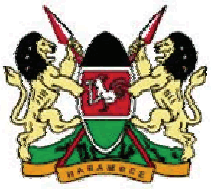
REPUBLIC OF KENYA

KENYA

Service Provision Assessment (SPA) 2010



Ministry of Medical Services
Ministry of Public Health and Sanitation

Kenya
Service Provision Assessment Survey
2010

National Coordinating Agency
for Population and Development
Nairobi, Kenya

Ministry of Medical Services
Nairobi, Kenya

Ministry of Public Health and Sanitation
Nairobi, Kenya

Kenya National Bureau of Statistics
Nairobi, Kenya

ICF Macro
Calverton, Maryland USA

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This report presents findings of the 2010 Kenya Service Provision Assessment (KSPA) Survey, which was implemented by the National Coordinating Agency for Population and Development in collaboration with the Ministry of Medical Services, the Ministry of Public Health and Sanitation, and the Kenya National Bureau of Statistics. ICF Macro provided technical assistance. The 2010 KSPA is part of the worldwide MEASURE DHS project which assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. The survey was funded by the United States Agency for International Development (USAID), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), the British Department for International Development (DfID) and the Danish International Development Agency (DANIDA) provided the financial support.

Additional information about the 2010 KSPA may be obtained from the National Coordinating Agency for Population and Development, the Chancery, 4th floor, Valley Road, Nairobi, Kenya. Telephone: 020.711-600/1; Fax: 020.271-6508.

Information about the MEASURE DHS project can be obtained from ICF Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA; Telephone: 301.572.0200; Fax: 301.572.0999; e-mail: reports@measuredhs.com; Internet: http://www.measuredhs.com.

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FOREWORD

The 2010 Kenya Service Provision Assessment (2010 KSPA) survey is a follow-up to the 1999 and 2004 KSPA surveys. This assessment was conducted soon after the 2008-09 Kenya Demographic and Health Survey (KDHS). The information from the 2010 KSPA gives an indication of our progress towards attaining the Millennium Development Goals (MDGs) and Kenya's Vision 2030. It also provides an assessment of the impact of activities implemented under the 2005-2010 National Health Sector Strategic Plan (NHSSP II).

The 2010 KSPA was designed to provide national and sub-national information on the availability and quality of services from a representative sample of 703 health facilities. These facilities included hospitals, health centres, dispensaries, maternities, clinics, and VCT centres. The managing authorities of these facilities included the government, nongovernmental organisations (NGOs), private, and faith-based organisations (FBOs). The facilities were stratified by type of health facility, managing authority, and province.

The services of interest to the 2010 KSPA included child health, family planning, maternal and newborn health care (antenatal and delivery care), sexually transmitted infections, tuberculosis, and HIV/AIDS.

The survey included interviews with the service providers, observations of a sample of consultations between the health care providers and clients seeking their services, and interviews with clients after they were served. Focus group discussions with mothers of children less than two years of age and in-depth interviews with community health workers were also conducted to provide qualitative information that would supplement the survey findings.

Although most of the facilities are equipped to provide primary health care and have essential commodity supplies and drugs available, the survey identified major weaknesses that require immediate remedy if we are to improve the quality of health service delivery.

In the second National Health Sector Strategic Plan (NHSSP II), the provision of targeted health services to different age cohorts in the population has been identified as one of the priority strategies for enhancing access to quality health care. This 2010 KSPA report is, therefore, an important tool in the nation's efforts to identify and address issues that inhibit provision of and access to quality health care.

It is hoped that policy and programme managers will focus on the problems identified through the three KSPAs and recent DHS surveys to ensure that implementation of activities in the proposed areas of intervention is done in a coordinated manner. To this end, we urge all stakeholders to play active roles in trying to close the gaps in the provision of high quality health services to the Kenyan population.

Wycliffe Ambetsa Oparanya, EGH, MP
Minister of State for Planning, National Development & Vision 2030

ACKNOWLEDGEMENTS

The 2010 Kenya Service Provision Assessment, the third to be conducted in Kenya, collected information on the delivery of health services in Kenya. It examined the capacity of facilities to provide good quality health services. The services that were assessed included: (1) child health promotion and treatment of childhood illnesses; (2) maternity care (antenatal, delivery, postpartum, and newborn); (3) family planning services; (4) services for the prevention and management of sexually transmitted infections (STIs); and (5) HIV/AIDS services. The 2010 SPA also included observations of service delivery and a community component that looked at the utilization of community services at the facility levels.

The Ministry of State for National Development and Vision 2030, through the National Coordinating Agency for Population and Development (NCAPD) and the Kenya National Bureau of Statistics (KNBS), the Ministry of Public Health and Sanitation (MOPHS), and the Ministry of Medical Services (MOMS), wishes to acknowledge the dedicated efforts and contribution of the national steering committee and technical committee, which comprised staff from the NCAPD, MOPHS; MOMS; KNBS; Nairobi City Council, University of Nairobi, the Population Council, and the National Aids Control Council. These committees were formed to oversee all the policy and technical issues related to the survey. In particular, they assisted in designing the instruments, collecting the data, and processing and analyzing the information. We acknowledge the special effort by the authors, who, in addition to other assignments, found time to work on their chapters.

We are grateful to all the health facilities that willingly cooperated with the research teams to provide the information that we are now sharing. We appreciate the contributions of the respondents at the health facilities—both providers and clients—who answered the research assistants' questions and allowed them to make observations. Thanks go, as well, to many others whose contributions also facilitated the successful survey process—the managers of the health facilities contacted, research assistants, the data processing team, scholars, and programme implementers. Outstanding facilitation at district and regional levels by the Regional Population Coordinators and the District Development Officers is acknowledged with thanks.

Our gratitude also goes to the participants at the instrument design workshop for their valuable input. We also thank the entire NCAPD Board for supporting the activity. And we especially thank Programming Specialist Jeanne Cushing of ICF Macro, who for the past 20 years has been providing her technical input to the Kenya process.

We sincerely appreciate the financial and technical support provided by the United States Agency for International Development (USAID) through ICF Macro under the MEASURE DHS Project. We also wish to thank the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Kingdom Department for International Development (DFID), and the Danish International Development Agency (DANIDA) for their financial support of the survey. The role played by BDO Githongo and Company in auditing the survey also is appreciated.

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ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOP	Annual Operation Plan
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
AVD	Assisted Vaginal Delivery
BEOC	Basic Essential Obstetric Care
BEmOC	Basic Emergency Obstetric Care
BCG	Bacille de Calmette et Guerin
CBO	Community-based Organisation
CDF	Constituency Development Fund
CEOC	Comprehensive Essential Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CPT	Cotrimoxazole Preventive Therapy
CS	Caesarean Section
CSS	Care and Support Services
CT	Counselling and Testing
CWC	Child Welfare Clinic
DALY	Disability Adjusted Life Years
D&C	Dilation and Curettage
DHMB	District Health Management Board
DHMT	District Health Management Team
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DMOH	District Medical Officer of Health
DOT	Direct Observation of Treatment
DOTS	Direct Observed Therapy, Short Course
DPHS	Director of Public Health and Sanitation
DPT	Diphtheria, Pertussis, Tetanus
DPT-HB	Diphtheria, Pertussis, Tetanus, and Hepatitis B vaccine
DR-TB	Drug-Resistant Tuberculosis
EmOC	Emergency Obstetric Care
ELISA	Enzyme-linked Immunosorbent Assay
EPI	Expanded Programme on Immunisation
ERSWEC	Economic Recovery Strategy for Wealth and Employment Creation
FBO	Faith-based Organisation
FP	Family Planning
HIV	Human Immunodeficiency Virus
HLD	High-level Disinfection
HSCC	Health Sector Coordinating Committee

IC	Infection Control
ICPD	International Conference on Population and Development
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITN	Insecticide-treated (bed) Net
IUCD	Intrauterine Contraceptive Device
IV	Intravenous
JICC	Joint Inter-Agency Coordinating Committee
JPWF	Joint Program of Work and Funding
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHPF	Kenya's Health Policy Framework
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
LLIN	Long Lasting Insecticidal Nets
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multi-drug Resistant Tuberculosis
MMR	Maternal Mortality Ratio
MOMS	Ministry of Medical Services
MOPH&S	Ministry of Public Health and Sanitation
MTEF	Medium-Term Expenditure Framework
MTRH	Moi Teaching and Referral Hospital
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
NGO	Non-governmental organisation
NPEP	National Poverty Eradication Plan
NSHIF	National Social Health Insurance Fund
NSHIS	National Social Health Insurance Strategy
OI	Opportunistic Infection
OPD	Outpatient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PCR	Polymerase chain reaction
PDR-TB	Poly-Drug Resistant Tuberculosis
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PID	Pelvic Inflammatory Disease
PITC	Provider-Initiated Testing and Counselling
PHMT	Provincial Health Management Team
PMSMT	Provincial Medical Services Management Team
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PNC	Postnatal Care

QA	Quality Assurance
RDT	Rapid Diagnostic Test
RPR	Rapid Plasma Reagin
SP	Sulfadoxine-pyrimethamine (Fansidar)
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFP	Temporary methods of Family Planning
TST	Time-, Steam-, and Temperature-sensitive (tape)
TT	Tetanus toxoid
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VDRL	Venereal Disease Research Laboratory (test)
WHO	World Health Organization
XDR-TB	Extremely Drug Resistant Tuberculosis
YFS	Youth Friendly Services

KEY FINDINGS

The 2010 Kenya Service Provision Assessment (2010 KSPA) survey, the third of its kind to be done in Kenya, collected data from a representative sample of 695 health facilities throughout the country. It was designed to provide information on the general performance of facilities that offer maternal, child, and reproductive health services as well as services for specific infectious diseases, including sexually transmitted infections (STIs), HIV/AIDS, tuberculosis (TB), and malaria.

Information was collected, using facility audit questionnaires, interviews with health service providers, observations of client-provider consultations, and exit interviews with clients, to assess the capacity of facilities to provide good quality services and also to assess the existence and the strengths and weaknesses of infrastructure and systems to support these services. The survey also sought to assess adherence to standards in the delivery of curative care for sick children, family planning, antenatal care (ANC), normal and complicated deliveries. Community health workers (CHWs) and mothers of children were interviewed in a sample of communities where these health facilities were located.

The 2010 NHFC provides national- and provincial-level information for hospitals, health centres, maternity facilities, clinics and dispensaries that offer maternal and child health (MCH) and HIV and AIDS-related services, and also from stand-alone voluntary counselling and testing (VCT) facilities.

The National Coordinating Agency for Population and Development (NCAPD) implemented the survey in collaboration with the Ministry of Medical Services (MOMS), the Ministry of Public Health and Sanitation (MOPHS), and the Kenya National Bureau of Statistics (KNBS). ICF Macro provided technical assistance under the MEASURE DHS project. Financial support for the 2010 KSPA came from the United States Agency for International Development (USAID), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), the British Department for International Development (DfID) and the Danish International Development Agency (DANIDA).

Below is a summary of the key findings of the 2010 KSPA:

FACILITY-LEVEL INFRASTRUCTURE, RESOURCES, AND SYSTEMS

- A full package of basic services—which includes outpatient care for sick children, services for adult STIs, temporary methods of family planning, ANC, immunisation, and child growth monitoring—is available in six of every ten facilities. Hospitals, health centres, maternity facilities and dispensaries are more likely than clinics and stand-alone VCT facilities to offer the full package of services.

- A little under half of facilities have regular water supply, i.e., year-round water is supplied by a tap in the facility from a protected or unknown source, or water is supplied from a protected well or pump, and water outlet is available within 500 meters of the facility. One of every four facilities has regular electricity or generator with fuel. Overall, only one of every ten facilities have regular supplies of water and electricity as well as client comfort amenities such as a functioning client latrine, a protected waiting area and a basic level of cleanliness.

- Two-thirds of facilities report holding routine management meetings at least once every six months; however, only one-third of facilities have documentation of a recent management meeting.

- A quarter of facilities report quality assurance activities and only eleven percent have documentation of quality assurance activities.

- Approximately six of every ten facilities have functioning equipment or the necessary chemicals for the method used to process equipment for reuse. More than seven of

every ten facilities have an adequate system for disposal of sharps waste.

CHILD HEALTH SERVICES

- Approximately seven of every ten facilities offer all three basic child health services—outpatient curative care for sick children, childhood immunisations, and growth monitoring.

- A little over eight out of ten facilities that offer child immunisation services and also store vaccines had all basic vaccines (BCG, DPT/pentavalent, polio, and measles) available on the day of the visit.

- Practically all facilities offer outpatient curative care for sick children. Among the facilities offering outpatient curative care for sick children, six of every ten have treatment guidelines for sick child services. Only one-third had IMCI chart booklets.

- All three first-line oral medicines (ORS, the first-line antimalarial (Coartem), and at least one oral antibiotic) are available in two-thirds of facilities that offer sick child services. Six of every ten facilities offering services for sick children have all pre-referral medicines—at least one first-line injectable antibiotic (chloramphenicol, ampicillin, cloxacillin, or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamicin), and intravenous solution with perfusion set.

- Four of every ten facilities that offer curative care for sick children meet the criteria for providing routine staff training. Routine supervision is common; eight of every ten facilities have routine supervision for child health services providers. Supervision is least common in Central province.

- Complete evaluation of sick children for general danger signs (the sick child's inability to eat or drink, vomiting everything, and febrile convulsions) during sick child visits are not routinely done. During only 13 percent of all observed sick child consultations did providers evaluate sick children for all three of these IMCI general danger signs.

- Among observed children who were diagnosed with pneumonia, a third had their respiratory rates checked and about nine of every ten were given an antibiotic.

- Caretakers of sick children are seldom given essential information for taking care of the sick child at home. For example, only a little over one in every ten caretakers received all three IMCI recommendations regarding fluid intake, food intake, and symptoms for which the sick child must be brought back to see a health provider.

FAMILY PLANNING SERVICES

- Three-quarters of facilities in Kenya offer temporary modern methods of family planning; the majority of these facilities (nine of every ten) offer FP services five or more days per week. The most commonly offered temporary modern methods of family planning in Kenyan health facilities are the combined oral contraceptive pills (95 percent of facilities offering any family planning services), the 2- or 3-month progestin-only injectables (95 percent), and the male condom (92 percent). Majority of facilities had the most commonly provided methods available on the day of the survey; there are some gaps, however.

- Over nine of every ten FP facilities assure both visual and auditory privacy during family planning counselling sessions. Visual aids for client education are available in eight of ten FP facilities; however, less than four of every ten of these facilities had family planning service guidelines available in the service delivery area on the day of the survey visit. Items for infection control (soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box) are available in the family planning service area in a little over half of these facilities.

- In eight of every ten family planning facilities, family planning providers routinely diagnose and treat STIs. Medicines for treating syphilis, trichomoniasis, chlamydia, and gonorrhoea are not readily available in these facilities.

- Only a small proportion of family planning facilities provide routine training for family planning service providers; however individual supervision of these providers is quite widespread.

- Few family planning clients have major issues with their visits to health facilities. Long waiting time to see a provider is the problem that clients most often mention.

MATERNAL HEALTH SERVICES

- Excluding stand-alone VCT facilities, ANC services are available in three-quarters of all facilities; they are least likely to be available in clinics. Close to six of every ten facilities offer ANC, postnatal care (PNC), and tetanus toxoid (TT) vaccine. Nine of every ten ANC facilities provide TT services every day that ANC services are offered.

- Overall, only a little over a third of ANC facilities have visual aids, ANC guidelines, and individual client cards —items considered important for provision of quality ANC counselling. Individual client cards are more likely to be available than either ANC guidelines or visual aids.

- Only one-quarter of ANC facilities have all five essential supplies for basic ANC services (blood pressure apparatus, foetoscope, iron and folic acid tablets, and TT vaccine) for basic ANC. All infection control items (soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps box) are available in six of every ten ANC facilities.

- Only one of every five ANC facilities has all medicines for managing common complications of pregnancy (a broad spectrum antibiotic, an antihelminthic, a first-line antimalarial, an antihypertensive, and at least one medicine for treating each of the following reproductive tract infections: trichomoniasis, gonorrhoea, chlamydia, syphilis and candidiasis.

- In little under nine of every ten ANC facilities, ANC service providers routinely diagnose and treat STI. On the day of the survey visit, close to half of ANC facilities had at least one medicines to treat each of the four common STIs—syphilis, gonorrhoea, chlamydia, and trichomoniasis.

- Eight of every ten ANC facilities have up-to-date ANC registers. Only about two of every ten of ANC facilities have documentation indicating that they monitor ANC coverage.

- First-visit ANC clients are more likely to be counselled or educated on nutrition, pregnancy risk signs and symptoms, exclusive breastfeeding, and postpartum family planning during ANC consultations than are follow-up clients. Clients who are at least eight months pregnant are more likely to be counselled on delivery plans than others clients.

- Normal delivery services are available in three of ten facilities, including 95 percent of hospitals. Caesarean sections are available almost exclusively in hospitals. Half of facilities have transportation support for maternity emergencies; private facilities are less likely to have transportation support than facilities managed by other authorities.

- About six of every ten facilities that offer normal delivery services have all infection control items (soap and running water or else hand disinfectant, sharps box, disinfecting solution, and clean latex gloves) at the service site.

- All basic equipment and supplies for conducting normal deliveries (scissors or a blade, cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineum) are available in the delivery area in six of every ten facilities offering delivery services. The availability of each of these items individually ranges from 75 percent of facilities having antibiotic eye ointment to 97 percent having scissors or a blade at the service site.

- Newborn respiratory support (infant-sized Ambu bag or equivalent) is available in seven of every ten facilities that offer delivery services, including 92 percent of hospitals. An external heat source is available in a little under four of every ten of these facilities, including 67 percent of hospitals. Practices that are considered supportive of new-

born health, such as weighing the newborn, providing vitamin A to the mother, and rooming-in, are common.

- Up-to-date delivery registers are available in nine of every ten delivery facilities; interestingly, maternity facilities are less likely to have up-to-date registers. Overall, four of every ten delivery facilities conduct reviews of maternal and/or newborn deaths or near-misses, including 64 percent of hospitals.

STI AND TUBERCULOSIS SERVICES

- STI services are available in over nine of every ten facilities. In almost all facilities offering STI services, these services are offered as part of general outpatient curative services. In about eight of every ten facilities that offer STI services, the services are also available in FP services sites, and in two-thirds of facilities they are also available in ANC sites. Specialised STI clinics are not common.

- The syndromic approach is the most widely used method to diagnose and treat STIs in Kenyan health facilities. On the day of the survey visit, nearly half of STI facilities had at least one medicine for treating each of the four common STIs.

- Nearly all STI facilities provide STI counselling under conditions that ensure both visual and auditory privacy. STI guidelines are available at the service delivery site in a little over half STI facilities. STI-related visual aids and educational materials also are widely available at STI service sites in these facilities. Eight of every ten STI facilities have male condoms available somewhere in the facility on the day of the survey; a little over half had condoms at the STI service site. Female condoms are less widely available.

- TB diagnosis, treatment and/or follow-up services are available in four of every ten facilities, including 93 percent of hospitals and 85 percent of health centres.

- Nearly nine of every ten facilities that offer TB treatment and/or follow-up services say that they follow the DOTS strategy. Of facilities following the DOTS strategy, close to nine of every ten had all first-line TB medicines available on the day of the visit.

- On average, better than eight of every ten facilities that offer TB diagnostic, treatment, and/or follow-up services routinely refer all newly diagnosed TB cases for HIV testing and counselling.

HIV/AIDS SERVICES

- Three-quarters of all health facilities in Kenya have an HIV testing system. Among these, nearly six of every ten have HIV testing capacity on-site or in an affiliated lab. A little under half of facilities with an HIV testing system have an informed consent policy for HIV testing, and nearly all have a register with HIV test results.

- Care and support services for HIV/AIDS clients are available in about two-thirds of facilities, excluding stand-alone VCT facilities. On average, a little over half of all facilities offer primary preventive treatment for opportunistic infections, such as cotrimoxazole preventive treatment.

- On average, 17 percent of all facilities (excluding stand-alone VCT facilities) prescribe ART and/or provide ART follow-up services, including eight of every ten hospitals and a little over half of health centres. Items to support ART services, such as national ART guidelines and other guidelines for the clinical management of ART, are widely available in facilities that provide ART services.

- Services to prevent mother-to-child transmission (PMTCT) of HIV are available in close to six of every ten facilities, including nearly nine of every ten hospitals and health centres. Only one-third of facilities reporting that they offer PMTCT actually offer all four components of the minimum PMTCT package, however. Nearly eight of every ten ANC facilities report offering PMTCT services.

COMMUNITY HEALTH WORKERS

- Community health workers would like to strengthen their connection to the local health facility. More than 80 percent of those

interviewed referred sick individuals to facilities. However, only one-third of CHWs reported that they received regular supervision from the ministries of health.

- Nearly all CHWS reported that they need assistance with transportation to better visit households and to facilitate travel of the sick to health facilities.

- The large majority of CHWs requested recognition from the government for the work they perform. They would like badges, certificates, or uniforms to identify their role in assisting people to receive care.

- While CHWs stated that they are volunteers, most of them want a small monthly salary to compensate them for the time spent in community work.

GROUP INTERVIEWS WITH MOTHERS

- Women in most of the groups spoke positively in general about the medical services available for sick children in government facilities. They seemed quite satisfied with the treatment of sick children as well as with the preventive services available.

- The one problem mothers face in getting treatment for sick children is lack of drugs at facilities. Mothers in two-thirds of the groups talked about the lack of drugs available as a problem. They want to be able to purchase drugs at the facility rather than be given a prescription to be filled elsewhere.

- Women go to a health facility to give birth so they have access to skilled care in case of complications. Women give birth at home because they have done so before without difficulty, they feel comfortable at home, and they have heard stories of required HIV tests and abuse by nurses in maternities.

- Very few women in these groups mentioned postpartum and postnatal services, and it seemed that women are not aware of the importance of these services.

KENYA


N
SUDAN
ETHIOPIA
Eastern
UGANDA
Rift Valley
North Eastern
SOMALIA
Western
Nyanza
Central
Nairobi
Coast
TANZANIA
Indian Ocean
0
125
250
500 Kilometres

SURVEY METHODOLOGY 1

Francis Kundu, Vane Lumumba, Paul Ametepi

1.1 OVERVIEW

The 2010 Kenya Service Provision Assessment (KSPA) is a facility-based survey designed to provide information on the preparedness of health facilities that offer maternal, child, family planning, and reproductive health services as well as services for specific infectious diseases, in particular sexually transmitted infections (STIs), HIV/AIDS, tuberculosis (TB), and malaria. The 2010 KSPA is the third survey of its kind to be conducted in Kenya; the first one was conducted in 1999, and the second was conducted in 2004. Whenever feasible and useful, this report will compare 2010 findings with findings from the two previous surveys.

Information to provide a comprehensive picture of the strengths and weaknesses of the service delivery environment for each assessed service was collected from a representative sample of facilities managed by the government, non-governmental organisations (NGOs), private for-profit organisations, and faith-based organisations (FBOs) in all eight provinces of the country.

The 2010 KSPA provides national and provincial-level representative information for hospitals, health centres, maternity and nursing homes, clinics, and stand-alone voluntary counselling and testing (VCT) facilities offering child health, maternal and newborn care, family planning, STI, and HIV/AIDS-related services. Findings from this survey can supplement household-based health information from the Kenya Demographic and Health Survey conducted in 2008-09, which provides information on health and the utilisation of services by the overall population.

1.2 INSTITUTIONAL FRAMEWORK AND OBJECTIVES OF THE KSPA

The National Coordinating Agency for Population and Development (NCAPD) implemented the 2010 KSPA in collaboration with the Ministry of Public Health and Sanitation (MOPHS), the Ministry of Medical Services (MOMS), and the Kenya National Bureau of Statistics (KNBS). The survey received technical support from ICF Macro. Financial support for the survey came from the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the British Department for International Development (DfID), and the Danish International Development Agency (DANIDA).

The objectives of the 2010 KSPA were to:

- Assess the preparedness of health facilities in Kenya to provide quality maternal and newborn care, child health, family planning, and reproductive health services, as well as services for certain infectious diseases (HIV/AIDS, STIs, malaria, and TB)
- Provide comprehensive information on the performance of different types of health facilities that provide essential health care services
- Identify gaps in the support services and resources
- Compare findings by region, facility type, and managing authority
- Describe the extent to which clients understand how to follow up on the service received
- Describe the processes used in providing child, maternal, family planning, and reproductive health services and the extent to which accepted standards for quality service provision are followed

- Describe clients' perceptions of services provided
- Provide information on the capacity of health facilities to provide HIV/AIDS preventive, diagnostic, and care and support services and
- Document current record-keeping practices.

Data collection instruments were developed to respond to the following basic questions:

1. To what extent are facilities prepared to provide essential services? What resources and support systems are available?

For each high-priority service, the 2010 KSPA used *Facility Inventory Questionnaires* and *Provider Interviews* to collect information on whether a facility has the capacity to provide the service at acceptable standards.

Capacity is measured by the presence of essential equipment and supplies in a location reasonably accessible when providing a service. Quality of services, which is one aspect of capacity, is measured by the following characteristics of facilities: training and supervision of staff, availability of service delivery protocols and client education materials, availability and use of health information records, the service delivery environment, and facility systems for maintaining equipment and supplies.

The survey assessed support systems for general management, quality assurance, logistics for medicines, infection control, and systems for monitoring activities (such as tracking service coverage rates and referrals). Interviewers asked whether a facility had these support systems in place and noted whether those systems were functioning.

A facility's basic infrastructure can affect the standard of health services provided and influence clients' willingness to use the facility. The 2010 KSPA collected data on whether facilities had electricity, water, and client amenities and on whether the facility kept records of services provided and on which days of the week. The 2010 KSPA also assessed staffing levels.

2. To what extent does the service delivery process meet generally accepted standards of care?

The 2010 KSPA interviewers observed interactions between clients and providers to assess whether the process followed in service delivery meets standards for acceptable content and quality. Observers sat in on consultations for sick children, STI services, family planning services, and antenatal care (ANC) services. Normal deliveries and the management of delivery complications were also observed. The interviewers recorded what information was shared between the client and the provider and what processes the provider followed when assessing the client, conducting procedures, and providing treatment. They also checked for the availability of written protocols or guidelines for each of the services assessed.

3. What issues affect clients' and service providers' satisfaction with the service delivery environment?

Each observed client was subsequently asked to participate in an exit interview to ascertain the client's perception of information shared and services received. This information provides further insight into the quality of the client-provider interaction. Also, providers were interviewed about their training and satisfaction with the work environment.

1.3 2010 KSPA Content and Methods for Data Collection

1.3.1 Content of the 2010 KSPA

The 2010 KSPA focused on basic health services, particularly those important for women and children. The following essential health care services, all interrelated to some extent, were assessed: child health, family planning, maternal health, and specific infectious diseases (STIs, HIV/AIDS, TB, and malaria).

For each of these services, the survey assessed whether components considered essential for quality health care services were present and functioning. The components assessed are those commonly promoted in various programmes supported by the government and development partners. The 2010 KSPA also assessed whether more sophisticated components were present, such as higher-level diagnostic and treatment modalities or support systems for health services that are usually introduced after basic-level services have been put in place.

The *child health component* of the survey was designed to assess the availability of preventive services (immunisation and growth monitoring) and outpatient care for sick children, with a focus on the process followed in providing services to sick children. Service provision was compared with the standards set in the guidelines for the World Health Organization's Integrated Management of Childhood Illness (IMCI).

The *family planning component* focussed on the process followed in counselling and providing contraceptive methods to family planning clients.

The *maternal health component* assessed counselling and screening during ANC visits, the delivery service environment, and care during the postpartum period.

The *infectious disease component* assessed the availability of services for diagnosing and treating STIs as well as the HIV/AIDS, TB, and malaria diagnostic and treatment programmes.

1.3.2 Methods for Data Collection

Four main types of data collection tools were used for the health facility component of the survey: the *Facility Audit Questionnaires*, the *Observation Protocol*, *Exit Interviews*, and *Health Worker/Provider Interview Questionnaires*.

In addition to the above-mentioned standard SPA tools, the following instruments were also used:

- *Observation of Routine (Normal) Delivery Care: Partograph, Active Management of the Third Stage of Labour, and Immediate Newborn Care*
- *Checklist for Management of Postpartum Haemorrhage*
- *Checklist for Manual Removal of Placenta*
- *Checklist for Internal Manual Compression of the Uterus*
- *Checklist for Compression of the Abdominal Aorta*
- *Checklist for Newborn Resuscitation*
- *Checklist for Severe Pre-eclampsia and Eclampsia*

These protocols were used to observe normal deliveries and how delivery-related complications are managed.

- *Guide for in-depth interviews with community health workers, including community health extension workers (CHEWs)*
- *Guide for focus group discussions with mothers of young children ages 0-2 years.*

These two guides supported the community component of the 2010 KSPA.

Using the *Facility Audit Questionnaires*, interviewers collected information on the availability of resources, support systems, and facility infrastructure elements necessary to provide a level of service that generally meets accepted national and international standards. The support services assessed were those that are commonly acknowledged as essential management tools for maintaining health services. The *Facility Audit Questionnaires* include child health, maternal and newborn care, family planning, HIV/AIDS, laboratory, and pharmacy modules. The HIV/AIDS modules assessed how clients with HIV/AIDS were handled, from counselling and testing through treatment, referral, and follow-up. Interviewers also collected information on health facility policies and practices related to collecting and reporting HIV/AIDS-related records and statistics on services provided to clients through the health facility.

The *Observation Protocol* was tailored to the service being provided. For sick child, ANC, family planning, delivery, and STI consultation services, the observer assessed the extent to which service providers adhered to standards of care, based on generally accepted practices for good-quality service delivery. The observations, which were recorded in a checklist, covered the process used in conducting specific procedures and examinations and also the content of information exchanged between the provider and the client (including history, symptoms, and advice).

After clients were observed receiving a service (except for clients observed receiving delivery services), they were asked to participate in an *Exit Interview* as they left the facility. The *Exit Interview* included questions on the client's understanding of the consultation or examination as well as his or her recall of instructions received about treatment or preventive behaviour. The interviewer also elicited the client's perception of the service delivery environment.

In the *Health Worker/Provider Interview*, service providers were interviewed regarding their qualifications (pre-service training, experience, and continued in-service training), the supervision they had received, and their perceptions of the service delivery environment.

1.4 SAMPLING

Data were collected from a representative sample of facilities in the country, a sample of health service providers at each sampled facility, and a sample of sick children, family planning, ANC, STI, and delivery clients.

1.4.1 Sample of Facilities

The sample of facilities included in the 2010 KSPA survey was randomly selected from a *Master Facility List* (MFL) of 6,192 functioning health facilities in Kenya at the time of the survey. The MFL, obtained from the division of Health Information Systems, Department of Standards and Regulatory Services, included hospitals, health centres, maternity and nursing homes, clinics, and stand-alone VCT facilities under public, faith-based, private and NGO managing authorities. A sample size of 703 facilities was selected for the survey. The sample was carefully designed to allow for key indicators to be presented at national and provincial levels, by type of facility, and by the different managing authorities. Hospitals, maternity facilities and stand-alone VCT facilities were oversampled.[1] All three national referral hospitals and all eight provincial hospitals in Kenya were included in the sample. The final KSPA sample covered approximately 11 percent of all facilities in the country.

Reclassification of health facilities

The creation of the MFL from the various lists of health facilities that existed in the country resulted in the re-classification of some facility types. For example, some health centres, mainly those managed by faith-based organisations, were re-classified to dispensary status. More health centres

[1] Hospitals, maternity facilities and stand-alone VCT facilities exist in fewer numbers than other types of facility types. In order to have enough numbers of these facility types in the sample, these three facility types were oversampled. Data are weighted during the analysis to compensate for over- or under-sampling, in order to normalise the findings and present data from these facilities as they exist in the country.

were upgraded to hospital status to serve the newly created districts in the country. Voluntary counselling and testing (VCT) facilities providing additional health services were reclassified as clinics and dispensaries. Over one thousand clinics that were previously not registered or indentified with the health ministries were added.

As a result of this re-classification and the addition of health facilities, the sampling frame for the 2010 KSPA (master list of facilities) is quite different from the sampling frame used for the 2004 KSPA. Therefore, findings from the 2010 KSPA, particularly at the level of facility type, do not lend themselves to direct comparison with findings from the 2004 KSPA. Any such comparison should be done with caution.

Table 1.1 presents a breakdown of the sampled facilities and outcomes following visits to those facilities. As shown, data were successfully collected from 99 percent of the 703 sampled facilities. Interviewers were not able to survey eight of the sampled facilities for various reasons, including inaccessibility due to poor roads. Survey protocol required that facilities that could not be surveyed be replaced with the nearest facility of the same type, in the same district, and under the same managing authority. However, there were no facilities in these districts that met the replacement criteria. Consequently, data were successfully collected from 695 facilities.

Table 1.1 Result of facility contact, by background characteristics

Percent distribution of facilities according to result, by background characteristics, Kenya SPA 2010

Background characteristic	Percent distribution of result of contact						Total percent[2]	Number of facilities
	Complete	Respondent not available	Refused	Duplicates an existing facility[1]	Closed	Unreachable		
Type of Facility								
Hospital	100	0	0	0	0	0	100	253
Health centre	100	0	0	0	0	0	100	101
Maternity	100	0	0	0	0	0	100	52
Clinic	99	0	0	1	0	0	100	104
Dispensary	97	1	0	0	1	2	100	152
Stand-alone VCT	98	0	0	0	2	0	100	41
Managing Authority								
Government	99	0	0	0	0	1	100	351
NGO	100	0	0	0	0	0	100	38
Private (for profit)	99	0	0	0	0	0	100	219
Faith-based organisation	98	0	1	0	1	0	100	95
Province								
Nairobi	99	0	1	0	0	0	100	90
Central	99	0	0	0	1	0	100	92
Coast	100	0	0	0	0	0	100	90
Eastern	99	1	0	0	0	0	100	91
North Eastern	95	0	0	0	0	5	100	59
Nyanza	99	0	0	0	1	0	100	91
Rift Valley	99	0	0	1	0	0	100	101
Western	100	0	0	0	0	0	100	89
Total	99	0	0	0	0	0	100	703

[1] For instances where one facility appears in the sample as two different facilities under two different names
[2] Due to rounding, some of the total percentages may not add up to exactly 100 percent.

Data analysis

Data were weighted during analysis to account for differentials caused by oversampling and undersampling and thus to represent the actual distribution of facilities in the country. Table 1.2 provides information on the weighted percent distribution of facilities included in the sample as well as the weighted and unweighted number of facilities by type of facility, managing authority, and region. Table 1.3 provides information on the weighted percent distribution of facilities providing specific services of interest as well as the weighted and unweighted number of facilities. **All other tables in this report use the weighted numbers of facilities only.** Tables 1.2 and 1.3 should be used to determine the actual number of facilities assessed by the KSPA. Table A-1.1 provides additional details on the distribution of the sample by type of facility and geographical location.

Table 1.2 Distribution of facilities by background characteristics

Percent distribution of facilities and number of facilities, by background characteristics, Kenya SPA 2010

Background characteristic	Percent distribution of facilities	Number of facilities	
		Weighted	Unweighted
Type of facility			
Hospital	7	51	252
Health centre	11	80	101
Maternity	2	17	52
Clinic	29	203	103
Dispensary	49	340	147
Stand-alone VCT	1	5	40
Managing authority			
Government	50	345	347
NGO	3	24	38
Private (for profit)	34	237	217
Faith-based organisation	13	89	93
Province			
Nairobi	6	45	89
Central	18	125	91
Coast	12	81	90
Eastern	17	118	90
North Eastern	3	24	56
Nyanza	12	83	90
Rift Valley	25	175	100
Western	6	44	89
Total	100	695	695

Table 1.3 Percentage of facilities providing specific services

Percentage and number of facilities providing specific services, Kenya SPA 2010

Service provided	Percent of facilities offering services	Number of facilities offering services	
		Weighted	Unweighted
Childhood immunisation (EPI)[1]	68	471	529
Curative care for sick children	96	666	641
Family planning (TFP)[2]	88	613	575
Antenatal care	73	509	561
Delivery	30	207	403
Sexually transmitted infections[3]	93	647	632
Tuberculosis[4]	42	290	423
Reported HIV testing system[5]	74	513	601
HIV/AIDS care and support services[6]	64	443	533
Antiretroviral therapy (ART) services[7]	16	115	285
Minimum package of PMTCT[8]	19	131	239
Total	-	695	695

[1] Routine series of DPT/Pentavalent, polio, and measles immunisations available in the facility.
[2] TFP refers to temporary methods of family planning. Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine contraceptive devices (IUCDs), male condoms or counselling on periodic abstinence (rhythm) method.
[3] A client with signs and symptoms that may be a sexually transmitted infection may receive services for the diagnosis and/or treatment from this facility.
[4] This may be any or all of the following: diagnosis, treatment, and follow-up.
[5] Facility reports conducting the HIV test in the facility or in an affiliated external laboratory, or having an agreement with a testing site that is expected to return results to the facility.
[6] Providers assigned to this facility provide treatment for any opportunistic infections or symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis, or Kaposi sarcoma), or provide (or prescribe) palliative care for patients (such as symptom or pain management or nursing care for the terminally ill), or provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or provide care for paediatric HIV/AIDS patients.
[7] Facility reports that providers in the facility prescribe antiretroviral treatment and/or provide clinical follow-up for ART clients. Outreach ART facilities are not included in this definition since providers come from another facility to provide the service.
[8] Minimum package of services for prevention of mother-to-child transmission (PMTCT) of HIV includes the availability of the following in the facility: an observed HIV testing system, ARV prophylaxis for mother and infant, counselling on infant feeding and maternal nutrition for HIV-positive mothers, and counselling on or provision of family planning.

1.4.2 Sample of Health Service Providers

A health service provider is defined as one who provides consultation services, counselling, health education, or laboratory services to clients. For example, health workers were not eligible for observation or interview if they only take measurements or complete registers and never provide any type of professional client services. The sample of health service providers was selected from providers who were present in the facility on the day of the survey and who provided services that were assessed by the 2010 KSPA. The aim was to interview an average of eight providers in each facility to cover providers of the range of services being assessed. In facilities with fewer than eight health care providers, all of the providers present on the day of the visit were interviewed. In facilities with more than eight providers, efforts were made to interview eight providers, including all providers whose work was observed. If interviewers observed fewer than eight providers, then they also interviewed a random selection of the remaining health care providers to obtain eight provider interviews. Data were weighted during analysis to account for the differentials caused by oversampling or undersampling of providers with a particular qualification in a facility type or

province. In a few cases the staff present on the day of the survey may not have been representative of the staff that usually provides the services being assessed.[2]

Table 1.4 provides general information on the weighted proportion of the providers interviewed as a percentage of the total number of providers assigned to facilities and present at the time of the survey, by background characteristics and provider qualification. It also gives the weighted and unweighted number of interviewed providers used for the analysis. Tables A-1.2.1 through A-1.2.4 provide additional information on the weighted and unweighted number of interviewed providers.

Table 1.4 Distribution of interviewed providers

Percent distribution and number of interviewed providers, by background characteristics, Kenya SPA 2010

Background characteristic	Percent distribution of interviewed providers	Number of interviewed providers	
		Weighted	Unweighted
Type of facility			
Hospital	32	979	1,882
Health centre	17	523	386
Maternity	3	100	183
Clinic	18	537	212
Dispensary	29	888	290
Stand-alone VCT	1	25	98
Managing authority			
Government	53	1,626	1,734
NGO	3	106	137
Private (for profit)	23	698	645
Faith-based organisation	20	621	535
Province			
Nairobi	13	389	400
Central	13	409	393
Coast	12	365	363
Eastern	16	499	466
North Eastern	2	63	176
Nyanza	14	413	391
Rift Valley	22	682	400
Western	8	231	462
Qualification of provider			
Specialists[1]	1	30	45
Medical officer	1	45	84
Clinical officer	13	400	558
BSN[2]	1	19	33
Registered nurse	19	587	820
Registered midwife	1	35	34
Enrolled nurse	21	646	615
Enrolled midwife	5	145	122
Nurse aide	6	173	33
Lab staff[3]	17	533	468
Other health-related specialists[4]	12	369	206
Other	2	69	33
Total	100	3,051	3,051

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Bachelor of Science in nursing.
[3] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[4] Other health-related staff includes nutritionist, health education officer, social worker, lay HIV counsellor, and Public Health Officer or Technician.

[2] For example, the survey may have taken place at the same time as a special training event for a group of specialists or on a day when evaluations took a certain type of provider away from services.

1.4.3 Sample for Observations and Exit Interviews

Clients were systematically selected for observation based on the number of clients expected for each service on the day of the survey. Where many clients were present and eligible for observation, the rule was to observe a maximum of five clients for each provider of the service, with a maximum of 15 observations for each service in any given facility. In order to achieve the target number of observations, the total number of expected clients was divided by five to derive the "N^{th}" interval for selecting the next client to be observed. For example, if a total of 15 clients were expected for a provider, 15/5 yielded the interval of three between clients seen by the provider in order to observe the maximum of five clients for that provider. Thus, every third client was observed. In practice, at some facilities, interviewers observed fewer clients than were eligible for observation. This occurred primarily where multiple services were being offered to clients at the same time in different locations in the facility.

Any family planning or ANC client who was also assessed by the provider for STI symptoms was observed both for elements related to STI services and elements related to either family planning or ANC, whichever was relevant. Interviewers attempted to conduct an exit interview with all observed clients or caretakers of observed sick children before they left the facility.

When several eligible ANC or family planning clients were waiting, interviewers tried to select two new clients for every follow-up client. The day's caseload and the logistics of organising observations did not always allow them to meet this objective.

Table 1.5 Distribution of observed consultations

Percent distribution and number of observed consultations for antenatal care, family planning, outpatient curative care for sick children, sexually transmitted infections, and deliveries, by type of facility, Kenya SPA 2010

Type of facility	Percent distribution of observed consultations	Number of observed consultations	
		Weighted	Unweighted
ANTENATAL CARE			
Hospital	36	510	872
Health centre	27	380	258
Maternity	1	18	53
Clinic	5	69	42
Dispensary	31	431	184
Total	100	1,409	1,409
FAMILY PLANNING			
Hospital	35	351	633
Health centre	25	251	181
Maternity	1	11	27
Clinic	9	95	46
Dispensary	30	301	123
Total	100	1,010	1,010
OUTPATIENT CURATIVE CARE FOR SICK CHILDREN			
Hospital	25	497	1,016
Health centre	19	392	353
Maternity	1	15	63
Clinic	8	163	123
Dispensary	47	949	461
Total	100	2,016	2,016
SEXUALLY TRANSMITTED INFECTIONS			
Hospital	27	44	120
Health centre	11	18	13
Maternity	2	4	6
Clinic	13	22	9
Dispensary	47	76	16
Total	100	164	164
DELIVERIES			
Hospital	83	521	577
Health centre	11	67	24
Maternity	4	28	23
Clinic	0	0	0
Dispensary	2	10	2
Total	100	626	626

[1] Stand-alone VCT facilities do not show up in this table because they do not provide any of the services observed as part of the survey and therefore are not eligible for inclusion.

For child health consultations, only children younger than five years of age who presented with an illness (rather than an injury or a skin or eye infection exclusively) were selected for observation.

Table 1.5 gives the weighted percent distribution of observed consultations as well as the weighted and unweighted numbers of observed clients, by service and facility type. Details on the characteristics of these clients are presented in the relevant chapters of this report.

The observations were weighted using facility weights to adjust for overrepresentation of facilities—and, thus, of observations—in the sample. In a few cases the clients present on the day of the survey might not be representative of the clients who normally receive the service being assessed.[3]

[3] For example, if the survey coincided with a special event, such as a health fair, or a specific campaign.

Tables A-1.4 through A-1.7 describe other aspects of service delivery, including the size of the facilities' catchment population (Table A-1.4) and the median number of staff assigned to facilities and present on the day of the survey, by provider and facility type (Tables A-1.5.1 and A-1.5.2). Tables A-1.6.1 and A-1.6.2 report the percentage of interviewed staff who provide counselling related to HIV/AIDS testing and have received training on that topic, and Table A-1.7 shows the median number of years of basic education and technical training (or qualification) reported by the interviewed providers.

1.5 SURVEY IMPLEMENTATION

1.5.1 Data Collection Instruments

The 2010 KSPA survey instruments were based on generic questionnaires developed by the MEASURE DHS project and were adapted for Kenya health services after consulting with technical specialists from MOPHS, MOMS, NGOs, and other key stakeholders knowledgeable about the health services and service programme priorities covered by the KSPA.

The survey instruments were pre-tested from 27th October to 13th November 2009. A total of 16 research assistants participated in the pre-test training. The research assistants consisted of eight health workers drawn from public, private, and faith-based health facilities and eight social scientists. All the research assistants were competitively recruited and underwent an intensive training session in Nakuru on the application of the questionnaires prior to pre-test. During the pre-test period data collection practice was conducted in nine facilities in Nakuru district. The nine facilities involved were not included in the main sample. The questionnaires were then finalised for main fieldwork and data collection.

1.5.2 Training and Supervision of Data Collectors

Data collectors were primarily recruited from among health workers (nurses and clinical officers) and from among social scientists experienced in survey implementation and interviewing. The main training for the 2010 KSPA took place in Nakuru in two phases. The first phase of the training took place from 30th November to 12th December 2009, while the second phase took place from 13th to 20th January 2010. NCAPD recruited a total of 78 research assistants for the survey. These were joined by another 10 research assistants who were recruited through Jhpiego specifically to collect data on deliveries. The 10 research assistants from Jhpiego and 10 others from the 78 recruited by NCAPD underwent special training in Nakuru between 5th and 10th January 2010 on the observation of deliveries. A consultant from ICF Macro and a team from NCAPD, MOPHS, MOMS, and KNBS conducted the training.

During the main training 16 teams were constituted from 88 research assistants. Each team consisted of a team leader, two to four interviewers (health workers), and at least one social scientist. A vehicle and a driver were allocated to each team. The 20 health workers who had received special training on observation of deliveries were paired, and each pair was assigned to one or two teams.

There were three levels of supervision: central level, provincial level, and team level. At the central level officers from NCAPD, MOPHS, MOMS, and KNBS regularly visited the teams to review their work and monitor data quality. In addition to this, there were officers who were assigned the roles of provincial coordinators and team coordinators. The team coordinators were each attached to one team and had the responsibility of making the necessary appointments for the teams with the health facilities to be visited and for making appointments for the community component.

1.5.3 Data Collection

Data collection commenced on 21st January 2010 and ended on 18th May 2010. The team leader had the responsibility of checking all administered questionnaires before leaving each facility. Each team was given a list of facilities to visit, giving the facilities' names, types, and locations. The

team coordinator made arrangements with the management of the facilities to be visited next at least one day before the visits so that managers could prepare to receive the interviewers.

On average, data collection took one day per facility. Every effort was made for teams to visit facilities on days when services being assessed would be offered. Whenever any of the services of interest was not being offered on the day of the visit, the teams returned on a day when the service would be offered to observe and interview the clients who came on that day. If, however, the service was offered on the day of the visit but no clients came, the teams did not revisit the facility.

Each interviewer ensured that the respondent for each component of the facility inventory was the most knowledgeable person for the particular service or system component being assessed. Informed consent was obtained from the facility in-charge, from all respondents for the facility inventory questionnaires, and from observed and interviewed providers and clients. Where required by the questionnaires, the research assistant indicated whether a specific item being assessed was observed, reported to be available but not observed, not available, or it was uncertain whether the item was available. Equipment, supplies, and resources for specific services were recorded as available only if they were in the relevant service delivery area or in an immediately adjacent room.

Through periodic field visits and spot checks, NCAPD, MOPHS, MOMS, and KNBS officers ensured quality control. Field-check tables generated by the data entry programme were also used to check the quality of the collected data, and, where necessary, NCAPD staff communicated with team leaders and sorted out any emerging problems.

1.5.4 Data Management and Report Writing

Data management and analysis were carried out as follows:

- **Management of questionnaires in the field.** After completing data collection in each facility, the interviewers reviewed the questionnaires before handing them over to the team leader, who reviewed them a second time. The questionnaires were then passed on to the team coordinators, who sent them to NCAPD headquarters by courier services.

- **Data sorting and editing at headquarters.** Once the questionnaires from each facility arrived at headquarters, they were sorted to ensure that they were in the correct order and none was missing. The office editor then edited to eliminate any mistakes that would prevent the computer from accepting information during data entry. In cases where there was a problem with the questionnaires from a facility, the data collection team was consulted so that the problem could be rectified. In some extreme cases the facility questionnaire could be returned to the team to check on the data.

- **Data entry.** Ten data operators entered the data under the supervision of one data entry supervisor and one NCAPD staff member. A data entry programme developed by ICF Macro using CSPro software was used for data entry. All questionnaires were entered twice (100 percent verification) to ensure that the data had been accurately keyed in. Data entry took place from January through May 2010. All ‘other’ responses were reviewed by NCAPD, MOMS, and MOPHS staff and recoded into categories relevant for data analysis.

- **Data processing.** The design of the tabulation plan and the preparation of the programmes for producing statistical tables were carried out from April through June 2010. Data analysis, including clarification of unclear information, was carried out from July through October 2010. During data analysis the analysis plan was revised on the basis of feedback from the KSPA management team.

- **Development of the final report.** The final report was written with input from staff of NCAPD, KNBS, MOMS, MOPHS, National AIDS/STD Control Programme (NASCOP) and National AIDS Control Council (NACC). ICF Macro provided technical oversight.

1.5.5 Data Analysis

The following conventions were observed during the analysis of the KSPA data:

- **Availability of items.** Unless specifically indicated, the 2010 KSPA considered only observed items to be available. Items that were reported as being available but were not observed or seen by the interviewers were not considered available.

- **Observations.** Many facilities provide routine services for clients, such as taking blood pressure, separately from the actual consultations, and there is often an interval between these events and the time when the primary provider assesses the client. It is not always logistically possible to follow a client through the entire system, so whenever these services were observed being provided outside the consultation room on the day of the survey, the observed client was assumed to have received these services. Where this system is used, multiple providers contribute to the services received by each client. The provider who ultimately diagnosed and prescribed was defined as the primary provider.

  Observers used a checklist to assess whether a practice occurred or a piece of information was shared between the provider and the client. They did not attempt to verify whether the practice was correct or if the information shared was correct or complete.

- **Provider information.** Frequently, providers indicated that they 'personally provided' a service that the facility did not offer. It may be that providers were referring to services that they provide outside the facility. For the 2010 KSPA only providers that offer the service in the particular facility where he or she was found during the survey were included in the analysis for that service.

- **Development of summary indicators.** Aggregating the data into summary indicators makes it possible to analyse many pieces of information and to see how they relate to the overall capacity to provide services. It also enables analysts to monitor changes in a facility's capacity to provide services and in its adherence to standards, because there may be improvements in some items but not in others. There are not yet generally accepted summary indicators of the health information collected in the KSPA. The summary indicators presented in this report represent an initial phase in the process of defining useful health information aggregates. They will be refined as users provide feedback on which summary indicators are most useful to policy-makers and programme implementers.

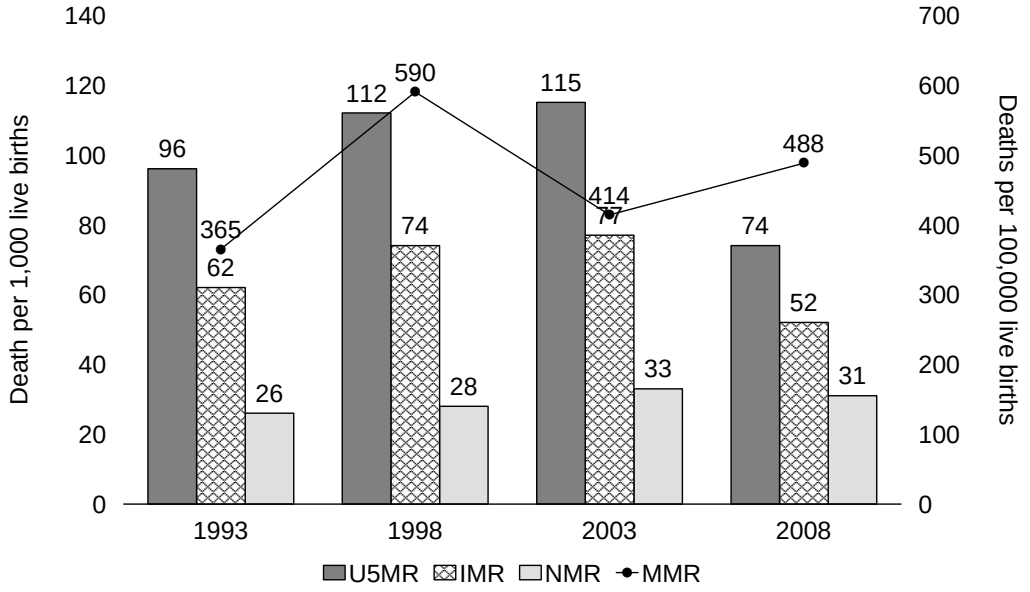
OVERVIEW OF THE HEALTH SYSTEM IN KENYA 2

Samuel Were, Paul Kizito, Catherine Ndei

2.1 HEALTH STATUS IN KENYA

A review of the health situation in Kenya shows that the health status of the people has improved only marginally in the past decades and, according to some indicators, has worsened (MOMS, MOPHS, 2010). Life expectancy in Kenya declined from 54.7 years in 1999 to 53 years in 2006. Other health impact indicators suggest stagnation and worsening of the health situation in the long term but with some signs of improvement at the end of the policy period (2010) for specific age cohorts (Figure 2.1). Currently, life expectancy at birth averages 57 years, with females living slightly longer (57 years) than males (56 years) (PRB, 2010).

Figure 2.1 **Trends in Health Impact Indicators during the Period of the Policy Review**



Source: Respective Demographic and Health Surveys KSPA 2010

Geographical and gender differences in age-specific health indicators persist. Further, many different conditions contribute to early death and widespread illness (Luoma et al., 2010). HIV/AIDS is by far the biggest problem, responsible for up to 29 percent of all deaths and 24 percent of all disabilities in the country. Other causes of death include conditions during and just after birth (9 percent of deaths), respiratory (chest) infections including tuberculosis (14 percent of deaths), diarrhoeal diseases (6 percent), malaria (5.8 percent), stroke (3.3 percent), heart attack (2.8 percent), road traffic accidents (1.9 percent), and violence (1.6 percent).

As these numbers indicate, Kenya, like other developing countries, is seeing the emergence of a "double burden of disease" because of changing lifestyles and the aging of the population. While communicable diseases remain common, there is also a growing incidence of non-communicable diseases—such as heart disease, diabetes, cancer, and mental illness—and medical conditions resulting from trauma and accidents.

Many interventions have been introduced, particularly since 2004, to address the high burden of communicable diseases. Investments have been made in HIV care, malaria, tuberculosis control, and maternal and child health. In addition, investments in changing behavioural risk factors, such as tobacco and alcohol use, are receiving high priority. These investments are complemented by investments in other health-related sectors, such as nutrition, access to safe water, education, and roads, among others, to contribute to the overall improvement in health.

Despite the high disease burden, recently there have been various notable improvements in some health indicators as well as accelerated economic growth just prior to the 2007 presidential elections. The infant mortality rate declined from 77 deaths per 1,000 live births in the period 1998-2003 to 52 per 1,000 in the period 2004-2008, while under-five mortality fell from 115 per 1,000 to 74 per 1,000 between these same periods (KNBS and Macro International, 2009). Children's nutrition also has improved. According to the latest KDHS (2008-09), the prevalence of exclusive breastfeeding among children under six months of age increased from 13 to 32 percent between 2003 and 2009. The prevalence of underweight children, however, remained the same, at 20 percent. Vitamin A supplementation decreased slightly, from 33 percent to 30 percent.

The maternal mortality ratio (MMR) is still high. In fact, it increased from 414 to 488 maternal deaths per 100,000 live births between the last two KDHS surveys (2003 and 2008-09) (KNBS and Macro International, 2009). High fertility, the high incidence of infectious diseases, poverty, and poor access to health services for pregnant women all contribute to high levels of maternal mortality.

2.2 Enabling Policies and Strategies to Improve Health Status

In the 1970s Kenya adopted the Primary Health Care (PHC) Strategy as the main approach to service delivery. The strategy emphasises disease prevention (immunisation), management of common diseases (malaria, pneumonia, diarrhoea, HIV/AIDS), health education and promotion, and rehabilitation of people with disabilities. The government has consistently focused its development strategies on combating ignorance, disease, and poverty. Investing in health is recognised as central to improving the quality of life, but the government faces socio-economic challenges in strengthening the country's health services. In response, the government has adopted the following seven enabling policies and strategies, which include commitments at both the national and international levels.

2.2.1 Kenya Vision 2030

The main objective of Kenya Vision 2030 is to transform Kenya into 'a newly industrializing, middle income country providing a high quality of life to all its citizens in a clean and secure environment' by the year 2030 (GoK, 2007). The ministries of health are expected to contribute to achieving this goal by working towards providing an efficient and high-quality health care system, meeting the best standards.

2.2.2 Poverty Reduction Strategy

In 1999 the government of Kenya put in place the National Poverty Eradication Plan (NPEP), which was aimed at reducing poverty in Kenya over the 1999 to 2010 period. One of the main areas identified to contribute to poverty reduction was health care. This focus on health supported the promotion and protection of good health as a basic human right that is essential to human welfare. A healthy workforce is a prerequisite to sustained economic and social development, whereas a high burden of disease significantly constrains economic development. The focus of the plan was to ensure the actualisation of the strategies and targets set out in the National Health Policy Framework (1994-2010) and the first National Health Sector Strategic Plan.

The NPEP was first implemented through the Interim Poverty Reduction Strategy Paper (2000-2003) and later through the Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC). The Kenya Household and Budget Survey was implemented during the period 2005-06.

This survey found that efforts to reduce poverty had yielded good results: The poverty level had declined from 57 percent in the late 1990s to 46 percent in 2005-06.

2.2.3 Millennium Development Goals

As part of the international agreement on the Millennium Development Goals (MDGs), the government of Kenya is committed to reducing child mortality by two-thirds and maternal mortality by three-fourths between 1990 and 2015. It is also committed to combating HIV/AIDS, malaria, and other diseases. Despite the improvements achieved by the country towards meeting the MDG targets, much more remains to be done before 2015.

2.2.4 National Health Policy

In 1994 the Ministry of Health produced Kenya's Health Policy Framework (KHPF), the government's blueprint for future development in the health sector. This policy document is based on a comprehensive situation analysis of the various factors affecting the health sector and addresses broadly the agenda for policy reform. The aim of the policy framework was to ensure that the health status of the Kenyan population improved. It set out the policy agenda for the health sector up to the year 2010. This included strengthening the central public policy of the ministries of health, adoption of an explicit strategy to reduce the burden of disease, and definition of a cost-effective essential care package. To operationalise this Health Policy Framework paper, the first and second National Health Sector Strategic Plans (NHSSP I (1999-2004) and NHSSP II (2005-2010)) were developed and implemented. Furthermore, before each financial year an Annual Operation Plan (AOP) is prepared.

2.2.5 National Health Sector Strategic Plan

The primary purposes of the National Health Sector Strategic Plan II (NHSSP-II) for 2005-2010 were to reduce the inequalities in health care and reverse the downward trend in health-related impact and outcome indicators. A thorough review of the experiences with Kenya's Health Policy Framework 1994-2010 and the efforts to implement NHSSP I yielded the basic design principles that guided the development of this second strategic plan. Under this plan, service delivery places human capital development and the human rights approach squarely at the core of its interventions.

Moreover, NHSSP II shifts the emphasis from decreasing the burden of disease to promoting healthy life styles of individuals and community health. It does this by introducing the Kenya Essential Package for Health (KEPH). Under the KEPH, nearly all health programmes centre on six phases of human development, and in this way complement each other, so that synergy and mutual reinforcement among the programmes can be achieved.

The six life phases are:

1. pregnancy and newborn
2. early childhood (two weeks to five years)
3. late childhood (6 to 12 years)
4. youth and adolescence (13 to 24 years)
5. adulthood (25 to 59 years)
6. elderly (60+ years)

The KEPH envisions the provision of comprehensive, integrated curative and preventive health services, available at the first point of contact and accessible to all. The existing vertical programmes will come together to provide services to the various age groups. Increasingly, they will cooperate and eventually merge into a common set of interventions, each set directed at the various age cohorts at the level of care that they provide. Once all programmes jointly focus on a phase in human development, their combined outputs are expected to be better than each one could have achieved individually. The Annual Operation Plans (AOPs) detail how the KEPH will be implemented.

All services included in the KEPH (primary health, etc.) function through a single delivery point. However, several programmes run vertically to the primary health programming (TB, malaria, and HIV/AIDS other than prevention of mother-to-child transmission (PMTCT); these are planned for and implemented outside of the primary health structures.

Six levels of service delivery

The KEPH approach also defines six service delivery levels, as illustrated in Figure 2.2. The government-run health care system comprises the following levels of facilities: tertiary hospitals (level 6); secondary hospitals (level 5); primary hospitals (level 4); health centres, maternities, nursing homes (level 3); dispensaries, clinics (level 2); and community, i.e., villages/households/individuals (level 1). The levels have different responsibilities:

- Level 1, the community level, is the foundation of the service delivery priorities, because it allows the community to define its own priorities so as to develop ownership and commitment to health services. Communities are empowered with information and skills. Only in this way can real change towards healthy life styles be achieved.

- Levels 2 and 3, which are, respectively, the dispensaries and clinics and the health centres, maternities, and maternity/nursing homes, handle primarily promotive and preventive care but also some curative services.

- Levels 4 through 6 are the primary, secondary, and tertiary hospitals, which focus mainly on the curative and rehabilitative aspects of the service delivery package.

The referral system among these levels depends on where the skills that are required to address a client's problems are available.

Figure 2.2 **Levels of Care Defined in the Kenya Essential Package for Health**

2.2.6 Public Service Reform Strategy

All public service reform initiatives and programmes are to ensure that the objectives of the Economic Recovery Strategy for Wealth and Employment Creation (2003-07) are achieved and in the process the country progressively achieves the MDGs.

The Public Service Reform Strategy (PSRS) aims to ensure that Kenya has an efficient and effective public service that functions ethically, is focused on the citizen, and is results-oriented. In support of these aims, a human resource management (HRM) strategy has been put in place to introduce value-driven, competency-based HRM practices, as well as to resolve wage-bill issues. Performance appraisal has just been introduced throughout the health workforce in support of HRM reforms.

2.2.7 Health Sector Reform

The underlying vision for health development and reforms in Kenya, as detailed in the Kenya Health Policy Framework (1994-2010), outlines reforms aimed at four key areas: sustainable, accessible, and affordable quality health care; resource mobilisation; participation and collaboration with other actors; and the regulatory role of the government. Under the policy the ministries of health would play mainly a regulatory and steering role, with authority delegated to the provinces and the districts. The National Health Sector Strategic Plan 1999-2004, and later NHSSP-II (2005-2010), strongly re-enforced the intent of these reforms.

The significant change of government in January 2003 ushered in a new era of policy-making in Kenya. In July 2004 a new policy for user fees at primary health care facilities was declared. The policy declaration stated that all services rendered (including diagnosis, laboratory tests, and pharmaceuticals) would cost only KSh 10 at the dispensary level (the lowest level of health care in Kenya) and KSh 20 at the health centre (the second level of health facilities).

The latest and most controversial reform to be introduced was the plan for a radical transformation of the National Hospital Insurance Fund (NHIF) into a mandatory National Social Health Insurance Fund (NSHIF). Contained in a task force report—the National Social Health Insurance Strategy (NSHIS) (February 2003), a Sessional Paper (August 2003), and a bill of law for Parliamentary debate (May 2004), the policy proposes replacing the current cost-sharing scheme with a prepaid insurance scheme. The insurance reform has, however, not been implemented due to policy handicaps.

2.3 The Health Care System

2.3.1 Introduction

As noted, Kenya's current health care systems are anchored on the Health Sector Policy Framework of 1994 and the subsequent National Health Sector Strategic Plans 1999-2004 and 2005-2010. These documents form the foundation of the health sector reform programmes and have guided their ongoing implementation. The introduction of the sector-wide approach (SWAp) to health planning and funding has gone a long way toward bringing together all the players in the sector in the spirit of public-private partnership. Also, as part of the reforms the introduction of the KEPH system has enhanced collaboration among the existing essential service packages and promoted a shift of focus from reducing the burden of disease to the promotion of healthy lifestyles of individuals and communities. In this respect the establishment of the six life-cycle cohorts and the classification of heath facilities into six levels of service delivery are important aspects of the KEPH system.

2.3.2 Kenya Health Services

Services at the provincial and district levels: As a result of health sector reforms that have decentralised health care, services are increasingly integrated at the national, provincial, and district levels. Under decentralisation the district handles supervisory responsibilities. Unfortunately, supervision has not been very effective, as one technical person may have to supervise several technical areas of service delivery at lower levels.

Structure of service delivery: The Provincial Health Management Team (PHMT) provides supervision and management support to the districts and sub-districts within the province.

At the district level district hospitals and mission hospitals provide curative services. The District Health Management Team (DHMT) and Public Health Unit of the district hospital manage public health services. The DHMT and District Health Management Board (DHMB) provide management and supervision support to rural health facilities (sub-district hospitals, health centres, and dispensaries).

At the sub-district level, health centres provide both preventive and curative services, as do dispensaries and community outreach services within the catchment areas. With the introduction of the community package, basic preventive and curative services for minor ailments are addressed at the community and household level.

Non-governmental organisations, faith-based organisations, and the private sector: Several health-oriented non-governmental organisations (NGOs) operate throughout the country. The population covered by these NGO health services cannot be easily determined, however. The ministries of health and external donors support the health services offered by NGOs and the private sector in several ways. Depending on their comparative advantage, NGOs, faith-based organisations (FBOs), and community-based organisations (CBOs) offer specific health services. The ministries of health provide support to mission health facilities by training their staff as well as seconding staff members to these facilities and providing drugs and vaccines.

Currently, the private sector (both for-profit and not-for-profit) contributes over 40 percent of health services in the country, providing mainly curative health services but very few preventive services.

Modalities exist for ministry of health supervision and monitoring of NGO, FBO, and other private-sector facilities. The NGOs and private facilities work with communities in collaboration with the DHMT. The community programmes report to the DHMBs, which in turn report to headquarters through the Provincial Health Management Boards. Their activities are guided by MOH standards and protocols.

Health facilities

The quality of health service delivery is influenced by the quality of the service delivery environment—specifically, the availability of adequate and serviceable facilities. The numbers of health facilities have grown significantly, from 6,190 in 2008 to 6,696 in 2009—an increase of 8.2 percent. Most of these health facilities continue to be financed through the Constituency Development Fund (CDF). These are annual budgetary allocations by central government to each parliamentary jurisdiction. The priorities for implementation of projects and programmes are identified by the constituents under the leadership of the member of parliament.

Table 2.1 gives a breakdown of health care facilities by management type. For more information on facilities, see sections 2.4.2 Hospitals and 2.4.3 District Health System.

Table 2.1 Service delivery system: Health facilities

		Private				
Type of service	Public	For profit	Not for profit	Faith-based organisation	Total private	Total
Tertiary hospitals (level 6)	4	0	0	0	0	4
Secondary hospitals (level 5)	10	0	0	0	0	10
Primary hospitals (level 4)	225	12	5	23	40	265
Other hospitals (level 4)	22	41	59	52	152	174
Health centres (level 3)	473	21	88	139	248	721
Nursing homes (level 3)	3	89	54	9	152	155
Dispensaries (level 2)	2,393	74	380	509	963	3,356
Clinics (level 2)	20	1,126	693	102	1,921	1,941
Laboratory—stand-alone	0	52	2	0	54	4
Dental clinics	0	10	1	0	11	11

Source: Ministry of Medical Services and Ministry of Public Health and Sanitation, 2010

2.3.3 Government Stewardship

Following the formation of the coalition government in 2008, the Ministry of Health was split into two separate ministries, the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS). The government of Kenya, through the two ministries of health, provides leadership for the entire process of health policy development. Their main functions include coordination of development plans, development of policy, development of investment plans, and monitoring implementation of the plans.

Various mechanisms facilitate the participation of faith-based organisations (FBOs) and civil society organisations in setting the health policy agenda in Kenya, including the Kenya Health Sector-Wide Approach to Planning (SWAp) and the Joint Programme of Work and Funding (JPWF).

Through the planning process the health ministries have tried to eliminate bias and inequality in service delivery. The current NHSSP II has as its goals the reduction of inequalities in health care services and reversing the downward trend in health-related outcome indicators. These goals are further articulated as the highest priority strategy in the Annual Operation Plan (AOP) 2009/10.

2.4 Organisation of the Health Care System

2.4.1 The Health Ministries

The two ministries have developed separate ministerial strategic plans, with pre-designed planning formats, in addition to the existing National Health Sector Strategic Plan.

Under the country's new decentralisation strategy, districts are responsible for delivering health services and implementing health programmes. They are considered to be the central element of the public health system (Wamai, 2009). At the provincial level management responsibilities are split between the Provincial Health Management Team (PHMT), a part of the MOPHS, and the Provincial Medical Services Management Team (PMSMT), a part of the MOMS. Under the split ministry structure, the MOMS is responsible for service delivery levels 4-6 (primary, secondary, and tertiary hospitals), and the MOPHS is responsible for primary health care facilities (levels 1-3).

Ministry of Public Health and Sanitation (MOPHS)

The mandate of the MOPHS is to support the attainment of the health goals of the people of Kenya by implementing priority interventions in public health, guided by the strategic framework provided by the Medium-Term Plan 2008-2012 and the wider health sector. This ministry is central in providing leadership to ensure implementation of the public health policy objectives and targets set in the Strategy for National Transformation (SNT) 2008-2012 and the MDGs. The various roles and functions of the MOPHS are stipulated in Presidential Circular No. 1/2008. The specific roles of the MOPHS are as follows:

a. Public health and sanitation policy
b. Preventive and promotive health services
c. Community health services
d. Health education
e. Reproductive health
f. Food quality and hygiene
g. Health inspection and other public health services
h. Quarantine administration
i. Oversight of all sanitation services
j. Preventive health programme including vector control
k. National public health laboratories
l. Government Chemist
m. Dispensaries and health centres (i.e., levels 2 and 3)

n. Kenya Medical Research Institute (KEMRI)
o. Radiation Protection Board
p. Member of the Kenya Medical Supplies Agency (KEMSA) Board
q. Member of the Kenya Medical Training College (KMTC) Board

As noted, the core function of the MOPHS is to provide primary care services at the first three levels of the health care system—the community, dispensary, and health centre—as outlined in Table 2.2.

Table 2.2 Primary care services of the Ministry of Public Health and Sanitation at the different levels of the health care system

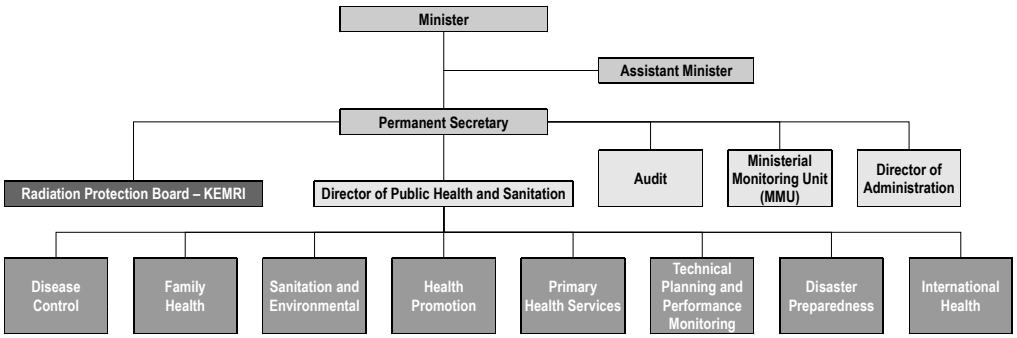
Level 1	Levels 2 and 3
• Reproductive health – Community midwifery – Family planning	• Maternal health care – Antenatal care – Delivery care – Postnatal care – Family planning
• Child health – Community nutrition	• Child health care – Immunisation – Growth monitoring
• Basic health care – Treatment of common ailments – Referral – Home-based care	• Basic health care/treatment of minor ailments
• TB/HIV/malaria – Follow-up/defaulters – Case management	• HIV/AIDS/TB, including voluntary counselling and testing, ART, and PMTCT
• School health programme	• Malaria
• Behaviour change communication	• Environmental health – Waste management
• Environmental health – Water – Sanitation and hygiene – Food safety	• Health promotion (behaviour change communication/health education)
• Community surveillance	• Outreach
	• Surveillance

MOPHS structure at the national level

As noted, the mandate assigned to MOPHS consists of public health and sanitation policy, preventive and promotive health services, and community health services. The particular focus is on service delivery at KEPH levels 1-3. Among the specific functions are health education, reproductive health, food quality and hygiene, quarantine administration, vector control, health inspection, and other public health services. All these functions are listed in Table 2.2 and reflected in the organogram in Figure 2.3.

The Permanent Secretary has responsibility for oversight of the overall operations of the ministry. In executing these functions, he receives support from the Director of Public Health and Sanitation, the Director of Administration, the Principal Accounts Controller, the Chief Finance Officer, and the Director of Human Resources. The Audit Department and the Ministerial Monitoring Unit provide additional support, through their respective mandates, to the Permanent Secretary.

Figure 2.3 **MOPHS Structure at the National Level**



The office of the Director of Public Health and Sanitation (DPHS) is responsible for the technical operations of the ministry. Eight departments provide support to and are directly under the supervision of the DPHS.

Ministry of Medical Services (MOMS)

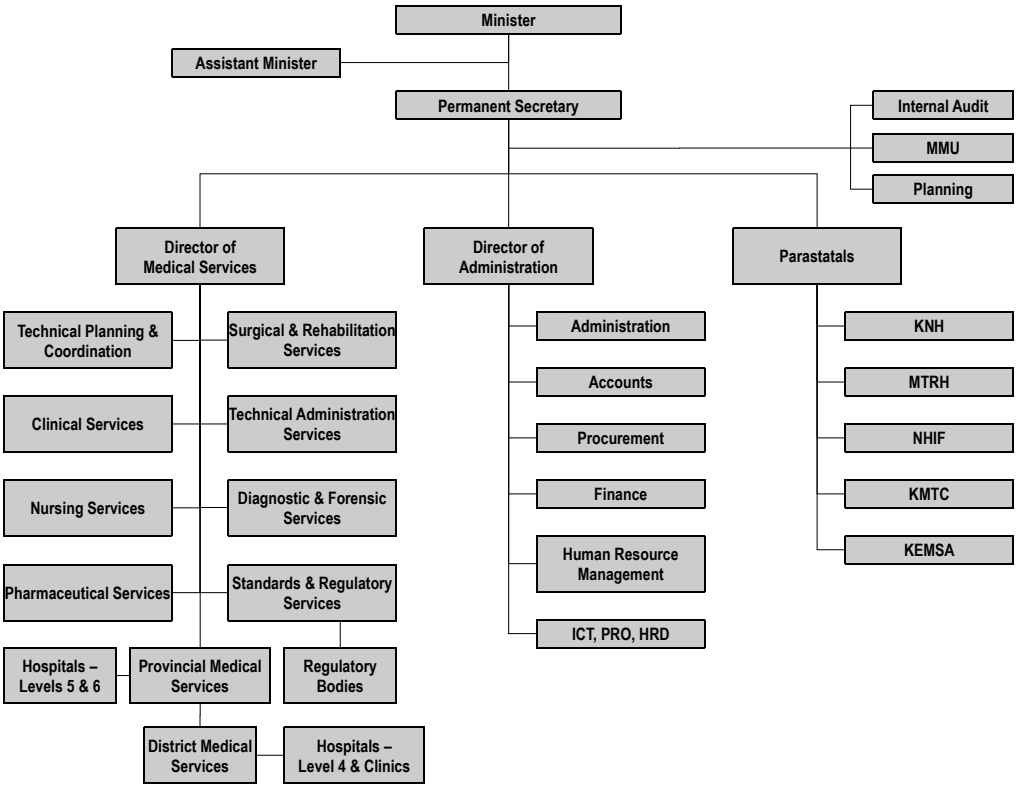
The functions of the Ministry of Medical Services (MOMS) relate to managing the implications of ill health and paying special attention to the social context of disease and health. They complement public health interventions by ensuring that essential medical care is made available where needed, when needed, and in appropriate amounts. The aim is to improve lives by responding to the legitimate medical needs of the population of Kenya. The central leadership role of the MOMS is to ensure that medical services are provided that contribute to the attainment of the medium-term development goals as outlined in NHSSP II and the First Medium-Term Plan (MTP) 2008-2012. The functions of the MOMS are derived from its core mandate, as defined in Presidential Circular No. 1/2008. The ministry's core functions are as follows:

a. Medical services policy
b. Curative services
c. HIV/AIDS and other sexually transmitted infections (STI) treatment and management
d. Maternal services
e. Rural medical services
f. Clinics and hospitals
g. Registration of doctors and paramedics
h. Nurses and midwives
i. National Hospital Insurance Fund
j. Clinical laboratory services
k. Kenya Medical Training College (KMTC)
l. Kenya Medical Supplies Agency (KEMSA)
m. Regulatory bodies for pharmacy and medicine
n. Member of KEMRI board

Activities of the Ministry of Medical Services respond directly to two constituencies. The first is the government of Kenya, by which it is mandated to provide medical services in a manner that supports attainment of the government's first MTP and, therefore, Vision 2030. Other government functions in the health sector are assigned to other ministries.

The second main constituency is the health sector as a whole. Here, MOMS provides stewardship and coordinates delivery of medical services in a manner that supports attainment of the overall NHSSP II objectives. Figure 2.4 shows the structure of the ministry at the national level.

Figure 2.4 **Current Organisational Structure of the Ministry of Medical Services**



Key: MMU = Ministerial Monitoring Unit; KNH = Kenyatta National Hospital; MTRH = Moi Teaching and Referral Hospital; NHIF = National Hospital Insurance Fund; KMTC = Kenya Medical Training College; KEMSA = Kenya Medical Supply Agency; ICT = Information and communication technology; PRO = Public Relations Office; HRD = Human resources development

The health ministries' linkages within government and the health sector

In the reorganisation of government, the MOPHS and the MOMS are grouped together with the ministries of Medical Services, Education, and Labour in the Human Resource Development sector. It is through the human resource cluster that the health ministries plan, budget, and obtain their resources.

In addition, the health ministries interact with other ministries outside the human resource sector, especially central ministries and departments (Finance, Vision 2030, Public Services, and Audit), as well as Parliament, on policy development, strategic planning, resource mobilisation and management, and monitoring and evaluation. Figure 2.5 shows the position of the health ministries in the national planning structure. Figure 2.6 depicts the linkages between the MOPHS, the MOMS, and other government ministries, departments, and agencies. Both health ministries provide stewardship to the health sector's development and implementing partners.

Figure 2.5 **Linkages between Government-Specific and Health Sector Planning Processes, Kenya Ministry of Medical Services**

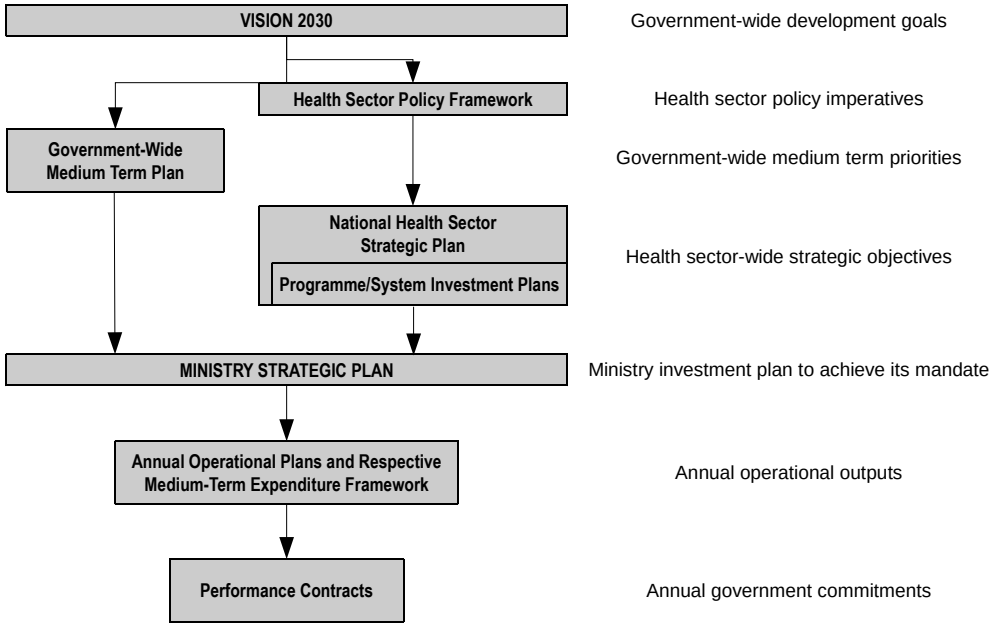
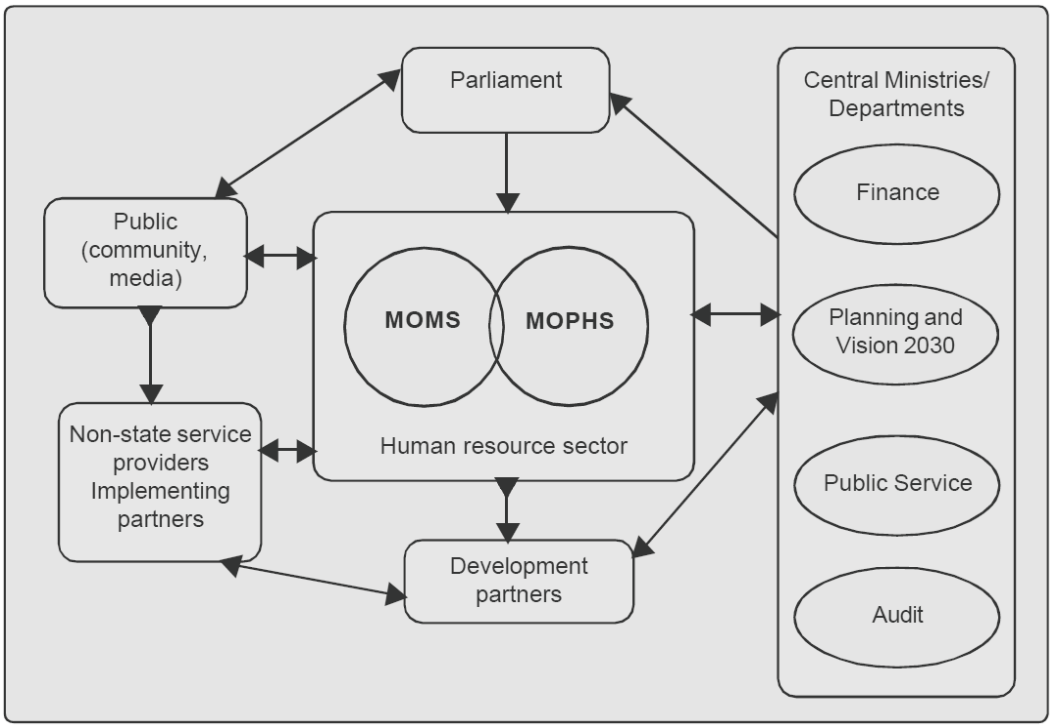


Figure 2.6 **Linkages of MOPHS, MOMS, Other Government Ministries/Agencies, and Other Health Sector Stakeholders**



National-level institutions

Six parastatal organisations operate under MOMS and MOPHS. All are semi-autonomous institutions (state corporations), each governed by a board of management. The broad mandate of the six parastatals is to facilitate, augment, and enable good quality service delivery by both the MOMS and the MOPHS. This mandate is achieved through training, research, offering technical logistical support, and setting standards to be followed in service delivery. The six parastatals are the Kenya Medical Supply Agency (KEMSA), the Kenya Medical Research Institute (KEMRI), the National Hospital Insurance Fund (NHIF), the Kenyatta National Hospital (KNH), the Moi Teaching and Referral Hospital (MTRH), and the Kenya Medical Training College (KMTC).

2.4.2 Hospitals

Hospitals represent the top end of a continuum of care, providing referral services for both clinical and public health conditions to the district health services. They play an important complementary role to primary care and constitute an important and integral part of the national health system.

Hospital structure

In Kenya hospital services are provided by public, private not-for-profit, private for-profit, and faith-based institutions. The degree of specialisation varies among hospitals. Public hospitals are divided into three groups, according to the level of services available and their responsibilities: primary hospitals (e.g., district hospitals), secondary hospitals (e.g., provincial hospitals), and tertiary hospitals (referral hospitals).

Primary hospitals

These hospitals provide preventive, promotive, outpatient curative, maternity, inpatient, emergency surgery, blood transfusion, laboratory, and other general services. They also provide in-service training, consultative services, and research in support of community-based health care programmes.

Secondary hospitals

These hospitals act as referral hospitals to their primary or district hospitals and provide specialised care. The provincial-level hospitals act as an intermediary between the national central level and the districts. They oversee the implementation of health policy at the district level, maintain quality standards, and coordinate and control all district health activities. Referral hospitals at the provincial level include the Aga Khan hospitals in Kisumu and Mombasa.

Tertiary hospitals, or national referral hospitals

These are at the apex of the health care system, providing sophisticated diagnostic, therapeutic, and rehabilitative services. The two national referral and teaching hospitals are Kenyatta National Hospital in Nairobi and Moi Teaching and Referral Hospital in Eldoret. Their private-sector equivalents are the Nairobi Hospital and the Aga Khan Hospital in Nairobi.

Hospital governance and management

As noted, at the provincial level management responsibilities are split between the Provincial Health Management Team (PHMT), part of the MOPHS, and the Provincial Medical Services Management Team (PMSMT), part of the MOMS. The MOMS is responsible for service delivery levels 4-6, and the MOPHS is responsible for levels 1-3. The PHMT is headed by the Provincial Director of Public Health and Sanitation. In line with the scope of the MOPHS mandate, all primary health services fall within the core functions of the PHMT and its subsidiary District Health

Management Teams (DHMTs). By comparison, the PMSMT is housed at the provincial general hospital of the province and is headed by the Provincial Director of Medical Services. The PMSMT focuses on curative services, provided under the MOMS (generally levels 4-6). MOMS personnel include medical services officers, health records officers, nursing officers, pharmacists, and health administration officers at both provincial and district levels.

2.4.3 District Health System

Kenya's health management system consists of eight administrative provinces, divided into districts. As noted, under the country's new decentralisation strategy, districts are responsible for delivering health services and implementing health programmes; they are considered to be the central element of the public health system. The district level concentrates on the delivery of health care services. These facilities generate their own expenditure plans and budget requirements, based on guidelines from headquarters transmitted through the provinces.

District health teams

Management of health care at the district level is headed by a District Medical Officer of Health (DMOH). The DMOH receives support from a District Health Management Board (DHMB), comprising officials appointed by the Ministries of Health and from local areas, and from a professional unit, the District Health Management Team (DHMT). The DHMT prepares technical advisories and the District Health Plan in consultation with local health actors and the DHMB.

Health sub-district

District and sub-district, or primary, hospitals offer referrals and guidance to the health centres. At the same time, they concentrate on the core functions required of their level, which include curative and rehabilitative activities.

Health centres

Health centres focus their attention on preventive and curative services, mostly adapted to local needs. They also offer ambulatory services to the communities.

Health centres have on staff registered clinical officers, registered community health nurses, laboratory technicians, and pharmaceutical technologists.

Dispensaries

Dispensaries are meant to be the first line of contact with the community. This function is shared by the health centres. The dispensaries provide a broad spectrum of preventive health services, which is critical to achieving the health sector reform focus on individual life-style and the community. They also offer basic curative services. Dispensaries are staffed with enrolled community nurses and community health extension workers.

Village Health Committees

The community level, comprising villages, households, and individuals, is the foundation of service delivery priorities in the new arrangements of the KEPH system of health care delivery. Village Health Committees are expected to be forums through which individuals and households can participate and contribute to their own health and that of the community. The main focus areas of community health services include health promotion, disease prevention, care-seeking and compliance with treatment and advice, governance and management of health services, and claiming of rights.

2.5 Human Resource Staffing

Successful implementation of the NHSSP II depends on appropriately trained health workers providing services from all health facilities.

Table 2.3 presents the numbers of registered medical personnel and those in training for the years 2008 and 2009. The total number of registered medical personnel increased by 4.7 percent between 2008 and 2009, from 76,883 in 2008 to 80,464 in 2009. With the exception of enrolled nurses and public health technicians, there was an increase in numbers of personnel in all categories of registered medical personnel. The number per 100,000 population increased slightly for registered nurses and clinical officers, to 40 and 15, respectively. The ratio decreased, however, for enrolled nurses and public health technicians, while it remained constant for other personnel. Personnel in training decreased by 17 percent, from 8,925 in 2008/09 to 7,397 in 2009/10.

Table 2.3 Number of registered medical personnel and personnel in training, 2008 and 2009

	Registered medical personnel				In training	
	2008		2009*		2008/09	2009/10*
Type of personnel	Number	Number per 100,000 population	Number	Number per 100,000 population	Number	Number
Doctors	6,623	17	6,897	17	3,172	2,437
Dentists	974	3	1,004	3	152	199
Pharmacists	2,860	7	2,921	7	339	349
Pharmaceutical technologists	1,815	5	1,950	5	509	207
BSc. Nursing	657	2	778	2	731	818
Registered nurses	14,073	37	15,948	40	1,847	1,989
Enrolled nurses	31,917	83	31,917	81	-	-
Clinical officers	5,035	13	5,888	15	1,509	1,076
Public health officers	6,960	18	7,192	18	666	322
Public health technicians	5,969	16	5,969	15	-	-
Total	76,883	203	80,464	204	8,925	7,397

Source: Ministry of Public Health and Sanitation
* Provisional.

2.6 HEALTH FINANCING

2.6.1 Introduction

Sources of financing the health sector include the government (representing the public sector budget allocation), households, private sector, donors, local foundations and others. According to the 2005/06 National Health Accounts, the total health expenditure in Kenya was equivalent to about 4.8 percent of gross domestic product (GDP) at current market prices, which translates into per capita health spending of KSh 1,987 (US$27) per year. Each source contributes about one-third of the expenditures. Households remain the largest contributors of health funds, at 35.9 percent, followed by donors (31 percent) and the government (29.3 percent).

Government expenditure on health was estimated at 6 percent of total government expenditures in 2008/09. The per capita government expenditure of US$27 falls below the targets set by the Abuja Declaration and by WHO (KNBS, 2010). According to the 2008/09 public expenditure review, the Ministries of Health continue to spend a large portion of their allocation on recurrent costs (including salaries) and on outpatient/inpatient care services (mostly in large secondary and tertiary hospitals). The two tertiary hospitals, Kenyatta and Moi, consume 16 percent of the ministries' recurrent budgets.

The health ministries' expenditures over the last five years have grown (in nominal value) from KSh 19 billion to KSh 32 billion representing an overall growth of 68 percent and an average annual growth of 18.4 percent, and exceeding the average inflation of 11.1 percent over the same

period. However, 2007/8 represented a temporary decrease, with the allocations to the health ministries declining by 27 percent and then increasing by 24 percent the following year.

2.6.2 Goal

The goal of health financing in NHSSP II is to raise sufficient financial resources to fund the plan while ensuring equity and efficiency in resource mobilisation, allocation, and utilisation during the plan period.

2.6.3 Financing Mechanisms for NHSSP-II

There are four main financial mechanisms for financing health services. These include health insurance, taxation, donor funds, and consumers' out-of-pocket spending.

2.6.4 Government Budget and Donor Budget Support

Since independence, government health care financing has come largely from tax revenue. Other strategies have been introduced over the years, however, following shortages of funds. These include cost-sharing, mandatory contribution to a health insurance scheme for salaried workers, and community financing.

The government budget allocation to the health sector—the MOMS and the MOPHS—for FY 2010/11 totalled KSh 41.5 bn, which amounts to KSh 1,064 (US$13.10) per capita. While the total government budget increased by 9.9 percent from 2009/10 to 2010/11, the proportion allocated to the health sector decreased from 7.0 percent in 2009/10 to 6.5 percent in 2010/11. The 2010/11 figure amounts to 1.5 percent of the GDP.

2.6.5 Donor Project Funding

Coordination of donors occurs at two levels: through bilateral negotiations and through individual donor participation in the Joint Inter-Agency Coordinating Committee (JICC) and the Health Sector Coordinating Committee (HSCC) and in the health sector review process. Also, donors must disclose their contributions to the health sector, whether on or off budget, during the Medium-Term Expenditure Framework (MTEF) (shadow budgeting) process and preparation of the Annual Operational Plan (AOP) to facilitate the government's identification of underfunded interventions.

In 2007 stakeholders in the health sector, including donors, signed the SWAp Code of Conduct; the overall objective of cooperation under this Code of Conduct is to ensure that ownership, alignment and partnership is taking place in line with the 2005 Paris Declaration on Aid Effectiveness. The Declaration defines the principles and commitments by which donors and developing countries intend to ensure that aid is as effective as possible in contributing to the Millennium Development Goals and other internationally agreed development objectives.

The development partner coordination structure, called Development Partners in Health Kenya (DPHK), with 15 members, reflects a significant milestone on the path towards alignment and efficient use of country systems by development partners, in line with the Paris declaration. The group communicates with the ministries directly on behalf of the development partners. It is envisioned that this approach will help to minimise the transaction costs for government in dealing with the donors and their agencies. The arrangement has improved information sharing among development partners and the ministries. During the time of the Sector Annual Review, 2009/10, documents were being made available to all donor partners and the ministries via a donor partner website, which maps donor priorities, activities, and funding in-country. In 2010, for the first time, donor commitments were reviewed as a group against expenditures.

2.6.6 Global Funding Initiatives

Social Health Insurance

The National Hospital Insurance Fund (NHIF) is mandated to facilitate access to quality and affordable health care services. NHIF collects contributions from individuals and pays hospital benefits to its members and their declared dependants. Total receipts for NHIF for the financial years 2004/05 to 2008/09 trended consistently upward. For example, receipts increased by 11.7 percent between 2007/08 to 2008/09, from KSh 4,811.3 million to KSh 5,374.0 million. Similarly, benefits accrued to members rose by 36.9 percent between 2008/08 and 2008/09, rising to KSh 2,813.0 million. However, contributions net of benefits declined by 7.1 percent, from Ksh 2,757.2 million in 2007/08 to Ksh 2,561.2 million in 2008/09.

Table 2.4 Numbers of registered members of the National Hospital Insurance Fund, 2005/06-2008/09

	Financial year			
Sector	2005/06	2006/07	2007/08	2008/09*
Formal	1,540,000	1,620,000	1,775,390	1,923,831
Informal	110,000	201,098	301,106	376,420
Total	1,650,000	1,821,098	2,076,496	2,300,251

Source: National Hospital Insurance Fund
* Provisional

The number of registered NHIF members grew by 10.8 percent, from 2,076,496 in 2007/08 to 2,300,251 in 2008/09, as shown in Table 2.4. In 2008/09 registered membership in the formal sector rose by 8.4 percent over the previous fiscal year, to 1,923,831. Membership in the informal sector rose by 25.0 percent, to 376,420. Enrolment from the informal sector, which has more than tripled since the financial year 2005/06, accounted for 16.4 percent of the total registered membership in 2008/09.

2.6.7 Community-Based Health Insurance Plans

Community-based health insurance is not yet well developed in Kenya. Since its introduction in 1999, about 32 schemes have been set up, with about 170,000 beneficiaries covered, according to 2006 data from the Kenya Community-Based Health Financing Association.

2.6.8 Exemptions from User Fees in Private Wings of Public Hospitals

Mostly due to high poverty levels, not all individuals could afford to pay the user fees introduced at the health facilities in 1989. Therefore, the government, introduced waivers and exemptions to cushion the very poor and vulnerable against the effects of user fees, which otherwise would discourage them from obtaining health services.

Health care providers are expected to absorb the cost of waivers and exemptions. Exemptions from user fees were made for specific health services including: treatment of children less than five years old, maternity services in dispensaries and health centres, TB treatment in public health facilities, and vaccinations.

2.7 General Recommendations for Future Health Sector Planning (2005-2012)

The overall thrust of planning for the future of the health sector should be to firmly address the deteriorating health status of the population. The goal should be to reduce health inequalities and to reverse the downward trend in impact and outcome indicators. These health inequalities exist between urban and rural populations and among districts and provinces. They are related to gender, education, and disability. The goal to reduce health inequalities can be achieved effectively only by involving the population itself in priority setting and consequently in the allocation of resources. This requires a fundamental change in the existing governance structures in order to enable communities to take ownership of the planning process.

Future planning needs to recognise that 'reversing the trends' cannot be achieved by the government health sector alone. Active involvement and partnership with other stakeholders in the

provision of health care is needed. A functioning health system should be established relying upon collaboration and partnership among all stakeholders whose policies and services have an impact on health outcomes.

The system should embrace sector-wide approach arrangements and increase flexibility for rapid disbursement of budgetary resources. A human resource plan will need to be developed to improve the primary health care skills of staff in the lower-level health facilities. Also, the new plan should strengthen monitoring, evaluation, and reporting systems. Additional resources should be dedicated to commodity security, especially for vaccines, reproductive health commodities, and essential drugs.

Gradually introducing the National Social Health Insurance Fund to provide universal health insurance coverage will help to reduce the current inequalities in access to health care.

FACILITY-LEVEL INFRASTRUCTURE, RESOURCES, MANAGEMENT, AND SUPPORT 3

Peter Nyakwara, Diana Kamar, Vane Lumumba, John Anampiu

3.1 BACKGROUND AND BASIC INFRASTRUCTURE

This chapter reports on resources, management, and support systems at the facility level. Although health care services can be offered under a variety of conditions, some common elements of the health system ensure their quality, acceptability, and utilisation. The first part of this chapter looks at the extent to which health care facilities in Kenya have the following resources:

- A basic package of services and staff qualified to deliver them
- Facility infrastructure to support service delivery and utilisation
- Twenty-four-hour emergency care.

The second part of the chapter considers whether the facilities have management systems in place to:

- Address management issues
- Develop staff capability through training and supervision
- Encourage community participation and mechanisms to decrease financial barriers to care.

Finally, the chapter considers whether Kenyan health care facilities provide the basic support systems so critical to the quality of services, including:

- Logistics systems to support the ongoing maintenance of equipment and infrastructure
- Medication delivery systems to ensure medicines, vaccines, and contraceptives are available when needed
- Infection control systems to ensure safe practices in the prevention of infection and illness.

3.1.1 Availability of Services and Staff

The availability of a basic package of health services, the frequency with which these services are offered, the presence of qualified staff for their delivery, and the overall ease of access to the health care system all contribute to client utilisation of services in a health facility. The Kenyan health care service delivery system comprises a network of facilities that provide both preventive and curative health services. Most hospitals and health centres are expected to offer a full range of basic services, including outpatient services for all age groups; maternal and child health care services (antenatal, delivery, and postnatal care); family planning; treatment of sexually transmitted infections (STIs); immunisation; and child growth monitoring. However, some specialised facilities (such as stand-alone VCT facilities) may not offer all services. If a facility does not offer all services, it should not be assumed that the facility is substandard. Clients may have to visit several facilities, however, to meet all of their family's basic health care needs. Table 3.1 and Figure 3.1 provide details on the availability of basic services and qualified staff. Additional information that describes the specific services available, by type of facility and province, is provided in Tables A-3.1.1 and A-3.1.2.

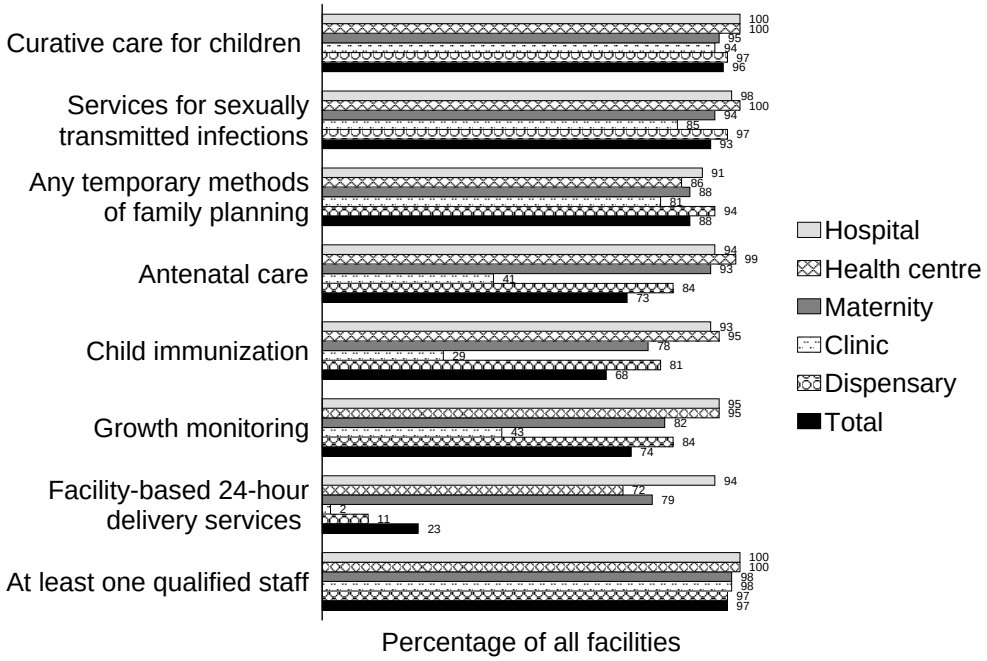
Table 3.1 Availability of basic services and qualified staff to meet client needs

Percentage of all facilities that provide basic services at or above minimum frequencies and that provide 24-hour delivery services, with qualified staff, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with: All basic services[1]	All basic services provided at or above minimum frequencies[2]	All basic services at or above minimum frequencies plus facility-based 24-hour delivery services	All basic services at or above minimum frequencies, plus facility-based 24-hour delivery services, and at least one qualified staff[3]	Number of facilities
Type of facility					
Hospital	85	82	80	80	51
Health centre	81	77	55	55	80
Maternity	69	59	58	58	17
Clinic	21	20	2	2	203
Dispensary	73	68	10	10	340
Stand-alone VCT	0	0	0	0	5
Managing authority					
Government	82	77	24	24	345
NGO	72	68	7	7	24
Private (for profit)	28	24	11	11	237
Faith-based organisation	54	54	28	28	89
Province					
Nairobi	46	41	21	21	45
Central	39	39	10	10	125
Coast	53	53	16	16	81
Eastern	57	56	16	16	118
North Eastern	61	61	39	39	24
Nyanza	85	77	36	36	83
Rift Valley	63	55	17	17	175
Western	85	78	28	28	44
Total	59	55	19	19	695

[1] Basic services include outpatient curative services for sick children and for adult sexually transmitted infections, and temporary or elective methods of family planning, antenatal care, child immunisation, and growth monitoring.
[2] The services and their defined minimum frequencies are as follows: curative care for children offered at least five days per week, STI services offered at least one day per week, and preventive or elective services (any temporary methods of family planning, antenatal care, immunisation, and growth monitoring) offered at least one day per week.
[3] In Kenya, qualified staff are specialists (surgeons, obstetricians/gynaecologists, paediatricians, physician specialists, and pathologists), medical officers, clinical officers, degree nurses (BSNs), registered nurses (RNs), registered midwives, enrolled nurses, and enrolled midwives.

Figure 3.1 Availability of Services and Staff to Meet Basic Client Needs (N=695*)



* Total includes 5 stand-alone VCT facilities. KSPA 2010

Basic services

Basic services are offered as a package by six of every ten health facilities (59 percent, including stand-alone VCT facilities) in Kenya. The services specified in Table 3.1 include outpatient curative services for sick children, services for adults with sexually transmitted infections, temporary methods of family planning, antenatal care (ANC), immunisation, and child growth monitoring. On average, the percentage of facilities that offer basic services (59 percent) is similar to the percentage of 57 percent at facilities that offered the same package of services in 2004. Offering the full package of services are the majority of maternity facilities (69 percent), dispensaries (73 percent), health centres (81 percent), and hospitals (85 percent).

Government facilities (82 percent) and NGO-managed facilities (72 percent) are more likely than faith-based and private facilities to offer the full package of basic services.

At the provincial level, facilities in North Eastern, Rift Valley, Nyanza, and Western provinces (ranging between 61 and 85 percent) are more likely to offer all basic services than facilities in other regions, particularly those in Central and Nairobi provinces (39 percent and 46 percent, respectively). Stand-alone VCT facilities are the least likely to offer any of these basic services.

The proportion of clinics that offers curative care for sick children (94 percent), STI services (85 percent) and family planning services (81 percent) are comparable to the proportions at hospitals, health centres, maternity facilities, and dispensaries that offer these services. However, clinics are much less likely to offer ANC (41 percent), child immunisation (29 percent), or child growth monitoring (43 percent) services (Tables A-3.1.1 and A-3.1.2).

Basic services at minimum frequencies

The 2010 KSPA defines services at minimum frequencies as follows: outpatient curative care services for children offered at least five days per week; STI services offered at least one day per week; and preventive or elective services (any temporary methods of family planning, ANC, child immunisations, and child growth monitoring) at least one day per week. Overall, 55 percent of all facilities provide the full range of basic services at or above minimum frequencies (see Table 3.1)

compared with 44 percent in 2004. The availability and distribution of basic services at or above minimum frequencies follows a pattern similar to that of the availability of services in general.

Basic services at minimum frequencies plus 24-hour delivery services

Only one of every five facilities (19 percent) offers the full range of services at minimum frequencies and also offers 24-hour facility-based delivery services (Table 3.1); the same proportion of facilities (19 percent) offers all of these services, and in addition, the facility has at least one qualified provider.

3.1.2 Facility Infrastructure Supportive of Quality Service and Client Utilisation

Relatively good health services can be provided even in minimal service delivery settings. However, both clients and providers are most likely to be satisfied with a facility if basic amenities and infrastructure components, such as a constant supply of clean water, a comfortable waiting area, and a clean latrine for clients, are available. These components also help staff to provide better services. Table 3.2 provides summary information on these infrastructure components by facility type, managing authority, and province. Tables A-3.2 and A-3.3 provides more details on their availability.

Table 3.2 Service and facility infrastructure

Percentage of facilities with client comfort amenities, a regular water supply onsite, and regular electricity supply, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with: All client comfort amenities[1]	Regular water supply[2]	Regular electricity supply or generator[3]	All basic client amenities, regular water supply, and regular electricity supply or generator	Number of facilities
Type of facility					
Hospital	89	58	68	38	51
Health centre	86	45	34	19	80
Maternity	81	57	55	31	17
Clinic	86	59	19	13	203
Dispensary	80	35	19	6	340
Stand-alone VCT	77	51	28	17	5
Managing authority					
Government	80	32	21	6	345
NGO	67	21	17	12	24
Private (for profit)	89	63	24	17	237
Faith-based organisation	83	59	44	24	89
Province					
Nairobi	71	60	48	26	45
Central	90	75	14	11	125
Coast	81	40	14	4	81
Eastern	79	45	24	15	118
North Eastern	76	51	21	14	24
Nyanza	85	22	33	8	83
Rift Valley	84	41	32	17	175
Western	86	23	16	3	44
Total	83	46	25	13	695

[1] The facility has a functioning client latrine, a waiting area that is protected from sun and rain, and a basic level of cleanliness; i.e., the floors are swept, and there is no obvious dirt or waste; counters, tables, and chairs are clean, without obvious dust or waste, and there is no broken equipment, papers, or boxes lying around to make the facility cluttered and dirty.
[2] Year-round water is supplied by a tap in the facility from a protected or unknown source, or water is supplied from a protected well or pump, and water outlet is available within 500 meters of the facility.
[3] Electricity is routinely available during service hours, or a backup generator with fuel is available on the day of the visit.

Eighty-three percent of health facilities have the full range of client comfort amenities[1], a slight decline from 89 percent in 2004. There is little variation in availability of client comfort amenities; however, stand-alone VCT facilities (77 percent), NGO facilities (67 percent), and facilities in Nairobi (71 percent) are among the least likely to have all client comfort amenities.

A regular water supply[2], is available in a little under half (46 percent) of all facilities, an improvement from 26 percent of facilities in 2004. Maternity facilities (57 percent), hospitals (58 percent), and clinics (59 percent) are more likely than other facility types to have a regular water supply. Health centres (45 percent) and dispensaries (35 percent) are less likely to have a regular water supply.

Only one-quarter of all facilities have ***regular, uninterrupted*** electricity (i.e., the facility is connected to a central power grid, or has solar power or both, and power is routinely available during regular service hours), or has a functioning generator with fuel (Table 3.2). Hospitals (68 percent) and maternity facilities (55 percent) are the types of facilities most likely to have regular electricity or a functioning generator with fuel. Health facilities in Nairobi province are much more likely to have regular electricity or a generator with fuel (48 percent) than facilities in other provinces (between 14 and 33 percent). Among managing authorities, the faith-based facilities reported the highest proportion with regular electricity or a generator with fuel (44 percent), followed by private for-profit facilities (24 percent).

Additional information in Table A-3.2 shows that, on average, seven of every ten facilities have electricity, i.e., they are connected to a central power grid, or have solar power or both. Dispensaries (53 percent) are much less likely than other facility types (between 87 percent of clinics and 96 percent of hospitals) to have electricity.

Client comfort amenities, a regular water supply, and regular electricity or a generator with fuel are present in only 13 percent of facilities. Hospitals, faith-based facilities, and those facilities in Nairobi province generally are more likely than other types to have all of these components.

3.1.3 Infrastructure and Resources to Support Quality 24-Hour Emergency Services

Not all types of health facilities are expected to provide 24-hour care; however, it is useful to assess their capacity to provide emergency services 24 hours a day. For the 2010 KSPA, a facility is said to have basic 24-hour emergency services if it offers emergency on-site treatment and has the capacity to monitor a seriously ill client overnight until it is possible to refer the client to an inpatient setting or another facility. This means that the facility must have at least two qualified providers, a duty schedule indicating that providers are on-site or on call 24 hours a day, available overnight beds, a client latrine, 24-hour emergency communication, and an on-site water source. Table 3.3 provides information on facilities that meet the preceding requirements and those that also have a regular supply of water and electricity. Figure 3.2 presents information on the availability of individual items.

Overall, only 13 percent of all facilities have the basic components to support 24-hour emergency services. This compares with a similar finding of 16 percent of facilities in 2004 (Table 3.3).

[1] Client comfort amenities include a functioning client latrine, a waiting area that is protected from sun and rain, and a basic level of cleanliness.

[2] Year-round water supplied by a tap in the facility from a protected or unknown source, or water from a protected well or pump and outlet is available within 500 meters of the facility.

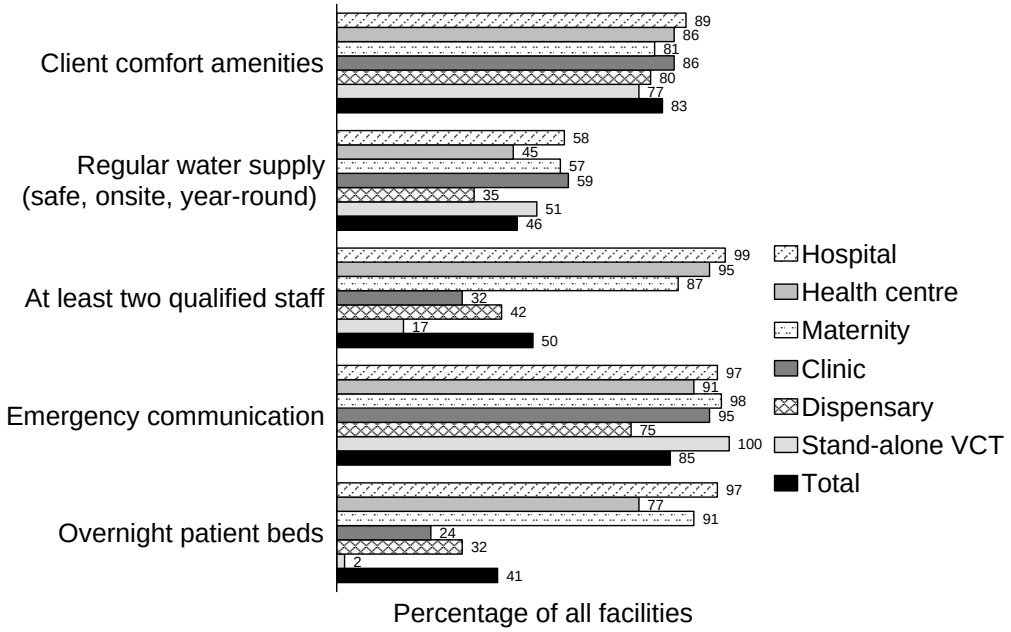
Table 3.3 Service and facility infrastructure to support quality 24-hour emergency services

Percentage of all facilities with basic components to support 24-hour emergency services and regular supplies of water and electricity, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with: Basic components to support 24-hour emergency services[1]	Basic components to support 24-hour emergency services plus regular water and electricity[2]	Number of facilities
Type of facility			
Hospital	79	41	51
Health centre	35	9	80
Maternity	47	28	17
Clinic	1	0	203
Dispensary	4	3	340
Stand-alone VCT	0	0	5
Managing authority			
Government	13	4	345
NGO	4	1	24
Private (for profit)	11	7	237
Faith-based organisation	22	15	89
Province			
Nairobi	17	7	45
Central	10	6	125
Coast	12	3	81
Eastern	13	7	118
North Eastern	8	1	24
Nyanza	18	4	83
Rift Valley	13	10	175
Western	17	3	44
Total	13	6	695

[1] At least two qualified providers assigned to facility, observed duty schedule indicating staff are on site or on call 24 hours a day, overnight beds, 24-hour emergency communication, and on-site water source at least some times during the year.
[2] All basic components plus a year-round onsite water source and either electricity routinely available during service hours or a backup generator with fuel

Figure 3.2 Availability of Items to Support Quality 24-hour Emergency Services (N=695)



KSPA 2010

At the provincial level, facilities in Nyanza (18 percent), Nairobi (17 percent), and Western (17 percent) provinces are slightly more likely to meet all the criteria than facilities in other provinces.

The basic components described above for 24-hour emergency services, plus a regular supply of water and electricity, are now available at only 6 percent of facilities, which compares with 9 percent of facilities in 2004. As expected, hospitals (41 percent) and maternity facilities (28 percent) are more likely than the other facility types to have these items (Table 3.3). Additional information is available in Table A-3.2.

Key Findings

Basic services: A full package of basic services (outpatient care for sick children, services for adult STIs, temporary methods of family planning, ANC, child immunisation, and child growth monitoring) is available in 6 of every 10 facilities, unchanged from 2004. Hospitals, health centres, maternity facilities, and dispensaries are more likely than clinics and stand-alone VCT facilities to offer all basic services.

A full package of all basic services available at the defined minimum frequency or above, together with 24-hour delivery services, is available at only 19 percent of all facilities, unchanged from 2004.

Infrastructure and emergency services: Eight of every ten facilities have the basic client comfort amenities, and a little under half have a regular water supply. Only a quarter of facilities have ***regular uninterrupted*** electricity or generator with fuel, even though approximately seven of every ten are connected to a central power grid, or have solar power or have both.

Overall, all basic client comfort amenities, a regular water supply, and a regular electricity supply or generator with fuel are available at only a little over one of every ten facilities.

3.2 Management Systems to Support and Maintain Quality Services and Appropriate Client Utilisation

Basic management and administrative systems are required to ensure that health services can consistently provide an acceptable level of quality.

3.2.1 Management Meetings, Quality Assurance, and Referral Systems

Information on the availability of functioning systems for each of the assessed components is shown in Table 3.4. Further information on the components is shown in Figures 3.3 and 3.4, and in Tables A-3.4 and A-3.5.

Management meetings

To function well, a health facility must have an established system in place for identifying and addressing management and administrative issues. This system may involve meetings to discuss scheduling and day-to-day issues or meetings to discuss broader management issues, such as financing, utilisation, or plans for health-related campaigns. The meetings must be regularly scheduled, however, and specific staff must have defined areas of responsibility. The 2010 KSPA looked for evidence of functioning management committee meetings held at least every six months and asked for official documentation of proceedings. The system is considered to be functioning if there is a record of committee meetings, with documented decisions and follow up on issues discussed.

Overall, 66 percent of health facilities reported having routine management committee meetings at least every six months; this compares with 69 percent of facilities in 2004; however, only 32 percent of facilities had actual documentation of a recent meeting (Table 3.4 and Figure 3.3), similar to 34 percent in 2004.

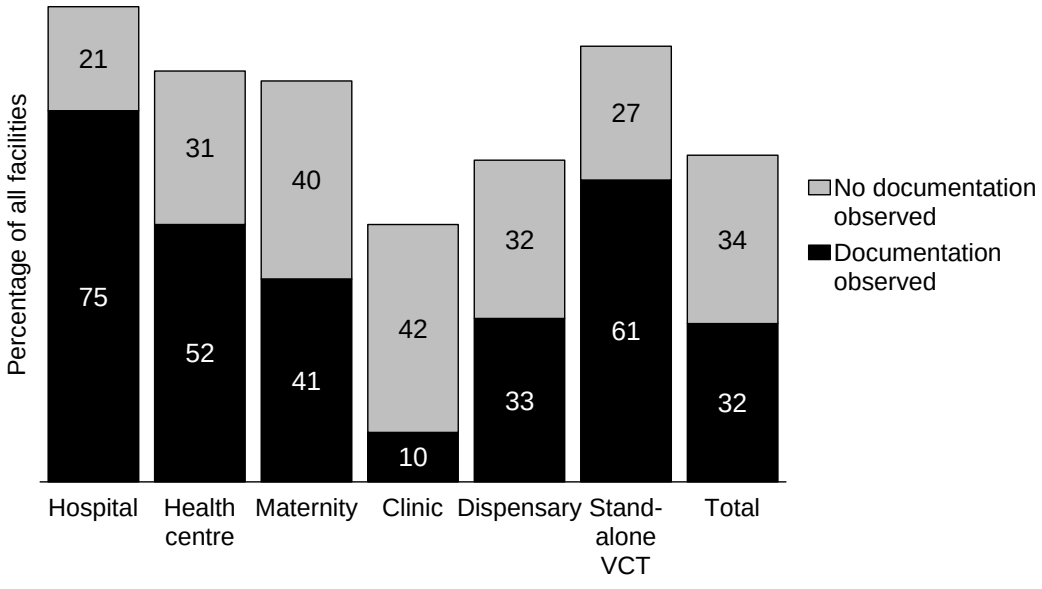
Table 3.4 Management, quality assurance, and referral systems

Percentage of facilities with documentation of management committee meetings, quality assurance (QA) activities, and referral systems, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with: Management committee meetings at least every 6 months and observed documentation of a recent meeting	Facility reports of QA activities; documentation observed	Clients referred outside facility and referral form observed[1]	Clients referred but no referral form observed[2]	Clients never referred outside facility	Don't know/ missing	Number of facilities
Type of facility							
Hospital	75	39	63	33	3	0	51
Health centre	52	14	65	33	1	0	80
Maternity	41	20	55	39	6	0	17
Clinic	10	5	35	57	8	0	203
Dispensary	33	8	50	44	5	0	340
Stand-alone VCT	61	59	85	12	3	0	5
Managing authority							
Government	40	11	58	36	6	0	345
NGO	34	12	61	34	5	0	24
Private (for profit)	15	9	36	57	7	0	237
Faith-based organisation	44	13	44	55	1	0	89
Province							
Nairobi	47	24	73	22	5	0	45
Central	27	3	40	56	4	0	125
Coast	16	10	42	52	5	2	81
Eastern	26	5	48	50	2	0	118
North Eastern	23	4	28	48	25	0	24
Nyanza	46	16	71	29	0	0	83
Rift Valley	36	11	38	52	10	0	175
Western	41	24	78	21	1	0	44
Total	32	11	49	45	5	0	695

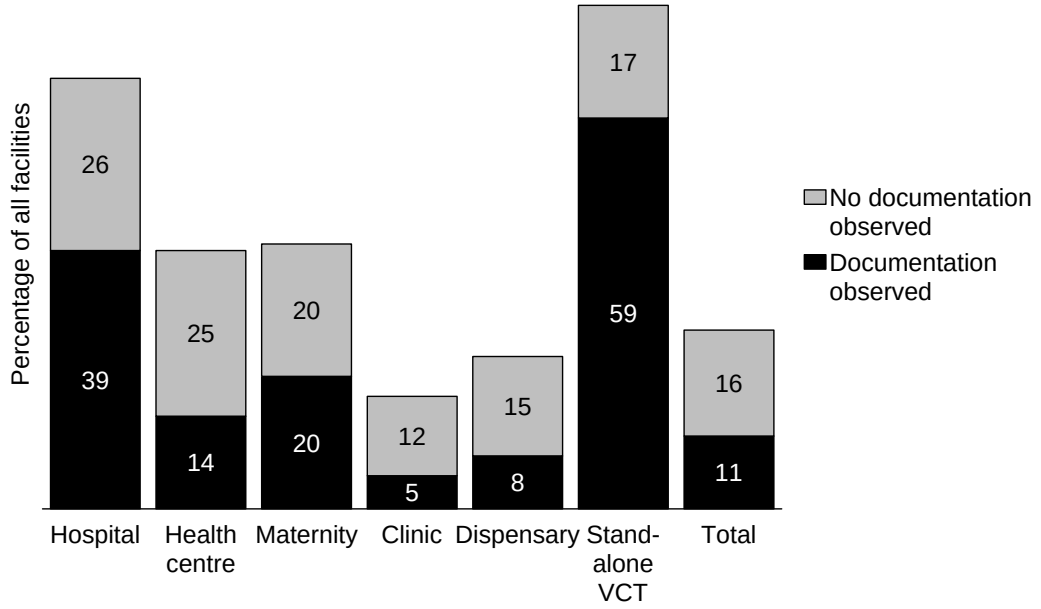
[1] The facility reports that they refer clients outside the facility and have a pre-printed referral form, or the facility reports that they routinely send the referred client with their medical record or file to the referral facility.
[2] The facility reports that they refer clients outside the facility but do not have a referral form to show, or they report that they write a referral note on a prescription form, a sheet of letterhead, or a blank sheet of paper, or only use verbal methods to refer clients.

Figure 3.3 Routine Management Committee Meetings at Least Every Six Months (N=695)



KSPA 2010

Figure 3.4 Quality Assurance Activities (N=695)



KSPA 2010

Facilities in Nairobi (47 percent) and Nyanza (46 percent) provinces are more likely than facilities in other provinces to have regular management committee meetings and to have documentation of recent meetings (Table 3.4).

Additional information on routine management committee meetings is available in Table A-3.4.

Quality assurance

Quality assurance (QA), an important component of service delivery, refers to a system for monitoring the quality of care, identifying problems, and instituting changes to resolve those problems. Quality assurance systems require an established standard against which quality is measured; there must also be systematic methods to assess results and develop interventions. The following are examples of QA activities and approaches:

- *A supervisory checklist for health systems*, which looks for the presence of equipment and supplies, the completeness of Health Management Information System (HMIS) accounts, and other process indicators.

- *A supervisory checklist for health service provision*, which verifies specific content in client assessments, treatments, or consultations. This list is often used to document the provision of care.

- *A facility-wide review of mortality*, which is a structured system to review the records of each client who dies. There will normally be a committee established for this purpose.

- *Audits of medical records or registers*, which check medical records for the presence of specific items or information and may assess if protocols were followed.

Table 3.4, Table A-3.5, and Figure 3.4 provide information on facilities reporting QA activities. Overall, only a quarter (27 percent) of health facilities report any QA activities (Table A-3.5). Hospitals (65 percent) and stand-alone VCT facilities (76 percent) are most likely to report QA activities. As shown in Table 3.4 and Figure 3.4, hospitals (39 percent) and stand-alone VCT facilities

(59 percent) are also more likely to report QA activities and have documentation of QA activities available compared with 20 percent of maternity facilities and 14 percent of health centres. Overall, only 11 percent of all facilities report QA activities and have documentation available.

Referral systems

When clients are referred to another facility without any formal documentation, they risk being refused services or having services delayed while the referral facility reassesses them as new clients. Thus, having a systematic means to refer clients to a higher-level (or different) facility is an important aspect of quality of care. Also, if clients are confident that they will be assisted in gaining access to higher-level (or other) facilities when needed, they may be less likely to bypass lower-level facilities for their health care needs. The 2010 KSPA collected information on whether facilities have any official printed forms that, at a minimum, document the reason for referral and list any treatment already provided to the client.

Overall, half (49 percent) of all facilities report that they refer clients outside the facility and also have referral forms or referral documents available (Table 3.4). Stand-alone VCTs (85 percent), health centres (65 percent), and hospitals (63 percent) were more likely than maternity facilities (55 percent), dispensaries (50 percent), and clinics (35 percent) to report that they refer clients and also have referral forms. NGO facilities (61 percent) and government facilities (58 percent) are the most likely to have referral forms. At the provincial level, facilities in Western province (78 percent) and Nairobi province (73 percent) seem most likely to refer and have client referral forms, while facilities in Rift Valley province (38 percent) and North Eastern province (28 percent) are least likely.

3.2.2 Supportive Management for Providers

The 2010 KSPA collected information on whether facilities have supervisory and staff development activities, which are important for supporting quality health care. Summary information on supportive management practices at the facility level is provided in Table 3.5, with further details provided in Tables A-3.6 and A-3.7.

External supervision

Supervision by external managers has many benefits. It can help ensure that system-wide standards and protocols are followed at the facility level and promote an organisational culture that expects such standards and protocols to be implemented. It provides an opportunity to expose staff to a wider scope of ideas and relevant experiences, including on-the-job training for some providers. It can also motivate service providers, especially if the supervisor is supportive. In the 2010 KSPA, a facility that reports at least one supervisory visit by external supervisors during the six months that precede the survey is defined as having routine external supervision.

Overall, 84 percent of facilities have routine external supervision (Table 3.5), compared with 87 percent in 2004. Clinics (62 percent) and maternity facilities (68 percent), are less likely than other facility types to have routine external supervision. Private facilities are also less likely than facilities managed by other authorities to have external supervision (63 percent, compared with between 88 percent and 95 percent of facilities managed by other authorities. Facilities in Nyanza (96 percent) and Western (92 percent) provinces have strong routine external supervision in contrast with facilities in Nairobi and North Eastern provinces (76 and 70 percent, respectively).

Table 3.5 Supportive management practices at the facility level

Percentage of facilities that had an external supervisory visit during the six months preceding the survey, and percentage of facilities where at least half of the interviewed health service providers report receiving routine training related to their work and personal supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with external supervisory visit during the six months preceding the survey	Number of facilities	Percentage of facilities having routine:			Percentage of facilities with supportive management practices[3]	Number of facilities where at least one eligible health service provider was interviewed[4]
			Training[1]	Personal supervision[2]	Training and personal supervision		
Type of facility							
Hospital	92	51	93	87	83	80	50
Health centre	95	80	92	94	85	84	79
Maternity	68	17	81	68	57	46	17
Clinic	62	203	67	58	42	33	195
Dispensary	94	340	83	89	77	76	327
Stand-alone VCT	82	5	78	96	76	63	5
Managing authority							
Government	95	345	86	91	80	79	332
NGO	88	24	89	90	84	78	24
Private (for profit)	63	237	66	60	43	34	229
Faith-based organisation	95	89	91	88	83	82	89
Province							
Nairobi	76	45	87	79	71	62	45
Central	80	125	74	68	54	49	120
Coast	78	81	86	76	68	58	79
Eastern	85	118	78	81	69	67	118
North Eastern	70	24	75	80	67	49	17
Nyanza	96	83	81	93	79	76	82
Rift Valley	84	175	80	81	69	69	170
Western	92	44	88	87	78	75	43
Total	84	695	80	80	68	64	673

[1] A facility has routine staff training if at least half of interviewed providers reported they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[2] A facility has routine staff supervision if at least half of interviewed providers reported they had been personally supervised at least once during the six months preceding the survey.
[3] A facility has supportive management practices if it has had an external supervisory visit during the six months preceding the survey and if staff have received routine training and personal supervision.
[4] Interviewed providers who did not personally provide one of the services assessed by the survey (e.g., administrators who might have been interviewed) are excluded.

Training

To maintain levels of knowledge and technical competence, health service providers must continually be exposed to new information. The 2010 KSPA assessed whether, during the 12 months preceding the survey, providers had received any formal or structured pre-service or in-service training related to the services they offer. Although it is recognised that providers may receive new information and individual instruction related to their work during routine supervisory visits, the 2010 KSPA assessed only structured, 'classroom-type' training. If at least half of the health service providers interviewed at a facility report receiving in-service or pre-service training relevant to their jobs within the 12 months that precede the survey, that facility is defined by the KSPA as having routine staff development activities.

Overall, about 8 of every 10 facilities satisfy these criteria for routine staff training (Table 3.5), compared with 76 percent of facilities in 2004. Hospitals (93 percent) and health centres (92 percent) are much more likely than the other facility types to have routine staff training. Private facilities are less likely than facilities managed by other authorities to meet the criteria for routine staff supervision (66 percent, compared with between 86 percent and 91 percent of facilities managed by other authorities). There is not much variation by province.

Supervision of health service providers

In addition to general facility-level supervision, the work of individual staff must be assessed so that each person's strengths and weaknesses can be identified and appropriate support can be

provided. If at least half of the interviewed health service providers in a facility reported being personally supervised at least once during the six months preceding the survey, the KSPA defines the facility as providing routine staff supervision.

Eight of every ten facilities meet the criteria for routine staff supervision (Table 3.5), similar to the 84 percent of facilities meeting the criteria in 2004. Stand-alone VCTs (96 percent) and health centres (94 percent) are most likely to have routine staff supervision. Private facilities are less likely than other facilities to have routine staff supervision. At the provincial level, the weakest level of supervision is among facilities in Central province, where only 68 percent of facilities meet the criteria for personal supervision.

3.2.3 Management Practices Supporting Community Involvement

Encouraging community input into a facility's functions makes the facility more accountable to the community it serves; it also helps the facility to better understand the community's needs. This increases the probability of better health-seeking behaviour, which in turn may improve the health of the population. Government policy recommends an interface with the community, especially at the dispensary level.

Community representation

Overall, half (51 percent) of facilities have routine community participation in some management meetings (Table 3.6), compared with 44 percent of facilities in 2004. Community participation in management meetings is most common in dispensaries (69 percent) and health centres (72 percent). At the provincial level, facilities in Nyanza (70 percent) and Eastern (63 percent) provinces are most likely to have routine community participation in management meetings.

One in every four facilities reports holding meetings at least once every six months and has documentation of a recent meeting available.

Client feedback

The 2010 KSPA also assessed whether facilities have a system to elicit and review client opinion. Of all facilities, only 10 percent have such a system (Table 3.6), which is similar to the 9 percent reported in 2004. Stand-alone VCTs (41 percent) and hospitals (38 percent) are more likely than other types of facilities to have systems to elicit client feedback.

Among the different management authorities, faith-based facilities (26 percent) are relatively more likely than government or NGO facilities (both 9 percent) to elicit and review client opinion. Client feedback systems, although uncommon across all provinces, are almost nonexistent in Rift Valley and Central provinces (both 3 percent).

3.2.4 Funding Mechanisms that Decrease Financial Barriers to Utilisation of Health Services

User fees may have a positive effect on the use of health facilities by increasing the funds available to the facility; they may also have a negative effect by deterring poor clients from using services. User fees with exemption schemes for vulnerable people often help to augment inadequate facility budgets. However, providing exemptions or discounts for poor clients can result in budget shortages if there is no system for reimbursing the facility for these exempted or discounted costs. Some other approaches also encourage appropriate use by poor clients and reimburse facilities for client services. These approaches include insurance plans, credit plans (delayed payment for services received today), and charity or equity funds that reimburse the costs of certain clients (thus increasing access to care by reducing out-of-pocket payments at the time of service utilisation). In any case, health facilities should clearly display their fees for service, if they charge for any services. This

improves accountability, reduces the likelihood of corruption, and helps clients calculate the costs they will incur in seeking services.

Almost all of the services provided in general public-sector facilities are free by government policy. Health insurance may be provided through an employer, or it may be purchased independently. People belonging to health insurance plans may have specific facilities where they receive services. Insurance plans cover services that their members receive from government health facilities through public-private partnerships.

Table 3.6 Management practices supporting community feedback

Percentage of facilities that have routine community participation in management meetings, which are held at least every six months and documented, which have a system of acquiring client opinion and feedback, which elicit client opinion and implement review, and which have a means to elicit community input or any mechanism for obtaining community input, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities: Where community participation in some management meetings is routine	Where meetings are held at least every six months and documentation of a recent meeting is observed	Where client opinion is elicited and a system for review is implemented[1]	Where a mechanism exists for obtaining community input on services[2]	Number of facilities
Type of facility					
Hospital	53	30	38	72	51
Health centre	72	51	18	73	80
Maternity	14	9	20	31	17
Clinic	17	4	3	18	203
Dispensary	69	33	7	70	340
Stand-alone VCT	48	19	41	63	5
Managing authority					
Government	76	39	9	78	345
NGO	62	27	9	65	24
Private (for profit)	18	7	5	22	237
Faith-based organisation	41	25	26	50	89
Province					
Nairobi	35	19	30	52	45
Central	37	22	3	39	125
Coast	43	17	6	44	81
Eastern	63	39	12	66	118
North Eastern	55	30	8	55	24
Nyanza	70	43	18	73	83
Rift Valley	51	16	3	51	175
Western	62	33	22	69	44
Total	51	26	10	55	695

[1] Some mechanism for eliciting client opinion is reported, and there is documentation indicating that client opinions are reviewed.
[2] Either community representation at management meetings or a system for eliciting and reviewing client opinion is in place.

User fees and additional sources of funding

Table 3.7 summarises information on facilities that charge routine user fees for adult curative care and on facilities that rely on external funding sources. Details on funding options and on components for which facilities charge fees appear in Tables A-3.8 and A-3.9.

Over 90 percent of facilities routinely charge some form of user fees for adult curative services (Table 3.7). Ninety-four percent of private facilities charge for adult curative services; the same is true of faith-based organisations and government facilities (98 percent).

Among facilities charging for adult curative services, only 20 percent post all their fees for clients. About 61 percent of the facilities charge for medicines, 30 percent charge for client consultations (Table A-3.9), and 54 percent charge for laboratory tests.

Table 3.7 Funding mechanism utilised in facilities

Percentage of facilities with routine user fees for adult curative care and any external source of revenue or funding, and percentage of facilities charging user fees that post all fees, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with: Any routine user fee for adult curative care	Any external source of revenue or funding during 2008/2009 financial year[1]	Number of facilities	Percentage of facilities that post all fees	Number of facilities having any user fees
Type of facility					
Hospital	97	74	51	58	49
Health centre	100	49	80	31	80
Maternity	96	54	17	9	16
Clinic	93	17	203	4	188
Dispensary	97	44	340	22	331
Stand-alone VCT	15	78	5	34	1
Managing authority					
Government	98	53	345	31	339
NGO	78	32	24	19	19
Private (for profit)	94	21	237	5	224
Faith-based organisation	94	39	89	18	84
Province					
Nairobi	76	36	45	15	34
Central	100	38	125	10	125
Coast	90	36	81	28	73
Eastern	100	38	118	24	118
North Eastern	99	19	24	14	24
Nyanza	99	41	83	26	82
Rift Valley	95	45	175	21	166
Western	98	48	44	24	43
Total	96	40	695	20	665

[1] This includes any revenue or funding from sources such as the Ministries of Health and other public ministries, insurance schemes, reimbursement by employers, government contribution to private-for-profit organisations, donor agencies, community programmes, and private/philanthropic agencies.

Overall, 40 percent of facilities report that they had an external source of revenue or funding during the 2008/09 financial year (Table 3.7), which is very similar to findings in 2004 (42 percent). This includes funding from the ministries of health and other public ministries, reimbursement by employers, insurance schemes, government contributions to private for-profit organisations, donor agencies, community programmes, and private/philanthropic agencies. Facilities in North Eastern province (19 percent) are the least likely to report external sources of revenue or funding.

3.2.5 Maintenance and Repair of Equipment

To provide quality services, a facility must have the means to ensure that facility equipment and infrastructure are in good working order. Some machinery requires routine preventive maintenance, while other equipment may require minor repairs or replacement. Buildings and infrastructure also require routine maintenance and periodic repair. In the 2010 KSPA, infrastructure refers to buildings and roads within the facility complex. Summary information on systems for maintenance and equipment repair or replacement is provided in Table 3.8. Detailed information on which systems are used and which people are responsible for maintaining a facility's equipment is provided in Tables A-3.10 and A-3.11.

Major equipment

Among facilities that have major equipment (such as a generator, steriliser, electric autoclave, and x-ray machines), nearly half (48 percent) report having preventive maintenance programmes for their equipment (Table 3.8). Sixty-nine percent of hospitals with major equipment report having preventive maintenance programmes for major equipment. Of the remaining categories of facilities that have major equipment, maternity facilities are more likely to have preventive maintenance programmes (59 percent) than clinics (48 percent) or health centres or dispensaries (both 35 percent).

Private facilities with major equipment are more likely than government or faith-based facilities to have preventive maintenance programmes (57 percent compared with 41 and 43 percent).

Table 3.8 Facility systems for maintenance and repair of equipment and infrastructure

Among facilities with major equipment, percentage that have a preventive maintenance programme for that equipment, and percentage of all facilities that have a system for repairing or replacing small equipment and a system for maintenance and repair of building or infrastructure, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with preventive maintenance programme for major equipment[1]	Number of facilities with major equipment[2]	Percentage of facilities with: System for repair or replacement of small equipment[3]	Percentage of facilities with: System for maintenance and repair of building or infrastructure	Number of facilities
Type of facility					
Hospital	69	41	96	66	51
Health centre	35	34	96	31	80
Maternity	59	13	98	41	17
Clinic	48	42	94	19	203
Dispensary	35	50	86	24	340
Stand-alone VCT	-	-	75	41	5
Managing authority					
Government	41	56	86	28	345
NGO	33	6	98	47	24
Private (for profit)	57	68	94	24	237
Faith-based organisation	43	52	92	24	89
Province					
Nairobi	46	27	90	45	45
Central	22	26	100	10	125
Coast	52	27	93	21	81
Eastern	71	19	86	47	118
North Eastern	47	2	82	17	24
Nyanza	40	24	98	31	83
Rift Valley	56	45	83	26	175
Western	43	11	89	17	44
Total	48	181	90	27	695

[1] Equipment such as a generator, steriliser, electric autoclave, X-ray machines, ultrasound equipment, or CT scans.
[2] Includes only facilities with a functioning generator, electric autoclave or steriliser, X-ray machine, ultrasound equipment, or CT scans, and facilities where caesarean sections are performed. The total number of facilities includes 1 stand-alone VCT facility with major equipment.
[3] Equipment such as stethoscopes, blood pressure cuffs, and sphygmomanometers

Among facilities with major equipment, 17 percent have on-site staff responsible for the routine maintenance of this major equipment, while 23 percent use external technicians (Table A-3.10). About 7 percent of these facilities use both internal and external staff for their maintenance work.

Small equipment

Ninety percent of all facilities have a system for repair or replacement of small equipment such as stethoscopes, sphygmomanometers, and blood pressure cuffs (Table 3.8). Such systems are widespread among facilities of all types. The systems for repair or replacement are most common in NGO facilities (98 percent) and least common in government facilities (86 percent). At the provincial level, facilities in North Eastern (82 percent) and Rift Valley (83 percent) provinces are less likely to have such a system.

Facilities use different methods to maintain or replace small equipment, including on-site repair, sending equipment outside for repair or replacement, and purchasing or paying for new equipment from funds on hand (Table A-3.10). Only 14 percent of facilities report on-site repair.

Infrastructure

Twenty-seven percent of all facilities have a system for maintenance and repair of their buildings or infrastructure (Table 3.8). Most hospitals (66 percent) have a system of maintenance and repair, while only 19 percent of clinics have such a system. About half of NGO facilities (47 percent) have a repair and maintenance system, compared with 24 percent of private and faith-based. There is wide variation in availability of repair and maintenance systems by province. Nairobi (45 percent) and Eastern (47 percent) provinces recorded the highest proportion of facilities with a system for maintenance and repair of buildings or infrastructure, while Central province reported the lowest (10 percent).

Key Findings

Management meetings: Approximately two-thirds of facilities have routine management meetings; however, only one-third have documentation of a recent meeting. These findings are similar to findings in 2004.

Quality assurance: A little over one-quarter of health facilities report QA activities, and one of every ten document their QA activities. Hospitals and stand-alone VCT facilities are most likely to report QA activities and have documentation of QA activities available.

Referral systems: Half of facilities report that they refer clients outside the facility and had referral forms or referral documents available.

External supervision: More than 80 percent of facilities receive routine external supervision. Clinics and maternity facilities are less likely than other facility types to receive routine external supervision. Private facilities are also less likely than facilities managed by other authorities to receive routine external supervision.

Routine staff training: Eight of every ten facilities meet the criteria for providing routine staff training, compared with three-quarters in 2004. Hospitals and health centres are much more likely than the other facility types to provide routine staff training.

Community representation: Half of facilities have routine community participation in some management meetings, compared with a little over four of every ten in 2004. Community participation in management meetings is most common in dispensaries and health centres.

Client opinion: Systems to elicit and review client opinion on facility activities are rare. Only one of every ten facilities has a formal system to elicit and review client feedback.

User fees: Nine in ten facilities charge a fee for adult curative services, but only 20 percent post these fees where clients can see them.

Equipment maintenance and repair: Almost half of facilities with major equipment have a preventive maintenance program.

3.3 LOGISTICS SYSTEMS FOR VACCINES, CONTRACEPTIVES, AND MEDICINES

To ensure that necessary pharmaceutical commodities are available for daily use, facilities must have storage conditions that protect commodities from damage, monitoring systems that minimise waste resulting from commodity expiration, and systems to monitor stock and ensure timely ordering and resupply. Summary information on storage conditions and stock monitoring for vaccines is presented in Table 3.9. Information on contraceptive methods, medicines, and antiretroviral drugs (ARVs) is presented in Table 3.10. Information on inventory systems for stored medicines, contraceptives, and ARVs is shown in Figure 3.5. Details on each element assessed for vaccine storage conditions are presented in Figure 3.6, and details for vaccine stock monitoring systems are shown in Figure 3.7. Similar information on storage conditions and stock monitoring systems for contraceptive methods is shown in Figure 3.8. Further details on storage conditions are provided in Tables A-3.12 and A-3.13. Details on commodity ordering systems and storage are given in Tables A-3.14 through A-3.18.

Table 3.9 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with adequate systems for monitoring storage temperature and vaccine stock, by background characteristics, Kenya SPA 2010

Background characteristics	Percentage of facilities with adequate system for monitoring		Number of facilities with stored vaccines observed
	Storage temperature[1]	Vaccine stock[2]	
Type of facility			
Hospital	83	51	48
Health centre	83	40	78
Maternity	72	34	12
Clinic	72	43	65
Dispensary	79	34	239
Managing authority			
Government	81	40	273
NGO	60	39	16
Private (for profit)	73	35	83
Faith-based organisation	83	35	70
Province			
Nairobi	82	48	31
Central	88	19	57
Coast	80	58	50
Eastern	80	33	78
North Eastern	97	25	14
Nyanza	79	64	64
Rift Valley	70	28	120
Western	82	37	28
Total	79	38	442

[1] Functioning thermometer in refrigerator, up-to-date temperature chart, and refrigerator temperature 2°C to 8°C at time of survey
[2] All vaccines normally carried are present, no expired items are present, items are stored by expiration date, a stock card/ledger is present for all normally stocked vaccines, and no stock out in the past 6 months.
Note: Stand-alone VCT facilities are excluded from analyses involving child health services, such as child immunisation and curative care for sick children.

All commodities were assessed to ensure the presence of a valid expiration date on at least one unit. For selected vaccines, contraceptive methods, and medicines, the entire stock was assessed for the validity of the expiration date, for storage by expiration date, and for concordance with the inventory. If any of the checked items was found to be out of compliance, the stock monitoring system for that commodity was marked as not functioning.

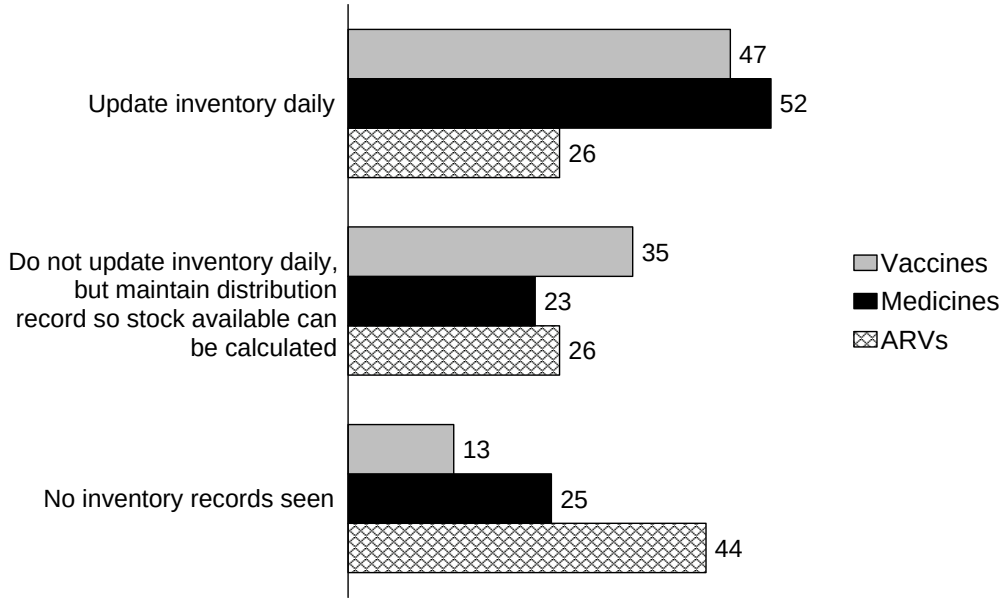
It is common for facilities not to update their inventory daily but instead to maintain a daily register (e.g., stock cards) of distributed items. They then periodically tally the distributed items and update the inventory only periodically, often monthly. Information on the inventory system used for medicines is presented in Figure 3.5.

Medicines: Fifty-two percent of facilities that stock medicines update their medicine inventory daily. Twenty-three percent use daily distribution registers and update inventory periodically as opposed to daily. Inventory records were not available at a quarter of facilities.

Vaccines: Forty-seven percent of facilities that stock vaccines update their vaccine inventory daily. Thirty-five percent use daily distribution registers and update inventory records periodically. Thirteen percent did not have inventory records.

ARVs: Only a quarter of facilities that stock ARVs update their ARV inventory daily; another quarter do not update their ARV inventory daily but instead maintain distribution records for periodic inventory update. More than 40 percent of facilities do not have any inventory system.

Figure 3.5 Inventory System Used for Stored Vaccines (N=442), Medicines (N=661), and ARVs (N=276)



KSPA 2010

3.3.1 Storage and Stock Monitoring Systems for Vaccines

Vaccines must be stored at an appropriate temperature to maintain their potency. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend monitoring refrigerator or cold box temperatures at least twice daily and recording the temperature on a graph as proof of monitoring (WHO, 1998). To assess facilities' vaccine storage conditions, the following were checked: (1) the presence of a functioning thermometer in the vaccine refrigerator, (2) a temperature of +2°C to +8°C at the time of the survey (the UNICEF recommendation for vaccine storage at the health centre level), and (3) a temperature graph, updated twice a day, for the prior 30 days.

Storage conditions

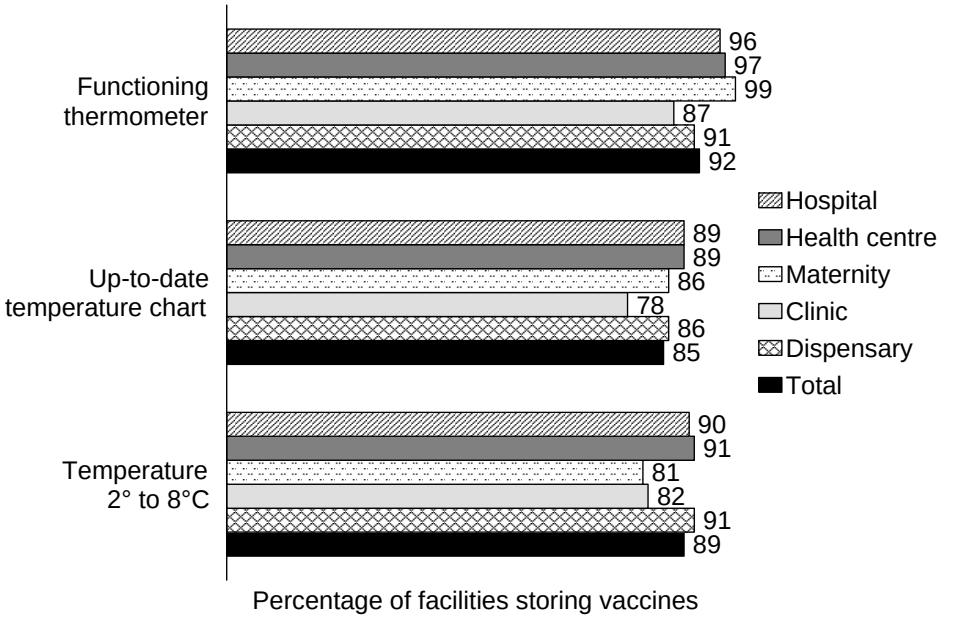
Among facilities that routinely store vaccines and where vaccines were observed, 79 percent had all the necessary components[3] for adequate temperature monitoring (Table 3.9) compared with 73 percent in 2004. Dispensaries (79 percent), hospitals, and health centres (both 83 percent), are more likely than clinics and maternity facilities to have an adequate system for monitoring vaccine storage temperature. Government and faith-based organisations (81 percent and 83 percent, respectively) and facilities in North Eastern and Central provinces (97 percent and 88 percent, respectively) are more likely than other facilities to meet all three criteria for monitoring storage temperatures.

Of the individual components, 92 percent of facilities had a functioning thermometer (compared with 97 percent in 2004), 85 percent had an up-to-date temperature chart (compared with 93 percent in 2004), and 89 percent had temperatures in the vaccine refrigerator between 2° and 8°C at the time of the assessment (Figure 3.6 and Table A-3.12).

More than nine of every ten facilities (93 percent compared with 99 percent in 2004) position their vaccine refrigerator so that it is protected from direct sunlight (Table A-3.12).

[3] A functioning thermometer in a vaccine refrigerator, an up-to-date temperature chart, and a refrigerator temperature between 2°C and 8°C at time of assessment

Figure 3.6 Elements for Monitoring Vaccine Storage Conditions (N=442)



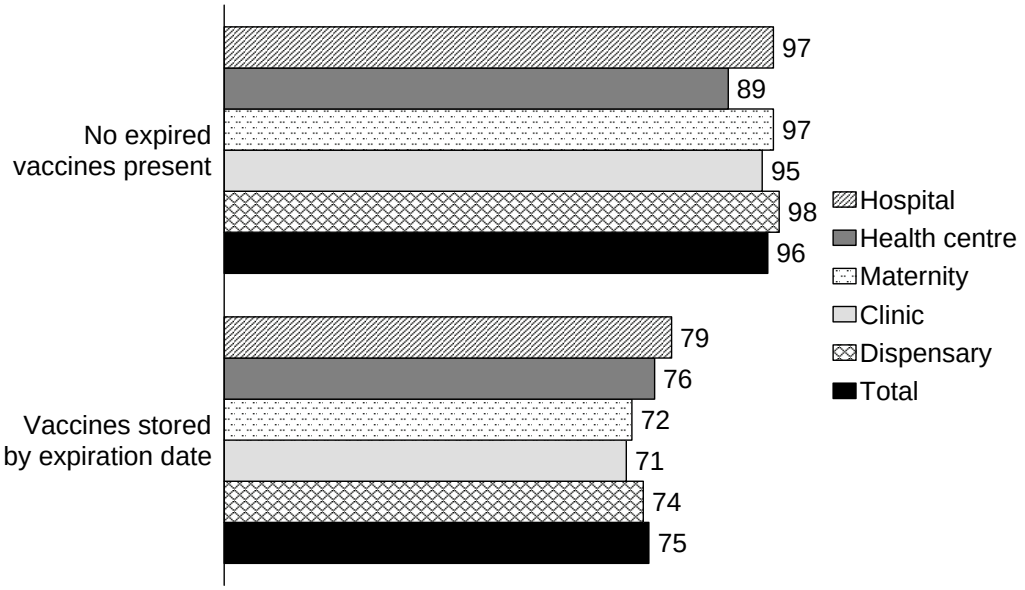
KSPA 2010

Stock monitoring systems

A facility is considered to have an adequate vaccine stock monitoring system if (1) all vaccines that are normally carried are present; (2) there are no expired items; (3) items are stored by expiration date; (4) a stock card or ledger is present for all normally stocked vaccines; and (5) there were no stock outages during the 6 months preceding the survey. Overall, 38 percent of facilities that store vaccines and that had vaccines observed on the day of the assessment have an adequate vaccine stock monitoring system (Table 3.9). Facilities in Nyanza province are most likely to have an adequate vaccine stock monitoring system (64 percent), while facilities in Central province (19 percent) and North Eastern province (25 percent) are the weakest in vaccine stock monitoring systems.

Additional information on the individual components of the stock monitoring system is available in Figure 3.7 and Table A-3.12.

Figure 3.7 Elements for Monitoring Vaccine Stock and Condition (N=334)



KSPA 2010

3.3.2 Storage and Stock Monitoring Systems for Contraceptive Methods, General Medicines, and Antiretroviral drugs

Storage conditions

To prevent chemical deterioration and contamination, facilities must store contraceptives and medicines in dry conditions; above the ground in an area protected from water, sun, pests, and rodents; and in a well-ventilated location.

Seventy-eight percent of facilities with stored contraceptives observed on the day of the survey had all the items necessary for properly storing contraceptives (Table 3.10)[4]. For storage of medicines, these conditions were available at 75 percent of facilities with stored medicines. The storage conditions for antiretroviral drugs (ARVs) were also assessed in health facilities where stored ARVs were observed. Among these facilities, the storage conditions were good in 92 percent of cases.

Information on the individual components of storage conditions is presented in Table A-3.13.

Stock monitoring systems

Stock monitoring systems were assessed for contraceptive methods, medicines, and ARVs. A facility is considered to have an adequate stock monitoring system if (1) all items that are normally carried are present; (2) no expired items are present; (3) items are stored by expiration date; (4) a stock card or ledger is present for all normally stocked items; and (5) there were no stock outs during the 6 months preceding the survey.

[4] A well-ventilated storage location for contraceptives was not a component of the assessment in 2004.

Table 3.10 Storage conditions and stock monitoring systems for contraceptives, medicines, and ARVs

Among facilities that store methods of contraception, medicines, and ARVs, percentage with good storage conditions and adequate stock monitoring systems in place, by background characteristics, Kenya SPA 2010

Background characteristic	Contraceptive methods			Medicines			ARVs		
	Percentage with all assessed items for system for storing methods[1]	Percentage with all assessed items for system for monitoring stock[2]	Number of facilities with stored contra-ceptive methods observed[5]	Percentage with all assessed items for system for storing medicines[1]	Percentage with all assessed items for system for monitoring stock[3]	Number of facilities with stored medicines observed[5]	Percentage with all assessed items for system for storing ARVs[1]	Percentage with all assessed items for system for monitoring stock[4]	Number of facilities with stored ARVs observed[5]
Type of facility									
Hospital	87	64	43	73	71	50	84	92	43
Health Centre	78	69	66	76	64	80	96	97	62
Maternity	89	76	14	93	64	16	94	95	7
Clinic	87	53	148	83	71	180	84	94	19
Dispensary	73	71	302	71	57	334	93	85	142
Managing authority									
Government	74	70	333	68	57	339	92	88	199
NGO	88	59	20	58	33	22	64	95	16
Private (for profit)	85	61	184	89	72	213	97	93	24
Faith-based organisation	76	59	37	78	71	88	98	93	35
Province									
Nairobi	88	72	29	92	67	39	99	99	18
Central	84	50	102	95	85	125	100	91	32
Coast	91	61	61	66	59	64	88	83	29
Eastern	75	70	93	74	72	115	98	100	42
North Eastern	69	44	16	58	46	23	87	92	6
Nyanza	72	69	76	47	36	80	76	84	61
Rift Valley	73	73	156	74	58	172	96	88	55
Western	84	73	41	88	55	43	96	88	30
Total	78	66	574	75	63	661	92	90	274

[1] Items are stored in a dry location, off the ground, protected from water, sun, pests, and rodents, and well ventilated.
[2] All contraceptive commodities that are normally carried are present, there are no expired commodities present, items are stored by expiration date, a stock card/ledger is present for all normally stocked contraceptive commodities, and there have been no stock shortages of normally carried contraceptive commodities in the past six months.
[3] All medicines that are normally carried are present, there is at least one of each carried medicine with a valid expiration date, medicines are stored by expiration date, there are up-to-date inventory records for normally carried medicines, and there have been no stock shortages of normally carried medicines in the past six months.
[4] All ARVs that are normally carried are present, there is at least one of each carried ARV with a valid expiration date, ARVs are stored by expiration date, there are up-to-date inventory records for normally carried ARVs, and there are no stock shortages of normally carried medicines in the past six months.
[5] The total number of facilities includes one stand-alone VCT facility.

About two-thirds (66 percent) of facilities with stored contraceptive methods observed had all items for adequate stock monitoring systems, as did facilities with stored medicines observed (63 percent) (Table 3.10). Compared with 2004, facilities had to satisfy additional conditions in 2010 in order to qualify as having an adequate stock monitoring system; nonetheless, the findings in 2010 are better than in 2004 for adequacy of stock monitoring systems. Ninety percent of facilities with stored ARVs observed had all items for adequate stock monitoring (Table 3.10).

Facilities in Eastern (70 percent), Nairobi (72 percent), Western, and Rift Valley (both 73 percent) provinces are the most likely to have adequate stock monitoring for contraceptives, while facilities in Central province (85 percent) are most likely to have an adequate stock monitoring system for medicines. There is not much provincial variation for ARVs; however, facilities in Eastern province (100 percent) are most likely to have stock monitoring systems in place compared with facilities in Nyanza, for example (84 percent) (Table 3.10).

Key Findings

Vaccine storage: About eight of every ten facilities that store vaccines and where vaccines were observed had all the necessary components to adequately monitor the cold chain; that is, they had a functioning thermometer in the vaccine refrigerator, an up-to-date temperature chart, and a refrigerator temperature between 2° and 8°C on the day of the survey. This is just slightly better than in 2004.

Nine of every ten facilities that store vaccines had their vaccine refrigerators positioned so they are protected from direct sunlight, compared with almost all facilities in 2004.

Vaccine stock monitoring: Systems for stock monitoring of vaccines were adequate in 38 percent of all facilities.

Storage of contraceptives, general medicines, and ARVs: Just under 80 percent of facilities with stored contraceptives observed had conditions for properly storing the commodities. Three-quarters of facilities with stored medicines and over 90 percent with stored ARVs met the criteria for proper storage of these medicines and ARVs.

Stock monitoring for contraceptives, general medicines, and ARVs: Stock monitoring of contraceptives was adequate in two-thirds of facilities with stored contraceptives observed, adequate in a little over six of every ten with stored medicines observed, and adequate in nine of every ten facilities with stored ARVs observed.

3.4 SYSTEMS FOR INFECTION CONTROL

Universal precautions refer to infection control measures that can prevent cross-infection from blood and other body fluids. All health workers who may come into contact with body fluids should exercise these universal precautions, working under the assumption that anyone may have an infectious condition (CDC, 1987; JHPIEGO, 2003).

The 2010 KSPA assessed conditions for infection control in all service delivery areas covered by the survey. The survey examined conditions to see whether providers could reasonably be expected to wash their hands between seeing different clients. It also checked for the presence of a box for secure disposal of sharp items such as disposable needles, which may be contaminated with HIV or other blood borne infections.

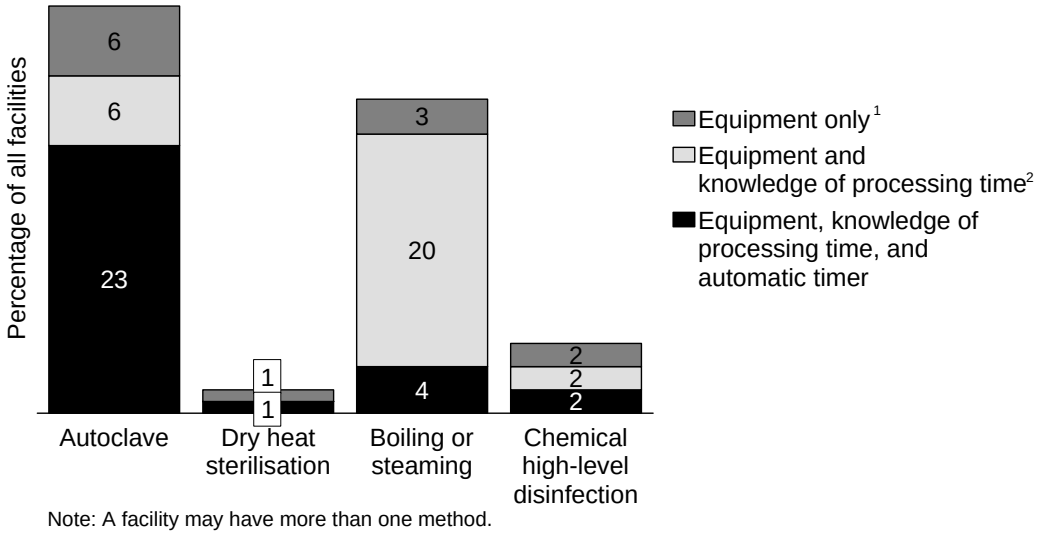
Summary information on facilities' capacity to process equipment for reuse is presented in Tables 3.11, and aggregate information on infection control measures available in service delivery areas is presented in Table 3.12. Figure 3.8 presents details on the various methods used by facilities to process equipment for reuse. Further information on processing methods, storage conditions for processed items, and infection control measures can be found in Tables A-3.19 through A-3.21.

3.4.1 Capacity for Adherence to Standards for Quality Sterilisation or High-Level Disinfection Processes

For most equipment that is used for client examination, either sterilisation or high-level disinfection (HLD) procedures are sufficient to prevent the spread of infection. However, to effectively kill the spores that cause illnesses such as tetanus, either dry-heat sterilisation or an autoclave system (or the less frequently used chemical sterilisation[5]) is required. This type of system is necessary for processing surgical equipment that will be reused, such as blade handles and scissors used to cut the umbilical cord. Depending on the size of the facility, different types of equipment may be processed using different methods or at more than one site in the facility. The information presented in this chapter refers to the primary site in the facility where equipment is processed.

[5] With formaldehyde or glutaraldehyde (Cydex).

Figure 3.8 Facilities with Indicated Elements for Processing Equipment Using Indicated Method (N=695)



Note: A facility may have more than one method.

[1] Sum of all percentages shown in bar. For example, for autoclave, percentage of facilities with equipment only is 35 percent.

[2] Sum of the two percentages from the bottom of the bar. For example, for autoclave, percentage of facilities with 'equipment and knowledge of processing time' is 29 percent.

KSPA 2010

Six of every ten facilities have functioning equipment (including the necessary chemicals for HLD) for the processing method used (see Table 3.11). Most hospitals (92 percent), maternity facilities (88 percent), and health centres (84 percent) have functioning equipment. Faith-based (80 percent) and private (62 percent) facilities are more likely to have functioning equipment than government facilities (55 percent) or NGOs (24 percent). At the provincial level, the availability of functioning equipment ranges from 17 percent of facilities in North Eastern province to 87 percent in Central province (Table 3.11).

A slightly smaller proportion of facilities (51 percent) has a functioning equipment as well as the correct knowledge of the processing time and temperature for the method (see Table 3.11). When presence of an automatic timer is added to the assessment (where applicable), the proportion declines to 24 percent of facilities (Table 3.11). Written guidelines for sterilisation or HLD processing in any service area were found in only 16 percent of all facilities.

As shown in Figure 3.8, the most commonly used methods for processing equipment are autoclaving and boiling/steaming. For autoclaving, 35 percent of all facilities have functioning equipment, 29 percent have the equipment plus knowledge of processing time, and 23 percent have the equipment, knowledge of processing time, and an automatic timer. For boiling or steaming, 27 percent of facilities have the necessary equipment (Figure 3.8).

Table 3.11 Capacity for processing of equipment: all methods

Percentage of facilities with the equipment, knowledge, timer, and guidelines to support quality sterilisation for high-level disinfection (HLD) of equipment, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with: Equipment	Equipment and knowledge of process time[1]	Equipment, knowledge of process time, and automatic timer[2]	Written guidelines for sterilisation or HLD present[3]	Number of facilities
Type of facility					
Hospital	92	85	69	52	51
Health centre	84	71	45	38	80
Maternity	88	81	55	37	17
Clinic	58	51	17	8	203
Dispensary	49	40	16	9	340
Stand-alone VCT	7	2	2	7	5
Managing authority					
Government	55	46	26	18	345
NGO	24	22	16	11	24
Private (for profit)	62	55	21	12	237
Faith-based organisation	80	65	30	16	89
Province					
Nairobi	58	49	34	19	45
Central	87	75	28	13	125
Coast	68	57	29	14	81
Eastern	47	38	18	10	118
North Eastern	17	15	15	9	24
Nyanza	51	41	26	29	83
Rift Valley	51	46	19	15	175
Western	72	65	35	23	44
Total	59	51	24	16	695

[1] Processing area has functioning equipment and power source for method and reports the correct processing time (or the equipment automatically sets the time) and processing temperature (if applicable) for at least one method. Definitions for capacity for each method assessed were functioning equipment and the following processing conditions:
- Dry heat sterilisation: Temperature at 160°C to 169°C and processed for at least 120 minutes, or temperature at least 170°C and processed for at least 60 minutes
- Autoclave: Wrapped items processed at least 30 minutes, unwrapped items processed at least 20 minutes
- Boiling or steaming: Items processed at least 20 minutes
- Chemical high-level disinfection: Items processed in chlorine-based or glutaraldehyde solution and soaked for at least 20 minutes

[2] This refers to a passive timer that can be set to indicate when a specified time has passed. This may be a part of the sterilisation process or the HLD equipment.

[3] Hand-written guidelines pasted on walls are acceptable.

3.4.2 Appropriate Storage Conditions for Processed Items

Facilities must be able to store processed items under sterile conditions. To maintain sterility or HLD status, items must be (1) stored in a dry location; (2) either wrapped in sterile, dry cloth or placed in a sterile or HLD-processed container that can clasp shut; and (3) marked with the processing date, because the sterile/HLD status cannot be ensured after one week unless the item is also sealed in plastic. Other common storage procedures, such as keeping unwrapped items in an autoclave or on a tray covered with a clean cloth, may be accepted in some settings but do not ensure sterile/HLD status.

Eighty-eight percent of the facilities had processed (sterilised or HLD disinfected) items present on the day of the survey (Table A-3.20). The same facility may have processed items stored under both sterile/HLD and non-sterile/HLD conditions.

Among facilities with processed items present on the day of the survey, 67 percent had processed items stored under sterile/HLD conditions (i.e., wrapped and sealed with time-steam-temperature strip or placed in a sterile/HLD container that clasps shut, and stored in a dry, clean area). Hospitals (88 percent) and stand-alone VCT facilities (100 percent) are most likely to have processed

items stored under these conditions. At the provincial level, facilities in Eastern province (79 percent) are the most likely to store processed items under sterile/HLD conditions.

Twenty percent of these facilities had processing dates observed on stored items, and only 19 percent of facilities had processed items under sterile/HLD conditions and also had processing dates on the sterilised items.

3.4.3 Infection Control in Service Delivery Area

Infections acquired in health facilities often complicate the delivery of health care worldwide. Strict compliance with infection control guidelines and constant vigilance are necessary to prevent such infections. The items considered relevant and necessary to prevent these infections include soap, running water, hand disinfectant, sharps boxes for appropriate disposal of sharps waste, disinfectant solution, and gloves. The presence of running water in a service delivery area does not necessarily imply that providers will wash their hands, or how and when they should. However, having running water and soap available in the area where services are provided, or in an immediately adjacent area, may increase the likelihood that they will do so.

As shown in Table 3.12, thirty-six percent of facilities have *all* infection control items (soap and running water, or else hand disinfectant, sharps box, disinfectant, and latex gloves) available in *all* assessed service delivery sites (66 percent of stand-alone VCTs, 51 percent of clinics, and 35 percent of dispensaries). Figure 3.9 and Table A-3.21 detail the availability of specific infection control items in all service delivery sites. Individually, soap (58 percent) and running water (68 percent) are available. Together, soap and running water are among the items least likely to be available, as is hand disinfectant (13 percent). Sharps boxes (90 percent) and clean or sterile latex gloves (83 percent) are widely available.

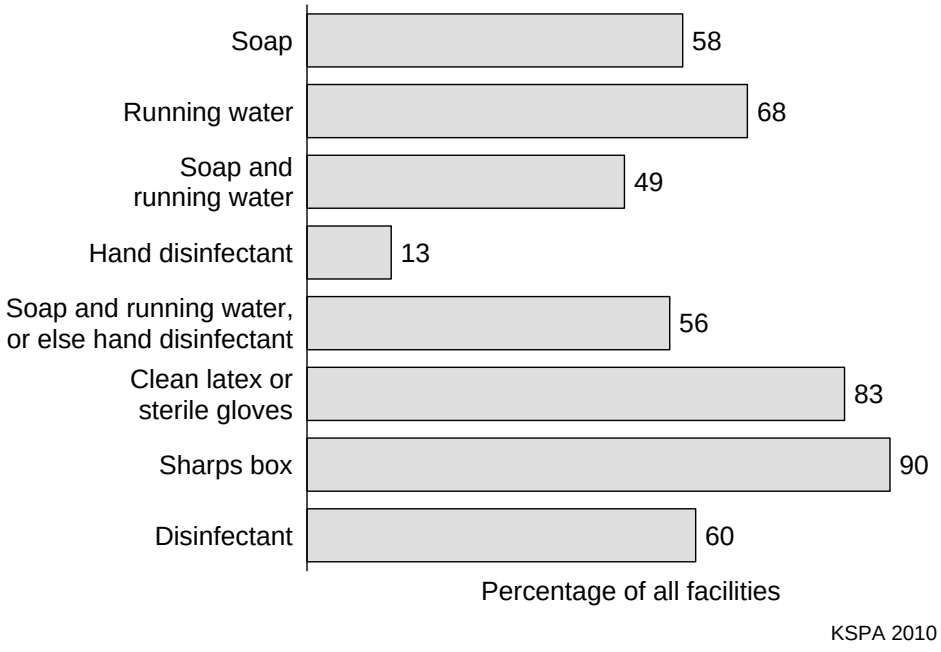
Table 3.12 Infection control and hazardous waste control

Percentage of facilities that have all items for infection control in all assessed service delivery areas, adequate disposal system for infectious and sharps waste, and infection control guidelines, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage with all items for infection control in all assessed service delivery areas[1]	Percentage with adequate final disposal system[2] for infectious waste	Percentage with adequate final disposal system[3] for sharps waste	Percentage with all items for infection control in any assessed service delivery areas[4]	Percentage with guidelines for disinfection and sterilisation in any assessed sterilisation area	Number of facilities
Type of facility						
Hospital	12	60	66	93	52	51
Health centre	21	61	68	79	39	80
Maternity	25	71	78	78	39	17
Clinic	51	72	77	66	8	203
Dispensary	35	60	72	70	9	340
Stand-alone VCT	66	63	83	82	7	5
Managing authority						
Government	30	56	68	72	19	345
NGO	20	62	75	49	11	24
Private (for profit)	50	73	79	70	12	237
Faith-based organisation	28	69	77	84	16	89
Province						
Nairobi	39	66	69	78	19	45
Central	54	65	77	82	13	125
Coast	47	77	78	77	14	81
Eastern	20	59	63	51	10	118
North Eastern	24	38	41	78	9	24
Nyanza	22	59	71	81	29	83
Rift Valley	36	64	79	70	15	175
Western	42	70	81	69	23	44
Total	36	64	73	72	16	695

[1] Soap and running water or else hand disinfectant, sharps box, disinfectant, and latex gloves in all assessed service areas.
[2] Infectious waste is collected and disposed of externally, or incinerated, or burned in a protected area or pit, or dumped in a protected area or covered pit; there was no unprotected infectious waste observed in any service site or waste disposal area on the day of the survey.
[3] Sharps waste is collected and disposed of externally, or incinerated, or burned in a protected area or pit, or dumped in a protected area or covered pit; there was no unprotected sharps waste observed in any service site or waste disposal area on any day of the survey.
[4] Soap and running water or else hand disinfectant, sharps box, disinfectant, and latex gloves in any assessed service areas.

Figure 3.9 Availability of Infection Control Items in All Assessed and Relevant Service Delivery Areas in a Facility (N=695)



For each of these items, except hand disinfectant, private facilities are more likely to have them compared with facilities managed by other authorities. With the exception of hand disinfectant, facilities in Central and Nairobi provinces are more likely than facilities in other provinces to have most of these items.

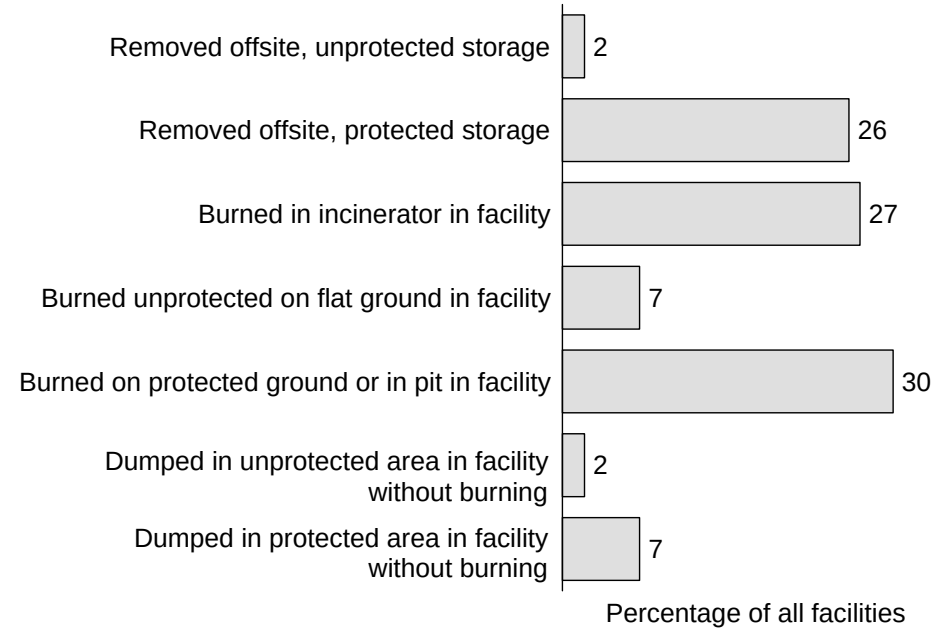
When infection control items are assessed for their availability at *any* of the assessed service delivery sites within a facility, and not at *all* the sites in the facility, the proportion of facilities that meet the criteria increases quite dramatically (Table 3.12). Though this is good, it is not expected that a provider will move from his or her station to another service site to wash hands between seeing clients. Ideally, each service site should have all items necessary for proper infection prevention.

The survey further looked for the availability of infection prevention guidelines. As evident from Table 3.12, the majority of facilities in the country do not have infection prevention guidelines. Indeed, only 16 percent of facilities have infection control guideline at *any* assessed service site.

3.4.4 Adequate Disposal of Hazardous Waste

Hazardous waste includes infectious waste (such as bandages and cotton balls that may be contaminated by blood or other bodily fluids) and sharps waste (such as needles and syringes, blades and ampoules). Appropriate final disposal of hazardous waste is another important aspect of infection control. The most effective means for hazardous waste disposal is incineration and subsequent burial of the residue. Burying items in deep pits is also an effective means of disposal. When assessing whether facilities have adequate waste disposal systems, the most important issue is verifying that there is a disposal process that eliminates the possibility of contamination through contact. If the waste is visible and not protected from animals or people, either before or after being removed, burned, or buried, there is an increased chance that people might inadvertently come in contact with it, risking infection. Details on waste disposal systems are provided in Table 3.12, Tables A-3.23.1 and A-3.23.2, and Figure 3.10.

Figure 3.10 Waste Disposal Methods for Sharps Waste (N=695)



Note: Other methods were not used. KSPA 2010

After determining which system each facility used, data collectors went either to the location where waste is stored prior to disposal or to the disposal site itself to assess whether there was potentially hazardous waste that was not protected.

Infectious waste

The disposal system for infectious waste is considered *adequate* if the waste is collected and disposed of externally, incinerated or burned in a protected area or pit, or dumped in a protected area or covered pit, *and* if there is no unprotected infectious waste observed in any service site or waste disposal area on the day of the survey. By these criteria, 64 percent of facilities have an adequate disposal system for infectious waste (Table 3.12). The percentage of facilities with an adequate system for disposal of infectious waste ranged from 60 percent for hospitals and dispensaries to 72 percent for clinics. Facilities in North Eastern province (38 percent) are the least likely to have an adequate infectious waste disposal system. Private facilities are more likely to have an adequate infectious waste disposal system than government facilities (73 and 56 percent, respectively).

Table A-3.23.1 shows details on disposal of infectious waste in health facilities.

Sharps waste

The disposal system for sharps waste is considered *adequate* if sharps waste is collected and disposed of externally, incinerated or burned in a protected area or pit, or dumped in a protected area or covered pit, *and* there is no unprotected sharps waste observed in any service site or waste disposal area on the day of the survey. About 73 percent of facilities have an adequate sharps waste disposal system.

Key Findings

Processing of equipment: Approximately six of every ten facilities have functioning equipment or the necessary chemicals for the method used to process equipment for reuse, as in 2004. Only one-quarter of facilities have the equipment, knowledge of the process time, and an automatic timer.

Storage of processed equipment: Two-thirds of facilities with processed equipment observed had equipment stored under sterile/HLD conditions.

Infection control: Thirty-six percent of facilities have *all* infection control items available in *all* assessed service delivery sites.

Adequate disposal of sharps waste: More than seven of every ten facilities have an adequate system for disposal of sharps waste.

CHILD HEALTH SERVICES 4

Annah Wamae, Collins Opiyo, Andolo Miheso, Lucy Kimondo

4.1 BACKGROUND

4.1.1 KSPA Approach to Collecting Child Health Information

Both the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) have estimated that about 10 million children under five years of age die each year, largely from preventable causes. Many sick children who are brought to health care providers do not receive adequate assessment and treatment (WHO, 1999). It is not uncommon for providers to treat the symptoms that are most evident, without conducting a full assessment of a child's health status or acting to prevent further diseases. For this reason, WHO and other agencies developed the Integrated Management of Childhood Illness (IMCI) strategy (WHO, 1997). This strategy advocates using every visit to a health care provider as an opportunity, not only to conduct a full assessment of the child's current health and possible underlying problems, but also to provide interventions, such as immunisation that can prevent illness or minimise its progression.

The IMCI strategy aims to reduce morbidity and mortality among children under age five years through the following three activities:

1. Improving health workers' skills through training and supportive supervision
2. Improving health systems, including equipment, supplies, organisation of work, and referral systems
3. Improving child care at the community and household levels in line with key family practices

Training and supportive supervision, through a holistic approach, help health workers assess and appropriately treat major childhood illnesses (including diarrhoea, malaria, pneumonia, measles, and other severe infections). At the time of the 2010 KSPA, the IMCI strategy was being implemented in 56 of 75 old districts at the health facility and community/household levels. WHO recommends that at least 60 percent of providers be trained in IMCI case management to ensure a critical mass for proper management of sick children. By employing the IMCI framework, the 2010 KSPA endeavours to provide useful information that can be used to judge progress in implementing the IMCI strategy across Kenyan health facilities. Therefore, this assessment uses IMCI protocols whenever possible in examining the delivery of child health services at the health facility level.

This chapter uses information obtained from the 2010 KSPA to address the following four central questions:

- What is the availability of outpatient curative services relevant to child health?
- To what extent do facilities offering immunisation services for children have the capacity to support good quality vaccination services?
- To what extent do facilities providing outpatient care for sick children have the capacity to support quality services in adherence to IMCI guidelines?

- To what extent do health service providers who treat sick children on an outpatient basis adhere to standards for good quality service provision?

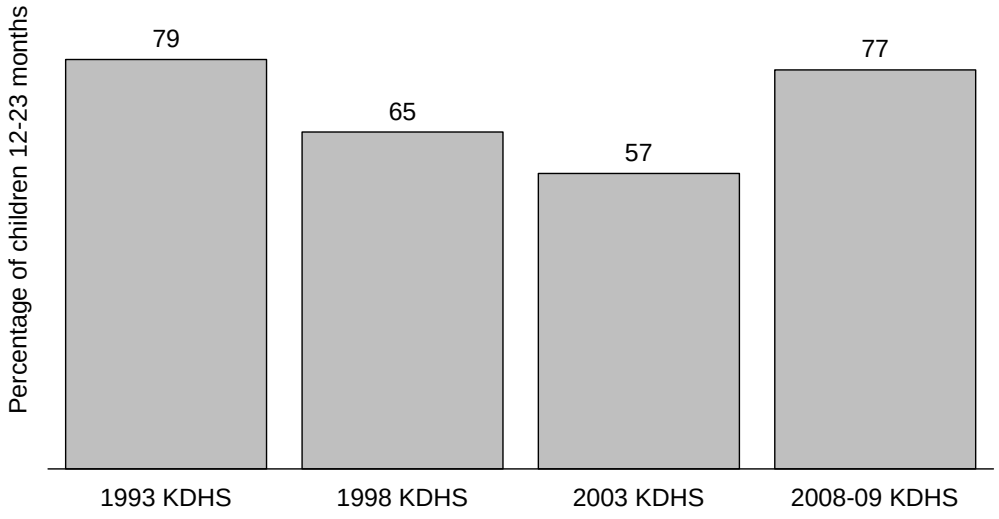
4.1.2 Health Situation of Children in Kenya

Vaccine coverage

Immunisation against vaccine-preventable diseases is vital to reducing child morbidity and mortality. The Expanded Programme on Immunisation (EPI) under the Ministry of Public Health and Sanitation (MOPHS) is aimed at ensuring that all children are fully immunised by their first birthday. Children should receive one dose of tuberculosis vaccine (BCG); three doses of the vaccine against diphtheria, pertussis, tetanus, hepatitis B, and Haemophilus influenza type b [(DPT-HepB + Hib1) or pentavalent]; four doses of oral polio vaccine (OPV); and one dose of measles vaccine. According to the 2008-2009 Kenya Demographic and Health Survey (2008-09 KDHS) (KNBS and Macro International, 2010), 77 percent of children ages 12-23 months were fully immunised, in line with the EPI target of 77 percent in the National Health Sector Strategic Plan II (NHSSP-II) for 2005-2010.

Figure 4.1 shows immunisation coverage rates since 1993.

Figure 4.1 **Children 12-23 Months who Received All Immunisations, Kenya 1993–2008-09**



KDHS = Kenya Demographic and Health Survey KSPA 2010

Nutritional status

Malnutrition is an underlying factor in a large proportion of the illnesses that cause death among children under five years of age. The 2008-09 KDHS found that 35 percent of children under five years in Kenya are stunted (short for their age), and 14 percent are severely stunted. The prevalence of stunting is higher among rural children than among urban children (37 versus 26 percent).

Childhood mortality and morbidity

The 2008-09 KDHS provides household-based child mortality data as well as information on what illnesses children experienced, and whether they received health care, during the two weeks

preceding the household survey visit (KNBS and ICF Macro, 2010). Key findings include the following:

- The infant mortality rate was estimated at 52 deaths per 1,000 live births for the 5-year period (2004-2008) preceding the survey, a reduction from the 67 deaths per 1,000 live births for the period five to nine years preceding the survey (1999-2003).

- The under-five mortality rate was estimated at 74 deaths per 1,000 live births, meaning that 1 in every 14 Kenyan babies does not survive to the fifth birthday.

- Eight percent of children under age five years showed symptoms of acute respiratory infection (ARI) at some time in the two weeks preceding the survey. Among those with symptoms of ARI, a little over half sought advice or treatment from a health facility or provider. About one of every four children under age five years had fever during the two weeks preceding the survey. Of those children, 23 percent took antimalarial medicine, and 36 percent took antibiotics.

- Seventeen percent of children under age five years had diarrhoea in the two weeks preceding the survey. The age group most affected by diarrhoea was age 6-23 months. Caregivers sought advice or treatment from a health facility or provider for 49 percent of all children who had diarrhoea during the two weeks preceding the survey.

- The recommended treatment for diarrhoeal diseases—other than dysentery, for which antibiotics are recommended—is fluid replacement. Thirty-nine percent of children with diarrhoea were given oral rehydration salts (ORS); 51 percent received home-made fluids. Altogether, 78 percent of children with diarrhoea received some form of oral rehydration therapy (ORT) or increased fluids. Fourteen percent of children with diarrhoea during the two weeks preceding the survey were given antibiotics.

- Fifty-one percent of children under age five years slept under a mosquito net (treated or untreated) the night before the survey; 47 percent slept under an insecticide-treated net (ITN) the night before the survey.

4.2 Availability of Child Health Services

4.2.1 Outpatient Curative Care, Child Immunisation, and Child Growth Monitoring

The 2010 KSPA assessed the availability of three basic child health services: out-patient curative care for sick children, routine childhood immunisation services under EPI, and routine growth monitoring services. Table 4.1 provides information on the availability of these services. Tables A-4.1.1, A-4.1.2, A-4.1.3, and A-4.2 provide further details on the frequency of child health services and on community outreach services.[1]

Health services in Kenyan facilities are relatively integrated. Sixty-eight percent of facilities (excluding stand-alone voluntary counselling and testing (VCT) facilities) provide all three basic child health services as a package (Table 4.1). In 2004, almost 8 of every 10 facilities provided all three services. Compared with 2004, there have been declines in the proportions of facilities providing childhood immunisation services (68 percent in 2010 versus 83 percent in 2004) and growth monitoring services (74 percent in 2010 versus 81 percent in 2004). The proportion of facilities providing out-patient curative care for sick children remained the same, at 97 percent in both 2010 and 2004.

[1] Community outreach refers to any services provided outside of the facility. For immunisations this might include activities related to campaigns, such as the polio eradication campaign.

Table 4.1 Availability of child health services

Percentage of facilities offering specific child health services at the facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities that provide: Curative outpatient care for sick children	Growth monitoring	Childhood immunisation[1]	All three basic child health services	Routine vitamin A supplementation	Treated mosquito nets to children under 1 year	Number of facilities
Type of facility							
Hospital	100	95	93	92	94	64	51
Health centre	100	95	95	93	96	73	80
Maternity	95	82	78	78	77	33	17
Clinic	94	43	29	29	35	11	203
Dispensary	97	84	81	80	87	65	340
Managing authority							
Government	97	89	88	86	94	70	344
NGO	96	80	80	80	80	71	22
Private (for profit)	95	48	34	34	40	12	236
Faith-based organisation	99	84	79	79	79	63	88
Province							
Nairobi	93	73	73	68	73	11	41
Central	96	58	45	45	45	19	125
Coast	89	58	57	55	57	44	81
Eastern	100	80	66	66	83	64	118
North Eastern	96	66	63	63	66	1	24
Nyanza	100	95	94	93	95	88	82
Rift Valley	97	77	75	74	81	53	174
Western	99	90	87	87	90	78	44
Total	97	74	68	68	73	49	690

[1] Childhood immunisation refers to the routine provision of DPT/pentavalent, polio, and measles vaccinations to children.

Clinics are the type of facility least likely (at 29 percent) to provide all three basic services. Private facilities, at 34 percent, lag behind other managing authorities (government 86 percent, NGOs 80 percent, and faith-based organisations 79 percent). The same was true in 2004, when private facilities (at 49 percent) were less likely than those of other managing authorities to provide all three services.

At the provincial level facilities in Central (45 percent) and Coast (55 percent) provinces are least likely to offer all three services as a package, mainly because growth monitoring and childhood immunisation are less likely to be offered there than in other provinces.

Out-patient curative care for sick children is the most commonly provided (in 97 percent of facilities) of the three basic services. These services are almost universally available across all facility types, managing authorities, and provinces, except in Coast province, where less than 90 percent of facilities offer curative care for sick children. In 2004, much as in 2010, curative care for sick children was almost universally available across all facility types, managing authorities, and provinces, except in Nairobi, where less than 90 percent of facilities offered curative care for sick children.

Although on average only 68 percent of all facilities offer child immunisation services, the great majority of hospitals (93 percent), health centres (95 percent), maternity facilities (78 percent), and dispensaries (81 percent) offer the service, compared with only 29 percent of clinics. Government facilities (88 percent) are the most likely to offer childhood immunisation services (Table 4.1).

Facilities in Central province (45 percent) are least likely to provide childhood immunisation services. Interestingly, according to findings of the 2008-09 KDHS, Central province has the highest proportion of children age 12-23 months who are fully vaccinated (KNBS and ICF Macro, 2010). By contrast, facilities in Nyanza (94 percent) and Western (87 percent) provinces are most likely to provide these services. Facilities in Nyanza province also have the highest level of provision of growth monitoring services (95 percent).

4.2.2 Vitamin A Supplementation and Insecticide-Treated Mosquito Nets

The 2010 KSPA also assessed provision of vitamin A supplementation and insecticide-treated mosquito nets (ITNs) to children under one year of age (Table 4.1). Overall, 73 percent of health facilities provide vitamin A supplementation to children under one year, while 49 percent provide treated mosquito nets. Health centres (96 percent) and hospitals (94 percent) are more likely to provide vitamin A supplementation than other types of facilities. Health centres (73 percent) also are most likely to provide treated mosquito nets. Government facilities (94 percent) are most likely to provide vitamin A supplementation, and NGO and government facilities are most likely to provide ITNs (71 and 70 percent, respectively). Among the provinces, facilities in Nyanza are most likely to provide both vitamin A supplementation (95 percent) and treated mosquito nets (88 percent) to children under one year. Facilities in North Eastern province are least likely to provide mosquito nets (only 1 percent), while facilities in Central province are least likely to provide vitamin A supplementation (45 percent).

Key Findings

Service availability: Seven in every ten facilities offer all three basic child health services (outpatient curative care for sick children, growth monitoring, and childhood immunisation). Outpatient curative care for sick children is the most commonly offered of these three child health services (97 percent of facilities), and childhood immunisation is the least offered service (68 percent). There has been a decrease in the availability of preventive child health services (child immunisation and growth monitoring) since 2004.

Facilities in Nyanza province have the highest level of provision of immunisation services (94 percent) and also are more likely to provide growth monitoring services (95 percent) than facilities in other provinces. Nyanza province also tops the rankings in providing vitamin A supplementation and treated bed nets for children under one year of age.

Private for-profit facilities are least likely to offer growth monitoring (48 percent) and immunisation services (34 percent). This contrasts with government health facilities, nearly 90 percent of which offer both services.

4.3 Capacity to Provide Quality Immunisation Services

This section addresses the following elements, which are important for quality immunisation services:

- Capacity to maintain the quality of vaccines
- Availability of vaccines and vitamin A
- Availability of equipment and supplies for vaccination sessions
- Availability of administrative components for monitoring immunisation activities

4.3.1 Capacity to Maintain the Quality of Vaccines

A lack of vaccine refrigerators, electricity, or other fuel (such as liquefied petroleum gas) to run electric generators for refrigerators are common reasons that facilities cannot or do not store vaccines. If a facility cannot maintain the cold chain and safely store vaccines, it must collect vaccines from a central location or a nearby facility with a refrigerator on the day(s) of service and then use mobile vaccine carriers and ice packs to maintain their temperature. The logistical challenges of maintaining the cold chain frequently result in limited availability of vaccination services. Information

on vaccine storage conditions with details on elements assessed are provided in Chapter 3, Tables 3.9 and A-3.12.

Temperature monitoring is extremely important to ensure the potency and effectiveness of vaccines (WHO, 2000a; WHO, 2004a). Overall, 79 percent of all facilities with stored vaccines observed on the day of the survey had an adequate system[2] for monitoring vaccine storage temperature (compared with 73 percent in 2004), while only 38 percent had an adequate system to monitor vaccine stocks[3] (Chapter 3, Table 3.9). NGO facilities (60 percent) and facilities in Rift Valley province (70 percent) are the least likely to have an adequate system to monitor storage temperature. Adequate systems to monitor vaccine stocks are uncommon, particularly in facilities in Central (19 percent), North Eastern (25 percent), and Rift Valley provinces (28 percent). Facilities in Nyanza province (64 percent) are most likely to have an adequate system to monitor vaccine stocks.

4.3.2 Availability of Vaccines and Vitamin A

The availability of child vaccines was assessed at facilities that provide immunisation services and also store vaccines. Figure 4.2 and Table 4.2 summarise these findings. Table A-4.3 provides additional information on vaccine availability by facility type, managing authority, and province.

Vaccines

According to survey findings, vaccines for the seven major childhood diseases are commonly available. Among eligible facilities 84 percent have all basic EPI vaccines (similar to 85 percent in 2004). NGO facilities and those in Rift Valley province are among the least likely to have all EPI vaccines.

Vitamin A

Vitamin A is essential for the functioning of the immune system, for healthy growth and development, and for protection from respiratory infections and night blindness. Because WHO recommends routinely distributing high-dose vitamin A capsules to children, many countries have added vitamin A supplementation to their EPI programmes. In Kenya the policy is to provide high-dose vitamin A once every six months from age 6 months through age 59 months. Findings of the 2010 KSPA show that 94 percent of facilities offering child immunisation services and storing vaccines have vitamin A available in the service delivery areas along with EPI vaccines, an increase from 74 percent in 2004 (Figure 4.2, Table A-4.3).

4.3.3 Availability of Equipment and Supplies for Vaccination Sessions

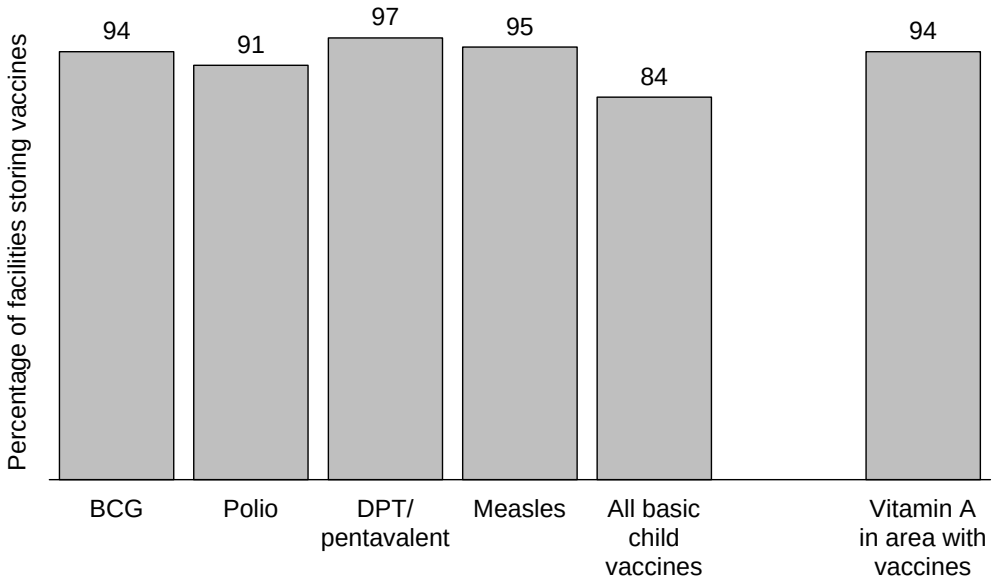
Table 4.2 and Figure 4.3 provide information on the availability of all the components assessed for quality immunisation services. Table A-4.4 details the availability of these items by facility type, managing authority, and province.

Overall, on the day of the survey only 37 percent of facilities that offer child immunisation services had available all equipment, items for infection control, and administrative components for providing quality child immunisation services (Table 4.2). NGO facilities stand out as the least likely to have all these items (4 percent), as do maternity facilities (24 percent).

[2] A functioning thermometer in vaccine refrigerator, an up-to-date temperature chart, and refrigerator temperature between 2˚ and 8˚C all observed at time of visit.

[3] All vaccines that are normally carried are present, there are no expired items present, items are stored by expiration date, stock card/ledger is present for all normally stocked vaccines, and no stock-out in past 6 months.

Figure 4.2 Availability of Vaccines among Facilities Offering Child Immunisation Services and Storing Vaccines (N=426)



KSPA 2010

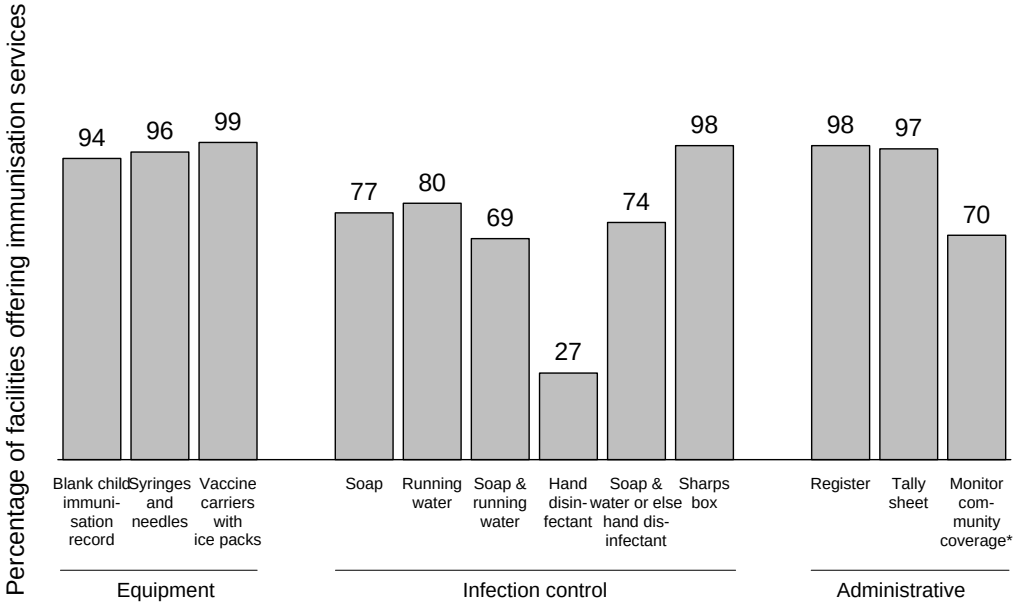
Table 4.2 Health system components required for childhood immunisation services

Among facilities offering child immunisation services, percentage that have all equipment, items for preventing infection, and records indicating good administrative practices; and, among facilities offering child immunisation services and storing vaccines, percentage that have all basic child vaccines and all components for providing quality child immunisation services, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering child immunisation that have:				Number of facilities offering child immunisation services[4]	Percentage of facilities offering child immunisation services and storing vaccine that have:		Number of facilities offering child immunisation services and storing vaccines
	All equipment[1]	All items for infection control[2]	Administrative components[3]	All equipment, items for infection control, and administrative components		All basic child vaccines[5]	All components for providing quality child immunisation services (including vaccines)	
Type of facility								
Hospital	83	48	77	35	47	90	33	47
Health centre	90	50	72	39	76	79	36	75
Maternity	77	57	40	24	13	94	24	12
Clinic	99	62	59	31	59	88	26	56
Dispensary	90	58	72	39	276	82	34	237
Managing authority								
Government	92	53	76	41	303	83	35	269
NGO	88	7	70	4	17	68	1	15
Private (for profit)	88	69	49	31	81	87	30	74
Faith-based organisation	84	68	66	40	70	87	33	69
Province								
Nairobi	89	56	45	27	30	91	28	29
Central	97	77	67	50	56	91	45	56
Coast	96	73	85	58	46	93	52	45
Eastern	86	36	80	23	77	83	21	73
North Eastern	90	35	70	21	15	89	23	14
Nyanza	91	47	82	36	77	88	33	61
Rift Valley	90	62	63	40	131	73	29	120
Western	75	50	57	30	38	80	33	27
Total	90	56	70	37	471	84	33	426

[1] Blank immunisation cards, syringes and needles, and vaccine carriers with ice packs (or facility reports purchasing ice).
[2] Soap and running water or else hand disinfectant, latex gloves, sharps container, and decontaminant.
[3] Tally sheet or register where vaccines provided are recorded and documentation of either DPT/pentavalent dropout rate or measles coverage.
[4] Includes all facilities offering immunisations at the facility.
[5] BCG, DPT/pentavalent, polio, and measles vaccines.

Figure 4.3 Availability of Equipment and Supplies for Immunisation Services (N=471)



* Measles coverage or DPT/pentavalent dropout rate is documented and documentation was observed.

KSPA 2010

Equipment

Nine of every ten facilities that offer child immunisation services had all equipment[4] necessary to provide quality services, compared with eight of every ten facilities in 2004. Maternity facilities were least likely in 2010 to have all equipment.

As for specific equipment, almost all (96 percent) eligible facilities had adequate supplies of syringes and needles (similar to 99 percent in 2004). Blank immunisation cards and vaccine carriers with ice packs were available at 94 and 99 percent of facilities, respectively (compared with 83 and 98 percent in 2004). Blank immunisation cards were least likely to be found in maternity facilities (Table A-4.4).

Infection control

Infection control is crucial to quality care during immunisations. Among facilities offering child immunisation services, 56 percent had all infection control items[5] (Table 4.2). Clinics are more likely to have these infection control items (62 percent) than are other facility types. Among the various managing authorities, NGO facilities are by far the least likely to have these items.

Looking at individual infection control items, three-quarters of facilities had soap and running water or else hand disinfectant. This suggests that service providers in one-quarter of facilities either use other sources of water to wash their hands (such as water in a basin, which is usually used multiple times) or simply do not wash their hands while providing immunisation services. Individually, an average of 77 percent had soap, 80 percent had running water, and only one-fourth had hand disinfectant.

[4] Blank immunisation cards, syringes and needles, and vaccine carriers with ice packs.
[5] Soap and running water or else hand disinfectant, latex gloves, sharps container, and decontaminant.

Administrative components

Measures often used for monitoring immunisation coverage include the pentavalent (DPT-HepB + Hib) dropout rate—the difference between the number of children who receive the first dose of pentavalent vaccine (DPT-HepB + Hib1) and the number who complete all three doses (DPT-HepB + Hib3)—and vaccine coverage rates. Measures of immunisation coverage require an estimate of the target population, which is provided by the Kenya National Bureau of Statistics through projections of household census results. KSPA 2010 specifically assessed whether pentavalent dropout rates or measles coverage information was readily available in Kenyan health facilities.

Findings from the survey show that, on the day of the visit, 70 percent of facilities had the necessary administrative components[6] available (Table 4.2), compared with 77 percent in 2004. Maternity facilities (40 percent) and private facilities (49 percent) were among the least likely to have these items. Individually, tally sheets or registers could be found in almost all eligible facilities, while 70 percent of facilities had documentation of either the DPT or pentavalent dropout rate (Figure 4.3, Table A-4.4).

Key Findings

Vaccines: All basic EPI vaccines for the seven major childhood diseases are available in eight of every ten eligible facilities. Each individual vaccine is missing in only 3 to 9 percent of facilities.

Equipment: Equipment and supplies for immunisation are available in 90 percent of facilities offering immunisation services.

Infection control: All items for infection control—soap and running water or else hand disinfectant, as well as latex gloves, sharps container, and decontaminant—are available in slightly over half of the facilities.

Administrative components: Tally sheets and registers are widely available. Documentation of measles coverage or DPT/pentavalent dropout rates is available in seven of every ten facilities.

4.4 CAPACITY TO PROVIDE QUALITY OUT-PATIENT CARE FOR SICK CHILDREN

To improve the diagnosis of illnesses and to minimise missed opportunities to provide preventive interventions, IMCI standards recommend that any consultation for a sick child also include—

- Assessing immunisation status and providing vaccines that are due
- Assessing nutritional status and counselling caretakers on identified problems
- Assessing overall health status
- Ensuring that the child receives the first dose of any prescribed medicine, including antibiotics, at the facility and leaves the facility with the necessary medications
- Ensuring that caretakers know how to administer medications and treatments, know about appropriate foods, and know how much food the child needs both during this illness and when not sick
- Ensuring that caretakers know when to return, either because signs indicate that the child must be seen immediately or because of scheduled follow-up

[6] Tally sheet or register where vaccines provided are recorded and documentation of either DPT/pentavalent dropout rate or measles coverage rate.

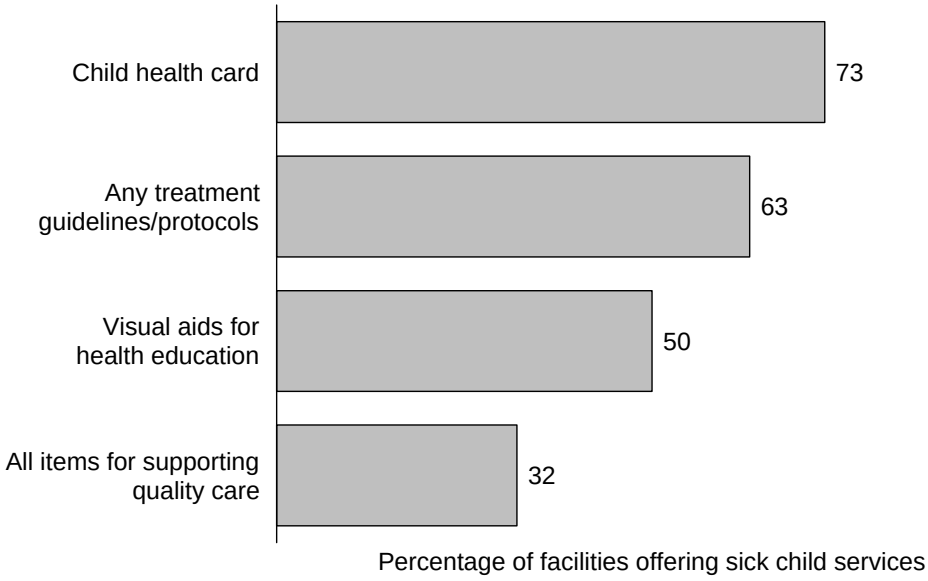
The 2010 KSPA assessed the availability of equipment, supplies, and health system components necessary to adhere to IMCI guidelines and to support quality out-patient care for sick children (WHO, 1997; WHO, 1999). Assessed elements are as follows:

- Infrastructure and resources to support good-quality assessment and counselling
- Equipment and supplies for adhering to IMCI guidelines for assessment of the sick child
- Essential medicines for treating sick children in accordance with IMCI guidelines
- IMCI job aids, including the chart booklet, recording form, and mother/caretaker cards

4.4.1 Infrastructure and Resources to Support Good-Quality Assessment and Counselling for the Sick Child

To support good-quality assessment and counselling, the following should ideally be readily available in areas where sick children receive services: items for infection control, including soap and running water or else hand disinfectant, sharps containers, and disinfectant; items to support quality services, such as individual child health cards; treatment guidelines and protocols; and visual aids. Figure 4.4 provides information on the availability of some of these items, with further details in Tables A-4.5 and A-4.6.

Figure 4.4 **Availability of Items to Support Quality Care for Sick Children (N=666)**



KSPA 2010

Treatment guidelines or protocols, which should be available for quick reference, were observed in 63 percent of facilities offering sick child services (compared with 22 percent in 2004) (Figure 4.4). Health centres and hospitals (85 and 78 percent, respectively) are more likely than other facility types to have treatment guidelines (Table A-4.5). Individual child health cards, which are important for continuity of care, were available in 73 percent of facilities (compared with 52 percent in 2004); visual aids were observed in half of facilities (compared with 29 percent in 2004).

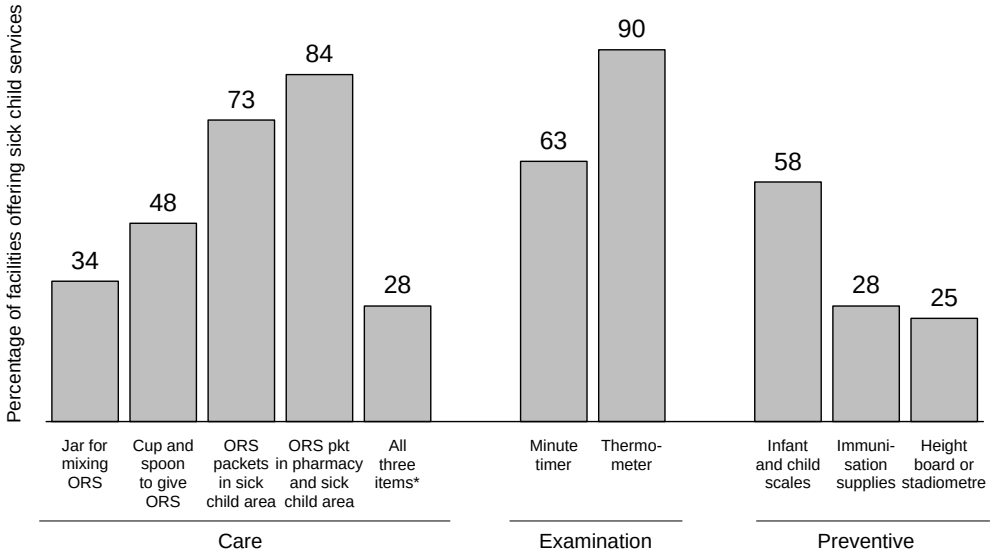
Kenya is promoting IMCI nationwide. Therefore, related items (such as chart booklets, counselling cards for providers, and caretaker cards) are expected to be available in all facilities. However, only one-third of facilities offering curative care for sick children had IMCI chart booklets

(an improvement from 11 percent in 2004), and one-fifth (22 percent) had IMCI mother cards (an improvement from 5 percent in 2004) (Table A-4.6). IMCI chart booklets are most likely to be available in health centres (53 percent) and hospitals (49 percent) and, among managing authorities, in facilities managed by government (52 percent) and nongovernmental organisations (60 percent). Facilities in Nyanza and Western provinces are more likely to have the IMCI chart booklet than facilities in other provinces.

4.4.2 Equipment and Supplies for Assessing and Providing Preventive Care for the Sick Child

The 2010 KSPA also assessed the availability of equipment and supplies necessary for evaluating the status of sick children and for providing preventive interventions, as established by IMCI guidelines. Figure 4.5 summarises information on these items. Table A-4.5 provides details by background characteristics, while Table A-4.7 provides information on the availability of sick child and EPI services on the same day in the same facility.

Figure 4.5 **Availability of Equipment and Supplies for Assessing Health Status and Management of the Sick Child (N=666)**



* Jar or pitcher, cup and spoon, and ORS packets available in facility

KSPA 2010

Among facilities offering sick child services, 28 percent had the capacity to offer immunisations, in the form of immunisation supplies (vaccines, syringes and needles, cold boxes, child immunisation cards, and items for infection control) in the service area on the day of the survey (Figure 4.5, Table A-4.5). Hospitals (38 percent) and health centres (40 percent) were more likely than other facility types to have all of these immunisation supplies.

Four in every ten facilities (39 percent) that provide curative care for sick children report that they provide immunisation services every day that sick child services are offered. On the day of the survey a slightly higher proportion (49 percent) was actually providing both services (Table A-4.7). Government facilities (56 percent) are the most likely to report offering EPI services on the same days that services for sick children are offered and where also most likely (at 66 percent) to be offering both services on the day of the survey.

Approximately seven of every ten facilities offering sick child services had an infant weighing scale (100 gram gradations) or a child weighing scale (250 gram gradations). Almost six of every ten had both types of scales (Table A-4.5).

Items for providing oral rehydration therapy (ORT) on-site (a cup and spoon, a jar for mixing, and ORS packets) are lacking in many facilities. Only 28 percent of facilities had all three necessary items at the service delivery site. However, ORS packets themselves are available in 84 percent of facilities and specifically at the sick child service areas in 73 percent of facilities (Table A-4.5). ORT Corners[7] are available in 26 percent of facilities overall and are more likely to be available in hospitals than in other facility types.

Although a sick child can be assessed with little equipment, certain minimal equipment is considered necessary for good care. The 2010 KSPA assessed whether facilities had a thermometer and some type of minute timer for counting respiration rates. Thermometers are available in 90 percent of facilities, and timers (including both personal wristwatches and facility-provided timers) are available in 63 percent of the facilities. Thermometers are about equally available in all facility types, but timers are notably less available in dispensaries (Table A-4.5).

4.4.3 Essential Medicines for Treating Sick Children

The IMCI guidelines have defined first-line, pre-referral, and other important medications for treating the sick child. The 2010 KSPA assessed the availability of all these essential medicines. Table 4.3 provides summary information on the availability of medicines for sick children. Table A-4.8 provides details on available medicines by type of facility.

Table 4.3 Medicines and supplies to support quality care for sick children

Percentage of facilities offering sick child services that have first-line, pre-referral, and other medicines and supplies, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with all essential medicines			Number of facilities offering curative outpatient care for sick children
	First-line[1]	Pre-referral[2]	All other medicines[3]	
Type of facility				
Hospital	86	83	36	50
Health centre	76	74	29	80
Maternity	63	90	42	16
Clinic	46	50	25	190
Dispensary	73	62	18	330
Managing authority				
Government	73	61	12	335
NGO	58	49	36	21
Private (for profit)	47	53	24	223
Faith-based organisation	92	91	62	87
Province				
Nairobi	82	70	55	38
Central	54	49	20	120
Coast	72	71	38	72
Eastern	75	69	17	118
North Eastern	80	81	8	23
Nyanza	64	54	32	82
Rift Valley	64	61	16	169
Western	62	68	15	43
Total	66	62	23	666

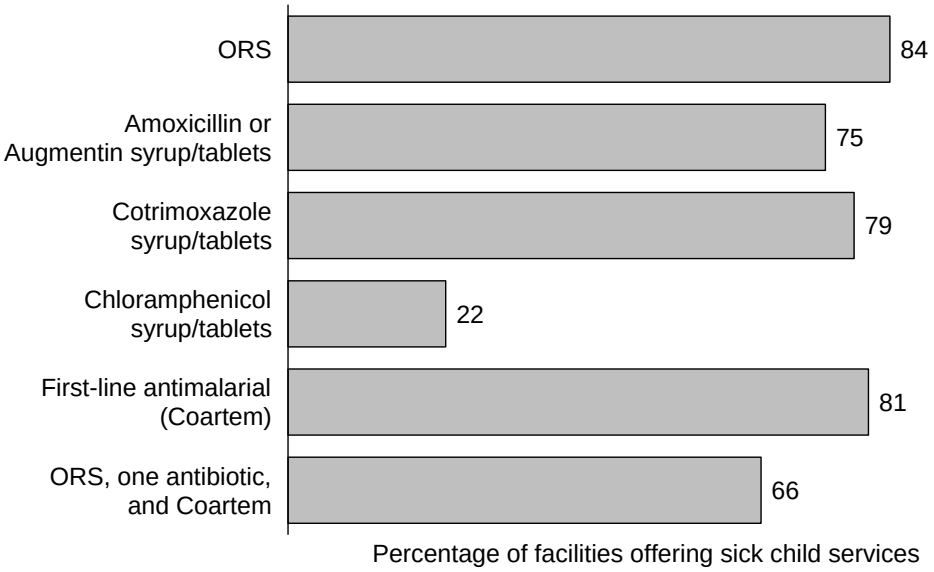
[1] ORS, Coartem, and at least one oral antibiotic (amoxicillin, amoxicillin-clavulanate, cotrimoxazole, or chloramphenicol).
[2] (1) Injectable chloramphenicol or at least one first-line injectable antibiotic (ampicillin or cloxacillin or penicillin), and (2) at least one second-line injectable antibiotic (ceftriaxone or gentamycin), and (3) intravenous solution (normal saline (0.9% NS), or dextrose and normal saline (5% D/NS), or lactated Ringer's solution, or plasma expanders, or 5% D/W), with perfusion set and sterile syringes.
[3] Aspirin or paracetamol, vitamin A, iron tablets, mebendazole or albendazole, and an antibiotic eye ointment.

[7] An ORT Corner is an area within a health facility with equipment for giving ORS solution to children with diarrhoea.

First-line medicines

First-line medicines include ORS, at least one oral antibiotic for respiratory infections, and first-line antimalarial medicine. All three first-line medicines are available in 66 percent of facilities (compared with 83 percent in 2004), with hospitals (86 percent) and faith-based organisations (92 percent) more likely to have them all than other facility types and managing authorities, respectively (Figure 4.6, Tables 4.3 and A-4.8). Cotrimoxazole (79 percent) is the most available first-line oral antibiotic in Kenyan facilities. The first-line antimalarial in Kenya is Coartem®, which is a combination of artemether and lumefantrine. Coartem is available in 81 percent of facilities, while artesunate is available in 15 percent, and amodiaquine is available in 23 percent. ORS is available in 84 percent of health facilities, with clinics being least likely to have ORS.

Figure 4.6 Availability of First-line Medicines for Treating Sick Children (N=666)



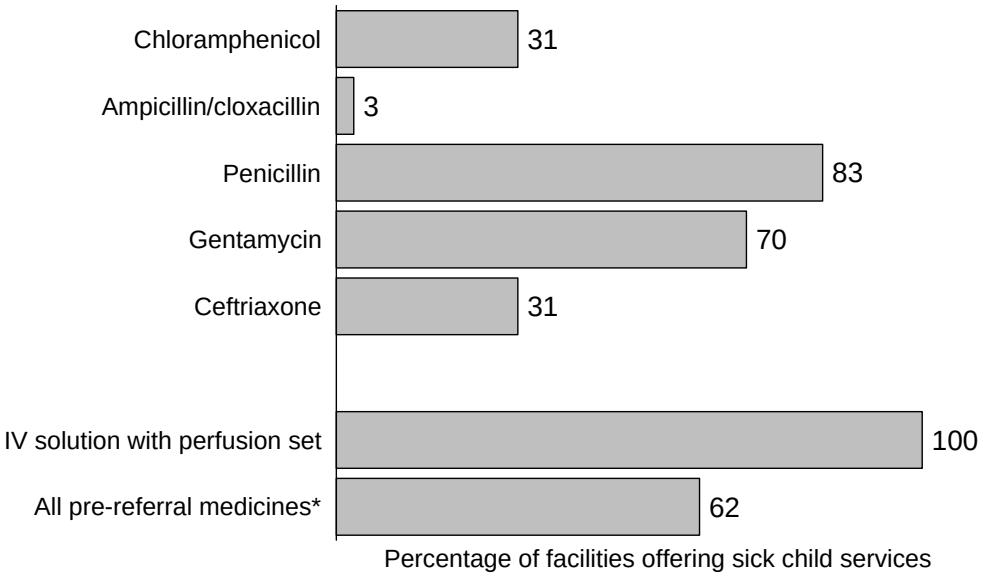
KSPA 2010

Pre-referral medicines

Pre-referral medicines include emergency injectable medications and intravenous solution with a perfusion set; these make possible urgent treatment and rehydration before admitting a sick child or referring a sick child to another facility, if necessary. It should be noted that IMCI guidelines authorise health facilities to provide rapid rehydration for severely dehydrated children using suitable intravenous solutions.

The 2010 KSPA considers health facilities to have all pre-referral medicines if they have at least one first-line injectable antibiotic (ampicillin or penicillin); at least one second-line injectable antibiotic (ceftriaxone or gentamicin) or injectable chloramphenicol; and intravenous solution (normal saline, lactated Ringer's solution, or dextrose and saline (0.9 percent); and a perfusion set and sterile syringes. In 2010, 62 percent of facilities offering out-patient curative care for sick children had all of these pre-referral medicines (Figure 4.7, Tables 4.3 and A-4.8), compared with only 23 percent of facilities in 2004. Maternity facilities (90 percent) and hospitals (83 percent) are more likely than other types of facilities to have all pre-referral medicines. Facilities managed by faith-based organisations (91 percent) and facilities in North Eastern province (81 percent) are more likely than other facilities to have all pre-referral medicines. Injectable penicillin (83 percent) is the most common pre-referral medicine available, while eight of every ten eligible facilities have intravenous solution with perfusion sets (Table A-4.8).

Figure 4.7 Availability of Pre-referral Injectable Medicines (N=666)



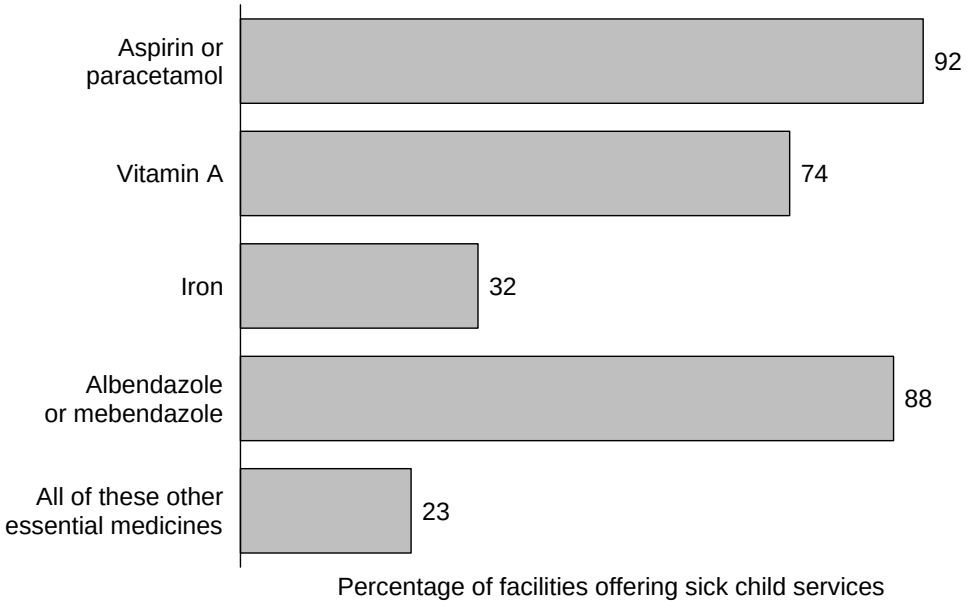
* Injectable chloramphenicol or ampicillin or cloxacillin or penicillin, and either gentamycin or ceftriaxone, and intravenous solution with perfusion set.

KSPA 2010

Other essential medicines and vitamin A

Some other medicines are less crucial for treating serious illness but nonetheless are important for managing common symptoms and illnesses. These include fever-reducing medicines (e.g., paracetamol), vitamin A, iron tablets or supplements, and de-worming medicines (mebendazole or albendazole). Overall, only 23 percent of health facilities have all of these other essential medicines (Table 4.3), even though aspirin or paracetamol, vitamin A, or de-worming medicines are available in 92, 74, and 88 percent of health facilities, respectively (Figure 4.8). Iron is the medicine most commonly missing.

Figure 4.8 Availability of Other Essential Medicines (N=666)



KSPA 2010

4.4.4 Infection Control Items

The 2010 KSPA also assessed the availability of infection control items at service delivery sites. Overall, 56 percent of facilities offering services for sick children have all infection control items (Table A-4.5). Soap and running water or else hand disinfectant was available at the service site in three-quarters of facilities. Practically all facilities (96 percent) had a sharps container. Individually, hand disinfectant is the least available infection control item, available only in one-quarter of facilities.

Key Findings

Treatment guidelines: Treatment guideline or protocols are available in six of every ten health facilities that offer sick child services. IMCI chart booklets are available in only one-third of facilities; this is an improvement over findings in 2004, however.

Medicines: All first-line oral medicines for childhood illnesses are available in two-thirds of facilities (a decline from 83 percent in 2004), while pre-referral medicines are found in six of every ten facilities, an improvement from 23 percent in 2004.

Infection control: Just over half of facilities had all infection control items available at the service site on the day of the survey.

4.5 Management Practices Supportive of Quality Sick Child Health Services

Management practices that support quality curative care for sick children include documentation and record-keeping, practices related to user fees, and staff supervision and development.

Summary information on the availability of these items appears in Table 4.4. Table A-4.9 provides statistics on use of sick child services, and Tables A-4.10.1, A-4.10.2, and A-4.11 provide more details on fees and other payment systems. Table A- 4.12 summarises information on training of child health service providers, while Tables A-4.13.1 through A-4.14 provide details on training and supervision from the perspective of the child health service provider.

4.5.1 Facility Documentation and Records

An up-to-date register is defined as a register that has an entry made within the past seven days that indicates, at the minimum, the child's age and diagnosis or the symptoms for which the child was brought to the facility. Eighty-five percent of facilities providing out-patient curative care for sick children have an up-to-date register (Table 4.4), as did 87 percent in 2004. Dispensaries (94 percent) and health centres (92 percent) are most likely to have up-to-date registers, while clinics are least likely to have up-to-date registers (66 percent). Government, faith-based organisation, and NGO facilities are more likely to have up-to-date registers than private facilities. Facilities in Nyanza and Western provinces are more likely to have up-to-date registers than facilities in other provinces.

4.5.2 Practices Related to User Fees

User fees may have a positive effect on the utilisation of health services in facilities by increasing the funds available to the facility, if there is a system for such funds to be channelled back to the facility. At the same time, they may have a negative effect on utilisation by deterring poor clients from using services. In any case, posting user fees in facilities that charge fees is an element of the quality of care, since it increases accountability and makes clients aware of costs associated with services.

Table 4.4 Management practices supportive of quality child health services

Percentage of facilities offering curative outpatient care for sick children that have an up-to-date client register and that charge user fees for sick child (SC) services, and percentage where health service providers report receiving routine training related to their work and personal supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering curative outpatient care for sick children with:		Number of facilities offering curative outpatient care for sick children	Percentage of facilities where child health service providers report receiving routine:		Number of facilities with interviewed child health service providers
	Up-to-date patient register[1]	User fees for SC services		Training related to child health[2]	Personal supervision[3]	
Type of facility						
Hospital	87	64	50	42	86	50
Health centre	92	70	80	43	93	79
Maternity	79	91	16	38	68	16
Clinic	66	94	190	34	56	177
Dispensary	94	71	330	41	88	319
Managing authority						
Government	94	61	335	43	91	323
NGO	89	58	21	26	89	21
Private (for profit)	68	96	223	33	58	209
Faith-based organisation	94	95	87	43	80	87
Province						
Nairobi	76	63	38	45	76	38
Central	83	85	120	39	62	115
Coast	75	65	72	38	80	70
Eastern	87	64	118	25	85	110
North Eastern	72	48	23	40	78	16
Nyanza	94	81	82	50	92	82
Rift Valley	86	90	169	41	78	168
Western	94	81	43	48	88	40
Total	85	77	666	39	79	640

[1] Register has entry within past seven days that indicates child's age and diagnosis or symptom.
[2] A facility has routine staff training if at least half of interviewed providers reported they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured training sessions and does not include individual instructions received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported they had been personally supervised at least once during the six months preceding the survey.

In Kenya the policy is to offer free health services in government facilities for all children under five years, in order to make these services accessible to all families. Survey findings show that three-quarters of all facilities (compared with 42 percent in 2004) offering services for sick children charge some form of user fees for services. This includes 61 percent of government facilities offering sick child services (Table 4.4). In contrast, only 15 percent of government facilities charged user fees in 2004. Over 90 percent of private and faith-based organisation facilities charge user fees compared with 58 percent of nongovernmental organisation facilities. Maternity facilities and clinics (91 and 94 percent, respectively) and facilities in Rift Valley province (90 percent) are among those most likely to charge fees for sick child services.

Among facilities that charge user fees, 23 percent charge for client charts or records, 30 percent charge for consultation, 45 percent for medicines, 43 percent for laboratory tests, and 27 percent for registration (Table A-4.10.1). Seventeen percent post all fees, 16 percent post some fees, and 67 percent do not post any fees. Faith-based organisation facilities that charge user fees are least likely to display fees.

Discounts or fee exemptions are quite common. Seventy-seven percent of sick child facilities that charge fees report offering discounts or exemptions to clients. Such discounts or exemptions are most likely to be offered in government or faith-based organisation facilities (both 83 percent). Facilities in Rift Valley and Nyanza provinces are more likely to offer discounts or exemptions than facilities in other provinces (Table A-4.10.1). Nearly six of every ten facilities that charge user fees say they waive fees altogether (expecting no payment) for clients who are unable to pay for services. Less than 10 percent say they refuse services if the client is unable to pay (Table A-4.10.2).

4.5.3 Training and Supervision

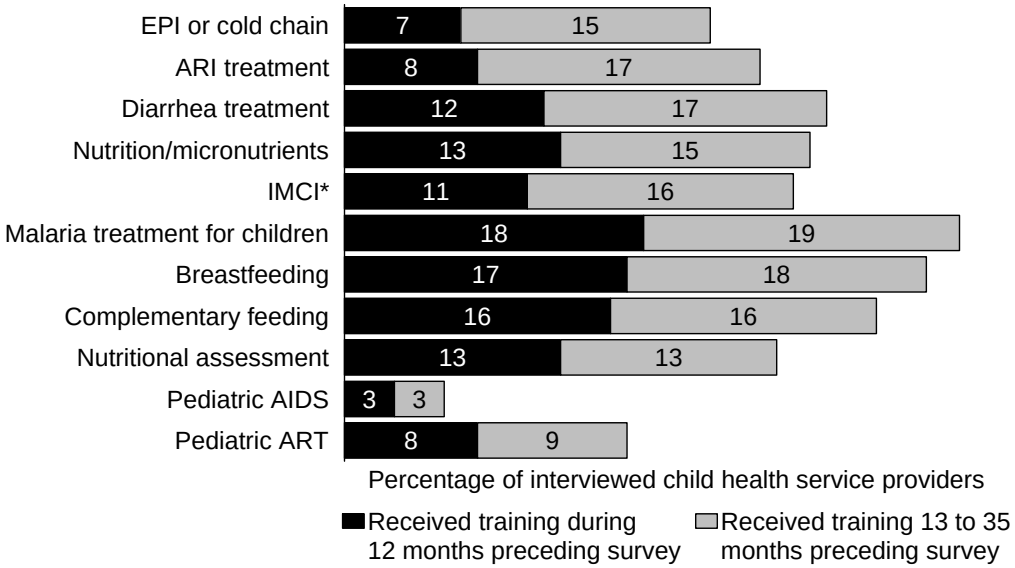
Training

The 2010 KSPA deems a facility to have routine staff training or staff development if at least half of interviewed providers report receiving pre- or in-service training related to their work during the 12 months preceding the survey. The training must be structured and based in the classroom; individualised or one-on-one instruction received during supervision is not included.

Using this definition, only four in every ten facilities that offer services for sick children qualify as providing routine staff training (Table 4.4). Still, this is an increase from 23 percent in 2004. Generally, there is not great variation by facility type, managing authority, or province; however, clinics (34 percent), NGO facilities (26 percent), and facilities in Eastern province (25 percent) are among the least likely to provide routine staff training (Table 4.4).

Of the interviewed child health service providers, 36 percent reported receiving structured training related to their work during the 12 months preceding the survey (Table A-4.12), compared with only 15 percent in 2004. Providers in hospitals (42 percent) and in facilities in Nyanza province (44 percent), Nairobi, and Western provinces (each 42 percent) are more likely than others to have received training during the 12 months preceding the survey. Malaria treatment in children, breastfeeding, and complementary feeding dominated training topics (18, 17, and 16 percent, respectively, of interviewed providers); the topic least trained on in the preceding 12 months was paediatric AIDS (3 percent) (Figure 4.9, Tables A-4.13.1 and A-4.13.2).

Figure 4.9 **Training Received by Interviewed Child Health Service Providers, by Topic and Timing of Most Recent Training (N=1,989)**



* Integrated Management of Childhood Illness

KSPA 2010

Supervision

If at least half of the service providers interviewed at a facility reported having been personally supervised at some time during the six months preceding the survey, the facility is considered to have routine staff supervision. Overall, 79 percent of facilities meet this criterion, compared with 84 percent in 2004. Health centres (93 percent), dispensaries (88 percent), and hospitals (86 percent) are the most likely to have routine staff supervision (Table 4.4). Among the provinces facilities in Central province are the least likely to have routine staff supervision.

Of the interviewed child health service providers, 75 percent said they had been personally supervised during the six months preceding the survey (Table A-4.12). Among those who had been supervised during the preceding six months, the reported median number of times supervised was three (Table A-4.14).

Key Findings

Client registers: Close to nine of every ten facilities had an up-to-date client register, a finding similar to that in 2004.

User fees: The overall proportion of facilities providing sick child services that charge user fees has increased from four of every ten facilities in 2004 to almost eight of every ten in 2010. The increase is most obvious among government facilities.

Training and supervision: Four of every ten facilities meet the criteria for providing routine staff training, an improvement from only two in every ten facilities in 2004. Routine supervision is common. Eight of every ten facilities have routine supervision for child health services providers. Supervision is least common in Central province.

4.6 Adherence to Guidelines for Sick Child Service Provision

To assess whether providers adhere to standards for providing good-quality services, the survey observed sick child consultations using observation checklists based on IMCI guidelines. The observers noted what information the provider shared and whether recommended procedures were carried out. They did not assess whether the information shared was correct or whether findings were appropriately interpreted.

Table 4.5 summarises providers' assessments, examinations, and subsequent treatments, by diagnosis or major symptoms. Tables A-4.15 and A-4.16 show what practices were observed during sick child consultations. Tables A-4.17 through A-4.23 provide details on observed practices and on information reported by caretakers during interviews. KSPA personnel interviewed all caretakers of the sick children whose consultations were observed.

4.6.1 Full Assessment of Illnesses

When there are not enough qualified curative care providers, less qualified persons can be trained to provide EPI and growth monitoring services as well as initial consultations for sick children. This assumes, however, that seriously ill children, with illnesses beyond the scope of staff's training, will be identified and referred to a better qualified provider. Hence, it is important to know how many facilities depend on referral systems for the management of severe illnesses. As noted in Chapter 3, 97 percent of all facilities in Kenya have at least one qualified health provider assigned to the facility (Figure 3.1, Table A-3.1.1).

The IMCI strategy was introduced in Kenya in 2000, with the main focus on facility-based IMCI. The focus was expanded in 2002 to household and community IMCI. According to a recent IMCI health facility survey implemented by the division of child health, MOPH, the IMCI strategy is being implemented in 56 of 75 old districts. IMCI protocols for assessing a sick child provide valid guidelines for quality of care, regardless of whether a provider has been trained in IMCI case management or not. When interpreting the findings, it is important to recognise that, even when following the IMCI guidelines, providers should use their judgment, based on the child's signs and symptoms.

Table 4.5 Assessments, examinations, and treatment for children, classified by diagnosis or major symptom

Percentage of observed children diagnosed by the provider with the indicated illness or symptom for whom the indicated IMCI assessment, physical examination, and/or treatment was provided, Kenya SPA 2010

	Respiratory illness			Febrile illness			Intestinal illness				
Item	Pneumonia/ broncho-pneumonia	Bronchial spasm/ asthma	Cough or other upper respiratory illness	Fever	Measles	Malaria	(Any diarrhoea or dysentery) with dehydra-tion	(Any diarrhoea or dysentery) without dehydra-tion	Any ear infection	Any throat diagnosis	All observed children
IMCI assessment											
Three main symptoms[1]	44	24	36	49	9	40	53	56	23	48	36
Three general danger signs[2]	13	3	11	18	0	16	14	12	7	0	13
Current eating or drinking habits	50	42	49	73	16	52	73	61	46	51	51
Advise continued feeding and increase food or fluids	19	17	20	29	16	28	46	39	14	12	23
Physical exam											
Temperature	98	93	91	92	100	92	95	85	79	97	91
Respiratory rate	34	37	25	37	17	26	30	19	40	25	25
Dehydration	23	14	15	23	0	22	61	35	25	7	20
Anaemia	74	78	56	64	64	66	71	57	47	60	61
Ear (looked in and felt behind)	10	14	12	13	0	13	14	12	81	25	13
Oedema	6	9	8	13	0	8	11	6	7	7	9
Body muscle	31	27	23	19	16	28	26	28	15	22	26
Referred for any lab test	23	23	24	21	16	33	39	23	23	22	25
Treatment											
Refer/ admit	18	15	8	14	6	11	35	8	3	6	12
Any antibiotic	93	77	84	73	100	67	60	73	94	90	72
Injectable antibiotic	42	18	10	10	3	13	11	12	25	9	13
Oral antibiotic	78	74	83	71	100	63	54	69	88	90	68
Any antimalarial[3]	48	38	48	62	0	91	50	48	29	12	51
First-line antimalarial[4]	37	24	36	52	0	70	38	38	10	9	39
Oral antimalarial	46	38	47	60	0	85	39	47	18	12	48
Injectable antimalarial	6	3	5	8	0	14	14	3	15	0	8
Oral bronchodilator	20	53	6	7	0	5	5	7	0	7	7
Oral medication for symptomatic treatment[5]	89	65	88	91	84	91	65	78	91	78	84
Oral rehydration (ORS)	8	12	7	14	0	15	74	57	1	0	12
Intravenous fluid	0	0	0	2	0	0	13	0	0	0	0
Zinc	2	2	3	3	0	5	34	24	2	0	5
Described signs or symptoms for immediately seeking help	45	24	34	41	16	41	24	42	38	30	36
Discussed follow-up visit	63	64	61	65	52	63	55	62	58	57	61
Number of children[6]	293	31	997	258	5	1,101	64	237	43	23	2,016

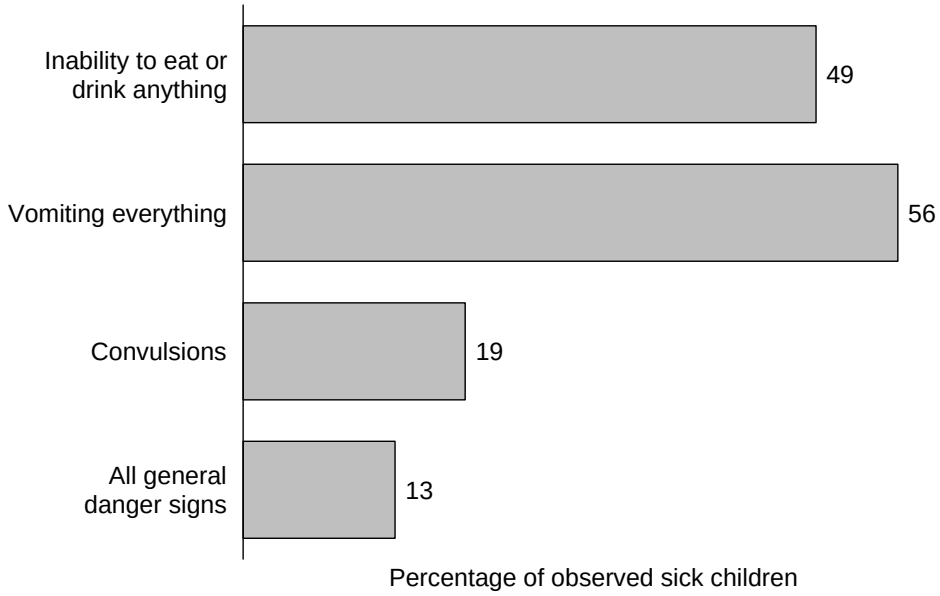
[1] The three IMCI main symptoms are: cough/difficult breathing, diarrhoea, and fever.
[2] The three IMCI general danger signs are: inability to eat/drink, vomiting everything, and febrile convulsions.
[3] Any antimalarial refers to either first-line, or artesunate, amodiaquine, or Fansidar, or other antimalarial not recommended by MOH, such as chloroquine.
[4] First-line antimalarial is Coartem.
[5] This may be an antipyretic, cough medicine, or other general treatment for symptoms.
[6] Child may be classified with more than one diagnosis; therefore, the numbers in the individual columns may add up to more than 2,016 children.

IMCI general danger signs

According to IMCI guidelines, providers should check for the following general danger signs whenever assessing a sick child: whether the child is unable to drink or drink, whether the child vomits everything, whether the child has had convulsions at home during this illness or a convulsion is observed in the facility, and whether the child is lethargic or unconscious.[8] If there is any doubt about the child's ability to drink, the provider should attempt to give the child something orally. Overall, only 13 percent of all observed sick children were assessed for all three general danger signs (Figure 4.10, Tables 4.5 and A-4.15) (compared with 6 percent in 2004). In general, 49 percent were assessed for whether they could eat or drink anything (including breastfeeding) (36 percent in 2004), 56 percent for whether they vomited everything (36 percent in 2004), and only 19 percent for convulsions (12 percent in 2004) (Figure 4.11, Table A-4.15). Sick children seen in maternities (26 percent) were slightly more likely to be assessed for all three danger signs than children seen in other types of facilities (ranging from 11 to 19 percent) (Table A-4.15).

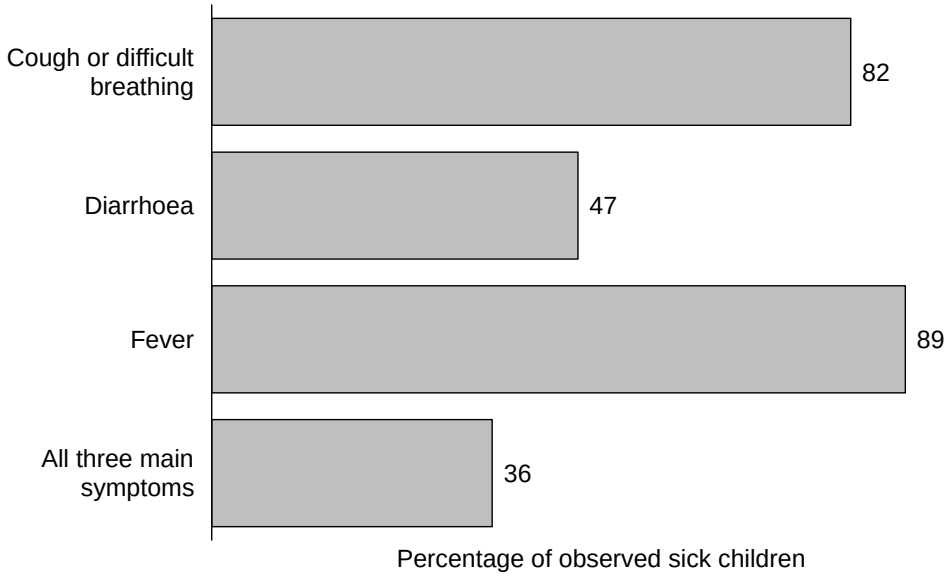
[8] Assessment for lethargy is not a part of the observation checklist because there is often not an observable component for this assessment.

Figure 4.10 Danger Signs Assessed During Observed Sick Child Consultations (N=2,016)



KSPA 2010

Figure 4.11 Main Symptoms Assessed During Observed Sick Child Consultations (N=2,016)



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IMCI main signs and symptoms

Regardless of the reason for the consultation, IMCI guidelines call for each child to be evaluated for three main symptoms: cough or difficulty breathing, diarrhoea, and fever. This information may be shared when the child's caretaker discusses the reason for the visit or, if it is not spontaneously mentioned, the provider may probe for these symptoms.

Providers assessed all three main symptoms in 36 percent of the consultations (Figure 4.11, Tables 4.5 and A-4.15), compared with 18 percent in 2004. Fever (89 percent versus 80 percent in 2004) and respiratory symptoms (82 percent versus 73 percent in 2004) were the symptoms most commonly assessed during sick child consultations. Diarrhoea was the least assessed (47 percent versus 35 percent of consultations in 2004).

Just over one in every ten consultations (12 percent) included an assessment of ear pain and/or discharge, another common childhood condition (Table A-4.15).

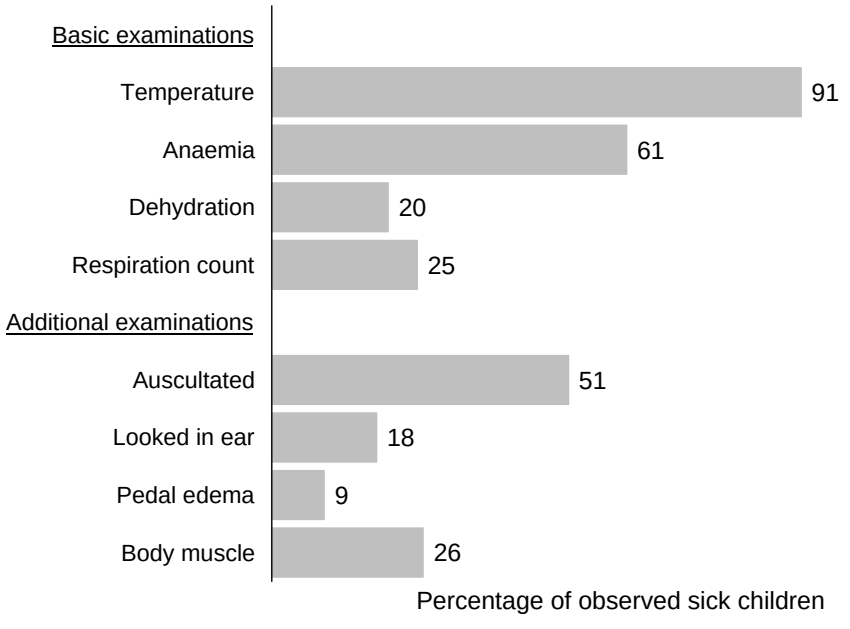
Physical examination

After obtaining information on the various signs and symptoms of illness, the provider should conduct a physical examination. This should include a hands-on evaluation of the child to (1) verify the presence or absence of fever, by touch or by measuring the child's temperature; (2) assess the state of dehydration by pinching the skin; (3) visually check if the child has anaemia by looking at the palms, conjunctiva, or mouth; and (4) count the rate of respirations if a respiratory problem is suspected.

Providers carried out all four of these evaluations during only 8 percent of consultations (Figure 4.12, Table A-4.15). The majority of children were assessed for fever (91 percent) and anaemia (61 percent), In contrast, dehydration and respiratory rates were checked in 20 and 25 percent of children, respectively. While differences among facility types are small, children seen in maternities (20 percent) were most likely to receive all four evaluations. Temperature was more likely to be checked in maternities (100 percent) than in other facility types (Table A-4.15). Checking for anaemia occurred most often in clinics (73 percent) and least often in health centres (58 percent) and dispensaries (57 percent).

Looking inside the ear and feeling behind the ear were done in 18 percent and 20 percent, respectively, of observed consultations. Pedal oedema was rarely assessed (9 percent of consultations). Musculature and general nutritional and physical status was assessed in less than one-third of consultations (26 percent) (Figure 4.12). Half of the children were auscultated. Additional information on physical examinations is available in Table A-4.15.

Figure 4.12 Elements of Physical Examination Conducted During Observed Sick Child Consultations (N=2,016)



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Feeding practices

There is a direct relationship between nutritional status and health. It is not uncommon for a child to be caught in a cycle of malnutrition and illness, where malnutrition makes a child more susceptible to illness, and the illness contributes to further malnutrition. Aggravating this cycle is the tendency for sick children to eat and drink less. Also, it is not uncommon for caretakers to limit a sick child's consumption of food and liquids.

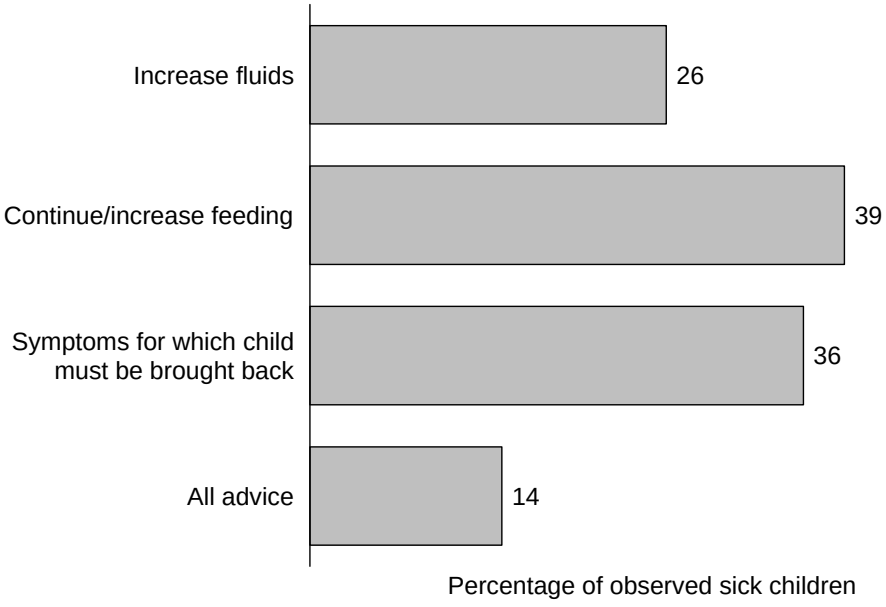
During observed sick child consultations, providers asked about normal feeding practices (that is, when the child is not sick) in about two of every five consultations (39 percent), regardless of the age of the child (Table A-4.18).

Essential advice to caretakers

According to the IMCI strategy, a sick child's caretaker should always receive the following essential advice before leaving the health facility: (1) give the sick child extra fluids during the illness, (2) continue to feed the sick child, and (3) watch for signs and symptoms that indicate the child should be brought back immediately to a health care provider.

Any one piece of advice was offered in less than 40 percent of consultations (between 26 and 39 percent) (Figure 4.13). Caretakers received all three pieces of advice during only 14 percent of sick child consultations, although this is an increase from 5 percent in 2004. Findings varied little among facility types (Table A-4.15).

Figure 4.13 Essential Advice Provided to Caretakers of Observed Sick Children (N=2,016)



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4.6.2 Diagnosis-Specific Assessments

At the end of each sick child consultation, providers were asked about the child's diagnosis or the major symptoms for which the child was seen, and the treatment prescribed, if any. IMCI guidelines indicate specific symptoms or diagnoses for which antibiotics should be prescribed or for which children should be admitted to the facility or referred to a higher level of care.

Although a simple observation does not provide enough information to determine the appropriateness of diagnosis and treatment, certain interventions can reasonably be expected for a given diagnosis. It is important to note that the 2010 KSPA does not evaluate the appropriateness of specific actions of providers.

Overall, 12 percent of observed sick children were either admitted or referred to another facility (Table 4.5).

Respiratory illness

Children with severe respiratory illnesses should be thoroughly examined by a provider and, if indicated, hospitalised. In most of these cases, recourse to antibiotics is warranted. Among children ultimately diagnosed with pneumonia, respiratory rate was checked in 34 percent of cases (compared with 46 percent in 2004) and temperature was checked in 98 percent of cases (compared with 85 percent in 2004) (Table 4.5). Overall, 18 percent of children diagnosed with pneumonia were either referred elsewhere or hospitalised. Ninety-three percent were put on some form of antibiotic (42 percent received an injectable antibiotic, and 78 percent, an oral antibiotic).

Of the children diagnosed with bronchial spasm/asthma, 93 percent had their temperature checked, and 77 percent were put on antibiotics (Table 4.5). Providers were even more likely (84 percent) to prescribe antibiotics for children diagnosed with cough or other respiratory illness and no other serious symptoms, such as fever or difficult or short breathing, even though such cases are most often viral in nature. With growing antibiotic resistance worldwide, rational use of antibiotics should be encouraged to ensure that these drugs are not overused.

Fever

For children with severe febrile illness (especially in high malaria risk areas), IMCI guidelines recommend the use of an antimalarial and antipyretic, followed by referral to appropriate facilities for further treatment. Most but not all children (92 percent) diagnosed with fever had their temperature taken (Table 4.5). Fourteen percent of children diagnosed with fever were either referred or admitted, and 73 percent received some form of antibiotics (10 percent received injectable antibiotics, and 71 percent received oral antibiotics). Six of every ten received an antimalarial, with 52 percent getting the first-line antimalarial in accord with the Kenya malaria treatment policy. Ninety-one percent received medication for symptomatic treatment (an antipyretic, cough medicine, or other general treatments for symptoms).

Malaria

The majority of sick children observed on the day of the survey were diagnosed with malaria (1,101 of 2,016 observed children) (Table 4.5). Of those diagnosed with malaria, four in every ten were assessed for all three IMCI main symptoms, and 16 percent were assessed for all three IMCI general danger signs. Temperature was assessed for 92 percent, and anaemia was assessed in 66 percent. Overall, 91 percent received some form of antimalarial medicine, although only 70 percent got the first-line treatment of Coartem. About one in every ten received an injectable antimalarial, while 85 percent were put on oral antimalarial. Sixty-seven percent received an antibiotic, while 91 percent received oral medication for symptomatic treatment.

Diarrhoea

KSPA observers in 2010 recorded the physical assessment and treatment of children diagnosed with intestinal illnesses. There were two categories of diagnoses: (1) any diarrhoea or dysentery with dehydration, and (2) any diarrhoea or dysentery without dehydration (Table 4.5). Providers assessed dehydration in six of every ten cases (61 percent) in the first category and in 35 percent of cases in the second category. Thirty-five percent of children in the first category

(diarrhoea or dysentery with dehydration) and only 8 percent of children in the second category (diarrhoea or dysentery without dehydration) were admitted or referred to another facility.

ORS was prescribed for 74 percent of children in the first category (diarrhoea or dysentery with dehydration), while 13 percent received intravenous fluids. Among children in the second category (diarrhoea or dysentery without dehydration), 57 percent were given ORS, and none was put on intravenous fluids. Children in the first category (diarrhoea or dysentery with dehydration) are more likely to be given zinc (34 percent) than children in the second category (24 percent).

4.6.3 Other Observed Practices

IMCI guidelines recommend that the first dose of any prescribed medicine, particularly antibiotics, should be administered at the facility so that treatment can begin immediately. This practice also provides opportunities to reiterate the dosage to the caretaker and to ensure that the child is able to take the medicine.

Among observed sick children who were prescribed or provided oral medicines, 34 percent were observed to receive the first dose at the facility (Table A-4.17). This practice was generally uncommon across all facility types. Sixty-five percent of caretakers were seen to receive explanation of *how* the prescribed treatment should be administered at home. Caretakers in maternity facilities and dispensaries are more likely than those in other facility types to receive information on how to administer the medicine. Only 20 percent of caretakers were asked by providers to repeat instructions to verify that they understood.

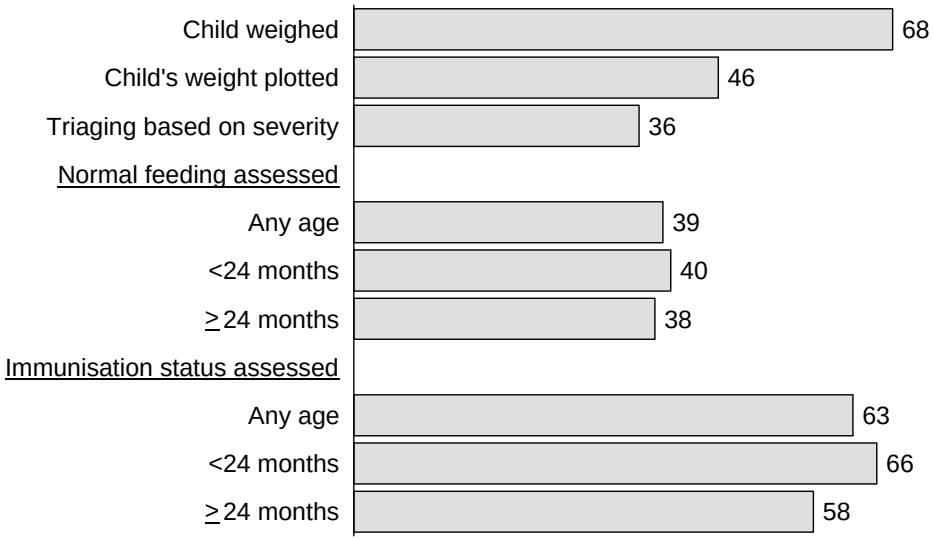
During exit interviews with caretakers of sick children who received oral medicine and/or prescription for home treatment, 95 percent reported being told how to give the medicine at home, and 96 percent said that they felt that they knew how to provide the medicine (Table A-4.17). This percentage is higher than was observed during consultations. It is possible that caretakers received instructions at the pharmacy when collecting the medicine or that they were remembering information from a prior visit for a similar episode.

4.6.4 Reducing Missed Opportunities for Promoting Child Health Care

The IMCI approach recommends evaluating children's growth to provide an objective assessment of their current nutritional status and to detect any chronic latent nutritional problems. Growth monitoring includes comparing the child's current weight with a standard (based on either height or age) and eliciting information on feeding patterns to determine whether the diet is adequate for the child's age and whether current feeding patterns pose any additional risk to the child's health status. The provider should take advantage of the consultation with the sick child and the caretaker to provide advice if there appears to be any nutritional problem and to offer encouragement for continuing good practices if the evaluation shows that the growth of the child is proceeding well. IMCI guidelines for feeding practices call for exclusive breastfeeding until six months of age, followed by the introduction of locally available foods based on a balanced nutritional plan, with continued breastfeeding until two years of age.

Sixty-eight percent of sick children were weighed; however, providers plotted the weight against a standard in only 46 percent of cases (Figure 4.14, Table A-4.18).

Figure 4.14 Observed Preventive Assessments of Sick Children (<24 months N=1,181; ≥24 months N=765, all children N=1,945)



KSPA 2010

Survey observers also monitored whether providers checked the immunisation status of sick children. Immunisation status was assessed for 63 percent of all observed sick children—66 percent of children under 24 months and 58 percent of children 24 months and older (Table A-4.18).

Key Findings

IMCI assessments: The rate of assessment of sick children for IMCI general danger signs (inability to eat or drink, vomiting everything, and febrile convulsions) during sick child visits is poor, albeit slightly better than in 2004. Overall, only 13 percent of observed sick child consultations involved assessment for all three general danger signs.

Treatment: The use of antibiotics is common, even when it may not be warranted. For example, two-thirds of children diagnosed with malaria were treated with antibiotics in addition to antimalarials. Children rarely receive the first dose of prescribed or provided oral medications at the facility.

Sixty-five percent of caretakers were observed being told how to administer medicine at home. Only 20 percent were asked to repeat the instructions to the provider.

Information to caregivers: Providers seldom provide caretakers with essential information regarding their children's illness. Only 14 percent of caretakers received all three pieces of advice recommended by IMCI guidelines regarding fluids and food intake and bringing the child back immediately for specified symptoms.

4.6.5 Counselling on Child Health Issues and Supporting Continuity of Care

Visual aids

According to survey findings, 50 percent of facilities that provide sick child services have visual aids (Figure 4.4). However, the actual use of visual aids during consultations with sick children is almost nonexistent, at 6 percent of observed sick child consultations (compared with 2 percent in 2004) (Table 4.6).

Table 4.6 Provider practices related to health education and continuity of care

Percentage of observations of sick children in which the provider used visual aids for health education of caretakers, the provider referred to the child health card, and the provider wrote on the child health card, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of observations where visual aids were used for health education	Use of individual health card: Percentage of observations where provider referred to card during consultation	Use of individual health card: Percentage of observations where provider wrote on card during or after consultation	Number of observed sick children
Type of facility				
Hospital	4	90	95	497
Health centre	4	86	91	392
Maternity	10	93	96	15
Clinic	3	86	93	163
Dispensary	8	92	95	949
Managing authority				
Government	7	92	96	1,477
NGO	1	92	99	68
Private (for profit)	3	82	88	221
Faith-based organisation	5	85	89	249
Province				
Nairobi	4	91	93	174
Central	6	93	96	163
Coast	3	96	98	230
Eastern	13	86	93	309
North Eastern	0	90	92	80
Nyanza	4	92	95	403
Rift Valley	9	86	92	432
Western	1	87	93	225
Total	6	90	94	2,016

Supporting continuity of care

Often, health services are organised so that a client's temperature and weight are measured, other routine services are provided, and information is recorded on the client's health card before the provider responsible for the consultation sees the client. The provider who then sees the client has information available to use during the consultation; this provider further documents findings from the consultation. Making such appropriate use of client cards by documenting events during consultations increases the accountability of the health care provider as well as the likelihood that the provider will have all relevant information both during the current visit and on subsequent visits, thus contributing to continuity of care.

Providers referred to a sick child's health card during 90 percent of observed consultations, apparently seeking information from previous assessments or visits (Table 4.6). Providers of sick child services wrote on the card during or after a consultation in 94 percent of observed consultations (Table 4.6).

4.7 CARETAKER OPINION FROM EXIT INTERVIEWS

Before leaving the facility, caretakers of observed sick children were interviewed about their opinions of the consultation process, the perceived quality of the provider's service, and the principal problems encountered on the day of the visit. The interviewer read a list of issues commonly related to client satisfaction and asked the caretaker to rate whether each issue posed a major problem, a minor problem, or no problem. Tables A-4.19 through A-4.23 provide information on caretakers' opinions and personal characteristics.

As expected, some caretakers were disgruntled with some aspects of their experience in the facility. For example, 25 percent of caretakers (ranging from 3 percent in maternity facilities to 35 percent in hospitals) considered the time they waited to see the provider to be a major problem (compared with 20 percent in 2004), and 18 percent considered the lack of medicines to be a major

problem (compared with 17 percent in 2004) (Table A-4.21). Only 8 percent considered the cost of services to be a major problem.

When asked about their choice of a health facility, 20 percent of the interviewed caretakers said the facility was not the one closest to their homes (Table A-4.22) (compared with 25 percent in 2004). The most common reasons for not visiting the nearest facility were that the nearest facility was more expensive (20 percent), had a bad reputation (19 percent), or lacked medicines (17 percent).

Caretakers interviewed in NGO and government facilities (29 and 26 percent, respectively) cited cost of services at the closest facility, compared with 15 percent of caretakers in private facilities. Also, caretakers in North Eastern province (65 percent) were more likely than those in other provinces to cite cost to explain why they did not visit the facility closest to home. References to the bad reputation of the closest facility were most common in NGO facilities and in Central province.

Key Findings

Visual aids: Providers rarely used visual aids for health education of caretakers during sick child consultations.

Major problems: One-quarter of caretakers considered the time they waited to see the provider to be a major problem, while 18 percent considered the lack of medicines to be a major problem.

Nearest facility: Twenty percent of caretakers said the facility visited was not the closest to their homes. One of the common reasons cited for not visiting the nearest facility was that it was more expensive.

FAMILY PLANNING SERVICES 5

Samuel Ogola, Shiphrah Kuria, Karugu Ngatia

5.1 BACKGROUND

5.1.1 KSPA Approach to Collection of Family Planning Service Information

Family planning is profoundly important for maternal and child health and a key element in upholding reproductive rights.

The use of contraceptive methods to plan families may be desirable for many reasons, including the following:

- Couples may wish to limit the size of their families or delay desired pregnancies.
- Spacing births benefits maternal and child health. Studies have shown that spacing births at least two to three years apart contributes significantly to decreasing infant mortality (Govindasamy et al., 1993; Rutstein, 2000). Although there are fewer studies on the effects of spacing births on maternal health, it is generally accepted that too frequent births result in maternal depletion of essential minerals and vitamins.
- Preventing pregnancies in women with chronic or acute illnesses that may make pregnancy more risky, such as tuberculosis, heart diseases, diabetes mellitus, and some STIs, including HIV/AIDS, can benefit these women's health.

Key factors contributing to the appropriate, efficient, and continuous use of contraceptives include the following (Murphy and Steele, 2000):

- Availability of a variety of contraceptive methods to address client preferences and ensure client-specific suitability of methods
- Counselling and screening of clients for appropriateness of methods
- Client education, using visual aids to increase information retention, regarding options, side effects, and appropriate use of the method
- Availability of infrastructure and resources necessary for providing quality family planning services, including guidelines and protocols, trained staff, a service delivery setting that allows client privacy, procedures for preventing infections, and equipment for client examinations
- Availability of other health services relevant for family planning clients, including education and services for STIs
- Programmes for groups with special needs to improve their access to and appropriate utilisation of family planning services

Wherever maternal health, reproductive health, or child health services are provided, facilities should strive to increase the appropriate use of family planning and contraceptive services, including client education.

The family planning component of the 2010 KSPA gathered information on the following:

- Availability of family planning services
- Quality and standards related to services offered
- Management and technical components supporting quality services
- Providers' adherence to guidelines and standards for service provision

This information was gathered using *Facility Audit Questionnaires*, *Observation Protocols*, and *Provider Interview Questionnaires*. Also, through client exit interviews information was collected from family planning clients as they left the service facilities. These questionnaires asked clients about their perceptions and experiences regarding the provision of services, their knowledge of a variety of issues related to their consultation, and their interactions with service providers.

This chapter provides detailed information on how family planning services are delivered—information that programmes can use to improve the availability and quality of these services. It uses information obtained by the 2010 KSPA to address the following central questions about the delivery of family planning services:

- What is the availability of family planning services?
- To what extent do the facilities offering family planning services have the infrastructure, resources, and supportive management required to support quality services?

5.1.2 Family Planning Services in Kenya

Over the last 50 years, Kenya has emerged as a leader in progress towards health and development goals, reducing child mortality, increasing school attendance among youth, lengthening life expectancy, and strengthening the economy. Kenya was an early leader in family planning in Africa, with a programme that was comprehensive, reached all communities, and had strong political leadership, from the 1960s up until the mid 1990s. As a result, the average number of births per woman dropped from about eight in the late 1970s to around five births per woman in the mid 1990s. During the 1990s, however, the family planning programme was weakened because the HIV epidemic emerged, donor funding declined, and political leadership was diverted to other challenges.

As a result, the increase in contraceptive use stalled, and the fertility level has remained the same for nearly ten years. One reason that fertility remains high, at 4.6 births per women today, is due to unmet need for family planning (KNBS and ICF Macro, 2010). One of every four married women in Kenya says that she would like to space her next pregnancy by two years or more, or not have any more children, but she is not using family planning. This is the unmet need for family planning. High unmet need for family planning leads to more than one million unplanned pregnancies every year in Kenya. Consequences of unplanned pregnancies include unsafely performed abortions, high-risk births, maternal deaths, and high fertility.

Throughout Kenya's early history, the population size remained very low. The 20th century population explosion all over the world meant Kenya's population also has increased, to about 39 million in 2010. At the current growth rate, the population will nearly double, to 71.5 million, by the year 2030.

Although it is sometimes said that a large population is good for economic growth, that can be true only if there are a healthy workforce, enough jobs, educated workers, and modern infrastructure. One way for Kenya to achieve the objectives of *The Vision 2030: First Medium Term Plan*[1] for all the

[1] *The Vision 2010: First Medium Term Plan (2008-2012)* succeeds the *Economic Recovery Strategy for Wealth and Employment Creation, 2003-2007* as the *National Medium Term Plan* for Kenya.

children who will be born is through reproductive health services and helping women to plan and space their pregnancies.

According to the 2008-09 Kenya Demographic and Health Survey (2008-09 KDHS), the contraceptive prevalence rate (CPR) (the proportion of currently married women age 15-49 who are using *any* contraceptive method—modern or traditional) is 46 percent. CPR among *all* women age 15-49 is 32 percent, and, among sexually active unmarried women, 50 percent. The level of use of *modern* contraceptive methods is 28 percent among all women and 39 percent among currently married women (KNBS and ICF Macro, 2010).

There has been a substantial increase in contraceptive use since the late 1970s, from 7 percent of married women in 1978 to the current 46 percent in 2008-09. The contraceptive prevalence rate remained the same between 1998 and 2003, but it increased slightly between 2003 and 2008-09. The increase in the overall CPR can be attributed to increased use of modern methods. Between 2003 and 2008-09 use of modern methods increased among currently married women from 32 to 39 percent, while use of traditional methods decreased slightly over the same period, from 8 to 6 percent among currently married women (CBS, MOH and ORC Macro, 2004; KNBS and ICF Macro, 2010).

The 2008-09 KDHS further shows that married women in urban areas are more likely to use a contraceptive method (53 percent) than their rural counterparts (43 percent). Although use of modern methods is generally higher in urban areas (47 percent) than in rural areas (37 percent), female sterilisation is slightly more common among rural women than among urban women.

Married women in Central province continue to have the highest contraceptive prevalence rate (67 percent), followed by Nairobi (55 percent) and Eastern province (52 percent). The lowest level of family planning use is recorded in the North Eastern province, at 4 percent.

The better educated a woman is, the more likely that she uses contraception. Sixty percent of married women with secondary education or more use a contraceptive method compared with 40 percent of women with incomplete primary education and only 14 percent of those who never attended school (KNBS and ICF Macro 2010).

5.2 AVAILABILITY OF FAMILY PLANNING SERVICES

The following definitions are used in this chapter:

- A facility is said to *offer* a family planning method if the facility reports that it provides the method, prescribes the method for clients to obtain elsewhere, or counsels clients on the method without actually making that method available to the client in the facility.

- A facility is said to *provide* a family planning method if the facility reports that it stocks the method and makes it available to clients when they visit the facility. In other words, these clients can obtain the method without leaving the facility.

Family planning methods differ in how they function and in their effectiveness, side effects, and mode of use. Given these issues, their acceptability and desirability also differs among users. To meet varying needs and demands for contraception, a variety of methods should be available at a frequency that meets common needs.

To understand the context of modern contraceptive use in Kenya, the 2010 KSPA assessed the availability of family planning services in health care facilities in Kenya.[2] Tables 5.1 and 5.2 summarise information on the availability of family planning services and how frequently they are offered. Figure 5.1 provides details on the availability of different methods of contraception in facilities that provide those methods, and Tables A-5.1 through A-5.4 provide further details on method availability by type of facility and region.

[2] Information presented in this chapter covers hospitals, health centres, maternity facilities, clinics, and dispensaries. Stand-alone VCT facilities are excluded from the analysis.

Table 5.1 Availability of family planning services

Percentage of all facilities offering temporary methods of family planning and sterilisation, by background characteristics, Kenya SPA 2010

Background characteristic	Temporary methods of family planning			Percentage offering male or female sterilisation	Percentage providing male or female sterilisation	Number of facilities
	Percentage offering any modern method of FP[1]	Percentage offering counselling on natural method[2]	Percentage offering any temporary method of FP[3]			
Type of facility						
Hospital	85	75	91	67	46	51
Health centre	83	64	86	33	20	80
Maternity	88	63	88	47	31	17
Clinic	80	44	81	18	3	203
Dispensary	89	59	94	22	2	340
Managing authority						
Government	96	64	97	33	11	344
NGO	89	36	89	24	7	22
Private (for profit)	84	46	84	21	7	236
Faith-based organisation	44	58	69	12	3	88
Province						
Nairobi	68	43	68	29	11	41
Central	89	33	90	9	6	125
Coast	75	72	83	26	7	81
Eastern	79	44	87	12	5	118
North Eastern	67	67	67	65	1	24
Nyanza	93	79	96	42	14	82
Rift Valley	92	64	95	27	8	174
Western	93	60	94	47	18	44
Total	85	56	89	26	8	690

[1] Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine devices (IUCDs), male condoms, or female condoms.
[2] Natural methods are the standard days method and periodic abstinence.
[3] Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, IUCDs, male condoms, female condoms, or counselling on the standard days or periodic abstinence method.
Note: There are 24 facilities that offer natural methods only.

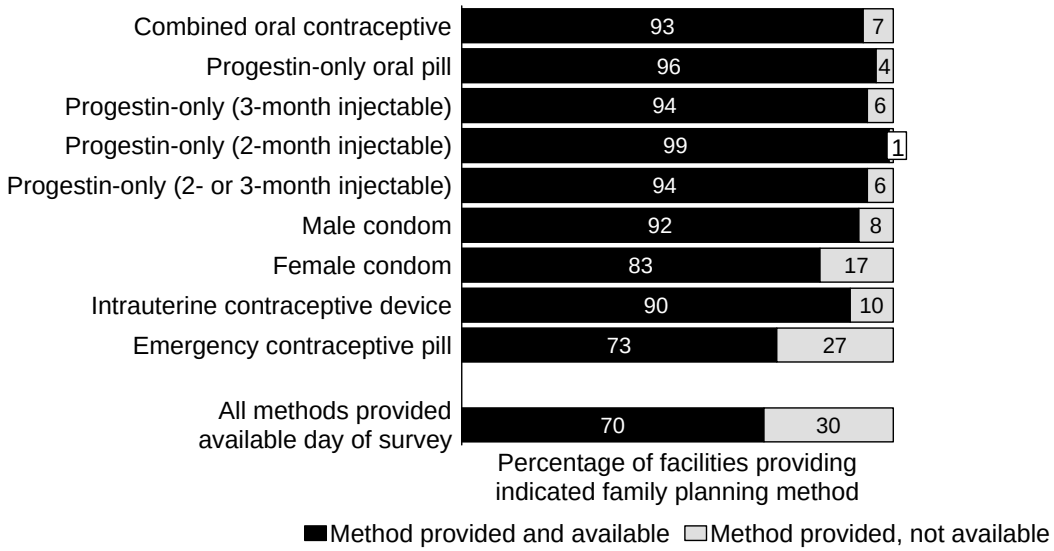
Table 5.2 Frequency of availability of family planning services

Among facilities offering temporary methods of family planning (TFP), percentage offering any temporary methods on the indicated number of days per week, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where TFP[1] services are offered:			Number of facilities offering temporary FP
	1-2 days per week	3-4 days per week	5 or more days per week	
Type of facility				
Hospital	7	1	91	46
Health centre	9	0	91	68
Maternity	18	2	80	15
Clinic	13	0	87	164
Dispensary	13	0	87	319
Managing authority				
Government	11	0	89	334
NGO	20	0	80	19
Private (for profit)	10	0	89	198
Faith-based organisation	21	0	79	61
Province				
Nairobi	10	1	89	28
Central	5	0	95	113
Coast	12	0	88	67
Eastern	16	0	83	102
North Eastern	0	0	100	16
Nyanza	20	0	80	79
Rift Valley	12	0	88	167
Western	8	0	92	41
Total	12	0	88	612

[1] Includes services for contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine devices (IUCDs), male condoms, female condoms, standard days method, or periodic abstinence.

Figure 5.1 Temporary Methods of Family Planning Provided and Availability of Method on Day of Visit



The denominator for each method is different. For example, the denominator for combined oral contraceptive is 557 facilities.

KSPA 2010

5.2.1 Contraceptive Method Mix and Method Availability

A facility that offers a wide variety of family planning methods is best able to meet clients' needs. However, some variation is expected in the methods offered because of differences in provider qualifications and training as well as the infrastructure required to provide certain methods safely. Methods that can be provided safely with minimal training are pills, injectables, and condoms as well as counselling on standard days method and periodic abstinence. Safely providing implants, IUCDs, female sterilisation, and male sterilisation requires a higher level of skill and more developed infrastructure.

Eighty-five percent of Kenyan health facilities offer some type of temporary modern methods of family planning[3], an increase from 75 percent of facilities in 2004 (see Table 5.1). From the perspective of managing authority, government facilities (85 percent in 2004 versus 96 percent in 2010) and private facilities (59 percent in 2004 versus 84 percent in 2010) increasingly offer family planning methods. Over the same period, however, the proportion of faith-based facilities offering modern methods of family planning declined, from 58 percent in 2004 to 44 percent in 2010.

Currently, there is little difference in the availability of family planning services by type of facility, ranging from 80 percent of clinics to 89 percent of dispensaries. Private (84 percent), NGO (89 percent), and government (96 percent) facilities are more likely than faith-based facilities (44 percent) to offer temporary methods of family planning.

Facilities in Nairobi and North Eastern provinces (68 percent and 67 percent, respectively) are least likely to offer family planning services, in contrast with facilities in Rift Valley, Nyanza, and Western provinces (at 92 to 93 percent) (Table 5.1).

[3] Facility provides, prescribes, or counsels clients on any of the following: contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine devices (IUCDs), male condoms, or female condoms.

Discussion of family planning availability in this chapter from this point onward will be limited to temporary methods (pills, condoms, implants, IUDS, injectables, and counselling on standard days or periodic abstinence) and among facilities offering these temporary methods. Approximately nine in ten (89 percent) of facilities in Kenya offer at least one of these temporary methods (see Table 5.1).

The most commonly offered temporary modern methods of family planning in Kenyan health facilities are combined oral contraceptive pills (95 percent of facilities offering any family planning services, versus 89 percent in 2004), the 2- or 3-month progestin-only injectables (95 percent versus 89 percent in 2004), and the male condom (92 percent versus 86 percent in 2004) (Table A-5.1) (NCAPD, MOH, CBS, and ORC Macro, 2005). Overall, since 2004 there has been an increase in the proportion of facilities offering specific modern methods of family planning. For example, compared with 2004, when 36 percent of facilities offering family planning services offered the IUCD, currently 55 percent offer the IUCD.

Sixty-three percent of family planning facilities offer counselling on the traditional periodic abstinence method, compared with 38 percent in 2004 (see Table A-5.1).

Technically, emergency contraception is not considered a family planning method but rather a backup method. Findings from the 2008-09 KDHS indicate that ever-use of emergency contraception is almost non-existent among all women, currently married women, and women age 15-49 who have ever used a contraceptive method. However, findings from the 2010 KSPA show that 83 percent of facilities that offer any family planning services report offering emergency contraception (Table A-5.1), compared with only 11 percent in 2004.

5.2.2 Frequency of Family Planning Services

In addition to a range of methods, it is important that facilities offer family planning services regularly enough to meet clients' needs. About nine of every ten family planning facilities offer family planning services five or more days per week (Table 5.2), similar to findings from 2004. Overall, there is no difference from 2004 in the frequency at which family planning facilities offer services.

5.2.3 Availability of Family Planning Methods on the Day of the Survey

Stock-outs of family planning methods can contribute to discontinuation and unwillingness to adopt any type of contraception. The survey assessed the availability of contraceptive methods on the day of the survey among facilities that report providing these methods. As seen in Figure 5.1, the majority of facilities providing the most popular methods had them in stock on the day of the survey.

There are some gaps, however. Among the facilities that report providing combined oral contraceptives, 7 percent did not have the method available on the day of the survey. Similarly, 94 percent of facilities that provide the 2- or 3-month progestin-only injectables had the method on the day of the survey (leaving a gap of 6 percent), while 92 percent of facilities that provide male condoms had them available on the day of the survey (leaving a gap of 8 percent). Nationwide, only seven of every ten facilities that report providing family planning methods actually had every method that they provide available on the day of the visit.

Additional information appears in Tables A-5.1 through A-5.4. For example, Table A-5.4 shows that availability of all provided methods on the day of the survey ranged from 42 percent of facilities reporting family planning provision in North Eastern province to 87 percent of such facilities in Nairobi and Western province.

Key Findings

Availability of family planning services: The proportion of facilities offering temporary modern methods of family planning increased from 75 percent in 2004 to 85 percent in 2010.

Approximately 9 of every 10 facilities offer at least one temporary method of family planning, including counselling on standard days or periodic abstinence.

Frequency of service availability: About nine of every ten family planning facilities offer family planning services five or more days per week, as in 2004.

Method availability on the day of the survey: A majority of facilities had the most commonly provided methods available on the day of the survey; there are some gaps, however.

5.3 COMPONENTS SUPPORTING QUALITY FAMILY PLANNING SERVICES

Facilities must have adequate infrastructure and resources available to support quality counselling and, when needed, examination of family planning clients. They should also have the equipment and supplies needed to provide each family planning method they offer. It is also important to make services for sexually transmitted infections (STIs), HIV counselling and testing services, and antiretroviral therapy (ART) services available to those who need them.

5.3.1 Infrastructure and Resources to Support Quality Family Planning

To provide quality counselling to family planning clients, facilities should be able to ensure some level of privacy and have individual client health cards or records, family planning guidelines, and relevant visual aids for client education. Since counselling about family planning often takes place in a location different from where procedures (such as pelvic examinations and IUCD insertions) are conducted, the conditions for counselling are assessed separately from those for procedures. Table 5.3 provides aggregate information on items to support quality counselling; Table A-5.5 provides details on the availability of visual aids and guidelines by facility type.

Only 25 percent of facilities offering temporary family planning have all items[4] to support quality counselling (Table 5.3). Overall, this is similar to findings in 2004, when 22 percent of family planning facilities had all items to support quality family planning counselling.

Currently, as in 2004, family planning service guidelines are not available in the majority of family planning facilities; some 36 percent of facilities have family planning guidelines, compared with 31 percent in 2004 (Table A-5.5).

[4] Items to support quality family planning (FP) counselling include a private room or visual barrier, individual client health cards, written guidelines for FP and visual aids for FP.

Table 5.3 Availability of infrastructure and resources to support services for temporary family planning methods

Percentage of facilities offering temporary family planning (TFP) methods that have the infrastructure and resources to support quality counselling, infection control, pelvic examination, and STI treatment, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with:			FP providers routinely treat STIs	Number of facilities offering temporary FP
	All items to support quality counselling[1]	All items for infection control[2]	Conditions for quality pelvic examination[3]		
Type of facility					
Hospital	40	66	43	46	46
Health centre	34	53	24	63	68
Maternity	27	52	51	70	15
Clinic	19	59	21	82	164
Dispensary	25	52	6	93	319
Managing authority					
Government	31	53	10	85	334
NGO	42	36	8	70	19
Private (for profit)	20	59	29	80	198
Faith-based organisation	6	54	10	88	61
Province					
Nairobi	39	52	39	56	28
Central	29	65	26	83	113
Coast	42	73	22	86	67
Eastern	23	37	5	89	102
North Eastern	1	24	1	91	16
Nyanza	21	60	14	78	79
Rift Valley	17	54	13	84	167
Western	38	51	14	83	41
Total	25	55	16	83	612

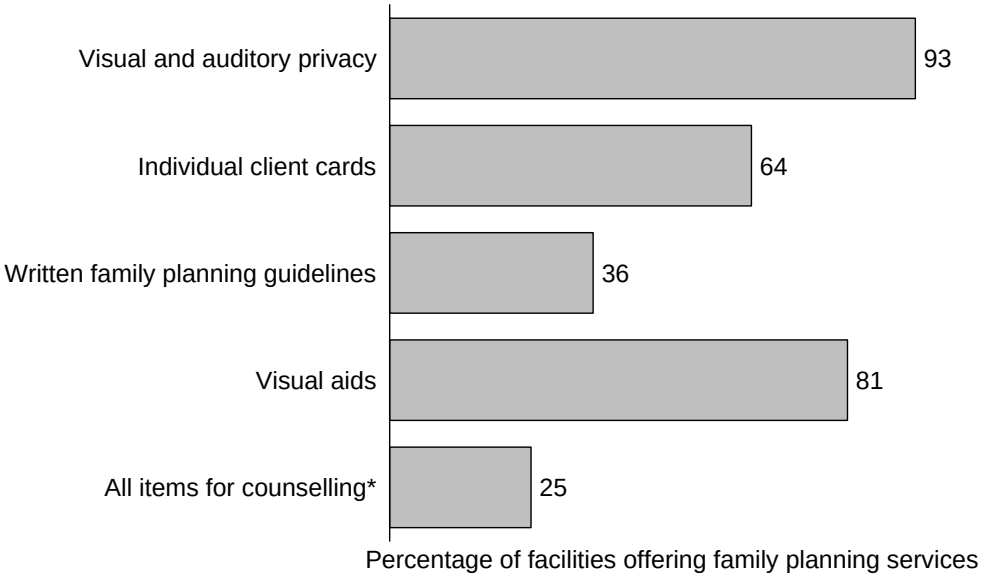
[1] A private room or a visual barrier, individual client health cards, written guidelines for FP, and visual aids for FP.
[2] Soap and running water or else hand disinfectant, disposable latex gloves, disinfecting solution, and sharps box.
[3] Private room offering visual and auditory privacy, examination bed, examination light, and vaginal speculum.

Family planning is often a sensitive issue to discuss. Counselling clients in situations where they cannot be overheard improves communication and ultimately the likelihood that the method provided is suitable for the client. Ninety-three percent of family planning facilities have conditions available to provide family planning counselling in privacy (Figure 5.2, Table A-5.5).

Individual client cards or records are important for monitoring a client over time. Because facilities often do not store client records, but rather give them to the clients to keep, the 2010 KSPA assessed the availability of blank cards for new family planning clients. Individual client cards are available in 64 percent of family planning facilities (Figure 5.2) (similar to 67 percent in 2004). The 2010 KSPA assessed whether facilities have family planning guidelines with information on eligibility screening and correct procedures for different methods. The guidelines were considered available for use only if they were in the family planning service delivery area or an immediately adjacent area. Only 36 percent of facilities (compared with 31 percent in 2004) had family planning guidelines available (Figure 5.2, Table A -5.5).

Visual aids also are important elements in good family planning counselling. They were available in the service delivery area in 81 percent of facilities (compared with 87 percent in 2004), including 90 percent of hospitals (Figure 5.2, Table A-5.5).

Figure 5.2 Items to Support Quality Counselling for Family Planning (N=612)



* Visual and auditory privacy, blank individual client cards, family planning guidelines, and visual aids

KSPA 2010

5.3.2 Infrastructure and Resources for Examinations

Uniquely among temporary family planning methods, the IUCD requires a pelvic examination before insertion.[5] In addition, a physical examination may occasionally be helpful to evaluate problems with a method or simply for routine checkups unrelated to the use of family planning methods. Such examinations require an adequate level of infection control as well as the infrastructure and items needed to examine the client.

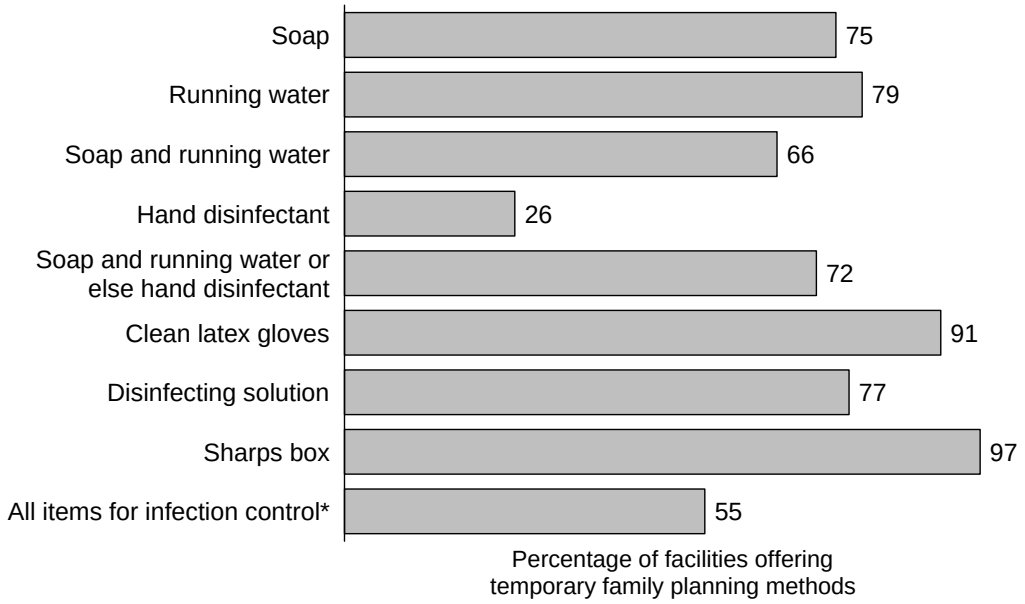
Table 5.3 provides summary information on items for infection control[6] and conditions for quality pelvic examination.[7] Figure 5.3 gives information on the availability of each specific infection control item. Details on the availability of specific infection control items and items for pelvic examination by facility type are provided in Table A-5.5.

[5] The diaphragm and cap also require pelvic examination before insertion; however, these two methods were not assessed by the 2010 KSPA.

[6] Items for infection control include soap and running water or else hand disinfectant, disposable latex gloves, disinfecting solution, and sharps box.

[7] Conditions for quality pelvic examination include a private room offering visual and auditory privacy, an examination bed, examination light, and vaginal speculum.

Figure 5.3 Items for Infection Control in Examination of Family Planning Clients (N=612)



* Soap and running water or else hand disinfectant, latex gloves, disinfecting solution, sharps box KSPA 2010

Items for pelvic examination

The 2010 KSPA assessed four items needed to conduct a quality pelvic examination for family planning clients: a private room to provide visual and auditory privacy, an examination bed or couch, an examination light, and a vaginal speculum. Only 16 percent of facilities have all these items (compared with 8 percent in 2004). The facilities most likely to have all four items are hospitals (43 percent) and maternity facilities (51 percent) (Table 5.3). The items most commonly missing are an examination light (available in 31 percent of facilities, an improvement from 22 percent in 2004), and the vaginal speculum (available in 32 percent of facilities, a slight improvement from 27 percent in 2004) (Table A-5.5). However, the other components are widely available; 94 percent of facilities have conditions to assure privacy (an improvement from 85 percent in 2004), and 97 percent have an examination bed or couch (unchanged from 2004).

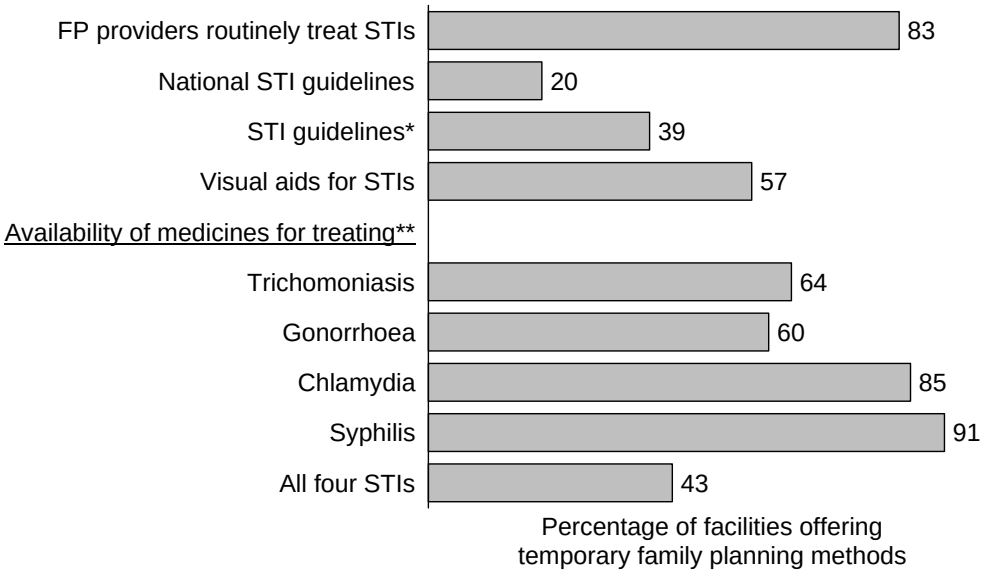
Infection control

The 2010 KSPA assessed the presence of items for infection control in areas where family planning procedures—such as pelvic examinations for IUCD insertions and provision of implants and injectables—most often take place. Items assessed for infection control were hand-washing supplies (running water and soap or else hand disinfectant), latex gloves, disinfecting solution, and a sharps box. All these items are available in the family planning service area in 55 percent of facilities (Table 5.3) (compared with 41 percent in 2004). This includes two-thirds of hospitals and six of every ten clinics. Facilities in Nyanza (60 percent), Central (65 percent), and Coast (73 percent) provinces are most likely to have all the items for infection prevention (Table 5.3). While facilities in the North Eastern province are the least likely to have these infection control items (24 percent), this is an improvement from 2 percent in 2004. The items most commonly lacking are soap and running water or else hand disinfectant (available in 72 percent of facilities) and disinfecting solution (available in 77 percent of facilities) (Table A-5.5).

5.3.3 Provision of STI Treatment for Family Planning Clients

Counselling for STI prevention, STI diagnosis, and treatment is an essential component of quality family planning care. It is particularly important to diagnose and treat STIs and other vaginal infections before an IUCD is inserted. Figure 5.4 provides information on the availability of items needed to provide STI services to family planning clients. Table A-5.8 provides details, by type of facility, on the availability of medicines for treating specific STIs.

Figure 5.4 Conditions to Support Quality STI Services for Family Planning Clients (N=612)



* Guideline for syndromic diagnosis and management, based on WHO syndromic guidelines.
** At least one medicine for treating each of the indicated STIs among facilities offering FP and where FP providers routinely treat STIs (N=508).

KSPA 2010

STI services by family planning providers

Family planning providers in 83 percent of family planning facilities routinely diagnose and treat STIs (compared with 66 percent in 2004) (Table 5.3, Figure 5.4, and Table A-5.8).

Family planning providers in hospitals are less likely to diagnose and treat STIs than family planning providers in other facility types; perhaps this is because the lower level facilities have integrated services by virtue of limited numbers of service providers, while at the hospitals there are specialised STI services that deploy different providers (Table 5.3).

Medicines to treat STIs

Medicines for treating four common STIs (specifically, trichomoniasis, gonorrhoea, chlamydia, and syphilis) are individually available in 60 percent (medicines for gonorrhoea) to 91 percent (medicines for syphilis) of facilities where family planning providers routinely diagnose and treat STIs (Figure 5.4). Additional information on the availability of individual medicines and by facility type is available in Table A-5.8.

STI service guidelines

The national guidelines on STI diagnosis and treatment are available in the family planning service area in only 20 percent of facilities, and STI guidelines based on the WHO syndromic approach are available in the family planning service area in 39 percent of family planning facilities (Figure 5.4). This is a decline from 2004, when STI guidelines were available at the family planning service site in six of every ten family planning facilities. Additional information on the availability of STI service guidelines can be found in Tables A-5.6 and A-5.7.

Visual aids

The 2010 KSPA collected information on the availability of different types of visual aids for client education, including STI- and HIV-related visual aids. STI- and HIV-related visual aids for client education are available in 57 percent of family planning facilities (Figure 5.4, Table A-5.5). Information was also collected on the availability of informational materials on STIs and HIV/AIDS

for clients to take home. Only 8 percent of family planning facilities have informational materials on STIs in general, while 18 percent have HIV/AIDS-specific informational materials available for clients to take home (Table A-5.6).

Additional information on visual aids and informational materials in facilities where family planning providers routinely treat STIs is available in Table A-5.7.

Key Findings

Items to support quality family planning counselling: All items to support quality family planning counselling are available in one of every four family planning facilities, a finding similar to that in 2004. Family planning service guidelines at the family planning service site is the item most frequently missing, as it was in 2004.

Infection control: All assessed items of infection control are available in family planning service areas in 55 percent of facilities, an improvement over 2004, when these items were available at the service site in about 40 percent of family planning facilities. Soap and running water, or else hand disinfectant, are the items most commonly missing.

Facilities in North Eastern province are the least likely to have all items for infection control, as in 2004; however, there is significant improvement over the 2004 findings.

STI services by family planning service providers: Family planning providers in eight of every ten family planning facilities routinely diagnose and treat STIs, an improvement over 2004, when family planning providers in six of every ten family planning facilities routinely diagnosed and treated STIs.

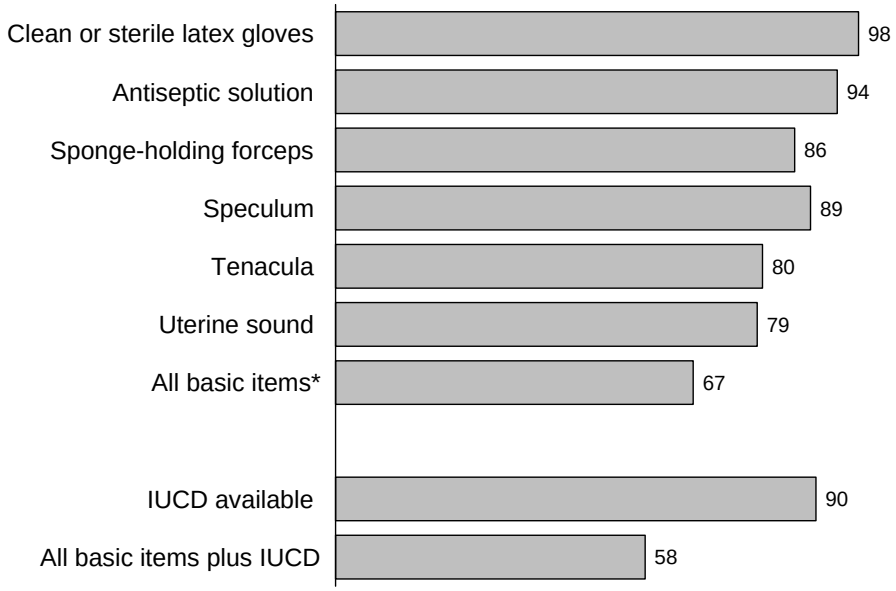
STI service guidelines: STI service guidelines are available at the family planning service site in less than half of family planning facilities, a decline from 2004, when these guidelines were available in six of every ten family planning facilities.

Medicines for treating STIs: Medicines for treating four common STIs (trichomoniasis, gonorrhoea, chlamydia, and syphilis) are individually available in 60 percent (medicines for gonorrhoea) to 91 percent (medicines for syphilis) of facilities where family planning providers routinely diagnose and treat STIs.

5.3.4 Availability of Equipment and Supplies for Specific Methods

A variety of equipment and supplies is desirable in order for facilities to effectively provide different contraceptive methods safely and to monitor clients. Figure 5.5 shows information on the availability of items for providing IUCDs. Tables A-5.9 through A-5.12 provide additional details on the availability of equipment and supplies for specific methods—including IUCDs, injectables, and implants—and for pelvic examinations.

Figure 5.5 Equipment for IUCD Insertion and Removal (N=220)



* Clean or sterile latex gloves, antiseptic solution, sponge-holding forceps, speculum, tenacula, and uterine sound.

KSPA 2010

Intrauterine contraceptive devices

As indicated in Figure 5.5 and Tables A-5.9 and A-5.10, among facilities that *provide* IUCDs (i.e., excluding facilities that only prescribe the method or refer clients elsewhere), nine of every ten (compared with eight of every ten in 2004) had IUCDs available on the day of the survey. While the availability of latex gloves remains unchanged since 2004 (almost universally available in both 2004 and 2010), there is modest improvement in the availability of other equipment to support provision of IUCD services. For example, the availability of sponge-holding forceps increased to 86 percent from 73 percent in 2004, and the availability of a speculum increased to 89 percent from 75 percent in 2004. Overall, availability of all basic items[8] increased to 67 percent in 2010 from 56 percent in 2004.

On the day of the survey, only 27 percent of the facilities (compared with 11 percent in 2004) had IUCDs, all associated equipment, and also satisfied all KSPA criteria[9] for quality insertion and removal of IUCDs (Table A-5.9).

Implant method

Among facilities that provide the implant method, 45 percent had all items[10] for implant insertion, while only 21 percent had the implant method and all associated equipment and also satisfied conditions for infection control (Table A-5.9).

Oestrogen-containing methods

Women receiving oestrogen-containing family planning methods benefit from blood pressure monitoring. Among facilities offering methods that contain oestrogen, nine of every ten had an apparatus to measure blood pressure at the family planning service delivery site (Table A-5.9). Health

[8] All basic items are disposable latex gloves, antiseptic solution, sponge-holding forceps, speculum, tenacula, and uterine sound.

[9] These criteria include all infection control items, visual privacy, an examination bed/table, an examination light, and the method.

[10] Sterile gloves, antiseptic solution, sponge-holding forceps, local anaesthetic (such as xylocaine or lignocaine), sterile syringe and needle, scalpel with blade, and any implant method with inserter.

centres and dispensaries were slightly less likely to have blood pressure equipment at the family planning service delivery site than are other facility types.

Injectable contraceptives

Among facilities providing injectable contraceptives, almost all (98 percent) had sterile needles and syringes (Table A-5.9).

Key Findings

Items to support provision of services: Nine of every ten facilities providing IUCDs had the method available in the facility on the day of the survey, a slight improvement from eight of every ten in 2004. Sixty-seven percent of IUCD facilities had all the basic items needed for IUCD insertion.

A little less than half of facilities providing implants had all items for implant insertion on the day of the survey.

Blood pressure equipment is available in about nine of every ten facilities offering family planning methods containing oestrogen, while sterile needles and syringes are available in almost all the facilities that offer injectable contraceptive methods.

5.4 MANAGEMENT PRACTICES THAT SUPPORT QUALITY FAMILY PLANNING SERVICES

Management practices for supporting quality family planning services include proper documentation and record-keeping, practices related to user fees, and staff supervision and development.

Summary information on management practices is provided in Table 5.4. Utilisation statistics for family planning services are provided in Table A-5.13. Information on user fees for family planning services is provided in Tables A-5.14 through A-5.16. Details on staff training and supervisory activities are provided in Tables A-5.17 through A-5.19.

5.4.1 Facility Documentation and Records

The 2010 KSPA assessed the availability of up-to-date family planning client registers, which are the most common source of data for health information systems. A register was defined as up-to-date if there was an entry within the past seven days, with information indicating the method or service provided and the client's status (first visit or follow-up visit).

Some 79 percent of facilities offering family planning services had an up-to-date register (compared with 76 percent in 2004) (Table 5.4). As in 2004 government and NGO facilities were most likely to have up-to-date client registers (88 percent of government facilities in 2004 versus 91 percent in 2010, and 98 percent of NGO facilities in 2004 versus 100 percent in 2010).

Table 5.4 Management practices to support services for temporary family planning methods

Percentage of facilities offering temporary family planning (TFP) methods that have an up-to-date client register and that charge user fees for FP services, and percentage of such facilities where interviewed FP service providers report routine training and supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities that offer temporary FP methods with:		Number of facilities offering temporary FP	Percentage of facilities where staff report receiving routine:		Number of facilities with interviewed FP service providers
	Observed up-to-date client register[1]	User fees for FP services		Training[2]	Personal supervision[3]	
Type of facility						
Hospital	86	70	46	26	88	45
Health centre	90	79	68	25	94	68
Maternity	75	95	15	50	75	15
Clinic	59	93	164	26	62	160
Dispensary	86	66	319	16	88	297
Managing authority						
Government	91	68	334	17	92	314
NGO	100	65	19	14	88	19
Private (for profit)	63	94	198	32	65	192
Faith-based organisation	57	58	61	18	76	59
Province						
Nairobi	86	92	28	46	77	28
Central	74	97	113	17	63	105
Coast	66	68	67	36	83	64
Eastern	77	70	102	14	93	99
North Eastern	15	1	16	8	87	10
Nyanza	90	70	79	25	92	79
Rift Valley	84	76	167	20	79	161
Western	93	71	41	17	86	39
Total	79	76	612	22	81	584

[1] Register has entry within past seven days that indicates visit status (first or follow-up) and service or method provided.
[2] A facility has routine staff training if at least half of interviewed providers reported that they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported that they had been personally supervised at least once during the six months preceding the survey.

5.4.2 Practices Related to User Fees

According to Kenyan government policy, family planning services in government facilities should be free. There should be no charge for any government-supplied contraceptive method, whether provided in a government or private facility; however, a few government facilities occasionally charge registration fees for the client card. Some private, for-profit facilities charge registration and consultation fees.

The 2010 KSPA found that three-quarters of facilities offering family planning (compared with half of facilities in 2004) charge some type of user fee for family planning services. This is most common in maternity facilities (95 percent), in clinics (93 percent) and in private for-profit facilities (94 percent) (Table 5.4). The proportion of government facilities charging user fees increased from four of every ten facilities in 2004 to about seven of every ten facilities in 2010, while the proportion of NGO facilities charging user fees has increased from 31 percent in 2004 to 65 percent in 2010 (Table 5.4). Among the provinces, facilities in Nairobi (92 percent) and Central province (97 percent) are most likely to charge fees for family planning. Although hospitals and dispensaries are less likely than other facility types to charge user fees, the proportions of both facility types that charge user fees also have increased since 2004.

User fees are charged mostly for the actual method (32 percent of facilities offering family planning) and laboratory tests (37 percent of such facilities) (Table A-5.14). Among family planning facilities where some form of user fees is charged, only in one of every five posts all fees for clients to see. It is more common for some fees to be posted in hospitals than in other facility types. No fees are posted in seven of every ten facilities (Table A-5.14).

5.4.3 Training and Supervision

Training

Since the types of contraceptive methods offered change over time, continual training for providers is important. Training aims to improve the quality of counselling, management of complications or side effects, and providers' judgment and skills in assessing which contraceptive methods are most suitable for individual clients.

A facility is considered to offer routine staff development activities if at least half of the interviewed family planning service providers at that facility have received any structured training relevant to family planning during the 12 months preceding the survey. This includes both pre-service and in-service training but excludes individual instruction received during routine supervision. Overall, only 22 percent of family planning facilities (compared with 34 percent in 2004) meet the criteria for providing routine staff development activities. Maternity facilities (50 percent) and facilities in Nairobi province (46 percent) are most likely to meet the criteria for providing routine staff development (Table 5.4).

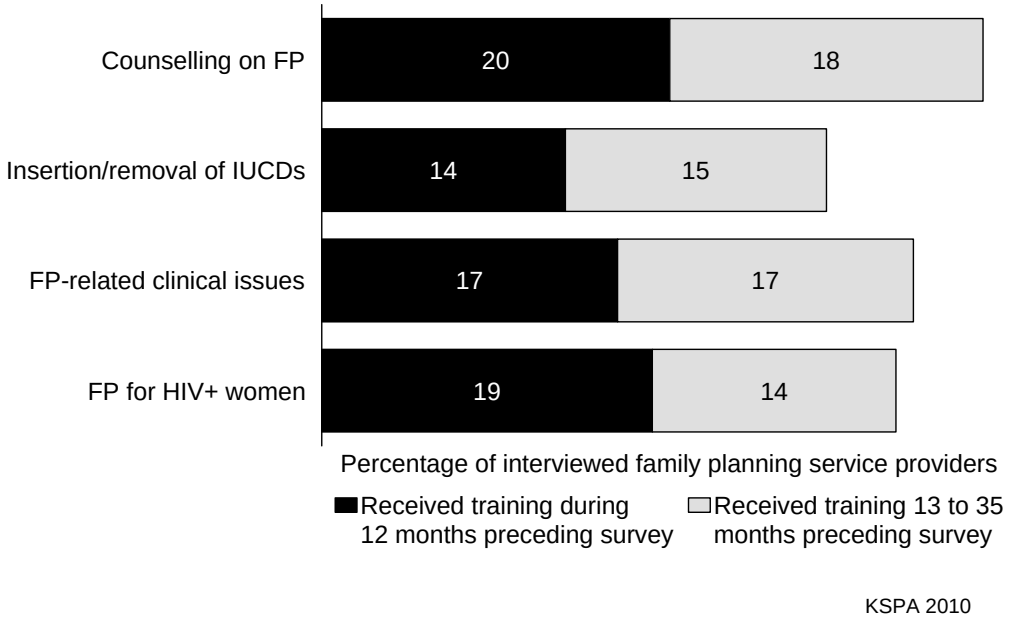
Among the interviewed family planning service providers, only about one-quarter reported receiving any family planning-related training during the 12 months preceding the survey (same as in 2004) (Table A-5.17), reflecting the small proportion of facilities meeting the criteria of providing routine staff development. There is little difference in the proportions of providers who report receiving training in various topics in the preceding 12 months, ranging from 14 percent receiving training in IUCD insertion/removal to 20 percent receiving training in family planning counselling (Table A-5.18 and Figure 5.6).

Supervision

Supervision of individual staff members helps to promote adherence to standards and to identify problems that contribute to poor services. If at least half of the interviewed family planning service providers at a facility reported having been personally supervised during the six months preceding the survey, the facility is considered to have routine staff supervision. Supervision of family planning providers is common, with 81 percent of family planning facilities meeting the criteria for routine staff supervision (a slight decline from 87 percent in 2004) (Table 5.4). Health centres (94 percent) are more likely to meet the criteria for routine staff supervision than other types of facilities. Government facilities (92 percent) and facilities in Eastern and Nyanza provinces (93 and 92 percent, respectively) are among the most likely to have routine staff supervision activities.

The median number of times family planning providers were supervised during the six months preceding the survey was three. Additional information on staff supervision is provided in Table A-5.19.

Figure 5.6 Training Received by Interviewed Family Planning Service Providers, by Topic and Timing of Most Recent Training (N=1,513)



KSPA 2010

Key Findings

Up-to-date client registers: The proportion of family planning facilities with up-to-date client registers showed very little improvement since 2004. Government facilities and NGO facilities are most likely to have up-to-date client registers.

User fees: The proportion of family planning facilities that charge user fees has increased from half in 2004 to three-quarters in 2010, with the greatest increases among government and NGO facilities.

Staff development: Only about one in every five family planning facilities provides routine staff development activities. Compared with 2004, there generally are slight decreases in the proportion of family planning facilities providing routine staff development activities and staff supervision to family planning providers.

5.5 Adherence to Standards for Quality Service Provision

To assess whether family planning providers adhere to service standards, KSPA personnel observed family planning client-provider interactions using observation check-lists that are based on commonly accepted guidelines for screening, counselling, and conducting procedures for family planning clients. The observers collected information on the following questions:

- Did providers talk about topics essential to determining the appropriateness of the methods discussed, and, where necessary, did they conduct the physical examination needed to screen clients for method eligibility?

- Did the conditions and procedures followed for provision of specific methods meet KSPA criteria for quality service provision?

The observers noted what information the provider shared with a client and whether an examination, where appropriate, was conducted prior to dispensing a method. They did not assess whether the information given was correct or whether findings were appropriately interpreted.

Information on clients' status and the principal reason for visiting the facility are provided in Tables A-5.20 and A-5.21. Table A-5.22 gives details on the primary method provided, prescribed, or discussed during this visit.

Exit interviews were conducted with all observed family planning clients, both new and continuing, as they left the facility. These clients were asked questions regarding the method they received to ascertain their understanding and knowledge of that method. Clients who left the facility with only a prescription for a method also were asked questions about that method. When two methods were prescribed or received, the client was asked questions about both methods.

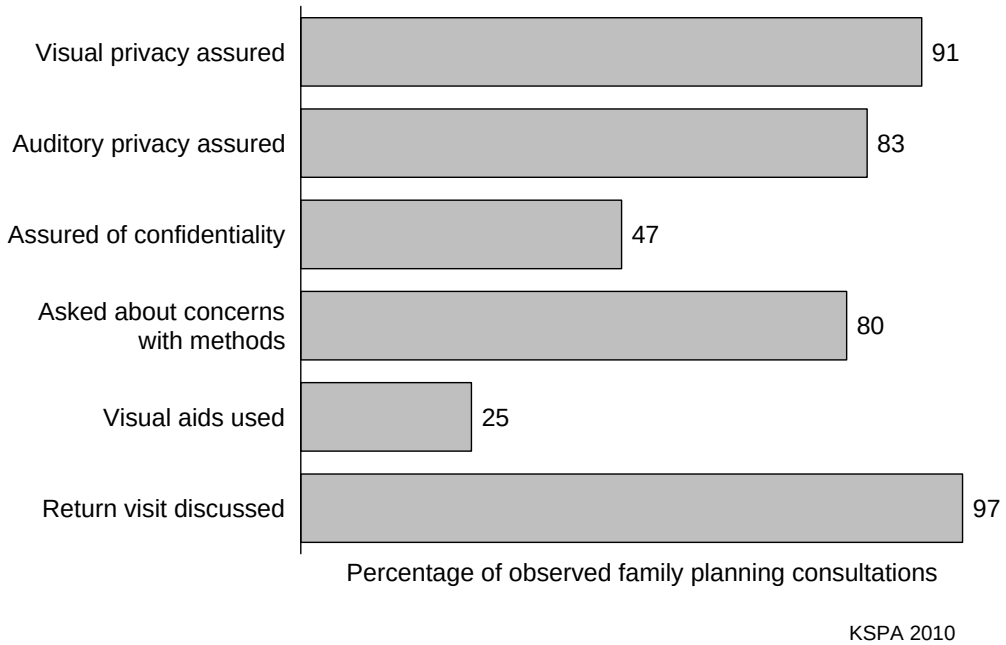
Figures 5.8 and 5.9 provide information on observed conditions and content of family planning counselling. Details on consultations for first-visit clients only are provided in Tables A-5.24 and A-5.25. Information from observations of specific methods or examinations is provided in Tables A-5.26 through A-5.28.

5.5.1 Counselling and Client Assessment

Sixteen percent of observed female family planning clients (compared with 29 percent in 2004) were making their first visit; the remaining 84 percent (compared with 71 percent in 2004) were continuing clients. Only 1 percent of all observed clients (compared with 5 percent in 2004) had never been pregnant (Table A-5.20).

Privacy is important to family planning counselling. About nine of every ten family planning counselling sessions were conducted under conditions that assured visual privacy (similar to 87 percent in 2004), and eight of every ten took place under conditions that assured auditory privacy (similar to 83 percent in 2004); however, clients were assured of confidentiality in only 47 percent of counselling sessions (compared with 41 percent in 2004) (Figure 5.7, Table A-5.23). Providers explicitly asked clients about their concerns with methods during eight of every ten consultations (compared with 69 percent in 2004), and return visits were almost always discussed with clients (97 percent compared with 92 percent in 2004). Visual aids were used in 25 percent of family planning consultations (compared with 14 percent in 2004).

Figure 5.7 Observed Conditions and Content of Family Planning Counselling (N=1,010)



KSPA 2010

Frequently, health services are organised so that measurements of blood pressure and weight and other routine activities take place before the client sees the provider, and the information is recorded on individual client cards. Thus, client cards play an important role in making this information available to providers during consultations and also in avoiding collection of the same information multiple times. Client cards are also crucial for monitoring family planning clients over time. Individual client cards are reviewed by family planning providers in 78 percent of consultations and written on during or after 95 percent of consultations (Table A-5.23).

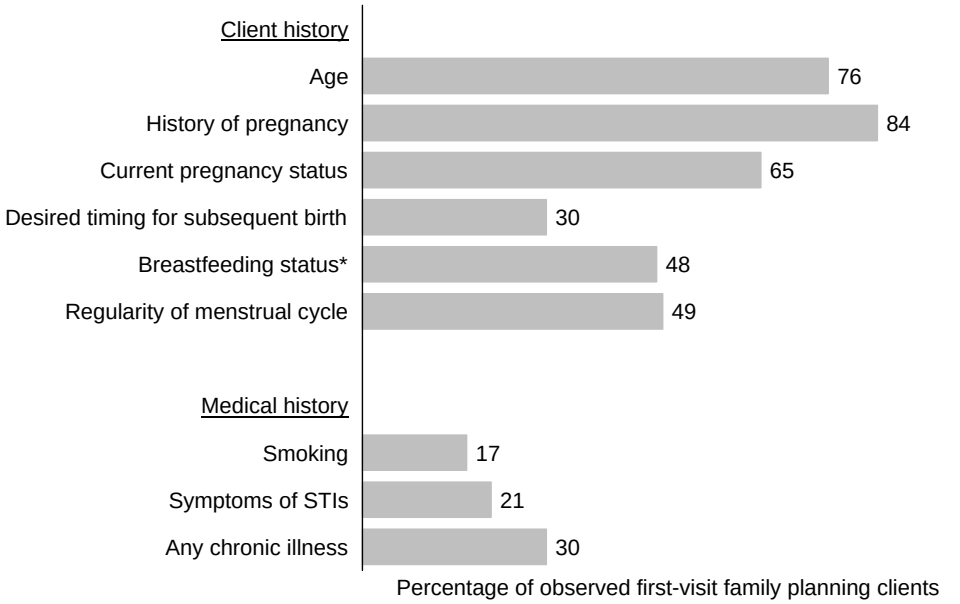
During a family planning visit, especially during a client's first visit, providers are expected to elicit information about the client's personal and health history to help them make an informed recommendation on contraceptive methods. This constitutes screening clients for the appropriateness of specific methods. During observed family planning counselling sessions, 76 percent of first-visit clients) were asked their age (similar to 73 percent in 2004), and 84 percent were asked about previous pregnancy (compared with 79 percent in 2004) (Figure 5.8). First-visit clients were less likely to be asked about their current pregnancy status (65 percent; 33 percent in 2004) or about desired timing for a subsequent birth (30 percent, similar to 32 percent in 2004).

Clients' medical history was assessed infrequently; 21 percent of clients were asked if they had symptoms of an STI (compared with 32 percent in 2004), and three of every ten were asked about chronic illnesses (compared with about five of every ten in 2004).

Only 20 percent of first-visit clients were asked about their partner's attitude towards family planning, compared with 32 percent in 2004 (Table A-5.25). Considering the current drive towards reducing HIV/AIDS rates, condoms were not discussed as frequently as expected. Use of condoms to prevent STIs was discussed with 25 percent of first-visit clients (compared with 34 percent in 2004), and as a dual method to prevent both pregnancy and STIs, with 23 percent of first-visit clients (compared with only 11 percent in 2004). STIs in general were discussed with 32 percent of first-visit family planning clients (compared with 28 percent in 2004).

Visual aids for client education are not routinely used during family planning consultations. Visual aids were used during only 25 percent of all family planning consultations (compared with 14 percent in 2004) (Table A-5.23). Visual aids were used somewhat more often with first-visit clients (40 percent), especially in clinics (61 percent) (Table A-5.25).

Figure 5.8 Observed Elements of Client History-taking for First-visit Family Planning Clients (N=161)



* Among those ever pregnant (N=160)

KSPA 2010

Key Findings

Conditions for client counselling: Family planning counselling sessions are conducted under conditions that assure visual privacy in about nine of every ten facilities and under conditions that assure auditory privacy in eight of every ten consultations; both findings were similar to findings in 2004.

Client history: Only three of every ten first-visit clients were asked about desired timing for a next birth, a finding similar to that in 2004. Visual aids are not used regularly during family planning consultations; although available in eight of every ten facilities, they were used during family planning sessions with four of every ten first-visit clients, not very different from 35 percent in 2004.

5.5.2 Method-Specific Assessments and Examinations

Experts recommend that clients receiving a family planning method containing oestrogen, whether oral or injectable, have their blood pressure monitored. About nine of every ten family planning clients using oestrogen-containing methods had their blood pressure measured[11] (compared with seven of every ten in 2004), and a similar proportion were weighed (compared with a little over nine of every ten in 2004) during their visit to the facility on the day of the survey (Table A-5.26). Clients visiting dispensaries were least likely to have blood pressure measured (77 percent of clients on methods containing oestrogen) (Table A-5.26).

5.5.3 Counselling of Clients

Whether they are new clients or are continuing contraception, family planning clients should receive certain information during their visits to a health facility. The provider should explain or review with the client how to use the method, the possible side effects, what to do for problems, and

[11] If the client attended a facility where measuring blood pressure is standard procedure before the consultation, the client was assumed to have had her blood pressure measured, even if this was not observed for the particular client.

when the client should return for a follow-up visit. Among clients who received oral contraceptive pills or injectables, 73 percent reported that providers explained how to use the method, and 61 percent said that the provider explained or mentioned possible side effects (Table A-5.27).

5.6 CLIENT OPINION FROM EXIT INTERVIEWS

After their consultations were observed, family planning clients were interviewed about issues commonly related to client satisfaction. These exit interviews also probed clients on their opinions of the services they had received that day. Details on components of counselling that were observed and reported by clients are presented in Table A-5.27, while details on client opinions are provided in Tables A-5.29 and A-5.30. Table A-5.31 provides information on the educational backgrounds and other characteristics of observed and interviewed clients.

5.6.1 Major Problems

Clients were asked to rate whether specific issues posed a major problem, a minor problem, or no problem at all for them during the visit. Few issues were considered major problems, and by a small proportion of clients (Table A-5.29). One-quarter of family planning clients considered waiting time to see a provider a major problem (compared with 20 percent in 2004), especially at hospitals, health centres, and dispensaries. The great majority of interviewed family planning clients did not consider lack of methods and medicines, the hours that a facility is open, or other issues to be major problems.

5.6.2 Nearest Health Facility

Fifteen percent of interviewed family planning clients (compared with 19 percent in 2004) said that the facility was not the one closest to their home (Table A-5.30). Although the numbers are small, 39 percent of family planning clients interviewed in maternity facilities and 27 percent in facilities managed by faith-based organisations reported that this was not the facility closest to home. Among clients not visiting the closest facility, 15 percent cited bad reputation as a reason for not visiting the closest facility, and 24 percent cited higher cost at the facility closest to their home. Just 2 percent said they had been referred to the facility where they were interviewed.

Key Findings

Major problems during visit to facility: Similar to findings in 2004, interviewed family planning clients considered few issues to be major problems. Waiting time to see a provider was the most cited problem.

Nearest health facility: Only a small proportion of interviewed family planning clients bypass the facility closest to their home. High cost of services and bad reputation are the main reasons that clients give for not visiting the facilities that are closest to them.

MATERNAL HEALTH AND NEWBORN CARE SERVICES 6

Felix Musili, Frank Kagema, Walter Mukhwana, Crispin Ndeda, Christopher Omolo

6.1 BACKGROUND ON MATERNAL AND NEWBORN HEALTH CARE IN KENYA

This chapter provides an overview of maternal and newborn health services in Kenya. It highlights the key aspects of maternal and newborn care, including the availability of staff and services for antenatal care (ANC), safe delivery, postnatal care (PNC), and management of obstetric complications.

This chapter addresses the following central questions about maternal and newborn health services:

1. What is the availability of antenatal care services, and to what extent do facilities have the capacity to support quality ANC services?

2. To what extent do health service providers adhere to service standards for ANC?

3. To what extent is PNC[1] available where ANC is offered, and to what extent do facilities have the capacity to support quality PNC services?

4. What is the availability of delivery services, and to what extent do facilities have the capacity to support quality delivery services?

5. To what extent are facilities prepared to provide quality newborn care?

6. What is the extent of certain beneficial newborn care practices[2] in facilities providing delivery services?

To determine which aspects of maternal health to assess, the 2010 Kenya Service Provision Assessment (2010 KSPA) draws on the findings and recommendations of Safe Motherhood initiatives.

6.1.1 Maternal Health Status and Health Care Utilisation

Complications of pregnancy and childbirth are among the leading causes of morbidity and mortality among Kenyan women. Recent estimates suggest that there are 488 maternal deaths per 100,000 live births[3] (KNBS and ICF Macro 2010).

Hospital records and hospital-based studies conclude that the majority of these deaths are due to one or more preventable direct obstetric complications. Postpartum haemorrhage (PPH) is the most common cause of maternal deaths in sub-Saharan Africa. Other direct causes are puerperal sepsis/infections, hypertensive disorders, obstructed labour/ruptured uterus, and complications of unsafe abortions. Major indirect causes are severe anaemia, malaria, HIV/AIDS, and tuberculosis. Also, for every woman who dies, 30 others are maimed by potentially lifelong disabilities such as obstetric fistula.

[1] The 2010 KSPA accepted any report of offering routine out-patient postnatal examination and services as PNC. Details on the content of PNC were not collected. Capacity was assessed by whether the facility could identify and manage postpartum infections and whether the newborn's weight could be measured.
[2] The 2010 KPSA assessed three newborn care practices—'warm chain', newborn feeding practices, and cord care.
[3] This is the maternal mortality ratio (MMR) during the 10-year period before the 2008-09 KDHS.

The 2008-09 Kenya Demographic and Health Survey (2008-09 KDHS) found that less than half (47 percent) of all pregnant women make the recommended four or more ANC visits. Sixty percent of urban women make four or more ANC visits compared with less than half (44 percent) of rural women. The data further show that most women do not receive antenatal care early in the pregnancy; only 15 percent of pregnant women obtain antenatal care in the first trimester of pregnancy; the median number of months at first visit is 5.7 (KNBS and ICF Macro 2010).

Tetanus toxoid injection is given to mothers to prevent neonatal tetanus, which previously was a major cause of infant mortality. The 2008-09 KDHS found that 73 percent of mothers ages 15-49 were protected against tetanus during the most recent birth of a live child.[4]

Malaria is among the common indirect causes of poor maternal health outcomes. Efforts to reduce malaria among pregnant women are being scaled up. By government of Kenya policy, insecticide treated mosquito nets are provided at no cost to pregnant women attending ANC clinics in district where malaria is endemic. For that reason, all government facilities offering ANC in all of Nyanza, Western and Coast provinces are expected to provide treated bed nets at no cost to pregnant women and children under one year of age, whereas parts of Rift Valley, Central, Eastern, Nairobi and North Eastern provinces are not covered under this programme.

According to the 2008-09 KDHS, 42 percent of women ages 15-49 with a live birth in the two years preceding the survey took an antimalarial drug. Thirty-six percent took one or more doses of SP/Fansidar, 15 percent took two or more doses of SP/Fansidar, while 34 percent received one or more doses of SP/Fansidar during an ANC visit. Only 14 percent, received intermittent preventive treatment (IPTp), defined as treatment with two or more doses of SP/Fansidar, at least one of which was during an ANC visit.

The same study found that 61 percent of households own at least one mosquito net (treated or untreated), while 56 percent own at least one insecticide-treated net (ITN).[5] Fifty-three percent of pregnant women ages 15-49 years had slept under an ITN the night before the survey (KNBS and ICF Macro 2010).

Anaemia is a leading indirect cause of maternal deaths. The 2008-09 KDHS found that 69 percent of women with a live birth in the five years preceding the survey took iron tablets or syrup to prevent anaemia during their last pregnancy.

According to the 2007 Kenya AIDS Indicator Survey (2007 KAIS), HIV prevalence in Kenya is estimated to be 7.1 percent in adults ages 15-64 years (NASCOP, 2009). Nearly one of every ten pregnant women in Kenya is infected with HIV, according to the survey. Children less than 15 years of age account for 16 percent of all HIV infections; most of these infections were acquired through mother-to-child transmission.

Despite the high antenatal care attendance,[6] the rate of delivery in a health facility is low. Only 43 percent of live births in the five years preceding the 2008-09 KDHS took place in a health facility (KNBS and ICF Macro, 2010). Mothers in Nairobi and Central provinces were most likely to deliver in a health facility, while mothers in North Eastern and Western provinces were least likely to do so. Urban women (75 percent, versus 35 percent of rural women) and those with secondary school education and above were most likely to deliver in a health facility. The older a woman was when she delivered, the less likely that she delivered in a health facility (KNBS and ICF Macro, 2010).

[4] Includes mothers with two injections during the pregnancy of her last birth, or two or more injections (the last within three years of the last live birth), or three or more injections (the last within five years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time before the last birth.

[5] An insecticide-treated net (ITN) is (1) a factory-treated net that does not require any further treatment (long-lasting net), (2) a pretreated net obtained within the past 12 months, or (3) a conventional net that has been soaked with insecticide within the past 12 months.

[6] According to the 2008-09 KDHS, 92 percent of women who had a live birth in the five years preceding the survey received antenatal care from a skilled provider, defined as a doctor, a nurse, or a midwife.

6.1.2 Maternal Health Policy Framework

The policy objective of the health sector is to reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators (NHSSP II). Ensuring access to the Minimum Health Care Package is the central strategy to this end. This same policy statement describes the minimum package for sexual and reproductive health and rights:

- Essential antenatal and obstetric care
- Family planning
- Adolescent reproductive health
- Gender-based violence issues

The national reproductive health policy, *Enhancing Reproductive Health Status for All Kenyans*, October 2007, has the following goals:

- Increasing equitable access to reproductive health services
- Improving the quality, efficiency, and effectiveness of service delivery at all levels
- Improving responsiveness to client needs

Also, the *Kenya Vision 2030* highlights the following key goals in maternal and newborn health:

- Reduce the infant mortality rate from 52 deaths per 1,000 live births in 2008-09 to 25 deaths per 1,000 live births in 2012
- Reduce the maternal mortality ratio from 488 deaths per 100,000 live births in 2008-09 to 147 deaths per 100,000 live births by 2012
- Accelerate full infant immunisation from 73 percent in 2006 to 95 percent by 2012
- Accelerate skilled birth attendance from 44 percent of deliveries in 2008-09 to 90 percent in 2012

Achieving these goals requires more emphasis on both preventive and promotive health care.

The 2010 *Kenya National Roadmap for Maternal and Newborn Health* further strengthens the foundation of the six pillars, which consist of (1) skilled attendance and an enabling environment to provide quality (skilled) care; (2) supportive health systems, which involve effective systems of referral, data management, procurement, training, supervision, and health management systems; (3) community action; (4) partnerships; (5) male involvement based on the principle of equity for all; and (6) respect for reproductive rights.

The National Health Policy objective for the National Health System is aimed at reversing the downward trends in health indicators. Additionally, the policy seeks to reduce existing inequalities among the regions and among different populations. These goals can be effectively achieved only by involving the populations themselves in decisions on priority setting and consequently in the equitable allocation of resources. Active involvement and partnership with other stakeholders in the provision of care is important.

The second National Health Sector Strategic Plan (NHSSP II) adopted the Kenya Essential Package of Health (KEPH). This focuses on the health needs of individuals throughout the stages of human life.

The six distinct phases of care (cohorts) are:

1. Pregnancy, delivery, and newborn care (up to two weeks of age)
2. Early childhood (three weeks to five years)
3. Late childhood (6 years to 12 years)
4. Adolescence (13 to 24 years)
5. Adulthood (25 to 59 years)
6. Elderly (60 years and older)

Each of these cohorts has special needs, and thus different interventions are appropriate. At the same time, services directed to each of these cohorts are complementary, leading to synergy and mutual reinforcement among the programmes.

The KEPH has also defined six levels of service delivery. Detailed information on these six levels of care is provided in chapter 2 of this report.

6.1.3 Definition of Maternal Health Concepts Used During Collection of KSPA Information

Maternal health is not only a women's issue; a mother's health has a direct bearing on the health of her newborn as well. The majority of pregnancies are normal, but about 15 percent of all pregnant women experience life-threatening pregnancy-related complications. Many complications and subsequent poor outcomes for women and newborns can be prevented or managed by providing quality care including early detection of problems and appropriate and timely interventions.

With the accumulation of evidence on best practices related to preventing maternal morbidity and mortality, some conventional (and traditional) maternal health practices and interventions have been re-examined in recent years. Subsequently, there have been changes in programmes, policies, and strategies.

Antenatal care (ANC): As noted, all pregnant women are at risk of developing complications. The aim of ANC is to achieve a good outcome for both the mother and baby and to prevent any complications that may occur in pregnancy, delivery, or the postpartum period. It is therefore important to ensure that all pregnant women have access to preventive interventions, early diagnosis and treatment, and emergency care when needed. It is now emphasised that ANC should include individual birth plans, education on danger signs, complication readiness, family planning counselling, prevention of mother-to-child transmission (PMTCT) of HIV, nutrition, and skilled and timely interventions to avoid adverse maternal and neonatal outcomes. This forms the basis of Focussed Antenatal Care (FANC), in which a minimum of four quality visits are recommended.

Delivery care: Since any delivery may have complications, the emphasis should be on using skilled and trained delivery care providers and ensuring that all women have access to life-saving emergency interventions at the time of labour and delivery. In many countries most deliveries occur at home, attended by traditional birth attendants (TBAs). Previously, extensive efforts and funds were directed towards upgrading the skills of TBAs. However, evidence now shows that in almost all cases the level of skills attained by so-called 'skilled' TBAs is less than what is considered safe. In essence, in-service training for TBAs cannot improve their skills to the level of competence needed.

A skilled attendant, as defined by the World Health Organization (WHO) and other international bodies, is a 'health professional—such as a midwife, doctor, clinical officer or nurse—who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns' (WHO, 2004b).

Postnatal care (PNC): There is an increasing emphasis on ensuring that women receive PNC beginning within 48 hours after delivery, for early diagnosis and management of postpartum complications. PNC also provides an opportunity to counsel the new mother on family planning and HIV/AIDS, to teach her how to care for herself and her newborn during the postnatal period, to promote exclusive breastfeeding, and to assess the newborn for problems. Targeted PNC includes check-ups up to one year after childbirth.

Newborn care: More attention has also been given recently to essential newborn care, with an increased awareness of the need to discourage some common practices detrimental to newborn health, such as slapping the newborn baby, holding the baby upside down, routine aspiration of a newborn's mouth and nose at birth, covering the baby with only a thin towel, separating the baby from the mother, immediately weighing the baby, early bathing, and giving pre-lacteal feeds. The aim is to promote evidence-based practices that contribute to improved newborn health, especially: drying

and wrapping the baby immediately upon delivery, delivery onto the abdomen, hygienic cord care, early initiation of breastfeeding, and delay in weighing and bathing.

Emergency obstetric care (EmOC): EmOC refers to care provided in health facilities to manage and treat the direct obstetric emergencies that cause the vast majority of maternal deaths during pregnancy, labour and delivery, and the postpartum period. Facilities are considered EmOC facilities if they provide a series of services or interventions known as signal functions over a designated 3-month period. The six signal functions that define a basic EmOC (BEmOC) facility are parenteral administration of antibiotics, oxytocic drugs, and anticonvulsants; manual removal of the placenta; removal of retained products of conception; and assisted vaginal delivery. Comprehensive EmOC (CEmOC) includes the six signal functions plus performance of caesarean sections and blood transfusions.

6.2 AVAILABILITY AND CAPACITY TO PROVIDE QUALITY MATERNAL AND NEWBORN CARE SERVICES

6.2.1 Availability of Antenatal and Postnatal Care Services

ANC is designed to promote healthy behaviours and preparedness during pregnancy, childbirth, and the postpartum period. It also is important for the early detection and treatment of complications. Information on the availability of ANC, PNC, and tetanus toxoid (TT) vaccine services in Kenyan health facilities is provided in Table 6.1. Table A-6.1 provides information on the availability of various family health services on the same day that ANC services are offered. Additional information on the availability of ANC and TT services is provided in Table A-6.2.

Currently, some 74 percent of all facilities (excluding stand-alone VCT facilities) offer ANC (compared with 79 percent in 2004), 59 percent offer PNC (compared with 35 percent in 2004), and 69 percent provide TT vaccine (compared with 84 percent in 2004). Fifty-six percent of facilities offer all three services (Table 6.1) (compared with 33 percent in 2004).

Table 6.1 Availability of antenatal care, postnatal care, and tetanus toxoid vaccine

Percentage of facilities offering antenatal care (ANC), postnatal care (PNC), and tetanus toxoid (TT) vaccine, and percentage offering all three services, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering the indicated services				Number of facilities
	ANC	PNC	TT vaccine	ANC, PNC, and TT	
Type of facility					
Hospital	94	92	94	91	51
Health centre	99	83	99	83	80
Maternity	93	82	83	74	17
Clinic	41	25	37	22	203
Dispensary	84	68	77	64	340
Managing authority					
Government	89	75	84	74	344
NGO	85	61	80	61	22
Private (for profit)	46	30	40	26	236
Faith-based organisation	88	72	84	69	88
Province					
Nairobi	79	68	78	66	41
Central	56	46	52	42	125
Coast	70	57	68	55	81
Eastern	71	62	66	56	118
North Eastern	69	56	63	56	24
Nyanza	94	86	90	82	82
Rift Valley	74	51	70	50	174
Western	94	68	82	66	44
Total	74	59	69	56	690

The availability of ANC seems to have declined slightly since 2004; however, the proportion of hospitals offering ANC increased from 84 percent in 2004 to 94 percent in 2010, and the proportion of government facilities offering ANC increased from 81 percent in 2004 to 89 percent in 2010.

Provincial comparisons show that 94 percent of facilities in Nyanza and Western provinces offer ANC services, compared with, at the other extreme, 56 percent of facilities in Central province and 69 percent in North Eastern province (Table 6.1).

The proportion of facilities offering TT vaccines declined slightly from 84 percent in 2004 to 69 percent in 2010.

Approximately three-quarters of facilities that offer ANC services do so five or more days per week, while nine of every ten provide TT every day that ANC is offered (Table A-6.2). All health centres and 98 percent of hospitals that offer ANC provide TT vaccine every day that ANC is offered. Additional information on the availability of TT services among facilities that offer ANC services is presented in Table A-6.2.

Key Findings

Service availability: Three-quarters of facilities offer ANC services, a slight decline from 2004. Three-quarters of facilities that offer ANC services do so five or more days per week.

The proportion of facilities offering PNC increased from one-third of all facilities in 2004 to six of every ten facilities in 2010.

The proportion of facilities offering TT vaccines declined from eight of every ten facilities in 2004 to seven of every ten facilities in 2010.

6.2.2 Infrastructure and Resources to Support Quality Assessment and Counselling of ANC and PNC Clients

To support quality assessment and counselling of ANC clients, the following are necessary: individual client cards, ANC guidelines or protocols, and visual aids for client education. Table 6.2 and Figure 6.1 present information on the availability of these items. Additional information, including a breakdown by facility type, is available in Tables A-6.3.1 and A-6.3.2.

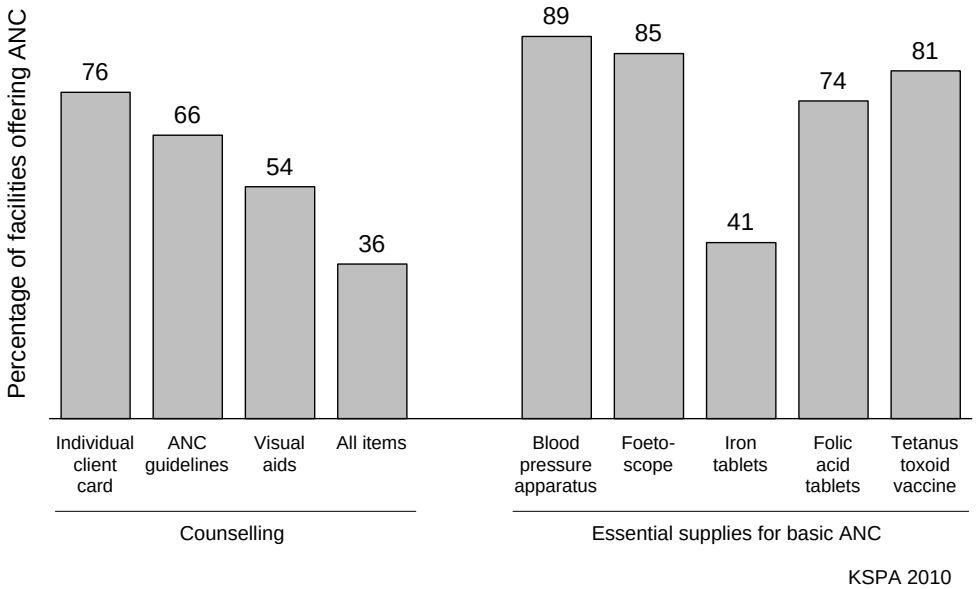
Table 6.2 Resources to support quality counselling and examinations for antenatal and postnatal care

Among facilities offering antenatal care (ANC), percentage with all items to support quality counselling for ANC and postnatal care (PNC), infection control, physical examinations, and basic ANC interventions, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering ANC services with:				Number of facilities offering ANC
	All items to support quality counselling[1]	All items for infection control[2]	All items for physical examination[3]	All essential supplies for basic ANC[4]	
Type of facility					
Hospital	52	67	49	42	48
Health centre	38	53	32	31	79
Maternity	32	58	63	48	16
Clinic	37	60	49	39	83
Dispensary	33	55	16	15	285
Managing authority					
Government	40	54	16	12	306
NGO	36	33	12	10	18
Private (for profit)	27	64	54	38	108
Faith-based organisation	34	62	46	60	78
Province					
Nairobi	37	61	55	54	33
Central	25	70	44	36	71
Coast	50	75	46	44	57
Eastern	47	35	19	19	84
North Eastern	18	25	9	6	17
Nyanza	53	54	17	20	78
Rift Valley	19	61	24	14	130
Western	46	52	21	20	41
Total	36	57	28	25	509

[1] Visual aids for health education, guidelines for ANC, and individual client card or record.
[2] Soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box.
[3] Room offering visual and auditory privacy, examination table, and examination light.
[4] Iron and folic acid tablets, tetanus toxoid vaccine, blood pressure apparatus, and foetoscope (Pinard).

Figure 6.1 Availability of Items to Support Quality ANC Services (N=509)



An individual ANC client card is used to monitor maternal and foetal condition during pregnancy and to keep track of the care given. It is an important tool for identifying risk factors for referral, assessing quality of care, ensuring standardisation of antenatal care, and helping in planning care for the client. Individual client health cards are available in 76 percent of the facilities offering ANC services (Figure 6.1, Table A-6.3.1), compared with 62 percent in 2004.

Written ANC guidelines or protocols that include details on how to manage common problems during pregnancy are available in 66 percent of facilities offering ANC services (compared with 31 percent in 2004). Visual aids for ANC client counselling are available in 54 percent of facilities that offer ANC services (compared with 30 percent in 2004).

Overall, 36 percent of facilities have all three items to support quality ANC counselling services—individual client cards, ANC guidelines or protocols, and visual aids for health education—an improvement from 10 percent in 2004. All three items to support quality ANC services are more likely to be available in hospitals than in lower-level facilities (Table 6.2). Also, they are most likely to be found in facilities in Coast (50 percent) and Nyanza (53 percent) provinces. The availability of items to support quality counselling for ANC has generally improved in all levels of care.

6.2.3 Infrastructure and Resources for Examinations

The 2010 KSPA assessed whether facilities have the necessary supplies, equipment, and conditions for infection control and for conducting client examinations in the ANC service area. Aggregate information on these elements is provided in Table 6.2. Information on specific equipment and supplies is given in Tables A-6.3.1 and A-6.3.2.

Infection control

Fifty-seven percent of the facilities offering antenatal care have all items necessary for infection control in the ANC service delivery area (compared with 37 percent in 2004). These items include soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and a sharps box (Table 6.2).[7] Health facilities in Central (70 percent) and Coast (75 percent) provinces are most likely to have all of these items for infection control. As evident in Tables A-6.3.1 and A-6.3.2, with the exception of hand disinfectant, each of these items is relatively widely available. Soap is available in three-quarters of facilities, running water in eight of every ten facilities, and soap and running water in two-thirds of facilities. Almost all the facilities offering ANC services have latex gloves and sharps boxes (92 and 98 percent, respectively).

Client examinations

The basic physical examinations performed during ANC visits include palpating the abdomen, examining the breasts, and sometimes conducting a pelvic examination. Hence, visual and auditory privacy, an examination bed/couch, and an examination light are necessary. Practically all ANC facilities (94 percent) can assure both visual and auditory privacy during client physical examination (compared with 88 percent in 2004). Ninety-seven percent of ANC facilities have an examination bed/couch (similar to 99 percent in 2004). Three of every ten ANC facilities have an examination light (Tables A-6.3.1 and A-6.3.2) (compared with two of every ten facilities in 2004). Only 28 percent of ANC facilities have all the elements for physical examination (Table 6.2). All three items together are found most often in maternity facilities (63 percent) (Table A-6.3.1), private facilities (54 percent) (Table A-6.3.2), and in Nairobi, Central, and Coast provinces (Table 6.2). Twenty-two percent of the facilities have all elements for physical examination and also specific components for infection control present (Tables A-6.3.1 and A-6.3.2).

[7] The items assessed in 2004 were soap and water, clean latex gloves, disinfecting solution, and sharps box.

6.2.4 Essential Equipment and Supplies for Basic ANC

A functioning blood pressure apparatus and foetoscope are essential equipment that should be available at all times in ANC service areas. Essential ANC supplies that should always be available include iron and folic acid tablets, de-worming medicines (mebendazole or albendazole tablets), sulfadoxine-pyrimethamine (SP/Fansidar), Rapid Plasma Reagin (RPR) kits, Multistix® for urine protein testing, and TT vaccines. The 2010 KSPA assessed the availability of five of these items: blood pressure machine, foetoscope (Pinard), iron and folic acid tablets, and TT vaccine.

Overall, only one-quarter of ANC facilities have all five essential items (Tables 6.2, A-6.3.1, and A-6.3.2), compared with 57 percent in 2004. As in 2004 facilities managed by faith-based organisations are the most likely to have all the basic ANC equipment and supplies; however, the percentage declined from 74 percent in 2004 to 60 percent in 2010. Among the provinces, facilities in Nairobi, Central, and Coast provinces are most likely to have the essential equipment and supplies (Table 6.2).

Key Findings

Items to support quality counselling: A little over one-third of ANC facilities have all three items to support quality ANC counselling services: individual client cards, ANC guidelines or protocols, and visual aids for health education. This is an improvement from 10 percent in 2004.

Infection control: About six of every ten ANC facilities have all infection control items available in the ANC service delivery area, compared with less than four of every ten in 2004.

Client examination: Over nine of every ten ANC facilities can assure both visual and auditory privacy during client examinations. However, only three of every ten facilities have an examination light.

Essential supplies for basic ANC: Only one-quarter of ANC facilities have all five essential supplies for basic ANC services, a decline from over half of facilities in 2004.

6.2.5 Additional Equipment and Supplies for Quality ANC and PNC Services

Other elements that support quality antenatal and postnatal care services include diagnostic capacity and medicines to treat common infections. Table 6.3 provides summary information on the medicines and laboratory capacities available in facilities. Tables A-6.4.1 through A-6.9 provide details on each item assessed, by type of facility and managing authority.

Pre-eclampsia and eclampsia (hypertensive disorders of pregnancy), anaemia, and sexually transmitted infections (STIs) can directly affect both maternal and newborn health. Basic essential obstetric care (BEOC) requires that a facility provide early treatment for complications of pregnancy to prevent them from progressing to more serious conditions. Standards for treatment may vary depending on ANC guidelines and policies and the qualifications of the service provider.

Table 6.3 Facility practices and resources for diagnosis and management of common problems and complications of pregnancy

Among facilities offering antenatal care (ANC), percentage where ANC providers can diagnose and treat sexually transmitted infections (STIs), percentage with medicines to manage common complications of pregnancy, and percentage with the capacity to conduct specific diagnostic tests, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage where ANC providers routinely treat STIs	Percentage with all medicines for treating pregnancy complications[1]	Percentage with capacity for conducting the indicated diagnostic test					Number of facilities offering ANC
			Anaemia[2]	Urine protein[3]	Urine glucose[4]	Blood grouping[5]	Syphilis[6]	
Type of facility								
Hospital	49	50	84	89	89	23	73	48
Health centre	81	18	59	61	60	3	39	79
Maternity	81	52	67	72	72	11	37	16
Clinic	89	22	31	46	47	5	28	83
Dispensary	91	11	21	25	23	0	9	285
Managing authority								
Government	83	6	28	30	30	3	20	306
NGO	92	15	18	21	21	0	23	18
Private (for profit)	90	26	40	53	53	5	27	108
Faith-based organisation	87	61	68	74	66	7	36	78
Province								
Nairobi	86	45	55	59	59	13	44	33
Central	88	16	37	58	58	3	30	71
Coast	87	20	35	45	45	9	40	57
Eastern	86	26	29	38	38	1	13	84
North Eastern	97	24	17	28	28	0	9	17
Nyanza	71	16	34	41	42	3	29	78
Rift Valley	87	11	39	30	26	4	14	130
Western	89	12	34	40	40	1	26	41
Total	85	19	36	41	40	4	24	509

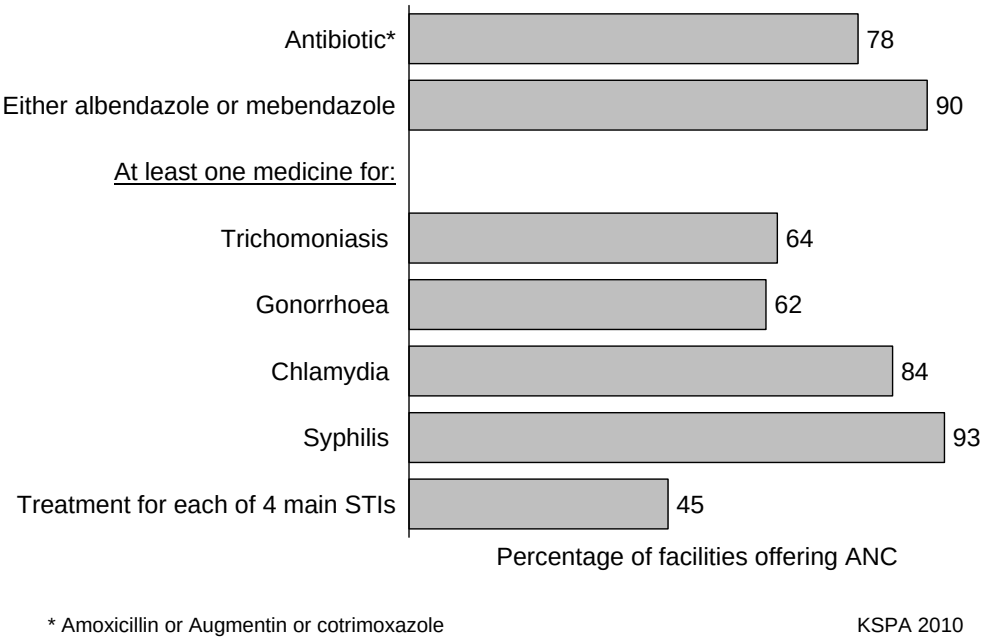
[1] At least one broad-spectrum antibiotic (amoxicillin or Augmentin or cotrimoxazole) AND either albendazole or mebendazole AND methyldopa (Aldomet) AND the first-line antimalarial AND at least one medicine for treating each of the following reproductive tract infections—trichomoniasis, gonorrhoea, chlamydia, syphilis, and candidiasis—all present.
[2] Includes any test: haemoglobinometer or calorimeter or centrifuge with capillary tubes, or filter paper methods.
[3] Dip sticks for urine protein or else acetic acid for checking urine albumin and flame for heating acetic acid.
[4] Dip sticks for urine glucose or else Benedict's solution for urine glucose testing with stove for boiling Benedict's solution.
[5] Anti-A, anti-B, anti-AB, and anti-D reagents, plus an incubator, Coomb's reagent, and glass slides all present.
[6] Either Venereal Disease Research Laboratory (VDRL) test or polymerase chain reaction (PCR) with functioning rotator or shaker, or rapid plasma reagin (RPR) test.

Treatment of STIs

Antenatal care service providers in 85 percent of facilities that offer ANC services routinely treat STIs (Table 6.3). This is more likely to be the case in dispensaries (91 percent) and clinics (89 percent) than in hospitals (49 percent). Facilities in North Eastern province (97 percent) are most likely to have ANC providers who routinely treat STIs.

Close to half (45 percent) of ANC facilities have at least one medicine to treat each of the four common STIs (trichomoniasis, chlamydia, gonorrhoea, and syphilis) (Figure 6.2), compared with 26 percent of ANC facilities in 2004. Generally, facilities are more likely to have medicines for treating syphilis (93 percent) and chlamydia (84 percent) than those for gonorrhoea (62 percent) and trichomoniasis (64 percent) (see also Tables A-6.4.1 and A-6.4.2). Maternity facilities (80 percent) are more likely than other facility types to have at least one medicine for each of the four STIs assessed.

Figure 6.2 Medicines for Managing Common Problems and Complications of Pregnancy (N=509)



Management of pregnancy complications

A facility is considered to have all medicines for managing common complications of pregnancy if it has the following: (1) at least one broad-spectrum antibiotic[8]; (2) an anthelminth[9]; (3) methyldopa (Aldomet); (4) the first-line antimalarial; and (5) at least one medicine for treating each of common reproductive tract infections.[10] Only a small percentage (19 percent) of ANC facilities had all medicines for managing the common complications of pregnancy on the day of the survey (Table 6.3) (still, an improvement from 4 percent in 2004). The current low percentage can be explained by the small proportion of facilities that had methyldopa (23 percent). Hospitals (50 percent), maternity facilities (52 percent), and faith-based organisation (FBO) facilities (61 percent) that provide ANC services are most likely to have all medicines for managing common complications of pregnancy. In contrast, dispensaries (11 percent), government facilities (6 percent), and facilities in Rift Valley (11 percent) and Western (12 percent) provinces are the least likely to have all these medicines (Tables 6.3, A-6.4.1, and A-6.4.2).

Most facilities have antibiotics, an anthelminth, and an antimalarial; as noted above, however, methyldopa is available in only a small proportion of ANC facilities, mainly hospitals (74 percent) and maternity facilities (65 percent) (Table A-6.4.1).

Intermittent preventive treatment

Almost all ANC facilities (96 percent) routinely provide intermittent preventive treatment (IPTp) as a component of ANC services (Tables A-6.4.1 and A-6.4.2), compared with 84 percent in 2004. All government-run facilities provide IPTp, as do nine of every ten facilities managed by other authorities.

[8] Amoxicillin or Augmentin (amoxicillin + clavulanate) or cotrimoxazole.
[9] Either albendazole or mebendazole.
[10] Trichomoniasis, gonorrhoea, syphilis, chlamydia and candidiasis.

Testing capacity

The 2010 KSPA also assessed whether facilities have the capacity[11] to test ANC and PNC clients' blood for anaemia, urine for protein, and urine for glucose; to determine blood group; and to diagnose and treat syphilis.

A little over one-third (36 percent) of ANC facilities have the capacity to test for anaemia (same as in 2004); 41 percent have the capacity to test urine for protein (compared with 38 percent in 2004); 40 percent can test for urine glucose (compared with 39 percent in 2004); and 24 percent can diagnose syphilis (substantially lower than 44 percent in 2004) (Table 6.3). There are wide variations in the capacity of facilities to conduct these tests, with hospitals, maternity facilities, and private and FBO facilities more likely to conduct these tests than other facility types or facilities managed by government and NGOs. Only 4 percent of all facilities have the capacity to do blood grouping.

Figure 6.3 and Tables 6.3 and A-6.5 through A-6.9 show what proportions of facilities report that they routinely screen ANC clients for these conditions and the proportions that actually have the testing capacity.

Sixty-one percent of ANC facilities make it a routine practice to screen ANC clients for anaemia, while 35 percent both intend to screen and also have anaemia testing capacity (Figure 6.3, Table A-6.5). Hospitals, maternity facilities, and FBO facilities are most likely both to intend to screen and to have anaemia testing capacity.

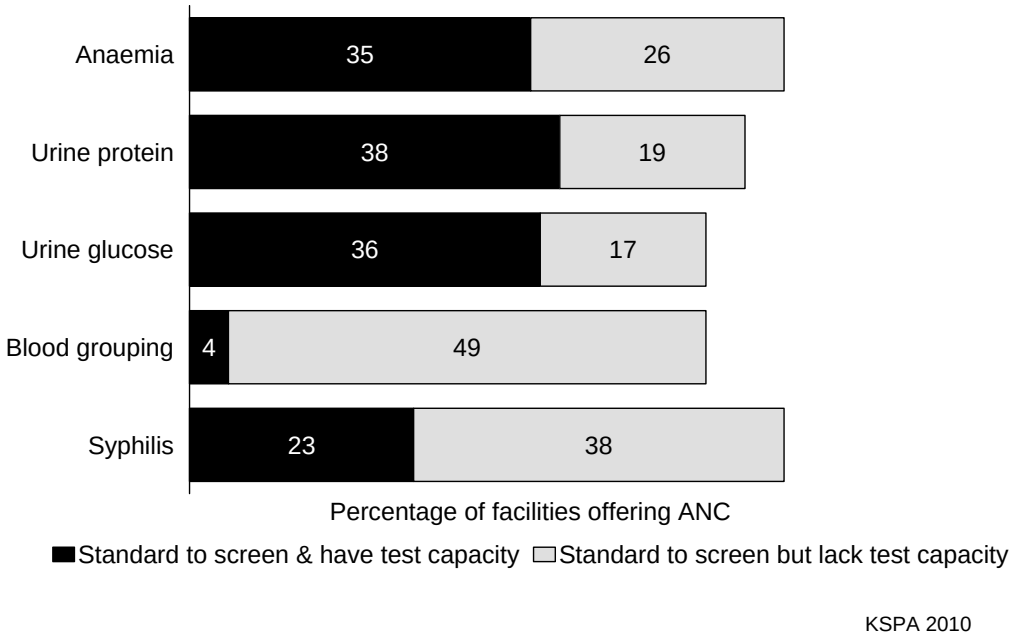
Fifty-seven percent of ANC facilities make it a routine practice to test ANC clients for urine protein, while 38 percent both intend to test and also have testing capacity for urine protein (Figure 6.3, Table A-6.6). Hospitals, maternity facilities, and FBO facilities are the most likely both to intend to test and to have urine protein testing capacity.

Fifty-three percent of ANC facilities make it a routine practice to screen ANC clients for urine glucose, while 36 percent both intend to screen and also have urine glucose testing capacity (Figure 6.3, Table A-6.7). Hospitals and FBO facilities are the most likely both to screen and to have urine glucose testing capacity.

Sixty-one percent of ANC facilities make it a routine practice to screen ANC clients for syphilis, but only 23 percent both intend to screen for syphilis and have syphilis testing capacity. These are most likely to be hospitals and, among management types, NGO facilities. These facilities are also most likely to be found in Nairobi and Central provinces (Figure 6.3, Table A-6.9).

[11] Facility has the capacity to conduct the test in-house or in an affiliated laboratory, or facility has a system to have the test done elsewhere and receive results back.

Figure 6.3 Facilities with Standard to Routinely Screen ANC Clients and Capacity to Conduct Indicated Tests (N=509)



KSPA 2010

Key Findings

STI services by ANC providers: There is an increase in the proportion of ANC facilities where ANC providers routinely treat STIs, from 75 percent in 2004 to 85 percent in 2010. Lower-level facilities that offer ANC services are more likely to have ANC providers that routinely treat STIs.

Medicines to treat common STIs: A little less than half of ANC facilities have at least one medicine to treat each of the four common STIs, an improvement from 26 percent in 2004.

Medicines to manage common complications of pregnancy: Overall, only one of every five ANC facilities had medicines to manage common complications of pregnancy on the day of the survey, compared with just 4 percent in 2004. While medicines for managing individual conditions were for the most part widely available, only a small proportion of ANC facilities had the medicine to manage hypertension in pregnancy.

Capacity for routine ANC tests: The capacity to conduct routine ANC tests is generally uncommon and is unchanged from 2004. Less than half of ANC facilities have the capacity to conduct each of the routine ANC tests of anaemia, urine protein, urine glucose, and syphilis, and only 4 percent have the capacity to do blood grouping. Hospitals, maternity facilities, and FBO facilities are generally more likely than others to have the capacity to perform these tests.

6.3 Management Practices Supportive of Quality ANC and PNC Services

Management practices that support quality antenatal and postnatal care services include documentation and record-keeping, posting user fees, and staff development and supervision.

Table 6.4 provides information on management practices supportive of quality ANC and PNC services. Tables A-6.10 through A-6.12.2 provide details on ANC and PNC service utilisation, user fees, and out-of-pocket payments for ANC services. Table A-6.13 provides information on supportive management for ANC service providers. Tables A-6.14.1 through A-6.15 provide detailed information on training and supervision for ANC service providers.

6.3.1 Facility Documentation and Records

Up-to-date client registers

Eight of every ten ANC facilities have up-to-date ANC client register (the same as in 2004), defined as a register with an entry during the preceding seven days that indicates, at minimum, whether this was the first or a follow-up visit (Table 6.4). Hospitals and health centres are more likely to have up-to-date ANC client registers than other facility types, while private facilities are less likely to have up-to-date registers than government or NGO facilities (61 compared with 88 percent). At the provincial level ANC facilities in Nyanza (93 percent) and Western (88 percent) provinces are the most likely to have these registers.

Overall, 22 percent of facilities offering ANC services have up-to-date registers of PNC client visits, an improvement from 5 percent in 2004. Hospitals (42 percent) and health centres (33 percent) are most likely to have up-to-date PNC registers. The highest percentages of facilities with up-to-date PNC registers are in Central (36 percent) and Nyanza (37 percent) provinces.

Monitoring ANC coverage

Monitoring ANC coverage rates (i.e., the proportion of eligible women in a catchment area who receive ANC services) is not common. Only 18 percent of ANC facilities have documentation indicating that they monitor ANC coverage (Table 6.4), compared with 13 percent in 2004. Facilities in North Eastern (41 percent) and Nyanza (29 percent) provinces are most likely to document ANC coverage, in contrast with facilities in Nairobi (1 percent) and Rift Valley (9 percent).

Table 6.4 Management practices supportive of quality maternal health services

Percentage of facilities offering antenatal care (ANC) that have an up-to-date client register, documentation of monitoring ANC coverage, and user fees for ANC and percentage of facilities where interviewed ANC providers report receiving routine training related to their work and personal supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Observed up-to-date patient registers[1] for:		Percentage of facilities offering ANC that have:		Number of facilities offering ANC	Percentage of facilities where staff report receiving routine:		Number of facilities with interviewed ANC providers[4]
	ANC	PNC	Documentation of monitoring ANC coverage	User fees for ANC		Training related to ANC[2]	Personal supervision[3]	
Type of facility								
Hospital	94	42	26	90	48	68	86	47
Health centre	93	33	16	89	79	72	93	77
Maternity	79	11	8	95	16	65	73	15
Clinic	61	15	11	89	83	65	68	78
Dispensary	81	19	19	69	285	72	92	266
Managing authority								
Government	88	27	23	69	306	74	92	288
NGO	88	19	3	99	18	66	87	18
Private (for profit)	61	12	11	89	108	56	71	101
Faith-based organisation	78	19	9	94	78	76	89	76
Province								
Nairobi	69	22	1	88	33	77	83	32
Central	81	36	24	97	71	55	69	63
Coast	76	19	10	77	57	83	86	52
Eastern	78	18	19	80	84	78	95	80
North Eastern	81	0	41	35	17	43	86	10
Nyanza	93	37	29	78	78	66	94	75
Rift Valley	79	17	9	68	130	72	90	130
Western	88	14	21	84	41	70	87	40
Total	81	22	18	78	509	70	87	483

[1] Register has entry within past seven days that indicates, at minimum, whether this was the first or a follow-up visit for ANC and, for PNC register, number of days postpartum.
[2] A facility has routine staff training if at least half of interviewed providers reported they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instructions received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported they had been personally supervised at least once during the six months preceding the survey.
[4] Includes only providers of ANC in facilities offering ANC services.

6.3.2 Practices Related to User Fees

User fees may have a positive effect on service utilisation by increasing the funds available to the facility if the system channels these funds back to the facility. At the same time, they may also have a negative effect by deterring poor clients from using these services. In any case, displaying user fees (or advertising that there are no fees for certain services) contributes to the quality of care by letting clients know the cost of services in advance.

ANC services are subsidised to some extent in all government facilities in Kenya. Overall, close to eight of every ten (78 percent) ANC facilities charge some form of user fees (compared with 67 percent in 2004) (Table 6.4). These are mostly NGO (99 percent), FBO (94 percent), and private (89 percent) facilities. Maternity facilities (95 percent), hospitals (90 percent) as well as health centres and clinics (both 89 percent) are more likely than dispensaries (69 percent) to charge user fees. Also, facilities in Central (97 percent), Nairobi (88 percent), and Western (84 percent) provinces are more likely than facilities in other provinces to charge user fees for ANC services. Information on specific items for which facilities charge is presented in Table A-6.11. Half of ANC facilities have discounts or fee exemptions for some clients.

Among ANC facilities that charge user fees, only one of every four posts all fees. Twelve percent post some fees, while 61 percent do not post any fees at all. Hospitals (49 percent), NGO facilities (47 percent), and facilities in Coast province (46 percent) are most likely to post all fees (Table A-6.11).

ANC clients were interviewed as they left the facility after receiving services. They were asked, among other things, if they paid any out-of-pocket fees for the services that they had received. Tables A-6.12.1 and A-6.12.2 provide information on the proportion of ANC clients who reported paying out-of-pocket fees for services received on the day of the survey and, if so, the amount.

6.3.3 Training and Supervision

ANC service providers were interviewed and information gathered on their qualifications and on any training and supervision that they had received.

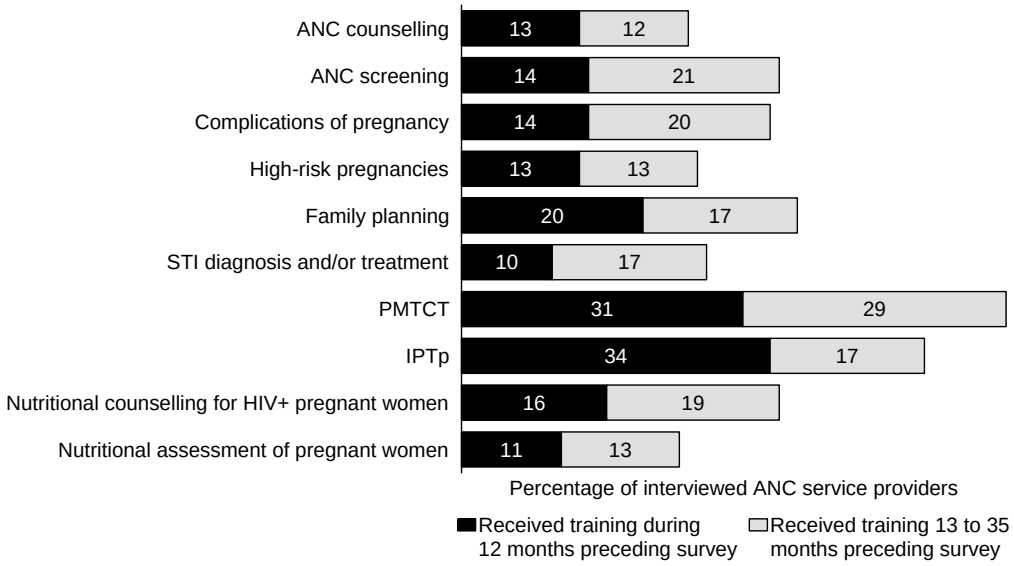
Training

Generally, a facility is considered as providing routine staff development activities if at least half of interviewed ANC providers said they had received structured pre-service or in-service training relevant to ANC during the 12 months preceding the survey.

Seventy percent of ANC facilities met this criterion, compared with 51 percent in 2004 (Table 6.4). There is little variation by facility type, although health centres and dispensaries (both 72 percent) are somewhat more likely than other facility types to meet this criterion. Government and FBO facilities are more likely than NGO and private facilities to meet the criterion.

Six of every ten interviewed ANC service providers (compared with four of every ten in 2004) reported having received training related to ANC during the 12 months preceding the survey (Table A-6.13). Providers in dispensaries and in government facilities are slightly more likely to have received recent training. The recent training topics most frequently reported by interviewed ANC service providers are prevention of mother-to-child transmission (PMTCT) of HIV (31 percent of interviewed ANC providers, similar to 29 percent in 2004) and Intermittent Preventive Treatment (IPTp) of malaria during pregnancy (34 percent of ANC providers) (Figure 6.4, Tables 6.14.1 and A-6.14.2).

Figure 6.4 Training Received by Interviewed ANC Service Providers, by Topic and Timing of Most Recent Training (N=1,486)



* IPTp = Intermittent preventive treatment in pregnancy KSPA 2010

Supervision

Supervising individual staff members helps promote adherence to standards and identify and resolve problems that contribute to poor services. A facility is considered to have routine staff supervision if at least half of interviewed providers report they had been personally supervised at least once during the preceding six months. Eighty-seven percent of ANC facilities meet the criterion for providing routine staff supervision (Table 6.4) (virtually the same as 86 percent in 2004). Health centres (93 percent), dispensaries (92 percent), government facilities (92 percent), and facilities in Eastern and Nyanza provinces (95 and 94 percent) are most likely to meet the criterion for providing routine staff supervision.

Information on the median number of times interviewed providers were supervised and the supervisors' specific activities is provided in Table A-6.15.

Key Findings

Up-to-date client registers: Eight of every ten ANC facilities have up-to-date ANC client registers, the same as in 2004. The availability of up-to-date PNC registers improved, from 5 percent in 2004 to 22 percent in 2010.

User fees: Over three-quarters of ANC facilities charge user fees for ANC services, compared with two-thirds in 2004. Facilities managed by FBOs and NGOs are most likely to charge user fees. Six of every ten facilities that charge user fees do not post any fees.

Staff development activities: Seven of every ten ANC facilities meet the criterion of routinely providing training to staff, an improvement from a little over half of ANC facilities in 2004. PMTCT and IPTp were the most common training topics, according to interviewed ANC providers.

In 2010 close to nine of every ten ANC facilities meet the criterion for having routine staff supervision, about the same as in 2004.

6.4 ADHERENCE TO STANDARDS FOR QUALITY ANC SERVICE PROVISION

To assess whether ANC providers adhere to service standards, KSPA personnel observed ANC consultations. The observation checklists were based on the elements of focussed ANC (FANC). The observers noted whether providers shared information on a topic and whether they conducted an examination. They did not assess whether the information shared was correct, whether an examination was properly done, or whether findings were correctly interpreted.

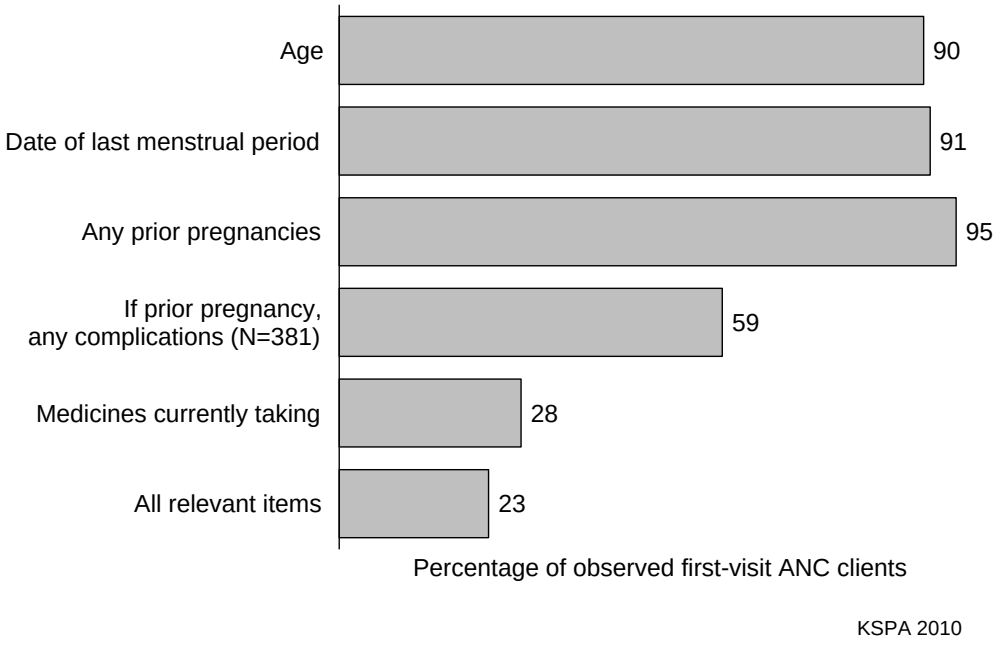
6.4.1 Appropriate Assessment and Examination for ANC Clients

Summary information from the observations of ANC consultations is provided in Figure 6.5. Table A-6.16 provides a breakdown of observed ANC clients, while Tables A-6.17 through A-6.20.2 provide details on assessments, examinations, and interventions for the observed ANC clients.

Client history

During a first ANC visit the provider is expected to elicit a basic medical history to assess the client for pre-existing risk conditions. In 90 percent and above of observed first-visit consultations, providers asked ANC clients about their age, date of last menses, and whether they had been pregnant previously (Figure 6.5, Table A-6.17). These percentages are improvements over 2004, when 80 to 85 percent were asked these questions. Clients were less likely to be asked about any medications they may be currently taking, both in 2004 and presently (28 percent in 2010 and 30 percent in 2004). Similarly, providers were less likely to ask first-visit ANC clients with prior pregnancies if they had had any complications with the previous pregnancies (59 percent, improved from 44 percent in 2004).

Figure 6.5 **Content of Client History Assessed for First-visit ANC Clients (N=556)**



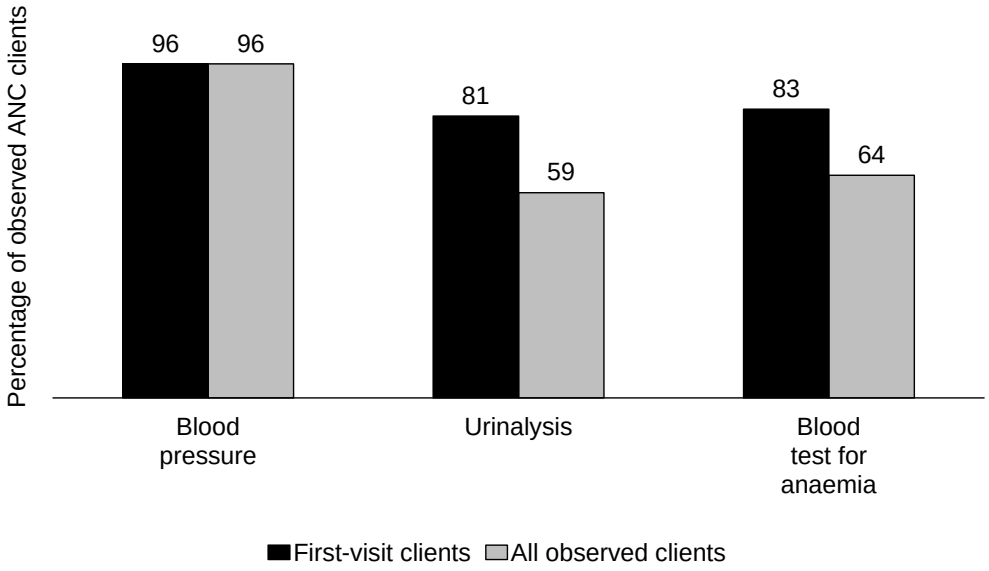
Monitoring progress of pregnancy

All ANC clients should receive periodic assessments to monitor the progress of pregnancy, such as measurement of blood pressure, and to identify any danger signs or risk factors for both maternal and foetal conditions, such as vaginal bleeding. To meet defined minimum standards, all pregnant women should be screened for syphilis at the first ANC visit within the first trimester and again in late pregnancy. Each ANC visit should include the following components: counselling to

seek help if vaginal bleeding occurs, measurement of blood pressure, as well as testing for anaemia, blood glucose, and urine protein. Laboratory testing capability is necessary for facilities to be able to provide some of these screening and preventive interventions. If a facility itself does not have the capacity to provide the service, it should have a referral system in place to provide ANC clients with access to the service.

Figure 6.6 provides information on the proportion of first-visit and all ANC clients who received some of these assessments during their visits. Tables A-6.17 and A-6.18 provide this and additional information by facility type.

Figure 6.6 ANC Assessments for First-visit (N=556) and All Observed ANC Clients (N=1,409)



KSPA 2010

Practically all first-visit and follow-up ANC clients (both 96 percent) had their blood pressure measured during ANC visits (compared with nine of every ten observed ANC clients in 2004). They were less likely to be tested for anaemia or to have their urine tested. Still, first-visit clients were more likely than clients on subsequent visits to have anaemia and urine tests (Figure 6.6, Tables A-6.17 and A-6.18). A slightly larger proportion of first-visit ANC clients had their blood tested for anaemia than in 2004 (83 percent versus 77 percent in 2004). Similarly, a slightly larger proportion of first-visit ANC clients had their urine tested than in 2004 (81 percent versus 74 percent in 2004).

Only three of every ten ANC clients were asked if they were having or had experienced any vaginal bleeding (see Table A-6.18). Less than half of ANC clients who were at least five months pregnant were asked if they felt foetal movement; however, foetal position was assessed for all ANC clients who were at least eight months pregnant.

Key Findings

Content of ANC: Ninety percent or more of first-visit ANC clients were asked their age, the date of their last menses, and whether they had had any prior pregnancies, compared with 80 to 85 percent in 2004.

Assessment during ANC visit: Nearly all ANC clients had their blood pressure measured during the visit (slightly better than in 2004). ANC clients were less likely to have their blood tested for anaemia or to have a urine test. In general, a slightly larger proportion of first-visit ANC clients had their blood tested for anaemia than in 2004, and a slightly larger proportion had their urine tested than in 2004.

6.4.2 Counselling to Promote a Healthy Outcome

Counselling topics

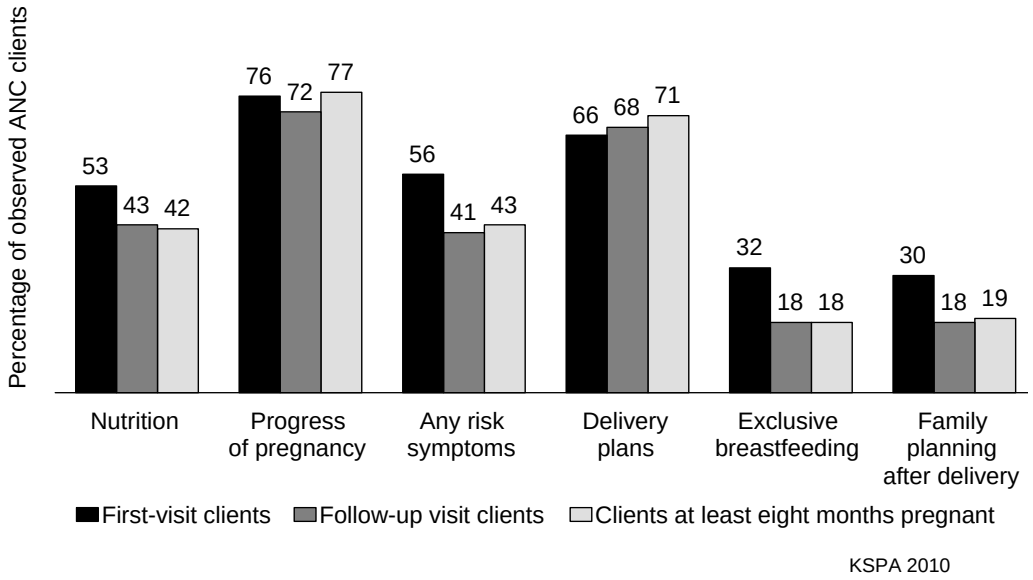
ANC providers are expected to routinely counsel clients on nutritional needs during pregnancy as well as on signs and symptoms that may indicate a problem with the pregnancy. It is not unreasonable to assume that all topics may not be discussed during every visit since most women make multiple ANC visits. Thus, the contents of counselling for first and follow-up visits are assessed separately.

Nutrition during pregnancy was discussed during consultations with half (53 percent) of first-visit clients, with four of every ten (43 percent) follow-up clients, and with four of every ten clients who were at least eight months pregnant (Figure 6.7) (see also Tables A-6.20.1 through A-6.20.3). Nutrition was discussed with a proportion of first-visit clients similar to that in 2004 (53 percent, versus 57 percent in 2004). However, for follow-up clients and for clients who were at least eight months pregnant, the percentage counselled on nutrition declined (42 and 43 percent in 2010 compared with 50 percent in 2004).

The proportion of first-visit clients with whom providers discussed the progress of the pregnancy was slightly higher than in 2004 (76 percent in 2010 versus 68 percent in 2004), whereas the proportion for follow-up clients and for clients at least eight months pregnant was about the same, at three-quarters of visits. Delivery plans were discussed with 71 percent of clients at least eight months pregnant, much higher than 42 percent in 2004. In contrast, neither family planning after childbirth nor exclusive breastfeeding was widely discussed with ANC clients. Each was addressed with only about 30 percent of first-visit clients and with about 20 percent of follow-up clients and clients at least eight months pregnant (Figure 6.7). Still, these findings are an improvement over 2004, when exclusive breastfeeding was discussed with just one of every ten clients overall, and family planning was discussed with about two of every ten first-visit clients and one of every ten follow-up clients and clients at least eight months pregnant.

Information by facility type and province on these counselling topics is available in Tables A-6.20.1 through A-6.20.3.

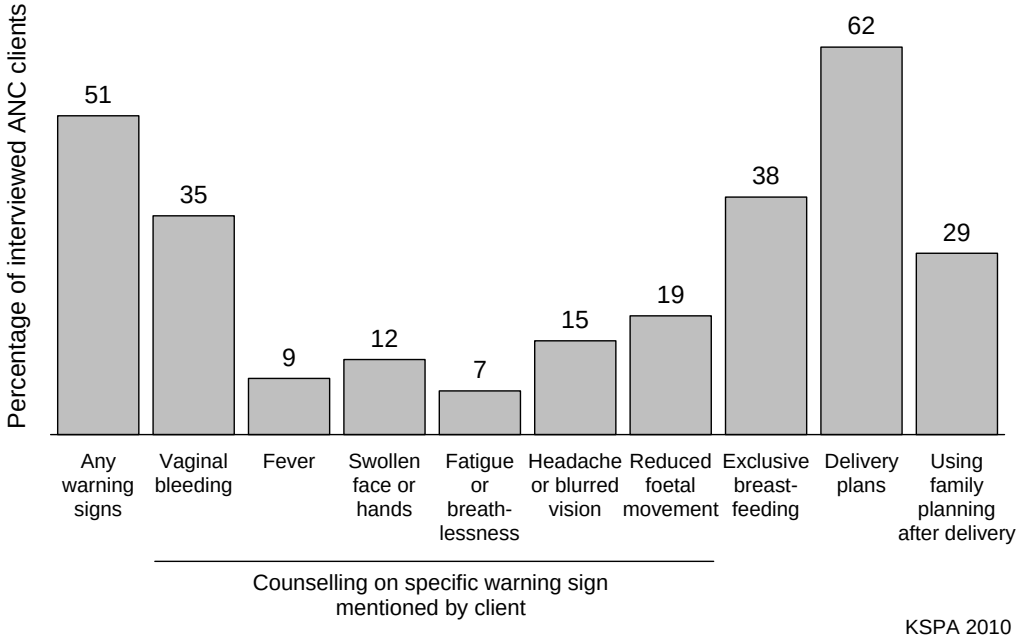
Figure 6.7 Counselling Topics Discussed during Observed First Visits (N=559) and Follow-up Visits (N=853) and with ANC Clients at Least Eight Months Pregnant (N=623), when Relevant



KSPA 2010

Observed ANC clients were interviewed as they left the facility. They were asked, among other things, about health topics that were discussed during the current or previous visits. Sixty-two percent of interviewed clients said the provider discussed delivery plans with them (compared with 51 percent of ANC clients in 2004). Three of every ten (29 percent) said a provider discussed family planning postpartum, while 38 percent said providers discussed exclusive breastfeeding with them (Figure 6.8, Tables A-6.21 and A-6.22).

Figure 6.8 Topics Reported by Interviewed Clients as Having Been Discussed Either during This or a Previous ANC Visit (N=1,409)



KSPA 2010

Interviewed clients were also asked to mention specific warning signs that were discussed during the current or previous ANC visits. Half (51 percent) said they had discussed warning signs and symptoms in general (compared with 36 percent in 2004); however, only small proportions of clients were able to name any of these warning signs. Vaginal bleeding is the most commonly mentioned warning/danger sign, mentioned by 35 percent of interviewed clients (compared with 31 percent in 2004), followed by reduced foetal movements (19 percent), headache or blurred vision (15 percent), and swollen face or hands (12 percent) (Figure 6.8, Tables A-6.21 and A-6.22). The least mentioned warning signs were fever (9 percent), fatigue or breathlessness (7 percent), and convulsions (1 percent).

Key Findings

ANC counselling topics: First-visit ANC clients in general are more likely to receive counselling on various health topics than follow-up clients.

There is an improvement over 2004 in the proportion of clients at least eight months pregnant who are counselled on delivery plans. However, the proportions of ANC clients counselled on either family planning or exclusive breastfeeding remain low, although substantially improved over 2004.

There is also an improvement over 2004 in the proportion of interviewed clients who said they were counselled by providers on various warning signs. However, the proportion of clients who could mention specific warning signs remains low.

6.4.3 Supporting Continuity of Care

Continuity of care, including monitoring changes between visits, is important to quality ANC. One of the more reliable ways to achieve continuity of care is to maintain a record of relevant history and findings as well as interventions or treatments provided. Details on providers' use of individual client cards during ANC visits are provided in Table A-6.24.

During 97 percent of first visits and 98 percent of follow-up consultations, the provider was seen to look at or refer to the individual client card during the consultation. Providers wrote on the cards of virtually all clients, both first-visit and follow-up.

Outcome of ANC visit

Information on the outcome of observed ANC visits is presented in Table A-6.25.

The great majority of clients (eight of every ten) were sent home after their meeting with the provider. Nineteen percent were referred to another provider within the facility, while one percent were referred to another facility. Intra-facility referral seems more common in hospitals (24 percent of ANC clients seen in hospitals) and maternity facilities (26 percent) compared with, at the opposite extreme, 8 percent of ANC clients seen in clinics.

6.5 Client Opinion of Service Provision

When observed ANC clients were interviewed as they left the facility, they were asked questions about their opinions of the services they received that day and about any problems they may have encountered.

6.5.1 Major Problem During Visit

The most common client concern was the waiting time to see a provider. About one-quarter (26 percent) of interviewed clients considered this to be a major problem for them (Table A-6.26). There is not much difference by facility type; however, clients in hospitals and health centres are more

likely to consider waiting time a major problem. Few clients mentioned other concerns, such as the attitude of the provider toward them or the cost of services, as major problems.

6.5.2 Facility Nearest Home

Twenty-three percent of interviewed ANC clients reported that the facility they were currently visiting was not the one closest to their home. When asked why they did not visit the closest facility, two of every ten cited the bad reputation of the nearest facility as the main reason (Table A-6.27). Fifteen percent cited the higher cost of services at the facility nearest their home.

6.6 AVAILABILITY OF DELIVERY SERVICES AND CAPACITY TO PROVIDE QUALITY DELIVERY CARE

The 2010 KSPA assessed the availability of emergency obstetric care and the presence of standards, equipment, and supplies and of health system components to support quality delivery services. The following aspects were assessed:

- Availability of delivery services and home delivery care practices
- Infrastructure and resources to support quality delivery services
- Practices related to signal functions
- Documentation of delivery procedures and outcomes

6.6.1 Availability of Delivery Services

Table 6.5 provides information on the availability of maternal health services as well as details on the availability of emergency transport and services supporting safe home delivery. Table A-6.29 provides information on median travel time using the most common transport system. Overall, there is a slight decline from 2004 in the availability of maternity services.

Normal deliveries

Three of every ten facilities offer services for normal deliveries (Table 6.5), compared with almost four of every ten facilities in 2004. Services for normal deliveries are almost universally available in hospitals (95 percent, the same as in 2004), and widely available in maternity facilities (85 percent, versus 87 percent in 2004) and health centres (83 percent). However, only 4 percent of clinics offer normal delivery services, contributing to the apparent overall decline in the availability of these services. There is not much variation among government, FBO, and NGO facilities; however, private facilities are much less likely to offer these services. There is notable variation among the provinces. For example, Nyanza (52 percent), Western (47 percent), and North Eastern (44 percent) provinces have a higher percentage of facilities offering delivery services than other provinces. Facilities in Central (13 percent) and Rift Valley (27 percent) provinces are least likely to offer normal delivery services.

Table 6.5 Availability of maternal health services

Percentage of facilities that offer specific maternity services, transportation for maternity emergencies, and services supporting safe home delivery with traditional birth attendants (TBAs), community health workers (CHWs), or community midwives, by background characteristics, Kenya SPA 2010

	Facility-based maternity services						Services supporting safe home delivery				
Background characteristic	Antenatal care (ANC)	Normal delivery services	Caesarean section	ANC and normal delivery services	ANC, normal delivery, and caesarean section	Transportation support for maternity emergencies[1]	Any home delivery services[2]	Active TBAs working with facility	Active CHWs working with facility	Active community midwives working with facility	Number of facilities
Type of facility											
Hospital	94	95	52	93	50	88	4	12	54	14	51
Health centre	99	83	1	83	1	77	9	17	64	9	80
Maternity	93	85	30	84	30	78	8	10	27	14	17
Clinic	41	4	0	4	0	31	2	2	12	0	203
Dispensary	84	21	0	21	0	47	3	24	57	4	340
Managing authority											
Government	89	36	3	36	3	55	4	27	68	7	344
NGO	85	38	4	37	3	64	30	20	66	2	22
Private (for profit)	46	16	5	15	5	36	1	2	13	1	236
Faith-based organisation	88	43	9	43	9	60	1	5	25	2	88
Province											
Nairobi	79	32	13	32	13	57	2	0	37	3	41
Central	56	13	4	13	4	30	0	2	20	5	125
Coast	70	27	4	27	4	53	4	8	39	5	81
Eastern	71	30	3	30	3	45	4	12	41	2	118
North Eastern	69	44	4	42	3	46	18	41	62	0	24
Nyanza	94	52	5	51	5	70	2	22	67	2	82
Rift Valley	74	27	4	26	3	50	3	25	47	3	174
Western	94	47	6	47	6	60	8	27	66	24	44
Total	74	30	5	30	5	49	3	15	44	4	690

[1] The facility has an ambulance, or there is a system in place whereby the facility provides some support for emergency transportation to a referral site.
[2] This may be either a routine service or services only for emergency cases.

Caesarean section

Services for caesarean sections are not expected to be widely available in all types of facilities. Overall, only 5 percent of facilities provide caesarean sections (compared with 7 percent in 2004). Half of hospitals provide the service, compared with 76 percent in 2004. Services for caesarean sections are uncommon among all managing authorities. As in 2004 only 3 percent of government facilities provide caesarean sections. This is because the majority of government facilities are lower level facilities that are not expected under normal circumstances to provide this service.

Transport for maternity emergencies

Availability of transportation during maternity emergencies is crucial to the welfare of both mother and newborn. One way to improve outcomes during such emergencies is to provide rapid transport to a facility where the appropriate services are available. Without a facility-supported emergency transportation system, the expectant mother and her family are forced to find their own means of transport during an emergency. Even when an ANC facility does not offer delivery services, it is desirable to have emergency transport available. For many home deliveries, the facility where a woman receives ANC may be the nearest health care facility where help can be sought in an emergency.

Overall, half (49 percent) of all facilities have transportation support for maternity emergencies[12] (Table 6.5). Hospitals (88 percent), maternity facilities (78 percent), and health centres (77 percent) are much more likely than other facility types to have such a system. Facilities managed by NGOs, FBOs, and the government also seem more likely to have transport for maternity emergencies than private facilities. Among the provinces facilities in Nyanza province are most to have such support.

[12] The facility has an ambulance, or there is a system in place whereby the facility provides some support for emergency transport to a referral site.

Among facilities having an emergency transportation system, three of every ten have an ambulance or a vehicle that is based in that facility; about two-thirds (64 percent) use a vehicle that is based at another facility; while one-quarter hire vehicles. Nearly half of facilities participate in schemes to offset the costs of transport (Table A-6.29). (Some facilities use more than one of these approaches.) Facilities in North Eastern province (15 percent) are much less likely than other facilities to have an ambulance but are likely to have access to a vehicle based at another facility (94 percent).

6.6.2 Domiciliary Care Practices

In countries where a large proportion of deliveries take place at home (frequently with the assistance of traditional birth attendants (TBAs), a support system from a health facility may increase a woman's chances of having a safe delivery. Research has found that every pregnancy is at risk; therefore, every pregnant woman should receive skilled care during delivery. The concept of domiciliary care operates on the understanding that skilled care can be provided at the community level. A common approach is for facility staff to attend home deliveries, either routinely or only in cases of emergency. Retired midwives in the community can also provide skilled care to women during home deliveries.

Only 3 percent of facilities in Kenya have services supporting safe home delivery (Table 6.5), similar to 5 percent in 2004. NGO facilities (30 percent) and facilities in North Eastern province (18 percent) stand out as most commonly providing home delivery services.

Fifteen percent of facilities report that they have active TBAs working with the facility, while 44 percent have active community health workers (CHWs) working with the facility. Health centres (64 percent) and government and NGO facilities (68 and 66 percent, respectively) are most likely to be working with CHWs. In Nyanza (67 percent), Western (66 percent), and North Eastern (62 percent) provinces, facilities are the most likely to have active CHWs working with them. As for TBAs, 41 percent of facilities in North Eastern province work with them, whereas there are no facilities in Nairobi that report working with active TBAs (Table 6.5). Only 4 percent of facilities have active community midwives working with the facility.

Key Findings

Services for normal deliveries: Thirty percent of facilities provide services for normal deliveries, a decline from 38 percent in 2004. The decline is due to the decline in the proportion of clinics providing the services. Facilities in Nyanza are more likely than those in other provinces to provide services for normal deliveries.

Caesarean sections: Only 5 percent of facilities provide caesarean section services, similar to 7 percent in 2004. Half of hospitals (a decline from 76 percent in 2004) provide the service.

Transportation support: Half of facilities have transportation support for maternity emergencies, with hospitals, health centres, and maternity facilities being most likely to have transportation support. Facilities in Nyanza province are more likely than those in other provinces to have transportation support.

6.6.3 Infrastructure and Resources to Support Quality Delivery Services

In addition to basic infrastructure that assures privacy and supports infection control, several types of equipment and medicines are needed to support safe deliveries. Tables 6.6 and 6.7 provide summary information on infrastructure, equipment, and supplies for delivery services, including medicines for normal and complicated deliveries and other elements to support quality deliveries (guidelines, partographs, and 24-hour delivery provider). Tables A-6.30 through A-6.36 provide details on elements assessed for delivery services, including processing of equipment for re-use, as well as information on equipment for emergency obstetric care. Information on supportive management and supervision is provided in Tables A-6.42 through A-6.44.

Table 6.6 Availability of elements for quality delivery services

Among facilities offering delivery services, percentage that have infection control items, sterilisation or high-level disinfection (HLD) capacity, infrastructure and furnishings, and other elements to support quality delivery services, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering delivery services with:				Number of facilities offering delivery services
	All items for infection control[1]	Capacity for sterilisation/ HLD processing[2]	All delivery room infrastructure and furnishings[3]	All other elements to support quality[4]	
Type of facility					
Hospital	69	66	55	48	48
Health centre	68	46	48	20	66
Maternity	54	50	68	18	14
Clinic	28	43	43	0	8
Dispensary	47	24	6	5	70
Managing authority					
Government	64	38	28	21	124
NGO	17	20	19	5	8
Private (for profit)	53	59	66	18	37
Faith-based organisation	53	52	41	22	38
Province					
Nairobi	69	62	76	25	13
Central	73	62	44	27	16
Coast	37	38	39	22	22
Eastern	40	29	26	25	35
North Eastern	75	27	23	8	11
Nyanza	53	35	32	17	43
Rift Valley	72	55	40	16	47
Western	66	47	29	26	21
Total	58	43	36	20	207

[1] Soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution for decontaminating reusable items, and sharps box.
[2] In location where delivery services equipment is processed, equipment and knowledge of minimum processing time for sterilising or HLD processing, and an automatic timing device were available.
[3] Bed, examination light, and privacy (both visual and auditory).
[4] Guidelines, partographs, and 24-hour delivery provider on site or on call, with duty schedule observed.

Infection control

Infection is one of the most common causes of maternal and neonatal morbidity and mortality. Therefore, infection control practices are essential for quality delivery care. Among facilities offering delivery services, about six of every ten (58 percent, compared with 40 percent in 2004) have all items for infection control available in the delivery service area. These items include soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution for decontaminating reusable items, and a sharps box (Tables 6.6 and A-6.30).[13] Hospitals (69 percent) and health centres (68 percent) are more likely than other facility types to have all infection control items.

Table A-6.30 provides information on the availability of individual items for infection control. The items most often missing are hand disinfectants (available in 32 percent of facilities) and soap (available in 65 percent of facilities).

Among managing authorities, government facilities (64 percent) are most likely to have all items for infection control, while NGO facilities are least likely (17 percent). Over half of all of the facilities in all the provinces except Coast and Eastern provinces (at 37 and 40 percent, respectively) have all items for infection control (Table 6.6).

[13] The items assessed for infection control in 2004 were soap, water, sharps box, disinfecting solution, and clean latex gloves.

Sterilisation of delivery equipment

The 2010 KSPA assessed the systems in place for the final processing of delivery equipment. Findings are presented in Tables 6.6 and A-6.31 through A-6.33.2.

Among facilities offering delivery services, 92 percent report that they process delivery equipment in the facility (16 percent in the delivery services area, 76 percent in the main facility area). Only 4 percent report that they process their equipment outside the facility. Four percent report that they do not process delivery equipment at all (Table A-6.31). Among the facilities that offer delivery services and process equipment in the facility, 46 percent use either dry heat or autoclave, and 2 percent use boiling or chemical high-level disinfection. Half (53 percent) report sterilisation but were missing either equipment or correct knowledge of processing time (Table A-6.32).

One-third (34 percent) of delivery facilities that process equipment in the facility had written guidelines for sterilisation or HLD procedures at the processing site (compared with 23 percent in 2004) (Table A-6.32). The availability of guidelines for sterilisation or HLD processing varies by facility type and among provinces. For example, guidelines are more likely to be available in hospitals (50 percent) than in clinics (14 percent) or dispensaries (12 percent).

Overall, by 2010 KSPA definitions, four of every ten facilities (43 percent) that offer delivery services have the capacity for sterilisation or HLD processing[14] (Table 6.6) (compared with 34 percent in 2004). The general lack of automatic timers at processing sites contributes to the low proportion of facilities at the lower levels of care that have the capacity to sterilise/HLD process equipment.

Infrastructure for delivery

Items to support quality delivery services were also assessed. Findings are presented in Table 6.6 and Figure 6.9.

A bed, examination light, and privacy (both visual and auditory) are considered basic delivery room infrastructure and equipment. Overall, only 36 percent of facilities that offer delivery services had all these basic items (compared with 29 percent in 2004). The best equipped facilities were maternities (68 percent) and hospitals (55 percent). Well-equipped facilities are most common in Nairobi province (76 percent) and in private facilities (66 percent) (Table 6.6). Looking at the items individually, 87 percent of facilities have both visual and auditory privacy (compared with 96 percent in 2004), and 79 percent have a bed (any type of bed or couch where a client can lie down and deliver a baby) (compared with 98 percent in 2004). However, only 47 percent have an examination light, compared with 31 percent in 2004 (Figure 6.9, Table A-6.30).

Elements to support quality delivery services

The partograph[15] is promoted internationally as a way to improve the quality of intrapartum care and to aid early identification of complications that may be associated with labour. Sixty-three percent of delivery facilities had blank partographs available at the service site (Figure 6.9), an improvement from 39 percent in 2004. Partographs are found most commonly in hospitals (84 percent), health centres (72 percent), and maternity facilities (66 percent) (Table A-6.30).

Service guidelines (or protocols) for emergency delivery services are not common at service delivery sites. Only one-quarter of facilities had guidelines for emergency obstetric care at the service site.

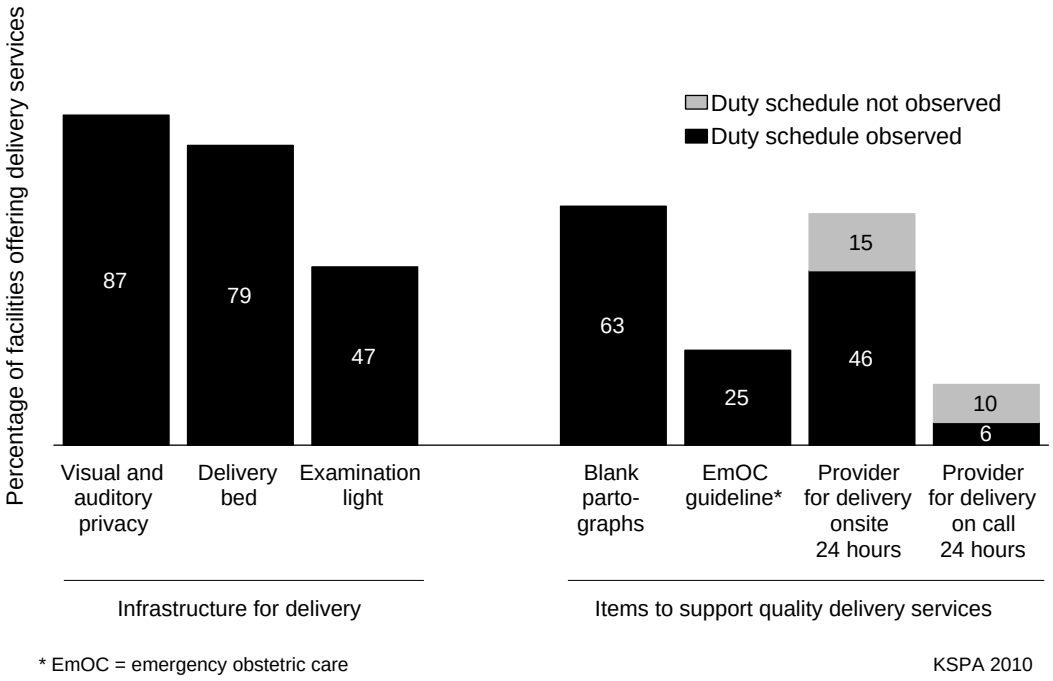
[14] In location where delivery services equipment is processed, equipment, knowledge of minimum processing time for sterilizing or HLD processing and an automatic timing device were available.

[15] The partograph is a tool that can be used by delivery service providers to monitor and assess the progress of labour and to identify when intervention is necessary.

Doctors (including general practitioners, obstetricians/gynaecologists, and clinical officers), registered nurses and midwives, and enrolled nurses and midwives are the principal facility-based delivery service providers in Kenya. Six of every ten facilities report that there is a delivery service provider on site 24 hours a day (compared with eight of every ten facilities in 2004); 15 percent did not have a duty schedule to support that claim (Figure 6.9, Table A-6.34).

Registered nurses/midwives and enrolled nurses/midwives are the providers most commonly on duty at night to provide delivery services in most delivery facilities (Table A-6.34).

Figure 6.9 **Items to Support Quality Delivery Services (N=207)**



* EmOC = emergency obstetric care

KSPA 2010

Key Findings

Infection control: Six of every ten facilities have all the items for infection control, an improvement from four of every ten facilities in 2004.

Processing of equipment: The majority of delivery service facilities report that they process equipment in the facility; however, according to the 2010 KSPA definition, less than half have the capacity for sterilisation or HLD processing, mainly because of the lack of automatic timers at processing sites.

The availability of guidelines for processing of equipment has improved from two of every ten facilities in 2004 to one-third of facilities.

Partographs and service guidelines: Blank partographs were available in nearly two-thirds of the facilities. Service guidelines are generally not widely available. Only one-quarter of delivery service facilities had emergency obstetric care guidelines available at delivery service sites.

Availability of delivery service providers: Six of every ten facilities report that there is a delivery service provider on site 24 hours a day, a decline from eight of every ten facilities in 2004; 15 percent did not have a duty schedule to support that claim.

Essential supplies for delivery services

Tables 6.7 and A-6.35 and Figures 6.10 and 6.11 provide information on the availability of medicines and supplies for quality services for normal and complicated deliveries.

Certain items are considered basic requirements for supporting a normal delivery; these include scissors or a blade, cord clamps or ties, a suction apparatus (bulb or machine), antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineum. The availability of individual items ranges from 70 percent having an antibiotic eye ointment to 97 percent having scissors or a blade at the service site (Figure 6.10 and Table A-6.35). All these items are available in the delivery area in only 57 percent of facilities overall (an increase from 36 percent in 2004), ranging from 40 percent of dispensaries to 80 percent of maternity facilities (Table 6.7). Women delivering at a facility are expected to bring some of these supplies with them.

Additional supplies and medicines for managing complications

To manage delivery complications, facilities need more than basic supplies. For common complications, they require additional medicines and supplies such as syringes and needles, intravenous solution with perfusion sets, injectable oxytocic, suture materials, a needle holder, and oral antibiotic.

In addition to these medicines and supplies for managing common complications, selected medicines and supplies for managing serious complications (such as anticonvulsants) should also be available. The standards call for emergency obstetric care (EmOC) facilities to have an emergency tray of drugs available, including anticonvulsants, antihypertensives, and oxytocics, among others.

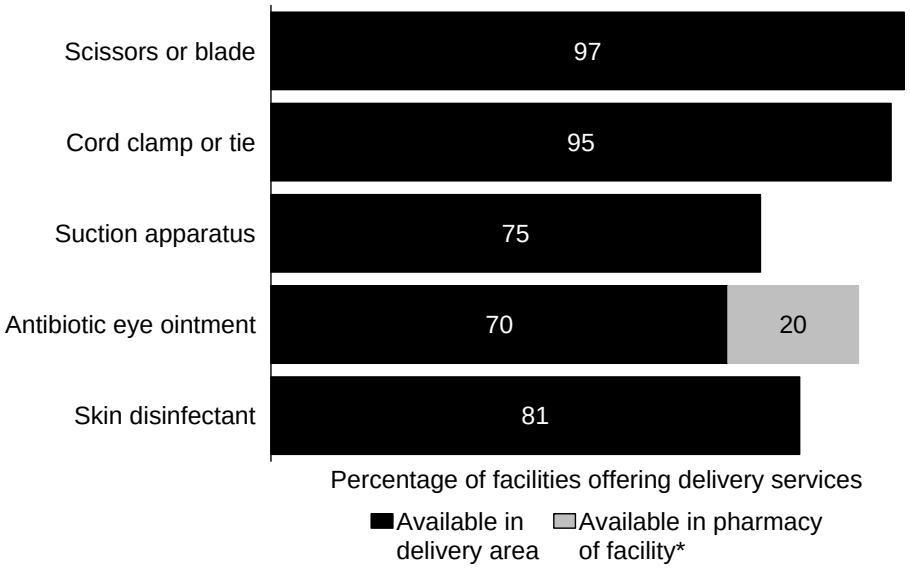
Table 6.7 Availability of medicines and supplies for normal and complicated delivery services

Percentage of facilities offering delivery services that have all essential supplies for delivery and additional medicines and supplies for complications, by background characteristics, Kenya SPA 2010

Background characteristic	All essential supplies for delivery[1]	Additional medicines and supplies for:		Number of facilities offering delivery services
		Common complications[2]	Serious complications[3]	
Type of facility				
Hospital	72	72	79	48
Health centre	61	48	62	66
Maternity	80	66	72	14
Clinic	43	50	57	8
Dispensary	40	35	52	70
Managing authority				
Government	50	40	62	124
NGO	5	51	64	8
Private (for profit)	74	68	72	37
Faith-based organisation	73	68	59	38
Province				
Nairobi	79	81	61	13
Central	88	77	57	16
Coast	60	59	75	22
Eastern	44	61	79	35
North Eastern	21	52	83	11
Nyanza	54	25	55	43
Rift Valley	64	49	46	47
Western	45	38	74	21
Total	57	51	63	207

[1] Scissors or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, skin disinfectant.
[2] Needle and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area; oral antibiotic (cotrimoxazole or amoxicillin) located in pharmacy or delivery room area.
[3] Injectable anticonvulsant (diazepam or magnesium sulphate) in delivery room/area and an antibiotic (penicillin or ampicillin or gentamicin) in delivery room area or pharmacy.

Figure 6.10 Essential Supplies for Delivery (N=207)



* 'Available in pharmacy of facility' in this figure is the sum of both bars. For example, for antibiotic eye ointment, the 'Available in pharmacy of facility' is 90 percent, while 'Available in delivery area' is 70 percent.

KSPA 2010

Common complications

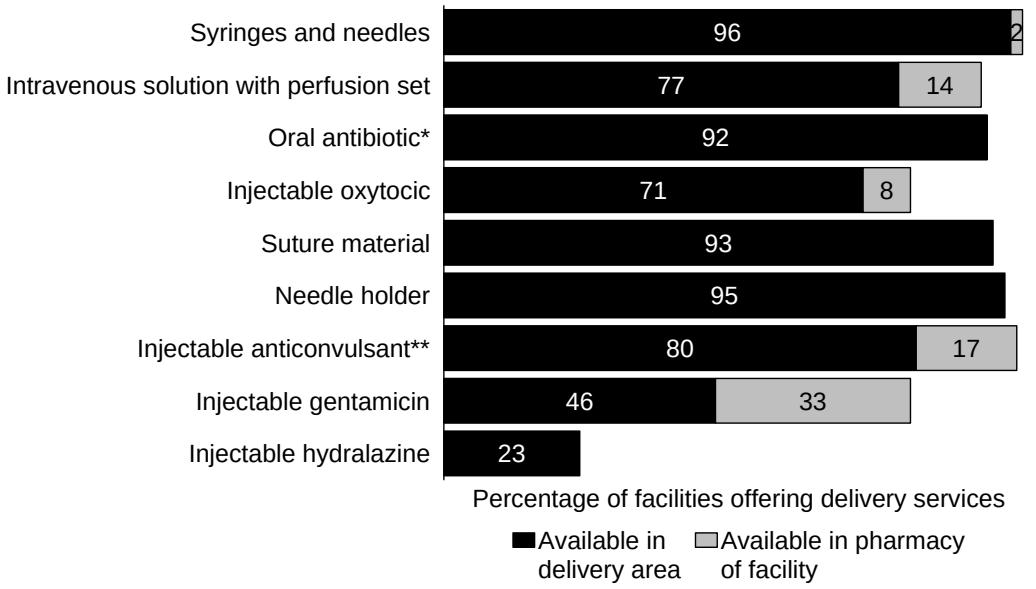
Fifty-one percent of facilities offering delivery services (compared with 26 percent in 2004) had all the medicines and supplies for managing common complications available on the day of the survey.[16] Hospitals (72 percent), maternity facilities (66 percent), and facilities in Nairobi (81 percent) and Central (77 percent) provinces were more likely to have all these medicines and supplies available than other facility types and facilities in other provinces, respectively (Table 6.7). Among managing authorities, private and FBO facilities (both 68 percent) were most likely to have all of these additional medicines and supplies.

As for individual items, almost all facilities had syringes and needles (96 percent of facilities), while oral antibiotics were available in 92 percent of facilities (Figure 6.11).

Overall, there has been an improvement since 2004 in the availability of medicines and supplies to manage common complications of pregnancy.

[16] Needle and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area and oral antibiotic (cotrimoxazole or amoxicillin) located in pharmacy or delivery room area

Figure 6.11 Additional Medicines and Supplies for Managing Complications of Delivery (N=207)



* Oral amoxicillin, Augmentin, ampicillin, or cotrimoxazole
** Diazepam or magnesium sulphate

KSPA 2010

Serious complications

Additional medicines and supplies for managing serious complications[17] are available in 63 percent of facilities that offer delivery services (Table 6.7) (compared with 13 percent in 2004). They are most common in hospitals (79 percent) and maternity facilities (72 percent), private facilities (72 percent), and facilities in North Eastern (83 percent) and Eastern (79 percent) provinces.

Injectable oxytocin is available in the delivery area in 71 percent of facilities that offer delivery services (Figure 6.11). Injectable anticonvulsants (diazepam or magnesium sulphate) for the management of pre-eclampsia and eclampsia are available in the delivery service area in 80 percent of these facilities. Injectable gentamicin is available in 79 percent of facilities (in 46 percent of facilities, in the delivery room, and in 33 percent, elsewhere in the facility). Injectable hydralazine was available in the delivery area of only 23 percent of facilities (compared with 32 percent in 2004), most commonly in hospitals and maternity facilities.

Overall, there has been a general improvement over 2004 in the availability of medicines and supplies for managing serious complications except for the decline in the availability of hydralazine.

6.7 NEWBORN CARE

6.7.1 Status of Newborn Health in Kenya

Child health indicators in Kenya have shown some improvement over the last five years. Compared with 2003 findings, the findings of the 2008-09 KDHS show a significant reduction in overall infant mortality, from 77 deaths per 1,000 live births in 2003 to 52 deaths per 1,000 live births in 2008-2009. Similarly, the under-five mortality rate declined from 115 deaths per 1,000 live births in 2003 to 74 deaths per 1,000 live births in 2009-09. These improvements can be attributed in part to various government programmes and interventions, including: (1) the substantial increases in child immunisation coverage nationwide, (2) improvement in key malaria indicators such as ownership and

[17] Injectable anticonvulsant (diazepam or magnesium sulphate) in delivery room area and antibiotic (penicillin or ampicillin or gentamicin) in delivery room area or pharmacy.

use of insecticide-treated mosquito nets, (3) preventive treatment of malaria during pregnancy, and (4) presumptive treatment of childhood fever with antimalarial medicines.

These interventions, however, do not have much impact on newborn mortality. Findings from the 2008-09 KDHS show that newborn mortality has changed little during the same period—33 per 1,000 live births in 2003 and 31 per 1,000 live births in 2008-09) (KNBS and ICF Macro, 2010). Neonatal mortality now accounts for approximately 60 percent of under-five mortality in Kenya (KNBS and ICF Macro, 2010).

Up to 50 percent of neonatal deaths occur within the first 24 hours of life, and 75 percent, during the first week of life (Zuppan, Ashman 2005). The common causes of neonatal deaths are infections, birth asphyxia, birth injuries, complications of prematurity and low birth weight, and birth defects. Complications of labour and maternal death are important determinants of foetal and neonatal survival and health (Kusiako *et al.*, 2000). Newborn health is directly linked to maternal health. Thus, improving birth outcomes depends on improving maternal health care during pregnancy, delivery, and the postpartum period. Improvements in maternal health care will help reduce newborn deaths.

Most newborn deaths occur at home and may involve newborn care practices of the families, which are based on tradition and are not necessarily beneficial, perhaps sometimes even harmful. In part to change this situation, the MOPH&S has made implementing community health services a top priority, with the plan that these community services can offer care quickly to newborns in trouble and also to advance healthful newborn care practices in the home. This is articulated well in the MOPHS Joint Programme of Work and Funding, 2006/07–2009/10 and in the MOPHS strategic plan of 2008-2010.

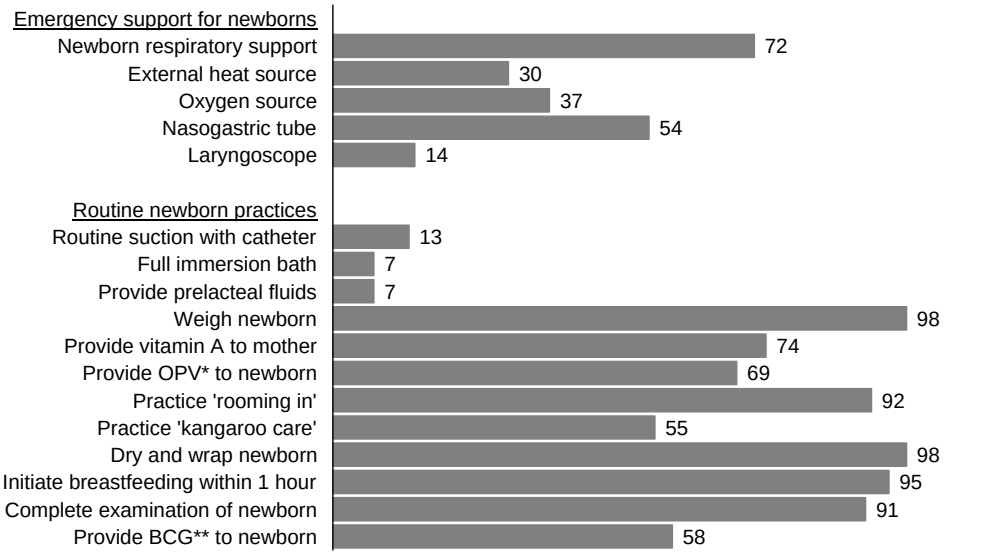
Kenya has developed a Child Survival and Development Strategy (CSDS) as well as the National Road Map for Maternal and Newborn Health. These two policy documents are the blueprints for improvement of maternal, newborn, and child health and nutrition, particularly through the country's health facilities. The MOPHS, in collaboration with stakeholders, has further developed an operationalisation manual for child survival and development. Under these policies the top priority evidence-based, cost-effective, and high-impact interventions for the newborn in Kenya include: skilled birth attendance, newborn resuscitation, antibiotic for infections, temperature control (the warm chain), hygienic cord care, early initiation of breastfeeding, exclusive breastfeeding, ARV prophylaxis, and hand washing (MOPHS, 2010 unpublished).

6.7.2 Newborn Care Services and Practices

The 2010 KSPA assessed routine newborn care practices and the availability of equipment and supplies for supporting newborn care in Kenyan health facilities. In addition, the survey noted the availability of equipment and supplies for emergency newborn care.[18] Details are provided in Figure 6.12, Tables A-6.36, A-6.38, A-6.39.1 and A-6.39.2.

[18] An infant-sized Ambu bag, external heat sources to maintain body heat in infants, especially premature newborns (including incubators and heat lamps), laryngoscopes, and endotracheal tubes, oxygen source, and nasogastric tube.

Figure 6.12 Emergency Support and Routine Practices for Newborn Care (N=207)



* OPV = oral polio vaccine
** BCG = Bacillus Calmette-Guérin, a tuberculosis vaccine

KSPA 2010

Equipment and supplies

Overall, 72 percent of facilities offering delivery services have newborn respiratory support in the form of a newborn-sized Ambu bag or equivalent (compared with 56 percent in 2004) (Figure 6.12). Hospitals (92 percent) are more likely to have newborn respiratory support than other facility types. Similarly, facilities in Rift Valley province are more likely than facilities in other provinces to have newborn respiratory support (Table A-6.36).

Thirty percent of facilities that offer delivery services (compared with 23 percent in 2004) have an external heat source for newborns (most often an incubator, although a heat light was considered sufficient) (Figure 6.12). These are most available in hospitals (67 percent) and maternity facilities (57 percent). Private facilities (54 percent) and facilities in Central (78 percent) and Nairobi (56 percent) provinces are most likely to have external heat sources (Table A-6.36).

An oxygen source is available in 37 percent of facilities. Hospitals (75 percent), private facilities (55 percent), and facilities in Nairobi (76 percent) and Central (71 percent) provinces are among the most likely to have oxygen sources (Figure 6.12, Table A-6.36).

Nasogastric tubes are available in 54 percent of the facilities (Figure 6.12, Table A-6.36). As with other equipment, they are most likely to be found in hospitals (76 percent), in privately run facilities (72 percent), and in facilities in Nairobi (69 percent) and Central (73 percent) provinces. Only 14 percent of facilities offering delivery services have a laryngoscope and endotracheal tube (Figure 6.12).

Reported newborn care practices

Facilities were asked if newborns and mothers delivering in their facilities underwent several routine practices. The findings are presented here.

In the past the use of catheter suction to stimulate respiration in newborns that are in some distress was a common practice in many health facilities. However, evidence has shown that this should not be a routine practice because it may cause injury to the newborn and also may risk mother-to-child transmission of HIV. Among facilities offering delivery services, only 13 percent (compared

with 42 percent in 2004) report routinely using catheter suction (Figure 6.12, Table A-6.38). This practice is most common in maternity facilities (34 percent).

Hypothermia contributes to the morbidity and mortality of newborns. It can be prevented by avoiding a full immersion bath during the first few hours after birth and instead drying the newborn and either immediately giving the infant to the mother for skin-to-skin contact or wrapping the newborn in a warm blanket. Newborn full immersion bathing is reported in only 7 percent of facilities that offer delivery services (compared with 20 percent in 2004). The practice is most common in maternity facilities (18 percent) and hospitals (10 percent). In contrast, 98 percent report drying and wrapping the newborn to keep it warm.

Since low birth weight is a risk indicator for infant death, weighing the newborn provides information essential to postnatal care. Although almost all facilities (98 percent) indicate that they routinely weigh newborns (compared with 91 percent in 2004), somewhat less—90 percent—have an available infant weighing scale in the delivery service area,, although this is an improvement over 78 percent in 2004 (Figure 6.12, Table A-6.38).

Vitamin A supplementation in poorly nourished children has been shown to decrease the risk of infection and death. Newborns can receive a healthful amount of vitamin A through breast milk. However, pregnant women are also at risk of developing vitamin A deficiency and therefore need vitamin A supplementation after delivery. Seventy-four percent of delivery facilities (compared with 53 percent in 2004) routinely provide vitamin A supplementation to new mothers (Figure 6.12). Sixty-nine percent of delivery facilities have vitamin A available in the delivery area, and 96 percent have vitamin A available either in the delivery area or in the pharmacy (Table A-6.38).

Sixty-nine percent of delivery facilities routinely provide newborns with oral polio vaccine (OPV), similar to 68 percent in 2004 (Figure 6.12). Fifty-eight percent of facilities routinely provide BCG.

Internationally, exclusively breastfeeding the infant in the first six months of life is promoted, while providing pre-lacteal liquids is discouraged. Providing pre-lacteal liquids to infants is practiced in only 7 percent of Kenyan facilities (compared with 13 percent in 2004). This practice is most common in maternity facilities (16 percent) (Figure 6.12, Table A-6.38).

'Rooming-in' means that the infant stays in the same room with the mother, either at all times or part of the time while the mother is in the facility and until she is discharged. This helps to promote exclusive breastfeeding and mother-child bonding. It is practised in 92 percent of Kenyan health facilities that offer delivery services (96 percent in 2004) (Figure 6.12, Table A-6.38). This practice is least likely in clinics (64 percent).

Kangaroo care, a technique wherein the newborn infant is held skin-to-skin with an adult to ensure physiological warmth and psychological bonding, is done in 55 percent of facilities (Figure 6.12). It is most common in hospitals, health centres, and maternity facilities and least likely to be done in clinics (21 percent) (Table A-6.38). Two other newborn care practices are found in over 90 percent of Kenyan health facilities: initiation of breastfeeding in the first hour (95 percent) and routine complete examination of the newborn before discharge (91 percent).

Overall, useful routine newborn care practices have become more common since 2004.

Observed newborn care practices

Waiting one to three minutes after birth to clamp the umbilical cord has been shown to result in an increase in neonatal haematocrit and haemoglobin levels, which in turn results in a significantly lower proportion of infants with anaemia (Cernadas J, Carroli G, Pellegrini L, et al, 2006). Cord clamping was delayed in only half of observed births (Table 6.8).

Slightly more than half of all observed live newborns (56 percent) were placed skin-to-skin with the mother (kangaroo care), and 60 percent were dried and wrapped. For the great majority of newborns (93 percent), the cord was clamped or tied and cut in a manner protecting the newborn from scissors or blade. Mothers of 76 percent of newborns were assisted to initiate breastfeeding. A little less than half of all observed newborns benefited from the three elements of essential newborn care—being dried and wrapped, having the cord tied or clamped and cut, and the mother helped to initiate breastfeeding. This was most likely to be the case in health centres (58 percent) and privately run facilities (57 percent), as well as in facilities in Nairobi (69 percent), Central (68 percent), and Rift Valley (65 percent) provinces.

Table 6.8 Elements of essential newborn care

Among observed deliveries, percentage where providers carried out or performed the following elements of essential newborn care immediately following the birth of the child, by background characteristics, Kenya SPA 2010

	Elements of essential newborn care							
Background characteristic	Delayed cord clamping	Number of births with cord clamping response	Placed newborn skin-to-skin	Dried and wrapped*	Tied cord or clamped and cut while protecting newborn from scissors or blade*	Helped mother to initiate breast-feeding*	Performed 3 indicated (*) elements of essential newborn care	Number of breathing newborns
Type of facility								
Hospital	52	463	60	59	93	76	46	455
Health centre	51	62	43	69	97	76	58	60
Maternity	45	26	23	56	87	71	29	26
Dispensary	0	7	0	0	100	100	0	7
Managing authority								
Government	50	431	60	57	95	77	46	419
NGO	37	21	19	50	88	81	46	20
Private (for profit)	80	35	65	86	94	72	57	35
Faith-based organisation	48	71	41	62	88	70	41	75
Province								
Nairobi	91	53	68	97	98	73	69	52
Central	29	62	52	75	85	86	68	66
Coast	29	39	37	42	92	55	28	40
Eastern	57	90	44	48	93	64	24	92
North Eastern	32	37	14	56	100	56	32	34
Nyanza	38	123	51	43	96	92	43	122
Rift Valley	88	96	89	83	91	83	65	92
Western	23	58	65	34	94	63	26	51
Total	51	558	56	60	93	76	46	548

Key Findings

Emergency support for newborn: The availability of an Ambu bag has improved from less than six of every ten delivery facilities in 2004 to seven of every ten. The availability of an external heat source also has improved since 2004. Nasogastric tubes are available in half of delivery facilities. Other equipment for emergency care of newborn, such as oxygen source and laryngoscope, are not so widely available.

Reported newborn care practices: Overall, the useful routine newborn care practices have become more common since 2004, while the useless and not-recommended practices have declined.

Observed newborn care practices: A little less than half of all observed newborns received the three elements of essential newborn care.

6.8 MANAGEMENT PRACTICES SUPPORTIVE OF QUALITY DELIVERY SERVICES

Table 6.9 provides information on management practices related to delivery services. Table A-6.34 provides information on the availability of delivery service providers. Tables A-6.41 and A-6.42 provide information on fees charged for delivery services and on supportive management for providers of delivery services. Tables A-6.43.1 through A-6.44 provide information on supervision and staff development from the provider's perspective.

Table 6.9 Facility-based supportive management practices

Among facilities offering delivery services, percentage with up-to-date client register, documentation of delivery coverage, mortality review, and user fees and percentage where interviewed providers of delivery services report receiving routine training and supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering delivery services with:				Number of facilities offering delivery services	Percentage of facilities with routine:		Number of facilities with interviewed providers of normal delivery services
	Observed up-to-date delivery register[1]	Documentation of monitoring delivery coverage	Facility reviews maternal and/or newborn deaths or near misses	User fee for delivery		Staff training[2]	Personal supervision[3]	
Type of facility								
Hospital	95	33	64	94	48	50	88	47
Health centre	89	36	44	90	66	44	93	66
Maternity	85	21	35	95	14	42	63	14
Clinic	100	7	36	64	8	57	100	8
Dispensary	86	52	18	61	70	43	95	69
Managing authority								
Government	93	48	42	74	124	48	92	123
NGO	87	60	11	19	8	62	95	8
Private (for profit)	86	15	42	97	37	48	83	37
Faith-based organisation	82	26	31	99	38	31	94	38
Province								
Nairobi	93	10	49	100	13	44	82	13
Central	85	24	66	100	16	43	91	16
Coast	90	34	48	68	22	45	95	22
Eastern	90	44	17	67	35	42	92	35
North Eastern	100	22	59	12	11	53	83	9
Nyanza	86	52	35	84	43	63	97	43
Rift Valley	89	23	34	99	47	28	87	46
Western	94	79	44	75	21	56	89	21
Total	90	38	39	80	207	45	91	205

[1] Register has an entry in the past 30 days that, at minimum, indicates delivery outcome.
[2] A facility has routine staff training if at least half of interviewed providers reported they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[3] A facility has routine staff supervision if at least half of interviewed providers reported they had been personally supervised at least once during the six months preceding the survey.

6.8.1 Facility Documentation and Records

A delivery register is considered up-to-date if there is an entry for the 30 days preceding the survey (based on the assumption that there should be at least one delivery per month in facilities that provide the service) and if the entry describes the birth outcome. Nine of every ten facilities that offer delivery services (compared with three-quarters in 2004) have an up-to-date delivery register (Table 6.9). Clinics (100 percent) and hospitals (95 percent) are most likely to have up-to-date registers.

The 2010 KSPA assessed whether facilities have any documentation indicating that in their catchment area they monitor deliveries under skilled care (or, for some programme strategies, deliveries that are attended by skilled providers affiliated with the facility). Thirty-eight percent of facilities that offer delivery services (compared with 14 percent in 2004) have documentation showing that they monitor delivery coverage in their catchment areas (Table 6.9). Although all levels of health facilities have poor documentation, over half of the dispensaries (52 percent), six of every ten NGO facilities, and eight of every ten facilities in Western province do have documentation of monitoring delivery coverage.

6.8.2 Systems for Quality Assurance, Including Maternal Death Reviews

One measure to assure the quality of delivery services is to systematically review all maternal and/or newborn deaths or near-misses to identify avoidable factors involved. This helps to develop interventions that avoid future deaths. While the 2010 KSPA did not assess the quality of these reviews, it did enquire whether facilities implemented the process. Overall, four of every ten facilities that offer delivery services conduct reviews of maternal and/or newborn deaths or near-misses (compared with 27 percent in 2004) (Table 6.9). The practice is most common in hospitals (64 percent) and health centres (44 percent) and also in facilities in Central (66 percent) and North Eastern (59 percent) provinces. They are least likely to be conducted by facilities in Eastern province (17 percent).

6.8.3 Practices Related to User Fees

Eighty percent of facilities offering delivery services charge some form of user fees for delivery-related services, compared with 74 percent in 2004 (Table 6.9). User fees are common at FBO (99 percent), private (97 percent), and government facilities (74 percent). In contrast, they are uncommon in NGO facilities (19 percent). All facilities, or virtually all, in Nairobi, Central, and Rift Valley provinces charge user fees.

Seventy-four percent of delivery facilities charge a fee for the actual delivery, while 14 percent have a fixed fee covering both ANC and normal delivery services. This and additional information on items for which fees are charged is presented in Table A-6.41.

Among the facilities that routinely charge for delivery-related services, 34 percent publicly post all the fees charged, while half do not post any fees at all (Table A-6.41). Government-run facilities (51 percent) and facilities in Rift Valley (48 percent) are the most likely to post fees.

6.8.4 Training and Supervision

Training

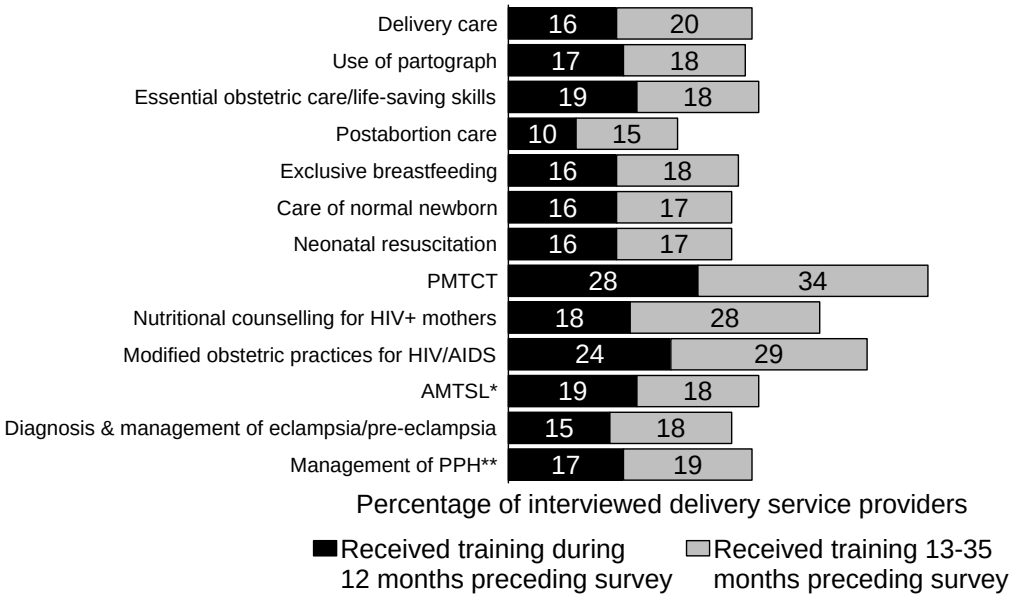
A facility is defined as providing routine staff training if at least half of the delivery service providers interviewed have received structured pre- or in-service training relevant to delivery services during the 12 months preceding the survey. This excludes individual instruction that occurs during routine supervision.

Forty-five percent of facilities meet the criterion of providing routine staff training (Table 6.9), compared with 32 percent in 2004. Clinics (57 percent) and hospitals (50 percent) are more likely than other facility types to provide routine staff training. NGO facilities (62 percent) and facilities in Nyanza (63 percent), Western (56 percent), and North Eastern (53 percent) provinces are the most likely to provide routine staff training.

Information is presented in Table A-6.42 on the proportion of interviewed providers who had received pre- or in-service training related to delivery services during the 12 months preceding the survey. Figure 6.13, Tables A-6.43.1, A-6.43.2, and A-6.43.3 show the specific training that these providers reported.

Forty percent of interviewed delivery service providers had received training related to delivery services during the 12 months preceding the survey (Table A-6.42). Providers in clinics (66 percent), NGO facilities (50 percent), and in Coast province (51 percent) and Nairobi and Nyanza provinces (both 49 percent) were most likely to have routine training. The topics most often covered were those related to delivery and newborn care, to essential obstetric care/life-saving skills, and to HIV/AIDS (Figure 6.13).

Figure 6.13 Training Received by Interviewed Delivery Service Providers, by Topic and Timing of Most Recent Training (N=881)



* Active management of 3rd stage of labour
** Post-partum haemorrhage

KSPA 2010

Staff supervision

A facility is defined as having routine staff supervision if at least half of the interviewed delivery service providers reported being personally supervised at least once during the six months preceding the survey. Nine of every ten delivery facilities meet this criterion. Maternity facilities (63 percent) are least likely to meet the criterion for staff supervision (Table 6.9).

Seventy-eight percent of interviewed delivery service providers had been supervised at least once during the six months preceding the survey (Table A-6.42).

Key Findings

Up-to-date client registers: The great majority of delivery facilities (nine of every ten) had an up-to-date delivery register (compared with three-quarters in 2004).

Review of maternal and/or newborn deaths or near misses: Overall, four of every ten facilities that offer delivery services (compared with 27 percent in 2004) conduct reviews of maternal and/or newborn deaths or near-misses.

6.9 PROVIDER KNOWLEDGE

Providers of delivery and newborn care services were interviewed to assess their knowledge of key normal delivery practices, essential newborn care, and obstetric complications. They were asked questions pertaining to labour and delivery practices, signs of postpartum haemorrhage (PPH), obstructed labour and the appropriate interventions, information to provide clients after an abortion, diagnosis and management of severe pre-eclampsia/eclampsia, and elements of immediate and essential newborn care. The findings are provided below.

Appropriate labour and delivery practices

Providers of delivery services were asked to mention specific observations and actions that they performed during the last delivery they conducted. They were expected to mention 11 items in four categories—(1) monitoring of foetal heart rate; (2) assessment of degree of moulding, cervical dilation, descent of the head, and degree of uterine contractions; (3) monitoring of the mother's blood pressure, pulse, and temperature; and (4) checking maternal uterine output, amniotic fluid, and meconium.

Nearly all providers (96 percent) said that they monitored the foetal heart rate during the last delivery they conducted, and nearly nine of every ten said they monitored maternal blood pressure (data not shown). Eight of every ten said that they assessed cervical dilatation; an equal proportion said they assessed maternal pulse. Only one of every five said they assessed the degree of moulding, while one of every ten said that they monitored the pregnant woman's urine output. Overall, only 3 percent of interviewed providers of delivery services correctly mentioned all ten items for appropriate monitoring of labour and delivery.

When asked where they recorded the information when monitoring the last labour and delivery they had attended, three-quarters said that they recorded the information on a partograph. A few factors could influence the use of partographs, including first and foremost, its availability. As reported earlier in this chapter (Table A-6.30), blank partographs were found in 63 percent of facilities that offer delivery services.

Postpartum haemorrhage (PPH)

Providers of delivery services also were asked to mention signs that they look for in a woman who presents with vaginal bleeding (or who develops bleeding after delivery) to assess the level of risk to the woman. They were expected to mention the following: (1) an uncontracted (atonic) uterus; (2) rapid pulse; (3) faint or weak pulse; (4) the amount of external bleeding; (5) the presence of retained placenta or products of conception; (6) genital tract injuries; (7) pallor; and (8) assessment of the woman's urinary bladder for fullness.

Half (53 percent) of interviewed providers mentioned that they look for an uncontracted (atonic) uterus. Three-quarters said they assess the amount of external bleeding; a little under half (47 percent) mentioned rapid pulse; and about half (52 percent) mentioned faint or weak pulse. Half (51 percent) said they look for pallor, and 48 percent mentioned injuries to the genital tract. Providers are less likely to mention checking for retained products (42 percent of providers) or checking the bladder for fullness (27 percent). Overall, only 7 percent of interviewed providers mentioned all eight items to assess the level of risk to a woman who presents with bleeding or develops heavy bleeding after delivery.

Obstructed labour

These providers also were asked to mention the key signs of obstructed labour. They were expected to mention the following: (1) maternal distress; (2) little or no descent of the presenting part of the foetus; (3) little or no change in cervical dilation; (4) development of Bandl's ring; (5) presence of severe moulding; (6) development of caput succedaneum; (7) first stage of labour lasting more than 12 hours; (8) second stage lasting more than 2 hours; (9) foetal death; (10) hot and dry vagina in the pregnant woman; and (11) inadequate pelvis.

Eight of every ten interviewed provider mentioned little or no descent of the presenting part, while 45 percent mentioned little or no change in cervical dilation. Half (51 percent) mentioned the development of Bandl's ring, and only two of every ten mentioned severe moulding. One-third mentioned a protracted first stage of labour (of more than 12 hours), while 18 percent mentioned a protracted second stage of labour (of more than 2 hours). Overall, only 5 percent of interviewed providers of delivery services mentioned all ten signs of obstructed labour.

Immediate and essential newborn care

Providers of newborn care also were asked questions pertaining to the newborn care that they had last provided. They were expected to mention the following as components of the care they provided: (1) wiped the newborn's face upon delivery of the head; (2) provided cord care by making sure it was cut under sterile conditions and applying nothing to the stump; (3) ensured that the baby was breathing; (4) provided thermal protection; (5) assessed and/or examined the newborn within one hour of birth; (6) weighed the newborn; (7) provided eye prophylaxis; (8) helped the women initial breastfeeding within one hour of the baby being born; and (9) administered a vitamin K injection to the newborn.

Thermal protection and wiping of the face once the head is delivered are the most widely known elements of immediate newborn care, reported by 81 and 79 percent of providers, respectively. All providers interviewed in clinics said that they wiped the face and also provided thermal protection. About six of every ten providers said that they provided cord care, while 65 percent said they initiated breastfeeding within one hour of the baby being born. Half (48 percent) said that they provided eye prophylaxis, while only 23 percent said that they gave the newborn a vitamin K injection.

6.10 EMERGENCY OBSTETRIC CARE

6.10.1 The Signal Functions for EmOC

Outcome indicators of maternal health, such as the maternal mortality ratio, require large numbers of observations in the denominator, and they are amenable to change only in the long term, over a minimum of four to five years. In recognition of these limitations, process indicators have been developed that better facilitate data collection and interpretation. These indicators, called the UN Process Indicators, which have been accepted by UN organisations, measure certain types of obstetric services that have a direct bearing on maternal outcomes, including mortality and morbidity. Availability of these critical services, or *signal functions*, is proven to significantly reduce maternal deaths and improve birth outcomes. They consist of:

1. Administration of parenteral antibiotics
2. Administration of parenteral oxytocic drugs
3. Administration of parenteral anticonvulsants/sedatives for pre-eclampsia and eclampsia
4. Manual removal of the placenta
5. Removal of retained products of conception
6. Assisted vaginal delivery
7. Blood transfusions
8. Surgery (caesarean section)

Facilities are considered *basic* emergency obstetric care (BEmOC) facilities if they provide the first six functions over a designated 3-month period and *comprehensive* emergency obstetric care (CEmOC) facilities if they provide all eight functions over a designated 3-month period.

The 2010 KSPA examined the availability of EmOC services among health facilities that provide delivery services. Because level 1 and level 2 facilities (dispensaries and clinics) are not expected to provide comprehensive emergency obstetric services, they are excluded from the subsequent analysis. Table 6.10.1 presents information on the proportions of facilities (hospitals, health centres, and maternity facilities) that had applied or carried out the signal functions at least once during the three months preceding the survey. Additional information on signal functions is presented in Tables A-6.39.1 and A-6.39.2.

Table 6.10.1 Signal functions for emergency obstetric care

Among hospitals, maternities, and health centres offering delivery services, percentage that report performing the signal functions for emergency obstetric care (EmOC) at least once during the three months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of hospitals, maternities, and health centres that applied or carried out parenteral:			Percentage of hospitals, maternities, and health centres that applied or carried out:							Number of hospitals, maternities and health centres offering delivery services
	Antibiotics	Oxytocics	Anti-convul-sants/ sedatives	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery (AVD)	Blood transfusion	Caesarean section	Basic EmOC[1]	Compre-hensive EmOC[2]	
Type of facility											
Hospital	84	93	51	60	70	13	42	47	9	7	48
Health centre	51	81	14	38	33	0	4	1	0	0	66
Maternity	67	85	24	33	62	2	23	31	0	0	14
Managing authority											
Government	57	84	21	46	47	3	14	13	2	2	79
NGO	46	26	26	20	46	6	46	46	6	6	2
Private (for profit)	79	91	39	47	63	10	23	38	6	4	27
Faith-based organisation	79	92	42	47	46	5	38	32	4	3	21
Province											
Nairobi	97	100	40	55	50	14	33	50	9	7	11
Central	70	82	38	52	44	8	29	39	5	4	12
Coast	64	86	48	55	63	8	30	32	3	3	9
Eastern	42	80	14	33	40	3	15	18	1	0	19
North Eastern	73	80	55	44	44	6	47	22	6	6	4
Nyanza	80	88	35	59	60	5	19	13	3	2	25
Rift Valley	62	86	23	41	50	4	14	14	3	3	36
Western	46	82	14	33	47	0	17	18	0	0	13
Total	65	86	29	46	50	5	20	22	3	3	129

[1] Facility applied the first six procedures (left to right) in the three months preceding the survey.
[2] Facility applied all basic EmOC procedures plus blood transfusion and caesarean section in the three months preceding the survey.

The following describes the availability of the signal functions in hospitals, health centres, and maternity facilities that offer delivery services. Any mention of 'facilities' refers only to hospitals, health centres, and maternity facilities.

Basic emergency obstetric care

Sixty-five percent of delivery facilities had administered parenteral antibiotics during the three months before the survey, compared with 36 percent in 2004 (Table 6.10.1). Hospitals (84 percent), private and faith-based facilities (each 79 percent), and facilities in Nairobi (97 percent) and Nyanza (80 percent) provinces were more likely than others to have administered parenteral antibiotics during that period.

Eighty-six percent had administered parenteral oxytocics during that period, compared with 30 percent in 2004. Only three of every ten facilities had provided parenteral anticonvulsants, compared with 23 percent in 2004.

During the three months before the survey, a little less than half (46 percent) of these delivery facilities had carried out manual removal of the placenta (compared with one-third in 2004), while half (50 percent) had removed retained products (compared with 20 percent in 2004).

Assisted vaginal delivery is rarely done. In Kenya assisted vaginal deliveries are performed primarily by medical officers and obstetrician/gynaecologists and, to a small extent, clinical officers. The procedure should involve as little trauma as possible, achieved by using a plastic cap vacuum extractor at low pressure. Only 5 percent of the facilities—most commonly hospitals (13 percent)—had performed an assisted vaginal delivery at least once during the three months preceding the survey (compared with 7 percent in 2004).

Overall, only 3 percent of delivery facilities had performed all six basic signal functions during the three months preceding the survey.

Caesarean section and blood transfusion services

Overall, only 22 percent of facilities that offer delivery services had performed a caesarean section at least once during the three months preceding the survey (compared with 19 percent in 2004). This service was limited almost exclusively to hospitals that offer delivery services (47 percent, versus 76 percent in 2004) and maternity facilities (31 percent, versus 22 percent in 2004) (Table 6.10.1).

One of every five facilities that offer delivery services had carried out blood transfusion at least once in the three months preceding the survey (compared with 16 percent in 2004) (Table 6.10.1).

Overall, during the three months preceding the survey, only a very small proportion of facilities (3 percent) had applied or carried out all eight signal functions that constitute comprehensive emergency obstetric care.

Table 6.10.2 shows information on hospitals, health centres and maternity facilities that report capacity to perform the signal functions.

Table 6.10.2 Reported capability for signal functions for emergency obstetric care

Among hospitals, maternities and health centres offering delivery services, percentage that report ability to perform the signal functions for emergency obstetric care (EmOC), by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of hospitals, maternities and health centres that report ability to carry out parenteral:			Percentage of hospitals, maternities, and health centres that report ability to carry out:							Number of hospitals, maternities and health centres offering delivery services
	Anti-biotics	Oxytocics	Anti-convul-sants/ sedatives	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery (AVD)	Blood transfusion	Caesarean section	Basic EmOC[1]	Compre-hensive EmOC[2]	
Type of facility											
Hospital	88	96	69	77	91	25	60	55	18	17	48
Health Centre	65	83	36	51	55	2	6	1	2	0	66
Maternity	82	97	44	51	72	12	50	36	8	5	14
Managing authority											
Government	69	86	44	58	70	7	16	14	6	4	79
NGO	46	46	46	46	46	26	46	46	26	26	2
Private (for profit)	89	97	54	65	80	22	60	47	16	14	27
Faith-based organisation	87	95	64	66	59	13	47	36	5	5	21
Province											
Nairobi	98	100	51	65	59	17	56	50	14	14	11
Central	70	85	56	57	65	9	42	42	7	7	12
Coast	74	96	59	64	88	17	45	36	8	5	9
Eastern	43	80	15	35	82	8	24	21	3	3	19
North Eastern	89	92	86	80	58	14	53	25	14	9	4
Nyanza	94	89	60	75	68	20	33	17	16	10	25
Rift Valley	71	89	46	58	67	8	20	19	8	7	36
Western	82	93	63	74	73	2	21	20	2	2	13
Total	76	89	49	61	70	11	31	25	9	7	129

[1] Capacity to apply or carry out the first six procedures (left to right).
[2] Capacity to apply or carry out all basic EmOC procedures plus blood transfusion and caesarean section.

Key Findings

Signal functions: With the exception of assisted vaginal deliveries, there is an overall improvement since 2004 in the proportion of delivery facilities that can apply or carry out the signal functions. However, only a small proportion had carried out all of the first six signal functions or all eight signal functions at least once during the three months preceding the survey.

SERVICES FOR COMMUNICABLE DISEASES: SEXUALLY TRANSMITTED INFECTIONS, REPRODUCTIVE TRACT INFECTIONS, TUBERCULOSIS, AND MALARIA

7

Elizabeth Juma, Christine Awuor, George Kichamu, Patricia Lasoi

7.1 BACKGROUND

7.1.1 KSPA Approach to Collection of Information on Sexually Transmitted Infections, Tuberculosis, and Malaria

Sexually transmitted infections (STIs)

Sexually transmitted infections (STIs), including HIV/AIDS, and reproductive tract infections (RTIs) have caused major health problems the world over. STIs and RTIs affect high proportions of the population and lead to infertility, morbidity, and even mortality in some cases. STIs are known to increase the risk of HIV infection. Pregnant women with STIs are more likely to have low birth weight babies, premature babies, and stillborn births (Cotch et al., 1997). There has been a recorded increase in STI infections in the recent past in Kenya.

The effects of STIs and RTIs on reproductive health are sometimes severe and life-threatening, and more so in women than in men. Complications include pelvic inflammatory disease (PID), infertility (in men and women), ectopic pregnancy, and other adverse pregnancy outcomes such as miscarriage, stillbirth, preterm birth, and congenital infection.

A 2004 UNAIDS/WHO report on HIV and AIDS estimated that about 40 million people are infected with HIV globally, with two-thirds of these living in sub-Saharan Africa. With the advent of HIV and AIDS, tuberculosis (TB), especially multi-drug-resistant TB (MDR-TB) is re-emerging as a communicable disease of public health significance. This is due to the fact that TB is one of the most common opportunistic infections among AIDS patients. It is estimated that about 6.5 million new TB infections occur every year, while 2 million die each year as a consequence of TB infection.

Sexual contact is the most common route of HIV transmission. Hence, preventive measures for STIs are equally relevant to the control of HIV and AIDS. Also, treating common STIs may reduce transmission of HIV in a population.

This chapter therefore uses data from the 2010 KSPA to address the following key questions:

- To what extent are STI services available?
- To what extent do facilities offering STI services have the capacity to support quality STI and HIV/AIDS services?
- To what extent is there evidence that health service providers adhere to standards for provision of quality STI and HIV/AIDS services?
- Do facilities have management practices supportive of quality STI and HIV/AIDS services?
- Do facilities have resources for diagnosing and managing TB?
- Are clients satisfied with the STI and HIV/AIDS services provided?

7.1.2 Health Situation Regarding STIs and RTIs in Kenya

Sexually transmitted infections and reproductive tract infections remain among the leading causes of disease burden in Kenya today. STIs/RTIS have also been shown to increase vulnerability to HIV infection. Despite their public health importance, STIs and RTIs have been overshadowed in the last 10 to 15 years by the focus on HIV/AIDS.

Evidence from the 2007 Kenya AIDS Indicator Survey (KAIS 2007) revealed that the prevalence of HSV-2 (which causes genital herpes) in the general population (ages 15-64 years) was 35.1 percent and that 80.7 percent of HIV-infected adults were also infected with HSV-2. The 2007 KAIS also found that, whereas the prevalence of syphilis among the general population was about 2 percent, it was higher among adults ages 50-64 years (4.4 percent among males and 2.5 percent among females). Among participants who were sero-positive for syphilis, 16.9 percent had HIV; 71.5 percent had HSV-2, and 15.9 percent had both HIV and HSV-2. The KAIS also identified significant levels of unmet need for both reproductive health programmes and HIV/AIDS/STI/RTI activities.

It is in view of this evidence that the National AIDS and STI Control Programme (NASCOP) and various partners have embarked on a programme to revitalise the STI/RTI programme at all service provision levels in Kenya.

7.1.3 Health Situation Regarding Tuberculosis in Kenya

Tuberculosis (TB) in Kenya is a major national health problem, among the top ten causes of morbidity and mortality. It is the fourth leading cause of death amongst Kenyans of all ages and ranks sixth amongst causes of morbidity as measured by Disability Adjusted Life Years (DALYs).[1] TB affects all age groups, but it takes its greatest toll on those 15-45 years of age.

Kenya ranks 13th on the list of 22 high-burden tuberculosis (TB) countries in the world and has the fifth highest burden in Africa. According to the World Health Organization (WHO's) Global TB Report 2009, Kenya had more than 132,000 new TB cases per year, for an annual incidence rate of 142 new sputum smear-positive (SS+) cases per 100,000 population.

The national tuberculosis case notification rates (CNR) have increased steadily, from 54 per 100,000 population in 1991 to an alarmingly 338 per 100,000 population for all forms of TB in 2007. In 2009, case notification stood at 284 per 100,000. Smear-positive pulmonary TB cases ranged from approximately 38/100,000 to 98/100,000 between 1990 and 2008. This reflects an increasing burden of TB in the country.

To address the growing burden of TB in Kenya, the country established the Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) in the Ministry of Public Health and Sanitation to coordinate TB control activities. Decentralisation of TB control services from national and sub-national levels down to the community level is intended to increase access to services. Some of the key strategies to support the management of TB in Kenya include strengthening the collaboration between TB and HIV control programmes, in order to promote the integrated delivery of TB and HIV services, and the promotion of private–public partnerships, in order to increase the number of private providers integrated into the TB service provider network, coupled with sustained public education campaigns, health care worker training, promotion of early care-seeking and adherence to treatment at the community level and better TB case management by health care providers.

The DLTLD began to implement the WHO-recommended DOTS (the internationally recommended strategy for TB control) in 1993 and reported 100 percent DOTS coverage by 1997. In 2005 the DOTS case detection rate reached WHO's target of 70 percent and in 2007 rose to 72 percent. Data from the national programme show the DOTS treatment success rate met WHO's

[1] DALY is the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

target of 85 percent in 2007. WHO estimates that there were 2,016 incident cases of multidrug-resistant (MDR) TB in Kenya in 2007 and only 4.1 percent of these cases were diagnosed and notified. The proportion of TB cases detected who are cured under directly observed treatment has risen from 78 percent in 2000 to 85.6 percent in 2007. By 2009 the treatment success rate for sputum-positive TB cases had risen to 86.4 percent, demonstrating a significant improvement. According to the 2009 DLTLD annual report, the number of reported TB cases has increased tenfold, from 11,625 in 1990 to 110,065 cases in 2009. The average annual increase over the past 10 years is 7 percent for all forms of TB. However, over the last 5 years, the annual increase of notified TB cases slowed down to an average of 1 percent.

The increase in the number of TB patients, particularly since the early 1990s, poses a major threat to the health and the economy of the country. This increasing number of TB cases is thought to be largely associated with the growing HIV epidemic; about half of all Kenyan TB patients are co-infected with HIV—44 percent in 2009. Other factors include poverty and social deprivation that have led to a proliferation of urban slums, congestion, and limited access to general health care services.

The annual decrease in the TB case notification rate is about 8 percent. By the end of 2009, cases of all forms of TB notified in the public sector numbered 110,065. WHO (2007) estimates that only 80 percent of TB cases are being detected in Kenya, meaning that the remaining 20 percent that go undetected continue to transmit tuberculosis. The TB epidemic has posed new challenges in the face of the HIV and the socio-economic environment. In addition to the role of TB in the HIV epidemic, another major challenge is drug-Resistant TB (DR-TB). This includes multi-drug resistant TB (MDR-TB), poly-drug resistant TB (PDR-TB), and extremely drug resistant TB (XDR-TB). WHO estimates that there were approximately 2,000 cases of multidrug-resistant TB in Kenya in 2007, although only 4.1 percent of these cases were diagnosed and notified (MOPHS, 2009). The highest proportion of those diagnosed with DR-TB is males ages 25-34. Some 27 percent of those with DR-TB were co-infected with HIV.[2]

The policies in place to improve the TB situation include the continued pursuit of quality DOTS expansion; enhancement of efforts to address TB/HIV, MDR-TB, and other special challenge; and health care system strengthening. The Ministry of Public Health and Sanitation oversees the coordination, monitoring, and evaluation of TB control efforts, and all TB drugs are sourced only from government facilities.

7.1.4 Health Situation Regarding Malaria in Kenya

In Kenya clinically diagnosed malaria is responsible for 30 percent of outpatient consultations, 15 percent of hospital admissions, and approximately 3.5 percent of inpatient deaths in endemic areas. About 15 million malaria cases were reported in 2006 (HMIS 2008).

Kenya is broadly divided into four malaria eco-epidemiological zones: endemic, highland epidemic-prone, seasonal low transmission including arid and semi–arid, and low-risk zones. The Kenya Malaria Indicator Survey of 2007 found a national parasite prevalence of 7.6 percent by rapid diagnostic test (RDT) and 3.5 percent by microscopy in children less than five years of age. The same study also found that children under five years of age residing in rural areas are twice as likely as their urban counterparts to be infected with malaria. There are variations in the malaria parasite prevalence across the country among under-fives: 17 percent in endemic areas, 1.4 percent in areas of seasonal transmission (arid and semi-arid lowlands), 1 percent in epidemic-prone areas, and 0.4 percent in malaria-free low-risk transmission areas. In 2009 a model-based map of the intensity of *P. falciparum* transmission in Kenya, as indicated by the proportion of infected children ages 2-10 years in the community, was produced. Based on this map, 78 percent of the population of Kenya live in areas where the parasite prevalence is less than 5 percent (Noor et al., 2009).

[2] Source: NLTP administrative data 2007

Malaria in children

Malaria is one of the leading causes of child morbidity and mortality. Infection with malaria also has long-term consequences for child development, including chronic anaemia and neurological complications leading to poor academic performance.

Malaria in pregnant women

Pregnant women are a vulnerable group in whom malaria has devastating effects. Malaria during pregnancy causes febrile illness, anaemia, an increase in the risk of maternal illness and death, miscarriage, stillbirth, low birth weight, and neonatal death.

Malaria in people living with HIV/AIDS

Malaria infection and fever rates are increased in people living with HIV/AIDS, especially those with low CD4 counts or high viral loads, and malaria in people living with HIV/AIDS is associated with more severe disease and death. In pregnancy women with HIV/AIDS experience more episodes of malarial fever and more malaria-related adverse birth outcomes than women who are not HIV-positive (Ter Kuile et al., 2004). During malaria attacks in persons infected with HIV, there is a transient increase in HIV transcription, which may accelerate progression to AIDS and increase transmission of HIV.

Malaria and poverty

Malaria is a major factor contributing to poverty in Africa. It is estimated that the total yearly economic burden of malaria in Africa is about US$12 billion (World Bank, 2008). Malaria's public health impact is compounded by costs, both direct (prevention and treatment) and indirect (labour time lost caring for the sick). In Kenya an estimated 170 million working days are lost annually as a result of malaria (Maneno et al., 1998) The household cost of a single episode of malaria in Africa ranges from US$4.50 in Mali to US$6.87 in Ghana. There is no reason to believe that the cost of a malaria episode in Kenya is less than that in Ghana; thus, malaria alone takes up more than 50 percent of Kenyan households' expenditure on health, which was estimated to average US$12 in 2007. Worldwide, malaria is estimated to reduce growth of the gross domestic product of a country by 1.3 percentage points per annum (Gallup and Sachs, 2001).

This chapter presents KSPA 2010 data on STIs, RTIs, TB, and malaria services offered throughout the country to support evidence-based programming and policy direction.

7.2 AVAILABILITY OF STI SERVICES

The 2010 KSPA assessed STI service availability and delivery conditions. In general, clients seeking health care specifically for symptoms of STIs are examined in a general outpatient department (OPD). Less commonly, there are specific STI clinics or service areas. Women clients seeking services for ANC or family planning may also require STI services. Hence, including STI screening and treatment as a component of these services may increase early detention and treatment.

Table 7.1 provides information on the availability of STI services, while Table A-7.1 provides information on the availability of STI services in facilities reporting no primary STI services.

Table 7.1 Availability of services for sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs) and, among these, percentage where STI services are provided in the indicated service area and percentage where STI services are offered five or more days per week, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering STI services as a primary service	Number of facilities	Among facilities offering STI services, percentage offering STI services in:[1] Primary service location: General outpatient (OPD)	Special clinic[2]	Comprehensive care centre (CCC)	Family planning[3]	ANC service area[3]	OPD or CCC, and FP and ANC service areas	Percentage of facilities where services for STIs are available at least 5 days per week	Number of facilities offering STI services
Type of facility										
Hospital	98	51	94	4	1	43	47	32	97	49
Health centre	100	80	99	1	0	54	80	50	92	80
Maternity	94	17	100	0	0	63	77	61	94	16
Clinic	85	203	94	6	0	75	42	38	93	172
Dispensary	97	340	98	2	0	89	77	71	96	329
Managing authority										
Government	97	344	98	2	0	83	74	66	97	332
NGO	90	22	99	0	1	69	86	69	99	20
Private (for profit)	87	236	95	5	0	74	46	42	92	206
Faith-based organisation	100	88	96	2	1	61	77	52	92	88
Province										
Nairobi	90	41	100	0	0	42	75	36	97	37
Central	92	125	85	14	0	81	54	44	99	115
Coast	90	81	98	0	2	75	68	62	92	73
Eastern	98	118	100	0	0	78	63	57	96	115
North Eastern	94	24	99	0	0	64	72	64	89	23
Nyanza	96	82	99	1	0	76	70	63	98	79
Rift Valley	92	174	99	0	0	83	66	57	91	160
Western	99	44	99	1	0	79	85	76	92	43
Total	94	690	97	3	0	77	66	56	95	646

[1] If services are integrated, they may be available at multiple sites in the same facility. In small facilities one service site and one provider may provide services for general outpatients, ANC, and family planning clients.
[2] These could be specialised STI clinics in the facility. In some cases the special clinic is the gynaecologic clinic for females and the urology clinics for males.
[3] In these cases providers of family planning and ANC services are reported to routinely diagnose and treat STI.

Table 7.1 shows that STI services, which include counselling only, testing, diagnosis, or treatment, were available in 94 percent of health facilities, essentially unchanged from 92 percent in 2004. Among facilities offering STI services, 97 percent of them offer the services as part of general outpatient curative services, while 3 percent have special clinics. Ninety-five percent of facilities offer STI services at least five days per week, with the services integrated into ANC services in two-thirds of the facilities. Among facilities that offer STI services, 56 percent report that the services are available to clients in the three relevant areas of general outpatient, family planning, and antenatal care (ANC) services.

Private, for-profit facilities (87 percent) and facilities in Nairobi and Coast provinces (both 90 percent) are somewhat less likely to offer STI services than other facilities.

Key Findings

Service availability: STI services are offered in 94 percent of facilities and are integrated into FP, ANC, and general outpatient services in slightly over half of facilities.

Private, for-profit facilities and facilities in Nairobi and Coast provinces are somewhat less likely than other facilities to offer STI services.

7.3 Capacity to Provide Quality STI Services

The 2010 KSPA assessed systems, infrastructure, equipment, and supplies for supporting quality STI services. Although STI services are provided in multiple sites in large facilities, information on whether facilities have the capacity to provide quality STI services comes only from the general OPD, which is the main STI service area.

Table 7.2 provides information on whether facilities have the infrastructure and resources to support STI counselling and examination services, while Figures 7.1, 7.2, and 7.3 provide information on items to support quality STI services, diagnosis, and utilisation and on the availability of tests for STIs.

Table 7.2 Availability of infrastructure and resources to support quality counselling and examinations for sexually transmitted infections

Among facilities offering services for sexually transmitted infections (STIs), percentage with all components to support counselling, diagnosis, and treatment for STIs, by background characteristics, Kenya SPA 2010

Background characteristic	All items to support quality counselling[2]	All conditions to provide quality physical exam[3]	Method for diagnosing STIs			Testing capacity for:[1]					Medicines to treat 4 major STIs[10]	Number of facilities offering STI services
			Etiologic	Syndromic[4]	Clinical	Syphilis[5]	Gonorrhoea[6]	Wet mount[7]	Chlamydia[8]	HIV/AIDS[9]		
Type of facility												
Hospital	38	26	89	74	53	72	66	96	6	88	71	49
Health centre	36	29	82	85	61	39	20	75	3	73	45	80
Maternity	33	42	93	53	41	38	49	79	2	71	85	16
Clinic	6	29	79	58	42	22	20	51	4	41	69	172
Dispensary	30	15	34	62	68	13	10	32	0	30	33	329
Managing authority												
Government	34	11	39	66	71	18	12	37	1	36	27	332
NGO	28	21	46	86	74	23	18	36	5	36	26	20
Private (for profit)	11	36	77	59	42	24	23	51	4	42	70	206
Faith-based organisation	22	32	84	64	42	42	35	87	2	73	83	88
Province												
Nairobi	30	38	74	77	65	41	29	58	1	44	78	37
Central	16	27	73	56	31	28	31	50	5	42	57	115
Coast	8	28	63	85	42	33	22	59	0	65	56	73
Eastern	24	12	43	46	64	13	22	52	2	38	41	115
North Eastern	18	0	32	52	73	8	5	34	0	16	68	23
Nyanza	51	24	63	90	67	29	12	51	4	49	39	79
Rift Valley	22	22	53	61	72	18	12	38	1	40	43	160
Western	43	18	55	62	62	25	14	53	1	40	36	43
Total	25	22	58	64	58	24	19	49	2	43	48	646

[1] Capacity to conduct a test does not mean the facility routinely utilises the test.
[2] Visual and auditory privacy, any guidelines and any visual aids or educational materials, individual client charts, and condoms in STI service delivery area.
[3] All infection control items (soap, water, latex gloves, disinfecting solution, and sharps box), visual privacy, examination bed, and examination light.
[4] This refers specifically to following the WHO syndromic approach algorithms.
[5] Either venereal disease research laboratory (VDRL) test or reactive protein reagin (RPR) test kit.
[6] Gram stain reagents and functioning microscope or culture capacity.
[7] Functioning microscope and slides.
[8] Geimsa stain for chlamydia.
[9] ELISA, Western Blot, or Rapid Antibody Test in facility.
[10] At least one medicine to treat each of four STIs: syphilis, gonorrhoea, trichomoniasis, and chlamydia.

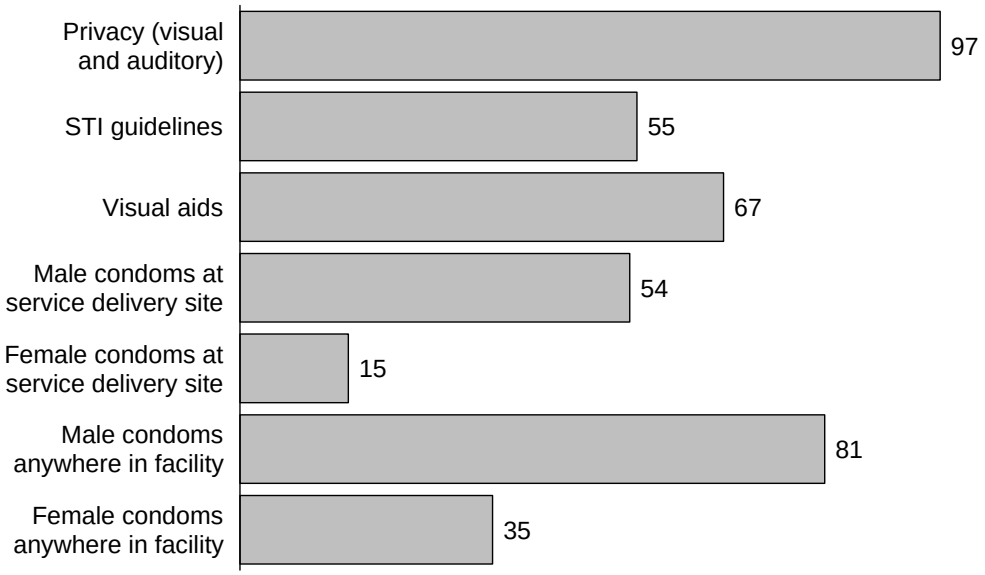
7.3.1 Infrastructure and Resources to Support Quality STI Assessment and Counselling

To achieve quality counselling on STIs, complete privacy is required to enhance open communication and trust between the service provider and the client. This is an important ingredient in adhering to protocols and set standards.

Ninety-seven percent of facilities provide counselling for STIs in an environment that allows for both visual and auditory privacy (Figure 7.1 and Table A-7.2), up from 87 percent in 2004. Fifty-five percent have STI guidelines in service delivery areas, down from 76 percent in 2004. Slightly over half (53 percent) have guidelines for the syndromic approach to STIs. The syndromic approach is a systematic method for assessing signs observed. This approach was widely implemented in Kenya in the early 1990s. The implementation involved training care providers, printing and distributing IEC and advocacy materials, purchasing and distributing STI drugs and test kits, and distributing condoms.

Two of every three facilities have visual aids for client education related to STIs, while nearly as many have educational materials on HIV and AIDS. By comparison, in 2004 half had visual aids.

Figure 7.1 Items to Support STI Services (N=646)



KSPA 2010

The availability of condoms at service delivery site enables the provider to readily demonstrate how to use them correctly and also ensures that the client can leave with them. However, only half of the facilities have male condoms at counselling sites, a decrease from 60 percent in 2004. Only 15 percent have female condoms. Overall, only one-quarter of facilities have all items that support quality counselling (Table A-7.2). These items include all the items described above: visual and auditory privacy, availability of STI guidelines, visual aids or other material for client education, and condoms in the STI service delivery area.

7.3.2 System Components to Support Utilisation of Services

As a result of the stigma frequently associated with having an STI, as well as the lack of symptoms in many infected people, special efforts are needed to promote early diagnosis and to encourage clients to seek modern medical help for STI symptoms. The 2010 KSPA assessed the existence of programme strategies and service delivery components that contribute to the availability and improved utilisation of STI services.

To interrupt STI transmission effectively, partners of clients with STIs must be tested, and, if they are infected, they must also be treated. The client is usually asked to notify the partner and ask him or her to be examined; this process is referred to as passive follow-up. Under certain circumstances the local health authorities may take the initiative to contact the partner, inform him or her about the possibility of STI infection, and recommend the appropriate course of action; this is known as active follow-up. Passive follow-up is the most widely used system of client notification, with 74 percent of facilities reporting that they use passive follow-up, compared with 10 percent of facilities using active follow-up. (In 2004, 67 percent relied on passive notification and 18 percent on active notification.) Sixteen percent of facilities have no follow-up system in place (Table A-7.2).

Key Findings

Items to support quality counselling: Only one-quarter of facilities have all the items to support quality STI counselling.

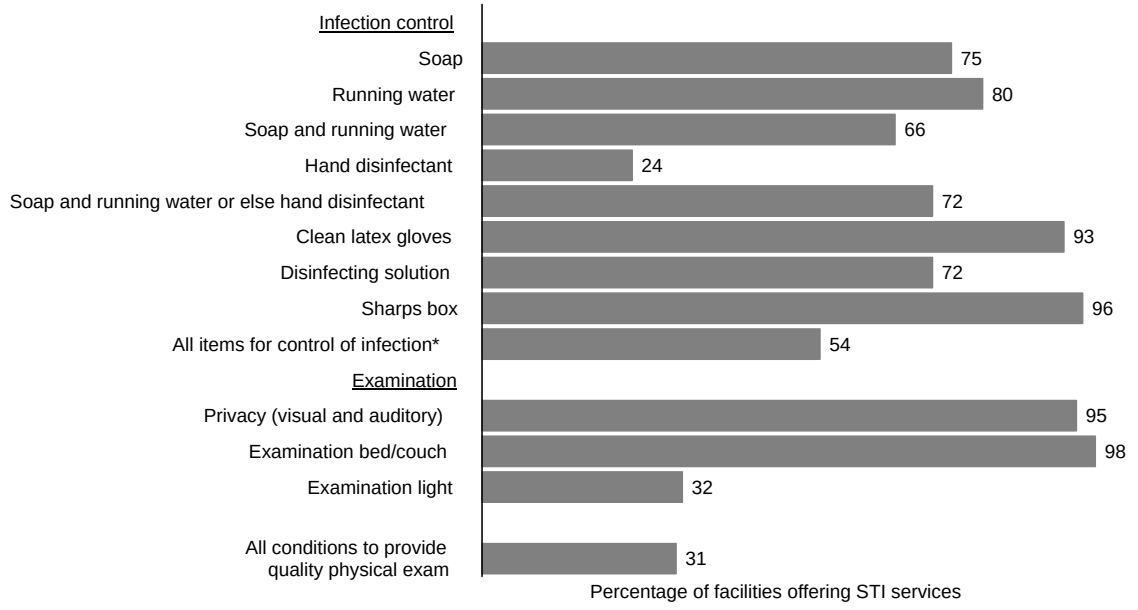
Service guidelines: STI guidelines are available at STI service sites in slightly over half of STI facilities.

Condoms: Four of every five facilities providing STI services have male condoms available anywhere in the facility, but only slightly over half have condoms in the STI service area.

7.3.3 Infrastructure and Resources for Examinations and Treatment

Facilities can offer better diagnosis and treatment for STIs when they have adequate infrastructure for physical examination, laboratory diagnostic support, and medicines for treating STIs. Table A-7.2 and Figure 7.2 look at availability of systems, infrastructure, and resources to support quality services for STIs.

Figure 7.2 **Items to Support Quality Examinations for STIs (N=646)**



* Soap and running water or else hand disinfectant, latex gloves, disinfecting solution, sharps box

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Infection control

All items for infection control are available in about half of facilities (54 percent), an improvement over 32 percent in 2004. Latex gloves and sharps boxes were the supplies most often available. Hand disinfectant is the least available item (24 percent) (Figure 7.2). Clinics are more likely to have all the items (58 percent) than hospitals (45 percent), at the other extreme. Waste receptacles are available in 18 percent of facilities, while only 12 percent of facilities have both waste receptacles and all items for infection control, as shown in Table A-7.2.

Physical examination

To be able to conduct quality physical examination, providers have to ensure there exist the necessary conditions and equipment, including privacy and the availability of an examination bed and light, as reported in Table A-7.2. Three of every ten facilities have all items to provide physical

examination, with maternities leading at 72 percent, followed by hospitals at 46 percent. Examination lights are available in only one-third of facilities, but examination beds can be found in nearly all the facilities.

Overall, only 22 percent of facilities have all the needed items for infection control and quality physical examinations.

Key Findings

Infection control: All items for infection control are available in half of the facilities.

Physical examination: Three of every ten facilities have all items to provide physical examinations, with maternities being most likely to have these items—seven of every ten.

Only 22 percent of facilities have all the needed items for infection control and quality physical examinations.

STI diagnosis

WHO recommends two approaches to diagnosing and providing STI services at the primary care facility level—the etiologic approach and the syndromic approach (WHO, 2001). The etiologic approach uses laboratory tests for diagnosing STIs and is more accurate than the syndromic approach. However, due to limited number of laboratories in Kenya, the syndromic approach is still used. Where neither approach is used, providers diagnose and prescribe medication based on their clinical judgement and clients' symptoms.

Fifty-eight percent of facilities use the clinical approach, and the same percentage use the etiologic approach, while 64 percent of facilities use the syndromic approach, down from eight in every ten in 2004. Hospitals and maternities are most likely to use the etiologic approach, as do nearly three of every four facilities in Nairobi (Table 7.2).

The most reliable way to ensure that clients receive laboratory test results is by conducting the tests in the facility. An alternative is to take the specimen and send it elsewhere for analysis and testing on the client's behalf. Tables 7.2 and A-7.3 provide information on the testing capability for each condition. Facilities are most likely to have the capacity to perform a wet mount test (49 percent, compared with 51 percent in 2004), followed by an HIV test (43 percent, compared with 19 percent in 2004).

STI treatment

Nearly half of the facilities have medicines to treat each of the four major STIs (syphilis, gonorrhoea, trichomoniasis, and chlamydia). Faith-based facilities, maternities, and facilities in Nairobi are more likely to have medicines for treatment of the four STIs than other facilities (Table 7.2). The medicines most widely available are injectable or oral penicillin for syphilis (85 percent), clotrimazole cream or suppositories for candidiasis (81 percent), and Nystatin oral or vaginal suppositories for candidiasis (71 percent), as shown in Table A-7.3. This table also shows that nine of every ten facilities have at least one medicine for treatment of syphilis, while 86 percent have medicines to treat chlamydia, and 67 percent have medicines to treat trichomoniasis.

7.4 MANAGEMENT PRACTICES SUPPORTIVE OF QUALITY SERVICES

Management practices to support quality STI services include documentation and record-keeping, practices related to user fees and staff supervision and development.

7.4.1 Facility Documentation and Records

Record-keeping and reporting on STIs and STI service utilisation are key elements in STI surveillance, aimed at improving programme management (WHO, 1999a). A register for STIs is considered up to date if there is an entry during the past seven days and if symptoms or a diagnosis consistent with STI is recorded. During the 2010 KSPA the records were checked for entries.

As Table 7.3 shows, only one-third of the facilities had up-to-date registers, compared with about half in 2004. Dispensaries (43 percent) are the facility type most likely to have a completed record, and Western province leads other provinces at 57 percent. Facilities in Coast and Central provinces are least likely to have up-to-date registers. Twenty-nine percent of facilities have records more than seven days old, with the highest percentage among NGO facilities (52 percent) and the lowest, private for-profit facilities (24 percent).

Table 7.3 Management practices supportive of quality services for sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs) with client register, and percentage where interviewed STI providers report receiving routine training on STIs and personal supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Observed client register with probable STI client recorded		Number of facilities offering STI services	Percentage of facilities with routine:		Number of facilities with interviewed providers of STI services[3]
	Entry within past 7 days	Most recent entry >7 days ago		Training[1]	Personal supervision[2]	
Type of facility						
Hospital	35	23	49	68	84	49
Health centre	34	32	80	58	93	79
Maternity	36	12	16	66	67	16
Clinic	11	27	172	42	56	163
Dispensary	43	31	329	56	89	312
Managing authority						
Government	41	31	332	57	91	314
NGO	21	52	20	66	88	20
Private (for profit)	19	24	206	43	58	196
Faith-based organisation	32	28	88	68	87	88
Province						
Nairobi	27	36	37	63	74	37
Central	17	40	115	51	60	111
Coast	17	7	73	57	79	72
Eastern	25	37	115	39	85	112
North Eastern	27	48	23	45	75	14
Nyanza	31	35	79	66	94	79
Rift Valley	51	17	160	56	84	152
Western	57	32	43	64	86	42
Total	32	29	646	54	80	618

[1] A facility has routine staff training if at least half of interviewed providers reported they had received pre- or in-service training related to their work during the 12 months preceding the survey. This refers to structured sessions and does not include individual instruction received during routine supervision.
[2] A facility has routine staff supervision if at least half of interviewed providers reported they had been personally supervised at least once during the six months preceding the survey.
[3] Includes providers offering STI services in facilities offering STI services in any clinic assessed in survey (e.g., outpatient, ANC, FP).

7.4.2 Practices Related to User Fees

User fees can have both negative and positive effects on use of facilities for treatment of STIs. Table A-7.4.2 shows the charging of fees for various items including health cards, consultations, tests, medicines, and registration. Between three and six in every ten facilities charge for one service or another, but very few have no charges. Posting of user fees for public information is poor; only 22 percent of facilities post all fees, while 66 percent do not post any fees.

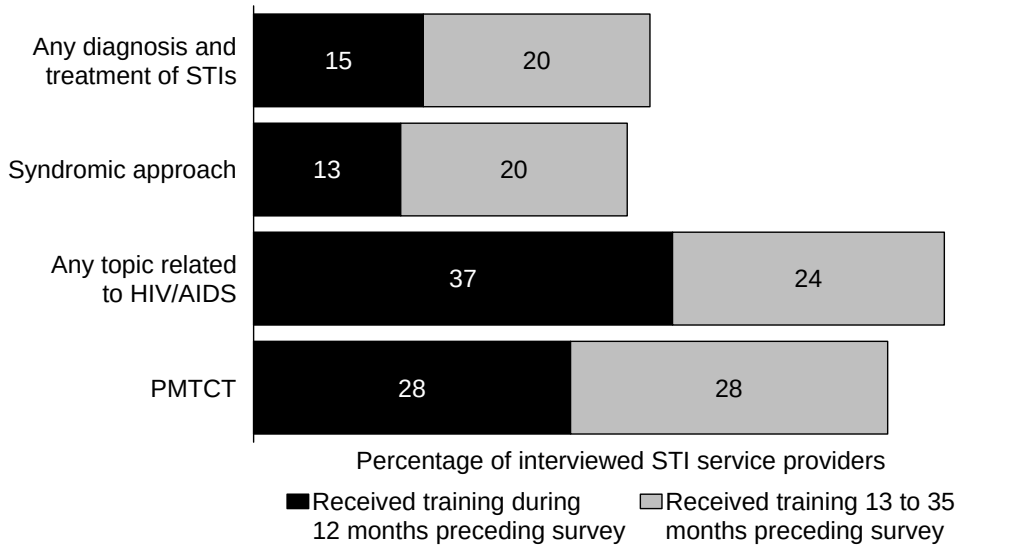
7.4.3 Staff Development and Supervision

Staff development

A facility is considered to provide routine staff development activities if at least half of its interviewed STI providers have received pre-service or in-service training related to STI services in the past 12 months. Slightly over half (54 percent) of facilities meet the criteria of providing routine training, down from 68 percent in 2004. Two-thirds of hospitals, maternities, faith-based organisations, and NGO facilities meet this criterion. Three of every five facilities in Nyanza, Western, and Nairobi provinces report undertaking staff development activities (Table 7.3).

Thirty-seven percent of interviewed STI providers received some form of HIV/AIDS training in the 12 months preceding the survey, while only 13 percent received training on the syndromic approach (Table A-7.5 and Figure 7.3).

Figure 7.3 **Training Received by Interviewed STI Service Providers, by Topic and Timing of Most Recent Training (N=1,604)**



PMTCT = Prevention of mother-to-child transmission of HIV KSPA 2010

Supervision

A facility is defined as providing routine supervision if at least half of the STI service providers have been personally supervised during the past six months. Routine supervision is available in four of every five facilities, compared with three of every five in 2004. The facilities of government, NGOs, and faith-based organisations show good supervision levels, with staff in nine of every ten facilities having been supervised (Table 7.3). Ninety-four percent of facilities in Nyanza province received supervision as contrasted with 60 percent in Central province.

Key Findings

Up-to-date client register: One-third of facilities offering STI services have up-to-date registers.

Staff development: Half of facilities provide routine staff training, and four of every five providing routine supervision. Supervision is weakest in Central province.

7.5 ADHERENCE TO STANDARDS FOR QUALITY SERVICE PROVISION

The 2010 KSPA assessed whether providers were adhering to set standards for quality service. This was done by observing STI client-provider consultations. The observation checklist was based on generally accepted standards for STI services.

7.5.1 Client Counselling

Table A-7.11 looks at observed consultations with STI clients to see the various topics that the providers discussed with them. Providers mentioned the relationship between the infection and sexual activity during 77 percent of the consultations. Nine of every ten clients received a prescription or medication at the end of the consultation, but only 13 percent received a prescription or medication for their sexual partner. All observed STI clients in health centres and maternities received prescriptions or medication.

Three of every five clients were instructed how to take medications. All clients in maternities received these instructions, but only 45 percent did in dispensaries. In 59 percent of consultations the provider discussed follow-up appointments. In 70 percent of consultations they encouraged partner referral.

Slightly over one-third of the clients were instructed on behaviour that could risk HIV infection. Just 40 percent of consultations included discussion of condoms for STI prevention. Providers offered condoms in only 12 percent of consultations, down from 21 percent in 2004, and they gave instructions on their use in only 17 percent (same as in 2004).

Using an individual client card is important to ensure that information is available during the next visit. In almost all STI consultations (94 percent), providers recorded information on individual client cards.

7.5.2 Client Opinion from Exit Interviews

Exit interviews were conducted with STI clients to get information on their experiences with the service provider on that day. When asked whether they had ever used a condom, 58 percent said they and their partner had used condoms in the past, compared with 38 percent in 2004 (Table A-7.12).

Forty percent of the clients reported that the provider talked about condoms during the visit, but only 7 percent said that they had been given condoms during the visit. The percentages are lower than the observed rates, showing clients' discomfort with discussing issues related to sex and condom use.

When asked about issues that may contribute to lack of use of condoms, 44 percent mentioned that it reduces a partner's satisfaction, and one-third said condoms reduce their own satisfaction. Forty-one percent said it is embarrassing to purchase condoms, and 28 percent said religion does not permit condom use.

During the exit interview clients also were asked their opinions on issues commonly related to client satisfaction. Clients were first required to identify issues without prompting, and then specific issues were probed and the client asked to indicate whether each of these was a big problem, a small problem, or not a problem. Waiting time was a big problem for 23 percent (Table A-7.13). Sixteen percent mentioned the availability of methods or medicines, while 11 percent cited the cost of services.

During the exit interviews clients were asked whether the facility was the nearest to their home and, if not, why they did not visit the nearest facility. Some 20 percent said this was not the nearest facility to their home (Table A-7.14). The largest single reason that these STI clients did not

go to their nearest facility was their preference for anonymity, cited by three of every ten interviewed clients.

7.6 RESOURCES FOR DIAGNOSIS AND MANAGEMENT OF TUBERCULOSIS

Despite comprehensive and advance treatments and therapies, tuberculosis remains one of the most common infectious diseases in the world. Further, as a common opportunistic infection associated with HIV and AIDS, TB is one of the leading causes of death in people infected with HIV. Information collected on TB-related services concerns any TB diagnostic services, TB treatment, and/or follow-up services and facilities following DOTS strategy and any treatment other than DOTS strategy.

7.6.1 Tuberculosis Diagnosis

Overall, about three of every ten facilities in Kenya offer TB diagnostic services (Table 7.4). A large proportion of hospitals (91 percent) and health centres (74 percent) offer TB diagnostic services, while 20 percent of dispensaries and 15 percent of clinics provide TB diagnostic services. Integration of TB diagnostic services in the maternities and clinics is, however, uncommon, at 39 and 15 percent, respectively. Among the managing authorities, facilities of faith-based organisations are more likely to provide TB diagnostic services (46 percent) than government facilities (38 percent) and NGO facilities (34 percent). Only 14 percent of the private (for-profit) facilities offer TB diagnostic services. At the provincial level, facilities in North Eastern (20 percent), and Eastern province (23 percent), and Rift Valley (25 percent) provinces are less likely to offer TB diagnostic services than facilities in other provinces.

Table 7.4 Availability of services for tuberculosis

Percentage of facilities providing any tuberculosis (TB) diagnostic services, any treatment and/or follow-up services, and, among facilities offering any TB treatment and/or follow-up services, percentage following the directly observed therapy short course (DOTS) treatment strategy or other treatment strategies, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage offering: Any TB diagnostic services	Any TB treatment and/or follow-up services	Any TB diagnostic, treatment, and/or follow-up services	Number of facilities	Among facilities providing any TB treatment and/or follow-up services, percentage following: Treatment through DOTS[1]	Treatment other than DOTS[2]	Number of facilities offering any TB treatment and/or follow-up services
Type of facility							
Hospital	91	90	93	51	92	8	46
Health centre	74	81	85	80	83	17	64
Maternity	39	21	41	17	100	0	4
Clinic	15	11	19	203	100	0	23
Dispensary	20	35	38	340	87	13	118
Managing authority							
Government	38	53	55	344	86	14	182
NGO	34	48	49	22	100	0	10
Private (for profit)	14	9	17	236	92	8	22
Faith-based organisation	46	45	57	88	94	6	40
Province							
Nairobi	43	45	48	41	78	22	18
Central	29	24	37	125	100	0	30
Coast	30	45	45	81	97	3	37
Eastern	23	42	44	118	98	2	49
North Eastern	20	22	22	24	100	0	5
Nyanza	48	58	59	82	89	11	48
Rift Valley	25	23	30	174	52	48	40
Western	39	61	66	44	100	0	27
Total	31	37	42	690	88	12	254

[1] Treatment strategy followed is either directly observed two months with five months follow-up or directly observed six months.
[2] The facility provides follow-up treatment to clients after the client has completed the first two months of direct observation elsewhere; or the facility diagnoses and treats while client is on admission, discharging the client for follow-up treatment elsewhere; or the facility provides full treatment to the client upon diagnosing TB, with no routine direct observation phase; or the facility diagnoses and prescribes or provides medicines only, with no follow-up.

Sputum and X-ray diagnostic capacities

All types of facilities have some capacity to stain sputum for TB diagnosis except dispensaries. Some 86 percent of hospitals and 61 percent of health centres, as well as 62 percent of clinics, 50 percent of maternities, and 28 percent of dispensaries have the capacity to stain sputum for TB diagnosis (Table A-7.16). Almost all hospitals (96 percent) and the great majority of health centres (82 percent), maternity facilities (91 percent), and clinics (88 percent) have a microscope for sputum examination. Only 4 percent of hospitals have the capacity to diagnosis TB through culture. The other facilities have no such capacity.

Only 10 percent of all the facilities have indication of X-ray TB diagnostic activities (Table A-7.20). Only 46 percent of hospitals, 15 percent of maternity facilities, and 14 percent of health centres have the capacity for x-ray diagnostics, while the percentages in clinics and dispensaries is below 10. Of the facilities using X-ray to diagnose TB, 67 percent of hospitals and 49 percent of maternities have this capacity.

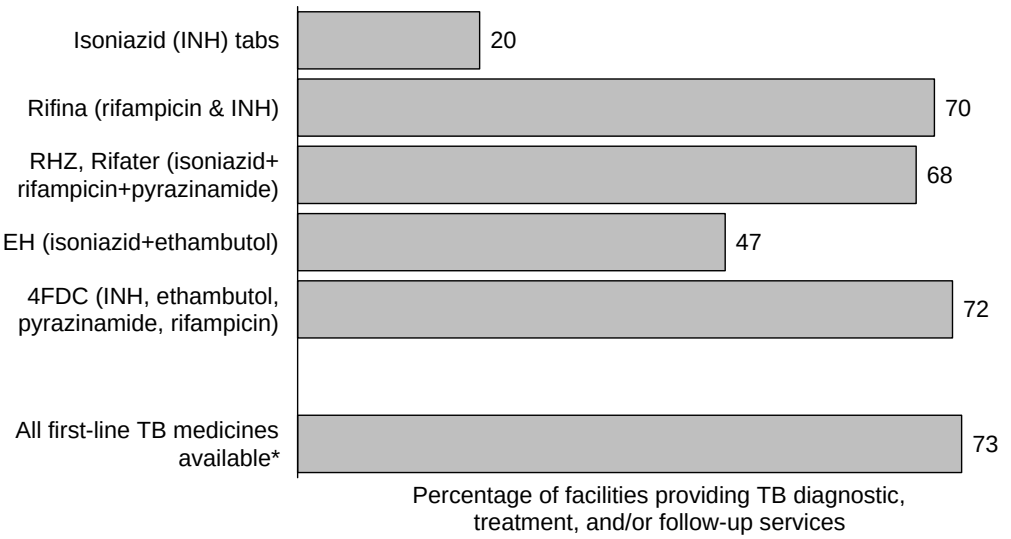
7.6.2 Tuberculosis Treatment and/or Follow-up Using DOTS Strategy

Tuberculosis treatment and availability of medicines

TB treatment or follow-up service is available in 37 percent of all facilities, including 90 percent in hospitals, 81 percent of health centres, and 35 percent of dispensaries (Table 7.4). Integration of these services into maternity facilities and clinics is uncommon, at 21 percent and 11 percent, respectively.

Among health facilities providing TB treatment and/or follow-up services, 84 percent have all first-line TB medicines available (Table A-7.19). Most of the hospitals (84 percent), health centres (82 percent), and dispensaries (88 percent) provide all first-line medicines. Levels are lower in clinics (70 percent) and maternities (65 percent). If facilities providing TB diagnosis as well as those offering treatment and/or diagnosis are considered, 73 percent of these facilities have all first-line medicines to treat TB, a figure unchanged from 2004. Rifina, RHZ, and 4FDC are the drugs most widely available (Figure 7.4).

Figure 7.4 **Availability of First-line Anti-TB Medicines among Facilities Providing TB Diagnostic, Treatment, and/or Follow-up Services (N=290)**



* Any combination of pyrazinamide, rifampicin, ethambutol, and isoniazid. If medicines provided are prepackaged for individual DOT clients, medicines had to be available for all DOTS clients currently on treatment from facility.

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Government facilities are more likely to offer treatment or follow-up service (53 percent) than FBO and NGO facilities (45 and 48 percent, respectively). The government-managed facilities are more likely to offer treatment and/or follow-up services (53 percent) than diagnostic services (38 percent). At the provincial level, more health facilities in Western and Nyanza provinces (61 and 58 percent) offer treatment and/or follow-up services than those in North Eastern (22 percent), Rift Valley (23 percent), or Central provinces (24 percent), at the other extreme.

Directly Observed Therapy Short Course (DOTS)

Close to nine of every ten facilities that offer TB treatment and/or follow-up services follow the Directly Observed Therapy Short Course (DOTS) strategy (Table 7.4). All maternities and clinics follow the DOTS Strategy. The great majority of hospitals, health centres, and dispensaries do also, but some provide treatments other than DOTS. There is not much variation by managing authority. Nearly all facilities, irrespective of managing authority or province, report that they are part of the national DOTS programme, have up-to-date client registers for DOTS. Six of every ten facilities have all TB indicators (Table A-7.19).

At the provincial level, all facilities in Central, North Eastern, and Western province that provide TB treatment follow the DOTS strategy. In Coast and Eastern provinces 97 and 98 percent of such facilities provide DOTS treatment. It is important to note that in Rift Valley province only 52 percent of facilities that treat TB follow the DOTS strategy (Table 7.4).

7.6.3 Supportive Management of TB Services

Laboratory diagnostic and clinical services

Personnel trainings and close supervision of TB service providers are important components supporting the diagnosis and treatment of TB patients. Among the interviewed providers of laboratory TB diagnostic services, slightly over 50 percent had received pre- or in-service training in the 12 months before the survey, and 76 percent were supervised in the 6 months before the survey (Table A-7.17.1). However, only 40 percent received both training and supervised within these time spans.

Among the clinical services providers, only 39 percent received some training in the 12 months before the survey, while 78 percent were personally supervised in the 6 months before the survey (Table A-7.17.2). Only 32 percent were both trained and supervised. It is important to note that all facility types had clinical service providers who had received training and/or supervision.

Records management of tuberculosis services

The incidence of tuberculosis, including drug-resistant forms, has increased significantly. It is important that facilities maintain accurate, complete, and up-to-date patient records in order to ensure patient compliance with treatment, to follow up diagnostic tests, and to document treatment outcomes. An effective recording and reporting system includes the laboratory register, the patient treatment card, and the TB patient register.

Of all the facilities offering any TB treatment, 84 percent were observed to have up-to-date client records (Table A-7.19). All clinics had client records. Some 95 percent of hospitals and 92 percent of maternity facilities had such records. Records were observed somewhat less often in health centres and dispensaries (85 and 77 percent, respectively), facilities where staff is often in short supply.

Among facilities using sputum testing to diagnose TB, 79 percent have all items for conducting these tests, while only 4 percent have a documented system for sending sputum elsewhere for TB diagnosis (Table A-7.20). This suggests that most of the sputum tests are conducted at the facilities.

Among management authorities, government facilities were least likely to have observed up-to-date records. Among the provinces, all facilities in Nairobi have records. In contrast, in Rift Valley province 58 percent of facilities had observed TB records.

7.6.4 Tuberculosis and HIV/AIDS Services

HIV prevalence among TB patients has been as high as 80 to 90 percent in some areas of sub-Saharan Africa including Kenya, according to the World Health Organization (WHO), which has recommended increasing collaboration between HIV and TB programmes. In 2005 the Kenya Division of Leprosy, Tuberculosis, and Lung Disease (DLTLD) added questions regarding HIV testing and treatment to the existing TB surveillance system for 2006-2009. The HIV testing among TB patients increased from 60 percent in 2006 to 88 percent in 2009.

Because TB is a common opportunistic infection in people who are HIV-positive, it is recommended that newly diagnosed TB patients be screened for HIV, and vice versa. Among facilities offering any TB diagnostic, treatment, and/or follow-up services, 82 percent routinely refer all newly diagnosed TB clients for HIV testing. Just 3 percent refer only clients who are suspected to be infected with HIV (Table A-7.21).

Among facilities offering TB services, 84 percent keep records of newly diagnosed TB clients referred for HIV testing, and 75 percent keep a register of current clients who are found to be HIV-positive (Table A-7.21). Hospitals and health centres are the types of facilities most likely to have each of these two records.

7.6.5 Tuberculosis Infection Control Plans

Facilities that provide TB services should have a written TB infection control plan that outlines a protocol for the prompt recognition, separation, provision of services, investigation for TB and referral of patients with suspected or confirmed TB disease.

For administrative support, each facility should have an infection control person or in larger facilities have a committee responsible for overseeing the infection control committee and developing a written infection control plan, monitoring its implementation, and providing effective training for health care workers and other staff in order to control the spread of TB.

Among facilities providing TB treatment, only three of every ten have TB infection control plans, while 17 percent have an inspection control focal person, and only 4 percent have a TB infection control (IC) committee with responsibility for ensuring that infection control procedures are implemented (Table A-7.22). Thus, 76 percent of the facilities have neither a focal person nor an IC committee. A few hospitals (14 percent) and health centres (3 percent) have both an IC focal person and an IC committee in place.

Among managing authorities, NGO facilities (45 percent) are most likely to have an IC focal person or IC committee, followed by government facilities at 25 percent.

For the management of cough patients in waiting areas, only 43 percent of facilities apply a standard operating procedure. Three percent use an N95 respirator that was observed during the survey.

7.7 The Malaria Control Strategy

The ultimate goal of malaria control is to reduce morbidity and prevent mortality due to malaria, thereby mitigating the socio-economic burden of the disease on Kenya. The basic malaria control strategies include:

- the provision of prompt diagnosis and effective treatment at all levels of the health care system
- integrated vector management including use of long-lasting insecticide-treated bed nets, indoor residual spraying and related measures
- intermittent preventive treatment of malaria in pregnancy
- surveillance, monitoring and evaluation, and operations research
- advocacy, communication, and social mobilisation.

The current malaria policy

Malaria prevention and treatment services are integrated into the routine health service delivery structure. Malaria treatment is the most common treatment provided by the health system, with 17 million doses of malaria medicines issued in 2009 in the public health care system alone. Artemether-lumefantrine (AL or Coartem) is the current first-line treatment for uncomplicated malaria. AL (or Coartem) is provided free of charge to all patients in public and faith-based health facilities nationwide. AL (or Coartem) is distributed in quarterly cycles to dispensaries and health centres in most of the country, while distribution to hospitals is done bimonthly. Quantities distributed are determined based on morbidity patterns and health facility returns on commodity consumption of malaria medicines. AL is delivered in four different weight-specific packages (6, 12, 18, and 24 tablets), each one with specific pictorial descriptions of appropriate AL use. In the absence of particular AL packs, treatment with AL is still possible but subject to improvisations in dispensing, either by cutting or combining different packs.

7.7.1 Malaria Diagnosis

The diagnosis of malaria is based on taking a good history, doing a thorough clinical examination, and conducting laboratory investigations. The 'gold standard' of laboratory malaria diagnosis is examination by microscope of blood smears for malaria parasites (i.e., microscopy). The reliability of microscopy depends heavily on the expertise and experience of the person who makes the stains and examines the blood smears. Malaria rapid diagnostic tests (RDTs) are an alternative to microscopy where good-quality microscopy services cannot be readily provided.

Following recommendations from the Roll Back Malaria partnership, Kenya has in 2010 adopted a policy of diagnosis-based treatment for all suspected cases of malaria. Parasitological confirmation of malaria is now recommended for all age groups in all epidemiological settings. Previously, confirmation of diagnosis was recommended only for older children and adults and for children less than five years old living in areas of low malaria risk.

7.7.2 Availability of Services for Malaria

The 2010 KSPA assessed the availability of services for malaria in Kenyan health facilities, specifically:

- Availability of malaria services, including laboratory diagnosis and treatment, among all facilities
- Distribution of free ITNs to ANC clients
- Training for providers of malaria services

Tables 7.5 and 7.6 provide information on availability of malaria services in Kenya health facilities.

7.7.3 Malaria Diagnosis and/or Treatment

Findings from the 2010 KSPA indicate that malaria services are widely available in Kenyan health facilities. Virtually all (99 percent) facilities offer malaria diagnosis and/or treatment services (Table 7.5).

Diagnostic capacity

Overall, 45 percent of health facilities have the capacity for parasitological diagnosis of malaria using either microscopy or rapid diagnostic tests. Similar to findings of the 2010 quality of malaria case management survey (Memusi et al., 2010), only 35 percent of government facilities have the capacity to provide malaria testing, compared with 87 percent of faith-based facilities. Among facility types, these tests are most available in hospitals (93 percent). For the most part, the available tests involve microscopy.

Among facilities offering malaria diagnosis and/or treatment services, 46 percent use microscopy to diagnose malaria. Rapid diagnostic tests for malaria have been available in a limited number of public health facilities in epidemic-prone districts in Kenya, mainly to support surveillance. Thus, the overall capacity to provide malaria rapid test for diagnosis is low, at only 6 percent of facilities that treat malaria.

Table 7.5 Malaria diagnosis and/or treatment services

Percentage of facilities offering malaria treatment services, percentage that have malaria laboratory diagnostic capacity, percentage offering malaria diagnosis and/or treatment services, and, among facilities offering malaria diagnosis and/or treatment services, percentage having the indicated components for supporting services for malaria, by background characteristics, Kenya SPA 2010

	Percentage of facilities that:				Among facilities offering malaria diagnosis and/or treatment services, percentage with:						
Background characteristic	Offer malaria treatment services	Have a lab diagnostic capacity for malaria[1]	Offer malaria diagnosis and/or treatment services	Number of facilities	Observed malaria treatment protocol in any relevant units	First-line anti-malaria medicines in the facility[2]	Stock-out of first-line anti-malarials in 6 months preceding the survey	Diagnostic capacity for malaria (blood smear)	Other diagnostic capacity for malaria (rapid test)	Treatment protocol in any relevant service site and first-line medicines in facility	Number of facilities offering malaria diagnosis and/or treatment services
Type of facility											
Hospital	100	93	100	51	52	88	20	92	19	46	51
Health centre	100	71	100	80	76	85	35	71	8	64	80
Maternity	98	75	98	17	34	68	10	74	17	22	17
Clinic	97	45	98	203	22	58	18	46	7	18	198
Dispensary	99	31	99	340	60	93	26	31	2	58	338
Managing authority											
Government	99	35	99	344	69	93	32	35	4	64	342
NGO	96	33	96	22	53	85	15	35	5	50	21
Private (for profit)	98	46	98	236	22	58	20	47	7	16	232
Faith-based organisation	100	87	100	88	48	92	5	87	9	47	88
Province											
Nairobi	93	53	93	41	40	84	23	57	4	34	38
Central	100	45	100	125	43	66	24	45	6	37	125
Coast	96	51	96	81	43	75	4	53	15	39	78
Eastern	100	51	100	118	55	85	33	51	1	52	118
North Eastern	97	37	100	24	16	77	35	37	12	16	24
Nyanza	100	50	100	82	68	84	18	50	8	56	82
Rift Valley	100	35	100	174	47	88	29	35	2	45	174
Western	99	49	99	44	74	84	23	46	6	63	43
Total	99	45	99	690	50	81	24	46	6	45	683

[1] Laboratory diagnostic capacity: a functioning microscope, slides, and stains must all be available, or rapid malaria test kit.
[2] First-line antimalarial is Coartem.

First-line medicines for the treatment of uncomplicated malaria

All facilities provide malaria treatment services (Table 7.5). At the time of the survey, 81 percent of facilities offering malaria diagnosis and/or treatment services had stocks of the first-line antimalarial medicine, including 93 percent of government facilities, 92 percent of faith-based facilities, 85 percent of NGO and only 58 percent of private health facilities. It is important to note here that AL (or Coartem) procured by the government is supplied only to government, faith-based, and some NGO facilities.

Thirty-two percent of government facilities reported stock-outs in the previous six months, compared with 5 percent of faith-based health facilities.

Malaria treatment guidelines/protocols

National guidelines for the diagnosis and treatment of malaria as well as treatment job aids and wall charts have been produced and distributed to health facilities nationwide from 2006 to 2010. Half of facilities providing malaria diagnosis and/or treatment services had treatment guidelines, including nearly 70 percent of government health facilities, 48 percent faith-based facilities, 53 percent of NGO facilities and only 22 percent of private facilities. This pattern may reflect the distribution of the guidelines and charts, which mainly targets facilities receiving AL (or Coartem) from the government.

7.7.4 Malaria-related Training for Providers

Ongoing training for service providers ensures that providers continue to learn the latest information pertaining to the services that they provide.

Survey findings show that, among facilities offering malarial diagnosis and/or treatment services, only 14 percent had at least one clinician provider of malaria services who had received malaria-related training in the previous 12 months. Forty-six percent of facilities had at least one nurse provider of malaria service who had received malaria-related training in the previous 12 months (Table 7.6).

Table 7.6 Provision of insecticide-treated nets and malaria-related training for providers

Among facilities offering malaria diagnosis and/or treatment services, percentage that distribute insecticide-treated nets (ITNs) to ANC clients and percentage where providers have received appropriate pre- or in-service malaria-related training, by background characteristics. Kenya SPA 2010

Background characteristic	Percentage of facilities offering malaria diagnosis and/or treatment services that:		At least 1 clinician provider[1] of malaria diagnosis or treatment services has received malaria-related pre- or in-service training in:		At least 1 nurse provider[2] of malaria diagnosis or treatment services has received malaria-related pre- or in-service training in:		Number of facilities offering malaria diagnosis and/or treatment services
	Distribute free ITNs to ANC clients	Have ITNs in facility	Preceding 12 months	Preceding 13-35 months	Preceding 12 months	Preceding 13-35 months	
Type of facility							
Hospital	64	60	55	18	49	15	51
Health centre	73	66	30	17	60	15	80
Maternity	31	41	27	14	41	15	17
Clinic	13	12	16	14	20	8	198
Dispensary	61	56	3	3	57	10	338
Managing authority							
Government	67	61	12	5	61	10	342
NGO	69	65	8	5	40	32	21
Private (for profit)	12	12	16	13	21	10	232
Faith-based organisation	64	60	18	14	52	12	88
Province							
Nairobi	10	20	25	17	41	13	38
Central	18	19	12	9	29	13	125
Coast	44	34	21	27	38	8	78
Eastern	60	63	15	4	55	5	118
North Eastern	29	5	17	5	27	18	24
Nyanza	92	76	12	8	47	15	82
Rift Valley	45	42	10	5	53	13	174
Western	79	78	16	3	64	3	43
Total	48	44	14	9	46	11	683

[1] Clinician providers include all specialists, medical officers, and medical assistants.
[2] Nurse providers include registered nurses/midwives and enrolled nurse/midwives.

7.7.5 Malaria Services for ANC Clients

The use of insecticide-treated bed nets (ITNs) can reduce malaria transmission among the population in general and in pregnant women and children in particular. Malaria preventive services in Kenya include the distribution of long-lasting insecticidal nets (LLIN) through antenatal clinics and child welfare clinics (CWC) in the malaria endemic, epidemic-prone, and seasonal risk zones. By

policy, LLIN are expected to be issued to pregnant women at the first contact during antenatal care and to all infants presenting for immunisation or well-baby clinics in the first year. Intermittent preventive treatment during pregnancy (IPTp) using sulphadoxine-pyrimethamine (SP) is provided as part of ANC services to pregnant women living in the malaria endemic districts of Nyanza, Western, and Coast provinces. All malaria prevention services are free of charge.

The 2010 KSPA assessed facilities offering malaria diagnosis and/or treatment services for the availability of ITNs and their provision, free of charge, to ANC clients.

About half (48 percent) of facilities that offer malaria diagnosis and/or treatment services report that they distribute ITNs to ANC clients (Table 7.6). Clinics (13 percent) and maternity facilities (31 percent) are much less likely than the other facility types to distribute ITNs to ANC clients. Private facilities (12 percent) as well as facilities in Nairobi (10 percent), Central (18 percent) and North Eastern (29 percent) provinces are also less likely than others to distribute ITNs.

Forty-four percent of facilities that offer malaria diagnosis and/or treatment services had ITNs available in the facility on the day of the survey.

Key Findings

Service availability: Malaria diagnosis and/or treatment services are universally available in Kenyan health facilities. All facilities offer malaria treatment services; however, a little under half have laboratory diagnostic capacity for malaria.

First-line antimalarial medicines: First-line antimalarial medicines were available in eight of every ten facilities. Government-owned and faith-based facilities are more likely to have the first-line malaria medicines available.

Treatment guidelines: Half of facilities had malaria treatment guidelines available, including seven of every ten government-owned facilities. Only one of every five private facilities had these service guidelines available.

Training for providers: Only a little over one in ten facilities had at least one clinician provider of malaria services who had received malaria related training in the 12 months before the survey, compared with forty-six percent with at least one nurse provider who had received similar training.

Distribution of ITNs: About half of facilities that offer malaria diagnosis and/or treatment services report that they distribute ITNs to ANC clients, and slightly less had ITNs available in the facility on the day of the visit.

HIV/AIDS SERVICES 8

Martin Sirengo, Francis Kundu, Bernard Mundia

8.1 BACKGROUND

An international technical working group, comprised of representatives from the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States Agency for International Development (USAID), and other entities, including nongovernmental organisations (NGOs) that implement HIV/AIDS services, has developed common indicators for measuring the quality of HIV/AIDS services provided through the formal health sector. These indicators fall under the following broad categories:

- Capacity to provide basic services for HIV/AIDS
- Capacity to provide advanced services for HIV/AIDS
- Availability of record-keeping systems for monitoring HIV/AIDS care and support
- Capacity to provide services for prevention of mother-to-child transmission (PMTCT) of HIV
- Availability of youth-friendly services (YFS)

The 2010 Kenya Service Provision Assessment (KSPA) measured components of each of these indicators from a sample of health facilities in Kenya.

8.1.1 HIV/AIDS in Kenya

The first case of HIV/AIDS in Kenya was reported in 1984. During the period 1984-1999, the National AIDS and STI Control Programme (NASCOP) coordinated the country's response through the HIV/AIDS Health Sector Response to HIV and AIDS. However, the health sector response alone proved insufficient, as the impact of the epidemic grew in terms of both loss of human life and adverse economic developments.

In 1997 the government of Kenya established new policy guidelines when the Parliament passed the policy blueprint, Sessional Paper No. 4 'AIDS in Kenya', recommending a multi-sectoral approach to HIV programming. Two years later, in 1999, HIV/AIDS was declared a national disaster. The National AIDS Control Council (NACC) was established to provide leadership and to coordinate a multi-sectoral national response to the epidemic. The NACC, in collaboration with stakeholders, has since developed and implemented three strategic plans, including the current Kenya AIDS Strategic Plan III (KNASP III 2009/10–2012/13). The current plan's main goals are to reduce the spread of HIV, to improve the quality of life of those infected and those affected, and to mitigate the socioeconomic impact of the epidemic. The plan is also meant to address emerging changes in the spread of HIV and AIDS as indicated by the Modes of Transmission Study in 2008 and the Kenya AIDS Indicator Survey (KAIS) of 2007.

Kenya is experiencing a mixed and geographically heterogeneous HIV epidemic, with characteristics of both a generalised epidemic among the mainstream population and a concentrated epidemic among specific groups (sex workers, men who have sex with men, and injecting drug users). Results from the 2008-09 Kenya Demographic and Health Survey (KDHS) and the 2007 Kenya AIDS Indicator Survey (2007 KAIS) indicate that HIV prevalence has steadily declined from 14 percent in

the 1990s to 6.3 percent among those ages 15-49 and 7.1 percent among the age group 15-64. Prevalence is higher among women than men (8.0 percent and 4.3 percent) (2008-09 KDHS). A significant revelation from 2008-09 KDHS was that younger women (ages 15-19 and 20-24) are three to four times more likely to be infected than men of the same age group. There is wide regional variation in prevalence among adults—for example, 13.9 percent in Nyanza province versus 0.9 percent in North Eastern province. Urban prevalence is still higher, at 7.2 percent, than in rural areas, at 6 percent. This difference applies to both sexes, although the urban-rural difference is much larger for women than for men.

According to the Kenya national HIV and AIDS spectrum modelling of 2009, it is estimated that a cumulative total of 1.4 million people are HIV-infected. The incidence is projected to rise, with an estimated 113,000 new infections per year. The epidemic has resulted in high levels of morbidity and mortality with an estimated 80,000 deaths annually. It has disproportionately affected men and women in the prime of their lives. The epidemic also has imposed a burden on the limited resources of the country and has had major social consequences due to the deaths of adults and the resulting massive numbers of orphans and vulnerable children—2.4 million.

The 2008-09 KDHS indicates significant improvement in prevention of HIV and AIDS. The data show that about 40 percent of males and 57 percent of females have been tested for HIV at some point. In 2009 approximately 72 percent (58,591) of pregnant HIV-infected women received antiretroviral (ARV) prophylaxis to reduce the risk of MTCT, while 45% of infants born to HIV-infected mothers received ARV for PMTCT. Further, programme statistics indicates that, overall, 380,000 adults are receiving ARV therapy (NASCOP 2009).

8.2 DEFINITION OF HIV/AIDS INDICATORS

The 2010 KSPA assessed the following HIV/AIDS-related services:

HIV Testing System[1]**:** The KSPA defines a facility as having an HIV testing system if clients are offered an HIV test conducted within the facility or in an affiliated laboratory, or the facility has a system for referring clients to an external testing site and receives test results back from that external site to follow up with clients after testing. A facility that simply refers clients elsewhere, expecting the other location to counsel and follow up on test results, is not defined as having an HIV testing system or offering HIV counselling and testing.

HIV Care and Support Services (CSS): Care and support services include any services that are directed towards improving the life of an HIV-positive person. These most often include treatment for opportunistic infections and illnesses that are commonly associated with or worsened by HIV infection, such as tuberculosis (TB), sexually transmitted infections (STIs), and malaria. Care and support services also may include palliative care and socioeconomic and psychological support services.

Antiretroviral therapy (ART): This refers to providing antiretroviral (ARV) medicines to treat HIV-positive persons and AIDS patients.

Post-exposure prophylaxis (PEP): This refers to providing prophylactic ARV drugs to persons who have been exposed to HIV.

Prevention of mother-to-child transmission (PMTCT): A facility is defined as offering PMTCT services if it offers any activities related to the prevention of mother-to-child transmission of HIV in pregnant or recently delivered women. The four components of PMTCT assessed include HIV testing for pregnant women, counselling on infant feeding practices (including counselling about

[1] This definition assumes that the facility counsels clients before and after the HIV testing on the prevention of HIV, the meaning of the test, transmission of the virus, living with HIV/AIDS, care and support, and other aspects of the condition.

exclusive breastfeeding), family planning counselling and/or referral, and provision of prophylactic ARV drugs to HIV-positive women and their newborn babies. PMTCT *plus* (ART+) refers to the provision of care and treatment, including ART as appropriate, to all HIV-positive women and HIV-infected members of their families.

Youth-friendly services (YFS) pertaining to HIV counselling and testing: This refers to specific programmatic strategies to encourage adolescents to utilise HIV services, particularly HIV counselling and testing services.

8.3 BASIC SERVICES FOR HIV/AIDS

8.3.1 Counselling and Testing

Generally accepted definitions for HIV counselling and testing services include the following key elements:

- Counselling must take place before testing. The counsellor must ascertain that the client is taking the test voluntarily and understands that he/she can interrupt or stop the process at any point.
- The counsellor shall ascertain that the client's mental state is sound and that he/she is not under the influence of any substance or undue pressure from any source. In case of doubt, the counsellor should consult or refer the client to senior colleagues.
- Where HIV testing involves a person who is unable to provide consent, a close relative or next of kin shall be given information and asked to provide consent.
- The client must receive an assurance that test results are confidential and that no one will be told the results without his/her consent.
- Both HIV-positive and HIV-negative clients must receive post-test counselling on preventive measures as well as treatment and follow-up as appropriate.
- Same-day test results are encouraged.

Counselling and testing services may be provided in a special counselling and testing unit. However, counselling and testing may also be provided in almost any setting, wherever a client or provider determines that the service is necessary. Therefore, information was gathered from different types of health facilities, namely hospitals, health centres, maternity facilities, clinics, dispensaries, and stand-alone VCT facilities. In these facilities information pertaining to counselling and testing was collected from the primary location where these services are offered.

Several elements have been defined as important for supporting the quality of counselling and testing services. For example, service sites must have guidelines and protocols and appropriate record-keeping systems to ensure that all key elements of counselling and testing are covered. Table 8.1 presents information on the availability of an HIV testing system in Kenyan health facilities. Table 8.1 also presents information on the availability of support systems for quality HIV counselling and testing, such as informed consent documents and record-keeping systems at HIV counselling and testing sites.

Table 8.1 System for testing and for providing results of HIV test

Percentage of facilities reporting an HIV testing system and, among these, percentage conducting HIV test in facility or at external site and percentage with policies and records in any relevant site, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities reporting an HIV testing system[1]	Number of facilities	Percentage of facilities with indicated items							Number of facilities reporting an HIV testing system
			HIV test available in facility or affiliated lab[2]	HIV test available in external testing site, records observed[3]	HIV rapid testing reported in facility	Informed consent policy for HIV testing[4]	Register with HIV test results	Record of clients receiving HIV test results[5]	All items for testing indicator[6]	
Type of facility										
Hospital	99	51	89	1	10	71	96	96	71	50
Health centre	95	80	76	0	24	64	99	99	64	76
Maternity	89	17	75	0	25	37	96	96	37	15
Clinic	55	203	65	0	35	28	87	87	27	111
Dispensary	75	340	39	0	60	45	97	96	44	257
Stand-alone VCT	100	5	100	0	0	93	95	95	88	5
Managing authority										
Government	79	345	46	0	54	54	99	98	53	272
NGO	96	24	41	0	59	48	95	95	47	23
Private (for profit)	58	237	66	0	34	27	87	87	26	138
Faith-based organisation	91	89	81	1	18	57	97	95	57	81
Province										
Nairobi	80	45	55	3	42	66	94	94	63	36
Central	66	125	59	0	41	46	100	100	46	82
Coast	82	81	73	0	27	23	82	78	23	66
Eastern	87	118	43	0	57	44	98	98	44	103
North Eastern	42	24	37	0	63	51	56	56	27	10
Nyanza	85	83	59	0	41	71	98	98	70	70
Rift Valley	61	175	63	0	37	34	98	98	34	106
Western	90	44	44	0	53	68	100	100	68	40
Total	74	695	57	0	43	47	95	95	46	514

[1] Facility reports conducting the test in the facility or in an affiliated external laboratory, or has an agreement with a testing site that is expected to return test results to the facility.
[2] HIV testing is confirmed in facility or in affiliated laboratory.
[3] HIV testing not available in facility, but there are observed records of testing conducted outside the facility, with test results.
[4] Having either the national guidelines for voluntary HIV counselling and testing or other HIV counselling and testing guidelines counts as having an informed consent policy for HIV testing. Availability of an informed consent document for the client to sign or keep, or any other informed consent document also counts as having an informed consent policy.
[5] If rapid test is done, record with client identifier and results is sufficient.
[6] HIV test available or records showing test results are received by facility, informed consent policy in any relevant service site, observed register with HIV test results, and observed register for clients receiving HIV test results.

Testing systems

Overall, three-quarters of all facilities report having an HIV testing system (Table 8.1), compared with 37 percent in 2004. Clinics (55 percent) and private facilities (58 percent) are among the least likely to report an HIV testing system.

Among the facilities that report having an HIV testing system, close to six of every ten have testing available and verifiable either in the facility or in an affiliated laboratory. As expected, all free-standing VCT facilities have testing either in the facility or in an affiliated laboratory. Also, nine of every ten hospitals and three of every four health centres and maternity facilities have testing available in the facility or in affiliated laboratory. Dispensaries are the least likely to have verifiable testing in facility or in an affiliated laboratory. Facilities managed by faith-based organisations (FBOs) and facilities in Coast province are more likely to have verifiable testing systems than facilities managed by other authorities or those in other provinces, respectively.

Informed consent policy and registers of test results

Among facilities reporting an HIV testing system, nearly half have an informed consent policy for HIV testing available[2] (Table 8.1), similar to the 50 percent of facilities in 2004. Stand-alone VCT facilities (93 percent) are more likely than other facility types to have informed consent

[2] Having either the national guidelines for voluntary HIV counselling and testing or other HIV counselling and testing guidelines counts as having an informed consent policy for HIV testing. Availability of an informed consent document for the client to sign or keep, or any other informed consent document also counts as having an informed consent policy.

policy documents available. Government (54 percent) and FBO-managed (57 percent) facilities, as well as facilities in Nyanza province (71 percent), are more likely than others to have informed consent policy documents.

Records of HIV test results are widely available (Table 8.1). Ninety-five percent of facilities that reported having a HIV testing system have a register for HIV test results available, compared with 77 percent in 2004. The same percentages of facilities that have registers of test results have records of providing clients with test results.

Additional information

Additional information on items to support provision of HIV testing services is available in Table A-8.1. For example, 90 percent of facilities with an HIV testing system have at least one counsellor trained in pre- and post-test counselling assigned to an HIV testing site (compared with 96 percent in 2004). Clinics and dispensaries are less likely than other facility types to have a trained counsellor assigned.

Eighty-eight percent of facilities with an HIV testing system offer visual and auditory privacy at the service site (compared with 76 percent in 2004), including all stand-alone VCT facilities and about nine of every ten hospitals, health centres, and dispensaries.

Key Findings

Testing systems: HIV testing systems are reported available in 74 percent of facilities, compared with less than four of every ten facilities in 2004. Testing is available either in the facility or in an affiliated laboratory in nearly six of every ten of these facilities. Dispensaries are least likely to have testing available either in the facility or affiliated laboratory.

Register with HIV test results: Ninety-five percent of facilities that report having an HIV testing system have registers for HIV test results available, compared with three-quarters of facilities in 2004.

Privacy: Most facilities that have HIV testing services are able to assure both visual and auditory privacy.

8.3.2 HIV/AIDS Care and Support Services

As a result of their suppressed immune systems, people living with HIV/AIDS are at higher risk of developing opportunistic infections such as TB. Also, if they contract malaria, people living with HIV are likely to experience more severe forms of the disease because of their weakened immune systems.

A facility is defined as providing HIV/AIDS care and support services if providers working in that facility provide treatment for any opportunistic infections or for symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis, or Kaposi sarcoma), or they provide (or prescribe) palliative care for patients (such as symptom or pain management or nursing care for the terminally ill), or they provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or they provide care for paediatric HIV/AIDS patients.

One of the important HIV/AIDS care and support strategies is the immediate treatment of opportunistic infections among HIV/AIDS clients. Facilities that offer care and support services for HIV/AIDS clients should also be able to offer services for TB, STIs, and malaria. The 2010 KSPA assessed the availability of several services among a subset of facilities that offer care and support services (CSS) for HIV/AIDS patients.

Table 8.2 presents information on the availability of HIV/AIDS care and support services. Table 8.3 shows summary information on the availability of specific basic clinical care and support services for HIV/AIDS among all facilities.

Table 8.2 Availability and documentation of HIV/AIDS care and support services

Percentage of facilities offering HIV/AIDS care and support services (CSS)[1] and, among these, percentage with the indicated record-keeping systems, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering HIV/AIDS care and support services	Number of facilities	Percentage of facilities offering HIV/AIDS care and support that have:		Number of facilities offering HIV/AIDS CSS
			Register with HIV/AIDS-related client diagnosis observed in any eligible service site	Record system for individual client appointments observed in any relevant outpatient programme site	
Type of facility					
Hospital	96	51	83	83	49
Health centre	86	80	79	66	68
Maternity	73	17	64	20	12
Clinic	49	203	32	16	99
Dispensary	63	340	64	23	214
Managing authority					
Government	71	344	70	42	243
NGO	79	22	92	40	17
Private (for profit)	49	236	31	11	116
Faith-based organisation	75	88	74	46	66
Province					
Nairobi	67	41	62	53	28
Central	39	125	51	20	49
Coast	74	81	48	38	60
Eastern	76	118	66	38	89
North Eastern	62	24	64	19	15
Nyanza	95	82	77	47	78
Rift Valley	53	174	50	18	92
Western	69	44	84	50	30
Total	64	690	61	35	442

[1] Providers assigned to this facility provide treatment for any opportunistic infections or symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis, or Kaposi sarcoma), or provide (or prescribe) palliative care for patients (such as symptom or pain management or nursing care for the terminally ill), or provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or provide care for paediatric HIV/AIDS patients.

Basic clinical care and support services for HIV/AIDS

Approximately two-thirds (64 percent) of facilities offer HIV/AIDS care and support services (CSS) (Table 8.2), compared with 68 percent in 2004. Hospitals (96 percent), health centres (86 percent) and maternity facilities (73 percent) are more likely to offer HIV/AIDS care and support services than dispensaries (63 percent) and clinics (49 percent). Private facilities (49 percent) are less likely than facilities managed by other authorities to offer HIV/AIDS care and support services. At the provincial level, at least six of every ten facilities in Nairobi, Coast, Eastern, North Eastern, Nyanza, and Western provinces offer the services, while less than half of facilities in Central province and about half in Rift Valley province do so.

Six of every ten facilities that offer HIV/AIDS care and support services have a register with HIV/AIDS-related client diagnosis observed in any eligible service site, with hospitals (83 percent) and health centres (79 percent) being more likely to have registers than other facility types. NGO facilities (92 percent) as well as government (70 percent) and FBO-managed (74 percent) facilities are more likely than private facilities (31 percent) to have a register. At least half of the facilities in each of the provinces have a client register with HIV/AIDS-related client diagnosis observed.

Records for individual client appointments are uncommon, although varying by type of facility, managing authority, and province. Overall, 35 percent of facilities that offer HIV/AIDS care

and support services have a record system for individual client appointments. Hospitals and health centres offering HIV/AIDS care and support services are more likely to have records for individual client appointments than other facility types. Privately run facilities are less likely than those managed by other authorities to have such records. At the provincial level, it is only in Nairobi, Nyanza, and Western provinces that about half of facilities offering HIV/AIDS care and support services have a record system for individual client appointments.

Table 8.3 Availability of HIV testing systems and basic medical care and support services for HIV/AIDS

Percentage of facilities that report an HIV testing system and offer treatment for various illnesses, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with:							Number of facilities
	Reported HIV testing system[1]	TB treatment and/or follow-up	Treatment of STIs	Treatment of malaria	Preventive treatment for TB with INH[2]	Primary preventive treatment for opportunistic infections such as CPT[3]	All services	
Type of facility								
Hospital	98	90	99	100	32	92	32	51
Health centre	95	81	100	100	23	91	23	80
Maternity	89	21	98	98	4	70	3	17
Clinic	55	11	94	97	5	32	1	203
Dispensary	75	35	99	99	7	52	6	340
Stand-alone VCT	100	7	19	15	2	20	2	5
Managing authority								
Government	79	53	98	99	11	65	10	345
NGO	96	44	85	90	1	65	1	24
Private (for profit)	58	9	95	98	4	33	1	237
Faith-based organisation	91	45	99	99	20	62	20	89
Province								
Nairobi	80	42	85	87	14	57	14	45
Central	66	24	100	100	2	43	2	125
Coast	82	45	95	96	4	50	0	81
Eastern	87	42	100	100	26	53	21	118
North Eastern	42	22	94	97	3	28	2	24
Nyanza	85	58	97	100	10	79	10	83
Rift Valley	61	23	97	99	6	53	5	175
Western	90	61	98	98	12	58	12	44
Total	74	37	97	98	10	54	8	695

[1] Facility reports conducting the test in the facility or in an affiliated external laboratory, or has an agreement with a testing site that is expected to return test results to the facility.
[2] This is the provision of isoniazid, either routinely to all HIV/AIDS clients regardless of their clinical condition or only selectively or sometimes to HIV/AIDS clients depending on their clinical condition.
[3] This refers to primary preventive treatment, such as cotrimoxazole preventive treatment (CPT), either routinely to all HIV/AIDS clients regardless of their clinical condition or only selectively or sometimes to HIV/AIDS clients depending on their clinical condition.

Malaria services among facilities offering HIV/AIDS care and support services

Even though the causes of malaria are not directly associated with HIV/AIDS, the World Health Organization's global Roll Back Malaria (RBM) initiative promotes the integration of malaria and HIV services to reduce morbidity and mortality associated with this dual infection.

As Table 8.3 shows, with the exception of stand-alone VCT facilities, nearly all facilities offer malaria treatment services. As further shown in Table A-8.5 (which excludes stand-alone VCT facilities), all facilities that offer HIV/AIDS care and support services offer malaria treatment services.

Malaria laboratory diagnostic capacity is not universally available, however. Fifty-three percent of facilities that offer HIV/AIDS care and support services have laboratory diagnostic capacity for malaria (Table A-8.5). Hospitals (93 percent), health centres (78 percent), and maternity facilities (81 percent) are more likely than clinics (52 percent) or dispensaries (35 percent) to have

laboratory diagnostic capacity for malaria. Nearly all FBO-managed facilities (96 percent) and about half of the private facilities have diagnostic capacity.

Among facilities offering HIV/AIDS CSS and also malaria treatment, two-thirds had malaria treatment guidelines available in any relevant malaria service site. Coartem, the recommended first-line treatment for malaria, was available in the great majority (84 percent) of the facilities.

Services for sexually transmitted infections among facilities offering HIV/AIDS care and support services

Available information suggests that sexually transmitted infections, particularly of the ulcerative type, increase the risk of contracting HIV/AIDS. Thus, screening, diagnosis, and treatment for STIs are basic services that must be provided to all at-risk clients.

Generally accepted standards for quality STI services include—

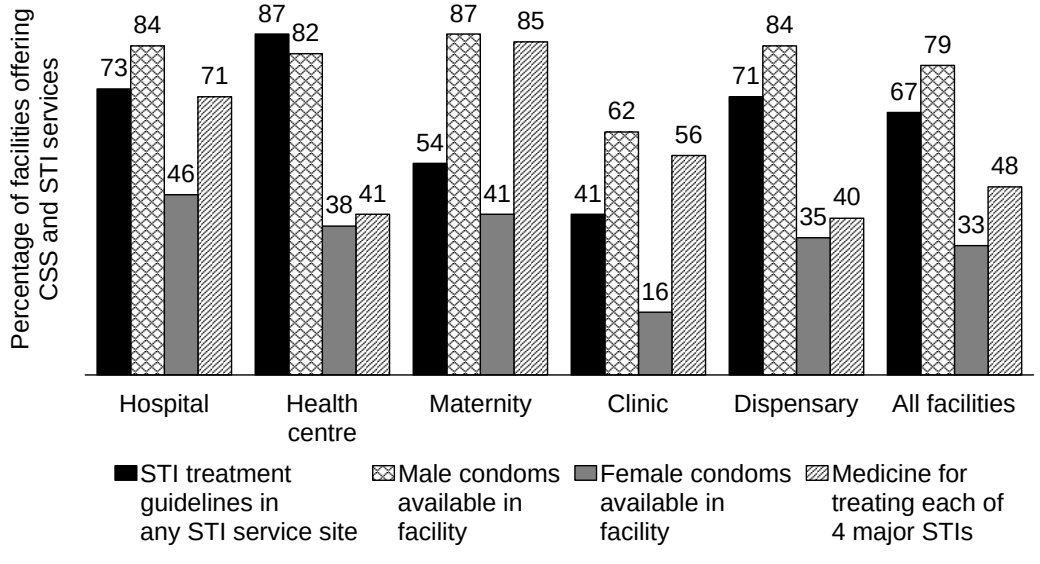
- Availability of diagnostic and treatment guidelines in all STI service sites
- Provision of appropriate treatment before the client leaves the facility

In addition, laboratory diagnosis is important, as it may be the only way to confirm the presence or absence of a sexually transmitted infection. International experts advocate that all newly diagnosed HIV/AIDS clients be screened for STIs, particularly syphilis.

Ninety-seven percent of all facilities offer STI treatment services (Table 8.3), and nearly all (99 percent) facilities that offer HIV/AIDS care and support services also offer STI treatment services (Table A-8.6).

STI treatment guidelines are not widely available at STI service sites. According to survey findings, two-thirds of facilities offering HIV/AIDS care and support services as well as STI services had STI treatment guidelines or protocols available at any STI service site on the day of the survey. Clinics, maternity facilities, and private facilities are least likely to have treatment guidelines available (Table A-8.6 and Figure 8.1).

Figure 8.1 Availability of Items in Facilities Offering HIV/AIDS Care and Support Services (CSS) and STI Services (N=436)



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Medicines for treating common STIs also are not widely available. Just about half (48 percent) of facilities offering CSS had at least one medicine for treating each of the four common STIs—syphilis, gonorrhoea, chlamydia, and trichomoniasis (Table A-8.6 and Figure 8.1), compared with 71 percent in 2004. Dispensaries (40 percent) and health centres (41 percent) are less likely than other facility types to have medicines available. Also, government (31 percent) and NGO-managed facilities (22 percent) are less likely to have medicines available than facilities managed by other authorities.

Nearly eight of every ten of these facilities (79 percent) had male condoms available either at the service site or in the pharmacy on the day of the survey, compared with 73 percent of facilities in 2004. Female condoms were less widely available; only one-third of facilities had them anywhere in the facility.

Primary preventive treatment of opportunistic infections

Results of cotrimoxazole trials conducted in Côte d'Ivoire, Malawi, South Africa, and Uganda show reductions in mortality of 25-46 percent with cotrimoxazole therapy and reduction of morbidity even in areas with high bacterial resistance (Mulenga, V, Ford, D. et. al, 2007). Cotrimoxazole preventive therapy (CPT) is now an integral component of the HIV/AIDS care and support package in Kenya.

Generally accepted standards for rolling out cotrimoxazole prophylaxis programmes include:

- Availability of protocols and guidelines for cotrimoxazole prophylaxis
- Availability of medicines (cotrimoxazole) in the health facilities
- Capacity in the form of training for health workers involved in CPT programmes

A little over half of all facilities offer primary preventive treatment (such as cotrimoxazole preventive therapy) for opportunistic infections (Table 8.3). Nine of every ten hospitals and health centres offer primary preventive treatment services. Additional information in Table A-8.9 shows that, among facilities offering HIV/AIDS care and support services, 70 percent routinely offer primary preventive treatment to HIV/AIDS clients. Private facilities are less likely to routinely offer primary preventive treatment than facilities managed by other authorities.

Among the facilities offering HIV/AIDS care and support services and reporting that they offer primary preventive treatment, 75 percent had cotrimoxazole available on the day of the survey, while 21 percent had cotrimoxazole preventive therapy guidelines or protocols available (Table A-8.9). About one in every four of these facilities had at least one provider of cotrimoxazole preventive therapy trained during the three years preceding the survey.

HIV/AIDS and tuberculosis collaboration

Tuberculosis is the most common opportunistic infection associated with HIV/AIDS, and it is among the leading causes of morbidity and mortality among people infected with HIV. It is estimated that, worldwide, more than 21 million people are co-infected with HIV and TB. People who are HIV-positive and infected with TB are up to 50 times more likely to develop active TB in a given year than people who are HIV-negative (WHO, 2007). Therefore, TB diagnosis and treatment is an important component of care for people living with HIV/AIDS.

To improve compliance with full treatment and avoid the proliferation of drug-resistant strains of TB, WHO advocates the Directly Observed Therapy, Short course (DOTS) strategy for TB treatment.

Generally accepted standards for good quality TB services include the following key elements:

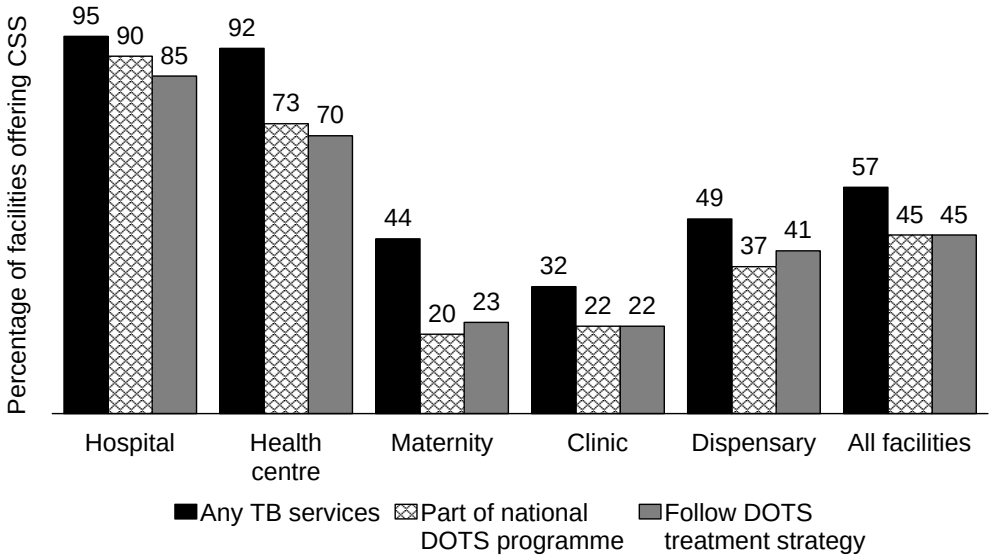
- Diagnosis based on sputum smear, with back-up or confirmation using X-rays
- Records that indicate newly identified cases, monitor the course of treatment, and monitor client adherence to the treatment protocol
- Standard guidelines and protocols for the TB diagnostic and treatment regimes
- A continuous supply of the TB treatment regime for each patient

TB screening is an important part of assessment of HIV-positive clients. Indeed, it is a component of WHO clinical staging for HIV/AIDS. This service has recently received increasing attention in HIV programmes (TB/HIV integration). As shown in Table 8.3, 37 percent of all facilities (including stand-alone VCT facilities) offer TB treatment and/or follow-up services. Stand-alone VCT facilities (7 percent), clinics (11 percent), and maternity facilities (21 percent) are among the least likely to offer TB treatment and/or follow-up facilities.

DOTS among facilities offering HIV/AIDS CSS

Table A-8.2 and Figure 8.2 show the availability of TB services, including treatment following the DOTS strategy, among facilities offering HIV/AIDS care and support services. Overall, 57 percent of these facilities offer TB diagnostic or treatment services, while 45 percent follow the DOTS treatment strategy. Hospitals (85 percent) and health centres (70 percent) are more likely than other facility types to follow the DOTS treatment strategy, whereas private facilities are less likely than facilities managed by other authorities to follow the DOTS strategy. At the provincial level, facilities in Western province (74 percent) are most likely to follow the DOTS strategy, in contrast with, for example, only two of every ten facilities in Rift Valley province.

Figure 8.2 TB Services in Facilities Offering HIV/AIDS Care and Support Services (CSS) (N=442)



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Facilities offering HIV/AIDS care and support systems and also following the DOTS treatment strategy were assessed for availability of DOTS client registers, TB treatment guidelines, and first-line TB medicines. Eighty-four percent of such facilities had all first-line TB medicines available on the day of the survey. Maternity facilities (68 percent) and clinics (69 percent) were less likely to have all first-line TB medicines than other facility types (Table A-8.2).

Additional information, in Table A-8.3, shows that half of facilities offering HIV/AIDS care and support services offer TB treatment services. Among these facilities nine of every ten follow the DOTS strategy. Three-quarters have TB treatment guidelines or protocols available at any service site, while almost nine of every ten have observed TB registers. Eighty-four percent had all first-line TB medicines available. The availability of all first-line TB medicines was highest in North Eastern (100 percent) and Central (96 percent) provinces and lowest in Coast (71 percent) province. Additional information on TB diagnosis is available in Table A-8.4.

The 2010 KSPA collected information on management practices that support the provision of TB, malaria, and STI services among the facilities that provide HIV/AIDS care and support services. These practices include training and supervision of providers of these services. Eighty-three percent of facilities offering HIV/AIDS care and support services meet the criteria for having routine training for providers of TB, malaria, and STI services (Table A-8.7). The differences by facility type and managing authority are minor; however, clinics (71 percent) and private facilities (72 percent) are less likely than others to meet these criteria. Supervision of providers is equally common.

Isoniazid treatment for prevention of tuberculosis in HIV/AIDS clients

Information on isoniazid given to HIV/AIDS clients to prevent TB is presented in Tables 8.3 and A-8.8. Only 10 percent of all facilities (excluding stand-alone VCT facilities) offer isoniazid preventive treatment to HIV/AIDS clients. Similarly, among facilities that offer HIV/AIDS care and support services, 10 percent routinely offer isoniazid preventive treatment to HIV/AIDS clients (Table A-8.8). Hospitals and health centres are more likely than other facility types to offer the service. Five percent of all facilities offer the service selectively, while another 5 percent routinely refer clients elsewhere for the service.

Key Findings

HIV/AIDS care and support services: Nearly two-thirds of facilities offer HIV/AIDS care and support services, with hospitals, health centres, and maternity facilities more likely to offer the service than dispensaries or clinics.

Sexually transmitted infections: Nearly all facilities that offer HIV/AIDS care and support services also offer STI treatment services.

Primary preventive treatment: A little over half of all facilities that offer HIV/AIDS care and support services also offer primary preventive treatment for opportunistic infections (such as cotrimoxazole preventive therapy).

8.4 Advanced Services for HIV/AIDS

Persons in an advanced stage of HIV/AIDS are usually seriously ill and require a more advanced level of treatment and follow-up than is available at many health facilities. Hospitals should, therefore, be fully capable of providing all of the advanced care and support services needed for monitoring and treating HIV/AIDS clients. As HIV/AIDS services expand, however, it is expected that many of these services will become available in lower level facilities as well. Current programmes are focused on increasing staff training, developing protocols and guidelines, ensuring that laboratory and medical equipment is adequate, and implementing record-keeping for HIV/AIDS services.

The activities and services assessed for advanced care and support include:

- Laboratory diagnostic capacity and the availability of medications for treating opportunistic infections

- Availability of services or a formal referral system for psychosocial and socioeconomic care and support services
- Antiretroviral therapy (ART)
- Post-exposure prophylaxis (PEP)

8.4.1 Advanced Treatment of Opportunistic Infections and Palliative Care for HIV/AIDS

For the purpose of this survey, a facility must meet the following requirements to be classified as having advanced treatment capacity:

- At least one medicine (or in some cases, two medicines) is available for the treatment of an indicated condition
- Treatment guidelines or protocols for common opportunistic infections are available in each service area
- At least one trained provider for an indicated service is available in the facility
- Laboratory diagnostic capacity exists for common HIV/AIDS-related illnesses

Training of health service providers to support comprehensive HIV/AIDS services

As part of the 2010 KSPA, providers were interviewed and asked questions pertaining to training that they had received as part of their jobs in the facilities where they work. The most common topics of training were psychosocial counselling and treatment of opportunistic infections. Information is presented in Table A-8.10.

Sixty-two percent of facilities that offer HIV/AIDS CSS had at least one provider trained in psychosocial counselling, and 46 percent had at least one provider trained in treatment of opportunistic infections. Dispensaries and clinics are less likely than the other facility types to have at least one provider trained for either psychosocial counselling or treatment of opportunistic infections. The proportions of health facilities with at least one provider trained in palliative care (13 percent), HIV/AIDS-related neurological disorders (13 percent), AIDS in children (31 percent), and nutritional rehabilitation (25 percent) are small compared with psychosocial counselling and treatment of opportunistic infections.

Staff supervision is more widely available. Overall, 75 percent of facilities met the criteria of having supervised staff available.[3]

Guidelines

The 2010 KSPA also assessed facilities for availability of specific service guidelines. Generally, service guidelines are not widely available. Only one of every five facilities that offer HIV/AIDS care and support services had guidelines for the treatment of opportunistic infections available on the day of the survey (Table A-8.11). Guidelines for the clinical management of HIV/AIDS in children were available in about three in every ten facilities, while guidelines for the clinical management of HIV/AIDS in adults were available in one-quarter of facilities. In most instances, hospitals and health centres were more likely than the other facility types to have had these guidelines available on the day of the survey.

[3] A facility is considered to have routine staff supervision if at least half of the interviewed providers of care and support services reported receiving personal supervision during the three months preceding the survey.

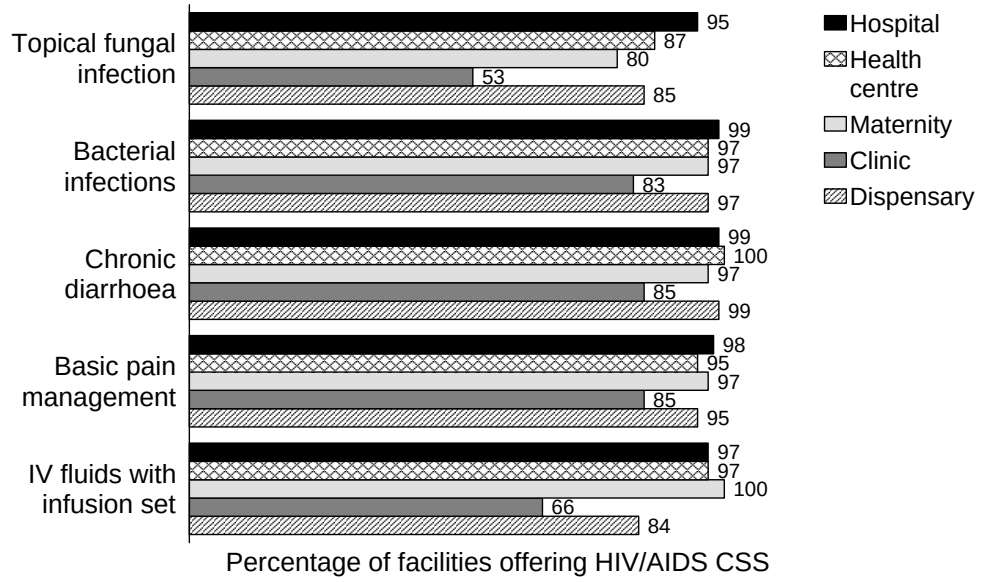
Treatment of opportunistic infections

Among facilities that offer HIV/AIDS care and support services, 17 percent report that they provide systemic intravenous treatment for specific fungal infections (e.g., cryptococcal). This includes seven of every ten hospitals and over half of maternity facilities (Table A-8.12).

Treatment for Kaposi sarcoma is available in only 10 percent of facilities that offer HIV/AIDS care and support services, mostly in hospitals (41 percent). Palliative care (symptom or pain management, or nursing care for the terminally ill) is available in two of every ten facilities, with hospitals (59 percent) and maternity facilities (44 percent) more likely than other facility types to offer the service. Psychosocial support services are widely available (in 95 percent of facilities offering HIV/AIDS care and support services).

Facilities also were assessed for the availability of medicines to manage several opportunistic infections and conditions. About eight of every ten facilities had at least one medicine to treat topical fungal infections, with clinics and private facilities less likely than other facility types to have the medicines (Table A-8.13, Figure 8.3). The majority of facilities also had at least one medicine to treat bacterial infections (94 percent of facilities), to manage chronic diarrhoea (96 percent), to control pain (93 percent), and to treat worm infestations (88 percent), as well as intravenous fluid with infusion set for rehydration (84 percent) and oral rehydration salts (89 percent). Clinics are less likely than other facility types to have these medicines.

Figure 8.3 **Availability of Medicines to Treat Common HIV/AIDS-related Conditions in Facilities Offering Care and Support Services (CSS) (N=442)**



KSPA 2010

Vitamin supplements are not widely available. Overall, only 22 percent of facilities have them available. Vitamin supplements were most available in maternity facilities (50 percent). Facilities in Nairobi (68 percent) are more likely to have vitamin supplements than those in other provinces.

Further information is presented in Table A-8.14 on the availability of additional medicines to manage or treat common opportunistic infections.

Laboratory capacity for monitoring HIV/AIDS clients

Laboratory capacity for monitoring HIV/AIDS clients is uncommon across all facility types (Table A-8.15). Only 38 percent of HIV/AIDS care and support facilities have the capacity to test for haemoglobin or haematocrit. This includes 83 percent of hospitals, 63 percent of health centres and 74 percent of maternity facilities, but only 31 percent of clinics and 21 percent of dispensaries. Liver function tests, BUN and serum creatinine testing capacity are most likely to be available in hospitals and in Nairobi, Coast, and Central provinces.

Key Findings

Trained staff: Availability of trained staff varies depending on training topic. On one hand, six of every ten facilities have at least one provider trained in psychosocial counselling and about half had a provider trained to treat opportunistic infections. On the other hand, only small proportions had providers trained in palliative care, AIDS in children, and other related topics.

Service guidelines: Generally, guidelines are not widely available.

Treatment of opportunistic infections: Treatment of opportunistic infections, including systemic IV treatment for fungal infections and Kaposi sarcoma, is available mostly in hospitals.

Laboratory capacity for monitoring HIV/AIDS clients: Laboratory capacity for monitoring HIV/AIDS clients is uncommon across all facility types.

8.4.2 Antiretroviral Therapy

The Ministry of Medical Services, together with partners, has embarked on a rapid scale-up of ART programmes in Kenya. The national ART programme guidelines call for the prescription and provision of ART by trained health personnel, who should regularly monitor the condition of these clients to ensure that an effective ARV regime is being implemented and that side effects are properly managed.

Elements identified as important for providing good quality ART services include the following:

- Staff trained in the provision of relevant services
- Protocols and guidelines for relevant care and support services
- A consistent supply of ARVs and good storage practices to maintain their quality and security
- A system for making client appointments for routine follow-up services
- An individual client record to assure continuity of care for the client
- Good record-keeping systems to track ART compliance

Antiretroviral drugs inhibit the replication of HIV and thus can significantly prolong and improve the quality of life of HIV-positive people. It is estimated that about 380,000 adults and 35,000 children in Kenya are currently on ART, according to a 2009 NASCOP report. This represents just about half the number of HIV-positive clients who are eligible for ART per the 2010 WHO guidelines on ART eligibility (of CD4 count of 350 and below).

Service availability

Overall, 17 percent of facilities (excluding stand-alone VCT facilities) prescribe ART and/or provide ART medical follow-up services (Table 8.4). These services are available mostly in hospitals (80 percent) and health centres (52 percent), in contrast with clinics (6 percent) and dispensaries (5 percent).

NGO-managed facilities (43 percent) are more likely than government (23 percent), FBO-managed (20 percent), and private (3 percent) facilities to offer ART services. At the provincial level, facilities in Nyanza (31 percent) and Nairobi (34 percent) provinces are more likely than facilities in other provinces to offer ART services.

ART guidelines

The national ART guidelines were available in six of every ten facilities that prescribe ART and/or provide ART medical follow-up services (Table 8.4). Other guidelines (such as guidelines for management of HIV/AIDS for workplace programmes and guidelines for the clinical management of HIV/AIDS infection in adults and in children) were available in 75 percent of these facilities.

Table 8.4 Laboratory system and items to support antiretroviral combination therapy services

Percentage of facilities offering antiretroviral therapy (ART) and, among these, percentage with indicated programme components, by background characteristics, Kenya SPA 2010

	Percentage of facilities that:						Percentage of facilities prescribing ART that have:					
Background characteristic	Prescribe ART only	Provide medical follow-up services only	Prescribe ART and provide medical follow-up services	Prescribe ART and/or provide medical follow-up services	Have outreach site for providers from outside facility	Number of facilities	National ART guideline	Other guidelines[1]	Adult first-line ART regimen available[2]	No stock-outs of normally stocked first-line ARVs in 6 months before the survey	Laboratory capacity for monitoring ART[3]	Number of facilities prescribing ART and/or providing medical follow-up services
Type of facility												
Hospital	2	0	74	80	2	51	57	74	99	94	78	40
Health centre	3	0	48	52	7	80	58	81	95	89	56	41
Maternity	2	0	10	11	0	17	82	48	100	100	82	2
Clinic	0	0	6	6	3	203	66	74	74	66	48	12
Dispensary	1	0	5	5	5	340	54	66	100	95	57	19
Managing authority												
Government	1	0	22	23	4	344	59	78	99	94	62	80
NGO	0	5	38	43	11	22	29	75	68	57	21	9
Private (for profit)	0	0	2	3	4	236	49	63	97	89	86	6
Faith-based organisation	1	0	18	20	6	88	71	66	91	85	84	18
Province												
Nairobi	5	3	33	34	9	41	77	87	99	83	49	14
Central	1	0	9	10	0	125	73	78	100	100	90	12
Coast	0	0	22	24	2	81	57	59	83	81	69	19
Eastern	0	0	12	12	2	118	78	81	100	98	72	15
North Eastern	0	0	7	9	0	24	32	68	95	84	32	2
Nyanza	1	0	29	31	24	82	51	83	96	96	60	25
Rift Valley	1	0	9	11	0	174	39	63	100	85	45	19
Western	0	0	17	17	2	44	44	82	90	81	87	8
Total	1	0	15	17	4	690	58	75	95	90	64	114

[1] Other guidelines such as guidelines for management of HIV/AIDS for workplace programmes, guidelines for the clinical management of HIV/AIDS infection in adults and in children, guidelines for home-based care services, or protocol for adherence counselling.
[2] Any of the following combination of ARVs: (1) stavudine, lamivudine, and nevirapine as separate ARVs or as combination drugs; (2) stavudine, lamivudine, and efavirenz; (3) zidovudine, lamivudine, and nevirapine, or else Combivir (AZT/3TC) and nevirapine; (4) zidovudine, lamivudine, and efavirenz, or else Combivir (AZT/3TC) and efavirenz.
[3] Either the laboratory in the facility conducts CD4, viral load, or total lymphocyte count (TLC) tests, or there is a system for sending blood samples for outside testing and receiving results

Antiretroviral medicines

The great majority (95 percent) of facilities that provide ART services had adult first-line ARV medicines available in the facility on the day of the survey (Table 8.4). Clinics (74 percent) and NGO-managed facilities (68 percent) are less likely than the other facility types to have these ARVs. At the provincial level, facilities in the Coast province are the least likely to have the adult first-line ARV medicines.

Stock-outs of ARV medicines are generally not common. Nine of every ten facilities that prescribe ART and/or provide follow-up services said they had not experienced a stock-out of normally stocked ARVs during the six months preceding the survey. Clinics are least likely to report no stock-outs (66 percent reported they did not experience stock-outs, meaning 34 percent did experience stock-outs). NGO-managed facilities are also more likely to report stock-outs during the same period (57 percent said they did not experience stock-outs, meaning 43 percent did).

Laboratory capacity for monitoring ART clients

Sixty-four percent of facilities that prescribe ART services have laboratory capacity for monitoring ART clients.[4] Hospitals (78 percent) and maternity facilities (82 percent) are more likely than health centres (56 percent) and dispensaries (57 percent) to have laboratory capacity for monitoring ART. Clinics (48 percent) are least likely.

Table A-8.18.1 provides additional information on the availability of items to support provision of ART services. For example, 88 percent of facilities that prescribe ART and/or provide ART medical follow-up services had observed recording systems for individual client appointments.

Key Findings

ART service availability: Less than two of every ten facilities either prescribe ART and/or provide ART follow-up services. These are mainly hospitals and health centres. The proportions are generally low; however, facilities in Nyanza and Nairobi provinces are more likely than facilities in other regions to offer ART services.

Guidelines: The national ART guideline and other ART guidelines are available in over half of facilities offering ART services, although there are some variations among the different facility types, managing authorities, and provinces.

Antiretroviral medicines: Nearly all facilities that provide ART services had first-line ARVs available in the facility on the day of the assessment. Clinics and NGO-managed facilities were less likely than others to have ARVs available. Stock-outs of ARVs are not common.

Laboratory capacity for monitoring ART clients: Sixty-four percent of facilities prescribing ART and/or providing ART medical follow-up services have laboratory capacity for monitoring ART clients.

8.4.3 Prevention of Mother-to-Child Transmission (PMTCT) of HIV

In Kenya transmission of HIV from mother to child is the most common way that children acquire HIV. The government of Kenya is promoting a 4-pronged PMTCT strategy that consists of primary prevention of HIV/AIDS; prevention of unintended pregnancies among HIV-positive women; use of a comprehensive treatment package that includes ARV drugs for HIV-positive pregnant women; and provision of comprehensive care to the mother, the newborn, and the family. The services are often offered in conjunction with antenatal and delivery services and may include a variety of interventions. The degree to which a facility offers the total package is often determined by the level of staffing and whether the facility offers either antenatal care or delivery services or both.

The generally accepted package for comprehensive PMTCT includes the following:

- HIV testing with pre- and post-test counselling for pregnant women
- Counselling HIV-positive women on infant feeding practices and family planning

[4] Either the laboratory in the facility conducts CD4 tests, viral load, or total lymphocyte count, or there is a system for sending blood samples for testing outside and receiving results back.

- Providing prophylactic ARV drugs to HIV-positive women during labour and delivery, and to the newborn within 72 hours of birth

- Linkage to long-term care including family planning services

Table 8.5 presents information on the availability of PMTCT services among all facilities, and Table 8.6 presents similar information on PMTCT services among facilities that offer ANC services.

Table 8.5 Availability of services for prevention of mother-to-child transmission of HIV

Percentage of facilities reporting that they offer PMTCT services; among these, percentage with specific PMTCT programme components, percentage with a minimum package of PMTCT services; and, among facilities with the minimum package of PMTCT services, percentage having all items for PMTCT+, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities reporting PMTCT services	Total number of facilities	Percentage of facilities offering any PMTCT services that offer indicated specific PMTCT services						Percent of facilities with a provider of PMTCT trained in the 3 years preceding the survey	Number of facilities offering any PMTCT services	Percentage of facilities offering minimum package of PMTCT and having all items for PMTCT+[2]	Number of facilities offering a minimum package of PMTCT
			Documented HIV testing system	ARV prophylaxis to prevent MTCT	Counselling on maternal nutrition and infant feeding	Family planning counselling or services	All four items for minimum PMTCT package[1]	ARV therapeutic treatment for HIV-infected women and families				
Type of facility												
Hospital	88	51	91	81	97	97	72	72	98	44	78	32
Health centre	92	80	74	83	96	92	57	48	92	74	50	42
Maternity	70	17	69	49	100	100	32	8	77	12	9	4
Clinic	24	203	67	33	91	98	26	20	71	48	29	12
Dispensary	66	340	34	62	93	99	19	11	66	223	32	43
Managing authority												
Government	74	344	44	72	94	99	34	30	76	254	59	87
NGO	71	22	38	82	96	100	31	30	96	15	97	5
Private (for profit)	27	236	60	38	92	100	22	6	70	63	16	14
Faith-based organisation	78	88	82	54	94	86	40	27	72	69	22	27
Province												
Nairobi	52	41	53	50	87	85	16	57	95	22	27	4
Central	46	125	58	51	91	96	30	20	62	57	53	17
Coast	47	81	77	55	100	100	41	43	80	38	55	15
Eastern	56	118	45	70	94	100	30	17	73	66	25	20
North Eastern	24	24	29	74	72	100	19	10	57	6	40	1
Nyanza	83	82	54	84	99	97	45	35	85	68	61	31
Rift Valley	61	174	49	57	93	97	30	20	73	107	52	32
Western	87	44	45	74	94	100	36	14	71	38	33	14
Total	58	690	53	64	94	97	33	25	75	401	48	133

[1] Minimum package of PMTCT includes the availability of the following: an HIV testing system in the facility, plus ARV prophylaxis for PMTCT for mother and infant, plus counselling on maternal nutrition and infant feeding for HIV-positive mothers, plus counselling on family planning, or family planning services for the mother.
[2] All components for the minimum PMTCT services package are available, and the facility offers ARV therapy for HIV-infected women and their HIV-infected children and family members.

PMTCT service availability among all facilities

Fifty-eight percent of all facilities report that they offer any PMTCT services (Table 8.5). Clinics (24 percent), private facilities (27 percent), and facilities in North Eastern province (24 percent) are less likely than the others to report provision of PMTCT services.

Among the facilities that report offering PMTCT services, availability of the various components of the PMTCT package varies quite widely, as follows:

- Fifty-three percent have an HIV testing system available.

- Sixty-four percent provide ARV prophylaxis to the mother and infant to prevent mother-to-child transmission of the virus.

- Ninety-four percent provide counselling on maternal nutrition and infant feeding.

- Ninety-seven percent provide family planning services or counselling.

Overall, only 33 percent of the facilities that report offering PMTCT services actually provide all four components of PMTCT services usually referred to as the minimum package of PMTCT services. Hospitals (72 percent) and health centres (57 percent) are more likely to provide the minimum package of PMTCT services than other facility types. Private facilities are less likely than government-, NGO-, and FBO-managed facilities to provide the minimum package. At the provincial level, facilities in Coast (41 percent) and Nyanza (45 percent) provinces are more likely than facilities in other provinces to provide the minimum package.

PMTCT service availability among facilities offering ANC services

Conventionally, PMTCT services tend to be offered from antenatal care (ANC) service sites by ANC service providers. As shown in Chapter 6, Table 6.1, 74 percent of all facilities (excluding stand-alone VCT facilities) offer ANC services. This sub-section of the report looks at the availability of PMTCT services among facilities that offer ANC services. As shown in Table 8.6, 78 percent of facilities that offer ANC services report that they offer any PMTCT services. Approximately nine of every ten hospitals and health centres that offer ANC services report that they offer PMTCT services. Clinics (58 percent) and private facilities (59 percent) as well as facilities in North Eastern province (35 percent) that offer ANC services are least likely to report offering PMTCT services.

Table 8.6 Availability of services for prevention of mother-to-child transmission of HIV among facilities offering ANC services

Among facilities offering ANC services, Percentage reporting that they offer PMTCT services; among these, percentage with specific PMTCT programme components, percentage with the minimum package of PMTCT services; and, among facilities with the minimum package of PMTCT, percentage having all items for PMTCT+, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of ANC facilities reporting PMTCT services	Total number of facilities offering ANC services	Percentage of facilities offering ANC and any PMTCT services that provide indicated specific PMTCT services: Documented HIV testing system	ARV prophylaxis to prevent MTCT	Counselling on maternal nutrition and infant feeding	Family planning counselling or services	All four items for minimum PMTCT package[1]	ARV therapeutic treatment for HIV-infected women and families	Percentage of facilities with a provider of PMTCT trained in the 3 years preceding the survey	Number of facilities offering ANC and any PMTCT services	Percentage of facilities offering ANC and minimum package of PMTCT and having all items for PMTCT+[2]	Number of facilities offering ANC and a minimum package of PMTCT[3]
Type of facility												
Hospital	92	48	92	81	97	97	72	72	98	44	78	32
Health centre	94	79	74	83	96	92	57	48	92	74	50	42
Maternity	75	16	69	49	100	100	32	8	77	12	9	4
Clinic	58	83	67	33	91	98	26	20	71	48	29	12
Dispensary	78	285	34	62	93	99	19	10	65	222	32	43
Managing authority												
Government	83	306	44	72	94	99	34	30	76	254	59	87
NGO	84	18	38	82	96	100	31	30	96	15	97	5
Private (for profit)	59	108	60	38	92	100	22	6	70	63	16	14
Faith-based organisation	86	78	82	55	93	86	41	25	72	67	22	27
Province												
Nairobi	65	33	54	50	87	86	16	56	95	21	27	4
Central	81	71	58	51	91	96	30	20	62	57	53	17
Coast	64	57	76	57	100	100	42	41	79	36	55	15
Eastern	78	84	45	70	94	100	30	17	73	66	25	20
North Eastern	35	17	29	74	72	100	19	10	57	6	40	1
Nyanza	88	78	54	84	99	97	45	35	85	68	61	31
Rift Valley	82	130	49	57	93	97	30	20	73	107	52	32
Western	93	41	45	74	94	100	36	14	71	38	33	14
Total	78	509	52	64	94	97	33	25	75	399	48	133

[1] Minimum package of PMTCT includes the availability of the following: an HIV testing system in the facility, plus ARV prophylaxis for PMTCT for mother and infant, plus counselling on maternal nutrition and infant feeding for HIV-positive mothers, plus counselling on family planning, or family planning services for the mother.
[2] All components for the minimum package PMTCT services are available, and the facility offers ARV therapy for HIV-infected women and their HIV-infected children and family members.

Among the facilities offering ANC and reporting that they offer PMTCT services, the availability of the various components of the PMTCT package varies. About half (52 percent) of these facilities have a documented HIV testing system (ranging from 34 percent of dispensaries to 92 percent of hospitals), 64 percent provide ARV prophylaxis (ranging from 33 percent of clinics to 83 percent of health centres), 94 percent provide counselling on maternal nutrition and infant feeding, and 97 percent provide family planning counselling or services. Overall, only one-third of facilities offering ANC and any PMTCT services actually provide all four components of the minimum

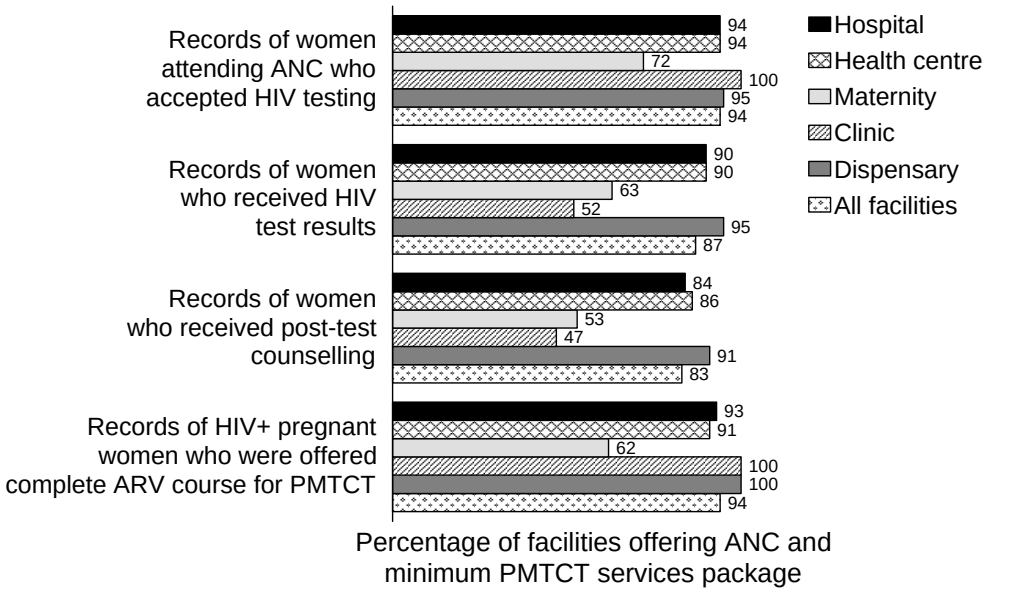
PMTCT package. This ranges from a low of 19 percent of dispensaries to a high of 72 percent of hospitals. Private facilities (22 percent) and facilities in Nairobi (16 percent) and North Eastern (19 percent) provinces are less likely than facilities in other provinces to provide the minimum PMTCT package.

Looked at from another perspective, among all facilities that offer ANC, only 26 percent offer all four components of the minimum PMTCT package (see Table A-8.21.2). Additional information on the availability of PMTCT services and items to support PMTCT services can be found in Figure 8.4.

Record-keeping for PMTCT services is widespread, with 94 percent of ANC facilities offering the minimum PMTCT package having records of women attending ANC and accepting HIV testing. Maternity facilities (72 percent) were less likely than the other facility types to have these records. Ninety-four percent of facilities offering ANC and the minimum PMTCT package also had records of HIV-positive pregnant women who were offered a complete course of ARV for PMTCT. The distributions across facility types, management authorities, and provinces are similar to those of the records of women accepting HIV testing.

Eighty-seven percent of facilities offering ANC and the minimum PMTCT package have records showing that women received their results after taking the HIV test. Records of women who received post-test counselling were available in 83 percent of facilities.

Figure 8.4 Record-keeping in ANC Facilities Offering Minimum PMTCT Services Package (N=133)



KSPA 2010

Key Findings

Availability of PMTCT services among all facilities: About six of every ten facilities report that they offer any PMTCT services. However, the availability of the four components of the minimum package varies substantially among these facilities. Overall, only one-third of facilities that report offering PMTCT services actually offer all four components of the minimum package of PMTCT services.

Availability of PMTCT services among facilities offering ANC services: Three-fourths of facilities offer ANC services. Among these, close to eight of every ten report that they offer PMTCT services. Overall, only one-third of ANC facilities offer all four components of the minimum package of PMTCT services.

8.4.4 Post-exposure Prophylaxis

Evidence is available from biomedical studies that there may be a window of opportunity to abort HIV infection by inhibiting viral replication following an exposure. Accidental exposure to HIV is predominantly via percutaneous and mucocutaneous routes. The risk of HIV infection among health care providers from needle sticks or exposure to infected bodily fluids has led to the need for post-exposure prophylaxis (PEP). The service must be available not only to health care providers, but also to anyone at risk as a result of inadvertent exposure (such as sexual assault victims and motor traffic accident victims). Even facilities that do not officially offer HIV/AIDS-related services should have access to PEP because it is frequently not known which clients may be infected with HIV.

The 2010 KSPA survey assessed availability of PEP services to health care providers. A little over half of all facilities report that their staffs has access to PEP services, either on-site or by referral (Table A-8.20). Among facilities reporting that PEP services are available, only 26 percent had PEP guidelines, and only 10 percent had a register of staff receiving PEP services. Only three of every ten had ARVs for PEP available on the day of the survey.

8.4.5 Youth-friendly Services

Designated youth-friendly services (YFS) are meant to help young people overcome barriers to access to health care, including HIV/AIDS services. Ideally, YFS involve young people in all aspects of programme planning, operations, and evaluation. The services should include culturally competent workers who are members of the intended clientele and sensitive to youth culture, ethnic cultures, and issues of gender, sexual orientation, and HIV status. YFS also should provide outreach services for homeless youth and tailored support groups for substance users and teen parents. The services usually have convenient locations and flexible hours, including walk-in hours, to improve accessibility to youth. The 2010 KSPA assessed the availability of youth-friendly HIV counselling and testing services. It also assessed the availability of guidelines, protocols, and trained providers to support the provision of these services.

Overall, only 7 percent of all facilities say they offer youth-friendly HIV testing services (Table A-8.17.2).

Among the facilities reporting an HIV testing system, only 10 percent report that they offer youth-friendly HIV testing services (Table A-8.17.1). Stand-alone VCT facilities (53 percent) are most likely to report offering youth-friendly services. Among the health facilities that say they offer youth-friendly services, 52 percent had policies or guidelines for YFS, and 77 percent have at least one provider trained for YFS.

THE COMMUNITY COMPONENT 9

P. Stanley Yoder, Joyce Olenja, Irene Muhunzu

9.1 INTRODUCTION

9.1.1 The Nature of a Community Component

The Ministry of Public Health and Sanitation (MPHS) in Kenya promotes health services at various levels, from the community to tertiary hospitals. In the Kenya Essential Package for Health, Level 1 refers to health care offered at the community level. The emphasis on the community level of health care can be seen in the minimum package of services described in the National Health Sector Strategic Plan (NHSSP) II 2005-2010. It is best described by the Community Strategy first formulated in 2006. The Community Strategy seeks to improve access to health care by supporting a cadre of community health workers (CHW) who promote the use of health services, refer the sick to facilities, and promote disease prevention. This chapter reports on data related to the performance of community health workers as described by the workers themselves and the perceptions of health services delivered by facilities as described by women using those services.

9.1.2 Community Strategy

At the local level, it is community health workers who provide health services to the population. This general designation also covers community-based distributors (CBDs) of family planning methods and traditional birth attendants (TBAs) in their redefined role as counsellors and key players in referral of pregnant mothers for skilled attendance at delivery. The Community Strategy envisions that community health extension workers (CHEWs), who are salaried government employees attached to health facilities, will supervise and support the work of CHWs, who are mostly unpaid volunteers. In most cases, the CHEWs will be a nurse or a public health officer.

9.1.3 The Community Component of the 2010 KSPA

The Community Component of the 2010 KSPA collected information from CHWs about their own activities, and from mothers of young children about their experiences with the use of health care services. Given the government emphasis on the community level in health services and concerns that maternal health was not improving more rapidly, the National Coordinating Agency for Population and Development (NCAPD) included a community component in the 2010 Kenya Service Provision Assessment (2010 KSPA). The NCAPD sought the following information to complement the rest of the SPA data: (1) data on the work of community health workers, including their perspectives on their own situations and their own performance, and (2) data on how clients consider the health services offered by the health care system.

In particular, the 2010 KPSA community component sought the perspectives of mothers of young children on the services they use regularly. Women gain experience with health services when they bring their children to a facility for preventive medicine or treatment of an illness, and when they attend antenatal clinics, use maternities for delivery, or request family planning services. Through focus group discussions the 2010 KSPA community component collected the views of groups of women on how well they are being served by facility staff. The KSPA community component—interviews with CHWs and group discussions with mothers—is called qualitative because it sought to elicit local perceptions about health services, it allowed respondents to determine what was most relevant, and it sought descriptions of activities, or narratives, to understand how health services are delivered in Kenya today.

Interviews with community health workers

The community component developed by the NCAPD examined the experiences and perspectives of CHWs related to their activities as CHWs: their training, the services they offer, and their own perspectives on their activities. The rationale for obtaining information on the work of CHWs is the importance of examining the following points:

- the capacity and knowledge of CHWs
- the services they provide
- the support they receive from health care facilities
- the challenges that CHWs confront
- the ideas they suggested for improving their own work situation

Group discussions with mothers

The KSPA teams organised group discussions with mothers of children less than two years old who lived in the catchment areas of health care facilities that were part of the KSPA sample. Each group was composed of 8 to 12 women, who gathered to discuss issues related to health services locally available, their own use of health services for themselves and their children, and their use of family planning. The women discussed the services that are performed well, those that are performed poorly, and their experiences with the use of child health services and services for pregnant women.

This chapter summarises the main findings from the interviews with community health workers and from the group discussions held with women with small children throughout the eight provinces of Kenya. The overall goals of this community component, as well as of this chapter, are to consider how the CHWs see themselves and their activities and to suggest revisions in their training or responsibilities that would improve their effectiveness, and to consider the experiences of women in using child health and maternal health services and to suggest changes that improve service performance.

9.2 METHODS

9.2.1 Community Health Worker Interviews

The 16 teams that collected the KSPA data from health care facilities each included one social scientist selected by the NCAPD. These social scientists had various duties to perform as team members, including interviewing CHWs and organizing focus group discussions with mothers of young children. The CHWs to be interviewed were selected in consultation with the staff at the health care facilities. The interviews of CHWs were to be distributed according to the different levels of health care facilities: 16 interviews each at provincial hospitals, district hospitals, health centres, and dispensaries, plus 8 each at maternities and clinics. The staff provided names and locations of community health workers affiliated with the facility, and the interviewers chose four to six CHWs in each location to be interviewed. The interviews were conducted in the local language; a total of 12 languages were used.

Interviews lasted from one hour to one and a half hours. Most of the 82 interviews were recorded and then transcribed in the language of the interview. In the majority of cases the transcriptions were then translated into English by the NCAPD for analysis. In the end 74 of the 82 transcriptions and translations were judged suitable for analysis. The transcribed and translated texts were entered into NUDIST (N6), a software programme that permits easy coding and sorting of themes. The software assists in the access, coding, and management of textual data. This report draws on those 74 interviews, conducted in 64 districts in the eight provinces of Kenya.

9.2.2 Group Discussions with Mothers of Young Children

Participants in the groups discussions with mothers were identified by the local administration (chief or elders) at the request of the regional population coordinator of the NCAPD before the KSPA team arrived. The protocol asked that a certain the number of focus groups be conducted among the population of the catchment area of each level of health care facility: 12 around provincial hospitals, 12 around district hospitals, 12 around health centres, and 12 near dispensaries, plus 6 close to maternities and 6 close to clinics.

Each discussion was directed by a moderator and assisted by a note-taker. The discussions were tape-recorded, then transcribed in the language spoken, translated into English, and typed in MS Word. Once the transcriptions and translations were completed, the NCAPD team found that 50 discussions were sufficiently complete for inclusion in the analysis and writing of a report. These 50 discussions covered all eight of the provinces in Kenya.

The NCAPD, with limited assistance from ICF Macro, developed the protocol for directing the discussions. The discussions began with questions about the kinds of health care facilities locally available (hospitals, health centres, dispensaries, clinics, etc.) and the service providers active in their area. The other portions of the discussions were structured around questions related to specific services that participants used: child health services, maternal health services, delivery in maternities or in homes, postpartum and postnatal care, and family planning. Respondents were asked to explain why some women do not come for antenatal care and why some women prefer to give birth at home rather than in a health care facility.

The texts were entered into the NUDIST software programme. The themes chosen for coding were derived from the study protocol as well as from a reading of the texts for relevant comments on topics of high priority. All common themes were coded and categorised in a standard way, using the 'tree nodes' structure so that comparisons could be made across sub-samples and easily analysed.

9.3 The Training and Services of Community Health Workers

9.3.1 The Training of a Community Health Worker

The core image of a community health worker is one of a dedicated and responsible individual who is willing and able to spend part of his or her time every week in public health activities to contribute to disease prevention and to improved use of health services. These activities may include: teaching how to avoid diseases, promoting specific health services, helping to find remedies for illness, teaching families how to care for the sick at home, providing referrals as needed, sometimes giving first aid, and helping people get to a clinic or hospital for care. A person becomes a CHW after training by any of a wide variety of agencies, in a range of topics, for periods that range from three days to several months or more. An individual CHW may participate in a number of different trainings offered by different agencies, depending on how many agencies are working in the area and their particular areas of emphasis.

The interviews with CHWs began with questions about how they had been chosen to be a CHW and the qualities that the trainers were seeking in CHW candidates. On one hand, the selection of an individual with experience as a volunteer presents advantages, since that person is likely to have learned how to relate to local people, and he or she may well continue their earlier work after becoming a CHW. On the other hand, a village resident without a history of social activism will be more likely to focus his/her activities as a CHW on the specific topics and skills acquired during the training itself. Similarly, there was a difference between those who had only one session of training on one or two topics, and those who participated in a number of different trainings on a wider set of topics: The former tended to focus their services on the contents of their recent training, while the latter provided a wider range of services.

Although the descriptions of training are often brief and abbreviated, it is possible to group them roughly into three types: nearly half of the CHWs were trained by one agency only, about one-fourth were trained by two agencies, and the other one-fourth were trained by more than two agencies.

Training: topics and duration

The number of agencies that trained CHWs is significant for two reasons. First, it speaks to the great variety of topics for training of CHWs; CHWs who are trained on a number of topics are likely to provide a wider variety of services. In addition, those who have served a number of years as CHWs are more likely to have been trained more than once. If the trainings conducted by public health officers (PHO) are combined, and those conducted as part of the USAID-funded APHIA II project are considered as one agency, a total of 39 agencies provided training for CHWs.

A similarly wide range can be seen in the training topics. The CHWs gave three types of answers to questions about the topic of training and the services they delivered. The first type of training was related to prevention of specific diseases, such as tuberculosis (TB), malaria, HIV/AIDS, or sexually transmitted infection (STI). A second type of training was related to specific services that CHWs offered, such as caring for the sick through home-based-care (HBC), encouraging adherence to treatment, first-aid, or de-worming. The third type consisted of training in health education: promotion of antenatal care (ANC), of voluntary testing and counselling (VCT) for HIV, and of immunisations; teaching about hygiene and sanitation: and giving talks on health topics of high priority to facility staff. Among training topics, 23 of the 74 CHWs mentioned HIV/AIDS, and 20 mentioned home-based care.

Over the years many programmes from the government, private agencies, nongovernmental organisations (NGOs), and other entities have trained community volunteers to provide health services. Responding to the tremendous variation in the agencies providing training, the range and duration of trainings, and the many topics covered, the Community Strategy has producing a standard two-week training curriculum on several specific topics to standardise the skills and services of CHWs. The Ministry of Health is seeking standardisation throughout the country and has elicited the support of implementing partners who work at the community level.

9.3.2 Services Provided by CHWs

The health services provided by CHWs in Kenya constitute the first line of services available at the community level. Since the CHWs serve as the key actors in this first line of service, it is critical that the services they provide be identified so that possible improvements can be suggested. The majority of the CHWs did not specify how many households or villages they were covering, although a small number of CHWs said that they had been assigned 20 households to monitor. The designation of specific numbers of targeted households has occurred largely where the Community Strategy has been rolled out and some structure has been established. (The protocol guiding the interviews emphasised the relationship of the CHWs to a health care facility rather than to the population being served.)

Overview of services

Given that the 74 CHWs named at least 39 different agencies from which they had received training, it is not surprising that they also named several dozen different services that they provide. In addition to the provision of referrals to facilities, a wide range of health education topics and specific services were identified related to many diseases and a variety of target populations.

The services provided can be divided into four categories according to the nature of the task, in the following fashion: (a) health education and preventive services; (b) promotion of specific health services; (c) direct services such as giving first-aid, home-based care, or family planning methods; and (d) referrals and other assistance in getting the sick to a health care facility.

The services provided by CHWs in Kenya in the past have focused mostly on reproductive health and the health of mothers and children (MCH). These services include the distribution of family planning methods within CBD programs, health education, and service promotion related to sanitation and child health (ANC, immunisations). Some CHWs help mothers diagnose a child's illness and decide what treatment to seek; some monitor the signs of complications in a pregnancy and assist the woman to seek care; some monitor the symptoms of TB or patients on antiretroviral therapy (ART) to make sure they take their medicine and treat any infections. Most importantly, they may accompany a sick person to a health care facility to assist arrival and being seen, or they may arrange transportation for the sick person. CHWs mentioned that they frequently seek transport for a person needing to get to a facility.

The major change to this traditional image in the services provided by CHWs has been the addition of services related to HIV and AIDS. More than half of the CHWs interviewed spoke of tasks they perform related to HIV infection or to individuals who are HIV-positive. These CHWs promote VCT and antiretroviral therapy (ART) services: they visit those who are sick with HIV; they teach family members how to care for those with HIV; they promote adherence to antiretroviral (ARV) medication regimens, and they track ART defaulters. Some have also been trained as counsellors for those with HIV.

Health education

The services most often described are activities that can be considered health education and preventive care. They think of themselves as educators in health matters. Many CHWs spoke about how often they give health talks or teach families how to improve their hygiene and sanitation or to use latrines. At least one-fourth of the CHWs talked about providing counselling for those with HIV or AIDS. Quite a few mentioned malaria prevention in the form of spraying or teaching about malaria prevention.

Promotion of health services

The services that CHWs most often promote are ANC services for pregnant women, VCT services for youth and adults, immunisation services for children, and prevention of mother-to-child transmission (PMTCT) services for pregnant women. Many also mentioned that they advise women to deliver in a facility. Examples of cases in which these tasks were highlighted include the following:

> *This assistance of mine I offer as shown by my training,… (and) as I visit a household to do registration and if I find a pregnant mother, I educate her about the signs of pregnancy. What she is supposed to take in mind, danger signs of pregnancy, danger signs of delivery like that of birth preparedness or, that is, individual birth plan.…I teach her to attend clinics, antenatal clinics, at least four times during pregnancy* (Rift Valley province).

Caring for the sick

A third category of services involves direct care and actions to reduce transmission of disease. While a few CHWS are closely attached to facilities and dispense drugs, many provide first-aid as needed. They also provide home-based-care for those with HIV and accompany the sick to the health care facility. CHWs were not asked specifically about the services they provide to people with special needs. However, they were asked about the challenges that people with special needs experience in seeking health services—those with HIV, the disabled, and the elderly. Some respondents were explicit about the particular needs of people living with HIV and of AIDS orphans, most probably because they were involved in existing programmes to address these groups of people. These observations were extended to cover people with disabilities and the elderly.

Among the 74 CHW interviews analysed, 54 made reference to the major challenges that the elderly face in accessing services: notably, general lack of food, the lack of funds to pay for transport

and medication; a preference for traditional medicine over modern medicine, and sometimes neglect by family members who themselves may not have the means to support the elderly. In terms of provision of support services, the CHWs were more preoccupied with people living with AIDS (PLWAs) and AIDS orphans and much less with people living with disability and the elderly. In only four instances CHWs (from Coast and Central provinces) noted that they are able to support the elderly, especially when it is determined that there is no family support, including taking them to the health facility for care. Even then, the cost of services was sometimes prohibitive, and in some instances prevented the elderly from being served. Below is an example of this as observed by one of the CHWs:

> *Sometimes you can take them to the health facility and they find that there are no drugs, so they are referred to a chemist or pharmacy to purchase those drugs. This demotivates them because they cannot afford to buy the drugs at the chemist, which makes them reluctant to go back to the hospital next time. And, worse, the illness may become severe due to lack of drugs* (Western province).

In one instance a CHW in Western province reported that there was a programme in place through the Red Cross to assist the elderly. However, the programme is limited, since it is part of an annual cycle lasting only a year and focuses only on the provision of food, bedding, and mosquito nets.

Actions that constitute preventive care include the indoor residual spraying (IRS) of residences against mosquitoes, de-worming, passing out oral rehydration salt (ORS) packets for diarrhoea, and distributing condoms. The services provided are, of course, a function of both the history of the CHW and the training they were given. Some CHWs received one or two weeks' training in maternal and child health, so they are likely to promote ANC services and immunisations, provide assistance in caring for sick children, and provide health education about sanitation, nutrition, breast-feeding, and signs of danger during pregnancy. A person with one or two weeks of training on HIV/AIDS will focus on the promotion of VCT, counselling those with HIV, providing home-based care, assisting with adherence to ARVs, and urging the sick to seek treatment at a facility.

Someone who has participated in a number of different trainings is likely to offer a wider range of services. Still, despite the disparate training given, nearly all CHWs understood their role in assisting the sick to obtain health care, through giving them referral forms to take to a facility, by assisting them in finding transportation, or by actually accompanying them. In that sense the CHWs play the critical role of intermediary between the sick and the personnel of facilities.

Referrals

Community health workers were asked about the system of referral they use, for referral was often emphasised by training programmes. A total of 82 percent of CHWs reported that they referred patients to a facility, either with a form that they fill out or with a hand-written note. A small number of CHWs either never had referral forms or no longer had them available, and therefore they improvised with notebooks and papers.

The actual forms used came from various sources. Although interviewers did not ask about the origin of the referral forms, CHWs mentioned several agencies that provided them with referral forms: APHIA II, the Ministry of Public Health and Sanitation, Eastern Deanery AIDS Relief Programme (EDARP), Pathfinder, and Samaritan's Purse. Some NGOs working in specific areas and programs have designed their own referral forms.

Some CHWs have a referral form from the MOPHS that comes with a self-carboned slip; one copy is the referral form given to the patient, while the other copy remains with the CHW. On these referral forms the CHW writes the name of the patient, the age, the nature of the health problem, the referral facility, his or her own name, and where he or she works as a CHW. A number of CHWs reported that patients with a form in hand were seen more promptly at the facility. A number of

CHWs said that some patients expected their health care would be free if they went with a referral form.

Some community health workers reported that they no longer received referral forms, and this has affected their work. But, increasingly, the CHWs use their mobile phones to contact the health facility and give details of the referral or, depending on their assessment of the seriousness of the problem, to call for an ambulance. In some cases a CHW may accompany a patient, especially when the CHW thinks the condition is serious.

9.3.3 Contacts with the Health Facility

Supervision

Each CHW is attached to a health care facility that has staff to monitor the CHW activities. The CHWs explained who supervised them and how often. About one-third of the CHWs reported that they are supervised. Usually, they are supervised by a member of staff from the nearest health facility, who could be a Community Health Extension Worker (CHEW), a public health officer (PHO), a public health nurse (PHN), or a designated officer from a programme for which they are working. Similarly, a few CHWs in Rift Valley were supervised by the District Tuberculosis and Leprosy Coordinator.

CHWs who reported little or no supervision largely come from regions where programmes or projects were not well established. This situation was described by one CHW based in Coast province:

> *Supervision is done, but, as you know, here the project has come late, at the end of last year. So we have not had much supervision with our seniors, but our field supervisor frequents here* (Coast province).

One-third of the CHWs interviewed reported that they are supervised either by the public health technician (PHT), the PHO, or the CHEW from the local facility. It is during supervision that any updates are given over and above the sessions of monthly reporting at the health facility. In short, supervision, like training, depends mainly on the affiliation of the CHW.

Record-keeping and reporting

The CHWs are typically asked to keep records of their activities for each month; some were required to prepare more than one report. For example, a CHW from Central province explained that he prepared two reports each month: one for the health centre and the other for the project he was working for:

Record-keeping books are provided by the health facility.… If you visit a place and gave a health talk, you note it down; if there is an outbreak [of disease], you note it down; and when we attend a Chief's baraza, we note what was said.… We write two reports; one at the health centre where they now know how many CHWs are there– but one for USAID is a report on your visit to the client (Central province).

Meetings with staff of the health facilities were fairly frequent and often coincided with the time that the CHWs went to the health facility to deliver their monthly reports. For some CHWs the monthly meetings are also the time for the collection of supplies such as contraceptives. The CHWs involved in intensive programmes visit a facility more often to attend clinics. Some CHWs meet less frequently–every three months–but can schedule meetings earlier than three months if there is need for it. Others have no real schedule for meetings.

Remuneration

The CHWs were all asked about the rewards and benefits they receive for their work. Nearly all said they are volunteers and work without a salary. However, 11 of the 74 CHWs reported that they received a monthly salary paid by the health programme that trained them or the facility they serve; several received a percentage from fees charged for health services.

The CHWs mentioned other types of rewards they receive: lunch and transport allowance of 100 or 200 Ksh during a training or seminar; occasional remunerations that were labelled as transport allowance or lunch allowance, mostly when they delivered their reports to the health facility or attended seminars or workshops; material goods that facilitate their work; or free health care. Finally, about one-third of CHWs mentioned that being trained was a real benefit to them, and that they would like to participate in more training.

Because of the different affiliations to programmes or to private health facilities, the remuneration package of CHWs who were paid varied widely, from Ksh 2,000 to 9,000 per month. These CHWs may often assist with work at the health facility over and above their extension work in the community. They were particularly involved in the weighing and growth monitoring activities at the facility level.

There has been an attempt to facilitate the work of CHWs particularly by assisting with local transport and essential items they might need. Some CHWs reported that they are given bicycles, motorcycles, gumboots, umbrellas, bags, or uniforms. With the spread of the mobile telephone technology, some CHWs even have received cell phones to improve their communication.

Finally, as a fringe benefit, a small number of CHWs received treatment for free at the health facility for themselves and their family members. Even without a formal payment for their services, free treatment for them and their families was regarded as a big benefit in a community setting where financial resources are scarce.

The heavy work load and lack of remuneration for their time does create problems for most CHWs. Descriptions such as the following were often heard in these interviews:

I: *Fine. In your opinion, on behalf of the CHWs, what do you think the government should give or how much should it pay CHWs if it were possible?*

R: *My view is that, though the work is voluntary, sometimes it is tricky. For instance, when it is time for cultivating, you are called and you are away for two to three days, your shamba is not attended to, and since you volunteered, you cannot say you won't go. Therefore, if the government can consider the CHWs and give them something small, to compensate for the days they are away, even if it is one hundred shillings per day, since here people are paid 150 per day, you can then leave somebody in your home and you attend to the CHW issues* (Central province).

9.3.4 Challenges in Service Provision

Community health workers listed several major challenges they face. One challenge mentioned by all the CHWs was transportation to their areas of operations and for clients to get to the nearest facility. A second challenge is not receiving any payment for their services. A third challenge is the lack of recognition of their important role by the health care staff and by the local population.

Transportation

Transport was most difficult for those in arid areas, where the distances stretch far. Although they were each expected to cover 20 households, according to the Community Strategy, for some CHWs the households were spread over a wide geographical area. The need to travel long distances substantially increases their workload and the time spent on all activities.

A comment that appeared in almost all the in-depth interviews was the heavy workload of CHWs and the resulting reduction in time available for their own personal work and needs. The following observations by two of the CHWs speak for the others:

> *(I work with) low pay, no formal training and being burdened by work* (North Eastern province).

> *…it's that one like I mentioned before: transport, and something to use when you are travelling, because you may take a week, you can use up to three or four days without doing your work. So, you see, it's a challenge to your family* (Eastern province).

Some CHWs have received bicycles to facilitate their travel around their area of service. However, in some instances, the CHWs were unable to keep the bicycles in working order for very long. In another instance, bicycles were not appropriate for women because, traditionally, women in that district do not ride bicycles.

Motivation

A second major challenge mentioned by all CHWs is that of motivation, or remuneration. While they acknowledged that their work is largely voluntary, they still think that they deserve some form of payment. This feeling of deserving payment increases when they hear that some CHWs do, in fact, receive monthly payments. While recognizing that their work was supposed to be voluntary, they did find it a major challenge to operate without some form of payment for motivation. They stated that their work involves visiting sick people, who make demands on them, demands that they could better satisfy if they had funds available. Some of the CHWs' expectations included food and financial support, especially where transport is required. For example:

> *Sometimes women who have been helped by the CHW may want to depend on her for everything; sometimes a CHW has to produce the fare if the woman has no transport and there is no ambulance* (Nairobi).

This sentiment was shared by a CHW from Nyanza province, who observed that even the health facility staff expected the CHW to sort out the issue of transport for patients they referred. This was beyond the means of one CHW, who, in frustration, offered this example of what can happen:

> *The government should offer vehicles and fuel which the community can use to ferry very sick patients and the disabled to the referral facilities. There was a time I had a very sick patient in the community. When I went to the district hospital, I was told to first fuel the ambulance so that they could assist me to bring the patient to the facility* (Nyanza province).

All the CHWs were asked what remuneration they would wish to receive. They all stated, after being prompted, that they would like to receive a monthly salary. The amount mentioned most often was 5,000 Ksh per month. These answers do not mean that most CHWs are demanding this amount, for some needed to be queried several times before they responded. However, 5,000 was the sum cited most often.

Recognition

Finally, community health workers were concerned about their role and status as service providers. Most of the CHWs said that they wanted more recognition for the work they are performing—recognition from the health care facility staff and from the local population. They observed that, without recognition of some sort, they could not work properly. The CHWs sought recognition in the form of either a closer affiliation with the formal health system or uniforms and badges that would give them visibility within the community, and would increase their identification with the health facility.

9.3.5 Community Health Workers: Their Own Concerns and Suggestions

Near the end of the interview, CHWs were invited to suggest ways that their situation and health services could be improved. They suggested a number of ways to increase the use of health care services and to improve the effectiveness of their own work. The CHWs indicated that their situation could be greatly improved if they could obtain assistance with transport, with supervision, with some material support, and with recognition.

Transportation

Transport remains a thorny issue. CHWs felt that they should not have to spend their own money so that they could visit the facility outside the scheduled meetings or during designated health campaigns. They wanted some scheme for reimbursement of these travel costs. In the same vein, they wanted financial assistance for the transport of patients to facilities.

Supervision

One of the key links with the health facility is through supervision by the PHO, the PHT, and the PHN. When asked what would improve their delivery of services, many CHWs said that more frequent supervision is important.

Material support

In their daily work in the community, the CHWs encounter situations where they could provide first-aid to sick people, but they do not have first-aid kits. They asked if kits could be provided.

The CHWs said that referral forms are important, enabling them to summarise the condition of their clients and helping the clients to obtain service more promptly at the health facility. While more than half (57 percent) of CHWs had referral forms that they used, some of the forms were valid for only one condition (HIV or family planning, for example), while others were generic. Many of the CHWs without referral forms asked that they be given blank forms.

Motivation

The community health workers said that they would like to be recognised by the MOH as a legitimate cadre of service providers and that they would also like more recognition from health care staff at facilities. They wanted badges and uniforms, for they believe that such markers would raise their profile and visibility in the community and among service providers at facilities. Regular personnel at health care facilities often wear badges and uniforms, and some CHWs would actually

like to move into a regular and permanent full-time position. Many CHWs made it clear that having something to wear or to display that would show their special role in the community would encourage them in their work.

As noted earlier, when asked about the rewards they received, nearly all CWS said they were volunteers and thus were not getting paid. They clearly were not expecting an actual monthly salary that they could live on. A small number received 2,000 to 2,500 Ksh a month from the facility or the programme that had trained them, and two CHWs received more. When pressed, the CHWs most often mentioned a payment of 5,000 Ksh per month as acceptable. These CHWs were not asking for a source of income; rather, they wanted a small amount that would help defray the expenses they incur in doing their jobs and that would show others that they play an important role. They wanted at least a token monthly payment.

9.3.6 Discussion: A View from the Outside

These interviews with community health workers identified issues that the CHWs feel should be addressed by the ministry. Their concerns focus on (1) the connection they have to a local health facility; (2) the assistance they need for travelling to visit the households for which they are responsible; (3) the recognition they seek from the government as well as from the facility staff; and (4) the motivation provided by the agency that trained them—motivation that includes money and materials.

Relation to the health facility

The relationship of CHWs to the medical staff of facilities is critical, for the CHWs form the bridge between the local population and the services offered by the facility. Nearly all CHWs understand very well the importance of referring individuals to facilities, and they understand the importance of increasing the use of services. Despite the diversity in training offered, most CHWs (82%) actively referred people to facilities. What is now needed is a standard form of referral that can be used for any condition (rather than service-specific ones), and wider distribution of these forms to all CHWs.

The situation concerning supervision of CHWs is less clear. Only one-third of CHWs reported that they were supervised regularly. Those supervised regularly were usually part of a specific programme with the necessary resources to follow up CHW activities. The Community Strategy emphasises supervision of CHWs to maintain the link between the health facility and the community as well as to maintain and monitor the quality of service.

Assistance with transportation

Nearly all interviewed CHWs mentioned difficulty in reaching all households and problems getting patients to a facility as a major challenge. In sparsely populated areas, a great deal of time is spent simply walking. A number of agencies, including the MOPHS, have tried to assist by providing CHWs with bicycles or motor bikes. Those with motor bikes have their problem solved, for they can transport sick persons themselves if needed. Given the wide diversity in the ecology of Kenya, the solution to this problem will necessarily be regional and specific to each area concerned.

Recognition from the government

The CHWs expressed the need for recognition of the importance of the tasks they are performing for the health facility and for the government. A small number spoke of the lack of understanding of their role by the local population. A larger number talked about the need for recognition by the facility staff for the referrals they provide; they would also like more regular supervision. An important proportion of CHWs do not feel that they are appreciated for what they do.

The solution that the CHWs have suggested is to provide them with symbolic indications of their role and their importance: badges, certificates, and uniforms. Such signs of significance would show the community that they are available to assist and also would link them more closely to the facility.

Motivation

The issue of the rewards offered to volunteers for services provided has always been challenging for CHW programmes. There is an inherent contradiction in outside expectations for community health workers. On one hand, they have volunteered to perform tasks without pay, something these CHWs readily acknowledged. On the other hand, the CHWs incur expenses in the process of doing their volunteer work, they are not often reimbursed, and they give up some of the time they need for their own farming or other income-earning activities.

Although CHWs acknowledge that the work of a CHW is voluntary, they are also quick to add that formalisation of their position vis-à-vis the health facility, and a monthly payment, would give them further motivation to work and to continue their activities. The individuals who have become CHWs are largely people with families but no formal employment to support them. Some CHWs think that volunteerism is a transitional stage in their life to something better. Others explain that, while their work is voluntary, once in a while it provides an opportunity for token allowances that come in handy, which is one of the reasons that many of them talked about their desire for additional trainings or workshops. In the application of the Community Strategy in ever larger areas, the government will need to address these issues over time.

9.4 Discussions with Mothers of Young Children

9.4.1 Introduction

As mentioned, as part of the 2010 KSPA, group discussions were held with mothers of children less than two years old who lived in the catchment areas of health care facilities that formed part of the KSPA sample. These group discussions sought the perspectives of women on the quality of the health services they use at local health care facilities.

9.4.2 Availability of Health Care Services

The way that the initial questions about health care services were asked varied somewhat from one group to another. Some moderators asked about the types of facilities that were present locally; others asked about the types of service providers the women called upon. Still others inquired about the specific types of services the women sought. The women who spoke about types of facilities mentioned government, private, and mission hospitals, as well as health centres, dispensaries, and clinics. The most common comments about government facilities were that services are free or not expensive, doctors and nurses are trained, and drugs are in short supply. Private facilities were often described as untrustworthy because they are staffed by trainees. Mission hospitals and dispensaries were described as more expensive but with far more reliable supplies of medicines.

When interviewers asked about service providers, most respondents mentioned community health workers, midwives or traditional birth attendants (TBAs), and traditional healers. The large majority of the groups reported that they had both CHWs and TBAs in their areas. About 20 percent reported that traditional healers were also active in providing treatments, most often for sick children.

These discussions of health care facilities and services were important to set up the discussions of the services that were performed well and those that were performed poorly. Each group was asked to describe the services that were performed well in their neighbourhood and which services needed improvement. The respondents named nearly all types of services several times as being performed well, but the most common services that were cited as being well-performed were treatment of sick children, ‘doing proper examinations’, having the right drugs available, and

providing rapid service. These responses should be read as indications that the women were happy with the services, and that the services were important to them. Respondents in three groups (out of a total of 50) said that their facility performed all services well.

Improvement of services

Most of the suggestions for improving services can be classified into three categories: comments about the lack of medicines available, about how doctors treated patients, and about the need for more doctors and nurses. This last group of comments was connected to waiting in long lines for treatment. A total of 32 groups (64 percent) talked about the lack of drugs available in local facilities as a problem, and 32 groups also mentioned the need for more medical staff. In 18 groups (36 percent) the women talked about how doctors treated patients rudely ('abused them'), ignored them, came to work drunk, or failed to respect the hours of service.

The lack of medicines available at facilities was a problem in two ways: one, it may mean that the appropriate treatment is not possible, and, two, it obliges the patient to seek the medication in a local chemist shop, where the drugs may be expensive. Respondents wanted to be able to obtain the medicines directly from the medical staff even if it meant some payment. They would like facilities to stock the drugs needed for treatment rather than to write a prescription to be filled in a pharmacy. The availability of medicines was one reason cited for patronizing a particular facility, just as the lack of drugs was mentioned as a reason for avoiding a facility. Participants in several groups talked about facilities that have only Panadol and Piriton available.

Women in about one-fourth of the groups talked very approvingly about the services they receive from doctors and nurses in general. In four of the groups mothers suggested that doctors and nurses should be paid higher salaries. Overall, respondents spoke more positively about services for children than for maternal health or maternities. They also expressed satisfaction, in most cases, with family planning services. However, more than one-third of the groups voiced complaints about the treatment they receive from doctors and nurses. Some suggested that the medical staff be given training in how to treat patients respectfully; mothers in a few groups said that doctors come to work drunk; a few others said that doctors visited with friends and family during office hours rather than attending to patients. As one woman from Western province stated, 'Doctors will come on their own time, and some fail to follow the queue when they come.' Participants in two groups asked that the doctors in their facility be transferred and replaced. One group said that the local community had made such a request but received no response. The most commonly mentioned context for patient abuse was during labour in maternities, where nurses would sometimes shout at women or slap them.

Women in nearly two-thirds of the groups talked about the great need for more doctors and nurses in facilities. Having more staff on duty would reduce the long queues for treatment, a very common complaint. The groups who were asked about waiting times for services reported that they waited from two to six hours for service. The promise of rapid treatment was often cited as a reason for seeking service at a particular facility. As one mother in Coast province said, 'When I have Ksh 500 and my child falls sick, I will take him to a private hospital because he will be served faster.' A small number of groups said that some small facilities, when the doctor or nurse was absent, would simply close temporarily. The addition of more medical staff, along with an increased supply of basic medicines, was the most common suggestion for improvement of health care services.

9.4.3 Health Care Services for Children

Participants were asked to discuss the services available to children in their local facilities. They provided lists of the services received by both well and sick children. Virtually all groups mentioned immunisations as a child health service, and nearly all said that immunisations were free. Most groups also said that their children were weighed, and some spoke of being given advice on nutrition if the child was underweight. Other services often mentioned were being given vitamin A supplementation, being given free mosquito nets, and health education. On the whole, the respondents seemed quite familiar with the preventive measures recommended for young children.

The majority of the groups stated that treatment of sick children is free in government facilities for children less than five years old, but not at private clinics. A number of groups reported that they can receive free or low cost treatment for sick children at government facilities, but often the necessary drugs are not available and they must go elsewhere to purchase medicines. They also expect to wait hours for services. In a number of groups, mothers said that they pay between 20 and 50 Ksh. for health cards for their children, and they often purchase drugs for treatment as well. Several groups said they use traditional medicines for treating sick children.

In general, respondents seemed quite satisfied with the treatment of sick children as well as with the preventive services available. Several groups spoke about the importance of doing lab tests for diagnosis before prescribing medicines. Overall, respondents wanted lab tests to be performed before the prescription of medicines, drugs to be available from those who treated the children, and more rapid service.

9.4.4 Health Care Services for Women

The discussion about maternal health services focused mainly on medical services available in the area for pregnant women, although that was initially specified by only some interviewers. Many groups first mentioned family planning as a service for women before moving to a discussion of the needs of pregnant women. The dialogue below from a discussion in Rift Valley province shows how these discussions were initiated.

> I: *Now, let us look at the third stage, mothers' health. The health of a mother in general, whether a pregnant mother, a sick mother, or something like that. What kinds of services for mothers are provided in hospitals in this area that you have mentioned…?*
>
> R2: *Family planning.*
>
> I: *Family planning. What else? Mary? We are looking at all the services mothers are given when they visit hospitals around here. You have just said family planning.*
>
> R3: *There is also antenatal.*
>
> I: *There is antenatal?*
>
> R3: *There is clinic.*
>
> I: *There is clinic. Clinic for what?*
>
> R3: *For pregnant women.*

The discussions of maternal health focused mainly on the services provided in antenatal clinics. Respondents were generally very familiar with the elements of ANC services. There is first of all a series of medical tests: weighing, checking for anaemia, checking blood pressure, tests of urine and stool specimens, and tests for HIV and syphilis. The doctors also check the position of the foetus to see if any complications should be expected during delivery. Also mentioned by one or two groups were tests for malaria, glucose level, and the use of ultrasound. The actions that these groups most often mentioned were weighing, checking the foetus, urinalysis, and HIV testing.

Second, the groups mentioned several preventive actions routinely offered. Most groups mentioned that women are offered anti-malarial pills, tetanus toxoid vaccines, and free mosquito nets. Also mentioned, but less frequently, were iron pills, de-worming tablets, vitamin A supplements, and counselling on hygiene. It can be assumed that HIV testing is accompanied by counselling on HIV prevention and living with the virus. Although HIV testing is an integral part of services for preventing mother-to-child transmission of HIV, the groups did not often mention this service.

Third, respondents in nearly all the groups stated that they attended antenatal services, but they acknowledged that some women do not use ANC services. Three explanations were offered for this: lack of money to pay fees or transport costs, shame at being pregnant, and fear of being required to take an HIV test. Given the low fees charged for services, it seems unlikely that lack of money would keep many women away. A few groups suggested that older women, as well as the very young, may be ashamed of being pregnant and thus would not want to be recognised by others while at the facility. Finally, most groups said that some women are afraid of taking an HIV test and therefore avoid ANC clinics. Several groups said that, if a woman knows her husband is HIV-positive, she will not want to be tested for fear that she will be found to be HIV-positive also.

9.4.5 Delivery Services

After the discussion of maternal health services, the respondents talked about how and where they went to give birth—at home or in a health facility—and how they thought about delivering at home versus delivering in a facility. They were also asked about the costs of delivering in each place. Factors influencing the choice of place of delivery included their experience in previous deliveries, the cost of the service, the distance to the health facility, and the general environment and reception by the service providers in the maternities compared with the care offered by traditional birth attendants. The groups included women who used only health facilities for delivery, women who had delivered only at home, and women who had delivered both at home and in hospital.

Delivery in a health care facility

Women were asked where they preferred to deliver and the reasons for their preference. A majority said that they preferred to deliver in health facilities. Their preference for delivery in a facility was linked to the knowledge that, if there were complications during delivery, they would receive immediate assistance. Nearly all the groups mentioned this reason. For example, in responding to the question on preferred place of delivery, a group of women in Coast province indicated that the hospital was the preferred place for delivery given the presence of specialists who are able to address any complications that may arise. Some groups particularly valued the possibility of referral to a more specialised health care facility if needed and the presence of an ambulance, as the following example illustrates:

> *The hospital is good because sometime you can deliver with complications and you will be attended to by specialists. However, if they are not there, they will provide an ambulance to transfer you to a better hospital* (Coast province).

Some women also spoke with appreciation of the care that they receive in a hospital. In a group from Western province, the majority of the women preferred the hospital because they knew that the staff is able to conduct medical tests and treat conditions appropriately. If the facility also has drugs available, that is all the more reason to use the services at the health facility. The women said that they are well aware that '*midwives [TBAs] in the village have no skills and do not use any precautions…*'.

Not all women who would prefer to deliver at the health facility actually do so, however. If transport is not available at the right moment, the baby arrives earlier than expected, or other circumstances keep a woman from travelling to a facility, she will give birth at home attended by a TBA.

Some of the women in these group discussions said they did not want to deliver at health facilities for fear of being tested for HIV. This sentiment emerged in the discussions with women in three groups in Coast province and one in Western province, where women were afraid even to attend ANC for fear of being tested for HIV. Women understand that HIV testing is an integral part of the ANC profile. This approach has worked well in some regions, but not in all. In the discussion of another group in Coast province, women preferred home delivery because they are confident all will go well, it is cheaper, and, above all, they avoid an HIV test.

Home delivery with traditional birth attendants

The reasons cited by these groups of women for giving birth at home include both aspects of home births that they value and aspects of a facility birth that they want to avoid. Some women have not had complications in previous pregnancies and deliveries, and they do not expect any. Therefore, they would opt to deliver their babies at home rather than go to the health facility. This reason is the mirror image of the reason for delivering in a facility: in case of complications, the doctors will care for you. These women just feel more comfortable at home with the care of a TBA. '*The TBA will pamper me*', one woman said. In a group in Western province, one of the participants noted, '*I've given birth to all my children at home. By God's grace I don't get any complications*'. In this group most women said they deliver at home.

Many women cited aspects of a hospital delivery that they wanted to avoid. That is, they deliver at home by default because they do not want the experience of delivering in a health facility. The three aspects to avoid that they cited most often were: (1) they did not want to take an HIV test (mentioned in 30 percent of the groups); (2) doctors and nurses in maternities abuse, and sometimes even beat, the women (mentioned in 26 percent of the groups); and (3) the women did not want male doctors to examine them (mentioned in 16 percent of the groups).

In general, preference for assistance by the TBA is based on local practice: women have always used them. It was also explained that, on the whole, TBAs treat women well compared with health facility staff, who often act disrespectfully to women, particularly during labour and delivery. In the discussion with a group of women in Nairobi province, one of the women said that she prefers to use the TBA: '*Most go to TBAs because they will pamper you as opposed to the hospitals, where you 'may even end up being beaten….I was mocked by the attendants [at the health facility] for crying*'. TBAs were lauded for their skills in massage during antenatal care and labour. This was commonly raised in some of the groups in Western and Rift Valley provinces. In one group in Rift Valley province, women talked about how the TBAs massage the abdomen and comfort the woman in labour.

In more than one-fourth of these groups, one or more persons talked about abuse, lack of respect, neglect, and general mistreatment that they expected from the nurses who staff maternities. Several women even have the impression that women in labour are sometimes beaten. For example, in all the group discussions in Coast province, women gave examples of what they described as abuse. Key reasons for home delivery were linked to hostility by service providers who may resort to verbal or physical abuse of women in labour. Similarly, in Western province, one of the participants referred to service providers' maltreatment of mothers ranging from neglect to actual physical harm to the extent that mothers '*are scared that the doctors will beat them up*'. Another group in Western province noted that women did not want to deliver at the health facility because '*some are afraid of abuse in the hospital*', and women in Coast province mentioned that others '*are afraid because doctors are normally harsh*'. In a group in Nyanza the women reported that nurses use insulting language with pregnant women, while '*most women prefer TBAs because they are pampered*'.

One group discussion summarised the situation in which mothers opt to give birth at home despite regularly going to the clinic for check-ups. The responses from four participants are typical of what many said about the health facility, particularly its overcrowding, and how conditions in hospitals might influence care-seeking (North Eastern province).

> R9: *Mostly, it's due to influence from peers. Young women hear of bad experiences in hospitals from their friends. Consequently, they are afraid and opt to give birth at home.*
>
> R3: *There are some who are used to giving birth at home because they don't have any complications. First, they start by giving birth at home. If they experience no complications, they go on. However, if they experience difficulties, the next time they'll opt to go to the hospital.*

R10: *Some women are embarrassed; they say it is men who deliver the babies.*

R9: *It is possible when you go to the labour wards in the hospital, you'll find other women, for example, six women together. Attending to all of them is difficult.*

In nearly half of all the discussion groups, respondents said that lack of money was one of the key reasons for not using the delivery services at the health facility. This comment may have referred to the cost of transport, but more likely the women were thinking of the cost of services themselves. It is unclear just what this means, since many facilities charge small fees for delivery, and some of these statements were made hypothetically. A facility delivery would normally cost between Ksh 880 and 2,000. In one area of Central province, many prefer the hospital because it is not too expensive, and they are referred if they have a serious problem. They reported that delivery at home with the TBAs cost up to Ksh 300 plus a *leso* (a cloth) and chicken, with TBAs offering the flexibility of phased payments.

The infrastructure and health facility environment in some health facilities was limited and unkempt, some women said, and respondents in several groups reported that the conditions would discourage one from using services for fear of catching an infection. The need to address cleanliness is urgent in some of the health facilities.

9.4.6 Family Planning

These group discussions indicated that family planning services were quite familiar to many, and perhaps to most, women participating. When asked about maternal health services or services available for women, many groups first mentioned family planning. The specific methods of family planning available in facilities that participants mentioned included the whole range: pills, injectables, the IUD (popularly known as the coil), implants, male condoms, the calendar method, tubal ligations, and, less often, vasectomies. The methods mentioned most often were pills, injections, coils, and condoms.

All groups included women who had used modern methods of family planning. In several groups, women spoke of other methods of family planning such as herbal medicine ('*you drink a glass every month*'), and in one other case of a capsule that is taken once a month. In one group in North Eastern province, there was mention of chewing castor oil seeds in addition to taking herbal medicines.

In the large majority of discussion groups, respondents reported that an injection was their preferred method of family planning. The reasons for this preference were largely the convenience that the injection provides and the fact that it can be used in secret. Women find injections convenient since they can forget about the method for three months, whereas they might forget to take pills on some days. The advantage of secrecy was also highlighted, particularly in situations where the couple may not have agreed on the need for family planning. Many groups made statements like the ones below:

Women prefer injections because no one will know. A husband may find the pills and become upset. Husbands do not like to use condoms; if you suggest them, they will think you are an immoral woman (Nyanza province).

Most of our husbands don't like family planning so we prefer injections to keep it a secret. Some women also prefer the pills even though remembering to take them is a problem (Eastern province).

[Women prefer injections because] it's easy and secretive. Some husbands don't like their wives to use them so with that they wouldn't notice a thing. With pills, one can forget to take them (Western province).

People prefer injections because they can use them in secret and because they may forget to take the pills (Coast province).

Participants were asked about the cost of the contraceptives. Some groups reported that all methods are free, but many others said they paid from Ksh 50 to 200 for a method. Some participants who lived in areas served by a project such as Marie Stopes International said that some family planning methods that would ordinarily be sold would actually be free or heavily subsidised. The price paid depended on the type of method. In the list of ideas for service improvement, several groups mentioned that all family planning services should be free.

When asked about service improvements, some groups also talked about the need for more thorough counselling for family planning before methods are provided. One group suggested: '*Improve blood examination before recommending the proper method of family planning*'. Several groups also emphasised the need to involve of male partners, who may not be supportive of family planning, forcing women to practice family planning in secrecy.

9.4.7 Summary of Discussions of Health Care Services

The suggestions made by these groups of women for improving services can be classified into three categories: comments about the lack of medicines available, about how doctors and nurses treat patients, and about the need for more doctors and nurses to reduce waits for treatment. A total of 32 groups (64 percent) talked about the problem of lack of drugs in local facilities, and 32 groups mentioned the need for more medical staff. In 18 groups (36 percent) women talked about how service providers treat patients rudely, ignored them, came to work drunk, or failed to respect the hours of service. For most of these groups, improvement of health services means providing a steady and reliable supply of medicines and employing more doctors and nurses.

Women use both the home and the health facility for delivery services. They give birth in hospitals so that, if there are complications during delivery, a doctor will be there to care for them, and they find this potential for highly skilled care reassuring. Women give birth at home because they have done so before without difficulty, they feel comfortable at home, and they have heard stories of required HIV tests and abuse by nurses in maternities.

Cultural practices and patterns of socialisation seem to play a part in women's preferences in some areas, particularly in the Muslim community in North Eastern province, where separation and limited interaction between the sexes is usual. Some discussion groups alluded to embarrassment and the discomfort of being touched or examined, especially by male service providers. These feelings may contribute to low use of facility-based services.

There was very little reference to postpartum and postnatal services, and it seemed that women are not aware of the importance of these services. In very limited circumstances individuals within the discussion groups referred to going to the health facility after a home delivery. Even then, this was often to take the baby for immunisation rather than specifically for the mothers own health.

9.4.8 Recommendations

- In in-service and pre-service training, begin to address the negative attitudes of some service providers and to the importance of customer-centred care as well as to improve interaction between service provider and client.

- Because of the reports of abuse of women during labour and delivery at health facilities, document systematically the treatment of women in maternities over time in order to identify remedies to the situation and correct misinformation.

- During ANC and community outreach services, emphasise the importance of postnatal care services for both mother and newborn.

- Given the reports that women use family planning secretly for fear of their partners, step up male involvement and enhance partner support so as to allow women to choose from the wide range of family planning methods available.

- Address the fears about HIV testing not only in order to promote testing but also to increase the use of facility-based ANC and delivery services.

- In training and deployment of service providers, take into account local sensitivities with regard to privacy and control over the conditions of physical exams, and in particular women's preference in some regions for same-sex service providers.

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ADDITIONAL TABLES

Appendix **A**

Chapter 1

Table A-1.1 Distribution of facility sample frame and final sample selection, by province

Number of facilities of each type that were in the sample frame, number selected for the survey sample, and percentage of eligible facilities of each type that were included in the sample, by province, Kenya SPA 2010

	Province																		
	Nairobi		Central		Coast		Eastern		North Eastern		Nyanza		Rift Valley		Western		Total		Percentage of total for facility type included in KSPA sample
Facilities	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	Sample frame	Selected for KSPA	
Type of facility																			
Hospital	43	26	51	36	42	31	71	33	22	22	86	33	98	37	37	35	450	253	56
Health centre	70	9	69	14	41	13	101	14	9	9	138	15	206	14	75	13	709	101	14
Maternity	19	3	22	7	19	7	18	8	7	5	24	7	27	9	15	6	151	52	34
Clinic	107	12	594	14	372	14	296	14	62	9	72	14	237	14	66	13	1,806	104	6
Dispensary	130	15	376	21	247	21	562	20	115	14	415	20	986	20	199	21	3,030	152	5
Stand-alone VCT	30	25	0	0	4	4	2	2	0	0	2	2	7	7	1	1	46	41	89
Total	399	90	1,112	92	725	90	1,050	91	215	59	737	91	1,561	101	393	89	6,192	703	11

Table A-1.2.1 Distribution of facility staff sample frame and final sample selection, by type of facility

Number of providers of each type that were present the day of the survey (sample frame), number selected for interview (SPA sample), and percentage of eligible providers of each type that were selected for interview, by type of facility and provider qualification, Kenya SPA 2010

	Type of facility														
	Hospital		Health centre		Maternity		Clinic		Dispensary		Stand-alone VCT		Total		Percentage of total for facility type included in KSPA sample
Types of providers	Sample frame	KSPA sample	Sample frame	KSPA sample	Sample frame	KSPA sample	Sample frame	KSPA sample	Sample frame	KSPA sample	Sample frame	KSPA sample	Sample frame	KSPA sample	
Specialists[1]	79	42	2	1	6	3	5	5	0	0	0	0	92	51	55
Medical officer	197	82	3	1	7	3	3	3	0	0	0	0	210	89	42
Clinical officer	594	383	93	76	36	30	57	51	25	22	7	5	812	567	70
BSN[2]	48	27	3	2	3	3	2	2	1	1	0	0	57	35	61
Registered nurse	1,136	598	127	105	61	45	50	36	53	45	12	7	1,439	836	58
Registered midwife	53	23	10	5	2	2	2	1	1	1	0	0	68	32	47
Enrolled nurse	697	356	96	84	47	39	45	45	113	109	6	6	1,004	639	64
Enrolled midwife	152	64	28	21	11	8	10	10	23	22	0	0	224	125	56
Nurse aide	90	4	18	4	31	8	23	6	32	10	1	1	195	33	17
Lab staff[3]	781	250	92	74	50	41	61	44	62	55	8	6	1,054	470	45
Other health-related specialists[4]	537	91	66	17	23	4	39	15	51	19	124	69	840	215	26
Other	91	17	35	6	13	2	6	0	26	10	8	5	179	40	22
Total	4,455	1,937	573	396	290	188	303	218	387	294	166	99	6,174	3,132	51

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Bachelor of Science in nursing.
[3] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[4] Other health-related staff includes nutritionist, health education officer, social worker, lay HIV counsellor, and Public Health Officer or Technician.

Table A-1.2.2 Distribution of interviewed health care providers, by provider qualification

Number of interviewed health care providers, by type of provider and type of facility, Kenya SPA 2010

Background characteristic	Type of facility						
	Hospital	Health centre	Maternity	Clinic	Dispensary	Stand-alone VCT	Total
Qualification of provider							
Specialists[1]	14	2	1	13	0	0	30
Medical officer	32	2	2	8	0	0	45
Clinical officer	147	91	16	108	37	1	400
BSN[2]	11	3	2	2	1	0	19
Registered nurse	249	117	23	88	108	2	587
Registered midwife	12	14	1	3	6	0	35
Enrolled nurse	156	88	16	84	302	1	646
Enrolled midwife	33	23	4	31	54	0	145
Nurse aide	6	23	10	25	109	0	173
Lab staff[3]	170	85	19	122	136	1	533
Other health-related specialists[4]	120	61	5	50	116	18	369
Other	28	15	2	4	18	1	69
Total interviewed staff	979	523	100	537	888	25	3,051

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Bachelor of Science in nursing.
[3] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[4] Other health-related staff includes nutritionist, health education officer, social worker, lay HIV counsellor, and Public Health Officer or Technician.

Table A-1.2.3 Distribution of interviewed health care providers, by facility type

Number of interviewed health care providers (weighted and unweighted), by type of provider and type of facility, Kenya SPA 2010

Type of provider and facility type	Number of interviewed providers	
	Weighted	Unweighted
Physician/medical officer/clinical officer		
Type of facility		
Hospital	193	490
Health centre	94	79
Maternity	19	34
Clinic	130	57
Dispensary	37	22
Stand-alone VCT	1	5
Total	474	687
Nurses[1]		
Type of facility		
Hospital	416	951
Health centre	208	183
Maternity	41	85
Clinic	174	81
Dispensary	411	155
Stand-alone VCT	3	13
Total	1,252	1,468
Midwives[2]		
Type of facility		
Hospital	45	86
Health centre	37	27
Maternity	5	10
Clinic	33	10
Dispensary	60	23
Total	180	156
Laboratory staff[3]		
Type of facility		
Hospital	170	250
Health centre	85	74
Maternity	19	40
Clinic	122	44
Dispensary	136	55
Stand-alone VCT	1	5
Total	533	468
Other health-related staff[4]		
Type of facility		
Hospital	120	85
Health centre	61	16
Maternity	5	4
Clinic	50	13
Dispensary	116	19
Stand-alone VCT	18	69
Total	369	206
Other[5]		
Type of facility		
Hospital	35	20
Health centre	38	7
Maternity	11	10
Clinic	29	7
Dispensary	127	16
Stand-alone VCT	2	6
Total	242	66
Type of facility		
Hospital	979	1,882
Health centre	523	386
Maternity	100	183
Clinic	537	212
Dispensary	888	290
Stand-alone VCT	25	98
Total	3,051	3,051

[1] Nurses include Bachelor of Science nurse, registered nurse, and enrolled nurse.
[2] Midwives include registered midwife, and enrolled midwife.
[3] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[4] Other health-related staff includes nutritionist, health education officer, social worker, lay HIV counsellor, and Public Health Officer or Technician.
[5] Other staff includes nurse aide and others not specified.

Table A-1.2.4 Distribution of interviewed nursing staff

Number of interviewed nursing staff (weighted and unweighted), by type of nurse and type of facility, Kenya SPA 2010

Type of nurse and facility type	Number of interviewed providers	
	Weighted	Unweighted
Bachelor of Science nurse		
Type of facility		
Hospital	11	25
Health centre	3	2
Maternity	2	3
Clinic	2	2
Dispensary	1	1
Total	19	33
Registered nurse		
Type of facility		
Hospital	249	589
Health centre	117	102
Maternity	23	43
Clinic	88	34
Dispensary	108	45
Stand-alone VCT	2	7
Total	587	820
Registered midwife		
Type of facility		
Hospital	12	25
Health centre	14	5
Maternity	1	2
Clinic	3	1
Dispensary	6	1
Stand-alone VCT	0	0
Total	35	34
Enrolled nurse		
Type of facility		
Hospital	156	337
Health centre	88	79
Maternity	16	39
Clinic	84	45
Dispensary	302	109
Stand-alone VCT	1	6
Total	646	615
Enrolled midwife		
Type of facility		
Hospital	33	61
Health centre	23	22
Maternity	4	8
Clinic	31	9
Dispensary	54	22
Total	145	122
Type of facility		
Hospital	460	1,037
Health centre	244	210
Maternity	45	95
Clinic	207	91
Dispensary	471	178
Stand-alone VCT	3	13
Total	1,432	1,624

Table A-1.3 Sample of observed and interviewed clients (unweighted numbers)

Number of clients attending facility on the day of the survey eligible for observation, number whose consultation was observed and client interviewed, and percentage of eligible clients who were observed, by type of service and type of facility, Kenya SPA 2010

Type of facility[1]	Total number of clients present on the day of the survey (eligible for observation)	Actual number of clients observed and interviewed	Percentage of eligible clients who were observed and interviewed
ANTENATAL CARE			
Hospital	2,685	872	32
Health centre	475	258	54
Maternity	60	53	88
Clinic	54	42	78
Dispensary	231	184	80
Total	3,505	1,409	40
FAMILY PLANNING			
Hospital	1,616	633	39
Health centre	273	181	66
Maternity	29	27	93
Clinic	50	46	92
Dispensary	139	123	88
Total	2,107	1,010	48
CURATIVE CARE FOR SICK CHILDREN			
Hospital	4,784	1,016	21
Health centre	925	353	38
Maternity	95	63	66
Clinic	180	123	68
Dispensary	903	461	51
Total	6,887	2,016	29
SEXUALLY TRANSMITTED INFECTIONS			
Hospital	135	120	89
Health centre	16	13	81
Maternity	10	6	60
Clinic	11	9	82
Dispensary	17	16	94
Total	189	164	87
DELIVERIES			
Hospital	887	577	65
Health centre	29	24	83
Maternity	28	23	82
Clinic	0	0	-
Dispensary	2	2	100
Total	946	626	66

[1] Stand-alone VCT facilities do not show up in this table because they do not provide any of the services observed as part of the survey and therefore are not eligible for inclusion.

Table A-1.4 Facility catchment area

Median population of assigned catchment areas for facilities providing data on a known catchment population, by background characteristics, Kenya SPA 2010

Background characteristic	Median population in catchment area	Number of facilities providing data on known catchment population
Type of facility		
Hospital	40,832	38
Health centre	13,227	60
Maternity	9,465	9
Clinic	6,044	63
Dispensary	6,235	276
Stand-alone VCT	74,010	2
Managing authority		
Government	8,542	293
NGO	8,255	16
Private (for profit)	5,070	85
Faith-based organisation	10,410	54
Province		
Nairobi	46,386	15
Central	6,241	77
Coast	10,089	41
Eastern	8,790	74
North Eastern	13,277	16
Nyanza	5,923	66
Rift Valley	5,641	126
Western	12,589	33
Total	8,348	448

Table A-1.5.1 Staffing patterns for SPA facilities, by doctors and nurses

Median number[1] of doctors and nurses assigned/seconded to or employed by the facility, by type of provider and type of facility, Kenya SPA 2010

	Median number of providers assigned/seconded to or employed by each facility								
Type of facility	Total medical/ nursing	Specialist[2]	Doctor/ medical officer	Clinical officer	BSN/ registered nurse/ midwife	Enrolled nurse	Enrolled midwife	Nurse aide	Number of facilities
Referral/provincial hospital	467	18	10	30	191	97	5	-	2
Hospital	23	-	2	4	8	5	-	-	49
Health centre	6	-	-	2	2	2	-	-	80
Maternity	7	-	-	1	2	1	-	1	17
Clinic	2	-	-	-	-	-	-	-	203
Dispensary	2	-	-	-	-	1	-	-	340
Stand-alone VCT	-	-	-	-	-	-	-	-	5

[1] Numbers were provided by facility administrators.
[2] Specialists includes obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.

Table A-1.5.2 Staffing patterns for SPA facilities, by other clinical/technical health care providers

Median number[1] of selected other clinical/technical health care providers assigned/seconded to or employed by the facility by type of provider and type of facility, Kenya SPA 2010

Type of facility	Median number of selected technical health care providers assigned/seconded to or employed by facility								Number of facilities
	Total other technical	Lab staff[2]	Pharmacy staff[3]	Nutritional staff	Social worker	HIV counsellor/ Lay counsellor	Public Health Officer/ Public Health Technician	Other technical not specified	
Referral/provincial hospital	54	27	9	8	2	4	3	5	2
Hospital	9	3	2	-	-	1	-	1	49
Health centre	3	2	-	-	-	-	-	-	80
Maternity	3	2	-	-	-	-	-	-	17
Clinic	1	1	-	-	-	-	-	-	203
Dispensary	1	-	-	-	-	-	-	-	340
Stand-alone VCT	5	-	-	-	-	4	-	-	5

[1] Numbers were provided by facility administrators.
[2] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[3] Pharmacy staff includes pharmacist, pharmaceutical technologist, and pharmacist assistant.

Table A-1.6.1 HIV/AIDS counselling and related training, by provider type

Percentage of interviewed staff who report that they provide counselling related to HIV testing and, among these, percentage who have received training during the three years preceding the survey, Kenya SPA 2010

Qualification of interviewed staff	Percentage who report providing counselling related to HIV testing	Number of interviewed staff	Percentage who have received training[5] on HIV counselling related to testing during the 3 years preceding the survey in the last:		Number of interviewed staff who provide HIV counselling
			12 months	13-35 months	
Qualification of provider					
Specialists[1]	74	30	30	13	22
Medical officer	81	45	13	26	36
Clinical officer	83	400	32	18	330
BSN[2]	66	19	24	40	12
Registered nurse	90	587	26	21	528
Registered midwife	87	35	18	12	31
Enrolled nurse	83	646	21	21	536
Enrolled midwife	78	145	13	14	113
Nurse aide	46	173	16	6	80
Lab staff[3]	0	533	0	0	0
Other health-related specialists[4]	94	369	63	24	347
Other	73	69	42	4	51
Total	68	3,051	31	20	2,087

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatrician, and pathologists.
[2] Bachelor of Science in nursing.
[3] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[4] Other health-related staff includes nutritionist, health education officer, social worker, lay HIV counsellor, and Public Health Officer or Technician.
[5] In-depth (or comprehensive) training for HIV/AIDS counsellors or refresher training on HIV/AIDS counselling or HIV/AIDS training of trainers (TOT) course or supervisors training course for counsellors at district and regional levels. These are country-specific courses defined by the MOH, which may be organized by the MOH or other agencies, such as WHO or NGOs.

Table A-1.6.2 HIV/AIDS counselling and related training, by facility type

Percentage of interviewed staff who report that they provide counselling related to HIV testing and, among these, percentage who have received training during the three years preceding the survey, Kenya SPA 2010

Type of facility	Percentage who report providing counselling related to HIV testing	Number of interviewed staff	Percentage who have received training[1] on HIV counselling related to testing during the 3 years preceding the survey in the last:		Number of interviewed staff who provide HIV counselling
			12 months	13-35 months	
Hospital	72	979	29	21	700
Health centre	76	523	34	18	399
Maternity	61	100	26	15	61
Clinic	53	537	36	22	283
Dispensary	70	888	28	19	621
Stand-alone VCT	92	25	50	25	23
Total	68	3,051	31	20	2,087

[1] In-depth (or comprehensive) training for HIV/AIDS counsellors or refresher training on HIV/AIDS counselling or HIV/AIDS training of trainers (TOT) course or supervisors training course for counsellors at district and regional levels. These are country-specific courses defined by the MOH, which may be organized by the MOH or other agencies, such as WHO or NGOs.

Table A-1.7 Education levels of interviewed health service providers

Median number of years of schooling reported by interviewed health service providers, by type of provider, Kenya SPA 2010

Type of provider	Median number of years of education[5]	Number of interviewed providers with information for basic education
Qualification of provider		
Specialists[1]	21	30
Medical officer	18	45
Clinical officer	15	400
BSN[2]	18	19
Registered nurse	16	587
Registered midwife	15	35
Enrolled nurse	14	646
Enrolled midwife	14	145
Nurse aide	13	173
Lab staff[3]	15	533
Other health-related specialists[4]	13	369
Other	14	69
Total	15	3,051

[1] Obstetrician/gynaecologists, surgeons, physician specialists, paediatricians, and pathologists.
[2] Bachelor of Science in nursing.
[3] Laboratory staff includes lab scientist, lab technologist, and lab technician/assistant.
[4] Other health-related staff includes nutritionist, health education officer, social worker, lay HIV counsellor, and Public Health Officer or Technician.
[5] This refers to the total number of years of schooling, from primary through secondary and any additional schooling.

Chapter 3

Table A-3.1.1 Availability of basic services by type of facility

Percentage of facilities offering basic services, packages of basic services, at or above minimum frequencies, 24-hour delivery of services, and qualified employed, assigned, or seconded staff, by type of facility, Kenya SPA 2010

Services	Type of facility						Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	Stand-alone VCT	
Services							
Curative care for children	100	100	95	94	97	2	96
Services for sexually transmitted infections (STI)	98	100	94	85	97	14	93
Any temporary methods of family planning (FP)	91	86	88	81	94	11	88
Antenatal care (ANC)	94	99	93	41	84	2	73
Child immunization (EPI)	93	95	78	29	81	0	68
Growth monitoring (GM)	95	95	82	43	84	2	74
Packages of services available							
All basic services at any frequency[1]	85	81	69	21	73	0	59
Facility-based 24-hour delivery services	94	72	79	2	11	0	23
At least one qualified staff[2]	100	100	98	98	97	32	97
All services, minimum frequency[3]	82	77	59	20	68	0	55
All services, minimum frequency and 24-hour delivery services	80	55	58	2	10	0	19
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	80	55	58	2	10	0	19
Number of facilities	51	80	17	203	340	5	695

[1] Any level of each of the following services is offered at the facility: curative care for children, services for adults with STIs, any temporary methods of family planning, antenatal care, child immunisation, and child growth monitoring.
[2] Qualified staff are specialists (surgeons, obstetricians/gynaecologists, paediatricians, physician specialists, and pathologists), medical officers, clinical officers, degree nurses (BSNs), registered nurses (RNs), registered midwives, enrolled nurses, and enrolled midwives.
[3] Curative services for children are provided five days per week, STI services are offered at least one day per week, preventive or elective services (any temporary methods of family planning, antenatal care, child immunisation, and growth monitoring are provided at least one day per week.

Table A-3.1.2 Availability of basic services by province

Percentage of facilities offering basic services and packages of basic services at minimum frequencies, with 24 hour delivery, and with qualified employed, assigned, or seconded staff, by province, Kenya SPA 2010

	Province								
Services	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total percentage
Services									
Curative care for children	86	96	88	100	96	100	96	98	96
Services for sexually transmitted infections (STIs)	84	92	90	98	94	96	91	98	93
Any temporary methods of family planning (FP)	64	90	82	87	67	96	95	93	88
Antenatal care (ANC)	73	56	70	71	69	94	74	94	73
Child immunization (EPI)	68	45	57	65	63	93	75	87	68
Growth monitoring (GM)	68	58	57	80	66	95	76	90	74
Packages of services available									
All basic services at any frequency[1]	46	39	53	57	61	85	63	85	59
Facility-based 24-hour delivery services	29	11	17	19	43	42	22	30	23
At least one qualified staff[2]	93	100	92	100	96	100	96	98	97
All services, minimum frequency[3]	41	39	53	56	61	77	55	78	55
All services, minimum frequency and 24-hour delivery services	21	10	16	16	39	36	17	28	19
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	21	10	16	16	39	36	17	28	19
Number of facilities	45	125	81	118	24	83	175	44	695

[1] Any level of each of the following services offered at the facility: curative care for children, services for adults with STIs, any temporary methods of family planning, antenatal care, child immunisation, and child growth monitoring.
[2] Qualified staff (Kenya specific) are specialists (surgeons, obstetricians/gynaecologists, paediatricians, physician specialists and pathologists), medical officers, clinical officers, degree nurses (BSNs), registered nurses (RNs), registered midwives, enrolled nurses and enrolled midwives.
[3] Curative services for children provided five days per week, services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, child immunisation, and growth monitoring) provided at least one day per week.

Table A-3.2 Facility infrastructure supportive of client utilization and quality services

Percentage of all facilities with client comfort amenities, infrastructure (regular electricity supply or generator and regular water supply), and staff and furnishings to support quality 24-hour emergency services, by type of facility, Kenya SPA 2010

	Type of facility						
Items	Hospital	Health centre	Maternity	Clinic	Dispensary	Stand-alone VCT	Total percentage
Client comfort amenities							
Client latrine	100	97	100	96	98	95	97
Protected waiting area	100	100	100	97	94	98	96
Clean facility	89	87	81	89	83	84	86
All client comfort items[1]	89	86	81	86	80	77	83
Facility infrastructure							
No electricity or generator	2	7	5	11	44	4	26
Generator observed with fuel	60	23	41	7	6	14	13
Regular electricity or generator	68	34	55	19	19	28	25
Any safe onsite water[2]	89	70	76	82	49	80	65
Regular water supply (any safe onsite and year-round)	58	45	57	59	35	51	46
Regular water and electricity[3]	43	19	35	13	8	19	14
All client amenities, regular water and electricity	38	19	31	13	6	17	13
Staff and furnishings							
At least two qualified staff[4]	99	95	87	32	42	17	50
Duty staff on site 24 hours[5]	91	55	66	7	7	3	20
Duty staff on-call 24 hours[5]	0	3	2	0	0	0	0
Qualified staff living onsite	72	72	48	22	36	5	39
Qualified staff living onsite, no duty roster seen or no duty roster	4	28	17	19	31	5	24
Emergency communication[6]	97	91	98	95	75	100	85
Overnight patient beds[7]	97	77	91	24	32	2	41
Basic components supporting 24-hour emergency services[8]	79	35	47	1	4	0	13
Basic plus regular water and electricity[9]	41	9	28	0	3	0	6
Electricity check							
Regular electricity[10]	23	17	31	12	14	19	15
Electricity[11]	96	91	94	87	53	93	72
Number of facilities	51	80	17	203	340	5	695

[1] Functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness
[2] Piped water from a protected or unknown source, or water from a protected well/pump and water outlet within 500 meters of facility
[3] Year-round, onsite water, and electricity routinely available during service hours or a generator with fuel
[4] Qualified staff are specialists (including surgeons, obstetricians/gynaecologists, paediatricians, physician specialists, and pathologists), medical officers, clinical officers, degree nurses (BSNs), registered nurses (RNs), registered midwives, enrolled nurses and midwives.
[5] A duty schedule or other documentation of official duty status was observed.
[6] A communication device is either in the facility or within a 5-minute walk and is available 24 hours a day.
[7] Either routine inpatient services or beds for overnight care available for emergencies
[8] At least two qualified staff assigned to facility, duty staff on site or on call 24 hours a day, overnight beds available, access to 24-hour emergency communication, and an onsite water source
[9] At least two qualified staff assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, access to 24-hour emergency communication, and regular water and electricity
[10] Facility reports it is connected to a central electric grid or has solar power or both, and power is never interrupted for more than two hours during regular service hours.
[11] Facility reports it is connected to a central electric grid or has solar power or both.

Table A-3.3 Facility infrastructure supportive of client utilization and quality services, by province

Percentage of all facilities with client comfort amenities, regular electricity and water supply, and staff and furnishings to support quality 24-hour emergency services, by province, Kenya SPA 2010

	Province								
Items	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total percentage
Client comfort amenities									
Client latrine	89	100	100	96	100	100	96	100	97
Protected waiting area	98	96	100	94	95	94	97	95	96
Clean facility	74	94	82	84	81	90	84	91	86
All client comfort items[1]	71	90	81	79	76	85	84	86	83
Facility infrastructure									
No electricity or generator	4	7	22	40	37	36	28	40	26
Generator observed with fuel	43	9	14	8	5	16	13	10	13
Regular electricity or generator	48	14	14	24	21	33	32	16	25
Any safe onsite water[2]	94	85	65	59	69	50	55	55	65
Regular water supply (any safe onsite and year-round)	60	75	40	45	51	22	41	23	46
Regular water and electricity[3]	27	12	6	16	15	11	18	7	14
All client amenities, regular water and electricity	26	11	4	15	14	8	17	3	13
Staff and furnishings									
At least two qualified staff[4]	81	31	47	48	45	69	46	72	50
Duty staff on site 24 hours[5]	26	14	20	17	24	27	20	23	20
Duty staff on-call 24 hours[5]	0	1	0	0	0	0	1	0	0
Qualified staff living onsite	15	29	45	30	59	52	46	39	39
Qualified staff living onsite, no duty roster seen or no duty roster	7	20	32	19	38	31	28	21	24
Emergency communication[6]	98	98	95	71	57	97	72	100	85
Overnight patient beds[7]	32	14	57	41	19	62	45	49	41
Basic components supporting 24-hour emergency services[8]	17	10	12	13	8	18	13	17	13
Basic plus regular water and electricity[9]	7	6	3	7	1	4	10	3	6
Number of facilities	45	125	81	118	24	83	175	44	695

[1] The floors are swept, with no obvious dirt or waste; counters, tables, and chairs are clean with no obvious dust or waste; and there is no broken equipment, papers, or boxes lying around to make the facility cluttered and dirty.
[2] Piped water is supplied from a protected or unknown source, or water is from a protected well/pump and water outlet within 500 meters of facility
[3] Year-round, onsite water and electricity routinely available during service hours or a generator with fuel
[4] Qualified staff are specialists (including surgeons, obstetricians/gynaecologists, paediatricians, physician specialists, and pathologists), medical officers, clinical officers, degree nurses (BSN)s, registered nurses (RNs), registered midwives, enrolled nurses and enrolled midwives.
[5] A duty schedule or other documentation of official duty status was observed.
[6] Communication device is either in the facility or within a 5-minute walk and is available 24 hours a day.
[7] Either routine inpatient services or beds for overnight care for emergencies are available.
[8] At least two qualified staff are assigned to the facility; duty staff are on site or on call 24 hours a day; there are overnight beds, there is access to 24-hour emergency communication, and an onsite water source.
[9] At least two qualified staff are assigned to the facility; duty staff are on site or on call 24 hours a day, there are overnight beds, there is access to 24-hour emergency communication, and there is regular water and electricity

Table A-3.4 Routine management meetings

Percentage of facilities reporting they have routine management meetings at specific intervals, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage			Number of facilities
	Monthly or more often	Every 2-3 months	Every 4-6 months	
Type of facility				
Hospital	82	13	1	51
Health centre	59	19	5	80
Maternity	61	19	2	17
Clinic	39	6	2	203
Dispensary	38	25	3	340
Stand-alone VCT	75	13	0	5
Managing authority				
Government	42	23	4	345
NGO	54	7	0	24
Private (for profit)	45	7	1	237
Faith-based organisation	53	26	1	89
Province				
Nairobi	69	14	0	45
Central	35	14	1	125
Coast	45	10	0	81
Eastern	48	19	4	118
North Eastern	39	6	0	24
Nyanza	52	18	3	83
Rift Valley	40	26	4	175
Western	50	14	6	44
Total	45	17	3	695

Table A-3.5 Quality assurance activities with documentation observed

Percentage of facilities reporting having quality assurance (QA) activities, and among facilities that report having quality assurance (QA) activities, percentage that both reported and had documentation of QA activity during the past one year, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage reporting routine QA activities[1]	Number of facilities	Percentage with documentation of any QA activity during past 1 year	Number of facilities reporting QA activities
Type of facility				
Hospital	65	51	60	33
Health centre	39	80	35	31
Maternity	40	17	50	7
Clinic	17	203	27	34
Dispensary	23	340	34	79
Stand-alone VCT	76	5	78	4
Managing authority				
Government	30	345	36	102
NGO	23	24	53	6
Private (for profit)	23	237	40	55
Faith-based organisation	28	89	48	25
Province				
Nairobi	44	45	55	20
Central	14	125	24	18
Coast	28	81	34	23
Eastern	27	118	19	31
North Eastern	12	24	36	3
Nyanza	31	83	53	26
Rift Valley	28	175	39	49
Western	39	44	60	17
Total	27	695	39	187

[1] Quality assurance activities assessed during the survey are supervisory checklists, mortality reviews, audits of medical records or registers, and presence of a QA committee.

Table A-3.6 Supportive management practices: Training and supervision at the facility level

Percentage of facilities where none, at least half, or all of the providers interviewed reported receiving training related to their work during the 12 months preceding the survey and reported receiving personal supervision during the 6 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Received training related to their work during the 12 months preceding the survey[1]			Were personally supervised during the 6 months preceding the survey			Number of facilities with interviewed providers[2]
	None	At least 50 percent	All	None	At least 50 percent	All	
Type of facility							
Hospital	3	59	33	2	64	23	50
Health centre	6	28	64	3	29	64	79
Maternity	8	34	48	18	37	30	17
Clinic	30	8	60	39	12	46	195
Dispensary	15	12	72	11	12	77	327
Stand-alone VCT	17	26	52	4	31	65	5
Managing authority							
Government	12	18	69	8	19	72	332
NGO	11	45	44	8	27	63	24
Private (for profit)	30	8	59	36	12	48	229
Faith-based organisation	5	27	64	10	33	55	89
Province							
Nairobi	6	32	54	15	41	39	45
Central	24	8	66	31	14	54	120
Coast	14	16	70	20	19	56	79
Eastern	17	18	59	15	17	65	118
North Eastern	24	15	60	19	10	70	17
Nyanza	15	20	61	6	23	69	82
Rift Valley	19	15	65	17	17	64	170
Western	10	19	69	13	15	72	43
Total	17	16	64	18	19	61	673

[1] Training includes only structured pre- or in-service sessions and does not include individual instruction received during routine supervision.
[2] Interviewed providers who do not personally provide any of the assessed services (i.e., managers other than those for clinical services who might have been interviewed) are excluded.

Table A-3.7 Supportive management practices: Training and supervision at the individual provider level

Among interviewed health service providers, percentage who reported receiving training related to their work and receiving personal supervision during specific time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of providers who received: Training during the 12 months preceding the survey[1]	Personal supervision in the 6 months preceding the survey	Training during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-59 months preceding the survey	Number of interviewed health service providers[2]
Type of facility					
Hospital	82	73	63	12	805
Health centre	83	84	70	14	436
Maternity	72	57	45	11	78
Clinic	69	61	46	19	412
Dispensary	75	82	63	13	737
Stand-alone VCT	76	87	69	19	23
Managing authority					
Government	80	81	66	13	1,389
NGO	77	82	67	20	92
Private (for profit)	66	58	41	20	523
Faith-based organisation	83	76	65	10	489
Province					
Nairobi	80	73	60	13	316
Central	74	69	56	19	329
Coast	82	70	58	15	287
Eastern	75	71	58	14	403
North Eastern	73	81	66	19	46
Nyanza	78	80	65	10	343
Rift Valley	77	79	61	13	575
Western	80	87	70	13	191
Total	77	75	61	14	2,492

[1] Training includes only structured pre- or in-service sessions and does not include individual instruction received during routine supervision
[2] Interviewed providers who do not personally provide any of the assessed services (i.e., managers other than those for clinical services) who might have been interviewed) are excluded.

Table A-3.8 Funding options

Among facilities charging user fees for adult curative care, percentage that use systems to decrease out-of-pocket fees for clients or to reimburse deferred client fees, and percentage that publicly post fees, by background characteristics, Kenya SPA 2010

Background characteristic	System for decreasing out-of-pocket fees: Discount/ exemption for some clients	Client can prepay for multiple visits one service	System for reimbursement of deferred client fees: Reimburse-ment by employer of client	Reimburse-ment by insurance	Reimburse-ment by community programs	Facility has any system to decrease out-of-pocket costs to client[1]	Fees posted publicly: All fees	Some fees	Number of facilities charging any user fees for adult curative care[2]
Type of facility									
Hospital	90	19	4	31	12	97	58	15	49
Health centre	88	6	1	2	16	89	31	25	80
Maternity	74	33	7	29	2	89	9	24	16
Clinic	68	16	0	3	0	70	4	10	188
Dispensary	84	3	1	0	23	84	22	14	331
Managing authority									
Government	90	2	0	2	26	91	31	13	339
NGO	95	3	3	2	0	95	19	24	19
Private (for profit)	67	19	2	6	0	71	5	12	224
Faith-based organisation	72	10	2	7	7	73	18	22	84
Province									
Nairobi	81	20	1	6	0	84	15	15	34
Central	59	5	1	8	12	61	10	16	125
Coast	91	21	0	3	1	92	28	7	73
Eastern	73	3	0	4	17	74	24	18	118
North Eastern	65	4	0	7	0	66	14	13	24
Nyanza	86	5	5	3	4	87	26	15	82
Rift Valley	91	13	0	3	28	94	21	12	166
Western	96	5	0	2	18	96	24	18	43
Total	80	9	1	4	14	82	20	14	665

[1] Discounts or exemptions, prepayment system, reimbursement by employer, insurance, or community programmes
[2] Totals include one stand-alone VCT facility

Table A-3.9 Components for which fees are charged

Among facilities charging user fees for adult curative care, percentage charging for client charts and records, consultations, medicines, lab tests and registration, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities charging for the indicated item:					Number of facilities charging any user fees for adult curative care
	Health card	Consultation	Medicine	Lab tests	Registration	
Type of facility						
Hospital	65	45	97	97	18	49
Health centre	74	20	57	83	47	80
Maternity	21	63	100	93	10	16
Clinic	23	49	95	57	8	188
Dispensary	59	18	36	38	51	331
Managing authority						
Government	67	15	30	40	59	339
NGO	52	9	70	45	36	19
Private (for profit)	22	55	95	60	7	224
Faith-based organisation	59	29	95	97	9	84
Province						
Nairobi	34	64	71	71	8	34
Central	36	39	74	51	31	125
Coast	40	34	65	59	37	73
Eastern	42	19	62	49	38	118
North Eastern	30	21	74	49	11	24
Nyanza	74	12	57	62	44	82
Rift Valley	60	31	48	51	34	166
Western	71	35	59	59	52	43
Total	50	30	61	54	35	665

[1] Totals include one stand-alone VCT facility.

Table A-3.10 Facility systems for maintenance and repair of equipment

Among facilities with major equipment, percentage with preventive maintenance programs for the equipment, percentage where onsite staff or external technicians perform maintenance, and among facilities with systems for repairing small equipment, percentage that use different methods to repair and replace equipment, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where preventive maintenance of major equipment is performed by:[1]				Number of facilities with major equipment[2]	Percentage reporting method used for maintenance or replacement of small equipment[3]			Number of facilities with system for small equipment repair[4]
	On-site staff	External technicians	Both onsite and external technicians	No routine maintenance		On-site repair	Send outside for repair	Petty cash for purchase of replacement or repair	
Type of facility									
Hospital	36	17	16	31	41	52	31	59	48
Health Centre	7	23	5	65	34	15	55	54	76
Maternity	8	41	10	41	13	24	27	69	17
Clinic	17	24	7	52	42	13	28	75	190
Dispensary	11	24	0	65	50	8	48	56	291
Managing authority									
Government	18	12	11	59	56	15	51	49	298
NGO	5	28	0	67	6	25	33	49	23
Private (for profit)	24	27	7	43	68	12	28	75	224
Faith-based organisation	9	31	3	57	52	17	40	79	82
Province									
Nairobi	12	24	9	54	27	23	30	78	40
Central	6	8	8	78	26	10	49	82	124
Coast	31	9	12	48	27	46	17	82	76
Eastern	15	55	1	29	19	5	35	23	101
North Eastern	20	12	14	53	2	15	43	42	20
Nyanza	11	22	6	60	24	9	70	42	81
Rift Valley	22	28	5	44	45	8	33	80	145
Western	16	23	3	57	11	17	52	29	39
Total	17	23	7	52	181	14	41	62	627

[1] Major equipment refers to generators, sterilizers and other large equipment where routine maintenance is recommended to extend the life of the machine.
[2] Totals include one stand-alone VCT facility.
[3] Minor or small equipment refers to stethoscopes, sphygmomanometers, other small equipment where either minor repairs or replacement are common when equipment is broken.
[4] Total includes four stand-alone VCT facilities

Table A-3.11 Facility systems for maintenance and repair of buildings

Among facilities with systems for maintenance and repair of buildings and infrastructure, percentage where onsite staff and outside workers are responsible for making repairs, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage where repairs on building or infrastructure are made by:			Number of facilities with system for maintenance and repair
	On-site staff	Persons hired from outside	Both on-site staff and externally hired	
Type of facility				
Hospital	62	25	14	33
Health centre	18	55	24	25
Maternity	24	66	5	7
Clinic	22	74	2	38
Dispensary	8	91	1	83
Managing authority				
Government	16	78	5	98
NGO	37	63	0	11
Private (for profit)	29	62	7	58
Faith-based organisation	25	57	18	21
Province				
Nairobi	26	62	11	20
Central	18	66	16	13
Coast	38	59	3	17
Eastern	13	86	0	55
North Eastern	50	28	3	4
Nyanza	20	74	6	26
Rift Valley	26	62	11	45
Western	23	62	16	7
Total	22	70	7	188

[1] Totals include two stand-alone VCT facilities.

Table A-3.12 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with adequate storage conditions and stock monitoring systems for vaccines, by background characteristics, Kenya SPA 2010

	Stock condition					Stock monitoring system						
Background characteristic	Functioning thermometer in refrigerator	Up-to-date temperature chart	Temperature 2°C to 8°C at time of visit	Adequate cold chain monitoring system[1]	Refrigerator protected from sun	In stock on day of survey	No expired vaccines among present on day of survey	Vaccines stored by expiration date, whether expired or not	Stock card present for vaccines in stock	Inventory up-to-date (for any vaccine with stock card)	No out of stock (for items with stock card)	Number of facilities with stored vaccines observed
Type of facility												
Hospital	96	89	90	83	94	83	97	79	48	60	42	48
Health Centre	97	89	91	83	95	79	89	76	39	57	42	78
Maternity	99	86	81	72	98	94	97	72	47	41	45	12
Clinic	87	78	82	72	95	94	95	71	42	45	36	65
Dispensary	91	86	91	79	90	83	98	74	40	42	45	239
Managing authority												
Government	93	89	91	81	92	81	95	76	43	51	47	273
NGO	93	64	89	60	99	73	100	71	0	40	15	16
Private (for profit)	86	80	78	73	88	94	96	70	44	41	45	83
Faith-based organisation	98	84	96	83	98	88	97	75	37	42	30	70
Province												
Nairobi	97	95	84	82	97	90	97	82	64	54	35	31
Central	93	92	92	88	93	95	95	69	50	27	67	57
Coast	90	84	90	80	99	88	96	65	37	67	44	50
Eastern	89	83	85	80	96	88	100	87	38	33	47	78
North Eastern	99	98	97	97	73	98	82	36	5	55	26	14
Nyanza	96	81	94	79	98	90	96	74	49	78	36	64
Rift Valley	91	83	86	70	84	71	93	75	30	39	35	120
Western	98	83	96	82	96	75	98	80	63	45	49	28
Total	92	85	89	79	93	84	96	75	41	47	43	442

[1] There is a functioning thermometer in refrigerator, the temperature chart is up-to-date, and the refrigerator temperature reads between 2°C and 8°C at the time of the visit.

Table A-3.13 Storage conditions and stock monitoring systems for contraceptive methods, medicines, and antiretroviral medicines (ARVs)

Among facilities that store clinical methods of contraception, medicines, and ARVs, percentage with proper storage conditions and stock monitoring systems for commodities, by background characteristics, Kenya SPA 2010

Background characteristic	Proper storage condition						Stock monitoring systems[1]						Number of facilities with stored commodities observed[3]
	Off the ground	Protected from water	Protected from sun	No evidence of pests or rodents	Room well ventilated	Good storage[2]	In stock today	No expired items present	Items stored by expiration date	Stock card present	Inventory up-to-date	No out of stock	
CONTRACEPTIVE METHODS													
Type of facility													
Hospital	96	96	97	97	95	87	69	94	64	57	-	30	43
Health Centre	88	99	94	98	98	78	78	98	69	57	-	34	66
Maternity	92	97	100	97	100	89	71	93	76	46	-	22	14
Clinic	94	95	95	98	93	87	65	84	57	30	-	18	148
Dispensary	93	96	93	92	94	73	84	95	72	47	-	41	302
Managing authority													
Government	91	96	92	94	95	74	85	97	70	52	-	42	333
NGO	98	98	96	95	95	88	42	100	59	19	-	8	20
Private (for profit)	96	96	96	99	94	85	66	87	63	35	-	21	184
Faith-based organisation	92	100	99	87	89	76	74	79	59	44	-	23	37
Province													
Nairobi	99	99	97	100	93	88	78	100	72	64	-	45	29
Central	93	95	93	100	93	84	74	75	55	39	-	31	102
Coast	98	100	98	96	100	91	57	100	61	46	-	26	61
Eastern	92	97	97	93	83	75	89	96	70	33	-	34	93
North Eastern	92	92	100	77	91	69	35	98	44	0	-	0	16
Nyanza	87	92	96	89	100	72	75	97	70	58	-	46	76
Rift Valley	94	96	87	96	100	73	85	94	73	42	-	27	156
Western	92	94	100	95	90	84	77	96	76	74	-	47	41
Total	93	96	94	95	95	78	77	93	67	45	-	33	574
MEDICINES													
Type of facility													
Hospital	82	91	97	94	93	73	2	79	84	88	69	1	50
Health Centre	83	87	98	94	93	76	0	80	73	80	61	0	80
Maternity	93	98	98	98	98	93	2	75	76	57	41	0	16
Clinic	93	98	100	95	91	83	13	93	75	39	27	3	180
Dispensary	81	97	100	86	94	71	7	79	70	78	54	2	334
Managing authority													
Government	78	93	99	86	93	68	5	77	71	84	61	2	339
NGO	62	87	100	82	75	58	1	84	50	70	18	0	22
Private (for profit)	97	99	100	97	93	89	13	91	75	39	27	2	213
Faith-based organisation	88	98	98	92	94	78	3	85	80	75	59	2	88
Province													
Nairobi	95	99	100	100	97	92	3	85	76	81	60	0	39
Central	100	99	100	100	96	95	18	95	90	60	46	6	125
Coast	79	100	100	86	90	66	3	76	81	75	58	0	64
Eastern	88	97	100	85	87	74	6	96	76	68	47	0	115
North Eastern	68	86	95	63	99	58	15	72	53	53	52	0	23
Nyanza	67	82	99	83	79	47	1	69	38	60	35	0	80
Rift Valley	80	96	99	91	99	74	7	79	76	71	48	3	172
Western	94	99	99	94	98	88	0	71	68	79	61	0	43
Total	85	95	99	90	93	75	7	83	73	68	49	2	661

Continued...

Table A-3.13—*Continued*

Background characteristic	Proper storage condition						Stock monitoring systems[1]						Number of facilities with stored commodities observed[3]
	Off the ground	Protected from water	Protected from sun	No evidence of pests or rodents	Room well ventilated	Good storage[2]	In stock today	No expired items present	Items stored by expiration date	Stock card present	Inventory up-to-date	No out of stock	
						ARVs							
Type of facility													
Hospital	93	97	98	96	94	84	44	92	-	80	46	28	43
Health Centre	98	98	100	98	98	96	61	97	-	61	28	34	62
Maternity	100	100	100	94	94	94	60	95	-	55	9	30	7
Clinic	100	100	100	84	84	84	62	94	-	62	19	23	19
Dispensary	100	100	100	94	95	93	83	85	-	45	23	30	142
Managing authority													
Government	98	99	100	95	96	92	72	88	-	52	25	30	199
NGO	100	100	100	80	64	64	86	95	-	47	16	32	16
Private (for profit)	100	100	100	98	97	97	67	93	-	76	41	24	24
Faith-based organisation	99	99	98	99	99	98	52	93	-	64	37	32	35
Province													
Nairobi	100	100	100	99	99	99	43	99	-	91	53	32	18
Central	100	100	100	100	100	100	69	91	-	56	25	31	32
Coast	99	100	100	89	89	88	67	83	-	55	32	24	29
Eastern	99	99	99	99	99	98	84	100	-	50	11	35	42
North Eastern	100	100	100	90	96	87	94	92	-	43	26	37	6
Nyanza	97	98	100	85	83	76	67	84	-	50	23	25	61
Rift Valley	98	98	99	99	99	96	67	88	-	46	38	23	55
Western	100	100	100	96	100	96	75	88	-	72	22	49	30
Total	99	99	100	95	95	92	70	90	-	56	27	30	274

[1] Only selected items were evaluated for the stock maintenance system. Contraceptive items assessed were oral pills, injectable progestin, IUCD, and condoms.
[2] Storage off the ground, protected from water, protected from sun, and without evidence of pests or rodents; room is well ventilated.
[3] Total includes one stand-alone VCT facility.

Table A-3.14 Reported reliability of ordering system for commodities: orders placed by facility

Percentage of facilities providing vaccinations, contraceptive methods, medicines, or ARVs, where decision on when to order the commodity is made by facility staff, and among these, percentage that consider receipt of supplies to be reliable and that received their most recent order during the 4 weeks preceding the survey visit, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where staff members determine and place commodity orders	Number of facilities storing vaccines, contraceptive methods, medicines, or ARVs	Receipt of ordered commodity: Always receive correct amount	Sometimes receive correct amount	Never receive correct amount	Most recent order received during the 4 weeks preceding the survey visit	Number of facilities that determine and place commodity orders
			VACCINES				
Type of facility							
Hospital	98	47	36	55	9	87	46
Health Centre	98	75	38	51	11	88	73
Maternity	98	12	30	51	20	89	11
Clinic	99	56	20	68	12	80	56
Dispensary	96	237	36	50	12	70	227
Managing authority							
Government	97	269	42	47	10	79	262
NGO	100	15	7	93	0	80	15
Private (for profit)	98	74	23	62	14	75	72
Faith-based organisation	94	69	21	57	20	70	65
Province							
Nairobi	97	29	9	64	24	87	28
Central	100	56	58	38	0	87	56
Coast	100	45	6	45	46	80	45
Eastern	95	73	25	51	24	70	70
North Eastern	91	14	52	48	0	42	12
Nyanza	99	61	27	71	1	69	61
Rift Valley	95	120	50	48	2	79	114
Western	94	27	20	75	5	80	26
Total	97	426	34	53	12	77	413
			CONTRACEPTIVE METHODS				
Type of facility							
Hospital	87	43	-	-	-	57	37
Health Centre	66	65	-	-	-	44	43
Maternity	95	14	-	-	-	61	14
Clinic	96	153	-	-	-	56	147
Dispensary	65	302	-	-	-	36	195
Managing authority							
Government	63	332	-	-	-	37	208
NGO	66	20	-	-	-	83	13
Private (for profit)	98	188	-	-	-	54	185
Faith-based organisation	82	37	-	-	-	45	30
Province							
Nairobi	92	28	-	-	-	74	26
Central	93	106	-	-	-	71	99
Coast	100	61	-	-	-	38	61
Eastern	70	93	-	-	-	46	65
North Eastern	72	16	-	-	-	2	12
Nyanza	58	75	-	-	-	45	44
Rift Valley	69	156	-	-	-	27	107
Western	55	41	-	-	-	41	22
Total	76	577	-	-	-	46	436
			MEDICINES				
Type of facility							
Hospital	90	50	25	61	12	63	45
Health Centre	62	80	32	54	11	53	49
Maternity	96	16	49	24	26	69	15
Clinic	97	180	58	28	14	53	175
Dispensary	52	334	30	58	8	42	175
Managing authority							
Government	49	339	19	68	8	41	168
NGO	58	22	65	22	11	83	13
Private (for profit)	100	213	56	31	12	51	212
Faith-based organisation	77	88	41	40	16	64	68
Province							
Nairobi	90	39	20	53	26	67	35
Central	93	125	57	33	8	59	116
Coast	89	64	37	52	11	56	57
Eastern	67	115	40	44	16	48	77
North Eastern	100	23	11	79	3	22	23
Nyanza	53	80	21	67	10	39	42
Rift Valley	51	172	48	36	9	42	88
Western	50	43	43	47	10	63	21
Total	70	661	41	46	11	50	460

Continued...

Table A-3.14—*Continued*

Background characteristic	Percentage of facilities where staff members determine and place commodity orders	Number of facilities storing vaccines, contraceptive methods, medicines, or ARVs	Receipt of ordered commodity:			Most recent order received during the 4 weeks preceding the survey visit	Number of facilities that determine and place commodity orders
			Always receive correct amount	Sometimes receive correct amount	Never receive correct amount		
			ARVs				
Type of facility							
Hospital	91	43	40	44	13	74	40
Health Centre	83	63	53	32	15	69	52
Maternity	75	8	50	46	0	61	6
Clinic	100	19	20	29	51	50	19
Dispensary	75	142	39	42	16	37	106
Managing authority							
Government	79	199	41	43	15	52	156
NGO	85	16	34	11	55	51	14
Private (for profit)	84	25	58	34	5	41	21
Faith-based organisation	90	36	32	37	27	68	32
Province							
Nairobi	82	19	28	35	29	70	16
Central	83	32	71	29	0	50	27
Coast	99	30	16	34	45	47	29
Eastern	81	42	23	31	46	48	34
North Eastern	41	6	5	86	5	14	2
Nyanza	64	61	50	50	0	64	39
Rift Valley	92	55	41	54	5	50	51
Western	80	31	59	19	16	52	25
Total	81	276	41	39	18	53	223

[1] Total includes one stand-alone VCT facility that determines and places orders for medicines and one that determines and places orders for ARVs.

Table A-3.16 System for ordering vaccines and contraceptive methods for facilities placing their own orders

Among facilities that provide immunisations or contraceptive methods and order their own supplies, percentage reporting that they use specific criteria to decide how much to order and when to order, by background characteristics, Kenya SPA 2010

Background characteristic	Amount ordered based on:[1]			Number of facilities
	Maintaining a fixed stock	Same amount ordered each time	Utilization	
VACCINES				
Type of facility				
Hospital	20	1	79	46
Health Centre	27	1	72	73
Maternity	19	0	81	11
Clinic	16	0	84	56
Dispensary	16	1	83	227
Stand-alone VCT	-	-	-	0
Managing authority				
Government	18	1	81	262
NGO	24	0	76	15
Private (for profit)	16	0	84	72
Faith-based organisation	22	2	77	65
Province				
Nairobi	9	4	87	28
Central	15	0	85	56
Coast	4	3	93	45
Eastern	25	0	75	70
North Eastern	10	0	90	12
Nyanza	10	0	90	61
Rift Valley	28	0	72	114
Western	28	3	70	26
Total	18	1	81	413
CONTRACEPTIVE METHODS				
Type of facility				
Hospital	13	0	87	37
Health Centre	14	2	83	43
Maternity	17	0	83	14
Clinic	9	0	91	147
Dispensary	10	0	90	195
Stand-alone VCT	0	0	100	0
Managing authority				
Government	13	0	87	208
NGO	0	0	100	13
Private (for profit)	8	0	92	185
Faith-based organisation	13	0	87	30
Province				
Nairobi	9	0	91	26
Central	13	0	87	99
Coast	11	0	89	61
Eastern	7	0	93	65
North Eastern	61	0	39	12
Nyanza	8	2	90	44
Rift Valley	6	0	94	107
Western	4	0	96	22
Total	10	0	89	436

Table A-3.17 System for ordering medicines and ARVs for facilities that place their own orders

Among facilities that provide medicines or ARVs and order their own supplies, percentage reporting that they use specific criteria to decide how much to order and when to order, by background characteristics, Kenya SPA 2010

Background characteristic	Amount ordered based on:[1]					Stock orders placed routinely:					Number of facilities
	Maintaining a fixed stock	Same amount ordered each time	Utilization	Other	Don't know/ missing	When stock falls to a pre-determined level	Fixed time	When needed	Other	Don't know/ missing	
MEDICINES											
Type of facility											
Hospital	13	0	78	0	8	21	49	21	0	8	45
Health Centre	12	0	83	3	3	16	38	42	0	4	49
Maternity	12	4	84	0	0	28	13	60	0	0	15
Clinic	9	0	88	1	2	11	14	69	1	4	175
Dispensary	11	1	82	0	6	14	51	29	0	6	175
Stand-alone VCT	16	0	84	0	0	32	42	26	0	0	1
Managing authority											
Government	13	1	83	1	3	14	61	22	0	3	168
NGO	1	0	85	0	14	7	52	27	0	14	13
Private (for profit)	10	0	86	1	3	12	13	69	1	5	212
Faith-based organisation	9	0	81	0	10	25	28	38	0	10	68
Province											
Nairobi	11	0	86	0	3	20	30	47	0	3	35
Central	13	0	87	0	0	13	32	51	0	4	116
Coast	6	1	92	0	1	15	44	41	0	1	57
Eastern	14	0	81	4	1	7	46	44	3	1	77
North Eastern	23	5	65	0	7	30	30	34	0	7	23
Nyanza	12	0	68	0	20	22	13	45	0	20	42
Rift Valley	4	0	89	0	7	12	32	49	0	7	88
Western	5	0	88	3	3	20	28	46	0	6	21
Total	11	0	84	1	4	14	34	46	1	5	460
ARVS											
Type of facility											
Hospital	14	2	84	0	1	16	58	26	0	1	40
Health Centre	15	0	84	2	0	17	41	42	0	0	52
Maternity	6	0	94	0	0	41	9	49	0	0	6
Clinic	3	0	97	0	0	46	30	24	0	0	19
Dispensary	13	0	86	1	0	26	16	56	1	1	106
Stand-alone VCT	52	0	48	0	0	36	64	0	0	0	1
Managing authority											
Government	7	0	92	1	0	21	27	50	1	1	156
NGO	31	0	69	0	0	5	63	33	0	0	14
Private (for profit)	6	1	93	0	0	21	36	44	0	0	21
Faith-based organisation	35	1	63	0	1	48	31	20	0	1	32
Province											
Nairobi	17	0	83	0	0	32	53	15	0	0	16
Central	2	1	97	0	0	13	32	56	0	0	27
Coast	7	0	93	0	0	32	30	33	0	5	29
Eastern	14	0	83	2	0	10	33	57	0	0	34
North Eastern	0	0	100	0	0	5	14	81	0	0	2
Nyanza	17	0	82	0	1	36	37	26	0	1	39
Rift Valley	20	1	80	0	0	21	22	58	0	0	51
Western	4	0	92	4	0	28	24	44	4	0	25
Total	12	0	86	1	0	24	31	44	0	1	223

[1] Multiple responses possible, hence percentage may add up to more than 100 percent.

Table A-3.18 System for ordering medicines and ARVs where order is placed by external authorities

Among facilities providing medicines and ARVs where stock orders are placed by external authorities, percentage where the amount provided is based on activity level or a fixed supply is provided, by background characteristics, Kenya SPA 2010

Background characteristic	System for determining amount provided: Based on activity level	Fixed supply	Don't know/ missing	Number of facilities where external authorities decide how much to order
	MEDICINES			
Type of facility				
Hospital	25	72	3	5
Health Centre	27	63	9	32
Maternity	60	0	40	1
Clinic	73	27	0	9
Dispensary	47	44	9	167
Managing authority				
Government	41	50	9	178
NGO	52	37	12	9
Private (for profit)	91	9	0	3
Faith-based organisation	64	34	3	22
Province				
Nairobi	41	59	0	5
Central	29	50	21	11
Coast	64	18	18	7
Eastern	35	56	8	41
North Eastern	-	-	-	0
Nyanza	52	39	9	40
Rift Valley	50	50	0	84
Western	31	40	29	25
Total	45	47	8	213
	ARVS			
Type of facility				
Hospital	74	11	15	4
Health Centre	78	22	0	10
Maternity	100	0	0	2
Clinic	-	-	-	0
Dispensary	86	10	4	32
Managing authority				
Government	80	15	5	38
NGO	100	0	0	2
Private (for profit)	100	0	0	5
Faith-based organisation	100	0	0	3
Province				
Nairobi	100	0	0	3
Central	51	49	0	5
Coast	100	0	0	2
Eastern	100	0	0	4
North Eastern	10	38	52	3
Nyanza	99	1	0	20
Rift Valley	61	39	0	4
Western	100	0	0	6
Total	84	12	4	48

Table A-3.19 Knowledge and capacity for autoclave processing of equipment

Among facilities with a functioning autoclave machine, percentage where the informant's response to questions on processing temperature and pressure was excellent or good, Kenya SPA 2010

Items	Percentage of facilities providing indicated response
Temperature	
Excellent[1]	78
Good[2]	6
Don't know/invalid	16
Pressure	
Excellent[3]	68
Good[4]	11
Don't know/invalid	21
Temperature and pressure	
Both excellent	62
Both al least good	9
Don't know/invalid response for temperature or pressure	29
Total number of facilities with functioning autoclave	232

[1] Autoclave had automatic temperature control, or response was 121°C to 132°C.
[2] Response was more that 132°C but was less than 361°C (high cut-off point was selected to include any response that appeared valid).
[3] Either automatic machine or response was PPI of 15-30 or ATM of 1 or 2.
[4] Response was PPI more than 30 and less than 61, or ATM more than 2 and less than 8 (high cut-off points were selected to include any response that appeared valid).

Table A-3.20 Storage conditions for sterilized or high-level disinfected items

Percentage of facilities with sterilized or high-level disinfected (HLD) items present and, among these facilities, percentage with specific storage conditions for processed items, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with sterilized or HLD items present	Number of facilities	Among facilities with sterilized or HLD items, percentage with:				Number of facilities with stored processed items
			Sterile/HLD status storage conditions[1]	Clean, but not sterile, storage conditions[2]	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilized items	
Type of facility							
Hospital	95	51	88	52	63	62	48
Health Centre	97	80	80	55	38	38	77
Maternity	97	17	72	45	53	47	16
Clinic	78	203	61	49	12	12	158
Dispensary	92	340	63	59	11	9	312
Stand-alone VCT	7	5	100	33	67	67	0
Managing authority							
Government	91	345	62	59	20	18	314
NGO	79	24	58	42	24	24	19
Private (for profit)	82	237	62	54	17	16	195
Faith-based organisation	95	89	95	45	26	26	84
Province							
Nairobi	67	45	76	57	42	40	30
Central	100	125	69	41	18	14	124
Coast	84	81	65	47	19	19	68
Eastern	84	118	79	57	11	10	99
North Eastern	60	24	68	60	9	9	14
Nyanza	85	83	58	67	34	34	70
Rift Valley	95	175	59	66	15	15	166
Western	91	44	70	40	34	34	40
Total	88	695	67	55	20	19	612

[1] Items are wrapped and sealed with time-steam-temperature (TST) tape or are in a sterile/HLD box that clasps shut, and storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer of autoclave, or sitting in disinfecting solution, and storage area is dry and clean.

Table A-3.21 Specific items for infection control that were available in ALL relevant service areas

Percentage of facilities where the indicated infection control items were either observed or reported available (when the service being assessed was not being offered at the time of the survey) in ALL of the service delivery areas assessed for that facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with these items in ALL service areas:[1]										Number of facilities
	Running water	Soap	Soap and running water	Hand disinfectant	Soap and running water or else hand disinfectant	Clean latex or sterile gloves	Sharps box	Disinfectant (Hibitane/ Alcohol)	All items present in all relevant sites	Waste receptacle[2]	
Type of facility											
Hospital	61	32	28	8	36	67	76	25	12	4	51
Health Centre	56	29	26	5	38	62	84	34	21	8	80
Maternity	76	37	31	2	34	78	85	48	25	8	17
Clinic	84	72	65	18	70	91	89	73	51	10	203
Dispensary	62	61	48	13	55	85	95	64	35	10	340
Stand-alone VCT	93	83	80	35	88	93	97	75	66	35	5
Managing authority											
Government	55	53	40	8	48	82	95	52	30	6	345
NGO	63	46	42	19	47	74	97	43	20	30	24
Private (for profit)	86	69	64	18	70	86	87	72	50	9	237
Faith-based organisation	71	53	46	17	51	81	77	64	28	14	89
Province											
Nairobi	85	66	61	21	67	86	87	48	39	26	45
Central	89	70	70	13	70	90	95	82	54	6	125
Coast	72	53	42	15	53	88	92	83	47	9	81
Eastern	64	56	48	19	56	74	80	27	20	11	118
North Eastern	41	40	23	11	37	90	95	52	24	6	24
Nyanza	56	50	40	12	47	72	88	45	22	5	83
Rift Valley	61	58	44	7	51	84	92	65	36	10	175
Western	63	60	46	11	51	85	95	72	42	3	44
Total	68	58	49	13	56	83	90	60	36	9	695

[1] Survey criteria required that the item be available in the service delivery room or immediately adjacent and that the item must be observed. If the service was not being provided on the day of the survey, a report that an item was normally available when services were being offered was noted and included in this table. In most cases this added only 0-1 percentage points. Items assessed for each service were: soap, running water, hand disinfectant, clean latex or sterile gloves, disinfectant and sharps box in immunization area, injection room, consultation area for sick children, and consultation/examination area for STI services, family planning, antenatal care, delivery services, general outpatient area, and VCT sites where blood is drawn or HIV testing is conducted.
[2] Waste receptacle with plastic liner and lid. This is not a component of the aggregate because, while important for infection control, it has not been commonly introduced.

Table A-3.22 Availability of supplies for preventing nosocomial infections

Percentage of facilities with infection control supplies available in facility stores, by back ground characteristics Kenya SPA 2010

Background characteristic	Percentage of facilities with the following items in store							All items for infection control indicator[2]	Number of facilities
	Hand washing soap	Liquid soap	Hand disinfectant	Latex gloves	Needles/ syringes	Disinfectant	All items present in stores[1]		
Type of facility									
Hospital	75	49	48	92	89	92	69	10	51
Health Centre	67	25	30	88	86	91	60	18	80
Maternity	69	49	44	91	93	87	81	19	17
Clinic	75	34	38	85	87	77	70	28	203
Dispensary	60	24	26	90	88	83	53	13	340
Stand-alone VCT	14	10	14	17	14	14	12	0	5
Managing authority									
Government	62	16	21	87	86	86	49	10	345
NGO	48	19	31	90	66	81	52	8	24
Private (for profit)	73	40	39	86	88	76	69	29	237
Faith-based organisation	69	57	55	98	98	86	82	23	89
Province									
Nairobi	60	60	47	85	86	81	68	21	45
Central	86	44	45	97	98	85	80	36	125
Coast	45	17	32	65	76	77	56	24	81
Eastern	67	36	30	88	84	88	58	11	118
North Eastern	46	18	27	80	85	80	40	0	24
Nyanza	61	11	19	88	84	84	54	3	83
Rift Valley	65	25	29	94	90	77	53	14	175
Western	79	17	25	92	85	90	65	24	44
Total	66	29	32	88	87	82	60	18	695

[1] (Hand washing soap or hand disinfectant), disinfectant, needles and syringes, and latex gloves are available in facility stores.
[2] Soap and running water or else hand disinfectant, sharps box, disinfecting solution, and latex gloves in all relevant service areas within facility, plus (soap or hand disinfectant), disinfectant for cleaning surfaces, needles and syringes, and latex gloves are in stock and facility has functioning equipment for sterilisation or high-level disinfection of equipment.

Table A-3.23.1 Waste disposal methods: infectious waste

Percentage of facilities that use specific methods to dispose of infectious waste, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities in which infectious waste is: Report no infectious waste	Removed offsite, unprotected storage	Removed offsite, protected storage	Burned in incinerator in facility	Burned unprotected on flat ground in facility	Burned on protected ground or in pit in facility	Dumped in unprotected area in facility without burning	Dumped in protected area in facility without burning	Other response/ missing	Number of facilities
Type of facility										
Hospital	1	2	8	49	8	31	1	1	0	51
Health Centre	0	1	4	41	11	36	4	3	0	80
Maternity	0	0	13	67	9	5	2	4	0	17
Clinic	1	3	36	16	10	21	4	10	0	203
Dispensary	0	0	3	18	15	57	3	4	0	340
Stand-alone VCT	17	5	53	5	5	15	0	0	0	5
Managing authority										
Government	0	0	2	15	18	57	3	4	0	345
NGO	2	1	25	29	0	44	0	0	0	24
Private (for profit)	1	2	33	23	8	20	4	8	0	237
Faith-based organisation	0	0	6	53	4	33	1	4	0	89
Province										
Nairobi	4	4	54	25	6	6	2	0	0	45
Central	0	0	17	17	12	34	4	16	0	125
Coast	0	0	26	32	8	34	0	0	0	81
Eastern	0	4	12	19	16	39	3	8	0	118
North Eastern	7	0	8	13	18	47	1	2	3	24
Nyanza	0	1	2	23	9	56	3	7	0	83
Rift Valley	0	0	6	29	15	48	3	0	0	175
Western	0	0	3	19	9	53	13	4	0	44
Total	1	1	14	23	12	41	3	5	0	695

Table A-3.23.2 Waste disposal methods: sharps waste

Percentage of facilities that use specific methods to dispose of sharps waste, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities in which sharps waste is: Report no sharps waste	Removed offsite, unprotected storage	Removed offsite, protected storage	Burned in incinerator in facility	Burned unprotected on flat ground in facility	Burned on protected ground or in pit in facility	Dumped in unprotected area in facility without burning	Dumped in protected area in facility without burning	Other response/ missing	Number of facilities
Type of facility										
Hospital	0	2	11	67	3	16	0	2	0	51
Health Centre	0	1	16	47	6	24	1	5	0	80
Maternity	0	0	17	64	4	7	2	6	0	17
Clinic	1	3	53	16	5	10	1	10	0	203
Dispensary	0	1	14	21	9	46	2	6	0	340
Stand-alone VCT	0	5	83	9	2	0	0	0	0	5
Managing authority										
Government	0	1	12	22	11	45	2	5	0	345
NGO	0	1	43	26	0	31	0	0	0	24
Private (for profit)	1	3	49	23	4	10	1	9	0	237
Faith-based organisation	0	0	12	54	3	21	1	8	0	89
Province										
Nairobi	0	6	69	23	2	0	0	0	0	45
Central	0	2	31	20	4	22	0	22	0	125
Coast	0	0	40	34	2	25	0	0	0	81
Eastern	2	4	14	28	12	30	3	7	0	118
North Eastern	0	0	12	18	15	46	5	1	3	24
Nyanza	0	0	21	26	2	43	3	5	0	83
Rift Valley	0	1	17	30	11	37	1	3	0	175
Western	0	0	29	28	6	26	6	4	0	44
Total	0	2	26	27	7	30	2	7	0	695

Chapter 4

Table A-4.1.1 Frequency of availability of child health services—curative care, growth monitoring, vitamin A and ITNs

Among facilities offering outpatient care for sick children, routine growth monitoring services, or BCG immunisation, percentage providing the service at the facility at specific frequencies, by background characteristics, Kenya SPA 2010

Background characteristic	Curative outpatient care for sick children				Growth monitoring				Routine provision of vitamin A supplementation				Treated mosquito nets			
	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service
	1-2	3-4	5+		1-2	3-4	5+		1-2	3-4	5+		1-2	3-4	5+	
Type of facility																
Hospital	2	1	95	50	10	1	88	48	10	2	88	48	11	3	87	32
Health centre	2	0	97	80	15	0	84	76	12	0	87	77	11	1	89	58
Maternity	5	0	93	16	26	2	70	14	27	0	71	13	31	5	64	6
Clinic	1	0	92	190	26	0	74	87	25	0	75	71	49	0	51	23
Dispensary	0	0	100	330	23	0	76	287	20	0	80	297	20	0	80	220
Managing authority																
Government	0	0	99	335	17	0	83	308	15	0	85	323	13	0	86	240
NGO	5	0	89	21	16	0	78	17	18	0	82	17	42	0	58	15
Private (for profit)	1	0	93	223	30	1	69	113	32	1	67	94	44	3	53	29
Faith-based organisation	1	0	99	87	29	0	70	74	17	2	81	70	27	1	73	56
Province																
Nairobi	7	1	89	38	28	1	70	30	30	4	66	30	27	0	73	4
Central	1	0	95	120	9	0	91	72	6	0	93	56	25	0	75	24
Coast	0	0	95	72	30	1	69	47	21	1	78	46	29	1	66	36
Eastern	0	0	99	118	7	0	93	94	7	0	93	97	5	0	95	76
North Eastern	0	0	89	23	27	0	73	16	27	0	73	16	0	50	50	0
Nyanza	2	0	96	82	10	0	90	78	13	0	87	78	11	0	88	73
Rift Valley	0	0	99	169	41	0	58	134	30	0	70	141	29	0	70	92
Western	1	0	99	43	16	1	77	40	19	0	81	40	28	1	71	34
Total	1	0	97	666	21	0	78	511	19	0	81	505	19	0	80	339

[1] Some facilities offer the service less than one day per week, and so percentages may not add to 100 percent.

Table A-4.1.2 Frequency of availability of child health services – Immunisation services

Among facilities offering routine child immunisation services, percentage providing the service at the facility at specific frequencies, by background characteristics, Kenya SPA 2010

Background characteristic	Routine polio immunisation				Routine pentavalent immunisation				Routine DPT immunisation				Routine measles immunisation				BCG immunisation			
	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service	Days per week[1]			Number of facilities offering this service
	1-2	3-4	5+		1-2	3-4	5+		1-2	3-4	5+		1-2	3-4	5+		1-2	3-4	5+	
Type of facility																				
Hospital	18	2	80	47	18	2	80	47	6	1	16	47	31	2	66	47	51	3	45	47
Health centre	21	0	79	76	23	0	76	76	10	0	24	76	50	2	47	76	65	1	31	77
Maternity	42	8	48	13	40	8	45	13	3	0	16	13	69	2	19	13	75	3	10	13
Clinic	51	0	49	59	51	0	49	59	17	0	24	59	61	0	33	59	76	0	16	56
Dispensary	43	0	52	276	43	0	52	276	9	0	9	276	50	0	42	276	62	0	27	274
Managing authority																				
Government	30	0	66	303	30	0	66	303	5	0	14	303	42	0	53	303	55	0	36	304
NGO	56	2	36	17	56	2	36	17	14	0	17	17	58	0	36	17	81	0	13	17
Private (for profit)	52	2	43	81	52	2	42	81	23	1	17	81	65	2	24	81	77	0	11	76
Faith-based organisation	49	1	50	70	51	1	48	70	12	0	13	70	68	1	30	70	82	2	13	70
Province																				
Nairobi	47	4	48	30	47	4	46	30	5	1	12	30	63	7	22	30	69	3	20	30
Central	21	1	77	56	21	1	77	56	8	0	8	56	31	0	67	56	57	0	37	54
Coast	42	0	55	46	43	0	54	46	10	0	9	46	50	1	46	46	54	0	39	46
Eastern	25	0	75	77	25	0	75	77	10	0	14	77	33	0	66	77	62	0	37	75
North Eastern	29	0	71	15	29	0	71	15	0	0	1	15	52	0	48	15	74	1	25	15
Nyanza	31	0	63	77	31	0	63	77	16	0	30	77	40	0	54	77	57	0	35	78
Rift Valley	55	0	41	131	56	0	39	131	11	0	14	131	72	0	18	131	72	0	13	131
Western	35	1	58	38	34	1	59	38	0	0	8	38	49	1	42	38	64	0	27	38
Total	38	1	59	471	38	1	58	471	10	0	14	471	50	1	44	471	64	1	28	467

[1] Some facilities offer the service less than one day per week, and so percentages may not add to 100 percent.

Table A-4.2 Availability of child health services through village outreach activities

Among all facilities, percentage offering curative care for sick children, routine growth monitoring, and child immunisation through outreach services to villages, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering indicated services through outreach					Number of facilities
	Sick child services	Growth monitoring	Routine series of child immunisation without BCG[1]	BCG services without routine series of child immunisation	All child immunisation including BCG[2]	
Type of facility						
Hospital	23	29	0	0	32	51
Health centre	27	32	0	1	32	80
Maternity	12	8	0	0	10	17
Clinic	6	5	0	0	5	203
Dispensary	16	16	0	0	17	340
Managing authority						
Government	18	22	0	0	22	344
NGO	21	21	0	0	21	22
Private (for profit)	3	3	0	0	3	236
Faith-based organisation	28	23	0	0	27	88
Province						
Nairobi	13	11	0	0	8	41
Central	1	3	0	0	3	125
Coast	23	28	0	0	31	81
Eastern	10	10	0	0	10	118
North Eastern	2	16	0	0	19	24
Nyanza	20	21	0	0	22	82
Rift Valley	17	15	0	0	16	174
Western	36	39	0	0	42	44
Total	14	16	0	0	16	690

[1] Oral polio vaccine (OPV), DPT/pentavalent, and measles vaccines but no BCG vaccine offered through outreach at least one day per month.
[2] OPV, DPT/pentavalent, measles, and BCG vaccines offered through outreach at least one day per month.

Table A-4.3 Availability of child vaccines and vitamin A

Among facilities offering child immunisation services and routinely storing vaccines, percentage with all valid child vaccines and vitamin A observed on the day of the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering immunisation services and storing vaccines with vaccines and vitamin A observed									Number of facilities offering child immunisation services and storing vaccines
	BCG	Polio	DPT or Pentavalent[1]	Measles	All basic child vaccines available[2]	Yellow fever	Anti-rabies vaccine	Snake anti-venom	Vitamin A in area with vaccines	
Type of facility										
Hospital	97	94	98	98	90	4	26	25	95	47
Health centre	96	87	98	96	79	2	12	12	92	75
Maternity	100	97	100	97	94	0	10	0	98	12
Clinic	94	94	100	100	88	0	15	2	91	56
Dispensary	93	91	96	93	82	0	6	9	95	237
Managing authority										
Government	96	89	96	93	83	0	10	13	94	269
NGO	71	96	100	100	68	0	4	4	100	15
Private (for profit)	91	95	99	99	87	1	15	3	90	74
Faith-based organisation	97	92	100	98	87	3	8	7	95	69
Province										
Nairobi	91	100	99	99	91	1	9	0	90	29
Central	96	100	100	95	91	0	1	4	100	56
Coast	100	93	100	100	93	0	8	9	95	45
Eastern	88	91	95	95	83	0	22	27	100	73
North Eastern	98	99	99	90	89	0	8	22	82	14
Nyanza	96	92	100	100	88	0	6	3	96	61
Rift Valley	95	84	94	89	73	2	9	5	88	120
Western	92	86	100	98	80	0	18	17	94	27
Total	94	91	97	95	84	1	10	10	94	426

[1] Pentavalent = DPT + hepatitis B + Haemophilus influenza B.
[2] BCG, polio, DPT/pentavalent, and measles vaccines.

Table A-4.4 Equipment, supplies, and record-keeping systems for child immunisation services

Among facilities offering child immunisation services, percentage with equipment and supplies, infection control items, and record-keeping systems observed, by background characteristics, Kenya SPA 2010

	Equipment and supplies			Items for infection control								Record-keeping system			
Background characteristic	Blank child immuni-sation records	Adequate syringes and needles	Vaccine carriers with ice pack[1]	Soap	Running water	Soap and running water (RW)	Hand disinfec-tant	Soap and RW or else hand disinfec-tant	Latex gloves	Sharps box	Decon-taminant	Register	Tally sheet or summary forms	Monitor-ing of commu-nity coverage[2]	Number of facilities offering child immunisation services
Type of facility															
Hospital	95	88	99	71	88	67	43	75	89	97	61	100	99	77	47
Health centre	93	95	100	71	85	68	22	70	86	95	65	100	99	72	76
Maternity	88	89	100	67	83	67	27	69	89	92	76	94	95	40	13
Clinic	100	100	99	88	84	79	40	80	97	100	80	88	100	59	59
Dispensary	92	98	99	78	76	67	24	74	94	98	75	99	95	72	276
Managing authority															
Government	95	97	99	74	76	65	20	70	93	99	71	100	100	76	303
NGO	88	100	100	38	71	32	30	51	68	100	56	94	88	70	17
Private (for profit)	92	95	99	84	94	82	37	87	93	97	79	90	92	49	81
Faith-based organisation	91	93	100	92	84	79	47	83	97	93	76	100	92	66	70
Province															
Nairobi	94	92	100	80	91	76	38	80	97	97	70	99	100	45	30
Central	100	97	100	84	94	83	31	83	96	100	92	100	100	67	56
Coast	99	96	100	85	75	71	51	78	99	99	91	100	100	85	46
Eastern	93	93	100	79	80	70	28	80	85	92	46	97	100	80	77
North Eastern	91	99	100	66	70	49	26	52	99	100	57	99	100	70	15
Nyanza	94	97	100	70	71	55	28	68	87	99	65	100	98	82	77
Rift Valley	91	99	100	77	80	72	19	73	95	98	77	97	91	63	131
Western	86	94	90	70	78	62	16	64	94	100	83	92	94	57	38
Total	94	96	99	77	80	69	27	74	93	98	73	98	97	70	471

[1] If a facility reported it purchased ice for the vaccines, this was accepted in place of the ice pack.
[2] Measles coverage or DPT/pentavalent dropout rate was documented and documentation observed.

Table A-4.5 Availability of equipment and supplies for curative outpatient care of the sick child

Among facilities that provide curative outpatient care for sick children, percentage with observed items in the service delivery area to support infection control, quality of services, preventive services, and assessment of the sick child, by type of facility, Kenya SPA 2010

Items	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Infection control items						
Soap	72	71	64	75	79	76
Running water	88	85	86	83	77	81
Soap & running water	69	69	64	67	66	67
Hand disinfectant	43	24	27	26	23	26
Soap & running water or else hand disinfectant	76	71	68	72	74	73
Latex gloves	90	87	91	94	95	93
Sharps container	96	95	93	92	99	96
Decontaminant	62	65	78	78	75	74
All items for infection control	49	50	58	58	56	56
Waste receptacle with plastic liner and lid	26	24	24	13	17	17
All items for infection control including waste receptacle	17	12	14	9	13	12
Items to support quality						
Child health card	80	78	79	72	72	73
Treatment guidelines/standards (any)	78	85	65	36	72	63
Visual aids for health education	65	55	56	40	52	50
All items to support quality of care	45	40	33	24	33	32
Preventive measures						
Capacity to provide vaccinations[1]	38	40	29	16	31	28
Infant weighing scale	88	90	83	36	81	70
Child weighing scale	84	78	67	43	80	69
Both infant and child weighing scales	77	72	56	29	69	58
Length board	37	28	12	12	19	19
Height board or stadiometre	50	42	23	14	23	25
Both types of board	28	22	9	8	14	14
All preventive measures	11	8	1	3	6	6
Equipment for assessment						
Thermometer	92	91	89	85	92	90
Timer[2]	72	65	63	74	55	63
Pitcher for mixing ORS	44	39	21	18	40	34
Cup/spoon for giving ORS	49	49	35	37	54	48
ORS packets in sick child service area	74	82	82	55	81	73
ORS packets in facility (pharmacy or sick child service area)	96	96	90	65	91	84
All three items for oral rehydration therapy	38	32	16	16	33	28
All equipment for assessment	24	27	14	14	22	20
ORT Corner observed[3]	40	31	10	6	34	26
Number of facilities offering sick child services	50	80	16	190	330	666

[1] Vaccines, equipment, vaccine carriers, immunisation cards, and all infection control items are all available. Register and monitoring of coverage were not considered essential for providing vaccines for sick children on the day of survey.
[2] Either a minute timer or wristwatch with a second hand that could be used to time one minute; includes facility equipment or one owned by a staff member.
[3] An ORT Corner is an area within a health facility with equipment for giving ORS solution to children with diarrhoea.

Table A-4.6 Availability of guidelines and teaching materials for outpatient care of sick children

Among facilities providing curative outpatient care for sick children, percentage where guidelines and client educational aids were observed to be available, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering sick child services that have:				Number of facilities offering sick child services
	Treatment guidelines[1]	IMCI chart booklet	IMCI mother cards	Other visual aids	
Type of facility					
Hospital	73	49	39	53	50
Health centre	82	53	35	50	80
Maternity	65	29	23	53	16
Clinic	35	12	6	38	190
Dispensary	68	43	25	43	330
Managing authority					
Government	75	52	32	52	335
NGO	71	60	66	70	21
Private (for profit)	37	13	7	34	223
Faith-based organisation	63	23	12	26	87
Province					
Nairobi	44	13	15	31	38
Central	29	19	12	28	120
Coast	80	36	23	60	72
Eastern	61	39	28	32	118
North Eastern	35	43	42	66	23
Nyanza	89	57	34	55	82
Rift Valley	62	34	12	47	169
Western	85	51	41	52	43
Total	61	35	22	43	666

[1] Any guidelines on management of childhood illnesses, or guideline on management of malaria.

Table A-4.7 Availability of immunisation services and outpatient care for sick children on the same day

Among facilities offering curative outpatient care for sick children, percentage reporting that child immunisation (EPI) is available every day that sick child services are offered, and percentage where both sick child and EPI services were observed being offered on the day of the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Among facilities offering sick child services, percentage where:		Number of facilities offering sick child services
	EPI services are reported to be available every day that sick child services are offered	On day of survey, both sick child and EPI services were available	
Type of facility			
Hospital	59	82	50
Health centre	59	85	80
Maternity	47	59	16
Clinic	13	22	190
Dispensary	46	50	330
Managing authority			
Government	56	66	335
NGO	34	53	21
Private (for profit)	14	23	223
Faith-based organisation	39	49	87
Province			
Nairobi	35	44	38
Central	31	40	120
Coast	27	45	72
Eastern	44	50	118
North Eastern	65	44	23
Nyanza	63	71	82
Rift Valley	35	43	169
Western	36	66	43
Total	39	49	666

Table A-4.8 Availability of medicines for treatment of the sick child

Among facilities that provide curative outpatient care for sick children, percentage where first-line, pre-referral, and other essential medications are available, by type of facility, Kenya SPA 2010

Items	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
First-line oral medicines						
Oral rehydration solution (ORS)	96	96	90	65	91	84
Antibiotic: amoxicillin or Augmentin syrup/tabs	90	69	90	87	67	75
Antibiotic: cotrimoxazole syrup/tabs	97	89	90	81	71	79
Antibiotic: chloramphenicol syrup/tabs	32	23	54	32	14	22
Any of above antibiotics	99	89	90	89	83	87
First-line antimalarial: Coartem[1]	88	85	69	58	93	81
Antimalarial: artesunate	22	7	37	26	8	15
Antimalarial: Fansidar	88	91	75	58	87	79
Antimalarial: amodiaquine syrup/tabs)	26	19	43	30	19	23
All first-line oral medicines[2]	86	76	63	46	73	66
Pre-referral medicines						
Injectable chloramphenicol	55	41	55	26	26	31
Injectable ampicillin or cloxacillin	15	8	10	2	0	3
Injectable penicillin	93	91	90	74	85	83
Injectable gentamycin	83	68	85	76	65	70
Injectable ceftriaxone	60	26	62	38	22	31
Intravenous solution with perfusion set[3]	96	96	100	61	82	79
Sterile syringes	99	100	100	100	99	100
All pre-referral medicines[4]	83	74	90	50	62	62
Other essential medicines						
Aspirin or paracetamol (antipyretic)	96	95	94	91	91	92
Vitamin A (any dose)	82	98	78	41	87	74
Iron tablet	42	31	49	43	23	32
Albendazole or mebendazole (deworming)	93	97	82	79	90	88
All other essential medicines	36	29	42	25	18	23
Number of facilities offering sick child services	50	80	16	190	330	666

[1] Coartem (artemether + lumefantrine) is the recommended first-line treatment for malaria in Kenya.
[2] ORS, at least one oral antibiotic, and Coartem.
[3] Intravenous solutions include: normal saline (0.9%NS) or dextrose and normal saline (5%D/NS) or lactated Ringers solution or plasmas expanders or 5%D/W.
[4] (1) Injectable chloramphenicol or at least one first-line injectable antibiotic (ampicillin or cloxacillin or penicillin) and (2) at least one second-line injectable antibiotic (ceftriaxone or gentamycin) and (3) intravenous solution with perfusion set and sterile syringes.

Table A-4.9 Facility utilization statistics for outpatient care for sick children

Among facilities providing curative outpatient care for sick children, the median number of sick-child consultations per month, by background characteristics, Kenya SPA 2010

Background characteristic	Median monthly number of sick-child consultations	Number of facilities providing consultation data
Type of facility		
Hospital	322	44
Health centre	308	75
Maternity	52	14
Clinic	42	117
Dispensary	149	327
Managing authority		
Government	183	326
NGO	221	18
Private (for profit)	42	147
Faith-based organisation	104	85
Province		
Nairobi	122	30
Central	51	100
Coast	177	51
Eastern	134	98
North Eastern	205	19
Nyanza	164	81
Rift Valley	148	155
Western	187	43
Total	138	577

[1] Median value for the average of the number of months out of the past 12 months for which data were available. Data are from health information system monthly reports available at the facility on the day of the survey. Data were requested for the 12 months prior to the survey, but occasionally the number of months was missing; for those facilities, 12 months were assumed. Information from the months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-4.10.1 Information on user fees for outpatient care for sick children

Percentage of facilities offering curative outpatient care for sick children that charge user fees for specific items and, among facilities with any user fees for sick child services, percentage that publicly post fees, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities charging for the indicated item:									Number of facilities offering sick child services	Discount or exemptions offered	Percentage where fees are posted in public view			Number of facilities having any user fees for sick child services
	Client chart or record	Consultation	Medicines	Lab tests	Registration	Weighing child	De-worming child	Fee varies by diagnosis	No charges or don't know			All fees are posted	Some fees are posted	No fees are posted	
Type of facility															
Hospital	23	46	40	48	20	6	16	26	36	50	75	42	17	41	32
Health centre	37	38	38	51	24	7	8	23	30	80	86	21	21	58	56
Maternity	17	80	87	79	19	37	35	64	9	16	74	6	12	82	15
Clinic	16	48	83	59	19	21	43	64	6	190	65	10	18	72	178
Dispensary	24	14	23	29	33	8	7	11	29	330	83	18	14	68	233
Managing authority															
Government	29	13	8	20	32	1	1	3	39	335	83	29	13	58	205
NGO	15	22	27	24	24	10	4	17	42	21	80	9	26	65	12
Private (for profit)	16	58	86	62	18	24	43	69	4	223	67	9	18	73	214
Faith-based organisation	22	31	82	86	29	24	26	40	5	87	83	6	18	76	82
Province															
Nairobi	13	37	62	52	13	23	32	44	37	38	76	4	14	82	24
Central	21	38	66	48	21	18	37	43	15	120	62	16	20	64	103
Coast	13	30	51	43	14	10	26	32	35	72	73	29	0	71	47
Eastern	16	19	39	43	17	17	16	35	36	118	74	20	12	68	75
North Eastern	21	17	30	29	4	0	13	23	52	23	73	3	12	85	11
Nyanza	32	28	28	36	39	8	5	26	19	82	85	17	15	68	67
Rift Valley	27	35	36	43	42	8	12	18	10	169	86	14	20	66	152
Western	41	29	47	41	28	4	5	22	19	43	76	17	21	61	35
Total	23	30	45	43	27	12	19	30	23	666	77	17	16	67	513

Table A-4.10.2 Procedures if client cannot pay for services

Among facilities with fees for sick child services, percentage who follow a specific procedure when clients are unable to pay the fee requested, according to background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities that:					Number of facilities having any user fees for sick child services
	Exempt from fee;, no payment expected	Exempt from fee; payment expected later	Provide no service; come when can pay	Accept payment in-kind	Other	
Type of facility						
Hospital	61	38	7	0	6	32
Health centre	68	42	3	5	5	56
Maternity	34	70	1	4	6	15
Clinic	29	70	9	0	4	178
Dispensary	76	32	4	0	1	233
Managing authority						
Government	89	19	0	1	0	205
NGO	68	67	0	9	7	12
Private (for profit)	32	71	8	1	3	214
Faith-based organisation	38	56	13	0	6	82
Province						
Nairobi	28	53	18	0	8	24
Central	54	47	5	0	5	103
Coast	40	70	0	1	5	47
Eastern	46	44	11	0	1	75
North Eastern	46	39	15	0	0	11
Nyanza	84	39	0	2	2	67
Rift Valley	60	44	5	1	0	152
Western	64	54	3	0	4	35
Total	57	48	6	1	3	513

Table A-4.11 Out-of-pocket payments for sick child consultations

Among interviewed caretakers of sick children, percentage who reported belonging to a programme to prepay or defer child health costs and percentage who reported paying any out-of-pocket fees for sick child services on the day of the survey; and, among caretakers who paid any fees for services, median amount (Kenyan shillings) paid, by type of facility, Kenya SPA 2010

Type of facility	Percentage who belong to prepayment or cost deferral programme	Percentage who paid any out-of-pocket fees this visit among those who:[1]		Number of interviewed caretakers	Median out-of-pocket fees (Kenyan shillings) paid by caretakers who paid anything for child health services on the day of survey, among those who:[1]		Number of interviewed caretakers providing valid responses about out-of-pocket payments who:	
		Belong to programme	Do not belong to programme		Belong to programme	Do not belong to programme	Belong to programme	Do not belong to programme
Hospital	19	12	34	456	230	50	30	143
Health centre	7	4	56	370	250	50	13	208
Maternity	31	20	61	14	570	301	3	8
Clinic	20	8	53	163	300	150	13	86
Dispensary	7	4	57	943	101	21	35	540
Total	11	6	51	1,945	190	41	94	985

[1] Includes any amount paid out-of-pocket, including fees for consultation, laboratory tests, medicines, or other.

Table A-4.12 Supportive management for providers of child health services

Among interviewed child health service providers, percentage who received training related to their work and personal supervision during the specified time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed service providers who received:				Number of interviewed child health service providers[2]
	Training related to child health during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey	Training related to child health during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the was 13-35 months preceding the survey	
Type of facility					
Hospital	42	73	33	21	591
Health centre	39	85	35	20	371
Maternity	35	57	21	18	73
Clinic	32	60	22	21	356
Dispensary	32	84	30	19	599
Managing authority					
Government	37	83	33	22	1,115
NGO	35	80	30	34	74
Private (for profit)	33	57	22	17	442
Faith-based organisation	38	74	29	16	358
Province					
Nairobi	42	71	33	25	228
Central	37	66	25	18	253
Coast	32	76	26	17	217
Eastern	27	72	20	21	356
North Eastern	38	80	33	31	38
Nyanza	44	81	39	22	287
Rift Valley	36	77	31	20	459
Western	42	87	40	13	151
Total	36	75	30	20	1,989

[1] This refers to structured training sessions (either in-service or pre-service) and does not include individual instruction received during routine supervision.
[2] Includes only providers of child health services in facilities offering child health services.

Table A-4.13.1 Training for child health service providers (I)

Among interviewed child health service providers, percentage who received pre- or in-service training on specific topics related to child health during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	EPI/cold chain		ARI treatment[1]		Diarrhoea treatment		Nutrition/ micronutrient deficiencies		IMCI[2]		Malaria treatment for children		Number of interviewed child health service providers[2]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility													
Hospital	8	13	11	14	14	16	15	14	12	16	18	17	591
Health centre	8	19	9	26	12	24	15	23	14	20	17	22	371
Maternity	11	13	7	16	12	16	16	10	11	17	18	17	73
Clinic	6	11	5	17	8	19	8	15	7	12	14	18	356
Dispensary	6	17	7	13	11	12	11	12	9	14	19	19	599
Managing authority													
Government	6	15	8	15	12	15	14	15	11	16	20	19	1,115
NGO	4	17	7	21	8	19	9	22	5	21	10	23	74
Private (for profit)	9	15	11	20	13	20	12	15	13	16	17	18	442
Faith-based organisation	7	15	5	16	9	17	10	17	7	12	11	17	358
Province													
Nairobi	9	19	7	22	12	19	13	17	8	18	14	24	228
Central	5	12	7	19	9	22	11	17	11	19	17	18	253
Coast	9	10	8	9	13	12	16	8	10	7	19	13	217
Eastern	4	11	5	14	5	16	7	13	5	11	10	19	356
North Eastern	7	25	2	31	7	28	22	24	7	29	23	34	38
Nyanza	7	19	14	20	18	21	17	22	17	19	23	19	287
Rift Valley	8	20	8	18	13	13	12	16	10	17	18	20	459
Western	9	5	12	9	16	11	13	7	18	15	26	10	151
Total	7	15	8	17	12	17	13	15	11	16	18	19	1,989

[1] Acute respiratory infection.
[2] Integrated Management of Childhood Illness.
[3] Includes only providers of child health services in facilities offering child health services.

Table A-4.13.2 Training for child health service providers (II)

Among interviewed child health service providers, percentage who received pre- or in-service training on specific topics related to child health during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Breastfeeding		Complementary feeding for infant		Nutritional assessment		Paediatric AIDS		Paediatric ART		Paediatric HIV/ARVs		Number of interviewed child health service providers[1]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility													
Hospital	19	15	19	14	16	12	3	3	9	11	4	4	591
Health centre	17	25	17	22	16	22	4	7	9	10	6	2	371
Maternity	19	13	17	12	12	11	7	1	11	7	7	4	73
Clinic	17	17	14	18	10	11	3	3	9	11	1	1	356
Dispensary	15	19	14	14	9	10	2	1	6	3	3	3	599
Managing authority													
Government	17	19	16	16	13	12	3	3	7	8	4	4	1,115
NGO	20	24	22	23	12	21	7	3	12	23	5	0	74
Private (for profit)	18	18	15	18	13	13	2	4	9	9	2	3	442
Faith-based organisation	16	16	17	14	10	13	2	2	9	8	4	1	358
Province													
Nairobi	21	20	20	17	11	15	9	11	10	16	7	0	228
Central	18	23	18	21	14	14	1	0	11	5	5	1	253
Coast	18	9	18	9	17	5	3	1	7	10	3	0	217
Eastern	10	13	8	13	7	11	2	1	6	5	1	1	356
North Eastern	15	29	14	32	19	24	0	0	2	7	0	1	38
Nyanza	21	21	18	19	15	20	5	5	13	13	4	1	287
Rift Valley	17	24	18	18	12	13	1	3	6	7	2	10	459
Western	19	9	13	8	13	7	2	0	7	5	7	1	151
Total	17	18	16	16	13	13	3	3	8	9	4	3	1,989

[1] Includes only providers of child health services in facilities offering child health services.

Table A-4.14 Supportive supervision for child health service providers

Among interviewed child health providers who were personally supervised in the 6 months preceding the survey, median number of times they were supervised, and percentage who reported specific activities of the supervisor during the last visit, by background characteristics, Kenya SPA 2010

Background characteristic	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that during the last supervisory visit the supervisor:						Number of providers of child health services who were supervised in the 6 months preceding the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	3	96	91	90	76	91	47	430
Health centre	3	97	91	91	79	93	60	314
Maternity	2	93	88	89	75	85	46	41
Clinic	3	94	89	88	75	85	42	214
Dispensary	3	98	90	80	73	92	53	502
Managing authority								
Government	3	97	91	83	75	93	53	923
NGO	3	96	97	99	83	89	67	59
Private (for profit)	3	95	90	87	73	86	34	253
Faith-based organisation	3	98	89	94	78	89	56	265
Province								
Nairobi	4	96	92	93	82	91	41	163
Central	3	99	93	95	80	91	43	167
Coast	3	95	84	81	84	95	63	165
Eastern	3	97	88	89	63	90	54	257
North Eastern	3	93	98	58	51	83	34	30
Nyanza	3	96	91	92	86	94	63	232
Rift Valley	2	97	92	77	73	89	49	354
Western	3	97	91	90	69	90	38	132
Total	3	97	91	87	76	91	51	1,500

[1] Includes only providers of child health services in facilities offering child health services.

Table A-4.15 Observed assessments, examinations, and treatments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Consultation conducted by specialist/ medical officer/clinical officer	88	45	43	47	7	38
Consultation conducted by BSN/registered nurse/midwife	8	30	32	14	18	18
Consultation conducted by enrolled nurse/ midwife/nurse aide	4	25	25	38	68	41
History: assessment of general danger signs						
Inability to eat or drink anything	49	47	61	47	50	49
Vomiting everything	59	54	58	63	54	56
Convulsions	19	15	34	24	18	19
All general danger signs	12	12	26	19	11	13
History: assessment of main symptoms						
Cough or difficult breathing	85	78	83	83	81	82
Diarrhoea	51	47	46	48	45	47
Fever	89	90	87	90	88	89
All three main symptoms[1]	40	35	40	40	33	36
Ear pain or discharge	11	13	30	19	10	12
All 3 main symptoms plus ear pain/discharge[2]	7	6	25	11	6	7
History: Other						
Asked about TB	6	4	7	5	3	4
Asked about 2 or more episodes of diarrhoea	13	10	14	6	8	10
Asked about mother's HIV status	7	12	14	7	9	9
Physical examination						
Felt temperature	78	71	85	68	66	70
Measured temperature (observed or system)[3]	70	71	77	90	79	76
Any assessment of temperature	92	87	100	96	92	91
Assessed anaemia: looked at palms	38	34	51	50	32	35
Assessed anaemia: looked at eye conjunctiva or mucosa of mouth	64	53	59	69	55	58
Any assessment of anaemia	68	58	66	73	57	61
Assessed dehydration	22	20	28	25	18	20
Counted respiratory rate	27	30	31	37	20	25
All key physical checks[4]	10	8	20	16	6	8
Auscultated	63	42	62	74	44	51
Check mouth and throat	42	28	47	52	31	35
Looked in ear	20	19	26	28	14	18
Felt behind ear	20	19	20	29	18	20
Checked for pedal oedema (press both feet)	7	10	14	14	8	9
Removed clothing and observed musculature	25	21	32	52	23	26
All physical checks[5]	2	0	11	6	1	2
Checked enlarged lymph nodes in 2+ sites	14	9	19	24	15	14
Checked mouth for oral thrush	27	22	30	34	23	25
Essential advice						
Increase fluids	25	25	25	26	28	26
Continue feeding	37	29	46	54	42	39
Symptoms for immediate return	30	34	19	42	40	36
All three essential messages	12	15	10	16	14	14
Drinking/feeding practice during illness						
Feeding/breastfeeding practices	50	43	49	60	45	47
Observed if child can drink or suck	13	15	16	8	19	16
Both assessments of drinking/feeding status	10	10	16	5	14	12
Number of observed children	497	392	15	163	949	2,016

[1] Assessed cough, diarrhoea, and fever.
[2] Assessed cough, diarrhoea, fever, and ear symptoms.
[3] Either the provider or another health worker is observed measuring the child's temperature, or the facility has a system in which all sick children have their temperature measured before a provider sees them.
[4] Counted respiratory rate, assessed presence of fever (either measured or by touch), and assessed presence of anaemia (either palms or mucosa).
[5] Counted respiratory rate, assessed presence of fever (either measured or by touch), assessed presence of anaemia (either palms or mucosa), auscultated, checked mouth and throat, checked ear, checked feet (pedal oedema), and checked musculature.

Table A-4.16 Children sent home with diagnosis and appropriate treatment

Percentage of observed children sent home after consultation with indicated diagnoses and, among them, percentage who received appropriate treatment, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Child diagnosis						
Diarrhoea without dysentery or amoebiasis	13	13	8	3	12	12
Pneumonia	12	12	8	13	15	13
Malaria	45	64	21	46	54	53
Diarrhoea, pneumonia, or malaria	60	72	32	54	66	65
Number of observed children sent home after consultation	351	311	12	115	848	1,637
Among children with indicated diagnosis, percent who received correct treatment						
Diarrhoea without dysentery or amoebiasis[1]	49	60	31	0	67	59
Pneumonia[2]	76	87	100	37	82	79
Malaria[3]	69	66	65	60	72	69
Diarrhoea, pneumonia, or malaria	70	69	61	59	75	72
Among children sent home, percentage with:						
Malaria diagnosis	45	64	21	46	54	53
Kenya treatment guidelines for malaria[4] were followed	8	12	16	3	10	10

[1] Child diagnosed with diarrhoea and treated with oral rehydration therapy, either initially at the facility or home oral rehydration, or both.
[2] Child diagnosed with pneumonia and treated with an injectable or oral antibiotic.
[3] Child diagnosed with malaria and treated with Coartem.
[4] Child has been sick for not more than a day, diagnosed with malaria at the facility, prescribed Coartem; caretaker counselled on signs and symptoms for which to bring child back immediately; caretaker feels comfortable/confident about how to proceed with treatment at home.

Table A-4.17 Prescriptions and medicines provided for the observed sick child (includes only children with complete exit interviews)

Among interviewed caretakers of sick children, percentage who reported child received dose of medicine or injection at the facility; among observed sick children who were prescribed or provided oral medicines, percentage whose caretakers were told how to administer medicine and percentage who received first dose at facility; and, among interviewed caretakers of children who received medicine or prescription, percentage who had medicine or prescription on departure from the facility, percentage who reported being told how to administer the medicine at home, and percentage who felt they understood how to administer each of the medicines at home, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Child was provided a dose of oral medicine at the facility	25	24	26	36	34	30
Child received injection at the facility or prescription for injection	13	26	19	26	20	20
Number of interviewed caretakers of sick children	456	370	14	163	943	1,945
Observed during consultation						
Caretaker told how to administer medications	55	60	70	67	71	65
Caretaker asked to repeat instructions	13	16	19	19	25	20
Child received first dose of prescribed oral medicine at facility	31	24	25	44	38	34
Antibiotic was prescribed	76	76	87	85	68	73
Number of observed sick children who were prescribed or provided oral medicines	415	359	13	152	899	1,838
Observed/reported during exit interview						
Caretaker has all medicines	54	52	76	82	64	61
Caretaker has some medicines and some prescriptions	37	41	16	10	32	33
Caretaker has only prescriptions	8	7	7	8	3	6
Child received or was prescribed an injectable medicine	13	25	18	24	20	20
Reported by caretaker						
Was told how to give the medicine at home	93	94	96	94	97	95
Feels comfortable in knowledge of how much of each medicine to give at home	94	94	96	93	98	96
Number of interviewed caretakers of sick children who received prescription, medicine, or both to be taken at home	446	361	14	157	918	1,896

Table A-4.18 Observed preventive assessments for sick children

Percentage of observed children whose weight, feeding, and immunisation status were assessed during the consultation and whose caretakers were interviewed, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Preventive measures						
Child weighed	73	65	42	69	66	68
Weight plotted	52	44	32	59	42	46
Triaging based on severity	48	25	29	34	35	36
Normal feeding assessed (<24 months)	43	39	59	54	36	40
Normal breastfeeding assessed (<24 months)	39	37	58	44	36	38
Normal feeding assessed (≥24 months)	31	36	19	41	42	38
Normal feeding/breastfeeding practices assessed (any age)	39	37	42	48	38	39
Immunisation status assessed (<24 months)	69	65	70	62	66	66
Immunisation status assessed (≥24 months)	55	67	23	61	57	58
Immunisation status assessed (any age)	64	65	50	62	63	63
Number of observed children whose caretakers were interviewed						
Number of observed children <24 months old	289	216	8	95	573	1,181
Number of observed children ≥24 months old	167	154	6	68	369	764
Number of observed children	456	370	14	163	943	1,945

Table A-4.19 Topics discussed and immunisations received by sick children (includes only children with complete exit interviews)

Percentage of interviewed caretakers of observed children who reported that a provider discussed selected topics; and percentage of interviewed caretakers of young children (<24 months) who brought an immunisation card to the facility and reported that the child received an immunisation during that visit, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Topics discussed by provider						
Weight or nutritional status of the child	23	28	11	19	23	24
General feeding practices	19	25	15	14	23	22
Give more food or liquid during the illness	12	15	11	6	15	13
Give same as usual amount of food or liquid during the illness	5	7	2	4	7	6
Was told diagnosis	46	48	67	54	48	48
Number of interviewed caretakers	456	370	14	163	943	1,945
Caretaker reports child <24 month received immunisation	5	4	3	2	3	4
Number of interviewed caretakers of children <24 months	289	216	8	95	573	1,181

Table A-4.20 Attitudes of a caregiver for sick children about new vaccination against malaria (includes only children with complete exit interviews)

Percentage of interviewed caretakers of observed children with specific attitudes about new vaccine against malaria, by type of facility, Kenya SPA 2010

Specific attitudes	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Would support vaccination of young children in their community	92	96	86	91	91	92
Number of interviewed caretakers	456	370	14	163	943	1,945
Would have their own child vaccinated with the vaccine	91	96	82	92	91	92
Number of interviewed caretakers with child under 5	451	362	14	158	905	1,890
If had a child under 5, would have child vaccinated with the vaccine	93	81	-	100	69	76
Number of interviewed caretakers with no child under 5	5	7	0	5	37	55

Table A-4.21 Feedback from caretakers of sick children on service problems (includes only children with complete exit interviews)

Percentage of interviewed caretakers of sick children who considered specific service issues to be major problems for them on the day of the visit, by type of facility, Kenya SPA 2010

Client service issue	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Behaviour/attitude of provider	3	2	0	0	1	1
Insufficient explanation about child's illness	10	6	3	8	6	7
Waiting time to see provider	35	28	3	11	21	25
Quality of examination and treatment	6	4	1	0	6	5
Availability of medicines	19	26	4	2	17	18
Days facility is open	2	6	4	4	6	5
Hours facility is open	11	11	6	9	7	9
Cleanliness of facility	2	1	0	2	2	2
Cost of services	9	9	9	5	7	8
Insufficient visual privacy	3	4	2	1	4	3
Insufficient auditory privacy	3	4	2	1	4	4
Number of interviewed caretakers of sick children	456	370	14	163	943	1,945

Table A-4.22 Caretakers' choice of facility (includes only children with complete exit interviews)

Among interviewed caretakers of sick children, percentage who reported this was not the closest health facility to their home and, among these, the main reasons that they did not go to the closest facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed caretakers who report this is not the closest facility to their home	Number of interviewed caretakers of sick children	Percentage of caretakers who say the main reason they did not go to the nearest facility is:									Number of interviewed caretakers for whom this was not the closest facility
			Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Other	Don't know/ missing	
Type of facility												
Hospital	32	456	6	17	6	13	4	23	7	24	0	147
Health centre	18	370	14	16	4	25	0	11	5	25	0	67
Maternity	46	14	4	10	22	13	12	8	0	26	5	7
Clinic	33	163	4	12	19	3	5	22	2	32	0	53
Dispensary	11	943	0	28	4	24	0	20	2	16	5	107
Managing authority												
Government	15	1,430	6	13	5	19	1	26	6	25	0	207
NGO	7	68	0	42	0	0	0	29	0	29	0	5
Private (for profit)	36	209	6	25	7	7	7	15	6	27	0	76
Faith-based organisation	39	239	5	27	13	21	2	9	1	17	6	92
Province												
Nairobi	31	162	0	37	5	10	5	22	7	15	0	50
Central	18	159	5	66	1	8	1	15	0	3	1	29
Coast	24	228	3	3	16	16	1	33	0	28	0	55
Eastern	19	305	14	12	4	17	5	9	9	29	0	57
North Eastern	5	78	0	0	0	31	0	65	0	4	0	4
Nyanza	19	381	5	13	8	6	0	19	5	44	0	73
Rift Valley	19	415	7	9	4	32	2	14	7	17	6	81
Western	15	216	0	31	14	20	1	25	1	7	1	32
Total	20	1,945	5	19	7	17	2	20	5	23	2	380

Table A-4.23 Educational characteristics of caretakers of observed sick children (includes only children with complete exit interviews)

Percent distribution of interviewed caretakers of sick children by educational level, and percentage of caretakers with primary, informal, or no education who are literate, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed caretakers who have:					Number of interviewed caretakers of sick children	Percentage of interviewed caretakers with primary, post-primary, technical, or no education who:				Number of interviewed caretakers with primary, post-primary, technical or no education
	No education	Primary	Post-primary/ technical	Secondary	Higher		Cannot read or write	Can read, cannot write	Can read and write	Missing	
Type of facility											
Hospital	8	48	1	29	13	456	26	3	68	3	264
Health centre	8	61	1	24	6	370	19	4	73	4	258
Maternity	7	36	1	27	29	14	30	1	66	3	6
Clinic	22	39	1	24	15	163	35	2	59	4	100
Dispensary	17	55	1	24	3	943	32	7	59	2	693
Managing authority											
Government	15	56	1	24	4	1,430	29	5	63	3	1,038
NGO	20	69	0	10	1	68	34	0	65	1	61
Private (for profit)	8	37	0	32	23	209	17	5	76	3	93
Faith-based organisation	10	43	1	31	15	239	34	5	55	6	129
Province											
Nairobi	4	28	1	43	24	162	6	2	81	11	54
Central	2	51	0	39	8	159	12	2	87	0	84
Coast	35	46	1	12	6	228	48	2	50	0	187
Eastern	7	60	3	23	7	305	38	5	56	0	213
North Eastern	78	17	0	5	0	78	78	9	13	0	74
Nyanza	5	71	0	18	5	381	8	3	82	7	291
Rift Valley	16	47	2	31	4	415	31	11	55	3	269
Western	5	64	1	24	6	216	20	3	76	1	150
Total	14	53	1	25	7	1,945	29	5	64	3	1,321

Chapter 5

Table A-5.1 Methods of family planning offered

Among facilities offering family planning services, percentage that provide, prescribe, or counsel clients on specific family planning methods, by type of facility, Kenya SPA 2010

Methods offered	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Combined oral contraceptive	94	97	100	95	94	95
Progestin-only oral pill	92	95	82	67	88	83
Progestin-only injectable (3-month)	94	96	97	98	94	95
Progestin-only injectable (2-month)	10	4	8	7	6	6
Progestin-only injectable (2- or 3-month)	94	96	97	98	94	95
Combined injectable (1-month)	9	3	13	7	6	6
Male condom	93	97	95	86	94	92
Female condom	71	58	70	44	40	46
Intrauterine contraceptive device	87	77	89	54	44	55
Implant	83	67	80	52	36	48
Counselling on natural (periodic abstinence) method	82	73	72	54	62	63
Moon beads for Standard Days Method (SDM)	32	28	22	19	12	18
Female sterilisation	73	38	54	22	23	29
Male sterilisation	52	24	36	20	19	22
At least two temporary modern methods[1]	94	97	100	98	95	96
At least four temporary modern methods[1]	94	97	98	74	89	87
Emergency contraceptive pill	87	90	88	68	88	83
Number of facilities offering temporary family planning	46	68	15	164	319	612

[1] Includes contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine devices (IUCD), and condoms (male or female). Permanent methods (sterilisation), natural methods (periodic abstinence), and emergency contraceptive pills are not included.

Table A-5.2 Methods of family planning provided

Among facilities offering family planning (FP) services, percentage that provide clients specific FP methods, by type of facility, Kenya SPA 2010

Methods provided	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Combined oral contraceptive	92	91	96	85	94	91
Progestin-only oral pill	89	82	73	56	85	77
Progestin-only injectable (3-month)	90	90	93	91	93	92
Progestin-only injectable (2-month)	5	3	3	1	2	2
Progestin-only injectable (2- or 3-month)	91	90	95	92	93	92
Combined injectable (1-month)	3	0	5	1	1	1
Male condom	92	91	89	79	93	89
Female condom	55	39	51	28	33	34
Intrauterine contraceptive device	74	66	76	34	23	36
Implant	67	53	72	34	18	31
Counselling on natural (periodic abstinence) method	29	19	34	23	26	25
Moon beads for Standard Days Method (SDM)	12	9	5	2	1	3
Female sterilisation	50	23	35	3	2	9
Male sterilisation	33	13	17	1	1	5
At least two temporary modern methods[1]	93	92	98	90	95	93
At least four temporary modern methods[1]	90	85	94	62	87	80
Emergency contraceptive pill	79	81	73	48	82	72
Number of facilities offering temporary family planning	46	68	15	164	319	612

[1] Includes contraceptive pills (combined or progestin-only), injectables (combined or progestin-only), implants, intrauterine devices (IUCD), and condoms (male or female). Permanent methods (sterilisation), natural methods (periodic abstinence), and emergency contraceptive pills are not included.

Table A-5.3 Availability of family planning methods by type of facility

Among facilities that provide clients the indicated family planning method, percentage where the method was available on the day of the survey, by type of facility, Kenya SPA 2010

Methods	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Combined oral contraceptive	98	98	96	86	95	93
Progestin-only oral pill	97	99	91	89	98	96
Progestin-only injectable (3-month)	98	98	93	84	98	94
Progestin-only injectable (2- month)	93	100	100	100	100	99
Progestin-only injectable (2- or 3-month)	98	98	94	84	98	94
Combined injectable (1-month)	65	-	0	100	0	36
Male condom	93	95	92	76	98	92
Female condom	80	79	71	81	87	83
Intrauterine contraceptive device	93	98	89	73	99	90
Implant	77	87	81	57	76	73
Moon beads for standard days method SDM	63	48	100	100	100	74
Emergency contraceptive pill	88	91	82	73	88	85
Every method provided by a facility was available the day of the survey	61	67	62	54	80	70

Table A-5.4 Availability of family planning methods by province

Among facilities that provide clients the indicated family planning method, percentage where the method was available on the day of the survey, by province, Kenya SPA 2010

Methods	Province								Total percentage
	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	
Combined oral contraceptive	99	87	88	96	75	91	97	99	93
Progestin-only oral pill	100	96	91	96	99	99	95	99	96
Progestin-only injectable (3-month)	100	84	90	100	77	99	97	99	94
Progestin-only injectable (2-month)	100	100	93	-	-	100	-	100	99
Progestin-only injectable (2- or 3-month)	100	84	90	100	77	99	97	99	94
Combined injectable (1-month)	100	31	100	0	-	0	-	-	36
Male condom	92	71	99	99	98	93	96	99	92
Female condom	98	82	97	79	100	86	77	86	83
Intrauterine contraceptive device	100	79	82	89	100	94	99	92	90
Implant	85	60	65	70	78	77	81	82	73
Moon beads for Standard Days Method (SDM)	100	62	81	25	100	-	51	-	74
Emergency contraceptive pill	89	76	88	86	54	91	86	97	85
Every method provided by a facility was available the day of the survey	87	52	70	80	42	67	73	87	70

Table A-5.5 Availability of infrastructure, resources, and systems for quality family planning services

Percentage of facilities offering temporary family planning (FP) services where items to support good counselling, infection control and physical examinations were observed to be available, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Items to support quality counselling						
Visual and auditory privacy	94	96	98	98	90	93
Visual privacy only	2	2	2	1	4	3
Auditory privacy only	1	0	0	0	0	0
No privacy	3	2	0	1	6	4
Individual client health cards	66	64	69	69	62	64
Written FP guidelines	58	50	37	29	34	36
Written STI guidelines	44	51	33	30	42	39
Visual aids for health education on family planning	90	86	84	72	83	81
Visual aids for health education on STIs including HIV/AIDS)	72	59	66	50	57	57
All items to support quality counselling[1]	40	34	27	19	25	25
All items to support quality counselling for FP and for STI services and client education[2]	20	20	17	11	15	15
Items for infection control						
Soap	84	72	65	83	70	75
Running water	85	85	82	89	71	79
Soap and running water	74	70	61	78	58	66
Hand disinfectant	41	28	29	25	23	26
Soap and running water or else hand disinfectant	81	74	63	79	67	72
Clean latex gloves	93	82	92	93	92	91
Disposable non-latex gloves	1	3	0	6	3	4
Disinfecting solution	79	72	68	80	77	77
Sharps box	98	98	96	92	99	97
All items for infection control[3]	66	53	52	59	52	55
Waste receptacle[4]	31	22	26	20	11	17
All items plus waste receptacle for infection control	23	16	21	12	7	11
Table cloth/plastic on any surface	86	91	89	93	79	85
Items for pelvic examination						
Visual and auditory privacy	96	96	98	99	90	94
Visual privacy only	3	4	0	0	3	2
Auditory privacy only	1	0	2	0	2	1
Examination bed or couch[5]	97	94	95	99	96	97
Examination light[6]	57	34	73	42	20	31
Vaginal speculum	67	59	72	33	18	32
All furnishings and equipment for pelvic examination[7]	43	24	51	21	6	16
All items for both infection control and pelvic examination[8]	34	16	31	17	5	12
Number of facilities offering temporary FP	46	68	15	164	319	612

[1] A private room or visual barrier, individual client health cards, written guidelines for FP, and any visual aids for FP.
[2] All items to support quality counselling, written STI guidelines, and visual aids for health education on STIs (including HIV/AIDS).
[3] Soap and running water or else hand disinfectant, disposable latex gloves, disinfecting solution, and sharps box.
[4] Pedal bin with plastic liner. While important for infection control, this is not an item that has been commonly introduced so it was not included in the aggregate for infection control.
[5] Any bed where a woman can lie down flat.
[6] Examination light, flashlight, or other spotlight source.
[7] Visual and auditory privacy, examination bed or couch, examination light, and vaginal speculum.
[8] Soap and running water or else hand disinfectant, disposable latex gloves, disinfecting solution, and sharps box; and visual and auditory privacy, examination bed, examination light, and vaginal speculum.

Table A-5.6 Availability of observed teaching and visual aids

Percentage of facilities offering temporary family planning (FP) services where specific teaching tools and visual aids were observed to be available, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Visual aids or teaching materials						
Samples of different methods	78	74	64	53	61	62
Flip charts for family planning	56	47	55	25	33	35
Balanced Counselling Strategy cards	18	13	21	8	7	9
Family planning checklists	52	49	32	19	26	29
Posters for general promotion of FP	68	58	51	38	46	47
Flip charts for STI/RTI	27	22	30	24	13	19
Video materials about STIs	7	3	0	4	3	4
Video materials about HIV/AIDS	9	6	0	4	4	4
Posters for general awareness of STIs or HIV/AIDS	60	44	53	40	49	47
Model for demonstrating how to use male condom	67	55	38	23	26	32
Model for demonstrating female condom	12	6	9	3	1	3
Pelvic model for demonstrating IUCD insertion	32	22	23	8	2	8
Arm model for demonstrating implant insertion	8	4	6	3	0	2
Information for client to take home						
On family planning	39	29	45	29	26	29
On STIs	12	9	9	8	8	8
On HIV/AIDS	27	25	24	10	20	18
Service guidelines						
Any family planning guidelines	58	50	37	29	34	36
National syndromic diagnosis and treatment of STIs/RTIs (based on WHO guidelines)	40	45	29	28	39	37
National guidelines for diagnosis and treatment of STIs/RTIs	27	27	22	16	20	20
Number of facilities offering temporary FP	46	68	15	164	319	612

Table A-5.7 Availability teaching and visual aids in facilities that offer family planning and STI services

Among facilities offering family planning (FP) services where FP providers routinely treat STIs, percentage where specific teaching materials and visual aids were observed to be available, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Visual aids or teaching materials						
Samples of different methods	81	72	66	51	60	60
Flip charts for family planning	57	51	66	25	32	34
Balanced Counselling Strategy cards	15	18	27	7	8	9
Family planning checklists	49	48	32	20	25	27
Posters for general promotion of FP	71	56	67	40	47	47
Flip charts for STI/RTI	26	22	39	28	12	18
Video materials about STIs	9	4	0	4	4	4
Video materials about HIV/AIDS	10	6	0	4	4	5
Posters for general awareness of STIs or HIV/AIDS	69	45	66	38	50	47
Model for demonstrating how to use male condom	67	62	35	18	26	29
Model for demonstrating female condom	9	8	7	0	1	2
Pelvic model for demonstrating IUCD insertion	29	23	20	7	1	6
Arm model for demonstrating implant insertion	10	6	9	4	0	2
Information for client to take home						
On family planning	40	34	42	26	24	26
On STIs	16	14	9	8	8	9
On HIV/AIDS	31	31	24	8	20	18
Service guidelines						
Any family planning guidelines	57	54	50	31	32	35
National syndromic diagnosis and treatment of STIs/RTIs (based on WHO guidelines)	42	46	36	33	41	39
National guidelines for diagnosis and treatment of STIs/RTIs	25	34	31	18	21	22
Number of facilities offering temporary FP where FP providers routinely treat STIs	21	43	10	135	298	508

Table A-5.8 Availability of medicines for treating sexually transmitted infections

Percentage of facilities offering temporary family planning (TFP) methods where FP providers routinely treat sexually transmitted infections (STIs), and, among these, percentage with specific medicines available, and percentage with at least one treatment for each of the four common STIs, by type of facility, Kenya SPA 2010

Item (illness treated)	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
FP providers routinely treat STIs	46	63	70	82	93	83
Number of facilities offering TFP	46	68	15	164	319	612
Metronidazole oral tabs/capsules (trichomoniasis)	76	50	78	73	46	55
Tinidazole (trichomoniasis)	57	26	64	64	19	34
Ceftriaxone (gonorrhoea)	51	22	55	36	21	27
Ciprofloxin (gonorrhoea)	75	33	74	64	36	46
Kanamycin injection (gonorrhoea)	10	0	8	5	1	3
Amoxicillin capsules or injection (chlamydia)	82	49	84	89	55	65
Augmentin tabs (chlamydia)	48	18	44	17	7	13
Norfloxacin (chlamydia, gonorrhoea)	36	15	67	62	16	30
Doxycycline (chlamydia, syphilis)	87	55	82	64	57	60
Tetracycline (chlamydia, syphilis)	13	7	17	26	2	10
Erythromycin tablets (chlamydia, syphilis)	69	37	55	42	39	41
Any injectable or oral penicillin (syphilis)	93	94	85	80	85	85
Nystatin oral or vaginal suppositories (candidiasis)	93	85	53	52	77	71
Miconazole cream or suppository (candidiasis)	22	16	22	12	18	17
Clotrimazole cream or suppository (candidiasis)	94	86	78	70	83	80
At least one medication for each of the following:						
Trichomoniasis	83	55	84	86	53	64
Gonorrhoea	84	48	81	78	52	60
Chlamydia	95	75	88	93	81	85
Syphilis	97	100	88	81	94	91
All four STIs assessed[1]	69	31	74	67	31	43
Number of facilities offering temporary FP where FP providers routinely treat STIs	21	43	10	135	298	508

[1] At least one medicine each for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis.

Table A-5.9 Availability of equipment and infrastructure for providing specific methods of contraception

Among facilities offering contraceptive methods containing oestrogen and among facilities providing injectable methods or intrauterine contraceptive devices (IUCDs), percentage with the equipment and infrastructure required to provide the method safely, by type of facility, Kenya SPA 2010

	Oestrogen containing method		Injectables		IUCD			Implants		
Type of facility	Percentage with blood pressure apparatus[1]	Number of facilities offering method with oestrogen	Percentage with sterile needle and syringe	Number of facilities providing injectable method	Percentage with basic items for IUCD insertion[2]	Percentage with all items and conditions for quality IUCD insertion[3]	Number of facilities providing IUCD	Percentage with items for implant insertion[4]	Percentage with all equipment, items for infection control, and infrastructure for implant insertion[5]	Number of facilities providing implants
Hospital	91	43	99	41	77	40	34	63	37	31
Health centre	85	66	99	62	62	23	45	29	11	37
Maternity	96	15	96	14	77	34	11	57	22	11
Clinic	95	156	95	151	73	32	57	46	25	55
Dispensary	86	301	98	296	59	18	73	41	13	56
Total	89	580	98	565	67	27	220	45	21	189

[1] Sphygmomanometer and a stethoscope, or an automatic blood pressure apparatus.
[2] Clean latex gloves, iodine antiseptic, speculum, forceps for holding gauze to clean cervix, tenacula, and uterine sound (or IUCD kit that includes tenacula and uterine sound).
[3] Basic items for IUCD insertion, all infection control items (soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution, and sharps box) and visual privacy, an examination bed or couch, an examination light, and IUCD method.
[4] Sterile gloves, antiseptic solution, sponge-holding forceps, local anaesthetic (such as xylocaine or lignocaine), sterile syringe and needle, scalpel with blade, and any implant method with inserter.
[5] Equipment for implant (including implant method), all infection control items (soap and running water or else hand disinfectant), disinfecting solution, and sharps box) and visual privacy, examination bed, and examination light.

Table A-5.10 Availability of items for providing the intrauterine contraceptive device

Among facilities that provide the intrauterine contraceptive device (IUCD), percentage that have specific supplies and equipment to support insertion and/or removal of IUCD, by type of facility, Kenya SPA 2010

	Type of facility					Total
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	percentage
Clean or sterile latex gloves	99	91	100	100	100	98
Antiseptic solution	89	86	94	100	97	94
Sponge-holding forceps	88	85	86	88	85	86
Speculum	91	90	94	97	80	89
Tenacula	87	73	89	94	68	80
Uterine sound	85	81	86	84	71	79
All basic items	77	62	77	73	59	67
IUCD method available	93	98	89	73	99	90
All basic items plus method	72	60	68	46	59	58
Number of facilities providing IUCD	34	45	11	57	73	220

Table A-5.11 Availability of items for pelvic examination of STI clients

Among facilities where FP providers routinely treat sexually transmitted infections (STIs), percentage that have specific supplies and equipment to support quality pelvic examination, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Visual and auditory privacy	95	100	97	99	90	94
Examination bed or couch	95	96	100	99	96	97
Examination light	54	30	71	41	19	28
Speculum	69	55	73	32	19	29
Protocol for STI diagnosis and treatment	44	53	41	33	44	42
All items	20	7	29	9	2	5
Number of facilities where FP providers routinely treat STIs	21	43	10	135	298	508

Table A-5.12 Availability of items for providing implant

Among facilities that provide the implant method, percentage that have specific supplies and equipment to support quality implant insertion and removal, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Sterile gloves	89	79	94	86	78	83
Antiseptic solution	88	88	91	100	98	95
Sponge-holding forceps	87	88	81	83	82	84
Local anaesthetic	94	93	91	100	88	94
Sterile syringe and needle	99	95	98	100	100	99
Scalpel with blade	85	50	77	85	75	75
Forceps for grasping implant	81	66	88	75	67	73
Canula and trochar for inserting implant plus implant method	85	68	77	81	58	72
Sealed implant pack	83	79	77	89	82	83
All items[1]	63	29	57	46	41	45
Number of facilities providing implants	31	37	11	55	56	189

[1] Sterile gloves, antiseptic solution, sponge-holding forceps, local anaesthetic, sterile syringe and needle, scalpel with blade, any forceps, and any implant method with inserter.

Table A-5.13 Facility utilisation statistics for family planning clients

Median number of family planning consultations per month, by background characteristics, Kenya SPA 2010

Background characteristic	Median number of FP consultations[1]	Number of facilities providing data on FP consultation
Type of facility		
Hospital	103	41
Health centre	83	62
Maternity	32	13
Clinic	29	116
Dispensary	34	298
Managing authority		
Government	54	325
NGO	40	19
Private (for profit)	27	147
Faith-based organisation	29	39
Province		
Nairobi	37	25
Central	39	95
Coast	63	52
Eastern	48	90
North Eastern	6	10
Nyanza	41	71
Rift Valley	21	147
Western	46	41
Total	39	530

[1] Data are from health information system monthly reports or registers available at the facility on the day of the survey. Data were requested for the 12 complete months preceding the visit, but, occasionally, some months were missing and the number of months used was less than 12. Information from the months for which data were available was divided by the number of months, and a median number of clients per month was calculated based on the average monthly number of clients for each facility.

Table A-5.14 Information on user fees for family planning services

Percentage of facilities offering family planning (FP) services that report charging user fees for specific items, and, among facilities with any FP user fees, percentage that offer discounts and that publicly post fees, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities charging for the indicated item:						Number of facilities offering TFP	Discount/ exemption for some clients	Fee varies by method	Percentage where fees are posted in public view			Number of facilities with any user fees for FP services
	Client card	Consult fee	Method	Tests	Registration	No charges/ don't know				All fees posted	Some fees posted	No fees posted	
Type of facility													
Hospital	19	21	39	62	14	30	46	63	53	46	19	34	32
Health centre	23	13	24	53	29	21	68	78	23	32	11	57	54
Maternity	35	38	82	79	17	5	15	68	73	9	6	85	14
Clinic	21	38	68	54	15	7	164	44	72	8	8	84	152
Dispensary	23	19	12	20	25	34	319	61	12	24	9	66	211
Managing authority													
Government	24	16	9	24	31	32	334	71	8	31	10	58	229
NGO	30	20	21	42	17	35	19	69	25	36	0	64	13
Private (for profit)	20	40	72	54	13	6	198	47	74	7	10	83	187
Faith-based organisation	17	19	33	54	4	42	61	24	40	23	5	73	36
Province													
Nairobi	27	26	59	50	17	8	28	49	61	15	4	80	26
Central	31	45	56	52	24	3	113	31	54	12	16	72	109
Coast	11	17	32	37	34	32	67	66	47	42	2	56	46
Eastern	6	22	18	39	28	30	102	60	25	22	2	76	71
North Eastern	0	0	0	1	0	99	16	100	0	0	0	100	0
Nyanza	30	15	30	30	14	30	79	77	38	29	1	70	55
Rift Valley	31	19	27	30	20	24	167	65	25	18	15	66	127
Western	13	27	18	42	17	29	41	77	22	22	10	68	29
Total	22	24	32	37	22	24	612	58	38	21	9	69	464

Table A-5.15 Out-of-pocket payments for family planning services

Among observed and interviewed female FP clients, percentage who reported paying any out-of-pocket fees for FP services on the day of the survey and, among these, median amount paid, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed FP clients paying any out-of-pocket fees	Number of interviewed FP clients	Median out-of-pocket payment (in Ksh) by FP clients who paid anything for FP services the day of survey[1]	Number of interviewed FP clients providing valid responses for out-of-pocket payments
Type of facility				
Hospital	55	351	41	194
Health centre	71	251	21	179
Maternity	96	11	61	11
Clinic	68	95	70	64
Dispensary	86	301	21	258
Managing authority				
Government	67	805	21	536
NGO	64	33	21	21
Private (for profit)	81	88	81	71
Faith-based organisation	92	85	51	78
Province				
Nairobi	78	59	31	46
Central	97	179	30	174
Coast	52	117	20	61
Eastern	87	178	21	154
North Eastern	0	6	-	0
Nyanza	55	111	40	61
Rift Valley	65	189	50	124
Western	51	172	21	87
Total	70	1,010	30	706

[1] Includes any amount paid out-of-pocket, including fees for consultation, laboratory test, medicines, or other services.

Table A-5.16 Out-of-pocket payments for specific family planning procedures

Among observed and interviewed female FP clients who received IUCD insertion or removal, implant insertion or removal, injectable contraceptive, or a pelvic exam without another procedure, percentage who paid any out-of-pocket fees on the day of the survey, and among these, median amount paid (Ksh), by the main procedure received, Kenya SPA 2010

Procedure	Percentage of clients who paid out-of-pocket fee	Total number of clients receiving procedure	Median out-of-pocket fee (Ksh) paid by client receiving indicated procedure[1]	Number of clients who paid out-of-pocket fee
IUCD insertion/removal	75	21	151	16
Implant insertion/removal	59	24	201	14
Injectable contraceptive	71	766	30	543
Pelvic exam[2]	60	2	100	1

[1] Includes any amount paid out-of-pocket, including fees for consultation, laboratory test, medicines, or other services.
[2] Includes family planning clients who received a pelvic exam but did not also receive an IUCD procedure, implant insertion or removal, or injectable contraceptive.

Table A-5.17 Supportive management for providers of family planning services

Among interviewed family planning (FP) service providers, percentage who received training related to their work and personal supervision during specific time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed service providers who received: FP-related training during the 12 months before the survey[1]	Personal supervision during the 6 months before the survey	FP-related training during the 12 months and personal supervision during the 6 months before the survey	Most recent training in the 13-35 months preceding the survey	Number of interviewed FP service providers[2]
Type of facility					
Hospital	27	76	22	20	418
Health centre	28	87	25	21	263
Maternity	36	59	20	21	58
Clinic	24	65	19	20	252
Dispensary	15	84	13	11	521
Managing authority					
Government	21	85	18	15	944
NGO	18	77	14	41	49
Private (for profit)	29	63	23	22	348
Faith-based organisation	20	73	17	15	172
Province					
Nairobi	33	69	28	30	111
Central	15	66	11	18	194
Coast	29	78	24	10	172
Eastern	19	79	15	20	271
North Eastern	12	89	11	25	22
Nyanza	27	84	19	20	221
Rift Valley	20	79	19	13	385
Western	26	88	24	14	137
Total	23	78	19	17	1,513

[1] This refers to structured sessions only; does not include individual instruction received during routine supervision.
[2] Includes only providers of family planning services in facilities offering FP services.

Table A-5.18 Training for family planning service providers on specific topics

Among interviewed family planning (FP) service providers, percentage who received pre- or in-service training[1] on specific topics during the 12 months or 13-35 months before the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Counselling on FP		FP-related clinical issues		Insertion/ removal of IUCDs		Insertion/ removal of implants		FP topics for HIV+ women		Any other FP topics		Number of interviewed FP service providers[2]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility													
Hospital	22	21	21	19	16	17	17	17	22	18	6	5	418
Health centre	24	23	16	25	16	19	16	21	24	18	4	6	263
Maternity	28	27	30	26	23	25	26	26	22	16	9	1	58
Clinic	23	20	18	17	12	14	14	14	22	15	4	1	252
Dispensary	14	10	13	10	11	9	11	9	13	8	2	2	521
Managing authority													
Government	18	15	16	15	13	13	13	12	18	12	3	3	944
NGO	12	44	13	35	8	27	8	29	15	34	7	3	49
Private (for profit)	26	22	22	22	21	19	20	20	23	18	5	2	348
Faith-based organisation	18	16	15	15	8	13	13	12	18	10	2	6	172
Province													
Nairobi	25	32	26	30	24	27	23	30	22	26	8	4	111
Central	15	18	8	18	7	14	7	14	15	14	3	1	194
Coast	27	11	27	10	22	10	24	10	27	9	2	0	172
Eastern	17	21	15	18	14	17	13	17	15	17	5	2	271
North Eastern	10	22	7	25	6	24	6	25	8	23	2	3	22
Nyanza	23	20	21	18	13	14	14	14	23	18	3	4	221
Rift Valley	18	15	16	16	14	13	16	12	19	11	5	7	385
Western	22	13	12	13	9	10	9	10	20	8	2	3	137
Total	20	18	17	17	14	15	15	15	19	14	4	3	1,513

[1] Includes structured training sessions only; does not include individual instruction received during routine supervision.
[2] Includes only providers of FP services in facilities offering FP services.

Table A-5.19 Supportive supervision for family planning service providers

Among interviewed family planning (FP) service providers who were personally supervised in the 6 months before the survey, median number of times they were supervised and percentage who report specific activities of the supervisor during the last visit, by background characteristics, Kenya SPA 2010

Background characteristic	Median number of times staff were supervised in the 6 months before the survey	Percentage of providers reporting that, during the last supervisory visit, the supervisor:						Number of FP service providers who were supervised in the 6 months before the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Deliver supplies	
Type of facility								
Hospital	3	97	91	91	77	91	49	319
Health centre	3	97	94	91	81	93	62	228
Maternity	2	94	88	92	75	83	45	34
Clinic	3	94	89	88	71	87	37	164
Dispensary	3	98	90	78	72	93	54	438
Managing authority								
Government	3	97	91	83	75	93	55	800
NGO	3	98	97	100	79	100	63	38
Private (for profit)	3	96	90	90	74	86	35	219
Faith-based organisation	3	97	93	94	72	89	59	126
Province								
Nairobi	3	98	92	89	81	94	52	77
Central	3	100	94	97	79	88	39	128
Coast	3	95	84	81	84	93	60	134
Eastern	3	97	90	89	61	93	53	214
North Eastern	3	98	99	66	58	88	45	20
Nyanza	3	95	90	92	84	94	69	185
Rift Valley	2	98	93	76	73	89	50	304
Western	3	97	92	90	76	90	33	121
Total	3	97	91	86	75	91	52	1,184

[1] Includes only providers of FP services in facilities offering FP services.

Table A-5.20 Description of observed female family planning clients

Among observed female family planning (FP) clients, percentage for whom this was the first or a follow-up visit for family planning at this facility, and percentage who reported no prior pregnancy, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of observed FP clients			Number of observed female family planning clients
	First visit	Follow-up visit	Never pregnant	
Type of facility				
Hospital	21	79	1	351
Health centre	12	88	1	251
Maternity	25	75	4	11
Clinic	10	90	5	95
Dispensary	15	85	0	301
Managing authority				
Government	15	85	1	805
NGO	18	82	0	33
Private (for profit)	18	82	5	88
Faith-based organisation	19	81	3	85
Province				
Nairobi	35	65	4	59
Central	8	92	1	179
Coast	26	74	0	117
Eastern	10	90	2	178
North Eastern	14	86	0	6
Nyanza	30	70	1	111
Rift Valley	16	84	1	189
Western	8	92	1	172
Total	16	84	1	1,010

Table A-5.21 User status and principal reason for visit for observed family planning clients

Among observed female family planning (FP) clients, percent distribution by user status and principal reason for seeking family planning service the day of the survey, and user status, Kenya SPA 2010

Principal reason for visit	Percentage of observed female family planning clients with indicated status
Current user at clinic for:	
Re-supply current method/routine visit	66
Elective method change	3
Discuss problem with current method	4
Discuss non-FP health problem	0
Elective discontinuation of FP	1
Other/missing reason for user's visit	0
Non-user	
Used method in past	11
Never used method	13
Reason for visit not determined	1
Number of observed female family planning clients	1,010

Table A-5.22 Method of choice for observed female family planning clients

Among observed and interviewed female family planning (FP) clients, percentage who received, were prescribed, or continued using specific FP methods at the end of the visit, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of FP clients who received, were prescribed, or continued to use as their main method:									Number of observed and interviewed female family planning clients
	Combined oral contra-ceptive or type unknown	Progestin-only pill	Progestin-only injectable (2 or 3 month)	Combined injectable (1 month)	Condom	IUCD	Implant	Other[1]	No method	
Type of facility										
Hospital	10	5	70	0	2	5	4	1	4	351
Health centre	9	2	84	1	3	1	0	0	2	251
Maternity	7	7	72	0	0	0	0	0	14	11
Clinic	10	5	82	0	3	2	5	0	0	95
Dispensary	16	4	78	0	0	0	0	0	2	301
Managing authority										
Government	12	3	77	0	2	2	2	0	3	805
NGO	14	8	82	0	0	1	2	0	4	33
Private (for profit)	3	7	79	0	4	6	1	3	3	88
Faith-based organisation	13	4	75	0	3	2	0	2	1	85
Province										
Nairobi	17	10	46	0	2	8	3	4	10	59
Central	23	6	65	1	1	2	1	0	1	179
Coast	10	2	82	0	0	0	4	0	5	117
Eastern	11	3	83	0	2	1	1	0	1	178
North Eastern	19	0	76	0	0	0	0	0	5	6
Nyanza	4	4	82	1	1	3	3	1	4	111
Rift Valley	5	2	83	0	5	3	1	0	3	189
Western	9	3	81	0	3	2	2	1	1	172
Total	11	4	77	0	2	2	2	1	3	1,010

[1] Other may include emergency contraception, counselling on periodic abstinence, or female sterilisation.

Table A-5.23 Components of counselling among observed female family planning clients

Among observed female family planning clients, percentage whose consultations included components that contribute to quality counselling, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Visual privacy assured	92	87	90	100	90	91
Auditory privacy assured	89	79	90	100	73	83
Client assured of confidentiality	50	39	43	49	49	47
Client asked her concerns about methods discussed or used	80	83	93	84	75	80
All counselling conditions met[1]	39	28	43	42	28	34
Individual client card reviewed during consultation	83	78	78	69	74	78
Individual client card written on after consultation	94	94	96	92	96	95
Visual aids used during consultation	33	18	15	27	21	25
Return visit discussed	97	98	92	93	97	97
Number of observed female family planning clients	351	251	11	95	301	1,010

[1] Visual and auditory privacy, confidentiality assured, and client asked her concerns about methods discussed or currently used.

Table A-5.24 General assessments, examinations, and interventions for observed first-visit female family planning clients

Percentage of observed first-visit family planning clients whose consultations included specific assessments and examinations, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Client history						
Age	88	69	100	60	63	76
Any history of pregnancy	88	85	100	100	72	84
Current pregnancy status	75	68	41	60	50	65
Desired timing for next child or desire for another child	37	13	46	29	30	30
Breastfeeding status (if ever pregnant)	46	55	0	45	50	48
Regularity of menstrual cycle	52	28	15	53	60	49
All elements of reproductive history[1]	20	0	0	20	19	15
Client medical history						
Asked about smoking	20	8	0	20	18	17
Asked about symptoms of sexually transmitted infections	30	4	0	8	21	21
Asked about any chronic illnesses	40	10	27	45	26	30
All risk-history[2]	14	4	0	8	6	9
Client examination						
Measured blood pressure	92	96	100	92	89	92
Measured weight	92	85	85	92	100	93
Client examination (specific exam information)						
Measured blood pressure (according to client)	86	96	69	92	83	87
Measured blood pressure (according to facility standard)	82	55	75	43	53	67
Measured weight (according to client)	88	85	85	92	97	90
Measured weight (according to facility standard)	78	55	44	43	64	67
Number of first-visit FP clients who have had previous pregnancy	71	31	3	9	45	160
Number of first-visit FP clients	72	31	3	9	45	161

[1] Asked about age, any history of pregnancy, current pregnancy status, desired timing for next child or desire for another child, and regularity of menstrual cycle.
[2] Asked about smoking, symptoms of STIs, and any chronic illnesses.

Table A-5.25 General assessments, examinations, and interventions for observed first-visit female family planning clients

Percentage of observed first-visit family planning clients whose consultations included specific assessments and examinations, by type of facility, Kenya SPA 2010

	Type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Discussion related to partner						
Partner attitude toward family planning	28	13	15	7	14	20
Partner status[1]	14	11	15	8	10	12
Either partner question	32	13	15	15	19	24
Discussion related to STIs and condoms						
Use of condoms to prevent STIs	23	21	0	32	32	25
Use of condoms as dual method[2]	23	19	0	32	27	23
Any discussion related to STIs[3]	32	34	15	32	32	32
Individual client card reviewed during consultation	80	87	75	85	59	76
Individual client card written on after consultation	94	96	100	92	97	95
Visual aids used during consultation	56	19	15	61	28	40
Client assured of confidentiality	55	31	44	45	44	46
Number of first-visit FP clients	72	31	3	9	45	161

[1] Asked about other partners for self or partner and about absence of partner.
[2] To prevent both pregnancy and STIs.
[3] Discussed risks of STIs, using condoms to prevent STIs, or using condoms as dual method.

Table A-5.26 Assessments of client who received contraceptives containing oestrogen

Among observed family planning (FP) clients who received a contraceptive containing oestrogen (either combined oral pills or combined injectable), percentage who had their blood pressure and weight measured, by type of facility, Kenya SPA 2010

	Type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Examination specific to oestrogen-based contraceptive						
Blood pressure measured	96	93	100	100	77	88
Weight measured	94	87	100	71	81	86
Number of clients receiving an oestrogen-based contraceptive	36	24	1	10	47	116

Table A-5.27 Counselling and client knowledge related to injectable and oral contraceptives

Among observed and interviewed female family planning clients who received oral contraceptive pills or injectables, percentage who were observed being told essential information about the method, percentage who reported that the provider explained their method to them, and percentage who knew the correct response to an exit interview question on their method, by type of facility, Kenya SPA 2010

	Type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Provider was observed to explain the item to the client						
When to take	82	88	68	81	78	82
Menstrual changes (side effects)	56	55	60	56	49	54
Non-menstrual side effects	42	39	34	22	40	39
Any side effects	60	59	64	56	52	57
What to do if she forgets	29	16	30	14	30	25
Follow-up visit	98	98	100	93	98	98
Client reported that the provider shared the indicated information						
Explained how to use the method	77	79	75	63	67	73
Explained about possible side effects	64	61	67	52	60	61
Explained what to do for problems	72	71	78	60	65	68
Mentioned follow-up visit	97	97	95	96	95	96
For all pill and injectable clients:						
Percentage who knew correct response for question about method	99	100	95	100	100	100
Number of observed and interviewed pill/injectable clients	297	239	10	89	291	926

Table A-5.28 Counselling and client knowledge related to condoms, IUCDs, and implants

Among observed and interviewed clients who received or were prescribed condoms, IUCDs, or implants, percentage who were observed being told essential information about the method; percentage who correctly answered a key question about using their method during exit interview; and percentage who reported that a provider instructed them on their method, Kenya SPA 2010

Components of consultation	Percentage of observed and interviewed clients
Condom clients were observed being told:	
Cannot use if allergic to latex	4
Can be used one time only	14
Lubricants that can/cannot be used	5
Can use as a backup method	5
About dual protection	28
Interviewed client received condom and knows to use condom only once	73
Number of observed and interviewed clients receiving condom	20
IUCD clients were observed being told:	
IUCD good for up to 12 years	81
To return to clinic 3-6 weeks post insertion or after first menses	71
About possible heavy bleeding	73
To return to clinic if side effects persist	73
Interviewed client received IUCD and knows how to make sure IUCD is in place	75
Number of clients receiving IUCD or prescription for IUCD	22
Implant clients were observed being told:	
Implant is good for three/five years	96
Menstrual changes might occur	88
Non-menstrual initial side effects that might occur	80
To return to clinic if side effects persist	86
Interviewed client received implant and knows how long implant protects against pregnancy	87
Number of clients receiving implants or prescription for implant	19
Summary of interviewed client responses	
Client knew the correct response for the survey question about their method	78
Client reported provider explained how to use the method	86
Client reported provider explained about possible side effects	73
Client reported provider explained what to do for problems	75
Client reported provider told about a follow-up visit	91
Number of observed and interviewed FP clients receiving condoms or else IUCDs, or implants or a prescription for them	60

Table A-5.29 Client feedback on services

Percentage of interviewed family planning who considered specific service issues to be a major problem on the day of the visit, by type of facility, Kenya SPA 2010

	Type of facility					
Client service issue	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Behaviour/attitude of provider	3	1	0	0	1	1
Inability to discuss problem	2	1	0	1	6	3
Insufficient explanation about method or problems	4	2	0	6	4	4
Waiting time to see provider	24	29	3	15	27	25
Quality of examination and treatment	2	3	0	0	4	2
Availability of methods or medicines	7	10	4	4	4	7
Days facility is open	2	8	0	0	3	4
Hours facility is open	7	12	0	4	8	8
Cleanliness of facility	3	1	0	1	0	1
Cost of services	7	8	0	4	3	6
Insufficient visual privacy	2	2	4	0	7	3
Insufficient auditory privacy	2	2	4	0	7	3
Number of interviewed FP clients	351	251	11	95	301	1,010

Table A-5.30 Client choice of facility

Among interviewed family planning (FP) clients, percentage who reported this was not the closest health facility to their home, and, among these clients, the main reason they did not go to the nearest facility, by background characteristics, Kenya SPA 2010

			Percentage of family planning (FP) clients who did not go to the nearest facility and mentioning the indicated item was a problem with the nearest facility									
Background characteristic	Percentage of interviewed FP clients who report this is not the closest facility to their home	Number of interviewed FP clients	Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Other	Don't know/ missing	Number of interviewed FP clients for whom this was not the closest facility to their home
Type of facility												
Hospital	20	351	8	11	16	4	13	23	2	22	1	71
Health centre	8	251	18	5	0	13	12	35	0	16	0	20
Maternity	39	11	0	10	10	8	17	9	0	47	0	4
Clinic	23	95	25	5	19	0	4	18	0	12	17	22
Dispensary	13	301	3	34	7	7	0	25	4	20	0	39
Managing authority												
Government	14	805	13	11	11	7	7	27	3	19	4	109
NGO	10	33	0	24	0	12	0	0	0	64	0	3
Private (for profit)	23	88	3	13	29	5	12	21	0	18	0	21
Faith-based organisation	27	85	5	38	4	0	13	17	0	22	0	23
Province												
Nairobi	30	59	4	21	7	6	11	23	4	25	0	18
Central	13	179	2	43	13	18	2	6	0	15	2	23
Coast	18	117	2	16	6	8	5	39	0	6	18	21
Eastern	19	178	31	2	10	2	7	27	0	21	0	33
North Eastern	43	6	11	0	0	11	0	22	55	0	0	2
Nyanza	26	111	0	10	25	0	6	18	4	37	0	28
Rift Valley	6	189	0	19	6	6	10	34	0	25	0	11
Western	11	172	23	7	10	2	25	25	0	9	0	19
Total	15	1,010	10	15	12	6	9	24	2	20	3	156

Table A-5.31 Educational characteristics of female family planning clients

Percent distribution of observed and interviewed female family planning clients according to educational level and percentage of clients with primary, informal, or no education who are literate, by background characteristics, Kenya SPA 2010

Background characteristic	Among interviewed FP clients, percentage with:					Number of interviewed FP clients	Percentage of interviewed FP clients with primary, post-primary/technical, or no education who:				Number of interviewed FP clients with primary, post-primary/ technical, or no education
	No education	Primary	Post-primary/ technical	Secondary	Higher		Cannot read or write	Can read, cannot write	Can read and write	Missing	
Type of facility											
Hospital	4	54	2	28	12	351	18	2	75	6	210
Health centre	5	63	3	25	5	251	20	5	74	1	176
Maternity	0	37	3	43	18	11	9	0	81	10	4
Clinic	9	50	9	16	16	95	18	6	70	6	65
Dispensary	7	69	3	18	3	301	24	7	67	2	239
Managing authority											
Government	5	63	3	23	6	805	21	6	71	3	569
NGO	15	73	0	5	6	33	33	0	66	2	29
Private (for profit)	7	36	11	23	23	88	8	0	81	11	47
Faith-based organisation	3	55	0	32	10	85	23	0	77	0	49
Province											
Nairobi	2	23	0	41	33	59	9	0	87	4	15
Central	2	66	0	28	4	179	18	4	77	0	121
Coast	22	61	0	10	7	117	32	8	56	5	96
Eastern	1	68	8	19	5	178	31	1	67	0	136
North Eastern	53	33	5	0	10	6	58	26	16	0	5
Nyanza	3	64	6	22	6	111	6	1	71	21	80
Rift Valley	4	58	6	24	8	189	13	10	77	0	129
Western	5	60	0	27	8	172	19	2	79	0	111
Total	5	60	3	23	8	1,010	20	5	72	3	695

Chapter 6

Table A-6.1 Availability of antenatal care and other family health services on the day of the survey

Among facilities offering antenatal care (ANC), percentage offering ANC, tetanus toxoid (TT) vaccine, family planning (FP), outpatient curative care for sick children (SC), and child immunisation (EPI) services on the day of the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering the indicated services on the day of the survey						Number of facilities offering ANC
	ANC	ANC and TT vaccine	ANC and FP	ANC and SC	ANC, FP, and SC services	ANC and EPI	
Type of facility							
Hospital	94	93	88	94	88	82	48
Health centre	92	91	81	92	81	83	79
Maternity	93	84	84	85	76	60	16
Clinic	87	71	85	86	84	43	83
Dispensary	82	71	81	82	80	57	285
Managing authority							
Government	87	79	86	86	85	72	306
NGO	88	77	88	88	88	56	18
Private (for profit)	86	69	83	85	82	39	108
Faith-based organisation	82	76	65	82	65	48	78
Province							
Nairobi	83	83	69	77	62	50	33
Central	99	88	94	99	93	62	71
Coast	89	78	88	89	88	56	57
Eastern	92	77	91	91	90	67	84
North Eastern	77	55	67	70	60	67	17
Nyanza	87	83	82	86	82	72	78
Rift Valley	74	68	71	74	71	52	130
Western	91	73	91	91	91	67	41
Total	86	77	82	85	81	61	509

Table A-6.2 Availability of antenatal care and tetanus toxoid vaccine services

Among facilities offering antenatal care (ANC), percentage offering ANC and tetanus toxoid (TT) vaccine on the indicated number of days per week and percentage offering TT every day that ANC is offered, by background characteristics, Kenya SPA 2010

Background characteristic	ANC services offered the indicated number of days per week[1]			TT services offered on the indicated number of days per week[1]					Number of facilities offering ANC
	1-2 days	3-4 days	5+ days	Not offered/ less than once a week	1-2 days	3-4 days	5+ days	TT every day ANC is offered	
Type of facility									
Hospital	12	2	85	1	2	1	96	98	48
Health centre	23	1	76	0	4	0	96	100	79
Maternity	13	4	83	5	4	8	78	90	16
Clinic	29	1	70	10	14	1	75	84	83
Dispensary	24	2	71	7	16	0	77	86	285
Managing authority									
Government	22	2	74	5	12	0	83	90	306
NGO	28	0	72	6	18	0	77	88	18
Private (for profit)	26	1	72	11	10	2	77	83	108
Faith-based organisation	24	3	71	4	12	0	83	96	78
Province									
Nairobi	29	5	65	0	12	1	85	97	33
Central	6	0	93	7	3	0	90	90	71
Coast	11	0	86	3	10	0	87	92	57
Eastern	13	0	87	8	15	0	77	88	84
North Eastern	14	0	86	9	0	0	91	91	17
Nyanza	28	2	70	4	9	1	86	93	78
Rift Valley	42	5	49	6	16	0	78	88	130
Western	23	1	77	13	21	1	64	79	41
Total	23	2	73	6	12	0	81	89	509

[1] Some facilities offer the services less often than one day per week, and so the total percentage may be less than 100 percent.

Table A-6.3.1 Availability of observed items to support quality antenatal care services

Percentage of facilities offering antenatal care (ANC) where supplies and equipment to support quality counselling, infection control, physical examinations, and basic ANC services were observed to be available in the ANC service area or adjacent to the consultation or examination room, by type of facility, Kenya SPA 2010

Item	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Items to support quality counselling						
Individual client health cards	88	78	84	69	76	76
ANC guidelines[1]	81	74	52	43	69	66
Visual aids for health education	65	59	59	45	54	54
All items to support quality counselling[2]	52	38	32	37	33	36
Items for infection control						
Soap	83	70	71	79	72	74
Running water	90	86	83	88	72	79
Soap and water	78	69	67	76	62	67
Hand disinfectant	43	26	29	31	19	25
Soap and running water or else hand disinfectant	83	71	69	76	68	71
Clean latex gloves	93	82	92	96	94	92
Disinfecting solution	81	71	70	80	76	76
Sharps box	98	97	95	98	98	98
All items for infection control[3]	67	53	58	60	55	57
Covered waste receptacle with plastic liner[4]	24	26	27	18	16	19
All items for infection control plus waste receptacle	18	16	22	16	10	13
Table cloth/plastic on any surface	87	87	96	99	84	87
Items for physical examination						
Visual and auditory privacy	95	96	98	100	91	94
Visual privacy only	4	4	0	0	3	2
Auditory privacy only	1	0	2	0	0	0
Examination bed/couch[5]	96	97	95	99	96	97
Examination light[6]	52	33	70	50	19	31
All elements for physical examination[7]	49	32	63	49	16	28
All elements for physical examination and specific components for infection control present[8]	39	24	40	31	14	22
Essential supplies for basic ANC						
Blood pressure apparatus	92	90	96	95	86	89
Foetoscope (Pinard)	98	92	95	76	82	85
Iron tablets[9]	50	37	58	79	28	41
Folic acid tablets[9]	83	73	76	77	72	74
Tetanus toxoid vaccine	98	95	77	64	80	81
All basic ANC equipment and medicines[10]	42	31	48	39	15	25
Number of facilities offering ANC	48	79	16	83	285	509

[1] Any antenatal care guidelines or protocols, or any other maternal or neonatal health guidelines or protocols.
[2] Individual client health cards, written ANC guidelines, and visual aids for health education.
[3] Soap and running water or else hand disinfectant, gloves, disinfecting solution for decontaminating reusable items, and sharps box.
[4] While important for infection control, a waste receptacle with plastic liner was not included in the aggregate for infection control.
[5] May be any type of bed or couch where a client can lie down flat.
[6] May be examination light, flashlight, or other spotlight source.
[7] Visual and auditory privacy, examination light, plus an examination bed/couch.
[8] Visual and auditory privacy, examination light, bed, and all infection control items excluding sharps box.
[9] Iron and folic acid may be separate tablets or one combined tablet.
[10] Blood pressure apparatus, foetoscope, iron and folic acid tablets, and tetanus toxoid vaccine.

Table A-6.3.2 Availability of observed items to support quality antenatal care services

Percentage of facilities offering antenatal care (ANC) where supplies and equipment to support quality counselling, infection control, physical examinations, and basic ANC services were observed to be available in the ANC service area or adjacent to the consultation or examination room, by managing authority, Kenya SPA 2010

	Managing authority				
Item	Government	NGO	Private (for profit)	Faith-based organisation	Total
Items to support quality counselling					
Individual client health cards	76	94	71	80	76
ANC guidelines[1]	73	55	47	68	66
Visual aids for health education	62	49	42	43	54
All items to support quality counselling[2]	40	36	27	34	36
Items for infection control					
Soap	72	47	79	78	74
Running water	75	54	92	82	79
Soap and water	64	41	77	70	67
Hand disinfectant	20	12	31	39	25
Soap and running water or else hand disinfectant	70	41	80	73	71
Clean latex gloves	91	87	94	97	92
Disinfecting solution	74	61	78	83	76
Sharps box	100	100	96	92	98
All items for infection control[3]	54	33	64	62	57
Covered waste receptacle with plastic liner[4]	16	29	25	23	19
All items for infection control plus waste receptacle	10	6	20	18	13
Table cloth/plastic on any surface	82	100	95	96	87
Items for physical examination					
Visual and auditory privacy	92	87	99	95	94
Visual privacy only	4	1	0	1	2
Auditory privacy only	0	0	0	0	0
Examination bed/couch[5]	96	100	99	96	97
Examination light[6]	18	12	56	51	31
All elements for physical examination[7]	16	12	54	46	28
All elements for physical examination and specific components for infection control present[8]	13	9	35	41	22
Essential supplies for basic ANC					
Blood pressure apparatus	87	69	88	100	89
Foetoscope (Pinard)	83	85	82	92	85
Iron tablets[9]	22	30	72	72	41
Folic acid tablets[9]	68	71	75	95	74
Tetanus toxoid vaccine	85	85	64	90	81
All basic ANC equipment and medicines[10]	12	10	38	60	25
Number of facilities offering ANC	306	18	108	78	509

[1] Any antenatal care guidelines or protocols, or any other maternal or neonatal health guidelines or protocols.
[2] Individual client health cards, written ANC guidelines, and visual aids for health education.
[3] Soap and running water or else hand disinfectant, gloves, disinfecting solution for decontaminating reusable items, and sharps box.
[4] While important for infection control, a waste receptacle with plastic liner was not included in the aggregate for infection control.
[5] May be any type of bed or couch where a client can lie down flat.
[6] May be examination light, flashlight or other spotlight source.
[7] Visual and auditory privacy, examination light, plus an examination bed/couch.
[8] Visual and auditory privacy, examination light, bed, and all infection control items excluding sharps box.
[9] Iron and folic acid may be separate tablets, or one combined tablet.
[10] Blood pressure apparatus, foetoscope, iron and folic acid tablets, and tetanus toxoid vaccine.

Table A-6.4.1 Availability of specific medicines and guidelines for antenatal and postnatal services

Among facilities offering antenatal care (ANC), percentage with medicines for managing common complications during pregnancy, percentage that routinely provide the indicated medicine or test as a component of ANC, and percentage with items for postnatal care, by type of facility, Kenya SPA 2010

	Type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Medicines for managing common complications during pregnancy						
Antibiotic[1]	99	86	87	88	68	78
Albendazole (anthelminth)	90	96	72	70	90	87
Mebendazole (anthelminth)	44	43	72	62	28	39
Either albendazole or mebendazole	94	97	79	81	91	90
First-line antimalarial[2]	88	85	70	67	93	86
Other antimalarial	99	98	90	84	96	94
Methyldopa (Aldomet)	74	22	65	25	12	23
Medicines for STIs						
Metronidazole (trichomoniasis)	71	58	79	81	46	57
Tinidazole (trichomoniasis)	59	32	70	60	21	34
Ceftriaxone (gonorrhoea)	59	26	63	38	20	29
Ciprofloxacin (gonorrhoea)	78	45	71	66	38	49
Kanamycin (gonorrhoea)	6	0	7	1	1	1
Amoxicillin (chlamydia)	83	56	87	86	53	63
Augmentin (chlamydia)	50	18	49	21	9	17
Norfloxacin (chlamydia, gonorrhoea)	38	26	71	64	18	30
Doxycycline (chlamydia, syphilis)	87	67	86	62	58	64
Tetracycline (chlamydia, syphilis)	17	7	16	16	1	6
Erythromycin (chlamydia, syphilis)	69	52	59	40	41	45
Any injectable or oral penicillin (syphilis)	93	91	90	80	84	86
Nystatin suppository or oral (candidiasis)	88	85	62	63	75	76
Miconazole cream or suppository (candidiasis)	21	18	21	13	14	15
Clotrimazole cream or suppository (candidiasis)	95	89	76	79	82	84
At least one medication for:						
Trichomoniasis	81	62	87	85	53	64
Gonorrhoea	84	57	85	81	52	62
Chlamydia	97	81	92	91	80	84
Syphilis	98	98	92	83	93	93
All four STIs assessed[3]	70	45	80	71	31	45
All medicines for ANC complications[4]	50	18	52	22	11	19
ANC service components						
Routine preventive antimalarial (IPTp)	94	99	95	87	98	96
ANC providers routinely treat STIs	49	81	81	89	91	85
Routine family planning counselling	81	84	82	92	90	88
Routine counselling about HIV/AIDS	95	98	89	90	95	94
Routine HIV testing	96	93	94	75	88	88
Routine HIV/AIDS counselling or HIV testing	98	98	96	90	95	95
Counselling on the four recommended ANC visits	97	97	97	97	98	98
Equipment related to postpartum care						
Thermometer	83	82	97	97	91	90
Infant scale	92	88	87	74	91	88
Guidelines for other ANC						
Any STI guidelines (including syndromic approach or diagnosis for STIs)	43	49	39	43	42	44
Number of facilities offering ANC	48	79	16	83	285	509

[1] Amoxicillin or Augmentin (amoxicillin + clavulanate) or cotrimoxazole.
[2] First-line antimalarial in Kenya is Coartem.
[3] At least one medicine each for treating trichomoniasis, gonorrhoea, Chlamydia, and syphilis.
[4] At least one broad-spectrum antibiotic (amoxicillin or Augmentin or cotrimoxazole); either albendazole or mebendazole; methyldopa (Aldomet); the first-line antimalarial; and at least one medicine for treating each of the following reproductive tract infections: trichomoniasis, gonorrhoea, chlamydia, syphilis, and candidiasis.

Table A-6.4.2 Availability of specific medicines and guidelines for antenatal and postnatal services

Among facilities offering antenatal care (ANC), percentage with medicines for managing common complications during pregnancy, percentage that routinely provide the indicated medicine or test as a component of ANC, and percentage with items for postnatal care, by managing authority, Kenya SPA 2010

Item	Managing authority				Total
	Government	NGO	Private (for profit)	Faith-based organisation	
Medicines for managing common complications during pregnancy					
Antibiotic[1]	71	87	90	86	78
Albendazole (anthelminth)	94	92	67	87	87
Mebendazole (anthelminth)	20	60	57	80	39
Either albendazole or mebendazole	95	95	77	90	90
First line antimalarial[2]	93	83	66	91	86
Other antimalarial	98	95	87	92	94
Methyldopa (Aldomet)	9	15	33	65	23
Medicines for STIs					
Metronidazole (trichomoniasis)	40	32	81	94	57
Tinidazole (trichomoniasis)	14	56	65	63	34
Ceftriaxone (gonorrhoea)	21	19	40	46	29
Ciprofloxacin (gonorrhoea)	39	12	64	72	49
Kanamycin (gonorrhoea)	1	0	3	1	1
Amoxicillin (chlamydia)	50	40	89	83	63
Augmentin (chlamydia)	9	5	26	42	17
Norfloxacin (chlamydia, gonorrhoea)	7	20	65	74	30
Doxycycline (chlamydia, syphilis)	57	88	70	74	64
Tetracycline (chlamydia, syphilis)	1	3	21	8	6
Erythromycin (chlamydia, syphilis)	38	35	45	77	45
Any injectable or oral penicillin (syphilis)	84	82	82	98	86
Nystatin suppository or oral (candidiasis)	81	68	59	81	76
Miconazole cream or suppository (candidiasis)	17	4	17	12	15
Clotrimazole cream or suppository (candidiasis)	85	81	75	93	84
At least one medication for:					
Trichomoniasis	46	65	90	94	64
Gonorrhoea	50	21	79	94	62
Chlamydia	79	100	92	89	84
Syphilis	93	100	86	100	93
All four STIs assessed[3]	28	21	72	81	45
All medicines for ANC complications[4]	6	15	26	61	19
ANC service components					
Routine preventive antimalarial (IPTp)	100	89	90	90	96
ANC providers routinely treat STIs	83	92	90	87	85
Routine family planning counselling	89	84	91	83	88
Routine counselling about HIV/AIDS	96	100	90	93	94
Routine HIV testing	91	89	76	90	88
Routine HIV/AIDS counselling or HIV testing	97	100	91	93	95
Counselling on the four recommended ANC visits	97	100	97	100	98
Equipment related to postpartum care					
Thermometer	87	87	97	93	90
Infant scale	90	78	79	92	88
Guidelines for other ANC					
Any STI guidelines (including syndromic approach or diagnosis for STIs)	44	42	41	46	44
Number of facilities offering ANC	306	18	108	78	509

[1] Amoxicillin or Augmentin (amoxicillin + clavulanate) or cotrimoxazole.
[2] First-line antimalarial in Kenya is Coartem.
[3] At least one medicine each for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis.
[4] At least one broad-spectrum antibiotic (amoxicillin or Augmentin or cotrimoxazole); either albendazole or mebendazole; methyldopa (Aldomet); the first-line antimalarial; and at least one medicine for treating each of the following reproductive tract infections: trichomoniasis, gonorrhoea, chlamydia, syphilis, and candidiasis.

Table A-6.5 Capacity to provide anaemia screening with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test for anaemia and/or a standard to routinely screen ANC clients for anaemia, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering ANC services that have:			Number of facilities offering ANC
	Capacity to conduct anaemia test[1]	Standard to screen ANC clients for anaemia	Standard to screen ANC clients for anaemia and capacity to conduct anaemia test	
Type of facility				
Hospital	84	96	82	48
Health centre	59	88	59	79
Maternity	67	87	67	16
Clinic	31	63	27	83
Dispensary	21	45	21	285
Managing authority				
Government	28	54	28	306
NGO	18	48	18	18
Private (for profit)	40	61	36	108
Faith-based organisation	68	93	68	78
Province				
Nairobi	55	77	52	33
Central	37	69	37	71
Coast	35	82	35	57
Eastern	29	61	26	84
North Eastern	17	28	17	17
Nyanza	34	62	34	78
Rift Valley	39	48	39	130
Western	34	55	34	41
Total	36	61	35	509

[1] Capacity to conduct an anaemia test using any of the following means: haemoglobinometer or calorimeter, Hemocue, centrifuge and capillary tubes for haematocrit, or any of the blotting paper tests.

Table A-6.6 Capacity to test urine protein with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test urine for protein and/or a standard to routinely screen ANC clients for urine protein, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering ANC services that have:			Number of facilities offering ANC
	Capacity to conduct urine protein test[1]	Standard to screen ANC clients for urine protein	Standard to screen ANC clients for urine protein and capacity to conduct urine protein test	
Type of facility				
Hospital	89	89	81	48
Health centre	61	79	55	79
Maternity	72	76	61	16
Clinic	46	67	45	83
Dispensary	25	42	23	285
Managing authority				
Government	30	48	28	306
NGO	21	42	21	18
Private (for profit)	53	61	49	108
Faith-based organisation	74	92	69	78
Province				
Nairobi	59	64	49	33
Central	58	69	58	71
Coast	45	76	41	57
Eastern	38	66	38	84
North Eastern	28	28	27	17
Nyanza	41	49	32	78
Rift Valley	30	45	29	130
Western	40	53	37	41
Total	41	57	38	509

[1] Dip sticks for urine protein or else acetic acid for checking urine albumin and flame for heating acetic acid.

Table A-6.7 Capacity to test urine glucose with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test urine for glucose and/or a standard to routinely screen ANC clients for urine glucose, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering ANC services that have:			Number of facilities offering ANC
	Capacity to conduct urine glucose test[1]	Standard to screen ANC clients for urine glucose	Standard to screen ANC clients for urine glucose and capacity to conduct urine glucose test	
Type of facility				
Hospital	89	85	77	48
Health centre	60	76	54	79
Maternity	72	69	55	16
Clinic	47	67	45	83
Dispensary	23	37	20	285
Managing authority				
Government	30	43	27	306
NGO	21	37	16	18
Private (for profit)	53	61	49	108
Faith-based organisation	66	88	57	78
Province				
Nairobi	59	64	49	33
Central	58	69	58	71
Coast	45	70	36	57
Eastern	38	65	37	84
North Eastern	28	28	27	17
Nyanza	42	46	30	78
Rift Valley	26	34	23	130
Western	40	52	37	41
Total	40	53	36	509

[1] Dip sticks for urine glucose or else Benedict's solution for urine glucose testing, with stove for boiling Benedict's solution, were assessed.

Table A-6.8 Capacity to provide blood grouping and Rh factor with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to determine blood group and Rh factor and/or a standard to routinely offer blood grouping and Rh factor tests to ANC clients, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering ANC services that have:			Number of facilities offering ANC
	Capacity to conduct blood grouping and Rh factor test[1]	Standard to offer blood grouping and Rh factor test to ANC clients	Standard to offer blood group and Rh factor test for ANC clients and capacity to conduct blood grouping and Rh test	
Type of facility				
Hospital	23	90	22	48
Health centre	3	75	2	79
Maternity	11	77	11	16
Clinic	5	60	5	83
Dispensary	0	37	0	285
Managing authority				
Government	3	43	3	306
NGO	0	39	0	18
Private (for profit)	5	62	5	108
Faith-based organisation	7	82	5	78
Province				
Nairobi	13	62	13	33
Central	3	67	3	71
Coast	9	75	9	57
Eastern	1	60	1	84
North Eastern	0	28	0	17
Nyanza	3	43	2	78
Rift Valley	4	36	4	130
Western	1	56	1	41
Total	4	53	4	509

[1] Anti-A, anti-B, anti-AB, and anti-D reagents plus an incubator, Coomb's reagent, and glass slides all present.

Table A-6.9 Capacity to test for syphilis with antenatal care

Among facilities offering antenatal care (ANC), percentage that have the capacity to test for syphilis and/or a standard to routinely screen ANC clients for syphilis, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering ANC services that have:			Number of facilities offering ANC
	Capacity to conduct syphilis test[1]	Standard to screen ANC clients for syphilis	Standard to screen ANC clients for syphilis and capacity to conduct syphilis test	
Type of facility				
Hospital	73	94	71	48
Health centre	39	84	38	79
Maternity	37	89	37	16
Clinic	28	69	26	83
Dispensary	9	45	9	285
Managing authority				
Government	20	53	20	306
NGO	23	48	23	18
Private (for profit)	27	65	25	108
Faith-based organisation	36	90	34	78
Province				
Nairobi	44	77	40	33
Central	30	69	30	71
Coast	40	82	40	57
Eastern	13	67	13	84
North Eastern	9	29	9	17
Nyanza	29	60	27	78
Rift Valley	14	45	13	130
Western	26	62	26	41
Total	24	61	23	509

[1] Either Venereal Disease Research Laboratory (VDRL) test or polymerase chain reaction (PCR) with functioning rotator or shaker, or rapid plasma reagin (RPR) test.

Table A-6.10 Utilisation of antenatal care and postnatal care services

Median average monthly number of antenatal care (ANC) clients (new and repeat clients) and postnatal care (PNC) clients for the 12 months preceding the survey, by type of facility, Kenya SPA 2010

Type of facility	Median monthly ANC visits[1]	Median monthly ANC re-visits[1]	Median monthly ANC visits ≥4*	Number of facilities reporting any of the ANC data	Median monthly PNC visits[1]	Number of facilities reporting PNC data
Hospital	58	82	16	46	17	31
Health centre	27	38	7	76	10	42
Maternity	10	14	4	13	7	5
Clinic	3	4	2	59	4	18
Dispensary	8	10	3	280	6	142
Total	10	13	4	474	7	237

* Data are from health information system monthly reports available at the facility on the day of the survey. Data were requested for the 12 months preceding the survey, but frequently some months were missing. Information from the months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-6.11 User fees for antenatal care services

Percentage of facilities offering antenatal care (ANC) that charge user fees for specific items or offer prepayment systems and discounts and percentage of facilities charging user fees that publicly post fees, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities charging for the indicated item:					Percentage of facilities with:			Number of facilities offering ANC	Percentage where fees are posted in public view			Number of facilities with routine fees for ANC services
	Client card	Consultation	Registration	Medicines	Laboratory tests	System to prepay for multiple visits	Discount/ exemption for some clients	No fees/ don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility													
Hospital	31	37	22	41	84	16	56	10	48	49	22	30	43
Health centre	32	23	34	29	71	8	59	11	79	34	15	51	70
Maternity	52	60	32	70	79	31	60	5	16	7	17	76	15
Clinic	28	57	26	62	58	21	58	11	83	10	4	86	74
Dispensary	24	23	27	15	34	9	45	31	285	28	11	61	196
Managing authority													
Government	23	15	29	11	37	6	50	31	306	38	14	48	210
NGO	32	36	38	17	35	6	84	1	18	47	2	51	18
Private (for profit)	26	63	24	65	59	26	53	11	108	7	6	87	96
Faith-based organisation	46	48	24	50	91	22	43	6	78	19	14	67	73
Province													
Nairobi	49	52	29	59	60	25	37	12	33	19	12	69	29
Central	27	49	36	50	60	18	56	3	71	13	18	69	68
Coast	23	28	30	30	54	20	59	23	57	46	5	48	44
Eastern	17	29	42	31	53	3	54	20	84	26	14	60	67
North Eastern	4	2	0	13	27	1	1	65	17	16	4	80	6
Nyanza	23	28	17	14	43	5	58	22	78	38	9	54	61
Rift Valley	39	22	19	21	43	18	44	32	130	28	11	61	88
Western	20	32	37	22	54	5	62	16	41	24	9	68	35
Total	27	31	28	29	50	12	51	22	509	27	12	61	398

Table A-6.12.1 Out-of-pocket payments for antenatal care services: First-visit clients

Among first-visit ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (KSh) paid on the day of the survey, by type of facility, Kenya SPA 2010

Type of facility	Percentage of interviewed first-visit ANC clients paying any out-of-pocket fees	Number of interviewed first-visit ANC clients	Median out-of-pocket payment (KSh) by first-visit ANC clients who paid anything for ANC services on day of survey[1]	Number of interviewed first-visit ANC clients providing valid responses on out-of-pocket payments
Hospital	80	208	150	163
Health centre	87	146	101	127
Maternity	66	8	351	6
Clinic	56	23	200	13
Dispensary	74	170	51	126
Total	79	556	101	435

[1] Includes any amount paid out-of-pocket for any service, including consultation, laboratory test, medicines, or other.

Table A-6.12.2 Out-of-pocket payments for antenatal care services: Follow-up clients

Among follow-up ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (KSh) paid on the day of the survey, by type of facility, Kenya SPA 2010

Type of facility	Percentage of interviewed follow-up visit ANC clients paying any out-of-pocket fees	Number of interviewed follow-up visit ANC clients	Median out-of-pocket payment (KSh) by follow-up visit ANC clients who paid anything for ANC services on day of survey[1]	Number of interviewed follow-up visit ANC clients providing valid responses on out-of-pocket payments
Hospital	51	303	51	153
Health centre	64	234	21	148
Maternity	66	10	50	7
Clinic	28	45	230	13
Dispensary	55	262	20	145
Total	55	853	21	466

[1] Includes any amount paid out-of-pocket for any service, including consultation, laboratory test, medicines, or other.

Table A-6.13 Supportive management for providers of ANC

Among interviewed antenatal care (ANC) service providers, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed service providers who received: Training related to ANC during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey	Training related to ANC during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	Number of interviewed ANC providers[2]
Type of facility					
Hospital	56	74	45	25	507
Health Centre	57	84	49	28	312
Maternity	58	55	36	21	63
Clinic	54	70	41	27	171
Dispensary	66	87	60	22	434
Managing authority					
Government	64	84	56	22	872
NGO	43	76	37	50	44
Private (for profit)	51	65	34	31	265
Faith-based organisation	55	77	45	24	305
Province					
Nairobi	63	72	48	22	150
Central	50	70	40	31	162
Coast	64	77	50	22	169
Eastern	58	80	48	26	258
North Eastern	52	87	43	32	26
Nyanza	58	82	48	30	229
Rift Valley	60	79	53	23	355
Western	62	88	56	12	136
Total	59	79	49	25	1,486

[1] This refers to structured pre- or in-service sessions, and does not include individual instructions received during routine supervision.
[2] Includes only providers of ANC services in facilities offering ANC services

Table A-6.14.1 Training for antenatal care service providers: (I)

Among interviewed antenatal care (ANC) service providers, percentage who received training[1] on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	ANC counselling		ANC screening		Complications of pregnancy		Family planning		Any STI diagnosis or treatment		Number of interviewed ANC service providers[2]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility											
Hospital	15	19	16	21	15	20	20	17	11	19	507
Health centre	10	28	10	33	12	29	24	23	10	20	312
Maternity	11	27	11	29	11	26	35	21	15	26	63
Clinic	11	10	19	10	11	10	21	16	9	15	171
Dispensary	13	18	14	17	14	17	15	13	9	14	434
Managing authority											
Government	12	20	16	20	15	19	21	16	10	15	872
NGO	23	44	23	47	24	35	13	33	9	16	44
Private (for profit)	13	19	13	19	13	17	28	20	11	22	265
Faith-based organisation	12	18	10	23	8	23	12	16	10	20	305
Province											
Nairobi	13	28	14	29	11	26	27	21	17	21	150
Central	7	14	9	12	9	13	13	18	8	23	162
Coast	13	21	18	21	14	22	26	10	10	12	169
Eastern	9	23	9	26	8	23	15	17	9	18	258
North Eastern	17	18	16	23	16	27	11	25	9	34	26
Nyanza	13	20	14	26	14	24	23	22	10	15	229
Rift Valley	16	20	18	20	19	20	20	17	11	19	355
Western	17	10	19	10	19	8	18	13	7	10	136
Total	13	20	14	21	14	20	20	17	10	17	1,486

[1] This refers to structured pre- or in-service training sessions and does not include individual instructions received during routine supervision.
[2] Includes only providers of ANC services in facilities offering ANC services.

Table A-6.14.2 Training for antenatal care service providers: (II)

Among interviewed antenatal care (ANC) service providers, percentage who received training[1] on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	PMTCT[2]		Intermittent Preventive Treatment (IPTp) of malaria for pregnant women		Nutritional counselling for HIV+ pregnant women		Nutritional assessment of pregnant women[3]		Number of interviewed ANC service providers[4]
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	34	29	27	15	18	17	12	12	507
Health centre	31	34	33	22	17	26	12	19	312
Maternity	35	25	28	27	13	22	10	19	63
Clinic	36	10	30	15	15	8	12	6	171
Dispensary	26	35	45	16	13	20	7	11	434
Managing authority									
Government	31	30	40	16	16	20	10	12	872
NGO	36	42	23	27	25	37	18	36	44
Private (for profit)	30	23	25	21	15	14	10	10	265
Faith-based organisation	32	30	26	16	14	18	12	14	305
Province									
Nairobi	51	27	21	21	22	19	16	12	150
Central	26	23	25	19	10	12	6	8	162
Coast	37	19	42	19	18	16	15	9	169
Eastern	20	42	36	12	9	21	5	14	258
North Eastern	29	35	34	25	18	24	12	14	26
Nyanza	34	33	31	20	21	26	14	22	229
Rift Valley	27	32	36	19	14	22	10	13	355
Western	35	15	44	11	21	7	12	4	136
Total	31	29	34	17	16	19	11	13	1,486

[1] This refers to structured pre- or in-service training sessions and does not include individual instruction received during routine supervision.
[2] Training on any topic related to prevention of mother-to-child transmission (PMTCT) of HIV, including counselling for PMTCT, guidelines to follow when dispensing and/or administering antiretroviral (ARV) drugs for PMTCT, nutritional counselling for the newborn of mothers with HIV, and record-keeping or other management of ARVs for PMTCT.
[3] Any training covering nutritional assessment such as body mass index (BMI) calculation and mid-upper arm circumference measurement.
[4] Includes only providers of ANC services in facilities offering ANC services.

Table A-6.15 Supportive supervision for antenatal care service providers

Among interviewed antenatal care (ANC) service providers who were personally supervised during the six months before the survey, median number of times providers were supervised and percentage who report specific activities by the supervisor during the last visit, by background characteristics, Kenya SPA 2010

Background characteristic	Median number of times staff were supervised in the 6 months before the survey	Percentage of providers reporting that, during the last supervisory visit, the supervisor:						Number of ANC service providers who were supervised in the 6 months before the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	3	97	91	91	74	90	49	376
Health centre	3	98	93	91	78	92	66	262
Maternity	3	95	93	90	75	85	52	35
Clinic	3	94	90	85	80	91	42	121
Dispensary	3	99	88	88	75	90	61	375
Managing authority								
Government	3	97	90	88	74	91	58	729
NGO	3	98	97	100	88	100	73	33
Private (for profit)	3	97	92	88	77	90	40	171
Faith-based organisation	3	98	92	94	79	87	59	236
Province								
Nairobi	4	98	92	93	82	93	41	108
Central	3	100	93	96	80	96	45	114
Coast	3	93	84	82	86	93	65	131
Eastern	3	98	92	92	65	88	56	208
North Eastern	3	98	98	63	55	89	43	23
Nyanza	3	96	91	91	86	94	68	187
Rift Valley	3	98	91	88	75	87	61	279
Western	3	97	92	89	67	89	39	120
Total	3	97	91	89	76	90	56	1,169

[1] Includes only providers of ANC services in facilities offering ANC services.

Table A-6.16 Characteristics of observed antenatal care clients

Among antenatal care (ANC) clients whose consultation was observed, percentage making their first or follow-up ANC visit, percentage for whom this was their first pregnancy and estimated gestational status, by background characteristics, Kenya SPA 2010

Background characteristic	Characteristics of observed ANC clients			Month of pregnancy				Number of observed ANC clients
	First ANC visit for this pregnancy	Follow-up ANC visit	First pregnancy	<5m	≥5m and <8m	≥8m	Missing	
Type of facility								
Hospital	41	59	35	5	50	44	0	510
Health centre	39	61	35	5	48	47	0	380
Maternity	45	55	37	4	51	45	0	18
Clinic	34	66	21	14	43	43	0	69
Dispensary	39	61	26	6	52	42	0	431
Managing authority								
Government	40	60	31	5	52	43	0	1,060
NGO	40	60	30	9	34	57	0	35
Private (for profit)	31	69	29	5	41	54	0	126
Faith-based organisation	41	59	36	9	49	42	0	188
Province								
Nairobi	29	71	44	7	45	47	0	188
Central	29	71	36	12	39	49	0	97
Coast	37	63	31	4	52	44	0	129
Eastern	38	62	25	4	52	43	0	184
North Eastern	32	68	28	4	68	29	0	30
Nyanza	48	52	28	5	57	39	0	239
Rift Valley	41	59	29	6	45	49	0	337
Western	45	55	34	6	54	40	0	205
Total	39	61	32	6	50	44	0	1,409

Table A-6.17 General assessments, examinations, and interventions for observed first-visit ANC clients

Among first-visit antenatal care (ANC) clients whose consultation was observed, percentage whose consultation included, specific assessments, examinations, and interventions and, among ANC clients with prior pregnancies, percentage whose consultation included a discussion of prior complications, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Client characteristics and Prior history						
Client's age	94	84	97	90	91	90
Date of last menstrual period	92	92	94	81	91	91
Any aspects related to prior pregnancy[1]	92	97	94	90	96	95
Any aspects of complications during prior pregnancy (if had prior pregnancy)	53	63	58	63	63	59
Medications client currently taking	24	29	26	12	34	28
All relevant elements for client history[2]	20	21	26	12	28	23
Laboratory tests and examinations						
Measure blood pressure	96	94	100	100	96	96
Weigh client	98	92	100	98	91	95
Urine test (protein)	91	72	76	79	75	81
Blood test (anaemia)	90	74	83	98	79	83
Preventive interventions						
Give or prescribe iron or folic acid tablets or both	59	56	37	78	64	60
Give or prescribe tetanus toxoid vaccine	80	79	77	85	79	79
Number of first-visit ANC clients	208	146	8	23	170	556
Among women with prior pregnancies, specific prior complications discussed:						
Stillbirth	46	37	51	35	47	44
Infant mortality first week after birth	37	27	47	35	28	32
Heavy bleeding during labour or postpartum	35	35	19	41	27	32
Assisted delivery	61	62	44	35	47	56
Previous abortion	60	59	60	66	74	64
Multiple pregnancies	59	60	59	31	49	55
Prolonged labour	36	51	34	31	26	37
Pregnancy-induced hypertension	36	41	51	35	30	35
Pregnancy-related convulsions	11	19	8	17	12	14
Number of observed first-visit ANC clients with prior pregnancy	134	105	5	17	121	381

[1] This includes any questions that would indicate whether the client had a prior pregnancy, such as number of prior pregnancies or complications during any previous pregnancies.
[2] Client's age, last menstrual period, medicines, any prior pregnancies, and, if there was a prior pregnancy, any questions related to complications during prior pregnancies.

Table A-6.18 Assessment of current health status of observed antenatal care clients

Among antenatal care (ANC) clients whose consultation was observed, percentage whose consultation included specific examinations and interventions, by type of facility, Kenya SPA 2010

Components of consultation	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Client questioned regarding						
Vaginal bleeding	31	29	35	21	27	29
Foetal movement (at least 5m pregnant)	45	51	59	31	46	46
Any other problems[1]	63	77	81	85	69	70
Client's knowledge of her HIV status	46	48	43	44	48	47
Basic physical examination						
Measure blood pressure	96	96	100	100	95	96
Urine test (protein)	74	56	49	59	45	59
Check foetal position (at least 8m pregnant)	99	100	92	100	99	99
Listened for foetal heart (at least 5m pregnant)	97	97	100	100	96	97
All questions and basic examination[2]	22	20	30	14	21	21
Other examinations						
Weigh client	99	96	96	98	96	97
Check uterine/fundal height[3]	97	95	98	100	94	96
Blood test (anaemia)	75	63	60	60	53	64
Preventive interventions						
Provider gave or prescribed iron or folic acid tablets	50	45	36	68	52	50
Provider explained purpose of iron or folic acid tablets	38	40	27	58	35	39
Provider explained how to take tablets	42	34	34	63	37	39
Provider gave or prescribed tetanus toxoid vaccine	50	53	52	39	48	50
Provider explained purpose of TT vaccine	29	30	33	18	30	29
Number of observed ANC clients at least 5 months pregnant	482	362	18	59	407	1,327
Number of observed ANC clients at least 8 months pregnant	225	179	8	30	180	623
Number of observed ANC clients	510	380	18	69	431	1,409

[1] Other problems include fever, headache or blurred vision, swollen face or hands, fatigue or breathlessness, persistent cough for two weeks or longer, or client's perception of a problem.
[2] Questions regarding vaginal bleeding, foetal movement (if at least five months pregnant), blood pressure measured, foetal position palpated or ultrasound performed (if at least eight months pregnant), and provider listened for foetal heartbeat (if client at least five months pregnant).
[3] Either by palpating the abdomen or using an ultrasound device to assess gestational age of the foetus.

Table A-6.19.1 Health education for antenatal care clients: Insecticide-treated bed nets

Among first- and follow-up visit antenatal care (ANC) clients whose consultations were observed, percentage who were counselled on insecticide-treated nets (ITNs), given ITNs free of charge, or purchased an ITN from a provider, by type of facility, Kenya SPA 2010

	Type of facility					
Counselling topic	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
First-visit ANC client						
Importance of using ITN explained	38	52	51	57	50	46
Given ITN free of charge	48	60	41	60	62	56
Client purchased ITN	1	0	5	0	1	1
Number of first-visit ANC clients	208	146	8	23	170	556
Follow-up visit ANC client						
Importance of using ITN explained	21	23	10	25	33	26
Given ITN free of charge	14	17	18	26	16	16
Client purchased ITN	1	1	0	0	1	1
Number of follow-up visit ANC clients	303	234	10	45	262	853

Table A-6.19.2 Health education for antenatal care clients: Intermittent prophylactic treatment (IPTp) of malaria

Among first- and follow-up visit antenatal care (ANC) clients, percentage observed to be counselled on intermittent prophylactic treatment (IPTp) for malaria and observed to ingest dose of IPTp in facility, by type of facility, Kenya SPA 2010

	Type of facility					
Counselling topic	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
First-visit ANC client						
Provider gave or prescribed IPTp	80	77	58	88	72	77
Provider explained purpose of IPTp	64	62	46	57	59	61
Provider explained how to take IPTp	69	58	54	73	61	64
Provider explained possible side effects of IPTp	21	21	13	10	14	18
Dose of IPT ingested in presence of provider	53	58	27	43	49	52
Importance of 2nd dose of IPTp explained	34	36	23	45	38	36
Number of first-visit ANC clients	208	146	8	23	170	556
Follow-up visit ANC client						
Provider gave or prescribed IPTp	55	63	23	19	71	60
Provider explained purpose of IPTp	37	35	18	13	49	38
Provider explained how to take IPTp	45	48	18	6	59	48
Provider explained possible side effects of IPTp	12	13	0	0	9	10
Number of follow-up visit ANC clients	303	234	10	45	262	853

Table A-6.20.1 Observed content of ANC counselling by type of facility

Percentage of first- and follow-up visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after childbirth, by type of facility, Kenya SPA 2010

	Type of facility					
Counselling topic	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
First-visit ANC client						
Nutrition[1]	54	60	49	53	48	53
Progress of pregnancy	72	78	84	95	77	76
Any risk symptoms for seeking help	56	52	70	31	61	56
Specific risk: vaginal bleeding	50	45	61	31	49	48
Specific risk: fever	24	22	13	5	18	21
Specific risk: shortness of breath, excessive fatigue	28	24	13	2	32	27
Specific risk: swelling of hands or face	39	24	33	15	34	32
Specific risk: headache or blurred vision	38	31	40	15	37	35
Specific risk: persistent cough	17	22	13	2	15	17
Specific risk: loss of or excessive foetal movement	38	40	49	2	40	38
Delivery plans	65	65	66	52	70	66
Exclusive breastfeeding	31	38	18	15	31	32
Family planning after childbirth	31	34	13	10	28	30
Provider used any visual aids	22	21	14	0	13	18
Number of first-visit ANC clients	208	146	8	23	170	556
Follow-up visit ANC client						
Nutrition[1]	45	39	35	34	46	43
Progress of pregnancy	73	73	74	80	67	72
Any risk symptoms for seeking help	39	47	32	26	42	41
Specific risk: vaginal bleeding	29	35	29	24	33	32
Specific risk: fever	11	19	11	7	15	14
Specific risk: shortness of breath, excessive fatigue	13	16	10	4	19	15
Specific risk: swelling of hands or face	22	23	20	6	30	24
Specific risk: headache or blurred vision	18	20	22	2	29	21
Specific risk: persistent cough	9	7	4	0	7	7
Specific risk: loss of or excessive foetal movement	28	39	19	6	35	32
Delivery plans	63	65	66	74	75	68
Exclusive breastfeeding	17	15	0	14	23	18
Family planning after childbirth	17	16	3	16	20	18
Provider used any visual aids	8	8	3	20	5	8
Number of follow-up visit ANC clients	303	234	10	45	262	853
All observed ANC clients						
Nutrition[1]	49	47	41	40	47	47
Progress of pregnancy	73	75	79	85	71	73
Any risk symptoms for seeking help	46	49	49	28	49	47
Specific risk: vaginal bleeding	38	39	43	27	39	38
Specific risk: fever	16	20	12	6	16	17
Specific risk: shortness of breath, excessive fatigue	19	19	11	3	24	20
Specific risk: swelling of hands or face	29	23	26	9	32	27
Specific risk: headache or blurred vision	26	24	30	7	32	26
Specific risk: persistent cough	12	12	8	1	10	11
Specific risk: loss of or excessive foetal movement	32	39	32	5	37	34
Delivery plans	64	65	66	67	73	67
Exclusive breastfeeding	23	24	8	15	26	23
Family planning after childbirth	23	23	8	14	23	22
Provider used any visual aids	14	13	8	14	9	12
Number of all observed ANC clients	510	380	18	69	431	1,409

[1] Any discussion about the quantity and quality of food to eat during the pregnancy.

Table A-6.20.2 Observed content of ANC counselling by province

Percentage of first- and follow-up visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after childbirth, by province, Kenya SPA 2010

	Province								
Counselling topic	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total
First-visit ANC client									
Nutrition[1]	63	89	54	43	49	48	69	28	53
Progress of pregnancy	90	87	71	75	36	80	90	47	76
Any risk symptoms for seeking help	46	81	36	56	24	56	83	26	56
Specific risk: vaginal bleeding	46	75	35	53	21	45	67	22	48
Specific risk: fever	29	30	16	27	8	15	27	10	21
Specific risk: shortness of breath, excessive fatigue	27	28	15	42	0	23	39	11	27
Specific risk: swelling of hands or face	35	40	25	37	6	36	42	13	32
Specific risk: headache or blurred vision	34	43	25	50	4	32	47	18	35
Specific risk: persistent cough	27	18	10	26	0	8	27	4	17
Specific risk: loss of or excessive foetal movement	35	69	23	41	16	44	50	13	38
Delivery plans	52	79	59	71	70	66	83	44	66
Exclusive breastfeeding	34	34	25	39	8	28	46	15	32
Family planning after childbirth	31	34	23	39	19	22	42	17	30
Provider used any visual aids	24	28	20	23	3	8	26	11	18
Number of first-visit ANC clients	55	28	48	70	10	115	137	92	556
Follow-up visit ANC client									
Nutrition[1]	42	77	32	42	66	41	50	17	43
Progress of pregnancy	82	86	54	80	28	80	69	58	72
Any risk symptoms for seeking help	34	67	38	39	3	41	58	18	41
Specific risk: vaginal bleeding	31	51	31	33	1	30	38	14	32
Specific risk: fever	17	30	13	16	1	11	17	2	14
Specific risk: shortness of breath, excessive fatigue	14	40	16	26	0	13	10	4	15
Specific risk: swelling of hands or face	19	40	31	29	3	28	27	3	24
Specific risk: headache or blurred vision	17	46	27	28	1	20	18	8	21
Specific risk: persistent cough	6	26	9	6	0	5	6	1	7
Specific risk: loss of or excessive foetal movement	22	54	20	35	0	30	51	11	32
Delivery plans	57	82	65	72	88	66	74	56	68
Exclusive breastfeeding	20	36	17	15	4	20	19	6	18
Family planning after childbirth	22	32	25	19	1	15	14	11	18
Provider used any visual aids	12	27	7	6	0	4	6	1	8
Number of follow-up visit ANC clients	134	68	81	114	20	124	200	112	853
All observed ANC clients									
Nutrition[1]	48	80	40	42	60	44	58	22	47
Progress of pregnancy	84	87	60	78	31	80	77	53	73
Any risk symptoms for seeking help	37	71	37	46	10	48	68	22	47
Specific risk: vaginal bleeding	36	58	32	41	8	37	50	18	38
Specific risk: fever	21	30	14	20	3	13	21	6	17
Specific risk: shortness of breath, excessive fatigue	18	36	16	32	0	18	22	7	20
Specific risk: swelling of hands or face	24	40	29	32	4	32	33	7	27
Specific risk: headache or blurred vision	22	45	26	36	2	26	29	13	26
Specific risk: persistent cough	12	23	9	14	0	6	15	2	11
Specific risk: loss of or excessive foetal movement	26	58	21	37	5	36	51	12	34
Delivery plans	55	82	63	72	82	66	78	51	67
Exclusive breastfeeding	24	36	20	24	5	24	30	10	23
Family planning after childbirth	24	33	24	27	7	19	25	13	22
Provider used any visual aids	15	27	12	12	1	6	14	5	12
Number of all observed ANC clients	188	97	129	184	30	239	337	205	1,409

[1] Any discussion about the quantity and quality of food to eat during the pregnancy.

Table A-6.20.3 Observed content of ANC counselling for clients at least eight months pregnant

Percentage of ANC clients at least eight months pregnant who were observed to receive counselling on delivery plans, exclusive breastfeeding, and family planning after childbirth, by type of facility, Kenya SPA 2010

	Type of facility					
Counselling topic	Hospital	Health centre	Maternity	Clinic	Dispensary	Total percentage
All observed ANC clients 8 or more months pregnant						
Nutrition[1]	43	43	33	18	44	42
Progress of pregnancy	76	79	84	84	76	77
Any risk symptoms for seeking help	43	48	47	13	43	43
Specific risk: vaginal bleeding	33	34	34	11	37	34
Specific risk: fever	12	16	4	4	14	13
Specific risk: shortness of breath, excessive tiredness	16	15	10	2	17	15
Specific risk: swelling of hands or face	25	20	12	4	32	24
Specific risk: headache or blurred vision	20	19	36	4	28	22
Specific risk: persistent cough	9	5	4	2	6	6
Specific risk: loss of or excessive foetal movement	29	40	30	2	33	32
Delivery plans	68	68	64	51	80	71
Exclusive breastfeeding	19	16	4	4	23	18
Family planning after childbirth	20	16	4	18	22	19
Provider used any visual aids	10	7	5	19	8	9
Number of ANC clients at least 8 months pregnant	225	179	8	30	180	623

[1] Any discussion about the quantity and quality of food to eat during the pregnancy.

Table A-6.21 ANC clients' reported health education received and knowledge related to warning signs during pregnancy, by type of facility

Among interviewed antenatal care (ANC) clients, percentage who said provider counselled them on warning signs for pregnancy, percentage who named specific warning signs, and percentage who said provider told them what to do in case of warning signs and discussed breastfeeding, delivery plans and supplies, and family planning during this visit or a previous visit, by type of facility, Kenya SPA 2010

	Type of facility					
Issue discussed during current/previous visit	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Provider counselled on:						
Any warning signs	57	50	74	47	44	51
Warning signs discussed (named by client)						
Vaginal bleeding	41	32	59	23	33	35
Fever	10	9	6	7	10	9
Swollen face or hands	14	11	20	6	9	12
Fatigue or breathlessness	7	9	7	10	4	7
Headache or blurred vision	15	16	31	8	15	15
Convulsions	2	2	8	1	0	1
Reduced foetal movement	21	18	37	21	18	19
What client was told to do if warning sign occurs						
Seek care at facility	56	49	73	47	47	51
Decrease activity	2	1	4	2	1	1
Change diet	0	0	0	0	1	0
Client reported provider discussed						
Exclusive breastfeeding	44	31	36	43	36	38
Exclusive breastfeeding for 4-6 months	9	2	6	0	4	5
Exclusive breastfeeding for 6 months	34	26	28	43	31	31
Delivery plans	61	61	75	47	66	62
Supplies to prepare for delivery	57	51	54	48	59	55
Using family planning after childbirth	30	29	24	31	26	29
Number of interviewed ANC clients	510	380	18	69	431	1,409

Table A-6.22 ANC clients' reported health education received and knowledge related to warning signs during pregnancy, by province

Among interviewed antenatal care (ANC) clients, percentage who said provider counselled them on warning signs for pregnancy, percentage who named specific warning signs, and percentage who said provider told them what to do in case of warning signs and discussed breastfeeding, delivery plans and supplies, and family planning during this visit or a previous visit, by province, Kenya SPA 2010

Issue discussed during current/previous visit	Province								Total
	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	
Provider counselled on:									
Any warning signs	57	78	46	47	1	37	50	62	51
Warning signs named by client									
Vaginal bleeding	51	50	27	26	1	23	34	48	35
Fever	15	4	7	1	0	7	7	25	9
Swollen face or hands	22	15	11	12	0	4	9	14	12
Fatigue or breathlessness	6	11	2	9	0	3	7	14	7
Headache or blurred vision	15	27	12	15	0	7	16	21	15
Convulsions	1	2	0	1	0	0	1	6	1
Reduced foetal movement	23	50	14	9	0	11	15	33	19
What client was told to do if warning sign occurs									
Seek care at facility	58	78	44	46	1	39	52	63	51
Decrease activity	0	0	0	0	0	0	1	7	1
Change diet	0	0	3	0	0	0	0	0	0
Client reported provider discussed									
Exclusive breastfeeding	48	46	28	34	11	38	35	43	38
Exclusive breastfeeding for 4-6 months	2	11	0	3	7	12	5	1	5
Exclusive breastfeeding for 6 months	43	33	26	30	3	24	28	40	31
Delivery plans	59	64	52	63	27	55	68	73	62
Supplies to prepare for delivery	63	73	40	52	13	48	57	64	55
Using family planning after childbirth	40	27	35	26	5	29	28	22	29
Number of interviewed ANC clients	188	97	129	184	30	239	337	205	1,409

Table A-6.23 Clients' plans for place of delivery

Among interviewed antenatal care (ANC) clients, percentage who reported planning where they will deliver, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of ANC clients who plan to deliver at:						Number of interviewed ANC clients
	This facility	Another facility	Private home	TBA's home	Other	Don't know/ missing	
Type of facility							
Hospital	80	11	3	0	2	4	510
Health centre	64	25	5	0	2	4	380
Maternity	84	10	1	0	1	3	18
Clinic	19	58	11	4	4	3	69
Dispensary	34	51	6	2	2	4	431
Managing authority							
Government	58	30	5	1	2	4	1,060
NGO	47	28	17	8	0	0	35
Private (for profit)	73	17	2	0	4	5	126
Faith-based organisation	56	36	4	1	2	1	188
Province							
Nairobi	46	49	0	0	1	4	188
Central	56	41	0	0	0	3	97
Coast	54	23	12	2	5	4	129
Eastern	51	37	6	0	0	5	184
North Eastern	41	5	22	7	0	26	30
Nyanza	66	24	2	0	5	3	239
Rift Valley	66	20	7	2	1	4	337
Western	63	28	6	1	2	0	205
Total	59	29	5	1	2	4	1,409

Table A-6.24 Use of client cards

Among first- and follow-up visit antenatal care (ANC) clients whose consultation was observed, percentage of consultations in which the provider looked at the client card during the consultation and who wrote on the client card at the end of the visit, by background characteristics, Kenya SPA 2010

Background characteristic	Provider looked at client card during consultation		Provider wrote on client card at end of visit		Number of first-visit ANC clients	Number of follow-up visit ANC clients
	First visit	Follow-up visit	First visit	Follow-up visit		
Type of facility						
Hospital	96	97	100	99	208	303
Health centre	99	99	100	99	146	234
Maternity	96	100	100	100	8	10
Clinic	91	100	100	100	23	45
Dispensary	97	98	100	100	170	262
Managing authority						
Government	96	98	100	99	426	634
NGO	100	100	100	100	14	21
Private (for profit)	94	97	100	99	39	87
Faith-based organisation	100	95	100	99	76	111
Province						
Nairobi	100	96	100	97	55	134
Central	97	95	100	100	28	68
Coast	100	97	100	100	48	81
Eastern	94	99	100	99	70	114
North Eastern	94	99	100	100	10	20
Nyanza	96	99	100	99	115	124
Rift Valley	95	99	100	100	137	200
Western	100	100	100	100	92	112
Total	97	98	100	99	556	853

Table A-6.25 Outcome of observed consultations

Among antenatal care (ANC) clients whose consultations were observed, percentage who went home, who were referred elsewhere in the same facility, who were admitted to the facility, who were referred outside the facility, and whose status was uncertain at the end of the consultation, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of ANC consultations where:					Number of observed ANC clients
	Client sent home	Client referred in same facility	Client admitted to facility	Client referred to another facility	Not known	
Type of facility						
Hospital	74	24	1	1	1	510
Health centre	80	19	0	0	1	380
Maternity	70	26	0	4	0	18
Clinic	89	8	0	3	0	69
Dispensary	81	15	0	2	3	431
Managing authority						
Government	78	19	0	1	2	1,060
NGO	81	19	0	0	0	35
Private (for profit)	83	14	0	2	0	126
Faith-based organisation	79	20	1	0	1	188
Province						
Nairobi	91	6	1	1	2	188
Central	89	9	0	0	1	97
Coast	56	43	0	1	0	129
Eastern	82	15	0	0	3	184
North Eastern	73	21	0	0	6	30
Nyanza	77	18	0	2	2	239
Rift Valley	83	13	0	2	1	337
Western	67	33	0	0	0	205
Total	78	19	0	1	1	1,409

Table A-6.26 Client feedback on service problems

Among interviewed ANC clients, percentage who said that they considered specific service issues to be a major problem on the day of the visit, by type of facility, Kenya SPA 2010

	Type of facility					
Client service issue	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Behaviour/attitude of provider	2	1	0	0	1	1
Inability to discuss problem	4	2	0	0	4	3
Insufficient explanation about pregnancy or problems	3	3	0	2	4	3
Waiting time to see provider	29	29	14	17	22	26
Quality of examination and treatment	1	1	2	0	2	1
Availability of medicines	6	13	6	8	9	9
Days facility is open	2	3	0	0	12	5
Hours facility is open	7	6	0	0	11	7
Cleanliness of facility	2	2	0	0	1	2
Cost of services	9	10	5	4	3	7
Insufficient visual privacy	1	1	2	0	4	2
Insufficient auditory privacy	2	1	2	0	5	2
Number of interviewed ANC clients	510	380	18	69	431	1,409

Table A-6.27 Client choice of facility

Among interviewed antenatal care (ANC) clients, percentage who reported this was not the closest health facility to their home and, among these, the main reason they did not go to the nearest facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed ANC clients who report this is not the facility nearest their home	Number of interviewed ANC clients	Percentage of ANC clients not visiting the facility nearest home who mention that the indicated item was a problem with the nearest facility									Number of interviewed ANC clients for whom this was not the closest facility
			Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Other	Don't know/ missing	
Type of facility												
Hospital	30	510	8	24	8	5	10	12	7	25	0	151
Health centre	18	380	11	7	0	12	13	5	2	50	0	70
Maternity	29	18	9	32	27	0	0	0	0	32	0	5
Clinic	26	69	0	9	6	0	11	9	0	50	13	18
Dispensary	17	431	13	27	6	10	5	31	0	8	0	74
Managing authority												
Government	18	1,060	9	15	5	12	7	23	5	24	0	187
NGO	17	35	0	27	0	20	0	0	0	53	0	6
Private (for profit)	40	126	7	25	10	0	15	0	3	35	5	50
Faith-based organisation	39	188	13	31	8	0	11	3	2	32	0	74
Province												
Nairobi	31	188	12	34	7	0	22	6	3	16	0	59
Central	25	97	2	55	11	2	2	18	8	3	2	24
Coast	21	129	3	6	7	7	13	19	3	41	1	27
Eastern	24	184	7	9	2	1	8	13	4	50	5	45
North Eastern	3	30	0	0	0	100	0	0	0	0	0	1
Nyanza	24	239	2	16	12	7	0	13	3	47	0	57
Rift Valley	25	337	16	13	3	16	10	22	5	17	0	84
Western	11	205	22	27	6	10	4	9	2	20	0	22
Total	23	1,409	10	21	6	7	9	15	4	28	1	317

Table A-6.28 Educational characteristics of antenatal care clients

Percent distribution of observed and interviewed antenatal care (ANC) clients by educational level and percentage of clients with primary, informal, or no education who are literate, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of all ANC clients: No education	Primary	Post-primary/ technical	Secondary	Higher	Number of interviewed ANC clients	Percentage of ANC clients with primary, informal or no education who: Cannot read or write	Can read, cannot write	Can read and write	Number of interviewed ANC clients with primary, informal or no education
Type of facility										
Hospital	6	45	1	30	18	510	22	2	73	266
Health Centre	5	63	1	23	9	380	18	4	75	261
Maternity	2	38	4	40	17	18	12	0	88	8
Clinic	12	55	0	21	11	69	19	0	78	46
Dispensary	12	59	2	24	4	431	27	5	61	309
Managing authority										
Government	9	59	1	24	6	1,060	23	4	68	736
NGO	11	59	0	26	4	35	21	0	79	25
Private (for profit)	3	30	1	30	36	126	12	0	88	43
Faith-based organisation	1	43	2	32	21	188	20	3	73	87
Province										
Nairobi	1	22	2	38	36	188	3	0	79	47
Central	0	61	0	28	11	97	9	0	91	59
Coast	24	49	0	21	6	129	44	0	55	94
Eastern	3	73	2	14	8	184	30	3	66	144
North Eastern	92	4	1	4	0	30	94	0	3	29
Nyanza	1	64	2	26	6	239	3	2	80	163
Rift Valley	11	52	1	29	8	337	26	9	65	214
Western	2	68	0	25	6	205	15	2	81	142
Total	8	54	1	26	11	1,409	22	3	70	891

Table A-6.29 Emergency maternity transportation systems

Among facilities that support transportation for obstetric emergencies, percentage with specific emergency transportation systems and median transportation time (in minutes) to referral facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage using the following emergency transportation systems: Facility-based ambulance or other vehicle[1]	Vehicle at another facility[2]	Facility hires vehicle	Other arrangement to support cost[3]	Median transportation time (in minutes) to referral facility using most common mode of emergency transportation: Dry season	Wet season	Number of facilities supporting emergency transportation
Type of facility							
Hospital	85	49	15	60	40	46	45
Health centre	50	59	26	59	35	46	62
Maternity	66	64	29	74	30	30	13
Clinic	28	62	30	41	30	30	62
Dispensary	10	71	26	35	36	60	160
Managing authority							
Government	25	71	17	46	46	60	189
NGO	26	61	49	40	46	120	14
Private (for profit)	41	60	31	47	21	30	86
Faith-based organisation	47	47	37	44	31	35	53
Province							
Nairobi	67	67	24	51	20	21	24
Central	26	54	25	47	31	46	38
Coast	24	75	4	39	60	60	43
Eastern	26	55	26	24	31	60	53
North Eastern	15	94	5	17	91	151	11
Nyanza	36	74	36	65	31	60	58
Rift Valley	34	59	30	47	35	35	88
Western	31	59	27	57	31	45	26
Total	32	64	25	46	31	46	341

[1] Ambulance or other vehicle that stays at the facility.
[2] Facility calls for dedicated ambulance or other vehicle from another facility to collect emergency patient.
[3] This may include facility or community financial support, such as funds set aside for emergencies, a community insurance scheme, a revolving fund, or some other system to help provide transport in times of need.

Table A-6.30 Availability of equipment, infrastructure, and staff for quality delivery services

Percentage of facilities offering delivery services that were observed to have equipment, supplies, and infrastructure in the delivery service area and staff for delivery services, by type of facility, Kenya SPA 2010

Item	Type of facility					Total percentage
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Infection control						
Soap	72	65	64	28	66	65
Running water	93	93	86	64	68	83
Soap and running water	68	64	53	28	56	60
Hand disinfectant	39	38	29	14	25	32
Soap and water or else hand disinfectant	76	81	61	28	65	71
Clean latex gloves	93	93	91	100	90	92
Disinfecting solution	90	90	82	100	78	86
Sharps box	96	97	92	100	87	93
All items for infection control[1]	69	68	54	28	47	58
Covered waste receptacle with plastic liner[2]	19	24	13	0	18	19
All items for infection control plus waste receptacle	15	21	10	0	11	15
Table cloth/plastic on any surface	92	92	94	100	85	90
Infrastructure for delivery						
Visual privacy and auditory privacy	90	94	100	100	73	87
Visual privacy only	6	4	0	0	16	8
Auditory privacy only	1	0	0	0	0	0
Delivery bed[3]	84	85	83	50	74	79
Examination light[4]	68	51	77	50	21	47
All elements of infrastructure[5]	55	48	68	43	6	36
Other items to support quality services						
Blank partograph	84	72	66	57	40	63
Essential maternal and neonatal care clinical guidelines for Kenya	22	16	12	7	2	12
Other guidelines for normal delivery	34	16	22	14	2	16
Guidelines for emergency obstetric care	42	30	21	14	11	25
Qualified delivery provider on site 24 hours[6]	86	54	63	0	13	46
Qualified delivery provider on call 24 hours[6]	2	4	2	36	9	6
All other items to support quality services[7]	48	20	18	0	5	20
Other Kenya guidelines						
Basic paediatric protocols	20	10	11	7	12	13
Neonatal resuscitation flow diagram	44	22	24	0	2	19
Protocol on neonatal feeding	43	26	18	7	11	24
Wall charts of EmONC	27	7	16	0	5	11
Protocols on management of jaundice	7	2	4	0	0	2
Number of facilities offering delivery services	48	66	14	8	70	207

[1] Soap and running water or else hand disinfectant, clean latex gloves, disinfecting solution for decontaminating reusable items, and sharps box.
[2] While important for infection control, this is not an item that has been commonly introduced and so was not included in the aggregate for infection control.
[3] Any type of bed or couch where a client can lie down and deliver a baby.
[4] Examination light, flashlight, or other spotlight source.
[5] Both visual and auditory privacy, examination bed, and examination light.
[6] A duty schedule must be observed.
[7] Guidelines, partograph, and delivery staff available 24 hours per day, with duty schedule observed.

Table A-6.31 Locations where delivery equipment is sterilised or disinfected

Among facilities that offer delivery services, percentage that process delivery equipment for reuse by sterilisation or high-level disinfection (HLD) in the indicated locations, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where delivery service equipment is processed in the indicated area[1]				Number of facilities offering delivery services
	Delivery service area	Main facility area	Outside facility	No processing of delivery equipment	
Type of facility					
Hospital	15	82	1	2	48
Health centre	23	75	1	1	66
Maternity	16	77	3	5	14
Clinic	0	100	0	0	8
Dispensary	11	71	8	10	70
Managing authority					
Government	18	73	2	7	124
NGO	1	57	40	1	8
Private (for profit)	8	88	3	1	37
Faith-based organisation	20	78	1	1	38
Province					
Nairobi	4	89	7	0	13
Central	16	84	0	0	16
Coast	2	92	6	0	22
Eastern	8	79	10	3	35
North Eastern	16	31	12	40	11
Nyanza	8	84	2	6	43
Rift Valley	42	58	0	0	47
Western	6	87	0	6	21
Total	16	76	4	4	207

[1] Main facility area and delivery processing area may be the same location in small facilities.

Table A-6.32 Sterilisation and capacity for disinfecting delivery service equipment in facilities that report equipment processing

Among facilities offering delivery services and reporting they sterilise equipment, percentage where facility has all items to support quality sterilisation or high-level disinfection (HLD) processes, and percentage with written guidelines at the site where delivery equipment is processed for reuse, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where the indicated procedure is the highest level available that meets all conditions for quality sterilisation/HLD of delivery equipment			Percentage of facilities with written guidelines for sterilisation or HLD procedures at processing site	Number of facilities offering delivery services and reporting processing of equipment in delivery or main area
	Dry heat or autoclave[1]	Boil/steam or chemical HLD[1]	Report sterilisation but missing equipment and/or knowledge[2]		
Type of facility					
Hospital	66	2	32	50	47
Health centre	45	3	52	41	64
Maternity	51	3	46	47	13
Clinic	43	0	57	14	8
Dispensary	29	0	71	12	57
Managing authority					
Government	39	2	59	33	113
NGO	35	0	65	33	5
Private (for profit)	61	1	38	40	35
Faith-based organisation	52	0	48	29	37
Province					
Nairobi	67	0	33	33	12
Central	61	1	38	32	16
Coast	41	0	59	28	20
Eastern	32	2	67	18	31
North Eastern	57	0	43	2	5
Nyanza	38	0	62	46	39
Rift Valley	51	4	45	40	47
Western	49	1	50	35	20
Total	46	2	53	34	190

[1] Functioning equipment, appropriate knowledge of temperature and time for method used, and an automatic timer are all present.

Table A-6.33.1 Storage conditions for sterilised or high-level disinfected delivery equipment: Facilities where items are present anywhere in facility

Percentage of facilities with stored sterilised or high-level disinfected (HLD) delivery instruments present and, among these, percentage that meet standards for good storage, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with stored sterilised/HLD delivery items present anywhere in facility	Number of facilities offering delivery services	Storage conditions are sterile[1]	Clean but not sterile storage conditions[2]	Processing dates observed on processed and stored items	Storage conditions are sterile and processing dates on sterilised items	Number of facilities with stored sterilised/HLD delivery items
Type of facility							
Hospital	99	48	86	5	58	57	48
Health centre	100	66	84	11	45	45	66
Maternity	97	14	76	18	57	45	14
Clinic	100	8	57	7	43	43	8
Dispensary	94	70	78	13	3	3	66
Managing authority							
Government	96	124	77	13	30	30	120
NGO	100	8	51	0	6	6	8
Private (for profit)	99	37	79	15	55	50	37
Faith-based organisation	100	38	99	0	39	38	38
Province							
Nairobi	100	13	74	19	60	49	13
Central	100	16	98	2	58	56	16
Coast	100	22	59	22	29	27	22
Eastern	100	35	94	3	15	15	35
North Eastern	100	11	83	3	15	15	11
Nyanza	93	43	64	19	40	40	40
Rift Valley	100	47	87	9	39	39	47
Western	90	21	89	4	39	38	19
Total	98	207	81	11	35	34	202

[1] Items are wrapped is sterile paper, sealed with tape, or stored in a sterile container with a lid that clasps shut, or stored under other sterile conditions, and the storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser or autoclave, or sitting in disinfecting solution.

Table A-6.33.2 Storage conditions for sterilised or high-level delivery equipment: Facilities where items are present in the delivery service area

Percentage of facilities with stored sterilised or high-level disinfected (HLD) delivery instruments present in the delivery service area and, among these, percentage that meet standards for good storage, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with stored sterilised/HLD delivery items present in the delivery area	Number of facilities offering delivery services	Storage conditions are sterile[1]	Clean but not sterile storage conditions[2]	Processing dates observed on processed and stored items	Storage conditions are sterile and processing dates on sterilised items	Number of facilities with stored sterilised/HLD delivery items in the delivery area
Type of facility							
Hospital	49	48	87	5	57	55	24
Health centre	49	66	79	15	43	43	33
Maternity	43	14	60	29	48	25	6
Clinic	36	8	100	0	100	100	3
Dispensary	34	70	84	11	0	0	24
Managing authority							
Government	39	124	75	17	37	37	49
NGO	45	8	100	0	3	3	4
Private (for profit)	36	37	74	16	65	53	13
Faith-based organisation	62	38	99	1	28	27	23
Province							
Nairobi	47	13	60	26	77	54	6
Central	60	16	100	0	66	66	10
Coast	51	22	58	32	45	42	11
Eastern	40	35	98	0	16	16	14
North Eastern	27	11	47	8	35	35	3
Nyanza	28	43	82	12	30	30	12
Rift Valley	58	47	83	15	28	28	27
Western	30	21	92	2	48	46	6
Total	43	207	82	12	37	35	89

[1] Items are wrapped is sterile paper, sealed with tape, or stored in a sterile container with a lid that clasps shut, or stored under other sterile conditions, and the storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser or autoclave, or sitting in disinfecting solution.

Table A-6.34 Delivery service providers

Among facilities offering delivery services, percentage where a qualified, trained delivery provider is available on site or on call 24 hours a day to conduct deliveries, with and without an observed duty schedule, and percentage where the provider on duty at night is most commonly a doctor, midwife, nurse, or other staff member, by background characteristics, Kenya SPA 2010

Background characteristic	Qualified, trained delivery provider available 24 hours, with observed duty schedule		Qualified, trained delivery provider available 24 hours, with no observed duty schedule		Percentage of facilities where provider commonly on duty to conduct delivery at night is:[1]						Number of facilities offering delivery services
	On site	On call	On site	On call	Doctor[2]	Clinical officer	Registered nurse/ midwife[3]	Enrolled nurse/ midwife[4]	Nursing aide	Other/ don't know	
Type of facility											
Hospital	86	2	5	4	26	12	88	85	2	1	48
Health centre	54	4	18	12	1	19	62	72	2	0	66
Maternity	63	2	21	7	11	16	66	73	16	2	14
Clinic	0	36	7	14	0	0	43	21	7	7	8
Dispensary	13	9	19	14	0	2	24	43	2	0	70
Managing authority											
Government	48	6	12	8	4	6	50	62	0	0	124
NGO	11	0	13	0	1	15	23	8	1	0	8
Private (for profit)	51	13	16	13	18	20	65	66	11	2	37
Faith-based organisation	44	1	26	16	10	15	67	76	6	0	38
Province											
Nairobi	85	0	0	15	21	15	85	63	12	0	13
Central	82	3	2	0	30	10	77	83	1	0	16
Coast	31	23	5	2	6	10	48	43	2	1	22
Eastern	41	2	5	15	3	3	34	55	0	0	35
North Eastern	65	22	11	1	3	19	80	47	1	0	11
Nyanza	31	9	23	19	3	18	48	72	3	1	43
Rift Valley	45	1	29	9	6	6	66	73	1	1	47
Western	40	0	17	7	2	12	36	49	11	0	21
Total	46	6	15	10	7	11	55	63	3	1	207

[1] At the same facility there may be more than one type of staff who routinely conduct night deliveries.
[2] Includes obstetrician/gynaecologists and medical officers.
[3] Includes registered nurses and registered midwives.
[4] Includes enrolled nurses and enrolled midwives.

Table A-6.35 Availability of medicines and supplies for quality delivery services

Percentage of facilities offering delivery services where specific medicines and supplies are observed to be in the delivery room (DR) and/or pharmacy, by type of facility, Kenya SPA 2010

Item	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Basic medicines and supplies for delivery						
Scissor or blade	96	96	97	100	97	97
Cord clamp or tie	99	100	95	64	92	95
Suction apparatus (bulb or machine)	90	81	88	79	56	75
Suction bulb	31	33	38	7	16	26
Suction machine	88	75	81	72	53	71
Antibiotic eye ointment for newborn (in delivery room)	72	64	77	93	69	70
Antibiotic eye ointment for newborn (in pharmacy or delivery room)	93	88	95	100	88	90
Skin disinfectant for perineum	87	87	94	100	78	85
All basic supplies for delivery[1]	72	61	80	43	40	57
Additional medicines and supplies for managing common complications of delivery						
Syringes and needles in DR	98	96	95	100	95	96
Syringes and needles in facility	100	100	100	100	95	98
Intravenous solution[2] and perfusion set in DR	88	84	83	57	63	77
Intravenous solution[2] and perfusion set in facility	96	95	97	57	85	91
Oral antibiotic[3] in facility	99	91	88	100	87	92
Injectable oxytocic medication in DR	80	69	89	93	59	71
Injectable oxytocic medication in facility	88	81	95	93	67	79
Suture material in DR	94	95	96	93	90	93
Needle holder in DR	97	98	97	100	89	95
All basic treatment interventions[4]	72	48	66	50	35	51
Additional medicines and supplies for managing serious complications						
Diazepam or magnesium sulphate in DR	85	78	72	93	78	80
Diazepam or magnesium sulphate in facility	98	97	96	93	97	97
Injectable amoxicillin or ampicillin in DR	10	2	12	0	2	4
Injectable amoxicillin or ampicillin in facility	29	12	35	0	2	13
Injectable procaine penicillin in DR	52	46	80	50	41	48
Injectable procaine penicillin in facility	66	62	86	64	55	62
Injectable gentamicin in DR	52	39	73	7	49	46
Injectable gentamicin in facility	92	77	100	57	71	79
All other medicines for complications[5]	79	62	72	57	52	63
Injectable hydralazine in DR	46	21	46	0	6	23
Injectable ergometrine/methergine in DR	21	22	49	0	5	17
Number of facilities offering delivery services	48	66	14	8	70	207

[1] Scissor or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, and skin disinfectant for perineum.
[2] Accepted intravenous solutions were 0.9% normal saline, dextrose 5% and normal saline (5%D/NS), lactated Ringer's solution, and plasma expanders.
[3] Oral amoxicillin, Augmentin (amoxicillin + clavulanate), ampicillin, or cotrimoxazole.
[4] Needles and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area, and oral antibiotic (cotrimoxazole or amoxicillin or ampicillin) located in pharmacy or delivery room area.
[5] Injectable anticonvulsant (diazepam or magnesium sulphate) in delivery room area, an injectable antibiotic (penicillin or ampicillin, or gentamicin) in delivery room area or pharmacy

Table A-6.36 Availability of services, equipment, and supplies for complications of labour and delivery: All facilities

Percentage of all facilities offering delivery services where specific services, equipment, and supplies are available for certain complications of labour and delivery, by background characteristics, Kenya SPA 2010

Background characteristic	Assist labour	Remove retained products				Emergency support for newborn					Number of facilities offering delivery services
	Vacuum extractor	Vacuum aspirator	D&C kit[1]	Blood transfusion services	Caesarean section	Newborn-sized Ambu bag or equivalent	Laryngo-scope and endo-tracheal tubes	Oxygen source	External heat source[2]	Naso-gastric tube	
Type of facility											
Hospital	20	64	45	60	55	92	30	75	67	76	48
Health centre	2	37	8	6	1	81	13	36	13	58	66
Maternity	10	50	32	50	36	69	23	57	57	67	14
Clinic	0	50	0	0	0	50	36	36	36	50	8
Dispensary	0	11	0	2	0	52	0	8	14	32	70
Managing authority											
Government	3	33	8	11	9	73	10	31	19	49	124
NGO	1	6	6	11	11	64	1	19	7	23	8
Private (for profit)	13	55	34	44	35	71	33	55	54	72	37
Faith-based organisation	7	35	22	27	20	70	14	42	47	58	38
Province											
Nairobi	13	47	34	48	42	76	30	76	56	69	13
Central	6	40	25	31	31	77	26	71	78	73	16
Coast	6	45	15	19	15	57	21	40	33	55	22
Eastern	3	22	12	13	11	81	13	31	20	54	35
North Eastern	5	18	5	29	8	42	2	12	6	26	11
Nyanza	8	30	16	19	10	53	11	22	19	54	43
Rift Valley	6	43	11	15	14	92	14	44	33	56	47
Western	1	48	15	13	13	73	4	20	18	35	21
Total	6	36	15	20	16	72	14	37	30	54	207

[1] Dilation and curettage kit.
[2] Most often an incubator, although a heat light would be sufficient.

Table A-6.37.1 Capacity to conduct caesarean section

Among facilities that offer caesarean section, percentage where basic items and staff were observed to be available, by background characteristics, Kenya SPA 2010

Background characteristic	Basic item					Additional components					Provider for conducting caesarean section on duty 24 hours[3]	Number of facilities offering caesarean section
	Operating table	Operating light	Scrub area in or adjacent to operating room	Sterilised instruments	All basic items observed[1]	Functioning suction bulb for mucus extraction	Disposable cord ties	Blanket to wrap newborn	Anaesthetist[2]	Anaesthesia giving set		
Type of facility												
Hospital	93	91	94	93	88	44	77	50	54	93	59	26
Health centre	100	100	100	100	100	100	100	100	0	100	0	1
Maternity	90	90	95	90	90	39	85	65	34	90	55	5
Managing authority												
Government	92	90	94	91	85	47	74	36	56	93	62	11
NGO	100	100	100	100	100	26	83	39	39	100	39	1
Private (for profit)	90	88	91	90	86	39	85	64	40	90	55	13
Faith-based organisation	97	97	100	97	97	54	76	62	59	95	55	8
Province												
Nairobi	97	97	97	97	97	49	100	97	58	97	70	6
Central	97	97	94	97	94	41	97	66	82	97	91	5
Coast	95	100	100	100	95	32	55	27	18	95	18	3
Eastern	75	75	88	75	75	25	44	19	56	75	50	4
North Eastern	100	100	100	100	100	88	100	50	100	100	100	1
Nyanza	93	86	93	93	86	35	79	63	7	93	35	4
Rift Valley	96	91	96	91	87	59	78	41	54	96	55	7
Western	85	85	89	89	80	54	80	38	41	85	45	3
Total	92	91	94	92	89	45	79	53	50	92	57	32

[1] Operating table, operating light, scrub area, and sterilised instruments.
[2] An anaesthetist was present and duty schedule was observed, or was reported as on call and a duty roster was observed. An additional 37 percent of facilities reported that they had an anaesthetist, but there was no duty schedule (see Table A-6.37.2).
[3] A provider skilled in performing a caesarean section was present and duty schedule was observed, or was reported as on call and a duty roster was observed. An additional 33 percent of facilities reported that they had a provider for performing caesarean section, but there was no duty roster (see Table A-6.37.2).

Table A-6.37.2 Reported anaesthetist and caesarean section providers

Percentage of facilities offering caesarean sections (C-sections) that reported having an anaesthetist and a provider for C-sections but did not have duty schedules available upon request, Kenya SPA 2010

Background characteristic	Anaesthetist reported, no duty schedule observed	Provider for C-sections reported, no duty schedule observed	Number of facilities offering caesarean section
Type of facility			
Hospital	36	32	26
Health centre	100	100	1
Maternity	33	24	5
Managing authority			
Government	32	28	11
NGO	61	61	1
Private (for profit)	43	34	13
Faith-based organisation	31	35	8
Province			
Nairobi	35	26	6
Central	12	6	5
Coast	59	73	3
Eastern	19	19	4
North Eastern	0	0	1
Nyanza	79	58	4
Rift Valley	41	36	7
Western	23	33	3
Total	37	33	32

Table A-6.38 Newborn care practices

Percentage of facilities that report the indicated practice is a routine component of newborn care, by type of facility, Kenya SPA 2010

Routine newborn care practices	Type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Routine suction with catheter	17	4	34	0	16	13
Full immersion bath within 24 hours after birth	10	5	18	0	5	7
Weigh newborn	100	98	100	100	95	98
Infant scale available	98	85	90	100	87	90
Provide vitamin A to mother	74	80	84	64	67	74
Vitamin A in delivery area	61	65	78	93	74	69
Vitamin A in pharmacy or delivery area	92	100	95	100	95	96
Provide OPV to newborn	77	70	76	93	60	69
Provide BCG to newborn	68	50	67	93	52	58
Provide prelacteal liquids to newborn	7	1	16	0	12	7
Practice rooming-in[1]	91	98	94	64	90	92
Routine kangaroo care	61	60	59	21	50	55
Drying and wrapping newborn to keep warm	99	100	98	100	97	98
Initiation of breastfeeding within first hour	95	97	93	100	92	95
Routine, complete (head-to-toe) examination of newborn before discharge	86	92	100	100	91	91
Administer vitamin K to newborn	43	26	32	0	9	23
Apply tetracycline eye ointment to both eyes	79	85	92	100	81	83
Number of facilities offering delivery services	48	66	14	8	70	207

[1] Newborn stays with mother in the same room, either at all times or part of the time, when woman is in the health facility and until she is discharged.

Table A-6.39.1 Emergency obstetric practices and neonatal resuscitation: All facilities offering delivery services

Among all facilities offering delivery services, percentage that ever provide specific interventions and percentage that report providing the intervention during the three months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Assisted delivery[1]		Removal of retained products[2]		Parenteral antibiotics		Parenteral oxytocic drugs		Parental anti-convulsants		Manual removal of placenta		Blood transfusion		Caesarean section		Neo-natal resusci-tation	Number of facilities offering delivery services
	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Within past 3 months	
Type of facility																		
Hospital	25	13	91	70	88	84	96	93	69	51	77	60	60	42	55	47	72	48
Health centre	2	0	55	33	65	51	83	81	36	14	51	38	6	4	1	1	44	66
Maternity	12	2	72	62	82	67	97	85	44	24	51	33	50	23	36	31	57	14
Clinic	0	0	93	7	7	0	93	86	7	0	14	7	0	0	0	0	7	8
Dispensary	0	0	23	9	53	35	75	73	21	6	21	13	2	0	0	0	19	70
Managing authority																		
Government	4	2	50	30	68	53	83	80	35	13	47	34	11	9	9	8	40	124
NGO	6	1	47	11	51	51	87	83	51	46	11	5	11	11	11	11	9	8
Private (for profit)	16	8	74	50	75	61	92	87	48	31	54	39	44	17	35	28	43	37
Faith-based organisation	7	3	57	41	49	44	83	81	36	24	40	29	27	21	20	18	53	38
Province																		
Nairobi	15	12	58	50	99	90	100	100	51	41	63	54	48	28	42	42	65	13
Central	7	6	48	32	65	65	89	87	42	29	43	39	31	22	31	29	52	16
Coast	7	3	83	27	43	27	80	76	31	20	27	23	19	13	15	13	23	22
Eastern	4	1	53	21	32	32	80	80	18	17	18	18	13	8	11	10	22	35
North Eastern	5	2	19	15	74	47	75	60	51	18	60	15	29	16	8	7	23	11
Nyanza	12	3	47	35	88	69	81	79	52	21	67	51	19	11	10	8	50	43
Rift Valley	6	3	63	50	66	59	92	90	35	17	44	31	15	10	14	11	52	47
Western	1	0	52	33	70	34	80	73	43	9	55	29	13	11	13	11	41	21
Total	7	3	55	35	65	52	85	82	38	20	46	33	20	13	16	14	42	207

[1] Use of forceps or ventouse (vacuum extractor).
[2] Manual vacuum aspiration or dilatation and curettage.

Table A-6.39.2 Emergency obstetric practices and neonatal resuscitation: Hospitals, health centres, and maternities offering delivery services

Among hospitals, health centres, and maternity facilities offering delivery services, percentage that ever provide specific interventions and percentage that report providing the intervention during the three months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Assisted delivery[1]		Removal of retained products[2]		Parenteral antibiotics		Parenteral oxytocic drugs		Parental anti-convulsants		Manual removal of placenta		Blood transfusion		Caesarean section		Neo-natal resusci-tation	Number of hospitals, health centres and mater-nities offering delivery services
	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Ever	Within past 3 months	Within past 3 months	
Type of facility																		
Hospital	25	13	91	70	88	84	96	93	69	51	77	60	60	42	55	47	72	48
Health centre	2	0	55	33	65	51	83	81	36	14	51	38	6	4	1	1	44	66
Maternity	12	2	72	62	82	67	97	85	44	24	51	33	50	23	36	31	57	14
Managing authority																		
Government	7	3	70	47	69	57	86	84	44	21	58	46	16	14	14	13	54	79
NGO	26	6	46	46	46	46	46	26	46	26	46	20	46	46	46	46	38	2
Private (for profit)	22	10	80	63	89	79	97	91	54	39	65	47	60	23	47	38	53	27
Faith-based organisation	13	5	59	46	87	79	95	92	64	42	66	47	47	38	36	32	68	21
Province																		
Nairobi	17	14	59	50	98	97	100	100	51	40	65	55	56	33	50	50	68	11
Central	9	8	65	44	70	70	85	82	56	38	57	52	42	29	42	39	70	12
Coast	17	8	88	63	74	64	96	86	59	48	64	55	45	30	36	32	54	9
Eastern	8	3	82	40	43	42	80	80	15	14	35	33	24	15	21	18	41	19
North Eastern	14	6	58	44	89	73	92	80	86	55	80	44	53	47	25	22	69	4
Nyanza	20	5	68	60	94	80	89	88	60	35	75	59	33	19	17	13	57	25
Rift Valley	8	4	67	50	71	62	89	86	46	23	58	41	20	14	19	14	53	36
Western	2	0	73	47	82	46	93	82	63	14	74	33	21	17	20	18	59	13
Total	11	5	70	50	76	65	89	86	49	29	61	46	31	20	25	22	56	129

[1] Use of forceps or ventouse (vacuum extractor).
[2] Manual vacuum aspiration or dilatation and curettage.

Table A-6.40 Utilisation of delivery services

Median average monthly number of vaginal deliveries and caesarean sections among facilities with data available on the day of the survey, by background characteristics, Kenya SPA 2010

Background Characteristics	Median monthly vaginal deliveries	Number of facilities reporting vaginal delivery data	Median monthly caesarean sections	Number of facilities reporting caesarean section data
Type of facility				
Hospital	33	47	11	25
Health centre	10	63	-	1
Maternity	12	13	2	5
Clinic	2	8	-	0
Dispensary	4	69	-	0
Managing authority				
Government	8	123	22	11
NGO	4	7	-	1
Private (for profit)	5	35	3	12
Faith-based organisation	9	36	21	7
Province				
Nairobi	30	12	6	6
Central	11	16	16	5
Coast	3	21	9	3
Eastern	5	35	26	3
North Eastern	7	11	-	1
Nyanza	7	39	8	4
Rift Valley	10	46	17	6
Western	5	21	4	3
Total	8	201	9	31

[1] Data are from health information system monthly reports or registers available at the facility on the day of the survey. Data were collected for the 12 months preceding the survey; however, frequently some months were missing. Information from the number of months for which data were available was summed, and an average monthly number of clients was calculated for each facility. This number was then used to calculate the median number of clients per month.

Table A-6.41 User fees for delivery services

Percentage of facilities offering delivery services that charge user fees of various kinds and, among these, percentage that offer discounts or exemptions and that publicly post fees, by background characteristics, Kenya SPA 2010

	Percentage of facilities charging for indicated item:							Number of facilities offering delivery services	Percentage where fees are posted in public view			Number of facilities having any routine charges for delivery services
Background characteristic	Normal delivery	ANC plus delivery (fixed fee)	Medicines	Tests	Discount/ exemption	Fee for care of a sick newborn	No charges or don't know		All fees posted	Some fees posted	No fees posted	
Type of facility												
Hospital	94	14	77	88	73	40	6	48	51	14	35	45
Health centre	81	18	35	68	75	15	10	66	27	17	55	60
Maternity	95	15	82	88	72	58	5	14	16	11	73	14
Clinic	64	7	50	50	64	14	36	8	0	57	43	5
Dispensary	51	11	39	41	48	19	39	70	34	16	49	43
Managing authority												
Government	65	13	36	52	67	8	26	124	46	19	35	92
NGO	19	0	19	19	17	7	81	8	0	25	75	2
Private (for profit)	94	13	77	85	62	47	3	37	14	16	70	36
Faith-based organisation	99	23	76	94	71	62	1	38	24	12	63	37
Province												
Nairobi	100	15	70	85	36	41	0	13	36	10	54	13
Central	100	6	72	81	79	44	0	16	28	4	68	16
Coast	58	1	37	47	54	16	32	22	23	38	39	15
Eastern	62	8	35	58	64	23	33	35	27	31	42	24
North Eastern	12	4	10	10	6	3	88	11	26	0	74	1
Nyanza	84	14	46	66	75	25	16	43	27	14	59	36
Rift Valley	83	35	65	74	79	27	1	47	48	15	36	46
Western	66	0	53	65	63	18	25	21	32	7	61	16
Total	74	14	50	64	65	25	20	207	34	17	49	167

Table A-6.42 Supportive management for providers of delivery services

Among interviewed delivery service providers, percentage who received work-related training and who received personal supervision during specific time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed service providers who received: Training related to delivery services during the 12 months before the survey[1]	Personal supervision during the 6 months before the survey	Training related to delivery services during the 12 months and personal supervision during the 6 months before the survey	Most recent training 13-35 months preceding the survey	Number of interviewed delivery service providers[2]
Type of facility					
Hospital	46	74	37	25	397
Health centre	37	83	31	30	268
Maternity	39	51	27	25	60
Clinic	66	75	41	25	13
Dispensary	29	93	28	37	143
Managing authority					
Government	41	85	36	27	530
NGO	50	85	39	41	22
Private (for profit)	45	63	31	27	155
Faith-based organisation	32	72	25	31	174
Province					
Nairobi	49	67	36	33	83
Central	40	82	31	20	73
Coast	51	75	39	23	80
Eastern	34	76	27	34	175
North Eastern	46	85	37	26	22
Nyanza	49	86	43	22	159
Rift Valley	32	73	27	37	199
Western	37	87	35	18	90
Total	40	78	33	28	881

[1] This refers to structured pre- or in-service training sessions and does not include individual instruction received during routine supervision.
[2] Includes only providers of delivery services in facilities offering delivery services.

Table A-6.43.1 Training for delivery service providers: Topics related to delivery and newborn care

Among interviewed delivery service providers, percentage who received pre- or in-service training on topics related to delivery during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Delivery care		Use of partograph		Active management of third stage of labour (AMTSL)		Essential obstetric care/ lifesaving skills (any of 4)		Post-abortion care		Exclusive breastfeeding		Care of normal newborn		Neonatal resuscitation		Number of interviewed delivery service providers
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility																	
Hospital	22	17	22	16	24	16	25	16	12	15	20	16	20	15	20	15	397
Health centre	13	26	15	23	18	21	18	21	13	17	14	22	14	18	13	19	268
Maternity	16	20	17	19	16	20	17	20	8	21	10	14	11	14	12	13	60
Clinic	5	29	5	29	10	29	9	25	9	25	5	25	32	25	32	25	13
Dispensary	8	16	10	13	9	14	8	17	1	10	12	19	12	19	10	19	143
Managing authority																	
Government	17	17	18	16	20	15	20	16	10	13	18	16	18	14	17	14	530
NGO	20	61	19	42	20	40	22	59	18	22	24	57	25	56	21	55	22
Private (for profit)	19	20	19	20	20	20	21	20	11	17	14	19	16	19	17	18	155
Faith-based organisation	10	23	13	21	16	19	15	20	8	20	11	20	11	18	11	18	174
Province																	
Nairobi	23	35	30	29	30	28	33	26	16	26	24	27	23	24	23	23	83
Central	13	7	13	7	17	7	16	8	7	7	14	9	10	7	13	7	73
Coast	18	18	19	17	20	16	18	16	10	10	23	12	28	12	30	10	80
Eastern	13	23	15	19	18	18	18	21	8	13	9	20	9	20	10	21	175
North Eastern	18	18	19	17	17	19	20	18	3	16	4	18	10	17	3	17	22
Nyanza	22	16	19	17	20	16	22	17	11	16	21	16	22	14	18	14	159
Rift Valley	13	25	13	23	16	21	16	22	9	21	13	24	15	22	13	23	199
Western	15	9	17	9	17	10	17	11	12	5	18	10	14	8	17	8	90
Total	16	20	17	18	19	18	19	18	10	15	16	18	16	17	16	17	881

Table A-6.43.2 Training for delivery service providers: Topics related to essential obstetric care/lifesaving skills

Among interviewed delivery service providers, percentage who received pre- or in-service training on topics related to essential obstetric care/lifesaving skills during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Essential obstetric care/lifesaving skills in general		Diagnosis and management of pre-eclampsia/ eclampsia		Management of post-partum haemorrhage		Removal of placenta or products of conception		Number of interviewed delivery service providers
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	21	16	19	16	21	16	18	16	397
Health centre	17	20	14	23	15	23	14	23	268
Maternity	15	23	14	19	13	21	10	21	60
Clinic	9	25	5	25	9	25	9	25	13
Dispensary	8	13	7	17	7	16	7	12	143
Managing authority									
Government	18	14	16	15	17	16	15	16	530
NGO	16	43	22	59	21	60	17	41	22
Private (for profit)	19	22	17	20	18	20	18	17	155
Faith-based organisation	13	20	10	21	13	21	10	22	174
Province									
Nairobi	27	29	28	30	28	29	25	26	83
Central	15	7	11	8	13	7	10	8	73
Coast	14	14	14	15	16	15	14	16	80
Eastern	14	17	11	20	15	21	14	17	175
North Eastern	16	27	12	24	11	19	9	21	22
Nyanza	19	18	18	17	19	16	18	18	159
Rift Valley	16	22	13	23	13	24	11	25	199
Western	15	8	15	9	16	9	14	7	90
Total	17	17	15	18	17	19	14	18	881

Table A-6.43.3 Training for delivery service providers: Topics related to HIV/AIDS

Among interviewed delivery service providers, percentage who received pre- or in-service training on topics related to HIV/AIDS during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	PMTCT[1]		Nutrition counselling for mothers with HIV/AIDS		Modified obstetric practices for HIV/AIDS		Nutrition of newborn of the HIV-infected woman		Number of interviewed delivery service providers
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	30	32	22	27	28	26	19	14	397
Health centre	29	33	19	25	25	27	14	18	268
Maternity	27	28	20	29	24	25	9	17	60
Clinic	34	25	0	25	9	25	0	25	13
Dispensary	19	43	9	37	12	42	11	19	143
Managing authority									
Government	27	36	19	27	25	29	17	14	530
NGO	42	28	24	39	26	42	23	58	22
Private (for profit)	33	28	18	30	28	25	16	18	155
Faith-based organisation	25	33	15	31	19	30	11	19	174
Province									
Nairobi	36	41	23	37	36	35	23	24	83
Central	27	26	14	18	20	14	13	8	73
Coast	30	33	19	28	24	28	20	12	80
Eastern	23	35	14	31	19	35	9	19	175
North Eastern	21	43	19	18	19	25	3	18	22
Nyanza	37	30	24	27	29	27	23	13	159
Rift Valley	23	40	17	34	23	34	13	23	199
Western	26	20	17	15	20	14	14	7	90
Total	28	34	18	28	24	29	16	16	881

[1] Any training on prevention of mother-to-child transmission (PMTCT) of HIV.

Table A-6.44 Supportive supervision for delivery service providers

Among interviewed delivery service providers who received a supervisory visit during the six months preceding the survey, median number of times providers were supervised and percentage who report specific activities of the supervisor during the last visit, by background characteristics, Kenya SPA 2010

Background characteristic	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that, during the last supervisory visit, the supervisor:						Number of delivery service providers who were supervised in past 6 months[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	2	96	90	89	75	90	48	293
Health centre	1	98	94	92	77	93	63	223
Maternity	1	95	92	89	78	84	51	30
Clinic	-	94	58	58	88	52	45	10
Dispensary	2	96	88	92	77	92	69	133
Managing authority								
Government	2	97	91	90	75	92	61	448
NGO	5	100	97	98	85	99	77	19
Private (for profit)	2	95	86	86	80	86	48	98
Faith-based organisation	1	97	92	93	76	86	48	125
Province								
Nairobi	3	99	85	93	78	96	50	56
Central	2	99	98	95	78	94	54	59
Coast	1	95	77	82	82	89	60	60
Eastern	2	97	93	94	66	89	61	133
North Eastern	2	97	98	63	53	88	35	19
Nyanza	2	96	90	91	84	93	65	137
Rift Valley	1	96	92	87	81	87	58	146
Western	-	97	93	95	69	91	45	79
Total	2	97	91	90	76	91	57	689

[1] Includes only providers of delivery services in facilities offering delivery services.

Table A-6.45 Use of partograph by delivery service providers

Among interviewed delivery service providers, percent distribution of reported partograph use, by background characteristics, Kenya SPA 2010

Background characteristic	Partograph use						Total	Number of interviewed delivery service providers
	During past 1 week	During past 2-4 weeks	During past 2-6 months	Over 6 months ago	Never	Don't know/ missing		
Type of facility								
Hospital	56	16	11	12	4	0	100	397
Health centre	41	19	15	16	9	0	100	268
Maternity	55	20	11	13	1	0	100	60
Clinic	25	27	9	10	29	0	100	13
Dispensary	10	21	20	31	18	0	100	143
Managing authority								
Government	44	20	11	16	9	0	100	530
NGO	33	3	12	21	31	0	100	22
Private (for profit)	52	17	14	11	5	1	100	155
Faith-based organisation	36	14	23	22	5	0	100	174
Province								
Nairobi	68	12	8	6	5	1	100	83
Central	57	12	19	12	1	0	100	73
Coast	45	24	10	15	6	0	100	80
Eastern	39	16	23	16	7	0	100	175
North Eastern	30	37	11	15	6	1	100	22
Nyanza	36	19	12	18	16	1	100	159
Rift Valley	41	20	11	22	6	0	100	199
Western	40	17	14	16	13	0	100	90
Total	43	18	14	16	8	0	100	881

Chapter 7

Table A-7.1 Availability of services for sexually transmitted infections (STIs) in facilities reporting no primary STI services

Among facilities reporting they do not offer primary services for STIs, percentage where service providers for antenatal care or family planning report that they offer STI diagnosis and treatment to their clients, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where providers report STI services are offered to clients attending the indicated service		Number of facilities reporting no STI services
	Family planning services	Antenatal care services	
Type of facility			
Hospital	0	0	1
Maternity	37	37	1
Clinic	18	7	31
Dispensary	50	50	11
Managing authority			
Government	50	50	12
NGO	0	0	2
Private (for profit)	19	7	30
Province			
Nairobi	0	0	4
Central	0	0	10
Coast	37	0	8
Eastern	0	0	2
North Eastern	0	0	2
Nyanza	29	12	3
Rift Valley	52	52	15
Western	0	0	1
Total	26	18	44

Table A-7.2 Availability of systems, infrastructure, and resources to support quality services for sexually transmitted infections

Among facilities offering services for sexually transmitted infections (STIs), percentage where the indicated systems and items to support utilization of STI services, quality counselling, infection control, and physical examination were observed to be available, by type of facility, Kenya SPA 2010

Item	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Items to support utilization of STI services						
Active partner follow-up system	9	11	11	8	11	10
Passive partner follow-up system[1]	86	84	82	68	72	74
No follow-up system for partners	5	6	7	24	17	16
Items to support quality counselling						
Individual client record/chart	82	87	81	63	68	71
Visual and auditory privacy	93	93	91	100	97	97
Visual privacy only	4	3	1	0	2	2
Auditory privacy only	1	2	0	0	0	0
No privacy	3	1	8	0	1	1
Any guidelines for STIs	64	81	53	34	59	55
Guidelines for syndromic approach to STIs	58	80	50	30	57	53
Any visual aids or educational materials for STIs (including HIV/AIDS)	75	89	68	47	71	67
Educational materials specific to HIV/AIDS	65	76	62	40	64	59
Male condoms at service delivery site	61	53	58	35	62	54
Female condoms at service delivery site	21	17	8	7	17	15
Male condoms anywhere in facility	90	86	88	57	91	81
Female condoms anywhere in facility	54	42	43	22	36	35
All items to support quality counseling[2]	38	36	33	6	30	25
Items for infection control						
Soap	72	69	58	79	76	75
Running water	87	84	86	86	75	80
Soap and running water	67	67	58	70	64	66
Hand disinfectant	43	25	23	24	22	24
Soap and running water or else hand disinfectant	74	72	62	74	71	72
Clean latex gloves	91	91	89	93	95	93
Disinfecting solution	55	63	81	75	76	72
Sharps box	95	93	92	93	98	96
All items for control of infection[3]	45	51	52	58	55	54
Waste receptacle[4]	25	22	18	19	15	18
All items for control of infection plus waste receptacle	15	13	8	14	10	12
Tablecloth or plastic on any surface	88	89	93	93	84	88
Items for physical examination						
Visual and auditory privacy	94	97	96	98	92	95
Visual privacy only	1	1	2	0	3	2
Auditory privacy only or no privacy	5	2	2	2	5	4
Examination bed/couch[5]	98	99	100	97	98	98
Examination light[6]	47	45	74	41	20	32
All items for examination	46	44	72	41	18	31
All items for infection control and physical examination[7]	26	29	42	29	15	22
Number of facilities offering STI services	49	80	16	172	329	646

[1] Mainly passive and only sometimes do active follow-up.
[2] Private room assuring visual and auditory privacy, any guidelines for STI diagnosis and/or treatment, any visual aids or educational materials, individual client chart, and male or female condoms in STI service area.
[3] Soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps box.
[4] While important for infection control, a waste receptacle with plastic liner was not included in the aggregate for infection control.
[5] Any type of couch or bed where a woman can lie down flat.
[6] Examination light, flashlight, or other spotlight source.
[7] All items for infection control, visual and auditory privacy, examination couch or bed, and examination light.

Table A-7.3 Availability of specific tests for diagnosis and medicines for treatment of sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs) that have equipment and tests for etiological diagnosis of STIs and medicines for treating STIs, by type of facility, Kenya SPA 2010

Item	Type of facility					Total
	Hospital	Health centre	Maternity	Clinic	Dispensary	
Items for etiologic examination						
Vaginal speculum	68	87	80	56	53	60
Swab stick for specimen	41	37	51	27	12	22
Syphilis test capacity[1]	72	39	38	22	13	24
Gonorrhoea test capacity[2]	66	20	49	20	10	19
Chlamydia test capacity[3]	6	3	2	4	0	2
Wet mount test capacity[4]	96	75	79	51	32	49
HIV/AIDS testing capacity[5]	88	73	71	41	30	43
All five laboratory tests	5	2	0	3	0	1
Medicines for treatment						
Metronidazole (trichomoniasis)	72	57	83	72	48	58
Tinidazole (trichomoniasis)	58	33	73	64	22	39
Ceftriaxone (gonorrhoea)	59	26	64	39	23	31
Ciprofloxin (gonorrhoea)	77	46	72	66	37	50
Kanamycin (gonorrhoea)	6	0	7	4	1	2
Amoxicillin (chlamydia)	84	57	88	87	58	68
Augmentin (chlamydia)	51	19	51	21	9	18
Norfloxacin (chlamydia, gonorrhoea)	38	27	76	58	21	34
Doxycycline (chlamydia, syphilis)	88	67	88	62	59	64
Tetracycline (chlamydia, syphilis)	17	7	19	21	3	10
Erythromycin (chlamydia, syphilis)	69	53	61	42	41	45
Any injectable or oral penicillin (syphilis)	93	91	90	78	85	85
Nystatin oral or vaginal suppositories (candidiasis)	88	85	60	52	75	71
Miconazole cream or suppositories (candidiasis)	23	18	22	13	16	16
Clotrimazole cream or suppositories (candidiasis)	94	89	75	69	84	81
At least one medicine for:						
Trichomoniasis	82	63	92	83	56	67
Gonorrhoea	84	57	87	79	54	64
Chlamydia	97	81	92	90	82	86
Syphilis	98	98	92	82	93	91
Each of the four STIs assessed[6]	71	45	85	69	33	48
Number of facilities offering STI services	49	80	16	172	329	646

[1] Either VDRL or PCR with functioning rotator or shaker, or RPR test.
[2] Gram stain reagents and functioning microscope and glass slides, or culture capacity, i.e., culture medium plus incubator.
[3] Giemsa stain for chlamydia and functioning microscope and glass slides, or PCR for chlamydia testing.
[4] Functioning microscope and glass slides.
[5] ELISA, Western Blot, Rapid Antigen Test, or any other HIV testing capacity is available in the facility.
[6] At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis available in the facility.

Table A-7.4.1 Supportive management of service providers for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received work-related training and personal supervision, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed service providers who received:				Number of interviewed providers of STI services[3]
	Training related to STI services during the 12 months preceding the survey[1]	Personal supervision during the 6 months preceding the survey[2]	Training related to STI services during the 12 months and personal supervision during the 6 months preceding the survey	Most recent training in the 13-35 months preceding the survey	
Type of facility					
Hospital	56	71	44	28	427
Health centre	49	85	44	33	311
Maternity	55	55	32	20	60
Clinic	43	59	30	23	262
Dispensary	50	83	42	30	544
Managing authority					
Government	51	83	43	31	928
NGO	58	77	49	34	47
Private (for profit)	40	57	27	29	343
Faith-based organisation	63	72	47	20	286
Province					
Nairobi	60	74	45	27	158
Central	52	64	38	28	222
Coast	55	75	44	21	176
Eastern	42	76	34	34	283
North Eastern	38	75	30	47	30
Nyanza	55	79	50	21	224
Rift Valley	49	76	38	36	372
Western	51	86	45	18	139
Total	51	75	41	29	1,604

[1] Training here refers to structured pre- or in-service sessions any time during the 12 months preceding the survey; it does not include instructions that they may have received during supervision.
[2] Providers were personally supervised any time during the six months preceding the survey.
[3] Includes only providers of STI services in facilities where STI services are offered in any assessed service site or location.

Table A-7.4.2 User fees for services for sexually transmitted infections

Percentage of facilities with user fees for STI services, and, among those with user fees, percentage where each of the indicated fee systems is utilized, and percentage publicly posting fees, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities charging for the indicated item						Number of facilities offering STI services	Percentage where fees are posted in public view			Number of facilities having any user fees for STI services
	Health card	Consul-tation	Medicines	Tests	Registra-tion	No charges or don't know		All fees posted	Some fees posted	No fees posted	
Type of facility											
Hospital	62	32	87	91	11	5	49	41	21	37	47
Health centre	59	14	60	78	42	0	80	35	16	49	79
Maternity	14	63	98	89	7	2	16	11	12	77	16
Clinic	21	51	89	75	16	4	172	10	11	79	165
Dispensary	44	17	36	35	41	8	329	23	9	68	302
Managing authority											
Government	51	10	31	38	49	8	332	32	9	60	307
NGO	58	19	64	43	44	7	20	47	17	37	18
Private (for profit)	19	57	90	75	13	3	206	9	13	78	200
Faith-based organisation	44	29	86	86	4	5	88	13	17	69	83
Province											
Nairobi	26	41	67	57	13	14	37	15	5	79	32
Central	36	40	78	75	33	0	115	17	14	70	115
Coast	26	28	57	57	41	10	73	39	0	61	66
Eastern	31	21	46	52	38	6	115	18	18	64	108
North Eastern	14	12	62	30	7	26	23	5	2	93	17
Nyanza	68	18	57	52	35	1	79	26	10	64	79
Rift Valley	44	29	53	52	19	7	160	22	13	65	148
Western	63	25	57	57	58	0	43	27	15	58	43
Total	40	28	59	56	31	6	646	22	12	66	608

Table A-7.5 Training for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received pre- or in-service training on specific topics during the 12 months or 13-35 months preceding the survey, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed providers who received training on specific topics								Number of interviewed STI service providers[2]
	Any diagnosis and treatment for STIs		Syndromic approach for diagnosing and treating STIs		Any course related to HIV/AIDS		Specific course related to PMTCT[1]		
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	17	23	14	22	43	27	33	28	427
Health centre	13	25	11	25	38	29	27	33	311
Maternity	19	25	17	26	36	20	30	26	60
Clinic	16	23	15	23	31	20	28	12	262
Dispensary	12	13	12	12	35	22	25	32	544
Managing authority									
Government	13	18	12	18	37	27	27	31	928
NGO	11	16	11	14	38	40	36	35	47
Private (for profit)	18	23	16	24	27	22	26	20	343
Faith-based organisation	15	23	15	21	50	15	34	25	286
Province									
Nairobi	21	24	20	24	50	23	37	27	158
Central	18	25	17	25	39	20	26	19	222
Coast	15	23	15	23	36	20	35	21	176
Eastern	12	19	9	17	31	22	18	36	283
North Eastern	15	36	15	36	17	39	24	34	30
Nyanza	12	16	11	15	45	22	33	26	224
Rift Valley	15	18	14	19	33	34	25	34	372
Western	9	10	8	10	32	17	32	16	139
Total	15	20	13	20	37	24	28	28	1,604

[1] Prevention of mother-to-child transmission of HIV.
[2] Includes only providers of STI services in facilities where STI services are offered in any assessed service site or location.

Table A-7.6 Supportive supervision for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs) who were personally supervised in the six months preceding the survey, median number of times they were supervised and percentage who report specific activities by the supervisor during the last visit, by background characteristics, Kenya SPA 2010

Background characteristic	Median number of times staff were supervised in the 6 months preceding the survey	Percentage of providers reporting that, during the last supervisory visit, the supervisor						Number of STI service providers who received supervision in the 6 months preceding the survey[1]
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Delivered supplies	
Type of facility								
Hospital	3	95	91	89	76	90	47	306
Health centre	3	97	92	91	77	92	58	265
Maternity	2	97	91	88	79	84	46	33
Clinic	3	92	85	84	73	88	36	155
Dispensary	3	99	89	83	76	91	54	450
Managing authority								
Government	3	97	90	84	76	92	55	768
NGO	3	94	97	100	84	95	66	37
Private (for profit)	3	95	89	86	72	87	33	197
Faith-based organisation	3	98	89	94	79	87	49	207
Province								
Nairobi	3	95	94	92	76	91	34	118
Central	3	99	95	97	80	93	39	143
Coast	3	94	82	77	82	95	58	132
Eastern	3	98	89	88	63	89	55	214
North Eastern	3	92	98	61	57	83	31	22
Nyanza	3	96	90	90	86	93	68	176
Rift Valley	2	97	88	81	80	87	53	284
Western	3	97	92	91	67	92	39	119
Total	3	97	90	87	76	91	51	1,209

[1] Includes only providers of STI services in facilities where STI services are offered in any assessed service site or location.

Table A-7.7 Utilisation of services for sexually transmitted infections

Median average monthly number of clients for sexually transmitted infections (STIs), by background characteristics, Kenya SPA 2010

Background characteristic	Median average number of STI clients per month[1]	Number of facilities reporting statistics[2]
Type of facility		
Hospital	8	29
Health centre	7	55
Maternity	6	8
Clinic	-	57
Dispensary	3	243
Managing authority		
Government	4	245
NGO	4	11
Private (for profit)	-	83
Faith-based organisation	5	54
Province		
Nairobi	7	25
Central	2	61
Coast	6	16
Eastern	3	66
North Eastern	1	16
Nyanza	4	58
Rift Valley	3	109
Western	5	41
Total	3	392

[1] Data are from health information system monthly reports available at the facility on the day of the survey. Data were requested for the 12 complete months preceding the survey, but frequently some months were missing. Information from the number of months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.
[2] Not all facilities had data available.

Table A-7.8 Service area where client was observed for sexually transmitted infection

Among observed clients who were assessed for possible sexually transmitted infections (STIs), percent distribution of clients according to their primary reason for visiting the facility, by background characteristics, Kenya SPA 2010

	Percentage of observed STI clients who came to the facility primarily for:						
Background characteristic	ANC services	Family planning services	Sick child services	STI/RTI assessment	Services at compre-hensive care centre	Other	Number of observed STI clients
Type of facility							
Hospital	0	5	14	35	4	42	44
Health centre	0	0	4	25	0	71	18
Maternity	0	0	0	49	0	51	4
Clinic	0	6	27	49	0	17	22
Dispensary	6	5	40	27	5	17	76
Managing authority							
Government	4	5	30	27	5	30	122
NGO	0	14	0	16	0	71	10
Private (for profit)	0	0	29	51	0	20	21
Faith-based organisation	0	0	3	75	0	22	11
Province							
Nairobi	0	27	7	47	13	7	8
Central	0	12	25	12	14	36	34
Coast	0	0	26	16	0	58	4
Eastern	0	0	5	10	0	85	10
North Eastern	0	0	0	99	1	0	23
Nyanza	16	5	0	32	0	47	29
Rift Valley	0	0	70	24	0	6	42
Western	0	0	20	9	0	71	15
Total	3	5	26	32	4	30	164

Table A-7.9 Assessments, laboratory tests, and examinations for observed clients with symptoms of sexually transmitted infections

Among observed clients with symptoms of sexually transmitted infections (STIs), percentage who were reassured about confidentiality, asked about client history, had laboratory diagnostic tests, and had a physical examination, by type of facility, Kenya SPA 2010

	Type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Reassured about confidentiality	59	78	100	100	72	73
Client history elicited						
Client symptoms	98	100	100	100	96	98
How long symptoms have been present	95	100	100	100	100	99
History of recent sexual contact	61	79	84	94	50	63
Symptoms in partner	54	72	51	89	42	55
Partner status[1]	72	60	87	66	88	78
All elements of client history[2]	34	47	38	61	17	31
Types of laboratory tests						
Any laboratory test (including blood)	60	71	100	95	53	63
Any blood test (reason not specified)	20	39	33	12	34	28
HIV test	12	26	18	28	4	12
Microscopic examination of discharge specimen	13	22	33	34	0	11
Microscopic examination of urine	48	47	100	74	53	55
Number of observed STI clients	44	18	4	22	76	164
Physical examination						
Physical examination of genitals (male)	34	21	0	13	50	29
Number of observed male STI clients	14	8	1	10	8	42
Physical examination of genitals (female)	29	37	0	28	33	31
Number of observed female STI clients	30	10	3	12	68	122

[1] Monogamous, multiple partners, non-monogamous partners, etc.
[2] Client symptoms, how long symptoms have been present, history of recent sexual contacts, symptoms in partner, and partner status.

Table A-7.10 Observed counselling for clients assessed for sexually transmitted infections

Among clients whose consultations for sexually transmitted infections (STIs) were observed, percentage for whom the indicated items were components of counselling, by type of facility, Kenya SPA 2010

	Type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Components of counselling						
Any mention of client diagnosis	85	69	87	95	89	86
Any mention of relationship between the infection and sexual activity	70	79	100	94	74	77
Client received prescription or medication	95	100	100	94	86	91
Client received prescription or medication for sexual partner	15	13	0	0	17	13
Client instructed about medications	67	81	100	83	45	61
Partner referral encouraged	67	78	100	89	63	70
Follow-up appointment discussed	56	54	70	67	59	59
Health education—risk of HIV/AIDS mentioned	52	57	47	55	16	36
Components of health education						
Discussed condoms for prevention	45	26	67	83	26	40
Instructed how to use condom	12	13	0	34	16	17
Offered condoms	12	26	20	0	11	12
Demonstrated how to put on a condom	6	13	0	0	11	8
Any discussion of condoms or HIV/AIDS	63	57	67	89	32	51
Wrote on client health card	96	85	100	73	100	94
Number of observed STI consultations	44	18	4	22	76	164

Table A-7.11 Knowledge and experience of condom use by clients

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percentage who reported previous condom use, factors contributing to lack of condom use, and receipt of condoms and counselling on day of visit, Kenya SPA 2010

Item	Percentage of clients
Client and partner have used condom before	58
Client agrees factor may contribute to lack of use of condoms	
Embarrassing to purchase	41
Problem with disposal	14
Embarrassing to discuss with partner	28
Reduces own sexual satisfaction	31
Reduces partner's sexual satisfaction	44
Religion doesn't allow use of condom	28
Client identified any of the above items as contributing to lack of use of condoms	65
Health workers talked about condoms today	40
Client received condoms today	7
Number of interviewed STI clients	164
Among clients who reported any items as contributing to lack of use of condoms, percentage who discussed the issue with provider	28
Number of interviewed STI clients who identified an item as contributing to lack of use of condoms	107

Table A-7.12 Client feedback on services

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percentage who considered specific service issues to be a big problem on the day of the visit, by type of facility, Kenya SPA 2010

	Type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Behaviour/attitude of provider	8	4	0	0	0	3
Insufficient explanation about method or problems	17	4	0	0	5	7
Waiting time to see provider	37	40	0	43	5	23
Quality of examination and treatment	19	0	16	0	0	5
Availability of methods or medicines	30	28	0	0	11	16
Days facility is open	6	0	0	0	6	4
Hours facility is open	11	9	0	0	6	7
Cost of services	17	10	38	34	0	11
Insufficient visual privacy	1	10	16	6	5	5
Insufficient auditory privacy	1	10	16	0	5	4
Number of interviewed STI clients	44	18	4	22	76	164

Table A-7.13 Clients' choice of facility

Among interviewed clients who received services for sexually transmitted infections (STIs), percentage who reported this was not the closest health facility to their home and, among these, the main reason they did not go to the nearest facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed STI clients who report this is not the facility closest to their home	Number of interviewed STI clients	Percentage of STI clients who say the main reason they did not go to the nearest facility is:								Number of interviewed STI clients for whom this was not the closest facility
			Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Other	
Type of facility											
Hospital	39	44	2	13	7	10	12	5	11	40	17
Health centre	15	18	0	41	59	0	0	0	0	0	3
Maternity	33	4	0	0	0	0	0	0	0	100	1
Clinic	52	22	0	12	12	0	64	0	0	12	12
Dispensary	0	76	-	-	-	-	-	-	-	-	0
Managing authority											
Government	13	122	2	19	17	9	12	3	10	28	16
NGO	18	10	0	75	0	0	0	0	0	25	2
Private (for profit)	59	21	0	2	11	0	61	0	0	26	12
Faith-based organisation	20	11	0	0	0	14	0	14	13	59	2
Province											
Nairobi	33	8	0	20	0	0	20	0	20	40	3
Central	5	34	0	82	0	0	18	0	0	0	2
Coast	40	4	0	40	0	20	0	40	0	0	1
Eastern	52	10	0	0	32	10	19	0	10	29	5
North Eastern	5	23	0	0	0	0	20	20	0	60	1
Nyanza	32	29	0	14	14	7	14	0	7	43	9
Rift Valley	22	42	0	9	9	0	64	0	0	18	9
Western	11	15	17	0	17	17	0	0	17	33	2
Total	20	164	1	15	13	5	29	3	6	29	32

Table A-7.14 Educational characteristics of STI clients

Among interviewed clients who received services for sexually transmitted infections (STIs), percent distribution according to educational status and, among STI clients with primary, post-primary/technical, or no education, percent distribution according to literacy status, by background characteristics, Kenya SPA 2010

Background characteristic	Percent distribution of interviewed STI clients according to educational level					Number of interviewed STI clients	Percent distribution of interviewed STI clients with primary, post-primary/technical, or no education according to literacy status			Number of STI clients with primary, post-primary/ technical, or no education
	No education	Primary	Post-primary/ technical	Secondary	Higher		Cannot read or write	Can read, cannot write	Can read and write	
Type of facility										
Hospital	19	37	3	34	7	44	32	2	60	26
Health centre	4	65	0	31	0	18	38	0	62	12
Maternity	33	16	0	38	13	4	33	33	33	2
Clinic	0	100	0	0	0	22	0	9	85	22
Dispensary	21	52	5	22	0	76	20	0	73	59
Managing authority										
Government	16	53	4	25	2	122	26	0	72	90
NGO	9	45	0	46	0	10	21	4	71	5
Private (for profit)	6	81	0	8	5	21	3	3	86	18
Faith-based organisation	41	35	0	21	3	11	3	24	22	8
Province										
Nairobi	0	54	0	33	13	8	0	47	53	4
Central	12	31	12	43	1	34	0	0	78	19
Coast	0	34	0	66	0	4	54	0	46	1
Eastern	10	65	0	20	5	10	36	0	64	7
North Eastern	86	11	0	3	0	23	87	5	7	22
Nyanza	0	66	4	28	2	29	0	0	87	21
Rift Valley	2	90	0	8	0	42	0	0	100	39
Western	4	54	0	35	7	15	32	0	68	9
Total	16	55	3	24	2	164	21	3	71	122

Table A-7.15 Laboratory capacity to provide services for tuberculosis (TB) and availability of TB medicines

Among facilities providing any tuberculosis (TB) services, percentage that have the capacity to test for TB and medicines for treating TB, by type of facility, Kenya SPA 2010

	Type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Have stain and slides for TB test[1]	86	61	50	62	28	50
Have microscope or fluoromicroscope	96	82	91	88	50	71
Capacity to stain and conduct microscopic sputum exam[2]	86	61	50	62	28	50
Capacity to culture	4	0	0	0	0	1
TB rapid test	5	0	0	0	0	1
Capacity to stain and conduct microscopic sputum test, culture, or conduct TB rapid test[3]	86	61	50	62	28	50
Availability of medicines						
Isoniazid (INH) tabs	41	24	19	13	12	20
Rifina (rifampicin and isoniazid)	89	79	46	49	66	70
RHZ, Rifater (isoniazid+rifampicin +pyrazinamide)	81	79	46	40	67	68
EH (isoniazid+ethambutol)	58	67	36	18	41	47
4FDC (INH, ethambutol, pyrazinamide, rifampicin)	84	79	47	57	70	72
Amikacin	14	1	0	8	2	4
Capreomycin injection	1	0	0	2	2	1
Cycloserine tabs	3	0	0	3	2	2
Ethionamide tabs	4	0	0	3	2	2
Levofluoxacine	12	1	8	11	2	5
Para-amino salicylic acid	1	0	0	0	2	1
Streptomycin injection	34	24	5	4	18	20
Other	5	5	0	3	0	2
Pre-packed DOTS TB drugs	74	72	33	43	77	70
All first-line TB medicines available[4]	82	77	33	43	79	73
Number of facilities providing TB diagnostic, treatment, and/or follow-up services	47	68	7	38	131	290

[1] AFB or Ziehl-Neelson test, with stain such as methyl blue present, and slides.
[2] Functioning microscope or fluoromicroscope and glass slides, plus all stains for AFB or Ziehl-Neelson test.
[3] AFB or Ziehl-Neelson test, with stain such as methyl blue present, and a functioning microscope and glass slides with covers; or agar plates for culture and a functioning incubator; or any rapid TB diagnostic test kit.
[4] Any combination of isoniazid, rifampicin, ethambutol, and pyrazinamide. If medicines provided are pre-packaged for individual DOTS clients, medicines had to be available for all DOTS clients currently on treatment from this facility.

Table A-7.16.1 Supportive management of TB services: Laboratory diagnostic services

Among interviewed providers of laboratory TB diagnostic services, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed providers of TB diagnostic services who:				Number of interviewed providers of laboratory TB diagnostic services[2]
	Received pre- or in-service training during the past 12 months[1]	Were personally supervised in the past 6 months	Both received pre- or in-service training during the past 12 months and were personally supervised during the past 6 months	Most recent pre- or in-service training was 13-35 months preceding the survey	
Type of facility					
Hospital	46	77	37	18	144
Health centre	56	80	40	20	68
Maternity	42	58	23	29	8
Clinic	29	67	29	11	35
Dispensary	78	75	59	5	50
Managing authority					
Government	56	78	40	16	180
NGO	82	85	82	13	8
Private (for profit)	40	58	33	15	57
Faith-based organisation	45	84	42	18	60
Province					
Nairobi	29	82	23	13	38
Central	43	63	36	16	35
Coast	67	95	63	7	43
Eastern	55	66	44	11	36
North Eastern	69	84	59	16	6
Nyanza	52	85	44	21	54
Rift Valley	51	60	25	21	67
Western	63	84	50	16	25
Total	52	76	40	16	305

[1] This refers to structured pre- or in-service training sessions; it does not include individual instructions received during routine supervision.
[2] Includes only providers of laboratory TB services in facilities where TB services are offered in any assessed service site or location.

Table A-7.16.2 Supportive management of TB services: Clinical services

Among interviewed clinical providers of TB services, percentage who received work-related training and personal supervision during specific time periods, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of interviewed clinical providers of TB services who:				Number of interviewed clinical providers of TB services[2]
	Received pre- or in-service training during the past 12 months[1]	Were personally supervised in the past 6 months	Both received pre- or in-service training during the past 12 months and were personally supervised during the past 6 months	Most recent pre- or in-service training was 13-35 months preceding the survey	
Type of facility					
Hospital	40	74	31	18	360
Health centre	32	86	30	24	242
Maternity	51	49	28	11	21
Clinic	53	70	39	14	99
Dispensary	36	84	34	25	202
Managing authority					
Government	36	81	32	22	596
NGO	42	73	30	14	33
Private (for profit)	41	63	24	16	102
Faith-based organisation	45	78	38	19	193
Province					
Nairobi	59	77	47	18	121
Central	46	76	36	12	113
Coast	42	75	34	26	111
Eastern	41	77	35	19	167
North Eastern	47	95	47	26	14
Nyanza	30	87	27	26	149
Rift Valley	22	70	19	22	162
Western	38	89	33	18	86
Total	39	78	32	21	924

[1] This refers to structured pre- or in-service training sessions; it does not include individual instructions received during routine supervision.
[2] Includes only clinical providers of TB services in facilities where TB services are offered in any assessed service site or location. Excludes providers of laboratory TB diagnostic services only.

Table A-7.17 Tuberculosis treatment and/or follow-up using the directly observed treatment short course strategy

Percentage of facilities following the directly observed treatment short course (DOTS) strategy and, among these, percentage having the indicated components, by background characteristics, Kenya SPA 2010

Background characteristic	Percent of facilities:		Number of facilities	Among facilities following DOTS strategy for TB treatment, percentage:					Number of facilities following DOTS strategy for TB treatment
	Offering any TB services	Following DOTS strategy for TB treatment		Reporting they are part of national DOTS programme	With observed up-to-date client register for DOTS	With observed TB treatment protocol at any site offering TB treatment following the DOTS strategy[1]	With all first-line TB medicines available[2]	With all items for TB indicator[3]	
Type of facility									
Hospital	93	83	51	99	97	89	85	76	42
Health centre	85	67	80	89	97	83	81	69	53
Maternity	41	21	17	90	92	71	65	45	4
Clinic	19	11	203	100	100	72	70	42	23
Dispensary	38	30	340	86	84	65	91	51	102
Managing authority									
Government	55	45	344	88	89	78	84	61	156
NGO	49	48	22	90	100	51	90	41	10
Private (for profit)	17	8	236	95	90	58	72	34	20
Faith-based organisation	57	43	88	100	99	77	93	71	38
Province									
Nairobi	48	35	41	100	100	92	84	76	14
Central	37	24	125	76	85	74	97	63	30
Coast	45	44	81	95	89	66	72	36	36
Eastern	44	41	118	85	100	83	85	69	48
North Eastern	22	22	24	100	96	98	100	94	5
Nyanza	59	52	82	94	83	67	88	51	43
Rift Valley	30	12	174	90	99	89	83	79	21
Western	66	61	44	98	90	59	84	49	27
Total	42	32	690	90	91	75	85	59	224

[1] National guideline for the management of TB, manual of the national TB and leprosy programme, or any other guideline on the management of TB.
[2] Any combination of pyrazinamide, rifampicin, ethambutol, isoniazid, and streptomycin. If medicines provided are pre-packaged for individual DOT clients, medicines had to be available for all DOT clients currently on treatment from this facility.
[3] Observed up-to-date client records or register for DOTS, observed TB treatment guidelines or protocols, plus all first-line TB medicines available in facility.

Table A-7.18 Items to support management of tuberculosis

Among facilities offering any tuberculosis (TB) treatment and/or follow-up services, percentage with observed up-to-date client register at any site offering TB treatment, with observed treatment protocols at any site offering TB treatment, and with all first-line medicines, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering TB treatment services with:				Number of facilities offering TB treatment and/or follow-up services
	Observed up-to-date client record or register at any site offering TB treatment	Observed TB treatment protocol at any site offering TB treatment[1]	All first-line TB medicines available[2]	All items for TB indicator[3]	
Type of facility					
Hospital	95	88	84	73	46
Health centre	85	83	82	61	64
Maternity	92	71	65	45	4
Clinic	100	72	70	42	23
Dispensary	77	65	88	48	118
Managing authority					
Government	80	76	83	55	182
NGO	100	51	90	41	10
Private (for profit)	90	59	73	35	22
Faith-based organisation	96	79	91	70	40
Province					
Nairobi	100	93	87	80	18
Central	85	74	97	63	30
Coast	88	66	73	35	37
Eastern	98	81	83	68	49
North Eastern	96	98	100	94	5
Nyanza	79	69	86	50	48
Rift Valley	58	78	77	46	40
Western	90	59	84	49	27
Total	84	74	84	55	254

[1] National guideline for the management of TB, manual of the national TB and leprosy programme, or any other guideline on the management of TB.
[2] Any combination of isoniazid, rifampicin, ethambutol, pyrazinamide, and streptomycin. If medicines provided are pre-packaged for individual DOTS clients, medicines had to be available for all DOTS clients currently on treatment from this facility.
[3] Observed client register for DOTS at any TB treatment site, observed TB treatment protocols at any TB treatment site, and all first-line TB medicines available in facility.

Table A-7.19 Resources and supplies for diagnosing tuberculosis

Percentage of facilities offering specific TB diagnostic methods and, among those using sputum and X-rays, percentage with capacity for diagnostic activities, by background characteristics. Kenya SPA 2010

Background characteristic	Percentage of facilities with indicated TB diagnostic activities				Total number of facilities	Among facilities using sputum test to diagnose TB, percentage with:					Number of facilities diagnosing TB using sputum test	Among facilities using X-ray to diagnose TB, percentage with X-ray capacity[5]	Number of facilities diagnosing TB using X-ray
	Any TB diagnostic services[1]	Sputum[2]	X-ray	Clinical symptoms		All items for conducting sputum test for TB[3]	Documented system for sending sputum elsewhere for TB diagnosis	Observed record of sputum test results	All items for TB indicator[4]	Staff trained in sputum TB test in 36 months preceding survey			
Type of facility													
Hospital	91	89	46	0	51	89	5	88	85	63	45	67	23
Health centre	74	66	14	5	80	76	7	81	74	67	53	19	11
Maternity	39	34	15	2	17	59	12	62	44	61	6	49	3
Clinic	15	14	9	0	203	81	2	59	48	48	29	21	19
Dispensary	20	14	3	4	340	74	0	79	69	73	49	0	11
Managing authority													
Government	38	33	9	2	344	76	4	80	73	65	113	23	32
NGO	34	27	23	2	22	73	10	81	81	79	6	0	5
Private (for profit)	14	14	8	0	236	81	4	55	44	56	32	55	18
Faith-based organisation	46	34	14	11	88	87	2	94	87	67	30	48	12
Province													
Nairobi	43	40	26	0	41	57	7	68	56	34	17	35	11
Central	29	22	9	6	125	83	5	53	53	57	27	29	12
Coast	30	28	18	2	81	82	4	93	86	72	23	30	15
Eastern	23	18	5	0	118	88	1	89	87	62	22	32	5
North Eastern	20	20	10	0	24	93	2	91	91	84	5	14	2
Nyanza	48	46	15	2	82	76	2	75	66	64	38	34	12
Rift Valley	25	21	3	4	174	81	6	85	73	79	37	86	4
Western	39	31	14	1	44	72	1	82	67	61	14	27	6
Total	31	26	10	3	690	79	4	78	70	64	181	34	67

[1] Includes diagnosis using sputum smears, by X-ray, by clinical symptoms, and any combination of the indicated methods.
[2] Includes diagnosing TB using sputum microscopy, sputum culture, and any TB rapid test using sputum.
[3] AFB or Ziehl-Neelson test, with stain such as methyl blue present, and a functioning microscope and glass slides with covers; or agar plates for culture and a functioning incubator; or any rapid TB diagnostic test kit.
[4] All items for conducting test or reported system for sending sputum elsewhere, and record of TB test results.
[5] Functioning X-ray machine with films and ability to process.

Table A-7.20 Tuberculosis and HIV services

Among facilities offering any tuberculosis (TB) services, percentage that refer TB clients for HIV testing, percentage with records on HIV testing and status of TB clients, and percentage with service providers trained on TB, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where newly diagnosed TB clients are referred for HIV testing		Percentage of facilities with observed records/register of:		TB service provider received TB-related training in:		Number of facilities offering any TB services
	All cases routinely referred[1]	Only suspect cases referred[2]	Newly diagnosed TB clients referred for HIV testing	Current TB clients who are also HIV-positive	12 months preceding the survey	13-35 months preceding the survey	
Type of facility							
Hospital	92	5	95	90	76	11	47
Health centre	90	4	93	84	51	22	68
Maternity	46	5	46	41	67	4	7
Clinic	62	0	62	60	62	0	38
Dispensary	83	2	84	72	39	23	131
Managing authority							
Government	91	3	92	83	49	22	189
NGO	96	0	96	96	67	33	11
Private (for profit)	50	3	51	44	49	5	40
Faith-based organisation	74	6	80	66	61	7	50
Province							
Nairobi	90	3	92	92	88	1	20
Central	63	0	63	52	52	12	47
Coast	100	0	96	84	59	11	37
Eastern	94	1	95	94	55	11	52
North Eastern	98	2	100	61	50	41	5
Nyanza	98	0	97	88	45	28	49
Rift Valley	60	6	65	51	32	27	52
Western	74	15	87	82	57	15	29
Total	82	3	84	75	52	17	290

[1] All newly diagnosed TB clients are routinely referred for HIV testing regardless of whether they show any signs of HIV infection.
[2] Only those newly diagnosed TB clients who are suspected to be infected with HIV are referred for HIV testing.

Table A-7.21 Tuberculosis infection control plans

Among facilities offering any tuberculosis (TB) treatment and/or follow-up services, percentage having TB infection control plans, by background characteristics, Kenya SPA 2010

Background characteristic	TB infection control (TB IC)						Facility applies SOP for management of cough patients in waiting area	N95 respirator		Number of facilities offering TB diagnostic treatment and/or follow-up services
	TB IC focal person	TB IC committee	Both TB IC focal person and IC committee	Either TB IC focal person or IC committee	Neither	TB IC plan		Facility uses N95 respirator, observed	Facility uses N95 respirator, reported but not seen	
Type of facility										
Hospital	31	10	14	54	44	54	66	10	7	47
Health centre	20	3	3	26	74	38	44	2	7	68
Maternity	10	0	0	10	90	35	52	0	4	7
Clinic	24	3	0	27	73	23	46	3	15	38
Dispensary	9	3	0	12	88	22	32	1	3	131
Managing authority										
Government	17	5	3	25	74	33	40	2	4	189
NGO	45	0	0	45	55	17	63	10	0	11
Private (for profit)	8	3	2	12	88	17	40	4	18	40
Faith-based organisation	19	3	2	24	76	38	49	4	6	50
Province										
Nairobi	41	7	5	53	47	56	72	5	14	20
Central	23	4	2	30	70	42	64	3	10	47
Coast	32	2	2	36	64	44	57	2	3	37
Eastern	6	2	5	13	87	9	22	1	10	52
North Eastern	13	22	2	37	63	72	74	2	0	5
Nyanza	11	5	2	19	81	28	35	1	1	49
Rift Valley	12	2	2	16	83	32	30	4	5	52
Western	12	4	2	18	82	17	36	4	0	29
Total	17	4	3	24	76	31	43	3	6	290

Chapter 8

Table A-8.1 Pre- and post-test counselling for HIV: Components in CT or prevention of mother-to-child transmission (PMTCT) testing site

Among facilities that have a system for HIV testing, percentage with programme components to support counselling and testing (CT) services, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with:		Percentage of facilities where any HIV testing site has:					Percentage of facilities with all items for counselling[3]	Number of facilities with HIV testing system[4]
	Observed written policy for routine provision of pre- and post-test counselling for HIV testing[1]	At least one counsellor trained in pre- and post-test counselling who is assigned to an HIV testing site	Observed guidelines for content of pre- and post-test counselling[2]	Observed guidelines or policy on confidentiality of HIV test results	Observed up-to-date record of clients receiving pre- and post-test counselling	Observed system linking test results with pre- and post-test counselling	Visual and auditory privacy possible in counselling areas		
Type of facility									
Hospital	84	95	84	82	90	89	93	75	50
Health centre	85	97	85	84	88	88	90	68	76
Maternity	67	93	63	51	70	60	81	36	15
Clinic	34	85	34	38	65	64	77	22	111
Dispensary	69	88	69	65	90	89	90	45	257
Stand-alone VCT	87	97	85	90	90	82	100	67	5
Managing authority									
Government	76	91	76	73	93	92	92	56	272
NGO	77	100	76	83	67	70	62	36	23
Private (for profit)	37	81	36	37	65	64	79	18	138
Faith-based organisation	75	96	75	69	88	86	94	62	81
Province									
Nairobi	66	92	65	66	64	68	80	43	36
Central	60	93	60	60	91	84	96	51	82
Coast	46	82	46	54	57	63	74	37	66
Eastern	58	85	58	51	83	90	95	35	103
North Eastern	68	62	68	67	55	55	76	28	10
Nyanza	92	96	92	91	96	83	87	65	70
Rift Valley	62	93	61	55	92	91	84	37	106
Western	90	93	90	87	99	93	94	78	40
Total	65	90	65	63	84	83	88	46	513

[1] Presence of Kenya National Guidelines for voluntary HIV counselling and testing, or any other guidelines or policy that specifically mentions that all clients receiving HIV test must be offered pre-test counselling or information and post- test counselling for both positive and negative test results in any relevant HIV counselling and testing service site.
[2] Pre-test counselling may consist of general education for groups or individual client counselling. Availability of the Kenya national guidelines for voluntary HIV counselling and testing, or any other guideline that specifies pre-test counselling or information sharing, and post-test counselling counts.
[3] Facility has written policy for provision of pre-test and post-test counselling for HIV testing, at least one trained counsellor assigned to counselling and testing site, observed guidelines for content of counselling, policy on confidentiality, records of clients receiving pre-test and post-test counselling, observed system linking test results with pre-/post-test counselling, and visual and auditory privacy in counselling areas.
[4] Facility either conducts the test, or has an affiliated external laboratory, or has an agreement with a testing site that is expected to return test results to the facility.

Table A-8.2 Tuberculosis treatment at HIV service sites using DOTS

Percentage of facilities offering HIV/AIDS care and support services (CSS) and, among these, percentage with various tuberculosis (TB) activities; and, among facilities offering HIV/AIDS CSS and TB treatment following the direct observation of therapy (DOTS) strategy, percentage with programme components that support TB treatment, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering HIV/AIDS CSS[1]	Number of facilities	Among facilities offering HIV/AIDS CSS, percentage with indicated TB activities:			Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and following DOTS strategy, percentage with:				Number of facilities offering HIV/AIDS CSS and following DOTS strategy
			Any TB diagnostic or treatment services[2]	Report they are part of national DOTS programme	Follow DOTS treatment strategy[3]		Observed client register for DOTS	Observed TB treatment protocol	All first-line TB medicines available[4]	All items for TB indicator[5]	
Type of facility											
Hospital	96	51	95	90	85	49	90	89	85	71	41
Health centre	86	80	92	73	70	68	94	82	79	64	48
Maternity	73	17	44	20	23	12	90	88	68	55	3
Clinic	49	203	32	22	22	99	100	71	69	39	22
Dispensary	63	340	49	37	41	214	80	65	90	49	87
Managing authority											
Government	71	344	66	55	57	243	85	79	82	58	138
NGO	79	22	62	54	60	17	100	51	90	41	10
Private (for profit)	49	236	29	17	16	116	84	60	73	28	19
Faith-based organisation	75	88	70	54	51	66	98	75	93	68	34
Province											
Nairobi	67	41	65	59	48	28	96	91	82	69	13
Central	39	125	72	36	47	49	85	68	96	61	23
Coast	74	81	56	53	54	60	90	64	71	33	33
Eastern	76	118	54	43	50	89	92	88	83	66	44
North Eastern	62	24	34	34	34	15	98	98	100	96	5
Nyanza	95	82	62	56	54	78	76	67	88	50	43
Rift Valley	53	174	40	23	19	92	93	87	80	72	18
Western	69	44	80	75	74	30	91	60	81	48	22
Total	64	690	57	45	45	442	88	75	84	56	201

[1] Providers assigned to this facility provide treatment for any opportunistic infections or symptoms related to HIV/AIDS (such as treatment for topical fungal infections, cryptococcal meningitis, or Kaposi sarcoma), or provide (or prescribe) palliative care for patients (such as symptom or pain management or nursing care for the terminally ill), or provide nutritional rehabilitation services, including the prescription or provision of fortified protein supplements, or provide care for paediatric HIV/AIDS patients.
[2] Facility conducts TB tests for TB diagnosis (sputum or X-ray or both), or these tests are done externally and there is record of test results, or providers diagnose TB based on clinical symptoms, or providers prescribe initial therapy or provide follow-up treatment services for TB patients.
[3] Treatment strategy followed is either directly observed two months with five months follow-up, or directly observed six months.
[4] Any combination of isoniazid (INH), rifampicin, ethambutol, and pyrazinamide. If medicines provided are pre-packaged for individual DOTS clients, medicines had to be available for all DOTS clients.
[5] Observed client records or register for DOTS and observed TB treatment protocols and all first-line TB medicines available in facility.

Table A-8.3 Treatment and/or follow-up for tuberculosis using any treatment strategy

Among facilities offering HIV/AIDS care and support services (CSS) and any tuberculosis treatment services, percentage having the indicated components for management of tuberculosis, by background characteristics, Kenya SPA 2010

Background characteristic	Percent of facilities offering TB treatment services	Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and offering any TB treatment services, percentage reporting they follow indicated treatment strategy:			Among facilities offering HIV/AIDS CSS and any TB treatment services, percentage with:				Number of facilities offering HIV/AIDS CSS and any TB treatment services
			DOTS[1]	Follow-up treatment[2] only	Other strategies[3]	Observed up-to-date client register at any site	Observed TB treatment protocol at any site	All first-line TB medicines available[4]	All items for TB indicator[5]	
Type of facility										
Hospital	93	49	92	3	6	95	88	84	73	45
Health centre	86	68	81	5	14	84	81	80	57	59
Maternity	23	12	100	0	0	90	88	68	55	3
Clinic	22	99	100	0	0	100	71	69	39	22
Dispensary	43	214	95	0	5	87	66	90	55	91
Managing authority										
Government	63	243	90	2	8	87	79	83	60	153
NGO	60	17	100	0	0	100	51	90	41	10
Private (for profit)	18	116	92	1	7	89	61	73	35	21
Faith-based organisation	55	66	94	3	3	96	77	90	67	36
Province										
Nairobi	62	28	77	0	23	100	92	86	78	17
Central	47	49	100	0	0	89	68	96	63	23
Coast	56	60	97	0	3	91	64	71	34	34
Eastern	51	89	98	1	2	98	87	82	72	45
North Eastern	34	15	100	0	0	98	98	100	96	5
Nyanza	61	78	89	3	8	79	69	86	50	48
Rift Valley	27	92	69	9	22	78	88	85	60	25
Western	74	30	100	0	0	92	60	81	49	22
Total	50	442	91	2	7	89	76	84	58	220

[1] Treatment strategy followed is either directly observed two months with five months of follow-up, or directly observed six months.
[2] Facility provides follow-up for TB clients only after clients have received intensive direct observation of treatment elsewhere.
[3] Facility does not provide directly observed treatment for TB patients, or patients are treated only as inpatients and discharged to a different facility for follow-up treatment services.
[4] Any combination of isoniazid (INH), rifampicin, ethambutol, and pyrazinamide. If medicines provided are pre-packaged for individual DOTS clients, medicines had to be available for all DOTS clients.
[5] Observed client register for DOTS and observed TB treatment protocols and all first-line TB medicines available in facility.

Table A-8.4 Resources and supplies for diagnosing tuberculosis

Among facilities offering HIV/AIDS care and support services (CSS), percentage diagnosing tuberculosis (TB) and percentage with the indicated diagnostic elements, by background characteristics, Kenya SPA 2010

Background characteristic	Among facilities offering HIV/AIDS CSS, percentage with indicated TB diagnostic activities:				Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and diagnosing TB using sputum,[2] percentage with:				Number of facilities offering HIV/AIDS CSS and diagnosing TB using sputum test	Among facilities offering HIV/AIDS CSS and diagnosing TB using X-ray, percentage with X-ray capacity[4]	Number of facilities offering HIV/AIDS CSS and diagnosing TB using X-ray
	Any TB diagnostic services[1]	Use sputum for TB diagnosis[2]	Use X-ray for TB diagnosis	Use clinical symptoms		All items for conducting sputum test for TB	Reported system for sending sputum elsewhere for TB diagnosis	Observed record of sputum test results	All items for indicator[3]			
Type of facility												
Hospital	94	92	48	0	49	88	5	88	85	45	67	23
Health centre	82	74	15	6	68	74	7	80	73	51	20	10
Maternity	44	38	21	3	12	73	0	75	53	5	49	3
Clinic	26	25	19	0	99	77	2	70	58	24	21	19
Dispensary	27	19	4	6	214	68	0	74	63	40	0	9
Managing authority												
Government	49	43	12	3	243	74	5	79	71	105	25	30
NGO	42	34	28	2	17	73	10	81	81	6	0	5
Private (for profit)	24	23	15	0	116	81	2	67	53	27	55	18
Faith-based organisation	55	40	17	15	66	85	2	93	85	27	51	11
Province												
Nairobi	61	57	39	0	28	60	2	71	59	16	35	11
Central	55	40	19	14	49	79	7	61	61	20	36	10
Coast	38	36	24	2	60	81	5	93	85	21	30	15
Eastern	29	24	6	0	89	88	1	89	87	22	32	5
North Eastern	33	32	16	0	15	93	2	91	91	5	14	2
Nyanza	50	49	15	2	78	76	2	75	66	38	34	12
Rift Valley	40	32	5	8	92	77	8	82	67	30	86	4
Western	54	43	18	2	30	70	1	81	65	13	30	5
Total	43	37	15	4	442	77	4	79	71	164	36	64

[1] Facility conducts TB tests for TB diagnosis (sputum or X-ray or both), or these tests are done externally and there is record of test results, or providers diagnose TB based on clinical symptoms.
[2] Includes sputum microscopy, culture, or rapid test.
[3] All items for conducting test or else documented system for sending sputum elsewhere and record of test results.
[4] Functioning X-ray machine with films.

Table A-8.5 Malaria diagnosis and treatment

Among facilities offering HIV/AIDS care and support services (CSS), percentage offering malaria treatment and, among these, percentage having the indicated components for supporting services for malaria, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities that offer malaria treatment services	Percentage of facilities with lab diagnostic capacity for malaria[1]	Number of facilities offering HIV/AIDS CSS	Among facilities offering HIV/AIDS CSS and malaria treatment services, percentage with:			Number of facilities offering HIV/AIDS CSS and offering malaria treatment services
				Observed malaria treatment protocol in any relevant site	Coartem in facility	Treatment protocol in any relevant site and Coartem in facility	
Type of facility							
Hospital	100	93	49	63	89	58	49
Health centre	100	78	68	84	86	72	68
Maternity	100	81	12	49	75	35	12
Clinic	100	52	99	35	60	18	99
Dispensary	100	35	214	73	94	69	214
Managing authority							
Government	100	43	243	76	91	69	243
NGO	100	33	17	64	94	60	17
Private (for profit)	100	54	116	36	60	18	116
Faith-based organisation	100	96	66	72	99	72	66
Province							
Nairobi	100	61	28	64	89	54	28
Central	100	63	49	74	79	54	49
Coast	100	58	60	54	77	44	60
Eastern	100	50	89	63	86	60	89
North Eastern	100	40	15	56	79	48	15
Nyanza	100	51	78	77	84	62	78
Rift Valley	100	48	92	51	88	48	92
Western	100	59	30	88	91	82	30
Total	100	53	442	65	84	56	442

[1] Microscopy or malaria rapid diagnostic test (RDT).

Table A-8.6 Diagnosis and treatment of sexually transmitted infections at HIV service sites: Treatment protocols

Percentage of facilities offering HIV/AIDS care and support services (CSS) that treat sexually transmitted infections (STIs) and, among these, percentage with programme components to support STI services (including treatment protocols at any service sites), by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities that offer STI treatment services	Number of facilities offering HIV/AIDS CSS	Percentage of facilities offering HIV/AIDS CSS and STI services with:					Number of facilities offering HIV/AIDS CSS and STI treatment services
			Observed STI treatment protocol in any relevant site	Medications for treating each major STI[1]	Male condoms in any service area or pharmacy	Female condoms in any service area or pharmacy	All items for STI services[2]	
Type of facility								
Hospital	99	49	73	71	84	46	43	48
Health centre	100	68	87	41	82	38	18	68
Maternity	100	12	54	85	87	41	37	12
Clinic	97	99	41	56	62	16	24	96
Dispensary	99	214	71	40	84	35	19	211
Managing authority								
Government	99	243	73	31	94	44	21	241
NGO	93	17	80	22	100	35	12	16
Private (for profit)	98	116	38	64	68	23	26	114
Faith-based organisation	100	66	91	93	38	9	28	66
Province								
Nairobi	96	28	69	83	72	41	33	27
Central	100	49	69	40	75	40	17	49
Coast	99	60	50	50	74	30	16	60
Eastern	100	89	82	48	78	29	32	89
North Eastern	100	15	52	69	83	15	19	15
Nyanza	97	78	81	40	89	42	25	76
Rift Valley	98	92	48	49	77	31	17	90
Western	100	30	79	39	83	22	25	30
Total	99	442	67	48	79	33	23	436

[1] At least one medicine for treating syphilis (doxycycline, erythromycin, penicillin, or tetracycline), at least one medicine for treating gonorrhoea (ceftriaxone, ciprofloxacin, or norfloxacin), at least one medicine for treating chlamydia (amoxicillin, doxycycline, erythromycin, norfloxacin, or tetracycline), and at least one medicine for treating trichomoniasis (metronidazole, tinidazole, or miconazole vaginal suppository).
[2] Observed treatment protocols in all relevant units, STI medicines available, and condoms in any service area or pharmacy.

Table A-8.7 Supportive management practices for providers of TB, malaria, or STI services

Among facilities offering HIV/AIDS care and support services (CSS), percentage with management practices that support treatment of TB, malaria, and STIs, including protocols at any relevant sites, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering HIV/AIDS CSS	Number of facilities	Percentage of facilities offering HIV/AIDS CSS with:			Number of facilities offering HIV/AIDS CSS
			Training for providers of TB, malaria, or STI services[1]	Supervision for providers of TB, malaria, or STI services[2]	All items for TB, malaria, and STI services, including guidelines or protocols at any relevant service sites[3]	
Type of facility						
Hospital	96	51	88	86	18	49
Health centre	86	80	91	93	8	68
Maternity	73	17	86	76	5	12
Clinic	49	203	71	62	2	99
Dispensary	63	340	85	88	4	214
Managing authority						
Government	71	344	86	90	8	243
NGO	79	22	86	92	3	17
Private (for profit)	49	236	72	63	2	116
Faith-based organisation	75	88	92	88	5	66
Province						
Nairobi	67	41	93	80	2	28
Central	39	125	81	78	2	49
Coast	74	81	96	77	5	60
Eastern	76	118	79	87	12	89
North Eastern	62	24	74	66	4	15
Nyanza	95	82	76	94	6	78
Rift Valley	53	174	84	77	2	92
Western	69	44	88	87	11	30
Total	64	690	83	83	6	442

[1] At least half of the interviewed providers of TB, malaria, or STI services reported they received pre- or in-service training related to one of these topics during the three years preceding the survey.
[2] At least half of the interviewed providers of TB, malaria, or STI services reported they were personally supervised at least once during the three months preceding the survey.
[3] All records, guidelines, medicines, and trained and supervised staff for offering tuberculosis, malaria, and STI services.

Table A-8.8 Isoniazid for preventing tuberculosis in HIV/AIDS clients

Among facilities offering HIV/AIDS care and support services (CSS), percentage that offer isoniazid preventive treatment for tuberculosis (TB) to HIV/AIDS clients and, among these, percentage with programme components supporting preventive treatment for TB, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering isoniazid preventative treatment for TB to HIV/AIDS clients: Offers routinely[1]	Offers selectively[2]	Routinely refers clients elsewhere[3]	Number of facilities offering HIV/AIDS CSS	Among facilities offering isoniazid preventative treatment for TB, percentage with: Observed guideline or protocol for isoniazid preventative treatment for TB in any relevant service site	Isoniazid available	At least one provider of isoniazid preventative treatment trained during the 3 years preceding the survey	Number of facilities offering HIV/AIDS CSS and reporting they offer isoniazid preventative treatment for TB
Type of facility								
Hospital	22	11	1	49	20	92	31	16
Health centre	17	6	1	68	28	93	28	16
Maternity	4	2	6	12	0	67	0	1
Clinic	3	7	5	99	20	29	49	10
Dispensary	8	2	6	214	15	85	0	22
Managing authority								
Government	11	5	5	243	22	95	17	38
NGO	1	0	0	17	-	-	-	0
Private (for profit)	2	7	6	116	22	26	33	11
Faith-based organisation	22	3	0	66	13	78	28	16
Province								
Nairobi	19	4	4	28	14	100	77	6
Central	4	2	0	49	11	95	29	3
Coast	0	5	0	60	0	0	0	3
Eastern	26	7	3	89	25	77	4	29
North Eastern	4	0	0	15	0	100	0	1
Nyanza	6	4	9	78	20	87	47	8
Rift Valley	5	5	9	92	28	75	34	10
Western	10	8	4	30	5	98	7	5
Total	10	5	5	442	20	80	22	65

[1] At least one site in facility routinely offers isoniazid preventive treatment to HIV/AIDS clients.
[2] At least one site in facility selectively offers isoniazid preventive treatment to HIV/AIDS clients, and no other site routinely offers or refers clients for it.
[3] At least one site in facility routinely refers HIV/AIDS clients elsewhere for isoniazid preventive treatment, and no other site routinely or selectively offers it.

Table A-8.9 Primary preventive treatment (cotrimoxazole preventive treatment) for opportunistic infections in HIV/AIDS clients

Percentage of facilities offering HIV/AIDS care and support services (CSS) that offer primary preventive treatment (such as cotrimoxazole preventive therapy (CPT)) for opportunistic infections to HIV/AIDS clients and, among these, percentage with programme components supporting CPT, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering primary preventive treatment (such as CPT) to HIVAIDS clients: Offers routinely[1]	Offers selectively[2]	Routinely refers clients elsewhere[3]	Number of facilities offering HIV/AIDS CSS	Among facilities ever offering CPT, percentage with: Observed protocol for CPT in any service sites	Cotrimoxazole available	At least one provider of CPT trained during the 3 years before the survey	Number of facilities offering HIV/AIDS CSS and reporting they ever offer primary preventive treatment (such as CPT)
Type of facility								
Hospital	93	2	1	49	27	97	50	46
Health centre	96	1	1	68	30	87	32	66
Maternity	68	12	5	12	25	88	24	10
Clinic	45	10	9	99	19	84	21	55
Dispensary	69	6	8	214	16	60	12	160
Managing authority								
Government	79	5	5	243	22	68	22	203
NGO	87	0	3	17	7	84	24	15
Private (for profit)	46	11	10	116	17	85	17	67
Faith-based organisation	79	0	6	66	26	87	36	52
Province								
Nairobi	80	6	11	28	44	100	64	24
Central	66	4	14	49	21	82	5	34
Coast	61	6	3	60	29	93	18	40
Eastern	65	4	5	89	19	87	9	61
North Eastern	36	1	0	15	4	100	4	6
Nyanza	83	0	7	78	22	63	39	65
Rift Valley	76	13	3	92	9	59	22	82
Western	72	7	10	30	28	61	22	24
Total	70	6	6	442	21	75	23	337

[1] At least one site in facility routinely offers CPT to HIV/AIDS clients.
[2] At least one site in facility selectively offers CPT to HIV/AIDS clients, and no other site routinely offers CPT or refers clients for CPT.
[3] At least one site in facility routinely refers HIV/AIDS clients elsewhere for CPT, and no other site routinely or selectively offers CPT.

Table A-8.10 Availability of trained providers to support advanced services for HIV/AIDS

Among facilities reporting they offer HIV/AIDS care and support services (CSS), percentage with trained and supervised providers to offer each of the indicated services, by background characteristics, Kenya SPA 2010

Background characteristic	Among facilities offering HIV/AIDS CSS, percentage with at least one provider trained in:[1]						Percentage of facilities offering HIV/AIDS CSS that have:		Number of facilities offering HIV/AIDS CSS
	Psychosocial counselling	Treatment of opportunistic infections	Palliative care	HIV/AIDS-related neurological disorders	AIDS in children	Nutritional rehabilitation for HIV/AIDS clients	Supervised providers of CSS for PLHA[2]	Trained and supervised staff available for all key services	
Type of facility									
Hospital	91	87	35	36	76	57	75	24	49
Health centre	74	72	24	18	55	39	85	14	68
Maternity	64	49	11	14	34	27	64	6	12
Clinic	58	42	8	10	26	10	53	8	99
Dispensary	54	31	8	7	16	20	82	4	214
Managing authority									
Government	62	46	13	15	33	28	86	10	243
NGO	83	57	17	18	57	24	97	17	17
Private (for profit)	56	41	5	7	22	11	49	2	116
Faith-based organisation	70	53	28	13	36	40	73	12	66
Province									
Nairobi	86	79	40	47	60	66	73	31	28
Central	61	46	3	4	24	8	78	1	49
Coast	67	46	10	10	40	17	67	9	60
Eastern	59	36	4	3	16	16	80	2	89
North Eastern	48	27	0	1	9	7	61	0	15
Nyanza	68	63	24	25	56	44	89	20	78
Rift Valley	55	34	16	10	19	23	65	6	92
Western	63	49	11	11	31	23	74	6	30
Total	62	46	13	13	31	25	75	9	442

[1] At least one provider of indicated HIV/AIDS service trained any time during the three years preceding the survey on a topic related to the indicated service.
[2] At least half of interviewed providers of care and support services for people living with HIV/AIDS (PLHA) report receiving personal supervision during the three months preceding the survey.

Table A-8.11 Protocols and guidelines to support advanced services for HIV/AIDS

Among facilities reporting they offer HIV/AIDS care and support services (CSS), percentage having guidelines or protocols for specific services in any CSS service site, by background characteristics, Kenya SPA 2010

Background characteristic	Among facilities offering HIV/AIDS CSS, percentage with observed guidelines and protocols for the following services in any CSS site:					Number of facilities offering HIV/AIDS CSS
	Opportunistic infections[1]	Symptomatic/ palliative care[2]	Clinical management of HIV/AIDS in children[3]	Clinical management of HIV/AIDS in adults[4]	Confidentiality guideline in any eligible service site[5]	
Type of facility						
Hospital	37	6	51	44	82	49
Health centre	35	8	49	40	73	68
Maternity	23	8	21	32	51	12
Clinic	12	5	18	18	26	99
Dispensary	15	4	24	21	42	214
Managing authority						
Government	23	6	31	28	53	243
NGO	30	6	35	49	75	17
Private (for profit)	13	5	15	18	24	116
Faith-based organisation	20	4	49	29	62	66
Province						
Nairobi	35	7	59	50	65	28
Central	18	5	19	16	53	49
Coast	24	5	24	29	45	60
Eastern	20	5	26	28	32	89
North Eastern	0	1	0	9	37	15
Nyanza	21	8	38	32	70	78
Rift Valley	8	0	27	12	33	92
Western	47	17	40	47	67	30
Total	20	5	29	26	48	442

[1] Any guideline or protocol that covers the management of opportunistic infections.
[2] Guidelines for home-based care services or any guideline/protocol on provision of symptomatic or palliative care.
[3] National ART guideline or any other protocol/guideline on the clinical management of HIV/AIDS in children.
[4] National ART guideline or any other protocol/guideline on the clinical management of HIV/AIDS in adults.
[5] The national VCT guideline or any other guideline on counselling for HIV testing or any written policy document or statement on confidentiality and disclosure of HIV test results or HIV/AIDS status.

Table A-8.12 Availability of advanced care and support services for HIV/AIDS

Among facilities that offer HIV/AIDS care and support services (CSS), percentage that report providing treatment for opportunistic infections, antiretroviral therapy (ART), post-exposure prophylaxis (PEP), and all advanced CSS services in the facility, by background characteristics, Kenya SPA 2010

Background characteristic	Treatment for opportunistic infections: Systemic IV treatment for specific fungal infections (e.g., for cryptococcal infections)	Treatment for Kaposi sarcoma	Palliative care such as symptom or pain management, or nursing care for the terminally ill (hospice care)	Nutritional rehabilitation[1]	Any psychosocial support services[2]	Prescribe ART and/or provide medical follow-up services	Post-exposure prophylaxis (PEP) for staff[3]	All advanced CSS[4]	Number of facilities offering HIV/AIDS CSS
Type of facility									
Hospital	69	41	59	82	98	83	89	23	49
Health centre	13	12	21	62	99	61	72	3	68
Maternity	56	18	44	53	94	15	52	0	12
Clinic	6	8	11	41	87	12	34	0	99
Dispensary	8	2	18	43	97	7	42	0	214
Managing authority									
Government	13	7	22	50	97	32	54	2	243
NGO	9	1	1	60	97	54	71	0	17
Private (for profit)	19	12	21	45	88	6	35	2	116
Faith-based organisation	26	19	28	55	99	27	58	8	66
Province									
Nairobi	20	25	35	68	93	51	86	7	28
Central	18	18	16	48	100	20	61	3	49
Coast	6	7	4	44	90	30	52	2	60
Eastern	22	5	6	66	95	16	31	2	89
North Eastern	31	19	34	53	85	14	19	1	15
Nyanza	17	8	25	58	92	33	80	3	78
Rift Valley	13	5	42	26	100	20	31	4	92
Western	17	18	26	50	98	25	49	4	30
Total	17	10	22	50	95	25	50	3	442

[1] Client education and provision of nutritional supplements.
[2] These are support services that are commonly needed by people living with HIV/AIDS, such as support groups, emotional/spiritual support, support for orphans or other vulnerable children, legal services, and social support such as food, materials, and income-generating projects. The facility reports that they offer the service, either in the facility or as an outreach service, or the facility reports that they refer clients to specific referral locations.
[3] Post-exposure prophylaxis is available to staff either in the facility or in another facility.
[4] All palliative care, ART, inpatient care, and post-exposure prophylaxis.

Table A-8.13 Availability of treatments for opportunistic infections and conditions

Among facilities offering HIV/AIDS care and support services (CSS), percentage with medicines to treat or manage opportunistic infections and other conditions, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering HIV/AIDS CSS and having at least one medicine for managing the indicated conditions or having the indicated item: Topical fungal infection[1]	Bacterial infections including pneumonia[2]	Vitamin supplementation[3]	Management of chronic diarrhoea[4]	Basic management of pain[5]	Anthelminths[6]	Intravenous fluid with infusion set for rehydration[7]	Oral rehydration salts	Number of facilities offering HIV/AIDS CSS
Type of facility									
Hospital	95	99	35	99	98	93	97	97	49
Health centre	87	97	21	100	95	98	97	95	68
Maternity	80	97	50	97	97	89	100	98	12
Clinic	53	83	34	85	85	72	66	71	99
Dispensary	85	97	12	99	95	90	84	93	214
Managing authority									
Government	83	97	4	99	94	91	87	93	243
NGO	94	86	23	100	100	100	73	83	17
Private (for profit)	58	85	39	87	87	74	71	75	116
Faith-based organisation	99	100	56	100	100	96	98	100	66
Province									
Nairobi	96	100	68	100	100	99	93	99	28
Central	77	100	31	100	100	91	90	99	49
Coast	69	80	19	80	78	79	81	89	60
Eastern	67	96	12	100	100	83	86	86	89
North Eastern	97	100	7	100	99	95	95	100	15
Nyanza	85	89	21	96	85	87	75	90	78
Rift Valley	87	98	16	98	96	90	83	83	92
Western	74	98	28	98	92	95	85	85	30
Total	79	94	22	96	93	88	84	89	442

[1] Clotrimazole or fluconazole or ketoconazole or nystatin.
[2] At least one of the following: amoxicillin, Augmentin, ampicillin, chloramphenicol, tetracycline, nalidixic acid, cotrimoxazole, erythromycin, or penicillin.
[3] Iron, or iron with folate, and any multivitamin, and vitamin B6 or other B vitamins.
[4] Loperamide, diphenoylate, or oral codeine.
[5] Paracetamol, aspirin, ibuprofen, or indomethacin.
[6] Albendazole or mebendazole.
[7] Normal saline, 5%D/NS, lactated Ringer's solution, plasma expanders, or 5%D/W and infusion sets.

Table A-8.14 Availability of medicines for advanced care of people living with HIV/AIDS

Among facilities offering HIV/AIDS care and support services (CSS), percentage with medicines to manage opportunistic infections and provide palliative care for the advanced care of people living with HIV/AIDS, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities providing systemic IV treatment for fungal infections	Among facilities offering HIV/AIDS CSS, percentage with at least two medicines to treat or manage:									Percentage of facilities with fortified protein supplement	Number of facilities offering HIV/AIDS CSS
		Cryptococcus fungal[1]	Bacterial respiratory infection[2]	Other bacterial infections[3]	Herpes[4] (both medications)	Herpes (only one medication)	Parasitic infection[5]	Herpes ophthalmic infection[6]	AIDS dementia complex[7]	Pain[8]		
Type of facility												
Hospital	69	48	93	99	4	40	94	46	91	66	22	49
Health centre	13	21	79	90	0	28	74	27	74	34	4	68
Maternity	56	46	91	94	0	34	91	39	86	91	7	12
Clinic	6	19	72	83	0	16	70	17	57	66	9	99
Dispensary	8	8	72	92	0	9	60	10	63	24	4	214
Managing authority												
Government	13	12	70	91	0	11	58	12	61	15	7	243
NGO	9	12	69	86	0	23	63	23	80	18	14	17
Private (for profit)	19	20	77	84	2	17	76	20	60	72	8	116
Faith-based organisation	26	39	98	100	0	40	98	45	98	92	4	66
Province												
Nairobi	20	53	93	100	3	44	97	48	86	84	15	28
Central	18	28	86	90	0	25	69	31	65	54	12	49
Coast	6	21	68	80	1	11	66	13	62	47	5	60
Eastern	22	10	83	92	0	8	69	9	71	31	7	89
North Eastern	31	13	92	100	0	3	91	3	82	25	14	15
Nyanza	17	19	64	87	1	22	66	22	57	32	6	78
Rift Valley	13	9	74	96	0	17	63	16	69	41	5	92
Western	17	14	68	85	0	21	65	27	61	40	2	30
Total	17	18	76	90	0	18	69	19	67	42	7	442

[1] Amphotericin B, fluconazole, itraconazole, and ketoconazole.
[2] Acyclovir, ceftriaxone, ciprofloxacine, gentamycin, cotrimoxazole, and dapsone.
[3] Tetracycline, nalidixic acid, cotrimoxazole, erythromycin, penicillin, doxycycline, clindamycin;, norfloxacin, oral cloxacillin, cloxacillin injection, amoxicillin oral, oral Augmentin, amoxicillin injection, oral ampicillin, ampicillin injection, oral chloramphenicol, chloramphenicol injection, oral clarithromycin, kanamycin injection, metronidazole i.v., spectinomycin injection, nitrofurantoin, cephalexin, cefotaxime, and sulfadiazine cream/ointment.
[4] Acyclovir or gancyclovir, (only one medicine required; may have both).
[5] Metronidazole, tinidazole, nalidixic acid, and cotrimoxazole.
[6] Either acyclovir ophthalmic or acyclovir oral.
[7] Cotrimoxazole, phenobarbital, Fansidar, and dexamethasone.
[8] One from each group. Group 1: diazepam, dapsone, indomethacin, prednisolone. Group 2: oral codeine, diclofenac injection, dipyrone injection, oral morphine.

Table A-8.15 Laboratory testing capacity for monitoring HIV/AIDS clients

Among facilities offering HIV/AIDS care and support services (CSS), percentage with laboratory testing capacity to conduct various tests or a system for receiving results when test is conducted outside the facility, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities with laboratory capacity[1] to conduct the following tests OR a documented system for sending blood and receiving results of the test:												Number of facilities offering HIV/AIDS CSS
	Kit for spinal tap	Culture media[2] and incubator	Haemo-globin or haemato-crit[3]	White cell count	Platelet count	BUN and serum creatinine[4]	Liver function test[4]	Serum glucose[4]	India ink test[5]	Gram stain[6]	Enzyme-linked immuno-sorbent assay (ELISA) for HIV	All lab equipment available excludes spinal tap	
Type of facility													
Hospital	30	36	83	45	45	53	56	64	42	66	25	13	49
Health centre	4	5	63	9	9	17	15	29	4	24	6	0	68
Maternity	18	30	74	25	25	37	39	51	10	56	10	5	12
Clinic	1	8	31	10	10	15	15	22	5	20	3	0	99
Dispensary	2	3	21	2	2	2	2	15	3	12	0	0	214
Managing authority													
Government	4	7	30	6	6	9	9	17	3	16	4	0	243
NGO	13	4	15	9	9	15	15	15	8	15	0	0	17
Private (for profit)	7	12	39	13	13	20	20	30	10	29	7	3	116
Faith-based organisation	7	11	73	23	23	21	23	51	22	40	6	3	66
Province													
Nairobi	13	26	52	36	36	33	34	44	12	38	16	6	28
Central	8	24	44	20	20	23	22	45	18	46	8	4	49
Coast	3	9	38	15	15	23	25	35	6	21	8	2	60
Eastern	7	2	27	5	5	6	7	8	3	23	1	0	89
North Eastern	1	1	24	4	4	4	4	4	1	6	0	0	15
Nyanza	3	8	37	7	7	11	11	19	6	15	3	1	78
Rift Valley	4	5	44	4	4	8	7	29	12	18	3	1	92
Western	6	7	38	8	8	13	14	25	6	18	8	2	30
Total	5	9	38	10	10	14	14	25	8	23	5	2	442

[1] Laboratory had all equipment and reagents to conduct the test available on the day of the survey.
[2] At least one of the following: chocolate agar, Thayer-Martin, modified Thayer-Martin, vancomycin-free selective medium (VFSM), or culture medium for TB (e.g., MGIT 960).
[3] The laboratory has a haematology analyzer capable of doing a total lymphocyte count, full blood count, platelet count, etc., or else has a haemoglobinometer/HemoCue, a calorimeter or spectroscope and Drabkin's solution, or a centrifuge and capillary tubes for haematocrit, or litmus paper for haemoglobin test with a valid expiration date, or any other anaemia test.
[4] The lab either had a functioning blood chemistry analyzer capable of providing serum creatinine, serum glucose, and liver function tests on the day of the survey or else had observed records of these tests conducted in an external lab.
[5] The lab either has India ink with a functioning microscope or has observed records of tests conducted in an external lab.
[6] Crystal or gentian violet and Lugol's iodine and acetone (or acetone alcohol) and neutral red (or carbol fuchsin or other counter stain) available in the lab on the day of the survey or else observed records of these tests conducted in an external lab.

Table A-8.16 Facilities with links to home or community care for HIV/AIDS clients

Among facilities offering HIV/AIDS care and support services (CSS), percentage with components supporting home and community care (HC), by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering HIV/AIDS CSS with: HC in facility or through outreach	HC through referral with written document naming a referral site[1]	HC through referral;, no written document but can name a HC referral site[2]	Observed written form for client referral[3]	At least one provider trained for HC	Number of facilities offering HIV/AIDS CSS
Type of facility						
Hospital	41	4	18	40	35	49
Health centre	39	0	21	31	29	68
Maternity	14	0	19	16	5	12
Clinic	15	1	28	24	15	99
Dispensary	19	1	30	22	14	214
Managing authority						
Government	27	2	24	25	22	243
NGO	17	1	48	28	13	17
Private (for profit)	10	0	29	23	10	116
Faith-based organisation	40	2	25	32	22	66
Province						
Nairobi	42	0	25	41	34	28
Central	12	1	18	15	10	49
Coast	23	0	25	18	15	60
Eastern	18	0	15	22	11	89
North Eastern	12	1	13	10	4	15
Nyanza	43	1	32	43	36	78
Rift Valley	10	1	43	17	10	92
Western	43	11	18	47	32	30
Total	24	1	26	26	18	442

[1] The facility offers HC through referrals, and at least one service site in the facility has a written document that names a referral site.
[2] The facility offers HC through referrals but no service site in the facility is able to show a document that names a referral site. However, at least one site in the facility is able to verbally name a referral site.
[3] The facility offers HC in the facility, through outreach, or through referrals and at least one site in the facility has an observed referral form for client HC services.

Table A-8.17.1 Youth-friendly services for HIV/AIDS

Percentage of facilities with an HIV testing system that offer youth-friendly services (YFS) for counselling and testing for HIV/AIDS and, among these, percentage with components supporting YFS, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering youth-friendly HIV testing services	Number of facilities with an HIV testing system	Percentage of facilities with:			Number of facilities offering youth-friendly HIV testing services
			Observed policy/ guidelines for YFS	At least one provider trained for YFS[1]	All items for YFS[2]	
Type of facility						
Hospital	21	50	42	84	37	10
Health centre	13	76	42	74	36	10
Maternity	6	15	60	31	31	1
Clinic	4	111	44	76	44	5
Dispensary	9	257	62	76	52	22
Stand-alone VCT	53	5	50	82	45	3
Managing authority						
Government	10	272	47	78	37	27
NGO	14	23	40	64	40	3
Private (for profit)	5	138	27	51	23	7
Faith-based organisation	17	81	77	89	71	13
Province						
Nairobi	21	36	30	78	25	8
Central	3	82	39	43	14	2
Coast	9	66	58	83	58	6
Eastern	7	103	63	100	63	7
North Eastern	0	10	-	-	-	0
Nyanza	13	70	52	55	23	9
Rift Valley	8	106	88	99	88	8
Western	27	40	32	65	29	11
Total	10	513	52	77	44	51

[1] Provider reports having received training related to youth-specific services during the three years preceding the survey, or facility in-charge reports there is a trained provider, but the provider was not present on the day of the survey.
[2] Facility offers youth-friendly HIV testing services, has observed policy or guidelines for YFS, and has at least one provider trained in YFS.

Table A-8.17.2 Youth-friendly services for HIV/AIDS

Percentage of all facilities that offer youth-friendly services (YFS) for counselling and testing for HIV/AIDS and, among these, percentage with components supporting YFS, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering youth-friendly HIV testing services	Number of facilities	Percentage of facilities with:			Number of facilities offering youth-friendly HIV testing services
			Observed policy/ guidelines for YFS	At least one provider trained for YFS[1]	All items for YFS[2]	
Type of facility						
Hospital	21	51	42	84	37	10
Health centre	12	80	42	74	36	10
Maternity	6	17	60	31	31	1
Clinic	2	203	44	76	44	5
Dispensary	7	340	62	76	52	22
Stand-alone VCT	53	5	50	82	45	3
Managing authority						
Government	8	345	47	78	37	27
NGO	13	24	40	64	40	3
Private (for profit)	3	237	27	51	23	7
Faith-based organisation	15	89	77	89	71	13
Province						
Nairobi	17	45	30	78	25	8
Central	2	125	39	43	14	2
Coast	7	81	58	83	58	6
Eastern	6	118	63	100	63	7
North Eastern	0	24	-	-	-	0
Nyanza	11	83	52	55	23	9
Rift Valley	5	175	88	99	88	8
Western	24	44	32	65	29	11
Total	7	695	52	77	44	51

[1] Provider reports having received training related to youth-specific services during the three years preceding the survey, or facility in-charge reports there is a trained provider, but the provider was not present on the day of the survey.
[2] Facility offers youth-friendly HIV testing services, has observed policy or guidelines for YFS, and has at least one provider trained in YFS.

Table A-8.18.1 Components supporting antiretroviral therapy services: Record-keeping and staff

Among all facilities, percentage prescribing antiretroviral therapy (ART) and/or providing medical follow-up services and, among these, percentage with indicated programme components, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities prescribing ART and/or providing medical follow-up services	Number of facilities	Percentage of facilities prescribing ART and/or providing medical follow-up services and:			Percentage of facilities prescribing ART and/or providing medical follow-up services and having trained provider of indicated services[1]:			Percentage of facilities prescribing ART and/or providing medical follow-up services and having supervised providers[2]	Number of facilities prescribing ART and/or providing medical follow-up services
			Having observed record system for individual client appoint-ments for ART clients	Having individual client record/ chart for ART clients	Having observed up-to-date register/ client cards where number of current ART clients can be calculated	ART prescription or clinical services	ART adherence counselling	Nutritional rehabilitation related to HIV/AIDS		
Type of facility										
Hospital	80	51	89	93	87	62	57	41	76	40
Health centre	52	80	88	92	95	55	45	32	93	41
Maternity	11	17	64	82	49	48	16	16	100	2
Clinic	6	203	91	100	74	95	69	52	100	12
Dispensary	5	340	87	100	100	61	38	32	86	19
Managing authority										
Government	23	344	92	96	90	58	46	35	87	80
NGO	43	22	63	100	98	94	67	11	100	9
Private (for profit)	3	236	76	76	61	51	44	38	67	6
Faith-based organisation	20	88	89	91	96	71	65	55	85	18
Province										
Nairobi	34	41	88	93	93	82	70	48	88	14
Central	10	125	96	97	91	56	49	12	84	12
Coast	24	81	98	98	79	69	48	44	80	19
Eastern	12	118	97	100	100	76	53	26	83	15
North Eastern	9	24	68	79	26	37	21	16	89	2
Nyanza	31	82	85	96	98	61	49	47	97	25
Rift Valley	11	174	74	86	93	38	39	35	78	19
Western	17	44	91	91	78	67	55	35	97	8
Total	17	690	88	94	90	63	50	37	87	114

[1] At least one interviewed provider of indicated service had related training in the past 12 months.
[2] At least half of interviewed providers of ART, adherence counselling, or nutritional rehabilitation for ART clients were personally supervised during past three months.

Table A-8.18.2 Components supporting antiretroviral therapy services: Medicines and lab capacity

Among all facilities, percentage prescribing antiretroviral therapy (ART) and/or providing medical follow-up services and, among these, percentage with indicated ART programme components, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities prescribing ART and/or providing medical follow-up services	Number of facilities	ART medicines:			ARVs storage:					Number of facilities prescribing ART and/or providing medical follow-up services
			Adult first-line ART regimen available[1]	No stock-outs for any normally stocked first-line ARVs during past 6 months	Up-to-date pharmacy stock cards for ARVs	Stored separate from other medicines[2]	Locked/ limited access	Separate from other medicines and locked/ limited access	Lab capacity for monitoring ART[3]	ART monitoring tests conducted outside; observed record for results	
Type of facility											
Hospital	80	51	99	94	88	70	98	68	53	24	40
Health centre	52	80	95	89	77	75	98	73	10	46	41
Maternity	11	17	100	100	64	49	100	49	82	0	2
Clinic	6	203	74	66	95	83	100	83	43	5	12
Dispensary	5	340	100	95	68	32	100	32	25	33	19
Managing authority											
Government	23	344	99	94	82	70	99	69	22	41	80
NGO	43	22	68	57	69	53	100	53	15	6	9
Private (for profit)	3	236	97	89	76	47	95	44	78	8	6
Faith-based organisation	20	88	91	85	84	64	96	61	74	10	18
Province											
Nairobi	34	41	99	83	95	63	99	63	47	1	14
Central	10	125	100	100	87	71	99	69	36	54	12
Coast	24	81	83	81	89	77	97	77	39	31	19
Eastern	12	118	100	98	94	79	100	79	27	45	15
North Eastern	9	24	95	84	68	47	100	47	32	0	2
Nyanza	31	82	96	96	63	35	99	34	32	28	25
Rift Valley	11	174	100	85	71	85	100	85	18	27	19
Western	17	44	90	81	85	78	90	68	36	51	8
Total	17	690	95	90	81	66	98	65	33	31	114

[1] Any of the following combination of ARVs: (1) stavudine, lamivudine, and nevirapine as separate ARVs or as combination drugs; (2) stavudine, lamivudine, and efavirenz; (3) zidovudine, lamivudine, and nevirapine or else Combivir (AZT/3TC) and nevirapine; (4) zidovudine, lamivudine, and efavirenz, or else Combivir (AZT/3TC) and efavirenz.
[2] ARVs stored in a separate location or in main pharmacy but separate from other medicines.
[3] Lab in facility can conduct CD4, viral load, or total lymphocyte count (TLC).

Table A-8.19 Protocols and guidelines for antiretroviral combination therapy services

Among all facilities, percentage prescribing antiretroviral therapy (ART) and/or providing medical follow-up services and, among these, percentage with the indicated items, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities prescribing ART and/or providing medical follow-up services	Number of facilities	Observed guidelines/protocols in ART site:		Number of facilities prescribing ART and/or providing medical follow-up services
			National ART guidelines	Other treatment guidelines[1]	
Type of facility					
Hospital	80	51	57	74	40
Health centre	52	80	58	81	41
Maternity	11	17	82	48	2
Clinic	6	203	66	74	12
Dispensary	5	340	54	66	19
Managing authority					
Government	23	344	59	78	80
NGO	43	22	29	75	9
Private (for profit)	3	236	49	63	6
Faith-based organisation	20	88	71	66	18
Province					
Nairobi	34	41	77	87	14
Central	10	125	73	78	12
Coast	24	81	57	59	19
Eastern	12	118	78	81	15
North Eastern	9	24	32	68	2
Nyanza	31	82	51	83	25
Rift Valley	11	174	39	63	19
Western	17	44	44	82	8
Total	17	690	58	75	114

[1] Other guidelines for the clinical management of HIV/AIDS infection in adults and in children, other guidelines for the management of opportunistic infections, or guidelines on provision of symptomatic or palliative care.

Table A-8.20 Post-exposure prophylaxis (PEP)

Among all facilities, percentage where staff have access to post-exposure prophylaxis[1] (PEP) and, among these, percentage where the indicated elements are present, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities where staff have access to PEP	Number of facilities	Percentage of facilities offering PEP and having:				Percentage of facilities offering PEP with indicated PEP ARV storage conditions			Number of facilities where staff have access to PEP
			Observed PEP guidelines[2]	Any record/ register of staff receiving PEP services	Any observed record for monitoring full compliance with PEP regime	Observed antiretroviral (ARV) for PEP[3]	Separate from other medications[4]	Locked[5]	Separate and locked	
Type of facility										
Hospital	89	51	64	46	13	80	72	77	67	45
Health centre	67	80	54	27	6	67	63	71	57	53
Maternity	56	17	31	17	7	30	23	27	19	10
Clinic	54	203	12	1	1	8	6	10	6	110
Dispensary	43	340	14	0	0	16	12	15	10	145
Stand-alone VCT	73	5	40	11	7	20	10	14	10	4
Managing authority										
Government	50	345	35	15	4	45	40	44	35	173
NGO	73	24	54	6	5	15	23	24	23	18
Private (for profit)	54	237	9	3	1	7	5	6	4	128
Faith-based organisation	53	89	29	16	4	38	28	39	28	47
Province										
Nairobi	83	45	25	11	4	30	33	35	32	37
Central	85	125	9	3	1	14	13	12	12	106
Coast	56	81	26	6	3	32	22	33	22	46
Eastern	27	118	27	17	2	55	38	52	35	31
North Eastern	17	24	11	11	0	27	27	24	24	4
Nyanza	78	83	52	15	8	41	36	40	31	65
Rift Valley	32	175	23	13	3	27	24	28	20	55
Western	50	44	45	24	3	34	30	33	29	22
Total	53	695	26	10	3	29	25	29	23	367

[1] The facility provides PEP to staff, or there is a system to refer staff elsewhere for PEP.
[2] The national ART guideline, the guideline for PEP for health care workers, or any other guideline that specifically mentions PEP and the regimen to follow is available at the site where PEP is prescribed, or any of these guidelines is available anywhere in the facility, or the wall chart on PEP is available in a visible place somewhere in the facility.
[3] The recommended PEP regimen includes the following ARVs in various combinations, and the assessment looked for the availability of any of these ARVs: zidovudine, lamivudine, tenofovir, efavirenz, lopinavir, indinavir, and nelfinavir. Any other ARV that is reported as used for PEP and available on the day of the survey is also captured.
[4] Stored alone and separate from other medications, including other ARVs.
[5] Locked apart from other medicines and other ARVs.

Table A-8.21.1 Availability of service records for PMTCT services

Percentage of facilities offering minimum package of PMTCT services and, among these, percentage with the indicated documentation observed and up-to-date, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering minimum package of PMTCT services	Total number of facilities	Percentage of facilities offering minimum package of PMTCT services and having indicated documentation:						Number of facilities offering minimum package PMTCT services
			Observed record of women attending ANC and who accepted HIV testing	Observed record of women who received HIV test results	Observed record of woman who received post-test counselling	Observed record of HIV+ pregnant women who were offered a complete ARV course for PMTCT	All records and results	PMTCT guidelines available in any PMTCT site	
Type of facility									
Hospital	63	51	94	90	84	93	77	87	32
Health centre	53	80	94	90	86	91	81	81	42
Maternity	22	17	72	63	53	62	44	51	4
Clinic	6	203	100	52	47	100	47	62	12
Dispensary	13	340	95	95	91	100	91	71	43
Managing authority									
Government	25	344	94	92	86	95	82	83	87
NGO	22	22	100	37	37	100	37	100	5
Private (for profit)	6	236	91	89	82	87	78	44	14
Faith-based organisation	31	88	94	80	81	93	79	68	27
Province									
Nairobi	8	41	74	74	74	63	63	52	4
Central	14	125	95	94	94	97	91	32	17
Coast	19	81	97	39	28	99	27	89	15
Eastern	17	118	98	96	88	100	87	58	20
North Eastern	5	24	90	90	90	100	90	90	1
Nyanza	37	82	91	91	87	99	86	92	31
Rift Valley	18	174	94	93	91	86	83	87	32
Western	32	44	100	100	95	94	89	92	14
Total	19	690	94	87	83	94	79	77	133

Table A-8.21.2 Availability of service records for PMTCT services among facilities offering ANC

Among facilities offering ANC services, percentage offering the minimum package of PMTCT services and, among these, percentage with the indicated documentation observed and up-to-date, by background characteristics, Kenya SPA 2010

Background characteristics	Percentage of facilities offering minimum package of PMTCT services	Total number of facilities offering ANC services	Percentage of facilities offering ANC and minimum package of PMTCT services and having indicated documentation:						Number of facilities offering ANC and minimum package PMTCT services
			Observed record of women attending ANC and who accepted HIV testing	Observed record of women who received HIV test results	Observed record of woman who received post-test counselling	Observed record of HIV+ pregnant women who were offered a complete ARV course for PMTCT	All records and results	PMTCT guidelines available in any PMTCT site	
Type of facility									
Hospital	67	48	94	90	84	93	77	87	32
Health centre	54	79	94	90	86	91	81	81	42
Maternity	24	16	72	63	53	62	44	51	4
Clinic	15	83	100	52	47	100	47	62	12
Dispensary	15	285	95	95	91	100	91	71	43
Managing authority									
Government	29	306	94	92	86	95	82	83	87
NGO	26	18	100	37	37	100	37	100	5
Private (for profit)	13	108	91	89	82	87	78	44	14
Faith-based organisation	35	78	94	80	81	93	79	68	27
Province									
Nairobi	11	33	74	74	74	63	63	52	4
Central	24	71	95	94	94	97	91	32	17
Coast	27	57	97	39	28	99	27	89	15
Eastern	23	84	98	96	88	100	87	58	20
North Eastern	7	17	90	90	90	100	90	90	1
Nyanza	40	78	91	91	87	99	86	92	31
Rift Valley	24	130	94	93	91	86	83	87	32
Western	34	41	100	100	95	94	89	92	14
Total	26	509	94	87	83	94	79	77	133

Table A-8.22 Availability of service records for PMTCT+ services

Percentage of facilities offering PMTCT+ services and, among these, percentage with the indicated up-to-date documentation, by background characteristics, Kenya SPA 2010

Background characteristic	Percentage of facilities offering PMTCT+ services	Total number of facilities	Percentage of facilities:			Number of facilities offering PMTCT+ services
			Observed record of HIV+ pregnant women put on ART	All elements and records for PMTCT+[1]	PMTCT women and family referred outside PMTCT unit for ART; no further follow-up by PMTCT clinic/unit	
Type of facility						
Hospital	50	51	54	47	19	25
Health centre	27	80	61	59	9	21
Maternity	2	17	-	-	-	0
Clinic	2	203	0	0	16	4
Dispensary	4	340	27	27	0	14
Managing authority						
Government	15	344	46	42	12	51
NGO	21	22	22	22	13	5
Private (for profit)	1	236	54	54	9	2
Faith-based organisation	7	88	78	74	2	6
Province						
Nairobi	2	41	20	20	60	1
Central	7	125	54	54	10	9
Coast	10	81	36	30	18	8
Eastern	4	118	39	29	25	5
North Eastern	2	24	-	-	-	0
Nyanza	23	82	66	63	3	19
Rift Valley	9	174	33	29	7	16
Western	11	44	47	47	24	5
Total	9	690	48	44	11	64

[1] All elements and records for PMTCT+ services are: HIV counselling and testing services, ARV prophylaxis for HIV-infected mother and her newborn, counselling on infant feeding and family planning for HIV-positive women, ARV treatment for HIV-positive women and her HIV-infected newborn and other family members, HIV counselling and testing records for ANC clients, records on ARV prophylaxis offered to HIV-infected ANC client, and records on therapeutic ARV for women receiving PMTCT services.

Table A-8.23 Facilities with record-keeping systems for monitoring HIV/AIDS care and support

Among all facilities offering the indicated HIV/AIDS-related care and support services (CSS), percentage with records of services received by clients and percentage submitting any reports on specified services, by background characteristics, Kenya SPA 2010

Background characteristic	Among facilities with HIV testing system, percentage:			Among facilities prescribing ART and/or providing medical follow-up services, percentage:			Among facilities offering HIV/AIDS CSS, percentage:			Among facilities with an HIV testing system, prescribing ART and/or providing medical follow-up services, and offering HIV/AIDS CSS, percentage	
	With records indicating clients receiving pre- and post-test counselling and received test results	Submitting any reports on HIV testing services	Number of facilities reporting an HIV testing system	With records indicating number of clients receiving ARV treatment	Submitting any reports on ART services	Number of facilities prescribing ART and/or providing medical follow-up services	With records documenting clients treated for HIV/AIDS-related illnesses	Submitting any reports on HIV/AIDS-related illnesses treated	Number of facilities offering HIV/AIDS CSS	With records of HIV/AIDS services offered and that routinely submit reports on these services	Number of facilities with an HIV testing system, prescribing ART and/or providing medical follow-up services, and offering HIV/AIDS CSS
Type of facility											
Hospital	90	81	50	87	96	40	83	94	49	70	40
Health centre	88	85	76	95	98	41	79	97	68	73	40
Maternity	70	63	15	49	82	2	64	81	12	49	2
Clinic	65	65	111	74	100	12	32	61	99	31	12
Dispensary	90	77	257	100	100	19	64	83	214	54	15
Stand-alone VCT	90	87	5	-	-	0	-	-	0	-	0
Managing authority											
Government	93	80	272	90	99	80	70	89	243	68	75
NGO	67	80	23	98	100	9	92	98	17	31	9
Private (for profit)	65	64	138	61	78	6	31	61	116	35	6
Faith-based organisation	88	80	81	96	96	18	74	86	66	77	18
Province											
Nairobi	64	62	36	93	95	14	62	76	28	53	14
Central	91	80	82	91	99	12	51	85	49	72	10
Coast	57	68	66	79	99	19	48	65	60	45	18
Eastern	83	65	103	100	98	15	66	85	89	86	15
North Eastern	55	71	10	26	84	2	64	83	15	16	2
Nyanza	96	79	70	98	100	25	77	95	78	71	25
Rift Valley	92	83	106	93	98	19	50	71	92	61	17
Western	99	94	40	78	91	8	84	97	30	78	8
Total	84	75	513	90	98	114	61	81	442	64	109

WEIGHTING OF FACILITIES IN KSPA

Appendix B

The sampling frame is a listing of all facilities eligible to be included in the survey. This is the basis for determining the proportional representation of different types of facilities within the provinces and the country. If the sampling fame is incomplete, this will influence how representative the sample findings are. For example, if the frame includes only government-managed facilities, the findings are representative only of government facilities. When only select non-governmental facilities are listed (e.g., faith-based) and the for-profit, non-governmental facilities are not included, the representativeness of the data will be affected.

In principle, a sample survey selects a sample of facilities proportionally to represent the type of facility and region. However, in some cases, the number of certain types of facilities is too small to provide enough information for meaningful analysis at the level data are presented. This is usually very significant when some of the services of interest, for example, services for HIV and AIDS, are more likely to be found in these particular facilities. Thus, the survey will usually over-sample this type of facility in order to have sufficient numbers (sample) for appropriate analysis.

Weighting mathematically corrects the proportion of facilities in the sample so that their information contributes proportional to their actual numbers in the country. This is of most importance when data from multiple types of facilities are combined to provide regional and national level results.

In the case of Kenya, 703 facilities were sampled for the 2010 KSPA survey. Hospitals, health centres, maternities and stand-alone VCT facilities for example were over-sampled since they exist in small numbers in the country and also provide most of the maternal health and HIV and AIDS services. The 2010 KSPA collected data from 252 sampled hospitals, which corresponds to about 36 percent of the total sample (252/703). However, the true proportion of hospitals in relation to other facility types as per the sampling frame for the 2010 KSPA survey is only 7 percent. Thus, for analysis, the number of hospitals was adjusted down to 51, which approximately reflects the actual percentage (7 percent) of the sample.

In the report, the weighted numbers are provided in the tables, providing information on what proportion of the total comes from any particular type of facility, managing authority or province. It is important to note, however, that all facilities in the sample are used when calculating percentages. For example, when calculating the percentage of hospitals providing a particular service, information from all 252 hospitals visited are used and not information from only 51 hospitals. So, whenever a weighted number looks too small to be meaningful, it is important to review the unweighted number to know how many actual facilities/interviews contribute to the percentage in question.

SURVEY PERSONNEL

Appendix C

ADVISORY COMMITTEE

Dr. Boniface K'Oyugi – CEO, NCAPD
Dr. Josephine Kibaru – Head - Family Health Department
Anthony Kilele – Director General, KNBS

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Dr. Annah Wamae
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Dr. Felix Musili
Dr. Martin Sirengo
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Francis Kundu
Prof. Joyce Olenja
Irene Muhunzu
Vane Lumumba
George Kichamu
Margaret Muthoni Mwangi

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David Nyaberi	Nairobi & Rift Valley	Nairobi & Maasai
Patricia Lasoi	Rift Valley	Kalenjin (Eldoret & Kericho)
Mary Gathitu	Central & Rift Valley	Kikuyu (Nyeri & Nakuru)
James Chembeni	Western	Luhya (Kakamega & Bungoma)
Samuel Ogola	Nyanza	Luo (Migori & Kisumu) & Kisii
Andolo Miheso	North Eastern	Somali
Peter Nyakwara	Coast	Swahili & Mijikenda
Diana Kamar	Eastern	Kamba & Meru/Embu

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Fidelis Ndung'u	Kikuyu (Nyeri)
Jane Wanjaria	Kamba
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Levi Mugilwa	Somali
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Penuel N. Ondienga	Kisii
Rose Wakuloba	Kalenjin (Eldoret)

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Rodgers Kazungu	Miji Kenda
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SURVEY INSTRUMENTS

Appendix **D**

AUDIT

2010 KENYA SERVICE PROVISION ASSESSMENT SURVEY
COVER SHEET

1. Facility Identification

001 **NAME OF FACILITY** _____

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

003 **PROVINCE** . . . . . [ ][ ]

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

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

006 **TYPE OF FACILITY**

NATIONAL REFERRAL HOSPITAL	01
PROVINCIAL HOSPITAL	02
DISTRICT HOSPITAL	03
SUB-DISTRICT HOSPITAL	04
OTHER HOSPITAL	05
HEALTH CENTRE	06
CLINIC	07
DISPENSARY	08
MATERNITY	09
STAND-ALONE HTC/VCT	10

007 **MANAGING AUTHORITY (OWNERSHIP)**

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

008 **ADJACENT FACILITY**

YES	1
NO	2

009 **INPATIENT ONLY**

YES	1
NO	2

2. Information about Interview

010 **DATE:** . . . . . DAY . . . . . [ ][ ]
MONTH . . . . . [ ][ ]
YEAR . . . . [2][0][1][0]

011 **Name of the Team Leader** _____ TEAM LEADER CODE . . . . . [ ][ ]

012 **INTERVIEWER VISITS:**

	Visit 1	Visit 2	Visit 3
DATE:	_____	_____	_____

RESULT CODES (LAST VISIT):
1 = COMPLETED
2 = RESPONDENT NOT AVAILABLE
3 = REFUSED
4 = PARTIALLY COMPLETED
6 = OTHER _____ (SPECIFY)

RESULT CODE . . . . . [ ]

CHECKED BY:

TEAM LEADER _____/__/__/____
INITIALS, DATE

CENTRAL EDITOR _____/__/__/_
INITIALS, DATE

3. GPS READING

1 Turn GPS machine on and wait until satellite page changes to "position"

2 Write Altitude

3 Press "MARK"

4 Highlight "AVERAGE" and press "ENTER"

5 Highlight "WAYPOINT NUMBER" and press "ENTER"

6 Enter 3-digit facility number

7 Wait 5 minutes

8 Highlight "SAVE" and press "ENTER"

9 Page to main menu, highlight "WAYPOINT LIST" and press "ENTER"

10. Highlight your waypoint

11. Copy information from waypoint list page- this is the average of all the satellite readings

12. 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.

013	WAYPOINT (FACILITY NUMBER)	NAME . . . . .
014	ELEVATION	ELEVATION . . . . .
015	LATITUDE	N/S . . . . . a DEGREES/DECIM b c
016	LONGITUDE	E/W . . . . . a **E** DEGREES/DECIM b c

CHECKLIST FOR QUESTIONNAIRES

TEAM LEADER:
USE THIS CHECKLIST TO ORGANISE YOUR DATA COLLECTION IN THE FACILITY.

REMEMBER, EVEN IF A SPECIFIC SERVICE IS NOT OFFERED AT A FACILITY, STILL A QUESTIONNAIRE (WITH THE APPROPRIATE "NO SERVICES" CODE CIRCLED) NEEDS TO BE RETURNED TO YOU.

	SECTION NUMBER	DESCRIPTION OF SERVICE	CHECK (√) FOR EVERY QRE COMPLETED
01	1	OPD AND HIV/AIDS GENERAL INFORMATION	
02	2a	VACCINE LOGISTICS	
03	2b	CHILD HEALTH SERVICES	
04	3a	FAMILY PLANNING (FP) SERVICES	
05	3b	CONTRACEPTIVE SUPPLIES	
06	4	ANTENATAL-POSTNATAL CARE (ANC-PNC)	
07	5	DELIVERY - NEWBORN CARE	
08	6	SEXUALLY TRANSMITTED INFECTIONS (STI)	
09	14	HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)	
10	15	LABORATORY AND OTHER DIAGNOSTICS (LAB)	
11	16	MEDICATION AND SUPPLIES (MEDS)	
12	17	TUBERCULOSIS DIAGNOSIS AND TREATMENT (TB)	
13	18	COUNSELLING AND TESTING (CT)	
14	19	ANTIRETROVIRAL THERAPY (ART)	
15	20	PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)	

IN THIS SECTION, PLEASE PUT THE TOTAL NUMBER OF OBSERVATIONS (OBS) AND CLIENT EXIT INTERVIEW (CEI) QUESTIONNAIRES COMPLETED FOR EACH OF THE FOUR AREAS (ANC, FP, SC, STI) AND THE TOTAL NUMBER OF HEALTH WORKER INTERVIEWS (HWI)

Number of questionnaires completed:	**Questionnaire Type** OBS	CEI
ANC OBSERVATION & CLIENT EXIT INTERVIEWS		
FAMILY PLANNING OBSERVATION & CLIENT EXIT INTERVIEW		
SICK CHILD OBSERVATION & CLIENT EXIT INTERVIEWS		
STI OBSERVATION & CLIENT EXIT INTERVIEWS		
OBSERVATION OF DELIVERIES		
HEALTH WORKER INTERVIEWS		
MATERNAL HEALTH PROVIDER KNOWLEDGE QUESTIONNAIRES		
NEONATAL HEALTH PROVIDER KNOWLEDGE QUESTIONNAIRES		

SECTION 1: GENERAL INFORMATION

FACILITY NUMBER | | | | | | **INTERVIEWER CODE** | | |

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR OUTPATIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Ministries of Health (MOPH & S; MOMS) and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be be recorded or shared. Information about your facility 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 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 these 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 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?

				2	0	1	0
DAY		MONTH		YEAR			

_____

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

100	May I begin the interview?	YES . 1 NO . 2	→ STOP

STAFF LISTING FORM

FACILITY NUMBER | | | | | |

INTERVIEWER CODE | | |

LIST ALL PROVIDERS WHO ARE PRESENT IN THE UNITS YOU WILL BE VISITING TO ADMINISTER QUESTIONNAIRES. FOR SMALL HEALTH FACILITIES (e.g., CLINICS) ALL PROVIDERS IN THE FACILITY SHOULD BE LISTED. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND PUT A CHECK MARK TO INDICATE THE SERVICES THE PROVIDER OFFERS. ALSO PUT A CHECK TO INDICATE IF A PROVIDER IS INTERVIEWED FOR FACILITY INFORMATION AND/OR INDIVIDUAL INTERVIEW.

			SERVICE PROVIDED							INTERVIEWED	
PROV SL NUM	Provider first name or initials	Qual-ification Code	ART	Any HIV counselling testing, VCT	Treatment HIV/AIDS related illnesses	Treatment Malaria STI TB	ANC FP Delivery PMTCT	Other client services (Child Hlth)	Conduct lab tests	Check if staff interview conducted YES facility	Yes individual
01											
02											
03											
04											
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23											

01 SPECIALIST (INCLUDING PATHOLOGISTS)
09 MEDICAL OFFICER
10 CLINICAL OFFICER
11 BACHELLOR SC. NURSE (BSN)
12 REGISTERED NURSE (incl. KRCHN)
13 REGISTERED MIDWIFE
14 ENROLLED NURSE
15 ENROLLED MIDWIFE
16 NURSE AIDE
17 PHARMACIST
18 PHARMACEUTICAL TECHNOLOGIST
19 PHARMACIST ASSISTANT
20 LAB SCIENTIST
21 LAB TECHNOLOGIST
22 LABORATORY TECHNICIAN/ASSISTANT
23 NUTRITIONIST/NUTRITION TECHNICIAN
24 HEALTH EDUCATION OFFICER
25 SOCIAL WORKER
26 HIV COUNSELOR/LAY COUNSELOR
96 OTHER_____

STAFF LISTING FORM

FACILITY NUMBER | | | | | |

INTERVIEWER CODE | | |

LIST ALL PROVIDERS WHO ARE PRESENT IN THE UNITS YOU WILL BE VISITING TO ADMINISTER QUESTIONNAIRES. FOR SMALL HEALTH FACILITIES (e.g., CLINICS) ALL PROVIDERS IN THE FACILITY SHOULD BE LISTED. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND PUT A CHECK MARK TO INDICATE THE SERVICES THE PROVIDER OFFERS.

ALSO PUT A CHECK TO INDICATE IF A PROVIDER IS INTERVIEWED FOR FACILITY INFORMATION AND/OR INDIVIDUAL INTERVIEW.

				SERVICE PROVIDED							INTERVIEWED	
PROV SL NUM.	Provider first name or initials	Qual-ification Code		ART	Any HIV counselling testing, VCT	Treatment HIV/AIDS related illnesses	Treatment Malaria STI TB	ANC FP Delivery PMTCT	Other client services (Child Hlth)	Conduct lab tests	Check if staff interview conducted YES facility	Check if staff interview conducted Yes individual
24												
25												
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				SERVICE PROVIDED							INTERVIEWED	
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ALSO PUT A CHECK TO INDICATE IF A PROVIDER IS INTERVIEWED FOR FACILITY INFORMATION AND/OR INDIVIDUAL INTERVIEW.

				SERVICE PROVIDED							INTERVIEWED	
PROV SL NUM	Provider first name or initials	Qual-ification Code		ART	Any HIV counselling testing, VCT	Treatment HIV/AIDS related illnesses	Treatment Malaria STI TB	ANC FP Delivery PMTCT	Other client services (Child Hlth)	Conduct lab tests	Check if staff interview conducted YES facility	Yes individual
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26 HIV COUNSELOR/LAY COUNSELOR
96 OTHER_____

2. Information About Services

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
101	How many days each week is the facility routinely open for outpatient curative services?	NUMBER OF DAYS . . . . . ☐☐ DON'T KNOW 8	
102	Does a trained health provider live on the facility premises?	YES . . . . . 1 NO 2	
103	Is there a health care worker assigned to and present at the facility at all times (24 hours a day) for emergencies? IF YES, ASK: Is there a duty schedule/call list for 24-hour staff coverage? IF YES, ASK TO SEE THIS.	YES, DUTY SCHEDULE OBSERVED . . . . . 1 YES, 24-HR ONSITE STAFF NO DUTY SCHEDULE SEEN . . . . 2 NO 24-HOUR ONSITE STAFF 3	→ 105
104	Is there a health care worker available away from the facility but officially on call, at all times (24 hours a day) for emergencies? IF YES, ASK: Is there a duty schedule/call list for 24-hour staff coverage? IF YES, ASK TO SEE THIS.	YES, DUTY SCHEDULE OBSERVED . . . . . 1 YES, 24-HR ONCALL STAFF NO DUTY SCHEDULE SEE . . . . . 2 NO 24-HOUR ONCALL STAF 3	

105 Now I have some questions about staffing for this facility. Please tell me how many staff with each qualification are currently assigned to or employed by this facility, and how many are actually present today. We want to know the highest technical or professional qualification that any staff may hold (such as nurse or doctor) regardless of the person's actual assignment or duties.

	QUALIFICATION	(A) ASSIGNED/EMPLOYED	(B) PRESENT TODAY
01	OBSTETRICIAN/GYNAECOLOGIST	☐☐☐	☐☐☐
02	PHYSICIAN SPECIALIST	☐☐☐	☐☐☐
03	PEDIATRICIAN	☐☐☐	☐☐☐
04	SURGEON	☐☐☐	☐☐☐
05	ANAESTHESIOLOGIST/ANAESTHETIST	☐☐☐	☐☐☐
06	CLINICAL OFFICER ANAESTHETIST	☐☐☐	☐☐☐
07	NURSE ANAESTHETIST	☐☐☐	☐☐☐
08	OTHER SPECIALIST (E.G., PATHOLOGIST)	☐☐☐	☐☐☐
09	MEDICAL OFFICER (NON-SPECIALIST)	☐☐☐	☐☐☐
10	CLINICAL OFFICER	☐☐☐	☐☐☐
11	BACHELLOR SCIENCE NURSE (BSN)	☐☐☐	☐☐☐
12	REGISTERED NURSE	☐☐☐	☐☐☐
13	REGISTERED MIDWIFE	☐☐☐	☐☐☐
14	ENROLLED NURSE	☐☐☐	☐☐☐
15	ENROLLED MIDWIFE	☐☐☐	☐☐☐
16	NURSE AIDE	☐☐☐	☐☐☐
17	PHARMACIST	☐☐☐	☐☐☐
18	PHARMACEUTICAL TECHNOLOGIST	☐☐☐	☐☐☐

19	PHARMACIST ASSISTANT			
20	LABORATORY SCIENTIST			
21	LABORATORY TECHNOLOGIST			
22	LABORATORY TECHNICIAN/ASSISTANT			
23	NUTRITIONIST/NUTRITION TECHNICIAN			
24	HEALTH EDUCATION OFFICER			
25	SOCIAL WORKER			
26	HIV COUNSELOR/LAY COUNSELOR			
27	OTHER (SPECIFY) _____			
28	SUM THE NUMBER OF STAFF REPORTED IN EACH COLUMN. VERIFY AND CORRECT THE TOTALS.			

106	In addition to the previously mentioned staff who are assigned to or employed by the facility, does this facility have any people who are **seconded,** that is they are not officially employed but are sent from other organizations, projects or volunteers (e.g., VSO), and who work routinely (either full or part time) and provide client services?	YES . . . . . 1 NO 2	→ 110

107 Please tell me how many staff with each of the following qualification or category are currently **seconded** to this facility, the number who work specifically with HIV/AIDS related services, and the number present today.

	QUALIFICATION	(a) # OF STAFF SECONDED	(b) # WORKING WITH HIV SERVICES	(c) # OF SECONDED STAFF PRESENT TODAY
01	(01) SPECIALIST (INCLUDING PATHOLOGIST)			
02	(09) MEDICAL OFFICER (NON-SPECIALIST)			
03	(10) CLINICAL OFFICER			
04	(11) BACHELLOR SCIENCE NURSE			
05	(12) REGISTERED NURSE			
06	(13) REGISTERED MIDWIFE			
07	(25) SOCIAL WORKER			
08	(26) HIV COUNSELOR/LAY COUNSELOR			
09	(96) OTHER: _____			
108	SUM THE NUMBER OF SECONDED STAFF IN Q107 WHO WORK WITH THE FACILITY.			

109	How many of the seconded staff that you have identified are foreigners? (FROM COLUMN (a))	# OF SECONDED STAFF WHO ARE FOREIGNERS. ..	
		DON'T KNOW 98	

110	Do you have an estimate of the size of the catchment population that this facility serves, i.e., the target or total population living in the area served by this facility? IF YES: How many people is that?	CATCHMENT POPULATION [ ][ ][ ][ ][ ][ ][ ] NO CATCHMENT AREA DEFINI 9999995 DON'T KNOW SIZE OF CATCHMENT POPULATIO . . 9999998	
111	Does this facility routinely provide inpatient care?	YES . . . . . 1 NO 2	→ 113
112	Does this facility have beds for overnight observation?	YES . . . . . 1 NO 2	 → 114
113	How many overnight or inpatient beds does this facility have?	NUMBER OF BEDS [ ][ ][ ]	
114	Does this facility have routine meetings for reviewing managerial or administrative matters? By this I mean any management meeting.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 117 → 117
115	How often do meetings to discuss the facility managerial and administrative matters take place?	MONTHLY OR LESS . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 MORE THAN EVERY 6 MONTHS 4	 → 117
116	Is an official record of management meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES OR NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED . . . . . 1 YES, REPORTED, NOT SE . . . . . 2 NO RECORD MAINTAINED 3	
117	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	 → 120 → 120
118	How often are routine meetings held with both facility staff and community members?	MONTHLY OR LESS . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 MORE THAN EVERY 6 MONTHS 4	 → 120
119	Is an official record of the meetings with both facility staff and community members maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES OR NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED . . . . 1 YES, REPORTED, NOT SEEN . . . . 2 NO RECORD MAINTAINED 3	
120	Does this facility have any system for obtaining clients' opinions about the health facility or its services? IF YES, ASK: What systems do you use? CIRCLE ALL METHODS THAT ARE USED FOR ELICITING CLIENTS' OPINIONS. PROBE FOR ALL METHODS USED.	SUGGESTION BOX. . . . . A CLIENT INTERVIEW/SURVEY FORM B CLIENT HELP DESK. . . . . C OFFICIAL MEETING WITH COMMUNITY LEADERS. . . . . D INFORMAL DISCUSSIONS WITH CLIENT OR COMMUNITY. . . . . E OTHER (SPECIFY) _____ X NO CLIENT FEEDBACK. . . . . Y DON'T KNOW. . . . . Z	 → 122 → 122
121	Is there a procedure for reviewing or reporting on clients' opinions? IF YES, ASK TO SEE A REPORT OR FORM ON WHICH DATA ARE COMPILED OR DISCUSSION IS REPORTED.	YES, REPORT SEEN . . . . . 1 YES, REPORT NOT SEEN . . . . . 2 NO 3	

122	Does this facility routinely carry out quality assurance activities? By this I mean some formal review system or comparison of work or system to a standard? An example may be ***facility-wide review of mortality***	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 124 → 124
123	Is there an official record of any quality assurance activities carried out during the past year? A REPORT OR MINUTES OF A QA MEETING, A SUPERVISORY CHECKLIST, A MORTALITY REVIEW, AN AUDIT OF RECORDS OR REGISTERS ARE ALL ACCEPTABLE.	YES, RECORD OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO RECORD MAINTAINED 3	
124	When was the last time a supervisor from outside this facility came here to visit?	WITHIN THE PAST 6 MONTHS . . . . 1 MORE THAN 6 MONTHS AGO . . . . . 2 NEVER SUPERVISED FROM OUTSIDE FACILITY 3	 → 126 → 126
124A	SOURCE OF INFORMATION FOR 124	MINUTES 1 VISITOR'S BOOK 2 LOG BOOK 3 NO RECORD MAINTAINED 4	

125	The most recent time during the past 6 months that a supervisor from outside the facility visited, did he or she:	YES	NO	DON'T KNOW	
01	Check some registers or books?	CHECKED REGISTERS 1	2	8	
02	Discuss problems?	DISCUSSED PROBLEMS 1	2	8	
03	Discuss policy or administrative matters?	DISCUSSED POLICY 1	2	8	
04	Discuss technical protocols or issues in service delivery practices?	DISCUSSED TECH. MATTERS 1	2	8	
05	Hold an official staff meeting?	STAFF MEETING 1	2	8	
06	Observe individual staff providing services?	SERVICE OBSERVED 1	2	8	
126	Does this facility have a program for routine maintenance and repair of **infrastructure?**	YES, ROUTINE MAINTENANCE . . . . 1 NO ROUTINE MAINTENANCE . . . . 2 DON'T KNOW 8			→ 128
127	Is the person(s) responsible for maintenance and repair of infrastructure assigned to and based in the facility or from outside the facility?	ONSITE STAFF . . . . . 1 OUTSIDE SUPPORT . . . . . 2 BOTH ONSITE AND OUTSIDE STAFF . . . . . 3 DON'T KNOW 8			
128	Does this facility have a program for routine preventive maintenance for **major equipment** such as a generator, refrigerator, and sterilization equipment? This means the equipment is checked periodically even if there is no problem.	YES, ROUTINE MAINTENANCE . . . . 1 NO ROUTINE MAINTENANCE . . . . . 2 DON'T KNOW 8			→ 130
129	Is the person(s) responsible for routine preventive maintenance for major equipment assigned to the facility or from outside the facility?	ONSITE STAFF . . . . . 1 OUTSIDE SUPPORT . . . . . 2 BOTH ONSITE AND OUTSIDE STAFF . . . . . 3 DON'T KNOW 8			

130	What is the system used for repairing or replacing small equipment (such as blood pressure cuffs or stethoscopes)? PROBE AND CIRCLE ALL THAT APPLY.	ONSITE MAINTENANCE . . . . . A PETTY CASH FOR PURCHASE REPLACEMENT OR REPAIR . . . . B SEND ELSEWHERE FOR REPAIR . . . . . C OTHER _____ (SPECIFY) X NO SYSTEM . . . . . Y DON'T KNOW . . . . . Z	
131	Does this facility have any routine user-fees or charges for any services for sick adults? This includes any fees, including those for registration, health card/booklets, medicines, or laboratory investigations?	YES. . . . . 1 NO. 2	→ 133A

		(a) FEE			(b) AMOUNT IN KSH
132	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for sick adults and the amount of the fee:	YES	NO	DK	
01	Fee for the client health card/booklet	1 → b	2 → 02	8 → 02	
02	Fee for registration	1 → b	2 → 03	8 → 03	
03	Fee for each consultation	1 → b	2 → 04	8 → 04	
04	Does the user fee vary depending on the diagnosis?	1	2	8	
05	Fees for medications	1	2	8	
06	Fees for laboratory tests	1	2	8	
07	Are discounts or exemptions from fees allowed for some clients	1	2	8	
08	Is there a system for clients to pre-pay for multiple visits for curative care?	1	2	8	

133	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	

		IF RESPONSE IS "YES" BUT AMOUNT IS NOT KNOWN WRITE "999999998" IN THE BOXES		
133A	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 2008/09 financial year and the amount. If **someone else** is more appropriate to provide financial information, please feel free to invite that person or refer me to that person. CONVERT ALL FIGURES TO **ANNUAL.**	YES	AMOUNT IN KSH	NO DK
01	MINISTRY OF PUBLIC HEALTH AND SANITATION	1		2 8
02	MINISTRY OF HEALTH (MEDICAL SERVICES)	1		2 8
03	OTHER PUBLIC MINISTRIES	1		2 8
04	MEDICAL SCHEMES (INSURANCE)	1		2 8
05	SOCIAL SECURITY FUND	1		2 8
06	REIMBURSEMENT BY EMPLOYER	1		2 8
07	GOVT. CONTRIBUTION TO PRIVATE (NFP)	1		2 8
08	USER FEES / OUT-OF-POCKET (DIRECT CHARGES)	1		2 8
09	DONOR AGENCIES/NGOs (SECULAR)	1		2 8
10	FAITH-BASED (E.G. MISSIONS, CHURCHES)	1		2 8
11	COMMUNITY PROGRAMS	1		2 8
12	OTHER (SPECIFY)_____	1		2 8

134	Please tell me the *most* common means of transport used by patients who are referred from other facilities to this facility for emergency services.	AMBULANCE. . . . . 01 PRIVATE CAR/BUS. . . . . 02 PUBLIC CAR/BUS. . . . . 03 MOTORCYCLE. . . . . 04 BICYCLE. . . . . 05 PEOPLE CARRY/PUSH OR PULL PATIENT. . . . . 06 ANIMALS CARRY/PULL PATIENTS. . . . . 07 OTHER (SPECIFY)_____ . 96 NEVER RECEIVE REFERRALS . . . . 95 DON'T KNOW 98	
135	Does this facility have a functional ambulance or other vehicle for emergency transportation for clients? IF YES, ASK TO SEE THE AMBULANCE OR VEHICLE.	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO . . . . . 3 DON'T KNOW 8	 → 138 → 138
136	Is fuel available today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
138	Does this facility have a generator for electricity? This may be a back-up or stand-by generator. IF YES, ASK TO SEE THE GENERATOR	YES, OBSERVED. . . . . 1 YES, REPORTED NOT SEEN. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	 → 140 → 140
139	Is the generator functional and is there fuel today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES, FUNCTIONAL WITH FUEL . . . 1 YES, FUNCTIONAL, NO FUEI. . . . . 2 NOT FUNCTIONAL . . . . . 3 DON'T KNOW 8	
140	Does this facility ever obtain electricity from a source other than a generator? PROBE FOR THE RIGHT ANSWER	YES, CENTRAL SUPPLY. . . . . 1 YES, SOLAR OR OTHER SOURCE. 2 YES, BOTH CENTRAL SUPPLY AND SOLAR. . . . . 3 NO. 4	 → 142
141	Is the electricity (not including any backup generator) always available during the times when the facility is providing services, or is it sometimes interrupted-for more than 2 hours?	ALWAYS AVAILABLE . . . . . 1 SOMETIMES INTERRUPTED 2	
142	What is the *most commonly used* source of water for the facility *at this time?*	PIPED INTO FACILITY . . . . . 01 PIPED ONTO FACILITY GROUND . . 02 PUBLIC TAP/STANDPIPI . . . . . 03 TUBEWELL/BOREHOLE . . . . . 04 PROTECTED DUG WELI . . . . . 05 UNPROTECTED DUG WEL . . . . . 06 PROTECTED SPRING . . . . . 07 UNPROTECTED SPRINC . . . . . 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	→ 144 → 144 → 145

143	Is water outlet from this source available onsite (that is, within 500m of the facility?) REPORTED RESPONSE IS ACCEPTABLE	YES, ONSITE . . . . . 1 NO 2	
144	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES . . . . . 1 NO 2	
145	Does this facility have a working phone or shortwave radio to call outside, that is available at all times client services are offered? CLARIFY THAT IF 24-HOUR EMERGENCY SERVICES ARE OFFERED, THIS REFERS TO 24-HOUR AVAILABILITY. CIRCLE ALL AVAILABLE.	YES, LANDLINE . . . . . A YES, CELL PHONE . . . . . B YES, PAY PHONE OR PERSONAL CELL PHONE ONLY . . . . . C YES, RADIO . . . . . D NO . . . . . Y	147
146	Is there a phone or shortwave radio within 5 minutes' distance from the facility that staff can use in an emergency? IF YES, ASK: Is that phone or shortwave radio available at all times services are offered?	YES, AVAILABLE ALL TIMES . . . . . 1 YES, NOT AVAILABLE ALL TIMES . . . . . 2 NO, NONE WITHIN 5 MINUTES 3	
147	Does the facility have a computer? IF YES, ASK: Is the computer functioning today? REPORTED RESPONSE IS ACCEPTABLE	YES, FUNCTIONING. . . . . 1 YES, NOT FUNCTIONING. . . . . 2 NO. 3	SKIP TO Q148A
148	Is there ever access to email/internet within the facility? REPORTED RESPONSE IS ACCEPTABLE	YES. . . . . 1 NO. 2	

148A	AT THIS POINT, ASK THE RESPONDENT TO TAKE YOU TO THE MAIN AREA WHERE EQUIPMENT IS CLEANED AND STERILIZED OR DISINFECTED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE PROCESSES USED. INTRODUCE YOURSELF AND PROCEED.		
149	What procedure is used for **decontaminating** and **cleaning** equipment before its final processing for reuse? PROBE, IF NECESSARY, TO DETERMINE CORRECT RESPONSE.	SOAKED IN DISINFECTANT SOLUTION AND THEN BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 01 BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAKED IN DISINFECTANT . . . . . 02 BRUSH SCRUBBED WITH SOAP AND WATER ONLY . . . . . 03 SOAKED IN DISINFECTANT, NOT BRUSH SCRUBBED . . . . . 04 CLEAN WITH SOAP AND WATER, NOT BRUSH SCRUBBED . . . . . 05 OTHER _____ (SPECIFY) 96 NO EQUIPMENT EVER REUSED . . . . . 07 → 155 DON'T DECONTAMINATE IN FACILITY . . . . 95 → 151	
150	Are there written guidelines for how to decontaminate equipment? IF YES, ASK: May I see them?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
151	What is the ***final method*** commonly used for disinfecting or sterilizing medical equipment (such as surgical instruments) before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE METHOD(S) USED FOR METAL EQUIPMENT SUCH AS SPECULUMS OR FORCEPS.	DRY-HEAT STERILIZATION . . . . . A AUTOCLAVING . . . . . B BOILING . . . . . C STEAM STERILIZATION . . . . . D CHEMICAL METHOD . . . . . E PROCESSED OUTSIDE FACILITY . . . . . F → 153(6) OTHER _____ (SPECIFY) X NONE . . . . . Y → 153(6)	

152 ASK IF EACH OF THE INDICATED ITEMS BELOW IS AVAILABLE, AND IF SO, ASK TO SEE IT AND IF IT IS **FUNCTIONING OR NOT (IF RELEVANT)**

	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Electric autoclave (PRESSURE AND WET HEAT)	1 → b	2 → b	3 → 02	8 → 02	1	2	8
02	Non-electric autoclave (PRESSURE/WET HEAT)	1 → b	2 → b	3 → 03	8 → 03	1	2	8
03	Electric dry heat sterilizer°	1 → b	2 → b	3 → 04	8 → 04	1	2	8
04	Electric boiler or steamer (no pressure)	1 → b	2 → b	3 → 05	8 → 05	1	2	8
05	Non-electric pot with cover (FOR STEAM/ BOIL)	1	2	3	8			
06	Heat source for non-electric equipment (STOVE OR COOKER)	1 → b	2 → b	3 → 07	8 → 07	1	2	8
07	Automatic timer (MAY BE ON EQUIPMENT)	1 → b	2 → b	3 → 08	8 → 08	1	2	8
08	TST Indicator strips or other item that indicates when sterilization is complete.	1	2	3	8			
09	Written protocols or guidelines for sterilization of disinfection	1	2	3	8			

153 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED

		(1) Dry heat sterilization	(2) Autoclave (steam with pressure)	(3) Boil	(4) Steam High Level Disinfection (HLD)	(5) Chemical High Level Disinfection (HLD)	(6) Initial decontamination
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 → 6	USED . . . . . 1 NOT USED . . 2 → 154
B	Temperature (centigrade)	TEMPERATURE AUTOMATIC . . . . 666 DON'T KNOW . . . 998	TEMPERATURE AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
C	Pressure		PRESS-URE AUTOMATIC 666 → 2E DON'T KNOW 998 → 2E				
D	Units of pressure		UNITS OF PRESSURE: KG/SQ CM . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4				
E	Minutes-when equipment is not wrapped in cloth	MINUTES AUTOMATIC . . . . 666 DON'T KNOW . . . 998	MINUTES AUTOMATIC . . . . . 666 NOT USED. . . . . 995 DON'T KNOW 998	MINUTES DON'T KNOW . . . 998	MINUTES DON'T KNOW . . . 998	MINUTES DON'T KNOW . . . 998	MINUTES DON'T KNOW . . . 998
F	Minutes when equipment is wrapped		MINUTES WRAPPED AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
G	Chemical disinfectant used					ALCOHOL. . . . . 01 BETADINE . . . . . 02 CHLORINE. . . . . 03 CIDEX . . . . . 04 FORMALDEHYDE. . . . 05 GLUTERALDEHYDE. . 06 DON'T KNOW. 98	ALCOHOL. . . . . 01 BETADINE . . . . . 02 CHLORINE. . . . . 03 CIDEX . . . . . 04 FORMALDEHYDE. . 05 GLUTERALDEHYDE 06 NO CHEMICAL . . . . 07 DON'T KNOW. 98
H	Formulation					LIQUID . . . . . 1 POWDER . . . . . 2 TABLET 3	LIQUID . . . . . 1 POWDER . . . . . 2 TABLET 3
I	Percent CHEMICAL before dilution					PERCENT DON'T KNOW . . 998	PERCENT DON'T KNOW . . 998
J	Mixture, parts solution and water					MIXTURE PARTS/LIQUID a) DISINFECTANT b) WATER DK 998	MIXTURE PARTS/LIQUID a) DISINFECTANT b) WATER DK 998

NO.	QUESTIONS	CODING CATEGORIES				GO TO
154	ASK TO SEE WHERE PROCESSED EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED PRIOR TO REUSE. INDICATE FOR EACH OF THE BELOW IF THIS STORAGE PRACTICE WAS OBSERVED OR REPORTED.	STORAGE CONDITIONS				
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile paper, sealed with tape	1	2	3	8	
02	Stored in sterile container with lid that clasps shut	1	2	3	8	
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8	
04	On tray, covered with cloth or wrapped w/out sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other sterile storage	1	2	3	8	
07	Other Non-sterile Storage	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
154A	IS THE STORAGE AREA DRY AND CLEAN?	YES . . . . . 1 NO 2				
	WASTE DISPOSAL					
155	Now I would like to ask you a few questions about the waste disposal practices for sharps waste, such as needles or blades. How does this facility ***finally*** dispose of sharps waste, or, what is the final disposal process for filled sharps boxes in this facility?	**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** (SPECIFY) 96 NEVER HAVE SHARPS WASTE 95				→ 156
155A	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 WASTE IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF NOT APPLICABLE, CIRCLE '8'.	WASTE VISIBLE, ***NOT*** PROTECTED . . . . . 1 WASTE VISIBLE, BUT PROTECTED . . . . . 2 NO WASTE VISIBLE . . . . . 3 WASTE SITE NOT INSPECTED 8				
155B	CHECK **Q155:** IS 09 OR **10** OR **11** CIRCLED (ANY SHARPS WASTE REMOVED OFFSITE FOR DISPOSAL?) YES ☐ NO ☐ →					156
155C	How is the sharps waste that is collected and removed offsite finally disposed?	INCINERATED . . . . . 1 **TAKEN TO LOCAL DUMP:** BURNED AND NOT BURRIED 2 BURNED AND BURRIED . . . 3 BURIED BUT NOT BURNED . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
156	Now I would like to ask you a few questions about the waste disposal practices for medical waste other than sharps, such as used bandages How does this facility ***finally*** dispose of medical waste other than sharps boxes?	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** (SPECIFY) 96 NEVER HAVE OTHER MEDICAL WASTE. . . . 95	→ 156D → 156D
156A	ASK TO SEE THE PLACE USED BY THIS FACILITY FOR DISPOSAL OF MEDICAL WASTE AND INDICATE THE CONDITION OBSERVED. IF WASTE IS DISPOSED OFF-SITE, OBSERVE THE SITE WHERE WASTE IS STORED PRIOR TO COLLECTION FOR OFF-SITE DISPOSAL. IF NOT APPLICABLE, CIRCLE '8'.	WASTE VISIBLE, ***NOT*** PROTECTED . . . . . 1 WASTE VISIBLE, BUT PROTECTED . . . . . 2 NO WASTE VISIBLE . . . . . 3 WASTE SITE NOT INSPECTED 8	
156B	CHECK **Q156:** IS **10** OR **11** OR **12** CIRCLED (ANY MEDICAL WASTE REMOVED OFFSITE FOR DISPOSAL?) YES ☐ NO ☐ →		156D
156C	How is the medical waste that is collected and removed offsite finally disposed?	INCINERATED. . . . . 1 **TAKEN TO LOCAL DUMP:** BURNED. . . . . 2 BURNED AND BURIED ..... 3 BURNED BUT NOT BURIED. . . . . 4 BURIED UNBURNED. . . . . 5 OTHER _____ (SPECIFY) 6 DON'T KNOW. 8	
156D	Is there a waiting area for clients where they are protected from sun and rain?	YES . . . . . 1 NO 2	
156E	Is there a toilet (latrine) in functioning condition that is available for clients to use?	YES . . . . . 1 NO 2	

157	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	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2
04	**WALLS:** REASONABLY CLEAN	1	2
05	**DOORS:** NO (OR MINOR) DAMAGE	1	2
06	**WALLS:** NO (OR MINOR) DAMAGE	1	2
07	**ROOF:** NO (OR MINOR) DAMAGE	1	2

NO.	QUESTIONS	CODING CATEGORIES	GO TO
08	**CEILING:** NO (OR LITTLE) WATER STAINS/DAMAGE	1 2	
09	NEEDLES, SHARPS OUTSIDE SHARPS BOX	1 2	
10	SHARPS BOX OVERFLOWING OR TORN/PIERCED	1 2	
11	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED	1 2	

AT THIS POINT, FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR, OR MOST KNOWLEDGEABLE ABOUT CLINICAL SERVICES, PARTICULARLY HIV/AIDS SERVICES IN THE FACILITY.

IF THE PROVIDER IS DIFFERENT FROM THE PREVIOUS RESPONDENT, INTRODUCE YOURSELF AND EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT CLINICAL SERVICES, PARTICULARLY HIV/AIDS-RELATED SERVICES, IN THE FACILITY.

NO.	QUESTIONS	CODING CATEGORIES	GO TO
158	Before proceeding, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this unit who are present today. Please give me the names and main service responsibility of this staff assigned to this unit, and present today, who provide any HIV/AIDS care and support services or services for TB, malaria, or STIs. COMPLETE THE STAFF LIST FOR THIS UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	
159	Now I want to know about any services for diagnosis and treatment. For each service I will mention, please tell me if providers assigned to this unit ever provide the service, refer clients for the service, or never offer the service at all.	**SERVICE OFFERED IN THIS FACILITY**: PROVIDE SERVICE THIS UNIT; SERVICE BY PROVIDERS FROM OTHER UNIT IN THIS FACILITY. **NO SERVICE THIS FACILITY**: REFER CLIENTS OUTSIDE FACILITY; NO SERVICE OR REFERRAL	
01	Do providers assigned to this unit prescribe treatment for malaria?	1 2 3 4	
02	Do providers assigned to this unit prescribe treatment for sexually transmitted infections (STI)?	1 2 3 4	161
160	Are all STI clients seen in this facility referred for HIV testing? IF YES, ASK: Are all of them routinely referred for the HIV testing?	YES, ROUTINELY . . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV +VE . . . . . 2 NO HIV TESTING REFERRAL FOR STI CLIENTS . . . . . 3 DON'T KNOW 8	
161	Are there any guidelines or protocols/policy for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see **all** the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2	→ 165

NO.	QUESTIONS	CODING CATEGORIES			GO TO
162	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	National guidelines for universal precautions	1 → b	2 → 02	3 → 02	
02	National guidelines for the management of malaria	1 → b	2 → 163	3 → 163	
163	**Other than the previously mentioned national** guidelines, are there any other protocols or guidelines available?	YES, OTHER PROTOCOLS/ GUIDELINES . . . . . 1 NO OTHER PROTOCOLS/GUIDELINES . . . 2			→ 165
164	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	Other protocols/guidelines for infection control?	1 → b	2 → 02	3 → 02	
02	Other protocols/guidelines for diagnosis or treatment of sexually transmitted infections?	1 → b	2 → 03	3 → 03	
03	Other protocols/guidelines or management of STIs?	1 → b	2 → 04	3 → 04	
04	Other protocols/guidelines for diagnosis or treatment of malaria?	1 → b	2 → 05	3 → 05	
05	Protocols/guidelines for intermittent preventive treatment (IPT) for malaria, during pregnancy?	1 → b	2 → 06	3 → 05	
06	Protocols/guidelines for routinely offering HIV tests to all STI clients?	1 → b	2 → 07	3 → 07	
07	Any guidelines for post-exposure prophylaxis (PEP)?	1 → b	2 → 165	3 → 165	

NO.	QUESTIONS	CODING CATEGORIES					GO TO
165	Now I would like to know whether providers assigned to this facility ever provide any **curative** care for illnesses that may be HIV/AIDS-related (such as opportunistic infections), or provide or refer the clients for **counselling** or **social support** services for help in living with HIV/AIDS.						
	For each service I will mention, please tell me if providers in this unit personally provide the service, refer clients for the service either within this facility or outside, or do not offer the service at all. Do providers in this unit personally: [READ EACH TOPIC BELOW]	SERVICE OFFERED IN THIS FACILITY			REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL	
		PROVIDE SERVICE THIS UNIT	REFER TO OTHER OUT PATIENT	INPATIENT SERVICE ONLY			
01	Prescribe treatment for any opportunistic infections or symptoms related to HIV/AIDS? This includes treating topical fungal infections.	1	2	3	4	5	
02	Provide systemic intravenous treatment of specific fungal infections such as cryptococcal meningitis?	1	2	3	4	5	
03	Provide treatment for Kaposi's sarcoma?	1	2	3	4	5	
04	Provide or prescribe palliative care for patients, such as symptom or pain management, or nursing care for the terminally ill or severely debilitated client? [HOSPICE CARE]	1	2	3	4	5	
05	Provide nutritional rehabilitation services? By this I mean providing client education and providing nutritional supplements?	1	2	3	4	5	
06	Prescribe or provide fortified protein supplementation (FPS)?	1	2	3	4	5	
07	Care for paediatric HIV/AIDS patients?	1	2	3	4	5	
166	Next I want to ask about **preventive** services that are sometimes provided to people with HIV/AIDS. For each service I mention, tell me if every HIV +ve client - is offered the service regardless of their condition (i.e., routinely offered) - is offered the service based on their condition (i.e., sometimes or selectively) - is never offered the service IF OFFERED, ASK: Is the preventive service offered in this unit, or is the client referred elsewhere to receive the service?	PROVIDE THE SERVICE IN THIS UNIT		REFER CLIENTS FOR THE SERVICE		NEVER OFFER SERVICE	
		ROUTINELY, FOR ALL HIV/AIDS CLIENTS	SOMETIMES/ SELECTIVELY	ROUTINELY, FOR ALL HIV/AIDS CLIENTS	SOMETIMES/ SELECTIVELY		
01	Testing or screening for tuberculosis?	1	2	3	4	5	
02	Preventive treatment for TB (INH + Pyridoxine)	1	2	3	4	5	
03	Primary preventive treatment for opportunistic infections such as Cotrimoxazole preventive treatment (CPT)	1	2	3	4	5	
04	Provide or prescribe micronutrient supplementation such as vitamins or iron?	1	2	3	4	5	
05	Advise clients about using family planning services for health reasons related to HIV/AIDS?	1	2	3	4	5	
06	Screening for other STIs	1	2	3	4	5	
07	Provide condoms for preventing further transmission of HIV/AIDS?	1	2	3	4	5	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
167	CHECK **166.03:** IS "1" OR "2" OR "3" OR "4" CIRCLED FOR PREVENTIVE TREATMENT FOR OIs? YES ☐ ↓ NO ☐ →		169
168	Is there any records of clients receiving CPT? IF YES, ASK TO SEE THE RECORDS AND INDICATE IF CLIENT SEX IS RECORDED	YES, OBSERVED, SEX RECORDED . . . . . 01 YES, OBSERVED, SEX NOT RECORDED . . . . . 02 RECORD REPORTED, NOT SEEN . . . . . 03 ONLY RECORDED IN INDIVIDUAL CLIENT CHART 04 INFORMATION NOT RECORDED 05	
169	CHECK **166.02**: IS "1" OR "2" OR "3" OR "4" CIRCLED FOR PREVENTIVE TREATMENT FOR TB? YES ☐ ↓ NO ☐ →		171
170	Is there any records of clients receiving Isoniazid (INH) for TB preventive Treatment? IF YES, ASK TO SEE THE RECORDS AND INDICATE IF CLIENT SEX IS RECORDED	YES, OBSERVED, SEX RECORDED . . . . . 01 YES, OBSERVED, SEX NOT RECORDED . . . . . 02 RECORD REPORTED, NOT SEEN . . . . . 03 ONLY RECORDED IN INDIVIDUAL CLIENT CHART 04 INFORMATION NOT RECORDED 05	
171	Other than the protocols and guidelines we have already seen, do you have any other written materials specific to HIV/AIDS services?	YES. . . . . 1 NO. 2	→173

172	IF YES, ASK TO SEE THE MATERIALS AND CHECK TO SEE IF ANY OF THE TOPICS BELOW ARE INCLUDED IN THESE OTHER PROTOCOLS/GUIDELINES	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	Other protocols/guidelines for the clinical management of HIV/AIDS infection in adults	1 → b	2 → 02	3 → 02	
02	Other protocols/guidelines for management of opportunistic infections in adults.	1 → b	2 → 03	3 → 03	
03	Other protocols/guidelines for the clinical management of HIV/AIDS infection in children	1 → b	2 → 04	3 → 04	
04	Protocols/guidelines on micronutrient supplementation	1 → b	2 → 05	3 → 05	
05	Protocols/guidelines on advanced nutritional support, such as fortified protein supplement to treat or prevent severe malnutrition?	1 → b	2 → 06	3 → 06	
06	Protocols/guidelines on provision of symptomatic or palliative care?	1 → b	2 → 07	3 → 07	
07	Protocols/guidelines on preventive therapy other than TB, such as cotrimoxazole to prevent pneumonia?	1 → b	2 → 08	3 → 08	
08	Protocols/guidelines on preventive therapy for tuberculosis (INH/Pyridoxine)	1 → b	2 → 09	3 → 09	
09	Other protocols/guidelines on community or home-based care for HIV/AIDS clients	1 → b	2 → 173	3 → 173	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
173	I want to ask about various support services that are commonly needed by people with HIV/AIDS. For each service I will ask about, please tell me if providers in this unit provide the service themselves, or if they refer clients for the service. IF YES FOR REFERRAL, PROBE FOR WHETHER THERE IS A WRITTEN DOCUMENT LISTING THE REFERRAL SITE OR IF THE PROVIDER CAN NAME A SPECIFIC REFERRAL SITE FOR THE SERVICE IN QUESTION.	YES, SERVICE IS AVAILABLE IN FACILITY OR THROUGH OUTREACH BY THIS FACILITY	YES, SERVICE PROVIDED THROUGH REFERRAL			NO SERVICE OR REFERRAL
			REFERRAL SITE OBSERVED ON WRITTEN LIST	REFERRAL LIST NOT SEEN. PROVIDER: CAN NAME SPECIFIC REFERRAL SITE FOR SERVICE	REFERRAL LIST NOT SEEN. PROVIDER: CANNOT NAME SITE	
01	Home-based care services for people living with HIV/AIDS, and their families?	1	2	3	4	5
02	Support group for people living with HIV/AIDS (PLWHA)?	1	2	3	4	5
03	Emotional/spiritual support for clients and/or family?	1	2	3	4	5
04	Support for orphans or other vulnerable children?	1	2	3	4	5
05	Social support, such as food, material, income generating projects and fee exemption for PLWHA and their families?	1	2	3	4	5
06	Legal services?	1	2	3	4	5
07	Counselling or health education for prevention of transmission of HIV/AIDS?	1	2	3	4	5
08	Education on HIV care for patients and their families?	1	2	3	4	5
09	Involve or refer to other services such as herbalist, acupuncture, traditional	1	2	3	4	5
10	Provide or refer providers of HIV/AIDS services for emotional/spiritual support? (i.e., Couselling supervision meetings)	1	2	3	4	5

174	Is there a record maintained of client referrals outside this unit? IF YES, ASK TO SEE DOCUMENTS WHERE REFERRALS ARE RECORDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 RECORDED ON CLIENT CHART ONLY 3 NO . . . . . 4 NO, NEVER REFER IN OR OUTSIDE FACILI . . . 5	→ 178
175	When you refer a client **to another unit** within the facility for services, do you use a pre-printed form, a note or a verbal report that specifies information about the client that should be shared? IF PRE-PRINTED, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN. . . . . 1 YES, REPORTED, NOT SEEN. . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD. . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER. . 4 VERBAL REPORT OR ACCOMPANIES CLIENT. . . . . 5 OTHER (SPECIFY) _____ 6 NEVER REFER WITHIN FACILITY. . . . . 7 DON'T KNOW. 8	
176	When you refer a client **to another facility** for services, do you use a pre-printed form, a note or a verbal report that specifies information about the client that should be shared? IF PRE-PRINTED, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN. . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT. . . . . 5 OTHER (SPECIFY) _____ 6 NEVER REFER OUTSIDE FACILITY . . . . 7 DON'T KNOW 8	→ 178

NO.	QUESTIONS	CODING CATEGORIES	GO TO
177	Is there any system for providing or receiving feedback for referrals made by or received by this facility? PROBE TO DETERMINE IF FEEDBACK IS EVER RECEIVED OR PROVIDED. ASK TO SEE DOCUMENTATION THAT SHOWS FEEDBACK HAS BEEN PROVIDED OR RECEIVED. CIRCLE ALL THAT APPLY.	YES, RECEIVE FEEDBACK, DOCUMENTATION OBSERVED . . . . . A YES, PROVIDE FEEDBACK DOCUMENTATION OBSERVED . . . . . B REPORTED SYSTEM, BUT NO DOCUMENTATION OBSERVED . . . . . C PROVIDE FEEDBACK ONLY IF REQUESTED BY PROVIDER D NO FEEDBACK FOR REFERRALS . . . . . Y	
178	Do you have a system for making individual client appointments for HIV/AIDS clients? IF YES, ASK TO SEE ANY EVIDENCE THAT THE SYSTEM FUNCTIONS	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
178A	CHECK 165: IS "1", "2" OR "3" CIRCLED? FOR SERVICES OFFERED IN THE FACILITY. YES ☐ NO ☐		→ 182
179	Are reports regularly compiled on the number of client visits to this unit or facility seeking treatment?	YES . . . . . 1 NO 2	→182
180	How frequently are the compiled reports submitted to someone outside of this unit or facility?	MONTHLY OR MORE OFTEN . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5	→182
181	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK. . . . . A FACILITY DIRECTOR/SUPERVISOR. . . . . B DISTRICT LEVEL. . . . . C PROVINCIAL LEVEL. . . . . D NATIONAL LEVEL . . . . . E DONOR AGENCY. . . . . F OTHER _____ X (SPECIFY)	
182	Now I want to ask you about post-exposure prophylaxis (PEP) for people who may have been exposed to HIV/AIDS. Is PEP available to staff in this facility? IF YES, ASK: Do providers in this unit prescribe the PEP or refer staff for PEP?	YES, PEP PRESCRIBED/STAFF REFERRED BY THIS UNIT . . . . . 1 YES, PEP PRESCRIBED/REFERRED IN OTHER UNIT THIS FACILITY . . . . . 2 YES, PEP PRESCRIBED/REFERRED IN THIS AND OTHER UNIT IN FACILITY 3 YES, STAFF CAN RECEIVE PEP FROM OTHER FACILITY IF DESIRED 4 NO ACCESS TO PEP 5	→189A →189A
183	Is there a register or record maintained in this facility for workers who have been prescribed PEP or have been referred for PEP? IF YES, ASK: May I see the register/record? IF REGISTER IS AVAILABLE ONLY IN ANOTHER LOCATION, GO TO THAT LOCATION AND CHECK THE REGISTER TO SEE WHICH INFORMATION IS AVAILABLE. CIRCLE THE CORRECT LETTER FOR EACH PIECE OF INFORMATION THAT IS RECORDED.	YES, REFERRED FOR PEP . . . . . A YES, RECEIVED PRE-PEP HIV TEST . . B YES, RECEIVED PEP ARV DRUGS . . C YES, RECEIVED POST-PEP HIV TEST D YES, RECORD NOT AVAILABLE E NO, INFORMATION RECORDED IN INDIVIDUAL HEALTH RECORD ONLY F NO RECORD FOR PEP . . . . . Y	
184	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . 2 NO 3	
185	What is the PEP regimen that is most commonly prescribed by providers in this facility? (1 OR 2 FOR LOW RISK; 3 OR 4 FOR HIGH RISK)	AZT + 3TC . . . . . 1 TDF + 3TC (FOR NO TOLERANCE OF AZT) 2 AZT + 3TC ***plus*** EFAVIRENZ ***or*** LOPINAVIR . . . 3 AZT + 3TC ***plus*** INDINAVIR ***or*** NELFINAVIR . . . 4 OTHER (SPECIFY) _____ 6	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
186	Are any PEP medicines stored in this unit or any other location in facility? IF YES, ASK TO SEE THE PEP MEDICINES	YES, THIS UNIT . . . . . A YES, OTHER LOCATION IN FACILITY B NO . . . . . Y	→189A
187	RECORD WHICH MEDICINES ARE PRESENT FOR PEP (SELECT THIS UNIT IF IN SEVERAL LOCATIONS)	ZIDOVUDINE (AZT) . . . . . A LAMIVUDINE (3TC) . . . . . B TENOFOVIR (TDF) . . . . . C EFAVIRENZ (EFV) . . . . . D LOPINAVIR (LPV) . . . . . E INDINAVIR (IDV) . . . . . F NELVINAVIR (NFV) . . . . . G OTHER(S) _____ H (SPECIFY)	
188	DESCRIBE THE STORAGE OF THE PEP MEDICINES. ARE THE PEP MEDICINES STORED SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE . . . . . 1 STORED WITH OTHER ARVS/APART FROM OTHER MEDICINES . . . . . 2 STORED WITH NON-ARV MEDS . . . . . 3 OTHER _____ 6 (SPECIFY)	
189	DESCRIBE THE SECURITY FOR THE PEP MEDICINES.	LOCKED APART FROM OTHER MEDS AND ARVS . . . . . 1 LOCKED, LIMITED ACCESS SITE . . 2 UNLOCKED OR NO LIMITED ACCESS . . 3	
189A	**ASK TO SEE THE AREA(S) IN THIS UNIT WHERE MOST CLIENTS ARE EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR THE SAME PURPOSE, <u>RANDOMLY</u> PICK ONE TO ASSESS.**		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN **Q190**, INDICATE WHICH SECTION THE DATA ARE RECORDED	CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1822] . . . . . 18 NOT PREVIOUSLY SEEN 19	191

NO.	QUESTIONS	CODING CATEGORIES			GO TO
190	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	AVAILABILITY			
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3	
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1	2	3	
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3	
13	DISPOSABLE NON-LATEX GLOVES	1	2	3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
15	DISPOSABLE NEEDLES	1	2	3	
16	AUTO-DISABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
17	DISPOSABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
18	PRIVATE ROOM	1 → 21	2	3	
19	AUDITORY PRIVACY	1	2	3	
20	VISUAL PRIVACY	1	2	3	
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	MALE CIRCUMCISION		
191	Is this facility part of the National Voluntary male medical circumcision program	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
191A	Do providers in this facility perform male medical circumcision? IF YES, ASK: Is the circumcision performed for children only, adults only, or for both children or adults?	CHILDREN ONLY. . . . . 1 ADULTS ONLY. . . . . 2 BOTH CHILDREN AND ADULTS. . . . . 3 NO MALE CIRCUMCISION. . . . . 4 DON'T KNOW. 8	→ 192 → 192
191B	Is there a fee for the male circumcision? IF YES, ASK: Please tell me the amount of the fee. If the fee varies for children and adult circumcision, please tell me the fee for ***adult*** male circumcision.	YES: 1 AMOUNT OF FEE IN KSH **[99998 IF FEE NOT KNOWN]**: ☐☐☐☐☐☐ NO: 2 DK: 8	
191C	Does this facility have a health worker who can perform male circumcision present in the facility or on call 24 hours a day? IF YES, ASK TO SEE A SCHEDULE	YES, PRESENT, SCHEDULE OBSERVED. . . . . 1 YES, PRESENT, SCHEDULE REPORTED BUT NOT SEEN. . . . . 2 YES, ON CALL, SCHEDULE OBSERVED. . . . . 3 YES, ON CALL, SCHEDULE REPORTED BUT NOT SEEN. . . . . 4 NO. 5	
191D	Is there a register where male circumcision data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED. . . . . 1 YES, REPORTED NOT SEEN. . . . . 2 NO RECORD MAINTAINED. 3	→192 →192
191E	RECORD THE TOTAL NUMBER OF MALE CIRCUMCISIONS AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS	NUMBER OF CIRCUMCISIONS ☐☐☐☐☐ DON'T KNOW 99998	
191F	RECORD THE NUMBER OF <u>ADULT</u> (14 +) MALE CIRCUMCISIONS AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS	NUMBER OF CIRCUMCISIONS ☐☐☐☐☐ DON'T KNOW 99998	
191G	RECORD THE NUMBER OF MONTHS OF DATA PRESENTED IN Q191E+Q191F FOR MALE CIRCUMCISIONS	MONTHS OF DATA. . . . . ☐☐ DON'T KNOW 98	
	MALE REPRODUCTIVE HEALTH SERVICES		
192	Do providers in this facility provide male reproductive health services, such as male infertility treatment, male family planning and STIs? IF YES, ASK: What male reproductive health services are provided by providers in this facility? PROBE: Anything else?	INFERTILITY TREATMENT. . . . . A FAMILY PLANNING. . . . . B DIAGNOSIS AND TREATMENT OF STIs. . . . . C SCREENING FOR PROSTATE CANCER. . . . . D OTHER: _____ X (SPECIFY) NO MALE RH SERVICES. . . . . Y	
	ELDER CARE		
193	Does this facility provide any services geared toward the elderly?	YES. . . . . 1 NO. 2	
194	Does this facility have the surgical capacity for cataract removal?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT		

2a. Vaccine Logistical System

Facility number: | | | | | | **Interviewer Code** | | |

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
200	Now I would like to find out about immunisation services provided to children or women (including pregnant women) either by or at your facility. Are any immunisation services provided, either as outreach or at the facility itself? IF YES: ASK: Do you provide immunisations for children only, for women only, or for both children and women?	YES, CHILDREN ONLY. . . . . 1 YES, WOMEN ONLY. . . . . 2 BOTH CHILDREN AND WOMEN. . . . . 3 NO IMMUNISATION SERVICES. 4	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF IMMUNISATION SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q201.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be be recorded or shared. Information about your facility 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 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 these 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 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
(Indicates respondent's willingness to participate)

DAY		MONTH		YEAR			
				2	0	1	0

201	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**
202	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?	YES, STORES VACCINES. . . . . 1 NOT NOW, REFRIGERATOR BROKEN. . . . . 2 STORES NO VACCINES. 3	→ 213 → 216
203	ASK TO GO WHERE VACCINES ARE STORED, AND EXPLAIN: I want to find out about your system for keeping vaccines. What type of equipment do you usually use to store your vaccines? CIRCLE ALL THAT APPLY	ELECTRIC REFRIGERATOR. . . . . A KEROSENE REFRIGERATOR. . . . . B GAS REFRIGERATOR. . . . . C SOLAR REFRIGERATOR. . . . . D OTHER_____ X (SPECIFY)	
204	ASK TO SEE THE REFRIGERATOR OR STORAGE EQUIPMENT AND TO BE ALLOWED TO READ THE TEMPERATURE INSIDE THE EQUIPMENT. INDICATE THE TEMPERATURE INSIDE THE REFRIGERATOR OR EQUIPMENT.	TEMPERATURE IN CENTIGRADE	
		NOT OBSERVED. 94	→ 206
		THERMOMETER NOT FUNCTIONING. 95	→ 206
		NO THERMOMETER. 96	→ 206

205	INDICATE WHETHER TEMPERATURE INSIDE COOLING UNIT IS ABOVE OR BELOW 0 (ZERO) DEGREES CENTIGRADE. FOR 0 DEGREES, CIRCLE 1.	ZERO OR POSITIVE (+) . . . . . 1 NEGATIVE (-) 2	
206	Do you have a cold-chain temperature-monitoring chart? IF YES, ASK: May I see it?:	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 208 → 208
207	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	
208	INDICATE WHETHER THE REFRIGERATOR OR STORAGE EQUIPMENT IS PROTECTED FROM DIRECT SUNLIGHT.	YES . . . . . 1 NO 2	

209 VALIDATION OF VACCINES

GO TO THE MAIN AREA WHERE VACCINES ARE STORED. ASK IF THE ITEMS LISTED ARE STOCKED/CARRIED IN THE FACILITY. IF YES, THEN PROCEED TO COLLECT INFORMATION ON EACH ITEM IN COLUMNS B-G.

	PRODUCT	A IS PRODUCT NORMALLY CARRIED OR STOCKED IN FACILITY 1=YES 2=YES BUT NOT TODAY 3=NO **IF 2 OR 3, SKIP TO NEXT ITEM**	B UNIT OF MEASURE 1=TAB/CAPS 2=VIALS 3=AMPOULES 4=PACKS 5=NA	C STOCK CARD OR LEDGER AVAILABLE 1=YES 2=NO	D VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY 1=YES,ALL UNITS 2=YES,ON SOME UNITS 3="NO UNITS" 5=NA	E ITEMS STORED BY DATE OF EXPIRATION **(FEFO)** 1=YES 2=NO 5=NA	F ITEMS ARRANGED BY VACCINE VIAL MONITOR (VVM) 1=YES 2=NO 5=NA	G STOCK OUT DURING PAST 6 MONTHS 1=YES 2=NO 8=DK
01	Tetanus Toxoid	☐	☐	☐	☐	☐	☐	☐
02	BCG and diluent	☐	☐	☐	☐	☐	☐	☐
03	Oral Polio Virus (OPV)	☐	☐	☐	☐	☐	☐	☐
04	Pentavalent	☐	☐	☐	☐	☐	☐	☐
05	DPT	☐	☐	☐	☐	☐	☐	☐
06	Measles vaccine and Diluent	☐	☐	☐	☐	☐	☐	☐
07	Anti-rabies vaccine	☐	☐	☐	☐	☐	☐	☐
08	Yellow Fever vaccine	☐	☐	☐	☐	☐	☐	☐
09	Anti-snake venom	☐	☐	☐	☐	☐	☐	☐
10	Vitamin A (NOT A FRIDGE ITEM)	☐	☐	☐	☐	☐	■	☐

210	CHECK 209(C). IS A STOCK CARD OR LEDGER AVAILABLE FOR ANY OF THE VACCINES? YES ☐ NO ☐ →		212
211	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM USED TO MONITOR THE AMOUNT OF VACCINE RECEIVED, THE AMOUNT ISSUED, AND THE AMOUNT PRESENT TODAY.	LEDGER/STOCK CARD NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED VACCINES. . . . . 1 LEDGER/STOCK CARD UPDATED DAILY. . . . . 2 OTHER SYSTEM _____ 6 (SPECIFY)	
212	When was the last time that you received a scheduled supply of vaccines? (i.e., from the main order and not interim order)	WITHIN PRIOR 4 FULL WEEKS. . . . . 1 BETWEEN 4-12 WEEKS. . . . . 2 MORE THAN 12 WEEKS AGO. . . . . 3 NO ROUTINE SUPPLY SYSTEM. . . . . 4 DON'T KNOW 8	
213	Does this facility determine the quantity of vaccines required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DIFFER BY VACCINE). . . . . 3 DON'T KNOW 8	 →216 →216
214	Routinely, when you order vaccines, which best describes the system you use to determine ***how much*** of each to order? Do you: - **Review** the amount of each vaccine remaining, and order to bring the stock amount to a pre-determined (fixed) amount (max stock level)? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each vaccine used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY) - Don't know	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
215	During the past 6 months, have you always, sometimes, or almost never received the amount of vaccine that you ordered (or that you were supposed to routinely receive)?	ALWAYS ..... 1 SOMETIMES ..... 2 ALMOST NEVER 3	
216	How many vaccine carriers do you have available?	ONE . . . . . 1 TWO OR MORE . . . . . 2 NONE 3	 →218
217	Are there ice packs for the vaccine carriers (four or five per carrier)? NOTE: 4-5 ICE PACKS=1 SET FOR A VACCINE CARRIER.	YES, ONE SET. . . . . 1 YES, TWO OR MORE SETS. . . . . 2 NO, USE PURCHASED ICE. . . . . 3 NO 4	
218	What type of <u>*injection equipment*</u> (i.e., syringes and needles) is used during routine immunization sessions at this facility?	DISPOSABLE NEEDLES AND SYRINGES, NOT AUTO-DESTRUCT. . . . . A DISPOSABLE NEEDLES AND SYRINGES, AUTO-DESTRUCT. . . . . B RE-USEABLE GLASS + METAL. . . . . C OTHER _____ X (SPECIFY)	
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.		

2b. Child Health Services

Facility number: | | | | | | **Interviewer Code:** | |

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
230	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis?	YES . . . . . 1 NO 2	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF CURATIVE CHILD HEALTH SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q231.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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
(Indicates respondent's willingness to participate)

				2	0	1	0
DAY		MONTH		YEAR			

231	May I begin the interview?	YES . . . . . 1 NO 2	→ **STOP**

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
232	Now I would like to ask you specifically about 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 outreach services are provided (if any).*		

	CHILD HEALTH 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 THROUGH OUTREACH (VILLAGE LEVEL) ACTIVITIES
01	Routine DPT-Hib+HepB immunisation (i.e., Pentavalent)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
02	Routine DPT immunization	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
03	Routine polio immunization	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
04	Routine measles immunization	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
05	BCG immunisations	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
06	Routine Vitamin A supplementation	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
07	Provision of treated mosquito nets to children under 1 year	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
08	Consultation or curative services for a sick child	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐
09	Growth monitoring or growth promotion (where a *healthy child* is routinely weighed, has the weight charted on a growth chart, and feeding advice is given.)	# OF DAYS 00=NO SERVICE ☐☐	# OF DAYS 00=NO SERVICE ☐☐

233	CHECK 232 (01a, 02a, 03a, 04a and 05a). DOES THE FACILITY PROVIDE ANY OF THESE VACCINES AT THE FACILITY? YES ☐ NO ☐ → 245		
234	Are routine immunisations for children available at the facility today?	YES . . . . . 1 NO 2	
235	Are immunisations offered in the facility on every day that sick child consultations are provided? IF YES, ASK: Are all vaccines offered?	YES, ALL VACCINES . . . . . 1 YES, SOME VACCINES, NOT ALL . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
236	Does this facility have any routine <u>user-fees</u> or <u>charges</u> for any child immunisation services? This includes any fees, including those for registration, client health card/booklets, or vaccines?	YES . . . . . 1 NO. 2	→ 239

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
237	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for child immunisation services, and if so, the amount of the fee:	(a) FEES: YES / NO / DON'T KNOW	(b) AMOUNT IN KSH
01	Fee for child welfare card?	1→01b; 2→02; 8→02	
02	Fee for administration of vaccine?	1→02b; 2→03; 8→03	
03	Fee for syringes provided by the facility?	1→03b; 2→04; 8→04	
04	Fee for vaccines?	1→04b; 2→05; 8→05	
05	Fee for weighing child?	1→05b; 2→06; 8→06	
06	Fee for deworming child?	1→06b; 2→07; 8→07	
07	Fee for Vitamin A?	1→07b; 2→08; 8→08	
08	Are there any other elements for which user-fees or charges are routinely asked for immunisation services? IF YES, SPECIFY _____	1→08b; 2→238; 8→238	
238	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED OR DISPLAYED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	
238A	What is the procedure if a child is unable to pay for any of the fees associated with child immunization services that are indicated above?	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 PAYMENT IN-KIND. . . . . D OTHER _____ X (SPECIFY)	
239	ASK YOUR RESPONDENT TO SHOW YOU ITEMS REQUIRED FOR IMMUNISATION SERVICES	OBSERVED / REPORTED, NOT SEEN / NOT AVAILABLE / DON'T KNOW	
01	National guidelines for immunisation or circular (e.g., Performance Monitoring Handbook)	1 / 2 / 3 / 8	
02	Unused individual child immunisation cards or booklets	1 / 2 / 3 / 8	
03	Tally sheets	1 / 2 / 3 / 8	
04	Summary forms	1 / 2 / 3 / 8	
05	Permanent register for recording immunisations	1 / 2→241 / 3→241 / 8→241	
240	ASK WHEN IMMUNISATIONS WERE MOST RECENTLY PROVIDED IN THE FACILITY AND VERIFY THAT THE REGISTER IS UP-TO-DATE.	UP-TO-DATE . . . . . 1 NOT UP TO DATE 2	
241	What is the current estimate for your DPT-Hib+HepB (OR DPT) dropout rate?	DPT-Hib+HepB (or DPT) DROPOUT RATE (%) ___ NO DROPOUT RATES. . . . . 995 → 242 DON'T KNOW . . . . . 998 → 242	
241A	RECORD THE SOURCE(S) OF INFORMATION FOR % DROPOUT RATE ESTIMATES.	WRITTEN REPORT . . . . . A GRAPH/CHART . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
242	Do you have an estimate of the target population for child immunisations in the facility catchment area, that is, children under 1 year of age? IF YES: What is the target?	TARGET POPULATION ☐☐☐☐☐ NO CATCHMENT AREA DEFINED 99995 DON'T KNOW 99998	→ 245 → 245
243	What is the current estimate for your facility's measles coverage. THIS IS AN ANNUALIZED RATE	MEASLES COVERAGE (%) . . ☐☐☐ NO COVERAGE RATES. . . . . .995 DON'T KNOW 998	→ 245 → 245
244	RECORD THE SOURCE(S) OF INFORMATION FOR % COVERAGE ESTIMATES.	WRITTEN REPORT . . . . . A GRAPH/CHART . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
245	CHECK Q232(08a): DOES FACILITY PROVIDE SICK-CHILD CONSULTATIONS? YES ☐ NO ☐		→ **END**
246	Do providers in this facility provide care to sick children following the IMCI guidelines?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
247	Does this facility have any routine user-fees or charges for any services related to curative care for children under 5 years? This includes any fees, including those for registration or for client health records.	YES . . . . . 1 NO 2	→ 250

248	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for curative care for children under 5 years:	(a) FEES YES	NO	DK	(b) AMOUNT IN KSH
01	Fee for registration?	1 → 01b	2 → 02	8 → 02	☐☐☐☐
02	Fee for the child health chart or record i.e., the outpatient card or booklet?	1 → 02b	2 → 03	8 → 03	☐☐☐☐
03	Fee for the consultation service?	1 → 03b	2 → 04	8 → 04	☐☐☐☐
04	Fee for overnight stay or overnight observation?	1 → 04b	2 → 05	8 → 05	☐☐☐☐
05	Is there a different fee depending on the child's diagnosis?	1	2	8	
06	Are there fees for medications?	1	2	8	
07	Are there fees for laboratory tests?	1	2	8	
08	Fee for weighing child?	1 → 08b	2 → 09	8 → 09	☐☐☐☐
09	Fee for deworming child?	1 → 09b	2 → 10	8 → 10	☐☐☐☐
10	Are discounts, exemptions or waivers from fees allowed for some sick clients?	1	2	8	
11	Is there a system for clients to pre-pay for multiple visits for curative care?	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
249	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED OR DISPLAYED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	
249A	What is the procedure if a child is unable to pay for any of the fees associated with curative care that are indicated above?	FEE EXEMPTED/DISCOUNTED, NO PAYMENT EXPECTED. . . . . A FEE EXEMPTED/DISCOUNTED, PAYMENT EXPECTED LATER. . . B NO SERVICE, ASKED TO COME BACK WHEN ABLE TO PAY. . . . . C PAYMENT IN-KIND. . . . . D OTHER _____ X SPECIFY	
250	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 SICK CHILDREN ARE SEEN BEFORE THE CONSULTATION .	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 252 → 252

251	OBSERVE IF THE BELOW ACTIVITIES ARE BEING CONDUCTED ROUTINELY. IF NOT SEEN ASK: Is [READ ACTIVITY YOU DO NOT SEE] routinely conducted for all sick children?	OBSERVED ACTIVITY	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 immunisation status	1	2	3	8
05	Providing group health education	1	2	3	8
06	Administering paracetamol 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

252	Is there an ORT corner at the facility? IF YES, ASK TO SEE WHERE THE ORT IS PROVIDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO ORT CORNER . . . . . 3 DON'T KNOW 8	
253	Is there a routine system for a health worker other than the one who examines the child to give him or her the first dose of **prescribed** oral medication? IF YES, ASK TO SEE WHERE THE FIRST DOSE IS PROVIDED.	YES, OBSERVED CHILD RECEIVING DOSE . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO ROUTINE SYSTEM . . . . . 3 DON'T KNOW 8	
254	Does this facility use blood tests to verify the diagnosis of malaria for children under 5 years? IF YES, ASK: Is this done always or only sometimes?	ALWAYS . . . . . 1 SOMETIME . . . . . 2 NEVER . . . . . 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
255	ASK TO GO TO THE ROOM OR AREA WHERE EXAMINATIONS OF SICK CHILDREN ARE CARRIED OUT. CHECK WHETHER EACH OF THE ITEMS BELOW IS EITHER IN THE ROOM/AREA WHERE THE SERVICE IS GIVEN OR IN AN ADJACENT ROOM.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	GENERAL INFORMATION [Q190] 11 FAMILY PLANNING [Q322] . . . 13 ANTENATAL [Q429] 14 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1822] 18 NOT PREVIOUSLY SEEN 19	257

		(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3	
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1	2	3	
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3	
13	DISPOSABLE NON-LATEX GLOVES	1	2	3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
15	DISPOSABLE NEEDLES	1	2	3	
16	AUTO-DISABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
17	DISPOSABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
18	PRIVATE ROOM	→ 21	2	3	
19	AUDITORY PRIVACY	1	2	3	
20	VISUAL PRIVACY	1	2	3	
21	MACKINTOSH OR PLASTIC COVERING ANY SURFACE	1	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
257	ASK TO SEE THE FOLLOWING	(a) AVAILABILITY				(b) FUNCTIONING		
	ITEMS FOR SICK CHILD CONSULTATIONS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Infant weighing scale	1→b	2→b	3 02	8 02	1	2	8
02	Child weighing scale	1→b	2→b	3 03	8 03	1	2	8
03	Length board	1→b	2→b	3 04	8 04	1	2	8
04	Height board or stadiometer	1→b	2→b	3 05	8 05	1	2	8
05	Thermometer	1→b	2→b	3 06	8 06	1	2	8
06	Timer or watch with seconds hand	1→b	2→b	3 07	8 07	1	2	8
07	Staff has watch with seconds hand	1	2	3	8			
08	Butterfly or scalp vein 21-23g, or branula (intercath) 22-24g	1	2	3	8			
09	Intravenous fluid (5%D/NS, NS, ringers lactate (½DD or full strength Hartman's) or 5%D/W	1	2	3	8			
10	Perfusion or IV administration set	1	2	3	8			
11	Calibrated 1/2 or liter measuring jar for ORS	1	2	3	8			
12	Cup and spoon	1	2	3	8			
13	ORS PACKETS OR SACHETS	1	2	3	8			
14	At least 3 buckets (for cleaning used cups)	1	2	3	8			
15	ORT register with an entry withing past 1 month	1	2	3	8			
16	Examination Table	1	2	3	8			
258	ASK TO SEE THE FOLLOWING MATERIALS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Medical protocols or clinical guidelines for children's illnesses	1	2	3	8			
02	IMCI chart booklet	1	2	3	8			
03	IMCI mother's cards	1	2	3	8			
04	Guideline/protocol on Management of Malaria	1	2	3	8			
05	Other visual aids for teaching caretakers	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
259	Is there a patient register where information on the diagnosis for each child is written? IF YES, ASK TO SEE THE REGISTER. TO BE VALID, THE REGISTER MUST INDICATE THAT THE CHILD IS BELOW 5 YEARS OF AGE AND THE DIAGNOSIS OR MAJOR SYMPTOM.	OBSERVED, SEPARATE <5 REGISTER . . . . . 1 OBSERVED, SEPARATE <13 REGISTER . . . . . 2 OBSERVED COMBINED ADULT AND <5 REGISTER . . . . . 3 YES, REPORTED, NOT SEEN . 4 NO REGISTER 5	→ 263 → 263
260	HOW MANY DAYS AGO WAS THE LAST ENTRY MADE IN THE REGISTER? NOTE: THE DAY OF THE INTERVIEW IS DAY "0".	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . . 2	
261	RECORD THE NUMBER OF UNDER 5 SICK CHILD VISITS FOR THE PAST 12 COMPLETED MONTHS	NUMBER ☐☐☐☐☐☐ DON'T KNOW 999998	→ 263
262	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . ☐☐ DON'T KNOW 98	
263	Are individual health records maintained for sick children, i.e., child welfare card or booklet IF YES, ASK TO SEE AN UNUSED COPY.	YES, OBSERVED. . . . . 1 YES, REPORTED, NOT SEEN. . . 2 NO. 3	
264	Are curative child health services available at the facility today?	YES . . . . . 1 NO 2	
265	If a sick child today is noticed to need an immunisation, can it be provided today? IF YES, CLARIFY THE SYSTEM FOR PROVIDING THE IMMUNISATION	YES, SEND TO ROUTINE IMMUNISATION SERVICE. . . . . 1 YES, SPECIAL SYSTEM FOR IMMUNISATION FOR SICK CHILDREN. . . . . 2 NO. 3	
	THANK YOUR RESPONDENT AND MOVE TO NEXT DATA COLLECTION POINT.		

3a. Family Planning Services

Facility number: | | | | | | **Interviewer Code:** | |

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	Does this facility offer any family planning services—including clinical methods, counselling on natural family planning or surgical sterilisation?	YES . . . . . 1 NO 2	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF FAMILY PLANNING SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q302.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be be recorded or shared. Information about your facility 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 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 these 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 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
(Indicates respondent's willingness to participate)

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

301	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**
302	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	
		DON'T KNOW 98	
303	Are family planning services being offered at this facility today, from the family planning clinic/unit?	YES . . . . . 1 NO 2	
303A	Are family planning services available in other sites in this facility, such as the comprehensive care center or counseling and testing site? IF YES, ASK: Can you please name the sites that also provide family planning services in this facility?	COMPREHENSIVE CARE CENTER. . . A COUNSELING & TESTING SITE. . . . . B POST-ABORTION CARE CENTER OR SERVICE SITE. . . . . C YOUTH FRIENDLY CENTER. . . . . D OTHER _____ X NO. . . . . Z	

304	Which of the following contraceptive methods do you provide, prescribe, or counsel about in this facility?	PROVIDED	PRESCRIBED/ COUNSELLED	NOT OFF-ERED	
01	Combined oral pills	1	2	3	
02	Progestin-only pills	1	2	3	
03	Combined Injectable (1 monthly)	1	2	3	
04	Progestin-only Injectable (2 monthly)	1	2	3	
05	Progestin-only Injectable (3 monthly)	1	2	3	
06	Male condom	1	2	3	
07	Female condom (e.g. FEMIDOM)	1	2	3	
08	Intrauterine Contraceptive Device (IUCD)	1	2	3	
09	Implant	1	2	3	
10	Emergency contraceptive pill	1	2	3	
11	Natural family planning methods (e.g., Rhythm, LAM)	1	2	3	
12	Standard Days Method (SDM) - Beads	1	2	3	
13	Male sterilisation (Vasectomy)	1	2	3	
14	Female sterilisation (Tubal ligation)	1	2	3	
15	Others _____ (SPECIFY)	1	2	3	

305	Does this facility have any routine user-fees or charges for any services related to family planning? This includes any fees, including those for registration, family planning cards or booklets, lab investigations, or contraceptive methods?	YES. . . . . 1 NO. 2	→ 308

		(a) FEES			(b) AMOUNT IN KSH
306	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for family planning services, and the amount of the fee.	YES	NO	DON'T KNOW	
01	Fee for the client family planning card or booklet	1→ b	2 → 02	8 → 02	
02	Fee for the consultation service? EITHER FIRST OF FOLLOW-UP VISIT	1→ b	2 → 03	8 → 03	
03	Fee or charge for the method provided	1	2 → 05	8 → 05	
04	Is there a different fee depending on the method provided?	1	2	8	
05	Fees or charges for laboratory tests	1	2	8	
06	Fee for registration	1→ b	2 → 07	8 → 07	
07	Are discounts or exemptions from fees allowed for some clients?	1	2	8	

307	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	

308	Does this facility have a system in which observations or parameters for family planning are routinely carried out before the consultation or client examination takes place?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			→ 310 → 310
309	ASK TO SEE THE PLACE WHERE FAMILY PLANNING CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.				
	OBSERVE IF THE BELOW ACTIVITIES ARE BEING CONDUCTED ROUTINELY. IF NOT SEEN ASK: Is [READ ACTIVITY YOU DO NOT SEE] routinely conducted for all family planning clients?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Conducting group health education sessions	1	2	3	8
310	ASK TO SEE WHERE COUNSELLING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY. . . . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 AUDITORY PRIVACY ONLY. . . . . 4 NO PRIVACY. 5			
311	Are any of the following visual aids for teaching available in the waiting area/counselling room or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Samples of various family planning methods	1	2	3	8
02	Flip charts for Family Planning	1	2	3	8
03	Flip charts for STI/RTI	1	2	3	8
04	Balance counseling strategy cards	1	2	3	8
05	Family planning checklists	1	2	3	8
06	Video materials for teaching about RTIs/STIs	1	2	3	8
07	Video materials for teaching about HIV/AIDS	1	2	3	8
08	Pelvic model for demonstrating IUCD	1	2	3	8
09	Arm model for demonstrating implants	1	2	3	8
10	Model for demonstrating how to use male condoms	1	2	3	8
11	Model for demonstrating how to use female condoms	1	2	3	8
12	Posters for general promotion of family planning	1	2	3	8
13	Posters for general awareness of RTIs/STIs or HIV/AIDS	1	2	3	8
312	Are any of the following types of information booklets or pamphlets for clients to take home available in the waiting area/counselling or the examination room?				
01	Printed material about family planning	1	2	3	8
02	Printed material about RTIs/STIs	1	2	3	8
03	Printed material about HIV/AIDS	1	2	3	8

313	Are any of the following guidelines or protocols for delivery of services available in the counselling room or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Guidelines or protocols on family planning	1	2	3	8
02	National Syndromic diagnosis and treatment of STIs/RTIs (based on WHO guidelines)	1	2	3	8
03	Guidelines for HIV/FP Integration	1	2	3	8
04	National guidelines for STI/RTI diagnosis or treatment	1	2	3	8

314	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE CHOSEN METHOD AND STATUS (NEW OR CONTINUING) FOR EACH CLIENT.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN. . . . . 2 NO 3	→ 318 → 318
315	HOW MANY DAYS AGO WAS THE LAST ENTRY MADE IN THE REGISTER? NOTE: THE DAY OF THE INTERVIEW IS DAY "0".	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . . 2	
316	RECORD THE **TOTAL** NUMBER OF FAMILY PLANNING **VISITS (NEW AND CONTINUING)** DURING THE PAST 12 COMPLETED MONTHS.	TOTAL FP VISITS [ ][ ][ ][ ][ ][ ] DON'T KNOW 999998	→ 318
317	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q316.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
318	Are individual records or cards maintained for family planning clients? IF YES, ASK TO SEE AN UNUSED RECORD OR CLIENT CARD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	
319	Does the family planning provider routinely treat STIs, or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIs . . . 1 REFERS TO OTHER PROVIDER OR LOCATION . . . . . 2 NO TREATMENT PROVIDED . . 3	
320	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING ARE CONDUCTED.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 321, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	ANTENATAL [Q428] . . . . . 14 DELIVERY [Q530A] . . . . . 15 STI [Q626B] . . . . . 16 NOT PREVIOUSLY SEEN 19	→ 321A

321 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

	ITEMS	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→ b	2→ b	3 02	8 02	1	2	8
02	Manual BP apparatus	1→ b	2→ b	3 03	8 03	1	2	8
03	Stethoscope	1→ b	2→ b	3 04	8 04	1	2	8
04	Automatic BP apparatus	1→ b	2→ b	3 05	8 05	1	2	8
05	Examination couch	1	2	3	8			

321A	ASK TO SEE THE AREA(S) IN THIS CLINIC/UNIT WHERE MOST CLIENTS ARE EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR IT, RANDOMLY PICK ONE TO ASSESS.	
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q322, INDICATE WHICH SECTION THE DATA ARE RECORDED	GENERAL INFORMATION [Q190]. . . . . 11 CHILD HEALTH [Q256]. . . . . 12 ANTENATAL CARE [Q429]. . . . . 14 DELIVERY [Q530]. . . . . 15 STI [Q626]. . . . . 16 SECTION 17-TB [Q1719]. . . . . 17 SECTION 18-CT [Q1822] 18 NOT PREVIOUSLY SEEN. . . . . 19 → 323

322 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED)	1 → 04	2	3
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3
05	HAND DISINFECTANT	1	2	3
06	SINGLE-USE HAND DRYING TOWELS	1	2	3
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1	2	3
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3
13	DISPOSABLE NON-LATEX GLOVES	1	2	3
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3
15	DISPOSABLE NEEDLES	1	2	3
16	AUTO-DISABLE SYRINGES (2, 3 OR 5 ml)	1	2	3
17	DISPOSABLE SYRINGES (2, 3 OR 5 ml)	1	2	3
18	PRIVATE ROOM	1 → 21	2	3
19	AUDITORY PRIVACY	1	2	3
20	VISUAL PRIVACY	1	2	3
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3

323	CHECK Q304(08) and (09): IS "1" CIRCLED IN EITHER QUESTION TO INDICATE THAT THE FACILITY PROVIDES IUCD OR IMPLANTS? YES ☐ NO ☐ →				QRE 3b
324	OBSERVE THE AVAILABILITY OF COMMON SUPPLIES FOR IUCD OR IMPLANTS SERVICES.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	Sterile gloves	1	2	3	
02	Antiseptic solution (such as iodine)	1	2	3	
03	Sponge holding forceps	1	2	3	
04	Sterile gauze pad or cotton wool	1	2	3	
325	CHECK Q304(08): IS "1" CIRCLED TO INDICATE THAT THE FACILITY PROVIDES IUCD? YES ☐ NO ☐ →				QRE 3b
326	OBSERVE THE AVAILABILITY OF MATERIALS FOR THE INSERTION 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	
327	CHECK Q304(09): IS "1" CIRCLED TO INDICATE THAT THE FACILITY PROVIDES IMPLANTS? YES ☐ NO ☐ →				QRE 3b
328	NOTE THE AVAILABILITY OF THE FOLLOWING ITEMS:	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	Local anaesthetic (such as lignocaine)	1	2	3	
02	Sterile syringe and needle	1	2	3	
03	Canula and trochar for inserting implants	1	2	3	
04	Sealed implants pack	1	2	3	
05	Scalpel with blade	1	2	3	
06	Minor surgery kit (e.g., artery forceps, haemostat)	1	2	3	
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.				

3b. Availability of Contraceptive Commodities

Facility number: | | | | | | **Interviewer: Code** | | |

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
350	Are any contraceptive COMMODITIES ever stored in this facility?	YES, IN FAMILY PLANNING SERVICE AREA . . . . . 1 YES, IN PHARMACY OR OTHER SITE NOT FP SERVICE AREA . 2 YES, AREA LOCKED, NO ACCESS . . . . . 3 NO 4	→ **END** → **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF FAMILY PLANNING COMMODITIES. IF THIS IS A NEW RESPONDENT, OBTAIN CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q351.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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
(Indicates respondent's willingness to participate)

				2	0	1	0
DAY		MONTH		YEAR			

351	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**

352	**VALIDATION OF CONTRACEPTIVES**						
	GO TO THE MAIN AREA WHERE CONTRACEPTIVES ARE STORED AND COLLECT INFORMATION ON VALIDATION OF THE LISTED CONTRACEPTIVES.	A PRODUCT NORMALLY STOCKED IN FACILITY	B UNIT OF MEASURE	C STOCK CARD AVAILABLE	D VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY	E ITEMS STORED BY DATE OF EXPIRATION	G STOCK OUT DURING PAST 6 MONTHS
	PRODUCT	1=YES 2=YES NOT TODAY 3=NO **IF 2 OR 3 SKIP TO NEXT ITEM**	1=TAB/CAPS 2=VIALS 3=AMPOULES 4=PACKS 6=CYCLES 5=NA	1=YES 2=NO	1=YES,ALL UNITS 2=YES,ON SOME UNITS 3= NO UNITS 5=NA	1=YES 2=NO 5=NA	1=YES 2=NO 8=DK
01	COMBINED ORAL PILLS	☐	☐	☐	☐	☐	☐
02	PROGESTIN-ONLY PILLS	☐	☐	☐	☐	☐	☐
03	COMBINED INJECTABLE (1 MONTHLY)	☐	☐	☐	☐	☐	☐
04	PROGESTIN-ONLY INJECTABLE (2 MONTHLY)	☐	☐	☐	☐	☐	☐
05	PROGESTIN-ONLY INJECTABLE (3 MONTHLY)	☐	☐	☐	☐	☐	☐
06	CONDOM (MALE)	☐	☐	☐	☐	☐	☐
07	CONDOM (FEMALE)	☐	☐	☐	☐	☐	☐
08	INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)	☐	☐	☐	☐	☐	☐
09	IMPLANTS	☐	☐	☐	☐	☐	☐
10	CYCLE BEADS FOR STANDARD DAYS METHOD (SDM)	☐	☐	☐	☐	☐	☐
11	EMERGENCY CONTRACEPTIVE PILLS	☐	☐	☐	☐	☐	☐

353	Are contraceptive commodities stored in the same location as other medicines?	YES 1 NO 2	
354	OBSERVE THE PLACE WHERE CONTRACEPTIVE COMMODITIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING CONDITIONS.		
01	ARE THE COMMODITIES OFF THE FLOOR?	YES . . . . . 1 NO 2	
02	ARE THE COMMODITIES PROTECTED FROM WATER?	YES . . . . . 1 NO 2	
03	ARE THE COMMODITIES PROTECTED FROM THE SUN?	YES . . . . . 1 NO 2	
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.).	YES . . . . . 1 NO 2	
05	IS THE STORAGE ROOM WELL VENTILATED?	YES . . . . . 1 NO 2	
355	When was the last time that you received a scheduled supply of contraceptive commodities? (i.e. from the main order & not interim order)	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS . . . . . 2 MORE THAN 12 WEEKS AGO . . 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8	
356	Does this facility determine the quantity of each contraceptive commodity required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DIFFER BY COMMODIT.) 3 DON'T KNOW 8	→ **END** → **END**
357	Routinely, when you order contraceptive commodities, which best describes the system you use to determine how much of each to order? Do you: - **Review** the amount of each method remaining, and order to bring the stock amount to a pre-determined (fixed) amount (max stock level)? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each method used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY) - DON'T KNOW	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.		

4. Antenatal and Postnatal Care

Facility Number: ☐☐☐☐☐ **Interviewer Code:** ☐☐

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
400	Does this facility offer antenatal (ANC) services , postnatal (PNC) services, or both? INDICATE THE SERVICES OFFERED.	YES, ANTENATAL ONLY . . . . . 1 YES, POSTNATAL ONLY . . . . . 2 YES, BOTH ANTENATAL AND POSTNATAL . . . . . 3 NO, NEITHER SERVICE 4	→ 419 → 431A

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF ANTENATAL CARE SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q401.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministry of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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
(Indicates respondent's willingness to participate)

DAY	MONTH	YEAR
☐☐	☐☐	2010

401	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**
402	How many days of the month are antenatal-care services provided at the facility? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	NUMBER OF DAYS ☐☐ DON'T KNOW 98	
403	Are antenatal-care services being provided at the facility today?	YES . . . . . 1 NO 2	
404	Does this facility have any routine user-fees or charges for any services related to antenatal care services? This includes any fees, including those for registration, client health card/mother-baby booklet, medicines or laboratory investigations?	YES . . . . . 1 NO. 2	→ 407

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
405	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for antenatal care services:	(a) FEES YES	NO	DON'T KNOW	(b) AMOUNT IN KSH
01	Is there a fee for the client health card?	1 → b	2 → 02	8 → 02	
02	Is there a fee for each consultation?	1 → b	2 → 03	8 → 03	
03	Are there fees for medications?	1	2	8	
04	Are there fees for laboratory tests?	1	2	8	
05	Is there a fee for registration?	1 → b	2 → 06	8 → 06	
06	Are discounts or exemptions from fees allowed for some clients?	1	2	8	
07	Is there a system for clients to pre-pay for multiple visits for care during pregnancy?	1	2	8	

406	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	
407	Does this facility have a system whereby observation or parameters for ANC clients are routinely carried out before the consultation?	YES . . . . . 1 NO . . . . . 2 → 409 DON'T KNOW . . . . . 8 → 409	

408	ASK TO SEE THE PLACE WHERE ANTENATAL CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.				
	OBSERVE IF THE BELOW ACTIVITIES ARE BEING CONDUCTED ROUTINELY. IF NOT SEEN ASK: Is [READ ACTIVITY YOU DO NOT SEE] routinely conducted for all antenatal care clients?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing clients	1	2	3	8
02	Taking blood pressure	1	2	3	8
03	Urine test for protein	1	2	3	8
04	Blood test for anaemia	1	2	3	8
05	Group health education sessions	1	2	3	8
06	Other_____ (SPECIFY)	1	2	3	8

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
409	Which of the following activities are performed as part of routine ANC services, i.e., each client has this test at least once during a pregnancy? FOR EACH TEST THAT IS ROUTINELY CONDUCTED (I.E., COL. a = 1), ASK TO SEE IF ALL ITEMS NEEDED FOR THE TEST ARE AVAILABLE IN THE ANC AREA, OR THE TESTS ARE CONDUCTED IN THE LAB.	(a) ROUTINE TESTING			(b) ITEMS FOR TEST AVAILABLE IN ANC UNIT TODAY			
		YES	NO	DON'T KNOW	YES	NO	TEST IN LAB	
01	Blood test for haemoglobin levels (anaemia)	1 → b	2 → 02	8 → 02	1	2	3	
02	Blood test for syphilis (VDRL)	1 → b	2 → 03	8 → 03	1	2	3	
03	Blood group	1 → b	2 → 04	8 → 04	1	2	3	
04	Test for RH factor	1 → b	2 → 05	8 → 05	1	2	3	
05	Urine test for protein	1 → b	2 → 06	8 → 06	1	2	3	
06	Urine test for glucose	1 → b	2 → 410	8 → 410	1	2	3	

		ROUTINE SERVICE			
		YES	NO	DON'T KNOW	
410	Which of the following types of treatment and services are routinely offered to antenatal clients?				
01	Counseling on the 4 recommended ANC visits	1	2	8	
02	Preventive antimalarial medication (IPT)	1	2	8	
03	Counselling about family planning	1	2	8	
04	Counselling about HIV/AIDS/PMTCT	1	2	8	
05	Testing for HIV/AIDS	1	2	8	
06	Making individualized birth plans (e.g., transport)	1	2	8	
411	Is tetanus toxoid vaccination available on all days antenatal care services are offered?	YES . . . . . 1 NOT ALL ANC DAYS . . . . . 2 TT NEVER OFFERED 3			→ 414
411A	Which tetanus toxoid vaccination schedule does this facility implement?	NEW SCHEDULE. . . . . 1 OLD SCHEDULE. . . . . 2 DON'T KNOW. 8			
412	How many days each week are tetanus toxoid vaccinations offered at this facility?	DAYS PER WEEK . . . . . ☐ LESS OFTEN THAN ONCE/WEEK 0 DON'T KNOW 8			
413	Is tetanus toxoid immunization available today?	YES . . . . . 1 NO 2			
414	Do antenatal care providers here routinely treat RTIs/STIs, or are clients referred to another provider or location for RTIs/STI treatment?	ROUTINELY TREATS STIs . . . . 1 REFER . . . . . 2 NO TREATMENT PROVIDED . . 3			
415	Is there a register (paper or electronic) where information on antenatal care clients' visits is recorded? IF YES, ASK TO SEE THE REGISTER/COMPUTER. FOR THE REGISTER TO BE VALID IT MUST SHOW CLIENTS' STATUS (NEW OR CONTINUING).	YES, REGISTER SEEN (PAPER) 1 YES, REGISTER SEEN (ELECTRON.) . . . . 2 YES, REGISTER NOT SEEN . 3 NO REGISTER KEPT 4			→ 418 → 418
416	HOW MANY DAYS AGO WAS THE LAST ENTRY MADE IN THE REGISTER/COMPUTER? NOTE: THE DAY OF THE INTERVIEW IS DAY "0".	WITHIN THE PAST 7 DAYS. . . . . 1 MORE THAN 7 DAYS OLD. 2			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
417	RECORD THE NUMBER OF FIRST (1ST) ANTENATAL CARE VISITS DURING PAST 12 COMPLETED MONTHS	NUMBER OF 1ST VISITS [ ][ ][ ][ ][ ][ ]	
417A	RECORD THE TOTAL NUMBER OF ANC RE-VISITS DURING PAST 12 COMPLETED MONTHS	NUMBER OF RE-VISITS [ ][ ][ ][ ][ ][ ]	
417B	RECORD THE TOTAL NUMBER OF WOMEN WHO MADE 4 OR MORE ANC VISITS DURING THE PAST 12 COMPLETED MONTHS.	# OF WOMEN MAKING 4+ ANC VISITS [ ][ ][ ][ ][ ]	
417C	RECORD THE TOTAL NUMBER OF WOMEN WHO HAD ELEVATED BLOOD PRESSURE OR PRE-ECLAMPSIA DURING THE PAST 12 COMPLETED MONTHS. (DIASTOLIC BP>90mm Hg)	# OF WOMEN WITH PRE-ECLAMPSIA [ ][ ][ ][ ][ ][ ] DK 999998	
417D	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q417, Q417A, Q417B AND 417C.	MONTHS OF DATA ..... [ ][ ]	
418	Does this facility distribute insecticide treated bed nets (ITNs) to ANC clients? IF YES, ASK: Are the ITNs routinely distributed to clients or only sometimes?	YES, ROUTINELY ..... 1 YES, ONLY SOMETIMES ..... 2 NO DISTRIBUTION OF ITNs 3	 → 418D
418A	Do you maintain a register or record (paper or electronic) on the number of ITNs distributed to ANC clients? IF YES, ASK: May I see a register or record on the number of ITNs distributed?	YES, OBSERVED (PAPER) ..... 1 YES, OBSERVED (ELECTRONIC) ..... 2 YES, REGISTER NOT SEEN ..... 3 NO REGISTER KEPT 4	 → 418D → 418D
418B	REVIEW THE RECORD. INDICATE THE NUMBER OF ITNS DISTRIBUTED IN THE PREVIOUS 12 COMPLETED MONTHS.	NUMBER OF ITNs GIVEN TO ANC CLIENTS [ ][ ][ ][ ][ ][ ]	
418C	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA ..... [ ][ ]	
418D	CHECK 400: IS EITHER "2" OR "3" CIRCLED? YES [ ] NO [ ] →		423
419	Is there a register (paper or electronic) where client information from postnatal care (PNC) visits is recorded? IF YES, ASK TO SEE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE NUMBER OF DAYS POSTNATAL AND INDICATE WHETHER OR NOT THERE ARE COMPLICATIONS.	YES, REGISTER SEEN (PAPER) ..... 1 YES, REGISTER SEEN (ELECTRONI... 2 YES, REGISTER NOT SEEN. ..... 3 NO REGISTER KEPT. 4	 → 424 → 424
420	HOW MANY DAYS AGO WAS THE LAST ENTRY MADE IN THE REGISTER/COMPUTER? NOTE: THE DAY OF THE INTERVIEW IS DAY "0".	WITHIN THE PAST 7 DAYS .... 1 MORE THAN 7 DAYS OLD 2	
421	HOW MANY POSTNATAL VISITS TOOK PLACE DURING THE PREVIOUS 12 COMPLETED MONTHS?	NUMBER OF PNC VISITS [ ][ ][ ][ ][ ][ ]	
422	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA ..... [ ][ ]	
423	What is the estimated annual rate of PNC coverage for this facility?	PNC % COVERAGE ..... [ ][ ][ ] DON'T KNOW 998	 → 424
423A	RECORD THE SOURCE OF INFORMATION FOR ESTIMATED PERCENT OF POSTNATAL CARE COVERAGE.	WRITTEN REPORT ..... A GRAPH/CHART ..... B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN ..... Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
424	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment area?	NUMBER OF BIRTHS . . . [ ][ ][ ][ ][ ][ ] NO CATCHMENT AREA DEFINED. 999995 DON'T KNOW 999998	
425	What is the estimated annual rate of ANC coverage for this facility?	ANC % COVERAGE . . . . . [ ][ ][ ] DON'T KNOW 998	→ 426
425A	RECORD THE SOURCE OF INFORMATION FOR ESTIMATED PERCENT OF ANTENATAL CARE COVERAGE.	WRITTEN REPORT . . . . . A GRAPH/CHART . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
426	Are individual client cards/records maintained for antenatal care clients? IF YES, ASK TO SEE AN UNUSED RECORD OR CARD	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
427	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 428, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q321] 13 DELIVERY [Q530A] . . . . . 15 STI [Q626B] . . . . . 16 NOT PREVIOUSLY SEEN 19	→ 428A

428 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

	ITEMS	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→ b	2→ b	3 → 02	8 → 02	1	2	8
02	Manual BP apparatus	1→ b	2→ b	3 → 03	8 → 03	1	2	8
03	Stethoscope	1→ b	2→ b	3 → 04	8 → 04	1	2	8
04	Automatic BP apparatus	1→ b	2→ b	3 → 05	8 → 05	1	2	8
05	Examination couch	1	2	3	8			

428A	ASK TO SEE THE AREA(S) IN THIS CLINIC/UNIT WHERE MOST CLIENTS ARE EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR IT, RANDOMLY PICK ONE TO ASSESS.		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS INDICATE WHICH SECTION THE DATA ARE RECORDED	GENERAL INFORMATION [Q190]. . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 DELIVERY [Q530] . . . . . 15 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1822] . . . . . 18 NOT PREVIOUSLY SEEN 19	→ 430

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
429	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.				
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3	
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1	2	3	
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3	
13	DISPOSABLE NON-LATEX GLOVES	1	2	3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
15	DISPOSABLE NEEDLES	1	2	3	
16	AUTO-DISABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
17	DISPOSABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
18	PRIVATE ROOM	1 → 21	2	3	
19	AUDITORY PRIVACY	1	2	3	
20	VISUAL PRIVACY	1	2	3	
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
430	EQUIPMENT AND SUPPLIES	(A) AVAILABILITY: OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	(B) FUNCTIONING: YES / NO / DON'T KNOW
	NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.					
01	Foetal stethoscope (Pinard)	1	2	3	8	
02	Adult weighing scale	1→b	2→b	3 → 03	8 → 03	1 / 2 / 8
03	Vaginal speculum (s)	1	2	3	8	
04	Vaginal speculum (m)	1	2	3	8	
05	Vaginal speculum (l)	1	2	3	8	
06	Thermometer	1→b	2→b	3 → 07	8 → 07	1 / 2 / 8
07	Infant weighing scale	1→b	2→b	3 → 08	8 → 08	1 / 2 / 8
08	Facility provided minute timer	1→b	2→b	3 → 09	8 → 09	1 / 2 / 8
09	Personal watch with seconds hand	1→b	2→b	3 → 10	8 → 10	1 / 2 / 8
10	Individual card/record for infant	1	2	3	8	
11	SP/Fansidar	1	2	3	8	
12	Iron tablets	1	2	3	8	
13	Folate tablets	1	2	3	8	
14	De-worming medicine	1	2	3	8	
15	Vitamin A	1	2	3	8	

431	NOTE THE AVAILIBILITY OF PROTOCOLS AND TEACHING MATERIALS.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Guidelines or protocols for antenatal care	1	2	3	8
02	Guidelines for Syndromic Approach or Dx for STIs	1	2	3	8
03	Other guidelines and protocols for reproductive health (e.g., maternal, neonatal health)	1	2	3	8
04	Visual aids for client education on subjects related to pregnancy or antenatal care	1	2	3	8

431A	Are there any active traditional birth attendants (TBAs) working with this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 432 → 432
431B	Do the TBAs refer women to this facility?	YES . . . . . 1 NO 2	
432	Are there any active community health workers (CHWs) working with this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 434 → 434
433	Do the CHWs refer women to this facility?	YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
434	Are there any active community midwives working with this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW. 8	 → 437 → 437
435	Do the community midwives refer women to this facility?	YES . . . . . 1 NO 2	
436	Does the facility or the ANC unit have safe delivery kits for distribution to community midwives? IF YES, ASK TO SEE ONE	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN. . . . . 2 NO 3	
437	What *is the most common* means of transport used by women coming from their homes to this facility for help during obstetric emergencies? IF THERE IS MORE THAN ONE MOST COMMON MEANS, PROBE TO DETERMINE ONE THAT IS MOST COMMONLY USED.	AMBULANCE . . . . . 01 PRIVATE CAR/BUS . . . . . 02 PUBLIC CAR/BUS . . . . . 03 MOTORCYCLE . . . . . 04 BICYCLE . . . . . 05 PEOPLE CARRY/PUSH OR PULL PATIENT . . . . . 06 ANIMALS CARRY/PULL PATIENTS. . . . 07 OTHER _____ . 96 (SPECIFY) NEVER RECEIVE EMERGENCY 95 DON'T KNOW 98	
438	Does this **facility** ever refer a woman to another facility for emergency obstetric care?	YES . . . . . 1 NO 2	 → END
439	Does this **facility** have a functional ambulance or other vehicle for emergency obstetric transportation? ACCEPT REPORTED RESPONSE.	YES . . . . . 1 NO 2	 → 441
440	Is there sufficient fuel available today for the ambulance to reach the nearest referral facility? ACCEPT REPORTED RESPONSE.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
441	What is the *most common* means by which women or sick neonates are transported from this **facility** to the nearest referral facility to receive help during an obstetric/sick newborn emergency?	AMBULANCE . . . . . 01 PRIVATE CAR/BUS . . . . . 02 PUBLIC CAR/BUS . . . . . 03 MOTORCYCLE . . . . . 04 BICYCLE . . . . . 05 PEOPLE CARRY/PUSH OR PULL PATIENT . . . . . 06 ANIMALS CARRY/PULL PATIENTS. . . . 07 OTHER _____ . 96 (SPECIFY)	
442	How long does it take, using this form of transportation, to get to the nearest referral facility? ASK THE TIME FOR DRY AND WET SEASON. IF CALL ELSEWHERE MUST BE MADE TO OBTAIN A VEHICLE, RECORD AVERAGE TIME FROM THE CALL TO THE PATIENT'S ARRIVAL AT THE REFERRAL FACILITY.	**01) DRY SEASON** MINUTES ☐☐☐ DON'T KNOW . . . . . 998 **02) WET SEASON** MINUTES . . . . ☐☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
443	Please tell me if this facility has any of the following mechanisms to support emergency obstetric or neonatal referrals.		YES	NO	DON'T KNOW	
01	Are there any funds set aside to help clients with emergency transportation?	PROVIDE FUNDS	1	2	8	
02	Does the facility hire a vehicle locally to provide emergency obstetric or neonatal transportation?	HIRE VEHICLE	1	2	8	
03	Is there a community-supported transport system that provides support for emergency obstetric or neonatal referrals?	COMMUNITY SUPPORT	1	2	8	
04	Is fuel set aside for emergency obstetric or neonatal referrals?	FUEL SET ASIDE	1	2	8	
05	Is there a revolving fund system for transportation for emergency obstetric or neonatal referrals?	REVOLVING FUND	1	2	8	
06	Does the facility radio or phone another facility to send transportation for emergency obstetric or neonatal referrals?	PHONE FOR TRANSPORT	1	2	8	
07	Is there any other system? IF YES, SPECIFY _____	OTHER	1	2	8	
	THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.					

5. Delivery and Newborn Care

Facility Number: ☐☐☐☐☐ **Interviewer Code:** ☐☐

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
500	Does this facility offer delivery services, including normal deliveries and other related services? IF YES, INDICATE RESPONSE THAT BEST REFLECTS THE CURRENT PRACTICE FOR DELIVERIES.	YES. . . . . 1 ONLY EMERGENCY DELIVERIES. . . . 2 NO DELIVERY SERVICES. 3	 → 550 → 550

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF DELIVERY SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q501.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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
(Indicates respondent's willingness to participate)

DAY	MONTH	YEAR
☐☐	☐☐	2010

501	May I begin the interview now?	YES . . . . . 1 NO 2	 → STOP
502	Do skilled attendants/midwives routinely provide home deliveries or attend home delivery emergencies as a part of the facility's services?	YES, ROUTINELY . . . . . 1 YES, EMERGENCY ONLY . . . 2 NO 3	 → 505
503	Is there a home delivery bag or kit for use by skilled attendants? IF YES, ASK TO SEE THE BAG/KIT.	YES, BAG SEEN . . . . . 1 YES, BAG NOT SEEN . . . . . 2 NO 3	
504	Do midwives/providers routinely provide home-based post-natal care (PNC) as part of their facility services?	YES, ROUTINELY . . . . . 1 YES, EMERGENCY ONLY . . . 2 NO 3	
505	Does the facility provide 24 hour coverage for delivery services?	YES . . . . . 1 NO 2	 → 508
506	Is a person skilled in conducting deliveries present at the facility or on call 24 hours a day, including weekends, to provide delivery care? IF YES, ASK TO SEE A SCHEDULE FOR 24-HOUR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	 → 508

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
507	At night, what level of provider is commonly on duty to conduct deliveries? IF DIFFERENT LEVELS ARE COMMONLY AVAILABLE, CIRCLE ALL RELEVANT LEVELS.	OBSTETRICIAN/ GYNECOLOGIST. . . . . A MEDICAL OFFICER. . . . . B CLINICAL OFFICERS. . . . . C R. NURSE. . . . . D R. MIDWIFE. . . . . E E. NURSE. . . . . F E. MIDWIFE. . . . . G NURSE AIDES. . . . . H OTHER _____ X (SPECIFY) DON'T KNOW. . . . . Z	
508	During normal working hours, what level of provider is commonly available to conduct complicated deliveries? IF DIFFERENT LEVELS ARE COMMONLY AVAILABLE, CIRCLE ALL RELEVANT LEVELS.	OBSTETRICIAN/ GYNECOLOGIST. . . . . A MEDICAL OFFICER. . . . . B CLINICAL OFFICERS. . . . . C R. NURSE. . . . . D R. MIDWIFE. . . . . E E. NURSE. . . . . F E. MIDWIFE. . . . . G NURSE AIDES. . . . . H OTHER _____ X (SPECIFY) DON'T KNOW. . . . . Z	
509	Does this facility have any routine user-fees or charges for delivery services? This includes any fees, including those for registration, mother-baby card, medicines, or laboratory investigations?	YES . . . . . 1 NO. 2	→ 512

		(a) FEES			(b) AMOUNT IN KSH
510	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for delivery services:	YES	NO	DON'T KNOW	
01	Is there a fee for normal delivery?	1→ 01b	2 → 02	8 → 02	
02	Is there a fee for the package of ANC and delivery services?	1→ 02b	2 → 03	8 → 03	
03	Is there a fee to take care of a sick newborn?	1	2	8	
04	Are there any fees or charges for medicines?	1	2	8	
05	Are there fees for laboratory or other diagnostic tests?	1	2	8	
06	Are discounts or exemptions from fees allowed for some clients?	1	2	8	

511	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3	
512	Is there a register where client information from attended births is recorded, i.e., a delivery register? IF YES, ASK TO SEE THE REGISTER.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 519 → 519

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
513	SCAN THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE THE RESPONSE FOR EACH TYPE OF INFORMATION ROUTINELY RECORDED FOR DELIVERIES. SEARCH ALL APPLICABLE REGISTERS/RECORDS MAINTAINED ROUTINELY.	BIRTH OUTCOME FOR INFANT. . . . . A MATERNAL OUTCOME. . . . . B TYPE OF DELIVERY. . . . . C MOTHER'S AGE. . . . . D GESTATIONAL AGE. . . . . E IF ANC RECEIVED. . . . . F HIV STATUS OF MOTHER. . . . . G NEWBORN WEIGHT. . . . . H IF PARTOGRAPH USED. . . . . I NONE OF ABOVE. . . . . Y	
514	INDICATE THE MOST RECENT DAY AND MONTH WHEN A DELIVERY WAS ATTENDED IN THIS FACILITY.	DAY. . ☐☐ MONTH. ☐☐ DK. . . . . 98 DK. 98	
515	How many women delivered at this facility during the previous 12 completed months? (EXCLUDE CAESAREAN SECTIONS)	NUMBER OF DELIVERIES . . ☐☐☐☐☐ DON'T KNOW. 99998	
516	How many of these deliveries (of Q.515) were registered as having had complications during labor and/or delivery?	NUMBER OF COMPLICATED DELIVERIES . . ☐☐☐☐☐ DON'T KNOW. 99998	
517	How many home-deliveries were conducted and reported to this facility by ***community midwives*** during the past 12 months?	NUMBER OF DELIVERIES . . ☐☐☐☐☐ DON'T KNOW. . . . . 99998 NO HOME DELIVERIES. 99995	
517A	**CHECK Q515,Q516, OR Q517: IS DATA RECORDED ?** **YES** ☐ **NO** ☐ →		**519**
518	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTIONS.	MONTHS OF DATA. . . . . ☐☐ DON'T KNOW 98	
519	What percentage of deliveries in your catchment area are conducted by this facility? In other words, what is your estimated annual coverage rate?	% COVERAGE. . . . . ☐☐☐ NO CATCHMENT AREA DEFINED. . 995 → 521 DON'T KNOW. . . . . 998 → 521	
520	RECORD THE SOURCE OF INFORMATION FOR THE ESTIMATED DELIVERY COVERAGE.	WRITTEN REPORT . . . . . A GRAPH/CHART . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
521	Are there any meetings where labour and delivery service statistics are discussed with staff from this facility, such as looking at changes in patterns or other items relevant to client services? IF YES, ASK TO SEE MINUTES OF A RECENT MEETING	YES, MINUTES SEEN. . . . . 1 YES, MINUTES NOT SEEN. . . . . 2 NO . . . . . 3 → 524	
522	Is there any evidence of looking at service data for monitoring and evaluation? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WRITTEN REPORT/MINUTES. . . . . A WALL CHART/GRAPH. . . . . B OTHER _____ X (SPECIFY) NO OBSERVED EVIDENCE. . . . . Y → 524	
523	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.	WITHIN THE PAST 3 MONTHS . . . 1 MORE THAN 3 MONTHS AGO . . . 2 DON'T KNOW 8	
524	Does the facility participate in regular reviews of maternal or newborn deaths or “near-misses”?	YES, FOR MOTHERS ONLY. . . . . 1 YES, FOR NEWBORNS ONLY. . . . . 2 →525A YES, FOR BOTH. . . . . 3 NO, DOES NOT PARTICIPATE. . . . . 4 → 526	
525	How often are reviews of maternal deaths or "near-misses" carried out?	EVERY: ☐☐ WEEKS ONLY WHEN CASE OCCURS. . . . . 53 DON'T KNOW. 98	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	CHECK: Q524. IS "1" CIRCLED TO INDICATE THAT THE FACILITY PARTICIPATES IN REGULAR REVIEW OF MATERNAL DEATHS ONLY? **NO** ☐ **YES** ☐ →		**526**
525A	How often are reviews of <u>newborn deaths or "near-misses"</u> carried out?	ALWAYS WITH MATERNAL REVIEWS 95 EVERY: ☐☐ WEEKS ONLY WHEN CASE OCCURS. . . . . 53 DON'T KNOW. 98	
526	Please tell me the ***<u>total number of beds</u>*** in the *<u>maternity ward/unit in this facility</u>*	# OF BEDS IN MATERNITY ☐☐☐ NO SPECIFIC MATERNITY BEDS. . . 000	
527	Please tell me the ***<u>total number of delivery beds/couches</u>*** available for delivery in this facility	# DELIVERY BEDS ☐☐☐	
528	ASK TO SEE THE ROOM(S) WHERE WOMEN IN LABOUR STAY UNTIL TIME FOR DELIVERY AND INDICATE THE SITUATION FOR PRIVACY	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY. . . . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY. . 2 VISUAL PRIVACY ONLY. . . . . 3 AUDITORY PRIVACY ONLY. . . . . 4 NO PRIVACY. . . . . 5 NO SEPARATE LABOR ROOM. 7	
529	ASK TO SEE THE ROOM(S) WHERE DELIVERIES TAKE PLACE. IF THE SAME *ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q530, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	GENERAL INFORMATION [Q190]. . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 STI [Q626] . . . . . 16 SECTION 17-TB [Q1719] . . . . . 17 SECTION 18-CT [Q1822] . . . . . 18 NOT PREVIOUSLY SEEN 19	530A

530	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE DELIVERY TAKES PLACE OR IN AN ADJACENT ROOM.				
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR DELIVERY	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1 2 3	
11	SHARPS CONTAINER ("SAFETY BOX")	1 2 3	
12	DISPOSABLE LATEX GLOVES	1 → 14 2 3	
13	DISPOSABLE NON-LATEX GLOVES	1 2 3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1 2 3	
15	DISPOSABLE NEEDLES	1 2 3	
16	AUTO-DISABLE SYRINGES (2, 3 OR 5 ml)	1 2 3	
17	DISPOSABLE SYRINGES (2, 3 OR 5 ml)	1 2 3	
18	PRIVATE ROOM	1 → 21 2 3	
19	AUDITORY PRIVACY	1 2 3	
20	VISUAL PRIVACY	1 2 3	
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1 2 3	
530A	LOOK AT THE ROOM WHERE DELIVERIES OCCUR TO ASSESS SUPPLIES AND EQUIPMENT.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 530B, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q321] 13 ANC-PNC [Q428] . . . . . 14 STI [Q626B] . . . . . 16 NOT PREVIOUSLY SEE 19	→ 531

530B	SUPPLIES AND EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam flashlight/torch or exam light acceptable)	1→b	2→b	3 → 02	8 → 02	1	2	8
02	Manual BP apparatus	1→b	2→b	3 → 03	8 → 03	1	2	8
03	Stethoscope	1→b	2→b	3 → 04	8 → 04	1	2	8
04	Automatic BP apparatus	1→b	2→b	3 → 05	8 → 05	1	2	8
05	Examination couch	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
531	OTHER SUPPLIES AND EQUIPMENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Infant scale	1→b	2→b	3 02	8 02	1	2	8
02	24-hr functioning light source (lantern acceptable)	1→b	2→b	3 03	8 03	1	2	8
03	Foetal stethoscope (Pinard)	1→b	2→b	3 04	8 04	1	2	8
04	Electronic foetal stethoscope	1→b	2→b	3 05	8 05	1	2	8
05	Skin antiseptic (e.g., Chlorhexidine, Povidine-Iodine (Betadine))	1	2	3	8			
06	Intravenous infusion set	1	2	3	8			
07	Syringes and needles	1	2	3	8			
08	Delivery pack	1 17	2	3	8			
09	Episiotomy scissors	1	2	3	8			
10	Baby scissors	1	2	3	8			
11	Blade (to cut cord)	1	2	3	8			
12	Swab holder	1	2	3	8			
13	Needle holder	1	2	3	8			
14	Forceps (large)	1	2	3	8			
15	Forceps (medium)	1	2	3	8			
16	Cord ties/clamp	1	2	3	8			
17	Suture material with needle	1	2	3	8			
18	Clean apron	1	2	3	8			
19	Eye protection (glasses)	1	2	3	8			
20	Face masks	1	2	3	8			
21	Boots for protection	1	2	3	8			
22	Sterile gloves	1	2	3	8			
23	Thermometer	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
532	**MEDICATIONS IN DELIVERY SERVICE AREA**	**(a) AVAILABILITY**				**(b) AT LEAST ONE VALID**		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Intravenous solutions: either Ringers lactate, 5%D/NS, or NS infusion	1→ b	2 02	3 02	8 02	1	2	8
02	Injectable Ergometrine	1→ b	2 03	3 03	8 03	1	2	8
03	Injectable oxytocin/ syntocinon	1→ b	2 04	3 04	8 04	1	2	8
04	Injectable diazepam (e.g. Valium)	1→ b	2 05	3 05	8 05	1	2	8
05	Injectable magnesium sulphate	1→ b	2 06	3 06	8 06	1	2	8
06	Calcium gluconate	1→ b	2 07	3 07	8 07	1	2	8
07	Hydralazine/apresoline Nifedipine	1→b	2 08	3 08	8 08	1	2	8
08	Injectable amoxicilin/ ampicillin	1→b	2 09	3 09	8 09	1	2	8
09	Injectable gentamicin	1→b	2 10	3 10	8 10	1	2	8
10	Tetracycline eye drops or ointment	1→b	2 11	3 11	8 11	1	2	8
11	Vitamin A 200,000 IU (oral)	1→ b	2 12	3 12	8 12	1	2	8
12	Benzyl penicillin injection	1→b	2 13	3 13	8 13	1	2	8
13	Tab. Metronidazole	1→b	2 14	3 14	8 14	1	2	8
14	Injectable Metronidazole	1→b	2 15	3 15	8 15	1	2	8
15	Vitamin K Injection	1→b	2 16	3 16	8 16	1	2	8
16	AZT+3TC+NVP Combined Tabs	1→ b	2 17	3 17	8 17	1	2	8
17	d4T+3TC+NVP Combined Tabs	→ b	2 18	3 18	8 18	1	2	8
18	AZT+3TC Combined Tabs	1→ b	2 19	3 19	8 19	1	2	8
19	AZT Tabs	1→ b	2 20	3 20	8 20	1	2	8
20	3TC Tabs	1→ b	2 21	3 21	8 21	1	2	8
21	NVP Tabs	1→ b	2 22	3 22	8 22	1	2	8
22	AZT syrup	1→ b	2 23	3 23	8 23	1	2	8
23	3TC syrup	1→ b	2 24	3 24	8 24	1	2	8
24	NVP syrup	1→ b	2 533	3 533	8 533	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
533	**EQUIPMENT AND SUPPLIES FOR NEWBORN CARE**	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Infant size bag (or tube) with mask for resuscitation (500mL)	1→ b	2→ b	3 02	8 02	1	2	8
02	Nasogastric tube	1→ b	2→ b	3 03	8 03	1	2	8
03	Laryngoscope and endotraqueal tubes (3-3$^{1/2}$)	1→ b	2→ b	3 04	8 04	1	2	8
04	Oxygen source	1→ b	2→ b	3 05	8 05	1	2	8
05	Incubator	1→ b	2→ b	3 06	8 06	1	2	8
06	Other source of heat for premature infant	1→ b	2→ b	3 07	8 07	1	2	8
07	Infant scale	1→ b	2→ b	3 08	8 08	1	2	8
08	Suction bulb for mucus extraction	1→ b	2→ b	3 09	8 09	1	2	8
09	Suction apparatus for use with catheter	1 →b	2→ b	3 10	8 10	1	2	8
10	Resuscitation table for baby with heat source	1	2	3	8			
11	Towel to wipe baby	1	2	3	8			
12	Blanket to wrap baby	1	2	3	8			
534	GUIDELINES/ PROTOCOLS	(a) AVAILABILITY						
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Essential maternal & Neonatal care clinical Guidelines for Kenya	1	2	3	8			
02	Other guidelines for normal delivery	1	2	3	8			
03	Guidelines for emergency obstetric care	1	2	3	8			
04	Basic pediatric protocols	1	2	3	8			
05	Neonatal resuscitation flow diagram	1	2	3	8			
06	Protocol on neonatal feeding	1	2	3	8			
07	Wallcharts of EmONC	1	2	3	8			
08	Protocol on management of jaundice	1	2	3	8			
09	Blank partographs	1	2	3	8			
	ANY PARTOGRAPH REGARDLESS OF WHETHER IT IS SEPARATE PAPERS OR ON THE MOTHER'S CARD							

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
535	CHECK Q533(05) IF INCUBATOR IS AVAILABLE IN UNIT YES, OBSERVED OR REPORTED ☐ NO ☐ →		537
536	Is there someone in the unit who has received technical training to operate the incubator?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
537	Now I will ask you a few questions about the management of 3rd stage of labour. For each of the following practices for managing 3rd stage of labour, please tell me if this is: **i)** a routine practice, or **ii)** selectively done (depending on the condition of the client or the provider conducting the delivery), or **iii)** it is never carried out.		
01	Administration of uterotonic medicine (e.g., Oxytocin)?	YES, ROUTINELY . . . . . 1 YES, SELECTIVELY . . . . . 2 NEVER CARRIED OUT. 3	→ 03 → 03
02	How many minutes after delivery of the baby is the medicine usually administered?	IMMEDIATELY/WITHIN 1 MINUTE. . . . 1 WITHIN 5 MINUTES. . . . . 2 NO SPECIFIC PRACTICE. . . . . 3 OTHER _____ 6 (SPECIFY)	
03	Application of controlled cord traction.	YES, ROUTINELY . . . . . 1 YES, SELECTIVELY . . . . . 2 NEVER 3	→ 05 → 05
04	Can you describe the technique used when applying cord traction? In other words, how is it actually done? DOES THE PROVIDER INDICATE THAT COUNTER TRACTION IS APPLIED TO THE UTERUS? **DO NOT PROMPT.**	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
05	Massaging the fundus through the abdomen.	YES, ROUTINELY . . . . . 1 YES, SELECTIVELY . . . . . 2 NEVER 3	
538	Now I want to ask you about routine practices related to the newborn at this facility. I am using the term "routine" to indicate that the activity is conducted for essentially all newborns or their mothers.		
01	Is skin-to-skin or Kangaroo Mother Care a normal practice in this facility? That is, as soon as possible after birth the baby is put in skin contact with the mother?	YES, ROUTINELY. . . . . 1 YES, NOT ROUTINELY. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	
02	Is rooming-in the normal practice in this facility? That is, does the newborn stay in the same bed with the mother?	YES, ROUTINELY. . . . . 1 YES, NOT ROUTINELY. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	
03	Does this facility routinely provide vitamin A to mothers before their discharge?	YES, ROUTINELY. . . . . 1 YES, NOT ROUTINELY. . . . . 2 NO. . . . . 3 DON'T KNOW. 8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
539	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 (Kangaroo MC)	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	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	
540	How is the umbilical cord treated? ASK FOR EACH ITEM IF IT IS APPLIED AND CIRCLE ALL PRACTICES THAT ARE ROUTINELY USED	APPLY SPIRIT/ALCOHOL . . . . . A APPLY OTHER ANTISEPTIC . . . . . B APPLY NOTHING TO CORD . . . . . C WRAP WITH DRY DRESSING . . . D OTHER _____ X (SPECIFY)			
541	How is the newly delivered placenta kept prior to final disposal? ASK TO SEE ANY CONTAINER THAT IS USED. CIRCLE ALL TYPES OF CONTAINERS REPORTED AND OBSERVED FOR IMMEDIATE PLACEMENT OF PLACENTA	**PUT IN CONTAINER** COVERED LEAKPROOF. . . . . A UNCOVERED LEAKPROOF. . . . . B DOUBLE PLASTIC BAGS. . . . . C NOT LEAKPROOF. . . . . D OTHER _____ X (SPECIFY)			
542	What are the most common methods used for final disposal of the placenta? …any others? CIRCLE ALL THAT APPLY.	GIVE TO FAMILY. . . . . A DISPOSE IN PLACENTA PIT. . . . . B INCINERATE. . . . . C BURN. . . . . D BURY. . . . . E OTHER _____ X (SPECIFY)			
543	Does this facility handle assisted deliveries—that is, use forceps or Ventous (vacuum extractor)? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES . . . . . 1 NO 2			→ 546

544	CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.							
		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Ventous (vacuum extractor)	1 → b	2 → b	3 → 545	8 → 545	1	2	8

545	Has an assisted delivery been conducted in this facility within the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8		
546	Has neonatal resuscitation been performed in this facility in the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

549 Now I am going to ask you about other medical interventions for management of complications during labour or delivery. For each intervention, please tell me if this is ever provided at this facility, and if yes, if it has been conducted in this facility within the past 3 months?

	INTERVENTION	(a) EVER PROVIDE			(b) PROVIDED IN PAST 3 MONTHS		
		YES	NO	DK	YES	NO	DK
01	Parenteral antibiotics (i.e., IV or IM)	1 → b	2 → 02	8 → 02	1	2	8
02	Parenteral oxytocics (i.e., IV or IM)	1 → b	2 → 03	8 → 03	1	2	8
03	Parenteral anti-convulsants for hypertensive disorders of pregnancy (i.e., IV or IM)	1 → b	2 → 04	8 → 04	1	2	8
04	Manual removal of placenta	1 → b	2 → 550	8 → 550	1	2	8

			GO TO
550	Does this facility provide blood transfusions? IF YES: Is there a blood bank or are there transfusion services only?	YES, TRANSFUSION, YES, BLOOD BANK . . . . . 1 YES, TRANSFUSION, NO BLOOD BANK . . . . . 2 NO BLOOD TRANSFUSION . . . 3	→ 552
551	Has blood transfusion been undertaken for maternity care by this facility during the past 3 months?	YES . . . . . 1 NO . . . . . 2 NO FACILITY DELIVERIES. . . . . 3 DON'T KNOW 8	→ 570
552	Does this facility ever perform emergency Caesarean sections?	YES . . . . . 1 NO 2	→ 561

553	Is there a fee for admissions to perform Caesarean sections for: [READ ITEMS LISTED IN 01 - 03] IF YES: Please tell me the amount of the fee for:	YES	AMOUNT IN KSH **[99998 IF FEE NOT KNOWN]**	NO	DK
01	GENERAL PUBLIC	1		2	8
02	PRIVATE USERS	1		2	8
03	FOREIGN PRIVATE USERS	1		2	8

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

554 ASK TO SEE THE ROOM WHERE CAESAREAN SECTIONS ARE PERFORMED. CHECK IF THE FOLLOWING EQUIPMENT AND SUPPLIES ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT ROOM

	EQUIPMENT AND SUPPLIES FOR CAESAREAN SECTION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Operating table	1→b	2→b	3 → 02	8 → 02	1	2	8
02	Operating light	1→b	2→b	3 → 03	8 → 03	1	2	8
03	Anaesthetic machine	1→b	2→b	3 → 04	8 → 04	1	2	8
04	Scrub area adjacent to or in the operating room	1	2	3	8			
05	Tray, drum, or package with sterilized instruments ready for use	1	2	3	8			
06	Emergency source of light	1→b	2→b	3 → 07	8 → 07	1	2	8
07	Suction apparatus for use with catheter	1→b	2→b	3 → 08	8 → 08	1	2	8
08	Suction bulb for mucus extraction	1→b	2→b	3 → 09	8 → 09	1	2	8
09	Disposable cord ties or clamps	1	2	3	8			
10	Blanket to wrap baby.	1	2	3	8			

555	Does this facility have a health worker who can perform a Caesarean section present in the facility or on call 24 hours a day (including weekends and public holidays)? IF YES, ASK TO SEE A SCHEDULE FOR 24-HOUR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	
556	Does this facility have an anaesthetist present in the facility or on call 24 hours a day (including weekends and public holidays)? IF YES, ASK TO SEE A SCHEDULE FOR 24-HOUR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	
557	Is there a register where Caesarean section data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 561 → 561
558	RECORD THE NUMBER OF CAESAREAN SECTIONS CONDUCTED AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF CAESAREAN. . . . ☐☐☐☐ DON'T KNOW. 9998	→ 561
559	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . ☐☐ DON'T KNOW 98	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
560	MONTH AND YEAR OF LAST CAESAREAN SECTION? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	MONTH ☐☐ YEAR ☐☐☐☐ DK . . . . 98 DK 9998	
561	Does this facility have a health worker who can repair obstetric fistulae?	YES . . . . . 1 NO . . . . . 2 → 565 DON'T KNOW . . . . . 8 → 565	
562	Is there a register where fistula repair data is recorded? IF YES, ASK: May I see the register?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 → 565 NO . . . . . 3 → 565	
563	RECORD THE NUMBER OF FISTULAE REPAIRED AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF FISTULAE REPAIRED . ☐☐☐☐ DON'T KNOW . . . . . 9998 → 565	
564	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA. . . . . ☐☐ DON'T KNOW 98	
565	Is this facility able to extract retained products of conception when necessary? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES . . . . . 1 NO . . . . . 2 → 570	

566 CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.

	EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Manual vacuum aspirator	1 → b	2 → b	3 → 02	8 → 02	1	2	8
02	Dilatation and curettage (D&C) kit	1	2	3	8			
03	Other _____	1 → b	2 → b	3 → 567	8 → 567	1	2	8

567	Has manual vacuum aspiration (MVA) been used to remove retained products of conception by this facility during the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
568	Has D & C been used to remove retained products of conception by this facility anytime during the past 3 months?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
	CERVICAL SCREENING		
570	Does this facility offer any services for screening changes in a woman's cervix to detect pre-cancerous and cancerous lesions? IF YES, WHICH SERVICES? PROBE: Anything else?	PAP SCREENING . . . . . A VISUAL INSPECTION . . . . . B HPV TEST . . . . . C OTHER _____ X (SPECIFY) NO . . . . . Y → 572 DON'T KNOW . . . . . Z	
571	If a woman is identified with a cervical pre-cancer (e.g., dysplasia), how is she commonly managed? Is she treated at, this facility, referred elsewhere, or both?	TREATED AT THIS FACILITY. . . . . A REFERRED WITHIN DISTRICT. . . . . B REFERRED OUTSIDE DISTRICT. . . . . C OTHER _____ X (SPECIFY) DON'T KNOW. . . . . Z	
572	AT THIS POINT, CHECK IF EITHER Q500 OR Q552 IS "1" [FACILITY OFFERS DELIVERY OR C-SECTION SERVICES]	YES . . . . . 1 NO . . . . . 2 → **END**	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	PROCESSING OF EQUIPMENT FOR REUSE		
573	After completing a delivery, what procedures does this service follow for initial handling of contaminated equipment (such as speculums, scalpel handles, etc.) that will be reused another time? IF THE UNIT PROCESSES SOME EQUIPMENT AND SENDS OTHER EQUIPMENT ELSEWHERE, INDICATE THE PROCEDURE FOR EQUIPMENT PROCESSED IN THIS SERVICE DELIVERY UNIT **IF VAGINAL DELIVERIES ARE CONDUCTED IN A DIFFERENT ROOM THAN CAESAREAN SECTION DELIVERIES, ASSESS THE PROCESSING EQUIPMENT FOR VAGINAL DELIVERIES.**	SOAKED IN DISINFECTANT SOLUTION AND THEN BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 01 BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAK IN DISINFECTANT . . . . . 02 BRUSH SCRUBBED WITH SOAP AND WATER ONLY . . . . . 03 SOAKED IN DISINFECTANT, NOT BRUSH SCRUBBED . 04 CLEAN WITH SOAP AND WATER, NOT BRUSH SCRUBBED . 05 OTHER _____ . 06 (SPECIFY) NO EQUIPMENT EVER REUSED 07 DON'T DECONTAMINATE HERE . . 95	→ 581 → 575
574	Are there written guidelines for how to decontaminate equipment? IF YES, ASK: May I see them?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO . 3	
575	Where is this equipment then ***finally*** processed prior to reuse? IF THE SYSTEM AT THAT LOCATION HAS ALREADY BEEN SEEN, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "2 " AND CONTINUE.	SECTION 1 [Q151-153] . . . . . 1 NOT PREVIOUSLY SEEN . . . . . 2 PROCESS OUTSIDE FACILITY 3 NO EQUIPMENT PROCESSED 4	→ 578(6) → 578(6) → 578(6)
576	What is the ***final method*** most commonly used for HLD or sterilizing medical equipment (such as surgical instruments) before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE METHOD(S) USED FOR METAL EQUIPMENT SUCH AS SPECULUMS OR FORCEPS.	DRY-HEAT STERILIZATION . . . A AUTOCLAVING . . . . . B BOILING. . . . . C STEAM HLD. . . . . D CHEMICAL HLD. . . . . E PROCESSED OUTSIDE FACILITY F	→ 578(6)

577	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Electric autoclave (PRESSURE AND WET HEAT)	1→ b	2→ b	3 02	8 02	1	2	8
02	Non-electric autoclave (PRESSURE/WET H)	1 →b	2 →b	3 03	8 03	1	2	8
03	Electric dry heat sterilizer	1→ b	2→ b	3 04	8 04	1	2	8
04	Electric boiler or steamer (no pressure)	1→ b	2→ b	3 05	8 05	1	2	8
05	Non-electric pot with cover (FOR STEAM/ BOIL)	1	2	3	8			
06	Heat source for non-electric equipment	1→ b	2→ b	3 07	8 07	1	2	8
07	Automatic timer (MAY BE ON EQUIPMENT)	1 →b	2 →b	3 08	8 08	1	2	8
08	TST Indicator strips or other item that indicates when sterilization is complete.	1	2	3	8			
09	Written protocols or guidelines for sterilization of disinfection	1	2	3	8			

578 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED

		(1) Dry heat sterilization	(2) Autoclave (steam with pressure)	(3) Boil	(4) Steam High Level Disinfection (HLD)	(5) Chemical High Level Disinfection (HLD)	(6) Initial decontamination
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 → 6	USED . . . . . 1 NOT USED . . 2 → 579
B	Temperature (centigrade)	TEMPERATURE [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW . . . 998	TEMPERATURE [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
C	Pressure		PRESS-URE [ ][ ][ ] AUTOMATIC 666 → 2E DON'T KNOW 998 → 2E				
D	Units of pressure		UNITS OF PRESSURE: KG/SQ CM . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4				
E	Minutes-when equipment is not wrapped in cloth	MINUTES [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW . . . 998	MINUTES [ ][ ][ ] AUTOMATIC . . . . . 666 NOT USED. . . . . 995 DON'T KNOW 998	MINUTES [ ][ ][ ] DON'T KNOW . . . 998	MINUTES [ ][ ][ ] DON'T KNOW . . . 998	MINUTES [ ][ ][ ] DON'T KNOW . . . 998	MINUTES [ ][ ][ ] DON'T KNOW . . . 998
F	Minutes when equipment is wrapped		MINUTES WRAPPED [ ][ ][ ] AUTOMATIC . . . . 666 DON'T KNOW . . . 998				
G	Chemical disinfectant used					ALCOHOL. . . . . 01 BETHADINE . . . . . 02 CHLORINE. . . . . 03 CIDEX . . . . . 04 FORMALDEHYDE. . . 05 GLUTERALDEHYDE. 06 DON'T KNOW. 98	ALCOHOL. . . . . 01 BETHADINE . . . . . 02 CHLORINE. . . . . 03 CIDEX . . . . . 04 FORMALDEHYDE. . 05 GLUTERALDEHYDE 06 NO CHEMICAL . . . . 07 DON'T KNOW. 98
H	Formulation					LIQUID . . . . . 1 POWDER . . . . . 2 TABLET 3	LIQUID . . . . . 1 POWDER . . . . . 2 TABLET 3
I	Percent CHEMICAL before dilution					PERCENT [ ][ ][ ] DON'T KNOW . . 998	PERCENT [ ][ ][ ] DON'T KNOW . . 998
J	Mixture, parts solution and water					MIXTURE PARTS/LIQUID a) DISINFECTANT [ ] b) WATER [ ][ ] DK 998	MIXTURE PARTS/LIQUID a) DISINFECTANT [ ] b) WATER [ ][ ] DK 998

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
579	INDICATE ALL STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (SUCH AS SPECULUM , FORC-EPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT PREVIOUSLY ASSESSED, CIRCLE "2" AND CONTINUE	SECTION 1 [Q154] . . . . . 1 NOT PREVIOUSLY SEEN 2				→ **END**
580	INDICATE STORAGE CONDITIONS FOR PROCESSED EQUIPMENT USED FOR THIS SERVICE DELIVERY AREA.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile paper, sealed with tape	1	2	3	8	
02	Stored in sterile container with lid that clasps shut	1	2	3	8	
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8	
04	On tray, covered with cloth or wrapped without sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other Sterile Storage	1	2	3	8	
07	Other Non-sterile Storage	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
580A	IS THE STORAGE LOCATION DRY AND CLEAN?	YES . . . . . 1 NO 2				
581	ASSESS CONDITION OF DELIVERY SERVICE AREA	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	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2			
04	**WALLS:** REASONABLY CLEAN					
05	**DOORS:** NO (OR MINOR) DAMAGE	1	2			
06	**WALLS:** NO (OR MINOR) DAMAGE	1	2			
07	**ROOF:** NO (OR MINOR) DAMAGE	1	2			
08	**CEILING:** NO (OR LITTLE) WATER STAINS/DAMAGE	1	2			
09	NEEDLES, SHARPS OUTSIDE SHARPS BOX	1	2			
10	SHARPS BOX OVERFLOWING OR TORN/PIERCED	1	2			
11	BANDAGES/INFECTIOUS WASTE LYING UNCOVERED	1	2			

THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.

6. Services for Reproductive Tract and Sexually Transmitted Infections

Facility Number: | | | | | | **Interviewer Code:** | | |

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
600	Does this facility offer any services for the diagnosis or treatment of STIs? That is, if a client comes with symptoms that may be an STI, will he or she receive any services for the diagnosis or treatment of the STI?	YES . . . . . 1 NO . . . . . 2 →	**END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF SERVICES FOR STIs. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH Q601.
READ THE FOLLOWING TO NEW RESPONDENTS:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a survey of health facilities to assist the government in knowing more about health services in Kenya. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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?

				2	**0**	**1**	**0**
Interviewer's signature	DAY		MONTH	YEAR			

(Indicates respondent's willingness to participate)

601	May I begin the interview now?	YES . . . . . 1 NO . . . . . 2 →	STOP
602	Are services for STI clients being offered at this facility today?	YES . . . . . 1 NO 2	
603	Are STI services primarily offered in a special STI clinic or through general outpatient services, or comprehensive care center?	SPECIAL STI CLINIC. . . . . 1 GENERAL OUTPATIENT. . . . . 2 COMPREHENSIVE CARE CENTER. 3	
604	How many days in a month are STI services available in either the special/the general clinic? USE A 4-WEEK MONTH TO CALCULATE DAYS	DAYS IN MONTH	
604A	Does this facility have any routine user-fees or charges for any STI related services? This includes any fees, including those for registration, health card/booklet, medicines or lab investigations?	YES. . . . . 1 NO. . . . . 2 →	605

604B	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for STI services and the amount of the fee:	(a) FEE YES	NO	DON'T KNOW	(b) AMOUNT IN KSH
01	Fee for the health card/booklet	1→ b	2 → 02	8 → 02	
02	Is there a fee for registration?	1→ b	2 → 03	8 → 03	
03	Fee for the consultation	1→ b	2 → 04	8 → 04	
04	Fee for lab test	1	2	8	
05	Fee for medicines?	1	2	8	

604C	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3
605	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY.	SYNDROMIC APPROACH. . . . . A ETIOLOGIC (LAB). . . . . B CLINICAL JUDGEMENT (NO PROTOCOL) C

606 FOR EACH OF THE FOLLOWING LABORATORY TESTS, ASK:
Does this service (or facility) use any laboratory test for diagnosing [THE INDICATED ILLNESS]?

IF YES, ASK:
Do you: 1) conduct the test in this facility, or, 2) collect the specimen and send it elsewhere for the test, or, 3) does the client have to go somewhere else for the test?

	FOR EACH TEST CONDUCTED AT FACILITY ASSESS AVAILABILITY OF EQUIPMENT AND SUPPLIES USING LABORATORY QRE.	CONDUCT TEST	COLLECT SPECI-MEN	SEND CLIENT ELSEWHERE	TEST NOT UTILISED	DON'T KNOW
01	Syphilis	1	2	3	4	8
02	Gonorrhea	1	2	3	4	8
03	HIV	1	2	3	4	8
04	Chlamydia	1	2	3	4	8
05	Trichomoniasis	1	2	3	4	8
06	Candidiasis	1	2	3	4	8

607	Does this facility have any STI guidelines IF YES, ASK TO SEE A COPY.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
608	Does the facility normally perform partner notification or follow-up? IF YES: Is the follow-up 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)?	YES, ALWAYS ACTIVE . . . . . 1 YES, SOMETIMES ACTIVE. . . . . 2 YES, ONLY PASSIVE. . . . . 3 NO. . . . . 4 DON'T KNOW 8	610
609	Do you have a form–a referral form or a register where records are kept about clients for active follow-up? IF YES, ASK TO SEE A COPY.	YES, FORM OBSERVED. . . . . 1 YES, REGISTER OBSERVED. . . . . 2 YES, FORM OR REGISTER REPORTED, NOT SEEN. . . . . 3 NO. 4	

610	Is there a register where information is recorded on STI consultations? IF YES, ASK TO SEE THE REGISTER. MAY BE GENERAL OPD REGISTERS.	YES, OBSERVED. . . . . 1 YES, REPORTED, NOT SEEN. . . . . 2 → 616 NO. . . . . 3 → 616	
611	SCAN THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE IF THE INDICATED INFORMATION IS RECORDED FOR ALL CLIENTS RECEIVING SERVICES THIS CLINIC/UNIT	CLIENT NAME. . . . . A CLIENT AGE. . . . . B CLIENT SEX. . . . . C DIAGNOSIS/MAIN SYMPTOM. . . . . D NONE OF THE ABOVE. . . . . Y	
612	WERE THERE ANY DIAGNOSES NOTED THAT INDICATED A CLIENT HAD AN STI OR A REPRODUCTIVE TRACT INFECTION? IF YES, CIRCLE WHICH OF THE INDICATED INFORMATION WAS OBSERVED FOR ANY CLIENTS	SYMPTOM (DISCHARGE/PAIN). . . . . A GENERAL DIAGNOSIS (STI/RTI). . . . . B SPECIFIC TYPE OF STI/RTI. . . . . C OTHER INDICATION OF STI/RTI _____ X (SPECIFY) NONE OF THE ABOVE. . . . . Y → 616	
613	HOW MANY DAYS AGO WAS THE LAST ENTRY MADE IN THE REGISTER? NOTE: THE DAY OF THE INTERVIEW IS DAY "0".	WITHIN THE PAST 7 DAYS . . . . . 1 MORE THAN 7 DAYS OLD 2	
614	RECORD THE **TOTAL** NUMBER OF CLIENTS WHO RECEIVED STI SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF STI CLIENTS [ ][ ][ ][ ]	
614A	RECORD THE NUMBER OF ***FEMALE*** CLIENTS WHO RECEIVED STI SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF FEMALE STI CLIENTS [ ][ ][ ][ ]	
615	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . [ ][ ]	
616	Is there any evidence of looking at service data for evaluating or monitoring services? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH. . . . . A WRITTEN REPORT/MINUTES. . . . . B OTHER_____ X (SPECIFY) NO OBSERVED EVIDENCE. . . . . Y	
617	Do you submit an official report externally that specifically identifies numbers of cases of STI syndromes, or specific STIs such as syphilis or HIV/AIDS seen by the facility services?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
618	ASK TO SEE WHERE COUNSELLING FOR CLIENTS WITH SYMPTOMS OF STI IS PROVIDED. DESCRIBE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY. . . . . 3 AUDITORY PRIVACY ONLY. . . . . 4 NO PRIVACY 5	

	ASK TO SEE EACH OF THE FOLLOWING ITEMS, AND ASSESS IF THE ITEM IS IN THE ROOM (OR AN ADJACENT ROOM) WHERE COUNSELLING OR EXAMINATION OF STI CLIENTS TAKES PLACE.				
619	**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 (e.g., Femidom) that can be given to the client	1	2	3	8
620	**SERVICE DELIVERY STANDARDS/PROTOCOLS**				
01	Guidelines for the syndromic management of Sexually Transmitted Diseases	1	2	3	8
02	Etiologic (laboratory) diagnosis of STIs	1	2	3	8
03	Any other Treatment protocols for STIs	1	2	3	8
04	Syndromic approach treatment flowchart	1	2	3	8
05	Guidelines for diagnosing HIV/AIDS	1	2	3	8
06	Cervical screening guidelines	1	2	3	8
621	Is there a policy (or guideline) that all STI clients should be offered an HIV test? IF YES, ASK TO SEE THE POLICY/GUIDELINE	YES, OBSERVED. . . . . 1 YES, REPORTED, NOT SEEN. . . . . 2 NO. 3			
622	Are all STI clients routinely referred for HIV testing?	YES, ROUTINELY. . . . . 1 ONLY IF CLIENT SUSPECTED TO BE HIV POSITIVE . . . . 2 NO. 3			
623	Where are the clients sent for HIV testing? PROBE FOR A SPECIFIC UNIT WITHIN FACILITY, OR SPECIFIC LOCATION OUTSIDE FACILITY TO BE NAMED	LOCATION NAMED INSIDE FACILITY . . . . . 1 OUTSIDE FACILITY . . . . . 2 DON'T KNOW SPECIFIC LOCATION 3			

624	Are individual client health records or booklets used? IF YES, ASK TO SEE EITHER A USED OR NEW CLIENT HEALTH CARD/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
625	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR STIs ARE CONDUCTED.		
	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 626, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	GENERAL INFORMATION [Q190]. . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] . . . . . 15 SECTION 17 - TB [Q1719] . . . . . 17 SECTION 18-CT [Q1822] . . . . . 1 NOT PREVIOUSLY SEEN 19	626A

626 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE CLIENTS ARE EXAMINED OR IN AN ADJACENT ROOM.

	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC LINER	1 → 11	2	3	
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1	2	3	
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3	
13	DISPOSABLE NON-LATEX GLOVES	1	2	3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
15	DISPOSABLE NEEDLES	1	2	3	
16	AUTO-DISABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
17	DISPOSABLE SYRINGES (2, 3 OR 5 ml)	1	2	3	
18	PRIVATE ROOM	1 → 21	2	3	
19	AUDITORY PRIVACY	1	2	3	
20	VISUAL PRIVACY	1	2	3	
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3	

626A	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 626B, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q321]. . . . . 13 ANTENATAL CARE [Q428]. . . . . 14 DELIVERY [Q530A]. . . . . 15 NOT PREVIOUSLY SEEN. 19	→ 627

626B	SUPPLIES AND EQUIPMENT REQUIRED FOR EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→ b	2→ b	3 → 02	8 → 02	1	2	8
02	Manual BP Apparatus	1→ b	2→ b	3 → 03	8 → 03	1	2	8
03	Stethoscope	1→ b	2→ b	3 → 04	8 → 04	1	2	8
04	Automatic BP Apparatus	1→ b	2→ b	3 → 05	8 → 05	1	2	8
05	Examination couch	1	2	3	8			

627	OTHER SUPPLIES AND EQUIPMENT REQUIRED FOR EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Vaginal speculum (s)	1→ b	2→ b	3 → 02	8 → 02	1	2	8
02	Vaginal speculum (m)	1→ b	2→ b	3 → 03	8 → 03	1	2	8
03	Vaginal speculum (l)	1→ b	2→ b	3 → 04	8 → 04	1	2	8
04	Swab sticks for taking specimen	1	2	3	8			

THANK YOUR RESPONDENT AND MOVE TO THE NEXT DATA COLLECTION POINT.

SECTION 14. HEALTH MANAGEMENT INFORMATION SYSTEM (RECORD KEEPING)

Facility Number: | | | | | |

QRE TYPE **14**

Interviewer Code: | | |

1400	INDICATE WHICH UNITS THESE DATA REPRESENT (WHEREVER RECORD KEEPING IS DONE)	OUTPATIENT ONLY . . . . . 1 INPATIENT ONLY . . . . . 2 BOTH IN AND OUTPATIENT . . . . . 3 NO HMIS IN FACILITY 4	→ **END**

FIND THE PERSON IN CHARGE OF THE HMIS REPORTS. IF HE/SHE IS NOT PRESENT, ASK TO SEE THE PROVIDER MOST KNOWLEDGEABLE ABOUT OR WHO WRITES HIV/AIDS HMIS REPORTS IN THIS FACILITY.

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE CLINIC/UNIT WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KENYA. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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

				2	0	1	0
DAY		MONTH		YEAR			

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1403	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1404	What is your technical background for completing the HMIS reports? PROBE IF NECESSARY	DATA CLERK/ACCOUNTANT . . . . . 1 HEALTH STATISTICS/MED RECORDS . . 2 PROFESSIONAL PROVIDER (e.g. R.NURSE) 3 SUB-PROFESSIONAL PROV.(e.g. E.NURSE). . . . 4 NON-CLINICAL PROV.(e.g. SOC.WORKER) 5 LABORATORY WORKER . . . . . 6 OTHER _____ 7 (SPECIFY)	
1405	Did you have special training in recording systems or reports for health information, such as training in the HMIS? IF YES, ASK: Was the training formal or informal? IF BOTH, RECORD FORMAL.	YES, FORMAL . . . . . 1 YES, INFORMAL . . . . . 2 NO 3	→ 1407
1406	When was your most recent training in HMIS or reporting on health statistics?	IN PAST 12 MONTHS . . . . . 1 IN PAST 1-3 YEARS . . . . . 2 MORE THAN 3 YEARS AGO 3	
1407	How many years have you been responsible for HMIS records/reports in this facility? RECORD '00' FOR LESS THAN ONE YEAR	YEARS	
1408	Do you conduct training of staff in HMIS, for example, recording, compiling, and reporting data? IF YES, ASK: Do you provide formal or informal training? IF BOTH, RECORD 'FORMAL'.	YES, FORMAL . . . . . 1 YES, INFORMAL . . . . . 2 NO 3	→ 1410
1409	Who do you train in HMIS? PROBE TO ARRIVE AT CORRECT RESPONSE	STAFF IN HMIS UNIT . . . . . A STAFF IN SERVICE UNITS . . . . . B STAFF IN HMIS AND SERVICE UNITS . . C STAFF IN OTHER FACILITIES D	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1410	Have you or other staff in this unit ever had any training in Strategic Information, such as monitoring and evaluation, or surveillance for HIV/AIDS?	YES . . . . . 1 NO 2	→ 1412
1411	Was the training on strategic information for HIV/AIDS, formal or informal? IF BOTH, RECORD 'FORMAL'.	FORMAL . . . . . 1 INFORMAL 2	

1412	Do you have any of the following guidelines/protocols? IF YES, ASK: May I see the guidelines please?	(a) OBSERVED	(a) REPORTED, NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	HMIS reporting guidelines (Standard Operating Procedures)	1 → b	2 → 02	3 → 02	
02	HIV/AIDS surveillance reporting guidelines	1 → b	2 → 03	3 → 03	
03	National technical guidelines for integrated disease surveillance and response	1 → b	2 → 04	3 → 04	
04	National HIV/AIDS reporting guidelines	1 → b	2 → 1413	3 → 1413	

1413	Do you receive or compile reports of services for confirmed or suspected HIV/AIDS cases from the following units? IF YES, ASK TO SEE A REPORT.	YES OBSERVED	YES, REPORTED NOT SEEN	NO REPORT	NOT APPLICABLE
01	Outpatient services (e.g., FP, STI, ANC)	1	2	3	4
02	Comprehensive Care Center (CCC)	1	2	3	4
03	Inpatient services	1	2	3	4
04	Laboratory services	1	2	3	4
05	Family planning services	1	2	3	4
06	STI services	1	2	3	4
07	Tuberculosis services	1	2	3	4
08	HIV counselling and testing services	1	2	3	4
09	Antiretroviral treatment services	1	2	3	4
10	Prevention of mother-to-child transmission services	1	2	3	4
11	Sources based outside facility (e.g., community health	1	2	3	4
12	Other _____ (SPECIFY)	1	2	3	4

1414	Do you receive or compile reports of deaths in the facility attributed to HIV/AIDS?	YES OBSERVED	YES REPORTED NOT SEEN	NO REPORT	NOT APPLIC.
	IF YES, ASK TO SEE A REPORT	1	2 → 1417	3 → 1419	4 → 1419

1415	RECORD THE NUMBER OF DEATHS ATTRIBUTED TO HIV/AIDS REPORTED FOR PAST 12 MONTHS	NUMBER OF DEATHS	
1416	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA	
1417	How frequently are reports on deaths submitted to someone outside of this facility?	MONTHLY OR LESS . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 MORE THAN EVERY 6 MONTHS . . . . . 4 NEVER 5	→ 1419
1418	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL . . . . C PROVINCIAL LEVEL . . . . D NATIONAL LEVEL . . . . E DONOR AGENCY . . . . . F OTHER _____ (SPECIFY) X	

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1419	Do you receive or compile reports of newly diagnosed HIV cases in the facility? IF YES, ASK TO SEE A REPORT	YES OBSERVED 1	YES REPORTED NOT SEEN 2 → 1422	NO REPORT 3 → 1424	NOT APPLIC. 4 → 1424
1420	RECORD THE NUMBER OF NEWLY DIAGNOSED HIV CASES DURING THE PAST 12 MONTHS	NEW HIV CASES . . . . . [ ][ ][ ][ ]			
1421	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]			
1422	How frequently are reports on newly diagnosed HIV cases submitted to someone outside of this facility?	MONTHLY OR LESS . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 MORE THAN EVERY 6 MONTHS . . . . . 4 NEVER 5			→ 1424
1423	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL . . . . C PROVINCIAL LEVEL . . . . . D NATIONAL LEVEL . . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)			
1424	Do you receive or compile reports on client diagnoses for inpatient admissions/discharges and/or outpatient visits? IF YES, ASK TO SEE A REPORT. RECORD THE NUMBER OF PATIENTS WITH THE FOLLOWING DIAGNOSES- USE EITHER THE COMPILED REPORT, THE COMPUTER SYSTEM, OR UNIT RECORDS SUBMITTED TO THE HMIS.	INFORMATION AVAILABLE INFORMATION REPORTED . . . . . 1 AVAILABLE, BUT NOT SEEN . . . . . 2 INFORMATION NOT AVAILABLE 3			 → 1428A → 1428A

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1425	INDICATE CLIENT INFORMATION FOR WHICH THE FOLLOWING QUESTION IS COMPLETED.	OUTPATIENT CLIENTS ONLY 1 INPATIENT CLIENTS ONLY 2 BOTH OUTPATIENT AND INPATIENT 3	
1426	RECORD THE NUMBER OF CLIENTS WITH THE ADMISSION/DISCHARGE/VISIT DIAGNOSES BELOW, FOR THE PAST 3 MONTHS OR FOR ABOUT 100 PATIENTS. ENSURE DATA INCLUDES PEDIATRICS AND ADULTS. IF MORE THAN ONE DIAGNOSIS IS INDICATED FOR A CLIENT, CHOOSE THE ONE MOST INDICATIVE OF HIV/AIDS RELATED ILLNESS. **IF THIS INFORMATION IS NOT FOUND IN THE HMIS, GO TO THE OUTPATIENT OR INPATIENT UNIT WHERE IT IS MORE LIKELY YOU WILL FIND IT.**		

		NUMBER (A) OUTPATIENT VISITS	NUMBER (B) INPATIENT ADMISSIONS/DISCHARGES
1	ORAL CANDIDIASIS/MOUTH SORES		
2	CRYPTOCOCCAL MENINGITIS		
3	TOXOPLASMOSIS		
4	KAPOSI'S SARCOMA		
5	AIDS-RELATED COMPLEX (ARC)		
6	HERPES ZOSTER/SIMPLEX		
7	PCP (PNEUMOCYSTIS CARINII PNEUMONIA)		
8	UNIDENTIFIED HIV-RELATED DIAGNOSIS (e.g., ISS)		
9	WASTING SYNDROME FAILURE TO THRIVE (FTT)		
10	CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)		
11	TUBERCULOSIS		
	OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES		
12	PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO)		
13	LYMPHADENOPATHY		
14	OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY) _____		

1427	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN THE PREVIOUS QUESTION		
1428	RECORD THE TOTAL NUMBER OF OUTPATIENT VISITS AND INPATIENT ADMISSIONS/ DISCHARGES FOR ALL HIV AND NON-HIV DIAGNOSES, FOR THE TIME PERIOD INDICATED IN Q.1426	TOTAL OPD VISITS TOTAL IPD ADMISSIONS/DISCHARGES	
1428A	Is there a register where information is recorded on malaria consultation? IF YES, ASK TO SEE THE REGISTER.	YES, OBSERVED ..... 1 YES, REPORTED NOT SEEI ..... 2 NO 3	→ END → END

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1429	RECORD THE NUMBER OF MALARIA CASES IN THE GROUPS INDICATED BELOW FOR THE PAST 12 COMPLETED MONTHS. FOR EACH GROUP, INDICATE IN COLUMN "A" THE TOTAL NUMBER OF REPORTED CASES SEEN AND IN COLUMN "B" THE NUMBER OF CONFIRMED CASES (BY RDT / LAB TEST).		
	AGE GROUPS / (A) TOTAL NUMBER OF CASES / (B) TOTAL NUMBER OF CASES TESTED / (C) NUMBER OF CONFIRMED CASES (BY LABORATORY OR TESTS)		
	1 ALL ADULTS (14 YRS AND UP)		
	2 PREGNANT WOMEN		
	3 CHILDREN UNDER 5 YEARS		
	4 CHILDREN 5 TO 13 YEARS		
	5 TOTAL CASES		
	DON'T KNOW 99998 / DON'T KNOW 99998 / DON'T KNOW 99998		
1430	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN THE PREVIOUS QUESTION — NUMBER OF MONTHS		
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 15: LABORATORY AND OTHER DIAGNOSTICS

Facility Number: | | | | | |

QRE TYPE **15**

Interviewer Code: | | |

1500	INDICATE SETTING FOR LAB	LAB IN FACILITY . . . . . 1 AFFILIATED EXTERNAL LAB . . . 2 AREA LOCKED/NO ACCESS . . . 3 FACILITY HAS NO LAB 4	→ **END**
1501	Does this lab provide services for both outpatients and inpatients, or does it provide services for outpatients only, or inpatients only?	OUTPATIENT ONLY . . . . . 1 INPATIENT ONLY . . . . . 2 BOTH OUT- AND INPATIENTS . . 3	
1503	CHECK QUESTION Q1500. IS THE RESPONSE '3', NO ACCESS?	YES . . . . . 1 NO 2	→ **STOP**

START DATA COLLECTION IN THE MAIN LABORATORY.
FOR EACH OF THE LABORATORY PROCEDURES OF INTEREST, GO TO THE MAIN LOCATION IN THE FACILITY WHERE THE TEST/INFORMATION IS LOCATED. IF A TEST/INFORMATION IS NOT IN THAT LOCATION, ASK IF IT IS ANYWHERE ELSE IN THE FACILITY AND GO THERE TO COMPLETE THE QUESTIONNAIRE.

IF THE PROVIDER IS DIFFERENT FROM ANY OF THE PREVIOUS RESPONDENTS, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE/SHE IS WILLING TO ANSWER A FEW QUESTIONS ABOUT LABORATORY SERVICES. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1' (YES) IN Q1504 BELOW AND GO ON TO Q1505.

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KENYA. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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

DAY	MONTH	YEAR
		2010

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1504	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1505	How many days in a week is the lab open to serve clients?	NUMBER OF DAYS OPEN	

1506 Now I have some questions about staffing for this LAB. Please tell me how many staff with each qualification are currently assigned to (or employed by) this lab, and how many are present today.

	QUALIFICATION	(a) STAFF ASSIGNED OR EMPLOYED	(b) STAFF PRESENT TODAY
01	(01) SPECIALIST (e.g., HAEMATOLOGIST)		
02	(20) LAB. SCIENTIST (e.g., B.Tech, B.Chem)		
03	(21) LAB.TECHNOLOGIST (i.e., Diploma)		
04	(22) LAB. TECHNICIAN/ASSISTANT		
05	(96) OTHER:_____		
06	SUM THE NUMBER OF LAB STAFF REPORTED IN EACH COLUMN		

1507 FILTER: ONLY DO THIS IF THE STAFF LIST HAS NOT BEEN COMPLETED. IF COMPLETED CIRCLE "1" AND SKIP TO Q1508, OTHERWISE, PROCEED:

Now I would like to identify laboratory staff (such as lab technicians, lab technologists) or other staff (such as doctors, nurses, and counsellors) who are assigned to this LAB who are present today

Please give me the names and main service responsibility of the staff assigned to this LAB and present today.

COMPLETE THE STAFF LIST FOR THIS LAB. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.

	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2

1508 Now I would like to know about guidelines and protocols that are available in this laboratory area.

	please tell me if you have any of the following guidelines/protocols in the laboratory area. IF YES, ASK: May I see the guidelines please?	(a) OBSERVED	(a) REPORTED AVAIL. NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	Laboratory Safety Guidelines	1 → b	2 → 02	3 → 02	
02	National Infection Prevention and control guidelines for health care services in Kenya	1 → b	2 → 03	3 → 03	
03	Other guidelines for blood safety	1 → b	2 → 04	3 → 04	
04	Other universal /standard precautions for healthcare workers	1 → b	2 → 05	3 → 05	
05	Other infection prevention guidelines	1 → b	2 → 06	3 → 06	
06	Guidelines for post-exposure (HIV/AIDS) prophylaxis (PEP) for healthcare workers	1 → b	2 → 07	3 → 07	
07	Manual for laboratory technicians for TB screening	1 → b	2 → 08	3 → 08	
08	Any standard operating procedures (SOPs)	1 → b	2 → 1509	3 → 1509	

HIV TESTING

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1509	Does this laboratory conduct any tests for HIV? IF YES, ASK: Are the tests done to determine a persons HIV status, or to screening blood for transfusion, or for some other reason? PROBE AND CIRCLE ALL THAT APPLY.	FOR CLIENT HIV STATUS . . . . . A BLOOD SCREENING FOR TRANSFUSION . . . . . B MANDATORY (FOR EMPLOYMENT /VISA/WORK PERMIT) . . . . . C NO . . . . . Y	→ 1524

1510	Are there any guidelines related to [READ TOPICS BELOW]: IF YES, ASK: May I see the guideline please.	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	Protocols/guidelines for HIV testing procedures (who to test, which test to use)	1 → b	2 → 02	3 → 02	
02	Any written guidelines on how to conduct HIV test (may be manufacturers instructions)	1 → b	2 → 03	3 → 03	
03	Written guidelines on confidentiality and disclosure of HIV test results	1 → b	2 → 04	3 → 04	
04	Other guidelines relevant to HIV/AIDS or related services _____ (SPECIFY)	1 → b	2 → 1511	3 → 1511	

1511 Now I would like to see the equipment and the reagents necessary to conduct various tests.

	For each of the following tests or equipment, I would like to know if it is used, if it is functioning today, and, if relevant, if all items to conduct the test are available today.	(a) TEST CONDUCTED: Yes	(a) TEST CONDUCTED: No	(b) ARE ALL ITEMS FOR TEST AVAILABLE? OBSERVED	(b) REPORTED NOT SEEN	(b) NOT AVAILABLE	(c) IS THE ITEM IN WORKING ORDER? YES	NO	DON'T KNOW
01	ELISA/EIA scanner/reader and all items for test	1 → b	2 → 02	1 → c	2 → c	3 → 02	1	2	8
02	CD4 Count machine, and all items for test	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	Rapid test for HIV	1 → b	2 → 05	1	2	3 → 05			
05	Western Blot test	1 → b	2 → 06	1	2	3 → 06			
06	PCR for viral load	1 → b	2 → 07	1	2	3 → 07			
07	PCR for DNA-EID	1 → b	2 → 08	1	2	3 → 08			
08	Other HIV test _____ (SPECIFY)	1 → b	2 → 1512	1	2	3 → 1512			

1512	Do you have any record of HIV test results for tests conducted in this laboratory? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS.	YES . . . . . 1 NO 2	→ 1514

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1513	INDICATE IF THE SPECIFIED INFORMATION IS AVAILABLE AND IF SO, RECORD THE INDICATED CLIENT NUMBERS FOR THE PAST 12 MONTHS.	(a) RECORD AVAILABLE AND OBSERVED: YES / REPORTED NOT SEEN / NO RECORD; (b) NUMBERS FROM OBSERVED RECORDS: NUMBER OF CLIENTS / MONTHS OF DATA	
01	TOTAL CLIENTS HAVING HIV TEST DONE	1 → b; 2 → 02; 3 → 02	
02	TOTAL RESULTS GIVEN TO PROVIDERS & CLIENTS	1 → b; 2 → 03; 3 → 03	
03	TOTAL POSITIVE RESULTS GIVEN TO PROVIDERS	1 → b; 2 → 04; 3 → 04	
04	TOTAL POSITIVE RESULTS GIVEN TO CLIENTS ONLY (e.g. SELF REQUESTED)	1 → b; 2 → 1514; 3 → 1514	
1514	Is there an established system for **external** quality control for the HIV tests conducted by this laboratory? IF YES, PROBE FOR SYSTEM USED. CIRCLE ALL THAT APPLY	YES, PROFICIENCY PANEL . . . A YES, EXTERNAL INSPECTION/ OBSERVATION OF TECHNIQUE B SEND BLOOD FOR RETESTING C NOT ROUTINE, BUT SOMETIMES D NO EXTERNAL QUALITY CONTROL Y	→ 1517 → 1517 → 1517 → 1520
1515	CHECK PREVIOUS QUESTION. IS C CIRCLED? IF YES ASK: How do you determine ***when*** to send a blood sample for retesting?	SEND EVERY FIXED NUMBER OF TESTS . . . . . 1 SEND PERCENT OF TESTS . . . 2 SEND, BUT NO FIXED NUMBER . 3	 → 1517
1516	Please tell me the specific number or percentage for when you send the blood sample for retesting.	RECORD % OR NUMBER FOR 1 OR 2 IN Q1515	
1517	Is there a record of the results from the external quality check? IF YES, ASK TO SEE THE RECORD OR REPORT WHERE THE RESULTS ARE RECORDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1520 → 1520
1518	What is the most recent date for an external quality check test result or error rate?	WITHIN PAST ONE MONTH . . . . . 1 WITHIN PAST 2-6 MONTHS . . . . . 2 MORE THAN 6 MONTHS 3	
1519	What is the most recent error rate that is recorded by external quality control?	PERCENT ERROR RATE . . . . . DON'T KNOW 98	
1520	Other than external Quality Control, is there any other system used for quality control of laboratory tests for HIV/AIDS?	INTERNAL QUALITY CONTROL . 1 OTHER _____ 2 DESCRIBE NO 3	 → 1522
1521	Is there a record of the results from the internal/ other quality check? IF YES, ASK TO SEE THE RECORD OR REPORT WHERE THE RESULTS ARE RECORDED.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1522	Are there any fees assessed for any services or items related to HIV/AIDS tests?	YES . . . . . 1 NO 2	→ 1524
1523	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE: YES / NO / NA; (b) AMOUNT IN KSH	
01	HIV RAPID TEST	1 → b; 2 → 02; 3 → 02	
02	ELISA TEST	1 → b; 2 → 03; 3 → 03	
03	TEST FOR CD4 COUNT	1 → b; 2 → 04; 3 → 04	
04	FULL BLOOD COUNT	1 → b; 2 → 1524; 3 → 1524	
1524	Do you send blood outside the facility for HIV diagnostic testing?	YES . . . . . 1 NO 2	→ 1529
1525	For which HIV test do you send blood outside?	ELISA/EIA . . . . . A WESTERN BLOT . . . . . B PCR . . . . . C OTHER _____ X SPECIFY	
1526	Do you have a record with the result of the HIV/AIDS tests conducted elsewhere? IF YES, ASK TO SEE THE REGISTER	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	→ 1528
1527	Does the register indicate if the client or the provider has received the results?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
1528	After receiving the results, how are the results provided to the client? PROBE TO ARRIVE AT THE RIGHT RESPONSES.	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT . . . A LAB TELLS CLIENT VERBALLY . . . . B LAB PROVIDES RESULTS TO HEALTH WORKER/UNIT AND THEY TELL CLIENT . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
1529	Is any HIV pre- or post-test counselling ever provided to clients in the laboratory area?	YES . . . . . 1 NO 2	
1530	Do you send blood samples outside the facility for CD4 count, total lymphocyte count (TLC) or viral load testing?	YES, CD4 . . . . . A YES, TLC . . . . . B YES, VIRAL LOAD . . . . . C NONE OF THE ABOVE . . . . . Y	→ 1533
1531	Do you have a record with results of the tests conducted elsewhere? IF YES, ASK TO SEE THE REGISTER	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
1532	After receiving the results, how are the results provided to the client?	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT . . . . A LAB TELLS CLIENT VERBALLY . . B LAB PROVIDES RESULTS TO HEALTHWORKER WHO TELLS CLIENT . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1533	Does this laboratory or unit regularly compile reports of newly diagnosed HIV cases?	YES . . . . . 1 NO 2	→ 1538
1534	How frequently are the compiled reports submitted to someone outside this laboratory (or unit)?	MONTHLY OR LESS . . . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 MORE THAN EVERY 6 MONTHS . . . . . 4 NEVER 5	→ 1536
1535	To whom are the reports sent? CIRCLE ALL THAT APPLY	RECORDS CLERK . . . . . A FACILITY DIRECTOR/SUPERVISOR. . B DISTRICT LEVEL . . . . . C PROVINCIAL LEVEL . . . . . D NATIONAL LEVEL . . . . . E DONOR AGENCY . . . . . F OTHER _____ X (SPECIFY)	
1536	ASK TO SEE THE REPORT FOR NEWLY DIAGNOSED HIV CASES DURING THE PAST 12 MONTHS AND RECORD THE NUMBER OF CASES.	NEW HIV CASES [ ][ ][ ][ ][ ] REPORT NOT SEEN 99996	→ 1538
1537	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA [ ][ ]	
1538	Do you record results by the unit ordering the HIV test or test results? IF YES, ASK TO SEE THE REGISTER AND INDICATE FROM WHICH UNITS RESULTS FOR TESTS ARE RECORDED.	YES . . . . . 1 NO 2	→ 1540

1539	HIV RESULTS ARE RECORDED SEPARATELY FOR:	YES	NO	NOT APPLICABLE
01	VCT / CITC unit	1	2	3
02	PMTCT UNIT	1	2	3
03	Surveillance sites	1	2	3
04	Blood bank or blood for transfusion	1	2	3
05	General or specialty outpatient units (other than VCT or PMTCT UNITS) - e.g., DTC	1	2	3
06	In-patient units, either by separate units or as total inpatient units	1	2	3
07	By sero-status, irrespective of source	1	2	3

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1540	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE MAIN LABORATORY OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3	
10	WASTE RECEPTACLE WITHOUT COVER OR LINER.	1	2	3	
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3	
13	DISPOSABLE NON-LATEX GLOVES	1	2	3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
15	DISPOSABLE NEEDLES	1	2	3	
16	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
18	PRIVATE ROOM	1 → 21	2	3	
19	AUDITORY PRIVACY	1	2	3	
20	VISUAL PRIVACY	1	2	3	
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3	
1541	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES . . . . . 1 NO 2			
1543	Is there an autoclave in this laboratory or an immediately adjacent area? IF YES ASK: Is it functioning?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 YES, NOT FUNCTIONING . . . . . 3 NO AUTOCLAVE 4			
1544	Do you decontaminate hazardous waste prior to disposal? IF YES, ASK WHAT PROCEDURE IS USED FOR DECONTAMINATION.	USE CHLORINE-BASED SOLUTION (e.g., GIK) A PHENOL B OTHER _____ (SPECIFY) . X NO . . . . . Y			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1545	What is the final procedure for disposing of hazardous laboratory waste? PROBE TO ARRIVE AT THE USUAL PRACTICE FOR THE LAB	**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 HARZARDOUS WASTE 95	
1547	Does this facility determine the quantity of each test kit or reagent that it needs and order that, or is the quantity that you receive determined elsewhere?	DETERMINES NEEDS AND ORDERS 1 NEEDS DETERMINED ELSEWHERE 2 BOTH (DEPENDS ON KIT/REAGENT) 3 DON'T KNOW 8	

		(a) TEST CONDUCTED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
1548	Now I would like to see specific tests, or equipment necessary for these tests. Are the following tests or equipment available and functioning today?	Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ANY HEMATOLOGY TESTS	1	2 → 1549						
02	Haematology analyzer (for total lymphocyte count, full blood count, platelet count, etc.)	1 → b	2 → 03	1 → c	2 → c	3 → 03	1 → 1549	2	8
03	Hemoglobinometer/HemoCue	1 → b	2 → 04	1 → c	2 → c	3 → 04	1	2	8
04	Colorimeter or spectroscope	1 → b	2 → 06	1 → c	2 → c	3 → 06	1	2	8
05	Drabkin's solution (for colorimeter)			1	2	3			
06	Centrifuge for hematocrit	1 → b	2 → 08	1 → c	2 → c	3 → 08	1	2	8
07	Capillary tubes for hematocrit			1	2	3			
08	Litmus paper for haemoglobin test (with valid expiration date)	1 → b	2 → 09	1	2	3			
09	Other anaemia test_____ (SPECIFY)	1 → b	2 → 1549	1	2	3			

NO.	QUESTIONS	CODING CATEGORIES	GO TO

		(a) TEST CONDUCTED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?			(c) IS THE ITEM IN WORKING ORDER?		
1549	Are the following tests or equipment available and functioning today?	Yes	No	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ANY SYPHILIS TESTS	1	2 → 1550						
02	VDRL	1 → b	2 → 03	1	2	3			
03	PCR for STIs (CTN)	1 → b	2 → 04	1	2	3			
04	Rotator or shaker			1 → c	2 → c	3 → 05	1	2	8
05	Rapid plasma reagin test (RPR)	1 → b	2 → 1550	1	2	3			

BLOOD TRANSFUSION AND SCREENING (MAY NEED TO GO TO OTHER UNIT)

1550	Does this facility ever conduct blood typing? IF YES, ASK TO SEE THE ITEMS BELOW.	YES . . . . . 1 NO 2	→ 1552

1551		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	Anti-A Reagent (with valid expiration date)	1	2	3
02	Anti-B Reagent (with valid expiration date)	1	2	3
03	Anti-AB Reagent (with valid expiration date)	1	2	3
04	Anti-D Reagent (with valid expiration date)	1	2	3
05	Incubator (37 degrees Celsius)	1	2	3
06	Coomb's reagent	1	2	3

1552	Is blood ever transfused in this facility?	YES . . . . . 1 NO 2	→ 1558
1553	Is blood ever stored anywhere in the facility prior to transfusion? IF YES, ASK TO SEE THE FRIDGE THAT IS USED AND INDICATE THE STORAGE CONDITIONS	BLOOD/PLASMA STORED ALONE . . 1 BLOOD STORED W/MEDS/VACCINES 2 BLOOD STORED W/LAB REAGENTS 3 NO BLOOD EVER STORED . . . . . 4 UNABLE TO OBSERVE/DK 8	
1554	Does any place in this facility do blood screening for infectious diseases prior to transfusion? IF THE FACILITY RECEIVES BLOOD THAT IS ALREADY SCREENED, RESPONSE "2" APPLIES.	YES . . . . . 1 BLOOD SCREENED OUTSIDE FACILITY . . . . . 2 NO SCREENING TESTS DONE 3	→ 1558

1555	Is blood that is transfused in this facility screened for any of the following diseases? IF YES, ASK: Is the blood "always", "most of the time", rarely" or "never" screened for:	ALWAYS	MOST OF THE TIME	RARELY	NEVER
01	Syphilis	1	2	3	4
02	Hepatitis B	1	2	3	4
03	Hepatitis C	1	2	3	4
04	HIV	1	2	3	4

1556	Do you ever send blood outside for screening for any of the 4 tests mentioned in the previous question?	YES . . . . . 1 NO 2	→ 1558

1557	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	Syphilis	1 → b	2	1	2
02	Hepatitis B	1 → b	2	1	2
03	Hepatitis C	1 → b	2	1	2
04	HIV	1 → b	2	1	2

NO.	QUESTIONS	CODING CATEGORIES	GO TO

BIOCHEMISTRY

		(a) TEST CONDUCTED		(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
1558	Are items for the indicated tests available today? Is the equipment functioning?								
01	Blood chemistry analyzer that provides serum creatinine, glucose, liver function tests)	1→b	2 → 02	1→c	2→c	3 → 02	1 → 1559	2	8
02	Other means for serum glucose	1→b	2 → 1559	1→c	2→c	3 → 1559	1	2	8
1559 01	URINE TESTS / EQUIPMENT	1	2 → 1560						
02	Any dip sticks for urine protein (with valid expiration date)	1→b	2 → 03	1	2	3			
03	Any dip sticks for urine glucose (with valid expiration date)	1→b	2 → 04	1	2	3			
04	Acetic acid for checking urine albumin	1→b	2 → 06	1	2	3			
05	Flame for heating acetic acid			1→c	2→c	3 → 06	1	2	8
06	Benedict's solution (for glucose testing)	1→b	2 → 08	1	2	3			
07	Stove for boiling Benedict's solution			1→c	2→c	3 → 08	1	2	8
08	Centrifuge for urine testing	1→b	2 → 1560	1→c	2→c	3 → 1560	1	2	8
1560	Pregnancy test	1→b	2 → 1561	1	2	3			

			GO TO
1561	Do you ever send ***blood or urine*** outside the facility for blood chemistries, LFTs, urinalysis or pregnancy tests?	YES . . . . . 1 NO 2	→ 1563

		(a) SEND SPECIMEN OUTSIDE FOR TEST		(b) RECORD OF TEST RESULTS OBSERVED	
		YES	NO	YES	NO
1562	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.				
01	Blood chemistries (e.g., serum creatinine, glucose, etc.)	1→b	2	1	2
02	Liver Function Test (LFT)	1→b	2	1	2
03	Urinalysis	1→b	2	1	2
04	Pregnancy test	1→b	2	1	2

NO.	QUESTIONS	CODING CATEGORIES	GO TO

MICROBIOLOGY

		(a)	(b)			(c)		
1563	Now I want to ask you about different laboratory equipment and tests. For each item I mention, please tell me if the item/test is available, if all items to conduct the test are present, and if equipment is functioning today,	EQUIPMENT/ TEST USED	**EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?**			**IS THE ITEM IN WORKING ORDER?**		
		Yes / No	OBSERVED	REPORTED NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	Microscope	1→b / 2 → 02	1 → c	2 → c	3 → 02	1	2	8
02	Refrigerator	1→b / 2 → 03	1 → c	2 → c	3 → 03	1	2	8
03	Incubator	1→b / 2 → 04	1 → c	2 → c	3 → 04	1	2	8
04	Test tubes	1→b / 2 → 05	1	2	3			
05	Centrifuge for CSF microscopy	1→b / 2 → 06	1 → c	2 → c	3 → 06	1	2	8
06	Glass slides and covers	1→b / 2 → 1564	1	2	3			
1564 01	**MALARIA TESTS**	1 / 2 → 1565						
02	Giemsa stain	1→b / 2 → 03	1	2	3			
03	Field stain	1→b / 2 → 04	1	2	3			
04	Rapid test (test strips, ICT, Paracheck, etc)	1→b / 2 → 05	1	2	3			
05	Other test for malaria_____ (SPECIFY)	1→b / 2 → 1564C	1	2	3			

1564C	Is there an established system for quality control for the reading of malaria slides that are prepared and read by this laboratory?	YES, INTERNAL QC . . . . . 1 YES, EXTERNAL QC . . . . . 2 YES, BOTH INTERNAL AND EXTERNAL QUALITY CONTROL . . 3 NO QUALITY CONTROL SYSTEM . . 4 DON'T PREPARE SLIDES 5 DON'T KNOW 8	

NO.	QUESTIONS	CODING CATEGORIES								GO TO
1565	OTHER MICROBIOLOGY TESTS	(a) TEST CONDUCTED		(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	Indian ink stain	1→b	2 1566	1	2	3				
1566 01	**GONORRHEA TESTS**	1	2 1567							
02	Chocolate agar (culture medium)	1→b	2 03	1	2	3				
03	Oxidase Reagent	1→b	2 04	1	2	3				
04	Thayer-Martin or Modified TM or Vancomycin-free selective medium (VFSM)	1→b	2 1567	1	2	3				
1567 01	**GRAM STAIN**	1	2 1568							
02	Crystal violet or Gentian violet			1	2	3				
03	Lugol's iodine			1	2	3				
04	Acetone or Acetone alcohol			1	2	3				
05	Neutral red, carbol fuchsin, or other counter stain			1	2	3				
1568 01	**CHLAMYDIA TEST**	1	2 1569							
02	Giemsa stain	1→b	2 03	1	2	3				
03	PCR	1→b	2 04	1	2	3				
04	Other test for chlamydia_____ (SPECIFY)	1	2 1569	1	2	3				
1569	Urine microscopy	1→b	2 1570	1	2	3				
1570 01	**TUBERCULOSIS TEST**	1	2 1570C							
02	Ziehl-Neelson test for AFB	1	2 06							
03	Carbol-Fuchsin			1	2	3				
04	20% Sulphuric Acid			1	2	3				
05	Methylene Blue			1	2	3				
06	Fluorescence Microscope (FM)	1→b	2 07	1	2	3 07	1	2	8	
07	New rapid test for TB	1→b	2 08	1	2	3				
08	Culture medium (e.g., MGIT 960)	1→b	2 09	1	2	3				
09	All items for other tests for TB SPECIFY_____	1→b	2 1570C	1	2	3				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1570C	Does this laboratory send TB specimens outside the facility for testing?	YES. . . . . 1 NO . . . . . 2 DON'T KNOW. 8	
1571	Is there a system for internal or external quality control for the TB sputum smears assessed in this laboratory?	YES, INTERNAL QUALITY CONTROL . . . . . 1 YES, EXTERNAL INSPECTION/OBSERVATION. . . . . 2 YES, BOTH INTERNAL AND EXTERNAL Q.C. . . . . 3 SEND SLIDE FOR RE-READING. . . . . 4 OTHER _____ 6 (SPECIFY) NO QUALITY CONTROL . . . . . 5 DON'T KNOW 8	→ 1573 → 1573
1572	Are there records of the results from the internal or external quality control procedures?	YES, RECORDS FOR IQC ONLY . . 1 YES, RECORDS FOR EQC ONLY . . 2 YES, RECORDS FOR BOTH QC PROCEDURES . . . . . 3 NEITHER RECORD FOUND 4 DON'T KNOW 8	
1573	Does this laboratory conduct sensitivity testing for TB drugs? IF YES, ASK IF ALL COMPONENTS ARE AVAILABLE TODAY	YES, ALL COMPONENTS PRESENT. . 1 YES, BUT NOT ALL COMPONENTS PRESENT TODAY . . . . . 2 NO SENSITIVITY TESTING 3	
1574	Does this laboratory have a record of TB test results? IF YES: May I please see the register?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	→ 1576 → 1576
1575	WHEN WAS THE LAST ENTRY IN THE REGISTER FOR TB TEST RESULTS?	WITHIN 30 DAYS . . . . . 1 MORE THAN 30 DAYS AGO 2	
1576	Do you ever send any specimen outside for Gram staining, Indian Ink staining, malaria testing or for culture?	YES . . . . . 1 NO 2	→ 1578

1577	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 ↓	1	2
02	Indian ink stain	1 → b	2 ↓	1	2
03	Malaria	1 → b	2 ↓	1	2
04	Specimen for culture	1 → b	2 ↓	1	2

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	PATHOLOGY		
1578	Does this facility have a pathology department or other location where PAP smears or histology exams are carried out? IF YES, ASK TO SPEAK WITH THE PERSON MOST FAMILIAR WITH THE TESTS	YES . . . . . 1 NO 2	→ 1580

1579	Do you have all items today, for performing:	ARE ALL ITEMS FOR TEST AVAILABLE?				
		AVAILABLE TODAY		NORMALLY AVAILABLE NOT TODAY	NO TEST IN THIS FACILITY	DON'T KNOW
		OBSERVED	REPORTED, NOT SEEN			
01	PAP smears? (e.g. slides, fixer)	1	2	3	4	8
02	Histology? (e.g. microscope, fixer, microtome, media)	1	2	3	4	8

		CODING CATEGORIES	GO TO
	X-RAY/IMAGING		
1580	Does this facility perform diagnostic X-rays, ultrasound, or computerized tomography? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED.	YES . . . . . 1 NO 2	→ **END**

1581	ASK TO SEE THE FOLLOWING EQUIPMENT. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:	(a) EQUIPMENT/ITEMS AVAILABLE?			(b) ITEM IN WORKING ORDER?		
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	X-RAY MACHINE	1 → b	2 → b	3 → 02	1	2	8
02	FILM FOR X-RAYS	1	2	3			
03	PROCESSING MACHINE FOR X-RAY FILMS	1 → b	2 → b	3 → 04	1	2	8
04	ULTRASOUND EQUIPMENT	1 → b	2 → b	3 → 05	1	2	8
05	CT SCAN	1 → b	2 → b	3 → **END**	1	2	8

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

SECTION 16: MEDICATION AND SUPPLIES

FACILITY NUMBER: | | | | | **Interviewer Code** | | | QRE TYPE **16**

1600	INDICATE WHICH CLIENTS HAVE ACCESS TO MEDICINES REPORTED IN THIS QRE.	OUTPATIENT ONLY . . . . . 1 INPATIENT ONLY . . . . . 2 BOTH IN AND OUTPATIENT . . . . . 3 AREA LOCKED/NO ACCESS . . . . . 4 NO MEDICINES STORED IN FACILITY 5	→**STOP** →**END**

FIND THE PERSON IN CHARGE OF MEDICINES. IF HE/SHE IS NOT PRESENT, ASK TO SEE THE PROVIDER MOST KNOWLEDGEABLE ABOUT PHARMACEUTICAL PROCEDURES.

IF THE PROVIDER IS DIFFERENT FROM THE PREVIOUS RESPONDENT, INTRODUCE YOURSELF, BRIEFLY. EXPLAIN THE PURPOSE OF YOUR VISIT, AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT PHARMACEUTICAL SUPPLIES FOR THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.
IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1604 BELOW AND GO ON TO Q1605.

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE PHARMACEUTICALS WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KENYA. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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

DAY	MONTH	YEAR
		2010

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1604	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
1605	Is counselling related to HIV/AIDS ever provided by staff from this medicine storage area? By counselling I mean providing information and support other than telling clients how to take the medicines you provide.	YES, GENERAL COUNSELLING RELATED TO HIV/AIDS . . . . . A YES, ADHERENCE COUNSELLING FOR ART . . . . . B NO COUNSELLING . . . . . Y	
1606	Is there a register or stock cards where the amount of each medicine received, the amount issued and the stock on hand today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 1609
1607	On average, how often do you update or reconcile your inventory/stock records? CIRCLE THE CLOSEST DESCRIPTION	DAILY . . . . . 01 WEEKLY . . . . . 02 MONTHLY . . . . . 03 EVERY 6 WEEKS . . . . . 04 EVERY 6 MONTHS . . . . . 05 WHENEVER I RECEIVE OR ISSUE STOCK . . . . . 06 NEVER 07	

1608	Is the stock maintenance system computerized? IF YES, ASK: Is it computerized for all medicines or only for ARVs?	YES, ALL MEDICINES . . . . . 1 YES, ARVs ONLY . . . . . 2 NO COMPUTERIZED SYSTEM 3	→ 1609
1608A	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION, FOR THE NON-COMPUTERIZED SYSTEM	STOCK RECORDS UPDATED DAY ITEM DISBURSED . . . . . 1 STOCK RECORDS NOT ALWAYS UPDATED WHEN ITEM DISBURSED, BUT REGISTER OF DISTRIBUTED ITEMS OBSERVED . . 2 OTHER _____ 6 (SPECIFY)	

ASK TO SEE THE FOLLOWING MEDICATIONS AND SUPPLIES. IF THE ITEM IS LOCATED IN A DIFFERENT PART OF THE FACILITY, GO THERE TO OBSERVE IT. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE: FOR ALL ITEMS THAT ARE OBSERVED, ASK IF THERE HAS BEEN ANY STOCK OUT (NONE OF THE MEDICINE AVAILABLE) DURING THE LAST SIX MONTHS.

1609	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE			NOT OBSERVED			(b) OUT OF STOCK IN LAST SIX MONTHS		
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	YES	NO	DK
01	Acetaminophen/ paracetamol (oral tabs)		2 → b	3 02	4 02	5 02	02	1	2	8
02	paracetamol (oral suspension)		2 → b	3 03	4 03	5 03	03	1	2	8
03	Acetylsalicylic acid/ aspirin (oral tabs)		2 → b	3 04	4 04	5 04	04	1	2	8
04	Acyclovir (ophthalmic)		2 → b	3 05	4 05	5 05	05	1	2	8
05	Acyclovir (oral)		2 → b	3 06	4 06	5 06	06	1	2	8
06	Albendazole (oral tabs)		2 → b	3 07	4 07	5 07	07	1	2	8
07	Amoxicillin (oral caps)	1 → b	2 → b	3 08	4 08	5 08	08	1	2	8
08	Amoxicillin (Oral suspension)	1 → b	2 → b	3 09	4 09	5 09	09	1	2	8
09	Amoxicillin/clavulanate (Augmentin) (oral tabs)		2 → b	3 10	4 10	5 10	10	1	2	8
10	Amoxicillin/clavulanate (Augmentin) (oral suspension)		2 → b	3 11	4 11	5 11	11	1	2	8
11	Amoxicillin (inj)	1 → b	2 → b	3 12	4 12	5 12	12	1	2	8
12	Ampicillin (inj)	1 → b	2 → b	3 13	4 13	5 13	13	1	2	8
13	Ampicillin (oral caps)	1 → b	2 → b	3 14	4 14	5 14	14	1	2	8
14	Ampicillin (Oral suspension)	1 → b	2 → b	3 15	4 15	5 15	15	1	2	8
15	Amphotericin B (inj)		2 → b	3 16	4 16	5 16	16	1	2	8
16	Bleomycin (Inj)		2 → b	3 17	4 17	5 17	17	1	2	8
17	Cefalexin (oral caps/tabs)		2 → b	3 18	4 18	5 18	18	1	2	8

	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	YES	NO	DK
18	Cefalexin (oral suspension)		2 → b	3 19	4 19	5 19	19	1	2	8
19	Cefotaxime (Inj)		2 → b	3 20	4 20	5 20	20	1	2	8
20	Ceftriaxone (Injection)	1 → b	2 → b	3 21	4 21	5 21	21	1	2	8
21	Chloramphenicol (oral caps)	1 → b	2 → b	3 22	4 22	5 22	22	1	2	8
22	Chloramphenicol (oral suspension)	1 → b	2 → b	3 23	4 23	5 23	23	1	2	8
23	Chloramphenicol (inj)	1 → b	2 → b	3 24	4 24	5 24	24	1	2	8
24	Cidofovir (injection)		2 → b	3 25	4 25	5 25	25	1	2	8
25	Ciprofloxacin (oral tabs)		2 → b	3 26	4 26	5 26	26	1	2	8
26	Clarithromycin (Biaxin) (oral tabs)		2 → b	3 27	4 27	5 27	27	1	2	8
27	Clarithromycin (oral suspension)		2 → b	3 28	4 28	5 28	28	1	2	8
28	Clindamycin (oral or inj)		2 → b	3 29	4 29	5 29	29	1	2	8
29	Clotrimazole (topical cream/ointment)		2 → b	3 30	4 30	5 30	30	1	2	8
30	Clotrimazole (vaginal pesaries)		2 → b	3 31	4 31	5 31	31	1	2	8
31	Codeine (oral tabs)		2 → b	3 32	4 32	5 32	32	1	2	8
32	Co-trimoxazole (oral tabs)		2 → b	3 33	4 33	5 33	33	1	2	8
33	Co-trimoxazole (oral suspension)		2 → b	3 34	4 34	5 34	34	1	2	8
34	Cloxacillin (oral caps)		2 → b	3 35	4 35	5 35	35	1	2	8
35	Cloxacillin (oral suspension)		2 → b	3 36	4 36	5 36	36	1	2	8
36	Cloxacillin (inj)		2 → b	3 37	4 37	5 37	37	1	2	8
37	Dapsone (oral tabs)		2 → b	3 38	4 38	5 38	38	1	2	8
38	Dexamethasone (oral tabs)		2 → b	3 39	4 39	5 39	39	1	2	8
39	Dexamethasone (inj)		2 → b	3 40	4 40	5 40	40	1	2	8
40	Diazepam (oral tabs)		2 → b	3 41	4 41	5 41	41	1	2	8
41	Diazepam (inj) (Valium)		2 → b	3 42	4 42	5 42	42	1	2	8

	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	NOT OBSERVED REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	(b) OUT OF STOCK IN LAST SIX MONTHS YES	NO	DK
42	Diclofenac (oral or inj)		2 → b	3 43	4 43	5 43	43	1	2	8
43	Dipyrone (inj) (Novalgin)		2 → b	3 44	4 44	5 44	44	1	2	8
44	Diphenoxylate (lomotil) (oral tabs/caps)		2 → b	3 45	4 45	5 45	45	1	2	8
45	Doxycycline (oral caps)	1 → b	2 → b	3 46	4 46	5 46	46	1	2	8
46	Ergometrine (or methergine Oral tabs)		2 → b	3 47	4 47	5 47	47	1	2	8
47	Syntocin or oxytocin (inj)		2 → b	3 48	4 48	5 48	48	1	2	8
48	Erythromycin (oral tabs)	1 → b	2 → b	3 49	4 49	5 49	49	1	2	8
49	Erythromycin (oral suspension)	1 → b	2 → b	3 50	4 50	5 50	50	1	2	8
50	Famciclovir (oral tabs)		2 → b	3 51	4 51	5 51	51	1	2	8
51	Fluconazole (oral or inj)		2 → b	3 52	4 52	5 52	52	1	2	8
52	Folic Acid (oral tabs)		2 → b	3 53	4 53	5 53	53	1	2	8
53	Ganciclovir (oral or inj)		2 → b	3 54	4 54	5 54	54	1	2	8
54	Gentamicin (inj)		2 → b	3 55	4 55	5 55	55	1	2	8
55	Gentian Violet (GV paint)		2 → b	3 56	4 56	5 56	56	1	2	8
56	Ibuprofen (oral tabs)		2 → b	3 57	4 57	5 57	57	1	2	8
57	Ibuprofen (oral syrup)		2 → b	3 58	4 58	5 58	58	1	2	8
58	Indomethacin (suppository)		2 → b	3 59	4 59	5 59	59	1	2	8
59	Iron tabs (oral)		2 → b	3 60	4 60	5 60	60	1	2	8
60	Iron tabs with folic		2 → b	3 61	4 61	5 61	61	1	2	8
61	Itraconazole (oral tabs/caps)		2 → b	3 62	4 62	5 62	62	1	2	8
62	Kanamycin (injection)	1 → b	2 → b	3 63	4 63	5 63	63	1	2	8
63	Ketoconazole (oral or topical)	1 → b	2 → b	3 64	4 64	5 64	64	1	2	8
64	Loperamide (Imodium) (oral tabs/caps)	1 → b	2 → b	3 65	4 65	5 65	65	1	2	8
65	Magnesium sulphate (injection)		2 → b	3 66	4 66	5 66	66	1	2	8
66	Mebendazole (oral tabs)		2 → b	3 67	4 67	5 67	67	1	2	8
67	Methyldopa (aldomet) (oral tabs)		2 → b	3 68	4 68	5 68	68	1	2	8
68	Metronidazole intravenous		2 → b	3 69	4 69	5 69	69	1	2	8
69	Metronidazole (oral tabs/caps)		2 → b	3 70	4 70	5 70	70	1	2	8

	GENERAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	NOT OBSERVED REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	(b) OUT OF STOCK IN LAST SIX MONTHS YES	NO	DK
70	Metronidazole (oral suspension)		2 → b	3 71	4 71	5 71	71	1	2	8
71	Miconazole (vaginal Pes)	1 → b	2 → b	3 72	4 72	5 72	72	1	2	8
72	Miconazole cream		2 → b	3 73	4 73	5 73	73	1	2	8
73	Morphine (oral powder for suspension)		2 → b	3 74	4 74	5 74	74	1	2	8
74	Multivitamins (oral tabs)		2 → b	3 75	4 75	5 75	75	1	2	8
75	Nalidixic acid (oral tabs)		2 → b	3 76	4 76	5 76	76	1	2	8
76	Nitrofurantoin (oral tabs)		2 → b	3 77	4 77	5 77	77	1	2	8
77	Nitrofurazone (ointment)		2 → b	3 78	4 78	5 78	78	1	2	8
78	Norfloxacin (oral tabs)	1 → b	2 → b	3 79	4 79	5 79	79	1	2	8
79	Nystatin (oral suspension)	1 → b	2 → b	3 80	4 80	5 80	80	1	2	8
80	Nystatin (vaginal Pes./cream)	1 → b	2 → b	3 81	4 81	5 81	81	1	2	8
81	Oral rehydration salts	1 → b	2 → b	3 82	4 82	5 82	82	1	2	8
82	Penicillin, Benzathine (Injection)		2 → b	3 83	4 83	5 83	83	1	2	8
83	Penicillin Benzyl (Injection)	1 → b	2 → b	3 84	4 84	5 84	84	1	2	8
84	Penicillin, procaine (Injection)	1 → b	2 → b	3 85	4 85	5 85	85	1	2	8
85	Penicillin-V (oral tabs/caps)	1 → b	2 → b	3 86	4 86	5 86	86	1	2	8
86	Penicillin-V (oral suspension)	1 → b	2 → b	3 87	4 87	5 87	87	1	2	8
87	Phenobarbital (oral or inj)	1 → b	2 → b	3 88	4 88	5 88	88	1	2	8
88	Prednisolone (or other steroid) (oral)		2 → b	3 89	4 89	5 89	89	1	2	8
89	Silver nitrate eye drop		2 → b	3 90	4 90	5 90	90	1	2	8
90	Spectinomycin, inj		2 → b	3 91	4 91	5 91	91	1	2	8
91	Sulfadiazine (cream/ointment)	1 → b	2 → b	3 92	4 92	5 92	92	1	2	8
92	Tetracycline (oral caps)		2 → b	3 93	4 93	5 93	93	1	2	8
93	Tetracycline eye ointment		2 → b	3 94	4 94	5 94	94	1	2	8
94	Tinidazole (oral tabs)		2 → b	3 95	4 95	5 95	95	1	2	8
95	Valganciclovir		2 → b	3 96	4 96	5 96	96	1	2	8
96	Vincristine (inj)		2 → b	3 97	4 97	5 97	97	1	2	8
97	Vitamin A (100,000 or 50,000 iu)		2 → b	3 98	4 98	5 98	98	1	2	8

	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE		NOT OBSERVED						
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	YES	NO	DK
98	Vitamin A (200,000iu)		2 → b	3 99	4 99	5 99	99	1	2	8
99	Vitamin B6 (pyridoxine) (oral tabs)		2 → b	3 100	4 100	5 100	100	1	2	8
100	Other B vitamins (oral)		2 → b	3 101	4 101	5 101	101	1	2	8
101	Xylocaine or lidocaine 1% or 2% (inj)		2 → b	3 102	4 102	5 102	102	1	2	8
102	Vitamin K (inj)		2 → b	3 1610	4 1610	5 1610	1610	1	2	8
1610	**ANTIMALARIALS**	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE		NOT OBSERVED						
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	YES	NO	DK
01	Dihydroartemisinine (oral tabs) (Cotexin, Arinate, Artesunate)	1 → b	2 → b	3 02	4 02	5 02	02	1	2	8
02	Artermether-Lumefantrine (AL, COARTEM)	1 → b	2 → b	3 03	4 03	5 03	03	1	2	8
03	Sulfadoxin+Pyrimethamine (Fansidar, Metakelfin, Orodar)	1 → b	2 → b	3 04	4 04	5 04	04	1	2	8
04	Quinine (oral tabs)	1 → b	2 → b	3 05	4 05	5 05	05	1	2	8
05	Quinine (inj)	1 → b	2 → b	3 06	4 06	5 06	06	1	2	8
06	Chloroquine (oral tabs)	1 → b	2 → b	3 07	4 07	5 07	07	1	2	8
07	Chloroquine (inj)	1 → b	2 → b	3 08	4 08	5 08	08	1	2	8
08	Amodiaquine (oral tabs)	1 → b	2 → b	3 09	4 09	5 09	09	1	2	8
09	Amodiaquine (oral syrup)	1 → b	2 → b	3 10	4 10	5 10	10	1	2	8
10	Mefloquine (oral tabs)	1 → b	2 → b	3 11	4 11	5 11	11	1	2	8
11	Other _____ (SPECIFY)	1 → b	2 → b	3 1611	4 1611	5 1611	1611	1	2	8
1611	**TUBERCULOSIS**									
01	Isoniazid (oral tabs)		2 → b	3 02	4 02	5 02	02	1	2	8
02	Isoniazid + Rifampicin (Rifina) (oral)		2 → b	3 03	4 03	5 03	03	1	2	8
03	Isoniazid+Rifampicin+ Pyrazinamide (RHZ, Rifater)		2 → b	3 04	4 04	5 04	04	1	2	8
04	Isoniazid + Ethambutol (EH)		2 → b	3 05	4 05	5 05	05	1	2	8
05	4FDC (combination INH, Ethambutol, Pyrazinamide, Rifampicin)		2 → b	3 06	4 06	5 06	06	1	2	8
06	Amikacin inj		2 → b	3 07	4 07	5 07	07	1	2	8
07	Capreomycin inj		2 → b	3 08	4 08	5 08	08	1	2	8
08	Cycloserin (oral tabs)		2 → b	3 09	4 09	5 09	09	1	2	8
09	Ethionamide (oral tabs)		2 → b	3 10	4 10	5 10	10	1	2	8
10	Levofloxacine (oral tabs)		2 → b	3 11	4 11	5 11	11	1	2	8
11	Para-amino Salicylic Acid (Powder) (PAS)		2 → b	3 12	4 12	5 12	12	1	2	8
12	Other _____ (SPECIFY)		2 → b	3 1612	4 1612	5 1612	1612	1	2	8

		(a) AVAILABILITY OF MEDICINES					(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE		NOT OBSERVED					
1612	**INTRAVENOUS SOLUTION** CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	YES	NO	DK
01	Normal Saline (0.9%NS)		2 → b	3 02	4 02	5 02	02	1	2	8
02	Dextrose and Normal Saline (5%D/NS)		2 → b	3 03	4 03	5 03	03	1	2	8
03	Ringers Lactate / Hartman solution	1 → b	2 → b	3 04	4 04	5 04	04	1	2	8
04	Darrow's solution (half strength)	1 → b	2 → b	3 05	4 05	5 05	05	1	2	8
05	Plasma Expander (e.g., 70% Dextrane, Haemacel)	1 → b	2 → b	3 1613	4 1613	5 1613	1613	1	2	8
1613	**OTHER**									
01	Infant formula		2 → b	3 02	4 02	5 02	02	1	2	8
02	Fortified protein supplement		2 → b	3 03	4 03	5 03	03	1	2	8
03	Therapeotic feeds (F75, F100)		2 → b	3 04	4 04	5 04	04	1	2	8
04	Male condom		2 → b	3 05	4 05	5 05	05			
05	Female condom		2 → b	3 1614	4 1614	5 1614	1614	1	2	8

1614	WERE THE MEDICINES ORGANIZED ACCORDING TO DATE OF EXPIRATION ("first expire, first out") VERIFY WHEN CHECKING INDICATED MEDICINES FOR ALL BEING VALID	YES, VERIFIED . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1615	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING CONDITIONS:		
01	ARE ALL THE MEDICINES OFF THE FLOOR?	YES . . . . . 1 NO 2	
02	ARE ALL THE MEDICINES PROTECTED FROM WATER?	YES . . . . . 1 NO 2	
03	ARE ALL THE MEDICINES PROTECTED FROM THE SUN?	YES . . . . . 1 NO 2	
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.)	YES . . . . . 1 NO 2	
05	IS THE STORAGE ROOM WELL VENTILATED?	YES . . . . . 1 NO 2	
1616	Is there a functioning refrigerator, separate from the one used for vaccines, used to store some medicines or reconstituted vials?	OBSERVED, FUNCTIONING . . 1 OBSERVED, NOT FUNCTIONING 2 REPORTED, NOT SEEN . . 3 SAME AS VACCINE FRIDGE . . 4 NO FRIDGE FOR MEDS . . 5	
1617	LOOK AT THE STORAGE AREA AND CIRCLE ALL THAT APPLY	AREA CAN BE LOCKED . . . . A LIMITED ACCESS . . . . B DOORS SOLID . . . . . C WINDOWS W/BARS/SHUTTERS . . D NONE OF THE ABOVE . . . . . Y	
1618	When was the last time that you received a scheduled supply of medicines ? (i.e. from the main order & not interim order)	WITHIN PRIOR 4 WEEKS . . . . 1 BETWEEN 4-12 WEEKS . . . . 2 MORE THAN 12 WEEKS AGO . . . . . 3 NO ROUTINE SUPPLY SYSTEM. . . . . 4 DON'T KNOW 8	
1619	Does this facility determine the quantity of each medicine required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DIFFERS BY MEDICINE) 3 DON'T KNOW 8	→ 1621 → 1623

1620	Do you always receive a standard fixed supply or does the quantity you receive vary according to the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL . . . . . 1 STANDARD FIXED SUPPLY . . 2 DON'T KNOW 8	
1620A	CHECK Q1619. IS "3" (BOTH) CIRCLED? YES ☐ NO ☐ → 1623		
1621	Routinely, when you order medicines, which best describes the system you use to determine ***how much*** of each to order? Do you: - **Review** the amount of each medicine remaining, and order to bring the stock amount to a pre-determined (fixed) amount (max stock level)? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each medicine used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY)	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUN . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
1622	Which of the following best describes the routine system for deciding ***when*** to order medicines? Do you: - **Place** order whenever stock levels fall to a predetermined level (the minimum stock level)? - **Have** a fixed time that orders are submitted? - **Place** an order whenever it is believed that there is a need, regardless of stock level? - **Other** _____ (SPECIFY)	PREDETERMINED LEVEL . . 1 FIXED TIME . . . . . 2 ORDER WHEN NEEDED . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
1623	If there is a shortage of a specific medicine between routine orders, what is the most common procedure followed by this facility? - Submit special/interim order to normal supplier - Facility purchases from private market (buy-out) - Clients must purchase from outside the facility - Facility borrows from neighboring facility - Nothing	SPECIAL ORDER . . . . . A FACILITY PURCHASE . . . . . B CLIENT PURCHASE OUTSIDE . . C FACILITY BORROWS . . . . . D NONE OF THE ABOVE . . . . . Y	
1624	During the past 6 months, have you always, sometimes, or almost never received the amount of each medicine that you ordered (or that you are supposed to routinely receive)?	ALWAYS . . . . . 1 SOMETIMES . . . . . 2 ALMOST NEVER 3	
1625	Does this facility stock any antiretroviral medicines? IF YES, CLARIFY THE PURPOSE OF THE ANTIRETROVIRAL MEDICINES	YES, FOR HIV/AIDS TREATMENT . . A YES, FOR PEP ONLY . . . . . B YES, FOR PMTCT . . . . . C NO . . . . . Y	→ 1644
1626	What is the source of your antiretrovirals?	CENTRAL MEDICAL STORES . . . . . A REGIONAL MEDICAL STORES . . B DISTRICT HOSPITAL PHARMACY . . C PRIVATE WAREHOUSE . . . . . D PRIVATE PHARMACY . . . . . E NGO/DONORS . . . . . F OTHER _____ (SPECIFY) X	
1627	Is there a register or stock cards where the quantity of each antiretroviral medicine received, the amount issued and the stock on hand today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 1629

1628	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION.	REGISTER/STOCK CARDS NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES . 1 REGISTER/STOCK CARDS UPDATED DAILY . . . . . 2 OTHER _____ (SPECIFY) . . . 6	

1629 ASK TO SEE THE FOLLOWING ANTIRETROVIRALS. IF THESE ARE LOCATED IN A DIFFERENT PART OF THE FACILITY, GO THERE TO OBSERVE IT. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE. FOR ALL ITEMS THAT ARE OBSERVED, ASK IF THERE HAS BEEN ANY STOCK OUT (NONE OF THE MEDICINE AVAILABLE) **ANYTIME DURING THE LAST SIX MONTHS.**

	ANTIRETROVIRAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE: ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	NOT OBSERVED: REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	(b) OUT OF STOCK IN LAST SIX MONTHS: YES	NO	DK
	NRTIs									
01	Zidovudine (ZDV,AZT) tabs	1 → b	2 → b	3 02	4 02	5 02	02	1	2	8
02	Zidovudine (ZDV,AZT) syrup	1 → b	2 → b	3 03	4 03	5 03	03	1	2	8
03	Abacavir/ABC tabs	1 → b	2 → b	3 04	4 04	5 04	04	1	2	8
04	Didanosine/ddI tabs	1 → b	2 → b	3 05	4 05	5 05	05	1	2	8
05	Lamivudine/3TC tabs	1 → b	2 → b	3 06	4 06	5 06	06	1	2	8
06	Lamivudine/3TC syrup	1 → b	2 → b	3 07	4 07	5 07	07	1	2	8
07	Stavudine 30 (D4T)	1 → b	2 → b	3 08	4 08	5 08	08	1	2	8
08	Stavudine syrup	1 → b	2 → b	3 09	4 09	5 09	09	1	2	8
09	Tenofovir (TDF) tabs	1 → b	2 → b	3 10	4 10	5 10	10	1	2	8
	NNRTIs									
10	Nevirapine (NVP) tabs	1 → b	2 → b	3 11	4 11	5 11	11	1	2	8
11	Nevirapine (NVP) syrup	1 → b	2 → b	3 12	4 12	5 12	12	1	2	8
12	Efavirenz (EFV) tabs/caps	1 → b	2 → b	3 13	4 13	5 13	13	1	2	8
13	Efavirenz (EFV) syrup	1 → b	2 → b	3 14	4 14	5 14	14	1	2	8
14	Delavirdine (DLV)	1 → b	2 → b	3 15	4 15	5 15	15	1	2	8

	ANTIRETROVIRAL MEDICINES CHECK INVENTORY	(a) AVAILABILITY OF MEDICINES OBSERVED AVAILABLE			NOT OBSERVED			(b) OUT OF STOCK IN LAST SIX MONTHS		
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	YES	NO	DK
	PROTEASE INHIBITORS									
15	LOPINAVIR (LPV)	1 → b	2 → b	3 → 16	4 → 16	5 → 16	→ 16	1	2	8
16	INDINAVIR (IDV)	1 → b	2 → b	3 → 17	4 → 17	5 → 17	→ 17	1	2	8
17	NELFINAVIR (NFV)	1 → b	2 → b	3 → 18	4 → 18	5 → 18	→ 18	1	2	8
18	SAQUINAVIR (SQV)	1 → b	2 → b	3 → 19	4 → 19	5 → 19	→ 19	1	2	8
19	RITONAVIR (RTV)	1 → b	2 → b	3 → 20	4 → 20	5 → 20	→ 20	1	2	8
20	ATAZANAVIR (ATV)	1 → b	2 → b	3 → 21	4 → 21	5 → 21	→ 21	1	2	8
21	FOSAMPRENAVIR (FPV)	1 → b	2 → b	3 → 22	4 → 22	5 → 22	→ 22	1	2	8
22	TIPRANAVIR (TPV)	1 → b	2 → b	3 → 23	4 → 23	5 → 23	→ 23	1	2	8
23	DARUNAVIR (DRV)	1 → b	2 → b	3 → 24	4 → 24	5 → 24	→ 24	1	2	8
24	LOPINAVIR-RITONAVIR tabs (LPV/r)	1 → b	2 → b	3 → 25	4 → 25	5 → 25	→ 25	1	2	8
25	LOPINAVIR-RITONAVIR syrup (LPV/r)	1 → b	2 → b	3 → 26	4 → 26	5 → 26	→ 26	1	2	8
	FUSION INHIBITORS									
26	Enfuvirtide (T-20)	1 → b	2 → b	3 → 27	4 → 27	5 → 27	→ 27	1	2	8
	COMBINED-3DRUGS									
27	[3TC/d4T(30)/NVP]	1 → b	2 → b	3 → 28	4 → 28	5 → 28	→ 28	1	2	8
28	[3TC/AZT/NVP]	1 → b	2 → b	3 → 29	4 → 29	5 → 29	→ 29	1	2	8
	COMBINED-2DRUGS									
29	[AZT+3TC]	1 → b	2 → b	3 → 30	4 → 30	5 → 30	→ 30	1	2	8
30	[D4T(30)+3TC]	1 → b	2 → b	3 → 31	4 → 31	5 → 31	→ 31	1	2	8
31	[Tenofovir + 3TC]	1 → b	2 → b	3 → 32	4 → 32	5 → 32	→ 32	1	2	8
32	OTHER: (SPECIFY)	1 → b	2 → b	3 → 1630	4 → 1630	5 → 1630	→ 1630	1	2	8

1630	DESCRIBE THE STORAGE OF THE ANTIRETROVIRAL MEDICINES. ARE THE ANTIRETROVIRALS STORED IN A LOCKED STORAGE UNIT AND SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE . . . . . 1 STORED WITH NON-ARV MEDICINES . . . . . 2 OTHER _____ 6 (SPECIFY)	
1631	OBSERVE THE PLACE WHERE THE ARVs ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING CONDITIONS:		
01	ARE ALL THE ARVs OFF THE FLOOR?	YES. . . . . 1 NO. 2	
02	ARE ALL THE ARVs PROTECTED FROM WATER?	YES. . . . . 1 NO. 2	
03	ARE ALL THE ARVs PROTECTED FROM THE SUN?	YES. . . . . 1 NO. 2	
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.)	YES. . . . . 1 NO. 2	
05	IS THE STORAGE ROOM WELL VENTILATED?	YES . . . . . 1 NO 2	
1632	LOOK AT THE ARV STORAGE AREA AND CIRCLE ALL THAT APPLY	AREA CAN BE LOCKED . . . . A LIMITED ACCESS . . . . . B DOORS SOLID . . . . . C WINDOWS W/BARS/SHUTTERS D NONE OF THE ABOVE . . . . . Y	
1633	When was the last time that you received a scheduled supply of ARVs?	WITHIN PRIOR 4 WEEKS . . . . 1 BETWEEN 4-12 WEEKS . . . . 2 MORE THAN 12 WEEKS AGO . . . . . 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8	
1634	Does this facility determine the quantity of ARVs required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 BOTH (DEPENDS ON ARV) . . . . . 3 DON'T KNOW 8	→ 1636 → 1638
1635	Do you always receive a standard fixed supply of ARVs, or does the quantity you receive vary according to the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL . . . . . 1 STANDARD FIXED SUPPLY . . 2 DON'T KNOW 8	
1635A	CHECK Q1634 AND INDICATE WHICH RESPONSE IS CIRCLED	"3" CIRCLED (BOTH, DEPENDS ON ARV) . . . 1 "2" CIRCLED (NEED DETERMINED ELSEWHERE) 2	 → 1638
1636	Routinely, when you order ARVs, which best describes the system you use to determine ***how much*** of each to order? Do you: - **Review** the amount of each ARV remaining, and order to bring the stock amount to a pre-determined (fixed) amount? - **Order** exactly the same quantity each time, regardless of the existing stock? - **Review** the amount of each ARV used since the previous order, and plan based on prior consumption and expected future consumption? - **Other** _____ (SPECIFY) - Don't know	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	

1637	Which of the following best describes the routine system (the main one) for deciding ***when*** to order ARVs? Do you: - **Place** order whenever stock levels fall to a predetermined level? - **Have** a fixed time that orders are submitted? - **Place** an order whenever there is believed to be a need, regardless of stock level? - **Other** _____ (SPECIFY) - Don't know	PREDETERMINED LEVEL . . 1 FIXED TIME . . . . . 2 ORDER WHEN NEEDED . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
1638	If there is a shortage of a specific ARV between scheduled orders, what is the most common procedure followed by this facility? - Submit interim order to normal supplier - Facility purchases from private market - Clients must purchase from outside the facility - Facility borrow from neighbouring facility - Nothing	SPECIAL ORDER . . . . . A FACILITY PURCHASE . . . . . B CLIENT PURCHASE OUTSIDE . . . . C FACILITY BORROWS . . . . . D NONE OF THE ABOVE . . . . . Y	
1639	During the past 6 months, have you always, sometimes, or almost never received the amount of each medicine that you ordered (or that you are supposed to routinely receive)?	ALWAYS . . . . . 1 SOMETIMES . . . . . 2 ALMOST NEVER 3	
1640	Are antiretroviral medicines for PEP stored in the same area as ARVs for treatment? IF YES, ASK TO SEE THE PEP MEDICINES.	YES . . . . . 1 NO . . . . . 2 DON'T STOCK ARVS FOR PEP 3	 →1642 →1644
1641	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	ZIDOVUDINE (AZT) . . . . . A LAMIVUDINE (3TC) . . . . . B TENOFOVIR (TDF) . . . . . C EFAVIRENZ (EFV) . . . . . D LOPINAVIR (LPV) . . . . . E INDINAVIR (IDV) . . . . . F NELVINAVIR (NFV) . . . . . G OTHER(S) _____ (SPECIFY) X NONE . . . . . Y	 →1644
1642	DESCRIBE THE STORAGE OF THE PEP ARVs. ARE THE PEP MEDICINES STORED SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE . . . . . 1 STORED WITH OTHER ARVS APART FROM OTHER MEDS 2 STORED WITH NON-ARV MEDICINES . . . . . 3 OTHER _____ (SPECIFY) 6	
1643	DESCRIBE THE SECURITY FOR THE PEP MEDICINES.	LOCKED APART FROM OTHER MEDS AND ARVS . . . . . 1 LOCKED, LIMITED ACCESS SIT . 2 UNLOCKED OR NO LIMITED ACCESS 3	

1644	Finally, I would like to see supplies that you have in stock. Please show me the following stock supply items: (IF NECESSARY, GO TO **CLINICAL SUPPLIES**)	a			b		
		OBSERVED	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE	OUT OF STOCK (OS) IN LAST SIX MONTHS		
					YES	NO	DK
01	Disposable needles (19 or 21 gauge)	1 → b	2 → 02	3 → 02	1	2	8
02	Disposable syringes (2,3, or 5 ml)	1 → b	2 → 03	3 → 03	1	2	8
03	Infusion sets for intravenous solution	1 → b	2 → 04	3 → 04	1	2	8
04	Canula for intravenous	1 → b	2 → 05	3 → 05	1	2	8
05	Clean non-latex, gloves	1 → b	2 → 06	3 → 06	1	2	8
06	Clean latex gloves	1 → b	2 → 07	3 → 07	1	2	8
07	Sterile latex gloves	1 → b	2 → 08	3 → 08	1	2	8
08	Spinal tap/lumbar puncture kits	1 → b	2 → 09	3 → 09	1	2	8
09	Disinfectant for cleaning surfaces (bleach or other cleaning solution such as chlorine or Chlorhexidine)	1 → b	2 → 10	3 → 10	1	2	8
10	Hand disinfectant	1 → b	2 → 11	3 → 11	1	2	8
11	Liquid soap	1 → b	2 → 12	3 → 12	1	2	8
12	Hand-washing soap	1 → b	2 → 13	3 → 13	1	2	8
13	Insecticide treated bed net	1 → b	2 → **End**	3 → **End**	1	2	8

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

SECTION 17: TUBERCULOSIS DIAGNOSIS AND TREATMENT

Facility Number: | | | | | | **Interviewer Code:** | | **QRE TYPE** **17**

1700	Does this facility offer services for Tuberculosis? By this I mean TB diagnosis or treatment or both.	YES, TB DIAGNOSIS . . . . . 1 YES, TB TREATMENT . . . . . 2 YES, BOTH TB DIAGNOSIS AND TREATMENT . . . . . 3 NO TB SERVICES 4	→ **END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF TB SERVICES IN THIS FACILITY, AND IF RELEVANT, SPECIFICALLY TB SERVICES RELATED WITH HIV/AIDS SERVICES.

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT TUBERCULOSIS SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1701 BELOW AND GO ON TO Q1702.

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KENYA. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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?

DAY	MONTH	YEAR
		2010

Interviewer's signature

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1701	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1702	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, TB field promoters and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today. COMPLETE THE STAFF LIST FOR THIS UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

		SERVICE OFFERED IN THIS FACILITY		NO SERVICE OFFERED IN THIS FACILITY	
1703	First, I would like to know about services for diagnosis and treatment of tuberculosis. For each service I will mention, please tell me if the service is offered in this facility and if providers assigned to this unit ever provide the service, refer clients for the service, or never offer the service at all.	PROVIDE SERVICE THIS UNIT	SERVICE BY PROVIDERS FROM OTHER UNIT THIS FACILITY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
01	Do providers in this facility make diagnosis that a client has tuberculosis?	1	2	3	4
02	Do providers in this facility prescribe medicines for treatment of tuberculosis?	1	2	3	4
03	Do providers in this facility provide follow-up treatment for clients with tuberculosis?	1	2	3	4

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1704	Does this facility have a TB infection control focal person and/or a TB infection control committee?	YES, A TB I.C. FOCAL PERSON . . . . 1 YES, A TB I.C. COMMITTEE . . . . . 2 YES, BOTH A TB I.C. FOCAL PERSON AND A TB I.C. COMMITTEE . . . . . 3 NO, NEITHER . . . . . 4 DON'T KNOW 8	
1705	Does this facility have a TB infection control plan (administrative, environmental, personal)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1706	Does this facility apply Standard Operating Procedures (SOP) for management of coughing patients in waiting areas?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1707	Does this facility use the N95 respirator (mask)? IF YES, ASK TO SEE RESPIRATOR	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
1708	Does this facility have sputum containers? IF YES, ASK TO SEE CONTAINERS	YES, OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 NO SPUTUM CONTAINER . . . . . 3 DON'T KNOW 8	
1709	What is the most common method used by providers in this facility for diagnosing TB?	SPUTUM SMEAR ONLY . . . . . 01 X-RAY ONLY . . . . . 02 EITHER SPUTUM OR X-RAY . . . 03 BOTH SPUTUM AND X-RAY . . . 04 CLINICAL SYMPTOMS ONLY . . . . 05 REFER WITHIN FACILITY . . . . 06 REFER TO OUTSIDE FACILITY . . . 07 NO TB DIAGNOSIS SERVICES . . . 08	1713 1713 1713 1713 1713 1713 → 1713
1710	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	
1711	Is there a record of clients who are referred for TB diagnosis? IF YES, ASK TO SEE THE RECORD AND CHECK IF TB DIAGNOSTIC RESULTS ARE RECORDED	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO RECORD 3	
1712	When you refer a client **to another facility** (outside this facility), do you use a pre-printed form, a note or a verbal report that specifies information about the client that should be shared? IF PREPRINTED, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD . . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER . . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT . . . . . 5 OTHER _____ 6 (SPECIFY) NEVER REFER OUTSIDE FACILITY . . 7 DON'T KNOW 8	
1713	Do you have any record or register of the number of newly diagnosed TB clients for this facility during the past twelve months?	YES, OBSERVED . . . . . 1 REPORTED NOT SEEN . . . . . 2 NO 3	→ 1716
1714	ASK TO SEE THE RECORDS AND RECORD THE NUMBER OF NEWLY DIAGNOSED TB CLIENTS FOR THE UNIT DURING THE PAST COMPLETED 12 MONTHS.	NUMBER OF CLIENTS [ ][ ][ ][ ]	
1715	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1716	Are there any TB-related guidelines or protocols for providers working in this unit? Guidelines or protocols that are posted on the wall are acceptable **IF YES, ASK:** May I see **all** the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES/PROTOCOLS . . . . 2 →	1718

1717	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	National Guidelines for the Management of Tuberculosis and Leprosy	1→b	2 → 02	3 → 02	
02	Manual of the national Tuberculosis and Leprosy program (to operationalize)	1→b	2 → 03	3 → 03	
03	Any other guideline on the management of TB	1→b	2 → 1718	3 → 1718	

1718	ASK TO SEE THE AREA(S) WHERE MOST TB PATIENTS OR THOSE RECEIVING TB RELATED SERVICES ARE SEEN, EXAMINED OR A PROCEDURE IS CARRIED OUT. OBSERVE THE CONDITION UNDER WHICH MOST CLIENT EXAMINATION TAKE PLACE. IF THERE ARE SEVERAL ROOMS FOR THE SAME PROCEDURE, RANDOMLY PICK ONE TO ASSESS.		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q1719, INDICATE WHICH SECTION THE DATA ARE RECORDED	GENERAL INFORMATION [Q190]. . . . . 11 CHILD HEALTH [Q256] . . . . . 12 FAMILY PLANNING [Q322] . . . . . 13 ANTENATAL CARE [Q429] . . . . . 14 DELIVERY [Q530] 15 STI [Q626] . . . . . 16 SECTION 18-CT [Q1822] . . . . . 18 NOT PREVIOUSLY SEEN 19	→ 1720

1719	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT AREA	(a) Availability OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE
01	RUNNING WATER (PIPED)	1 → 04	2	3
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3
05	HAND DISINFECTANT	1	2	3
06	SINGLE-USE HAND DRYING TOWELS	1	2	3
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER		2	3
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3
13	DISPOSABLE NON-LATEX GLOVES	1	2	3
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3
15	DISPOSABLE NEEDLES	1	2	3
16	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3
17	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3
18	PRIVATE ROOM	1 → 21	2	3
19	AUDITORY PRIVACY	1	2	3
20	VISUAL PRIVACY	1	2	3
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1720	Is this facility included in the national DOTS program?	YES . . . . . 1 NO 2	
1721	What treatment strategy is followed by providers in this facility for TB treatment?	DIRECT OBSERVE 2M, FU 5M . . . 1 DIRECT OBSERVE 6M . . . . . 2 FOLLOW UP CLIENTS ONLY AFTER FIRST 2M DIRECT OBSERVATION ELSEWHERE . . . . . 3 DIAGNOSE AND TREAT WHILE INPATIENT. DISCHARGE TO OTHER UNIT 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	→ 1725 → 1726 → 1725 → 1726 → **END**
1722	What is the strategy for the direct observed treatment during the first two months of treatment or until the client is sputum negative? CIRCLE ALL STRATEGIES USED BY THIS FACILITY FOR THE DOT.	CLIENT HOSPITALIZED . . . . . A CLIENT COMES TO FACILITY . . . B OUTREACH WORKER GOES TO CLIENT . . . . . C COMMUNITY WORKER OR FAMILY OBSERVES . . . . . D OTHER _____ X (SPECIFY)	
1723	Do you have a record or register that shows the clients who are currently receiving DOTS? IF YES, ASK TO SEE THE REGISTER/RECORD	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	→ 1725 → 1725
1724	IS THE RECORD/REGISTER UP-TO-DATE FOR THE PRIOR WEEK FOR ALL CLIENTS RECEIVING THEIR DOTS MEDICATIONS? ASK YOUR RESPONDENT IF INFORMATION IS NOT READILY AVAILABLE IN THE RECORDS.	YES . . . . . 1 NO 2	
1725	Does this facility provide routine follow-up for any clients who are placed on TB treatment? That is follow-up clients when they are at home, and after the initial 2 months of treatment?	YES . . . . . 1 NO 2	→ 1731
1726	Do you have individual client charts or records for clients receiving TB treatment? IF YES, ASK TO SEE A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
1727	Do you have a register or list of clients currently being followed by this facility for TB treatment, including those being treated on DOTS and no direct observation?	'ES, REGISTER OR LIST WITH DOTS ANI NON-DOTS OBSERVED . . . . . 1 ONLY HAVE DOTS CLIENTS . . . . . 2 NO 3	→ 1731

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1728	ASK TO SEE THE REGISTER AND INDICATE THE DATE THE MOST RECENT CLIENT WAS ADMITTED TO TB TREATMENT.	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS AGO . . . . . 2 REGISTER NOT SEEN 3	→ 1731
1729	USING EITHER THE CARDS OR REGISTER, RECORD THE TOTAL NUMBER OF CLIENTS WHO ARE CURRENTLY ON TB TREATMENT AND WHO ARE FOLLOWED UP IN THIS UNIT.	TOTAL NUMBER OF CLIENTS ON TB TREATMENT/FU [ ][ ][ ][ ]	
1730	RECORD THE NUMBER OF FEMALE CLIENTS CURRENTLY ON TB TREATMENT BY THIS UNIT.	NUMBER OF FEMALE CLIENTS [ ][ ][ ][ ] DON'T KNOW 9998	
1731	Do you have a register or record that shows the treatment **outcome** for clients who received TB treatment from this facility but are no longer under treatment? IF YES, ASK TO SEE THE REGISTER/RECORD	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 UNIT DOES NOT PROVIDE TB FOLLOW-UP SERVICES . . . 3 NO 4	
1732	Are newly diagnosed cases of TB (or cases followed up by this facility), counselled and tested for HIV?	YES, ALL CASES . . . . . 1 SUSPECT CASES ONLY . . . . . 2 NO . . . . . 3 DON'T KNOW 8	 → 1736 → 1736
1733	Do you have a register or list of new TB patients who were counselled and tested for HIV? IF YES, ASK TO SEE THE REGISTER OR LIST.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1736 → 1736
1734	How many new TB patients werecounselled and tested for HIV/AIDS in the past twelve completed months?	NUMBER OF NEW TB CLIENTS REFERRED [ ][ ][ ][ ]	
1735	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . [ ][ ]	
1736	Do you have any record of clients currently under TB treatment who are also diagnosed as HIV positive or as having AIDS? YES, ASK TO SEE THE REGISTER/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	 → 1738
1737	How many patients currently under TB treatment in this facility are also diagnosed as HIV positive or as having AIDS?	NUMBER OF TB CLIENTS WITH HIV/AIDS [ ][ ][ ][ ] DON'T KNOW 9998	
1738	What is the original source of your TB medicines? IF MEDICINES ARE SUPPLIED FROM OTHER FACILITIES, CLARIFY IF THIS IS PART OF THE NATIONAL TB CONTROL PROGRAM OR NOT. CIRCLE ALL THAT APPLY	CENTRAL MEDICAL STORES . . . A OTHER FACILITY (NOT PART OF NATIONAL TB PROGRAM) B DIRECT PURCHASE . . . C DONATIONS FROM NGOS . . . . . D OTHER _____ X (SPECIFY)	
1739	Are any TB medicines that are individually packaged for clients kept in this unit? IF YES, ASK TO SEE THE MEDICINES AND INDICATE IF PREPACKAGED MEDICINES ARE AVAILABLE FOR ALL CLIENTS.	YES, AVAILABLE FOR ALL CLIENTS. . 1 YES, AVAILABLE FOR SOME, NOT ALL CLIENTS . . . . . 2 NO INDIVIDUALLY PACKAGED TB MEDICINES IN CLINIC/UNIT . . 3 NO TB MEDICINES STORED IN UNIT AREA 4	
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 18: COUNSELLING AND TESTING

Facility Number: | | | | | | **Interviewer Code:** | | | QRE TYPE **18**

1800	Does this facility offer HIV counselling and testing services? i.e., do providers in this facility prescribe or offer the HIV tests, or refer clients to units within this facility or to other facilities for HIV tests?	YES, HIV COUNSELING ONLY . . . . . 1 YES, HIV TESTING ONLY . . . . . 2 YES, BOTH HIV COUNSELING AND TESTING SERVICES . . . . . 3 NO HIV/AIDS COUNSELING OR TESTING SERVICES 4	→**END**

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF HIV/AIDS COUNSELING AND TESTING IN THIS FACILITY

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT HIV COUNSELING ANDTESTING SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW.

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1802 BELOW AND GO ON TO Q1803.

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KENYA. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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

				2	**0**	**1**	**0**
DAY		MONTH		YEAR			

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1802	May I begin the interview now?	YES . . . . . 1 NO 2	→STOP

NO	QUESTIONS	CODING CATEGORIES	GO TO
1803	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technologists / technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today. COMPLETE THE STAFF LIST FOR THIS CLINIC/UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

NO	QUESTIONS	CODING CATEGORIES	GO TO
	HIV COUNSELING		
	CHECK Q1800: IS "1" OR "3" CIRCLED? YES ☐	NO ☐ → 1814	
1804	How many days each week are HIV counselling services available in this facility? This means the counselling is conducted by staff in this facility.	DAYS PER WEEK . . . . . ☐ LESS THAN ONE DAY PER WEEK. . 0	
1805	How many months have counselling services been offered from this facility?	MONTHS . . . . . ☐☐☐ DON'T KNOW. 998	
1806	Does this facility have a counsellor who has been trained for both HIV pre-test and post-test counselling? IF YES, ASK IF THE PERSON IS PRESENT TODAY AND ENSURE THAT PERSON IS INTERVIEWED FOR THE HEALTH WORKER INTERVIEW	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . . . . 2 NO 3	
1807	ASK TO SEE WHERE COUNSELLING RELATED TO HIV/AIDS IS PROVIDED. DESCRIBE THE SETTING WHERE CLIENT COUNSELLING RELATED TO HIV/AIDS IS PROVIDED	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . . . . 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . . . 3 AUDITORY PRIVACY ONLY. . . . . 4 NO PRIVACY 5	
1808	How is HIV counselling provided? Is it individual only, couples only, or both? PROBE TO ARRIVE AT EXACT PRACTICE USED.	INDIVIDUAL ONLY. . . . . 1 COUPLES ONLY. . . . . 2 BOTH INDIVIDUAL AND COUPLES. . . . . 3 INDIVIDUAL + COUPLE + GROUP SESSIONS. 4	→ 1811
1809	Are there records of the couple and/or group HIV counselling/information sessions? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS AND RECORD THE NUMBER OF SESSIONS THAT HAVE BEEN CONDUCTED.	YES, ... ☐☐☐ NUMBER OF SESSIONS NO RECORDS ON COUPLE/GROUP SESSIOINS. 995	→ 1811
1810	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA . . . . . ☐☐	
1811	Which staff most commonly provide HIV **pre-test** counselling for clients in this facility? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	LAY HIV COUNSELLORS. . . . . 01 UNTRAINED LAY PERSONNEL . . . . . 02 CITC (VCT) COUNSELLORS FROM OUTSIDE UNIT . . . . . 03 TRAINED STAFF FROM THIS UNIT. . . . . 04 TRAINED AND UNTRAINED STAFF FROM THIS UNIT DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 05 BOTH OUTSIDE STAFF AND TRAINED STAFF FROM THIS UNIT PROVIDE COUNSELLING, DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 06 CLIENTS ALWAYS SENT TO ANOTHER UNIT FOR PRE-TEST COUNSELLING. 07	
1812	Which staff most commonly provide HIV **post-test** counselling for clients with **negative** test results in this facility? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	LAY HIV COUNSELLORS. . . . . 01 UNTRAINED LAY PERSONNEL . . . . . 02 CITC (VCT) COUNSELLORS FROM OUTSIDE UNIT . . . . . 03 TRAINED STAFF FROM THIS UNIT 04 TRAINED AND UNTRAINED STAFF FROM THIS UNIT DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 05 BOTH OUTSIDE STAFF AND TRAINED STAFF FROM THIS UNIT PROVIDE COUNSELLING, DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 06 CLIENTS ALWAYS SENT TO ANOTHER UNIT FOR POST-TEST COUNSELLIN . . . . . 07 NO POST TEST COUNSELLING FOR NEGATIVE RESULTS. 08	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1813	Which staff most commonly provide HIV **post-test** counselling for clients with **positive** test results in this facility? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	LAY HIV COUNSELLORS. . . . . 01 UNTRAINED LAY PERSONNEL …….. 02 CITC (VCT) COUNSELLORS FROM OUTSIDE UNIT . . . . . 03 TRAINED STAFF FROM THIS UNIT 04 TRAINED AND UNTRAINED STAFF FROM THIS UNIT DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 05 BOTH OUTSIDE STAFF AND TRAINIED STAFF FROM THIS UNIT PROVIDE COUNSELLING, DEPENDING ON TIME AND STAFF AVAILABILITY. . . . . 06 CLIENTS ALWAYS SENT TO ANOTHER UNIT FOR POST-TEST COUNSELLIN(. . . . . 07 NO POST TEST COUNSELLING. 08	
	HIV TESTING CHECK 1800: IS "2" OR "3" CIRCLED? YES ☐ NO ☐		→ 1828
1814	How many days each week are HIV testing services available in this facility? This means that a client can receive the HIV test or have their blood drawn for testing either inside or outside the facility	DAYS PER WEEK . . . . . ☐ LESS THAN ONE DAY PER WEEK. . 0	
1815	How many months have HIV testing services been offered from this facility?	MONTHS . . . . . ☐☐☐ DON'T KNOW. 998	
1816	Do you conduct HIV rapid testing in this facility?	YES. . . . . 1 NO. 2	→ 1819
1817	How many months have HIV **rapid** testing services been offered from this facility?	# OF MONTHS ☐☐☐ DON'T KNOW. 998	
1818	Which staff most commonly provide HIV rapid testing in this facility?	LAY HIV COUNSELLORS. . . . . 1 NURSES. . . . . 2 LABORATORY STAFF. . . . . 3 OTHER (SPECIFY) 6	
1819	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	**TESTING IN THIS FACILITY** TEST IN THIS UNIT. . . . . A CLIENT SENT TO CITC (VCT) UNIT . . . . . B CLIENT SENT TO PMTCT UNIT. . . . . C CLIENT REFERRED TO OTHER UNIT OTHER THAN CITC/PMTCT. . . . . D BLOOD DRAWN IN THIS UNIT BY UNIT STAFF, TEST CONDUCTED ELSEWHERE . . . . . E BLOOD DRAWN IN THIS UNIT BY UNIT STAFF, AND SENT TO LAB. . . . . F BLOOD DRAWN IN THIS UNIT BY **EXTERNAL STAFF, TEST** CONDUCTED ELSEWHERE . . . . . G BLOOD DRAWN IN THIS UNIT BY **EXTERNAL STAFF,** AND SENT TO LAI H CLIENT SENT TO LAB IN THIS FACILITY I **TESTING OUTSIDE FACILITY:** CLIENT SENT ELSEWHERE OUTSIDE THIS FACILITY. . . . . J BLOOD DRAWN IN THIS UNIT, SENT OUTSIDE FACILITY FOR TESTING. . . K	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1820	What is the normal practice for this unit if a person voluntarily asks for an HIV test? PROBE TO CLARIFY WHICH RESPONSE IS MOST ACCURATE.	PROVIDE SERVICE AT TIME OF VISIT THROUGH THIS UNIT . . . . . 1 MAKE APPOINTMENT FOR TEST IN THIS FACILITY ANOTHER TIME. . . 2 REFER/TELL TO RETURN LATER WITHOUT APPOINTMENT, FOR TEST WITHIN FACILITY . . . . . 3 REFER TO SITE OUTSIDE FACILITY WITHOUT APPOINTMENT. . 4 DON'T PROVIDE SERVICE OR REFERRAL. 5	

CHECK 1819:
"A" OR "E" OR "F" OR "G" OR "H" OR "K" CIRCLED (BLOOD DRAWN IN UNIT) → [ ]

"A" OR "E" OR "F" OR "G" OR "H" OR "K" **NOT** CIRCLED **AND** "B" OR "C" OR "D" OR "I" CIRCLED (CLIENT SENT-FACILITY) 1828 → [ ]

ONLY "J" CIRCLED (CLIENT SENT OUTSID 1825 → [ ]

1821	ASK TO SEE WHERE BLOOD IS USUALLY DRAWN FOR HIV TESTING. IF THERE ARE SEVERAL ROOMS FOR THE SAME PROCEDURE, RANDOMLY PICK ONE TO ASSESS.		
	IF THE SAME EXAMINATION AREA/ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q1822, INDICATE WHICH SECTION THE DATA ARE RECORDED	GENERAL INFORMATION [Q190]. . . . . 11 CHILD HEALTH [Q256]. . . . . 12 FAMILY PLANNING [Q322]. . . . . 13 ANTENATAL CARE [Q429]. . . . . 14 DELIVERY [Q530]. . . . . 15 STI [Q626]. . . . . 16 SECTION 17 [Q1719]. . . . . 17 NOT PREVIOUSLY SEEN. 19	1823

1822	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT AREA	(a) AVAILABILITY			
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 → 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 → 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP/LIQUID SOAP	1	2	3	
05	HAND DISINFECTANT	1	2	3	
06	SINGLE-USE HAND DRYING TOWELS	1	2	3	
07	WASTE RECEPTACLE WITH LID (PEDAL BIN) AND PLASTIC BIN LINER	1 → 11	2	3	
08	OTHER WASTE RECEPTACLE (NOT PEDAL BIN) WITH PLASTIC BIN LINER	1 → 11	2	3	
09	WASTE RECEPTACLE WITH LID (PEDAL BIN) WITHOUT PLASTIC BIN LINER	1 → 11	2	3	
10	WASTE RECEPTACLE WITHOUT LID AND WITHOUT PLASTIC BIN LINER	1	2	3	
11	SHARPS CONTAINER ("SAFETY BOX")	1	2	3	
12	DISPOSABLE LATEX GLOVES	1 → 14	2	3	
13	DISPOSABLE NON-LATEX GLOVES	1	2	3	
14	DISINFECTANT [E.G., HIBITANE, ALCOHOL]	1	2	3	
15	DISPOSABLE NEEDLES	1	2	3	
16	AUTO-DISABLE SYRINGES (3 OR 5 ml)	1	2	3	
17	DISPOSABLE SYRINGES (3 OR 5 ml)	1	2	3	
18	PRIVATE ROOM	1 → 21	2	3	
19	AUDITORY PRIVACY	1	2	3	
20	VISUAL PRIVACY	1	2	3	
21	MACKINTOSH/PLASTIC ON ANY SURFACE	1	2	3	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1823	CONDITION OF SERVICE DELIVERY AREA: WERE ANY USED SHARPS OR BANDAGES OUTSIDE THEIR PROPER CONTAINERS, OR THE SHARPS CONTAINER OVERFLOWING/BROKEN?	YES . . . . . 1 NO 2	
1824	ARE ALL SURFACE AREAS IN THE BLOOD DRAWING AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES . . . . . 1 NO 2	
	CHECK Q1819: IS "J" OR "K" CIRCLED, IMPLYING EITHER CLIENT IS SENT ELSEWHERE OUTSIDE FACILITY, OR BLOOD IS DRAWN IN THE UNIT AND SENT TO AN EXTERNAL LAB FOR TESTING? YES, "J" OR "K" CIRCLED ☐ ↓	NO, "J" OR "K" NOT CIRCLED ☐ →	1828
1825	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 . . . . . 2 DON'T KNOW 8	
1826	Is there a record maintained for clients who are referred for HIV tests or when blood is sent outside the facility for the HIV test? IF YES, ASK: May I see the record? MARK RESPONSE THAT BEST REFLECTS THE PRACTICE.	YES, RECORD OBSERVED WITH CLIENT TEST RESULTS. . . . . 1 YES, RECORD MAINTAINED IN LAB . . . 2 YES, RECORD REPORTED, BUT NOT SEEN. . . . . 3 NO RECORD MAINTAINED. 4	
1827	When you refer a client **to another facility** for HIV counseling and testing services, do you use a pre-printed form that specifies information about the client that should be shared, that is, an official referral form? IF YES, ASK: May I see a copy of the form?	YES, PREPRINTED FORM SEEN. . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD. . . . . 3 WRITE NOTE ON PRESCRIPTION FORM, LETTERHEAD OR BLANK PAPER. . . . . 4 VERBAL REPORT OR ACCOMPANIES CLIENT. . . . . 5 OTHER (SPECIFY)_____ 6 NEVER REFER OUTSIDE FACILITY 7 DON'T KNOW. 8	

COUNSELING AND TESTING STATISTICS

1828	Are records kept for clients who receive any counselling or testing from this facility? IF YES, ASK TO SEE THE RECORDS AND INDICATE WHAT TYPE OF INFORMATION IS AVAILABLE.	RECORD AVAILABLE IN THIS UNIT. . . . . 1 RECORD IN CLIENT INDIVIDUAL RECORD ONLY. . . . . 2 → RECORDS MAINTAINED BY VCT/CT COUNSELORS FROM ANOTHER UNIT IN THE FACILITY. . . . . 3 NO RECORDS. . . . . 4 →	1831 1833

1829	GO TO WHERE THERE IS COUNSELLING AND /OR TESTING RECORDS FOR THE FACILITY AND INDICATE WHICH INFORMATION IS AVAILABLE FOR THE PAST 12 COMPLETED MONTHS	(A) RECORD AVAILABILITY			(B) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED, NOT SEEN	NO RECORD	NUMBER OF CLIENTS	MONTHS OF DATA
01	TOTAL CLIENTS/PATIENTS RECEIVING INDIVIDUAL PRE-TEST COUNSELLING	1 → b	2 02	3 02		
02	TOTAL CLIENTS/PATIENTS RECEIVIN POST-TEST COUNSELLING	1 → b	2 03	3 03		
03	TOTAL CLIENTS/PATIENTS WHO GO TESTED FOR HIV	1 → b	2 04	3 04		
04	TOTAL FEMALE CLIENTS/PATIENTS WHO GOT TESTED FOR HIV	1 → b	2 05	3 05		
05	TOTAL CLIENTS/PATIENTS 15-24 YRS WHO GOT TESTED FOR HIV	1 → b	2 06	3 06		
06	TOTAL CLIENTS/PATIENTS 0-14 YRS WHO GOT TESTED FOR HIV	1 → b	2 07	3 07		
07	TOTAL CLIENTS WHO RECEIVED HIV TEST RESULTS	1 → b	2 08	3 08		
08	TOTAL CLIENTS WITH POSITIVE (+) HIV TEST RESULTS	1 → b	2 09	3 09		
09	TOTAL FEMALE CLIENTS WITH POSITIVE (+) HIV TEST RESULTS	1 → b	2 10	3 10		
10	TOTAL CLIENTS WITH POSITIVE (+) HIV TEST WHO RECEIVED RESULTS	1 → b	2 1830	3 1830		

NO	QUESTIONS	CODING CATEGORIES	GO TO
1830	WHAT IS THE MOST RECENT DATE RECORDED FOR HIV COUNSELLING?	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS . . . . . 2 NO DATE RECORDED . . . . . 3 NO RECORD FOR COUNSELLING . 4	→ 1833
1831	Is there a client number or other identifier for clients receiving pre and post test counselling? IF YES, ASK TO SEE A REGISTER.	YES, OBSERVED. . . . . 1 YES, REPORTED NOT SEEN. . . . . 2 NO. 3	
1832	Is there a mechanism where you can link the HIV test result with the client who received pre and post test counselling? IF YES, ASK TO SEE HOW THE SYSTEM WORKS	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
1833	Are reports regularly compiled on the number of clients in this facility who receive testing or counselling services for HIV/AIDS? IF YES, ASK FOR EACH QUESTION AND CIRCLE LETTER FOR INFORMATION THAT IS COMPILED	YES, NEGATIVE TEST RESULTS. . . . . A YES, POSITIVE TEST RESULTS. . . . . B YES, COUNSELLING . . . . . C NO . . . . . Y	→ 1836
1834	How frequently are any of the compiled reports submitted to someone outside of this facility?	MONTHLY OR MORE FREQUENTLY. . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS. . . . . 3 MORE THAN EVERY 6 MONTHS. . . . . 4 NEVER. 5	→ 1836
1835	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL. . . . . C PROVINCIAL LEVEL. . . . . D NATIONAL LEVEL. . . . . E DONOR AGENCY. . . . . F OTHER (SPECIFY)_____ X	
1836	Are there any CT-related guidelines/protocols for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see all the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2	→ 1840

1837	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAILABLE	(b) YEAR OF PUBLICATION
01	National Guidelines for HTC	1 → b	2 → 02	3 → 02	
02	Algorithm of testing	1 → b	2 → 03	3 → 03	
03	Infection prevention and control (IPC) guidelines	1 → b	2 → 1838	3 → 1838	
04	PEP guidelines	1 → b	2 → 1838	3 → 1838	

1838	**Other than the previously mentioned national** guidelines, are there any other protocols or guidelines for counselling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES . . . . . 1 NO OTHER PROTOCOLS/ GUIDELINES 2	→ 1840

NO	QUESTIONS	CODING CATEGORIES			GO TO
		(a)			(b)
1839	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OR PUBLICATION
01	Other protocols/guidelines for pre-test counselling?	1 → b	2 → 02	3 → 02	
02	Other protocols/guidelines for post-test counselling for both positive and negative test results?	1 → b	2 → 03	3 → 03	
03	Is there any written policy that all clients receiving HIV tests must be offered pre-test counselling or information, and post test counselling?	1 → b	2 → 04	3 → 04	
04	Is there any policy on HIV testing procedures, that is what test should be done, and when?	1 → b	2 → 05	3 → 05	
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 → 06	3 → 06	
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 → 07	3 → 07	
07	Any other informed consent policy (e.g., verbal)?	1 → b	2 → 08	3 → 08	
08	Is there a written policy on confidentiality provided to the client that specifies that no one will be told the HIV test result without the permission of the client?	1 → b	2 → 09	3 → 09	
09	Any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client?	1 → b	2 → 1840	2 → 1840	
1840	Is an individual client chart/record/card maintained for clients who receive services through this unit? (e.g., health booklet) 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? IF YES, ASK TO SEE A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 YES, ONLY AVAILABLE IN OTHER FACILITY AREA . . . . . 3 YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER _____ 6 (SPECIFY) NO INDIVIDUAL CLIENT CHART/RECORD 7			
	FAMILY PLANNING FOR HIV POSITIVE CLIENTS				
1841	Are family planning services routinely provided for all HIV positive clients?	YES, ALWAYS . . . . . 1 YES, SOMETIMES . . . . . 2 NO . . . . . 3 → 1845			
1842	Who most often provides counselling about use and methods of family planning available?	PROVIDER, THIS UNIT . . . . . 1 PROVIDER, FP UNIT . . . . . 2 REFERRED OUTSIDE THIS FACILIT` . . . 3			
1843	Who most often examines the client and provides or prescribes methods of family planning for HIV positive clients?	PROVIDER, THIS UNIT . . . . . 1 PROVIDER, FP UNIT . . . . . 2 REFERRED OUTSIDE THIS FACILITY. . . 3			
1844	Please show me any guidelines or protocols on counselling and screening for appropriate family planning methods.	GUIDELINES OBSERVED . . . . . 1 GUIDELINES REPORTED, NOT SEEN . 2 NO GUIDELINES AVAILABLE 3			

NO	QUESTIONS	CODING CATEGORIES	GO TO
	YOUTH FRIENDLY SERVICES		
1845	Does this facility have any specific youth-friendly services (YFS - Youth Friendly Corner/location)?	YES . . . . . 1 NO 2	→ 1849
1846	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINES.	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO 3	
1847	Do you have a staff member who has had specific training for providing youth friendly services? IF YES, ASK: Is the staff member present today?	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . . . . 2 NO 3	
1848	What are the key components of the youth friendly services that are offered in this facility? In other words, what provisions are made in this facility to encourage the youth to utilize services that are geared towards them? DO NOT READ RESPONSES TO RESPONDENT! PROBE: Anything else?	DISCOUNT FEES . . . . . A NO FEES . . . . . B EDUCATION/COUNSELLING . . . . . C ADOLESCENT PARTICIPATION . . . . . D COMMUNITY SUPPORT AND PARTICIPATION. . . . . E ADOLESCENT FRIENDLY STAFF. . . . . F ADOLESCENT FRIENDLY ENVIRONMENT (E.G., SERVICE IN SEPARATE ROOM) G ADOLESCENT FRIENDLY PROCEDURES H NETWORKING AND COLLABORATION. . I OTHER _____ X (SPECIFY)	
	COMMUNITY BASED SERVICES		
1849	Does this facility have links with community based health workers or volunteers for HIV/AIDS services? IF YES, ASK: What types of services do the community based workers provide? CIRCLE ALL THAT APPLY	YES, DISTRIBUTE ARVS . . . . . A YES, REFER FOR ART ELIGIBILITY . B YES, HOME/PALLIATIVE CAR . . . . . C YES, CLIENT TREATMENT SUPPORT D YES, PRETEST COUNSELLING . . . E YES, PREVENTIVE EDUCATION . . . . . F YES, ADHERENCE COUNSELLING . G YES, EMOTIONAL/SOCIAL SUPPORT H YES, DEFAULTER FOLLOW UP . . . . . I YES, NOT HIV/AIDS RELATED . . . . . J YES, OTHER HIV/AIDS RELATED _____ X (SPECIFY) NO . . . . . Y	→ **END**
1850	When clients are referred to community based health workers or volunteers, do you have a formal system for making the referral, such as a referral slip or other means? IF YES, ASK: What method do you use?	YES, REFERRAL SLIP OBSERVED . . . 01 YES, REFERRAL SLIP REPORTED, NOT SEEN . . . . . 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD . . . . . 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD . . . . . 04 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIEN . . . . . 05 WRITE NOTE/LETTER (UNSTRUCTURED) . . . . . 06 OTHER _____ 96 (SPECIFY) NO METHOD USED 95	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1851	When community based health workers refer clients to the facility, is there a formal system for making the referral such as a referral slip or other means? IF YES, ASK: What method do you use?	YES, REFERRAL SLIP OBSERVED . 01 YES, REFERRAL SLIP REPORTED, NOT SEEN . . . . . 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD . . . . . 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD . . . . . 04 CHW GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) . . . . . 05 WRITE NOTE/LETTER (UNSTRUCTURED) . . . . . 06 OTHER _____ (SPECIFY) . . . 96 NO METHOD USED 95	
1852	Do you have a reporting format that the community health worker completes, or that facility staff complete for the community work? IF YES, ASK TO SEE A COPY OF A RECENT REPORT	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
1853	Is there a system for periodic supervision of the community health worker? IF YES, ASK TO SEE EVIDENCE OF A SYSTEM SUCH AS A SUPERVISORY SCHEDULE/CHECKLIST/REPORT	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
1854	When was the most recent ***training session*** for community health workers who are linked with this facility?	WITHIN PAST 30 DAYS . . . . . 1 WITHIN PAST 2-6 MONTHS . . . . . 2 WITHIN PAST 7-12 MONTHS . . . . . 3 MORE THAN 12 MONTHS AGO . . . . . 4 NO TRAINING . . . . . 5 DON'T KNOW 8	
1855	When was the most recent ***meeting*** with community health workers who are linked with this facility?	WITHIN PAST 30 DAYS . . . . . 1 WITHIN PAST 2--6 MONTHS . . . . . 2 WITHIN PAST 7-12 MONTHS . . . . . 3 MORE THAN 12 MONTHS AGO . . . . . 4 NO MEETING . . . . . 5 DON'T KNOW 8	
1856	Does this facility have any system in place to motivate the CHW who are linked to this facility? IF YES, ASK: What systems to you have in place?	MONETARY COMPENSATION. . . . . A TRAINING. . . . . B IN-KIND (E.G., BICYCLES) . . . . . C JOB AIDS. . . . . D NO. . . . . Y OTHER _____ (SPECIFY) . . . X	
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 19: ANTIRETROVIRAL THERAPY (ART)

Facility Number: | | | | | | **Interviewer Code:** | | QRE TYPE **19**

1900	Does this facility offer any services related to antiretroviral therapy? IF YES, ASK: Do providers in this facility actually prescribe the treatment or provide follow-up services for persons receiving ART, including providing community-based services, or do providers from another facility use this place as an outreach site? PROBE AND CIRCLE ALL THAT APPLY	PRESCRIBE ADULT ART. . . . . A PRESCRIBE PEDIATRIC ART. . . . . B PROVIDE ADULT FOLLOW-UP. . . . . C PROVIDE PEDIATRIC FOLLOW-UP. . . . . D OUTREACH SITE FOR PROVIDERS FROM ANOTHER FACILITY. . . . . E → **END** NO ART SERVICES. . . . . F → **END**	

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF ART SERVICES IN THIS FACILITY

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT ART SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1902 BELOW AND GO ON TO Q1903.

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KENYA. 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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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

DAY	MONTH	YEAR
		2010

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

1902	May I begin the interview now?	YES . . . . . 1 NO . . . . . 2 → STOP	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1903	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today COMPLETE THE STAFF LIST FOR THIS CLINIC/UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1904	How many days each week are ART services available in this facility for adult and pediatric patients? (IF LESS THAN ONCE PER WEEK, CODE "0")	A) DAYS PER WEEK: ADULT. . . . . [ ] B) DAYS PER WEEK: PEDIATRIC. . . . . [ ]	
1905	How many months have ART services been offered from this facility for adults and pediatric patients?	1) # OF MONTHS ADULTS. . [ ][ ][ ] DON'T KNOW. . . . . 998 2) # OF MONTHS PEDIATRICS. . . . . [ ][ ][ ] DON'T KNOW. 998	
1906	Is there an overall person specifically in charge of ART services in this facility, both adult and paediatric?	YES . . . . . 1 NO ONE PERSON IN CHARGE OF ART 2	→ 1908
1907	What is the qualification of the person in charge of ART services in this facility?	SPECIALIST/CONSULTANT . . . . . 01 MEDICAL OFFICER/PHYSICIAN . . . . . 02 CLINICAL OFFICER . . . . . 03 REGISTERED NURSE . . . . . 04 ENROLLED NURSE . . . . . 05 OTHER (SPECIFY) 96	
1908	Which ARV medicines are prescribed or dispensed in this facility? CIRCLE ALL THAT APPLY. AFTER THE RESPONSE, READ THE NAME OF EACH MEDICINE THAT IS NOT MENTIONED, TO VERIFY THAT THE MEDICINE IS NOT PRESCRIBED OR DISPENSED BY THIS UNIT IF A COMBINATION DRUG IS USED, CIRCLE THE COMPONENTS THAT ARE INDICATED IN LIST (E.G., FOR STAVUDINE40+LAMIVUDINE+ NEVIRAPINE, CIRCLE D, B, AND I)	**NRTIs** ZIDOVUDINE (ZDV, AZT). . . . . A LAMIVUDINE (3TC). . . . . B DIDANOSINE (ddI). . . . . C STAVUDINE (d4T) OR D3T. . . . . D ABACAVIR (ABC). . . . . E EMTRICITABINE (FTC). . . . . F TENOFOVIR (TDF). . . . . G **NNRTIs** NEVIRAPINE (NVP). . . . . I EFAVIRENZ (EFZ). . . . . J DELAVIRDINE (DLV). . . . . K **PROTEASE INHIBITORS** LOPINAVIR (LPV). . . . . L INDINAVIR (IDV). . . . . M NELFINAVIR (NFV). . . . . N SAQUINAVIR (SQV). . . . . O RITONAVIR (RTV). . . . . P ATAZANAVIR (ATV). . . . . Q FOSAMPRENAVIR (FPV). . . . . R TIPRANAVIR (TPV). . . . . S DARUNAVIR (DRV). . . . . T LOPINAVIR-RITONAVIR (LPV/r). . . . . U **FUSION INHIBITORS** ENFUVIRTIDE (T-20). . . . . V OTHER (SPECIFY) X	
1909	What is the most commonly prescribed or dispensed *adult* first-line ART regimen in this facility?	STAVUDINE (d4T) + LAMIVUDINE (3TC) *plus* NEVIRAPINE (NVP) . . . . . 1 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) *plus* NEVIRAPINE (NVP) . . . . . 2 STAVUDINE (d4T) + LAMIVUDINE (3TC) *plus* EFAVIRENZ (EFV). . . . . 3 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) *plus* EFAVIRENZ (EFV). . . . . 4 NO ROUTINE FIRST-LINE REGIMEN. 5	
1909A	What is the most commonly prescribed or dispensed *pediatric* first-line ART regimen in this facility?	STAVUDINE (d4T) + LAMIVUDINE (3TC) *plus* NEVIRAPINE (NVP). . . . . 1 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) *plus* NEVIRAPINE (NVP). . . . . 2 NO ROUTINE FIRST-LINE REGIMEN. 5	

NO.	QUESTIONS	CODING CATEGORIES	GO TO

1910 Now I want to know about eligibility criteria used for placing adult clients on ART. For each stage of HIV that I will describe & each criteria I mention please indicate if an **adult** client at that stage is eligible for ART in this facility.

	DISEASE STAGE & CRITERIA	ELIGIBILITY		
		YES	NO	DON'T KNOW
01	WHO stage 3 or 4, irrespective of CD4 cell count	1	2	8
02	CD4 cell counts ≤ 250 CELLS/CUBIC MM (≤ 350 FOR PREGNANT WOMEN) irrespective of WHO clinical stage	1	2	8
03	Client meets social eligibility criteria	1	2	8

1910A For each stage of HIV that I will describe & each criteria I mention, please indicate if a **pediatric** client at that stage is eligible for ART in this facility.

	DISEASE STAGE & CRITERIA	ELIGIBILITY		
		YES	NO	DON'T KNOW
	CHILDREN **UNDER** 18 MONTHS - PCR positive:			
01	WHO Stage 1 or 2; CD4% < 20%	1	2	8
02	WHO Stage 3 regardless of CD4%	1	2	8
03	Regardless of any WHO stage or CD4 count	1	2	8
	CHILDREN **UNDER** 18 MONTHS - NO PCR AVAILABLE			
04	Mother HIV positive and Child Stage 3 with CD4% <20%	1	2	8
	CHILDREN **OVER** 18 MONTHS - HIV ANTIBODY POSITIVE			
05	WHO Stage 1 or 2; CD4% <15%	1	2	8
06	WHO Stage 3 regardless of CD4%	1	2	8

1911 Are social or other criteria related to the client's personal situation considered prior to starting ART?

IF YES, ASK:

Which of the following criteria are considered prior to starting ART?

READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.

- Geographic Criteria . . . . . A
- Proof of Capacity to Attend Clinic Regularly . . . . . B
- Disclosure to Significant Other/Partners (If Applicable) C
- **NO ART IF SOCIAL PROBLEM:**
  - Alcohol . . . . . D
  - Drug Addict . . . . . E
  - Mental Illness . . . . . F
  - Homelessnes . . . . . G
- Ability to Pay . . . . . H
- Other _____ (Specify) X
- No Social Criteria Applied . . . . Y

1912 Are adherence criteria considered prior to starting ART?

IF YES, ASK:
Which of the following eligibility criteria are considered prior to starting a client on ART?

READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.

- CONSISTENT USE OF COTRIMOXAZOLE OR TB TREATMENT . . . . . A
- REQUIRED PRE-ART CLINIC VISITS MADE ON TIME . . . . . B
- TREATMENT ASSISTANT OR SUPPORTER IDENTIFIED C
- OTHER _____ (SPECIFY) X
- NO ADHERENCE CRITERIA APPLIED Y

1913 Is a total lymphocyte count (TLC) always done prior to starting a client on ART?

- YES 1
- NO 2

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1915	Is a CD4 T Cell count always determined prior to starting a client on ART? IF YES, ASK: What is the most common practice for providing the test? i.e., where is the test conducted?	YES, CONDUCTED IN THIS FACILITY. . . . 1 YES, CLIENT REFERRED OUTSIDE. . . . . 2 YES, BLOOD SENT OUTSIDE. . . . . 3 NO. 4	→ 1917
1916	After the initial CD4 T cell count, do you re-test for a follow up level? IF YES, ASK: How often is follow-up testing usually done? (SELECT ONE LETTER ONLY, FROM A TO E) Is follow-up also done depending on the patient's condition? IF YES, CIRCLE "F" ALSO	EVERY MONTH . . . . . A EVERY 2-3 MONTHS . . . . . B EVERY 4-6 MONTHS . . . . . C EVERY YEAR . . . . . D ONCE ONLY, WITHIN 1 MONTH E DEPENDING ON PATIENT CONDITION F OTHER _____ X (SPECIFY) NO FOLLOW-UP TESTIN. . . . . Y	
1917	Is an HIV RNA Viral load level always done prior to starting ART? IF YES, ASK: What is the most common practice for providing the test? i.e., where is the test conducted?	YES, CONDUCTED IN THIS FACILITY . . . 1 YES, CLIENT REFERRED OUTSIDE . . 2 YES, BLOOD SENT OUTSIDE . . . . 3 NO 4	→ 1919
1918	After the initial HIV RNA Viral load level, do you retest for a follow up level? IF YES, ASK: How often is follow-up testing usually done? (SELECT ONE LETTER ONLY, FROM A TO E) Is follow-up also done depending on the patient's condition? IF YES, CIRCLE "F" ALSO	EVERY MONTH . . . . . A EVERY 2-3 MONTHS . . . . . B EVERY 4-6 MONTHS . . . . . C EVERY YEAR . . . . . D ONCE ONLY, WITHIN 1 MONTH E DEPENDING ON PATIENT CONDITION F OTHER _____ X (SPECIFY) NO FOLLOW-UP TESTIN. . . . . Y	

1919 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	Haemoglobin/hematocrit	1	2	3	8
02	Full blood count (Haemogram)	1	2	3	8
03	Pregnancy test for women	1	2	3	8
04	Renal function tests (serum creatinine and U&E)	1	2	3	8
05	Urinalysis	1	2	3	8
06	Liver function tests	1	2	3	8
07	TB sputum test	1	2	3	8
08	Hepatitis B	1	2	3	8
09	Chest X-ray	1	2	3	8
10	Any other routine tests _____ (SPECIFY)	1	2	3	8

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1919A	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	Haemoglobin/hematocrit	1	2	3	8	
02	Full blood count	1	2	3	8	
03	Pregnancy test for women	1	2	3	8	
04	Renal function tests (serum creatinine and U&E)	1	2	3	8	
05	Urinalysis	1	2	3	8	
06	Liver function tests	1	2	3	8	
07	TB sputum test	1	2	3	8	
08	Hepatitis B	1	2	3	8	
09	Chest X-ray	1	2	3	8	
10	Any other routine tests _____ (SPECIFY)	1	2	3	8	

1920	When a client is started on ART, are any of the following types of counselling offered? IF YES, RECORD WHETHER THE COUNSELLING IS ALWAYS OR ONLY SOMETIMES OFFERED.	ALWAYS	SOMETIMES	NEVER	DON'T KNOW	
01	Pre-treatment medication use counselling?	1	2	3	8	
02	Follow-up counselling to discuss adherence to ART medicines?	1	2	3	8	
03	Follow-up counselling to discuss adherence to medication plan in presence of significant others?	1	2	3	8	
04	Secondary prevention counselling	1	2	3	8	
1921	CHECK Q1920 IF THERE IS ANY COUNSELLING RELATED TO ART? I.E., IS (01) OR (O2) OR (03) OR (04) = 1 (ALWAYS) OR 2 (SOMETIMES)?	YES ..... 1 NO 2				→ 1924
1922	Who provides the counselling for ART medicines? CIRCLE ALL THAT APPLY.	PRESCRIBING PHYSICIAN/MO/ OR CLINICAL OFFICER. . . . . A OTHER CONSULTANT/PHYSICIAN/ CLINICAL OFFICER. . . . . B REG. NURSE/REG. MIDWIFE. . . . . C ENR. NURSE/ENR. MIDWIFE. . . . . D TRAINED COUNSELOR ..... E PHARMACIST ..... F COMMUNITY/PLWHA WORKER OR "EXPERT PATIENT" . . . . . G OTHER _____ (SPECIFY) X				
1923	Have all of the people you just mentioned who provide counselling for ART medicines been trained in counselling for adherence to ART?	YES ..... 1 NO ..... 2 DON'T KNOW 8				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1924	Are there any fees levied for any services or items related to ARV treatment?	YES . . . . . 1 NO 2	→ 1927

1925	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES	(a) FEE NO	(a) FEE NA	(b) AMOUNT IN KSH
01	ART CLIENT CARDS	1 → b	2 → 02	3 → 02	
02	CONSULTATION SERVICE	1 → b	2 → 03	3 → 03	
03	ARV MEDICINES (ESTIMATE COST PER MONTH)	1 → b	2 → 04	3 → 04	
04	CD4 COUNT	1 → b	2 → 05	3 → 05	
05	OTHER LAB TEST _____ (SPECIFY) (e.g. FHG, U/E/C,LFTs, CBC)	1 → b	2 → 1926	3 → 1926	

1926	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME FEES POSTED ONLY . . 2 NO POSTED FEES 3	
1927	Are there any **ART-related** guidelines or protocols for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see <u>all</u> the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS 2	→ 1932

1929	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	(a) OBSERVED	(a) REPORTED AVAILABLE NOT SEEN	(a) NOT AVAIL.	(b) YEAR OF PUBLICATION
01	National ART guidelines	1 → b	2 → 02	3 → 02	
02	Guidelines for paediatric clients	1 → b	2 → 03	3 → 3	
03	Kenya National Clinical manual for ARV providers	1 → b	2 → 1932	3 → 1932	

1932	Where is information for patients receiving ART through this facility recorded? CIRCLE ALL THAT APPLY. ASK TO SEE THE REGISTERS USED FOR FOLLOW-UP OF ART PROGRAM	GENERAL OPD REGISTER WITH HIV/AIDS AND NON-HIV/AIDS CLIENTS. . . . . A SPECIFIC REGISTER FOR HIV/AIDS CLIENTS . . . . . B SPECIFIC REGISTER ONLY FOR CLIENTS RECEIVING ART. . . . . C INDIVIDUAL CLIENT CARD. . . . . D COMPUTERIZED . . . . . E NO RECORD KEPT . . . . . Y	→ 1944
1933	SCAN THE REGISTER (OR COMPUTER) FOR ALL NEW ENTRIES FOR THE PAST ONE FULL MONTH AND INDICATE WHICH INFORMATION IS COMPLETED FOR ALL CLIENTS STARTED ON ART.	ELIGIBILITY CRITERIA. . . . . A DATE OF ELIGIBILITY. . . . . B NEITHER INFORMATION COMPLETED . . . . . Y	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1934	ASK TO SEE CLIENT INDIVIDUAL RECORDS. RANDOMLY SELECT 10 INDIVIDUAL CLIENT RECORDS/CARDS AND INDICATE WHICH INFORMATION IS PRESENT ON **ALL** 10 CARDS.	TREATMENT SUPPORTER ..... A DATE OF ENROLLMENT IN ART ..... B ELIGIBILITY CRITERIA ..... C CURRENT ARV REGIMEN BEING USED D NONE OF ABOVE ITEMS ..... Y	
1935	ASK TO SEE THE REGISTER/CARD OR COMPUTER RECORDS, AND INDICATE THE DATE OF THE MOST RECENT TIME ART WAS PROVIDED.	WITHIN PAST 30 DAYS ..... 1 MORE THAN 30 DAYS AGO ..... 2 REGISTER/RECORDS NOT SEEN. 3	→ 1944
1936	How many ***adult clients*** are currently on ***care*** and how many are on ***treatment*** in this facility? **ADULTS: 14 YEARS AND OLDER**	1) TOTAL NUMBER OF ADULTS ON CARE ☐☐☐☐☐ NONE ..... 00000 DON'T KNOW ..... 99998 2) TOTAL NUMBER OF ADULTS ON TREATMENT ☐☐☐☐☐ NONE ..... 00000 DON'T KNOW 99998	
1937	How many ***children*** are currently on ***care*** and how many are on ***treatment*** in this facility? **CHILDREN: 0-13 YEARS**	1) TOTAL NUMBER OF CHILDREN ON CARE ☐☐☐☐☐ NONE ..... 00000 DON'T KNOW ..... 99998 2) TOTAL NUMBER OF CHILDREN ON TREATMENT ☐☐☐☐☐ NONE ..... 00000 DON'T KNOW 99998	
1938	How many children below 18 months of age are currently receiving ART *(treatment)* through this facility?	TOTAL NUMBER OF CHILDREN <18MO ON TREATMENT. . ☐☐☐☐☐ NONE ..... 00000 DON'T KNOW 99998	
1939	Since the beginning of the ART services, how many clients have been lost to follow-up.	# OF LOST TO F.U. ☐☐☐☐ NONE ..... 0000 DON'T KNOW 9998	
1940	During the past 12 full months, how many ART clients have died?	# OF CLIENTS WHO HAVE DIED . . . ☐☐☐☐ NONE ..... 0000 DON'T KNOW 9998	→ 1942
1941	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA ..... ☐☐	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1942	During the past 12 full months, how many ART clients have been lost to follow-up?	# OF CLIENTS LOST TO FOLLOW-UP ☐☐☐☐ NONE ..... 0000 DON'T KNOW 9998	→ 1944
1943	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA ..... ☐☐	
1944	Are reports regularly compiled on the numbers of clients receiving ART?	YES ..... 1 NO 2	→ 1947
1945	How frequently are the compiled reports submitted to someone outside of this facility?	MONTHLY OR LESS ..... 1 EVERY 2-3 MONTHS ..... 2 EVERY 4-6 MONTHS ..... 3 MORE THAN EVERY 6 MONTHS ..... 4 NEVER 5	→ 1947
1946	To whom do you send these reports? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL. ..... C PROVINCIAL LEVEL. ..... D NATIONAL LEVEL. ..... E DONOR AGENCY. ..... F OTHER _____ X (SPECIFY)	
1947	Is an individual client record/card where information on an individual client is recorded, and which provides information on previous visits of this client maintained? IF YES, ASK TO SEE A BLANK OR CURRENT RECORD.	YES, OBSERVED. ..... 1 YES, REPORTED, NOT SEEN. ..... 2 YES, RECORD AVAILABLE IN OTHER UNIT IN THIS FACILITY. ..... 3 NO. 4	
1948	Do you have a system for making individual client appointments for follow-up? IF YES, ASK TO SEE ANY RECORD INDICATING THE SYSTEM FUNCTIONS	YES, OBSERVED ..... 1 YES, REPORTED, NOT SEEN ..... 2 NO 3	→ 1950
1949	Does the appointment system indicate if the client kept the appointment or not?	YES ..... 1 NO 2	
1950	Does this facility provide nutrition rehabilitation services for HIV/AIDS patients? NUTRITIONAL REHABILITATION REFERS TO EDUCATION ABOUT EATING WELL, EARLY IDENTIFICATION OF DEFICIENCIES, PROVIDING FORTIFIED PROTEIN SUPPLEMENT (FPS). IF YES, ASK: Which of the following are routine components of nutritional rehabilitation services? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.	Nutritional Counselling ..... A Teach early identification of deficiencies ..... B Provide vitamins ..... C Provide fortified protein supplement. D Provide high protein foods E Provide other diet supplement ..... Other _____ X (specify) No services Y	
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE		

SECTION 20: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) SERVICES

Facility Number: | | | | | | **Interviewer Code:** | | QRE TYPE **20**

2000	Does this facility provide the minimum package of services for PMTCT, i.e., HIV counseling and testing, and provision of ARV prophylaxis regimens?	YES . . . . . 1 NO 2	→ **END**
2001	How are the PMTCT services in this facility organized and provided? PROBE TO CAPTURE ALL POSSIBLE WAYS THE FACILITY ORGANIZES PMTCT SERVICES AND CIRCLE ALL THAT APPLY.	SEPARATE PMTCT SERVICES . . . . . A PMTCT AND CCC SERVICES TOGE . . . . . B PMTCT WITH ANC SERVICES . . . . . C PMTCT WITH ANC AND DELIVERY AS ONE SYSTE . . . . . D PMTCT WITH DELIVERY . . . . . E	

CHECK 2001: IF MORE THAN ONE SYSTEM IS REPORTED, ASK FOR THE MAIN SYSTEM USED IN THE FACILITY. GO TO THAT LOCATION TO COLLECT THIS INFORMATION.

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE PROVISION OF PMTCT SERVICES IN THIS FACILITY.

IF THIS IS A NEW RESPONDENT, INTRODUCE YOURSELF. BRIEFLY EXPLAIN THE PURPOSE OF YOUR VISIT AND ASK IF HE/SHE WOULD BE WILLING TO ANSWER A FEW QUESTIONS ABOUT ART SERVICES IN THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT STATEMENT BELOW

IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q2003 BELOW AND GO ON TO Q2004.

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to to assist the government in knowing more about health services in KENYA.
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 and will ask to see patient registers. However, no patient names from the registers will be recorded or shared. Information about your facility 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 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 these 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 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

				2	0	1	0
DAY		MONTH		YEAR			

SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

2003	May I begin the interview now?	YES . . . . . 1 NO 2	→ **STOP**

NO.		CODING CATEGORIES	GO TO
2004	First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counsellors, social workers, and laboratory technicians) who are assigned to this unit who are present today. Please give me the names and main service responsibility of the staff assigned to this unit and present today COMPLETE THE STAFF LIST FOR THIS UNIT. DO NOT DUPLICATE SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES . . . . . 1 NO 2	

NO.		CODING CATEGORIES	GO TO
2005	How many months have PMTCT services been offered in this facility? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS . . . . . [ ][ ][ ] DON'T KNOW. 998	

2006 For each service I will mention, please tell me if providers in this unit or facility offer the service or refer clients for the service, either in this facility or outside, for prevention of mother-to-child transmission of HIV

	SERVICE	SERVICE OFFERED IN THIS FACILITY: OUTPATIENT — OFFERED THIS UNIT	SERVICE OFFERED IN THIS FACILITY: OUTPATIENT — REFER TO OTHER UNIT THIS FACILITY	SERVICE OFFERED IN THIS FACILITY: INPATIENT SERVICE ONLY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
01	Offer HIV testing	1	2	3	4	5
02	Offer group pre-test information or counselling	1	2	3	4	5
03	Offer individual HIV pre-test information or counselling	1	2	3	4	5
04	Offer individual HIV post-test counselling	1	2	3	4	5
05	Offer couple counselling for HIV+ women	1	2	3	4	5
06	Couple counseling to post-partum women (up to 6 weeks)	1	2	3	4	5
07	Offer counselling on infant feeding to HIV positive women	1	2	3	4	5
08	Offer counselling on maternal nutrition to HIV positive women	1	2	3	4	5
09	Offer counselling on family planning	1	2	3	4	5
10	Offer family planning services	1	2	3	4	5
11	Offer counselling on condom use for dual protection	1	2	3	4	5
12	Distribute condoms to PMTCT clients	1	2	3	4	5
13	Offer ARV prophylaxis for pregnant women	1	2	3	4	5
14	Offer ARV prophylaxis for newborn	1	2	3	4	5
15	Provide breast-milk substitutes for newborns of HIV positive women	1	2	3	4	5
16	Offer follow-up counselling for HIV positive women on linkage to long-term care	1	2	3	4	5
17	Offer ARV therapy (long-term treatment) for HIV positive women	1	2	3	4	5
18	Offer ARV therapy for family members of HIV positive women	1	2	3	4	5
19	Offer women-to-women support group services	1	2	3	4	5
20	Offer PMTCT services in labor and delivery services	1	2	3	4	5
21	Offer follow-up services for HIV-exposed babies	1	2	3	4	5
22	Routinely offer TB screening to PMTCT clients	1	2	3	4	5
23	Offer follow-up services for TB-exposed babies	1	2	3	4	5

2007	When the various services offered for PMTCT are provided, is this recorded anywhere so that you can see what services a pregnant woman has received? IF YES, ASK TO SEE WHERE THIS INFORMATION IS RECORDED AND ANSWER THE FOLLOWING QUESTIONS.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 → 2009 RECORDED IN INDIVIDUAL CLIENT CARD/RECORD, NOT COMPILED FOR REPORTING . . . . . 3 → 2009 NO . . . . . 4 → 2009	

NO.		CODING CATEGORIES	GO TO

		(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
	IT MAY BE NECESSARY TO REVIEW **ANC** AS WELL AS **PMTCT** RECORDS TO COLLECT THE INFORMATION.	OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
2008 01	TOTAL HIV POSITIVE WOMEN RECEIVING COUNSELLING ON FAMILY PLANNING IN PAST 12 MOS.	→ b	2 → 02	3 → 02		
02	TOTAL HIV POSITIVE WOMEN RECEIVING INFANT FEEDING COUNSELLING IN PAST 12 MONTHS	→ b	2 → 03	3 → 03		
03	TOTAL HIV POSITIVE WOMEN RECEIVING COUPLES COUNSELLING IN PAST 12 MONTHS	→ b	2 → 2009	3 → 2009		

2009	Are there any PMTCT-related guidelines/protocols for providers working in this unit? Guidelines that are posted on the wall are acceptable. IF YES, ASK: May I see all the guidelines and protocols that are available here?	YES, GUIDELINES/PROTOCOLS AVAILABLE . . . . . 1 NO GUIDELINES OR PROTOCOLS . 2	→ 2013

		(a)			(b)	
	ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have *[NAME OF GUIDELINE]*?	OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OF PUBLICATION	
2010 01	Guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS in Kenya	1 → b	2 → 02	3 → 02		
02	Early Infant Diagnosis protocol	1 → b	2 → 2011	3 → 2011		

2011	**Other than the previously mentioned national** guidelines, are there any other protocols or guidelines for counselling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES . . . . . 1 NO OTHER PROTOCOLS/ GUIDELINES 2	→ 2013

NO.		CODING CATEGORIES			GO TO
			(a)		(b)
2012	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OF PUBLICATION
01	Other protocols/guidelines for pre-test counselling?	1 → b	2 → 02	3 → 02	
02	Other protocols/guidelines for post-test counselling for both positive and negative test results?	1 → b	2 → 03	3 → 03	
03	Is there any written policy that all clients receiving HIV tests must be offered pre-test counselling or information, and post test counselling?	1 → b	2 → 04	3 → 04	
04	Is there any policy on HIV testing procedures, that is what test should be done, and when? (e.g., algorithm)	1 → b	2 → 05	3 → 05	
05	HIV Manual for the Processing of samples, use of HIV rapid test kits, and data management?	1 → b	2 → 06	3 → 06	
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 → 07	3 → 07	
07	Is there a written policy on confidentiality provided to the client, that specifies that no one will be told the HIV test result without the client's permission?	1 → b	2 → 08	3 → 08	
08	Any other guidelines for PMTCT services?	1 → b	2 → 2013	3 → 2013	

2013	How many days each week is HIV testing available in this facility for pregnant women? (IF LESS THAN ONCE PER WEEK, CODE "0")	DAYS PER WEEK . . . . . [ ] DON'T KNOW 8	
2013A	How many days each week is HIV testing available to post-natal women, i.e., up to 6 weeks after delivery? (IF LESS THAN ONCE PER WEEK, CODE "0")	DAYS PER WEEK . . . . . [ ] DON'T KNOW 8	
2014	What is the most common procedure followed for offering HIV testing to pregnant women? RECORD THE RESPONSE THAT BEST REFLECTS THE PRACTICE. PROBE IF NECESSARY.	OFFERED WHEN VOLUNTARILY REQUESTED BY PREGNANT WOMAN. . . . . 1 OFFERED TO ALL ANC CLIENTS AT FIRST VISIT. . . . . 2 OFFERED SELECTIVELY TO ANC CLIENTS AT FIRST VISIT, BASED ON SOCIAL/MEDICAL HISTORY. . . . . 3 OTHER _____ 6 (SPECIFY)	
2015	Are all HIV positive women instructed to bring the exposed infant for an HIV test? IF YES, ASK WHETHER ALL ANC CLIENTS ARE INSTRUCTED OR ONLY THOSE DELIVERING AT THE FACILITY	YES, FOR ALL HIV POSITIVE WOMEN. . . . . 1 YES, FOR FACILITY DELIVERIES ONLY. . . . . 2 NO. 3	→ 2022
2016	At what age of the exposed infant are the women instructed to bring him/her for PCR testing? INDICATE AGE IN WEEKS	AGE (IN WEEKS) INFANT TO BE BROUGHT FOR HIV TESTING [ ][ ] DON'T KNOW 98	

NO.		CODING CATEGORIES	GO TO
2017	Do providers in this unit actually prescribe or provide the antiretroviral medicine to HIV positive pregnant women for PMTCT? (for prophylaxis or treatment) IF YES, ASK: What are the ARV regimes used? CIRCLE ALL THAT APPLY.	NEVIRAPINE ALONE. . . . . A ZIDOVUDINE ALONE. . . . . B sdNVP FOLLOWED BY ZIDOVUDINE AND LAMIVUDII C ZIDOVUDINE AND NEVIRAPINE ONLY . . . . . D ZIDOVUDINE FROM 28 WKS + sdNVP FOLLOWED BY ZIDOVUDINE AND LAMIVUDINE. . . . . E HAART FOR THE ELIGIBLE. . . . . F OTHER (SPECIFY) _____ X NO ARV AVAILABLE FROM THIS UNIT FOR PMTCT. . . . . Y	→ 2022
2018	What is the practice for dispensing the ARV prophylaxis to the HIV positive pregnant woman? PROBE TO ARRIVE AT CORRECT RESPONSES	PROVIDE TO WOMEN ATTENDING ANC SAME DAY HIV STATUS IS CONFIRMED FOR SELF ADMINISTRATION AT TIME OF LABOUR. . . . . A PROVIDE TO WOMEN WHO DELIVER IN FACILITY, AT TIME OF DELIVERY. . . . . B PROVIDE TO WOMEN ATTENDING ANC STARTING AT 28 WEEKS . . . . . C OTHER (SPECIFY) _____ X	
2020	Which ARV prophylaxis is used for the newborn for PMTCT?	NEVIRAPINE ONLY. . . . . A ZIDOVUDINE (or AZT) ONLY. . . . . B NVP TO NEWBORN WITHIN 72 HRS OF DELIVERY, FOLLOWED WITH AZT ONLY FOR 4-6 WKS . . . . . C NVP TO NEWBORN WITHIN 72 HRS OF DELIVERY, FOLLOWED WITH 3TC FOR 7 DAYS + AZT FOR 4-6 WKS. . . . D OTHER _____ X (SPECIFY) NO ARV PROPHYLAXIS FOR NEWBORN . . . . . Y	→ 2022
2021	What is the practice for dispensing the ARV prophylaxis to the newborn of the HIV positive woman?	PROVIDER GIVES ARVs TO NEWBORN AFTER BIRTH A GIVES TO ANC WOMAN FOR SELF ADMINISTRATION TO NEWBORN AFTER BIRTH. . . . . B INSTRUCTS MOTHER TO BRING INFANT TO FACILITY FOR ARV WITHIN 72 HOURS AFTER BIRTH. . . . . C OTHER _____ X (SPECIFY)	
2022	Now I would like to look at ANC records, including those that provide information on any PMTCT counselling and testing services Do you have a record or register of the total number of first-visit ANC clients over the past 12 months? IF YES, ASK TO SEE THE RECORD/REGISTER.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	→ 2025 → 2025
2023	RECORD THE TOTAL NUMBER OF FIRST VISIT ANC CLIENTS DURING THE PAST 12 MONTHS.	NUMBER OF FIRST VISIT ANC CLIENTS ☐☐☐☐	
2024	INDICATE NUMBER OF MONTHS OF DATA AVAILABLE IN PREVIOUS QUESTION	MONTHS OF DATA . . . . . ☐☐	
2025	Are there any records or registers that provide numbers of ANC clients receiving pre- or post-test counselling or HIV testing? GO TO WHERE PMTCT RECORDS ARE MAINTAINED FOR THE FOLLOWING INFORMATION. THE INFORMATION MAY BE KEPT IN ANC AND DELIVERY UNITS.	YES . . . . . 1 YES, IN CCC STATISTICS BUT NOT SPECIFIC FOR ANC . . . . . 2 NO 3	→ 2028 → 2028

NO.		CODING CATEGORIES	GO TO

		(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
2026	ASK TO SEE ANY RECORD OR REGISTER OF ANC CLIENTS WHO RECEIVED HIV TEST OR COUNSELLING SERVICES DURING THE PAST 12 MONTHS, AND RECORD THE CORRECT RESPONSE					
01	TOTAL ANC CLIENTS RECEIVING INDIVIDUAL PRE-TEST COUNSELLING	→ b	2 → 03	3 → 03		
02	TOTAL ANC CLIENTS RECEIVING POST-TEST COUNSELLING	→ b	2 → 04	3 → 04		
03	TOTAL CLIENTS WHO OPTED OUT	→ b	2 → 04	3 → 04		
04	TOTAL ANC CLIENTS WHO GOT AN HIV TEST	→ b	2 → 05	3 → 05		
05	TOTAL ANC CLIENTS WHO RECEIVED HIV TEST RESULTS	→ b	2 → 06	3 → 06		
06	TOTAL ANC CLIENTS WITH POSITIVE HIV TEST	→ b	2 → 07	3 → 07		
07	TOTAL ANC CLIENTS WITH POSITIVE (+) HIV TEST WHO RECEIVED TEST RESULTS	→ b	2 → 2027	3 → 2027		

2027	WHAT IS THE MOST RECENT DATE RECORDED FOR HIV TEST COUNSELLING?	WITHIN PAST 30 DAYS . . . . . 1 MORE THAN 30 DAYS . . . . . 2 NO DATE RECORDED . . . . . 3 NO COUNSELLING RECORDED 4	→ 2030
2028	Is there a mechanism for linking the HIV test result with the client who received pre- and post-test counselling? IF YES, ASK TO SEE HOW THE SYSTEM WORKS	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO . . . . . 3 SEROSTATUS NOT ASSESSED 4	→ 2033
2029	Is there a mechanism for linking the counselling and test results with the receipt of ARV for the mother and the newborn? IF YES, ASK TO SEE THE RECORDS.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO RECORD 3	

		(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
2030	AMONG THE WOMEN FOR WHOM TESTING INFORMATION WAS AVAILABLE **(Q2026)** INDICATE IF INFORMATION ON RECEIVING ARV, AND ON THEIR NEWBORN IS AVAILABLE. IF INFORMATION ONLY AVAILABLE IN DELIVERY AREA, CIRCLE '2'.					
01	NUMBER OF HIV POSITIVE WOMEN WHO WERE PROVIDED ARV FOR PMTCT	→ b	2 → 02	3 → 02		
02	NUMBER OF INFANTS BORN TO HIV POSITIVE WOMEN	→ b	2 → 03	3 → 03		
03	NUMBER OF NEWBORNS OF HIV POSITIVE WOMEN WHO WERE PROVIDED ARV PROPHYLAXIS	→ b	2 → 04	3 → 04		
04	NUMBER OF HIV POSITIVE INFANTS.	→ b	2 → 05	3 → 05		
05	TOTAL NUMBER OF BIRTHS FOR ALL WOMEN	→ b	2 → 2031	3 → 2031		

NO.		CODING CATEGORIES	GO TO
2031	Is there any record of HIV positive pregnant women who begin ARV treatment? (HAART) IF YES, ASK TO SEE THE RECORD/REGISTER	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 WOMEN REFERRED TO ART OUTSIDE THIS UNIT. NO FURTHER FOLLOW-UP FROM THIS UNIT . . . . . 3 NO RECORDS . . . . . 4 HAART NOT AVAILABLE 5	
2033	Do you compile and submit any statistics for pregnant women and infants receiving PMTCT services? IF YES, ASK: Which statistics do you compile & submit for pregnant women (and infants) receiving PMTCT services? CIRCLE ALL THAT APPLY	**NUMBER OF PREGNANT WOMEN** RECEIVING PRETEST COUNSELLING. . . . . A RECEIVING POSTTEST COUNSELLING. . . . . B TESTED FOR HIV . . . . . C SERO POSITIVE FOR HIV . . . . . D RECEIVING ARVs FOR PMTCT . . . . . E ON HAART. . . . . F **INFANTS OF HIV POSITIVE WOMEN** NUMBER OF HIV-EXPOSED INFANTS. . . . . G RECEIVING ARV FOR PMTCT. . . . . H NUMBER TESTED FOR HIV. . . . . I NO STATISTICS COMPILED. . . . . Y	→ 2036
2034	How frequently are any of the compiled reports submitted to someone outside of this unit?	MONTHLY OR MORE FREQUENTLY. . . . . 1 EVERY 2-3 MONTHS. . . . . 2 EVERY 4-6 MONTHS. . . . . 3 MORE THAN EVERY 6 MONTHS . 4 NEVER SUBMIT REPORTS. 5	→ 2036
2035	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL . . . . . C REGIONAL LEVEL . . . . . D NATIONAL LEVEL . . . . . E DONOR AGENCY . . . . . F OTHER _____ (SPECIFY) X	
2036	Are there any fees charged for any services or items related to PMTCT services?	YES . . . . . 1 NO 2	→ 2038

		(a) FEE			(b) AMOUNT IN KSH
2037	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	YES	NO	NA	
01	Fee for HIV test	1→b	2 → 02	3 → 02	
02	Fee for antiretroviral prophylaxis for mother	1→b	2 → 03	3 → 03	
03	Fee for ART for mother	1→b	2 → 04	3 → 04	
04	Fee for antiretroviral prophylaxis for newborn	1→b	2 → 05	3 → 05	
05	Fee for CD4 test	1→b	2 → 06	3 → 06	
06	Fee for Hb test	1→b	2 → 2037A	3 → 2037A	

2037A	Are the official fees posted or displayed so that the client can easily see them? IF YES, VERIFY BY ASKING TO SEE WHERE FEES ARE POSTED	YES, ALL FEES POSTED . . . . . 1 YES, SOME FEES POSTED ONLY . . . 2 NO POSTED FEES 3	
2038	Is an individual client record/card maintained for clients who receive services through this unit? 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? IF YES, ASK TO SEE AN UNUSED OR CURRENT CARD/RECORD.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 YES, ONLY AVAILABLE IN OTHER FACILITY AREA . . . . . 3 YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS. . . . . 4 OTHER _____ SPECIFY 6 NO INDIVIDUAL CLIENT CARD/ RECORD 7	

NO.		CODING CATEGORIES	GO TO
2039	Are there delivery services in this facility, where PMTCT clients can receive services? IF YES, ASK: Is there any mechanism for linking the PMTCT clients from ANC to labour and delivery for continuum of care? PROBE TO DECIDE IF PMTCT SERVICES IN THE DELIVERY UNIT ARE LINKED WITH PMTCT SERVICES FROM ANC, OR WHETHER THE DELIVERY UNIT PROVIDES PMTCT AS A SEPARATE PROGRAM.	YES, DELIVERY SERVICES LINKED WITH PMTCT FROM ANC . . . . . 1 DELIVERY SERVICES PROVIDE PMTCT SERVICES UNDER DIFFERENT SYSTEM. THIS **QUESTIONNAIRE IS BEING ADMINISTERED IN DELIVERY ARE** . . . . . 2 NO DELIVERY SERVICES OR ONLY EMERGENCY SERVICES 3	→ GO TO DELIVERY UNIT & CONT. QRE → **END**
2040	Is the HIV serostatus routinely assessed for all women who deliver in the facility? IF YES, ASK: What methods do you use to assess the serostatus of these women? RECORD ALL ACCEPTED METHODS FOR ASSESSING SEROSTATUS	CLIENT HISTORY . . . . . A CLIENT ANC RECORD . . . . . B ROUTINE TESTING . . . . . C OFFERED TO ALL/TEST ONLY IF WOMAN GIVES CONSENT . . . . . D OFFER ONLY IF SUSPECT HIV . . . . . E OTHER _____ X SPECIFY SEROSTATUS NOT ROUTINELY ASSESSED . . . . . Y	
2041	Is pre-test counselling routinely offered to women in labour whose HIV status is unknown?	YES . . . . . 1 NO 2	→ 2045
2042	What is the most common practice for providing **pre-test** counselling for women in labour? CIRCLE ALL THAT APPLY	TRAINED PMTCT COUNSELLOR COMES TO UNIT. . . . . 1 TRAINED UNIT STAFF PROVIDE COUNSELLING . . . . . 2 NOT ALWAYS COUNSELLED BY TRAINED STAFF. . . . . 3 PRETEST COUNSELLING NOT ROUTINE. 6	
2043	What is the most common practice for providing **post-test** counselling to HIV positive women who were tested when admitted for delivery?	TRAINED PMTCT COUNSELLOR COMES TO UNIT . . . . . 1 TRAINED UNIT STAFF PROVIDE COUNSELLING . . . . . 2 NOT ALWAYS COUNSELLED BY TRAINED STAFF . . . . . 3 POST TEST COUNSELLING NOT ROUTINE 6	
2045	Are records on HIV test counselling available in this unit? IF YES, ASK TO SEE RECORDS AND VERIFY IF BOTH PRETEST AND POST TEST ARE RECORDED.	YES, OBSERVED RECORD OF PRE AND POST TEST COUNSELLIN . . . . . 1 REPORTED RECORDS KEPT WITH PMTCT/VCT CLINIC/UNIT . . . . . 2 RECORDED IN CLIENT INDIVIDUAL CARD/RECORD ONLY . . . . . 3 COUNSELLING NOT ROUTINELY RECORDED 4	

NO.		CODING CATEGORIES	GO TO
2047	Is there a register or record where the HIV (+) women who deliver in the facility and receive the ARV at the time of delivery are recorded? IF YES, ASK TO SEE THE REGISTER. THIS MAY BE AN MOH REGISTER OTHER OTHER THAN MOH REGISTER 333, OR A REGISTER KEPT FOR ANC PMTCT RECIPIENTS	YES, MOH MATERNITY REGISTER 333 OBSERVED. . . . . 1 YES, OTHER MATERNITY REGISTER OBSERVED. . . . . 2 YES, REPORTED, NOT SEEN. . . . . 3 NO . 4	→ 2049 → 2049

		(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
2048	ASK TO SEE RELEVANT RECORDS FOR THE DATA REQUESTED BELOW FOR THE PAST 12 MONTHS AND RECORD THE CORRECT RESPONSE.	OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
01	TOTAL DELIVERIES IN THE FACILITY	1 → b	2 → 02	3 → 02		
02	TOTAL HIV POSITIVE WOMEN DELIVERING IN THE FACILITY	1 → b	2 → 03	3 → 03		
03	TOTAL HIV POSITIVE WOMEN DELIVERING IN THE FACILITY AND RECEIVING ARV PROPHYLAXIS	1 → b	2 → 04	3 → 04		
04	TOTAL HIV-EXPOSED NEWBORNS WHO RECEIVED ARV PROPHYLAXIS	1 → b	2 → 2049	3 → 2049		

2049	Is there a written protocol/guideline for providing ARV prophylaxis for PMTCT to HIV positive women who deliver in this facility? IF YES, ASK TO SEE THE GUIDELINE	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	

		(a)			(b)
2050	ASK ABOUT ANY GUIDELINES FOR HIV TEST COUNSELLING IN THE DELIVERY UNIT	OBSERVED	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR OF PUBLICATION
01	National PMTCT guidelines	1 → b	2 → 02	3 → 02	
02	National HTC (VCT) guidelines	1 → b	2 → 03	3 → 03	
03	OTHER _____ (SPECIFY)	1 → b	2 → 2051	3 → 2051	

2051	Do you have any protocols or job aids for delivery to prevent mother-to-child transmission of HIV/AIDS? IF YES, ASK TO SEE THEM.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3	
2052	What labour, delivery and postnatal practices are implemented in this facility to decrease mother to child transmission of HIV/AIDS? DO NOT READ RESPONSES. PROMPT THE RESPONDENT BY ASKING: For example, have you changed any labour and delivery practices because of the risk of HIV/AIDS? PROBE: Anything else? CIRCLE ALL THAT ARE MENTIONED.	NO ROUTINE EPISIOTOMY . . . . . A MINIMIZE INSTRUMENT DELIVERY . . . . . B HIBITANE VAGINAL CLEANSING . . . . . C MINIMIZE VAGINAL EXAM . . . . . D MINIMIZE ARTIFICIAL RUPTURE OF MEMBRANES . . . . . E CAESAREAN SECTION . . . . . F ARV PROPHYLAXIS IF HIV POSITIVE . . . . . G AVOID MILKING CORD/IMMEDIATE CLAMP CORD . . . . . H AVOID SUCTION OF THE NEWBORN . . . . . I ENCOURAGE EXCLUSIVE BREASTFEEDING. . . . . J APPROPRIATE USE OF PARTOGRAPH. . . . . K ACTIVE MGT OF 3RD STAGE LABOUR. . . . . L OTHER _____ (SPECIFY)(SPECIFY) X NONE . . . . . Y DON'T KNOW . . . . . Z	

NO.		CODING CATEGORIES	GO TO
2053	Is there a register or record where PNC visit information is recorded? IF YES, ASK TO SEE THE REGISTER. THIS MAY BE THE MOH REGISTER 406 OR OTHER REGISTER	YES, MOH REGISTER 406 OBSERVED. . . . . 1 YES, OTHER MOH PNC REGISTER OBSERVED. . . . . 2 YES, REPORTED, NOT SEEN. . . . . 3 NO. 4	→ **END** → **END**

2054	ASK TO SEE RELEVANT RECORDS FOR THE DATA REQUESTED BELOW FOR THE PAST 12 MONTHS AND RECORD THE CORRECT RESPONSE.	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
01	TOTAL PNC VISITS IN THE FACILITY	1→ b	2 → 02	3 → 02		
02	TOTAL PNC WOMEN WHO WERE COUNSELED	1→ b	2 → 03	3 → 03		
03	TOTAL PNC WOMEN WHO WERE TESTED FOR HIV	1→ b	2 → 04	3 → 04		
04	TOTAL PNC WOMEN WHO RECEIVED HIV TEST RESULTS	1→ b	2 → 05	3 → 05		
05	TOTAL PNC WOMEN WHO TESTED HIV POSITIVE	1→ b	2 → 06	3 → 06		
06	COUPLE COUNSELLING FOR PNC WOMEN	1→ b	2 → 07	3 → 07		
07	TOTAL PNC WOMEN TESTED WITH THEIR PARTNERS	1→ b	2	3		
	THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE					

OBSERVATION

AND

CLIENT EXIT INTERVIEWS

Sample List for Antenatal Care Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS

IF THERE ARE MORE THAN 25 CLIENTS USE EXTRA SAMPLE LISTS TO LIST THEM ALL.

Expected No. of Clients

	NAME	FIRST VISIT	FOLLOW-UP
001			
002			
003			
004			
005			
006			
007			
008			
009			
010			
011			
012			
013			
014			
015			
016			
017			
018			
019			
020			
021			
022			
023			
024			
025			

Total Clients Listed

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Antenatal Care Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS

IF THERE ARE MORE THAN 25 CLIENTS USE EXTRA SAMPLE LISTS TO LIST THEM ALL.

Expected No. of Clients | | | |

	NAME	FIRST VISIT	FOLLOW-UP
026			
027			
028			
029			
030			
031			
032			
033			
034			
035			
036			
037			
038			
039			
040			
041			
042			
043			
044			
045			
046			
047			
048			
049			
050			

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Antenatal Care Client Observation

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

				FACILITY #

EXPECTED NUMBER OF CLIENTS

IF THERE ARE MORE THAN 25 CLIENTS USE EXTRA SAMPLE LISTS TO LIST THEM ALL.

Expected No. of Clients | | | |

	NAME	FIRST VISIT	FOLLOW-UP
051			
052			
053			
054			
055			
056			
057			
058			
059			
060			
061			
062			
063			
064			
065			
066			
067			
068			
069			
070			
071			
072			
073			
074			
075			

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Antenatal Care Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS

IF THERE ARE MORE THAN 25 CLIENTS USE EXTRA SAMPLE LISTS TO LIST THEM ALL.

Expected No. of Clients | | | |

	NAME	FIRST VISIT	FOLLOW-UP
076			
077			
078			
079			
080			
081			
082			
083			
084			
085			
086			
087			
088			
089			
090			
091			
092			
093			
094			
095			
096			
097			
098			
099			
100			

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Antenatal Care Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS

IF THERE ARE MORE THAN 25 CLIENTS USE EXTRA SAMPLE LISTS TO LIST THEM ALL.

Expected No. of Clients | | | |

	NAME	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 calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Observation of Antenatal-Care Consultation

1. Facility Identification

QTYPE | O | A | N |

Name of the facility: _____

Location of the facility: _____

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

2. Provider Information

Provider category:
- SPECIALIST. 01
- MEDICAL OFFICER 09
- CLINICAL OFFICER 10
- BACHELLOR SCIENCE NURSE 11
- REGISTERED NURSE 12
- REGISTERED MIDWIFE 13
- ENROLLED NURSE 14
- ENROLLED MIDWIFE 15
- NURSE AIDE 16

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 | 0 |

Name of the observer: _____

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 [NAME OF OBSERVER]. I am representing the Ministries of Health and NCAPD. We are conducting a study of all health facilities in Kenya 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 the 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 2010		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministries of Health and NCAPD. We are conducting a study of health services in health facilities in Kenya. I would like to be present while you are receiving services today, in order to better 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 services will be provided on 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? 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	__ __ : __ __	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:	YES	NO	NA	DK	
01	Client's age	1	2		8	
02	Medications the client is taking	1	2		8	
03	Date client's last menstrual period began	1	2		8	
04	Number of prior pregnancies client has had	1	2		8	
105	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:					
01	Prior stillbirth(s)	1	2	5	8	
02	Infant(s) who died in the first week of life	1	2	5	8	
03	Heavy bleeding, during or after delivery	1	2	5	8	
04	Previous assisted delivery (caesarean section, ventouse, or forceps)	1	2	5	8	
05	Previous abortions	1	2	5	8	
06	Previous multiple pregnancies	1	2	5	8	
07	Previous prolonged labor	1	2	5	8	
08	Previous pregnancy induced hypertension	1	2	5	8	
09	Previous pregnancy related convulsions	1	2	5	8	
106	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY:					
01	Vaginal bleeding	1	2		8	
02	Fever	1	2		8	
03	Headache or blurred vision	1	2		8	
04	Swollen face or hands	1	2		8	
05	Tiredness or breathlessness	1	2		8	
06	Whether the client has felt the baby move	1	2		8	
07	Persistent cough for 2 weeks or longer	1	2		8	
08	Client's knowledge of her HIV status	1	2		8	
09	Whether there are any other symptoms or problems the client thinks might be related to this pregnancy	1	2		8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
107	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:	YES	NO	DK	
01	Take the client's blood pressure	1	2	8	
02	Weigh the client	1	2	8	
03	Examine conjunctiva/palms for anaemia	1	2	8	
04	Examine legs/feet/hands for oedema	1	2	8	
05	Examine for swollen glands	1	2	8	
06	Palpate the client's abdomen for fetal presentation (or conduct ultrasound)	1	2	8	
07	Palpate the client's abdomen for uterine height (or conduct ultrasound)	1	2	8	
08	Listen to the client's abdomen for fetal heartbeat	1	2	8	
09	Examine the client's breasts	1	2	8	
10	Conduct vaginal examination/exam of perineal area	1	2	8	
11	Perform or refer for anaemia test	1	2	8	
12	Perform or refer for blood grouping	1	2	8	
13	Perform or refer for urine test	1	2	8	
14	Perform or refer the client for a syphilis test	1	2	8	
15	Perform HIV test	1	2	8	
16	Refer for HIV test	1	2	8	
17	Provide counselling related to HIV test	1	2	8	
18	Refer for counselling related to HIV test	1	2	8	
19	Look at the client's health card/booklet (either before beginning the consultation or while collecting information or examining the client)	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
108	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENTS OR COUNSELLING:	YES	NO	DK	
01	Prescribed or gave iron pills or folic acid (IFA) or both	1	2 → 05	8 → 05	
02	Explained the purpose of iron or folic acid	1	2	8	
03	Explained how to take iron or folic-acid pills	1	2	8	
04	Explained side effects of iron pills	1	2	8	
05	Prescribed or gave a tetanus toxoid (TT) injection	1	2 → 07	8 → 07	
06	Explained the purpose of the TT injection	1	2	8	
07	Prescribed or gave Mebendazole	1	2 → 09	8 → 09	
08	Explained the purpose of Mebendazole	1	2	8	
09	Prescribed or gave anti-malarial prophylaxis	1	2 → 15	8 → 15	
10	Explained the purpose of the preventive treatment with anti-malaria medications	1	2	8	
11	Explained how to take the anti-malarial medications	1	2	8	
12	Explained possible side effects of malaria pills	1	2	8	
	DIRECT OBSERVATION:				
13	Observed that the 1st dose of IPT is given in the facility	1	2	8	
14	Importance of further doses of IPT explained	1	2	8	
15	Importance of using ITN explained explicitly	1	2	8	
16	Given voucher for ITN/given ITN free of charge	1 → 109	2	8	
17	ITN purchased by the client	1	2	8	
109	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT PREPARATIONS:	YES	NO	DK	
01	Discussed nutrition (i.e., quantity or quality of food to eat) during pregnancy	1	2	8	
02	Informed the client about the progress of the pregnancy	1	2	8	
	Mentioned the following danger signs as risk factors for which the woman should return to the facility	YES	NO	DK	
03	Vaginal bleeding	1	2	8	
04	Fever	1	2	8	
05	Excessive tiredness or breathlessness	1	2	8	
06	Swollen hands and face	1	2	8	
07	Severe headache or blurred vision	1	2	8	
08	Persistent cough	1	2	8	
09	Loss of, or excessive fetal movement	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
110	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:	YES	NO	DK	
01	Asked the client where she will deliver	1	2	8	
02	Advised the client to prepare for delivery (e.g. set aside money, arrange for emergency transportation)	1	2	8	
03	Advised the client to use a skilled health worker during delivery	1	2	8	
04	Discussed with client what items to have on hand at home for emergencies (e.g., sterile blade)	1	2	8	
05	Discussed importance of immunisation for the newborn	1	2	8	
06	Discussed care for the newborn (i.e., warmth, hygiene and early initiation of breastfeeding)	1	2	8	
07	Discussed early initiation and prolonged breastfeeding	1	2	8	
111	RECORD WHETHER THE PROVIDER ADVISED EXCLUSIVELY BREASTFEEDING THE INFANT FOR UP TO 6 MONTHS.	1	2	8	
112	RECORD WHETHER THE PROVIDER DISCUSSED FAMILY PLANNING FOR USE AFTER DELIVERY	1	2	8	
113	RECORD WHETHER THE PROVIDER ASKED WHETHER THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS.	1	2	8	
114	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELLING DURING THE CONSULTATION.	1	2	8	
115	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD USED. . . . . 3 DON'T KNOW 8			
116	ASK THE PROVIDER HOW MANY WEEKS PREGNANT THE CLIENT IS.	WEEKS OF PREGNANCY . . . . . ☐☐ DON'T KNOW 98			
117	ASK THE PROVIDER WHETHER THIS IS 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			
118	ASK THE PROVIDER WHETHER THIS IS THE CLIENT'S FIRST PREGNANCY.	FIRST PREGNANCY. . . . . 1 NOT FIRST PREGNANCY. 2			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
119	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 DON'T KNOW 8	
120	RECORD THE TIME THE OBSERVATION ENDED.	. . . . . ☐☐ : ☐☐	
	Observer's comments:		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for Antenatal Care Client

1. Facility Identification

QTYPE | X | A | N |

Name of the facility: _____

Location of the facility: _____

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

AGREES

2. Information About Interview

DATE: _____

DAY . . . . . | | |

MONTH . . . . . | | |

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

Name of the interviewer: _____

INTERVIEWER CODE . . . . . | | |

Client code: _____

CLIENT CODE ..... | | | |

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministries of Health and NCAPD. We are conducting a study of health services in all health facilities in KENYA. In order to improve the services this facility offers, we would like to ask you some questions about your experience 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: __ | __ | 2010	
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 an immunisation 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 → 106
103	CHECK ANTENATAL-CARE CARD/BOOK, OR IMMUNISATION 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. . . . . 4 DON'T KNOW. 8	
104	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD?	# OF WEEKS. . . . . __ D.K. = 98	
105	DOES THE CARD INDICATE THE CLIENT HAS RECEIVED IPT? (IF NON MALARIOUS AREA, CIRCLE "NOT APPLICABLE")	YES, 1 DOSE ..... 1 YES, 2 DOSES ..... 2 YES, 3DOSES ..... 3 YES, 4 DOSES ..... 4 NO ..... 5 NOT APPLICABLE ..... 6 DON'T KNOW/UNCLEAR 8	
106	How many weeks pregnant do you think you are? IF RESPONSE IS IN MONTHS, CALCULATE WEEKS, USING 4 WEEKS PER MONTH.	WEEKS . . . . . __ D.K. = 98	
107	Is this your first pregnancy?	YES . . . . . 1 NO 2	
108	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
109	During this visit, or previous visits, did the 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	→ 111 → 114 → 114
110	ASK TO SEE THE CLIENT'S IRON/FOLIC ACID/IRON WITH FOLIC ACID PILLS.	SAW PILLS . . . . . 1 SAW PRESCRIPTION . . . . . 2 NO PILLS OR PRESCRIPTION SEEN 3	
111	During this visit or previous visits, has a provider explained to you how to take the iron pills?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
112	During this or previous visits, has a provider discussed with you the side effects of the iron pill?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
113	Please tell me any side effects of the iron pill that you know of.	NAUSEA . . . . . A BLACK STOOLS . . . . . B CONSTIPATION . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
114	During this or previous visits, has a provider given or prescribed any anti-malarial pills for you? SHOW THE CLIENT TABLET OF SP-BASED DRUGS	YES, THIS VISIT . . . . . 1 YES, THIS/PREVIOUS VISIT 2 YES, PREVIOUS VISIT . . . . . 3 NO . . . . . 4 DON'T KNOW 8	→ 116 → 117 → 117
114A	Did you swallow the anti-malaria pills or you still have it with you?	SWALLOWED. . . . . 1 STILL HAVE IT. 2	→ 117
115	ASK TO SEE THE CLIENT'S ANTI-MALARIAL PILLS.	SAW PILLS. . . . . 1 SAW PRESCRIPTION. . . . . 2 NO PILLS OR PRESCRIPTION SEEN. 3	
116	Did a provider explain to you how to take the anti-malarial pills?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
117	Do you own an ITN, that is a net that has been treated with an insecticide to protect you from mosquito bites?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
118	During this visit or a previous visit, did a provider offer you an ITN free of charge or offer to sell you one? IF THE CLIENT WILL PICK UP OR BUY THE ITN WITHIN THE FACILITY, THAT COUNTS AS PROVIDER OFFERING THE ITN.	YES, OFFERED FREE NOW 1 YES, OFFERED FREE IN PREVIOUS VISIT 2 YES, OFFERED FOR SALE NOW (THIS VISIT) 3 YES, OFFERED FOR SALE IN PREVIOUS VISIT 4 NO, NOT OFFERED 5	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
119	During this visit or previous visits, has a provider asked you whether you had ever received a tetanus toxoid (TT) injection?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
120	Have you ever received a tetanus toxoid (TT) injection, including one you may have received today? IF YES: Including any TT injection you received today, how many times in total during your lifetime have received a tetanus toxoid injection? (INJECTION MAY HAVE BEEN RECEIVED EITHER AT THIS FACILITY OR ELSEWHERE.)	NUMBER OF TETANUS INJECTIONS RECEIVED [ ][ ] NEVER . . . . . 96 DON'T KNOW 98	
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 . . . . . 1 NO 2	
122	Please tell me any things you know of that you should have in preparation for your 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/SCISSORS TO CUT CORD . . . . . D OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
123	Do you have money set aside for the delivery? IF YES, PROBE	YES, ENOUGH . . . . . 1 YES, BUT NOT ENOUGH . . . . 2 NO 3	
124	During this visit or previous visits, has a provider talked with you about any signs of complications (danger signs) that should warn you of problems with the pregnancy?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 127 → 127
125	Please tell me any signs of complications (danger signs) that you know of. CIRCLE ALL RESPONSES YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT (E.G., "ANYTHING ELSE?")	ANY VAGINAL BLEEDING . . . A FEVER . . . . . B SWOLLEN FACE OR HAND . . . C TIREDNESS OR BREATHLESSNESS . . . . . D HEADACHE OR BLURRED VISION . . . . . E CONVULSIONS . . . . . F BABY STOPS MOVING OR REDUCED FETAL MOVEMENT . . . . . G OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
126	What did the provider advise you to do if you experienced any of the warning signs? CIRCLE LETTER FOR ALL COURSES OF ACTION THE CLIENT MENTIONS. PROBE WITHOUT USING SPECIFIC ANSWERS.	SEEK CARE AT A FACILITY . . A DECREASE ACTIVITY . . . . . B CHANGE DIET . . . . . C OTHER _____ X (SPECIFY)	
127	Do you know any danger signs during/after delivery? IF YES: What danger signs do you know?	BLEEDING . . . . . A FEVER . . . . . B GENITAL INJURIES . . . . . C NO . . . . . Y	
128	During this visit or previous visits, has a provider talked to you about what you should eat during your pregnancy?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
129	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?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 131 → 131
130	For how many months did the provider recommend that you exclusively breastfeed, that is, that you do not give your baby liquid or food in addition to your breast milk?	4 TO 6 MONTHS. . . . . 1 6 MONTHS. . . . . 2 OTHER. . . . . 6 DON'T KNOW 8	
131	During this visit or previous visits, did the provider talk to you about where you plan to deliver your baby?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
132	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 AT OTHER HEALTH FACILITY 2 AT HOME . . . . . 3 AT TBA's HOME 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
133	During this or previous visits, did a provider talk with you about using family planning after the birth of your baby?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	

4. Information About Client's 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 ANC services.		
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?	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 PROBLEM	DK
01	Time you waited	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your pregnancy with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any problem you had today that I did not mention	_____ (SPECIFY)	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 facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services 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
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB ☐☐☐☐☐☐ 2) MEDICINE ☐☐☐☐☐☐ 3) CONSULT ☐☐☐☐☐☐ 4) OTHER ☐☐☐☐☐☐	
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 nearest facility? 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 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes best your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	VERY SATISFIED. . . . . 01 MORE OR LESS SATISFIED 02 NOT SATISFIED. 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

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 us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐ DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended?	PRIMARY. . . . . 1 POST-PRIMARY/VOCATIONAL. 2 SECONDARY/A-LEVEL. . . . . 3 COLLEGE (MIDDLE LEVEL). . . 4 UNIVERSITY. 5	
304	What is the highest (standard, form, year) you completed at that level?	GRADE ☐☐	SECONDARY AND ABOVE → 306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . 1 YES, READ ONLY . . . . . 2 NO 3	
	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!		
306	RECORD THE TIME THE INTERVIEW ENDED	☐☐ : ☐☐	
307	**Interviewer's comments:**		

Sample List for Family Planning Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
IF THERE ARE MORE THAN 25 CLIENTS FILL-IN MORE SAMPLE LISTS TO GET THE TOTAL NUMBER OF CLIENTS

Expect. No. of Clients | | | |

	NAME	FIRST VISIT	FOLLOW-UP
001			
002			
003			
004			
005			
006			
007			
008			
009			
010			
011			
012			
013			
014			
015			
016			
017			
018			
019			
020			
021			
022			
023			
024			
025			

Total clients listed | | | |

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Family Planning Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
IF THERE ARE MORE THAN 25 CLIENTS FILL-IN MORE SAMPLE LISTS
TO GET THE TOTAL NUMBER OF CLIENTS

Expect. No. of Clients | | | |

	NAME	FIRST VISIT	FOLLOW-UP
026			
027			
028			
029			
030			
031			
032			
033			
034			
035			
036			
037			
038			
039			
040			
041			
042			
043			
044			
045			
046			
047			
048			
049			
050			

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Family Planning Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
IF THERE ARE MORE THAN 25 CLIENTS FILL-IN MORE SAMPLE LISTS TO GET THE TOTAL NUMBER OF CLIENTS

Expect. No. of Clients | | | |

	NAME	FIRST VISIT	FOLLOW-UP
051			
052			
053			
054			
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Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

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 category:

SPECIALIST	01
MEDICAL OFFICER	09
CLINICAL OFFICER	10
BACHELLOR SCIENCE NURSE	11
REGISTERED NURSE	12
REGISTERED MIDWIFE	13
ENROLLED NURSE	14
ENROLLED MIDWIFE	15
NURSE AIDE	16

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 | 0 |

Name of the observer: _____

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 [NAME OF OBSERVER]. I am representing the Ministries of Health and NCAPD. We are conducting a study of all health facilities in Kenya 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 the 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? _____ DAY __ MONTH __ 2010 YEAR Interviewer's signature (Indicates respondent's willingness to participate)		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministries of Health and NCAPD. We are conducting a study of health services in health facilities in Kenya. I would like to be present while you are receiving services today, in order to better understand how family planning 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 services will be provided on 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? Do I have your permission to be present at this consultation? _____ DAY __ MONTH 2010 YEAR 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	__ : __	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
103	RECORD THE SEX OF CLIENT.	MALE . . . . . 1 FEMALE 2				
104	CLIENT STATUS. (OBSERVER TO COMPLETE)	YES	NO	DK	NA	
01	INDICATE WHETHER THE CLIENT HAS HAD ANY PREVIOUS CONTACT WITH A PROVIDER AT THIS FAMILY PLANNING UNIT.	1	2	8		
02	(IF FEMALE) INDICATE WHETHER THE CLIENT HAS EVER BEEN PREGNANT.	1	2	8	5	
105	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	1	2	8		
02	Number of living children	1	2	8		
03	Last delivery date or age of youngest child	1	2	8	5	
04	History of complications with pregnancy	1	2	8	5	
05	Last menstrual period (assess if currently pregnant)	1	2	8	5	
06	Desire for a child or more children	1	2	8		
07	Desired timing for birth of next child	1	2	8		
08	Breastfeeding status	1	2	8	5	
09	Regularity of menstrual cycle	1	2	8	5	
106	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS.	YES	NO	DK		
01	Took the client's blood pressure	1	2	8		
02	Weighed the client	1	2	8		
03	Asked the client about smoking	1	2	8		
04	Asked the client about symptoms of STIs (e.g., abnormal discharge)	1	2	8		
05	Asked the client about chronic illnesses (heart disease, diabetes, hypertension, liver or jaundice problem, breast cancer)	1	2	8		
06	Looked at the client's health card (either before beginning the consultation or while collecting information or examining the client)	1	2	8		

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
107	RECORD WHETHER THE PROVIDER TOOK ANY OF THE FOLLOWING STEPS TO ASSURE THE CLIENT OF PRIVACY.	YES	NO	DK	
01	Ensured visual privacy	1	2	8	
02	Ensured auditory privacy	1	2	8	
03	Assured the client orally of confidentiality	1	2	8	
04	Asked the client about questions or concerns regarding methods currently used	1	2	8	
05	DID THE CLIENT SAY SHE HAD ANY CONCERNS OR ASK ANY QUESTIONS ABOUT SIDE EFFECTS OR ABOUT THE METHOD?	1	2	8	
108	RECORD WHETHER THE PROVIDER DISCUSSED ANY OF THESE ISSUES RELATED TO SEXUAL PARTNERS AND CHOICE OF FAMILY PLANNING METHOD.				
01	Partner's attitude toward family planning	1	2	8	
02	Partner status (number of sexual partners for client or for client's partner; partner's absence)	1	2	8	
03	Risk of STIs/HIV	1	2	8	
04	Use of condoms to prevent STIs/HIV	1	2	8	
05	Using condoms as along with another method (dual method) to prevent pregnancy and STIs/HIV	1	2	8	
109	INDICATE WHICH METHOD(S) WERE **PROVIDED OR PRESCRIBED** DURING THIS VISIT. IF CONDOMS WERE PRESCRIBED 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]	COMBINED PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . C MALE CONDOM. . . . . D FEMALE CONDOM. . . . . E IUCD. . . . . F PROGESTIN INJECTABLE. . . . . I MONTHLY INJECTABLE. . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM) . . . . . L STANDARD DAYS METHOD (SDM - THE "BEADS") M LAM. . . . . N VASECTOMY . . . . . O FEMALE STERILISATION . . . P EMERGENCY CONTRACEPTION . . . . . Q OTHER _____ X (SPECIFY) NO METHOD . . . . . Y			→ 111

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
110	FOR THE METHOD(S) IN QUESTION 109, INDICATE WHETHER THE RELEVANT INFORMATION WAS ASSESSED/DISCUSSED	YES	NO	DK	NA
	PILLS OR INJECTIONS				5 → 07
01	When to take (pill daily; injection either every month or every 2 months or every 3 months)	1	2	8	
02	Changes that may occur with menstruation (decreased flow or amenorrhea, spotting)	1	2	8	
03	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
04	What to do if forget pill or do not get injection on time	1	2	8	
05	Method does not protect against STI	1	2	8	
06	Should return to clinic if side effects continue	1	2	8	
	CONDOMS				5 → 12
07	Client cannot use if allergic to latex	1	2	8	
08	Can be used only one time	1	2	8	
09	Some lubricants may be used (male condom—water soluble only; female condom—any lubricant)	1	2	8	
10	Use as backup if client fears other method will fail	1	2	8	
11	Dual protection (from pregnancy and against STI/HIV)	1	2	8	
	IUCD				5 → 18
12	Good for up to 5 years or 12 years	1	2	8	
13	Should return to the clinic 3-6 weeks post insertion or after first menses	1	2	8	
14	Common side effects that may occur (heavy bleeding for first few months post insertion, spotting, or mild abdominal cramps)	1	2	8	
15	Should return to clinic if side effects continue	1	2	8	
16	User should regularly check strings after menstruation	1	2	8	
17	Method does not protect against STI	1	2	8	
	IMPLANTS				5 → 23
18	Good for 3-5 years	1	2	8	
19	Changes that may occur with menstruation (irregular bleeding, decreased flow, spotting)	1	2	8	
20	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
21	Should return to clinic if side effects continue	1	2	8	
22	Method does not protect against STI	1	2	8	
	RHYTHM METHOD or PERIODIC ABSTINENCE (INCLUDING STANDARD DAYS METHOD)				5 → 26
23	How to identify a woman's fertile period	1	2	8	
24	No intercourse during woman's fertile period without alternative method (condom)	1	2	8	
25	Method does not protect against STI	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	DK	NA
	LACTATIONAL AMENORRHEA (LAM)				5 → 30
26	Slight risk of pregnancy during the time shortly before menstruation resumes	1	2	8	
27	Most effective with exclusive breastfeeding without menstruation	1	2	8	
28	Not effective after menstruation begins again	1	2	8	
29	Method does not protect against STI	1	2	8	
	VASECTOMY				5 → 36
30	Partner is protected from pregnancy after 3 months	1	2	8	
31	Use of a back-up method for the next 3 months	1	2	8	
32	Procedure intended to be permanent; slight risk of failure	1	2	8	
33	Warning signs that may occur after surgery (severe pain, tenderness, bleeding)	1	2	8	
34	Should return to clinic if experience warning signs	1	2	8	
35	Method does not protect against STI	1	2	8	
	FEMALE STERILIZATION				5 → 41
36	Protect from pregnancy immediately	1	2	8	
37	Procedure intended to be permanent, slight risk of failure	1	2	8	
38	Warning signs that may occur after surgery (severe pain, light-headedness, fever, bleeding, missed periods)	1	2	8	
39	Should return to clinic if experience warning sign	1	2	8	
40	Method does not protect against STI	1	2	8	
	EMERGENCY CONTRACEPTION				5 → 111
41	If vomit within 2 hours, need another dose	1	2	8	
42	If next period is unusually light or fails to occur within 4 weeks, return for pregnancy check	1	2	8	
43	First dose to be taken within 120 hours of contact	1	2	8	
44	Second dose should be taken 12 hours after first dose	1	2	8	
45	Not for routine contraception and therefore regimen not to be repeated/taken more than three times in any one month	1	2	8	
46	Method does not protect against STI	1	2	8	
111	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S CARD	YES . . . . . 1 NO . . . . . 2 NO CLIENT CARD USED 3 DON'T KNOW 8			
112	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELLING ABOUT FAMILY PLANNING METHODS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			
113	RECORD WHETHER THE PROVIDER DISCUSSED A RETURN VISIT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			

5. Clinical Observation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	INDICATE WHETHER ANY CLINICAL PROCEDURE WAS CONDUCTED DURING THIS VISIT. CLINICAL PROCEDURES INCLUDE PELVIC EXAMINATIONS, OR PROVIDING THE IUCD, INJECTABLE METHOD, OR IMPLANT.	YES . . . . . 1 NO 2	→ 301
202	INDICATE WHETHER CLINICAL PROVIDER IS PERSON WHO PROVIDED COUNSELLING.	YES . . . . . 1 NO 2	→ 206
	READ TO PROVIDER: Hello, I am representing the Ministries of Health and NCAPD. 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. [Mrs. ___] has agreed that she has no objection to my presence. Observing all components of the services provided to [Mrs. ___] 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) DAY | MONTH | YEAR: 2 0 1 0		
203	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
204	RECORD THE TYPE OF PROVIDER PERFORMING MOST OF THE CLINICAL EXAMINATION.	SPECIALIST. . . . . 01 MEDICAL OFFICER . . . . . 09 CLINICAL OFFICER . . . . . 10 BSN …… 11 REGISTERED NURSE . . . . . 12 REGISTERED MIDWIFE . . . . . 13 ENROLLED NURSE . . . . . 14 ENROLLED MIDWIFE . . . . . 15 NURSE AIDE . . . . . 16 OTHER _____ 19 (SPECIFY)	
205	RECORD THE SEX OF THE PROVIDER CONDUCTING THE CLINICAL EXAMINATION.	MALE . . . . . 1 FEMALE 2	
206	INDICATE CLINICAL PROCEDURE(S) CONDUCTED DURING THIS VISIT.	PELVIC EXAM . . . . . A IUCD INSERTED/REMOVED . B INJECTABLE GIVEN . . . . . C IMPLANT INSERTED/ REMOVED . . . . . D CANCER SCREENING. . . . . E	

6. Pelvic Examination

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
207A	CHECK Q206: WAS A PELVIC EXAMINATION / CANCER SCREENING CONDUCTED?	YES . . . . . 1 NO 2			→ 208A
207	RECORD WHETHER THE FOLLOWING OCCURRED DURING OR AFTER THE EXAMINATION		YES	NO	N.A.
01	ENSURED THAT CLIENT HAD VISUAL PRIVACY	VISUAL PRIVACY	1	2	
02	ENSURED THAT CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY	1	2	
03	EXPLAINED PROCEDURE BEFORE STARTING	EXPLAIN PROCEDURE BEFOREHAND	1	2	
04	PREPARED ALL INSTRUMENTS BEFORE STARTING PROCEDURE	PREPARED INSTRUMENTS	1	2	
05	USED STERILISED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILISED/HLD INSTRUMENTS	1	2	
06	WASHED/DISINFECTED HIS/HER HANDS (INCL. SOAP) BEFORE STARTING PROCEDURE	WASHED/DISINF HANDS	1	2	
07	PUT ON LATEX GLOVES BEFORE STARTING PROCEDURE	PUT ON GLOVES	1	2	
08	ASKED THE CLIENT TO TAKE SLOW DEEP BREATHS AND RELAX MUSCLES	ASKED CLIENT TO RELAX MUSCLES	1	2	
09	INSPECTED THE EXTERNAL GENITALIA	INSPECTED GENITALIA	1	2	
10	EXPLAINED SPECULUM PROCEDURE (IF USED)	EXPLAINED SPECULUM	1	2	5
11	INSPECTED THE CERVIX AND VAGINAL MUCOSA (USED SPECULUM AND LIGHT)	INSPECTED CERVIX	1	2	5
12	PERFORMED A BIMANUAL EXAMINATION (TWO FINGERS IN VAGINA, OTHER HAND PALPATING ABDOMEN)	PERFORMED BIMANUAL EXAM	1	2	
13	WASHED/DISINFECTED HANDS AFTER REMOVING GLOVES	WASHED/DISINF HANDS AFTER	1	2	
14	WIPED CONTAMINATED SURFACES WITH DISINFECTANT	DISINFECTED AREA	1	2	
15	PLACED REUSABLE GLOVES OR INSTRUMENTS IN CHLORINE SOLUTION IMMEDIATELY AFTER THE PROCEDURE.	DECONTAMINATED GLOVES OR INSTRUMENTS	1	2	

7. IUD Insertion and/or Removal

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
208A	CHECK 206: WAS AN IUCD EITHER INSERTED OR REMOVED?	YES . . . . . 1 NO 2				→ 210A
208	INDICATE PROCEDURE CONDUCTED.	IUCD INSERTION . . . . . A IUCD REMOVAL . . . . . B IUCD CHECKUP C				
209	RECORD WHETHER THE FOLLOWING OCCURRED DURING OR AFTER THE EXAMINATION		YES	NO	N.A.	
01	ENSURED THAT CLIENT HAD VISUAL PRIVACY	VISUAL PRIVACY	1	2		
02	ENSURED THAT CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY	1	2		
03	EXPLAINED PROCEDURE BEFORE STARTING	EXPLAINED PROCEDURE BEFOREHAND	1	2		
04	(FOR NEW CLIENT) RECONFIRMED CLIENT CHOICE OF METHOD	RECONFIRMED CHOICE	1	2	5	
05	(FOR NEW CLIENT) CONFIRMED CLIENT NOT PREGNANT	CONFIRMED CLIENT NOT PREGNANT	1	2	5	
06	PREPARED ALL INSTRUMENTS BEFORE STARTING PROCEDURE	PREPARED INSTRUMENTS	1	2		
07	USED STERILISED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILISED/HLD INSTRUMENTS	1	2		
08	WASHED/DISINFECTED HANDS BEFORE STARTING PROCEDURE	WASHED/DISINF HANDS	1	2		
09	PUT ON LATEX GLOVES BEFORE STARTING PROCEDURE	PUT ON GLOVES	1	2		
10	PERFORMED A SPECULUM EXAMINATION (FOR RTI/STI OR CERVICAL CANCER SCREENING) BEFORE CONDUCTING BIMANUAL EXAMINATION	SPECULUM EXAM	1	2	5	
11	PERFORMED A BIMANUAL EXAMINATION (TWO FINGERS IN VAGINA OTHER HAND PALPATING ABDOMEN)	BIMANUAL EXAM	1	2	5	
12	INSPECTED THE CERVIX AND VAGINAL MUCOSA (USE SPECULUM AND LIGHT)	VISUALISED CERVIX	1	2	5	
13	USED A TENACULUM	USED TENACULUM	1	2	5	
14	SOUNDED THE UTERUS BEFORE INSERTING IUCD	SOUNDED UTERUS	1	2	5	
15	USED THE NO-TOUCH TECHNIQUE FOR INSERTION	NO-TOUCH TECHNIQUE	1	2	5	
16	WASHED/DISINFECTED HANDS AFTER REMOVING GLOVES	WASHED/DISINF HANDS AFTER	1	2		
17	ASKED CLIENT TO WAIT AND REST FOR 5 MINS AFTER INSERTION OF IUCD	ASKED CLIENT TO WAIT 5 MINS	1	2		
18	WIPED CONTAMINATED SURFACES WITH DISINFECTANT	DISINFECTED AREA	1	2		

19	PLACED REUSABLE GLOVES OR INSTRUMENTS IN CHLORINE SOLUTION IMMEDIATELY AFTER THE PROCEDURE.	DECONTAMINATED GLOVES OR INSTRUMENTS	1	2	
20	WAS THE CLIENT TOLD THAT IUCD IS GOOD FOR UP TO 5 (LNg) OR 12 (Cu) YEARS?	TOLD GOOD FOR UP TO 5 OR 12 YEARS	1	2	5
21	WAS THE CLIENT INSTRUCTED TO RETURN TO THE CLINIC 3 TO 6 WEEKS POST INSERTION OR AFTER FIRST MENSES?	INSTRUCTED TO RETURN IN 3-6 WEEKS	1	2	5
22	WAS THE CLIENT INSTRUCTED TO REGULARLY CHECK THE STRINGS AFTER MENSTRUATION?	INSTRUCTED CHECK STRINGS	1	2	5
23	WAS THE CLIENT TOLD THAT SHE MAY EXPERIENCE SIDE EFFECTS (HEAVY BLEEDING FOR FIRST FEW MONTHS, SPOTTING, OR MILD ABDOMINAL CRAMPS)?	TOLD ABOUT SIDE EFFECTS	1	2	5
24	WAS THE CLIENT INSTRUCTED TO RETURN TO CLINIC IF SIDE EFFECTS CONTINUED?	INSTRUCTED TO RETURN TO CLINIC	1	2	5
25	WAS THE CLIENT PROVIDED WITH A CARD STATING THE DATE IUCD WAS INSERTED AND THE FOLLOW-UP DATE?	CARD PROVIDED	1	2	5
26	(IF IUCD REMOVED): SHOW IUCD TO CLIENT	REMOVED IUCD SHOWN	1	2	5

8. Injectable Contraceptives

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
210A	CHECK Q206: WAS A CONTRACEPTIVE INJECTION GIVEN?	YES . . . . . 1 NO 2			→ 212A
211	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:		YES	NO	NA
01	(With a **new client**) Reconfirmed the client's choice of method	RECONFIRMED CHOICE	1	2	5
02	(With a **new client**) Verified that client was not pregnant	CONFIRMED CLIENT NOT PREGNANT	1	2	5
03	(**Continuing client**) Checked the client's card to ensure giving injection at correct time	ENSURED CORRECT TIMING	1	2	5
04	Ensured that the client had visual privacy	VISUAL PRIVACY	1	2	
05	Ensured that the client had auditory privacy	AUDITORY PRIVACY	1	2	
06	Washed/disinfected hands before giving the injection	WASHED/DISINF HANDS	1	2	
07	Prepared injection in area with clean table or tray to set items on	PREPARED IN CLEAN LOCATION	1	2	
08	(**If using disposables**) Used new syringe and needle from a sterile sealed pack	USED NEW/CLEAN NEEDLE	1	2	5
09	Saw the provider open the new packet with syringe and needle	SAW PROVIDER OPEN PACKET	1	2	5
10	Removed needle from multiple dose vial each time	REMOVED NEEDLE	1	2	5
11	Stirred or mixed the bottle *before* drawing dose (DEPO)	STIRRED BOTTLE	1	2	5
12	Cleaned and air-dried the injection site *before* injection	CLEANED AND AIR-DRIED THE SITE	1	2	
13	Drew back plunger *before* giving injection	DREW BACK PLUNGER	1	2	
14	Allowed dose to self-disperse instead of massaging the site	NO MASSAGE	1	2	
15	Disposed of sharps in puncture-resistant container (not overflowing or pierced)	DISPOSED OF SHARPS	1	2	
211A	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			

9. Implants Insertion or Removal

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
212A	CHECK 206: WERE IMPLANTS EITHER INSERTED OR REMOVED?	YES . . . . . 1 NO 2			→ 301
212	INDICATE PROCEDURE CONDUCTED.	INSERTION . . . . . A REMOVAL . . . . . B			
213	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:		YES	NO	N.A.
01	Reconfirmed the client's choice of method (new client)	RECONFIRMED CHOICE	1	2	5
02	Verified that client was not pregnant (new client)	CONFIRMED CLIENT NOT PREGNANT	1	2	5
03	Ensured that the client had visual privacy	VISUAL PRIVACY	1	2	
04	Ensured that the client had auditory privacy	AUDITORY PRIVACY	1	2	
05	Explained the procedure before starting it	EXPLAINED PROCEDURE BEFOREHAND	1	2	
06	Prepared all instruments before the procedure	PREPARED INSTRUMENTS	1	2	
07	Used sterilised or high-level disinfected instruments	STERILISED/HLD INSTRUMENTS	1	2	
08	Washed/disinfected hands *before* the procedure	WASHED/DISINF HANDS	1	2	
09	Put on sterile gloves and maintain sterility during insertion	GLOVES AND STERILITY	1	2	
10	Cleaned skin where incision was made with antiseptic	USED ANTISEPTIC	1	2	
11	Used sterile towel to protect area	USED STERILE TOWEL	1	2	
12	Used new or sterilised needle and syringe for local anaesthetic	USED STERILE NEEDLE	1	2	
13	Allowed time for local anaesthetic to take effect prior to making incision	ALLOWED TIME FOR ANESTHETIC TO WORK	1	2	
14	Disposed of sharps in puncture-resistant containers	DISPOSED OF SHARPS	1	2	
15	Wiped contaminated surfaces with disinfectant	DISINFECTED AREA	1	2	
16	Placed instruments in a chlorine solution immediately after completing the procedure	DECONTAMINATED INSTRUMENTS	1	2	
17	Washed/disinfected hands *after* removing gloves	WASHED/DISINF HANDS AFTER	1	2	
18	Explained care of incision area and removal of the bandage	EXPLAINED INCISION CARE	1	2	

			YES	NO	NA
19	Discussed return visit to remove plaster	DISCUSSED RETURN	1	2	
20	Provided woman with card stating date implant was inserted and date when 3 or 5 years of implant would be completed	PROVIDED CARD	1	2	5
21	WAS THE CLIENT INSTRUCTED THAT THE IMPLANT IS GOOD FOR 3-5 YEARS? (DEPENDING ON TYPE)	TOLD IMPLANT GOOD 3-5 YEARS	1	2	5
22	WAS THE CLIENT TOLD ABOUT POSSIBLE MENSTRUAL CHANGES (SIDE EFFECTS)?	TOLD MENSTRUAL CHANGES	1	2	5
23	WAS THE CLIENT TOLD ABOUT OTHER (NON-MENSTRUAL) SIDE-EFFECTS SUCH AS NAUSEA, WEIGHT GAIN, OR BREAST TENDERNESS?	TOLD OTHER SIDE-EFFECTS	1	2	5
24	WAS THE CLIENT INSTRUCTED TO RETURN TO CLINIC IF SIDE EFFECTS PERSISTED?	RETURN TO CLINIC	1	2	5
214	(IN THE CASE OF REMOVAL): Did the provider show each implant stick removed to the client and reassure her that all were removed?	SHOW REMOVED IMPLANT	1	2	5
215	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			

10. Client's Family Planning Status

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	AFTER THE CONSULTATION, COMPLETE THE FOLLOWING INFORMATION		
301	RECORD THE CLIENT'S FAMILY PLANNING STATUS AT THE BEGINNING OF THE CONSULTATION.	CURRENT USER . . . . . 1 NONUSER, USED IN PAST . . 2 NONUSER, NO PAST USE . . 3 NOT DETERMINED 8	 → 304 → 306 → 306
302	RECORD 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	RECORD 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	 → 307 → 307 → 307 → 307 → 308
304	RECORD THE CLIENT'S MOST RECENT USE OF CONTRACEPTION. (NON-USER, USED IN THE PAST)	WITHIN PAST 6 MONTHS . . . . 1 SIX OR MORE MONTHS AGO . . 2 NOT DETERMINED 8	
305	RECORD THE OUTCOME OF THE VISIT. (NON-USER, USED IN THE PAST)	RESTARTED PRIOR METHOD 1 ADOPTED DIFFERENT METHOD . . . . . 2 PLANNED DIFFERENT METHOD, NOT RECEIVED TODAY . . . 3 RECEIVED INFORMATION/ COUNSELLING ONLY . . . . . 4 NOT DETERMINED 8	→ 307 → 307 → 307 → 308 → 308
306	RECORD THE OUTCOME OF THE VISIT. (NON-USER, NO PAST USE)	ACCEPTED TO START METHOD . . . . . 1 DID NOT DECIDE ON METHOD 2	 → 308

307	DID CLIENT LEAVE FACILITY WITH 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 (SPECIFY)	
308	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	
309	RECORD THE TIME THE OBSERVATION ENDED	☐☐ : ☐☐	
310	**Observer's comments:**		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for Family Planning Client

1. Facility Identification

QTYPE . . . . . | X | F | P |

Name of the facility: _____

Location of the facility: _____

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

LANGUAGE OF QUESTIONNAIRE: ENGLISH

2. Information About Interview

DATE _____

DAY . . . . . | | |

MONTH . . . . . | | |

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

Name of the interviewer: _____

INTERVIEWER CODE . . . . . | | |

Client code: _____

CLIENT CODE: . . . . . | | | |

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministries of Health and NCAPD. We are conducting a study of health services in a sample of health facilities in KENYA. In order to improve the services this facility offers, we would like to ask you some questions about your experience 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 0		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ **END**
101	RECORD THE TIME THE INTERVIEW STARTED	__ : __	
102	Have you ever been to this clinic before for family planning services?	YES (FEMALE CLIENT). . . . . 1 NO (FEMALE CLIENT). . . . . 2 YES (MALE CLIENT). . . . . 3 NO (MALE CLIENT). 4	 → 104 → 104
103	Have you ever been pregnant?	YES . . . . . 1 NO 2	
104	Were you doing anything to prevent pregnancy when you came today?	YES . . . . . 1 NO 2	→ 106
105	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
106	What method were you (last) using? IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C MALE CONDOM. . . . . D FEMALE CONDOM. . . . . E IUCD. . . . . F PROGESTIN INJECTABLE. . . . . I MONTHLY INJECTABLE. . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM) . . . . . L STANDARD DAYS METHOD (SDM - THE "BEADS") M LAM. . . . . N VASECTOMY . . . . . O FEMALE STERILISATION . . . P EMERGENCY CONTRACEPTION . . . . . Q OTHER _____ X (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	Did the provider ask you today whether you were having (or had had) a problem with the method?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
108	Have you been having (did you have) a problem with the method?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 111 → 111
109	Did the provider suggest any action(s) you should take to resolve the problem?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
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 PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C MALE CONDOM. . . . . D FEMALE CONDOM. . . . . E IUCD. . . . . F PROGESTIN INJECTABLE. . . . . I MONTHLY INJECTABLE. . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM) . . . . . L STANDARD DAYS METHOD (SDM - THE "BEADS") M LAM. . . . . N VASECTOMY . . . . . O FEMALE STERILISATION . . . P EMERGENCY CONTRACEPTION . . . . . Q OTHER _____ X (SPECIFY)	
114	Did the provider talk to you about any of the method(s) you just mentioned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
115	What (other) family planning methods did the provider talk with you about? CIRCLE ALL METHODS MENTIONED.	COMBINED PILL. . . . . A PROGESTIN-ONLY PILL. . . . . B PILL (TYPE UNSPECIFIED). . . . . C MALE CONDOM. . . . . D FEMALE CONDOM. . . . . E IUCD. . . . . F PROGESTIN INJECTABLE. . . . . I MONTHLY INJECTABLE. . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM) . . . . . L STANDARD DAYS METHOD (SDM - THE "BEADS") M LAM. . . . . N VASECTOMY . . . . . O FEMALE STERILISATION . . . P EMERGENCY CONTRACEPTION . . . . . Q OTHER _____ X (SPECIFY)	
116	What family planning method did you either receive or get a prescription or referral for? CIRCLE ALL METHODS THE CLIENT HAS RECEIVED (REC) OR HAS A PRESCRIPTION OR A REFERRAL (PRES) FOR. IF THE CLIENT IS CONTINUING USING A PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION, OR REFERRAL ON THIS VISIT, CIRCLE Y. CHECK PACKET OR PRESCRIPTION TO CONFIRM TYPE OF PILL OR INJECTION	REC / PRES COMBINED PILL . . . . . A A PROGESTIN-ONLY PILL . . . . . B B PILL (TYPE UNSPECIFIED) . C C MALE CONDOM . . . . . D D FEMALE CONDOM . . . . . E E IUD . . . . . F F PROGESTIN INJECTABLE (2-3M) I I MONTHLY INJECTABLE . . . . . J J IMPLANT . . . . . K K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE). . . L L STANDARD DAYS METHOD (SDM - THE "BEADS") M M LAM. . . . . N N VASECTOMY . . . . . O O FEMALE STERILISATION . . . . . P P EMERGENCY CONTRACEPTION . . . . . Q Q CONTINUING WITH METHOD IN QUESTION 106 . . . . . Y Y OTHER _____ X X (SPECIFY) NO METHOD . . . . . Z → 201 Z → 201 ***[ONLY SKIP TO 201 IF BOTH "Z" ARE CIRCLED, IE, NO METHOD EITHER RECEIVED OR PRESCRIBED]. OTHERWISE CONTINUE TO Q117***	
117	Does your method protect against Sexually Transmitted Infections (STIs) and HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

118	During your consultation, 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
119	MARK BELOW THE METHOD THAT IS CIRCLED IN QUESTION 116. THEN, ASK THE CLIENT THE QUESTION RELATED TO THAT METHOD			
01	PILL (ANY PILL)	How often do you take the pill?	ONCE A DAY . . . . . 1 OTHER 2 DON'T KNOW 8	
02	CONDOM (BOTH MALE & FEMALE)	How many times can you use a condom?	ONCE . . . . . 1 OTHER 2 DON'T KNOW 8	
03	CONDOM (FEMALE)	What type of lubricant can you use with the female condom?	ANY OIL OR LUBRICANT . . . . . 1 OTHER 2 DON'T KNOW 8	
04	IUCD	What should you do to make sure that your IUCD is in place?	CHECK STRING . . . . . 1 OTHER 2 DON'T KNOW 8	
05	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	
06	INJECTABLE (MONTHLY)	How long does the Norigynon injection provide protection from pregnancy?	1 MONTH. . . . . 1 OTHER 2 DON'T KNOW 8	
07	IMPLANT	How long does your implant provide protection against pregnancy?	3-5 YEARS . . . . . 1 OTHER 2 DON'T KNOW 8	
08	NATURAL METHOD (RHYTHM/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 OTHER . . . . . D DON'T KNOW . . . . . Z	
09	LAM	Can you use this method if your menstrual period has returned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
10	MALE STERILISATION (VASECTOMY)	After you have been sterilised (and after the first 3 months), can you make a woman pregnant again?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	
11	FEMALE STERILISATION)	After you have been sterilised, could you ever become pregnant again?	YES. . . . . 1 NO. . . . . 2 DON'T KNOW. 8	

4. Information About Client's 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 family planning services.		
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?	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 PROBLEM	DK
01	Time you waited	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your health with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines/methods at this facility	MEDS/METHODS	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any problem you had today that I did not mention	_____ (SPECIFY)	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 facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 206

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
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
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB ☐☐☐☐☐☐ 2) MEDICINE ☐☐☐☐☐☐ 3) CONSULT ☐☐☐☐☐☐ 4) OTHER ☐☐☐☐☐☐	
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 nearest facility? 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 MEDICINES . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 WAS REFERRED . . . . . 07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes **best** your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	VERY SATISFIED. . . . . 01 MORE OR LESS SATISFIED 02 NOT SATISFIED. 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

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 us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐ DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended?	PRIMARY. . . . . 1 POST-PRIMARY/VOCATIONAL. 2 SECONDARY/A-LEVEL. . . . . 3 COLLEGE (MIDDLE LEVEL). . . 4 UNIVERSITY. 5	
304	What is the highest grade (Standard, form, year) you completed at that level?	GRADE ☐☐	SECONDARY AND ABOVE → 306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . 1 YES, READ ONLY . . . . . 2 NO 3	
	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!		
306	RECORD THE TIME THE INTERVIEW ENDED	☐☐ : ☐☐	
307	**Interviewer's comments:**		

Sample List for Sick Child Observation

Date | | | | | **2** | **0** | **1** | **0** | | | | | |

DAY MONTH YEAR FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF EXPECTED SICK CHILDREN HERE | | |

	INITIALS OF CHILD	AGE (MONTHS)
001		
002		
003		
004		
005		
006		
007		
008		
009		
010		
011		
012		
013		
014		
015		
016		
017		
018		
019		
020		
021		
022		
023		
024		
025		

Total children listed | | | |

Sample calculation: Divide the total number of expected clients by 5 to find the "N^{th}" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3^{d} client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Sick Child Observation

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

					FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF EXPECTED SICK CHILDREN HERE | | | |

	INITIALS OF CHILD	AGE (MONTHS)
026		
027		
028		
029		
030		
031		
032		
033		
034		
035		
036		
037		
038		
039		
040		
041		
042		
043		
044		
045		
046		
047		
048		
049		
050		

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Sick Child Observation

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

					FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF EXPECTED SICK CHILDREN HERE | | |

	INITIALS OF CHILD	AGE (MONTHS)
051		
052		
053		
054		
055		
056		
057		
058		
059		
060		
061		
062		
063		
064		
065		
066		
067		
068		
069		
070		
071		
072		
073		
074		
075		

Sample calculation: Divide the total number of expected clients by 5 to find the "N^{th}" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3^{rd} client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Sick Child Observation

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

					FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF EXPECTED SICK CHILDREN HERE | | | |

	INITIALS OF CHILD	AGE (MONTHS)
076		
077		
078		
079		
080		
081		
082		
083		
084		
085		
086		
087		
088		
089		
090		
091		
092		
093		
094		
095		
096		
097		
098		
099		
100		

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for Sick Child Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF EXPECTED SICK CHILDREN HERE | | |

	INITIALS OF CHILD	AGE (MONTHS)
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 calculation: Divide the total number of expected clients by 5 to find the "N^{th}" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3^{rd} client that comes to the service. If 5 or less, try to observe all clients.

Observation of Sick Child Consultation

1. Facility Identification

QTYPE | O | S | C |

Name of the facility: _____

Location of the facility: _____

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

2. Provider Information

Provider category:
- SPECIALIST. 01
- MEDICAL OFFICER 09
- CLINICAL OFFICER 10
- BACHELLOR SCIENCE NURSE 11
- REGISTERED NURSE 12
- REGISTERED MIDWIFE 13
- ENROLLED NURSE 14
- ENROLLED MIDWIFE 15
- NURSE AIDE 16

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 | 0 |

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 [NAME OF OBSERVER]. I am representing the Ministries of Health and NCAPD. We are conducting a study of health facilities in Kenya 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 Sick Child 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 the 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? _____ DAY __ MONTH __ 2010 YEAR Interviewer's signature (Indicates respondent's willingness to participate)		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministries of Health and NCAPD. We are conducting a study of health services in health facilities in Kenya. I would like to be present while you are receiving services today, in order to better 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 services will be provided on 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? Do I have your permission to be present at this consultation? _____ DAY __ MONTH __ 2010 YEAR 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	RECORD SEX OF THE CHILD.	MALE . . . . . 1 FEMALE 2	
104	RECORD THE VISIT TYPE (THIS REFERS TO THIS SICKNESS).	FIRST VISIT . . . . . 1 FOLLOW-UP . . . . . 2 DON'T KNOW 8	

5. Provider's Interaction With Caretaker and Child

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING **MAJOR SYMPTOMS**.	YES	NO	DK	
01	Fever	1	2	8	
02	Cough or difficult breathing (e.g. fast breathing or chest indrawing)	1	2	8	
03	Diarrhoea	1	2	8	
04	Ear pain or discharge	1	2	8	
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING.				
01	Whether the child is unable to drink or breastfeed at all	1	2	8	
02	Whether the child vomits everything	1	2	8	
03	Whether the child has had convulsions with this sickness	1	2	8	
107	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING **PHYSICAL EXAMINATIONS**.				
01	Take child's temperature by thermometer	1	2	8	
02	Feel the child for fever or body hotness	1	2	8	
03	Count respiration (breaths)	1	2	8	
04	Auscultate child (listen to chest with stethoscope) or count pulse	1	2	8	
05	Check skin turgor for dehydration (pinch abdominal skin)	1	2	8	
06	Check for pallor by looking at palms	1	2	8	
07	Check for pallor by looking at conjunctiva or mouth	1	2	8	
08	Check mouth and throat	1	2	8	
09	Check for neck stiffness	1	2	8	
10	Look in child's ear	1	2	8	
11	Feel behind child's ear	1	2	8	
12	Undress child to examine (up to shoulders/ down to ankles)	1	2	8	
13	Press both feet to check for oedema	1	2	8	
14	Weigh the child IF YES:	1	2 → 107A	8 → 107A	
15	Plot weight on growth chart	1 → 107A	2	8	
16	Compare child's weight to standard weight	1	2	8	

107A	RECORD WHETHER A PROVIDER CHECKED FOR SUSPECTED SYMPTOMATIC HIV INFECTION BY DOING OR ASKING FOR **ANY OF THE FOLLOWING.**	YES		NO	DK	
01	Asked about TB in any parent in the last 5 years	1		2	8	
02	Asked If child has ever had two or more episodes of diarrhoea lasting 14 days or more.	1		2	8	
03	Checked for enlarged lymph nodes in two or more of the following sites: neck, axillae, groin	1		2	8	
04	Checked mouth for oral trush	1		2	8	
05	Asked about mother's HIV status	1		2	8	
108	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH **BY DOING ANY OF THE FOLLOWING:**	YES	NO	NA	DK	
01	Offered the child something to drink or ask the mother to put the child to the breast (IF CHILD DRINKS OR FEEDS AT BREAST DURING VISIT, THIS COUNTS AS "YES")	1	2	5	8	
02	Asked about normal feeding practices when the child is not ill	1	2	5	8	
03	Asked about normal breastfeeding practices when the child is not ill	1	2	5	8	
04	Asked about feeding or breastfeeding practices for the child during this illness	1	2	5	8	
05	Mentioned the child's weight or growth to the caretaker, or discussed the growth chart with the caretaker	1	2	5	8	
06	Looked at the child's immunisation card or asked the caretaker about child's vaccination history	1	2	5	8	
07	Asked if child received Vitamin A within past 6 months	1	2	5	8	
08	Looked at the child's health card either before beginning the consultation, or while collecting information from the caretaker, or when examining the child (THIS ITEM MAY BE EITHER THE VACCINATION CARD OR ANOTHER HEALTH CARD).	1	2	5	8	
09	(IF CHILD 2 YEARS AND ABOVE): Asked if child received de-worming medication in last 6 months.	1	2	5	8	

109	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING WHEN COUNSELLING THE CARETAKER.	YES	NO	DK	NA	
01	Provided general information about feeding or breast-feeding the child even when not sick	1	2	8		
02	Told the caretaker to give extra fluids to the child during this sickness	1	2	8		
03	Told the caretaker to continue feeding the child during this sickness	1	2	8		
04	Told the caretaker what illness(es) the child has	1	2	8		
05	Described signs and/or symptoms in the child for which the caretaker should immediately bring the child back	1	2	8		
110	RECORD WHETHER THE CHILD WAS REFERRED TO ANOTHER PROVIDER OR FOR A LABORATORY TEST	1	2 → 111	8 → 111		
01	WAS CHILD REFERRED TO ANOTHER PROVIDER?	1	2	8		
02	WAS CHILD REFERRED FOR A LABORATORY TEST?	1	2	8		
03	DID THE PROVIDER EXPLAIN THE REASON FOR THE REFERRAL?	1	2	8		
04	WAS A REFERRAL SLIP GIVEN?	1	2	8		
05	DID THE PROVIDER EXPLAIN WHERE (OR TO WHOM) TO GO?	1	2	8		
06	DID THE PROVIDER EXPLAIN WHEN TO GO FOR REFERRAL?	1	2	8		
111	THIS QUESTION REFERS TO MEDICINES THE CARETAKER WILL GIVE TO THE CHILD AT HOME, AND DOES NOT INCLUDE PARACETAMOL OR ORS PROVIDED FOR IMMEDIATE TREATMENT	YES	NO	DK		
01	Prescribed or provided oral medications during consultation	1	2 → 112	8 → 112		
02	Explained how to administer oral treatment(s)	1	2	8		
03	Asked the caretaker to repeat the instructions for the medications	1	2	8		
04	Gave the first dose of the oral treatment	1	2	8		

112	RECORD WHETHER A PROVIDER USED ANY VISUAL AIDS WHEN PROVIDING INDIVIDUAL HEALTH EDUCATION OR COUNSELLING TO THE CARETAKER ABOUT THE CHILD.	YES NO DK 1 2 8	
113	RECORD WHETHER THE MAIN PROVIDER REFERRED TO THE CHILD'S HEALTH CARD/ BOOKLET BEFORE OR DURING THE CONSULTATION.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD OR BOOKLET USED . . . . . 3 DON'T KNOW 8	→ 115
114	RECORD WHETHER THE MAIN PROVIDER WROTE ON THE CHILD'S HEALTH CARD/ BOOKLET	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD OR BOOKLET USED . . . . . 3 DON'T KNOW 8	
115	RECORD WHETHER ANYONE DISCUSSED A FOLLOW-UP VISIT FOR THE CHILD	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
116	RECORD THE OUTCOME OF THE CONSULTATION. [THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED]	CHILD SENT HOME . . . . . 1 CHILD REFERRED TO PROVIDER AT SAME FACILITY . . . . . 2 CHILD ADMITTED TO SAME FACILITY . . . . . 3 CHILD SENT TO LAB . . . . . 4 CHILD REFERRED TO OTHER FACILITY 5	
117	RECORD THE TIME WHEN THE CONSULTATION ENDED.	☐☐ : ☐☐	

6. Diagnosis, Severity and Treatment

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 INDICATE A YES OR NO. FINALLY, ASK ABOUT THE TREATMENT THAT WAS EITHER PRESCRIBED OR PROVIDED. IF NECESSARY, PROMPT.

	DIAGNOSIS (OR MAIN SYMPTOM, IF NO DIAGNOSIS)				
201	**DEHYDRATION**	SEVERE	SOME	NO	DK
	1) DEHYDRATION	1	2	3	8
202	**RESPIRATORY SYSTEM**	**YES**	**NO**		
	1) PNEUMONIA	1	2		
	2) BRONCHO-PNEUMONIA	1	2		
	3) BRONCHIAL SPASM/ASTHMA	1	2		
	4) UPPER RESPIRATORY INFECTION (URI)	1	2		
	5) RESPIRATORY ILLNESS, DIAGNOSIS UNCERTAIN	1	2		
	6) COUGH, DIAGNOSIS UNCERTAIN	1	2		
203	**DIGESTIVE SYSTEM**				
	1) PERSISTENT DIARRHOEA	1	2		
	2) DIARRHOEA	1	2		
	3) DYSENTERY	1	2		
	4) AMEBIASIS	1	2		
	5) OTHER DIARRHOEA _____ (SPECIFY)	1	2		
204	**MALARIA**				
	1) MALARIA (CLINICAL DIAGNOSIS)	1	2		
	2) MALARIA (BLOOD SMEAR OR RAPID TEST)	1	2		
205	**FEVER/MEASLES**				
	1) FEVER	1	2		
	2) SUSPECTED MEASLES	1	2		
	3) MEASLES WITH COMPLICATIONS (e.g., MOUTH/EYE OR SEVERE)	1	2		
206	**EAR**				
	1) MASTOIDITIS	1	2		
	2) ACUTE EAR INFECTION	1	2		
	3) CHRONIC EAR INFECTION	1	2		
	4) OTHER EAR INFECTION	1	2		
207	**THROAT**				
	1) SORE THROAT	1	2		
	2) OTHER THROAT DX (SPECIFY) _____	1	2		
208	**OTHER DIAGNOSIS**				
	1) OTHER DIAGNOSIS _____ (SPECIFY)	1	2		

209	CHECK RESPIRATORY ILLNESSES IN 202 ABOVE. IS CODE "1" CIRCLED FOR ANY OF THE RESPIRATORY ILLNESSES 01 - 06?	YES 1 NO 2	→ 210
209A	CLARIFY WITH THE PROVIDER IF THERE WAS WHEEZING ASSOCIATED WITH THE ILLNESS.	YES, WHEEZING . . . . . 1 NO WHEEZING . . . . . 2 NOT CERTAIN 8	
210	ASK ABOUT PRESCRIPTION, TREATMENT AND ACTIONS TAKEN FOR ILLNESS AND PROBE "ANYTHING ELSE?"		
	WAS TREATMENT / ADVICE PROVIDED	YES. . . . . 1 NO. 2	→ 217

	TREATMENT/PRESCRIPTION FOR VARIOUS ILLNESSES	PRESCRIBED YES	PRESCRIBED NO	PRESCRIBED DK	GIVEN YES	GIVEN NO	GIVEN DK
211	**GENERAL**						
	1) BENZYL PENICILLIN INJECTION	1	2	8	1	2	8
	2) OTHER ANTIBIOTIC INJECTION	1	2	8	1	2	8
	3) OTHER INJECTION	1	2	8	1	2	8
	4) CO-TRIMOXAZOLE TABLETS	1	2	8	1	2	8
	5) CO-TRIMOXAZOLE SYRUP	1	2	8	1	2	8
	6) AMOXICILLIN CAPSULES	1	2	8	1	2	8
	7) AMOXICILLIN SYRUP	1	2	8	1	2	8
	8) OTHER ANTIBIOTIC TABLET/SYRUP	1	2	8	1	2	8
	9) PARACETAMOL	1	2	8	1	2	8
	10) OTHER FEVER REDUCING MEDICINE	1	2	8	1	2	8
	11) ZINC (for Diarrhoea) (SPECIFY DAILY DOSE in mg) ☐☐	1	2	8	1	2	8
	12) VITAMINS (OTHER THAN VITAMIN A)	1	2	8	1	2	8
	13) COUGH SYRUPS/OTHER MEDICATION FOR SYMPTOMATIC TREATMENT	1	2	8	1	2	8
212	**RESPIRATORY**						
	1) NEBULISER OR INHALER	1	2	8	1	2	8
	2) INJECTABLE BRONCHODILATOR (e.g., ADRENALINE)	1	2	8	1	2	8
	3) ORAL BRONCHODILATOR	1	2	8	1	2	8
	4) DRY EAR BY WICKING	1	2	8	1	2	8
213	**MALARIA**						
	1) INJECTABLE QUININE	1	2	8	1	2	8
	2) OTHER INJECTABLE ANTIMALARIAL (E.G., FANSIDAR, ARTEMETHER)	1	2	8	1	2	8
	3) ORAL FANSIDAR (SP)	1	2	8	1	2	8
	4) ORAL ACT/AL (E.G., COARTEM)	1	2	8	1	2	8
	5) ORAL AMODIAQUINE	1	2	8	1	2	8
	6) ORAL ARTEMETER	1	2	8	1	2	8
	7) ORAL QUININE	1	2	8	1	2	8
	8) OTHER ORAL ANTIMALARIAL _____ (SPECIFY)	1	2	8	1	2	8

		PRESCRIBED			GIVEN			
214	**DEHYDRATION**	YES	NO	DK	YES	NO	DK	
	1) HOME ORT (PLAN A)	1	2	8	1	2	8	
	2) INITIAL ORT IN FACILITY (4 HOURS - PLAN B)	1	2	8	1	2	8	
	3) INTRAVENOUS FLUIDS (PLAN C)	1	2	8	1	2	8	
215	**OTHER TREATMENT & ADVICE**							
	1) VITAMIN A (MAY ALSO BE FOR IMMUNIZATION)	1	2	8	1	2	8	
	2) FEEDING SOLID FOODS	1	2	8	1	2	8	
	3) FEEDING EXTRA LIQUIDS	1	2	8	1	2	8	
	4) FEEDING BREAST MILK	1	2	8	1	2	8	
215A	5) (CHECK 108, 09)	1 (216)	2 6	8 6	1 (216)	2 6	8 6	
	6) PRESCRIBED/GAVE DEWORMING TABLETS	1	2	8	1	2	8	
216	1) ANY OTHER TREATMENT (SPECIFY)	1	2	8	1	2	8	
217	Did you give or refer the child for an immunisation other than VITAMIN A supplementation? IF NO: Why not?	YES, GAVE. . . . . 1 YES, REFERRED . . . . . 2 NOT DUE FOR IMMUNISATION/ COMPLETED IMMUNISATION. . . 3 VACCINE NOT AVAILABLE. . . . . 4 CHILD TOO SICK. . . . . 5 NOT DAY FOR IMMUNISATION. . . . . 6 DID NOT CHECK FOR IMMUNISATION 7						
218	RECORD THE TIME THE OBSERVATION ENDED.							

Observer's comments:

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for Caretaker of Sick Child

1. Facility Identification

QTYPE . . . . . | X | S | C |

Name of the facility: _____

Location of the facility: _____

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

2. Information About Interview

DATE: _____	DAY . . . . . | | | |
	MONTH . . . . . | | | |
	YEAR . . . . . | 2 | 0 | 1 | 0 |
Name of the interviewer: _____	INTERVIEWER CODE . . . . . | | |
Client code [USE SAME NUMBER FROM OBSERVATION]	CLIENT CODE: . . . . . | | | |
Sex of caretaker (1=Male; 2=Female) _____	SEX OF CARETAKER . . . . . | |

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CARETAKER: Hello, I am_____. As my colleague mentioned, we are representing the Ministries of Health and NCAPD. We are conducting a study of health services in all health facilities in KENYA. In order to improve the services this facility offers, we would like to ask you some questions about your experience 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: 2010	
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES . . . . . 2 CHILD REFERRED/ADMITTED (NOT POSSIBLE TO CONTINUE) 3	→ END → END
101	RECORD THE TIME THE INTERVIEW STARTED	[ ][ ] : [ ][ ]	
102	What is the name of the sick child?	NAME _____	
103	What month and year was [NAME] born?	MONTH . . . . . [ ][ ] DON'T KNOW MONTH . . . . . 98 YEAR . . . . . [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
104	WERE YOU ABLE TO ASCERTAIN THE EXACT BIRTH DATE OF THE CHILD?	YES . . . . . 1 NO 2	
105	How old is [NAME] in completed months?	AGE IN MONTHS . . . . . [ ][ ] DON'T KNOW. 9 8	
106	Did you bring [NAME] to the facility today because he or she had any of the following problems?	YES NO	
01	Cough or difficult breathing	COUGH/DIFF. BREATH. 1 2	
02	Diarrhea	DIARRHEA. 1 2	
03	Fever/body hotness at home	FEVER/BODY HOTNESS 1 2	
04	Vomiting everything	VOMITING EVERYTHING 1 2	
05	Feeding problems	FEEDING PROBLEMS 1 2	
06	Convulsions	CONVULSIONS 1 2	
07	Excessive sleepiness	SLEEPINESS 1 2	

107	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 OTHER _____ X (SPECIFY) NO OTHER REASON . . . . . Y	
108	Has [NAME] been brought to this facility before for this same sickness?	YES . . . . . 1 NO . . . . . 2 → 110 DON'T KNOW . . . . . 8 → 110	
109	IF YES: How long ago was that?	WITHIN THE PAST WEEK . . . . 1 WITHIN THE PAST 2-4 WEEKS 2 MORE THAN 4 WEEKS AGO . 3 DON'T KNOW 8	
110	How many days ago did the illness for which you brought [NAME] here begin? IF LESS THAN 1 DAY, WRITE 00 IN THE BOXED CELLS.	DAYS AGO . . . . . [ ][ ] DON'T KNOW 98	
111	Did the provider tell you what illness [NAME] has?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
112	What would you do if [NAME] does not get completely better or becomes worse… for example, would you come back to this facility?	RETURN TO FACILITY . . . . . 1 GO TO OTHER FACILITY . . . 2 GO TO OTHER HEALTH WORKER/PHARMACY . . . . . 3 GO TO TRADITIONAL HEALER . . . . . 4 WAIT . . . . . 5 DON'T KNOW 8	
113	Did the provider tell you about any signs or symptoms you may see for which you must immediately bring the child back? 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? CIRCLE THE SYMPTOM LISTED IF THE CARETAKER UNDERSTANDS THAT THE CHILD SHOULD BE BROUGHT BACK IF THE SYMPTOM EITHER FAILS TO GO AWAY OR BECOMES WORSE.	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	

114	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	
115	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 8	→ 120
116	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	
117	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 QUESTIONNAIRE	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
118	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 QUESTIONNAIRE	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
119	Has [NAME] been given a dose of any of these medications here at the facility already?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
120	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 INJ . . . . . 1 YES, RECEIVED PRESC. FOR INJ. . . . . 2 NO . . . . . 3 DON'T KNOW 8	
121	Did anyone at the health facility weigh [NAME] today?	YES . . . . . 1 NO 2	
122	Did anyone talk to you today about [NAME]'s weight and how [NAME] is growing?	YES . . . . . 1 NO 2	
123	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	

124	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	
125	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	
126	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	
127	Did the provider instruct you to go to another facility, another provider, or for a laboratory test for further care for your child?	YES . . . . . 1 NO 2	→ 129

128		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?	1	2	8
03	Were you told who to see for the referral?	1	2	8
04	Were you told why you were to go for the referral?	1	2	8

129	Did you see another health provider or traditional healer before coming here? IF YES, ASK: Whom did you see? CIRCLE ALL THAT APPLY	YES, OTHER PROVIDER . . . . . A YES, TRADITIONAL HEALER . B NO . . . . . Y	

130 Now I would like to talk with you about a new malaria vaccine and would like to know your thoughts about it. A malaria vaccine may soon become available for children under five. I will give you some information about the vaccine. After I read each statement, please tell me whether you think children under five should receive the vaccine.

READ:
The vaccine would reduce the chances of getting severe malaria (e.g., malaria with convulsions) in a vaccinated child.
The vaccine causes discomfort similar to other childhood vaccines.
The vaccine may be given at the same health facility and at the same time as other childhood vaccines.
The vaccine may require 4-5 jabs (shots) to receive full benefit.
Because malaria can occur several times in a child, and because of how this vaccine is, it may not offer full protection against all episodes, that is, a child who is vaccinated with this vaccine could still get malaria.
The vaccine does not change the need to prevent malaria through other ways. Even if the child is vaccinated, his/her family will need to continue doing malaria prevention practices (e.g., sleeping under an insecticide-impregnated bednet, taking prevention tablets during preganncy, having the houses sprayed with insecticide, etc.)

	After hearing these statements:	YES	NO	DK	NA	
01)	Would you support that a young child gets vaccinated with this vaccine in your community? Why? (YES or NO): _____	1	2	8 → 02		
	ASK IF SHE HAS A CHILD UNDER FIVE: IF YES ASK 02 AND SKIP 03. IF SHE DOES NOT HAVE A CHILD, ASK 03) AND CIRCLE "5" IN 02)					
02)	Would you have your own child vaccinated with this vaccine? Why? (YES or NO): _____	1	2	8 → END	5 → END	
03)	If you had a child under five, would you have him/her vaccinated with this vaccine? Why? (YES or NO): _____	1	2	8 → END	5 → END	

4. Information About Client's 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 child health services.		
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?	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	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your child's health with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any other problem?	_____ (SPECIFY)	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 facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services 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
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB ☐☐☐☐☐☐ 2) MEDICINE ☐☐☐☐☐☐ 3) CONSULT ☐☐☐☐☐☐ 4) OTHER ☐☐☐☐☐☐	
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 nearest facility? IF CARETAKER 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 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes best your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	VERY SATISFIED 01 MORE OR LESS SATISFIED 02 NOT SATISFIED 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

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 us to improve services.		
300	What is your relationship to [NAME]?	MOTHER . . . . . 1 FATHER . . . . . 2 SIBLING . . . . . 3 AUNT OR UNCLE . . . . . 4 GRAND MOM/GRAND DAD. . . . 5 OTHER _____ 6 (SPECIFY)	
301	How old were you at your last birthday?	AGE IN YEARS . . . . . [ ][ ] DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended?	PRIMARY. . . . . 1 POST-PRIMARY/VOCATIONAL. 2 SECONDARY/A-LEVEL. . . . . 3 COLLEGE (MIDDLE LEVEL). . . 4 UNIVERSITY. 5	
304	What is the highest (standard, form, year) you completed at that level?	GRADE [ ][ ]	SECONDARY AND ABOVE → 306
305	Do you know how to read or how to write?	YES, READ AND WRITE . . 1 YES, READ ONLY . . . . . 2 NO 3	
	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!		
306	RECORD THE TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
307	**Interviewer's comments:**		

Sample List for STI Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF CLIENTS EXPECTED TODAY HERE

Expect. No. of Clients | | | |

	NAME
001	
002	
003	
004	
005	
006	
007	
008	
009	
010	
011	
012	
013	
014	
015	
016	
017	
018	
019	
020	
021	
022	
023	
024	
025	

Total Clients listed | | |

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g. if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service. If 5 or less, try to observe all clients.

Sample List for STI Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF CLIENTS EXPECTED TODAY HERE

Expect. No. of Clients | | | |

	NAME
026	
027	
028	
029	
030	
031	
032	
033	
034	
035	
036	
037	
038	
039	
040	
041	
042	
043	
044	
045	
046	
047	
048	
049	
050	

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g.
if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service.
If 5 or less, try to observe all clients.

Sample List for STI Client Observation

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

FACILITY #

EXPECTED NUMBER OF CLIENTS
INDICATE THE TOTAL NUMBER OF CLIENTS EXPECTED TODAY HERE

Expect. No. of Clients | | | |

	NAME
051	
052	
053	
054	
055	
056	
057	
058	
059	
060	
061	
062	
063	
064 065	
066	
067	
068	
069	
070	
071	
072	
073	
074	
075	

Sample calculation: Divide the total number of expected clients by 5 to find the "Nth" interval to observe. E.g.
if 15 clients total are expected: 15/5 = 3: you should try and observe every 3rd client that comes to the service.
If 5 or less, try to observe all clients.

Observation of STI Consultation

1. Facility Identification

QTYPE | O | S | I |

Name of the facility: _____

Location of the facility: _____

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

2. Provider Information

Provider category:

SPECIALIST	01
MEDICAL OFFICER	09
CLINICAL OFFICER	10
BACHELLOR SCIENCE NURSING	11
REGISTERED NURSE	12
REGISTERED MIDWIFE	13
ENROLLED NURSE	14
ENROLLED MIDWIFE	15
NURSE AIDE	16

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

Service where client is observed

ANC	1	STI	4
FP	2	CCC	5
SC	3	OTHER _____ (SPECIFY)	6

SERVICE WHERE OBSERVATION OCCURRED |

Date: _____

DAY . . . . . | |

MONTH . . . . . | |

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

Name of the observer: _____

OBSERVER CODE . . . . . | |

Client code: _____

CLIENT CODE . . . . . | | |

4. Observation of STI 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 [NAME OF OBSERVER]. I am representing the Ministries of Health and NCAPD. We are conducting a study of all health facilities in Kenya 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 STI 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 the 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 2010		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ **END**
	READ TO CLIENT: Hello, I am_____. I am representing the Ministries of Health and NCAPD. We are conducting a study of health services in health facilities in Kenya. I would like to be present while you are receiving services today, in order to better understand how 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 services will be provided on 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? Do I have your permission to be present at this consultation? DAY __ __ MONTH __ __ YEAR 2010 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 . . . . . __ __ : __ __		

5. Provider's Interaction with Client

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	DK	
103	RECORD WHETHER THE PROVIDER ADVICED THE CLIENT THAT ANY INFORMATION SHARED DURING THE CONSULTATION IS CONFIDENTIAL	1	2	8	
104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR WHETHER THE CLIENT GAVE ANY OF THE FOLLOWING INFORMATION ABOUT MEDICAL SYMPTOMS AND TYPES OF RELATIONSHIPS:				
01	Symptoms the client is having	1	2	8	
02	How long the client has had the present symptoms	1	2	8	
03	The client's recent history of sexual contacts	1	2	8	
04	Symptoms in sexual partners	1	2	8	
05	The client's current sexual relationship status (monogamous; multiple partners; nonmonogamous partners)	1	2	8	
105	RECORD IF THE CLIENT IS MALE OR FEMALE	MALE . . . . . 1 FEMALE 2			
106	RECORD WHETHER THE PROVIDER EXAMINED THE CLIENT'S GENITALIA	YES, MALE CLIENT . . . . . 1 YES, FEMALE CLIENT . . . . . 2 NO . . . . . 3 DON'T KNOW 8			 → 108 → 109 → 109
107	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING ACTIONS IN REGARD TO PRIVACY AND HYGIENE (FOR **MALE** CLIENTS)		YES	NO	NA
01	Ensures the client's visual privacy	VISUAL PRIVACY	1	2	
02	Ensures the client's auditory privacy	AUDITORY PRIVACY	1	2	
03	Explains the procedure to the client before beginning	EXPLAINS PROCEDURE FIRST	1	2	
04	Washes hands before conducting the examination	WASHES HANDS	1	2	
05	Wears clean latex gloves	WEARS GLOVES	1	2	
06	Makes sure the client's genitalia are fully exposed	GEN. FULLY EXPOSED	1	2	
07	FOR MALE CLIENTS NOT CIRCUMCISED: Retracts foreskin to inspect for lesions or discharge	RETRACTS FORESKIN	1	2	5
08	Places instruments in a disinfectant solution immediately after complete procedure	DECONTAMINATES INSTRUMENTS	1	2	5

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
108	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING THE PHYSICAL EXAMINATION FOR THE **FEMALE** CLIENT:		YES	NO	NA
01	Ensure the client's visual privacy	VISUAL PRIVACY	1	2	
02	Ensure the client's auditory privacy	AUDITORY PRIVACY	1	2	
03	Explain the procedure to the client before beginning	EXPLAIN PROCEDURE FIRST	1	2	
04	Wash his/her hands before the examination	WASH HANDS	1	2	
05	Put on new latex gloves before the examination	PUT ON GLOVES	1	2	
06	Have client lie down during the examination	HAVE CLIENT LIE DOWN	1	2	
07	Separate and inspect labia for lesions or dicharge	SEPARATE AND INSPECT LABIA	1	2	
08	Explain the speculum procedure (if applicable)	EXPLAIN SPECULUM	1	2	5
09	Prepare all instruments before the examination	PREPARE INSTRUMENTS	1	2	5
10	Use sterilized (or high-level disinfected) instruments	DISINFECT INSTRUMENTS	1	2	5
11	Ask the client to take slow, deep breaths and relax all muscles	ASK CLIENT TO RELAX MUSCLES	1	2	
12	Inspect the cervix and vaginal mucosa (by aiming a light inside the inserted speculum)	INSPECT CERVIX	1	2	
13	Perform a bimanual exam (one hand inside the vagina and the other palpating the uterus through the abdomen)	BIMANUAL EXAMINATION	1	2	
14	Wash hands after removing his/her gloves	WASH HANDS AFTER	1	2	
15	Wash contaminated surface with disinfectant	DISINFECT AREA	1	2	
16	Place instruments in a disinfectant solution immediately after complete procedure	DECONTAMINATE INSTRUMENTS	1	2	5
109	RECORD WHETHER A SPECIMEN WAS TAKEN OR A LABORATORY EXAMINATION WAS ORDERED FOR THE CLIENT.	YES NO DON'T KNOW		1 2 8	 → 112 → 112
110	RECORD WHETHER ANY OF THE FOLLOWING TYPES OF TESTS WERE MENTIONED:		YES	NO DK	
01	Blood - not specifying for HIV/AIDS	BLOOD TEST	1	2 8	
02	Microscopic examination of specimen of vaginal or urethral discharge	DISCHARGE MICROSCOPY	1	2 8	
03	Microscopic examination of urine	URINE MICROSCOPY	1	2 8	
04	Test for HIV or AIDS	HIV/AIDS	1	2 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
111	DESCRIBE WHETHER THE PROVIDER AT ANY TIME EITHER ASKED THE CLIENT TO AGREE TO OR PERMIT THE ORDERING OR TAKING OF A SPECIMEN TO CHECK FOR INFECTION OR SPECIFICALLY MENTIONED AN STI (SUCH AS SYPHILIS OR HIV/AIDS)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
112	RECORD WHETHER THE PROVIDER MENTIONED TO OR DISCUSSED WITH THE CLIENT THE FOLLOWING TOPICS:		
01	The diagnosis	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
02	Any relationship between the infection and sexual activity	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
113	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING ACTIONS WITH REGARD TO PRESCRIPTIONS OR MEDICATIONS		
01	Give the client a prescription or medication(s)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 →115 →115
02	Give the client a prescription or medication(s) for the client's sexual partner	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
114	RECORD WHETHER THE PROVIDER INSTRUCTED THE CLIENT ON THE IMPORTANCE OF COMPLETING THE FULL COURSE OF TREATMENT (COMPLIANCE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
115	RECORD WHETHER THE CLIENT WAS ENCOURAGED TO REFER HIS/HER SEXUAL PARTNER(S) FOR TREATMENT	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
116	RECORD WHETHER THE PROVIDER GAVE THE CLIENT A FOLLOW-UP DATE TO RETURN FOR A REEXAMINATION / CHECK-UP	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
117	RECORD WHETHER ANY VISUAL AIDS WERE USED FOR CLIENT EDUCATION ABOUT STIs OR HIV/AIDS	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
118	RECORD WHETHER THE RISK OF HIV/AIDS WAS MENTIONED	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
119	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING IN REGARD TO STIs AND PREVENTION	YES NO DK	
01	Advice the client to abstain / be faithful	ABSTAIN / FAITHFUL 1 2 8	
02	Talk about the role of condoms in preventing STIs and HIV/AIDS transmission	DISCUSS CONDOMS 1 2 8	
03	Instruct the client on how to use condoms	INSTRUCT 1 2 8	
04	Demonstrate how to put on a condom	DEMONS-TRATE 1 2 8	
05	Offer condoms to the client	OFFER 1 2 8	
120	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD . . . . . 3 DON'T KNOW 8	
121	RECORD THE TIME WHEN THE OBSERVATION ENDED	☐☐ : ☐☐	
122	**Observer's comments:**		

MEASURE *DHS* SERVICE PROVISION ASSESSMENT

Exit Interview for STI Client

1. Facility Identification

QTYPE . . . . . | X | S | I |

Name of the facility: _____

Location of the facility: _____

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

2. Information About Interview

DATE _____

DAY . . . . . | | |

MONTH . . . . . | | |

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

Name of the interviewer: _____

INTERVIEWER CODE . . . . . | | |

Client code: _____

CLIENT CODE: . . . . . | | | |

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	READ TO CLIENT: Hello, I am_____. As my colleague mentioned, we are representing the Ministries of Health and NCAPD. We are conducting a study of health services in all health facilities in KENYA. In order to improve the services this facility offers, we would like to ask you some questions about your experience 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: 2010		
100	May I begin the interview now?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ STOP
101	RECORD THE TIME THE OBSERVATION STARTED	☐☐ ☐☐	
102	Did the health worker give you a diagnosis of your medical problem today - that is, did he or she tell you what is causing it?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
103	Were you given any injections, medications or prescriptions today? IF YES, ASK: What were you given?	INJECTION(S). . . . . A MEDICINES. . . . . B PRESCRIPTIONS. . . . . C NO TREATMENT/MEDICATIONS. . . Y	→ 106
103A	CHECK Q103. IS "B" OR "C" OR BOTH CIRCLED?	YES. . . . . 1 NO. 2	→ 106
104	ASK TO SEE ALL MEDICATIONS THAT THE CLIENT RECEIVED AND ANY PRESCRIPTIONS NOT YET SUPPLIED. CIRCLE THE RESPONSE THAT BEST DESCRIBES THE MEDICATIONS OR PRESCRIPTIONS SEEN	HAS ALL MEDS. . . . . 1 HAS SOME MEDS; SOME PRESCRIPTION NOT SUPPLIED 2 NO MEDS SEEN; HAS PRESCRIPTION ONLY 3	
105	How long do you plan to take these medications?	UNTIL SYMPTOMS DISAPPEAR. . . . 1 UNTIL MEDICATION IS COMPLETED. . . . . 2 OTHER (SPECIFY)_____ 6 DON'T KNOW 8	
106	Did a health worker talk to you about how to protect yourself against STIs or HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
107	What are some ways you can protect yourself from infections transmitted by sexual activity?	USE CONDOMS . . . . . A HAVE ONLY ONE SEXUAL PARTNER . . . . . B OTHER (SPECIFY)_____ X DON'T KNOW . . . . . Z	
108	Did the health worker offer you an HIV/AIDS test or ask you to have one done?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
109	Have you ever used a condom? IF YES, ASK: When was the last time you used a condom?	WITHIN PAST 1 MONTH. . . . . 1 2-3 MONTHS AGO. . . . . 2 4-6 MONTHS AGO. . . . . 3 OVER 6 MONTHS AGO. . . . . 4 NEVER USED A CONDOM. 5	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
110	I want to ask your opinion of some reasons people might not use a condom. As I mention each please tell me if you think that it might be, or has been, a reason you might not use condoms. Tell me if you think it has been or could be a major problem, a minor problem, or not a problem for you to decide whether to use condoms.		
	How great a problem is each of the following about condoms	MAJOR MINOR NO PROB-LEM DK	
01	Embarrassing to purchase or obtain condoms	EMBARRASSING TO OBTAIN 1 2 3 8	
02	Difficult to dispose of the condoms	PROBLEM WITH DISPOSAL 1 2 3 8	
03	Embarrassing to discuss with your sex partner	EMBARRASSING TO DISCUSS 1 2 3 8	
04	Reduces your own sexual satisfaction	REDUCES OWN 1 2 3 8	
05	Reduces your partner's sexual satisfaction	REDUCES PARTNER'S 1 2 3 8	
06	My religion does not allow me	RELIGION NOT ALLOWS 1 2 3 8	
110A	Did the health worker talked to you about abstinence / being faithful as a way to prevent STIs today?	YES . . . . . 1 NO 2	
111	Did you discuss with the health worker any of the issues related to using condoms that we just referred to?	YES . . . . . 1 NO 2	
112	Did the health worker talk to you about condoms or mention condoms today?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
113	Were you given any condoms today?	YES . . . . . 1 NO 2	
114	Did you receive a blood test today or did the health worker take a specimen from you for a laboratory examination?	YES . . . . . 1 NO 2	→ 201
115	Did the health worker explain to you what the laboratory test was for? IF YES: What was the test for?	YES, INFECTION OR STI . . . . . A YES, HIV OR AIDS . . . . . B YES, OTHER . . . . . X NO . . . . . Y DON'T KNOW . . . . . Z	

4. Information About Client's 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 STI services.		
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?	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	WAITING TIME	1	2	3	8
02	Ability to discuss problems or concerns about your health with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines/methods at this facility	MEDS/METHODS	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Cost for services or treatments	COST	1	2	3	8
13	Any problem you had today that I did not mention	_____ (SPECIFY)	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 facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services 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
205A	Please tell me how much you paid for each of the following services you received today: RECORD AMOUNT AS "OTHER" IF RESPONDENT DOES NOT KNOW WHAT THE MONEY WAS PAID FOR. MUST ADD UP TO AMOUNT IN Q205	1) LAB ☐☐☐☐☐☐ 2) MEDICINE ☐☐☐☐☐☐ 3) CONSULT ☐☐☐☐☐☐ 4) OTHER ☐☐☐☐☐☐	
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 nearest facility? IF CARETAKER 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 (SPECIFY) DON'T KNOW 98	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	
209	In general, which of the following statements describes best your opinion of the services given today at this facility: (READ ALL STATEMENTS; CHECK ONLY ONE) 01) I am **very satisfied** with the services given 02) I am **more or less satisfied** with the services given 03) I am not satisfied with the services given	VERY SATISFIED. . . . . 01 MORE OR LESS SATISFIED 02 NOT SATISFIED. 03	
210	Will you recommend this health facility to a friend or family member? (CHECK ONLY ONE)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

5. Personal Characteristics of Client

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 us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐ DON'T KNOW. 98	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended?	PRIMARY. . . . . 1 POST-PRIMARY/VOCATIONAL. 2 SECONDARY/A-LEVEL. . . . . 3 COLLEGE (MIDDLE LEVEL). . . 4 UNIVERSITY. 5	
304	What is the highest (standard, form, year) you completed at that level?	GRADE ☐☐	SECONDARY AND ABOVE → 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!		
307	**Interviewer's comments:**		

HEALTH WORKER

INTERVIEW

HEALTH WORKER INTERVIEW

Facility Number: | | | | | |

QRE **25**

Interviewer Code: | | |

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

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

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

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

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

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

Number of STI 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

NO, NOT PREVIOUSLY INTERVIEWED **2** → **STOP**

READ THE FOLLOWING CONSENT FORM

Good day! My name is _____. We are here on behalf of the Ministries of Health and NCAPD conducting a study to assist the government in knowing more about health services in KE`
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 these 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 survey. Do you have any questions about the study? Do I have your agreement to proceed?

_____ | | | | | | 2 | 0 | 1 | 0 |
Interviewer's signature — DAY | MONTH | YEAR

SIGNATURE OF INTERVIEWER INDICATES INFORMED CONSENT WAS PROVIDED.

101	May I begin the interview now?	YES . . . . . 1 NO 2	→STOP
101A	Are there additional Health Worker Questionnaires?	MATERNAL HEALTH CARE KNOWLEDGE A NEONATAL HEALTH CARE KNOWLEDGE B NO ADDITIONAL QUESTIONNAIRES FOR HW Y	

1. Education and Experience

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
102	I would like to ask you some questions about your educational background. How many years of education have you completed in total? This is starting from your primary, secondary and further education.	YEARS	
103	What is your current professional/technical/medical qualification?	SPECIALIST (ANY CODE 01-08). . . . . 01 MEDICAL OFFICER (NON-SPECIALIST). . . . . 09 CLINICAL OFFICER. . . . . 10 BACHELLOR SCIENCE NURSE . . . . . 11 REGISTERED NURSE. . . . . 12 REGISTERED MIDWIFE. . . . . 13 ENROLLED NURSE. . . . . 14 ENROLLED MIDWIFE. . . . . 15 NURSE AIDE. . . . . 16 LABORATORY SCIENTIST. . . . . 20 LABORATORY TECHNOLOGIST. . . . . 21 LABORATORY TECHNICIAN/ASSISTANT. . . . . 22 NUTRITIONIST/NUTRITION TECHNICIAN. . . . . 23 HEALTH EDUCATION OFFICER. . . . . 24 SOCIAL WORKER. . . . . 25 HIV COUNSELOR/LAY COUNSELOR. . . . . 26 NO TECHNICAL QUALIFICATION . . . . . 30 OTHER (SPECIFY) _____ 96	
104	What year did you graduate (or complete) with this qualification? IF NO TECHNICAL QUALIFICATION (30), ASK: What year did you complete any basic training for your current position?	YEAR	
105	In what year did you start working in this facility?	YEAR	
106	In what year did you start working in your ***current position*** in this facility? IF YEAR IS NOT KNOWN, PROBE AND MAKE THE BEST ESTIMATE	YEAR	
107	What was your age at your last birthday?	AGE AT LAST BIRTHDAY (YRS) .	

2. GENERAL TRAINING AND SERVICES PROVIDED IN CURRENT POSITION IN THIS FACILITY

	200 First I want to ask you about some general training courses. During the past 3 years, have you received any pre-service or in-service training on: [READ TOPIC]. IF YES, ASK: Was that training within the past 1 year? IF NOT WITHIN THE PAST 1 YEAR, ASK: Was that training within the past 3 years?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	Infection Control, including Universal Precautions and waste management?	1	2	3
02	Any specific training related to injection safety?	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 (PLWHA)?	1	2	3

201	As part of your services in this facility, have you received any dose of Hepatitis B vaccine? **IF YES, ASK:** How many doses have you received so far?	YES, ONE DOSE . . . . 1 YES, TWO DOSES . . . . 2 YES, THREE DOSES . . 3 NO 4	
202	Are you a manager or in-charge for any clinical services?	YES . . . . . 1 NO 2	
203	CHECK Q103 FOR PROVIDER QUALIFICATION CODE 20, 21 OR 22 (i.e., LABORATORY-RELATED) CIRCLED → 701 CODE 20, 21 OR 22 **NOT** CIRCLED		

204	Now I want to ask you about services you **personally** provide. For each service I mention, tell me if you provide the service. I will then ask you if you have received any pre-service (i.e., while studying) or in-service ("on-the-job") training of such service. Please remember, I am asking about services you provide in your current position in this facility.			
	Do you …….. [READ TOPIC]. IF INDICATED, ASK: How long have you provided this service? IF LESS THAN 1 YEAR WRITE '00'.	a		b
		YES	NO	DURATION IN YEARS
01	Diagnose and/or treat RTIs / STIs?	1 → b	2 → 02	
02	Diagnose and/or treat malaria ?	1	2	
03	Diagnose, treat, or provide follow-up for tuberculosis? IF YES, ASK: How long have you provided TB services? THEN ASK: Do you [READ FOLLOWING LIST OF SERVICES]	1 → b	2 → 09	
04	Diagnose tuberculosis based on clinical symptoms?	1	2	
05	Diagnose tuberculosis based on sputum tests or analysis?	1	2	
06	Prescribe treatment for tuberculosis?	1	2	
07	Provide follow-up treatment for tuberculosis?	1	2	
08	Participate in the Direct Observation Treatment Short-course (DOTS) strategy?	1	2	
09	Provide any services that are designed to be Youth Friendly, i.e., that have a specific aim to encourage adolescent utilization?	1	2	
10	Provide any diagnostic, treatment or follow-up services to the elderly or disabled as part of your job in this facility?	1	2	

205	During the past three years have you received any pre-service (i.e., while studying), or in-service ("on-the job") training on any of the topics I have just mentioned, and specifically on [READ TOPIC]…? IF YES, ASK: Was this during the past 1 year? IF NOT WITHIN THE PAST 1 YEAR, ASK: Was that training within the past 3 years?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	Diagnosing and treating sexually transmitted infections (STIs)?	1	2	3
02	As part of STIs, the syndromic management for STIs?	1	2	3
03	As part of STIs, drug resistance to STI treatment medications?	1	2	3
04	Any topic related to malaria? IF RESPONSE IS EITHER "1" OR "2", ASK: Did the training cover any of the following topics:	1	2	3 08 ↵
05	Diagnosis and treatment of malaria?	1	2	3 08 ↵
06	Specifically diagnosing and treating malaria in children?	1	2	3
07	Intermittent Preventive Treatment (IPT) of malaria for pregnant women? (prophylaxis)	1	2	3
08	Any topic related to tuberculosis? IF RESPONSE IS EITHER "1" OR "2", ASK: Did the training cover any of the following topics:	1	2	3 13 ↵
09	Diagnosing tuberculosis (TB) using sputum test?	1	2	3
10	Diagnosing TB using clinical symptoms?	1	2	3
11	The DOTS (Direct observed treatment short-course) strategy?	1	2	3
12	Follow-up treatment for TB clients?	1	2	3
13	Any topic specific to youth friendly services? This includes addressing psychological or health issues of particular relevance to adolescents?	1	2	3
14	Any topic specific to the diagnosis and management of conditions in the elderly? IF RESPONSE IS EITHER "1" OR "2", ASK: Did the training cover any of the following topics:	1	2	3 301 ↵
16	Identification and diagnosis of chronic conditions in the elderly?	1	2	3
17	Identification, diagnosis / management of falls in the elderly?	1	2	3
18	Identification and diagnosis / management of incontinence in the elderly?	1	2	3
19	Identification and diagnosis / management of immobility in the elderly?	1	2	3
20	Identification and diagnosis / management of confusion in the elderly?	1	2	3

3. Child Health Services

301	In your **current** position, and as a part of your work for this facility, do you personally provide any child health services?	YES . . . . . 1 NO 2	→ 303
302	How many years in total have you provided such services (service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS	
303	During the past three years have you received any pre-service or in-service training on subjects related to child health or childhood illness?	YES . . . . . 1 NO 2	→ 401

		YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
304	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)... IF YES, ASK: When was the most recent training?			
01	EPI/cold chain?	1	2	3
02	Acute Respiratory Infection (ARI) treatment?	1	2	3
03	Diarrhoea treatment?	1	2	3
04	Malaria treatment for children?	1	2	3
05	Nutrition/micronutrient deficiencies?	1	2	3
06	Nutritional assessment (e.g., Body Mass Index calculation, Mid-Upper Arm Circumference measurement)?	1	2	3
07	Breast feeding (including exclusive breast-feeding)?	1	2	3
08	Complementary feeding of infants?	1	2	3
09	Integrated Management of Childhood Illnesses (IMCI)?	1	2	3
10	Other (ON CHILD HEALTH)? _____ (SPECIFY)	1	2	3

4. Family Planning

401	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	→ 403
402	How many years in total have you provided such services (service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS	YEARS	
403	During the past three years have you received any pre-service or in-service training on subjects related to family planning?	YES . . . . . 1 NO 2	→ 501

		YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
404	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)... IF YES, ASK: When was the most recent training?			
01	General counselling for family planning?	1	2	3
02	Insertion/removal of IUCDs?	1	2	3
03	Insertion/removal of implants?	1	2	3
04	Clinical management for family planning methods, including side effects?	1	2	3
05	Family planning for HIV positive women?	1	2	3
06	Other (ON FAMILY PLANNING)? _____ (SPECIFY)	1	2	3

5. Maternal Health

501	During the past three years have you received any pre-service or in-service training on subjects related to maternal or newborn health and HIV/AIDS?	YES . . . . . 1 NO 2	→ 503

		YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
502	Did you receive the training in any topic related to [READ TOPIC]… IF YES, ASK: When was the most recent training?			
01	Prevention of mother-to-child transmission (PMTCT) of HIV/AIDS?	1	2	3
02	Nutrition counselling for newborn of mother with HIV/AIDS?	1	2	3
03	Modified obstetric practices as relates to HIV?	1	2	3

503	In your **current** position, and as a part of your work for this facility, do you personally provide any **antenatal** or **postnatal care** services? IF YES, INDICATE WHICH SERVICE IS PROVIDED.	YES, ANTENATAL . . . . . 1 YES, POSTNATAL . . . . . 2 YES, BOTH . . . . . 3 NO, NEITHER 4	→ 505
504	How many years in total have you provided such services? (service may have been in another facility). IF LESS THAN 1 YEAR, WRITE "00" IN THE BOXES	YEARS	
505	Do you ***personally*** provide any **PMTCT** services? 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	
506	During the past 3 years have you received any pre- or in-service training on subjects related to antenatal or postnatal care?	YES . . . . . 1 NO 2	→ 508

		YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
507	Did you receive the training in any topic related to [READ TOPIC]… IF YES, ASK: When was the most recent training?			
01	ANC screening (e.g., blood pressure, urine glucose and protein)?	1	2	3
02	Counselling for ANC (e.g., nutrition, FP and newborn care)?	1	2	3
03	Complications of pregnancy and their management?	1	2	3
04	Any topic related to pregnancy and HIV/AIDS or PMTCT?	1	2	3 '09
05	Antiretroviral prophylactic treatment for prevention of mother to child transmission (PMTCT) of HIV?	1	2	3
06	Nutritional counselling for the newborn of mothers with HIV/AIDS?	1	2	3
07	Record keeping for PMTCT?	1	2	3
08	Nutrition counselling for the pregnant woman with HIV/AIDS?	1	2	3
09	Nutritional assessment of the pregnant woman, such as Body Mass Index calculation and Mid-Upper Arm circumference measurement?	1	2	3

508	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	→ 512
509	How many years in total have you provided such services? (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS	YEARS ……	
510	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	

511	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	
512	During the past three years have you received any pre- or in-service training on subjects related to delivery care?	YES . . . . . 1 NO 2	→ 514

		YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
513	Did you receive the training in any topic related to [READ TOPIC]… IF YES, when was the most recent training?			
01	Routine care for labour and normal vaginal delivery?	1	2	3
02	Use of partograph?	1	2	3
03	Active Management of Third Stage of Labour (AMTSL)?	1	2	3
04	Emergency obstetric care (EmOC)/Life saving skills (LSS) - in general?	1	2	3
05	Specifically, diagnosis and Management of Pre-eclampsia/Eclampsia?	1	2	3
06	Specifically, management of post-partum hemorrhage?	1	2	3
07	Specifically, removal of placenta or products of conception? (CAN MENTION D&C, VACUUM EXTRACTION, etc.)	1	2	3
08	Post abortion care?	1	2	3
09	Special delivery care practices for preventing mother-to-child transmission (PMTCT) of HIV/AIDS?	1	2	3
10	Other (ON DELIVERY SERVICES)? _____ (SPECIFY)	1	2	3

514	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	→ 516
515	How many years in total have you provided such services? (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS	YEARS	
516	During the past three years have you received any pre- or in-service training on subjects related to newborn care?	YES . . . . . 1 NO 2	→ 601

		YES, IN PAST 1 YR	YES, IN PAST 2-3 YRS	NO TRAINING WITHIN PAST 3 YRS
517	Did you receive the training in any topic related to [READ TOPIC]… IF YES, when was the most recent training?			
01	Essential newborn care (e.g., cord care, warming, early breastfeeding)?	1	2	3
02	Neonatal resuscitation?	1	2	3
03	Breastfeeding (including exclusive breastfeeding)?	1	2	3
04	Nutrition for the newborn of the HIV infected woman?	1	2	3
05	Other (ON NEWBORN HEALTH)? _____ (SPECIFY)	1	2	3

6. HIV/AIDS SERVICES

		(a) YES	(a) NO	(b) DURATION IN YEARS
601 01	Do you provide any counselling related to HIV testing? (Service may have been in another facility) IF YES, ASK: How long have you provided such services? IF LESS THAN 1 YEAR, WRITE "00" IN THE BOXES **Now, do you provide:**	1 → b	2 → 602	
02	Pre-test counselling?	1	2	
03	Post-test counselling for HIV positive clients?	1	2	
04	Follow-up counselling for HIV, after the initial post-test counselling or emotional support?	1	2	
602 01	Do you provide education to patients and families on prevention of HIV/AIDS?	1	2	
02	Do you provide counselling on care and support of the HIV/AIDS infected person who is seriously ill?	1	2	
03	Do you provide nutrition counselling to HIV/AIDS infected clients?	1	2	
04	Do you yourself actually prescribe / conduct the HIV test for clients?	1	2	
603 01	Do you provide any services related to prevention of mother to child transmission of HIV/AIDS? IF YES: How long?	1 → b	2 → 604	
02	Do you provide nutrition counselling for the newborn of the HIV infected woman?	1	2	
03	Do you counsel HIV positive women about family planning?	1	2	
04	Do you ever provide or prescribe the preventive antiretroviral therapy for prevention of mother to child transmission (i.e., PMTCT)?	1	2	
604 01	Do you ever provide any follow-up services for HIV positive clients? This includes providing preventive treatments, treatment for opportunistic infections, ART, and palliative care, that is providing treatment for pain and symptoms of the seriously ill HIV/AIDS clients? IF YES, ASK: How long? Now, do you **specifically** provide:	YES 1 → b	NO 2 → 605	DURATION IN YEARS
02	Clinical management of HIV/AIDS-related neurological disorders?	1	2	
03	Diagnosis and/or treatment of opportunistic infections? IF YES, ASK: How long?	1 → b	2 → 04	
04	Prescribe antiretroviral therapy (ART)? IF YES, ASK: How long?	1 → b	2 → 05	
05	Provide medical follow-up for clients on antiretroviral therapy?	1	2	
06	Provide adherence counselling for ART?	1	2	
07	Provide or prescribe preventive treatment for TB (INH)?	1	2	
08	Provide or prescribe preventive treatment for other opportunistic infections (OIs) such as Cotrimoxazole Preventive Therapy (CPT)?	1	2	
09	Provide paediatric AIDS care?	1	2	
10	Provide nursing care, or train caregivers and patients in how to care for someone with HIV/AIDS? This includes providing palliative, or symptomatic care and support services? IF YES, How long?	1 → b	2 → 12	
11	Do you provide home based care?	1 → 604A	2	
12	Do you provide training or support for others who provide home-based care?	1	2	

604A	Do you attend the regular counselling supervision meetings for support of the counsellors? IF YES, When was the last meeting you attended?	YES, LAST MONTH OR MORE RECENTLY ..... 1 YES, IN LAST 2-3 MONTHS ..... 2 YES, 4 OR MORE MONTHS AGO ..... 3 NEVER 6	
605			
01	Do you ever provide counselling for post-exposure prophylaxis (PEP)?	1 2	
02	Do you ever prescribe medicines for post-exposure prophylaxis (PEP)?	1 2	
606	Do your clients who are HIV positive actively participate in the services that you provide or the services that they receive? IF YES, ASK: How do they actively participate? CIRCLE ALL THAT APPLY	SUPPORT GROUPS ..... A DELIVER MEDS FOR OTHER CLIENTS WHO ARE TOO SICK TO ATTEND CLINIC ..... B OTHER _____ (SPECIFY) X NO ACTIVE PARTICIPATION . Y NO SERVICES TO HIV CLIENTS ..... Z	

607	Now I would like to know about pre-service or in-service training you have received during the past 3 years on any of the topics I will mention. First I want to know about specific trainings, then, I want to know if you received any other training on the topics I will mention. Did you receive [READ TRAINING COURSE]... IF YES, ASK: Was this during the past 1 year?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS	
01	In-depth (or comprehensive) training for HIV/AIDS counsellors (3 weeks)?	1	2	3	
02	Refresher training on HIV/AIDS counselling?	1	2	3	
03	Comprehensive Care and Treatment course?	1	2	3	
04	HIV/AIDS Training of trainers course (TOT)?	1	2	3	
05	Training course for counsellors' supervisors? at district and regional level (VCT)?	1	2	3	
07	Health facility home-based care providers' training?	1	2	3	
08	Community level home-based care providers' training?	1	2	3	
09	Syndromic STI care management training?	1	2	3	
10	Syphilis screening training?	1	2	3	
11	Indent system training on STI commodities?	1	2	3	
12	Peer health education training?	1	2	3	
13	Youth friendly health service training (YFS)?	1	2	3	
14	HMIS training?	1	2	3	
15	Integrated Management of Adult Illnesses (IMAI) training?	1	2	3	
16	Prescribing ART?	1	2	3	
17	Diagnosis and treatment of opportunistic infections (OI)?	1	2	3	
18	ARV medicine adherence training?	1	2	3	
19	Paediatric ART training?	1	2	3	
608	Apart from the previously mentioned trainings, during the past 3 years, have you received any pre- or in-service training related to any other aspect of HIV/AIDS prevention, counselling, or care and support?	YES ..... 1 NO 2			→701

609	IF YES, Ask: Did this training provide information about [READ TOPIC]…? IF YES, ASK: was this during the past 1 year? MULTIPLE TOPICS MAY HAVE BEEN COVERED IN ONE TRAINING. IF THE RESPONDENT TELLS YOU THAT A TOPIC WAS COVERED AS PART OF A PREVIOUS TRAINING, CIRCLE RESPONSE "4" OR "5".	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS	COVERED IN ANOTHER TRAINING PAST 1 YEAR	COVERED IN ANOTHER TRAINING PAST 2-3 YEARS
01	HIV pre-test and post-test counselling?	1	2	3	4	5
02	HIV testing procedures, that is, which tests to order, and when?	1	2	3	4	5
03	Follow-up counselling, after the initial post-test counselling or emotional support for HIV/AIDS clients?	1	2	3	4	5
04	Educational needs of patients and families about HIV/AIDS care?	1	2	3	4	5
05	General nutritional counselling for HIV/AIDS clients?	1	2	3	4	5
06	Primary prevention of HIV, such as behaviour change education, partner counselling, condom promotion and distribution?	1	2	3	4	5
07	Tuberculosis INH preventive therapy for HIV/AIDS clients?	1	2	3	4	5
08	Cotrimoxazole preventive therapy (CPT) for HIV/AIDS clients for pneumonia?	1	2	3	4	5
09	Clinical management of HIV/AIDS-related neurological disorders?	1	2	3	4	5
10	Ordering or prescribing laboratory tests for monitoring of ART?	1	2	3	4	5
11	Nutritional rehabilitation for HIV/AIDS patients?	1	2	3	4	5
12	Nutritional assessment, such as Body-Mass Index calculation and Mid-Upper Arm Circumference measurement?	1	2	3	4	5
13	Any other topic specific to paediatric AIDS care?	1	2	3	4	5
14	Training on provision of palliative care, to manage symptoms of the seriously ill HIV/AIDS client?	1	2	3	4	5
15	Ordering or prescribing Post-exposure prophylaxis (PEP)?	1	2	3	4	5

7. Laboratory services

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

		a PROVIDES SERVICE	
702	Do you conduct any of the following laboratory tests?	YES	NO
01	Examining sputum smears for tuberculosis?	1	2
02	Any of the blood tests for HIV?	1	2
03	Any of the laboratory tests for monitoring antiretroviral therapy (e.g., creatinine, TLC)?	1	2

703	During the past three years have you received any pre-service or in-service training related to different laboratory tests for tuberculosis, HIV or for screening blood prior to transfusion?	YES . . . . . 1 NO 2	→ 800

704	Did you receive preservice or in-service training for [READ TOPIC] during the past 3 years? IF YES, ASK: Was this during the past 1 year?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
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

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	I want to know if you can estimate how much of your total work time each week is spent providing services related to HIV/AIDS. This may include counselling, testing, providing clinical care and support, social support services, or record keeping related to HIV/AIDS. What percent of your time do you estimate this is? IF NO HIV/AIDS-RELATED SERVICES CODE "000"	AVERAGE WEEKLY PERCENTAGE OF WORK TIME . ☐☐☐ DON'T KNOW/NOT CERTAIN 998	
802	During the past 12 months, if you add together all of the formal training you have received related to HIV/AIDS, how many days is this? For example, a one-week training is usually 5 days, a four-week training is usually 20 days of training. IF TRAINING WAS LESS THAN ONE FULL DAY, ENTER 001. PROBE IF NECESSARY. IF NO DAYS OF TRAINING, ENTER 000	NUMBER OF DAYS OF . . . . . HIV/AIDS RELATED TRAINING IN PAST 12 MONTHS ☐☐☐	
803	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	806
804	How many times in the past six months has your work been supervised?	NUMBER OF TIMES . . . . . ☐☐	

			YES	NO	DK
805	The last time you were personally supervised, did your supervisor do any of the following:				
01	Deliver supplies?	DELIVERED SUPPLIES	1	2	8
02	Check your records or reports?	CHECKED RECORD	1	2	8
03	Observe your work?	OBSERVED WORK	1	2	8
04	Provide any feedback (either positive or negative) on your performance?	FEEDBACK	1	2 → 07	8
05	Give you verbal feedback that you were doing your work well?	VERBAL PRAISE	1	2	8
06	Provide any written comment that you were doing your work well?	WRITTEN PRAISE	1	2	8
07	Provide updates on administrative or technical issues related to your work?	PROVIDED UPDATES	1	2	8
08	Discuss problems you have encountered?	DISCUSSED PROBLEMS	1	2	8

806	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	
807	Are there any opportunities for promotion in your current job?	YES . . . . . 1 NO . . . . . 2 UNCERTAIN/DON'T KNOW 8	

808	Do you personally receive any salary supplement, that is, money outside of your routine salary, that is related to your work in this facility?	YES . . . . . 1 NO 2	→ 810
809	Which type(s) of salary supplement do you receive? PROBE: Anything else?	MONTHLY OR DAILY SALARY SUPPLEMENT. . . . . A PERDIEM WHEN ATTENDING TRAINING. . . . . B DUTY ALLOWANCE. . . . . C PAYMENT FOR EXTRA ACTIVITIES (NOT ROUTINELY PROVIDED). . . . . D OTHER _____ X (SPECIFY)	
810	In your current position, have you ever received any non-monetary incentives for the work you do? This might include such things as time off, discounts for medicines or other items, uniforms or other clothing, food, training, or other things like this.	YES . . . . . 1 NO 2	→ 812
811	Describe any incentives that you have received. CIRCLE ALL THAT APPLY.	TIME OFF / HOLIDAYS ..... 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 _____ X (SPECIFY)	
812	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? CIRCLE ONLY **THREE** ITEMS. IF THE PROVIDER MENTIONS MORE THAN THREE ITEMS, ASK THE PROVIDER TO PRIORITIZE TO ONLY THREE. IF THE PROVIDER DOES NOT MENTION THREE ITEMS, PROBE FOR ANY OTHERS IN AN ATTEMPT TO HAVE THREE ANSWERS.	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 _____ W (SPECIFY) OTHER _____ X (SPECIFY)	

813	Now I would like to asK for your impressions about a new malaria vaccine which may soon become available. for children under five. I will give you some information about the vaccine. After I read the statements, please tell me whether you think children under five should receive this vaccine. READ: The vaccine would reduce the chances of getting severe malaria (e.g., malaria with convulsions) in a vaccinated child. The vaccine causes discomfort similar to other childhood vaccines. The vaccine may be given at the same health facility and at the same time as other childhood vaccines. The vaccine may require 4-5 jabs (shots) to receive full benefit Because malaria can occur several times in a child, and because of how this vaccine is, it may not offer full protection against all episodes, that is, a child who is vaccinated with this vaccine could still get malaria. The vaccine does not reduce the need to carry out malaria prevention activities, for example, sleeping under an insecticide-impregnated bednet, taking prevention tablets during pregnancy, having the houses sprayed with insecticide, etc.				
	After hearing these statements:	YES	NO	DK	
a)	Do you think the vaccine should be introduced in this facility and children under five receive it?	1	2	8 → 900	
b)	Why? _____				

9. Working with HIV/AIDS clients

900 Finally, I would like to ask you a few additional questions about HIV/AIDS and working with clients who may have HIV/AIDS.

What should you do if you got a needle stick injury?

PROBE: Anything else?

CIRCLE ALL THAT ARE MENTIONED.

- SQUEEZE FINGER . . . . . A
- WASH/SOAK IN DISINFECTANT (BLEACH, IODINE, ALCOHOL) . . B
- WASH WITH SOAP AND WATER . . C
- REPORT TO MANAGER . . . . . D
- LEARN PATIENT HIV STATUS . . . . E
- GET AN HIV TEST IMMEDIATELY . . F
- GET AN HIV TEST AFTER SOME TIME . . . . . G
- GET HIV TEST DEPENDING ON HIV STATUS OF PATIENT . . H
- GET COUNSELLING I
- GET ANTIRETROVIRAL OR REFERRAL FOR ARVs . . . . . J
- OTHER _____ (SPECIFY) X
- NOTHING . . . . . Y
- DON'T KNOW . . . . . Z

901 Have you had any needle stick injuries in the last 6 months?

- YES 1
- NO 2
- DON'T KNOW 8

902 Do you think that a health care worker who has HIV but is not sick, should be allowed to continue to work?

- YES 1
- NO 2
- DON'T KNOW 8

903 In the past 12 months, have you seen or observed the following happen in this health care facility because a client was known or suspected of having HIV/AIDS? READ EACH SCENARIO BELOW

		YES	NO	NA	DK
01	Testing a client for HIV infection without their consent	1	2	5	8
02	Requiring some clients to be tested for HIV before scheduling surgery	1	2	5	8
03	Using latex gloves for performing non-invasive exams on clients suspected of HIV	1	2	5	8
04	Extra precautions been taken in the sterilisation of instruments used on HIV-positive patients	1	2	5	8
05	Health providers gossiping about a client's HIV status	1	2	5	8
06	Because a patient is HIV-positive a senior health provider pushing the client to a junior provider	1	2	5	8
07	An HIV-positive patient receiving less care/attention than other patients	1	2	5	8

904 Have you ever heard the word stigma?

IF NOT, EXPLAIN: WHEN PEOPLE DISCRIMINATE OR HAVE A NEGATIVE ATTITUDE AGAINST A PERSON WHO IS PHYSICALLY AFFECTED BY A DISEASE OR CONDITION

- YES (SPONTANEOUSLY) 1
- YES (AFTER EXPLANATION) 2
- NO (EVEN AFTER EXPLANATION) ..... 3 → 911

905 Does stigma occur **in** health facilities?

- YES 1
- NO . . . . . 2 → 907
- UNCERTAIN/DON'T KNOW . . . . . 8 → 907

906	Please give me some examples of stigma in the health facility PROBE BY ASKING: Any other examples?	USING LATEX GLOVES FOR NON-INVASIVE PROCEDURE ON SUSPECT/HIV+ CLIENTS . . A EXTRA PRECAUTION IN THE sterilisation OF EQUIP USED ON HIV+ CLIENTS . . . . . B PROVIDERS GOSSIPING ABOUT A CLIENT'S HIV STATUS . . . . . C LESS CARE/ ATTENTION GIVEN TO HIV+ CLIENTS . . . . D SENIOR STAFF PUSHING HIV+ CLIENT TO JUNIOR STAFF . . . . E STAFF UNWILLING TO SHAKE HANDS WITH HIV+ CLIENTS . . . . F OTHER _____ X (SPECIFY)	
907	Does stigma occur **outside** health facilities?	YES . . . . . 1 NO . . . . . 2 → 911 UNCERTAIN/DON'T KNOW . . . . . 8 → 911	
908	Where have you observed or heard stigma occur? PROBE: Anything else?	HOUSEHOLD/FAMILY . . . . . A COMMUNITY . . . . . B WORKPLACE . . . . . C PLACES OF WORSHIP . . . . . D PLACES OF ENTERTAINMENT . . . . E OTHER _____ X (SPECIFY)	
909	Please give me some examples of stigma that occur **outside** health facility	SEPARATION/DIVORCE WHEN ONE PARTNER BECOMES HIV+ . . . . A NEIGHBORS/FAMILY GOSSIPING ABOUT CLIENT'S HIV STATUS . . B NOT BUYING FROM OR PATRONIZING HIV+ PERSON'S BUSINESS . . . . . C FAMILIES/NEIGHBORS RELUCTANT TO PROVIDE MONEY TOWARDS CARE FOR HIV+ PERSONS . . . . . .D FAMILY MEMBERS UNWILLING TO SHARE BED/UTENSILS WITH HIV+ PERSONS . . . . . .E OTHER _____ X (SPECIFY)	
910	If you ever saw any of the above types of stigma happening to a person because s/he is a PLWHA, would you be willing to inform to authorities or relevant groups if they existed?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
911	I don't want to know the result, but have you ever had an HIV test?	YES . . . . . 1 NO . . . . . 2 → 913	
912	The last time you had an HIV test, did you yourself ask for the test, were you encouraged to take it, was it offered to you and you accepted, or was it required?	ASK SELF . . . . . 1 ENCOURAGED TO TAKE IT . . . . . 2 WAS OFFERED . . . . . 3 WAS REQUIRED 4	
913	Finally, please tell me: In your opinion, how effective are condoms in preventing HIV infections when used correctly? Are they completely effective (100 percent) or not at all effective (0 percent) or somewhere in between? HELP THE RESPONDENT TO ESTIMATE A PERCENTAGE.	CONDOM EFFECTIVENESS ☐☐☐ DON'T KNOW 998	
	Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential.		

MCHIP

Sample List for Normal Delivery Care Client Observation

Date DAY MONTH YEAR FACILITY #

IF THERE ARE MORE THAN 25 CLIENTS, USE ANOTHER SAMPLE LIST. Expected No. of deliveries

	NAME
001	
002	
003	
004	
005	
006	
007	
008	
009	
010	
011	
012	
013	
014	
015	
016	
017	
018	
019	
020	
021	
022	
023	
024	
025	

Total deliveries Listed

Sample List for Normal Delivery Care Client Observation

Date | | | | | | | | | | | | | | | | |
DAY MONTH YEAR FACILITY #

IF THERE ARE MORE THAN 25 CLIENTS, USE ANOTHER SAMPLE LIST. | | |

	NAME
26	
27	
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Observation of Routine ("Normal") Delivery-Care Consultation

1. Facility Identification

QTYPE [O] [D] [C]

Facility Number: [ ][ ][ ][ ][ ]

Interviewer Code: [ ][ ]

Provider SERIAL Number: [ ][ ]

Provider Sex: (1=MALE; 2=FEMALE) [ ]

Provider Status: (1=Assigned; 2=Seconded) [ ]

Provider category:

SPECIALIST (OB-GYN)	01
MEDICAL OFFICER	09
CLINICAL OFFICER	10
BACHELLOR SCIENCE NURSE	11
REGISTERED NURSE	12
REGISTERED MIDWIFE	13
ENROLLED NURSE	14
ENROLLED MIDWIFE	15
NURSE AIDE	16

PROVIDER CATEGORY [ ][ ]

3. Information About Observation

Date: _____

DAY [ ][ ]

MONTH [ ][ ]

YEAR [2][0][1][0]

Name of the observer: _____

OBSERVER CODE [ ][ ]

Client code: _____

CLIENT CODE [ ][ ][ ]

ADDITIONAL SECTIONS INCLUDED (**CIRCLE**):

OBSERVATION OF POSTPARTUM HEMORRHAGE (OPH)	A
OBSERVATION OF HEMORRHAGE - REMOVAL OF PLACENTA (OHP)	C
OBSERVATION OF HEMORRHAGE - BIMANUAL COMPRESSION OF UTERUS (OHU)	D
OBSERVATION OF HEMORRHAGE - COMPRESSION OF THE ABDOMINAL AORTA (OHA)	E
OBSERVATION OF SEVERE PRE-ECLAMPSIA AND ECLAMPSIA (OPE)	F
OBSERVATION OF NEWBORN RESUSCITATION (NBR)	G
NO ADDITIONAL SECTIONS	Y

OBSERVATION OF ROUTINE (NORMAL) DELIVERY CARE:
PARTOGRAPH, ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR, AND IMMEDIATE NEWBORN CARE

No.	QUESTION / TASK	CODING CLASSIFICATION	GO TO

FIND A HEALTH WORKER INVOLVED IN DELIVERY CARE SERVICES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW 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 [NAME OF OBSERVER]. I am representing the Ministries of Health and NCAPD. We are conducting a study of all health facilities in Kenya 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 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 the 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?

				2	0	1	0
DAY		MONTH		YEAR			

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

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

READ TO CLIENT: Hello, I am_____. I am representing the Ministries of Health and NCAPD. We are conducting a study of health services in health facilities in Kenya. I would like to be present while you are receiving services today, in order to better understand how delivery services are provided in this facility. Other persons in this facility are also being asked to participate.

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 services will be provided on 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 you may quit at any time. Whether you agree to participate or not will not affect the services you receive. There is no direct benefit to you from taking part in the study but the findings will inform those in charge of improving services. If, at any point, you would prefer I leave please feel free to tell me. I can give you a phone number at the end of the consultation if you have any concerns about my presence here.

Do you have any questions for me? 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	☐☐ : ☐☐	

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
SECTION 1: INITIAL CLIENT ASSESSMENT						
	RECORD WHETHER THIS SECTION WAS OBSERVED	YES ..... 1 NO 2				→ **SEC 2**
	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)	YES	NO	NA	DK	
103	Respectfully greets the pregnant woman	1	2	5	8	
104	Introduces himself/herself	1	2		8	
105	Encourages the woman to have a support person present throughout labor and birth	1	2	5	8	
106	Asks woman (and support person, if pst) if she has any questions	1	2	5	8	
107	Checks client card or assesses for age, length of pregnancy, and parity	1	2	5	8	
108	Asks whether she has experienced at least one danger sign (headaches, fever, discharge, swelling of the hands and face, and convulsions/loss of consciousness, vaginal bleeding)	1	2	5	8	
109	Asks about complications during previous pregnancies, including at least one of these: high blood pressure, convulsions, postpartum hemorrhage, previous C-section, stillbirths, prolonged labour	1	2	5	8	
110	Washes his/her hand before any initial examination	1	2	5	8	
111	Explains procedures to woman (support person) before proceeding	1	2	5	8	
112	Takes temperature	1	2	5	8	
113	Takes pulse	1	2	5	8	
114	Takes blood pressure	1	2	5	8	
115	Asks/notes amount of urine output	1	2	5	8	
116	Tests urine for presence of protein	1	2	5	8	
117	Performs general examination (e.g., for anemia, oedema)	1	2	5	8	
118	Performs abdominal examination:					
1)	Checks fundal height, presentation and lie	1	2	5	8	
2)	Checks fetal heart rate with fetoscope / ultrasound	1	2	5	8	
119	Performs vaginal examination (cervical dilation; fetal descent, position, membranes, meconium)	1	2	5	8	
120	Informs the pregnant woman of findings	1	2	5	8	
SECTION 2: CARE AND DOCUMENTATION DURING LABOR						
	RECORD WHETHER THIS SECTION WAS OBSERVED	YES ..... 1 NO 2				→ **SEC 3**
	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)	YES	NO	NA	DK	
201	Initiated use of partograph during labor	1	2	5		
202	Which WHO partograph used Used old WHO partograph (starts at 3 cm dilatation) 1 Used new WHO partograph (starts at 4 cm dilatation) 2 Used other partograph _____ (specify): 3 DK 8					
203	Initiated used 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	5	8	
204	If "action" line reached on partograph: consults specialist / others or refers	1	2	5	8	
205	Washes his/her hands before initial examination of woman	1	2	5	8	
206	Uses drapes	1	2	5	8	
207	Explains all procedures in labor to the woman and her support person	1	2	5	8	
208	Encourages fluids/food throughout labor	1	2	5	8	
209	Encourages/assists the woman to ambulate and assume different positions throughout labor	1	2	5	8	

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
210	Sets delivery pack at bedside	1	2	5	8	
211	Wears high-level disinfected or sterile surgical gloves for vaginal examination, speculum examination, during birth, suturing and/or uterine massage	1	2	5	8	
212	Wears clean protective clothing during birth that protects face, hands and body from contact with body fluids	1	2	5	8	
213	Prepares uterotonic drug to use for AMTSL	1	2	5	8	
1)	Oxytocin					
2)	Ergometrine	1	2	5	8	
3)	Syntometrine	1	2	5	8	
4)	Prostaglandins	1	2	5	8	
214	Prepares newborn resuscitation equipment and checks that it works (DeLee suction or suction machine/tubing; ambu bag and infant-size mask; oxygen if available; tubing and mask)	1	2	5	8	
215	Supports the mother through the entire labour period (in a friendly way)	1	2	5	8	
SECTION 3: CARE DURING 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)		YES	NO	NA	DK	
300	As baby comes out, supports perineum	1	2	5	8	
301	Note time of the delivery of the baby (Use 24 hour clock):	1	2	5	8	
302	Note time the cord was clamped (Use 24 hour clock or indicate <1 minute)	1	2	5	8	
303	Verifies the presence of another fetus prior to giving the uterotonic	1	2	5	8	
304	Gives uterotonic (oxytocin, ergometrine, syntometrine, prostaglandins) a) at delivery of the anterior shoulder b) within one minute of delivery of the baby c) after delivery of the placenta	DELIVERY SHOULDER ..... 1 DELIVERY NEWBORN ..... 2 DELIVERY PLACENTA ..... 3 DOES NOT GIVE ..... 4 DON'T KNOW 8				→ 308 → 308
305	Which uterotonic given?	Oxytocin ..... 1 Ergometrine ..... 2 Syntometrine ..... 3 Prostaglandins 4				
306	Dose of uterotonic given and type of units of medication (e.g. IU, mg) (IF NECESSARY, ASK AFTERWARDS)	A) DOSE ☐☐☐ B) UNITS IU ..... 1 mg ..... 2 ML ..... 3 mcg 4				
307	Route uterotonic given:	IM ..... 1 IV push (bolus) ..... 2 IV drip ..... 3 IV drip plus IM ..... 4 ORAL ..... 5 VAGINAL ..... 6 SUBLINGUAL ..... 7 RECTAL 8				
308	Applies traction to the cord applying counter traction to the uterus	1	2	5	8	
309	Performs uterine massage immediately following the delivery of the placenta	1	2	5	8	
310	Assesses the integrity of the placenta and membranes	1	2	5	8	
311	Evaluates the quantity of vaginal bleeding	1	2	5	8	
312	Assesses for perineal and vaginal lacerations	1	2	5	8	
313	Takes vital signs 15 minutes after birth	1	2	5	8	
314	Palpates uterus 15 minutes after delivery of placenta	1	2	5	8	
314A	**IS THERE SEVERE HEMORRHAGE?**	Yes 2 1				→ OPH
		No 2 2				
314B	**ARE THERE CONVULSIONS OR OTHER SYMPTOMS OF PE/ECLAMPSIA ?.**	Yes 2 1				→ OPE
		No 2 2				

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
SECTION 4: IMMEDIATE NEWBORN CARE						
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)		YES	NO	NA	DK	
401	Immediately assesses the newborn's respiratory efforts and, if breathing normally or crying, place on the mother's abdomen "skin to skin"	1	2	5	8	
402	Immediately dries, discards the wet towel and covers with a dry towel (and hat, if available)	1	2	5	8	
403	Ties or clamps cord when pulsations stop, or by 2 - 3 minutes after birth (not immediately after birth)	1	2	5	8	
404	Cuts, and ties or clamps cord, protecting newborn from scissors or blade.	1	2	5	8	
405	Assists the mother to initiate breastfeeding within the first hour.	1	2	5	8	
406	Provides Tetracycline Eye Ointment prophylaxis	1	2	5	8	
407	Administers Vitamin K	1	2	5	8	
408	**IS NEWBORN BREATHING ?.**	Yes . . . . . 2 1 No 2 2				→ NBR
SECTION 5: INFECTION PREVENTION AND DOCUMENTATION AFTER BIRTH		YES	NO	NA	DK	
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)						
501	Disposes of all sharps in a puncture-proof container immediately after use	1	2	5	8	
502	Decontaminates all reusable instruments in 0.5% chlorine solution	1	2	5	8	
503	Disposes of all contaminated waste in leakproof containers	1	2	5	8	
504	Removes apron and wipe with chlorine solution	1	2	5	8	
505	Washes hands thoroughly with soap and water and dries them	1	2	5	8	
506	Completes summary of labour	1	2	5	8	
507	Completes maternity register/birth log	1	2	5	8	
	ASK TO SEE THE PARTOGRAPH AND CHECK:					
508	Completes partograph with birth date, time, delivery method, estimated blood loss	1	2	5	8	
509	Partograph plotted at least every half hour during labor with: fetal heart tones, maternal pulse and frequency and duration of contractions	1	2	5	8	
510	BP recorded on partograph at least every four hours during labor (as long as diastolic is less than 90mmHg)	1	2	5	8	
511	RECORD THE OUTCOME OF THE CONSULTATION. [RECORD THE OUTCOME AT THE TIME THE OBSERVATION CONCLUDED]	CLIENT GOES TO RECUPERATION WARD . . . . . 1 CLIENT REFERRED (TO OTHER PROVIDER / ROOM) AT SAME FACILITY . . . . . 2 CLIENT REFERRED TO OTHER FACILITY . . . . . 3 COMPLICATIONS - GO TO OTHER QREs (e.g. OPH, OPE) . . . . . 4 OTHER _____ (SPECIFY) . . . . 6 DON'T KNOW 8				OPH, OPE

No.	QUESTION / TASK		CODING CLASSIFICATION	GO TO
512	RECORD THE TIME THE OBSERVATION ENDED. ……..		☐☐.☐☐	
513	DID YOU SEE ANY OF THE FOLLOWING HARMFUL OR INAPPROPRIATE PRACTICES (CIRCLE ALL THAT APPLY):	USE OF ENEMA	A	
		PUBIC SHAVING	B	
		LAVAGE OF THE UTERUS AFTER DELIVERY	C	
		MANUAL EXPLORATION OF THE UTERUS AFTER DELIVERY	D	
		FUNDAL PRESSURE	E	
		RESTRICTION OF FOOD AND FLUIDS DURING LABOR	F	
		ROUTINE USE OF EPISIOTOMY	G	
		ROUTINE ASPIRATION OF NB MOUTH AND NOSE AS SOON AS HEAD IS BORN	H	
		SLAPPING NEWBORN	I	
		HOLDING NEWBORN UPSIDE DOWN	J	
		MILKING THE NEWBORN'S CHEST	K	

Observer's comments:

CHECKLIST FOR MANAGEMENT OF POSTPARTUM HEMORRHAGE

FACILITY NUMBER | | | | | |

PROVIDER SERIAL NUMBER (FROM STAFF LISTING CODE) | | | | |

OBSERVER CODE | | |

CLIENT CODE | | | |

QTYPE **O** **P** **H**

YOU SHOULD HAVE OBTAINED INFORMED CONSENT FROM THE PROVIDER MANAGING THIS CONDITION.
IF NOT, ENSURE YOU GET INFORMED CONSENT BEFORE PROCEEDING (EVEN IF ABBREVIATED).

200	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES	1	END
		NO	2	

No.	QUESTION / TASK	CODING CLASSIFIC. YES	NO	NA	DK	
	RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY HAVE BEEN PERFORMED BEFORE, OTHERS MAY BE DONE SIMULTANEOUSLY OR BY MORE THAN ONE PROVIDER)					
201	Tells the woman what is going to be done and responds to her questions and concerns.	1	2	5	8	
202	Provides reassurance to woman and/or support person, as feasible.	1	2	5	8	
203	Shouts for help to urgently mobilize all available staff.	1	2	5	8	
204	Massages the uterus to expel blood and blood clots	1	2	5	8	
205	Administers oxytocin 10 IU IM (may also give oxytocin 20 U in 1 litre IV fluids at 60 drops per minute, 0.2 mg ergometrine IM if not hypertensive, or misoprostol 600 mcg orally/rectally if oxytocin not available).	1	2	5	8	
206	If bleeding persists despite a firm uterus, inspects the perineum, vagina, and cervix for tears and repair.	1	2	5	8	
206A	IF LACERATIONS OF THE PERINEUM, CERVIX OR VAGINA ARE FOUND, INITIATES REPAIR (I.E., OBTAINS SUTURE AND INFUSES LOCAL ANESTHETIC AND REPAIRS ACCORDINGLY)	1	2	5	8	
207	Starts an IV infusion and infuse normal saline or Ringer's lactate at rate of 1 liter in 15-20 min, then 1 liter in the next 40 minutes, or as appropriate.	1	2	5	8	
208	Makes a rapid evaluation of the general condition of the woman and her vital signs (pulse, blood pressure, respirations, temperature).	1	2	5	8	
209	If shock is identified (pulse >110 beats/minute, systolic BP <90 mmHg, respirations >30/minute, pallor, cold clammy skin; anxiousness/confusion/unconsciousness, urine output <30 mL/hr), begins treatment immediately with IV infusion if not already begun and oxygen if available.	1	2	5	8	
210	If shock is identified and not responding to IV infusion, gives blood if available.	1	2	5	8	
211	If bleeding continues, performs bedside clotting test.	1	2	5	8	
212	Catheterizes the bladder.	1	2	5	8	
213	If placenta is expelled, checks to see if it is complete.	1	2	5	8	

213A	**IF PLACENTA IS NOT EXPELLED, GO TO QRE STARTING 400; MAY NEED TO RETURN TO REMAINING STEPS BELOW.**	PLACENTA EXPELLED Y PLACENTA NOT EXPELLED N	1 2	→ 400
213B	**IF PLACENTA IS EXPELLED, THERE ARE NO RETAINED FRAGMENTS AND NO TEARS, AND BLEEDING CONTINUES, PERFORMS FIRST INTERNAL BIMANUAL COMPRESSION OF THE UTERUS (CIRCLE "A" AND GO TO QRE STARTING 500)**	INTERN BIMANUAL COMPRESSION Y N	1 2	→ 500
213C	**IF NECESSARY, PERFORMS COMPRESSION OF THE ABDOMINAL AORTA (CIRCLE "B" AND GO TO QRE STARTING 600).** **MAY NEED TO RETURN TO REMAINING STEPS BELOW.**	ABDOMINAL AORTA COMPRESSION Y N	1 2	→ 600
213D	**IF ALL OF THE ABOVE IS DONE AND BLEEDING CONTINUES , SURGICAL INTERVENTION IS REQUIRED - RECORD BELOW.**			
214	Prepares for referral to another level of care as appropriate if unable to carry out these measures, or if ruptured uterus is suspected.	1	2	5	8	
215	If referred, monitors vaginal bleeding, takes the woman's vital signs, writes referral note and accompanies woman during referral (if possible).	1	2	5	8	

216	RECORD THE OUTCOME OF THE CONSULTATION.	CLIENT GOES TO RECUPERATION WARD	1
		CLIENT GOES FOR SURGERY AT SAME FACILITY	2
		CLIENT REFERRED TO OTHER FACILITY FOR SURGERY	3
		DEATH	4
		OTHER _____ (SPECIFY)	5
		DON'T KNOW	8
217	RECORD THE TIME THE OBSERVATION ENDED.		

Observer's comments:

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA

400A	QUESTIONNAIRE COMPLETED	Yes	1	QTYPE	O H P
		No	2		

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
	RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY HAVE BEEN PERFORMED BEFORE, MAY BE DONE SIMULTANEOUSLY, OR BY MORE THAN ONE PROVIDER) CIRCLE "5" (NA) IF SOMETHING IS "NOT APPLICABLE"	YES	NO	NA	DK	
GETTING READY						
400	Prepares the necessary equipment.	1	2	5	8	
401	Tells the woman (and her support person) what is going to be done, listens to her, and responds attentively to her questions/concerns, reassuring her as feasible.	1	2	5	8	
402	Asks the woman to empty her bladder or inserts a catheter.	1	2	5	8	
403	Gives parenteral anesthesia (pethidine or morphine).	1	2	5	8	
404	Gives prophylactic antibiotics (ampicillin 2 g IV PLUS metronidazole 500 mg IV).	1	2	5	8	
405	Puts on personal protective barriers.	1	2	5	8	
MANUAL REMOVAL OF PLACENTA		1	2	5	8	
406	Washes hands and forearms thoroughly and puts on high-level disinfected or sterile surgical gloves (uses elbow-length gloves, if available).	1	2	5	8	
407	Holds the umbilical cord with a clamp and pulls the cord gently.	1	2	5	8	
408	Places the fingers of one hand into the uterine cavity and locates the placenta.	1	2	5	8	
409	Provides counter-traction abdominally above the symphysis pubis.	1	2	5	8	
410	Moves arm back and forth in a smooth lateral motion until the whole placenta is separated from the uterine wall.	1	2	5	8	
411	Withdraws the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally.	1	2	5	8	
412	Gives oxytocin (20 IU) in IV fluid.	1	2	5	8	
413	Has an assistant massage the fundus to encourage atonic uterine contraction.	1	2	5	8	
414	(IF THERE IS CONTINUED HEAVY BLEEDING) gives ergometrine by IM injection (if BP is not >140/90) or prostaglandins.	1	2	5	8	
415	Examines the uterine surface of the placenta to ensure that it is complete.	1	2	5	8	
POSTPROCEDURE TASKS		1	2	5	8	
416	Removes gloves and discards them in a leak-proof container or plastic bag	1	2	5	8	
417	Washes hands thoroughly.	1	2	5	8	
418	Monitors vaginal bleeding, takes the woman's vital signs at regular intervals, and makes sure that the uterus is firmly contracted.	1	2	5	8	

CHECKLIST FOR INTERNAL BIMANUAL COMPRESSION OF THE UTERUS

500A	QUESTIONNAIRE COMPLETED	1	Yes	QTYPE	O H U
		2	No		

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
	RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY HAVE BEEN PERFORMED BEFORE, MAY BE DONE SIMULTANEOUSLY, OR BY MORE THAN ONE PROVIDER) CIRCLE "5" (NA) IF SOMETHING IS "NOT APPLICABLE"	YES	NO	NA	DK	
GETTING READY						
500	Tells the woman (and her support person) what is going to be done, listens to her and responds attentively to her questions and concerns, reassuring her as feasible.	1	2	5	8	
501	Puts on personal protective barriers.	1	2	5	8	
BIMANUAL COMPRESSION						
502	Washes hands thoroughly and puts on sterile surgical gloves.	1	2	5	8	
503	Cleans vulva and perineum with antiseptic solution.	1	2	5	8	
504	Inserts hand into anterior vaginal fornix, forms a fist, and applies pressure against the anterior wall of the uterus.	1	2	5	8	
505	Places other hand on abdomen behind uterus, presses the hand deeply into the abdomen and applies pressure against the posterior wall of the uterus.	1	2	5	8	
506	Maintains compression until bleeding is controlled and the uterus contracts.	1	2	5	8	
POSTPROCEDURE TASKS						
507	Removes gloves and discards them in leak-proof container or plastic bag	1	2	5	8	
508	Washes hands thoroughly.	1	2	5	8	
509	Monitors vaginal bleeding, takes the woman's vital signs frequently and makes sure that the uterus is firmly contracted.	1	2	5	8	

CHECKLIST FOR COMPRESSION OF THE ABDOMINAL AORTA

600A QUESTIONNAIRE COMPLETED Yes 1
No 2

QTYPE | O | H | A |

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
	RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY HAVE BEEN PERFORMED BEFORE, MAY BE DONE SIMULTANEOUSLY, OR BY MORE THAN ONE PROVIDER) CIRCLE "6" (NA) IF SOMETHING IS "NOT APPLICABLE"	YES	NO	NA	DK	
GETTING READY						
600	Tells the woman what is going to be done, listens to her, and responds attentively to her questions and concerns, reassuring her as feasible.	1	2	5	8	
COMPRESSION OF THE ABDOMINAL AORTA						
601	Places a closed fist just above the umbilicus and slightly to the left.	1	2	5	8	
602	Applies downward pressure over the abdominal aorta directly through the abdominal wall.	1	2	5	8	
603	With the other hand, palpates the femoral pulse to check the adequacy of compression.	1	2	5	8	
604	Maintains compression until bleeding is controlled.	1	2	5	8	
POSTPROCEDURE TASKS						
605	Monitors vaginal bleeding, take the woman's vital signs frequently, and ensures the uterus is firmly contracted.	1	2	5	8	

CHECKLIST FOR SEVERE PRE-ECLAMPSIA AND ECLAMPSIA

FACILITY NUMBER
PROVIDER SERIAL NUMBER (FROM STAFF LISTING CODE)
OBSERVER CODE
CLIENT CODE

QTYPE [O] [P] [E]

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
	RECORD WHETHER THE PROVIDER CARRIED OUT THE FOLLOWING STEPS AND/OR EXAMINATIONS: (SOME OF THE FOLLOWING STEPS MAY HAVE BEEN PERFORMED BEFORE, MAY BE DONE SIMULTANEOUSLY, OR BY MORE THAN ONE PROVIDER) CIRCLE "5" (NA) IF SOMETHING IS "NOT APPLICABLE"	YES	NO	NA	DK	
GETTING READY						
700	Calls for help.	1	2	5	8	
701	Greets, or acknowledges. the woman and/or her family as appropriate	1	2	5	8	
702	Keeps woman and/or family informed of condition throughout management.	1	2	5	8	
703	Rapidly evaluates vital signs (pulse, BP, breathing) and level of consciousness if not already done.	1	2	5	8	
704	**MANAGEMENT IF WOMAN IS FOUND UNCONSCIOUS**					
705	Checks airway and ensures clear airway.	1	2	5	8	
706	Props her on her left side.	1	2	5	8	
707	Checks for neck rigidity. If neck is rigid, uses appropriate isolation precautions to protect staff and other patients in case woman is found to have meningitis.	1	2	5	8	
708	**MANAGEMENT IF A WOMAN IS CONVULSING OR IF DIASTOLIC BP >110 mmHg WITH PROTEINURIA 2+ OR MORE**					
709	Gives anticonvulsant drugs as soon as vein is accessible. Gives MgSO4 4 g IV slowly over 5 minutes.	1	2	5	8	
710	Advises that she will experience a feeling of warmth when MgSO4 is given.	1	2	5	8	
711	Follows promptly with 10 g of MgSO4 solution, 5 g in each buttock as deep IM injection, with 1mL of 2% lidocaine in the same syringe.	1	2	5	8	
712	Ensures that aseptic technique is used when giving a deep IM injection.	1	2	5	8	
713	Gives diazepam IV 10 mg over 2 minutes, followed by 40 mg of diazepam in 500 ml IV fluids to keep the woman sedated but rousable.	1	2	5	8	
714	(IF DIASTOLIC PRESSURE REMAINS ABOVE 110 mmHg), gives antihypertensive drugs (nifedipine or apresoline). Attempts to reduce the diastolic BP to <100 mmHg but not below 90 mmHg.	1	2	5	8	
715	**MANAGEMENT DURING A CONVULSION**					
716	Gather equipments (airway, suction, mask and bag, oxygen) and gives oxygen at 4-6 L per minute.	1	2	5	8	
717	Protects the woman from injury but does not actively restrain her.	1	2	5	8	
718	Places the woman on her left side to reduce risk of aspiration of secretions, vomitus, and blood.	1	2	5	8	
719	After the convulsion, aspirates the mouth and throat as necessary.	1	2	5	8	
720	**MANAGEMENT OF FOLLOW-UP DOSES OF MAGNESIUM SULPHATE**					
721	(IF CONVULSIONS PERSIST OR RECUR AFTER 15 MINUTES), gives MgSO4, 2 g over 5 minutes.	1	2	5	8	
722	Continues to give MgSO4 5 g IM plus 1 mL 2% lidocaine (into alternate buttocks) every 4 hours.	1	2	5	8	
723	Before giving each dose of MgSO4, ensures that the woman's: i) respiratory rate is at least 16 breaths per minute; ii) patellar reflexes are present; iii) urinary output is at least 30 mL per hour over 4 hours.	1	2	5	8	

No.	QUESTION / TASK	CODING CLASSIFICATION				GO TO
724	**GENERAL MANAGEMENT OF ECLAMPSIA**					
725	As soon as convulsion is controlled and vein is accessible, starts an IV infusion and infuses IV fluids (normal saline or Ringer's lactate).	1	2	5	8	
726	Maintains a strict fluid balance chart and monitor amount of fluid administered and urine output to ensure that there is no fluid overload.	1	2	5	8	
727	Catheterizes the bladder using strict aseptic technique, monitors urine output, and tests urine for proteinuria.	1	2	5	8	
728	(IF URINE OUTPUT IS LESS THAN 30mL PER HOUR): i) withholds MgSO4 and infuses IV fluids at 1 L per 8 hours; ii) monitors the development of pulmonary edema.	1	2	5	8	
729	**Never leaves the woman alone** (A CONVULSION FOLLOWED BY ASPIRATION OF VOMITUS MAY CAUSE DEATH OF WOMAN AND FOETUS).	1	2	5	8	
730	Observes vital signs (including respiratory rate), reflexes, and foetal heart rate every 15 minutes, then hourly once woman is stabilized.	1	2	5	8	
731	(IN CASE OF RESPIRATORY ARREST), assists ventilation (mask and bag, intubation) and gives calcium gluconate 1 g (10mL of 10% solution) IV slowly until respiratior begins to antagonize the effects of the magnesium sulfate.	1	2	5	8	
732	Auscultates the lung bases hourly for râles indicating pulmonary oedema. If râles are heard, withhold fluids and give furosemide 40 mg IV once.	1	2	5	8	
733	Assesses clotting status with a bedside clotting test (FAILURE OF A CLOT TO FORM AFTER 7 MINUTES OR A SOFT CLOT THAT BREAKS DOWN EASILY SUGGESTS COAGULOPATHY).	1	2	5	8	
734	**GENERAL MANAGEMENT OF PREGNANCY**					
735	Assesses the cervix. (IF THE CERVIX IS FAVORABLE - SOFT, THIN, PARTLY DILATED), ruptures the membranes and induces labour using oxytocin or prostaglandins.	1	2	5	8	
736	(IF THE CERVIX IS UNFAVOURABLE - FIRM, THICK, CLOSED), ripens the cervix using, i) prostaglandins or a baloon catheter; ii) delivery by Caesarean section.	1	2	5	8	

CHECKLIST FOR NEWBORN RESUSCITATION

FACILITY NUMBER	
PROVIDER SERIAL NUMBER (FROM STAFF LISTING CODE)	
OBSERVER CODE	
CLIENT CODE	

QTYP: **N** **B** **R**

(Many of the following steps/tasks should be performed simultaneously.)

PROCEDURE	WHETHER PERFORMED

GETTING READY

Note: Newborn resuscitation equipment should be available and ready for use at all births. Hands should be washed and gloves worn before touching the newborn.

IF NOT OBTAINED PREVIOUSLY, BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE PATIENT OR CARETAKER. 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 [NAME OF OBSERVER]. I am representing the Ministries of Health and NCAPD. We are conducting a study of all health facilities in Kenya with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this patient in order to understand how Neonatal Resuscitation services are provided in this facility.

Information from this observation is confidential. Neither your name nor that of the patient 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 patients will be entered in the 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
		2010

800. CHECK TO SEE IF THE FOLLOWING EQUIPMENT AND SUPPLIES ARE LAID OUT AND PREPARED FOR USE AT TIME OF NEONATAL RESUSCITATION:

	PREPARED		
	YES	NO	DK
01. Timer (clock or watch with seconds hand)	1	2	8
02. Self-inflating ventilation bag (500 mL)	1	2	8
03. Face mask	1	2	8
04. Oxygen	1	2	8
05. Catheter	1	2	8
06. Suction machine	1	2	8
07. Bulb syringe	1	2	8
08. Gloves	1	2	8
09. At least three cloths/blankets (one to dry; one to cover; one to elevate shoulders)	1	2	8

PROCEDURE	WHETHER PERFORMED		
RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:			
801. RESUSCITATION USING BAG AND MASK			
	YES	NO	DK
01. Quickly dries and wraps or covers the newborn, except for the head, face and upper chest.	1	2	8
02. Places the newborn on his/her back on a clean, warm surface.	1	2	8
03. Tells the woman (and her support person) what is going to be done, listens to her and provides support and reassurance, as feasible.	1	2	8
04. Places the head in a neutral position to open the airway.	1	2	8
06. Clears the airway by suctioning **the mouth first** and **then the nose**:	1	2	8
06. Introduces catheter no more than 5 cm into the newborn's mouth and suction while withdrawing catheter.	1	2	8
07. Introduces catheter no more than 3 cm into each nostril and suction while withdrawing catheter.	1	2	8
08. Ensures mucus, blood or meconium is thoroughly suctioned from the newborn's mouth and/or nose	1	2	8
09 NEWBORN STARTS TO BREATHE SPONTANEOUSLY	1 = YES -> SKIPS TO Q. 21 2 = NO -> CONTINUE BELOW		
10. Quickly rechecks the position of the newborn's head to make sure that the neck is in a neutral position (not blocking the airway).	1	2	8
11. 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
12. Squeezes the bag with two fingers only or with the whole hand, depending on the size of the bag.	1	2	8
13. Checks the seal by ventilating two times and observing the rise of the chest	1	2	8
14. NEWBORN'S CHEST IS RISING	1 = YES -> CONTINUE 2 = NO -> SKIP TO 16		
15. Ventilates at a rate of 30 breaths/minute.(IF RESPONDED "1" THEN SKIP TO STEP # 21)	1	2	8
16. Checks the position of the head again to make sure the neck is in neutral position (perpendicular).	1	2	8
17. Repeats suction of mouth and nose to remove mucus, blood or meconium from the airway	1	2	8
18. Repositions the mask on the newborn's face to improve the seal between mask and face.	1	2	8
19. Squeezes the bag harder to increase ventilation pressure.	1	2	8
20. Ventilates for 1 minute and then stops and quickly assesses if the newborn is breathing spontaneously.	1	2	8

PROCEDURE		WHETHER PERFORMED			
21 BREATHING IS NORMAL (i.e., 30–60 breaths/minute) AND THERE IS NO INDRAWING OF THE CHEST AND NO GRUNTING:	1 = YES, NO INDRAWING/GRUNTING -> CONTINUE 2 = YES, BUT WITH SEVERE INDRAWING -> SKIP TO 26 3 = NO GASPING/BREATHING AFTER 20 MINUTES OF VENTILATION -> SKIP TO 31				
22. Places in skin-to-skin contact with mother.		1	2	8	
23. Explains to mother what care was given to the newborn		1	2	8	
24. Counsels mother on what signs to look for to identify recurrence of breathing difficulty and what action to take.		1	2	8	
25. Rechecks breathing after several minutes		1	2	8	
26. Checks for heart rate (femoral, cord, listening)	NORMAL HR (≥60) = 1 --> skip to 29 LOW HR (<60) = 2 --> CONTINUES BELOW				
27. Compresses chest - 3 compressions per 1 breath for a min.		1	2	8	
28. Ventilates with oxygen (SKIP TO 30).		1	2	8	
29. Encourages mother to begin breastfeeding. SKIP TO Q. 802		1	2	8	
30. Arranges immediate transfer for special care. SKIP TO Q. 802		1	2	8	
31. Stops ventilating.		1	2	8	
32. Explains to the mother (and her support person if available) what happened, listen to her and responds attentively to her questions and concerns		1	2	8	
802. POSTPROCEDURE TASKS					
01. Disposes of disposable suction catheters and mucus extractors in a leak proof container or plastic bag.		1	2	8	
02. Takes the valve and mask apart and inspects for cracks and tears.		1	2	8	
03. Washes the valve and mask and checks for damage first with 0.5% chlorine solution and then with water and detergent and rinses.		1	2	8	
04. Selects a method of sterilization or high-level disinfection: (SILICONE AND RUBBER BAGS AND PATIENT VALVES CAN BE BOILED FOR 10 MINUTES, AUTOCLAVED AT 136° C OR DISINFECTED IN AN APPROPRIATE CHEMICAL SOLUTION)		1	2	8	
05. Washes hands thoroughly with soap and water		1	2	8	
06. Air dries hands.		1	2	8	
07. After chemical disinfection, rinses all parts with clean water		1	2	8	
08. Allows parts to air dry		1	2	8	
09. Reassembles the bag.		1	2	8	
10. Tests the bag to make sure that it is functioning: Blocks the valve outlet by making an airtight seal with the palm of his/her hand and observes if the bag re-inflates when the seal is released.		1	2	8	
11. Tests the bag to make sure that it is functioning: Repeats the test with the mask attached to the bag.		1	2	8	

PROCEDURE	WHETHER PERFORMED			
803. DOCUMENTING RESUSCITATION PROCEDURES				
OBSERVE WHETHER THE PROVIDER RECORDED THE FOLLOWING DETAILS:				
1. Time of birth	1	2	8	
2. Condition of the newborn at birth (APGAR)	1	2	8	
3. Procedures necessary to initiate breathing	1	2	8	
4. Time from birth to initiation of spontaneous breathing	1	2	8	
5. Clinical observations during and after resuscitation measures	1	2	8	
6. Outcome of resuscitation measures	1	2	8	
7. In case of failed resuscitation measures, possible reasons for failure	1	2	8	
8. Names of providers involved	1	2	8	

PROVIDER

KNOWLEDGE

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Maternal Health Provider Knowledge Interview

1. Facility Identification

QTYPE ..... M H K

Facility Number: ☐☐☐☐☐

Interviewer Code: ☐☐

Provider SERIAL Number: ☐☐

Provider Sex: (1=MALE; 2=FEMALE) ☐

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

2. Provider Information

Provider category:

Specialist	01	Registered Midwife . . .	13
Medical Officer	09	Enrolled Nurse	14
Clinical Officer	10	Enrolled Midwife	15
Bachellor Sc. Nurse	11	Nurse Aid	16
Registered Nurse . .	12		

Other _____ 96
(SPECIFY)

Sex of provider: (1=Male; 2=Female)

Code for provider should be the same as the one used for all other provider interviews/observations (SL).

PROVIDER CATEGORY . . . . . ☐☐

3. Information About Interview

Date: _____

Name of the interviewer: _____

Time Interview started: _____

DAY . . . . . ☐☐

MONTH . . . . . ☐☐

YEAR 2 0 1 0

MATERNAL HEALTH PROVIDER KNOWLEDGE QUESTIONNAIRE

EXPLAIN TO THE HEALTH WORKER THAT HIS/HER NAME WAS PROVIDED AS A KNOWLEDGEABLE MATERNAL HEALTH PROVIDER AVAILABLE ON THAT DAY. VALIDATE WITH THE HEALTH WORKER THAT HE/SHE DOES PROVIDE SOME MATERNAL HEALTH SERVICES IN THIS FACILITY.

Now I will read a statement explaining the survey and asking your consent for responding to survey questions

Hello. My name is _____. I am here on behalf of the Ministries of Health and NCAPD to assist the government in knowing more about the availability of maternal, child, and reproductive health services as well as specific infectious diseases such as HIV/AIDS and tuberculosis.
Your facility was selected to participate in this study. I will be asking you specific questions about your experiences with maternal and delivery services and then will ask about various situations related to labour, delivery, and the postpartum period. We are trying to understand practices about a variety of maternal and neonatal conditions and the management of these conditions. The information you provide me is completely confidential and will not be shared with anyone else without your consent. No one, including your supervisor, will know what you tell me.

You may refuse to answer any question and may choose to stop the interview at any time. The information you provide me is extremely important and valuable, as it will help the government and the health facilities involved in Maternal Health to improve formulation of policy and the delivery of services.
Do you have any questions for me at this time?

100	Do I have your agreement to participate? Thank you. Let us begin now.	YES . . . . . 1 NO 2	→STOP
101	RECORD THE TIME AT BEGINNING OF INTERVIEW ☐☐ ☐☐		

PROVIDER KNOWLEDGE

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	Please answer the following questions to the best of your knowledge. Most of the questions I will be asking you will require multiple responses from you. Please provide all responses that come to mind. I will probe sometimes to help you remember some more information.		
	DELIVERY AND NEWBORN CARE		
103	Do you personally provide delivery care? By that I mean conducting the actual deliveries of newborns.	YES . . . . . 1 NO 2	→109
104	When was the last time that you conducted a delivery?	IN PAST WEEK ..... 1 IN PAST MONTH ..... 2 IN PAST 6 MONTHS . . . . . 3 MORE THAN 6 MONTHS AGO . . . . . 4 DON'T REMEMBER 8	
105	Please tell me, when you last conducted a delivery what observations or monitoring did you carry out during labour and delivery? PROBE FOR ANY OTHER OBSERVATIONS OR MONITORING CONDUCTED.	MONITORED FETAL HEART RATE ..... A ASSESSED DEGREE OF MOULDING . . B ASSESSED CERVICAL DILATATION . . . C ASSESSED DESCENT OF HEAD . . . . . D MONITORED UTERINE CONTRACTIONS E MONITORED MATERNAL BP . . . . . F MONITORED MATERNAL PULSE . . . . . G MONITORED MATERNAL TEMPERATURE ..... H CHECKED THE URINE ..... I CHECKED FOR AMNIOTIC FLUID - MECONIUM ..... J OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
106	Please tell me where you recorded the above-mentioned activities	ON A PARTOGRAPH ..... A IN CLIENT'S NOTES . . . . . B ON CLIENT'S ANC CARD ..... C ON A PIECE OF PAPER ..... D OTHER _____ X SPECIFY DID NOT RECORD ..... Y DON'T KNOW ..... Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
107	Of the list of procedures I am going to read you, please tell me which procedures are carried out **routinely** during labor and delivery	YES NO DK	
01	Artificial Rupture of Membranes	ARTIFICIAL RUPTURE 1 2 8	
02	Episiotomies	EPISIOTOMIES 1 2 8	
03	Shavings	SHAVING 1 2 8	
04	Suctioning of Nose and Nasopharynx of Newborn	SUCTIONING 1 2 8	
05	Enema	ENEMA 1 2 8	
06	Other Procedures _____ (SPECIFY)	OTHER 1 2 8	
108	What actions during labour and delivery would you take in an HIV+ woman to prevent / reduce mother-to-child transmission of the virus? PROBE FOR ANY OTHER ACTIONS.	PMTCT COUNSELLI' A PROVIDE ARV PROPHYLAXIS IN EARLY LABOUR …….. B WIPE NOSE, MOUTH, EYES OF NEWBORN WITH GAUZE, AVOIDING SUCTION .. C NO ROUTINE EPISIOTOMY ……. D MINIMIZE INSTRUMENT DELIVERY …….. E HIBITANE VAGINAL CLEANSING ……. F MINIMIZE VAGINAL EXAM …….. G MINIMIZE ARTIFICIAL RUPTURE OF MEMBRANES …….. H AVOID MILKING CORD/IMMEDIATE CLAMP CORD ……. I APPROPRIATE USE OF PARTOGRAPH .. J ACTIVE MGT OF 3RD STAGE LABOUR .. K PROVIDE ARV PROPHYLAXIS TO INFANT L OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
109	Please tell me, when a woman presents with or develops heavy bleeding after birth (postpartum), what signs do you look for to assess the level of risk to the woman? PROBE FOR ANY OTHER SIGNS OR SYMPTOMS.	UNCONTRACTED / ATONIC UTERUS ... A RAPID PULSE …….. B FAINT/WEAK PULSE …….. C AMOUNT OF EXTERNAL BLEEDING . . . D RETAINED PRODUCTS/PLACENTA . . . E GENITAL TRACT INJURIES …….. F PALLOR …….. G CHECK IF BLADDER IS FULL . . . . . H OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
110	In the case of tears and lacerations, in which locations of the genital tract are they likely to occur?	PERI-URETHRAL (ANTERIOR) A VAGINAL B CERVIX C PERINEUM D OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
111	What actions, diagnostic test or interventions are appropriate for a woman who presents with, or develops heavy bleeding postpartum from atonic/ uncontracted uterus? PROBE: Any other actions or interventions?	REASSURE WOMAN …….. A MASSAGE THE FUNDUS …… B EMPTY URINARY BLADDER . . . . . C GIVE UTEROTONICS IM OR IV . . . . . D PERFORM BIMANUAL COMPRESSION OF UTERUS E PERFORM ABDOMINAL COMPRESSION OF AORTA F START IV FLUIDS …….. G TAKE BLOOD FOR Hb, GROUPING AND X-MATCHING …….. H REFER TO DOCTOR OR HOSPITAL . . . . I RAISE FOOT OF BED . . . . . J OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
112	What actions, diagnostic tests or interventions are appropriate for a woman with retained placenta/ products of conception after delivery? PROBE: Any other actions or interventions?	REASSURE WOMAN ..... A EMPTY URINARY BLADDER ..... B REPEAT UTEROTONIC ..... C MANUALLY REMOVE PLACENTA/ PRODUCTS ..... D GIVE IV FLUIDS ..... E MONITOR VITAL SIGNS FOR SHOCK ... F CHECK CONTRACTION OF UTERUS ....G MASSAGE FUNDUS AFTER REMOVAL .. H GIVE ANTIBIOTICS ..... I TAKE BLOOD FOR GROUPING & X-MATCHING ..... J PREPARE FOR THEATER IF BLEEDING DOES NOT STOP ..... K REFER TO DOCTOR OR HOSPITAL ... L OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
	OBSTRUCTED LABOR		
113	Please tell me, what are the key signs of obstructed labor? PROBE: Any other signs or symptoms?	MATERNAL DISTRESS ..... A NO DESCENT OF PRESENTING PART ..... B NO CHANGE IN CERVICAL DILATION ... C BANDL'S RING ..... D SEVERE MOULDING ..... E FETAL DISTRESS ..... F CAPUT SUCCEDANEUM ..... G FIRST STAGE > 12 HRS ..... H SECOND STAGE > 2 HRS ..... I FETAL DEATH ..... J HOT DRY VAGINA ..... K INADEQUATE PELVIS ..... L OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
114	What actions or interventions are appropriate for a woman with obstructed labor? PROBE: Any other actions or interventions?	REASSURE WOMAN A START IV FLUIDS ..... B CONTINUOUS BLADDER DRAINAGE BY CATHETER ..... C ATTEMPT USE OF VENTOUSE (INSTRUMENTAL DELIVERY) ..... D PREPARE FOR C-SECTION ..... E CALL DOCTOR OR REFER ..... F PARENTERAL ANTIBIOTICS ..... G TAKE BLOOD FOR GROUPING & X-MATCHING ..... H MONITOR VITAL SIGNS ..... I OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
	POSTPARTUM INFECTIONS		
115	Please tell me, what diagnostic tests or evaluations are appropriate with a woman who presents after 72 Hrs postpartum (home delivery) with general malaise? PROBE: Any other actions or evaluations?	ASSESS FOR VAGINAL BLEEDING .... A CHECK FOR RAPID/FAINT PULSE .... B CHECK FOR HIGH FEVER ..... C CHECK FOR LOW BLOOD PRESSURE .. D CHECK FOR LOWER ABDOMINAL PAIN AND TENDERNESS ..... E CHECK FOR FOUL-SMELLING VAGINAL DISCHARGE ..... F CHECK FOR ANAEMIA DO RAPID DIAGNOSTIC TEST (MALARIA) G OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
116	What actions, diagnostic tests or interventions are appropriate for a woman with general malaise after delivery? PROBE: Any other actions or interventions?	START IV FLUIDS ..... A GIVE PARENTERAL ANTIBIOTICS ..... B GIVE ANALGESICS/ANTIPYRETICS ... C START MALARIA PROPHYLAXIS IN ENDEMIC AREAS ..... D TAKE ENDOMETRIAL SWABS ..... E DO ULTRASOUND F START MALARIA TREATMENT IF RDT IS POSITIVE ..... G PERFORM MANUAL VACUUM ASPIRATION ..... H PERFORM CONVENTIONAL EVACUATION (D&C) ..... I REFER TO DOCTOR OR HOSPITAL ... J OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
	POST-ABORTION CARE		
117	Please tell me, what information do you give to patients who present with complications resulting from incomplete or unsafe abortion? PROBE: Any other information?	STI/HIV-AIDS ..... A PAP SMEAR/VIAA/VILI ..... B FAMILY PLANNING ..... C INFERTILITY ..... D PERSONAL CARE ..... E RISKS OF ABORTION ..... F OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
	PRE-ECLAMPSIA - ECLAMPSIA		
	Now I would like to present you with a scenario you might encounter in your practice, and ask you to tell me the actions and interventions that will be needed to manage such cases. As before, there may be more than one action / intervention for each question. **For the following questions I would like to sit next to you so we can read the questions together.**		
	READ: Section One Mrs. C. is brought to the emergency department of the district hospital by her husband after she complained of a severe headache this morning. The following information is available from Mrs. C.'s antenatal record • She is 20-years old • This is her first pregnancy • She is 37 weeks of gestation • She had two antenatal care visits during this pregnancy at 20 and 33 weeks gestation and there was nothing that indicated a problem		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
118	Given the clinical information above, which information MUST be obtained IMMEDIATELY in order to initiate emergency management on her condition?	TIME OF ONSET OF PRESENT SYMPTOMS A LEVEL OF CONSCIOUSNESS ..... B FUNDAL HEIGHT C ANY CONVULSIONS ..... D CHECK VITAL SIGNS (TEMP, BP, PULSE RESPIRATIONS) ..... E LISTEN TO / ASSESS FOETAL HEART TONES ..... F FOETAL MOVEMENT G CHECK URINE PROTEIN ..... H CHECK FOR ABDOMINAL TENDERNESS I ANY LEAKING OF FLUID FROM VAGINA J CHECK FOR VAGINAL BLEEDING .... K OTHER _____ X SPECIFY DON'T KNOW ..... Z	

READ: Section Two

Mrs. C. reports onset of severe headache and blurred vision six hours prior to coming to the clinic. She denies upper abdominal pain or decreased urine output, and fetal movement is normal.

Further information:

- BP 160/120 mm Hg
- Pulse 84/minute
- Temp 37.2°C
- Respirations 18/minute
- Fetal Heart Tones 140 beats per minute
- Fundal Height Appropriate for gestational age
- Abdomen Non-tender
- Patellar reflexes Normal
- Urine 3+ protein
- Contractions Two in ten minutes lasting 20 seconds by palpation

120	Given the information presented above, what is your working diagnosis?	KIDNEY INFECTION ..... 1 SEVERE PRE-ECLAMPSIA ..... 2 MALARIA ..... 3 ECLAMPSIA ..... 4 IN LABOUR 5	
121	What action do you believe is appropriate in managing the MOST urgent presenting condition?	PROVIDE ANTIMALARIAL ..... 1 SEND HOME ON STRICT BED REST .... 2 IF AVAILABLE, STABILIZE WITH MAGNESIUM SULFATE AND ANTI-HYPERTENSIVES ..... 3 DOCUMENT FINDINGS AND IMMEDIATELY REFER MRS. C TO A HIGHER LEVEL .. 4	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
122	If Mrs. C. had been having a convulsion at the time she came to the clinic, what IMMEDIATE actions SHOULD be taken? PROBE: Anything else?	GIVE INTRAVENOUS DIAZEPAM …….. A ADMINISTER OXYGEN AT 4-6 L PER MINUTE IF AVAILABLE …….. B ACTIVELY RESTRAIN …….. C PLACE IN SIDE LYING POSITION ….. D PROTECT FROM INJURY …….. E GIVE MAGNESIUM SULFATE …….. F PROVIDE ANTIHYPERTENSIVES (NIFEDIPINE OR APRESOLINE) …….. G OTHER _____ X SPECIFY DON'T KNOW . . . . . Z	
123	What ESSENTIAL equipment and supplies MUST be available at the referral facility for someone with this condition? PROBE: Anything else?	IV WITH NORMAL SALINE OR RINGERS LACTATE …….. A URINARY CATHETER AND URINARY BAG …….. B PATELLAR HAMMER …….. C WRIST RESTRAINTS …….. D SUCTION MACHINE & CATHETER …. E OXYGEN & ADULT MASK …….. F INJECTABLE MAGNESIUM SULPHATE .. G CALCIUM GLUCONATE …….. H INJECTABLE ANTIHYPERTENSIVES …. I INJECTABLE QUININE …….. J ARTEMISININ COMBINATION THERAPY .. K OTHER _____ X SPECIFY DON'T KNOW . . . . . Z	
	READ: Scenario 3 One hour after the treatment, Mrs. C still has a moderate headache, but she has no further convulsions. Further information: • BP 140/100 mm Hg • Pulse 84/minute • Temp 37.2°C • Respirations 18/minute • Lungs Clear to auscultation • Foetal Heart Tones 140 beats per minute • Abdomen Non-tender • Urine output 40mL/hour • Patellar reflexes Normal • Contractions Three in ten minutes lasting 40–60 seconds by palpation • Cervix Soft, 4 cm dilation • Fetus Cephalic presentation, head not palpable above the symphysis pubis • Fetal Heart Tones 130–140 beats per minute		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
124	What are the APPROPRIATE next steps in management given the condition of Mrs. C at the current time? PROBE: Anything else?	REPEAT MgSO4 4 HOURS AFTER LAST DOSE IF RESPIRATIONS AND REFLEXES ARE NORMAL ..... A REPEAT MgSO4 ONLY IF MRS C HAS ANOTHER CONVULSION ..... B MAINTAIN DIASTOLIC BP BETWEEN 90-100 THRU ANTI-HYPERTENSIVES .... C ARRANGE FOR IMMEDIATE C-SECTION .. D MONITOR HER LABOUR & BEGIN PARTOGRAPH ..... E INDUCE LABOUR IMMEDIATELY ..... F AUSCULTATE LUNGS HOURLY ..... G RECORD FLUID INTAKE & OUTPUT HOURLY ..... H GET & RECORD RESPIRATIONS, REFLEXES & PATELLAR REFLEXES HOURLY ..... I USE ERGOMETRINE WITH AMTSL .... J OTHER _____ X SPECIFY DON'T KNOW ..... Z	
125	RECORD TIME THE INTERVIEW ENDED	[ ][ ] : [ ][ ]	
	Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential		

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT

Neonatal Health Provider Knowledge Interview

1. Facility Identification

QTYPE ..... | N | H | K |

Facility Number: | | | | | |

Interviewer Code: | | |

Provider SERIAL Number: | | |

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

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

2. Provider Information

Provider category:

Specialist	01	Registered Midwife . . .	13
Medical Officer	09	Enrolled Nurse	14
Clinical Officer	10	Enrolled Midwife	15
Bachellor Sc. Nurse	11	Nurse Aid	16
Registered Nurse . .	12		

Other _____ 96
(SPECIFY)

Sex of provider: (1=Male; 2=Female)

Code for provider should be the same as the one used for all other provider interviews/observations (SL).

PROVIDER CATEGORY . . . . . | | |

3. Information About Interview

Date: _____

DAY . . . . . | | |

MONTH . . . . . | | |

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

Name of the interviewer: _____

Time Interview started: _____

NEONATAL HEALTH PROVIDER KNOWLEDGE QUESTIONNAIRE

EXPLAIN TO THE HEALTH WORKER THAT HIS/HER NAME WAS PROVIDED AS A KNOWLEDGEABLE NEONATAL HEALTH PROVIDER AVAILABLE ON THAT DAY. VALIDATE WITH THE HEALTH WORKER THAT HE/SHE DOES PROVIDE SOME NEONATAL HEALTH SERVICES IN THIS FACILITY.

Now I will read a statement explaining the survey and asking your consent for responding to survey questions

Hello. My name is _____. I am here on behalf of the Ministries of Health and NCAPD to assist the government in knowing more about the availability of maternal, child, and reproductive health services as well as specific infectious diseases such as HIV/AIDS and tuberculosis.
Your facility was selected to participate in this study. I will be asking you specific questions about your experiences with delivery and neonatal services and then will ask about various situations related to labour, delivery, and the postpartum period. We are trying to understand levels of practice about a variety of maternal and neonatal conditions and the management of these conditions. The information you provide me is completely confidential and will not be shared with anyone else without your consent. No one, including your supervisor, will know what you tell me.

You may refuse to answer any question and may choose to stop the interview at any time. The information you provide me is extremely important and valuable, as it will help the government and the health facilities involved in Maternal-Neonatal Health to improve formulation of policy and the delivery of services.
Do you have any questions for me at this time?

200	Do I have your agreement to participate? Thank you. Let us begin now.	YES . . . . . 1 NO 2	→STOP
201	RECORD THE TIME AT BEGINNING OF INTERVIEW ☐☐ ☐☐		

PROVIDER KNOWLEDGE

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	Please answer the following questions to the best of your knowledge. Most of the questions I will be asking you will require multiple responses from you. Please provide all responses that come to mind. I will probe sometimes to help you remember some more information.		
	DELIVERY AND NEWBORN CARE		
203	Do you personally provide neonatal care? By that I mean conducting the actual care of newborns.	YES . . . . . 1 NO 2	→ 209
204	When was the last time that you provided care for a newborn?	IN PAST WEEK ……. 1 IN PAST MONTH ……. 2 IN PAST 6 MONTHS ……. 3 MORE THAN 6 MONTHS AGO . . . . . 4 DON'T REMEMBER ……. 8	
205	Please tell me, the last time you provided newborn care, what was the care you gave the newborn immediately after birth and in the first few hours thereafter. PROBE: Anything else?	WIPED FACE AFTER BIRTH OF HEAD . A CORD CARE (STERILE-CUT; APPLYING NOTHING TO STUMP B ENSURED BABY WAS BREATHING . . . C PROVIDED THERMAL PROTECTION . . . D BATHED NEWBORN SHORTLY AFTER BIRTH E SUCTIONED NEWBORN WITH BULB F INITIATED BREAST FEEDING WITHIN 1 HOUR . . . . . G ASSESSED/EXAMINED NEWBORN WITHIN 1 HOUR ……. H WEIGHED NEWBORN . . . . . I PROVIDED EYE PROPHYLAXIS . . . . . J ADMINISTERED VITAMIN K ……. K GAVE PRELACTEAL FEEDS …… L OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
206	Can you please tell me the signs and symptoms of infection (sepsis) in a newborn? PROBE: Anything else?	POOR/NO BREASTFEEDING . . . . . A HYPO/HYPERTHERMIA . . . . . B RESTLESSNESS/IRRITABILITY . . . . . C BREATHING DIFFICULTIES . . . . . D INFECTION FOCI ON SKIN OR IN THROAT OR EYE . . . . . E NO APPARENT SOURCE OF INFECTION F OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
207	What actions or interventions would you take for a a newborn weighing less than 2.5kg? PROBE: Anything else?	PROVIDE THERMAL PROTECTION . . . A PROVIDE EXTRA SUPPORT TO MOTHER TO ESTABLISH AND MAINTAIN BREASTFEEDING . . . . . B MONITOR NEWBORN CLOSELY FOR FOR FIRST 24 HOURS . . . . . C ENSURE INFECTION PREVENTION . . . D MONITOR SUCKING CAPACITY . . . . . E REFER TO HOSPITAL . . . . . F OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	NEONATAL RESUSCITATION		
	Now I would like to present you with a scenario you might encounter in your practice, and ask you to tell me the actions and interventions that will be needed to manage such cases. As before, there may be more than one action / intervention for each case. **For the following questions I would like to sit next to you so we can read the questions together.**		
	READ: Section One Mrs. F. is in labour and is brought to the maternity ward at the health center by her mother-in-law. The midwife on duty welcomed them and admitted Mrs. F to the labor ward. The following information is available from the history and physical exam conducted by the midwife: • 25 years old, gravida 3, para 2 • 39 weeks gestation • Previous pregnancies and deliveries: Normal • Antenatal course: Normal • Blood pressure: 110/70 mm Hg • Pulse: 84 beats per minute • Temperature: 37°C • Respirations: Normal • Fundal height: Normal for gestational age • Fetal heart tones: 132 beats per minute • Contractions: 3 in ten minutes, lasting 40 seconds • Cervical exam: 8 cm; membranes intact		
208	The midwife filled in the partograph and began preparations for the birth. What BASIC equipment and supplies must be available to ensure the baby receives appropriate IMMEDIATE CARE after birth? PROBE: Anything else?	BUTTERFLY NEEDLE A 2 DRY WARM TOWELS OR CLOTHS B SELF-INFLATING VENTILATION BAG C GLUCOSE SOLUTION D ADULT SIZE FACE MASK SIZE 1 E NEWBORN SIZE FACE MASK SIZE 0 F OXYGEN CYLINDER G MUCUS EXTRACTOR / SUCTION / BULB SYRINGE H STERILE DISINFECTED CLAMPS, SCISSORS, AND CORD TIES I FLAT SURFACE WITH WARM CLOTH J CLOCK OR WATCH WITH SECONDS K SOURCE OF WARMTH: HEATING LAMP L OTHER _____ X SPECIFY DON'T KNOW . . . . . Z	
	FOR THE FOLLOWING SECTIONS, PLEASE **GIVE THE QUESTIONNAIRE TO THE PROVIDER**, ASKING HIM/HER TO ONLY READ THE SECTIONS AS WRITTEN, AND THEN PROCEED PLACING THE RESPONSES AS INSTRUCTED.		

NO.	QUESTIONS	CODING CATEGORIES	GO TO

READ: Section 2

The midwife assisted Mrs. F to give birth to Baby K, a girl weighing 3.1 Kilos, without any difficulty. The amniotic fluid was not meconium-stained. However, Baby K did not cry at birth.

209 What actions should the midwife take? Select the ESSENTIAL ACTION STEPS in **CHRONOLOGICAL** ORDER (starting with the #1 as the first step) from the list below.(Note: some steps will not be selected)

	Action Steps	Number essential steps in chronological order	
1)	Dries baby by rubbing her head-to-toe with a dry towel/cloth		
2)	Covers baby with the used wet cloth		
3)	Throws away the used wet cloth		
4)	Observes that baby is not breathing after drying and wrapping		
5)	Wraps baby in dry second towel or cloth		
6)	Refers the mother and baby to another health facility immediately		
7)	Places the baby on her back on a firm, flat surface		
8)	Places a small folded cloth under the baby's shoulder so that the head is extended		
9)	Suctions first the baby's mouth then the nose using bulb syringe or mucus extractor		
10	Suctions only while pulling out the bulb syringe or mucus extractor		
11	Observes that baby is still not breathing after suctioning		
12	Takes no action and classifies baby as stillbirth		
13	Holds the baby upside down and gently slaps the back		
14	Briefly tells the mother her baby is not breathing and needs special assistance immediately		

READ: Section 3

The midwife observes that after performing the initial steps the baby is still not breathing.

210 What actions should the midwife take? Select the ESSENTIAL ACTION STEPS in **CHRONOLOGICAL** ORDER (starting with the #1 as the first step) from the list below.

	Action Steps	Number essential steps in chronological order
1)	Administers oxygen to the baby	
2)	Tests to make sure air is entering the lungs by squeezing the bag 2 – 3 times and observe the chest rise with each squeeze	
3)	Covers baby's nose and mouth with face mask size 1, and makes sure that a seal is formed over the chin, mouth, and nose	
4)	Ventilates the baby by squeezing the bag about 30 times per minute	
5)	Refers the mother and baby to another health facility immediately	
6)	After one minute of ventilation stops and checks to see if the baby is on her own.	
7)	Notes that the chest does not rise, so stops ventilation.	
8)	Baby breathes spontaneously 30 times/minute, and no chest indrawing or grunting is noted; discontinues ventilation with bag and mask.	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
	READ: Section 4 The midwife now observes that the baby is breathing spontaneously 40 times/minute, and has no chest indrawing or grunting.		
211	What actions should the midwife take? Select the ESSENTIAL ACTION STEPS in **CHRONOLOGICAL** ORDER (starting with the #1 as the first step) from the list below.		

	Action Steps	Number essential steps in chronological order
1)	Continues to carry out ventilation with bag and mask, adding oxygen	
2)	Documents resuscitation information on mother's record	
3)	Places the baby in skin-to-skin contact with the mother and initiates breastfeeding	
4)	Informs the mother that the baby must be referred immediately to the district hospital	
5)	Explains to the mother what care was given to the baby, what signs she should look for if breathing difficulty occurs, and what action to take	
6)	Bathes the baby with warm water	
7)	Administers an intravenous glucose solution	

PROVIDER: PLEASE GIVE THIS QUESTIONNAIRE BACK TO THE INTERVIEWER. THANK YOU.

212	INTERVIEWER: RECORD TIME THE INTERVIEW ENDED	☐☐ : ☐☐	

Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential