pregnancy	B
03	Discussed the importance of at least 4 ANC visits	C
04	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

IRON PROPHYLAXIS

111	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01	Prescribed or gave iron pills or folic acid (IFA) or both	A
02	Explained the purpose of iron or folic acid	B
03	Explained how to take iron or folic-acid pills	C
04	Explained side effects of iron pills	D
05	None of the above	Y

TETANUS TOXOID INJECTION

112	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01	Prescribed or gave a tetanus toxoid (TT) injection	A
02	Explained the purpose of the TT injection	B
03	None of the above	Y

DEWORMING

113	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENTS	
01	Prescribed or gave Mebendazole/Albendazole	A
02	Explained the purpose of Mebendazole/Albendazole	B
03	None of the above	Y

MALARIA

114	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT OR COUNSELLING:	
01	Gave (or offered) malaria prophylaxis medicine (SP) to client during the consultation	A
02	Prescribed malaria prophylaxis medicine (SP) to client to obtain elsewhere	B
03	Explained the purpose of the preventive treatment with anti-malaria medicine	C
04	Explained how to take the anti-malaria medicine	D
05	Explained possible side effects of the anti-malaria medicine	E
06	Provided ITN to client as part of consultation or instructed client to obtain ITN elsewhere in facility	F
07	Explicitly explained importance of using ITN to client	G
	DIRECT OBSERVATION:	
08	Dose of IPT is taken in presence of provider (DOT) as part of consultation	H
09	Importance of further doses of IPT explained	I
10	None of the above	Y

NO.	QUESTION / OBSERVATIONS	CODES

PREPARATION FOR DELIVERY

115	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:	
01	Asked the client where she will deliver	A
02	Advised the client to prepare for delivery (e.g. set aside money, arrange for emergency transportation)	B
03	Advised the client to use a skilled health worker for delivery	C
04	Discussed with client what items to have on hand at home for emergencies (e.g., blade)	D
05	None of the above	Y

NEWBORN AND POSTPARTUM RECOMMENDATIONS

116	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT NEWBORN OR POSTPARTUM CARE IN ANY OF THE FOLLOWING WAYS:	
01	Discussed care for the newborn (i.e., warmth, hygiene and cord care)	A
02	Discussed early initiation and prolonged breastfeeding	B
03	Discussed exclusive breastfeeding	C
04	Discussed importance of vaccination for the newborn	D
05	Discussed family planning options for after delivery	E
05A	Discussed post-natal care and importance of post-natal care	F
06	None of the above	Y

OVERALL OBSERVATIONS OF INTERACTION

117	RECORD WHETHER THE PROVIDER ASKED IF THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS.	YES, ASKED QUESTIONS. . . . . 1 NO, DID NOT ASK QUESTIONS. 2	
118	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELLING DURING THE CONSULTATION.	YES, USED VISUAL AIDS. . . . . 1 NO AIDS USED. 2	
119	RECORD WHETHER THE PROVIDER LOOKED AT THE CLIENT'S HEALTH CARD (EITHER BEFORE BEGINNING THE EXAM, WHILE COLLECTING INFORMATION OR EXAMINING THE CLIENT).	YES, LOOKED AT CARD. . . . . 1 NO, DID NOT LOOK AT CARD. . . . . 2 NO HEALTH CARD USED. 3	→ 121
120	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
121	RECORD THE OUTCOME OF THE CONSULTATION. [RECORD THE OUTCOME AT THE TIME THE OBSERVATION CONCLUDED]	CLIENT GOES HOME. . . . . 1 CLIENT REFERRED (TO LAB OR OTHER PROVIDER) AT SAME FACILITY. . . . . 2 CLIENT ADMITTED TO SAME FACILITY. . . . . 3 CLIENT REFERRED TO OTHER FACILITY. 4	

NO.	QUESTION / OBSERVATIONS	CODES

QUESTIONS TO ANC PROVIDER

ASK THE PROVIDER THE FOLLOWING QUESTIONS AND VERIFY IN THE ANC REGISTER OR ON CLIENT'S ANC CARD

122	How many weeks pregnant is the client?	WEEKS OF PREGNANCY	
123	Is this the client's 1st, 2nd, 3rd, 4th or 5th visit for antenatal care **at this facility for this pregnancy**?	FIRST VISIT. . . . . 1 SECOND VISIT. . . . . 2 THIRD VISIT. . . . . 3 FOURTH VISIT. . . . . 4 FIFTH OR MORE VISIT. . . . . 5 DON'T KNOW. 8	
124	Has the client had a previous pregnancy, regardless of the duration or outcome of that pregnancy, or is this the client's first pregnancy?	FIRST PREGNANCY. . . . . 1 NOT FIRST PREGNANCY. . . . . 2 DON'T KNOW. 8	
124A	CHECK Q.123: NOT CLIENT'S FIRST VISIT (RESPONSE "1" NOT CIRCLED) ☐ ↓ CLIENT'S FIRST VISIT (RESPONSE "1" CIRCLED) ☐ → 125		
124B	What is the date of this clients last ANC visit for this pregnancy?	DAY. . . . . ☐☐ DON'T KNOW . . . . . 98 MONTH. . . . . ☐☐ DON'T KNOW . . . . . 98 YEAR. . . . . ☐☐☐☐ DON'T KNOW 9998	
125	RECORD THE TIME THE OBSERVATION ENDED.	☐☐:☐☐	

Observer's comments:

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

ANC CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

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

INFORMATION ABOUT INTERVIEW

DATE: _____

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . 2 0 1 |

Name of the interviewer: _____

INTERVIEWER CODE. . . . . | | | |

CLIENT CODE. . . . . | | | |

1. Information About Visit - ANTENATAL CARE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministry of Health. We are conducting a study of health facilities in Malawi in order to improve the services this facility offers and would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | YEAR: 2 0 1		
100	May I begin the interview now?	AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED. . . . . :		
102	Do you have an antenatal care card/book, or a vaccination card with you today? IF YES: ASK TO SEE THE CARD/BOOK.	YES . . . . . 1 NO, CARD KEPT WITH FACILITY . . . . . 2 NO CARD/BOOK USED 3	→106
103	CHECK THE ANC CARD, HEALTH PASSPORT OR VACCINATION CARD. INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS TOXOID.	YES, 1 TIME. . . . . 1 YES, 2 TIMES. . . . . 2 YES, 3 OR MORE TIMES. . . . . 3 NO RECORD. 4	
104	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD, BOOK, OR VACCINATION CARD?	# OF WEEKS. . . . . __ NOT AVAILABLE. 95	
105	DOES THE CARD INDICATE THE CLIENT HAS RECEIVED IPT? IF YES INDICATE NUMBER OF DOSES	YES, 1 DOSE. . . . . 1 YES, 2 DOSES. . . . . 2 YES, 3 DOSES. . . . . 3 YES, 4 DOSES. . . . . 4 NO 5	
106	Have you ever been pregnant, regardless of the duration or outcome, or is this your first pregnancy?	FIRST PREGNANCY. . . . . 1 NOT FIRST PREGNANCY. 2	
107	Is this your first antenatal visit at this facility for this pregnancy? IF THIS IS NOT THE 1ST VISIT, ASK: How many times have you visited this antenatal clinic for this pregnancy?	FIRST VISIT . . . . . 1 SECOND VISIT . . . . . 2 THIRD VISIT . . . . . 3 FOURTH VISIT . . . . . 4 MORE THAN 4 VISITS 5	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108	During this visit (or previous visits) did a provider give you iron pills, folic acid or iron with folic acid, or give you a prescription for them? SHOW THE CLIENT AN IRON PILL, A FOLIC-ACID PILL, OR A COMBINED PILL.	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→112
109	During this visit (or previous visits) has a provider explained to you how to take the iron pills?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
110	During this visit (or previous visits) has a provider discussed with you the side effects of the iron pill?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→112
111	Please tell me any side effects of the iron pill that you know of. PROBE: ANY OTHER?	NAUSEA . . . . . A BLACK STOOLS . . . . . B CONSTIPATION . . . . . C OTHER_____ X DON'T KNOW . . . . . Z	
112	During this visit (or previous visits) has a provider given you any pills to prevent you from getting malaria? SHOW THE CLIENT TABLET OF SP-BASED DRUGS	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→114
113	Were you asked to swallow the pills while still in the facility and in the presence of a provider?	YES. . . . . 1 NO. 2	
114	During this visit (or a previous visit) did a provider advice you to use mosquito net that has been treated with an insecticide?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
115	During this visit (or a previous visit) did a provider offer you a mosquito net that has been treated with an insecticide free of charge?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→117
116	During this visit (or a previous visit) did a provider offer to sell you a mosquito net that has been treated with an insecticide or recommend a place to buy one?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	
117	During this visit (or previous visits) has a provider talked to you about nutrition or what is good for you to be eating during your pregnancy?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
118	During this visit or previous visits, has a provider talked with you about any signs that should warn you of problems or complications with the pregnancy?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→121
119	Please tell me any signs of complications (danger signs) that you know of. CIRCLE ALL RESPONSES CLIENT MENTIONS. YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	VAGINAL BLEEDING. . . . . A FEVER. . . . . B SWOLLEN FACE OR HAND. . . . C TIREDNESS OR BREATHLESSNESS. . . . . D HEADACHE OR BLURRED VISION. . . . . E SEIZURES/CONVULSIONS. . . . . F REDUCED OR NO FETAL MOVEMENT. . . . . G OTHER. . . . . X DON'T KNOW ANY. . . . . Z	
120	What did the provider advise you to do if you experienced any of the signs of complications? CIRCLE LETTER FOR ALL COURSES OF ACTION THE CLIENT MENTIONS. PROBE WITHOUT USING SPECIFIC ANSWERS.	SEEK CARE AT A FACILITY. . . . . A REDUCE PHYSICAL ACTIVITY. . . . . B CHANGE DIET. . . . . C OTHER_____ X (SPECIFY) PROVIDER DID NOT ADVISE. . . . Y	
121	During this visit (or previous visits) has a provider discussed things you should have in preparation for this delivery? This may include planning in case of emergency, things you should bring to a facility, or things you should prepare at home for this delivery.	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . . 2 YES PREVIOUS VISIT ONLY. . . . . 3 NO. . . . . 4 DON'T KNOW ANY. 8	→123
122	Please tell me some of the things you know of that you should have in preparation for the delivery. CIRCLE ALL RESPONSES YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	EMERGENCY TRANSPORT. . . . A MONEY. . . . . B DISINFECTANT. . . . . C STERILE BLADE OR SCISSORS TO CUT CORD. . . . D OTHER_____. . . . . X DON'T KNOW . . . . . Z	
123	Do you have money set aside for the delivery? IF YES, ASK: Do you think you have enough?	YES, ENOUGH . . . . . 1 YES, BUT NOT ENOUGH . . . . . 2 NO 3	
124	During this visit (or previous visits) did a provider talk to you about where you plan to deliver your baby?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
125	Have you decided where you will go for the delivery of your baby? IF YES PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY OR AT HOME.	AT THIS HEALTH FACILITY. . . . . 1 OTHER HEALTH FACILITY. . . . 2 AT HOME. . . . . 3 AT TBA's HOME. . . . . 4 OTHER LOCATION_____ 6 NO/DON'T KNOW. 8	
126	Do you know any complications during or immediately following childbirth? IF YES: What danger signs do you know?	EXCESSIVE BLEEDING. . . . . A FEVER. . . . . B GENITAL INJURIES. . . . . C NO. . . . . Y	
127	During this visit (or previous visits) has a provider given you advice on the importance of exclusively breastfeeding—that is, about giving your baby nothing apart from breast milk for a specific period of time?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . . 3 NO. . . . . 4 DON'T KNOW. 8	→129
128	For how many months did the provider recommend that you exclusively breastfeed, that is, that you do not give your baby any fluids or food in addition to breast milk?	BETWEEN 4 TO 6 MONTHS. . . . . 1 6 MONTHS. . . . . 2 OTHER. . . . . 6 DON'T KNOW 8	
129	During this visit (or previous visits) did a provider talk with you about using family planning after the birth of your baby?	YES, THIS VISIT ONLY. . . . . 1 YES, THIS & PREVIOUS VISIT. . . . 2 YES PREVIOUS VISIT ONLY. . . . 3 NO. . . . . 4 DON'T KNOW. 8	→201

2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve services in general.			
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation? TRY TO DETERMINE THE TIME THE CLIENT ARRIVED AT THE FACILITY AND WHEN THE FACILITY OPENS FOR SERVICES. WE ARE INTERESTED IN THE WAITING TIME FROM THE TIME THE FACILITY OFFICIALLY OPENS.	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	

202 Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.

		MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited to see a provider	1	2	3	8
02	Ability to discuss problems or concerns about your pregnancy	1	2	3	8
03	Amount of explanation you received about the problem or treatment	1	2	3	8
04	Privacy from having others see the examination	1	2	3	8
05	Privacy from having others hear your consultation discussion	1	2	3	8
06	Availability of medicines at this facility	1	2	3	8
07	The hours of service at this facility, i.e., when they open and close	1	2	3	8
08	The number of days services are available to you	1	2	3	8
09	The cleanliness of the facility	1	2	3	8
10	How the staff treated you	1	2	3	8
11	Cost for services or treatments	1	2	3	8

203	Are you a part of any prepayment plan (such as medical aid, insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this or any other facility?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
204	Were you charged, or did you pay fees for any services your received or were provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT ☐☐☐☐☐☐ DON'T KNOW 999998	
206	Is this the closest health facility to your home?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 208 → 208
207	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER. . . . . 96 DON'T KNOW 98	
208	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today READ ALL STATEMENTS, CIRCLE ONLY ONE 01) I AM **VERY SATISFIED** WITH THE SERVICES I RECEIVED IN FACILITY . . . . . 1 02) I AM **MORE OR LESS SATISFIED** WITH THE SERVICES I RECEIVED. . . . . 2 03) I AM **NOT SATISFIED** WITH THE SERVICED I RECEIVED 3		
209	Will you recommend this health facility to a friend or family member?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

3. Client Personal Characteristics

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help to improve services in general.			
302	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
304	What is the highest level of school you attended?	PRIMARY. . . . . 1 SECONDARY. . . . . 2 HIGHER. 3	→306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . 1 YES, READ ONLY . . . . . 2 NO 3	
306	RECORD THE TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

Sample List for FAMILY PLANNING Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY #

TOTAL # OF FP CLIENTS ON DAY OF VISIT FOR ALL PROVIDERS

USE THIS FORM TO LIST FP CLIENTS SELECTED FOR FP OBSERVATION FOR PROVIDER #1

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
201			
202			
203			
204			
205			
206			
207			
208			
209			
210			
211			
212			
213			
214			
215			
216			
217			
218			
219			
220			
221			
222			
223			
224			
225			

Sample List for FAMILY PLANNING Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY #

USE THIS FORM TO LIST FP CLIENTS SELECTED FOR FP OBSERVATION FOR PROVIDER #2

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
226			
227			
228			
229			
230			
231			
232			
233			
234			
235			
236			
237			
238			
239			
240			
241			
242			
243			
244			
245			
246			
247			
248			
249			
250			

Sample List for FAMILY PLANNING Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

			FACILITY #

USE THIS FORM TO LIST FP CLIENTS SELECTED FOR FP OBSERVATION FOR PROVIDER #3

	NAME/INITIALS	FIRST VISIT	FOLLOW-UP
251			
252			
253			
254			
255			
256			
257			
258			
259			
260			
261			
262			
263			
264			
265			
266			
267			
268			
269			
270			
271			
272			
273			
274			
275			

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

OBSERVATION OF FAMILY PLANNING CONSULTATION

1. Facility Identification

QTYPE | O | F | P |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

2. Provider Information

Provider Qualification Category:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTOR	01
SPECIALISTS MEDICAL DOCTOR	02
CLINICAL OFFICER (DEGREE LEVEL)	03
CLINICAL TECHNICIAN (DIPLOMA)	04
MEDICAL ASSISTANT	05
REGISTERED NURSE (BSN)	07
REGISTERED NURSE MIDWIFE (BSN)	08
REGISTERED PSYCHIATRIC NURSE	09
REGISTERED NURSE WITH DIPLOMA	10
ENROLLED NURSE	11
COMMUNITY HEALTH NURSE	12
ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN	13
ENROLLED NURSE MIDWIFE	14
ENVIRONMENTAL HEALTH OFFICER	24
HEALTH SURVEILLANCE ASSISTANTS (HSA)	25
HTC COUNSELORS (NON-HSA)	26

PROVIDER CATEGORY | | |

SEX OF PROVIDER: (1=Male; 2=Female)	SEX OF PROVIDER	
PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]	PROVIDER SL NUMBER		

3. Information About Observation

Date:	DAY		| MONTH		| YEAR 2 0 1	
Name of the observer: _____	INTERVIEWER/OBSERVER CODE			
Client code:	CLIENT CODE			

4. Observation of Family Planning Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

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

	READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing the Ministry of Health. We are conducting a study of health facilities in Malawi with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how family planning services are provided in this facility. Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database. Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation. Do I have your permission to be present at this consultation? Interviewer's signature (Indicates respondent's willingness to participate) DAY __ MONTH __ YEAR 2 0 1		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**

	READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health We are conducting a study of health services in Malawi. I would like to be present while you are receiving services today in order to understand how family planning services are provided in this facility. We are not evaluating the [PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of services will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me at this time? Do I have your permission to be present at this consultation?		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED. . . . . __ __ : __ __		
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	
104	RECORD THE SEX OF CLIENT.	MALE . . . . . 1 FEMALE 2	

NO.	QUESTIONS / OBSERVATIONS	CODES

CLIENT HISTORY (FEMALE CLIENTS ONLY)

105	INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:	
01	Last delivery date or age of youngest child	A
02	Last menstrual period (assess if currently pregnant)	B
03	Breastfeeding status	C
04	Regularity of menstrual cycle	D
05	None of the above	Y

CLIENT HISTORY (ALL CLIENTS)

106	CLIENT'S PERSONAL INFORMATION AND REPRODUCTIVE HISTORY. INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:	
01	Age of client	A
02	Number of living children	B
03	Desire for a child or more children	C
04	Desired timing for birth of next child	D
05	None of the above	Y

PHYSICAL EXAMINATION

107	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS:	
01	Took the client's blood pressure	A
02	Weighed the client	B
03	Asked the client about his/her smoking habits	C
04	Asked the client about symptoms of STIs (e.g., abnormal vaginal/urethral discharge)	D
05	Asked the client about any chronic illnesses (heart disease, diabetes, hypertension, liver disease, or breast cancer)	E
06	None of the above	Y

PARTNER AND STIS

108	RECORD WHETHER THE PROVIDER DISCUSSED ANY OF THE FOLLOWING ISSUES RELATED TO SEXUAL PARTNERS AND CHOICE OF FAMILY PLANNING METHOD.	
01	Partner's attitude toward family planning (in favor of, or against idea of family planning)	A
02	Partner status (number of client's sexual partners, or of client's partner; periods of partner's absence)	B
03	Client's perceived risk of STIs/HIV	C
04	Use of condoms to prevent STIs/HIV	D
05	Using condoms along with another method (dual method) to prevent both pregnancy and STIs/HIV	E
06	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

QUESTIONS/CONCERNS

109	RECORD WHETHER THE PROVIDER OR CLIENT DID ANY OF THE FOLLOWING	
01	Provider asked client is he/she had questions or concerns regarding current method	A
02	Client expressed concerns about method, or asked questions about method, including possible side effects of method.	B
03	None of the above	Y

PRIVACY/CONFIDENTIALITY

110	RECORD WHETHER THE PROVIDER TOOK ANY OF THE FOLLOWING STEPS TO ASSURE THE CLIENT OF PRIVACY	
01	Ensured visual privacy	A
02	Ensured auditory privacy	B
03	Assured the client orally of confidentiality	C
04	None of the above	Y

METHODS PROVIDED OR PRESCRIBED

111

VERIFY METHOD WITH PROVIDER AND INDICATE WHICH METHOD(S) WERE EITHER PROVIDED OR PRESCRIBED DURING THIS VISIT. IF CONDOMS WERE EITHER PRESCRIBED OR PROVIDED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.

IF CLIENT IS CONTINUING CLIENT WHO RECEIVED REFILLS FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUCD DURING THIS VISIT, CIRCLE THE METHOD THAT WAS REPLENISHED IN COLUMN B.

CAUTION!
AT LEAST ONE RESPONSE MUST BE REPORTED FOR EACH OF THE COLUNMS
IF NO METHOD IS PRECRIBED, THEN "Y" SHOULD BE CIRCLED IN COLUMN "A"

	METHOD	(A) PRESCRIBED TO BE FILLED LATER/DIFFERENT LOCATION	(B) PROVIDED TO CLIENT IN FACILITY
01	COMBINED ORAL PILL	A	A
02	PROGESTIN-ONLY ORAL PILL	B	B
03	ORAL PILL (TYPE UNSPECIFIED)	C	C
04	COMBINED INJECTABLE (MONTHLY)	D	D
05	PROGESTIN-ONLY INJECTABLE (2 OR 3-MONTHLY)	E	E
06	MALE CONDOM	F	F
07	FEMALE CONDOM	G	G
08	IUCD	H	H
09	IMPLANT	I	I
10	EMERGENCY CONTRACEPTION	J	J
11	CYCLE BEADS FOR STANDARD DAYS METHOD	K	K
12	COUNSELING ON PERIODIC ABSTINENCE	L	L
13	VASECTOMY (MALE STERILIZATION)	M	M
14	TUBAL LIGATION (FEMALE STERILIZATION)	N	N
15	LACTATIONAL AMENORHEA	O	O
16	OTHER (E.G., SPERMICIDE, DIAPHRAGM)	X	X
17	NO METHOD	Y	Y

NO.	QUESTIONS / OBSERVATIONS	CODES
	FOR Q112-129, CIRCLE THE APPROPRIATE LETTERS TO INDICATE IF THE INFORMATION UNDER EACH RELEVANT SECTION WAS DISCUSSED OR SHARED WITH THE CLIENT.	
112	CHECK Q111: ARE "A", "B", "C", "D" OR "E" CIRCLED IN EITHER OR BOTHCOLUMNS? YES ☐ NO ☐ →	114
113	**PILLS OR INJECTIONS**	
01	When to take (pill daily; injection either every month or every 2 or 3 months)	A
02	Changes that may occur with menstruation (decreased flow or amenorrhea, spotting)	B
03	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	C
04	What to do if forget pill or do not get injection on time	D
05	Method does not protect against STIs, including HIV	E
06	Should return to clinic if side effects appear or persist	F
07	None of the above	Y
114	CHECK Q111: ARE "F" OR "G" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ →	116
115	**CONDOMS**	
01	Client cannot use if allergic to latex	A
02	Each condom can be used only one time	B
03	Some lubricants may be used (male condom— water soluble only; female condom —any lubricant)	C
04	Can be used as backup method if client fears other method will fail	D
05	Dual protection (from pregnancy and against STIs, including HIV)	E
06	None of the above	Y
116	CHECK Q111: IS "H" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ →	118
117	**INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)**	
01	Good for up to 5 years or 12 years	A
02	Should return to the clinic 3-6 weeks post insertion or after first menses	B
03	Common side effects that may occur (heavy bleeding for first few months post insertion, spotting or mild abdominal cramps)	C
04	Should return to clinic if side effects continue	D
05	User should regularly check strings after each menstruation	E
06	Method does not protect against STIs, including HIV	F
07	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES
118	CHECK Q111: IS "I" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ → 120	
119	**IMPLANTS**	
01	Good for 3-5 years	A
02	Changes that may occur with menstruation (irregular bleeding, decreased flow, spotting)	B
03	Initial side effects that may occur (such as nausea, weight gain, breast tenderness)	C
04	Should return to clinic if side effects continue	D
05	Method does not protect against STIs, including HIV	E
06	None of the above	Y
120	CHECK Q111: IS "J" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ → 122	
121	**EMERGENCY CONTRACEPTION**	
01	Take another dose if vomit within 2 hours of taking a dose	A
02	Return for pregnancy check if period is unusually light or fails to occur within 4 weeks	B
03	First dose to be taken within 120 hours of unprotected sexual contact	C
04	Second dose should be taken 12 hours after first dose	D
05	Not for routine contraception and therefore regimen not to be repeated or taken more than three times in any one month	E
06	Method does not protect against STIs, including HIV	F
07	None of the above	Y
122	CHECK Q111: IS "K" OR "L" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ → 124	
123	**PERIODIC ABSTINENCE OR STANDARD DAYS METHOD**	
01	How to identify a woman's fertile period	A
02	No intercourse during woman's fertile period without alternative method (condom)	B
03	Method does not protect against STIs, including HIV	C
04	None of the above	Y
124	CHECK Q111: IS "M" CIRCLED IN EITHER COLUMN "A" OR COLUMN "B"? YES ☐ NO ☐ → 126	
125	**VASECTOMY**	
01	Partner is protected from pregnancy after 3 months	A
02	Use of a back-up method for the next 3 months	B
03	Procedure intended to be permanent; slight risk of failure	C
04	Warning signs that may occur after surgery (severe pain, tenderness, bleeding)	D
05	Should return to clinic if experience warning signs	E
06	Method does not protect against STIs, including HIV	F
07	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES
126	CHECK Q111: IS "N" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ → 128	
127	**FEMALE STERILIZATION**	
01	Protect from pregnancy immediately	A
02	Procedure intended to be permanent, slight risk of failure	B
03	Warning signs that may occur after surgery (severe pain, light-headedness, fever, bleeding, missed periods)	C
04	Should return to clinic if experience warning sign	D
05	Method does not protect against STIs, including HIV	E
06	None of the above	Y
128	CHECK Q111: IS "O" CIRCLED IN EITHER OR BOTH COLUMNS? YES ☐ NO ☐ → 130	
129	**LACTATIONAL AMENORRHEA (LAM)**	
01	Slight risk of pregnancy during the time shortly before regular menstruation resumes	A
02	Must be exclusively (or near-exclusively) breastfeeding	B
03	Not effective after menstruation begins again	C
04	Infant must be less than 6 months	D
05	Method does not protect against STIs, including HIV	E
06	None of the above	Y

ADDITIONAL PROVIDER ACTIONS

130	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING	
01	Look at client's health card at any time before beginning the consultation, while collecting information or while examining the client	A
02	Wrote on the client's health card	B
03	Used any visual aids for health education or counseling about family planning methods	C
04	Discussed a return visit	D
05	None of the above	Y

CONFIRM WITH PROVIDER

131	CONFIRM THE FOLLOWING WITH THE PROVIDER AT THE END OF THE CONSULTATION. CHECK THE CLIENT CARD OR REGISTER IF NECESSARY.		
01	Has this client had any previous contact with a family planning provider in this facility?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
02	Has this client ever been pregnant?	YES. . . . . 1 NO. . . . . 2 MALE CLIENT. . . . . 3 DON'T KNOW. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES

5. CLINICAL OBSERVATION

201	INDICATE WHICH OF THE FOLLOWING PROCEDURES WAS CONDUCTED DURING THIS VISIT		
01	PELVIC EXAMAMINATION	A	
02	IUCD INSERTION AND/OR REMOVAL OR IUCD CHECKUP	B	
03	INJECTABLE GIVEN	C	
04	IMPLANT INSERTION AND/OR REMOVAL	D	
05	NONE OF THE ABOVE	Y	→ 301
202	IS THE CLINICAL PROVIDER THE SAME PERSON WHO PROVIDED COUNSELLING?	YES . . . . . 1 NO 2	→ 206

READ TO PROVIDER: Hello, I am representing the Ministry of Health. We are conducting a study of health facilities, with the goal of finding ways to improve the delivery of services. I would like to observe the procedure you will conduct with this client. [Ms. ___] has agreed that she has no objection to my presence. Observing all components of the services provided to [Ms. ___] will help us to better understand how health services are provided.

Any information relating to this procedure will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me.

Do you have any questions for me? Do I have your permission to be present during this procedure?

Interviewer's signature

(Indicates respondent's willingness to participate)

				2	0	1	
DAY		MONTH		YEAR			

203	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ 301

204	RECORD THE TYPE OF PROVIDER PROVIDING MOST OF THE CLINICAL EXAMINATION.	Provider Qualification Category: GENERALIST [NON-SPECIALIST] MEDICAL DOCTOR. . . . . 01 SPECIALISTS MEDICAL DOCTOR . . . . . 02 CLINICAL OFFICER (DEGREE LEVEL). . . . . 03 CLINICAL TECHNICIAN (DIPLOMA). . . . . 04 MEDICAL ASSISTANT. . . . . 05 REGISTERED NURSE (BSN). . . . . 07 REGISTERED NURSE MIDWIFE (BSN). . . . . 08 REGISTERED PSYCHIATRIC NURSE . . . . . 09 REGISTERED NURSE WITH DIPLOMA. . . . . 10 ENROLLED NURSE. . . . . 11 COMMUNITY HEALTH NURSE. . . . . 12 ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN. . . . . 13 ENROLLED NURSE MIDWIFE . . . . . 14 ENVIRONMENTAL HEALTH OFFICER. . . . . 24 HEALTH SURVEILLANCE ASSISTANTS (HSA) . . . . . 25 HTC COUNSELORS (NON-HSA). 26	
205	RECORD THE SEX OF THE PROVIDER CONDUCTING THE CLINICAL EXAMINATION.	MALE . . . . . 1 FEMALE 2	

NO.	QUESTIONS / OBSERVATIONS	CODES

6. PELVIC EXAMINATION

206	**CHECK Q201:** WAS A PELVIC EXAMINATION CONDUCTED?	YES. . . . . 1 NO. 2	→ 210

BEFORE PROCEDURE

207	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE	
01	Ensured that client had visual privacy	A
02	Ensured that client had auditory privacy	B
03	Explained procedure to client before starting	C
04	Prepared all instruments before starting procedure	D
05	Washed hands with soap and water or disinfected hands before starting procedure	E
06	Put on latex gloves before starting procedure	F
07	NONE OF THE ABOVE	Y

DURING PROCEDURE

208	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE	
01	Used sterilized or high level disinfected (HLD) instruments	A
02	Asked the client to take slow deep breaths and to relax muscles	B
03	Inspected the external genitalia	C
04	Explained speculum procedure to client (if speculum used)	D
05	Inspected the cervix and vaginal mucosa (using speculum and light)	E
06	Performed a bimanual examination (TWO FINGERS IN VAGINA, OTHER HAND PALPATING ABDOMEN)	F
07	NONE OF THE ABOVE	Y

AFTER PROCEDURE

209	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER THE PROCEDURE	
01	Removed gloves	A
02	Washed or disinfected hands after removing gloves	B
03	Wiped contaminated surfaces with disinfectant	C
04	Placed reusable instruments in chlorine-based disinfecting solution immediately after the procedure	D
05	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

7. IUCD INSERTION AND/OR REMOVAL

210	**CHECK 201:** WAS AN IUCD EITHER INSERTED OR REMOVED?	IUCD INSERTION . . . . . A IUCD REMOVAL . . . . . B IUCD CHECKUP . . . . . C NONE OF THE ABOVE. . . . . Y	→ 215

BEFORE PROCEDURE

211	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE.	
01	Ensured that client had visual privacy	A
02	Ensured that client had auditory privacy	B
03	Explained procedure to client before starting	C
04	**(FOR NEW CLIENT)** Reconfirmed client choice of method	D
05	**(FOR NEW CLIENT)** Confirmed client is not pregnant	E
06	Prepared all instruments before starting procedure	F
07	Washed or disinfected hands before starting procedure	G
08	Put on latex gloves before starting procedure	H
09	Clean cervix and vagina with antiseptic	I
10	None of the above	Y

DURING PROCEDURE

212	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE.	
01	Performed a bimanual examination (TWO FINGERS IN VAGINA, OTHER HAND PALPATING ABDOMEN)	A
02	Conducted a speculum examination before performing bimanual examination	B
03	Inspected the cervix and vaginal mucosa (USING SPECULUM AND LIGHT)	C
04	Used a tenaculum	D
05	Sounded the uterus before inserting IUCD	E
06	Explained any of the above procedures	F
07	Used the no-touch technique for IUCD insertion	G
08	Used sterilized or high level disinfected (HLD) instruments	H
09	None of the above	Y

AFTER PROCEDURE

213	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER PROCEDURE.	
01	Removed gloves	A
02	Washed or disinfected hands after removing gloves	B
03	Asked client to wait and rest for 5 minutes after inserting IUCD	C
04	Wiped contaminated surfaces with disinfectant	D
05	Placed reusable instruments in chlorine-based disinfecting solution immediately after the procedure	E
06	NONE OF THE ABOVE	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

CLIENT - PROVIDER INTERACTION

214	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER PROCEDURE.	
01	Client told that IUCD is good for up to 5 or 12 years	A
02	Client instructed to return to the clinic 3 to 6 weeks after insertion or after first menses	B
03	Client instructed to regularly check the strings after each menstruation	C
04	Client told she may experience side effects (e.g., heavy bleeding for first few months, spotting, or mild abdominal cramps)	D
05	Client instructed to return to clinic if side effects persisted	E
06	Client provided with a card stating the date IUCD was inserted and the follow-up date	F
07	**(IF IUCD REMOVED)**: Show the removed IUCD to client	G
08	NONE OF THE ABOVE	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

8. INJECTABLE CONTRACEPTIVES

215	**CHECK Q201:** WAS AN INJECTABLE CONTRACEPTIVE GIVEN?	YES . . . . . 1 NO 2	→ 220

BEFORE PROCEDURE

216	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE.	
01	(With a **new client**) Reconfirmed the client's choice of method	A
02	(With a **new client**) Verified that client was not pregnant	B
03	(**Continuing client**) Checked the client's card to ensure giving injection at correct time	C
04	Ensured visual privacy	D
05	Ensured auditory privacy	E
06	Washed/disinfected hands before giving the injection	F
07	Prepared injection in area with clean table or tray to set items on	G
08	None of the above	Y

DURING PROCEDURE

217	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE	
01	(**If using disposables**) Used new syringe and needle from a sterile sealed pack	A
02	Opened new packet of syringe and needle	B
03	Removed needle from multiple dose vial each time	C
04	Stirred or mixed the bottle *before* drawing dose (Depo)	D
05	Cleaned and air-dried the injection site *before injection*	E
06	Drew back plunger *before* giving injection	F
07	Allowed dose to self-disperse instead of massaging the site	G
08	None of the above	Y

AFTER PROCEDURE

218	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER THE PROCEDURE		
01	Disposed of sharps in puncture-resistant container (not overflowing or pierced)		A
02	Tell client not to massage injection site		B
03	Tell the client when to come back for her next injection		C
04	None of the above		Y
219	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY. . . . . 1 PROVIDED BY CLIENT. . . . . 2 DON'T KNOW. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES

9. IMPLANT INSERTION AND/OR REMOVAL

220	CHECK 201: WERE IMPLANTS EITHER INSERTED OR REMOVED?	IMPLANT INSERTION. . . . . A IMPLANT REMOVAL. . . . . B NONE OF THE ABOVE. . . . . Y	→ 301

BEFORE PROCEDURE

221	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING BEFORE PROCEDURE.	
01	(With a **new client**) Reconfirmed the client's choice of method	A
02	(With a **new client**) Verified that client was not pregnant	B
03	Ensured visual privacy	C
04	Ensured auditory privacy	D
05	Explained the procedure to client before starting	E
06	Prepared all instruments before the procedure	F
07	Used sterilized or high-level disinfected instruments	G
08	Washed/disinfected hands *before* the procedure	H
09	Put on sterile gloves and maintain sterility during insertion	I
10	None of the above	Y

DURING PROCEDURE

222	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING PROCEDURE.	
01	Cleaned skin where incision was made with antiseptic	A
02	Used sterile towel to protect area	B
03	Used new or sterilized needle and syringe for local anesthetic	C
04	Allowed time for local anesthetic to take effect prior to making incision	D
05	None of the above	Y

AFTER PROCEDURE

223	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING AFTER PROCEDURE.	
01	Disposed of sharps in puncture-resistant containers	A
02	Wiped contaminated surfaces with disinfectant	B
03	Placed instruments in a chlorine solution immediately after completing the procedure	C
04	Removed gloves	D
05	Washed/disinfected hands *after* removing gloves	E
06	Explained care of incision area and removal of the bandage	F
07	Discussed return visit to remove plaster	G
08	Provided client with card or health passport stating date implant was inserted and date when the lifespan of the implant will be completed (3 or 5 years later)	H
08A	Provider asked client to palpate or feel area where implant was inserted	I
09	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

PROVIDER/CLIENT INTERACTION

224	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING.	
01	Client instructed that the implant is good for 3-5 years (# OF YEARS DEPENDS ON TYPE)	A
02	Client told about possible menstrual changes and/or side effects	B
03	Client told about other (NON-MENSTRUAL) side effects such as nausea, weight gain, or breast tenderness	C
04	Client instructed to return to clinic if side effects persisted	D
05	**(IN THE CASE OF REMOVAL):** Client shown each implant stick that was removed and assured that all have been removed	E
06	Provided client with a card stating date that implant was inserted and date when implant should be removed	F
07	None of the above	Y

225	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY. . . . . 1 PROVIDED BY CLIENT. . . . . 2 DON'T KNOW. 8	

NO.	QUESTIONS / OBSERVATIONS	CODES

10. CLIENT'S FAMILY PLANNING STATUS

TO BE ASKED OF PROVIDER AFTER CONSULTATION

	AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS		
301	What was the client's family planning status at the beginning of this consultation?	CURRENT USER . . . . . 1 NONUSER, USED IN PAST . . . 2 NONUSER, NO PAST USE . . . 3 NOT DETERMINED 8	 → 304 → 304 → 304
302	What was the client's principal reason for the visit?	RESUPPLY/ROUTINE FOLLOW-UP . . . . . 1 DISCUSS PROBLEM WITH METHOD. . . . . 2 DESIRE TO CHANGE METHOD (NO PROBLEM). . . . . 3 DESIRE TO DISCONTINUE FP (NO PROBLEM). . . . . 4 DISCUSS OTHER PROBLEM. . . . 5	
303	What was the outcome of the visit? (FOR CURRENT USER)	CONTINUED WITH CURRENT METHOD . . . . . 1 SWITCHED METHOD . . . . . 2 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, CONTINUED USE OF CURRENT METHOD . . . . . 3 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, DISCONTINUED CURRENT METHOD . . . . . 4 DECIDED TO STOP USING FAMILY PLANNING 5	 → 305 → 305 → 305 → 305 → 306
304	What was the outcome of the visit? (IF NOT A CURRENT USER)	ACCEPTED TO START METHOD . . . . . 1 DID NOT DECIDE ON METHOD 2	 → 306
305	Did the client leave the facility with a method? IF NO, RECORD THE REASON THE CLIENT DID NOT RECEIVE METHOD.	YES, LEFT WITH METHOD . . . 1 NO, METHOD NOT IN STOCK . . 2 NO, REQUIRES APPOINTMENT . . . . . 3 NO, DELAY RECEIVING DUE TO HEALTH PROBLEM . . . 4 NO, PREGNANCY STATUS UNCERTAIN . . . . . 5 OTHER. 6	
306	INDICATE WHETHER THE PROVIDER WROTE IN OR ON AN INDIVIDUAL CLIENT'S CARD AFTER THE CONSULTATION.	YES . . . . . 1 NO . . . . . 2 NO INDIVIDUAL CARD USED . . 3 DON'T KNOW 8	
307	RECORD THE TIME THE OBSERVATION ENDED.	☐☐ : ☐☐	
308	**Observer's comments:**		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

FP CLIENT EXIT INTERVIEW

FACILITY IDENTIFICATION

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

PROVIDER SERIAL # [FROM STAFF LISTING FORM]. . . . . | | |

INFORMATION ABOUT INTERVIEW

DATE: _____

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . 2 0 1 |

Name of the interviewer: _____

INTERVIEWER CODE | | |

CLIENT CODE. . . . . | | |

1. Information About Visit - FAMILY PLANNING

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministry of Health. We are conducting a study of health facilities in Malawi in order to improve the services this facility offers and would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | YEAR: | | | | 2 | 0 | 1 | |		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED	| | | : | | |	
102	RECORD THE SEX OF THE CLIENT	MALE. . . . . 1 FEMALE. 2	
103	Before coming to this facility today, were you taking any steps or using any methods to prevent a pregnancy?	YES . . . . . 1 NO 2	→ 105
104	Have you used a family planning method or taken any steps to prevent pregnancy at any time during the past 6 months?	YES . . . . . 1 NO 2	→ 112
105	What method were you (last) using? BROBE TO OBTAIN INFORMATION ON ALL METHODS THE CLIENT WAS LAST USING. IF THE CLIENT SIMPLY SAYS "CONDOMS" PROBE TO CLARIFY IF MALE OR FEMALE CONDOMS	COMBINED ORAL PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C COMBINED INJECTABLE (MONTHLY). . . . . D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY). . . . E MALE CONDOM. . . . . F FEMALE CONDOM. . . . . G IUCD. . . . . H IMPLANT. . . . . I EMERGENCY CONTRACEPTION. . . . . J CYCLE BEADS FOR STANDARD DAYS METHOD (SDM). . . . . K NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L MALE STERILIZATION (VASECTOMY). . . . . M FEMALE STERILIZATION (TUBAL LIGATION). . . . N LACTATIONAL AMENORRHEA. . . . . O OTHER_____ X	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
106	Did a provider ask you today whether you were having (or had had) a problem with the method?	YES, ASKED. . . . . 1 NO, DID NOT ASK 2	
107	Have you been having (did you have) any problems with the method?	YES . . . . . 1 NO 2	→ 110
108	Did you mention the problem to the provider during the consultation?	YES . . . . . 1 NO 2	→ 110
109	Did the provider suggest any action(s) you should take to resolve the problem?	YES . . . . . 1 NO 2	
110	What was the outcome of this visit—did you decide to continue (restart) the same method or to switch methods?	CONTINUE WITH OR RESTART SAME METHOD. . . . . 1 SWITCH METHOD. . . . . 2 STOP USING METHOD (DUE TO PROBLEMS). . . . . 3 STOP USING METHOD (ELECTIVE-NO PROBLEMS). . . . 4	→ 201
111	Had you thought about switching methods, and which method to switch to, before you came here today?	YES . . . . . 1 NO 2	→ 113 → 115
112	Had you thought about what family planning method you wanted to use before you came here today?	YES . . . . . 1 NO 2	→ 115
113	What method was that? IF CLIENT MENTIONS CONDOMS ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED ORAL PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C COMBINED INJECTABLE (MONTHLY). . . . . D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY). . . . E MALE CONDOM. . . . . F FEMALE CONDOM. . . . . G IUCD. . . . . H IMPLANT. . . . . I EMERGENCY CONTRACEPTION. . . . . J CYCLE BEADS FOR STANDARD DAYS METHOD (SDM). . . . . K NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L MALE STERILIZATION (VASECTOMY). . . . . M FEMALE STERILIZATION (TUBAL LIGATION). . . . N LACTATIONAL AMENORRHEA. . . . . O OTHER_____ X	
114	Did the provider talk to you about any of the method(s) you just mentioned?	YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
115	What (other) family planning methods did the provider talk with you about? CIRCLE ALL METHODS MENTIONED.	COMBINED ORAL PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C COMBINED INJECTABLE (MONTHLY). . . . . D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY). . . . E MALE CONDOM. . . . . F FEMALE CONDOM. . . . . G IUCD. . . . . H IMPLANT. . . . . I EMERGENCY CONTRACEPTION. . . . . J CYCLE BEADS FOR STANDARD DAYS METHOD (SDM). . . . . K NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L MALE STERILIZATION (VASECTOMY). . . . . M FEMALE STERILIZATION (TUBAL LIGATION). . . . N LACTATIONAL AMENORRHEA. . . . . O OTHER_____ X	

116	What family planning method did you either receive or get a prescription or referral for? CIRCLE ALL METHODS THE CLIENT HAS A PRESCRIPTION OR A REFERRAL (PRES), OR RECEIVED IN FACILITY (REC). IF THE CLIENT IS CONTINUING WITH A PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION OR REFERRAL DURING THIS VISIT, CIRCLE "Y" CHECK PACKET OR PRESCRIPTION TO CONFIRM TYPE OF PILL OR INJECTION	PRES/REF REC COMBINED ORAL PILL. . . . . A A PROGESTIN-ONLY PILL. . . . . B B PILL (TYPE UNSPECIFIED). . . . . C C COMBINED INJECTABLE (MONTHLY). . . . . D D PROGESTIN-ONLY INJ. (2 TO 3-MONTHLY). . . . E E MALE CONDOM. . . . . F F FEMALE CONDOM. . . . . G G IUCD. . . . . H H IMPLANT. . . . . I I EMERGENCY CONTRACEPTION. . . . . J J CYCLE BEADS FOR STANDARD DAYS METHOD (SDM). . . . . K K NATURAL METHODS (PERIODIC ABSTINENCE). . . . . L L MALE STERILIZATION (VASECTOMY). . . . . M M FEMALE STERILIZATION (TUBAL LIGATION). . . . N N LACTATIONAL AMENORRHEA. . . . . O O OTHER_____ X X CONTINUING WITH METHOD IN Q105. . . . . Y Y NO METHOD. . . . . Z Z → 201 ***[ONLY SKIP TO 201 IF BOTH "Z" ARE CIRCLED IE, NO METHOD EITHER RECEIVED OR PRESCRIBED] OTHERWISE CONTINUE TO Q117***

117	During your consultation today, did the provider		YES	NO	DK
01	Explain how to use the method?	HOW TO USE	1	2	8
02	Talk about possible side effects?	TELL SIDE EFFECTS . .	1	2	8
03	Tell you what to do if you have any problems?	TELL PROBLEMS	1	2	8
04	Tell you when to return for follow-up?	TELL WHEN RETURN . .	1	2	8

NO.	QUESTIONS		CODING CLASSIFICATION	GO TO
118	MARK BELOW THE METHOD THAT IS CIRCLED IN QUESTION 116. THEN, ASK THE CLIENT THE QUESTION RELATED TO THAT METHOD			
A	PILL (ANY PILL)	How often do you take the pill?	ONCE A DAY. . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
B	CONDOM (MALE)	How many times can you use one condom?	ONCE . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
C	CONDOM (FEMALE) [country-specific, depends on type of female condom available]	What type of lubricant can you use with the female condom?	ANY OIL OR LUBRICANT . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
D	IUCD	What should you do to make sure that your IUCD is in place?	CHECK STRING . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
E	PROGESTIN INJECTABLE (e.g. DEPO-PROVERA) 2-3 MONTHS)	How long does the injection provide protection from pregnancy?	2-3 MONTHS . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
F	MONTHLY INJECTABLE	How long does the injection provide protection from pregnancy?	1 MONTH. . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
G	IMPLANT [country-specific, depends on type of implant available?]	How long does your implant provide protection against pregnancy?	3-5 YEARS . . . . . 1 OTHER. . . . . 2 DON'T KNOW 8	
H	NATURAL METHOD (PERIODIC ABSTINENCE OR SDM)	How do you recognize the days on which you should not have sexual intercourse?	BODY TEMPERATURE RISES A MUCUS IN VAGINA . . . . . B DAYS 12-16 OF THE MENSTRUAL CYCLE. . . . . C WHITE BEAD' DAYS/DAYS 8-19 OF MENSTRUAL CYCLE. . . . . D OTHER . . . . . X DON'T KNOW . . . . . Z	
I	VASECTOMY [obvs. section asks if provider counsels on slight risk]	After you have been sterilized (and after the first 3 months), can you make a woman pregnant again?	YES, DEFINITELY. . . . . 1 YES, ONLY SLIGHT RISK 2 NO. . . . . 3 DON'T KNOW. 8	
J	TUBAL LIGATION [obvs. section asks if provider counsels on slight risk]	After you have been sterilized, could you ever become pregnant again?	YES, DEFINITELY. . . . . 1 YES, ONLY SLIGHT RISK. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	
K	LAM	Can you use this method if your menstrual period has returned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
119	Does your method protect against Sexually Transmitted Infections (STIs), including HIV/AIDS?		YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 201

2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve services in general.			
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation? TRY TO DETERMINE THE TIME THE CLIENT ARRIVED AT THE FACILITY AND WHEN THE FACILITY OPENS FOR SERVICES. WE ARE INTERESTED IN THE WAITING TIME FROM THE TIME THE FACILITY OFFICIALLY OPENS.	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	

202 Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.

		MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited to see a provider	1	2	3	8
02	Ability to discuss problems or concerns about your method	1	2	3	8
03	Amount of explanation you received about the problem or treatment	1	2	3	8
04	Privacy from having others see the examination	1	2	3	8
05	Privacy from having others hear your consultation discussion	1	2	3	8
06	Availability of family planning commodities at this facility	1	2	3	8
07	The hours of service at this facility, i.e., when they open and close	1	2	3	8
08	The number of days services are available to you	1	2	3	8
09	The cleanliness of the facility	1	2	3	8
10	How the staff treated you	1	2	3	8
11	Cost for services or treatments	1	2	3	8

203	Are you a part of any prepayment plan (such as medical aid, insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this or any other facility?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
204	Were you charged, or did you pay fees for any services your received or were provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT ☐☐☐☐☐☐ DON'T KNOW 999998	
206	Is this the closest health facility to your home?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 208 → 208
207	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER. . . . . 96 DON'T KNOW 98	
208	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today READ ALL STATEMENTS, CIRCLE ONLY ONE 01) I AM **VERY SATISFIED** WITH THE SERVICES I RECEIVED IN FACILITY . . . . . 1 02) I AM **MORE OR LESS SATISFIED** WITH THE SERVICES I RECEIVED. . . . . 2 03) I AM **NOT SATISFIED** WITH THE SERVICED I RECEIVED 3		
209	Will you recommend this health facility to a friend or family member?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

3. Client Personal Characteristics

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help to improve services in general.			
302	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
304	What is the highest level of school you attended?	PRIMARY. . . . . 1 SECONDARY. . . . . 2 HIGHER. 3	→306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . 1 YES, READ ONLY . . . . . 2 NO 3	
306	RECORD THE TIME THE INTERVIEW ENDED [ ][ ] : [ ][ ]		
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

Sample List for SICK CHILD Observation

Date | | | | | **2** | **0** | **1** | |
DAY MONTH YEAR

FACILITY # | | | | | |

TOTAL # OF SICK CHILDREN ON DAY OF VISIT FOR ALL PROVIDERS | | |

USE THIS FORM TO LIST SICK CHILDREN SELECTED FOR OBSERVATION FOR PROVIDER #1

	NAME/INITIALS OF SAMPLED SICK CHILDREN	AGE IN MONTHS
301		
302		
303		
304		
305		
306		
307		
308		
309		
310		
311		
312		
313		
314		
315		
316		
317		
318		
319		
320		
321		
322		
323		
324		
325		

Sample List for SICK CHILD Observation

Date | | | | | **2** | **0** | **1** | | DAY MONTH YEAR

					FACILITY #

USE THIS FORM TO LIST SICK CHILDREN SELECTED FOR OBSERVATION FOR PROVIDER #2

	NAME/INITIALS OF SAMPLED SICK CHILDREN	AGE IN MONTHS
326		
327		
328		
329		
330		
331		
332		
333		
334		
335		
336		
337		
338		
339		
340		
341		
342		
343		
344		
345		
346		
347		
348		
349		
350		

Sample List for SICK CHILD Observation

Date | | | | | **2** | **0** | **1** | | DAY MONTH YEAR

					FACILITY #

USE THIS FORM TO LIST SICK CHILDREN SELECTED FOR OBSERVATION FOR PROVIDER #3

	NAME/INITIALS OF SAMPLED SICK CHILDREN	FOLLOW-UP
351		
352		
353		
354		
355		
356		
357		
358		
359		
360		
361		
362		
363		
364		
365		
366		
367		
368		
369		
370		
371		
372		
373		
374		
375		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

OBSERVATION OF SICK CHILD CONSULTATION

1. Facility Identification

QTYPE | S | C | O |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

2. Provider Information

Provider Qualification Category:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTOR	01
SPECIALISTS MEDICAL DOCTOR	02
CLINICAL OFFICER (DEGREE LEVEL)	03
CLINICAL TECHNICIAN (DIPLOMA)	04
MEDICAL ASSISTANT	05
REGISTERED NURSE (BSN)	07
REGISTERED NURSE MIDWIFE (BSN)	08
REGISTERED PSYCHIATRIC NURSE	09
REGISTERED NURSE WITH DIPLOMA	10
ENROLLED NURSE	11
COMMUNITY HEALTH NURSE	12
ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN	13
ENROLLED NURSE MIDWIFE	14
ENVIRONMENTAL HEALTH OFFICER	24
HEALTH SURVEILLANCE ASSISTANTS (HSA)	25
HTC COUNSELORS (NON-HSA)	26

PROVIDER CATEGORY | | |

SEX OF PROVIDER: (1=Male; 2=Female) — SEX OF PROVIDER . . . . . | |

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] — PROVIDER SL NUMBER . . . . . | | |

3. Information About Observation

Date: . . . . .

DAY . . . . . | | |
MONTH . . . . . | | |
YEAR . . . . . | 2 | 0 | 1 | |

Name of the observer: _____

OBSERVER CODE . . . . . | | | |

Client code: . . . . .

CLIENT CODE . . . . . | | | |

4. OBSERVATION OF SICK CHILD CONSULTATION

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

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

READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing the Ministry of Health. We are conducting a study of health facilities in Malawi with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how services for sick children are provided in this facility.

Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database.

Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation.

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

Interviewer's signature
(Indicates respondent's willingness to participate)

DAY ____ MONTH ____ YEAR 2 0 1 ____

100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**

READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health. We are conducting a study of health services in Malawi. I would like to be present while you are receiving services today in order to understand how sick child services are provided in this facility.

We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential.

Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me.

After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me at this time? Do I have your permission to be present at this consultation?

Interviewer's signature
(Indicates respondent's willingness to participate)

101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CARETAKER.	YES . . . . . 1 NO 2	→ **END**

102	RECORD THE TIME THE OBSERVATION STARTED	____ : ____	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	
104	RECORD SEX OF THE CHILD. CONFIRM SEX OF CHILD WITH THE PROVIDER	MALE . . . . . 1 FEMALE 2	

5. PROVIDER INTERACTION WITH CARETAKER AND CHILD

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

CLIENT HISTORY

105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING **MAIN SYMPTOMS**	
01	Fever	A
02	Cough or difficult breathing (e.g., fast breathing or chest in-drawing)	B
03	Diarrhea	C
04	Ear pain or discharge	D
05	None of the above	Y
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING **GENERAL DANGER SIGNS**	
01	Child is unable to drink or breastfeed	A
02	Child vomits everything	B
03	Child has had convulsions with this illness	C
04	None of the above	Y
107	RECORD WHETHER A PROVIDER CHECKED FOR **SUSPECTED SYMPTOMATIC HIV** INFECTION BY **ASKING FOR ANY OF THE FOLLOWING:**	
01	Mother's HIV status	A
02	TB disease in any parent in the last 5 years	B
03	Two or more episodes of diarrhea in child each lasting 14 days or more	C
04	None of the above	Y

PHYSICAL EXAMS

108	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING **PHYSICAL EXAMINATIONS ON THE SICK CHILD**	
01	Took child’s temperature by thermometer	A
02	Felt the child for fever or body hotness	B
03	Counted respiration (breaths) for 60 seconds	C
04	Auscultated child (listen to chest with stethoscope) or count pulse	D
05	Checked skin turgor for dehydration (e.g., pinch abdominal skin)	E
06	Checked for pallor by looking at palms	F
07	Checked for pallor by looking at conjunctiva	G
08	Looked into child's mouth	H
09	Checked for neck stiffness	I
10	Looked in child’s ear	J
11	Felt behind child’s ear	K
12	Undressed child to examine (up to shoulders/down to ankles)	L
13	Pressed both feet to check for edema	M
14	Weighed the child	N
15	Plotted weight on growth chart	O
16	Checked for enlarged lymph nodes in 2 or more of the following sites: neck, axillae, groin	P
17	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

OTHER ASSESSMENTS

109	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH **BY DOING ANY OF THE FOLLOWING:**	
01	Offered the child something to drink or asked the mother to put the child to the breast MARK AS YES IF YOU OBSERVE CHILD DRINKS OR BREASTFEEDS DURING VISIT	A
02	Asked about normal ***feeding*** habits or practices when the child is not ill	B
03	Asked about normal ***breastfeeding*** habits or practices when the child is not ill	C
04	Asked about feeding or breastfeeding habits or practices for child during this illness	D
05	Mentioned the child's weight or growth to the caretaker, or discussed growth chart	E
06	Looked at the child's immunization card or asked caretaker about child vaccination history	F
07	Asked if child received Vitamin A within past 6 months	G
08	Looked at the child's health card either before beginning the consultation, or while collecting information from the caretaker, or while examining the child THIS ITEM MAY BE EITHER THE VACCINATION CARD OR OTHER HEALTH CARD	H
09	Wrote on the child's health card	I
10	Asked if child received any de-worming medication in last 6 months	J
11	None of the above	Y

COUNSELING OF CARETAKER

110	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING	
01	Provided general information about feeding or breastfeeding the child even when not sick	A
02	Told the caretaker to give extra fluids to the child during this illness	B
03	Told the caretaker to continue feeding the child during this illness	C
04	Told the caretaker what illness(es) the child has	D
05	Described signs and/or symptoms in the child for which to immediately bring child back	E
06	Used a visual aid to educate caretaker	F
07	None of the above	Y

ADDITIONAL COUNSELING

111	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING THIS REFERS ONLY TO MEDICINES THAT THE CARETAKER WILL GIVE TO THE SICK CHILD AT HOME AND DOES NOT INCLUDE STAT DOSES OR ONE TIME MEDS GIVEN TO THE CHILD DURING THE VISIT (E.G., ORS OR PAIN MEDICINE) FOR URGENT TREATMENT OF SYPMTOMS.	
01	Prescribed or provided oral medications during or after consultation	A
02	Explained how to administer oral treatment(s)	B
03	Asked the caretaker to repeat the instructions for giving medications at home	C
04	Gave the first dose of the oral treatment	D
05	Discuss follow-up visit for the sick child	E
06	None of the above	Y

NO.	QUESTIONS / OBSERVATIONS	CODES

REFERRALS AND ADMISSIONS

112	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING		
01	RECOMMEND THAT CHILD BE HOSPITALIZED URGENTLY (I.E., ADMITTED TO THE HOSPITAL OR REFERRED TO ANOTHER HOSPITAL)		A
02	REFERRED CHILD TO ANOTHER PROVIDER WITHIN FACILITY FOR OTHER CARE		B
03	REFERRED CHILD FOR A LABORATORY TEST WITHIN OR OUTSIDE FACILITY		C
04	EXPLAINED THE REASON FOR (ANY) REFERRAL		D
05	GAVE REFERRAL SLIP TO CARETAKER		E
06	EXPLAINED WHERE (OR TO WHOM) TO GO		F
07	PROVIDER EXPLAINED WHEN TO GO FOR REFERRAL		G
07A	NOTIFY CARETAKER SPECIFICALLY OF A MALARIA RDT OR BF RESULT		H
08	NONE OF THE ABOVE		Y
113	WHAT WAS THE OUTCOME OF THIS CONSULTATION? [THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED]	TREATED AND SENT HOME. . . . . 1 CHILD REFERRED TO PROVIDER, SAME FACILITY. . . . . 2 CHILD ADMITTED, SAME FACILITY. . . . . 3 CHILD SENT TO LAB. . . . . 4 CHILD REFERRED TO OTHER FACILITY. 5	

NO.	QUESTIONS / OBSERVATIONS	CODES

6. DIAGNOSIS

ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS FOR THE SICK CHILD. IF A DIAGNOSIS OF DEHYDRATION WAS MADE, ASK IF IT WAS SEVERE, MILD, OR MODERATE AND INDICATE ACCORDINGLY. FOR ANY OTHER DIAGNOSIS, SIMPLY CIRCLE THE DIAGNOSIS MADE.

	DIAGNOSIS (OR MAIN SYMPTOM, IF NO DIAGNOSIS)		
201	**DEHYDRATION**		
	SEVERE DEHYDRATION	1	
	MODERATE DEHYDRATION	2	
	MILD DEHYDRATION	3	
	NONE OF THE ABOVE	4	
202	**RESPIRATORY SYSTEM**		
	PNEUMONIA / BRONCHOPNEUMONIA	A	
	BRONCHIAL SPASM / ASTHMA	B	
	UPPER RESPIRATORY INFECTION (URI)	C	
	RESPIRATORY ILLNESS, DIAGNOSIS UNCERTAIN	D	
	COUGH, DIAGNOSIS UNCERTAIN	E	
	NONE OF THE ABOVE	Y	
203	**DIGESTIVE SYSTEM / INTESTINAL**		
	DIARRHOEA	A	
	DYSENTERY	B	
	AMEBIASIS	C	
	OTHER DIGESTIVE / INTESTINAL (SPECIFY)_____	X	
	NONE OF THE ABOVE	Y	
204	**MALARIA**		
	MALARIA (CLINICAL DIAGNOSIS)	1	
	MALARIA (BLOOD SMEAR)	2	
	MALARIA (RAPID DIAGNOSTIC TEST)	3	
	NONE OF THE ABOVE	4	
205	**FEVER/MEASLES**		
	FEVER OF UNKNOWN ORIGIN	1	
	MEASLES WITH NO COMPLICATIONS	2	
	MEASLES WITH COMPLICATIONS (E.G., MOUTH/EYE OR SEVERE)	3	
	NONE OF THE ABOVE	4	
206	**EAR**		
	MASTOIDITIS	A	
	ACUTE EAR INFECTION	B	
	CHRONIC EAR INFECTION	C	
	OTHER EAR INFECTION	X	
	NONE OF THE ABOVE	Y	
206A	**MALNUTRITION**		
	SEVERE MALNUTRITION	1	
	MODERATE MALNUTRITION	2	
	MILD MALNUTRITION	3	
	NONE OF THE ABOVE	4	
207	**THROAT**		
	SORE THROAT	1	
	OTHER THROAT DIAGNOSIS (SPECIFY)_____	2	
	NONE OF THE ABOVE	3	
208	**OTHER DIAGNOSIS**		
	ANY OTHER DIAGNOSIS_____	1	
	NO OTHER DIAGNOSIS	2	

NO.	QUESTIONS / OBSERVATIONS	CODES

7. TREATMENT

ASK ABOUT THE TREATMENT THAT WAS EITHER PRESCRIBED OR PROVIDED. PROMPT IF NECESSARY.

209	Did you prescribe any treatment today for this child? IF YES, CIRCLE ALL TREATMENTS THAT WERE PRESCRIBED OR PROVIDED TO CHILD IN THE FOLLOWING QUESTIONS	YES. . . . . 1 NO. 2	→ 215
210	**GENERAL TREATMENT**		
01	BENZYL PENICILLIN INJECTION		A
02	OTHER ANTIBIOTIC INJECTION		B
03	OTHER INJECTION		C
04	CO-TRIMOXAZOLE TABLETS		D
05	CO-TRIMOXAZOLE SYRUP		E
06	AMOXICILLIN CAPSULES		F
07	AMOXICILLIN SYRUP		G
08	OTHER ANTIBIOTIC TABLET/SYRUP		H
09	PARACETAMOL		I
10	OTHER FEVER REDUCING MEDICINE		J
11	ZINC		K
12	VITAMINS (OTHER THAN VITAMIN A)		L
13	COUGH SYRUPS/OTHER MEDICATION		M
14	NONE OF THE ABOVE		Y
211	**RESPIRATORY**		
01	NEBULISER OR INHALER		A
02	INJECTABLE BRONCHODILATOR (E.G., ADRENALINE)		B
03	ORAL BRONCHODILATOR		C
04	DRY EAR BY WICKING		D
05	NONE OF THE ABOVE		Y
212	**MALARIA**		
01	INJECTABLE QUININE		A
02	INJECTABLE ARTEMETHER / ARTESUNATE		B
03	OTHER INJECTABLE ANTIMALARIAL (E.G., FANSIDAR)		C
04	SUPPOSITORY ARTEMETHER / ARTESUNATE		D
05	ORAL ACT/AL (E.G., COARTEM)		E
06	ORAL ARTEMETER / ARTESUNATE		F
07	ORAL AMODIAQUINE		G
08	ORAL FANSIDAR (SP)		H
09	ORAL QUININE		I
10	OTHER ORAL ANTIMALARIAL		J
11	NONE OF THE ABOVE		Y

NO.	QUESTIONS / OBSERVATIONS	CODES
213	**DEHYDRATION**	
01	HOME ORT (PLAN A)	A
02	INITIAL ORT IN FACILITY (4 HOURS - PLAN B)	B
03	INTRAVENOUS FLUIDS (PLAN C)	C
03A	HOME ORT (PLAN A) WITH ZINC	D
04	NONE OF THE ABOVE	Y
213A	**MALNUTRITION**	
01	CHILD ADMITTED OR REFERRED TO ANOTHER FACILITY (SEVERE MALNUTRITION).	1
02	MOTHER COUNSELED ACCORDING TO FEEDING RECOMMENDATION (MODERATE MAL). . .	2
03	MOTHER ADVISED ON WHEN TO RETURN TO FACILITY (MILD MALNUTRITION).	3
04	NONE OF THE ABOVE	4
214	**OTHER TREATMENT & ADVICE**	
01	VITAMIN A (MAY ALSO BE FOR IMMUNIZATION)	A
02	FEEDING SOLID FOODS	B
03	FEEDING EXTRA LIQUIDS	C
04	FEEDING BREAST MILK	D
05	PRESCRIBED/GAVE DEWORMING TABLETS	E
06	ANY OTHER TREATMENT_____	X
07	NONE OF THE ABOVE	Y

ASK PROVIDER

215	Is this [NAME'S] first visit to this facility for this illness, or is this a follow-up visit?	FIRST VISIT . . . . . 1 FOLLOW-UP . . . . . 2 DON'T KNOW. 8	
215A	Did [NAME] have a malaria RDT done anywhere in this facility before coming into this consultation room to see you today?	YES . . . . . 1 NO 2	→216
215B	Did you see, or did the client show you the malaria RDT result as part of this consultation?	YES . . . . . 1 NO 2	→216
215C	What was the malaria RDT result?	RDT POSITIVE. . . . . 1 RDT NEGATIVE. 2	
216	Did you **vaccinate** the child during this visit or or refer the child for **vaccination** today other than VITAMIN A supplementation? IF NO: Why not?	YES, VACCINATED CHILD. . . . . 1 YES, REFERRED . . . . . 2 NOT DUE FOR, OR COMPLETED VACCINATION. . 3 VACCINE NOT AVAILABLE. . . . . 4 CHILD TOO SICK. . . . . 5 NOT DAY FOR VACCINATION. . . . . 6 DID NOT CHECK FOR VACCINATION. 7	
217	RECORD THE TIME THE OBSERVATION ENDED.	☐☐ : ☐☐	

Observer's comments:

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

SICK CHILD CARETAKER EXIT INTERVIEW

FACILITY IDENTIFICATION

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

PROVIDER SERIAL # [FROM STAFF LISTING FORM]. . . . . | | |

INFORMATION ABOUT INTERVIEW

DATE: _____

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . 2 0 1 |

Name of the interviewer: _____

INTERVIEWER CODE. . . . . | | | |

CLIENT CODE. . . . . | | | |

1. Information About Visit - CARETAKER OF SICK CHILD

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministry of Health. We are conducting a study of health facilities in Malawi in order to improve the services this facility offers and would like to ask you some questions about your experiences here today. Please know that whether you decide to allow this interview or not is completely voluntary and will not affect services you receive during any future visit. You may refuse to answer any question, and you may stop the interview at any time. Information from this interview may be provided to researchers for analyses, but neither your name nor the date of services will be on any shared information, so your identity will remain completely confidential. Do you have any questions for me? Do I have your permission to continue with the interview? Interviewer's signature (Indicates respondent's willingness to participate)	DAY | MONTH | YEAR: __ | __ | 2 0 1 _	
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED	__ : __	
102	What is the name of the sick child?	NAME _____	

CLIENT AGE

103	What month and year was [NAME] born?	MONTH . . . . . __ DON'T KNOW MONTH . . . . . 98 YEAR . . . . . ____ DON'T KNOW YEAR 9998	
104	How old is [NAME] in completed months?	AGE IN MONTHS . . . . . __ DON'T KNOW. 9 8	

SIGNS AND SYMPTOMS OF CURRENT ILLNESS

105	Has [NAME] had fever with this illness or any time in the past two days?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
106	Has [NAME] had a convulsion with this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
107	Does [NAME] have cough or difficulty breathing with this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
108	Can [NAME] drink, eat or breastfeed?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
109	Does [NAME] vomit everything when he/she eats or breastfeeds during this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

110	Has [HE/SHE] had watery and frequent stools with this illness or any time in the past two days?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
111	Has [HE/SHE] been excessively sleepy or lethargic during this illness?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
112	For what other reason(s) did you bring [NAME] to this health facility today? CIRCLE ALL ITEMS THE RESPONDENT MENTIONS PROBE: Anything else?	EAR PROBLEMS. . . . . A SKIN SORE/PROBLEMS. . . . . B INJURY. . . . . C EYE PROBLEM. . . . . D OTHER _____ X (SPECIFY) NO OTHER REASON . . . . . Y	
113	Has [NAME] been brought to this facility before for this same illness? IF YES, ASK: How long ago was that?	WITHIN THE PAST WEEK. . . . . 1 WITHIN THE PAST 2-4 WEEKS. . . . 2 MORE THAN 4 WEEKS AGO. . . . . 3 NO. . . . . 4 DON'T KNOW. 8	
114	How many days ago did the illness for which you brought [NAME] here begin? IF LESS THAN 1 DAY, ENTER 00	DAYS AGO. . . . . [ ][ ] DON'T KNOW. 98	

INFORMATION PROVIDED TO CARETAKER

115	Did the provider tell you what illness [NAME] has?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
116	What would you do if [NAME] does not get completely better or becomes worse?	RETURN TO FACILITY. . . . . 1 GO TO OTHER FACILITY. . . . . 2 GO TO OTHER HEALTH WORKER OR /PHARMACY. . . . . 3 GO TO TRADITIONAL HEALER. . . . 4 NOTHING, JUST WAIT. . . . . 5 DON'T KNOW. 8	
117	Did the provider tell you about any signs or symptoms you may see for which you must immediately bring the child back? IF YES, ASK: Can you tell me what these are? IF NECESSARY, PROBE: Were there any serious symptoms or danger signs for which you were told to bring [NAME] back immediately?	FEVER . . . . . A BREATHING PROBLEMS . . . . . B BECOMES SICKER . . . . . C BLOOD IN STOOL . . . . . D VOMITING . . . . . E POOR/NOT EATING . . . . . F POOR/NOT DRINKING . . . . . G OTHER _____ X (SPECIFY) NO, NONE . . . . . Y DON'T KNOW . . . . . Z	
118	Did the provider tell you anything about bringing [NAME] back to the health facility for follow-up or non-emergency reasons? IF YES: Why were you to return?	MORE MEDICINES . . . . . A IF SYMPTOMS INCREASE OR BECOME WORSE . . . . . B FOLLOW-UP APPOINTMENT. . . . . C VIT. A SUPPLEMENTATION. . . . . D LAB TEST RESULTS. . . . . E CHILD ADMITTED. . . . . F ROUTINE IMMUNISATION . . . . . G OTHER _____ X (SPECIFY) NO. . . . . Y DON'T KNOW . . . . . Z	

TREATMENT AND CARETAKER COMFORT LEVEL

119	Did the provider give or prescribe any medicines for [NAME] to take at home?	YES, GAVE MEDS. . . . . 1 YES, GAVE PRESCRIPTION. . . . . 2 GAVE MEDS AND PRESCRIPTION. . . . . 3 NO 4	→ 124
120	ASK TO SEE ALL MEDICATIONS THAT THE CARETAKER RECEIVED AND ANY PRESCRIPTIONS THAT HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.	HAS ALL MEDS. . . . . 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS. . . . . 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY. 3	
121	Did a provider at the facility explain to you how to give these medicines to [NAME] at home? IF “2” OR “8” SEND CLIENT BACK TO PROVIDER AT THE END OF THE INTERVIEW	YES. . . . . 1 NO. . . . . 2 DON’T KNOW. 8	
122	Do you feel comfortable or confident that you know how much of each medication to give [NAME] each day and for how many days to give it? IF “2” OR “8” SEND CLIENT BACK TO PROVIDER AT THE END OF THE INTERVIEW	YES. . . . . 1 NO. . . . . 2 DON’T KNOW. 8	
123	Has [NAME] been given a dose of any of these medications here at the facility already?	YES. . . . . 1 NO. . . . . 2 DON’T KNOW. 8	
124	Did [NAME] receive an injection for treating the sickness here at the facility today? IF NO, CHECK PRESCRIPTIONS AND RECORD IF THERE IS A PRESCRIPTION FOR AN INJECTION.	YES, RECEIVED INJECTION. . . . . 1 YES, RECEIVED PRESCRIPTION FOR INJECTION. . . . . 2 NO . . . . . 3 DON’T KNOW 8	
125	Did anyone at the health facility weigh [NAME] today?	YES . . . . . 1 NO 2	
126	Did anyone talk to you today about [NAME]’s weight and how [NAME] is growing?	YES . . . . . 1 NO 2	
127	Did any provider ask you today about the types of foods and amounts that you normally feed [NAME] when [NAME] is not sick?	YES . . . . . 1 NO . . . . . 2 CANNOT REMEMBER 8	
128	What did the provider tell you about feeding solid foods to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . 3 GIVE NOTHING/DON’T FEED . . 4 DIDN’T DISCUSS . . . . . 6 NOT CERTAIN 8	
129	What did the provider tell you about giving fluids (or breast milk, if the child is breastfed) to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . 3 GIVE NOTHING/DON’T FEED . . 4 DIDN’T DISCUSS . . . . . 6 DON’T KNOW 8	

130	Was [NAME] given a vaccination today? IF YES, ASK TO SEE THE HEALTH CARD OR BOOKLET TO VERIFY.	YES, OBSERVED. . . . . 1 REPORTED, NOT SEEN. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	

REFERRAL

130A	Before [NAME] was seen by the health care provider who treated [HIM/HER] today, was a finger or heel stick done anywhere in this facility for blood to be taken for a test?	YES. . . . . 1 NO. 2	
131	Did the health care provider who treated [NAME] today instruct you to take [HIM/HER] to see another provider, or to go to the laboratory in this facility for a finger or heel stick for blood to be taken for a tes?	YES. . . . . 1 NO. 2	→ 134
132	Did you take [NAME] to the provider or laboratory for the finger or heel stick?	YES. . . . . 1 NO. 2	→ 134
133	Were you told the result of the test that was done?	YES. . . . . 1 NO. 2	
134	Did the provider instruct you to take [NAME] to see a provider in another facility, or for a laboratory test outside of this facility, for further care for [NAME]?	YES. . . . . 1 NO. 2	→ 136

135	Regarding this referral, please tell me:	YES	NO	DK	
01	Were you given any paper or record to take with you for the referral?	1	2	8	
02	Were you told ***where*** to go for the referral?	2	2	8	
03	Were you told ***who*** to see for the referral?	1	2	8	
04	Were you told ***why*** you are to go for the referral?	1	2	8	
05	Do you intend to go to this (these) referral(s)?	1	2	8	

136	Did you take [NAME] to see another health provider or traditional healer before coming here? IF YES, ASK: Whom did you see and where? CIRCLE ALL THAT APPLY	YES, OTHER PROVIDER THIS FACILITY. . . . . A YES, OTHER PROVIDER DIFFERENT FACILITY. . . B YES, TRADITIONAL HEALER. . . . . C SAW NO ONE . . . . . Y	

CLIENT RE-EXAMINATION

	READ TO CLIENT: As part of this interview, and in order to improve services that this and other facilities provide, I will like to take a few measurements on [CHILD]. It will only take a few minutes As with the rest of the interview, whether you decide to let me take these measurements on [CHILD] is completely voluntary and will not affect services you receive during this or future visits. However, we are counting on your cooperation to obtain information to help improve service provision in general. Do you have any questions at this time? Do I have your permission to proceed? Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | **2 0 1** YEAR	
150	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ 201
151	**CHECK Q107 ABOVE** DOES THE CHILD HAVE COUGH OR DIFFICULTY BREATHING WITH THIS CURRENT ILLNESS?	YES. . . . . 1 NO. 2	→ 153
152	PERFORM A 60-SECOND RESPIRATORY RATE COUNT ON THE CHILD ENSURE THAT THE CHILD IS CALM DURING THE 60-SECOND COUNT	RESPIRATORY RATE/MINUTE	
153	EXAMINE THE CHILD FOR THE FOLLOWING SIGNS OF ANEMIA. CIRCLE ALL SIGNS THAT YOU SEE.	PALE PALM. . . . . A PALE EYELIDS. . . . . B PALE TONGUE. . . . . C NONE OF THE ABOVE. . . . . Y	
154	MEASURE THE CHILD'S TEMPERATURE	TEMPERATURE IN °CELCIUS.	
155	ASSESS THE CONSCIOUSNESS LEVEL OF CHILD. IS HE/SHE CONSCIOUS, LETHARGIC OR UNCONSCIOUS? GENTLY AROUSE CHILD IF HE/SHE APPEARS TO BE SLEEPING **NOTE: CONTACT A HEALTH CARE PROVIDER IF YOU FIND THE SICK CHILD TO BE EITHER LETHARGIC OR UNCONSCIOUS**	CONSCIOUS. . . . . 1 LETHARGIC/UNCONSCIOUS. 2	

2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve services in general.			
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation? TRY TO DETERMINE THE TIME THE CLIENT ARRIVED AT THE FACILITY AND WHEN THE FACILITY OPENS FOR SERVICES. WE ARE INTERESTED IN THE WAITING TIME FROM THE TIME THE FACILITY OFFICIALLY OPENS.	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	

202 Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were **major** or **minor** problems for you.

		MAJOR	MINOR	NO PROB-LEM	DK
01	Time you waited to see a provider	1	2	3	8
02	Ability to discuss problems or concerns about [CHILD'S] illness	1	2	3	8
03	Amount of explanation you received about the problem or treatment	1	2	3	8
04	Privacy from having others see the examination	1	2	3	8
05	Privacy from having others hear your consultation discussion	1	2	3	8
06	Availability of medicines at this facility	1	2	3	8
07	The hours of service at this facility, i.e., when they open and close	1	2	3	8
08	The number of days services are available to you	1	2	3	8
09	The cleanliness of the facility	1	2	3	8
10	How the staff treated you	1	2	3	8
11	Cost for services or treatments	1	2	3	8

203	Are you a part of any prepayment plan (such as medical aid, insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this or any other facility?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
204	Were you charged, or did you pay fees for any services your received or were provided today?	YES . . . . . 1 NO 2	→ 206

205	What is the total amount you paid for all services or treatments you received at this facility today?	TOTAL AMOUNT ☐☐☐☐☐☐ DON'T KNOW 999998	
206	Is this the closest health facility to your home?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	→ 208 → 208
207	What was the main reason you did not go to the facility nearest to your home? IF CLIENT MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . .03 NO MEDICINE . . . . . .04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . .07 OTHER. . . . . 96 DON'T KNOW 98	
208	In general, which of the following statements best describes your opinion of the services you either received or were provided at this facility today READ ALL STATEMENTS, CIRCLE ONLY ONE 01) I AM **VERY SATISFIED** WITH THE SERVICES I RECEIVED IN FACILITY . . . . . 1 02) I AM **MORE OR LESS SATISFIED** WITH THE SERVICES I RECEIVED. . . . . 2 03) I AM **NOT SATISFIED** WITH THE SERVICED I RECEIVED 3		
209	Will you recommend this health facility to a friend or family member?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

3. Client Personal Characteristics

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help to improve services in general.			
301	What is your relationship to [SICK CHILD]?	MOTHER . . . . . 1 FATHER . . . . . 2 SIBLING . . . . . 3 AUNT OR UNCLE . . . . . 4 GRAND MOM/GRAND DAD. . . . 5 OTHER _____ 6 (SPECIFY)	
302	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
304	What is the highest level of school you attended?	PRIMARY. . . . . 1 SECONDARY. . . . . 2 HIGHER. 3	→ 306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . 1 YES, READ ONLY . . . . . 2 NO 3	
306	RECORD THE TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		

Interviewer's comments:

Sample List for NORMAL DELIVERY Observation

Date | | | | | **2** | **0** | **1** | | | | | | | | |
DAY MONTH YEAR FACILITY #

TOTAL # OF DELIVERIES ON DAY OF VISIT FOR ALL PROVIDERS | | |

USE THIS FORM TO LIST PREGNANT WOMEN SELECTED FOR OBSERVATION FOR <u>INTERVIEWER</u> #1

	NAME/INITIALS OF SELECTED PREGNANT WOMAN	AGE IN YEARS
501		
502		
503		
504		
505		
506		
507		
508		
509		
510		
511		
512		
513		
514		
515		
516		
517		
518		
519		
520		
521		
522		
523		
524		
525		

Sample List for NORMAL DELIVERY Observation

Date | | | | | **2** | **0** | **1** | | DAY MONTH YEAR

				FACILITY #

USE THIS FORM TO LIST PREGNANT WOMEN SELECTED FOR OBSERVATION FOR INTERVIEWER #2

	NAME/INITIALS OF SELECTED PREGNANT WOMAN	AGE IN YEARS
526		
527		
528		
529		
530		
531		
532		
533		
534		
535		
536		
537		
538		
539		
540		
541		
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543		
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545		
546		
547		
548		
549		
550		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT SURVEY

OBSERVATION OF LABOR & DELIVERY AND NEONATAL RESUSCITATION

1. Facility Identification

QTYPE | L | D | O |

Name of the facility: _____

Location of the facility: _____

FACILITY NUMBER . . . . . | | | | | |

2. Provider Information

Provider Qualification Category:

GENERALIST [NON-SPECIALIST] MEDICAL DOCTOR	01
SPECIALISTS MEDICAL DOCTOR	02
CLINICAL OFFICER (DEGREE LEVEL)	03
CLINICAL TECHNICIAN (DIPLOMA)	04
MEDICAL ASSISTANT	05
REGISTERED NURSE (BSN)	07
REGISTERED NURSE MIDWIFE (BSN)	08
REGISTERED PSYCHIATRIC NURSE	09
REGISTERED NURSE WITH DIPLOMA	10
ENROLLED NURSE	11
COMMUNITY HEALTH NURSE	12
ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN	13
ENROLLED NURSE MIDWIFE	14
ENVIRONMENTAL HEALTH OFFICER	24
HEALTH SURVEILLANCE ASSISTANTS (HSA)	25
HTC COUNSELORS (NON-HSA)	26

PROVIDER QUALIF. CATEGORY | | |

SEX OF PROVIDER: (1=Male; 2=Female)

SEX OF PROVIDER . . . . . | |

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]

PROVIDER SL NUMBER . . . . . | | |

3. Information About Observation

Date: . . . . . .

DAY . . . . . | | |

MONTH . . . . . | | |

YEAR . . . . . | 2 | 0 | 1 | |

Name of the observer: _____

INTERVIEWER/OBSERVER CODE | | | |

Client code: . . . . . .

CLIENT CODE . . . . . | | | |

4. Observation of Labor and Delivery and Neonatal Resuscitation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION.		
	READ TO PROVIDER: Hello. I am [OBSERVER]. I am representing the Ministry of Health We are conducting a study of health facilities in Malawi with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how normal delivery services are provided in this facility. Information from this observation is confidential. Neither your name nor that of the client will be recorded. The information acquired during this observation may be used by the MOH or other organizations to improve services, or for research on health services; however, neither your name nor the names of your clients will be entered in any database. Do you have any questions for me? If at any point you feel uncomfortable you can ask me to leave. However, we hope you won't mind our observing your consultation. Do I have your permission to be present at this consultation? _____ Interviewer's signature (Indicates respondent's willingness to participate) DAY | MONTH | YEAR: 2 0 1		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministry of Health We are conducting a study of health services in Malawi. I would like to be present while you are receiving services today in order to understand how normal deiveyr services are provided in this facility. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. And although information from this observation may be provided to researchers for analyses, neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefe I leave please feel free to tell me. _____ Interviewer's signature (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ **END**
102	RECORD THE TIME THE OBSERVATION STARTED . . . . . __ : __		
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	

SECTION 1: INITIAL CLIENT ASSESSMENT				
Question	**Yes**	**No**	**DK**	**Go to**
RECORD WHETHER THE PROVIDER CARRIED OUT ANY OF THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY BE PERFORMED SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER)				
INTRODUCTION AND HISTORY TAKING				
Q104:				
01) Respectfully greets the pregnant woman	**1**	**2**	**8**	
02) Encourages the woman to have a support person present during labor and birth	**1**	**2**	**8**	
03) Asks women (and support person) if she has any questions	**1**	**2**	**8**	
04) Checks client card OR asks client her age, length of pregnancy, and parity	**1**	**2**	**8**	
Q105: Asks whether she has experienced any of the following for current pregnancy:				
01) Vaginal bleeding	**1**	**2**	**8**	
02) Fever	**1**	**2**	**8**	
03) Severe headaches and/or blurred vision	**1**	**2**	**8**	
04) Swollen face or hands	**1**	**2**	**8**	
05) Convulsions or loss of consciousness	**1**	**2**	**8**	
06) Severe difficulty breathing	**1**	**2**	**8**	
07) Persistent cough for 2 weeks or longer	**1**	**2**	**8**	
08) Severe abdominal pain	**1**	**2**	**8**	
09) Foul smelling vaginal discharge	**1**	**2**	**8**	
10) Frequent or painful urination	**1**	**2**	**8**	
11) Whether the client has felt a decrease or stop in fetal movement	**1**	**2**	**8**	
12) If there are any other problems the client is concerned about	**1**	**2**	**8**	
Q106: Checks woman's HIV status (checks card or asks woman)	**1**	**2**	**8**	
Q107: Offers woman HIV test	**1**	**2**	**8**	
Q108: Is woman HIV positive? *(OBSERVER: LISTEN AND RECORD ANSWER; CIRCLE DON'T KNOW IF STATUS IS UNKNOWN OR NOT DISCUSSED)*	**1**	**2**	**8**	**No/DK→ Q110**
Q109: Asks about or counsels on the following topics for HIV positive mothers:				
01) Asks if client is currently taking ARVS	**1**	**2**	**8**	**No/DK → Q109_02**
01a) Asks client when she took last dose ARVs	**1**	**2**	**8**	
02) Explains why the mother should take ARVs	**1**	**2**	**8**	
03) Explains when and how the mother should take ARVs	**1**	**2**	**8**	
04) Administers ARVs to mother	**1**	**2**	**8**	
05) Explains why the newborn should take ARVs	**1**	**2**	**8**	
06) Explains when and how newborn should take ARVs	**1**	**2**	**8**	
Q110: Client has any previous pregnancies? *(OBSERVER: LISTEN AND RECORD ANSWER)*	**1**	**2**	**8**	**No/DK → Q112**
Q111: Asks about complications during previous pregnancies:				
01) Heavy bleeding during or after delivery	**1**	**2**	**8**	
02) Anemia	**1**	**2**	**8**	
03) High blood pressure	**1**	**2**	**8**	
04) Convulsions	**1**	**2**	**8**	
05) Multiple pregnancies (twins or above)	**1**	**2**	**8**	
06) Prolonged labor	**1**	**2**	**8**	
07) C-section	**1**	**2**	**8**	
08) Assisted delivery (forceps, ventouse)	**1**	**2**	**8**	
09) Prior neonatal death (death of baby less than 1 month old)	**1**	**2**	**8**	
10) Prior stillbirth (baby born dead that does not breathe or cry)	**1**	**2**	**8**	
11) Prior abortion/miscarriage (loss of pregnancy)	**1**	**2**	**8**	

EXAMINATION				
Q112: Washes his/her hands with soap and water or uses hand disinfectant before any initial examination	**1**	**2**	**8**	
Q113: Explains procedures to woman (support person) before proceeding	**1**	**2**	**8**	
Q114: Takes temperature	**1**	**2**	**8**	
Q115: Takes pulse	**1**	**2**	**8**	
Q116: Takes blood pressure	**1**	**2**	**8**	**No/DK → Q117**
01) Take client's blood pressure in sitting or lateral position	**1**	**2**	**8**	
02) Take blood pressure with arm at heart level	**1**	**2**	**8**	
Q117: Asks/notes amount of urine output	**1**	**2**	**8**	
Q118: Tests urine for presence of protein	**1**	**2**	**8**	
Q119: Performs general examination (e.g. for anemia, edema)	**1**	**2**	**8**	
Q120: Performs the following steps for abdominal examination:				
01) Checks fundal height with measuring tape	**1**	**2**	**8**	
02) Checks fetal presentation by palpation of abdomen	**1**	**2**	**8**	
03) Checks fetal heart rate with fetoscope/Doppler/ultrasound	**1**	**2**	**8**	
Q121: Performs vaginal examination	**1**	**2**	**8**	
Q122: Wears high-level disinfected or sterile gloves for vaginal examination	**1**	**2**	**8**	
Q123: Informs pregnant woman of findings	**1**	**2**	**8**	
END OF SECTION 1				

SECTION 2: INTERMITTENT OBSERVATION OF FIRST STAGE OF LABOR

Question	Yes	No	DK	Go to
RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY BE PERFORMED SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER)				
PROGRESS OF LABOR				
Q201: At least once, explains what will happen in labor to woman (support person)	1	2	8	
Q202: At least once, encourages woman to consume fluids/food during labor	1	2	8	
Q203: At least once, encourages/assists woman to ambulate and assume different positions during labor	1	2	8	
Q204: OBSERVER: IS THE SUPPORT PERSON PRESENT AT SOME POINT DURING LABOR?	1	2	8	
Q205: Drapes woman (one drape under buttocks, one over abdomen)	1	2	8	
Q206: Partograph used to monitor labor	1	2		No→Q212
Q207: Action line on partograph reached	1	2	8	No/DK→Q212
Q208: RECORD TIME ACTION LINE WAS REACHED (USE 24-HR CLOCK FORMAT)	☐☐:☐☐			
Q209: If action line reached on partograph, was any <u>definitive</u> action taken?	1	2	8	No/DK→Q212
Q210: RECORD TIME ACTION WAS TAKEN (USE 24-HR CLOCK FORMAT)	☐☐:☐☐			
Q211: WHAT DEFINITIVE ACTION WAS TAKEN? (CIRCLE ALL THAT APPLY):	Code			
Consult with specialist	A			
Refer to other facility for specialist	B			
Prepare for assisted delivery	C			
Prepare for C-section	D			
Other (specify_____)	X			
EXAMINATION & PROCEDURES				
Question	**Yes**	**No**	**DK**	**Go to**
Q212: Washes his/her hands with soap and water or uses antiseptic prior to any examination of woman	1	2	8	
Q213: Wears high-level disinfected or sterile surgical gloves	1	2	8	
Q214: Puts on clean protective clothing in preparation for birth (goggles, gown or apron)	1	2	8	
Q215: Explains procedures to woman (support person) before proceeding	1	2	8	
Q216: Number of vaginal examinations *(TO THE BEST OF YOUR ABILITY, UPDATE THE ANSWER TO THIS QUESTION DURING INTERMITTENT OBSERVATION OF THE FIRST STAGE OF LABOR)*	☐☐			
Q217: Augments labor with oxytocin	1	2	8	No/DK → Q219
Q218: Oxytocin administered intravenously (IV)	1	2	8	
Q219: Performs artificial rupture of membrane	1	2	8	
Q220: Administers antibiotics	1	2	8	No/DK → Q223
Q221: Why were antibiotics administered (CIRCLE ALL THAT APPLY)?	Code			
Treatment for chorioamnionitis	A			
Management of pre-labor rupture of membranes	B			
Preparation for C-section	C			
Routine/prophylactic	D			
Don't know	Z			

Q222: Which antibiotic was administered? (CIRCLE ALL THAT APPLY)	
Penicillin	A
Ampicillin	B
Gentamicin	C
Metronidazole	D
Cephalosporin	E
Other (Specify) _____	X
Don't know	Z

PREPARATION FOR DELIVERY

CHECK TO SEE IF THE FOLLOWING EQUIPMENT AND SUPPLIES ARE LAID OUT IN PREPARATION FOR DELIVERY. IF SOME SUPPLIES ARE IN A BIRTH KIT, LOOK/ASK TO DETERMINE WHICH ITEMS ARE INCLUDED.

Question	Yes	No	DK	Go to
Q223: Prepares uterotonic drug to use for AMTSL	1	2	8	No/DK → Q225

Q224: Which drug	Code
Oxytocin	1
Ergometrine	2
Syntometrine	3
Misoprostol	4

Question	Yes	No	DK	Go to
Q225: Timer (clock or watch with seconds hand)	1	2	8	
Q226: Self-inflating ventilation bag (250 or 500 mL)	1	2	8	
Q227: Newborn face mask size 0	1	2	8	
Q228: Newborn face mask size 1	1	2	8	
Q229: Suction bulb	1	2	8	
Q230: Catheter	1	2	8	
Q231: Suction machine	1	2	8	
Q232: At least two cloths/blankets (one to dry; one to cover)	1	2	8	
Q233: Cap/hat for the newborn	1	2	8	
Q234: Disposable cord ties or clamps	1	2	8	
Q235: Sterile scissors or blade	1	2	8	
Q236: Has the woman completed the first stage of labor?	1	2		Yes → Q300
Q237: Was the woman referred to another facility for care before she went into active labor/second stage of labor?	1	2		Yes → Q547

IF FIRST STAGE OF LABOR IS NOT COMPLETE, CHECK ANSWERS IN THIS SECTION AGAIN 15-30 MINUTES LATER

END OF SECTION 2

SECTION 3: CONTINUOUS OBSERVATION OF SECOND & THIRD STAGE OF LABOR

Question	Yes	No	DK	Go to
RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY BE PERFORMED SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER).				
PREPARATION FOR DELIVERY				
Q301: Washes his/her hands with soap and water or uses antiseptic before any examination of woman *(OBSERVER: CIRCLE "YES" IF DONE PREVIOUSLY AND NO CONTAMINATION)*	1	2	8	
Q302: Wears high-level disinfected or sterile surgical gloves *(OBSERVER: CIRCLE "YES" IF NO CONTAMINATION)*	1	2	8	
Q303: Puts on clean protective clothing (goggles, gown or apron) in preparation for birth *(OBSERVER: CIRCLE "YES" IF NO CONTAMINATION)*	1	2	8	
Q304: Performs episiotomy	1	2		
Q305: Presentation of baby is cephalic (head first)	1	2	8	
DELIVERY AND UTEROTONIC				
Q306: As baby's head is delivered, supports perineum	1	2	8	
Q307: Record time of the delivery of the baby (USE 24-HR CLOCK FORMAT)	☐☐:☐☐			
Q308: Checks for another baby prior to administering the uterotonic	1	2	8	
Q309: Second baby present? *(CIRCLE "1" IF MULTIPLE BABIES)*	1	2		
Q310: Administers uterotonic?	1	2		**No → Q317**
Q311: Record time uterotonic given (USE 24-HR CLOCK FORMAT)	☐☐:☐☐			
Q312:Timing of administration of uterotonic	**Code**			
At delivery of anterior shoulder	**1**			
Within 1 min of delivery of baby	**2**			
Within 3 min of delivery of baby	**3**			
More than 3 min after delivery of baby AND before delivery of the placenta	**4**			
More than 3 min of delivery of baby and after delivery of placenta	**5**			
Q313: Which uterotonic given				
Oxytocin	**1**			
Ergometrine	**2**			
Syntometrine	**3**			
Misoprostol	**4**			
Q314: Record dose of uterotonic given (OBSERVER: IF NOT SURE, ASK)	☐☐			
Q315: Units of medication (OBSERVER: IF NOT SURE, ASK)				
IU	**1**			
mg	**2**			
mL	**3**			
mcg	**4**			
Q316: Route uterotonic given:				
IM	**1**			
IV	**2**			
Oral	**3**			
Other (specify _____)	**6**			
Q317: Record time the cord was clamped (USE 24-HR CLOCK FORMAT)	☐☐:☐☐			
Question	**Yes**	**No**	**DK**	
Q318: Applies traction to the cord while applying supra-pubic counter traction	1	2	8	
Q319: Performs uterine massage immediately following delivery of placenta	1	2	8	
Q320: Administers uterotonic only after placenta is delivered *(OBSERVER: CIRCLE "DON'T KNOW" IF NO UTEROTONIC WAS GIVEN)*	1	2	8	
Q321: Assesses completeness of the placenta and membranes	1	2	8	
Q322: Assesses for perineal and vaginal lacerations	1	2	8	
Q323: OBSERVER: DID MORE THAN ONE HEALTH WORKER ASSIST WITH THE BIRTH?	1	2		
Q324: OBSERVER DID MOTHER GIVE BIRTH IN LITHOTOMY POSITION?	1	2		
Q325: OBSERVER: WAS A SUPPORT PERSON FOR MOTHER PRESENT AT BIRTH?	1	2		
END OF SECTION 3				

SECTION 4: IMMEDIATE NEWBORN AND POSTPARTUM CARE				
Question	**Yes**	**No**		**Go to**
RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY BE PERFORMED SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER)				
IMMEDIATE CARE				
Q401: Immediately dries baby with towel	**1**	**2**	**8**	
Q402: Discards the wet towel	**1**	**2**	**8**	
Q403: IS THE BABY BREATHING OR CRYING? ***IF BABY IS NOT BREATHING OR CRYING, GO TO RESUSCITATION CHECKLIST STARTING Q501***	**1**	**2**		**No → Q500**
Q404: Places baby on mother's abdomen "skin-to-skin"	**1**	**2**	**8**	
Q405: Covers baby with dry towel	**1**	**2**	**8**	
Q406: If not placed skin to skin, wraps baby in dry towel	**1**	**2**	**8**	
Q407: Ties or clamps cord when pulsations stop, or by 2-3 minutes after birth (not immediately after birth)	**1**	**2**	**8**	
Q408: Cuts cord with clean blade or clean scissors	**1**	**2**	**8**	
Q409: OBSERVER: IS A SUPPORT PERSON FOR MOTHER PRESENT?	**1**	**2**		
HEALTH CHECK				
Q410: Checks baby's temperature 15 minutes after birth	**1**	**2**	**8**	
Q411: Checks baby's skin color 15 minutes after birth	**1**	**2**	**8**	
Q412: Takes mother's vital signs 15 minutes after birth	**1**	**2**	**8**	
Q413: Palpates uterus 15 minutes after delivery of placenta	**1**	**2**	**8**	
FIRST HOUR AFTER BIRTH				
Q414: Mother and newborn kept in same room after delivery (rooming-in)	**1**	**2**	**8**	
Q415: Baby bathed within the first hour after birth	**1**	**2**	**8**	
Q416: Baby kept skin-to-skin with mother for the first hour after birth	**1**	**2**	**8**	
Q417: Breastfeeding initiated within the first 30 minutes after birth	**1**	**2**	**8**	
Q417a: Breastfeeding initiated within the first hour after birth	**1**	**2**	**8**	
Q418: Applies tetracycline eye ointment to newborn's eyes for prophylaxis	**1**	**2**	**8**	
Q419: Administers Vitamin K to newborn	**1**	**2**	**8**	
Q420: IS THE MOTHER HIV POSITIVE? ***(OBSERVER: LISTEN AND RECORD ANSWER; CIRCLE "DON'T KNOW" IF STATUS OF WOMAN IS UNKNOWN OR IS NOT DISCUSSED.***	**1**	**2**	**8**	**No/DK → Q422**
Q421: Administers ARVs to newborn	**1**	**2**	**8**	
Q422: Administers antibiotics to mother postpartum	**1**	**2**	**8**	**No/DK → Q425**
Q423: Why were antibiotics administered?	**Code**			
Treatment for chorioamnionitis	**1**			
Routine/prophylactic	**2**			
Third stage/postpartum procedure	**3**			
Don't know	**8**			
Q424: Which antibiotic was administered? (CIRCLE ALL THAT APPLY)				
Penicillin	**A**			
Ampicillin	**B**			
Gentamicin	**C**			
Metronidazole	**D**			
Cephalosporin	**E**			
Other (specify_____)	**X**			
Don't know	**Z**			

CLEAN-UP AFTER BIRTH				
RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY BE PERFORMED SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER)				
Question	**Yes**	**No**		**Go to**
Q425: Disposes of all sharps in a puncture-proof container immediately after use	**1**	**2**	**8**	
Q426: Decontaminates all reusable instruments in 0.5% chlorine solution	**1**	**2**	**8**	
Q427: Sterilizes or uses high-level disinfection for all reusable instruments	**1**	**2**	**8**	
Q428: Disposes of all contaminated waste in leak-proof containers	**1**	**2**	**8**	
Q429: Removes apron and wipe with chlorine solution	**1**	**2**	**8**	
Q430: Washes his/her hands with soap and water or uses antiseptic	**1**	**2**	**8**	
REMEMBER TO THANK CLIENT AND PROVIDER FOR THEIR PARTICIPATION IN THE STUDY				
END OF SECTION 4 –IF NEWBORN RESUSCITATION IS NOT OBSERVED, **COMPLETE Q500 AND Q547** *THEN GO TO SECTION 6 TO COMPLETE OUTCOME AND REVIEW OF DOCUMENTATION SECTION*				

SECTION 5: CKECKLIST FOR NEWBORN RESUSCITATION (TOOL 5)				
Question	**Yes**	**No**	**DK**	**Go to**
Q500: WAS THERE A NEWBORN RESUSCITATION?	**1**	**2**	**8**	**No/DK → Q547**
RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY BE PERFORMED SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER)				
Q501: RECORD TIME RESUSCITATION STARTED (USE 24-HR CLOCK FORMAT)	☐☐:☐☐			
Q502: Clears the airway by suctioning the mouth first and then the nose	**1**	**2**	**8**	
Q503: Stimulates baby with back rubbing	**1**	**2**	**8**	
Q504: OBSERVER: DOES NEWBORN START TO BREATHE OR CRY SPONTANEOUSLY?	**1**	**2**		**Yes→Q531**
Q506: Ties or clamps cord immediately	**1**	**2**	**8**	
Q507: Cuts cord with clean blade or clean scissors	**1**	**2**	**8**	
Q508: Places the newborn on his/her back on a clean, warm surface or towel	**1**	**2**	**8**	
Q509: Places the head in a slightly extended position to open the airway	**1**	**2**	**8**	
Q510: Tells the woman (and her support person) what is going to be done	**1**	**2**	**8**	
Q511: Listens to woman and provides support and reassurance	**1**	**2**	**8**	
Q512: Checks mouth, back of throat and nose for secretions, and clears if necessary	**1**	**2**	**8**	
Q513: Places the correct-sized mask on the newborn's face so that it covers the chin, mouth and nose (but not eyes)	**1**	**2**	**8**	
Q514: Checks the seal by ventilating two times and observing the rise of the chest	**1**	**2**	**8**	
Q515: OBSERVER: IS NEWBORN'S CHEST RISING IN RESPONSE TO VENTILATION?	**1**	**2**		**Yes→Q524**
Q515a: Calls for help	**1**	**2**	**8**	
Q516: Checks the position of the newborn's head to make sure that the neck is in a slightly extended position (not blocking the airway)	**1**	**2**	**8**	
Q517: Checks mouth, back of throat and nose for secretions, and clears if necessary	**1**	**2**	**8**	
Q518: Checks the seal by ventilating two times and observing the rise of the chest	**1**	**2**	**8**	
Q519: OBSERVER: IS NEWBORN'S CHEST RISING IN RESPONSE TO VENTILATION?	**1**	**2**		**Yes→Q524**
Q520: Checks the position of the newborn's head again to make sure that the neck is in slightly extended position	**1**	**2**	**8**	
Q521: Repeats suction of mouth and nose to clear secretions, if necessary	**1**	**2**	**8**	
Q522: Checks the seal by ventilating two times and observing the rise of the chest	**1**	**2**	**8**	
Q523: OBSERVER: IS NEWBORN'S CHEST RISING IN RESPONSE TO VENTILATION?	**1**	**2**		**Yes→Q524**
IF NEWBORN'S CHEST IS NOT RISING AFTER TWO ATTEMPTS TO READJUST, OBSERVER SHOULD CALL FOR SUPERVISOR TO INTERVENE. IF A HEALTH WORKER COMPETENT IN RESUSCITATION IS NOT AVAILABLE, OBSERVER MAY CHOOSE TO INTERVENE.				
Q524: Ventilates at a rate of 30 to 50 breaths/minute	**1**	**2**	**8**	
Q525: Conducts assessment of newborn breathing after 1 minute of ventilation	**1**	**2**		**No→Q527**
Q526: Condition of newborn at assessment	**Code**			
Respiration rate 30-50 breaths/minute and no chest in-drawing	**1**			**→Q531**
Respiration rate <30 breaths/minute with severe in-drawing	**2**			
No spontaneous breathing	**3**			
Q526a: Checks for heart rate	**1**	**2**	**8**	
	Yes	**No**	**DK**	**Go to**
Q527: Continues Ventilation and baby cries before 10 minutes	**1**	**2**		**Yes→Q529**

Q528: Conducts assessment of newborn breathing after prolonged ventilation (10 minutes)	**1**	**2**		**No→Q530**
Q529: Condition of newborn at assessment	**Code**			
Respiration rate 30-50 breaths/minute and no chest in-drawing	**1**			**→Q531**
Respiration rate <30 breaths/minute with severe in-drawing	**2**			
No spontaneous breathing	**3**			
Question	**Yes**	**No**	**DK**	**Go to**
Q530: Continues Ventilation	**1**	**2**		
Q531: OBSERVER: RECORD TIME THAT RESUSCITATION ACTIONS ENDED (OR TIME OF DEATH IF BABY DOES NOT SURVIVE) (USE 24-HR CLOCK FORMAT)	☐☐ : ☐☐			
Q532: Was the resuscitation successful? ***(OBSERVER: CIRCLE " No" IF NEWBORN DIED)***	**1**	**2**		
Q533: Arranges transfer to special care either in facility or to outside facility	**1**	**2**	**8**	
Q534: Explains to the mother (and her support person if available) what happened	**1**	**2**	**8**	
Q535: Listens to mother and responds attentively to her questions and concerns	**1**	**2**	**8**	
Q536: OBSERVER: DID YOU CALL FOR HELP OR INTERVENE DURING THE RESUSCITATION TO SAVE THE LIFE OF NEWBORN?	**1**	**2**		
CLEANUP AFTER NEWBORN RESUSCITATION				
Question: DID THE PROVIDER DO ANY OF THE FOLLOWING	**Yes**	**No**	**DK**	**Go to**
540: disposes of disposable suction catheters and mucus extractors in a leak-proof container or plastic bag	**1**	**2**	**8**	
541: Takes the bag and mask apart and inspects for cracks and tears	**1**	**2**	**8**	
542: Decontaminates the bag and mask in 0.5% chlorine solution	**1**	**2**	**8**	
543: Sterilizes or uses high-level disinfection for bag, valve and mask	**1**	**2**	**8**	
544: Decontaminates reusable suction device in 0.5% chlorine solution	**1**	**2**	**8**	
545: Sterilizes or uses high-level disinfection for reusable suction devices	**1**	**2**	**8**	
546: Washes his/her hands with soap and water or uses antiseptic	**1**	**2**	**8**	
547: OBSERVER: RECORD TIME THAT LABOR & DELIVERY OBSERVATION ENDED (USE 24-HR CLOCK FORMAT)	☐☐ : ☐☐			

SECTION 6: OUTCOME & REVIEW OF DOCUMENTATION				
Question	**Code**			
COMPLETE THIS SECTION FOR ALL CLIENTS				
CONDITION OF MOTHER & NEWBORN AT END OF OBSERVATION	**Yes**	**No**	**DK**	**Go to**
Q600: Was the woman referred to another facility for care before she went into active labor/second stage of labor?	**1**	**2**		**IF YES → Q603**
RECORD THE STATUS OF MOTHER AND NEWBORN AT THE END OF FIRST HOUR AFTER BIRTH.				
Q601: RECORD OUTCOME FOR THE MOTHER				
Goes to recuperation ward	**1**			
Referred to specialist, same facility	**2**			
Goes to surgery, same facility	**3**			
Referred, other facility	**4**			
Death of mother	**5**			
Don't know	**8**			
Q602: RECORD OUTCOME FOR THE NEWBORN OR FETUS				
Goes to normal nursery	**01**			
Referred to specialist, same facility	**02**			
Referred, other facility	**03**			
Goes to ward with mother	**04**			
Newborn death	**05**			
Fresh stillbirth	**06**			
Macerated stillbirth	**07**			
Don't know	**98**			
POTENTIALLY HARMFUL PRACTICES				
Q603: DID YOU SEE ANY OF THE FOLLOWING HARMFUL OR INAPPROPRIATE PRACTICES BY HEALTH WORKERS? CIRCLE ALL THAT APPLY				
Use of enema	**A**			
Pubic shaving	**B**			
Apply fundal pressure to hasten delivery of baby or placenta	**C**			
Lavage of uterus after delivery	**D**			
Slap newborn	**E**			
Hold newborn upside down	**F**			
Milking the newborn's chest	**G**			
Excessive stretching of the perineum	**H**			
Shout, insult or threaten the woman during labor or after	**I**			
Slap, hit or pinch the woman during labor or after	**J**			
None of the above	**Y**			
Q604: DID YOU SEE ANY OF THE FOLLOWING PRACTICES DONE WITHOUT AN APPROPRIATE INDICATION? CIRCLE ALL THAT APPLY				
Manual exploration of the uterus after delivery	**A**			
Use of episiotomy	**B**			
Aspiration of newborn's mouth and nose as soon as head is born	**C**			
Restrict food and fluids in labor	**D**			
None of the above	**Y**			
REVIEW OF PARTOGRAPH AND/OR CHART FOR COMPLETENESS				
Question	**Yes**	**No**	**DK**	**Go to**
Q605: OBSERVER: CHECK Q500. WAS THERE NEWBORN RESUSCITATION?	**1**	**2**		**No → Q611**
EXAMINE CHART TO DETERMINE WHETHER THE HEALTH WORKER RECORDED THE FOLLOWING INFORMATION:				
Q606: Condition of the newborn at birth	**1**	**2**	**8**	
Q607: Procedures necessary to initiate breathing	**1**	**2**	**8**	
Q608: Time from birth to initiation of spontaneous breathing or time of death if unsuccessful	**1**	**2**	**8**	
Q609: Any clinical observations during resuscitation, including baby vital signs	**1**	**2**	**8**	
Q610: Final outcome of resuscitation measures	**1**	**2**	**8**	
EXAMINE PARTOGRAPH IF AVAILABLE				
Q611: Partograph used to monitor labor	**1**	**2**		**No → Q630**

Q612: Which partograph used	Code			
Old WHO partograph (latent phase)	1			
New WHO partograph (at 4cm dilatation)	2			
Other partograph	3			
Question	**Yes**	**No**	**DK**	**Go to**
Q613: Initiated use of partograph at the appropriate time according to partograph used (New WHO partograph starts at 4 cm; old version starts at 3 cm)	1	2	8	
EXAMINE PARTOGRAPH TO DETERMINE WHETHER THE HEALTH WORKER RECORDED THE FOLLOWING INFORMATION WHILE THE WOMAN WAS IN ACTIVE LABOR:				
Q614: Fetal heart rate plotted at least every half hour	1	2	8	
Q615: Cervical dilatation plotted at least every four hours	1	2	8	
Q616: Descent of head plotted at least every one hour	1	2	8	
Q617: Frequency and duration of contractions plotted at least every one hour	1	2	8	
Q618: Maternal pulse plotted at least every one hour	1	2	8	
Q619: BP recorded at least every one hour	1	2	8	
Q620: Temperature recorded at least every two hours	1	2	8	
Q621: OBSERVER: DID YOU SEE PROVIDER FILL OUT PARTOGRAPH AFTER DELIVERY, WITH INFORMATION THAT SHOULD BE ENTERED DURING LABOR? (CIRCLE "DON'T KNOW" IF PARTOGRAP USE WAS NOT OBSERVED)	1	2	8	
EXAMINE PARTOGRAPH TO DETERMINE WHETHER THE HEALTH WORKER RECORDED THE FOLLOWING INFORMATION ABOUT THE DELIVERY				
Q622: Birth time	1	2	8	
Q623: Delivery method	1	2	8	
Q624: Birth weight	1	2	8	
DATA EXTRACTION FROM PARTOGRAPH AND/OR CHART				
Q625: OBSERVER: WAS ACTION LINE ON PARTOGRAPH REACHED?	1	2	8	No/DK → Q630
Q626: OBSERVER: RECORD TIME ACTION LINE WAS REACHED (USE 24-HR CLOCK FORMAT)	__ __ : __ __			
Q627: OBSERVER: IF ACTION LINE WAS REACHED ON PARTOGRAPH, WAS ANY DEFINITIVE ACTION TAKEN?	1	2	8	No/DK → Q630
Q628: OBSERVER: RECORD TIME ACTION WAS TAKEN. ENTER *98:98 IF UNKNOWN.* USE 24-HR CLOCK FORMAT	__ __ : __ __			
Q629: OBSERVER: WHAT DEFINITIEVE ACTION WAS TAKEN?	Code			
Consult with clinician	1			
Consult with senior nurse or midwife	2			
Refer to other facility for care	3			
Prepare for assisted delivery	4			
Prepare for C-section	5			
Other (specify_____)	6			
FOR THE FOLLOWING QUESTIONS: EXAMINE PARTOGRAPH AND/OR CHART TO DETERMINE THE FOLLOWING INFORMATION. IF THE INFORMATION IS NOT IN THE CHART OR PARTOGRAPH, BUT THE OBSERVER KNOWS THE INFORMATION OR PREVIOUSLY RECORDED THE INFORMATION IN ANOTHER SECTION, HE OR SHE SHOULD FILL IN THEIR OWN ANSWER. IF THE INFORMATION IN THE CHART OR PARTOGRAPH DIFFER FROM OBSERVER'S INFORMATION, USE OBSERVER'S INFORMATION.				
Q630: RECORD AGE OF WOMAN	__ __			
Q631: RECORD THE GRAVIDITY OF THE WOMAN	__ __			
Q632: RECORD THE PARITY OF THE WOMAN PRIOR TO THIS DELIVERY	__ __			
Q633: RECORD TIME OF ADMISSION TO LABOR WARD. ENTER *98:98 IF UNKNOWN.* USE 24-HR CLOCK FORMAT	__ __ : __ __			
Q634: RECORD CENTIMETERS DILATED UPON ADMISSION TO LABOR WARD. ENTER *98 IF UNKNOWN*	__ __			
Q635: RECORD TIME MEMBRANES RUPTURED. ENTER *98:98 IF UNKNOWN* (USE 24-HR CLOCK FORMAT)	__ __ : __ __			

Q636: HOW DID THE MEMBRANES RUPTURE?	**Code**			
Spontaneous	**1**			
Artificial	**2**			
Don't know	**8**			
Q637: RECORD TYPE OF DELIVERY				
Spontaneous vaginal	**1**			
Assisted (instrumented)	**2**			
Caesarean	**3**			
Don't know	**8**			
Q638: RECORD TIME OF BIRTH. ENTER 98:98 IF UNKNOWN. USE 24-HR CLOCK FORMAT				
Q639: RECORD BIRTH WEIGHT IN GRAMS. ENTER 9998 IF UNKNOWN				
Q640: RECORD GESTATIONAL AGE IN WEEKS AT BIRTH. ENTER 98 IF UNKNOWN.				
Question	**Yes**	**No**	**DK**	**Go to**
Q641: WAS WOMAN DIAGNOSED WITH SEVERE PE/E?	**1**	**2**	**8**	**No/DK → Q643**
Q642: WAS BABY DELIVERED WITHIN 24 HOURS OF PE/E DIAGNOSIS?	**1**	**2**	**8**	
Q643: DID THE MOTHER HAVE BLOOD LOSS OF MORE THAN 500ML?	**1**	**2**	**8**	**No/DK → Q645**
Q644: WAS SHE DIAGNOSED WITH POSTPARTUM HEMORRHAGE?	**1**	**2**	**8**	
Q645: DID THE MOHTER DEVELOP A FEVER OF 38° C OR HIGHER DURING LABOR?	**1**	**2**	**8**	**No/DK → Q647**
Q646: WAS SHE DIAGNOSED WITH CHORIOAMNIONITIS DURING LABOR?	**1**	**2**	**8**	
Q647: WERE ANTIBIOTICS ADMINISTERED TO MOTHER AT ANY TIME?	**1**	**2**	**8**	**No/DK → Q651**
Q648: WHEN WERE ANTIBIOTICS ADMINISTERED? CIRCLE ALL THAT APPLY	**Code**			
1st stage	**A**			
2nd stage	**B**			
3rd stage	**C**			
Postpartum	**D**			
Q649: WHY WERE ANTIBIOTICS ADMINISTERED? CIRCLE ALL THAT APPLY	**Code**			
Treatment for chorioamnionitis	**A**			
After pre-labor rupture of membranes	**B**			
Preparation for C-section	**C**			
Routine/prophylactic	**D**			
Third stage/postpartum procedure	**E**			
Don't know	**Z**			
Q650: WHICH ANTIBIOTICS WAS ADMINISTERED? CIRCLE ALL THAT APPLY				
Penicillin	**A**			
Ampicillin	**B**			
Gentamicin	**C**			
Metronidazole	**D**			
Cephalosporin	**E**			
Other (specify_____)	**X**			
Don't know	**Z**			
Question	**Yes**	**No**	**DK**	**Go to**
Q651: IS MOTHER HIV POSITIVE? CIRCLE "DON'T KNOW" IF HIV STATUS IS UNKNOWN OR WAS NOT DISCUSSED	**1**	**2**	**8**	**No/DK → Q654**
Q652: WAS NEWBORN GIVEN ARV(s)?	**1**	**2**	**8**	**No/DK → Q654**
Q653: RECORD TYPE OF ARV(s) GIVEN TO NEWBORN	**Code**			
NVP	**1**			
AZT	**2**			
3TC	**3**			
Don't know	**8**			

Q654: ***PLEASE COMMENT ON THE QUALITY OF CARE PROVIDED:***

Was mother treated respectfully? Informed of procedures to herself and her baby? Was the situation chaotic or calm? Were there any major delays in needed treatment? If so, for what drugs/procedures and why? Were multiple health workers involved? Who? If maternal or newborn/fetal death occurred, describe the circumstances. Was the mother counseled about the death of newborn/fetus?

Facility Summary Sheet

FACILITY SUMMARY SHEET

Facility No.:_____ Team No.:_____

Facility Name:_____ Closing Date:_____

	TOTAL NUMBER OF HEALTH WORKERS INTERVIEWED	TOTAL NUMBER OF OBSERVATIONS/EXITS ADMINISTERED			
		ANC	FAMILY PLANNING	SICK CHILD	L&D
TOTAL (FROM INVENTORY QUESTIONNAIRE) →					
		TOTAL NUMBER OF OBSERVATIONS/EXITS ASSOCIATED WITH LISTED HEALTH WORKERS			
	HEALTH WORKER SERIAL NUMBER (Staff Listing Form)	ANC	FAMILY PLANNING	SICK CHILD	L&D

Provider Listing Form

STAFF LISTING FORM

FACILITY NUMBER ☐☐☐☐☐ **TOTAL NUMBER OF PROVIDERS LISTED** ☐☐ **INTERVIEWER CODE** ☐☐☐

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						HIV/AIDS RELATED	MALARIA	TB	STI	NCD										
01																			01	01
02																			02	02
03																			03	03
04																			04	04
05																			05	05
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18																			18	18
19																			19	19
20																			20	20

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10 REGISTERED NURSE WITH DIPLOMA
11 ENROLLED NURSE
12 COMMUNITY HEALTH NURSE
13 ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN
14 ENROLLED NURSE MIDWIFE
15 PHARMACIST
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18 PHARMACY ASSISTANT
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21																		**21**	**21**
22																		**22**	**22**
23																		**23**	**23**
24																		**24**	**24**
25																		**25**	**25**
26																		**26**	**26**
27																		**27**	**27**
28																		**28**	**28**
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34																		**34**	**34**
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37																		**37**	**37**
38																		**38**	**38**
39																		**39**	**39**
40																		**40**	**40**

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41																		41	41
42																		42	42
43																		43	43
44																		44	44
45																		45	45
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47																		47	47
48																		48	48
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56																		56	56
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63																		63	63
64																		64	64
65																		65	65
66																		66	66
67																		67	67
68																		68	68
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01 GENERALIST MEDICAL DOCTOR
02 SPECIALIST MEDICAL DOCTOR
03 CLINICAL OFFICER (DEGREE LEVEL)
04 CLINICAL TECHNICIAN (DIPLOMA)
05 MEDICAL ASSISTANT
06 ANESTHETIST
07 REGISTERED NURSE (BSN)
08 REGISTERED NURSE MIDWIFE (BSN)
09 REGISTERED PSYCHIATRIC NURSE
10 REGISTERED NURSE WITH DIPLOMA
11 ENROLLED NURSE
12 COMMUNITY HEALTH NURSE
13 ENROLLED MIDWIFE / NURSE MIDWIFE TECHNICIAN
14 ENROLLED NURSE MIDWIFE
15 PHARMACIST
16 PHARMACY TECHNOLOGIST
17 PHARMACY TECHNICIAN
18 PHARMACY ASSISTANT
19 LABORATORY TECHNOLOGIST / SCIENTIST
20 LABORATORY TECHNICIAN
21 LABORATORY ASSISTANT
22 RADIOGRAPHER
23 DENTAL THERAPIST / TECHNICIAN
24 ENVIRONMENTAL HEALTH OFFICER
25 HEALTH SURVEILLANCE ASSISTANTS (HSA)
26 HTC COUNSELORS (NON-HSA)
95 NO TECHNICAL QUALIFICATION
96 OTHER_____

STAFF LISTING FORM

FACILITY NUMBER ☐☐☐☐☐ **INTERVIEWER CODE** ☐☐☐

LIST ALL CLINICAL STAFF / PROVIDERS WHO ARE PRESENT TODAY IN THIS FACILITY. COMPILE THIS LIST AS THE TEAM MOVES FROM ONE SERVICE AREA (OR DEPARTMENT) TO ANOTHER OBTAINING INFORMATION ON THE SERVICES THAT THE FACILITY PROVIDES AND FOR WHICH INVENTORY SECTIONS ARE BEING COMPLETED, AND/OR FOR WHICH CLIENT-PROVIDER OBSERVATIONS ARE BEING DONE. WRITE THE HEALTH WORKER'S QUALIFICATION CODE IN THE COLUMN **"PROVIDER QUALIFICATION CODE"**. PUT CHECK MARKS IN THE APPROPRIATE COLUMNS UNDER "SERVICES PROVIDED IN FACILITY" TO INDICATE THE SERVICE THAT THE PROVIDER PROVIDES IN THE FACILITY. IN THE LAST-BUT-ONE COLUMN**"INTERVIEWED FOR INVENTORY"**, CIRCLE THE LINE NUMBER IF THE PROVIDER WAS INTERVIEWED FOR ANY SECTION OF THE INVENTORY QUESTIONNAIRE. FINALLY, IN THE LAST COLUMN **"SELECTED FOR HEALTH WORKER INTERVIEW"** CIRCLE THE LINE NUMBER IF THE PROVIDER IS SELECTED TO BE INTERVIEWED WITH THE INDIVIDUAL HEALTH WORKER QUESTIONNAIRE.

PROV SERIAL NUMBER	PROVIDER FIRST NAME OR INITIALS	PROVIDER QUALIF'N CODE		SERVICES PROVIDED IN FACILITY														INTERVIEWED FOR INVENTORY	SELECTED FOR HEALTH WORKER INTERVIEW
				PRESCRIBE ART	HIV COUNSELING AND TESTING	DIAGNOSIS/TREATMENT					ANTENATAL CARE	PMTCT	DELIVERY	FAM PLANNING	CHILD HEALTH	SURGERY	CONDUCT LABORATORY TESTS	OTHER CLIENT SERVICES	
						HIV/AIDS RELATED	MALARIA	TB	STI	NCD									
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96 OTHER_____