

COVER SHEET			
1. Facility Identification			
001	NAME OF FACILITY	_____	
002	LOCATION OF FACILITY	_____	
003	REGION	<div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div>	
004	DISTRICT	<div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div>	
005	WARD CODE	<div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div>	
006	URBAN/RURAL	RURAL URBAN	1 2
007	FACILITY NUMBER	<div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div>	
008	TYPE OF FACILITY REFERRAL HOSPITAL 01 REGIONAL HOSPITAL 02 DISTRICT HOSPITAL 03 OTHER HOSPITAL 04 SPECIALIZED HOSPITAL 05 HEALTH CENTER 06 DISPENSARY 07 STAND-ALONE (VCT, PMTCT OR ART) 08 OTHER _____ 96 <div style="text-align: center;">(SPECIFY)</div>		
009	ADJACENT TO FACILITY	YES NO	1 2
010	MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC.) 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE 5 OTHER _____ 6 <div style="text-align: center;">(SPECIFY)</div>		
2. Information about Interview			
011	Date: _____	DAY <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div> MONTH <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div> YEAR <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div>	
012	Name of the interviewer _____	INTERVIEWER CODE <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin-left: 5px;"></div>	
013	INTERVIEWER VISITS: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"> Visit 1 DATE _____ TEAM LEADER _____ </div> <div style="text-align: center;"> Visit 2 _____ _____ </div> <div style="text-align: center;"> Visit 3 _____ _____ </div> </div>		
014	RESULT CODES: 1 = COMPLETED 2 = RESPONDENT NOT AVAILABLE 3 = REFUSED 4 = PARTIALLY COMPLETED 6 = OTHER		
		RESULT CODE	<div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div>

3. GPS READING		
015	WAYPOINT NAME (FACILITY NUMBER)	<div></div> <div></div> <div></div>
016	ZONE	<div></div> <div></div> <div></div>
017	EASTING	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>
018	NORTHING	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>
4. NUMBER OF OBSERVATION/EXIT & PROVIDER QUESTIONNAIRES COMPLETED AT FACILITY:		
1	PROVIDER INTERVIEWS	<div></div> <div></div>
2	CHILD OBSERVATION	<div></div> <div></div>
3	FP OBSERVATION	<div></div> <div></div>
4	ANC OBSERVATION	<div></div> <div></div>
5	STI OBSERVATION	<div></div> <div></div>
019 CHECKED BY MONITOR/SUPERVISOR:		<div></div>
SIGNATURE _____ DATE _____		

**FACILITY CHECKLIST FOR HIV/AIDS QUESTIONNAIRES:
OUTPATIENT & INPATIENT SERVICES**

FACILITY NUMBER:

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I would like to start by asking about the overall facility organization and availability of services.

For each of the clinics/units/departments that I mention, please indicate if it exists as a separate/distinct entity in the facility and not a component of another clinic/unit/department.

IF A DISTINCT CLINIC/UNIT/DEPARTMENT EXISTS, ASK: Are services offered from this particular clinic offered only by providers from this clinic/unit/department, or are they offered by providers from the OPD, IPD or other clinic/unit/department.

IF THE CLINIC/UNIT/DEPARTMENT EXISTS AS A DISTINCT ENTITY, LIST IT AND DETERMINE WHAT APPLICABLE SPECIALTY QUESTIONNAIRES NEED TO BE COMPLETED FOR THAT CLINIC/UNIT/DEPARTMENT, MARKING THE SERVICE BOX ON THE SAME LINE AS THAT CLINIC/UNIT/DEPARTMENT. COMPLETE AN OPD/IPD QRE FOR ALL LISTED UNITS, AS WELL AS THE INDICATED SPECIALTY QRE FOR SERVICES PROVIDED FROM THAT MAIN CLINIC/UNIT. IN THE "ELIGIBLE QUESTIONNAIRE" COLUMN, INDICATE WITH AN " / " IF A PARTICULAR QUESTIONNAIRE IS REQUIRED, AND AS SOON AS THAT SECTION IS DONE, MAKE A COMPLETE "X" IN THE BOX TO INDICATE THAT THIS SECTION WAS REQUIRED AND IT IS DONE

LINE #	CLINIC/UNIT	DESCRIPTION OF CLINIC/UNIT	ELIGIBLE QUESTIONNAIRES (QRE) SERVICE PROVIDED							
			Mod B or C OPD or IPD	Mod D HMIS	Mod E LAB	Mod F PHARM	Mod G TB	Mod H VCT	Mod I ART	Mod J PMTCT
01	1 8	Service statistics (HMIS/med records)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	1 9	Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	2 0	Pharmacy/Medical supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04		Outpatient (OPD) or Inpatient (IPD)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
07			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OUTPATIENT (OPD) CLINIC/UNITS

01= General Outpatient	09= Specific HIV/AIDS Only (may be ART unit)	17= Social Services Department/home based care/ community services (HIV/AIDS specific)
02= Pediatric Outpatient	10= Specific Diagnoses (Including HIV/AIDS)	18= Service statistics/medical records/HMIS
03= Antenatal Care	11= STI	19= Laboratory (OPD &/or IPD)
04= Family Planning	12= Gynecology	20= Pharmacy
05= Delivery (Outpatient)	13= Urology	96= Other OPD _____
06= Tuberculosis (TB)	15= Emergency/Casualty	(SPECIFY)
07= VCT or CT (may be stand alone)		
08= PMTCT	16= Social Services Department/ home-based care/community services (not HIV/AIDS specific)	

INPATIENT (IPD) UNITS

22=Inpatient medical (adult or adult and pediatric)	26= HIV/AIDS Only Inpatient	30= Hospice
23= Inpatient medical/surgical (adult or adult and pediatric)	27= Specific Diagnoses (Including HIV/AIDS)	97= Other IPD
24=Inpatient surgical (adult or adult and pediatric)	28= Tuberculosis (TB)	
25=Inpatient pediatric	29= Delivery (Inpatient)	

LINE #	CLINIC/UNIT	DESCRIPTION OF CLINIC/UNIT	ELIGIBLE QUESTIONNAIRES (QRE) SERVICE PROVIDED							
			Mod B or C OPD or IPD	Mod D HMIS	Mod E LAB	Mod F PHARM	Mod G TB	Mod H VCT	Mod I ART	Mod J PMTCT
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
			OPD or IPD	HMIS	LAB	PHARM	TB	VCT	ART	PMTCT
TOTAL QRES COMPLETED										

OUTPATIENT (OPD) CLINIC/UNITS		
01= General Outpatient	09= Specific HIV/AIDS Only (may be ART unit)	17= Social Services Department/home based care/ community services (HIV/AIDS specific)
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23= Inpatient medical/surgical (adult or adult and pediatric)	27= Specific Diagnoses (Including HIV/AIDS)	97= Other IPD
24=Inpatient surgical (adult or adult and pediatric)	28= Tuberculosis (TB)	
25=Inpatient pediatric	29= Delivery (Inpatient)	

1. General Information/Overview			
Facility Number: 		Interviewer Code: 	
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR PATIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and National Bureau of Statistics to assist the government in knowing more about health services.</p> <p>Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p>			
Interviewer's signature (Indicates respondent's willingness to participate)		Date	
100	May I begin the interview?	YES 1 NO 2	→ STOP
First I would like to ask you some general questions about how this facility is organized, and what infrastructure and resources are available. Then I will have some specific questions about HIV/AIDS services that may be provided from this facility.			
101	In addition to regular healthcare services, does the facility ever provide services for clients who are known or suspected to be HIV/AIDS infected or to have HIV/AIDS related illnesses?	YES 1 NO 2	→ 103
102	Is there one person who is responsible overall for services specifically related to HIV/AIDS services? IF YES, ASK THE NAME AND ASK IF THAT PERSON CAN BE CALLED TO PARTICIPATE IN THE GENERAL DISCUSSION. IF THERE IS A DIFFERENT PERSON FOR INPATIENT AND FOR OUTPATIENT SERVICES RELATED TO HIV/AIDS ASK FOR THE PERSON MOST KNOWLEDGEABLE ABOUT OUTPATIENT SERVICES RELATED TO CARE AND SUPPORT FOR HIV/AIDS CLIENTS WHO IS AVAILABLE TODAY. WHILE THE HIV/AIDS PERSON IS BEING CALLED, CONTINUE WITH Q103.	YES, 1 NAME OF HIV/AIDS SERVICE RESPONSIBLE PERSON NO ONE PERSON RESPONSIBLE FOR HIV/AIDS SERVICES ... 2	

2. Information About Services				
NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
103	How many days each week is the facility routinely open for outpatient curative services?	NUMBER OF DAYS <input type="text"/> DON'T KNOW 8		
104	Does a trained health provider live on the facility premises?	YES 1 NO 2		
105	Is there a trained health provider assigned to and present at the facility at all times (24 hours a day) for emergencies? IF YES, ASK: Is there a duty schedule 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		→107
106	Is there a trained health provider 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 for 24-hour staff coverage? IF YES, ASK TO SEE THIS.	YES, DUTY SCHEDULE OBSERVED 1 YES, 24-HR ON CALL STAFF NO DUTY SCHEDULE SEEN ... 2 NO 24-HOUR ON CALL STAFF ... 3		
107	Now I have some questions about staffing for this facility. Please tell me how many staff with this qualification this facility is authorized to have, that is staffing norms, and then tell me how many staff with this qualification are actually in post and the average full time numbers at post past 3 months. We want to know the highest technical qualification that any staff may hold (such as a nurse or doctor) regardless of the person's actual assignment or specialist studies. IF NO STAFFING NORM, RECORD '000'			
	QUALIFICATION	(a) STAFFING NORMS	(b) ACTUAL NUMBER IN POST	(c) AVERAGE NUMBER FULL-TIME AT POST PAST 3 MONTHS
01	Anaesthesiologist/Anaesthetist	<input type="text"/>	<input type="text"/>	<input type="text"/>
02	Clinical Officer Anaesthetist	<input type="text"/>	<input type="text"/>	<input type="text"/>
03	Nurse Anaesthetist	<input type="text"/>	<input type="text"/>	<input type="text"/>
04	Obstetrician/Gynaecologist	<input type="text"/>	<input type="text"/>	<input type="text"/>
05	Surgeon	<input type="text"/>	<input type="text"/>	<input type="text"/>
06	Pediatrician	<input type="text"/>	<input type="text"/>	<input type="text"/>
07	Other Physician Specialist/Consultant	<input type="text"/>	<input type="text"/>	<input type="text"/>
08	Medical Doctor	<input type="text"/>	<input type="text"/>	<input type="text"/>
09	Medical Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>
10	Assistant Medical Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>
11	Other Clinical Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>
12	Registered Nurse/Nursing Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>
13	Nurse Midwife	<input type="text"/>	<input type="text"/>	<input type="text"/>
14	Public Health Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>
15	Trained Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
	QUALIFICATION	(a) STAFFING NORMS	(b) ACTUAL NUMBER IN POST	(c) AVERAGE NUMBER FULL-TIME AT POST PAST 3 MONTHS	
16	Auxiliary Nurse/Medical Attendant . .	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
17	Pharmacist	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
18	Pharmaceutical Technician	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
19	Pharmaceutical Assistant	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
20	Laboratory Technologist	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
21	Laboratory Technician	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
22	Laboratory Assistant	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
23	Nutritionist/Nutrition Technician	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
24	Health Education Officer	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
25	Record Technician/Statistical Clerk . .	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
26	Health Administrative Officer	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
27	Social Worker	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
28	HIV/AIDS Counselor	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
29	Other Counselor	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
30	Pathologist	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
31	Clinical Assistant	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
32	All other staff with clinical training or providing client services	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
33	All other support staff (non-clinical manager, medical records, cleaners, etc)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
34	SUM THE NUMBER OF STAFF REPORTED IN COLUMN (b)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	You have told me that there are (TOTAL STAFF) who are employed by this facility. Is this correct? IF NOT CORRECT, PROBE AND CHANGE ITEM 107 (01-33) AS NECESSARY.				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																				
108	In addition to the previously mentioned staff, who are employed by the facility, does this facility have any people who are not officially employed but who work routinely (either full or part time part time) and who provide client services? This might include seconded staff from other organizations or volunteers.	YES 1 NO 2	→ 111																																				
109	Please tell me the qualification of the people who are seconded to the facility and indicate if they work specifically with HIV/AIDS related services or with other services.	<table border="1"> <thead> <tr> <th></th><th colspan="2">SERVICES</th></tr> <tr> <th></th><th>(a) HIV/AIDS ONLY</th><th>(b) OTHER</th></tr> </thead> <tbody> <tr> <td>DOCTOR . . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>MEDICAL OFFICER . . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>AMO . . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>CLINICAL OFFICER . . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>NURSE . . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>COUNSELOR .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>LAB TECH/ ASSISTANT .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>COMMUNITY WORKER . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>OTHER . . .</td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>(SPECIFY)</td><td></td><td></td></tr> </tbody> </table>		SERVICES			(a) HIV/AIDS ONLY	(b) OTHER	DOCTOR . . .	<input type="text"/>	<input type="text"/>	MEDICAL OFFICER . . .	<input type="text"/>	<input type="text"/>	AMO . . .	<input type="text"/>	<input type="text"/>	CLINICAL OFFICER . . .	<input type="text"/>	<input type="text"/>	NURSE . . .	<input type="text"/>	<input type="text"/>	COUNSELOR .	<input type="text"/>	<input type="text"/>	LAB TECH/ ASSISTANT .	<input type="text"/>	<input type="text"/>	COMMUNITY WORKER . .	<input type="text"/>	<input type="text"/>	OTHER . . .	<input type="text"/>	<input type="text"/>	(SPECIFY)			
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OTHER . . .	<input type="text"/>	<input type="text"/>																																					
(SPECIFY)																																							
110	SUM THE NUMBER OF SECONDED STAFF IN Q109 WHO WORK WITH THE FACILITY.	TOTALS <input type="text"/>																																					
111	How many staff (either regular or seconded) work here who are foreign? PROBE, IF NECESSARY	NUMBER OF FOREIGN STAFF <input type="text"/> DON'T KNOW98																																					
112	Do you have an estimate of the size of the catchment population that this facility serves that is, the target, or total population living in the area served by this facility? IF YES: How many people is that?	CATCHMENT POPULATION <input type="text"/> NO CATCHMENT AREA 9999995 DON'T KNOW SIZE OF CATCHMENT POPULATION 9999998																																					
113	Does this facility routinely provide inpatient care?	YES 1 NO 2	→115																																				
114	Does this facility have beds for overnight observation?	YES 1 NO 2	→116																																				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO				
115	How many overnight or inpatient beds does this facility have?	NUMBER OF BEDS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>					
116	Does this facility have routine meetings for reviewing managerial or administrative matters?	YES 1 NO 2 DON'T KNOW 8	→119 →119				
117	How often do meetings to discuss the facility managerial and administrative matters take place?	MONTHLY OR MORE OFTEN .. 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS THAN EVERY 6 MONTHS OR IRREGULARLY 4	→119				
118	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 SEEN 2 NO RECORD MAINTAINED 3					
119	Are there any <i>routine</i> meetings about facility activities or management issues that include both facility staff and community members?	YES 1 NO 2 DON'T KNOW 8	→122 →122				
120	How often are routine meetings held with both facility staff and community members?	MONTHLY OR MORE OFTEN .. 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS THAN EVERY 6 MONTHS OR IRREGULARLY 4	→122				
121	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					
122	Does this facility have any system for determining clients' opinions about the health facility or its services? IF YES, CIRCLE ALL METHODS THAT ARE USED FOR ELICITING CLIENTS' OPINIONS. PROBE FOR ALL METHODS USED.	SUGGESTION BOX A CLIENT SURVEY FORM B CLIENT INTERVIEW FORM C OFFICIAL MEETING WITH COMMUNITY LEADERS D INFORMAL DISCUSSIONS WITH CLIENT OR COMMUNITY E OTHER X (SPECIFY) NO CLIENT FEEDBACK Y DON'T KNOW Z	→125 →125				
123	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					
124	In the past 3 months, have any changes been made in the program as a result of client opinion? IF YES, INDICATE IF THE CHANGE(S) ARE RELATED TO ANY OF THE LISTED TOPICS.	YES, CHANGE IN SERVICES OR TIMES OFFERED OR WAY SERVICES ARE PROVIDED A YES, CHANGE FOR CLIENT COMFORT B OTHER X (SPECIFY) NO Y DON'T KNOW Z					

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
125	Does this facility routinely carry out quality assurance activities? By this I mean some formal review system or comparison of work or systems to a standard?	YES	1			→129
		NO	2			→129
		DON'T KNOW	8			
126	Is this system implemented throughout the facility or only in specific services?	THROUGHOUT FACILITY	1			
		ONLY SPECIFIC SERVICES ...	2			
127	Now I want to ask about common quality assurance activities. For each activity I ask, please tell me if this is used anywhere in the facility. IF YES, ASK: Can I see some document or record that shows this has been carried out during the past year? A REPORT OR MINUTES OF A MEETING WHERE THE QA ACTIVITY IS REFERRED TO ARE ACCEPTABLE.					
		METHOD USED				
		DOCUMENT OBSERVED	DOCUMENT REPORTED, NOT SEEN	METHOD NOT USED	DON'T KNOW	
01	Supervisory checklist of health system components (such as service-specific equipment, medications, and records)	1	2	3	8	
02	Supervisory checklist of health service provision (such as an observation checklist)	1	2	3	8	
03	Facility-wide review of mortality	1	2	3	8	
04	Periodic audit of medical records or service registers	1	2	3	8	
05	Quality assurance committee or staff reports	1	2	3	8	
06	Other _____ (SPECIFY)	1	2	3	8	
128	Please tell me who is responsible for the quality assurance activities, and if they are assigned within the facility (INTERNAL) or outside the facility (EXTERNAL) or both from within and external to the facility.					
	FOR EACH OF THE LISTED OPTIONS, INDICATE WHICH RESPONSE BEST DESCRIBES THE PERSONNEL RESPONSIBLE FOR QUALITY ASSURANCE	INTERNAL TO FACILITY	EXTERNAL TO FACILITY	BOTH INTERNAL AND EXTERNAL	NOT AC-TIVE WITH QUALITY ASSUR-ANCE	DK
01	Individual staff members	1	2	3	4	8
02	Individual supervisors	1	2	3	4	8
03	Management committee (MAY BE DISTRICT OR REGIONAL MANAGEMENT TEAM)	1	2	3	4	8
04	Special quality assurance committee or team	1	2	3	4	8
05	Special quality assurance staff	1	2	3	4	8
06	Other _____ (SPECIFY)	1	2	3	4	8

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
129	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	→131 →131
130	The most recent time during the past 6 months that a supervisor from outside the facility visited, did he or she	<div>YES NO DON'T KNOW</div>	
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	
131	When you refer a client to another facility for services, do you use an official referral form? That is a preprinted form that specifies information about the client that should be shared? IF YES, ASK: May I see a copy of the form?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN . . . 2 NO FORM USED 3 NEVER REFER CLIENTS 4 DON'T KNOW 8	→133
132	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD . . . 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) . . . 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER 6 (SPECIFY) NO 7	
133	Does this facility have a program for routine maintenance and repair of infrastructure ? IF YES, ASK: Is the person responsible for maintenance and repair of infrastructure assigned to the facility, or from outside the facility?	YES, ONSITE STAFF 1 YES, OUTSIDE SUPPORT 2 YES, BOTH ONSITE AND OUTSIDE STAFF 3 NO ROUTINE MAINTENANCE . . . 4 DON'T KNOW 8	
134	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. IF YES, ASK: Is the person responsible for routine preventive maintenance for major equipment assigned to the facility or from outside the facility?	YES, ONSITE STAFF 1 YES, OUTSIDE SUPPORT 2 YES, BOTH ONSITE AND OUTSIDE STAFF 3 NO ROUTINE MAINTENANCE . . . 4 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
135	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 _____ X (SPECIFY) NO SYSTEM Y DON'T KNOW Z	
136	Does this facility have any routine user-fees or charges for any services for sick adults? This includes any fees, including those for registration or for client health records.	YES 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES 2	→139
137	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for sick adults:	YES NO DON'T KNOW	
01	Is there a fee for the client health card?	CLIENT CARD 1 2 8	
02	Is there a fee for each consultation?	CONSULTATION 1 2 8	
03	Does the user fee vary depending on the diagnosis?	FEE VARIES BY 1 2 8 DIAGNOSIS	
04	Are there user fees for medications?	MEDICINE 1 2 8	
05	Are there user fees for laboratory tests?	TESTS 1 2 8	
06	Is there a fee for registration?	REGISTRATION 1 2 8	
07	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ 1 2 8 EXEMPTIONS	
08	Is there a system for clients to pre-pay for multiple visits for curative care?	PRE-PAY FOR 1 2 8 MULTIPLE	
138	Are the official fees posted 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	
139	Does this facility receive any funding that helps to cover the cost of services provided to clients, other than from the routine running budget or direct client fees? For example, do insurance programs, the government, community programs, or donors ever reimburse the facility for services provided to clients for whom fees were exempted or discounted? IF YES, ASK: Which type of plans are used? PROBE FOR RESPONSE.	EQUITY (CHARITY) FUND A FOR POOR REIMBURSED BY EMPLOYER OF CLIENT B INSURANCE C OTHER _____ X (SPECIFY) NO Y DON'T KNOW Z	
140	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 A PRIVATE CAR/BUS B PUBLIC CAR/BUS C MOTORCYCLE D BICYCLE E PEOPLE CARRY/PUSH OR PULL PATIENT F ANIMALS CARRY/PULL PATIENTS G OTHER _____ X (SPECIFY) NEVER RECEIVE REFERRALS ... Y DON'T KNOW Z	
141	Does this facility have a functional ambulance or other vehicle for emergency transportation for clients? ACCEPT REPORTED RESPONSE.	YES 1 NO 2 DON'T KNOW 8	→143 →143
142	Is fuel available today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
143	Please tell me if this facility has any of the following systems to support emergency 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 transportation?	HIRE VEHICLE 1 2 8	
03	Is there a community health insurance scheme that helps to fund emergency referrals?	COMMUNITY SUPPORT 1 2 8	
04	Is fuel set aside for emergency referrals?	FUEL SET ASIDE 1 2 8	
05	Is there a revolving fund system for transportation for emergency referrals?	REVOLVING FUND 1 2 8	
06	Does the facility radio or phone another facility to send transportation for emergency referrals?	PHONE FOR TRANSPORT 1 2 8	
07	Is there any other system? If YES, SPECIFY _____	OTHER 1 2 8	
144	Does this facility have a generator for electricity? This may be a back-up or stand-by generator.	YES, OBSERVED 1 YES, REPORTED NOT SEEN ... 2 NO 3 DON'T KNOW 8	→ 146 → 146
145	Is the generator functional and is there fuel today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES, FUNCTIONAL WITH FUEL . 1 YES, FUNCTIONAL, NO FUEL 2 NOT FUNCTIONAL 3 DON'T KNOW 8	
146	Does this facility ever obtain electricity from a source other than a generator?	YES, CENTRAL SUPPLY 1 YES, SOLAR OR OTHER SOURCE 2 NO 3	→ 149
147	Is the electricity (not including any backup generator) always available during the times when the facility is providing services, or is it sometimes interrupted?	ALWAYS AVAILABLE 1 SOMETIMES INTERRUPTED ... 2	→ 149
148	IF SOMETIMES INTERRUPTED, ASK: How many <i>days</i> during the past week was the electricity <i>not available for at least 2 hours</i> during a time the facility was open for services? THIS INCLUDES EMERGENCY SERVICES.	NUMBER OF DAYS <i>NOT AVAILABLE</i> PAST WEEK . <input type="text"/> NEVER INTERRUPTED 2 HOURS OR MORE 0	
149	What is the <i>most commonly used</i> source of water for the facility <i>at this time</i> ?	PIPED FROM PROTECTED SOURCE 10 PIPED FROM UNPROTECTED SOURCE 11 PIPED FROM UNKNOWN SOURCE 12 NON-PIPED PROTECTED (E.G., PROTECTED WELL) ... 20 NON-PIPED UNPROTECTED (E.G. UNPROTECTED WELL, RAIN) ... 21 RIVER OR LAKE OR POND 30 OTHER 96 (SPECIFY) DON'T KNOW 98 NO WATER SOURCE 00	→ 153

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
150	Is water outlet from this source available onsite (that is, within 500m of the facility?) REPORTED RESPONSE IS ACCEPTABLE	YES, ONSITE 1 NO 2	
151	Does the availability of water from this source vary by season?	YES 1 NO 2	
152	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES 1 NO 2	
153	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.	YES, LANDLINE 1 YES, CELL PHONE 2 YES, PAY PHONE OR PERSONAL CELL PHONE ONLY 3 YES, RADIO 4 NO 5	→155 →155 →155 →155
154	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	
155	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	→ 157
156	Is there ever access to email/internet within the facility? (REPORTED RESPONSE IS ACCEPTABLE)	YES 1 NO 2	
157	AT THIS TIME CHECK Q101 TO SEE IF THE FACILITY OFFERS HIV/AIDS RELATED SERVICES.	YES 1 NO 2	→169
158	Are new staff who work with HIV/AIDS clients in any capacity, routinely trained or instructed on a policy for confidentiality and disclosure of HIV test results or client status?	YES 1 NO 2 DON'T KNOW 8	
159	Now I want to ask you about post-exposure prophylaxis (PEP) for people who may have been exposed to HIV. Are at-risk clients, for example, rape victims, offered or referred for PEP? IF YES, ASK: Is the PEP provided in this facility, or are clients referred elsewhere for PEP?	YES, PEP IN THIS FACILITY . . . 1 YES, REFERRED TO OTHER FACILITY FOR PEP 2 NO PEP AVAILABLE 3 DON'T KNOW 8	
160	Is PEP available for staff in this facility if they are exposed to HIV? IF YES, ASK: Is the PEP available in this facility or do staff receive PEP from another facility?	YES, THIS FACILITY 1 YES, OTHER FACILITY ONLY . . . 2 NO PEP AVAILABLE 3	→169

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
161	Is there a central location in the facility where staff receive prescriptions or referrals for PEP?	YES 1 NO, PROVIDERS IN VARIOUS SITES PRESCRIBE PEP ... 2 NO PEP DRUGS AND NO SYSTEM FOR REFERRAL ... 3	→ 169
162	GO TO MAIN PEP SERVICE SITE. IF NO CENTRAL SERVICE SITE FOR PEP, GO TO MAIN STORAGE SITE FOR PEP MEDICINES. Is there a centrally maintained register or record that shows that a worker has been prescribed PEP or has been referred for PEP? IF YES, ASK: May I see the register/record? GO TO WHERE THE RECORD/REGISTER IS MAINTAINED AND CHECK 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 NO RECORDS THIS LOCATION, BUT RECORDS KEPT IN DIFFERENT SERVICE UNITS E NO RECORD, INFORMATION IN INDIVIDUAL HEALTH RECORDS ONLY F NO RECORD FOR PEP Y	
163	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES.	YES, OBSERVED, COMPLETE... 1 YES, OBSERVED, INCOMPLETE 2 YES, REPORTED, NOT SEEN ... 3 NO 4	
164	ASK TO GO TO THE MAIN PLACE IN THE FACILITY WHERE PEP MEDICINES ARE STORED, AND INDICATE IF MEDICINES ARE AVAILABLE, AND IF YES, IF INFORMED CONSENT WAS RECEIVED FROM RESPONDENT.	NO PEP MEDICINES IN FACILITY 1 PEP MEDICINES STORED SAME AREA AS ARVS FOR TREATMENT 2 YES, INFORMED CONSENT ... 3 NO INFORMED CONSENT 4	→ 169 → 169
165	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	COMBIVIR (ZDV/3TC) A STAVUDINE/LAMIVUDINE B STAVUDINE/LAMIVUDINE <i>plus</i> INDINAVIR C STAVUDINE/LAMIVUDINE and EFV or NVP D OTHER COMBINATION E _____(SPECIFY)_____ OTHER ONE ARV USED ALONE F _____(SPECIFY)_____ NONE Y	→ 169
166	What is the PEP regimen that is most commonly prescribed?	COMBIVIR (ZDV/3TC) 1 STAVUDINE/LAMIVUDINE 2 STAVUDINE/LAMIVUDINE <i>plus</i> INDINAVIR 3 STAVUDINE/LAMIVUDINE and EFV or NVP..... 4 OTHER ONE ARV USED ALONE 5 _____ OTHER 6 _____(SPECIFY)_____	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
167	DESCRIBE THE STORAGE OF THE PEP MEDICINES. ARE THE PEP MEDICINES STORED IN A LOCKED STORAGE UNIT AND SEPARATE FROM OTHER MEDICINES OR SUPPLIES?	STORED ALONE 1 STORED WITH OTHER ARVS AND APART FROM OTHER MEDICINES 2 STORED WITH NON-ARV MEDS 3 OTHER 6 (SPECIFY)	
168	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	
ASK THE RESPONDENT TO TAKE YOU TO THE MAIN AREA WHERE EQUIPMENT IS CLEANED AND STERILIZED OR DISINFECTED AND ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE PROCESSES USED.			
169	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 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 95	→ 176
170	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	
171	Besides decontaminating and cleaning , what is the method most commonly used for sterilizing reusable syringes and needles? CIRCLE ALL THAT APPLY.	DRY-HEAT STERILIZATION ... A AUTOCLAVING B BOILING C STEAM D CHEMICAL METHOD E DISCARD/DISPOSABLES ONLY F OTHER X (SPECIFY) NONE Y	
172	Besides decontaminating and cleaning , what is the final process most 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 MINOR SURGICAL EQUIPMENT.	DRY-HEAT STERILIZATION ... A AUTOCLAVING B BOILING C STEAM D CHEMICAL METHOD E PROCESS OUTSIDE FACILITY F OTHER X (SPECIFY) NONE Y	→ 174(6) → 174(6)

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
	GO TO WHERE EQUIPMENT IS PROCESSED AND ASK IF THE INDICATED ITEMS ARE AVAILABLE IN THE MAIN PROCESSING AREA, AND ASSESS THE FUNCTIONING STATUS AND PROCEDURES FOLLOWED AT THIS SITE.							
173	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 (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 or disinfection	1	2	3	8			

174 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 without pressure	(5) Chemical High Level Disinfectant (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 → 175
B Temperature (centigrade)	TEMPERATURE [][] AUTOMATIC 666 DONT KNOW ... 998	TEMPERATURE [][] AUTOMATIC 666 DONT KNOW ... 998				
C Pressure		PRESS- URE [][] AUTOMATIC 666 → 2E DONT 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 DONT KNOW ... 998	MINUTES [][] AUTOMATIC 666 DONT KNOW 998	MINUTES [][] DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998
F Minutes when equipment is wrapped		MINUTES WRAPPED [][] AUTOMATIC 666 DONT KNOW ... 998				
G Chemical disinfectant used	GIK 1 CHLORINE 2 CIDEX 3 BETADINE 4 ALCOHOL 5 OTHER 6 DONT KNOW 8					GIK 1 CHLORINE 2 CIDEX 3 BETADINE 4 ALCOHOL 5 OTHER 6 DONT KNOW 8
H Percent solution before dilution	PERCENT [][] DONT KNOW 98					PERCENT [][] DONT KNOW 98
I Mixture, parts solution and water	MIXTURE PARTS a) DISINFECTANT [][] b) WATER [][] DK 000					MIXTURE PARTS a) DISINFECTANT [][] b) WATER [][] DK 000

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
175	ASK TO SEE WHERE CENTRAL OR EXTERNALLY PROCESSED ITEMS ARE STORED AND INDICATE FOR EACH OF THE BELOW IF THIS STORAGE PRACTICE WAS OBSERVED OR REPORTED.	OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile cloth, 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 clean	1	2	3	8	
07	Other not clean	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
09	Is storage location dry and clean?	1	2	3	8	
176	Now I would like to ask you a few questions about the waste disposal practices for sharp items such as needles or blades . How does this facility finally dispose of sharp items, or what is the final disposal process for filled sharps boxes?	BURNED IN INCINERATOR . . 02 BURNED AND BURIED 03 BURNED AND REMOVED TO OFFSITE DUMP 04 BURNED AND NOT BURIED . 05 BURIED, NOT BURNED . . . 06 THROWN IN TRASH/OPEN PIT 07 THROWN IN PIT LATRINE . . 08 REMOVED OFFSITE 09 OTHER _____ 96 (SPECIFY)				
177	Now I would like to ask you a few questions about the waste disposal practices for hazardous waste such as used bandages. How does this facility finally dispose of contaminated waste?	SAME AS FOR SHARP ITEMS 01 BURNED IN INCINERATOR . . 02 BURNED AND BURIED 03 BURNED AND REMOVED TO OFFSITE DUMP 04 BURNED AND NOT BURIED . 05 BURIED, NOT BURNED . . . 06 THROWN IN TRASH/OPEN PIT 07 THROWN IN PIT LATRINE . . 08 REMOVED OFFSITE 09 OTHER _____ 96 (SPECIFY)				→ 179
178	ASK TO SEE THE PLACE USED FOR WASTE DISPOSAL OF SHARP ITEMS 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.	WASTE VISIBLE, <i>NOT</i> PROTECTED 1 WASTE VISIBLE, PROTECTED 2 NO WASTE VISIBLE 3 WASTE SITE NOT INSPECTED 8				
179	ASK TO SEE THE PLACE USED FOR WASTE DISPOSAL OF CONTAMINATED 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.	WASTE VISIBLE, <i>NOT</i> PROTECTED 1 WASTE VISIBLE, PROTECTED 2 NO WASTE VISIBLE 3 WASTE SITE NOT INSPECTED 8				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
180	CHECK Q176 AND Q177 ; IS 04 OR 09 CIRCLED (ANY WASTE REMOVED OFFSITE FOR DISPOSAL?) YES <input type="checkbox"/> NO <input type="checkbox"/>		182
181	How is the waste that is collected and removed offsite finally disposed?	INCINERATED 1 TAKEN TO LOCAL DUMP AND BURNED 2 TAKEN TO LOCAL DUMP AND NOT BURNED 3 OTHER 6 (SPECIFY) DON'T KNOW 8	
182	Is there a waiting area for clients where they are protected from sun and rain?	YES 1 NO 2	
183	Is there a toilet (latrine) in functioning condition that is available for clients to use? IF YES, ASK TO SEE THE TOILET/LATRINE AND INDICATE THE CONDITION	YES, FUNCTIONING AND CLEAN 1 YES, FUNCTIONING, NOT CLEAN 2 YES, NOT FUNCTIONING 3 NO CLIENT TOILET/LATRINE . . 4	
184	ASSESS GENERAL CLEANLINESS OF FACILITY • A FACILITY IS CLEAN IF THE FLOORS ARE SWEEPED AND COUNTERS AND TABLES ARE WIPED AND FREE OF OBVIOUS DIRT OR WASTE. • A FACILITY IS NOT CLEAN IF OBVIOUS DIRT OR WASTE OR BROKEN OBJECTS ARE ON THE FLOORS OR COUNTERS.	FACILITY CLEAN 1 FACILITY NOT CLEAN 2	

2a. Vaccine Logistical System			
Facility Number: <input type="text"/> <input type="text"/> <input type="text"/>		Interviewer Code: <input type="text"/> <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
200	<p>Now I would like to find out about immunization services provided to children or pregnant women either by or at your facility. Are any immunization services provided, either as outreach or at the facility itself?</p> <p>IF YES: ASK: Do you provide immunizations for children only, for pregnant women only, or for both children and pregnant women? CIRCLE RESPONSE.</p>	<p>YES, CHILDREN ONLY 1</p> <p>YES, PREGNANT WOMEN ONLY 2</p> <p>BOTH CHILDREN AND PREGNANT WOMEN 3</p> <p>NO IMMUNIZATION SERVICES EVER PROVIDED 4</p>	<p>Section 2b (Q250)</p>
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF IMMUNIZATION 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:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> <p>_____ Date</p>			
201	May I begin the interview now?	<p>YES 1</p> <p>NO 2</p>	→ STOP
202	<p>Does this facility routinely store <i>any</i> vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided? KEEPING VACCINES 1-2 DAYS ONLY FOR IMMEDIATE USE IS NOT CONSIDERED AS STORING VACCINES</p>	<p>YES, STORES VACCINES 1</p> <p>STORES NO VACCINES 2</p>	→ 215
203	<p>ASK TO GO WHERE VACCINES ARE STORED, AND EXPLAIN:</p> <p>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</p>	<p>ELECTRIC REFRIGERATOR A</p> <p>KEROSENE REFRIGERATOR B</p> <p>GAS REFRIGERATOR C</p> <p>SOLAR REFRIGERATOR D</p> <p>COLD BOX E</p>	
204	<p>INDICATE THE TEMPERATURE INSIDE THE REFRIGERATOR OR COLD BOX.</p> <p>IF MORE THAN ONE SYSTEM/STORAGE EQUIPMENT IS USED, SELECT THE ONE WHERE DPT-HB IS STORED AND CHECK THE TEMPERATURE</p>	<p>TEMPERATURE CENTIGRADE <input type="text"/><input type="text"/></p> <p>NOT OBSERVED 94</p> <p>THERMOMETER NOT FUNCTIONING 95</p> <p>NO THERMOMETER 96</p>	<p>→ 206</p> <p>→ 206</p> <p>→ 206</p>

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																
205	INDICATE WHETHER TEMPERATURE INSIDE COOLING UNIT IS ABOVE OR BELOW 0 (ZERO) DEGREES CENTIGRADE. FOR 0 DEGREES, CIRCLE 1.	POSITIVE (+) 1 NEGATIVE (-) 2																																																	
206	Do you have a cold-chain temperature-monitoring chart? IF YES, ASK: May I see it?: IF MORE THAN ONE SYSTEM/STORAGE EQUIPMENT IS USED, SELECT THE ONE WHERE DPT-HB IS STORED AND CHECK THE TEMPERATURE CHART	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.	YES, COMPLETED 1 NO, NOT COMPLETED 2																																																	
208	INDICATE WHETHER THE REFRIGERATOR OR COLD BOX IS PROTECTED FROM DIRECT SUNLIGHT.	YES 1 NO 2 DON'T KNOW 8																																																	
209	Is there a register or stock cards where the amount of each vaccine received, the amount disbursed, and the amount present today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→211 →211																																																
210	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION.	STOCK RECORDS UPDATED DAY ITEM DISBURSED 1 STOCK RECORDS NOT ALWAYS UPDATED WHEN ITEM DIS- BURSED, BUT REGISTER OF DISTRIBUTED ITEMS OBSERVED 2 OTHER 6 (SPECIFY)																																																	
211	ASK TO SEE THE VACCINES. CHECK ALL OF EACH VACCINE, TO VERIFY 1) IF THEY WERE ARRANGED BY EXPIRY DATE OR VVM; 2) IF THERE ARE ANY EXPIRED UNITS PRESENT; AND 3) THAT THE INVENTORY AND SUPPLY MATCH (Q214). IF NECESSARY, ADD ITEMS FROM DAILY RECORD OR PRESCRIPTIONS AND SUBTRACT THESE FROM THE INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE.																																																		
	VACCINES CHECK INVENTORY AND STOCK AGREEMENT (Q214) FOR ALL RELEVANT ITEMS	(a) <u>AVAILABILITY OF VACCINES</u> <table border="1"> <thead> <tr> <th colspan="3">OBSERVED AVAILABLE</th> <th colspan="3">NOT OBSERVED</th> </tr> <tr> <th>ALL VALID</th> <th>AT LEAST ONE VALID</th> <th>AVAILABLE BUT NONE VALID</th> <th>REPORTED AVAILABLE, NOT SEEN</th> <th>NOT AVAIL-ABLE TODAY/DK</th> <th>NEVER AVAIL-ABLE</th> </tr> </thead> <tbody> <tr> <td>1 → b</td> <td>2 → b</td> <td>03 02 ↙</td> <td>4 02 ↙</td> <td>5 02 ↙</td> <td>6 02 ↙</td> </tr> <tr> <td>1 → b</td> <td>2 → b</td> <td>03 03 ↙</td> <td>4 03 ↙</td> <td>5 03 ↙</td> <td>6 03 ↙</td> </tr> <tr> <td>1 → b</td> <td>2 → b</td> <td>03 04 ↙</td> <td>4 04 ↙</td> <td>5 04 ↙</td> <td>6 04 ↙</td> </tr> <tr> <td>1 → b</td> <td>2 → b</td> <td>03 05 ↙</td> <td>3 05 ↙</td> <td>5 05 ↙</td> <td>6 05 ↙</td> </tr> <tr> <td>1 → b</td> <td>2 → b</td> <td>03 06 ↙</td> <td>4 06 ↙</td> <td>5 06 ↙</td> <td>6 06 ↙</td> </tr> <tr> <td>1 → b</td> <td>2 → b</td> <td>03 212 ↙</td> <td>4 212 ↙</td> <td>5 212 ↙</td> <td>6 212 ↙</td> </tr> </tbody> </table>	OBSERVED AVAILABLE			NOT OBSERVED			ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE	1 → b	2 → b	03 02 ↙	4 02 ↙	5 02 ↙	6 02 ↙	1 → b	2 → b	03 03 ↙	4 03 ↙	5 03 ↙	6 03 ↙	1 → b	2 → b	03 04 ↙	4 04 ↙	5 04 ↙	6 04 ↙	1 → b	2 → b	03 05 ↙	3 05 ↙	5 05 ↙	6 05 ↙	1 → b	2 → b	03 06 ↙	4 06 ↙	5 06 ↙	6 06 ↙	1 → b	2 → b	03 212 ↙	4 212 ↙	5 212 ↙	6 212 ↙	(b) STOCK OUT IN LAST SIX MONTHS YES NO DK
OBSERVED AVAILABLE			NOT OBSERVED																																																
ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL-ABLE TODAY/DK	NEVER AVAIL-ABLE																																														
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1 → b	2 → b	03 212 ↙	4 212 ↙	5 212 ↙	6 212 ↙																																														
01	Tetanus toxoid [GO TO LOCATION WHERE TT IS STORED]		1 2 8																																																
02	BCG and dilutant		1 2 8																																																
03	Oral polio (OPV)		1 2 8																																																
04	DPTHB (DPT+HepB)		1 2 8																																																
05	Measles and dilutant		1 2 8																																																
06	Vitamin A		1 2 8																																																

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
212	Were any expired vaccines observed?	YES 1 NO 2	
213	WERE THE VACCINES ORGANIZED ACCORDING TO DATE OF EXPIRATION (FIRST EXPIRE, FIRST OUT) IN THE FRIDGE OR COLD BOX? VERIFY WHEN COMPLETING Q211	YES, VERIFIED 1 NO 2	
214	FOR EACH OF THE FOLLOWING VACCINES RECORD IF THE AMOUNT OF STOCK ON THE STOCK CARD OR REGISTER MATCH THE INVENTORY OBSERVED IN STORAGE OR IF THE CORRECT AMOUNT CAN RAPIDLY BE CALCULATED	STOCK AND INVENTORY MATCH YES NO VACCINE NEVER AVAILABLE DK/ REGISTER NOT AVAIL	
01	TETANUS TOXOID	1 2 3 8	
02	BCG	1 2 3 8	
03	ORAL POLIO	1 2 3 8	
04	DPTHB (DPT+HepB combined)	1 2 3 8	
05	MEASLES	1 2 3 8	
215	When was the last time that you received a routine supply of vaccines?	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8	
216	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	→219 →221
217	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	
218	CHECK Q216 TO SEE IF '3' (BOTH) IS CIRCLED. YES <input type="checkbox"/> NO <input type="checkbox"/>		221
219	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? - 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 utilization and expected future activity? - 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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
220	<p>Which of the following best describes the routine system for deciding when to order vaccines? Do you:</p> <ul style="list-style-type: none"> - Place order whenever stock levels fall to a predetermined level? - Have a fixed time that orders are submitted? IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. - Place an order whenever there is believed to be a need, regardless of stock level? - Other _____ (SPECIFY) - Don't know 	<p>PREDETERMINED LEVEL 1</p> <p>FIXED TIME 2</p> <p>EVERY . <input type="text"/> <input type="text"/> WEEKS</p> <p>ORDER WHEN NEEDED 3</p> <p>OTHER 6</p> <p>DON'T KNOW 8</p>	
221	<p>During the past 3 months, have you always, sometimes, or almost never received the amount of vaccines that you ordered (or that you are supposed to routinely receive)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p>	
222	<p>How many vaccine carriers do you have available?</p>	<p>ONE 1</p> <p>TWO OR MORE 2</p> <p>NONE 3</p>	→ 224
223	<p>Are there ice packs for the vaccine carriers (four or five per carrier)?</p>	<p>YES, ONE SET 1</p> <p>YES, TWO OR MORE SETS 2</p> <p>NO, USE PURCHASED ICE 3</p> <p>NO 4</p>	
224	<p>What type of injection equipment is used during routine immunization sessions at this facility?</p>	<p>SINGLE-USE A</p> <p>STERILIZABLE B</p> <p>AUTO-DESTRUCT C</p> <p>OTHER _____ X (SPECIFY)</p>	

2b. Child Health Services			
Facility Number: <input type="text"/> <input type="text"/> <input type="text"/>		Interviewer Code: <input type="text"/> <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
250	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	→ Section 3a(Q300)
<p>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 Q251. READ THE FOLLOWING TO NEW RESPONDENTS:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p>			
Interviewer's signature (Indicates respondent's willingness to participate)		Date	
251	May I begin the interview?	YES 1 NO 2	→ Section 3a(Q300)

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
252	Now I would like to ask you specifically about child health services. 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 <i>at the facility, and how many days per month outreach services are provided (if any).</i>			
	CHILD HEALTH SERVICE (USE A 4-WEEK MONTH TO CALCULATE # OF DAYS FOR OUTREACH)	(a) FACILITY SERVICE	(b) OUTREACH (VILLAGE LEVEL SERVICES)	
01	Routine series of immunizations for children (DPT-HB, polio)	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	
02	Routine series of immunizations for children (Measles)	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	
03	BCG immunizations	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	
04	Routine Vitamin A supplementation	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	
05	Consultation or curative services for a sick child	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	
06	Growth monitoring or growth promotion (where a <i>healthy child</i> is routinely weighed, has the weight charted on a growth chart, and feeding advice is given.)	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	# OF DAYS PER MONTH <input type="text"/> <input type="text"/> NO SERVICE 00	
253	CHECK 252 (01a) AND INDICATE WHETHER ROUTINE CHILD IMMUNIZATIONS ARE EVER PROVIDED AT THE FACILITY YES <input type="checkbox"/> NO <input type="checkbox"/>			268
254	Are routine immunizations for children available at the facility today?	YES 1 NO 2		
255	Are immunizations offered in the facility on every day that sick child consultations are provided? IF YES: Are all vaccines offered?	YES, ALL VACCINES 1 YES, SOME VACCINES, NOT ALL 2 NO 3 DON'T KNOW 4		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
256	Does this facility have any routine user-fees or charges for any child immunization services? This includes any fees, including those for registration or for client health records.	YES 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES 2	→259
257	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for child immunization services:	YES NO DON'T KNOW	
01	Is there a fee for the child immunization chart or record?	IMMUNIZATION 1 2 8 CHART/RECORD	
02	Is there a fee for syringes provided by the facility?	SYRINGES 1 2 8	
03	Is there a fee for immunization services?	IMMUNIZATION 1 2 8 SERVICE	
04	Is there a fee for any vaccines?	VACCINE 1 2 8	
05	Are there any other elements for which user-fees or charges are routinely asked for immunization services? IF YES, SPECIFY _____	OTHER 1 2 8	
258	Are the official fees posted 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	
259	ASK TO SEE THE ROOM(S) WHERE IMMUNIZATIONS ARE GIVEN. WAS THE ROOM ALREADY OBSERVED WHEN ASSESSING THE THERAPEUTIC INJECTION ROOM?	YES, DATA PROVIDED IN THERAPEUTIC INJ ROOM [284-285] 1 YES, DATA PROVIDED IN EXAMINATION ROOM [280-281] 2 NO, DATA NOT YET COLLECTED 3	→262 →262

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
260	ASK TO GO TO THE ROOM WHERE IMMUNIZATIONS ARE ADMINISTERED. CHECK FOR EACH OF THE FOLLOWING ITEMS FOR WHETHER THE ITEM IS EITHER IN THE ROOM WHERE IMMUNIZATIONS ARE PROVIDED OR IN AN ADJACENT ROOM.					
	ITEMS FOR IMMUNIZATION SERVICES	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Sharps box for disposable needles and syringes	1	2	3	8	
02	BCG syringes, at least five (with needles)	1	2	3	8	
03	At least five 2-5 ml syringes (with 21 gauge needles)	1	2	3	8	
04	At least 5 autodestruct syringes	1	2	3	8	
05	Waste receptacle with lid and plastic liner	1	2	3	8	
06	Hand-washing soap	1	2	3	8	
07	Single-use hand-drying towel	1	2	3	8	
08	Water for washing hands	1	2	3 262	8 262	
261	How is water being made available for use in the immunization area <u>today</u> ?	PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3				
262	OTHER ITEMS REQUIRED FOR IMMUNIZATION SERVICES	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Blank, individual child immunization cards or MCH card No. 1	1	2	3	8	
02	Tally sheets or register sheets	1	2	3	8	
03	Permanent register for recording immunizations	1	2 → 264	3 → 264	8 264	
263	ASK WHEN IMMUNIZATIONS 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				
264	What is the current estimate for your DPT dropout rate?	DPT DROPOUT RATE (%) <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998				
265	Do you have an estimate of the target population for child immunizations in the facility catchment area? IF YES: How many children is that?	TARGET POPULATION <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NO CATCHMENT AREA 99995 DON'T KNOW 99998				→ 267 → 267
266	What is the current estimate for your facility's measles coverage?	MEASLES COVERAGE (%) .. <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998				
267	RECORD THE SOURCE(S) OF INFORMATION FOR % COVERAGE AND DROPOUT RATE ESTIMATES.	WRITTEN REPORT A GRAPH/CHART B OTHER X (SPECIFY) NO COVERAGE RATES Y SOURCE NOT KNOWN Z				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
268	CHECK Q252(05a): DOES FACILITY PROVIDE SICK-CHILD CONSULTATIONS? YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 3a(Q300)
269	How many staff assigned to this unit have received training on IMCI guidelines?	NUMBER OF STAFF TRAINED IN IMCI <input type="text"/> <input type="text"/> NONE 00 DON'T KNOW 98	
270	Are IMCI guidelines ever used when assessing and treating sick children? IF YES, CLARIFY IF THE GUIDELINES ARE ROUTINELY FOLLOWED OR SOMETIMES, DEPENDING ON THE SITUATION.	ALWAYS FOLLOW IMCI 1 SOMETIMES FOLLOW IMCI 2 NEVER USE IMCI GUIDELINES 3 DON'T KNOW 8	
271	Does this facility have any routine user-fees or charges for any services related to curative care for children? This includes any fees, including those for registration or for client health records.	YES 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES . 2	→ 274
272	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for curative care for children:	YES NO DON'T KNOW	
01	Is there a fee for the child health chart or record?	IMMUNIZATION CARD/RECORD 1 2 8	
02	Is there a fee for the consultation service?	FEE FOR CONSULT 1 2 8	
03	Is there a different fee depending on the child's diagnosis?	VARY BY DIAGNOSIS 1 2 8	
04	Are there user fees for medications?	MEDICINES 1 2 8	
05	Are there user fees for laboratory tests?	TESTS 1 2 8	
06	Is there a fee for registration?	REGISTRATION 1 2 8	
07	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1 2 8	
08	Is there a system for clients to pre-pay for multiple visits for curative care?	PREPAY FOR MULTIPLE 1 2 8	
273	Are the official fees posted 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	
274	Does this facility have a system whereby certain measures and activities 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	→ 277 → 277

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO																																																																							
275	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 immunization status	1	2	3	8																																																																								
05	Assessing Vitamin A supplementation status	1	2	3	8																																																																								
06	Group health education	1	2	3	8																																																																								
07	Paracetamol and/or sponge for fever	1	2	3	8																																																																								
276	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																																																																											
277	Is there a routine system for someone other than the health worker 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																																																																											
278	Does this facility ever use blood tests to verify the diagnosis of malaria?	YES 1 NO 2				→280																																																																							
279	<p>For each of the tests for malaria that I mention, please tell me if the test is conducted in this facility, if the specimen is collected and sent elsewhere, or if the client is sent elsewhere, or if the test is not utilized at all.</p> <p>FOR EACH MALARIA TEST CONDUCTED AT FACILITY, ASSESS AVAILABILITY OF EQUIPMENT AND SUPPLIES USING LAB QUESTIONNAIRE.</p> <p>ASSESS IN COLUMN "B" IF TEST IS ALWAYS, SOMETIMES OR NEVER USED.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2"></th><th colspan="5">a</th><th colspan="2">b</th></tr> <tr> <th></th><th>CONDUCT TEST</th><th>COLLECT SPECI- MEN</th><th>SEND CLIENT ELSEWHERE</th><th>TEST NOT UTILIZED</th><th>DON'T KNOW</th><th>ALWAYS</th><th>SOMETIMES</th></tr> </thead> <tbody> <tr> <td>01</td><td>Giemsa Stain,</td><td>1→b</td><td>2→b</td><td>3→b</td><td>4</td><td>8</td><td>1</td><td>2</td></tr> <tr> <td>02</td><td>Field Stain.</td><td>1→b</td><td>2→b</td><td>3→b</td><td>4</td><td>8</td><td>1</td><td>2</td></tr> <tr> <td>03</td><td>Acridine Orange</td><td>1→b</td><td>2→b</td><td>3→b</td><td>4</td><td>8</td><td>1</td><td>2</td></tr> <tr> <td>04</td><td>Rapid test</td><td>1→b</td><td>2→b</td><td>3→b</td><td>4</td><td>8</td><td>1</td><td>2</td></tr> <tr> <td>05</td><td>Other test for malaria</td><td>1→b</td><td>2→b</td><td>3→b</td><td>4</td><td>8</td><td>1</td><td>2</td></tr> <tr> <td></td><td>(SPECIFY)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>								a					b			CONDUCT TEST	COLLECT SPECI- MEN	SEND CLIENT ELSEWHERE	TEST NOT UTILIZED	DON'T KNOW	ALWAYS	SOMETIMES	01	Giemsa Stain,	1→b	2→b	3→b	4	8	1	2	02	Field Stain.	1→b	2→b	3→b	4	8	1	2	03	Acridine Orange	1→b	2→b	3→b	4	8	1	2	04	Rapid test	1→b	2→b	3→b	4	8	1	2	05	Other test for malaria	1→b	2→b	3→b	4	8	1	2		(SPECIFY)							
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03	Acridine Orange	1→b	2→b	3→b	4	8	1	2																																																																					
04	Rapid test	1→b	2→b	3→b	4	8	1	2																																																																					
05	Other test for malaria	1→b	2→b	3→b	4	8	1	2																																																																					
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NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
280	ASK TO GO TO THE PLACE WHERE EXAMINATIONS OF SICK CHILDREN ARE CARRIED OUT. CHECK WHETHER EACH OF THE ITEMS BELOW IS EITHER IN THE ROOM WHERE THE SERVICE IS GIVEN OR IN AN ADJACENT ROOM.								
		(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 scale	1→b	2→b	3 02 ↙	8 02 ↙	1	2	8	
02	Child scale	1→b	2→b	3 03 ↙	8 03 ↙	1	2	8	
03	Thermometer	1→b	2→b	3 04 ↙	8 04 ↙	1	2	8	
04	Timer or facility provided watch/clock with second hand	1→b	2→b	3 05 ↙	8 05 ↙	1	2	8	
05	Staff has watch with second hand	1	2	3	8				
06	Butterfly or scalp vein 21-23g, or branula (intercath) 22-24g	1	2	3	8				
07	Intravenous fluid (D5NS, NS, ringers lactate (1/2 strength-darrows, or full strength Hartman's)	1	2	3	8				
08	D5W intravenous fluid	1	2	3	8				
09	Perfusion sets	1	2	3	8				
10	Jar or pitcher for oral rehydration solution (ORS)	1	2	3	8				
11	Cup and spoon	1	2	3	8				
12	ORS PACKETS	1	2	3	8				
13	Sharps container	1	2	3	8				
14	BCG syringes, at least 5 (with needles)	1	2	3	8				
15	At least five 2-5 ml syringes (with 21 gauge needles)	1	2	3	8				
16	At least 5 auto-destruct syringes	1	2	3	8				
17	Waste receptacle with lid and plastic liner	1	2	3	8				
18	Already mixed decontaminating solution	1	2	3	8				
19	Disinfectant (not yet mixed)	1	2	3	8				

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
	ITEMS FOR SICK CHILD CONSULTATIONS	(a) AVAILABILITY				
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
20	Hand-washing soap	1	2	3	8	
21	Single-use hand-drying towel	1	2	3	8	
22	Water for washing hands	1	2	3 282	8 282	
281	How is water being made available for use in the child consultation area <i>today</i> ?	PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3				
282	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 counseling cards for provider to use	1	2	3	8	
04	IMCI mother's cards (to give to caretaker)	1	2	3	8	
05	Other visual aids for teaching caretakers	1	2	3	8	
283	ASK TO SEE THE ROOM(S) WHERE THERAPEUTIC (TREATMENT) INJECTIONS ARE GIVEN. WAS THE ROOM ALREADY OBSERVED WHEN ASSESSING THE IMMUNIZATION OR THE EXAMINATION ROOM?	YES, DATA PROVIDED IN : IMMUNIZATION ROOM [260-261] 1 →286 YES, DATA PROVIDED IN : EXAMINATION ROOM [280-281] 2 →286 NO, DATA NOT YET COLLECTED 3 NO THERAPEUTIC INJ. 4 →286				
284	FOR THE FOLLOWING ITEMS, CHECK WHETHER EACH ITEM IS EITHER IN THE ROOM WHERE NON-VACCINATION INJECTIONS ARE BEING PROVIDED OR IN AN ADJACENT ROOM.					
	ITEMS REQUIRED TO PROVIDE INJECTION SERVICES	OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	
01	Sharps container	1	2	3	8	
02	BCG syringes, at least five (with needles)	1	2	3	8	
03	At least five 2-5 ml syringes (with 21 gauge needles)	1	2	3	8	
04	At least 5 autodestruct syringes	1	2	3	8	
05	Waste receptacle with lid and plastic liner	1	2	3	8	
06	Hand-washing soap	1	2	3	8	
07	Single-use hand drying towel	1	2	3	8	
08	Water for washing hands	1	2	3 286	8 286	
285	How is water being made available for use in the injection room area <i>today</i> ?	PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
286	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 COMBINED ADULT AND <5 REGISTER 2 YES, REPORTED, NOT SEEN ... 3 NO REGISTER 4	→290 →290
287	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS ... 1 MORE THAN 7 DAYS OLD ... 2	
288	RECORD THE NUMBER OF SICK CHILDREN, BELOW 5 YEARS OF AGE, WHO RECEIVED CONSULTATION SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998	→ 290
289	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
290	Are individual health records or charts maintained for sick children? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN . 2 NO 3	
291	Are curative child health services available at the facility today?	YES 1 NO 2	
292	If a sick child today is noticed to need an immunization, can it be provided today? IF YES, CLARIFY THE SYSTEM FOR PROVIDING THE IMMUNIZATION	YES, SEND TO ROUTINE IMMUNIZATION SERVICE 1 YES, SPECIAL SYSTEM FOR IMMUNIZATIONS FOR SICK CHILDREN 2 NO 3	
293	Is there any system for recording referrals that are made to specialists or for laboratory tests? IF YES, ASK TO SEE EVIDENCE OF A SYSTEM TO KEEP TRACK OF REFERRALS	YES, OBSERVED 1 YES, REPORTED, NOT SEEN . 2 NO 3	

3a. Family Planning Services			
	Facility Number: <input type="text"/> <input type="text"/> <input type="text"/>	Interviewer Code: <input type="text"/> <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	Are sterilization procedures for men or women ever performed at this facility? IF YES, INDICATE WHICH PROCEDURES ARE CONDUCTED.	YES, MALE STERILIZATION . A YES, FEMALE STERILIZATION B NO STERILIZATION Y	
301	Does this facility offer any other family planning services—including clinical methods or counseling on natural family planning?	YES 1 NO 2	→ Sec. 4 (Q400)
<p>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.</p> <p>READ THE FOLLOWING TO NEW RESPONDENTS:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> <p>_____ Date</p>			
302	May I begin the interview now?	YES 1 NO 2	→ Sec. 4 (Q400)
303	How many days of the week are family planning services offered at this facility?	NUMBER OF DAYS <input type="text"/>	
304	Are family planning services being offered at this facility today?	YES 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
305	Which of the following methods of contraception is provided, prescribed, or do you provide counseling about in this facility?	PROVIDED	PRESCRIBED/ COUNSELED	NOT OFF- ERED	
01	Combined oral pill	1	2	3	
02	Progestin-only pill	1	2	3	
03	Combined injectable (with estrogen) (1 monthly)	1	2	3	
04	Progestin-only injectable (2 or 3 monthly) (e.g., DEPO or Microgynon)	1	2	3	
05	Male condom	1	2	3	
06	Female condom	1	2	3	
07	Intrauterine device	1	2	3	
08	Implant (6 rod, 1 rod, Norplant, Implanon)	1	2	3	
09	Spermicides	1	2	3	
10	Diaphragm	1	2	3	
11	Emergency contraceptive pill	1	2	3	
12	Counseling on natural methods	1	2	3	
13	Others _____ (SPECIFY)	1	2	3	
306	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 or for client health records.	YES 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES . 2			→309
307	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for family planning services:		YES	NO	DON'T KNOW
01	Is there a fee for the client family planning chart or record?	FP CARD/RECORD	1	2	8
02	Is there a fee for the consultation service? EITHER FIRST OF FOLLOW-UP VISIT	FEE FOR CONSULT	1	2	8
03	Is there a different fee depending on the method of contraception provided?	VARY BY METHOD	1	2	8
04	Are there any fees or charges for the method provided?	METHOD	1	2	8
05	Are there any fees or charges for laboratory tests?	LAB TESTS	1	2	8
06	Is there a fee for registration?	REGISTRATION	1	2	8
07	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTION	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
308	Are the official fees posted 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				
309	Does this facility have a system in which measurements of or activities for family planning are routinely carried out before the consultation or client examination takes place?	YES 1 NO 2 DON'T KNOW 8				→311 →311
310	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	
04	Other _____ (SPECIFY)	1	2	3	8	
311	ASK TO SEE WHERE COUNSELING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AND AUDITORY PRIVACY 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY ... 3 NO PRIVACY 4				
312	Are any of the following visual aids for teaching available in the counseling 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	Other visual aids for teaching about family planning or specific contraceptive methods	1	2	3	8	
03	Visual aids for teaching about STIs	1	2	3	8	
04	Visual aids for teaching about HIV/AIDS	1	2	3	8	
05	Model for demonstrating how to use condoms	1	2	3	8	
06	Posters for general promotion of family planning	1	2	3	8	
07	Posters for general awareness of STIS or HIV/AIDS	1	2	3	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
313	Are any of the following types of information booklets or pamphlets for clients to take home available in the counseling or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Printed matter about family planning	1	2	3	8	
02	Printed matter about STIs	1	2	3	8	
03	Printed matter about HIV/AIDS	1	2	3	8	
314	Are any of the following guidelines or protocols for delivery of services available in the counseling room or the examination room?					
01	Family Planning Program components and standards	1	2	3	8	
02	Family Planning Procedure manual 2004	1	2	3	8	
03	Any other Guidelines or protocols on family planning	1	2	3	8	
04	Syndromic diagnosis and treatment of STIs (based on WHO guidelines)	1	2	3	8	
05	Other guidelines for STI diagnosis or treatment	1	2	3	8	
315	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				→ 319 → 319
316	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS ... 1 MORE THAN 7 DAYS OLD ... 2				
317	RECORD THE NUMBER OF TOTAL CLIENTS , NEW AND CONTINUING, WHO RECEIVED FAMILY PLANNING SERVICES DURING THE PAST 12 COMPLETED MONTHS.	TOTAL CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998				→ 319
318	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q317.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98				
319	Are individual records or charts maintained for family planning clients? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3				
320	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				
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING ARE CONDUCTED.						
321	IF THE SAME EXAMINATION ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN 322-324, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	ANTENATAL [Q428-Q430] ... 1 DELIVERY [Q520-Q522] 2 STI [Q622-Q624] 3 NOT PREVIOUSLY SEEN 4				→ 325 → 325 → 325

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
322	DESCRIBE THE SETTING OF THE EXAMINATION ROOM. IF THIS IS THE SAME ROOM AS THAT USED FOR COUNSELING (Q311), CIRCLE THE SAME RESPONSE AS IN Q311	PRIVATE ROOM WITH VISUAL AND AND AUDITORY PRIVACY . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY ... 3 NO PRIVACY 4						
323	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.							
		(a) AVAILABILITY				(b) FUNCTIONING		
	ITEMS REQUIRED TO PROVIDE FAMILY PLANNING SERVICES	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	Table or bed for gynecological exam	1	2	3	8			
03	Clean (or sterile) latex gloves	1 05 ↙	2	3	8			
04	Other disposable, non-latex gloves	1	2	3	8			
05	Sharps container	1	2	3	8			
06	At least five or more 2-5 ml syringes (with needles) MAY BE WITH INJ. METHOD	1	2	3	8			
07	Already mixed decontaminating solution	1	2	3	8			
08	Disinfectant (not yet mixed)	1	2	3	8			
09	Waste receptacle with lid and plastic liner	1	2	3	8			
10	Hand-washing soap	1	2	3	8			
11	Single-use hand drying towel	1	2	3	8			
12	Water for hand washing	1	2	3 325 ↙	8 325 ↙			

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
324	How is water being made available for use in the family planning service area <i>today</i> ?	PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3				
325	NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.					
		(a) AVAILABILITY			(b) FUNCTIONING	
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES NO DON'T KNOW
01	Blood pressure apparatus	1 →b	2 →b	3 ↙ 02 ↙	8 ↙ 02 ↙	1 2 8
02	Stethoscope	1 →b	2 →b	3 ↙ 326 ↙	8 ↙ 326 ↙	1 2 8
326	CHECK Q305(07) and (08): DOES FACILITY OFFER IUD OR IMPLANT? YES <input type="checkbox"/> NO <input type="checkbox"/>					332
327	NOTE THE AVAILABILITY OF COMMON SUPPLIES FOR IUD OR IMPLANT SERVICES.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Sterile gloves	1	2	3	8	
02	Antiseptic solution (such as iodine)	1	2	3	8	
03	Sponge holding forceps	1	2	3	8	
04	Gauze pad or cotton wool	1	2	3	8	
328	CHECK Q305(07): DOES FACILITY OFFER IUD? YES <input type="checkbox"/> NO <input type="checkbox"/>					330
329	NOTE THE AVAILABILITY OF MATERIALS FOR THE INSERTIONS OF IUD	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Vaginal speculum small	1	2	3	8	
02	Vaginal speculum medium	1	2	3	8	
03	Vaginal speculum large	1	2	3	8	
04	Tenacula	1	2	3	8	
05	Uterine sound	1	2	3	8	
330	CHECK Q305(08): DOES FACILITY OFFER IMPLANT? YES <input type="checkbox"/> NO <input type="checkbox"/>					332

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
331	NOTE THE AVAILABILITY OF THE FOLLOWING ITEMS:	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Local anesthetic (such as lidocaine)	1	2	3	8
02	Sterile syringe and needle	1	2	3	8
03	Cannula and trochar for inserting Implant	1	2	3	8
04	Sealed implanon pack	1	2	3	8
05	Scalpel with blade	1	2	3	8
06	Forceps for grasping implant (artery forceps or hemostat or tweezers or mosquito forceps)	1	2	3	8
332	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 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 95			→ END
333	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			
334	Where is this equipment then 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 "3 " AND CONTINUE.	SECTION 1 [Q173-174] 1 DELIVERY [Q555-556] 2 NOT PREVIOUSLY SEEN 3 PROCESS OUTSIDE FACILITY 4 NO EQUIPMENT PROCESSED 5			→ 337(6) → 337(6) → 337(6) → 337(6)

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
334a	Besides decontaminating and cleaning, what is the final process most commonly used for sterilizing reusable syringes and needles?	DRY-HEAT STERILIZATION ...	A					
		AUTOCCLAVING	B					
		BOILING	C					
		STEAM STERILIZATION	D					
		CHEMICAL METHOD	E					
		DISCARD/DISPOSABLES ONLY ...	F					
		OTHER _____	X					
		(SPECIFY)						
		NONE	Y					
335	Besides decontaminating and cleaning, what is the final process most commonly used for disinfecting or sterilizing medical equipment (such as speculums and/or 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					
		AUTOCCLAVING	B					
		BOILING	C					
		STEAM STERILIZATION	D					
		CHEMICAL METHOD	E					
		PROCESSED OUTSIDE FACILITY ...	F		→ 338			
		OTHER _____	X					
		(SPECIFY)						
		NONE	Y		→ END			
	GO TO WHERE EQUIPMENT IS PROCESSED AND ASK IF THE INDICATED ITEMS ARE AVAILABLE IN THE MAIN PROCESSING AREA, AND ASSESS THE FUNCTIONING STATUS AND PROCEDURES FOLLOWED AT THIS SITE.							
336	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 or disinfection	1	2	3	8			

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 without pressure	(5) Chemical High Level Disinfectant (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 → 338																												
B	Temperature (centigrade)	TEMPERATURE [][][] AUTOMATIC 666 DONT KNOW ... 998																																
C	Pressure	TEMPERATURE [][][] AUTOMATIC 666 DONT KNOW ... 998																																
D	Units of pressure	PRESS- URE [][][] AUTOMATIC 666 → 2E DONT KNOW 998 → 2E 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 DONT KNOW ... 998	MINUTES [][][] DONT KNOW ... 998	MINUTES [][][] DONT KNOW ... 998	MINUTES [][][] DONT KNOW ... 998	MINUTES [][][] DONT KNOW ... 998																												
F	Minutes when equipment is wrapped	MINUTES WRAPPED [][][] AUTOMATIC 666 DONT KNOW ... 998																																
G	Chemical disinfectant used	<table border="0"> <tr> <td>GIK</td><td>1</td><td>GIK</td><td>1</td> </tr> <tr> <td>CHLORINE</td><td>2</td><td>CHLORINE</td><td>2</td> </tr> <tr> <td>CIDEX</td><td>3</td><td>CIDEX</td><td>3</td> </tr> <tr> <td>BETADINE</td><td>4</td><td>BETADINE</td><td>4</td> </tr> <tr> <td>ALCOHOL</td><td>5</td><td>ALCOHOL</td><td>5</td> </tr> <tr> <td>OTHER</td><td>6</td><td>OTHER</td><td>6</td> </tr> <tr> <td>DONT KNOW</td><td>8</td><td>DONT KNOW</td><td>8</td> </tr> </table>					GIK	1	GIK	1	CHLORINE	2	CHLORINE	2	CIDEX	3	CIDEX	3	BETADINE	4	BETADINE	4	ALCOHOL	5	ALCOHOL	5	OTHER	6	OTHER	6	DONT KNOW	8	DONT KNOW	8
GIK	1	GIK	1																															
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ALCOHOL	5	ALCOHOL	5																															
OTHER	6	OTHER	6																															
DONT KNOW	8	DONT KNOW	8																															
H	Percent solution before dilution	<table border="0"> <tr> <td>PERCENT</td><td>[][]</td><td>PERCENT</td><td>[][]</td> </tr> <tr> <td>DONT KNOW</td><td>98</td><td>DONT KNOW</td><td>98</td> </tr> </table>					PERCENT	[][]	PERCENT	[][]	DONT KNOW	98	DONT KNOW	98																				
PERCENT	[][]	PERCENT	[][]																															
DONT KNOW	98	DONT KNOW	98																															
I	Mixture, parts solution and water	<table border="0"> <tr> <td>MIXTURE PARTS</td><td>[][]</td><td>MIXTURE PARTS</td><td>[][]</td> </tr> <tr> <td>a) DISINFECTANT</td><td>[][]</td><td>a) DISINFECTANT</td><td>[][]</td> </tr> <tr> <td>b) WATER</td><td>[][]</td><td>b) WATER</td><td>[][]</td> </tr> <tr> <td>DK</td><td>000</td><td>DK</td><td>000</td> </tr> </table>					MIXTURE PARTS	[][]	MIXTURE PARTS	[][]	a) DISINFECTANT	[][]	a) DISINFECTANT	[][]	b) WATER	[][]	b) WATER	[][]	DK	000	DK	000												
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b) WATER	[][]	b) WATER	[][]																															
DK	000	DK	000																															

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
338	ASK TO SEE WHERE EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED, PRIOR TO USING. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "3" AND CONTINUE.	SECTION 1 [Q175] 1 DELIVERY [Q558] 2 NOT PREVIOUSLY SEEN 3				→ End → End
339	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 cloth, sealed with TST 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 TST sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other stored, clean and covered	1	2	3	8	
07	Other stored, not clean and/or uncovered	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
09	Storage location dry and clean	1	2	3	8	

3b. Availability of Contraceptive Supplies			
Facility Number: <input type="text"/> <input type="text"/> <input type="text"/>		Interviewer Code: <input type="text"/> <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
350	Are any contraceptive methods 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	→ STOP → STOP
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF FAMILY PLANNING COMMODITIES. IF THIS IS A NEW RESPONDENT, OBTAIN INFORMED CONSENT BELOW. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 351. READ THE FOLLOWING TO NEW RESPONDENTS:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see stock records. No patient names from records will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>			
351	May I begin the interview now?	YES 1 NO 2	→ STOP
352	Is there a register or stock cards where the amount of each contraceptive method received, the amount disbursed, and the amount present today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 354 → 354
353	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION.	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)	

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO		
354	FOR ALL ITEMS INDICATE THE CORRECT AVAILABILITY STATUS, ASK ABOUT STOCK-OUT DURING THE PAST 6 MONTHS, AND CHECK THE CURRENT STOCK AGAINST THE INVENTORY RECORDS, MARKING THE CORRECT RESPONSE IN Q356. IF UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE.									
	CONTRACEPTIVE METHODS	(a) AVAILABILITY OF CONTRACEPTIVES						(b) STOCK OUT IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY AND STOCK AGREEMENT (Q357) FOR ALL RELEVANT ITEMS	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	Combined oral pill	1 → b	2 → b	3 ↘ 02 ↘	4 ↘ 02 ↘	5 ↘ 02 ↘	6 ↘ 02 ↘	1	2	8
02	Progestin-only pill	1 → b	2 → b	3 ↘ 03 ↘	4 ↘ 03 ↘	5 ↘ 03 ↘	6 ↘ 03 ↘	1	2	8
03	Combined injectable (monthly)	1 → b	2 → b	3 ↘ 04 ↘	4 ↘ 04 ↘	5 ↘ 04 ↘	6 ↘ 04 ↘	1	2	8
04	Progestin-only injection (2 or 3 monthly)	1 → b	2 → b	3 ↘ 05 ↘	4 ↘ 05 ↘	5 ↘ 05 ↘	6 ↘ 05 ↘	1	2	8
05	Condoms (male)	1 → b	2 → b	3 ↘ 06 ↘	4 ↘ 06 ↘	5 ↘ 06 ↘	6 ↘ 06 ↘	1	2	8
06	Condoms (female)	1 → b	2 → b	3 ↘ 07 ↘	4 ↘ 07 ↘	5 ↘ 07 ↘	6 ↘ 07 ↘	1	2	8
07	Intrauterine device (IUD)	1 → b	2 → b	3 ↘ 08 ↘	4 ↘ 08 ↘	5 ↘ 08 ↘	6 ↘ 08 ↘	1	2	8
08	Implant	1 → b	2 → b	3 ↘ 09 ↘	4 ↘ 09 ↘	5 ↘ 09 ↘	6 ↘ 09 ↘	1	2	8
09	Spermicide	1 → b	2 → b	3 ↘ 10 ↘	4 ↘ 10 ↘	5 ↘ 10 ↘	6 ↘ 10 ↘	1	2	8
10	Diaphragm	1 → b	2 → b	3 ↘ 11 ↘	4 ↘ 11 ↘	5 ↘ 11 ↘	6 ↘ 11 ↘	1	2	8
11	Emergency contraceptive	1 → b	2 → b	3 ↘ 355 ↘	4 ↘ 355 ↘	5 ↘ 355 ↘	6 ↘ 355 ↘	1	2	8
355	WERE ANY EXPIRED METHODS OBSERVED?				YES 1 NO 2					
356	WERE THE METHODS ORGANIZED ACCORDING TO EXPIRY DATE ("first expire, first out")? (VERIFY WHEN COMPLETING PREVIOUS SECTION).				YES, VERIFIED 1 NO 2 DON'T KNOW 8					

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
357	FOR EACH OF THE FOLLOWING METHODS RECORD IF THE AMOUNT OF STOCK ON THE STOCK CARD OR REGISTER MATCH THE INVENTORY OBSERVED IN STORAGE OR IF THE CORRECT AMOUNT CAN RAPIDLY BE CALCULATED	STOCK AND INVENTORY MATCH				
		YES	NO	METHOD NEVER AVAILABLE	DK/ REGISTER NOT AVAIL.	
01	COMBINED ORAL PILL	1	2	3	8	
02	PROGESTIN-ONLY PILL	1	2	3	8	
03	COMBINED MONTHLY INJ	1	2	3	8	
04	PROGESTIN ONLY INJ	1	2	3	8	
05	MALE CONDOM	1	2	3	8	
06	FEMALE CONDOM	1	2	3	8	
07	IUD	1	2	3	8	
08	IMPLANT	1	2	3	8	
09	SPERMICIDE	1	2	3	8	
10	DIAPHRAGM	1	2	3	8	
11	EMERGENCY CONTRACEPTIVE	1	2	3	8	
358	Are contraceptive supplies stored in the same location as other medicines?	YES 1 NO 2				→ 360
359	OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OR EACH OF THE FOLLOWING CONDITIONS.					
01	ARE THE METHODS OFF THE FLOOR AND PROTECTED FROM WATER?	YES 1 NO 2 DON'T KNOW 8				
02	ARE THE METHODS PROTECTED FROM SUN?	YES 1 NO 2 DON'T KNOW 8				
03	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.).	YES 1 NO 2 DON'T KNOW 8				
360	When was the last time that you received a routine supply of contraceptive methods?	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8				
361	Does this facility determine the quantity of each contraceptive method required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE 2 DON'T KNOW 8				→ 363 → 365
362	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				→ 365 → 365 → 365

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
363	<p>Routinely, when you order contraceptive methods, which best describes the system you use to determine how much of each to order? Do you:</p> <ul style="list-style-type: none"> - Review the amount of each method 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 method used since the previous order, and plan based on prior utilization and expected future activity? - Other _____ (SPECIFY) DON'T KNOW 	<p>ORDER TO MAINTAIN FIXED STOCK 1</p> <p>ORDER SAME AMOUNT 2</p> <p>ORDER BASED ON UTILIZATION 3</p> <p>OTHER 6</p> <p>DON'T KNOW 8</p>	→ 365
364	<p>Which of the following best describes the routine system for deciding when to order contraceptive methods? Do you:</p> <ul style="list-style-type: none"> - Place order whenever stock levels fall to a predetermined level? - Have a fixed time that orders are submitted? IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. - Place an order whenever there is believed to be a need, regardless of stock level? - Other _____ (SPECIFY) Don't know 	<p>PREDETERMINED LEVEL 1</p> <p>FIXED TIME 2 EVERY <input type="text"/> <input type="text"/> WEEKS</p> <p>ORDER WHEN NEEDED 3</p> <p>OTHER 6</p> <p>DON'T KNOW 8</p>	
365	<p>If there is a shortage of a specific method between routine orders, what is the most common procedure followed by this facility?</p> <ul style="list-style-type: none"> - Submit special order to normal supplier - Facility purchases from private market - Clients must purchase from outside the facility 	<p>SPECIAL ORDER 1</p> <p>FACILITY PURCHASE 2</p> <p>CLIENT PURCHASE OUTSIDE 3</p>	
366	<p>During the past 3 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)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p>	

4. Antenatal and Postpartum Care			
Facility Number: <input type="text"/>		Interviewer Code <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
400	Does this facility offer antenatal services , postpartum services, or both? INDICATE THE SERVICES OFFERED.	YES, ANTENATAL A YES, POSTPARTUM B NO, NEITHER SERVICE Y	→ 433
	<p>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:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>_____ Interviewer's signature Date (Indicates respondent's willingness to participate)</p>		
401	May I begin the interview now?	YES 1 NO 2	→ STOP
402	How many days of the week are antenatal-care services provided at the facility?	NUMBER OF DAYS <input type="text"/>	
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 or for client health records.	YES 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES 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:	<div style="text-align: right;"> YES NO DON'T KNOW </div>						
01	Is there a fee for the client health card?	ANC CARD/RECORD	1	2	8			
02	Is there a fee for each consultation?	FEE FOR CONSULT	1	2	8			
03	Are there user fees for medications?	MEDICINE	1	2	8			
04	Are there user fees for laboratory tests?	TESTS	1	2	8			
05	Is there a fee for registration?	REGISTRATION	1	2	8			
06	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS	1	2	8			
07	Is there a system for clients to pre-pay for multiple visits for care during pregnancy?	PRE-PAY FOR MULTIPLE	1	2	8			
406	Are the official fees posted 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 measurements or procedures for ANC clients are routinely carried out before the consultation?	YES 1 NO 2 DON'T KNOW 8			→409 →409			
408	ASK TO SEE THE PLACE WHERE ANTENATAL 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 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 anemia	1	2	3	8			
05	Conducting group health education sessions	1	2	3	8			
409	Which of the following activities are performed as part of routine services, that is, each client has this test at least once. INDICATE CORRECT RESPONSE FOR (B) FOR EACH TEST CONDUCTED.	(a) ROUTINE TESTING		(b) ITEMS FOR TEST AVAILABLE ANC UNIT TODAY				
		YES	NO	DON'T KNOW	YES	NO	TEST IN LAB	
01	Blood test for anemia	1→ b	2→ 02	8→ 02	1	2	3	
02	Blood test for syphilis	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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
410	Which of the following types of treatment and services are routinely offered to antenatal clients?	ROUTINELY OFFERED TO ALL ANC CLIENTS YES NO DK	
01	Preventive antimalarial medication	1 2 8	
02	Counseling about family planning	1 2 8	
03	Voluntary counseling about HIV/AIDS	1 2 8	
04	Voluntary testing for HIV/AIDS	1 2 8	
411	Is tetanus toxoid vaccination available all days antenatal care services are offered?	YES 1 NOT ALL ANC DAYS 2 TT NEVER OFFERED 3	→ 414
412	How many days each week are tetanus toxoid vaccinations offered at this facility?	DAYS PER WEEK <input type="text"/> NEVER OFFERED 0 DON'T KNOW 8	
413	Is tetanus toxoid immunization available today?	YES 1 NO 2	
414	Do antenatal care providers here routinely treat STIs, or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIs 1 REFERS 2 NO TREATMENT PROVIDED 3	
415	Is there a register where information on antenatal care clients' visits is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID IT MUST SHOW CLIENTS' STATUS (NEW OR CONTINUING).	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3	→ 419 → 419
416	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS 1 MORE THAN 7 DAYS OLD 2	
417	RECORD THE NUMBER OF ANTENATAL CLIENTS, NEW AND FOLLOW-UP WHO RECEIVED SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF ANC VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998	→ 419
418	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
419	Is there a register where client information from postpartum (PP) visits is recorded? IF YES, ASK TO SEE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE NUMBER OF DAYS POSTPARTUM AND INDICATE WHETHER OR NOT THERE ARE COMPLICATIONS.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3 NO PP SERVICES 4	→ 423 → 423 → 423

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
420	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS 1 MORE THAN 7 DAYS OLD 2	
421	How many postpartum visits took place during the previous 12 complete months?	NUMBER OF PNC VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998	→ 423
422	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
423	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment areas?	NUMBER OF BIRTHS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NO CATCHMENT AREA ... 999995 DON'T KNOW 999998	→ 426 → 426
424	What is the estimated annual rate of antenatal-care coverage for this facility?	ANC % COVERAGE <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	→ 426
425	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/charts/records maintained for antenatal care clients? IF YES, AS TO SEE A BLANK RECORD OR CHART.	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 428-430, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q322-Q324] 1 DELIVERY [Q520-Q522] 2 STI [Q622-Q624] 3 NOT PREVIOUSLY SEEN 4	→ 431 → 431 → 431
428	DESCRIBE THE SETTING OF THE EXAMINATION ROOM.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY .. 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY 3 NO PRIVACY 4	

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.								
	EQUIPMENT REQUIRED FOR ANTENATAL CARE POSTPARTUM SERVICES	(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	Table or bed for gynecological exam	1	2	3	8				
03	Clean (or sterile) latex gloves	1 05 ↙	2	3	8				
04	Other disposable, non-latex gloves	1	2	3	8				
05	Sharps container	1	2	3	8				
06	At least five or more 2-5 ml syringes (with 21 gauge needles)	1	2	3	8				
07	Already mixed decontaminating solution	1	2	3	8				
08	Disinfectant (not yet mixed)	1	2	3	8				
09	Waste receptacle with lid and plastic liner	1	2	3	8				
10	Hand washing soap	1	2	3	8				
11	Single-use hand drying towel	1	2	3	8				
12	Water for hand washing	1	2	3 431 ↙	8 431 ↙				
430	How is water being made available for use in the antenatal care service area <i>today</i> ?	PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3							

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
431	NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.								
		(a) AVAILABILITY				(b) FUNCTIONING			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW	
01	Blood pressure apparatus	1 → b	2 → b	3 02 ↙	8 02 ↙	1	2	8	
02	Stethoscope	1 → b	2 → b	3 03 ↙	8 03 ↙	1	2	8	
03	Fetal stethoscope (Pinard)	1 → b	2 → b	3 04 ↙	8 04 ↙	1	2	8	
04	Thermometer	1 → b	2 → b	3 05 ↙	8 05 ↙	1	2	8	
05	Infant scale	1 → b	2 → b	3 06 ↙	8 06 ↙	1	2	8	
06	Adult weighing scale	1 → b	2 → b	3 07 ↙	8 07 ↙	1	2	8	
07	Vaginal speculum (s)	1	2	3	8				
08	Vaginal speculum (m)	1	2	3	8				
09	Vaginal speculum (l)	1	2	3	8				
432	NOTE THE AVAILABILITY OF PROTOCOLS AND TEACHING MATERIALS.		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Focused Antenatal care, malaria and syphilis during pregnancy orientation package for service providers (FANC)		1	2	3	8			
02	Any other Guidelines or protocols for antenatal care		1	2	3	8			
03	Guidelines for Syndromic Approach for STIs		1	2	3	8			
04	Other guidelines or protocols for diagnosing or treating STIs		1	2	3	8			
05	Visual aids for client education on subjects related to pregnancy or antenatal care		1	2	3	8			
433	Does this facility have a formal relationship with traditional birth attendants (TBAs) in which they receive training or other types of support?		YES 1 NO 2			→ 437			
434	Is there any documentation on activities with TBAs (such as lists of affiliated TBAs or records of their training)?		YES, OBSERVED 1 YES, REPORTED, NOT SEEN .. 2 NO 3						
435	Please tell me how many TBAs report to this facility? ENTER "00" FOR "NONE"		# OF TBAs REPORTING <input type="text"/> <input type="text"/> DON'T KNOW 98						
436	Does anyone from this facility supervise the activities of the TBAs?		YES 1 NO 2 DON'T KNOW 8						
437	Do the TBAs refer women to this facility?		YES 1 NO 2						

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO						
438	What is the <i>most common</i> 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, CIRCLE THE NUMBER FOR ALL THAT APPLY.	AMBULANCE A PRIVATE CAR/BUS B PUBLIC CAR/BUS C MOTORCYCLE D BICYCLE E PEOPLE CARRY/PUSH OR PULL PATIENT F ANIMALS CARRY/PULL PATIENTS G OTHER X (SPECIFY) NEVER RECEIVE EMERGENCY Y							
439	Does this facility have a functional ambulance or other vehicle for emergency obstetric transportation? ACCEPT REPORTED RESPONSE. CIRCLE 3 IF FACILITY IS REFERRAL SITE.	YES 1 NO 2 REFERRAL SITE 3 DON'T KNOW 8	→ 441 → 443 → 441						
440	Is fuel available today? ACCEPT REPORTED RESPONSE.	YES 1 NO 2 DON'T KNOW 8							
441	Please tell me if this facility has any of the following systems to support emergency obstetric referrals.	<div style="text-align: right;">DON'T</div> <div style="text-align: center;">YES NO KNOW</div>							
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 transportation?	HIRE VEHICLE 1 2 8							
03	Is there a community health insurance scheme that provides support for emergency obstetric referrals?	COMMUNITY SUPPORT 1 2 8							
04	Is fuel set aside for emergency obstetric referrals?	FUEL SET ASIDE 1 2 8							
05	Is there a revolving fund system for transportation for emergency obstetric referrals?	REVOLVING FUND 1 2 8							
06	Does the facility radio or phone another facility to send transportation for emergency obstetric referrals?	PHONE FOR TRANSPORT 1 2 8							
07	Is there any other system? IF YES, SPECIFY _____	OTHER 1 2 8							
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..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> DON'T KNOW 998 02 WET SEASON MINUTES..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> DON'T KNOW 998							
443	Are ANC clients with HIV/AIDS or suspected HIV/AIDS ever provided services related to HIV/AIDS in this clinic/unit? This includes services related to prevention of mother to child transmission (PMTCT).	YES 1 NO 2	Q: PMTCT QRE						

5. Delivery and Newborn Care			
Facility Number: <input type="text"/> <input type="text"/> <input type="text"/>		Interviewer Code: <input type="text"/> <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
500	Does this facility offer services for normal deliveries? IF YES, INDICATE RESPONSE THAT BEST REFLECTS THE CURRENT PRACTICE FOR DELIVERIES.	YES 1 NO, HAVE INFRASTRUCTURE, NO SERVICE PROVIDED 2 ONLY HOME DELIVERIES 3 NO 4	→ 540 → 540 → 540
<p>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:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>			
501	May I begin the interview now?	YES 1 NO 2	→ STOP
502	Please tell me the total number of beds in the maternity ward/unit in this facility	# OF BEDS IN MATERNITY <input type="text"/> <input type="text"/> <input type="text"/>	
503	Does the facility provide 24 hour coverage for delivery services?	YES 1 NO 2	→ 506
504	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	→ 506

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
505	At night, what level of provider is most commonly on duty to conduct deliveries? IF DIFFERENT LEVELS ARE COMMONLY AVAILABLE, CIRCLE ALL RELEVANT LEVELS.	OBSTETRICIAN/ GYNECOLOGIST A MEDICAL DOCTOR B MEDICAL OFFICER C ASSISTANT MEDICAL OFFICER D CLINICAL OFFICER E MIDWIFE (NURSE TRAINED IN MIDWIFERY OR MIDWIFE... F QUALIFIED NURSE (NOT TRAINED IN MIDWIFERY) G PRIMARY LEVEL (NURSE OR MIDWIFE) H ASSISTANT/AUXILIARY I OTHER X (SPECIFY) DON'T KNOW Z	
506	During normal working hours, what level of provider is most commonly available to conduct complicated deliveries?	OBSTETRICIAN/ GYNECOLOGIST A MEDICAL DOCTOR B MEDICAL OFFICER C ASSISTANT MEDICAL OFFICER D CLINICAL OFFICER E MIDWIFE (NURSE TRAINED IN MIDWIFERY OR MIDWIFE F QUALIFIED NURSE (NOT TRAINED IN MIDWIFERY) G PRIMARY LEVEL (NURSE OR MIDWIFE) H ASSISTANT/AUXILIARY I OTHER X (SPECIFY) DON'T KNOW Z	
507	Does this facility have any routine user-fees or charges for any services related to delivery services? This includes any fees, including those for registration or for client health records.	YES 1 NO, CLIENTS HAVE NO OUT-OF-POCKET CHARGES OR USER-FEES ... 2	→ 510
508	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for antenatal care services:	YES NO DON'T KNOW	
01	Is there a fee for normal delivery?	FEE FOR DELIVERY 1 2 8	
02	Is there a fee for the package of ANC and delivery services?	FIXED ANC PLUS DELIVERY FEE 1 2 8	
03	Are there any fees or charges for medicines?	MEDICINES 1 2 8	
04	Are there fees for laboratory or other diagnostic tests?	TESTS 1 2 8	
05	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1 2 8	
509	Are the official fees posted 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	
510	Is there a register where client information from attended births is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW BIRTH OUTCOME FOR MOTHER AND INFANT.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 514 → 514
511	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 30 DAYS ... 1 MORE THAN 30 DAYS OLD 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
512	How many women delivered at this facility during the previous 12 completed months? (EXCLUDE C-SECTION IF POSSIBLE)	NUMBER OF DELIVERIES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998	→ 514
513	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
514	What percentage of deliveries in your catchment area are conducted by this facility (what is your estimated annual coverage rate?)	% COVERAGE <input type="text"/> <input type="text"/> <input type="text"/> NO CATCHMENT AREA ... 995 DON'T KNOW 998	→ 516 → 516
515	RECORD THE SOURCE OF INFORMATION FOR THE ESTIMATED DELIVERY COVERAGE.	WRITTEN REPORT A GRAPH/CHART B OTHER X (SPECIFY) SOURCE NOT KNOWN Z	
516	Do 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	→ 519
517	Is there a home delivery bag or kit? IF YES, ASK TO SEE THE BAG/KIT.	YES, BAG SEEN 1 YES, BAG NOT SEEN 2 NO 3	→ 519 → 519
518	INDICATE WHETHER THE ITEMS LISTED ARE IN THE DELIVERY BAG OR NOT.	YES NO	
01	Soap	1 2	
02	Scissor or blade	1 2	
03	Clamp or umbilical tie	1 2	
04	Ergometrine oral	1 2	
05	Ergometrine inj. with syringe and needle	1 2	
06	Decontaminant	1 2	
07	IV Fluid with infusion set	1 2	
08	Sutures	1 2	
09	Dissecting forceps	1 2	
10	Clean gloves	1 2	
11	Cotton wool	1 2	
519	ASK TO SEE THE ROOM WHERE NORMAL DELIVERIES ARE CONDUCTED. IF THE SAME EXAMINATION ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN 520-522, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q322-Q324] 1 ANTENATAL [Q428-Q430] 2 STI [Q622-Q624] 3 NOT PREVIOUSLY SEEN 4	→ 523 → 523 → 523
520	DESCRIBE THE SETTING OF THE DELIVERY ROOM.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY ... 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY 3 NO PRIVACY 4	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
521	NOTE THE AVAILABILITY AND CONDITION OF SUPPLIES AND EQUIPMENT REQUIRED FOR DELIVERY SERVICES. EQUIPMENT MAY BE IN DELIVERY ROOM OR AN ADJACENT ROOM.								
	EQUIPMENT REQUIRED FOR DELIVERY SERVICES	(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	Table or bed for delivery	1	2	3	8				
03	Sterile latex gloves	1 05 ↘	2	3	8				
04	Other disposable non-latex gloves	1	2	3	8				
05	Sharps container	1	2	3	8				
06	At least five or more 2-5 ml syringes (with 21 gauge needles)	1	2	3	8				
07	Already mixed decontaminating solution	1	2	3	8				
08	Disinfectant (not yet mixed)	1	2	3	8				
09	Waste receptacle with lid and plastic liner	1	2	3	8				
10	Soap for hand washing	1	2	3	8				
11	Single-use hand-drying towel	1	2	3	8				
12	Water for hand washing	1	2	3 523 ↘	8 523 ↘				
522	How is water being made available for use in the delivery service area <i>today</i> ?				PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3				

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
523	NOTE THE AVAILABILITY AND CONDITION OF OTHER SUPPLIES AND EQUIPMENT.								
		(a) AVAILABILITY				(b) FUNCTIONING			
	OTHER SUPPLIES AND EQUIPMENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW	
01	24-hour functioning light source (lantern acceptable)	1 → b	2 → b	3 02 ↙	8 02 ↙	1	2	8	
02	Skin antiseptic (such as Chlorhexidine, Savlon, or Dettol)	1	2	3	8				
03	Intravenous infusion set	1	2	3	8				
04	Syringes and needles	1	2	3	8				
05	Suture material with needle	1	2	3	8				
06	Sterile scissors or blade	1	2	3	8				
07	Needle holder	1	2	3	8				
08	Sterile gloves	1	2	3	8				
524	MEDICATIONS IN DELIVERY SERVICE AREA					(b) AT LEAST ONE VALID			
						YES	NO	DON'T KNOW	
01	Intravenous solutions: either Ringers lactate, D5NS, or NS infusion	1 → b	2 02 ↙	3 02 ↙	8 02 ↙	1	2	8	
02	Injectable ergometrine/methergine	1 → b	2 03 ↙	3 03 ↙	8 02 ↙	1	2	8	
03	Injectable oxytocin/syntocin	1 → b	2 04 ↙	3 04 ↙	8 04 ↙	1	2	8	
04	Injectable diazepam	1 → b	2 05 ↙	3 05 ↙	8 05 ↙	1	2	8	
05	Injectable magnesium sulfate	1 → b	2 06 ↙	3 06 ↙	8 06 ↙	1	2	8	
06	Hydralazine or apresoline inj.	1 → b	2 07 ↙	3 07 ↙	8 07 ↙	1	2	8	
07	Injectable amoxicillin or ampicillin	1 → b	2 08 ↙	3 08 ↙	8 08 ↙	1	2	8	
08	Injectable gentamicin	1 → b	2 09 ↙	3 09 ↙	8 09 ↙	1	2	8	
09	Antibiotic eye drops or ointment (not chloramphenicol)	1 → b	2 10 ↙	3 10 ↙	8 10 ↙	1	2	8	
10	Vitamin A 200,000 IU (oral)	1 → b	2 11 ↙	3 11 ↙	8 11 ↙	1	2	8	
11	Procaine penicillin injection	1 → b	2 12 ↙	3 12 ↙	8 12 ↙	1	2	8	
12	Nevirapine tabs	1 → b	2 13 ↙	3 13 ↙	8 13 ↙	1	2	8	
13	Nevirapine syrup	1 → b	2 525 ↙	3 525 ↙	8 525 ↙	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
525	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	Bag and mask or tube and mask (infant size) for resuscitation	1 → b	2 → b	3 02 ↙	8 02 ↙	1	2	8
02	Incubator	1 → b	2 → b	3 03 ↙	8 03 ↙	1	2	8
03	Other source of heat for premature infant	1 → b	2 → b	3 04 ↙	8 04 ↙	1	2	8
04	Infant scale	1 → b	2 → b	3 05 ↙	8 05 ↙	1	2	8
05	Suction bulb for mucus extraction	1 → b	2 → b	3 06 ↙	8 06 ↙	1	2	8
06	Suction apparatus for use with catheter	1 → b	2 → b	3 07 ↙	8 07 ↙	1	2	8
07	Resuscitation table for baby with heat source	1	2	3	8			
08	Disposable cord ties or clamps	1	2	3	8			
09	Towel or blanket to wrap baby	1	2	3	8			
10	Vitamin K (Inj)	1	2	3	8			
11	Referral card for a newborn	1	2	3	8			
526	GUIDELINES/ PROTOCOLS							
01	Guidelines for normal delivery	1	2	3	8			
02	Guidelines for emergency obstetric care	1	2	3	8			
03	Blank partographs ANY PARTOGRAPH REGARDLESS OF WHETHER IT IS SEPARATE PAPERS OR ON THE MOTHERS CARD	1	2	3	8			
527	CHECK Q525(02) IF INCUBATOR IS AVAILABLE IN UNIT YES, OBSERVED OR REPORTED <input type="checkbox"/> NO <input type="checkbox"/>						529	
528	Is there someone in the unit who has received technical training to operate the incubator?	YES 1 NO 2 DON'T KNOW 8						
529	Now I want to ask you about routine practices related to the newborn at this facility. I am using the word "routine" to indicate that the activity is conducted for essentially all newborns or their mothers.							
01	Is rooming-in the normal practice in this facility? That is, does the newborn stay in the same room with the mother?	YES 1 NO 2 DON'T KNOW 8						
02	Does this facility routinely provide vitamin A to mothers before their discharge?	YES 1 NO 2 DON'T KNOW 8						

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO			
530	Does this facility routinely observe any of the following practices postpartum or related to newborns?	YES	NO	DON'T KNOW				
01	Suction the newborn by means of catheter	1	2	8				
02	Weigh the newborn	1	2	8				
03	Give full bath (immerse newborn in water) within 24 hours of birth	1	2	8				
04	Give the newborn prelacteal liquids	1	2	8				
05	Give the newborn OPV prior to discharge	1	2	8				
06	Give the newborn BCG prior to discharge	1	2	8				
531	Does the facility participate in regular reviews of maternal or newborn deaths or "near-misses"?	YES, FOR MOTHERS 1 YES, FOR NEWBORNS 2 YES, FOR BOTH 3 NO, DOES NOT PARTICIPATE 4			→ 533			
532	How often are reviews of maternal and/or infant deaths and/or near misses carried out?	EVERY WEEKS <input type="text"/> <input type="text"/> WHEN CASE OCCURS 53 DON'T KNOW 98						
533	Does this facility handle assisted deliveries—that is, use forceps or ventouse (vacuum extractor)? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES 1 NO 2			→ 536			
534	CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.							
		(a) AVAILABILITY		(b) FUNCTIONING				
		OBSERVED NOT SEEN	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Ventouse (vacuum extractor)	1 → b	2 → b	3 535 ↙	8 535 ↙	1	2	8
535	Has an assisted delivery been conducted in this facility within the past 3 months?	YES 1 NO 2 DON'T KNOW 8						
536	Is this facility able to extract retained products of conception when necessary? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES 1 NO 2			→ 538			
537	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 → b	2 → b	3 03 ↙	8 03 ↙	1	2	8
03	Other _____	1 → b	2 → b	3 538 ↙	8 538 ↙	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
538	Has manual vacuum aspiration or D & C been used to remove retained products of conception by this facility during the past 3 months?	YES 1 NO 2 DON'T KNOW 8	
539	Now I am going to ask you about other medical interventions for management of complications during labor 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 YES NO DK (b) PROVIDED IN PAST 3 MONTHS YES NO DK	
01	Parenteral oxytocin drugs	1 → b 2 8 02 02	1 2 8
02	Parenteral anti-convulsants for pregnancy-induced hypertension	1 → b 2 8 03 03	1 2 8
03	Manual removal of placenta	1 → b 2 8 540 540	1 2 8
540	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	→ 542
541	Has blood transfusion been performed for maternity care by this facility during the past 3 months?	YES 1 NO 2 DON'T KNOW 8	
542	Does this facility ever perform caesarean sections?	YES 1 NO 2	→ 550
543	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 OBSERVED REPORTED, NOT SEEN NOT AVAILABLE DON'T KNOW (b) FUNCTIONING YES NO DON'T KNOW	
01	Operating table	1 → b 2 → b 3 8 02 02	1 2 8
02	Operating light	1 → b 2 → b 3 8 03 03	1 2 8
03	Anesthesia giving set	1 → b 2 → b 3 8 04 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 8 07 07	1 2 8
07	Suction machine	1 → b 2 → b 3 8 544 544	1 2 8
544	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)?	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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
545	Does this facility have an anesthetist present in the facility or on call 24 hours a day (including weekends)?	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	
546	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	→ 550 → 550
547	RECORD THE NUMBER OF CAESAREAN SECTIONS CONDUCTED AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF CAESAREAN . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→ 549
548	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
549	What is the date of the last caesarean section? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	MONTH YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 989998	
550	AT THIS POINT, CHECK IF EITHER Q500 OR Q542 IS "1" [FACILITY OFFERS DELIVERY SERVICES]	YES 1 NO 2	→ Sec. 6 (Q601)
551	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 95	→ END
552	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	
553	Where is this equipment then 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 "3" AND CONTINUE.	SECTION 1 [Q173-174] 1 FAMILY PLANNING [Q336-337] 2 NOT PREVIOUSLY SEEN 3 PROCESS OUTSIDE FACILITY 4 NO EQUIPMENT PROCESSED 5	→ 556(6) → 556(6) → 556(6) → 556(6)
553a	Besides <i>decontaminating and cleaning</i> , what is the final process most commonly used for sterilizing reusable syringes and needles? CIRCLE ALL THAT APPLY	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E DISCARD/DISPOSABLES ONLY F OTHER X (SPECIFY) NONE Y	
554	Besides <i>decontaminating and cleaning</i> , what is the final process most 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 OTHER X (SPECIFY) NONE Y	→ 557 → END

NO.	QUESTIONS		CODING CLASSIFICATION				GO TO		
555	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 ster- ilization is complete.	1	2	3	8			
	09	Written protocols or guidelines for ster- ilization of disinfection	1	2	3	8			

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 without pressure	(5) Chemical High Level Disinfectant (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 → 557																												
B	Temperature (centigrade)	TEMPERATURE [][] AUTOMATIC 666 DONT KNOW ... 998																																
C	Pressure	TEMPERATURE [][] AUTOMATIC 666 DONT KNOW ... 998																																
D	Units of pressure	PRESS- URE [][] AUTOMATIC 666 → 2E DONT KNOW 998 → 2E 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 DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998	MINUTES [][] DONT KNOW ... 998																												
F	Minutes when equipment is wrapped	MINUTES WRAPPED [][] AUTOMATIC 666 DONT KNOW ... 998																																
G	Chemical disinfectant used	<table border="0"> <tr> <td>GIK</td><td>1</td><td>GIK</td><td>1</td> </tr> <tr> <td>CHLORINE</td><td>2</td><td>CHLORINE</td><td>2</td> </tr> <tr> <td>CIDEX</td><td>3</td><td>CIDEX</td><td>3</td> </tr> <tr> <td>BETADINE</td><td>4</td><td>BETADINE</td><td>4</td> </tr> <tr> <td>ALCOHOL</td><td>5</td><td>ALCOHOL</td><td>5</td> </tr> <tr> <td>OTHER</td><td>6</td><td>OTHER</td><td>6</td> </tr> <tr> <td>DONT KNOW</td><td>8</td><td>DONT KNOW</td><td>8</td> </tr> </table>					GIK	1	GIK	1	CHLORINE	2	CHLORINE	2	CIDEX	3	CIDEX	3	BETADINE	4	BETADINE	4	ALCOHOL	5	ALCOHOL	5	OTHER	6	OTHER	6	DONT KNOW	8	DONT KNOW	8
GIK	1	GIK	1																															
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H	Percent solution before dilution	<table border="0"> <tr> <td>PERCENT</td><td>[][]</td><td>PERCENT</td><td>[][]</td> </tr> <tr> <td>DONT KNOW</td><td>98</td><td>DONT KNOW</td><td>98</td> </tr> </table>					PERCENT	[][]	PERCENT	[][]	DONT KNOW	98	DONT KNOW	98																				
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DONT KNOW	98	DONT KNOW	98																															
I	Mixture, parts solution and water	<table border="0"> <tr> <td>MIXTURE PARTS</td><td>[][]</td><td>MIXTURE PARTS</td><td>[][]</td> </tr> <tr> <td>a) DISINFECTANT</td><td>[][]</td><td>a) DISINFECTANT</td><td>[][]</td> </tr> <tr> <td>b) WATER</td><td>[][]</td><td>b) WATER</td><td>[][]</td> </tr> <tr> <td>DK</td><td>000</td><td>DK</td><td>000</td> </tr> </table>					MIXTURE PARTS	[][]	MIXTURE PARTS	[][]	a) DISINFECTANT	[][]	a) DISINFECTANT	[][]	b) WATER	[][]	b) WATER	[][]	DK	000	DK	000												
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b) WATER	[][]	b) WATER	[][]																															
DK	000	DK	000																															

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
557	INDICATE ALL STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (SUCH AS SPECULUM , FORCEPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT PREVIOUSLY ASSESSED, CIRCLE "3" AND CONTINUE.	SECTION 1 [Q175] 1 FAMILY PLANNING [Q339] 2 NOT PREVIOUSLY SEEN 3			→ Sec. 6 → Sec. 6
558	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 cloth, sealed with TST 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 TST sealing tape	1	2	3	8
05	In container with disinfectant or antiseptic	1	2	3	8
06	Other stored, clean and covered	1	2	3	8
07	Other stored, not clean and/or uncovered	1	2	3	8
08	Date of sterilization written on packet or container with processed items	1	2	3	8
09	Storage location dry and clean	1	2	3	8

6. Services for Reproductive Tract and Sexually Transmitted Infections			
Facility Number: <input type="text"/> <input type="text"/> <input type="text"/>		Interviewer Code: <input type="text"/> <input type="text"/>	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
601	First, I want to ask specifically about services for clients with symptoms that may be STIs. If a client comes with symptoms that may be an STI, does this facility offer any services for diagnosis or treatment of STIs?	YES 1 NO 2	→ 627
<p>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 Q602. READ THE FOLLOWING TO NEW RESPONDENTS:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>			
602	May I begin the interview now?	YES 1 NO 2	→ STOP
603	Are services for STI clients being offered at this facility today?	YES 1 NO 2	
604	Are STI services primarily offered in a special clinic or through general outpatient services?	SPECIAL CLINIC 1 GENERAL OUTPATIENT 2	
605	How many days per week are STI services available in either the special/the general clinic?	NUMBER OF DAYS <input type="text"/>	
606	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY.	SYNDROMIC APPROACH .. A ETIOLOGIC (LAB) B CLINICAL JUDGMENT C	
607	Does this facility have a protocol regarding confidentiality for STI clients? IF YES, ASK TO SEE A COPY.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO				
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, SOMETIMES ACTIVE . . 1 YES, ONLY PASSIVE 2 NO 3	→ 610 → 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/REGISTER I 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. FOR THE REGISTER TO BE VALID, IT MUST SHOW CLIENTS' NAME, AGE, SEX, AND DIAGNOSIS OR MAIN SYMPTOM.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN. 2 NO 3	→ 615 → 615				
611	Does the register indicate a specific type of STI that was diagnosed?	YES 1 NO 2					
612	How recent is the date of the most recent entry for a probable STI or reproductive tract infection?	WITHIN THE PAST 7 DAYS . . 1 MORE THAN 7 DAYS OLD . . 2					
613	RECORD THE NUMBER OF CLIENTS WHO RECEIVED STI SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> STI CLIENTS . . DON'T KNOW 9998					→ 615
614	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> DON'T KNOW 98					
615	Do you submit an official report externally (usually to the Ministry of Health or a public-health agency responsible for communicable diseases) that specifically identifies numbers of cases of venereal diseases (syphilis, gonorrhea) or HIV/AIDS seen by the facility services? IF YES: Is the report generated from consultation records or from the laboratory?	YES, CONSULTATION 1 YES, LABORATORY 2 YES, BOTH 3 NO 4					
616	ASK TO SEE WHERE COUNSELING 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 NO PRIVACY 4					

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
	ASK TO SEE EACH OF THE FOLLOWING ITEMS, AND ASSESS IF THE ITEM IS IN THE ROOM (OR AN ADJACENT ROOM) WHERE COUNSELING OR EXAMINATION OF STI CLIENTS TAKES PLACE.					
617	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	Posters on STIs (MAY INCLUDE HIV/AIDS)	1	2	3	8	
04	Posters on HIV/AIDS					
05	Model to demonstrate use of condom	1	2	3	8	
	INFORMATION FOR CLIENT TO TAKE HOME					
06	About STIs	1	2	3	8	
07	About HIV/AIDS	1	2	3	8	
08	Condoms that can be given to the client	1	2	3	8	
618	SERVICE DELIVERY STANDARDS/PROTOCOLS					
01	Sexually transmitted infections, a manual for service providers, 2003(RCHS,NACP)	1	2	3	8	
02	National Guidelines for STI treatment	1	2	3	8	
03	Etiologic (laboratory) diagnosis of STIs	1	2	3	8	
04	Any other Treatment protocols for STIs	1	2	3	8	
05	Syndromic approach guidelines (treatment chart)	1	2	3	8	
06	Guidelines for diagnosing HIV/AIDS	1	2	3	8	
619	Is there a policy that all STI clients should be offered an HIV/AIDS test? IF YES, ASK TO SEE THE POLICY	1	2	3	8	
620	Are individual client health records or charts used? IF YES, ASK TO SEE EITHER A USED OR NEW CLIENT HEALTH CARD/CHARD/RECORD.	1	2	3	8	
621	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR STIs ARE CONDUCTED.					
	IF THE <i>SAME EXAMINATION ROOM</i> HAS ALREADY BEEN OBSERVED FOR ITEMS IN 622-624, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FP [Q322-Q324] 1 ANTENATAL [Q428-Q430] 2 DELIVERY [Q520-Q522] 3 NOT PREVIOUSLY SEEN 4 COUNSELING AND EXAM IN SAME ROOM [Q616] 5			→ 625 → 625 → 625	
622	DESCRIBE THE SETTING OF THE EXAMINATION ROOM. IF THIS IS THE SAME ROOM WHERE COUNSELING OCCURS (Q616), CIRCLE THE SAME RESPONSE AS IN Q616	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY .. 3 NO PRIVACY 4				

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
623	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.								
	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	Table or bed for gynecological exam	1	2	3	8				
03	Clean (or sterile) latex gloves	1 05 ↙	2	3	8				
04	Other clean disposable gloves	1	2	3	8				
05	Sharps container	1	2	3	8				
06	At least five or more 2-5 ml syringes (with 21 gauge needles)	1	2	3	8				
07	Already mixed decontaminating solution	1	2	3	8				
08	Disinfectant (not yet mixed)	1	2	3	8				
09	Waste receptacle with lid and plastic liner	1	2	3	8				
10	Soap for hand washing	1	2	3	8				
11	Single-use hand-drying towel	1	2	3	8				
12	Water for hand washing	1	2	3 625 ↙	8 625 ↙				
624	How is water being made available for use in the service area <i>today</i> ?	PIPED 1 BUCKET WITH TAP 2 BUCKET OR BASIN 3							
625	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN AN ADJACENT ROOM.								
	OTHER EQUIPMENT REQUIRED FOR EXAMINATION	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW				
01	Vaginal speculum (s)	1	2	3	8				
02	Vaginal speculum (m)	1	2	3	8				
03	Vaginal speculum (l)	1	2	3	8				
04	Swab sticks for taking specimens.	1	2	3	8				

NO.	QUESTIONS	CODING CLASSIFICATION					GO TO
626	<p>FOR EACH OF THE FOLLOWING LABORATORY TESTS, ASK:</p> <p>Does this service use any laboratory test for diagnosing [THE INDICATED ILLNESS]?</p> <p>IF NOT, ASK: Do you collect the specimen and send it elsewhere for the test, or does the client have to go somewhere else for the test?</p>						
	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 UTILIZED	DON'T KNOW	
01	Syphilis	1	2	3	4	8	
02	Gonorrhea	1	2	3	4	8	
03	HIV/AIDS test	1	2	3	4	8	
04	Chlamydia	1	2	3	4	8	
627	Are clients with HIV/AIDS or suspected HIV/AIDS, or with tuberculosis ever provided services related to HIV/AIDS in this clinic/unit?	<p>YES 1</p> <p>NO 2</p>				<p>End Q: OPD</p>	

SECTION B: HIV/AIDS OUTPATIENT CARE																		
Facility Number: <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>		QRE TYPE <div style="border: 2px solid black; padding: 2px; font-weight: bold; font-size: 1.2em;">B</div>																
Interviewer: Code <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>																		
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT HIV/AIDS SERVICES OFFERED BY THIS CLINIC/UNIT. INTRODUCE YOURSELF AND BRIEFLY EXPLAIN THE SURVEY. ENSURE ELIGIBILITY FOR QRE.																		
200	INDICATE WHICH OUTPATIENT CLINIC/UNIT THE DATA IN THIS QUESTIONNAIRE REPRESENTS	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>																
		<div style="display: inline-block; text-align: center; width: 40px;">Line #</div> <div style="display: inline-block; text-align: center; width: 40px;">Unit #</div>																
201	MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC) 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE 5 OTHER _____ 6 <div style="text-align: center; margin-top: 5px;">(SPECIFY)</div>																	
202	RECHECK QUESTIONNAIRE AT THE END OF THIS INTERVIEW AND VERIFY THAT ALL APPLICABLE SECTIONS WERE COMPLETED FOR THIS CLINIC/UNIT. FINALLY, MARK ON FACILITY CHECKLIST EACH QRE COMPLETED FOR THIS CLINIC/UNIT.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">APPLICABLE & COMPLETED</th> <th style="width: 20%; text-align: center;">NOT APPLICABLE</th> </tr> </thead> <tbody> <tr> <td>(V)CT Q206, Q208 & Q210</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>PMTCT Q215</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TB Q219 (01, 02, 03)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>ART Q225 (07, 08)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>			APPLICABLE & COMPLETED	NOT APPLICABLE	(V)CT Q206, Q208 & Q210	1	2	PMTCT Q215	1	2	TB Q219 (01, 02, 03)	1	2	ART Q225 (07, 08)	1	2
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TB Q219 (01, 02, 03)	1	2																
ART Q225 (07, 08)	1	2																
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 HIV/AIDS-RELATED SERVICES IN THE CLINIC/UNIT. 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 Q203 BELOW AND GO ON TO Q205.																		
FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE CLINIC/UNIT WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING: Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey. Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified. We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person. You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed? <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%;"> Interviewer's signature _____ SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED. </div> <div style="width: 35%;"> Date _____ </div> </div>																		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
210	Does this clinic/unit have an agreement with the referral site for HIV tests that test results will be returned to the clinic/unit, either directly or through the client?	YES 1 NO 2	Q: VCT → 212
211	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	
212	When you refer a client to another facility for services, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN ... 2 NO FORM USED 3 NEVER REFER OUTSIDE FACILITY ... 4 DON'T KNOW 8	→ 214
213	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD ... 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD ... 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) ... 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER 6 (SPECIFY) NO 7	
214	What is the normal practice for this clinic/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 CLINIC/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	
215	Does this clinic/unit provide any services related to preventing transmission of HIV/AIDS between the mother and the child (PMTCT)?	YES 1 NO 2	Q: PMTCT
216	Is an individual client chart/record/card maintained for clients who receive services through this clinic/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 A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, ONLY AVAILABLE IN OTHER CLINIC/UNIT 3 CLINIC/UNIT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS ... 4 OTHER 6 SPECIFY NO INDIVIDUAL CLIENT CHART/RECORD 7	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
217	Is there a written policy on confidentiality and disclosure of HIV test results or HIV/AIDS status available in this clinic/unit? IF YES: May I see the written policy?	YES, OBSERVED WRITTEN POLICY OR DOCUMENT PROVIDED TO CLIENT... 1 YES, OBSERVED WRITTEN POLICY OR NATIONAL VCT GUIDELINES... 2 YES, REPORTED, NOT SEEN... 3 NO... 4				→ 219
218	Does the policy specify that no one can be informed of the HIV/AIDS status without the client's consent?	YES... 1 NO... 2				
219	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 clinic/unit ever provide the service, refer clients for the service, or never offer the service at all.	SERVICE OFFERED IN THIS FACILITY		NO SERVICE THIS FACILITY		
		PROVIDE SERVICE THIS CLINIC	SERVICE BY PROVIDERS FROM OTHER CLINIC/UNIT THIS FACILITY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL	
01	Do providers assigned to this clinic/unit prescribe medicines for treatment of tuberculosis?	1 TB QRE ↙	2	3	4	
02	Do providers assigned to this clinic/unit make diagnosis that a client has tuberculosis?	1 TB QRE ↙	2	3	4	
03	Do providers assigned to this clinic/unit provide follow-up treatment for clients with tuberculosis?	1 TB QRE ↙	2	3	4	
04	Do providers assigned to this clinic/unit prescribe treatment for sexually transmitted infections (STI)?	1	2	3	4	
05	Do providers assigned to this clinic/unit prescribe treatment for malaria?	1	2	3	4	
220	Are there any guidelines or 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?	SOME GUIDELINES/PROTOCOLS AVAILABLE... 1 SOME GUIDELINES/PROTOCOLS AVAILABLE- NONE SEEN... 2 NO GUIDELINES OR PROTOCOLS... 3				→ 224

NO.	QUESTIONS	CODING CATEGORIES				GO TO
221	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(a)			(b)	
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL. DATE ON OBSERVED MANUAL YEAR	
01	National Guidelines for the clinical management of HIV and AIDS	1 → b	2 → b	3 02	4 02	
02						
03	National Infection Prevention and control guidelines for health care services in Tanzania	1 → b	2 → b	3 04	4 04	
04	National Guidelines for Voluntary Counseling and Testing	1 → b	2 → b	3 05	4 05	
05	Guidelines for management of HIV/AIDS for Frontline workers	1 → b	2 → b	3 06	4 06	
06	National guidelines for prevention of mother-to-child transmission of HIV(PMTCT)	1 → b	2 → b	3 07	4 07	
07	Guidelines for Home Based Care Services	1 → b	2 → b	3 08	4 08	
08	Guidelines for home based care services in Tanzania	1 → b	2 → b	3 09	4 09	
09	A Guideline for counselors in Tanzania with special emphasis on HIV/AIDS/STDs counseling	1 → b	2 → b	3 10	4 10	
10	Guidelines and Standards for Counseling and Supervision	1 → b	2 → b	3 11	4 11	
11	Management of Tuberculosis, manual for health workers	1 → b	2 → b	3 12	4 12	
12	Manual of the national Tuberculosis and Leprosy program in Tanzania	1 → b	2 → b	3 222	4 222	
222	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			→224	
223	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a)			(b)	
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL. DATE ON MANUAL YEAR	
01	Other protocols/guidelines for infection control	1 → b	2 → b	3 02	4 02	
02	Other protocols/guidelines for diagnosis or treatment of sexually transmitted infections?	1 → b	2 → b	3 03	4 03	
03	WHO protocols/guidelines on syndromic management of STIs?	1 → b	2 → b	3 04	4 04	
04	Other protocols/guidelines for diagnosis or treatment of malaria?	1 → b	2 → b	3 05	4 05	
05	Protocols/guidelines for intermittent preventive treatment (IPT) for malaria, during pregnancy?	1 → b	2 → b	3 06	4 05	
06	Protocols/guidelines for routinely offering HIV tests to all STI clients?	1 → b	2 → b	3 07	4 07	
07	Any guidelines for post-exposure prophylaxis?	1 → b	2 → b	3 224	4 224	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
224	Do providers assigned to this clinic/unit ever provide any curative care for illnesses that may be HIV/AIDS related, such as opportunistic infections, or provide or refer the clients for counseling or social support services for help in living with HIV/AIDS?	YES 1 NO, HIV/AIDS CLIENTS ARE REFERRED ELSEWHERE IN THIS FACILITY ... 2 NO, HIV/AIDS CLIENTS ARE REFERRED TO OTHER FACILITY 3 NEVER PROVIDE THESE SERVICES OR REFER CLIENTS WITH HIV/AIDS FOR SERVICES ... 4				→ 230 → 233 → 247
225	For each service I will mention, please tell me if providers in this clinic/unit personally provide the service, refer clients for the service, or do not offer the service at all. Do providers in this clinic unit personally : [READ EACH TOPIC BELOW]	SERVICE OFFERED IN THIS FACILITY			REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL
		PROVIDE SERVICE THIS CLINIC	REFER TO OTHER CLINIC	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 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	Prescribe antiretroviral treatment?	1 ART QRE ↙	2	3	4	5
08	Provide follow-up services for persons receiving antiretroviral treatment (THIS INCLUDES PROVIDING COMMUNITY BASED SERVICES)	1 ART QRE ↙	2	3	4	5
09	Care for pediatric HIV/AIDS patients?	1	2	3	4	5

NO.	QUESTIONS	CODING CATEGORIES				GO TO
226	Next I want to ask about preventive services that are sometimes provided to people who have HIV/AIDS. For each service I mention, tell me if every HIV positive client is offered the service regardless of their condition (routinely offered) or if the service is offered based on the condition of the client (selectively offered) or if it is never offered. If offered, is the preventive service offered in this clinic/unit or is the client referred elsewhere to receive the preventive service?	PROVIDE THE SERVICE IN THIS CLINIC/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)	1	2	3	4	5
03	Primary preventive treatment, that is, before the client is ill, for opportunistic infections such as Cotrimoxazole 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	Provide condoms for preventing further transmission of HIV/AIDS?	1	2	3	4	5
227	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				→229
228	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)				(b)
		COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON MANUAL YEAR
01	Other protocols/guidelines for the clinical management of HIV/AIDS infection in adults	1 → b	2 → b	3 02 ↙	4 02 ↙	
02	Other protocols/guidelines for management of opportunistic infections in adults.	1 → b	2 → b	3 03 ↙	4 03 ↙	
03	Other protocols/guidelines for the clinical management of HIV/AIDS infection in children	1 → b	2 → b	3 04 ↙	4 04 ↙	
04	Protocols/guidelines on micronutrient supplementation	1 → b	2 → b	3 05 ↙	4 05 ↙	
05	Protocols/guidelines on advanced nutritional support, such as fortified protein supplement to treat or prevent severe malnutrition?	1 → b	2 → b	3 06 ↙	4 06 ↙	
06	Protocols/guidelines on provision of symptomatic or palliative care?	1 → b	2 → b	3 07 ↙	4 07 ↙	
07	Protocols/guidelines on preventive therapy other than TB, such as cotrimoxazole to prevent pneumonia?	1 → b	2 → b	3 08 ↙	4 08 ↙	
08	Protocols/guidelines on preventive therapy for tuberculosis	1 → b	2 → b	3 09 ↙	4 09 ↙	
09	Other protocols/guidelines on community or home-based care for HIV/AIDS clients	1 → b	2 → b	3 10 ↙	4 10 ↙	
10	Other protocols/guidelines on counseling for HIV testing or VCT?	1 → b	2 → b	3 11 ↙	4 11 ↙	
11	Other protocols/guidelines on PMTCT	1 → b	2 → b	3 12 ↙	4 12 ↙	
12	Other protocols/guidelines on ART/ARVs	1 → b	2 → b	3 13 ↙	4 13 ↙	
13	Other protocols/guidelines on PEP	1 → b	2 → b	3 229 ↙	4 229 ↙	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
229	I want to ask about various support services that are commonly needed by people with HIV/AIDS. For each service I ask about, please tell me if providers in this clinic/unit ever 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 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 (PLHA)?	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 PLHA and their families?	1	2	3	4	5
06	Legal services?	1	2	3	4	5
07	Counseling 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 providers such as herbalist, acupuncture, traditional	1	2	3	4	5
10	Provide or refer providers of HIV/AIDS services for emotional/spiritual support?	1	2	3	4	5
230	Is there a record maintained of client referrals outside this clinic/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 FACILITY 5				→238
231	When you refer a client to another clinic/unit within this facility, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO FORM USED 3 NEVER REFER WITHIN FACILITY 4 DON'T KNOW 8				→233 →233

NO.	QUESTIONS	CODING CATEGORIES	GO TO
232	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER _____ 6 (SPECIFY) NO 7	
233	When you refer a client to another facility for services, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO FORM USED 3 NEVER REFER OUTSIDE FACILITY 4 DON'T KNOW 8	→235 →235 →237 →235
234	Does the referral form have a place where the name and location of the referral site can be entered?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→236 →236 →236
235	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER _____ 6 (SPECIFY) NO 7	
236	Is there any system for providing or receiving feedback for referrals made by or received by this clinic/unit? 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	
237	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	
238	CHECK Q225 AND RECORD IF ANY RESPONSES ARE '1', INDICATING THIS CLINIC/UNIT PROVIDES CLINICAL SERVICES FOR HIV/AIDS.	YES 1 NO 2	→247

NO.	QUESTIONS	CODING CATEGORIES	GO TO																												
239	Where can we find information on the numbers of clients seen in this clinic/unit who received services for HIV/AIDS related diagnoses, such as opportunistic infections? PROBE TO DETERMINE THE SYSTEM USED. IF THE CLINIC/UNIT COMPILES REPORTS AND THE REPORTS HAVE SPECIFIC DIAGNOSES, INFORMATION MAY BE COLLECTED FROM CENTRAL LOCATION. CLINIC/UNIT RECORDS MUST STILL BE OBSERVED FOR THE MOST RECENT DATE. IF REPORTS DO NOT CAPTURE HIV/AIDS DIAGNOSES, REVIEW THE CLINIC/UNIT REGISTER AS INSTRUCTED BELOW.	CLINIC/UNIT REGISTER/RECORDS . 1 OR COMPUTER CENTRAL FACILITY LOCATION (RECORDS OR COMPUTERIZED) . 2 NO RECORD MAINTAINED 3	→244 →247																												
240	<p>EXPLAIN: I want to review the record/register to count the number of clients with HIV/AIDS related illnesses who have received services in this clinic/unit during the past year. If the diagnoses I am looking for are compiled for reports, I can use those reports, otherwise, I need to review the clinic/unit records. START WITH ENTRIES FROM THE LAST DAY OF THE MOST RECENT COMPLETED MONTH, AND REVIEW LISTED DIAGNOSES/SYMPTOMS FOR 12 FULL MONTHS OR FOR 1000 CLIENT VISITS, WHICHEVER IS THE LEAST NUMBER OF CLIENTS. BE CERTAIN TO COMPLETE THE INFORMATION FOR THE FULL MONTH IN WHICH THE 1000TH CLIENT VISIT FELL.</p> <p>IF MORE THAN ONE REGISTER IS USED, BE CERTAIN TO SCAN ALL REGISTERS WHERE ELIGIBLE CLIENTS MAY HAVE BEEN RECORDED FOR THE TIME PERIOD BEING REVIEWED. IF THERE ARE MORE THAN ONE OF THE BELOW LISTED DIAGNOSES/SYMPTOMS FOR ONE CLIENT, CHOOSE THE SYMPTOM OR DIAGNOSIS MOST SPECIFIC FOR HIV/AIDS. DO NOT RECORD THE SAME CLIENT VISIT UNDER MORE THAN ONE OF THE BELOW LISTED DIAGNOSES/SYMPTOMS.</p> <table border="1"> <thead> <tr> <th></th><th>NUMBER OF VISITS</th></tr> </thead> <tbody> <tr> <td>1 ORAL CANDIDIASIS/MOUTH SORES</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>2 CRYPTOCOCCAL MENINGITIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>3 TOXOPLASMOSIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>4 KAPOSI'S SARCOMA</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>5 AIDS-RELATED COMPLEX (ARC)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>6 HERPES ZOSTER/SIMPLEX</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>7 PCP (PNEUMOCYSTIS CARINII PNEUMONIA)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>8 IMMUNOSUPPRESSION/ HIV/AIDS OR RVD</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>9 WASTING SYNDROME FAILURE TO THRIVE (FTT)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>10 CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>11 TUBERCULOSIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>12 OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>13 OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> </tbody> </table>		NUMBER OF VISITS	1 ORAL CANDIDIASIS/MOUTH SORES	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2 CRYPTOCOCCAL MENINGITIS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	3 TOXOPLASMOSIS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	4 KAPOSI'S SARCOMA	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	5 AIDS-RELATED COMPLEX (ARC)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	6 HERPES ZOSTER/SIMPLEX	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	7 PCP (PNEUMOCYSTIS CARINII PNEUMONIA)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	8 IMMUNOSUPPRESSION/ HIV/AIDS OR RVD	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9 WASTING SYNDROME FAILURE TO THRIVE (FTT)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10 CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	11 TUBERCULOSIS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	12 OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	13 OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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241	RECORD THE NUMBER OF MONTHS OF DATA THAT IS REPRESENTED IN PREVIOUS QRE	NUMBER OF FULL MONTHS OF DATA	<input type="text"/> <input type="text"/>																												
242	RECORD THE TOTAL NUMBER OF VISITS FROM WHICH DIAGNOSTIC INFORMATION WAS COLLECTED	TOTAL NUMBER OF VISITS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																												

NO.	QUESTIONS	CODING CATEGORIES	GO TO
243	WHAT IS THE MOST RECENT DATE THAT ANY HIV/AIDS OR NON-HIV/AIDS CLIENT DIAGNOSES ARE RECORDED?	WITHIN PAST 30 DAYS 1 MORE THAN 30 DAYS AGO 2 REGISTER NOT SEEN 3	
244	Are reports regularly compiled on the number of visits by clients who seek treatment from this clinic/unit?	YES 1 NO 2	→247
245	How frequently are the compiled reports submitted to someone outside of this clinic/unit?	MONTHLY OR MORE OFTEN 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5	→247
246	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/CBOH/NAC) C REGIONAL LEVEL (MOH/CBOH/TACAIDS) D NATIONAL LEVEL (MOH/CBOH/TACAIDS) E DONOR AGENCY F OTHER X (SPECIFY) _____	
247	Now I want to ask you about post-exposure prophylaxis (PEP) for people who may have been exposed to HIV/AIDS. Is PEP available for staff in this clinic/unit? IF YES, ASK: Do providers in this clinic/unit prescribe the PEP or refer staff for PEP?	YES, PEP PRESCRIBED/STAFF REFERRED BY THIS CLINIC/UNIT 1 YES, PEP PRESCRIBED/REFERRED IN OTHER SITE THIS FACILITY ... 2 YES, STAFF CAN RECEIVE PEP FROM OTHER FACILITY IF DESIRED 3 NO ACCESS TO PEP 4	→255 →255 →255
248	Is there a register or record maintained in this clinic/unit for workers who have been prescribed PEP or have been referred for PEP? IF YES, ASK: May I see the register/record? CHECK 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 NO RECORDS THIS LOCATION BUT RECORDS KEPT IN DIFFT SERVICE UNITS E NO, INFORMATION RECORDED IN INDIVIDUAL HEALTH RECORD ONLY F NO RECORD FOR PEP Y	
249	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/GUIDELINES	YES, OBSERVED COMPLETE 1 YES, OBSERVED, INCOMPLETE 2 YES, REPORTED NOT SEEN 3 NO 4	
250	What is the PEP regimen that is most commonly prescribed?	COMBIVIR (ZDV/3TC) 1 STAVUDINE/LAMIVUDINE 2 STAVUDINE/LAMIVUDINE plus INDINAVIR 3 STAVUDINE/LAMIVUDINE and EFV or NVP 4 OTHER ONE ARV USED ALONE 5 (SPECIFY) _____ OTHER 6 (SPECIFY) _____	
251	Are any PEP drugs stored in this clinic/unit? IF YES, ASK TO SEE THE PEP DRUGS	YES 1 NO 2	→255
252	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	COMBIVIR (ZDV/3TC) A STAVUDINE/LAMIVUDINE B STAVUDINE/LAMIVUDINE plus INDINAVIR C STAVUDINE/LAMIVUDINE and EFV or NVP D OTHER COMBINATION E (SPECIFY) _____ OTHER ONE ARV USED ALONE F (SPECIFY) _____ NONE Y	→255

NO.	QUESTIONS	CODING CATEGORIES			GO TO
253	DESCRIBE THE STORAGE OF THE PEP MEDICINES. ARE THE PEP MEDICINES STORED IN A LOCKED STORAGE UNIT AND 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)			
254	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			
255	Does this clinic/unit ever keep patients overnight for observation or treatment? IF THE RESPONSE IS NO, PROBE FOR CORRECT RESPONSE.	YES 1 NO, PATIENTS NEEDING OBSERVATION OR TREATMENT ARE ADMITTED TO THE FACILITY INPATIENT UNITS .. 2 NO OVERNIGHT CARE 3			
256	Is there a waiting area for clients where they are protected from sun and rain?	YES 1 NO 2			
257	Is there a client toilet or latrine that patients from this clinic/unit can use? IF YES, ASK TO SEE THE TOILET/LATRINE AND INDICATE THE CONDITION	YES, FUNCTIONING, CLEAN 1 YES, FUNCTIONING, NOT CLEAN ... 2 YES, NOT FUNCTIONING 3 NO CLIENT TOILET/LATRINE 4			
ASK TO SEE THE AREA(S) IN THIS CLINIC/UNIT WHERE MOST CLIENTS WITH HIV/AIDS RELATED ILLNESSES OR THOSE RECEIVING HIV/AIDS RELATED SERVICES ARE EXAMINED. OBSERVE THE CONDITIONS UNDER WHICH CLIENT EXAMINATION TAKES PLACE. IF THERE ARE SEVERAL ROOMS FOR THE SAME PURPOSE, RANDOMLY PICK ONE TO ASSESS					
258	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
12	RAPID TEST FOR HIV	1	2	3	
13	DISPOSABLE NEEDLES	1	2	3	
14	DISPOSABLE SYRINGES	1	2	3	
15	EXAMINATION TABLE	1	2	3	
16	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → 259	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	

NO.	QUESTIONS	CODING CATEGORIES			GO TO
259	Is there a procedure room in this clinic/unit that is different from the clinic/unit just assessed? IF YES, ASK TO SEE AND INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE	YES 1 NO 2			→ 261
260	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
12	RAPID TEST FOR HIV	1	2	3	
13	DISPOSABLE NEEDLES	1	2	3	
14	DISPOSABLE SYRINGES	1	2	3	
15	EXAMINATION TABLE	1	2	3	
16	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → 261	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
261	Is this the main outpatient clinic/unit?	YES 1 NO 2			→ 266

NO.	QUESTIONS	CODING CATEGORIES			GO TO
262	Is there a separate dermatology, or dental clinic/unit? IF YES, GO TO EACH UNIT AND ASSESS THE PROCEDURES ROOM. IF NO PROCEDURES ROOM, ASSESS A CLIENT EXAMINATION ROOM FOR THE FOLLOWING ITEMS. INDICATE WHICH UNIT THE FOLLOWING INFORMATION IS FROM.	DERMATOLOGY 1 DENTAL 2 NONE 3			→ 266
263	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
12	RAPID TEST FOR HIV	1	2	3	
13	DISPOSABLE NEEDLES	1	2	3	
14	DISPOSABLE SYRINGES	1	2	3	
15	EXAMINATION TABLE	1	2	3	
16	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → 264	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
264	INDICATE WHICH UNIT THE FOLLOWING INFORMATION IS FOR. IF NO ELIGIBLE UNIT REMAINS, CIRCLE '3'.	DERMATOLOGY 1 DENTAL 2 NO ELIGIBLE UNITS 3			→ 266

NO.	QUESTIONS	CODING CATEGORIES			GO TO
		OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
265	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA				
01	RUNNING WATER	1 →03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 →08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 →10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
12	RAPID TEST FOR HIV	1	2	3	
13	DISPOSABLE NEEDLES	1	2	3	
14	DISPOSABLE SYRINGES	1	2	3	
15	EXAMINATION TABLE	1	2	3	
16	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 →266	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
266	<p>ASK TO SPEAK WITH THE PERSON MOST FAMILIAR WITH CLEANING AND PROCESSING EQUIPMENT FOR REUSE.</p> <p>What procedure is used for decontaminating and cleaning equipment before its final processing for reuse?</p> <p>PROBE, IF NECESSARY, TO DETERMINE CORRECT RESPONSE.</p>	<p>SOAKED IN DISINFECTANT SOLUTION AND THEN BRUSH SCRUBBED WITH SOAP AND WATER 01</p> <p>BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAKED IN DISINFECTANT 02</p> <p>BRUSH SCRUBBED WITH SOAP AND WATER ONLY 03</p> <p>SOAKED IN DISINFECTANT, NOT BRUSH SCRUBBED 04</p> <p>CLEAN WITH SOAP AND WATER, NOT BRUSH SCRUBBED 05</p> <p>OTHER _____ (SPECIFY) 06</p> <p>NO EQUIPMENT EVER REUSED 07</p> <p>DON'T DECONTAMINATE 95</p>			→ 274
267	Are there written guidelines for how to decontaminate equipment? IF YES, ASK: May I see them?	<p>YES, OBSERVED 1</p> <p>YES, REPORTED, NOT SEEN 2</p> <p>NO 3</p>			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
268	Where is this equipment then processed prior to reuse?	THIS CLINIC/UNIT 1 OTHER CLINIC/UNIT THIS FACILITY 2 ENTER CLINIC/UNIT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NON CLINIC/UNIT (E.G., CENTRAL PROCESSING, THEATER, THIS FACILITY) 3 SEND TO OTHER FACILITY 4 OTHER 6 (SPECIFY) _____ NO ITEMS EVER PROCESSED 7	QRE:OPD →272(06) →272(06) →272(06) →272(06)
269	<i>Besides decontaminating and cleaning, what is the final process most commonly used for disinfecting or sterilizing syringes and needles?</i> CIRCLE ALL THAT APPLY.	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E DISCARD/USE DISPOSABLE ONLY F OTHER X (SPECIFY) _____ NONE Y	
270	<i>Besides decontaminating and cleaning, what is the final process most commonly used for disinfecting or sterilizing medical equipment (such as speculums and/or surgical instruments) before they are reused?</i> 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 OTHER X (SPECIFY) _____ NONE Y	→272(06) →272(06)

NO.	QUESTIONS	CODING CATEGORIES				GO TO
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)						
271	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 ster- ilization is complete.	1	2	3	8	
09	Written protocols or guidelines for ster- ilization of disinfection	1	2	3	8	

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 without pressure	(5) Chemical High Level Disinfectant (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 → 273
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 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 GIK 1 CHLORINE 2 CIDEX 3 BETADINE 4 ALCOHOL 5 OTHER 6 DON'T KNOW 8					GIK 1 CHLORINE 2 CIDEX 3 BETADINE 4 ALCOHOL 5 OTHER 6 DON'T KNOW 8
H	Percent solution before dilution PERCENT [][] DON'T KNOW 98					PERCENT [][] DON'T KNOW 98
I	Mixture, parts solution and water MIXTURE PARTS a) DISINFECTANT [][] b) WATER [][] DK 000					MIXTURE PARTS a) DISINFECTANT [][] b) WATER [][] DK 000

SECTION C: INPATIENT CARE																		
Facility Number:	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	QRE TYPE	<div style="border: 2px solid black; width: 30px; height: 30px; display: inline-block; line-height: 30px;">C</div>															
Interviewer Code:	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>																	
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT HIV/AIDS SERVICES OFFERED BY THIS UNIT. INTRODUCE YOURSELF AND BRIEFLY EXPLAIN THE SURVEY. ENSURE ELIGIBILITY FOR QRE.																		
300	INDICATE WHICH INPATIENT UNIT THE DATA IN THIS QUESTIONNAIRE REPRESENTS	<div style="border: 1px solid black; width: 100px; height: 25px; display: inline-block;"></div> <div style="display: flex; justify-content: space-around; font-size: small;"> Line # Unit # </div>																
301	MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC. 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE 5 OTHER _____ 6 <div style="text-align: center; font-size: small;">(SPECIFY)</div>																	
302	RECHECK QUESTIONNAIRE AT THE END OF THIS INTERVIEW AND VERIFY THAT ALL APPLICABLE SECTIONS WERE COMPLETED FOR THIS UNIT. FINALLY, MARK ON FACILITY CHECKLIST EACH QRE COMPLETED FOR THIS UNIT.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">APPLICABLE & COMPLETED</th> <th style="width: 20%; text-align: center;">NOT APPLICABLE</th> </tr> </thead> <tbody> <tr> <td>(V)CT Q306, Q308 & Q310</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>PMTCT Q315</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TB Q319 (01, 02, 03)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>ART Q326 (07, 08)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>			APPLICABLE & COMPLETED	NOT APPLICABLE	(V)CT Q306, Q308 & Q310	1	2	PMTCT Q315	1	2	TB Q319 (01, 02, 03)	1	2	ART Q326 (07, 08)	1	2
	APPLICABLE & COMPLETED	NOT APPLICABLE																
(V)CT Q306, Q308 & Q310	1	2																
PMTCT Q315	1	2																
TB Q319 (01, 02, 03)	1	2																
ART Q326 (07, 08)	1	2																
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 HIV/AIDS-RELATED SERVICES IN THE UNIT. 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 Q303 BELOW AND GO ON TO Q305.																		
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE UNIT WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> <p>_____ Interviewer's signature</p> </div> <div style="width: 35%;"> <p>_____ Date</p> </div> </div> <p>SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>																		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
311	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	
312	When you refer a client to another facility for services, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN ... 2 NO FORM USED 3 NEVER REFER OUTSIDE FACILITY ... 4 DON'T KNOW 8	→ 314
313	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER 6 (SPECIFY) NO 7	
314	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	
315	Does this unit provide any services related to preventing transmission of HIV/AIDS between the mother and the child (PMTCT)?	YES 1 NO 2	Q:PMTCT
316	Is an individual client chart/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 A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, ONLY AVAILABLE IN OTHER UNIT 3 ENTER UNIT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER 6 SPECIFY NO INDIVIDUAL CLIENT CHART/RECORD 7	
317	Is there a written policy on confidentiality and disclosure of HIV test results or HIV/AIDS status available in this UNIT? IF YES: May I see the written policy?	YES, OBSERVED WRITTEN POLICY OR DOCUMENT PROVIDED TO CLIENT ... 1 YES, OBSERVED WRITTEN POLICY .. 2 YES, REPORTED, NOT SEEN 3 NO 4	→ 319

NO.	QUESTIONS	CODING CATEGORIES				GO TO
318	Does the policy specify that no one can be informed of the HIV/AIDS status without the client's consent?	YES 1 NO 2				
319	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		NO SERVICE THIS FACILITY		
		PROVIDE SERVICE THIS CLINIC	SERVICE BY PROVIDERS FROM OTHER CLINIC/UNIT THIS FACILITY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL	
01	Do providers assigned to this unit prescribe medicines for treatment of tuberculosis?	1 TB QRE	2	3	4	
02	Do providers assigned to this unit make diagnosis that a client has tuberculosis?	1 TB QRE	2	3	4	
03	Do providers assigned to this unit provide follow-up treatment for clients with tuberculosis?	1 TB QRE	2	3	4	
04	Do providers assigned to this unit prescribe treatment for sexually transmitted infections (STI)?	1	2	3	4	
05	Do providers assigned to this unit prescribe treatment for malaria?	1	2	3	4	
320	Are there any guidelines or 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?	SOME GUIDELINES/PROTOCOLS AVAILABLE 1 SOME GUIDELINES/PROTOCOLS AVAILABLE- NONE SEEN 2 NO GUIDELINES OR PROTOCOLS 3				→ 324
321	First I would like to ask about national ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(a)			(b)	
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	National Guidelines for the clinical management of HIV and AIDS	1 → b	2 → b	3 02	4 02	
02						
03	National Infection Prevention and control guidelines for health care services in Tanzania	1 → b	2 → b	3 04	4 04	
04	National Guidelines for Voluntary Counseling and Testing	1 → b	2 → b	3 05	4 05	
05	Guidelines for management of HIV/AIDS for Frontline workers	1 → b	2 → b	3 06	4 06	
06	National guidelines for prevention of mother-to-child transmission of HIV (PMTCT)	1 → b	2 → b	3 07	4 07	
07	Guidelines for Home Based Care Services	1 → b	2 → b	3 08	4 08	
08	Guidelines for home based care services in Tanzania	1 → b	2 → b	3 09	4 09	
09	A Guideline for counselors in Tanzania with special emphasis on HIV/AIDS/STD counseling	1 → b	2 → b	3 10	4 10	
10	Guidelines and Standards for Counseling and Supervision	1 → b	2 → b	3 11	4 11	
11	Management of Tuberculosis, manual for health workers	1 → b	2 → b	3 12	4 12	
12	Manual of the national Tuberculosis and Leprosy program in Tanzania	1 → b	2 → b	3 322	4 322	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
322	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				→ 324
323	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a)				(b)
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	Other protocols/guidelines for infection control	1 → b	2 → b	3 02 ↙	4 02 ↙	<input type="text"/>
02	Other protocols/guidelines for diagnosis or treatment of sexually transmitted infections?	1 → b	2 → b	3 03 ↙	4 03 ↙	<input type="text"/>
03	WHO protocols/guidelines on syndromic management of STIs?	1 → b	2 → b	3 04 ↙	4 04 ↙	<input type="text"/>
04	Other protocols/guidelines for diagnosis or treatment of malaria?	1 → b	2 → b	3 05 ↙	4 05 ↙	<input type="text"/>
05	Protocols/guidelines for intermittent preventive treatment (IPT) for malaria, during pregnancy?	1 → b	2 → b	3 06 ↙	4 05 ↙	<input type="text"/>
06	Protocols/guidelines for routinely offering HIV tests to all STI clients?	1 → b	2 → b	3 07 ↙	4 07 ↙	<input type="text"/>
07	Any guidelines for post-exposure prophylaxis?	1 → b	2 → b	3 324 ↙	4 324 ↙	<input type="text"/>
324	Do providers assigned to this clinic/unit ever provide any curative care for illnesses that may be HIV/AIDS related, such as opportunistic infections, or provide or refer the clients for counseling or social support services for help in living with HIV/AIDS?	YES 1 NO, HIV/AIDS CLIENTS ARE REFERRED ELSEWHERE, THIS FACILITY 2 NO, HIV/AIDS CLIENTS ARE REFERRED TO OTHER FACILITY 3 NEVER PROVIDE THESE SERVICES OR REFER CLIENTS WITH HIV/AIDS FOR SERVICES 4				→ 331 → 334 → 350
325	Where are inpatients who may have HIV/AIDS placed, in relation to other non-HIV/AIDS inpatients? PROBE FOR CORRECT RESPONSE.	MIXED (HIV/AIDS AND OTHER) 1 CLUSTERED (HIV/AIDS IN SEPARATE PART OF ROOM WITH OTHERS) 2 SEPARATE UNIT/ROOM FOR HIV/AIDS 3				

NO.	QUESTIONS	CODING CATEGORIES				GO TO
326	For each service I will mention, please tell me if providers in this UNIT personally provide the service, refer clients for the service, or do not offer the service at all. Do providers in this clinic unit personally : [READ EACH TOPIC BELOW]	SERVICE OFFERED IN THIS UNIT BY:		CLIENT REFERRED		SERVICE NEVER OFFERED
		PROVIDERS FROM THIS UNIT	PROVIDERS FROM OTHER CLINIC/UNIT	CLINIC/UNIT IN THIS FACILITY	OUTSIDE FACILITY	
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 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	Prescribe antiretroviral treatment	1 ART QRE	2	3	4	5
08	Provide follow up services for persons receiving antiretroviral treatment (THIS INCLUDES PROVIDING COMMUNITY BASED SERVICES)	1 ART QRE	2	3	4	5
09	Care for pediatric HIV/AIDS patients?	1	2	3	4	5

NO.	QUESTIONS	CODING CATEGORIES				GO TO
327	Next I want to ask about preventive services that are sometimes provided to people who have HIV/AIDS. For each service I mention, tell me if every HIV positive client is offered the service regardless of their condition (routinely offered) or if the service is offered based on the condition of the client (selectively offered) or if it is never offered. If offered, is the preventive service offered in this clinic/unit or is the client referred elsewhere to receive the preventive service?	PROVIDE THE SERVICE IN THIS CLINIC/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)	1	2	3	4	5
03	Primary preventive treatment, that is, before the client is ill, for opportunistic infections such as Cotrimoxazole 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	Provide condoms for preventing further transmission of HIV/AIDS?	1	2	3	4	5
328	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 → 330				
329	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)				(b)
		COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	Other protocols/guidelines for the clinical management of HIV/AIDS infection in adults	1 → b	2 → b	3 02	4 02	
02	Other protocols/guidelines for management of opportunistic infections in adults.	1 → b	2 → b	3 03	4 03	
03	Other protocols/guidelines for the clinical management of HIV/AIDS infection in children	1 → b	2 → b	3 04	4 04	
04	Protocols/guidelines on micronutrient supplementation	1 → b	2 → b	3 05	4 05	
05	Protocols/guidelines on advanced nutritional support, such as fortified protein supplement to treat or prevent severe malnutrition?	1 → b	2 → b	3 06	4 06	
06	Protocols/guidelines on provision of symptomatic or palliative care?	1 → b	2 → b	3 07	4 07	
07	Protocols/guidelines on preventive therapy other than TB, such as cotrimoxazole to prevent pneumonia?	1 → b	2 → b	3 08	4 08	
08	Protocols/guidelines on preventive therapy for tuberculosis	1 → b	2 → b	3 09	4 09	
09	Other protocols/guidelines on community or home-based care for HIV/AIDS clients	1 → b	2 → b	3 10	4 10	
10	Other protocols/guidelines on counseling for HIV testing or VCT?	1 → b	2 → b	3 11	4 11	
11	Other protocols/guidelines on PMTCT	1 → b	2 → b	3 12	4 12	
12	Other protocols/guidelines on ART/ARVs	1 → b	2 → b	3 13	4 13	
13	Other protocols/guidelines on PEP	1 → b	2 → b	3 330	4 330	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
330	I want to ask about various support services that are commonly needed by people with HIV/AIDS. For each service I ask about, please tell me if providers in this UNIT ever 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		REFERRAL LIST NOT SEEN. PROVIDER:	NO SERVICE OR REFERRAL
			REFERRAL SITE OBSERVED ON WRITTEN LIST	CAN NAME SPECIFIC REFERRAL SITE FOR SERVICE		
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 (PLHA)?	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 PLHA and their families?	1	2	3	4	5
06	Legal services?	1	2	3	4	5
07	Counseling 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 providers such as herbalist, acupuncture, traditional	1	2	3	4	5
10	Provide or refer providers of HIV/AIDS services for emotional/spiritual support?	1	2	3	4	5
331	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 FACILITY 5				→ 339
332	When you refer a client to another UNIT within this facility, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO FORM USED 3 NEVER REFER WITHIN FACILITY 4 DON'T KNOW 8				→ 334 → 334

NO.	QUESTIONS	CODING CATEGORIES	GO TO
333	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER _____ 6 (SPECIFY) NO 7	
334	When you refer a client to another facility for services, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN ... 2 NO FORM USED 3 NEVER REFER OUTSIDE FACILITY . 4 DON'T KNOW 8	→ 336 → 336 → 338 → 336
335	Does the referral form have a place where the name and location of the referral site can be entered?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 337 → 337 → 337
336	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER _____ 6 (SPECIFY) NO 7	
337	Is there any system for providing or receiving feedback for referrals made by or received by this UNIT? 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	
338	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	
339	CHECK Q326 AND RECORD IF ANY RESPONSES ARE '1', INDICATING THIS UNIT PROVIDES CLINICAL SERVICES FOR HIV/AIDS.	YES 1 NO 2	→ 348

NO.	QUESTIONS	CODING CATEGORIES	GO TO																												
340	Where can we find information on the numbers of clients seen in this unit who received services for HIV/AIDS related diagnoses, such as opportunistic infections? PROBE TO DETERMINE THE SYSTEM USED. IF THE UNIT COMPILES REPORTS AND THE REPORTS HAVE SPECIFIC DIAGNOSES, INFORMATION MAY BE COLLECTED FROM CENTRAL LOCATION UNIT RECORDS MUST STILL BE OBSERVED FOR THE MOST RECENT DATE. IF REPORTS DO NOT CAPTURE HIV/AIDS DIAGNOSES, REVIEW THE UNIT REGISTER AS INSTRUCTED BELOW.	INFORMATION COLLECTED FROM: UNIT REGISTER/RECORDS OR COMPUTER 1 CENTRAL FACILITY LOCATION (RECORDS OR COMPUTERIZED) . . . 2 NO RECORD MAINTAINED 3	→ 345 → 348																												
341	<p>EXPLAIN: I want to review the record/register to count the number of clients with HIV/AIDS related illnesses who have received services in this UNIT during the past year. If the diagnoses I am looking for are compiled for reports, I can use those reports, otherwise, I need to review the UNIT records. START WITH ENTRIES FROM THE LAST DAY OF THE MOST RECENT COMPLETED MONTH, AND REVIEW LISTED DIAGNOSES/SYMPTOMS FOR 12 FULL MONTHS OR FOR 1000 CLIENT ADMISSIONS/DISCHARGES, WHICHEVER IS THE SMALLEST NUMBER. BE CERTAIN TO COMPLETE THE INFORMATION FOR THE FULL MONTH IN WHICH THE 1000TH CLIENT ADMISSION/DISCHARGE FELL.</p> <p>IF MORE THAN ONE REGISTER IS USED, BE CERTAIN TO SCAN ALL REGISTERS WHERE ELIGIBLE CLIENTS MAY HAVE BEEN RECORDED FOR THE TIME PERIOD BEING REVIEWED. IF THERE ARE MORE THAN ONE OF THE BELOW LISTED DIAGNOSES/SYMPTOMS FOR ONE CLIENT, CHOOSE THE SYMPTOM OR DIAGNOSIS MOST SPECIFIC FOR HIV/AIDS. DO NOT RECORD THE SAME CLIENT VISIT UNDER MORE THAN ONE OF THE BELOW LISTED DIAGNOSES/SYMPTOMS.</p> <table border="1"> <thead> <tr> <th></th><th>NUMBER OF ADMISSIONS/DISCHARGES</th></tr> </thead> <tbody> <tr> <td>1 ORAL CANDIDIASIS/MOUTH SORES</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>2 CRYPTOCOCCAL MENINGITIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>3 TOXOPLASMOSIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>4 KAPOSII'S SARCOMA</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>5 AIDS-RELATED COMPLEX (ARC)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>6 HERPES ZOSTER/SIMPLEX</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>7 PCP (PNEUMOCYSTIS CARINII PNEUMONIA)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>8 IMMUNOSUPPRESSION/ HIV/AIDS OR RVD</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>9 WASTING SYNDROME FAILURE TO THRIVE (FTT)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>10 CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>11 TUBERCULOSIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>12 OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>13 OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY) _____</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> </tbody> </table>				NUMBER OF ADMISSIONS/DISCHARGES	1 ORAL CANDIDIASIS/MOUTH SORES	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2 CRYPTOCOCCAL MENINGITIS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	3 TOXOPLASMOSIS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	4 KAPOSII'S SARCOMA	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	5 AIDS-RELATED COMPLEX (ARC)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	6 HERPES ZOSTER/SIMPLEX	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	7 PCP (PNEUMOCYSTIS CARINII PNEUMONIA)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	8 IMMUNOSUPPRESSION/ HIV/AIDS OR RVD	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9 WASTING SYNDROME FAILURE TO THRIVE (FTT)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	10 CHRONIC DIARRHEA (MUST SPECIFY CHRONIC)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	11 TUBERCULOSIS	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	12 OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	13 OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY) _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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NO.	QUESTIONS	CODING CATEGORIES	GO TO
342	RECORD THE NUMBER OF MONTHS OF DATA THAT IS REPRESENTED IN PREVIOUS QUESTION	NUMBER OF FULL MONTHS OF DATA <input type="text"/> <input type="text"/>	
343	RECORD THE TOTAL NUMBER OF ADMISSIONS/DISCHARGES FROM WHICH DIAGNOSTIC INFORMATION WAS COLLECTED	TOTAL NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
344	WHAT IS THE MOST RECENT DATE THAT ANY HIV/AIDS OR NON-HIV/AIDS CLIENT DIAGNOSES ARE RECORDED?	WITHIN PAST 30 DAY: 1 MORE THAN 30 DAYS AGO 2 REGISTER NOT SEEN 3	
345	Are reports regularly compiled on the number of admissions/discharges of clients for this unit?	YES 1 NO 2	→ 348
346	How frequently are the compiled reports submitted to someone outside of this unit?	MONTHLY OR MORE OFTEN 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5	→ 348
347	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/CBOH/TACAIDS) C REGIONAL LEVEL (MOH/CBOH/TACAIDS) D NATIONAL LEVEL (MOH/CBOH/TACAIDS) E DONOR AGENCY F OTHER X (SPECIFY) _____	
348	I am now interested in knowing about the number of adult and pediatric HIV/AIDS patients that are inpatients in this unit today. I am also interested in knowing about how many adult and pediatric inpatients are here today, in total, both HIV/AIDS and non-HIV/AIDS. IF INFORMATION IS NOT AVAILABLE IN MEDICAL RECORDS OR REGISTERS, ASK WHEN YOU VISIT EACH RELEVANT UNIT AND SUM THE NUMBERS SO THAT A TOTAL IS PROVIDED FOR ALL UNITS COVERED IN THIS QRE , BOTH HIV/AIDS INPATIENTS AND ALL INPATIENTS.		
01	How many adult inpatients are there today who are probable or confirmed diagnosis of HIV/AIDS? By adults I mean people 15 years and older.	ADULTS, HIV/AIDS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
02	How many pediatric inpatients are there today who are probable or confirmed diagnosis of HIV/AIDS? By pediatric I mean people younger than 15 years of age.	PEDIATRICS, HIV/AIDS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
03	How many adult inpatients are there today in total, including all diagnoses.	ADULTS, TOTAL <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
04	How many pediatric inpatients are there today in total, including all diagnoses.	PEDIATRICS, TOTAL <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
349	INDICATE THE SOURCE OF DATA FOR THE NUMBER OF HIV/AIDS PATIENTS IN THE UNIT TODAY	REGISTER/RECORDS A VERBAL FROM STAFF IN INPATIENT UNITS B NO INFORMATION AVAILABLE Y	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
350	Now I want to ask you about post-exposure prophylaxis (PEP) for people who may have been exposed to HIV/AIDS. Is PEP available for staff in this UNIT? 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 SITE THIS FACILITY 2 YES, STAFF CAN RECEIVE PEP FROM OTHER FACILITY IF DESIRE... 3 NO ACCESS TO PEP 4	→ 358 → 358 → 358
351	Is there a register or record maintained in this UNIT for workers who have been prescribed PEP or has been referred for PEP? IF YES, ASK: May I see the register/record? CHECK 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 NO RECORDS THIS UNIT E NO, INFORMATION RECORDED IN INDIVIDUAL HEALTH RECORD ONLY F NO RECORD FOR PEP Y	
352	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES	YES, OBSERVED COMPLETE 1 YES, OBSERVED, INCOMPLETE 2 YES, REPORTED NOT SEEN 3 NO 4	
353	What is the PEP regimen that is most commonly prescribed?	COMBIVIR (ZDV/3TC) 1 STAVUDINE/LAMIVUDINE 2 STAVUDINE/LAMIVUDINE plus INDINAVIR 3 STAVUDINE/LAMIVUDINE and EFV or NVP 4 OTHER ONE ARV USED ALONE 5 _____ (SPECIFY) OTHER _____ (SPECIFY) 6	
354	Are any PEP drugs stored in this UNIT? IF YES, ASK TO SEE THE PEP DRUGS	YES 1 NO 2	→ 358
355	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	COMBIVIR (ZDV/3TC) A STAVUDINE/LAMIVUDINE B STAVUDINE/LAMIVUDINE plus INDINAVIR C STAVUDINE/LAMIVUDINE and EFV or NVP D OTHER COMBINATION _____ (SPECIFY) E OTHER ONE ARV USED ALONE _____ (SPECIFY) F NONE Y	→ 358
356	DESCRIBE THE STORAGE OF THE PEP MEDICINES. ARE THE PEP MEDICINES STORED IN A LOCKED STORAGE UNIT AND 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 _____ (SPECIFY) 6	
357	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	

NO.	QUESTIONS	CODING CATEGORIES			GO TO
358	Is there a client toilet or latrine that patients from this unit can use? IF YES, ASK TO SEE THE TOILET/LATRINE AND INDICATE THE CONDITION	YES, FUNCTIONING, CLEAN 1 YES, FUNCTIONING, NOT CLEAN 2 YES, NOT FUNCTIONING 3 NO CLIENT TOILET/LATRINE 4			
359	RANDOMLY SELECT ONE OF THE PATIENT AREAS TO ASSESS FOR INFECTION PREVENTION. INDICATE IF THE FOLLOWING ITEMS ARE AVAILABLE EITHER IN THE PATIENT AREA, OR IN AN ADJACENT AREA WITH REASONABLE PROXIMITY FOR USE BY PROVIDERS, IF NEEDED.				
	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
12	RAPID TEST FOR HIV	1	2	3	
13	DISPOSABLE NEEDLES	1	2	3	
14	DISPOSABLE SYRINGES	1	2	3	
15	EXAMINATION TABLE	1	2	3	
16	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → 360	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
360	Is there a treatment/procedure room in this unit that is different from the patient area we just assessed? IF YES, ASK TO SEE AND INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE	YES 1 NO 2			→ 362

NO.	QUESTIONS	CODING CATEGORIES			GO TO
361	INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
12	RAPID TEST FOR HIV	1	2	3	
13	DISPOSABLE NEEDLES	1	2	3	
14	DISPOSABLE SYRINGES	1	2	3	
15	EXAMINATION TABLE	1	2	3	
16	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → 362	2	3	
17	AUDITORY PRIVACY	1	2	3	
18	VISUAL PRIVACY	1	2	3	
362	<p>ASK TO SPEAK WITH THE PERSON MOST FAMILIAR WITH CLEANING AND PROCESSING EQUIPMENT FOR REUSE.</p> <p>What procedure is used for decontaminating and cleaning equipment before its final processing for reuse?</p> <p>PROBE, IF NECESSARY, TO DETERMINE CORRECT RESPONSE.</p>	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 06 (SPECIFY) NO EQUIPMENT EVER REUSED 07 DON'T DECONTAMINATE 95			→ 370
363	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			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
364	Where is this equipment then processed prior to reuse?	THIS UNIT 1 OTHER UNIT THIS FACILITY 2 ENTER UNIT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NON UNIT (E.G., CENTRAL PROCESSING, THEATER, THIS FACILITY) 3 SEND TO OTHER FACILITY 4 OTHER 6 (SPECIFY) NO ITEMS EVER PROCESSED 7	 →368(6) →368(6) →368(6) →368(6)
365	<i>Besides decontaminating and cleaning, what is the final process most commonly used for disinfecting or sterilizing syringes and needles?</i> CIRCLE ALL THAT APPLY.	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E DISCARD/USE DISPOSABLE ONLY F OTHER X (SPECIFY) NONE Y	
366	<i>Besides decontaminating and cleaning, what is the final process most commonly used for disinfecting or sterilizing medical equipment (such as speculums and/or surgical instruments) before they are reused?</i> 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 OTHER X (SPECIFY) NONE Y	 →368(6) →368(6)

NO.	QUESTIONS	CODING CATEGORIES				GO TO		
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)								
367	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	TTS Indicator strips or other item that indicates when ster- ilization is complete.	1	2	3	8			
09	Written protocols or guidelines for ster- ilization of disinfection	1	2	3	8			

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 without pressure	(5) Chemical High Level Disinfectant (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 → 369
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	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	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 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	MINUTES WRAPPED [][][] AUTOMATIC 666 DON'T KNOW ... 998				
G	Chemical disinfectant used G1K 1 CHLORINE 2 CIDEX 3 BETADINE 4 ALCOHOL 5 OTHER 6 DON'T KNOW 8	G1K 1 CHLORINE 2 CIDEX 3 BETADINE 4 ALCOHOL 5 OTHER 6 DON'T KNOW 8				
H	Percent solution before dilution PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98				
I	Mixture, parts solution and water MIXTURE PARTS a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS a) DISINFECTANT [][] b) WATER [][] DK 000				

NO.	QUESTIONS	CODING CATEGORIES				GO TO
369	ASK TO SEE WHERE CENTRAL OR EXTERNALLY PROCESSED ITEMS ARE STORED AND 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 cloth, 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 clean	1	2	3	8	
07	Other not clean	1	2	3	8	
08	Date of sterilization written on packet or container with processed items	1	2	3	8	
09	Is storage location dry and clean?	1	2	3	8	
370	<p>Now I would like to ask you a few questions about the waste disposal practices for sharp items such as needles or blades. How does this unit finally dispose of sharp items, or what is the final disposal process for filled sharps boxes?</p> <p>IF ITEMS ARE TAKEN TO CENTRAL LOCATION FOR FINAL DISPOSAL, CIRCLE '09'</p> <p>REMOVED OFFSITE.</p>	<p>BURNED IN INCINERATOR 02 BURNED AND BURIED 03 BURNED AND REMOVED TO OFFSITE DUMP 04 BURNED AND NOT BURIED . . 05 BURIED, NOT BURNED 06 THROWN IN TRASH/OPEN PIT 07 THROWN IN PIT LATRINE 08 REMOVED OFFSITE 09 NOT APPLICABLE 95 OTHER _____ 96 (SPECIFY)</p>				
371	<p>Now I would like to ask you a few questions about the waste disposal practices for hazardous waste such as used bandages. How does this unit finally dispose of contaminated waste?</p> <p>IF ITEMS ARE TAKEN TO CENTRAL LOCATION FOR FINAL DISPOSAL, CIRCLE '09'</p> <p>REMOVED OFFSITE.</p>	<p>SAME AS FOR SHARP ITEMS 01 BURNED IN INCINERATOR 02 BURNED AND BURIED 03 BURNED AND REMOVED TO OFFSITE DUMP 04 BURNED AND NOT BURIED . . 05 BURIED, NOT BURNED 06 THROWN IN TRASH/OPEN PIT 07 THROWN IN PIT LATRINE 08 REMOVED OFFSITE 09 NOT APPLICABLE 95 OTHER _____ 96 (SPECIFY)</p>				→ 373

NO.	QUESTIONS	CODING CATEGORIES	GO TO
372	ASK TO SEE THE PLACE USED BY THIS UNIT FOR DISPOSAL OF SHARP ITEMS 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.	WASTE VISIBLE, <i>NOT</i> PROTECTED 1 WASTE VISIBLE, PROTECTED 2 NO WASTE VISIBLE 3 WASTE SITE NOT INSPECTED 8	
373	ASK TO SEE THE PLACE USED FOR WASTE DISPOSAL OF CONTAMINATED 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.	WASTE VISIBLE, <i>NOT</i> PROTECTED 1 WASTE VISIBLE, PROTECTED 2 NO WASTE VISIBLE 3 WASTE SITE NOT INSPECTED 8	
374	CHECK Q370 AND 371 , IS 04 OR 09 CIRCLED (ANY WASTE REMOVED OFFSITE FOR DISPOSAL)? YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 376
375	How is the waste that is collected and removed offsite finally disposed?	INCINERATED 1 TAKEN TO LOCAL DUMP AND BURNED 2 TAKEN TO LOCAL DUMP AND NOT BURNED 3 OTHER 6 (SPECIFY) DON'T KNOW 8	
376	ASSESS GENERAL CLEANLINESS OF UNIT. • A UNIT IS CLEAN IF THE FLOORS ARE SWEEPED AND COUNTERS AND TABLES ARE WIPED AND FREE OF OBVIOUS DIRT OR WASTE. • A UNIT IS NOT CLEAN IF OBVIOUS DIRT OR WASTE OR BROKEN OBJECTS ARE ON THE FLOORS OR COUNTERS.	UNIT CLEAN 1 UNIT NOT CLEAN 2	
377	Now I would like to ask you few questions about availability of adult and pediatrics beds and bed nets ASK TO SEE THE WARD AND COUNT NUMBER OF BEDS WITH AND WITHOUT BED NETS FOR THIS WARD		
01	How many adult beds are in this ward?	OBSERVED PRESENT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	NOT AVAILABLE 9995
02	How many adult bed nets are in this ward?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9995
03	How many pediatric beds are in this ward?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9995
04	How many pediatric bed nets are in this ward?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	9995

NO.	QUESTIONS	CODING CATEGORIES			GO TO
404	What is your technical background for completing the HMIS reports? PROBE IF NECESSARY	CLERK/ACCOUNTANT A HEALTH STATISTICS/MED RECORDS . B CLINICAL SERVICE PROVIDER C NON-CLINICAL SERVICE PROVIDER . D LABORATORY WORKER E COMPUTER TRAINING F OTHER X _____ (SPECIFY)			
405	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			→ 408
406	How long was your training in HMIS? RECORD EITHER DAYS OR MONTHS WHICHEVER IS MOST APPROPRIATE. IF MORE THAN ONE TRAINING, ADD THE DURATION OF ALL TRAINING.	NUMBER OF DAYS 1 <input type="text"/> <input type="text"/> NUMBER OF MONTHS 2 <input type="text"/> <input type="text"/>			
407	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			
408	How many years have you been responsible for HMIS records/reports in this facility? RECORD '00' FOR LESS THAN ONE YEAR	YEARS <input type="text"/> <input type="text"/>			
409	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			→ 414
410	Who do you train in HMIS?	STAFF IN HMIS UNIT 1 STAFF IN SERVICE UNITS 2 STAFF IN HMIS AND SERVICE UNITS . 3			
411	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			→ 414
412	Was the training on strategic information for HIV/AIDS, formal or informal? IF BOTH, RECORD 'FORMAL'.	FORMAL 1 INFORMAL 2			
413	How long was the most recent training on strategic information for HIV/AIDS?	DAYS <input type="text"/> <input type="text"/>			
414	Do you have the following guidelines? IF YES, ASK: May I see the guidelines please?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	HMIS reporting guidelines	1	2	3	
02	HIV/AIDS surveillance reporting guidelines	1	2	3	
03	National technical guidelines for integrated disease surveillance and response	1	2	3	
04	National HIV/AIDS reporting guidelines	1	2	3	

NO.	QUESTIONS	CODING CATEGORIES			GO TO
415	Do you receive or compile reports of services for confirmed or suspected HIV/AIDS cases from the following clinics/units? IF YES, ASK TO SEE A REPORT.	YES OBSERVED	YES, REPORTED NOT SEEN	NO REPORT	NOT APPLICABLE
01	Outpatient services	1	2	3	4
02	Inpatient services	1	2	3	4
03	Laboratory services	1	2	3	4
04	Tuberculosis services	1	2	3	4
05	HIV counseling and testing services	1	2	3	4
06	Antiretroviral treatment services	1	2	3	4
07	Prevention of mother-to-child transmission services	1	2	3	4
08	Sources based outside facility (community health workers, traditional birth attendants, etc.)	1	2	3	4
416	Do you receive or compile reports of deaths in the facility attributed to HIV/AIDS? IF YES, ASK TO SEE A REPORT	YES OBSERVED	YES, REPORTED NOT SEEN	NO REPORT	NOT APPLIC.
		1	2 → 419	3 → 421	4 → 421
417	RECORD THE NUMBER OF DEATHS ATTRIBUTED TO HIV/AIDS REPORTED FOR PAST 12 MONTHS	NUMBER OF DEATHS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
418	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>			
419	How frequently are reports on deaths submitted to someone outside of this facility?	MONTHLY OR MORE OFTEN 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5			→ 421
420	To whom outside the facility, are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOH/CBOH/NAC) ... C REGIONAL LEVEL (MOH/CBOH/NAC) ... D NATIONAL LEVEL (MOH/CBOH/NAC) ... E DONOR AGENCY F OTHER X (SPECIFY) _____			
421	Do you receive or compile reports of newly diagnosed HIV cases in the facility? IF YES, ASK TO SEE A REPORT	YES OBSERVED	YES, REPORTED NOT SEEN	NO REPORT	NOT APPLIC.
		1	2 → 424	3 → 426	4 → 426
422	RECORD THE NUMBER OF NEWLY DIAGNOSED HIV CASES DURING THE PAST 12 MONTHS	NEW HIV/AIDS CASES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
423	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>			
424	How frequently are reports on newly diagnosed HIV cases submitted to someone outside of this facility?	MONTHLY OR MORE OFTEN 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5			→ 426

NO.	QUESTIONS	CODING CATEGORIES	GO TO																																																																				
425	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOH/CBOH/NAC) ... C REGIONAL LEVEL (MOH/CBOH/TACAIDS) D NATIONAL LEVEL (MOH/CBOH/TACAIDS) E DONOR AGENCY F OTHER X (SPECIFY)																																																																					
426	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 CLINIC/UNIT RECORDS SUBMITTED TO THE HMIS, WHICHEVER TYPE OF REPORT INCLUDES THE DIAGNOSES REQUESTED BELOW.	INFORMATION AVAILABLE, DATA NOT YET RECORDED 1 INFORMATION AVAILABLE, OPD AND IPD DATA ALREADY RECORDED IN OPD AND/OR IPD QRE 2 INFORMATION REPORTED AVAILABLE, BUT NOT SEEN 3 INFORMATION NOT AVAILABLE 4	→ END → END → END																																																																				
427	INDICATE CLIENT INFORMATION FOR WHICH THE FOLLOWING QUESTION IS COMPLETED.	OUTPATIENT CLIENTS ONLY 1 INPATIENT CLIENTS ONLY 2 BOTH OUTPATIENT AND INPATIENT 3																																																																					
428	RECORD THE NUMBER OF CLIENTS WITH THE ADMISSION/DISCHARGE/VISIT DIAGNOSES BELOW, FOR THE PAST 12 MONTHS. 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.	<table border="1"> <thead> <tr> <th></th><th>(A) OUTPATIENT VISITS</th><th>NUMBER</th><th>(B) INPATIENT ADMISSIONS/DISCHARGES</th></tr> </thead> <tbody> <tr><td>1 ORAL CANDIDIASIS/MOUTH SORES</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>2 CRYPTOCOCCAL MENINGITIS</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>3 TOXOPLASMOSIS</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>4 KAPOSI'S SARCOMA</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>5 AIDS-RELATED COMPLEX (ARC)</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>6 HERPES ZOSTER/SIMPLEX</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>7 PCP (PNEUMOCYSTIS CARINII PNEUMONIA)</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>8 IMMUNOSUPPRESSION/ HIV/AIDS OR RVD</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>9 WASTING SYNDROME</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>FAILURE TO THRIVE (FTT)</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>10 CHRONIC DIARRHEA</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>(MUST SPECIFY CHRONIC)</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>11 TUBERCULOSIS</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>12 OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> <tr><td>13 OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY)</td><td><input type="text"/></td><td></td><td><input type="text"/></td></tr> </tbody> </table>		(A) OUTPATIENT VISITS	NUMBER	(B) INPATIENT ADMISSIONS/DISCHARGES	1 ORAL CANDIDIASIS/MOUTH SORES	<input type="text"/>		<input type="text"/>	2 CRYPTOCOCCAL MENINGITIS	<input type="text"/>		<input type="text"/>	3 TOXOPLASMOSIS	<input type="text"/>		<input type="text"/>	4 KAPOSI'S SARCOMA	<input type="text"/>		<input type="text"/>	5 AIDS-RELATED COMPLEX (ARC)	<input type="text"/>		<input type="text"/>	6 HERPES ZOSTER/SIMPLEX	<input type="text"/>		<input type="text"/>	7 PCP (PNEUMOCYSTIS CARINII PNEUMONIA)	<input type="text"/>		<input type="text"/>	8 IMMUNOSUPPRESSION/ HIV/AIDS OR RVD	<input type="text"/>		<input type="text"/>	9 WASTING SYNDROME	<input type="text"/>		<input type="text"/>	FAILURE TO THRIVE (FTT)	<input type="text"/>		<input type="text"/>	10 CHRONIC DIARRHEA	<input type="text"/>		<input type="text"/>	(MUST SPECIFY CHRONIC)	<input type="text"/>		<input type="text"/>	11 TUBERCULOSIS	<input type="text"/>		<input type="text"/>	12 OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES	<input type="text"/>		<input type="text"/>	PYREXIA/FEVER UNKNOWN ORIGIN (PUO/FUO) LYMPHADENOPATHY	<input type="text"/>		<input type="text"/>	13 OTHER DIAGNOSIS INDICATING CLIENT HAD HIV/AIDS RELATED ILLNESS (SPECIFY)	<input type="text"/>		<input type="text"/>	
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429	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN THE PREVIOUS QUESTION	<input type="text"/>	<input type="text"/>																																																																				

NO.	QUESTIONS	CODING CATEGORIES		GO TO
430	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.428	TOTAL OPD VISITS	TOTAL IPD ADMISSIONS	
		<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE				

SECTION E: LABORATORY AND OTHER DIAGNOSTICS									
Facility Number: <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div>		QRE TYPE <div style="display: inline-block; width: 30px; height: 30px; border: 2px solid black; text-align: center; line-height: 30px; font-size: 24px; font-weight: bold;">E</div>							
Interviewer: Code <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div>		CLINIC/UNIT CODE <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; text-align: center; line-height: 20px;">1</div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; text-align: center; line-height: 20px;">9</div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-left: 10px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-left: 5px;"></div>							
		Line # Unit #	Parent Line #						
500	INDICATE SETTING FOR LAB	LAB IN FACILITY 1 AFFILIATED EXTERNAL LAB 2 AREA LOCKED/NO ACCESS 3 FACILITY HAS NO LAB 4	→ STOP						
501	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							
502	MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC) 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE 5 OTHER _____ 6 <div style="text-align: center; font-size: 10px;">(SPECIFY)</div>								
503	CHECK QUESTION Q500. IS THE RESPONSE '3', NO ACCESS?	YES 1 NO 2	→ STOP						
504	RECHECK QUESTIONNAIRE AT THE END OF THIS INTERVIEW AND VERIFY THAT ALL APPLICABLE SECTIONS WERE COMPLETED FOR THIS UNIT. FINALLY, MARK ON FACILITY CHECKLIST EACH QRE COMPLETED FOR THIS UNIT.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">APPLICABLE & COMPLETED</td> <td style="text-align: center;">NOT APPLICABLE</td> </tr> <tr> <td style="text-align: center;">(V)CT (Q529)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </table>		APPLICABLE & COMPLETED	NOT APPLICABLE	(V)CT (Q529)	1	2	
	APPLICABLE & COMPLETED	NOT APPLICABLE							
(V)CT (Q529)	1	2							
<p>START DATA COLLECTION IN THE MAIN LABORATORY.</p> <p>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. COMPLETE ONE DIFFERENT QUESTIONNAIRE FOR SERVICES AVAILABLE ONLY TO INPATIENTS, ONE FOR SERVICES ONLY AVAILABLE TO OUTPATIENTS, AND ONE FOR SERVICES AVAILABLE TO BOTH OUTPATIENTS AND INPATIENTS.</p> <p>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.</p> <p>IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER '1' (YES) IN Q505 BELOW AND GO ON TO Q506.</p>									

Hello. My name is _____. We are here on behalf of the Ministry of Health, and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.

Your facility was randomly selected to participate in this study. We will be asking you questions about various laboratory services and will ask to see laboratory registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.

We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.

You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?

Interviewer's signature _____ Date _____
SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.

505	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP
NO.	QUESTIONS	CODING CATEGORIES	GO TO
506	How many days in a week is the lab open to serve clients?	NUMBER OF DAYS OPEN <input type="text"/>	
507	<p>First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counselors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this clinic/unit who are present today.</p> <p>Please give me the names and main service responsibility of the 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 CLINIC/UNIT. DO NOT DUPLICATE HIV/AIDS SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.</p>		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES 1 NO 2	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
508	First I would like to know about guidelines and protocols that are available in this laboratory area.					
	For each topic I mention, please tell me if you have any protocols and guidelines relating to this topic in the laboratory area? IF YES: May I see the guidelines please?	(a)				(b)
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	Laboratory Safety Protocols	1 → b	2 → b	3 ↘ 02 ←	4 ↘ 02 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
02	National Infection Prevention and control guidelines for health care services in Tanzania, MOH	1 → b	2 → b	3 ↘ 03 ←	4 ↘ 03 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
03	Other guidelines for blood safety	1 → b	2 → b	3 ↘ 04 ←	4 ↘ 04 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
04	Other universal /standard precautions for healthcare workers	1 → b	2 → b	3 ↘ 05 ←	4 ↘ 05 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
05	Other infection prevention guidelines	1 → b	2 → b	3 ↘ 06 ←	4 ↘ 06 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
06	Guidelines for post-exposure (HIV/AIDS) prophylaxis for healthcare workers	1 → b	2 → b	3 ↘ 07 ←	4 ↘ 07 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
07	Manual for laboratory technicians for TB screening	1 → b	2 → b	3 ↘ 08 ←	4 ↘ 08 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
08	Any standard operating procedures (SOPs)	1 → b	2 → b	3 ↘ 509 ←	4 ↘ 509 ←	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
HIV TESTING						
509	Does this laboratory conduct any tests for HIV? IF YES, CIRCLE ALL THAT APPLY	FOR CLIENT HIV STATUS A BLOOD SCREENING FOR TRANSFUSION B MANDATORY (FOR EMPLOYMENT/ VISA/WORK PERMIT C NO Y				→ 524

NO.	QUESTIONS	CODING CATEGORIES				GO TO			
510	Are there any guidelines related to any of the topics I will ask, in the laboratory area? IF YES, ASK: May I see the guideline please.	(a)				(b)			
		OBSERVED, COM- PLETE INCOM- PLETE		REPORTED AVAIL. NOT SEEN NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR				
01	National standard guidelines for health laboratory services	1 → b	2 → b	3 02 ↙ 4 02 ↘					
02	National guidelines on Voluntary Counseling and Testing	1 → b	2 → b	3 03 ↙ 4 03 ↘					
03	Other protocols/guidelines for HIV testing procedures (who to test, which test to use)	1 → b	2 → b	3 04 ↙ 4 04 ↘					
04	Any written guidelines on how to conduct HIV test (may be manufacturers instructions)	1 → b	2 → b	3 05 ↙ 4 05 ↘					
05	Written guidelines on confidentiality and disclosure of HIV test results	1 → b	2 → b	3 06 ↙ 4 06 ↘					
06	Other guidelines relevant to HIV/AIDS or related services (SPECIFY)	1 → b	2 → b	3 511 ↙ 4 511 ↘					
511	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		(b) ARE ALL ITEMS FOR TEST AVAILABLE?		(c) IS THE ITEM IN WORKING ORDER?			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	YES	NO	DON'T KNOW
01	ELISA 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	All items for Western Blot test	1 → b	2 06 ↘	1	2	3 06 ↘			
06	All items for PCR for viral load	1 → b	2 07 ↘	1	2	3 07 ↘			
07	Other HIV test (SPECIFY)	1 → b	2 512 ↘	1	2	3 512 ↘			
512	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				→ 514			

NO.	QUESTIONS	CODING CATEGORIES		GO TO
513	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	(B) NUMBERS FROM OBSERVED RECORDS	
		YES REPORTED, NOT SEEN NO RECORD	NUMBER OF CLIENTS MONTHS OF DATA	
01	TOTAL CLIENTS RECEIVING HIV TEST	1 → b 2 <input type="checkbox"/> 02 <input type="checkbox"/> 3 <input type="checkbox"/> 02 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
02	TOTAL CLIENTS WITH POSITIVE HIV TEST RESULT	1 → b 2 <input type="checkbox"/> 03 <input type="checkbox"/> 3 <input type="checkbox"/> 03 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
03	TOTAL CLIENTS OR PROVIDERS WHO WERE PROVIDED TEST RESULTS	1 → b 2 <input type="checkbox"/> 04 <input type="checkbox"/> 3 <input type="checkbox"/> 04 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
04	TOTAL CLIENTS WITH POSITIVE TESTS WHERE RESULTS WERE PROVIDED	1 → b 2 <input type="checkbox"/> 514 <input type="checkbox"/> 3 <input type="checkbox"/> 514 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
514	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		→ 517 → 517 → 517 → 520
515	CHECK PREVIOUS QUESTION. IS C CIRCLED? IF YES ASK: How do you determine when to send a blood sample for retesting?	YES, SEND EVERY FIXED NUMBER OF TESTS 1 YES, SEND PERCENT OF TESTS 2 YES, BUT NO FIXED NUMBER 3 DO NOT SEND BLOOD ELSEWHERE 4		→ 517 → 520
516	Please tell me how you decide when to send a blood sample for retesting.	RECORD CORRECT NUMBER FOR 1 OR 2 IN Q515 <input type="text"/> <input type="text"/> <input type="text"/>		
517	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		→ 520 → 520
518	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		
519	What is the most recent error rate that is recorded by external quality control?	PERCENT ERROR RATE <input type="text"/> <input type="text"/> DON'T KNOW 98		
520	Is there any other system used for quality control of laboratory tests for HIV/AIDS?	INTERNAL QUALITY CONTROL 1 OTHER 2 DESCRIBE NO 3		→ 522
521	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																												
522	Are there any fees assessed for any services or items related to HIV/AIDS tests?	YES	1		→ 524																												
		NO	2																														
523	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	<table border="1"> <thead> <tr> <th colspan="3">(a)</th> <th>(b)</th> </tr> <tr> <th>YES</th> <th>FEE</th> <th>NO</th> <th>AMOUNT IN TSHS.</th> </tr> <tr> <th></th> <th></th> <th>NA</th> <th></th> </tr> </thead> <tbody> <tr> <td>1 → b</td> <td>2 ↙ 02 ↙</td> <td>3 ↙ 02 ↙</td> <td></td> </tr> <tr> <td>1 → b</td> <td>2 ↙ 03 ↙</td> <td>3 ↙ 03 ↙</td> <td></td> </tr> <tr> <td>1 → b</td> <td>2 ↙ 04 ↙</td> <td>3 ↙ 04 ↙</td> <td></td> </tr> <tr> <td>1 → b</td> <td>2 ↙ 524 ↙</td> <td>3 ↙ 524 ↙</td> <td></td> </tr> </tbody> </table>			(a)			(b)	YES	FEE	NO	AMOUNT IN TSHS.			NA		1 → b	2 ↙ 02 ↙	3 ↙ 02 ↙		1 → b	2 ↙ 03 ↙	3 ↙ 03 ↙		1 → b	2 ↙ 04 ↙	3 ↙ 04 ↙		1 → b	2 ↙ 524 ↙	3 ↙ 524 ↙		
(a)			(b)																														
YES	FEE	NO	AMOUNT IN TSHS.																														
		NA																															
1 → b	2 ↙ 02 ↙	3 ↙ 02 ↙																															
1 → b	2 ↙ 03 ↙	3 ↙ 03 ↙																															
1 → b	2 ↙ 04 ↙	3 ↙ 04 ↙																															
1 → b	2 ↙ 524 ↙	3 ↙ 524 ↙																															
01	FEE FOR RAPID TEST																																
02	FEE FOR ELISA TEST																																
03	FEE FOR CD4 TEST																																
04	FEE FOR COMPLETE BLOOD COUNT																																
524	Do you send blood outside the facility for HIV diagnostic testing?	YES	1		→ 529																												
		NO	2																														
525	For which HIV test do you send blood outside?	ELISA A WESTERN BLOT B PCR C OTHER X SPECIFY																															
526	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		→ 528																												
		YES, REPORTED, NOT SEEN	2																														
		NO	3																														
527	Does the register indicate if the client or the provider has received the results?	YES, OBSERVED	1																														
		YES, REPORTED, NOT SEEN	2																														
		NO	3																														
528	After receiving the results, how are the results provided to the client?	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT 1 LAB TELLS CLIENT VERBALLY ONLY 2 LAB PROVIDES RESULTS TO HEALTHWORKER/CLINIC/UNIT AND THEY TELL CLIENT 3 OTHER 6 (SPECIFY) DON'T KNOW 8																															
529	Is any pre or post HIV test counseling ever provided to clients in the laboratory area?	YES	1		Q:VCT																												
		NO	2																														
530	Do you send blood outside the facility for CD4 count, total lymphocyte count or viral load testing?	YES	1		→ 533																												
		NO	2																														
531	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																														
532	After receiving the results, how are the results provided to the client?	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT 1 LAB TELLS CLIENT VERBALLY ONLY 2 LAB PROVIDES RESULTS TO HEALTHWORKER WHO TELLS CLIENT 3 OTHER 6 (SPECIFY) DON'T KNOW 8																															

NO.	QUESTIONS	CODING CATEGORIES		GO TO
533	Does this laboratory or unit regularly compile reports of newly diagnosed HIV/AIDS cases?	YES 1 NO 2		→538
534	How frequently are the compiled reports submitted to someone outside of this clinic/unit laboratory?	MONTHLY OR MORE OFTEN 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5		→536
535	To whom are the reports sent? CIRCLE ALL THAT APPLY	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/CBOH/TACAI) C REGIONAL LEVEL (MOH/CBOH/TACAID) D NATIONAL LEVEL (MOH/CBOH/TACAID) E DONOR AGENCY F MAIN FACILITY LABORATORY G OTHER X (SPECIFY)		
536	ASK TO SEE THE REPORT FOR NEWLY DIAGNOSED HIV/AIDS CASES DURING THE PAST 12 MONTHS AND RECORD THE NUMBER OF CASES.	NEW HIV/AIDS CASES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> REPORT NOT SEEN 99996		→538
537	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>		
538	Do you record results by the clinic/unit ordering the HIV test or test results? IF YES, ASK TO SEE THE REGISTER AND INDICATE FROM WHICH CLINICS/UNITS RESULTS FOR TESTS ARE RECORDED.	YES 1 NO 2		→540
539	HIV RESULTS ARE RECORDED SEPARATELY FOR:	YES	NO	NOT APPLICABLE
01	VCT	1	2	3
02	PMTCT/VCT	1	2	3
03	Surveillance	1	2	3
04	Blood bank or blood for transfusion	1	2	3
05	General or specialty outpatient clinic/units (except VCT or PMTCT)	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
540	ASSESS THE LABORATORY AREA. FOR INFECTION PREVENTION CONDITIONS. INDICATE IF ITEMS LISTED BELOW ARE AVAILABLE IN THE LABORATORY, OR IMMEDIATELY ADJACENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 541	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
541	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2			
542	Is blood for HIV/AIDS testing drawn in the laboratory or an adjacent area? IF YES, INDICATE IF THIS IS THE SAME AREA ASSESSED IN Q540.	YES, SAME AREA 1 DIFFERENT AREA 2 NO BLOOD DRAWN 3			→544 →544

NO.	QUESTIONS	CODING CATEGORIES			GO TO
543	ASK TO SEE WHERE THE BLOOD IS DRAWN FOR THE HIV/AIDS TEST AND INDICATE IF THE FOLLOWING ARE AVAILABLE IN THE ROOM OR IMMEDIATELY ADJACENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	PRIVATE ROOM (VISUAL AND AUDITORY PRIVACY)	1 → 544	2	3	
11	AUDITORY PRIVACY	1	2	3	
12	VISUAL PRIVACY	1	2	3	
544	Is there a functioning autoclave in this laboratory or an immediately adjacent area?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, NOT FUNCTIONING 3 NO 4			
545	Do you decontaminate hazardous waste prior to disposal? IF YES, ASK WHAT PROCEDURE IS USED FOR DECONTAMINATION.	AUTOCLAVE A DECONTAMINATE IN CHLORINE-BASE SOLUTION B OTHER X (SPECIFY) NO Y			
546	What is the final procedure for disposing of hazardous laboratory waste?	BURNED IN INCINERATOR 02 BURNED AND BURIED 03 BURNED AND REMOVED TO OFFSITE DUMP 04 BURNED AND NOT BURIED 05 BURIED, NOT BURNED 06 THROWN IN TRASH/OPEN PIT 07 THROWN IN PIT LATRINE 08 REMOVED OFFSITE 09 OTHER 96 (SPECIFY)			

NO.	QUESTIONS	CODING CATEGORIES			GO TO
547	Now I would like to see specific equipment necessary for other tests Is the following equipment available, and is it functioning today?	(a) TEST CONDUCTED Yes No		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE? OBSERVED REPORTED, NOT SEEN NOT AVAILABLE	(c) IS THE ITEM IN WORKING ORDER? YES NO DON'T KNOW
01	ANY HEMATOLOGY TESTS	1 2 548			
02	Hematology analyzer/Coulter (for total lymphocyte count, full blood count, platelet count,)	1→b 2 03	1 → c 2 → c 3 03	1→548 2 8	
03	Hemoglobinometer/hemacue	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 hemoglobin test (with valid expiration date)	1→b 2 09	1 2 3		
09	Other anemia test _____ (SPECIFY)	1→b 2 548	1 2 3		
548	01 SYPHILIS TESTS	1 2 549			
	02 VDRL	1→b 2 04	1 2 3		
	03 Rotator or shaker		1 → c 2 → c 3 04	1 2 8	
	04 Rapid plasma reagin test (RPR)	1→b 2 549	1 2 3		
BLOOD TRANSFUSION AND SCREENING					
549	Does this facility ever conduct blood typing? IF YES, ASK TO SEE THE REAGENTS BELOW.	YES 1 NO 2			→551
550		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	Anti-A Reagent (valid expiration date)	1	2	3	
02	Anti-B Reagent (valid expiration date)	1	2	3	
03	Anti-AB Reagent (valid expiration date)	1	2	3	
551	Is blood ever transfused in this facility?	YES 1 NO 2			→556
552	Does any place in this facility do blood screening for infectious diseases prior to transfusion?	YES 1 BLOOD SCREENED OUTSIDE FACILITY 2 NO SCREENING TESTS DONE 3			→556

NO.	QUESTIONS	CODING CATEGORIES				GO TO
553	Is blood that is transfused in this facility screened for any of the following diseases? IF YES, ASK, Is the blood screened for this disease always, most of the time, rarely, or never?	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	
554	Do you ever send blood outside for any of the previously mentioned tests?	YES 1 NO 2				→556
555	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.	(a) SEND BLOOD OUTSIDE FOR TEST YES NO		(b) RECORD OF TEST RESULTS OBSERVED 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	
556	DO INFECTION PREVENTION CONDITIONS NEED TO BE ASSESSED FOR THIS LABORATORY AREA?	YES 1 NO, LABORATORY ALREADY ASSESSED 2				→559
557	ASSESS THE LABORATORY AREA. FOR INFECTION PREVENTION CONDITIONS. INDICATE IF ITEMS LISTED BELOW ARE AVAILABLE IN THE LABORATORY, OR IMMEDIATELY ADJACENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE		
01	RUNNING WATER	1 → 03	2	3		
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3		
03	HAND-WASHING SOAP	1	2	3		
04	SINGLE-USE HAND DRYING TOWELS	1	2	3		
05	SHARPS CONTAINER	1	2	3		
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3		
07	DISPOSABLE NON-LATEX GLOVES	1	2	3		
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 558	2	3		
09	DISINFECTANT (NOT YET MIXED)	1	2	3		
558	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2				

NO.	QUESTIONS	CODING CATEGORIES						GO TO	
BIOCHEMISTRY									
559	Are items for the indicated tests available today? Is the equipment functioning?	(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	Blood chemistry analyzer that provides serum creatinine, glucose, liver function tests)	1→b	2 02↙	1→c	2→c	3 02↙	1→560	2	8
02	Other means for serum glucose	1→b	2 560↙	1→c	2→c	3 560↙	1	2	8
560	URINE TESTS	1	2 561↙						
01									
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	2 561↙	1→c	2→c	3 561↙	1	2	8
561	Pregnancy test	1→b	2 562↙	1	2	3			
562	Do you ever send blood or urine outside for any of the previously mentioned tests?	YES			1			→564	
		NO			2				
563	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.	(a) SEND BLOOD OUTSIDE FOR TEST		(b) RECORD OF TEST RESULTS OBSERVED					
		YES	NO	YES	NO				
01	Blood chemistries (serum creatinine and glucose)	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				
564	DO INFECTION PREVENTION CONDITIONS NEED TO BE ASSESSED FOR THIS LABORATORY AREA?	YES			1			→567	
		NO, LABORATORY ALREADY ASSESSED			2				

NO.	QUESTIONS	CODING CATEGORIES			GO TO				
565	ASSESS THE LABORATORY AREA. FOR INFECTION PREVENTION CONDITIONS. INDICATE IF ITEMS LISTED BELOW ARE AVAILABLE IN THE LABORATORY, OR IMMEDIATELY ADJACENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE					
01	RUNNING WATER	1 → 04	2	3					
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3					
03	HAND-WASHING SOAP	1	2	3					
04	SINGLE-USE HAND DRYING TOWELS	1	2	3					
05	SHARPS CONTAINER	1	2	3					
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3					
07	DISPOSABLE NON-LATEX GLOVES	1	2	3					
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 566	2	3					
09	DISINFECTANT (NOT YET MIXED)	1	2	3					
566	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2							
MICROBIOLOGY									
567	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,	(a) EQUIPMENT/ TEST USED		(b) EQUIPMENT/ALL ITEMS FOR TEST AVAILABLE?		(c) IS THE ITEM IN WORKING ORDER?			
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
01	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	Glass slides and covers	1 → b 2 568 ↘		1	2	3			
568	MALARIA TESTS	1 2 569 ↘							
01	Giemsa stain	1 → b 2 03 ↘		1	2	3			
02	Field stain	1 → b 2 04 ↘		1	2	3			
03	Rapid test (test strips, ICT, paracheck, etc)	1 → b 2 05 ↘		1	2	3			
04	Acridine Orange (AO microscope, and acridine orange stain)	1 → b 2 06 ↘		1	2	3			
05	Other test for malaria _____ (SPECIFY)	1 → b 2 569 ↘		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?		
		Yes	No	OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE NOT TODAY	YES	NO	DON'T KNOW
569	Indian ink stain	1→b	2 570 ↓	1	2	3			
570 01	GONORRHEA TESTS	1	2 571 ↓						
02	Chocolate agar (culture medium)	1→b	2 571 ↓	1	2	3			
571 01	GRAM STAIN	1	2 572 ↓						
02	Crystal violet			1	2	3			
03	Lugol's iodine			1	2	3			
04	Acetone			1	2	3			
05	Neutral red, carbol fuchsin, or other counterstain			1	2	3			
572 01	CHLAMYDIA TEST	1	2 573 ↓						
02	Giemsa stain	1→b	2 03 ↓	1	2	3			
03	Other test for chlamydia (SPECIFY)	1	2 573 ↓	1	2	3			
573 HIV	Urine microscopy	1→b	2 574 ↓	1	2	3			
574 01	TUBERCULOSIS TEST	1	2 575 ↓						
02	AFB or Ziehl-Neelson test, with stain, such as methyl blue, present	1→b	2 03 ↓	1	2	3			
03	New rapid test for TB	1→b	2 04 ↓	1	2	3			
04	Agar plates for culture	1→b	2 05 ↓	1	2	3			
05	All items for other tests for TB (SPECIFY)	1→b	2 575 ↓	1	2	3			
575	Does this facility ever send sputum outside the facility for testing?	YES 1 NO 2							
576	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			→578 →578		
577	When was the last entry in the register for TB test results?			WITHIN 30 DAYS 1 MORE THAN 30 DAYS AGO 2					
578	Do you ever send blood outside for any of the previously mentioned tests?			YES 1 NO 2			→580		

NO.	QUESTIONS	CODING CATEGORIES				GO TO
579	INDICATE IF THERE IS AN OBSERVED RECORD OF RESULTS FOR TESTS CONDUCTED OUTSIDE.	(a) SEND BLOOD OUTSIDE FOR TEST YES NO		(b) RECORD OF TEST RESULTS OBSERVED 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	
580	DO INFECTION PREVENTION CONDITIONS NEED TO BE ASSESSED FOR THIS LABORATORY AREA?	YES 1 NO, LABORATORY ALREADY ASSESSED 2				→583
581	ASSESS THE LABORATORY AREA. FOR INFECTION PREVENTION CONDITIONS. INDICATE IF ITEMS LISTED BELOW ARE AVAILABLE IN THE LABORATORY, OR IMMEDIATELY ADJACENT	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE		
01	RUNNING WATER	1 →03	2	3		
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3		
03	HAND-WASHING SOAP	1	2	3		
04	SINGLE-USE HAND DRYING TOWELS	1	2	3		
05	SHARPS CONTAINER	1	2	3		
06	DISPOSABLE LATEX GLOVES	1 →08	2	3		
07	DISPOSABLE NON-LATEX GLOVES	1	2	3		
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 →582	2	3		
09	DISINFECTANT (NOT YET MIXED)	1	2	3		
582	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2				
583	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				→585
584	Do you have all items today, for performing.	ARE ALL ITEMS FOR TEST AVAILABLE?				
		AVAILABLE TODAY		NORMALLY AVAILABLE NOT TODAY	NO TEST THIS FACILITY	DON'T KNOW
		OBSERVED	REPORTED, NOT SEEN			
01	PAP smears?	1	2	3	4	8
02	Histology?	1	2	3	4	8

NO.	QUESTIONS	CODING CATEGORIES			GO TO		
585	Does this facility perform diagnostic X-rays? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED.	YES	1		→END		
		NO	2				
586	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:	(b) EQUIPMENT/ITEMS AVAILABLE?			(c) ITEM IN WORKING ORDER?		
		OBSERVED	REPORTED, NOT SEEN	NORMALLY AVAILABLE BUT NOT TODAY	YES	NO	DON'T KNOW
01	X-RAY MACHINE	1 → c	2 → c	3 02 ↙	1	2	8
02	FILM FOR X-RAYS	1	2	3			
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE							

SECTION F: MEDICATION AND SUPPLIES			
Facility Number: 		Interviewer Code 	
		CLINIC/UNIT CODE 	
		<div style="display: flex; justify-content: space-between; font-size: small;"> Line # Unit # Parent Line # </div>	
600	INDICATE WHICH CLIENTS HAVE ACCESS TO MEDICINES REPORTED IN THIS QRE.	<div style="display: flex; justify-content: space-between;"> <div> OUTPATIENT ONLY 1 INPATIENT ONLY 2 BOTH IN AND OUTPATIENT 3 AREA LOCKED/NO ACCESS 4 NO MEDICINES STORED IN FACILITY 5 </div> <div style="text-align: right;">→STOP</div> </div>	
601	MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC.) 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE 5 OTHER 6 <div style="text-align: center; font-size: small;">(SPECIFY) _____</div>		
602	CHECK QUESTION Q600. IS THE RESPONSE 4', NO ACCESS?	<div style="display: flex; justify-content: space-between;"> <div> YES 1 NO 2 </div> <div style="text-align: right;">→STOP</div> </div>	
603	RECHECK QUESTIONNAIRE AT THE END OF THIS INTERVIEW AND VERIFY THAT ALL APPLICABLE SECTIONS WERE COMPLETED FOR THIS UNIT. FINALLY, MARK ON FACILITY CHECKLIST EACH QRE COMPLETED FOR THIS UNIT.	<div style="display: flex; justify-content: space-between;"> <div> APPLICABLE & COMPLETED (V)CT Q605 (A) 1 ART (Q605 (B) 1 </div> <div> NOT APPLICABLE 2 2 </div> </div>	
FIND THE PERSON IN CHARGE OF MEDICINES. IF HE/SHE IS NOT PRESENT, ASK TO SEE THE PROVIDER MOST KNOWLEDGEABLE ABOUT PHARMACEUTICAL PROCEDURES.			
<p>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 REPORTS COMPILED BY THE FACILITY. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.</p> <p>IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q604 BELOW AND GO ON TO Q605.</p> <p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE PHARMACEUTICALS WHO IS PRESENT TODAY. READ THE FOLLOWING GREETING: Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various medicines and pharmaceutical practices for this facility. We will ask to see various reports and records for pharmaceuticals. No patient names from registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports t unit will only present information in aggregate form so that your facility can not be identified. We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p>			
<div style="display: flex; justify-content: space-between;"> <div>Interviewer's signature _____</div> <div>Date _____</div> </div> <p>SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>			

604	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→STOP
NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
605 HIV	Is counseling related to HIV/AIDS ever provided by staff from this medicine storage area? By counseling, I mean providing information and support other than telling clients how to take the medicines you provide.	YES, GENERAL COUNSELING RELATED TO HIV/AIDS A YES, ADHERENCE COUNSELING FOR ART B NO COUNSELING Y	QRE:VCT QRE:ART
606	Is there a register or stock cards where the amount of each medicine received, the amount disbursed, and the amount present today is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→608
607	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN PREVIOUS QUESTION.	STOCK RECORDS UPDATED DAY ITEM DISBURSED 1 STOCK RECORDS NOT ALWAYS UPDATED WHEN ITEM DIS- BURSED, 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.			

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
608	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES					(b) OUT OF STOCK IN LAST SIX MONTHS			
		OBSERVED AVAILABLE			NOT OBSERVED					
		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	Acetaminophen/ paracetamol (oral)		2 → b	3 02 ↙	4 02 ↙	5 02 ↙	6 02 ↙	1	2	8
02	Acetylsalicylic acid/ aspirin (oral)		2 → b	3 03 ↙	4 03 ↙	5 03 ↙	6 03 ↙	1	2	8
03	Acyclovir (ophthalmic)		2 → b	3 04 ↙	4 04 ↙	5 04 ↙	6 04 ↙	1	2	8
04	Acyclovir (oral)		2 → b	3 05 ↙	4 05 ↙	5 05 ↙	6 05 ↙	1	2	8
05	Albendazole (oral)		2 → b	3 06 ↙	4 06 ↙	5 06 ↙	6 06 ↙	1	2	8
* 06	Amoxicillin (amoxil)	1 → b	2 → b	3 07 ↙	4 07 ↙	5 07 ↙	6 07 ↙	1	2	8
07	Amoxicillin/clavulanate (Augmentin) (oral)		2 → b	3 08 ↙	4 08 ↙	5 08 ↙	6 08 ↙	1	2	8
08	Amoxicillin (inj)	1 → b	2 → b	3 09 ↙	4 09 ↙	5 09 ↙	6 09 ↙	1	2	8
* 09	Ampicillin (inj)	1 → b	2 → b	3 10 ↙	4 10 ↙	5 10 ↙	6 10 ↙	1	2	8
10	Ampicillin (oral)	1 → b	2 → b	3 11 ↙	4 11 ↙	5 11 ↙	6 11 ↙	1	2	8
11	Amphotericin B (inj)		2 → b	3 12 ↙	4 12 ↙	5 12 ↙	6 12 ↙	1	2	8
12	Bleomycin (Inj)		2 → b	3 13 ↙	4 13 ↙	5 13 ↙	6 13 ↙	1	2	8
13	Cefalexin (oral)		2 → b	3 14 ↙	4 14 ↙	5 14 ↙	6 14 ↙	1	2	8
14	Cefotaxime (Inj)		2 → b	3 15 ↙	4 15 ↙	5 15 ↙	6 15 ↙	1	2	8
15	Ceftriaxone (Rocephin)(inj)	1 → b	2 → b	3 16 ↙	4 16 ↙	5 16 ↙	6 16 ↙	1	2	8
* 16	Chloramphenicol (oral)	1 → b	2 → b	3 17 ↙	4 17 ↙	5 17 ↙	6 17 ↙	1	2	8
17	Chloramphenicol (inj)	1 → b	2 → b	3 18 ↙	4 18 ↙	5 18 ↙	6 18 ↙	1	2	8
18	Cidofovir		2 → b	3 19 ↙	4 19 ↙	5 19 ↙	6 19 ↙	1	2	8

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED			YES	NO	DK
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY/DK	NEVER AVAIL- ABLE			
19	Cidovar	1 → b	2 → b	3 20 ↙	4 20 ↙	5 20 ↙	6 20 ↙	1	2	8
* 20	Ciprofloxacin (oral)		2 → b	3 21 ↙	4 21 ↙	5 21 ↙	6 21 ↙	1	2	8
21	Clarithromycin (Biaxin) (oral)		2 → b	3 22 ↙	4 22 ↙	5 22 ↙	6 22 ↙	1	2	8
22	Clindamycin (oral or inj)		2 → b	3 23 ↙	4 23 ↙	5 23 ↙	6 23 ↙	1	2	8
23	Clotrimazole (topical)		2 → b	3 24 ↙	4 24 ↙	5 24 ↙	6 24 ↙	1	2	8
24	Clotrimazole (vaginal supp)		2 → b	3 25 ↙	4 25 ↙	5 25 ↙	6 25 ↙	1	2	8
25	Codein (oral)		2 → b	3 26 ↙	4 26 ↙	5 26 ↙	6 26 ↙	1	2	8
* 26	Co-trimoxazole (oral)		2 → b	3 27 ↙	4 27 ↙	5 27 ↙	6 27 ↙	1	2	8
27	Cloxacillin (oral)		2 → b	3 28 ↙	4 28 ↙	5 28 ↙	6 28 ↙	1	2	8
28	Cloxacillin (inj)		2 → b	3 28 ↙	4 28 ↙	5 28 ↙	6 28 ↙	1	2	8
29	Dapsone (oral)		2 → b	3 30 ↙	4 30 ↙	5 30 ↙	6 30 ↙	1	2	8
30	Dexamethasone (oral)		2 → b	3 31 ↙	4 31 ↙	5 31 ↙	6 31 ↙	1	2	8
31	Dexamethasone (inj)		2 → b	3 32 ↙	4 32 ↙	5 32 ↙	6 32 ↙	1	2	8
32	Diazepam (oral)		2 → b	3 33 ↙	4 33 ↙	5 33 ↙	6 33 ↙	1	2	8
33	Diazepam (inj) (Valium)		2 → b	3 34 ↙	4 34 ↙	5 34 ↙	6 34 ↙	1	2	8
34	Diclofenac (oral or inj)		2 → b	3 35 ↙	4 35 ↙	5 35 ↙	6 35 ↙	1	2	8
35	Dipyron (inj) (Novalgin)		2 → b	3 36 ↙	4 36 ↙	5 36 ↙	6 36 ↙	1	2	8
36	Diphenoxylate (lomotil) (oral)		2 → b	3 37 ↙	4 37 ↙	5 37 ↙	6 37 ↙	1	2	8
* 37	Doxycycline (oral)	1 → b	2 → b	3 38 ↙	4 38 ↙	5 38 ↙	6 38 ↙	1	2	8
38	Ergometrine or methergine Oral)		2 → b	3 39 ↙	4 39 ↙	5 39 ↙	6 39 ↙	1	2	8
39	Syntocin or oxytocin (inj)		2 → b	3 40 ↙	4 40 ↙	5 40 ↙	6 40 ↙	1	2	8
* 40	Erythromycin (oral)	1 → b	2 → b	3 41 ↙	4 41 ↙	5 41 ↙	6 41 ↙	1	2	8
41	Famciclovir		2 → b	3 42 ↙	4 42 ↙	5 42 ↙	6 42 ↙	1	2	8
42	Fluconazole (oral or inj)		2 → b	3 43 ↙	4 43 ↙	5 43 ↙	6 43 ↙	1	2	8

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
	GENERAL MEDICINES CHECK INVENTORY AND STOCK AGREEMENT (Q615) FOR ALL ITEMS WHERE * IS BESIDE ITEM NUMBER	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE TODAY/DK	NEVER AVAILABLE	YES	NO	DK
43	Folic Acid (oral)		2 → b	3 44 ↙	4 44 ↙	5 44 ↙	6 44 ↙	1	2	8
44	Ganciclovir (oral or inj)		2 → b	3 45 ↙	4 45 ↙	5 45 ↙	6 45 ↙	1	2	8
* 45	Gentamicin (inj)		2 → b	3 46 ↙	4 46 ↙	5 46 ↙	6 46 ↙	1	2	8
46	Gentian Violet (GV paint)		2 → b	3 47 ↙	4 47 ↙	5 47 ↙	6 47 ↙	1	2	8
47	Ibuprofen (oral)		2 → b	3 48 ↙	4 48 ↙	5 48 ↙	6 48 ↙	1	2	8
48	Indomethacin (suppository)		2 → b	3 49 ↙	4 49 ↙	5 49 ↙	6 49 ↙	1	2	8
49	Iron tablets (oral)		2 → b	3 50 ↙	4 50 ↙	5 50 ↙	6 50 ↙	1	2	8
50	Iron tablets with folic		2 → b	3 51 ↙	4 51 ↙	5 51 ↙	6 51 ↙	1	2	8
51	Itraconazole (oral)		2 → b	3 52 ↙	4 52 ↙	5 52 ↙	6 52 ↙	1	2	8
52	Kanamycin (inj)	1 → b	2 → b	3 53 ↙	4 53 ↙	5 53 ↙	6 53 ↙	1	2	8
53	Ketoconazole (oral or topical)	1 → b	2 → b	3 54 ↙	4 54 ↙	5 54 ↙	6 54 ↙	1	2	8
54	Loperamide (immodium) (oral)	1 → b	2 → b	3 55 ↙	4 55 ↙	5 55 ↙	6 55 ↙	1	2	8
55	Magnesium sulfate (inj)		2 → b	3 56 ↙	4 56 ↙	5 56 ↙	6 56 ↙	1	2	8
56	Mebendazole (oral)		2 → b	3 57 ↙	4 57 ↙	5 57 ↙	6 57 ↙	1	2	8
57	Methyldopa (aldomet) (oral)		2 → b	3 58 ↙	4 58 ↙	5 58 ↙	6 58 ↙	1	2	8
58	Metronidazole intravenous		2 → b	3 59 ↙	4 59 ↙	5 59 ↙	6 59 ↙	1	2	8
* 59	Metronidazole (oral)		2 → b	3 60 ↙	4 60 ↙	5 60 ↙	6 60 ↙	1	2	8
60	Miconazole (vaginal supp)	1 → b	2 → b	3 61 ↙	4 61 ↙	5 61 ↙	6 61 ↙	1	2	8
61	Miconazole cream		2 → b	3 62 ↙	4 62 ↙	5 62 ↙	6 62 ↙	1	2	8
62	Morphine (oral)		2 → b	3 63 ↙	4 63 ↙	5 63 ↙	6 63 ↙	1	2	8
63	Multivitamins (oral)		2 → b	3 64 ↙	4 64 ↙	5 64 ↙	6 64 ↙	1	2	8
* 64	Nalidixic acid (oral)		2 → b	3 65 ↙	4 65 ↙	5 65 ↙	6 65 ↙	1	2	8
65	Nitrofurantoin (oral)		2 → b	3 66 ↙	4 66 ↙	5 66 ↙	6 66 ↙	1	2	8

NO	MEDICATION/SUPPLY ITEM				CODING CATEGORIES						
	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS			
		OBSERVED AVAILABLE			NOT OBSERVED						
		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	
66	Nitrofurazone (ointment)		2 → b	3 67 ↙	4 67 ↙	5 67 ↙	6 67 ↙	1	2	8	
67	Norfloxacin (oral)	1 → b	2 → b	3 68 ↙	4 68 ↙	5 68 ↙	6 68 ↙	1	2	8	
68	Nystatin (oral)	1 → b	2 → b	3 69 ↙	4 69 ↙	5 69 ↙	6 69 ↙	1	2	8	
69	Nystatin (vaginal supp.)	1 → b	2 → b	3 70 ↙	4 70 ↙	5 70 ↙	6 70 ↙	1	2	8	
70	Oral rehydration salts	1 → b	2 → b	3 71 ↙	4 71 ↙	5 71 ↙	6 71 ↙	1	2	8	
* 71	Penicillin, Benzathine (inj)		2 → b	3 72 ↙	4 72 ↙	5 72 ↙	6 72 ↙	1	2	8	
72	Penicillin Benzyl (inj)	1 → b	2 → b	3 73 ↙	4 73 ↙	5 73 ↙	6 73 ↙	1	2	8	
* 73	Penicillin, procaine (inj)	1 → b	2 → b	3 74 ↙	4 74 ↙	5 74 ↙	6 74 ↙	1	2	8	
74	Penicillin-V (oral)	1 → b	2 → b	3 75 ↙	4 75 ↙	5 75 ↙	6 75 ↙	1	2	8	
75	Phenobarbital (oral or inj)	1 → b	2 → b	3 76 ↙	4 76 ↙	5 76 ↙	6 76 ↙	1	2	8	
76	Prednisolone (or other steroid) (oral)		2 → b	3 77 ↙	4 77 ↙	5 77 ↙	6 77 ↙	1	2	8	
77	Silver nitrate eye drop		2 → b	3 78 ↙	4 78 ↙	5 78 ↙	6 78 ↙	1	2	8	
78	Spectinomycin, inj		2 → b	3 79 ↙	4 79 ↙	5 79 ↙	6 79 ↙	1	2	8	
79	Sulfadiazine (oral)	1 → b	2 → b	3 80 ↙	4 80 ↙	5 80 ↙	6 80 ↙	1	2	8	
80	Tetracycline (oral)		2 → b	3 81 ↙	4 81 ↙	5 81 ↙	6 81 ↙	1	2	8	
81	Tetracycline eye ointment		2 → b	3 82 ↙	4 82 ↙	5 82 ↙	6 82 ↙	1	2	8	
82	Tinidazole (oral)		2 → b	3 83 ↙	4 83 ↙	5 83 ↙	6 83 ↙	1	2	8	
83	Valganciclovir		2 → b	3 84 ↙	4 84 ↙	5 84 ↙	6 84 ↙	1	2	8	
84	Vincristine (inj)		2 → b	3 85 ↙	4 85 ↙	5 85 ↙	6 85 ↙	1	2	8	
85	Vitamin A (25,000 or 50,000 iu)		2 → b	3 86 ↙	4 86 ↙	5 86 ↙	6 86 ↙	1	2	8	
86	Vitamin A (10,000iu)		2 → b	3 87 ↙	4 87 ↙	5 87 ↙	6 87 ↙	1	2	8	
87	Vitamin B6 (pyridoxine) (oral)		2 → b	3 88 ↙	4 88 ↙	5 88 ↙	6 88 ↙	1	2	8	
88	Other B vitamins (oral)		2 → b	3 89 ↙	4 89 ↙	5 89 ↙	6 89 ↙	1	2	8	
89	Xylocaine or lidocaine 1% or 2% (inj)		2 → b	3 90 ↙	4 90 ↙	5 90 ↙	6 90 ↙	1	2	8	
90	Vitamin K (inj)		2 → b	3 609 ↙	4 609 ↙	5 609 ↙	6 609 ↙	1	2	8	

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
609	ANTIMALARIALS	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED			YES	NO	DK
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY/DK	NEVER AVAIL- ABLE			
01	Artemisinin (oral) (Cotexin, Arinate, Artesunate)	1 → b	2 → b	3 02 ↙	4 02 ↙	5 02 ↙	6 02 ↙	1	2	8
02	Artemether-Lumefantr (COARTEM)	1 → b	2 → b	3 03 ↙	4 03 ↙	5 03 ↙	6 03 ↙	1	2	8
03	Sulfadoxin+Pyrimethamine Fansidar, Metakelfin, Oradar)	1 → b	2 → b	3 04 ↙	4 04 ↙	5 04 ↙	6 04 ↙	1	2	8
04	Quinine (oral)	1 → b	2 → b	3 05 ↙	4 05 ↙	5 05 ↙	6 05 ↙	1	2	8
05	Quinine (inj)	1 → b	2 → b	3 06 ↙	4 06 ↙	5 06 ↙	6 06 ↙	1	2	8
06	Chloroquine (oral)	1 → b	2 → b	3 07 ↙	4 07 ↙	5 07 ↙	6 07 ↙	1	2	8
07	Chloroquine (inj)	1 → b	2 → b	3 08 ↙	4 08 ↙	5 08 ↙	6 08 ↙	1	2	8
08	Amodiaquine (oral)	1 → b	2 → b	3 09 ↙	4 09 ↙	5 09 ↙	6 09 ↙	1	2	8
09	Other _____ (SPECIFY)	1 → b	2 → b	3 610 ↙	4 610 ↙	5 610 ↙	6 610 ↙	1	2	8
610	TUBERCULOSIS									
01	Ethambutol (oral)		2 → b	3 02 ↙	4 02 ↙	5 02 ↙	6 02 ↙	1	2	8
02	Isoniazid (oral)		2 → b	3 03 ↙	4 03 ↙	5 03 ↙	6 03 ↙	1	2	8
03	Pyrazinamide (oral)		2 → b	3 04 ↙	4 04 ↙	5 04 ↙	6 04 ↙	1	2	8
04	Rifampin (oral)		2 → b	3 05 ↙	4 05 ↙	5 05 ↙	6 05 ↙	1	2	8
05	Streptomycin (inj)		2 → b	3 06 ↙	4 06 ↙	5 06 ↙	6 06 ↙	1	2	8
06	Isoniazid + rifampin (Rifina) (oral)		2 → b	3 610 ↙	4 610 ↙	5 610 ↙	6 610 ↙	1	2	8
07	Isoniazid+rifampin+ pyrazinamide (RHZ, Rifater)		2 → b	3 08 ↙	4 08 ↙	5 08 ↙	6 08 ↙	1	2	8
08	Isoniazid + ethambutol (EH)		2 → b	3 09 ↙	4 09 ↙	5 09 ↙	6 09 ↙	1	2	8
09	4FDC (combination INH, Ethambutol, pyrazinamide, rifampin)		2 → b	3 10 ↙	4 10 ↙	5 10 ↙	6 10 ↙	1	2	8
10	Other _____ (SPECIFY)		2 → b	3 611 ↙	4 611 ↙	5 611 ↙	6 611 ↙	1	2	8

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
611	INTRAVENOUS SOLUTION	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY AND STOCK AGREEMENT (Q615) FOR ALL ITEMS WHERE * IS BESIDE ITEM NUMBER	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 ↙	6 02 ↙	1	2	8
02	Dextrose and Normal Saline (D5NS)		2 → b	3 03 ↙	4 03 ↙	5 03 ↙	6 03 ↙	1	2	8
* 03	Ringers Lactate	1 → b	2 → b	3 04 ↙	4 04 ↙	5 04 ↙	6 04 ↙	1	2	8
* 04	Plasma Expander	1 → b	2 → b	3 612 ↙	4 612 ↙	5 612 ↙	6 612 ↙	1	2	8
612	OTHER									
01	Infant formula		2 → b	3 02 ↙	4 02 ↙	5 02 ↙	6 02 ↙	1	2	8
02	Fortified protein supplement		2 → b	3 03 ↙	4 03 ↙	5 03 ↙	6 03 ↙	1	2	8
03	Male condom		2 → b	3 04 ↙	4 04 ↙	5 04 ↙	6 04 ↙	1	2	8
04	Female condom		2 → b	3 613 ↙	4 613 ↙	5 613 ↙	6 613 ↙	1	2	8
613	WERE ANY EXPIRED MEDICINES OBSERVED?	YES 1 NO 2								
614	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								

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES		
615	FOR EACH OF THE FOLLOWING MEDICINES RECORD IF THE AMOUNT OF STOCK ON THE STOCK CARD OR REGISTER MATCH THE INVENTORY OBSERVED IN STORAGE OR IF THE CORRECT AMOUNT CAN RAPIDLY BE CALCULATED	STOCK AND INVENTORY MATCH		
		YES	NO	MEDICINE NEVER AVAILABLE
01	Amoxicillin oral	1	2	3
02	Ampicillin injectable	1	2	3
03	Chloranphenicol oral	1	2	3
04	Ciprofloxacin oral	1	2	3
05	Co-trimoxazole oral	1	2	3
06	Doxycycline oral	1	2	3
07	Erythromycin oral	1	2	3
08	Gentamicin, injectable	1	2	3
09	Metronidazole oral	1	2	3
10	Nalidixic acid oral	1	2	3
11	Penicillin, Benzathine, injectable	1	2	3
12	Penicillin, procaine, injectable	1	2	3
13	Ringers Lactate	1	2	3
14	Plasma Expander	1	2	3
616	FOR EACH OF THE FOLLOWING MEDICINES, INDICATE IF THERE IS AN OVERSTOCKAGE TODAY (THAT IS, IS THERE MORE THAN _____ PRESENT?)			
		(a) ESTIMATED NUMBER OF TABLETS/VIALS DISTRIBUTED PRIOR 6 FULL MONTHS	(b) NUMBER OF TABLETS/VIALS AVAILABLE TODAY	
01	Artemisinin (oral) (Cotexin, Arinate, Artesonate)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
02	Artemether-Lumefantrine (COARTEM)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
03	Sulfadoxin+Pyrimethamine Fansidar, Metakelfin, Oradar)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
04	Quinine (oral)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
05	Quinine (inj)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
06	Chloroquine (oral)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
07	Chloroquine (inj)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
08	Amodiaquine (oral)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
09	Acetaminophen/ paracetamol (oral)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	
10	Other antimalarial (SPECIFY)	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	<div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div>NONE 000000 DK 999998</div>	

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
617	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OR EACH OF THE FOLLOWING CONDITIONS.		
01	ARE THE MEDICINES OFF THE FLOOR AND PROTECTED FROM WATER?	YES 1 NO 2 DON'T KNOW 8	
02	ARE THE MEDICINES PROTECTED FROM SUN?	YES 1 NO 2 DON'T KNOW 8	
03	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC.).	YES 1 NO 2 DON'T KNOW 8	
618	When was the last time that you received a routine supply of medicines?	WITHIN PRIOR 4 WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8	
619	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 DON'T KNOW 8	→ 621 → 623
620	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	→ 623 → 623 → 623

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
621	<p>Routinely, when you order medicines, which best describes the system you use to determine how much of each to order? Do you:</p> <ul style="list-style-type: none"> - Review the amount of each medicine 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 method used since the previous order, and plan based on prior utilization and expected future activity? - Other _____ (SPECIFY) - Don't know 	<p>ORDER TO MAINTAIN FIXED STOCK 1</p> <p>ORDER SAME AMOUNT 2</p> <p>ORDER BASED ON UTILIZATION 3</p> <p>OTHER 6</p> <p>DON'T KNOW 8</p>	
622	<p>Which of the following best describes the routine system for deciding when to order medicines? Do you:</p> <ul style="list-style-type: none"> - Place order whenever stock levels fall to a predetermined level? - Have a fixed time that orders are submitted? IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. - Place an order whenever there is believed to be a need, regardless of stock level? - Other _____ (SPECIFY) - Don't know 	<p>PREDETERMINED LEVEL .. 1</p> <p>FIXED TIME 2 EVERY <input type="text"/> <input type="text"/> WEEKS</p> <p>ORDER WHEN NEEDED 3</p> <p>OTHER 6</p> <p>DON'T KNOW 8</p>	
623	<p>If there is a shortage of a specific medicine between routine orders, what is the most common procedure followed by this facility?</p> <ul style="list-style-type: none"> - Submit special order to normal supplier - Facility purchases from private market - Clients must purchase from outside the facility. 	<p>SPECIAL ORDER 1</p> <p>FACILITY PURCHASE 2</p> <p>CLIENT PURCHASE OUTSIDE .. 3</p>	
624	<p>During the past 3 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)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p>	
625	<p>Does this facility stock any antiretroviral medicines? IF YES, CLARIFY THE PURPOSE OF THE ANTIRETROVIRAL MEDICINES</p>	<p>YES, FOR HIV/AIDS TREATMENT 1</p> <p>YES, FOR PEP ONLY 2</p> <p>NO 3</p>	→ 636
626	<p>Is there a register or stock cards where the amount of each antiretroviral medicine received, the amount disbursed, and the amount present today is recorded? IF YES, ASK: May I see the records?</p>	<p>YES, OBSERVED 1</p> <p>YES, REPORTED, NOT SEEN 2</p> <p>NO 3</p>	→ 628

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES									
627	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 6 (SPECIFY)									
628	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) DURING THE LAST SIX MONTHS										
ANTIRETROVIRAL MEDICINES		(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS			
		OBSERVED AVAILABLE			NOT OBSERVED			YES NO DK			
		ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY/DK	NEVER AVAIL- ABLE				
01	Zidovudine (ZDV,AZT)	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
02	Zidovudine (ZDV,AZT) syrup	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
03	Abacavir/ABC	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
04	Didanosine/ddI	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
05	Efavirenz(EFZ)200	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
06	Efavirenz(EFZ)600	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
07	Lamivudine/3TC	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
08	Lamivudine/3TC syrup	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
09	Nevirapine (NVP)	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
10	Nevirapine(NVP) syrup	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
11	Stavudine 40 (D4T)	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
12	Stavudine 30 (D4T)	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
13	COMBINED 3DRUGS [3TC/d4T(30)/NVP]	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
14	COMBINED 3 DRUGS [3TC/d4T(40)/NVP]	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
15	COMBINED 2 DRUGS [AZT+3TC]	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
16	COMBINED 2 DRUGS [ZDV+3TC]	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
17	COMBINED 2 DRUGS [D4T(30)+3TC]	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
18	COMBINED 2 DRUGS [D4T(40)+3TC]	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
19	NRTIs (Tenofovir disoproxil fumarate [Viread])	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
20	Protease inhibitors (indinavir [Crixivan], nelfinavir [Viracept], ritonavir [Norvir], saquinavir [Invirase])	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	
21	Other (SPECIFY)	1 → b	2 → b	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	1	2	8	

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
629	DESCRIBE THE STORAGE OF THE ANTIVIRAL MEDICINES. ARE THE ANTIVIRALS 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) _____	
630	DESCRIBE THE SECURITY FOR THE ANTIRETROVIRAL MEDICINES.	LOCKED APART FROM OTHER MEDS AND ARVS 1 LOCKED, LIMITED ACCESS SITE 2 UNLOCKED OR NO LIMITED ACCESS 3	
631	CHECK ALL ANTIRETROVIRAL DRUGS. IS THE AMOUNT PRESENT ON THE REGISTER/STOCK CARD THE SAME AS THAT YOU SEE IN THE INVENTORY FOR ALL AVAILABLE ANTIRETROVIRAL DRUGS OR CAN THE AMOUNTS CAN RAPIDLY BE RECONCILED?	YES 1 NO 2	
632	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	→636
633	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	COMBIVIR (ZDV/3TC) A STAVUDINE/LAMIVUDINE ... B STAVUDINE/LAMIVUDINE +INDINAVIR C STAVUDINE/LAMIVUDINE and EFV or NVP..... D OTHER COMBINATION E (SPECIFY) _____ OTHER ONE ARV USED ALONE F (SPECIFY) _____ NONE Y	→636
634	DESCRIBE THE STORAGE OF THE PEP MEDICINES. ARE THE PEP MEDICINES STORED IN A LOCKED STORAGE UNIT AND 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 6 (SPECIFY) _____	
635	DESCRIBE THE SECURITY FOR THE PEP MEDICINES.	LOCKED APART FROM OTHER MEDS AND ARVS 1 LOCKED, LIMITED ACCESS S. 2 UNLOCKED OR NO LIMITED ACCESS 3	

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES					
636	Finally, I would like to see supplies that you have in stock. Please show me the following stock supply items:	a			b		
		OBSERVED	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE	OUT OF STOCK IN LAST SIX MONTHS		
					YES	NO	DK
01	Disposable needles (19 or 21 guage)	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	Cannulae 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-washing soap	1 →b	2 11 ↙	3 11 ↙	1	2	8
11	Insecticide treated bed net	1 →b	2 12 ↙	3 12 ↙	1	2	8
12	Voucher book for ITN	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 G: TUBERCULOSIS DIAGNOSIS AND TREATMENT			
Facility Number: <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div>		QRE TYPE G	
Interviewer Code: <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div>			
700	INDICATE THE SERVICE SETTING FOR THIS SECTION	<div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: 0.8em;"> Line # Unit # </div>	
701	MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC) 2 PARASTATAL 3 FAITH BASED ORGANIZATION. 4 PRIVATE 5 OTHER _____ 6 <div style="text-align: center; margin-top: 5px;">(SPECIFY)</div>		
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT THE TB SERVICES IN THIS CLINIC/UNIT, AND IF RELEVANT, SPECIFICALLY TB SERVICES RELATED WITH HIV/AIDS SERVICES			
<p>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 TUBERCULOSIS SERVICES IN THE CLINIC/UNIT. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.</p> <p>IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q702 BELOW AND GO ON TO Q704.</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about the tuberculosis services, and services for HIV/AIDS and tuberculosis. We will ask to see various reports and records for tuberculosis services. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that unit will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p>			
Interviewer's signature _____ SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.		Date _____	
702	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO
704	<p>First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counselors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this clinic/unit who are present today.</p> <p>Please give me the names and main service responsibility of the 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 CLINIC/UNIT. DO NOT DUPLICATE HIV/AIDS SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.</p>		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES 1 NO 2	
705	What is the most common method used by providers in this clinic/unit for diagnosing TB?	SPUTUM SMEAR ONLY 1 X-RAY ONLY 2 EITHER SPUTUM OR X-RAY 3 BOTH SPUTUM AND X-RAY 4 CLINICAL SYMPTOMS ONLY 5 REFER TO OUTSIDE FACILITY ... 6 NO TB DIAGNOSIS SERVICES ... 7	→ 710 → 710 → 710 → 710 → 710
706	Does this clinic/unit have an agreement with a referral site for TB test results to be returned to the clinic/unit either directly or through the client?	YES 1 NO 2	→ 708
707	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	
708	When you refer a client to another facility for services, do you use a preprinted 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, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO FORM USED 3 NEVER REFER OUTSIDE FACILITY 4 DON'T KNOW 8	→ 710 → 710
709	Do you use any (other) method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE/CARD 1 WRITE NOTE ON PRESCRIPTION FORM OR LETTERHEAD 2 PROVIDER GIVES VERBAL REPORT TO SITE OR ACCOMPANIES CLIENT) 3 WRITE NOTE/LETTER ON BLANK PAPER 4 OTHER _____ 6 (SPECIFY) NO 7	

NO.	QUESTIONS	CODING CATEGORIES				GO TO				
710	WAS INFORMATION FOR OPD QRE 221 OR IPD Q321, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY COLLECTED FOR THIS CLINIC/UNIT?	YES 1 NO 2				→ 711 (03)				
711	Do you have any guidelines/protocols for diagnosis and treatment of tuberculosis? IF YES, ASK: May I see the guidelines/ protocols?	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="text-align: center;">(a)</div> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 15%;">OBSERVED, COM- PLETE</th> <th style="width: 15%;">REPORTED INCOM- PLETE</th> <th style="width: 15%;">AVAIL. NOT SEEN</th> <th style="width: 15%;">NOT AVAIL.</th> </tr> </table> </div> <div style="width: 45%;"> <div style="text-align: center;">(b)</div> <div style="text-align: center;">DATE ON OBSERVED MANUAL YEAR</div> </div> </div>				OBSERVED, COM- PLETE	REPORTED INCOM- PLETE	AVAIL. NOT SEEN	NOT AVAIL.	
OBSERVED, COM- PLETE	REPORTED INCOM- PLETE	AVAIL. NOT SEEN	NOT AVAIL.							
01	Management of Tuberculosis, manual for health workers	1 →b	2 →b	3 02 ↙	4 02 ↙	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>				
02	Manual of the national Tuberculosis and Leprosy program in Tanzania	1 →b	2 →b	3 03 ↙	4 03 ↙	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>				
03	Other than previously mentioned national guidelines, are there any other protocols or guidelines for TB diagnosis and treatment available? IF YES, SPECIFY .	1 →b	2 →b	3 712 ↙	4 712 ↙	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>				
712	Do you have any record of the number of newly diagnosed TB clients for this clinic/unit, during the past twelve months?	YES, OBSERVED 1 NO 2				→ 715				
713	ASK TO SEE THE RECORDS AND RECORD THE NUMBER OF NEWLY DIAGNOSED TB CLIENTS FOR THE CLINIC/UNIT DURING THE PAST COMPLETED 12 MONTHS.	NUMBER OF CLIENTS <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>								
714	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>								
715	Is this facility included in the national DOTS program?	YES 1 NO 2								
716	What treatment strategy is followed by providers in this clinic/unit for TB treatment?	DIRECT OBSERVE 2M, FU 6M 1 DIRECT OBSERVE 6M 2 FOLLOW UP CLIENTS ONLY AFTER FIRST 2M DIRECT OBSERVATION ELSEWHERE 3 DIAGNOSE AND TREAT WHILE INPATIENT. DISCHARGE TO OTHER CLINIC/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				→ 720 → 721 → 720 → 721 → END				
717	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/ FAMILY OBSERVES D OTHER X (SPECIFY)								
718	Do you have a record or register that show 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				→ 720 → 720				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
719	Is the record/register up-to-date for the prior week for all clients receiving their DOTS medications?	YES 1 NO 2	
720	Does this clinic/unit 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? IF NO, PROBE TO DETERMINE WHERE FOLLOW-UP OF TB CLIENTS FROM THIS CLINIC/UNIT IS CONDUCTED.	YES 1 NO 2	→733
721	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	
722	Do you have a register or list of clients currently being followed by this unit for TB treatment, including those being treated on DOTS and no direct observation?	YES, REGISTER OR LIST OBSERVED 1 ONLY HAVE DOTS CLIENTS 2 NO 3	→ 726
723	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	→ 726
724	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 CLINIC/UNIT.	TOTAL NUMBER OF CLIENTS ON TB TREATMENT	
725	RECORD THE NUMBER OF FEMALE CLIENTS CURRENTLY ON TB TREATMENT BY THIS CLINIC/UNIT.	NUMBER OF FEMALE CLIENTS DON'T KNOW 9998	
726	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	
727	Are newly diagnosed cases of TB (or cases followed up by this clinic/unit), referred for an HIV test or for counseling about HIV/AIDS?	YES, ALL REFERRED 1 SUSPECT CASES ONLY REFERRED 2 NO 3 DON'T KNOW 8	→ 731 → 731
728	Do you have a register or list of new TB patients who were referred for an HIV test or for HIV test counseling? IF YES, ASK TO SEE THE REGISTER OR LIST.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 731 → 731
729	How many new TB patients were referred for an HIV/AIDS test or counseling in the past twelve months?	NUMBER OF NEW TB CLIENTS REFERRED	
730	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA	

NO.	QUESTIONS	CODING CATEGORIES				GO TO																																																																																																																														
731	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				→ 733																																																																																																																														
732	How many patients currently under TB treatment in this clinic are also diagnosed as HIV positive or as having AIDS?	NUMBER OF TB CLIENTS WITH HIV/AIDS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> DON'T KNOW 9998																																																																																																																																		
733	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.	NATIONAL TB CONTROL PROGRAM A OTHER FACILITY (NOT PART OF NATIONAL TB PROGRAM) B DIRECT PURCHASE C DONATIONS FROM NGOS D OTHER X (SPECIFY) _____																																																																																																																																		
734	Are any TB medicines that are individually packaged for clients kept in this clinic/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 CLINIC/UNIT AREA 4				→ END																																																																																																																														
735	Does this clinic/unit have tuberculosis medicines in bulk jars? IF YES, ASK TO SEE THE MEDICINES.	YES 1 BULK MEDICINES NOT IN THIS CLINIC/UNIT 2 NO TB MEDICINES IN FACILITY. 3				→ END → END																																																																																																																														
736	BULK JAR MEDICINES FOR TUBERCULOSIS	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <table border="1"> <thead> <tr> <th rowspan="2"></th><th colspan="2">OBSERVED</th><th rowspan="2">REPORTED AVAILABLE, NOT SEEN</th><th rowspan="2">NOT AVAILABLE</th><th colspan="3">OUT OF STOCK IN LAST SIX MONTHS</th></tr> <tr> <th>ALL UNITS VALID</th><th>AT LEAST ONE UNIT VALID</th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> <tbody> <tr><td>01 Ethambutol</td><td rowspan="10" style="background-color: #cccccc;"></td><td>2 → b</td><td>3 02 ↙</td><td>4 02 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>02 Isoniazid</td><td>2 → b</td><td>3 03 ↙</td><td>4 03 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>03 Pyrazinamide</td><td>2 → b</td><td>3 04 ↙</td><td>4 04 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>04 Rifampin</td><td>2 → b</td><td>3 05 ↙</td><td>4 05 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>05 Streptomycin</td><td>2 → b</td><td>3 06 ↙</td><td>4 06 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>06 Isoniazid + rifampin (Rifina)</td><td>2 → b</td><td>3 07 ↙</td><td>4 07 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>07 Isoniazid + rifampin + pyrazinamide (RHZ, Rifater)</td><td>2 → b</td><td>3 08 ↙</td><td>4 08 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>08 Isoniazid + ethambutol (EH)</td><td>2 → b</td><td>3 09 ↙</td><td>4 09 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>09 4FDC (combination INH, Ethambutol, pyrazinamide, rifampin)</td><td>2 → b</td><td>3 10 ↙</td><td>4 10 ↙</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>10 Other _____ (SPECIFY)</td><td>2 → b</td><td>3 737 ↙</td><td>4 737 ↙</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table> </div> <div style="width: 65%;"> <div style="text-align: center; margin-bottom: 5px;">a</div> <table border="1" style="width: 100%;"> <thead> <tr> <th>REPORTED AVAILABLE, NOT SEEN</th><th>NOT AVAILABLE</th></tr> </thead> <tbody> <tr><td>3</td><td>4</td></tr> <tr><td>02 ↙</td><td>02 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>03 ↙</td><td>03 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>04 ↙</td><td>04 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>05 ↙</td><td>05 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>06 ↙</td><td>06 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>07 ↙</td><td>07 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>08 ↙</td><td>08 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>09 ↙</td><td>09 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>10 ↙</td><td>10 ↙</td></tr> <tr><td>3</td><td>4</td></tr> <tr><td>737 ↙</td><td>737 ↙</td></tr> </tbody> </table> <div style="text-align: center; margin-top: 5px;">b</div> </div> </div>					OBSERVED		REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE	OUT OF STOCK IN LAST SIX MONTHS			ALL UNITS VALID	AT LEAST ONE UNIT VALID	YES	NO	DK	01 Ethambutol		2 → b	3 02 ↙	4 02 ↙	1	2	8	02 Isoniazid	2 → b	3 03 ↙	4 03 ↙	1	2	8	03 Pyrazinamide	2 → b	3 04 ↙	4 04 ↙	1	2	8	04 Rifampin	2 → b	3 05 ↙	4 05 ↙	1	2	8	05 Streptomycin	2 → b	3 06 ↙	4 06 ↙	1	2	8	06 Isoniazid + rifampin (Rifina)	2 → b	3 07 ↙	4 07 ↙	1	2	8	07 Isoniazid + rifampin + pyrazinamide (RHZ, Rifater)	2 → b	3 08 ↙	4 08 ↙	1	2	8	08 Isoniazid + ethambutol (EH)	2 → b	3 09 ↙	4 09 ↙	1	2	8	09 4FDC (combination INH, Ethambutol, pyrazinamide, rifampin)	2 → b	3 10 ↙	4 10 ↙	1	2	8	10 Other _____ (SPECIFY)	2 → b	3 737 ↙	4 737 ↙	1	2	8	REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE	3	4	02 ↙	02 ↙	3	4	03 ↙	03 ↙	3	4	04 ↙	04 ↙	3	4	05 ↙	05 ↙	3	4	06 ↙	06 ↙	3	4	07 ↙	07 ↙	3	4	08 ↙	08 ↙	3	4	09 ↙	09 ↙	3	4	10 ↙	10 ↙	3	4	737 ↙	737 ↙	
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SECTION H: COUNSELING AND TESTING			
Facility Number: <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div>		QRE TYPE H	
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800	INDICATE THE SERVICE SETTING FOR THIS SECTION.		<div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: flex; justify-content: flex-end; font-size: 8px; margin-top: 2px;"> Line # Unit # </div>
801	<div> MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC) 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE 5 OTHER 6 <div style="text-align: center; margin-top: 5px;">(SPECIFY)</div> </div>		
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT COUNSELING AND TESTING SERVICES PROVIDED BY THIS UNIT.			
<p>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 HIV/AIDS-RELATED SERVICES IN THE DEPARTMENT. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW.</p> <p>IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q802 BELOW AND GO ON TO Q804.</p> <p>Now I will read a statement explaining the survey and asking your consent for responding to survey questions.</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> Interviewer's signature _____ Date _____ </div> <p>SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>			
802	Do I have your agreement to participate? Thank you. Let's begin now.	YES NO	→ STOP

NO	QUESTIONS	CODING CATEGORIES	GO TO
804	<p>First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counselors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this clinic/unit who are present today.</p> <p>Please give me the names and main service responsibility of the 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 CLINIC/UNIT. DO NOT DUPLICATE HIV/AIDS SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.</p>	<p>RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.</p> <p>STAFF LIST COMPLETED YES 1 NO 2</p>	
805	How many days each week are counseling services for HIV/AIDS available in this clinic/unit? This means the counseling is conducted by staff in this clinic/unit.	<p>DAYS PER WEEK <input type="text"/></p> <p>NO COUNSELING SERVICES 0</p>	→ 815
806	How many months have counseling services been offered from this clinic/unit? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS <input type="text"/> <input type="text"/> <input type="text"/>	
807	Does this clinic/unit have a counselor who has been trained for both pretest and post test counseling? IF YES, ASK IF THE PERSON IS PRESENT TODAY AND ENSURE THAT PERSON IS INTERVIEWED FOR THE HEALTH WORKER INTERVIEW	<p>YES, PRESENT TODAY 1 YES, NOT PRESENT TODAY 2 NO 3</p>	
808	DESCRIBE THE SETTING WHERE CLIENT COUNSELING RELATED TO HIV/AIDS IS PROVIDED	<p>PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY 1 OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY 3 NO PRIVACY 4</p>	
809	How is pretest counseling or information provided?	<p>INDIVIDUAL ONLY 1 GROUP ONLY 2 BOTH INDIVIDUAL AND GROUP ... 3 NO PRETEST COUNSELING 4</p>	<p>→ 812</p> <p>→ 813</p>
810	Are there records of the group pretest information sessions? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS AND RECORD THE NUMBER OF SESSIONS THAT HAVE BEEN HELD.	<p>YES, <input type="text"/><input type="text"/><input type="text"/></p> <p>NUMBER OF SESSIONS</p> <p>NO RECORDS ON GROUP COUNSELING 995</p>	→ 812
811	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>	

NO	QUESTIONS	CODING CATEGORIES	GO TO
812	Which staff most commonly provide pre test HIV counseling for clients in this clinic/unit? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	VCT/CT COUNSELORS FROM OUTSIDE UNIT 1 TRAINED UNIT STAFF PROVIDE COUNSELING 2 TRAINED AND UNTRAINED UNIT STAFF , DEPENDING ON TIME AND STAFF AVAILABILITY. 3 BOTH OUTSIDE STAFF AND TRAINED UNIT STAFF PROVIDE COUNSELING, DEPENDING ON TIME AND STAFF AVAILABILITY. 4 CLIENTS ALWAYS SENT TO ANOTHER CLINIC/UNIT FOR PRE-TEST COUNSELING 5	
813	Which staff most commonly provide post-test HIV counseling for clients in this clinic/unit with negative results? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	VCT/CT COUNSELORS FROM OUTSIDE UNIT 1 TRAINED UNIT STAFF PROVIDE COUNSELING 2 BOTH OUTSIDE STAFF AND TRAINED UNIT STAFF PROVIDE COUNSELING, DEPENDING ON TIME AND STAFF AVAILABILITY. 3 CLIENTS ALWAYS SENT TO ANOTHER CLINIC/UNIT FOR POST-TEST COUNSELING..... 4 NO POST TEST COUNSELING FOR NEGATIVE RESULTS. 5	
814	Which staff most commonly provide post-test HIV counseling for clients in this clinic/unit with positive results? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	VCT/CT COUNSELORS FROM OUTSIDE UNIT 1 TRAINED UNIT STAFF PROVIDE COUNSELING 2 BOTH OUTSIDE STAFF AND TRAINED UNIT STAFF PROVIDE COUNSELING, DEPENDING ON TIME AND STAFF AVAILABILITY. 3 CLIENTS ALWAYS SENT TO ANOTHER CLINIC/UNIT FOR POST-TEST COUNSELING..... 4 NO POST TEST COUNSELING 5	
815	Are records kept for clients who receive any counseling or testing from this clinic/unit? IF YES, ASK TO SEE THE RECORDS AND INDICATE WHAT TYPE OF INFORMATION IS AVAILABLE.	RECORD AVAILABLE THIS CLINIC/ UNIT 1 RECORD IN CLIENT INDIVIDUAL RECORD ONLY 2 RECORDS MAINTAINED BY VCT/CT COUNSELORS FROM OUTSIDE CLINIC/UNIT 3 NO RECORDS 4	→ 819 → 819 → 819

NO	QUESTIONS	CODING CATEGORIES			GO TO
816	REVIEW THE COUNSELING AND/OR TESTING RECORDS AVAILABLE ON THIS CLINIC/ UNIT, AND INDICATE WHICH INFORMATION IS AVAILABLE.	(A) RECORD AVAILABILITY			(B) NUMBERS FROM OBSERVED RECORDS
		OB- SERVED	REPORTED, NOT SEEN	NO RECORD	NUMBER OF CLIENTS
01	UNIT ONLY RECORDS CLIENT ID AND TEST RESULT, NO WRITTEN RECORDS OF COUNSELING OR RECEIPT OF TEST RESULTS	1 → b	2 02 ↘	3 02 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
02	TOTAL CLIENTS RECEIVING INDIVIDUAL PRE-TEST COUNSELING	1 → b	2 03 ↘	3 03 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
03	TOTAL CLIENTS RECEIVING POST-TEST COUNSELING	1 → b	2 04 ↘	3 04 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
04	TOTAL CLIENTS WHO RECEIVED HIV TEST RESULTS	1 → b	2 05 ↘	3 05 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
05	TOTAL CLIENTS WITH POSITIVE TESTS WHO RECEIVED RESULTS	1 → b	2 06 ↘	3 06 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
06	TOTAL CLIENTS WITH POSITIVE HIV TEST RESULT	1 → b	2 07 ↘	3 07 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
07	TOTAL FEMALE CLIENTS RECEIVING HIV TEST	1 → b	2 08 ↘	3 08 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
08	TOTAL CLIENTS AGE 15-24 YEARS RECEIVING HIV TEST	1 → b	2 09 ↘	3 09 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
09	TOTAL CLIENTS RECEIVING HIV TEST	1 → b	2 817 ↘	3 817 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 06 ↘
817	What is the most recent date recorded for any counseling?	WITHIN PAST 30 DAYS 1 MORE THAN 30 DAYS 2 NO DATE RECORDED 3 NO RECORD FOR COUNSELING . . . 4			→ 819
818	Is there a client number or other identifier for clients receiving pre and post test counseling?	YES 1 NO 2			
819	How many days each week are testing services for HIV available in this clinic/unit? 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 <input type="text"/> NO HIV TESTING SERVICE 0			→ 823
820	How many months have HIV testing services been offered from this clinic/unit? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS <input type="text"/> <input type="text"/> <input type="text"/>			

NO	QUESTIONS	CODING CATEGORIES	GO TO
821	DID YOU OBSERVE RECORDS FOR HIV TESTING AND TEST RESULTS? IF NO, ASK, Where are the records for HIV testing kept? AND RECORD THE CORRECT RESPONSE.	YES, OBSERVED 1 RECORDS MAINTAINED ELSEWHERE IN FACILITY 2 ENTER CLINIC/UNIT NUMBER RECORDS IN LAB 3 RECORDS IN STATISTICS/ MED REC. OFFICE 4 OTHER 6 (SPECIFY) NO HIV TEST RECORDS 7 DON'T KNOW 8	
822	Is there a system where you can link the HIV test result with the client who received pre and post test counseling? IF YES, ASK TO SEE HOW THE SYSTEM WORKS	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
823	Are reports regularly compiled on the number of clients in this clinic/unit who receive testing or counseling 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, COUNSELING C NO Y	→ 826
824	How frequently are any of the compiled reports submitted to someone outside of this clinic/unit?	YES, MONTHLY OR MORE OFTEN . 1 YES, EVERY 2-3 MONTHS 2 YES, EVERY 4-6 MONTHS 3 YES LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5	→ 826
825	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVIS... B DISTRICT LEVEL (MOH/CBOH/TACA . C REGIONAL LEVEL(MOH/CBOH/TACAI D NATIONAL LEVEL(MOH/CBOH/TACA. E DONOR AGENCY F OTHER X (SPECIFY)	
826	When a client agrees to an HIV test, what is the procedure that is followed? 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 CLINIC/UNIT A CLIENT SENT TO (V)CT CLINIC/UNIT . B CLIENT SENT TO PMTCT CLINIC/UNIT C CLIENT REFERRED OTHER CLINIC/UNIT THIS FACILITY (NON-VCT/PMTCT) D BLOOD DRAWN IN THIS CLINIC/UNIT BY CLINIC/UNIT STAFF, TEST CONDUCTED ELSEWHERE ... E BLOOD DRAWN IN THIS CLINIC/UNIT BY EXTERNAL STAFF, TEST CONDUCTED ELSEWHERE ... F CLIENT SENT TO LAB THIS FACILITY G TESTING OUTSIDE FACILITY: CLIENT SENT ELSEWHERE OUTSIDE THIS FACILITY H OTHER X (SPECIFY)	

NO	QUESTIONS	CODING CATEGORIES			GO TO
FILTER: CHECK PREVIOUS QUESTION: IF A OR E OR F CIRCLED: → GO TO Q827 ONLY IF A OR E OR F NOT CIRCLED AND: B OR C OR D OR G CIRCLED: → GO TO Q829 IF ONLY H OR X CIRCLED: → GO TO Q830					
827	ASK TO SEE WHERE BLOOD IS DRAWN FOR THE HIV TEST AND INDICATE IF THE ITEM IS AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA	OBSERVED	REPORTED NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	RAPID TEST FOR HIV	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	DISPOSABLE SYRINGES	1	2	3	
14	EXAMINATION TABLE	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → 828	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
828	ARE ALL SURFACE AREAS IN THE BLOOD DRAWING AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2			
829	CHECK Q826. IF RESPONSE IS B,C OR D, ENSURE ELIGIBLE OPD/IPD AND VCT/PMTCT QRE IS COMPLETED FOR INDICATED UNIT PRIOR TO LEAVING FACILITY. IF RESPONSE IS 'G' ENSURE ELIGIBLE LABORATORY QRE HAS BEEN COMPLETED.				

NO	QUESTIONS	CODING CATEGORIES				GO TO								
830	WAS INFORMATION FOR OPD QRE 221 OR IPD Q321, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY ASKED FROM THIS RESPONDENT?	YES	1	→ 833										
		NO	2											
831	Are there any guidelines or 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?	SOME GUIDELINES/PROTOCOLS AVAILABLE 1 SOME GUIDELINES/PROTOCOLS AVAILABLE- NONE SEEN 2 NO GUIDELINES OR PROTOCOLS . 3			→ 835									
832	First I want to ask about some of the national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	<table border="1"> <thead> <tr> <th colspan="2">(a)</th><th colspan="2">(b)</th></tr> <tr> <th>OBSERVED, COM- PLETE</th><th>INCOM- PLETE</th><th>REPORTED AVAIL. NOT SEEN</th><th>NOT AVAIL</th><th>DATE ON OBSERVED MANUAL YEAR</th></tr> </thead> </table>				(a)		(b)		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL	DATE ON OBSERVED MANUAL YEAR
(a)		(b)												
OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL	DATE ON OBSERVED MANUAL YEAR										
01	National Guidelines for the clinical management of HIV and AIDS	1 → b	2 → b	3 02	4 02									
02														
03	National Infection Prevention and control guidelines for health care services in Tanzania	1 → b	2 → b	3 04	4 04									
04	National Guidelines for Voluntary Counseling and Testing	1 → b	2 → b	3 05	4 05									
05	Guidelines for management of HIV/AIDS for Frontline workers	1 → b	2 → b	3 06	4 06									
06	National guidelines for prevention of mother to child transmission of HIV(PMTCT)	1 → b	2 → b	3 07	4 07									
07	Guidelines for Home Based Care Services	1 → b	2 → b	3 08	4 08									
08	Guidelines for home based care services in Tanzania	1 → b	2 → b	3 09	4 09									
09	A Guideline for counselors in Tanzania with special emphasis on HIV/AIDS/STDs counselling	1 → b	2 → b	3 10	4 10									
10	Guidelines and Standards for Counseling and Supervision	1 → b	2 → b	3 833	4 833									
833	Other than the previously mentioned national guidelines, are there any other protocols or guidelines for counseling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES 1 NO OTHER PROTOCOLS/ GUIDELINES 2			→ 835									

NO	QUESTIONS	CODING CATEGORIES				GO TO
		(a)		(b)		
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL	DATE ON OBSERVED MANUAL YEAR
834	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:					
01	Other protocols/guidelines for pretest counseling?	1 → b	2 → b	3 02 ↙	4 02 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
02	Other protocols/guidelines for post test counseling for both positive and negative test results?	1 → b	2 → b	3 03 ↙	4 03 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
03	Is there any written policy that all clients receiving HIV tests must be offered pretest counseling or information, and post test counseling?	1 → b	2 → b	3 04 ↙	4 04 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
04	Is there any policy on HIV testing procedures, that is what test should be done, and when?	1 → b	2 → b	3 05 ↙	4 05 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 → b	3 06 ↙	4 06 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 → b	3 07 ↙	4 07 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
07	Any other informed consent policy?	1 → b	2 → b	3 08 ↙	4 08 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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 → b	3 09 ↙	4 09 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
09	Any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client?	1 → b	2 → b	3 835 ↙	4 835 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
835	Is an individual client chart/record/card maintained for clients who receive services through this clinic/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 A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, ONLY AVAILABLE IN OTHER FACILITY AREA 3 ENTER CLINIC/UNIT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER 6 SPECIFY NO INDIVIDUAL CLIENT CHART/ RECORD 7				

NO	QUESTIONS	CODING CATEGORIES	GO TO
YOUTH FRIENDLY SERVICES			
836	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC UNIT 1 YES, OTHER LOCATION IN FACILITY 2 NO 3	→ 840 → 840
837	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED, COMPLETE 1 YES, OBSERVED, NOT COMPLETE 2 YES, REPORTED NOT SEEN 3 NO 4	
838	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	
839	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. What are the key components of the youth friendly services that are offered in this clinic/unit? ASK FOR EACH ITEM. CIRCLE ALL THAT APPLY.	SERVICES IN SEPARATE ROOM A DISCOUNT FEES B NO FEES C EDUCATION/COUNSELING D OTHER X (SPECIFY)	
840	Are family planning services routinely provided for all HIV positive clients?	YES, ALWAYS 1 YES, SOMETIMES 2 NO 3	→ 844
841	Who most often provides counseling about use and methods of family planning available?	PROVIDER, THIS CLINIC/UNIT 1 PROVIDER FP CLINIC/UNIT 2 REFERRED OUTSIDE THIS FACILITY 3	→ 844 → 844
842	Who most often examines the client and provides or prescribes methods of family planning for HIV positive clients?	PROVIDER, THIS CLINIC/UNIT 1 PROVIDER FP CLINIC/UNIT 2 REFERRED OUTSIDE THIS FACILITY 3	
843	Please show me any guidelines or protocols on counseling 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
COMMUNITY BASED SERVICES			
844	Does this facility have links with community based health workers or volunteers? 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 CARE C YES, CLIENT TREATMENT SUPPORT D YES, PRETEST COUNSELING E YES, PREVENTIVE EDUCATION F YES, OTHER HIV/AIDS RELATED ... X NO Y	→ END
845	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 1 YES, REFERRAL SLIP REPORTED, NOT SEEN 2 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 3 WRITE ON PRESCRIPTION FORM/LETTERHEAD 4 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 5 WRITE NOTE/LETTER (UNSTRUCTURED) 6 OTHER 7 (SPECIFY) _____ NO METHOD USED 8	
846	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, What method is used?	YES, REFERRAL SLIP OBSERVED 1 YES, REFERRAL SLIP REPORTED, NOT SEEN 2 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 3 WRITE ON PRESCRIPTION FORM/LETTERHEAD 4 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 5 WRITE NOTE/LETTER (UNSTRUCTURED) 6 OTHER 7 (SPECIFY) _____ NO METHOD USED 8	
847	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	
848	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 OR REPORT	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
849	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 AGC..... 4 NO TRAINING 5 DON'T KNOW 8	
850	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 AGC..... 4 NO TRAINING 5 DON'T KNOW 8	
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE			

SECTION I: ANTIRETROVIRAL THERAPY					
Facility Number:		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>		QRE TYPE I	
Interviewer Code:		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>			
900	INDICATE THE SERVICE SETTING FOR THIS SECTION	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="text-align: right; font-size: small;">Line # Unit #</div>			
901	MANAGING AUTHORITY <div style="display: flex; justify-content: space-between;"> <div> GOVERNMENT-PUBLIC GOVERNMENT-NOT PUBLIC (MILITARY, ETC) PARASTATAL FAITH BASED ORGANIZATION PRIVATE OTHER </div> <div style="border-bottom: 1px solid black; flex-grow: 1; text-align: center;">(SPECIFY)</div> <div style="text-align: right;"> 1 2 3 4 5 6 </div> </div>				
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT ART SERVICES PROVIDED BY THIS UNIT.					
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<div style="display: flex; justify-content: space-between;"> <div>Interviewer's signature</div> <div>Date</div> </div> <div style="text-align: center;">SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</div>					
902	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→STOP		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
904	<p>First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counselors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this clinic/unit who are present today</p> <p>Please give me the names and main service responsibility of the 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 CLINIC/UNIT. DO NOT DUPLICATE HIV/AIDS SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.</p>		
	RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.	STAFF LIST COMPLETED YES 1 NO 2	
905	How many days each week are ART services available in this clinic/unit?	DAYS PER WEEK <input type="text"/>	
906	How many months have ART services been offered from this clinic/unit? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.	MONTHS <input type="text"/> <input type="text"/> <input type="text"/>	
907	Is there a person specifically in charge of ART? IF YES, ASK: Is the person in charge of ART assigned to this clinic/unit, or assigned to another clinic/unit?	YES, ASSIGNED THIS CLINIC/UNIT 1 YES, ASSIGNED OTHER CLINIC/UNIT 2 NO ONE PERSON IN CHARGE OF ART 3	→ 909 → 909
908	What is the qualification of the person in charge of ARV services?	CONSULTANT/SPECIALIST 01 MEDICAL DOCTOR 02 MEDICAL OFFICER/AMO 03 CLINICAL OFFICER 04 NURSING OFFICER/PHN 05 NURSE/MIDWIFE/TRAINED NURSE 06 PHARMACY WORKER (ANY QUAL) 07 OTHER 96 (SPECIFY) _____	
909	<p>Which ARV drugs are prescribed in this clinic/unit? CIRCLE ALL THAT APPLY.</p> <p>AFTER THE RESPONSE, READ THE NAME OF EACH DRUG THAT IS NOT MENTIONED, TO VERIFY THAT THE DRUG IS NOT PRESCRIBED. BY THIS CLINIC/UNIT</p> <p>IF A COMBINATION DRUG IS USED, CIRCLE THE COMPONENTS THAT ARE INDICATED IN LIST (E.G., FOR STAVUDINE40+LAMIVUDINE+NEVIRAPINE, CIRCLE "J, F, AND G)</p>	AZT+3TC A ZIDOVUDINE (ZDV,AZT) B ABACAVIR (ABC) C DIDANOSINE (DDL) D EFAVIRENZ (EFZ) E LAMIVUDINE (3TC) F NEVIRAPINE (NVP) G NRTI (TENOFIVIR DISOPROXIL FUMARATE/VIREAD) H PROTEASE INHIBITORS (INDINAVIR [CRIXIVAN], NELFINAVIR [VIRACEPT], RITONAVIR [NORVIR], SAQUINAVIR [INVIRASE] I STAVUDINE (d4T) OR D3T J OTHER X (SPECIFY) _____	
910	What is the most commonly prescribed first-line ART regimen?	STAVUDINE (d4T) + LAMIVUDINE (3TC) <i>plus</i> NEVIRAPINE (NVP) 1 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) <i>plus</i> NEVIRAPINE (NVP) 2 STAVUDINE (d4T) + LAMIVUDINE (3TC) <i>plus</i> EFAVIRENZ (EFV) 3 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) <i>plus</i> EFAVIRENZ (EFV) 4 NO ROUTINE FIRST-LINE REGIMEN 6	

NO.	QUESTIONS	CODING CATEGORIES					GO TO																																																																															
911	<p>Now I want to know about any eligibility criteria used for placing clients on ARV Therapy. For each stage of AIDS that I will describe & each criteria I mention please indicate if a client at that stage is eligible for ART from this facility.</p> <p>READ EACH STAGE AND EACH CRITERIA AND CIRCLE ALL THAT APPLY</p> <table border="1"> <tr> <td>WHO stage 1=No symptoms of illness WHO stage 2 = SOME SYMPTOMS, MOSTLY AMBULATORY WHO STAGE 3 = SOME SYMPTOMS IN BED MORE THAN NORMAL WHO STAGE 4 = SOME SYMPTOMS MOST OF TIME IN BED</td><td colspan="6">ELIGIBILITY CRITERIA</td></tr> <tr> <td></td><td>CLIENT NOT ELIGIBLE</td><td>ADHER. CRITERIA</td><td>CD4+ T LYMPH. COUNT</td><td>HIV VIRAL LOAD</td><td>COMMIT- TEE</td><td>DOCTOR OPINION</td></tr> <tr> <td>01 WHO stage 1 - No symptoms of illness</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>02 WHO stage 1 - No symptoms and pregnant</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>03 WHO stage 2 - Symptomatic</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>04 WHO stage 2 - Symptomatic and pregnant</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>05 WHO stage 3 - Symptomatic</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>06 WHO stage 3 - Symptomatic and pregnant</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>07 WHO stage 4 - Symptomatic</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>08 WHO stage 4 - Symptomatic and pregnant</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>09 Current active life-threatening OI disease (e.g., TB, meningitis)</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> <tr> <td>10 Newborn of HIV infected mother</td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td></tr> </table>	WHO stage 1=No symptoms of illness WHO stage 2 = SOME SYMPTOMS, MOSTLY AMBULATORY WHO STAGE 3 = SOME SYMPTOMS IN BED MORE THAN NORMAL WHO STAGE 4 = SOME SYMPTOMS MOST OF TIME IN BED	ELIGIBILITY CRITERIA							CLIENT NOT ELIGIBLE	ADHER. CRITERIA	CD4+ T LYMPH. COUNT	HIV VIRAL LOAD	COMMIT- TEE	DOCTOR OPINION	01 WHO stage 1 - No symptoms of illness	A	B	C	D	E	F	02 WHO stage 1 - No symptoms and pregnant	A	B	C	D	E	F	03 WHO stage 2 - Symptomatic	A	B	C	D	E	F	04 WHO stage 2 - Symptomatic and pregnant	A	B	C	D	E	F	05 WHO stage 3 - Symptomatic	A	B	C	D	E	F	06 WHO stage 3 - Symptomatic and pregnant	A	B	C	D	E	F	07 WHO stage 4 - Symptomatic	A	B	C	D	E	F	08 WHO stage 4 - Symptomatic and pregnant	A	B	C	D	E	F	09 Current active life-threatening OI disease (e.g., TB, meningitis)	A	B	C	D	E	F	10 Newborn of HIV infected mother	A	B	C	D	E	F	
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10 Newborn of HIV infected mother	A	B	C	D	E	F																																																																																
912	<p>Are social or other criteria related to the client's personal situation considered prior to starting ART? IF YES, Tell me which of the following criteria are considered prior to starting ART? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.</p>	<p>GEOGRAPHIC CRITERIA A</p> <p>PROOF OF CAPACITY TO ATTEND B</p> <p>CLINIC REGULARLY B</p> <p>DISCLOSURE TO SIGNIFICANT OTHER (IF APPLICABLE) C</p> <p>NO ART IF SOCIAL PROBLEM:</p> <p>ALCOHOLIC D</p> <p>DRUG ADDICT E</p> <p>MENTAL ILLNESS F</p> <p>HOMELESS G</p> <p>ABILITY TO PAY H</p> <p>OTHER X</p> <p>(SPECIFY) _____</p> <p>NO SOCIAL CRITERIA APPLIED Y</p>																																																																																				
913	<p>Are adherence criteria considered prior to starting ART? IF YES, Tell me which of the following eligibility criteria are considered prior to starting a client on ART? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.</p>	<p>CONSISTENT USE OF COTRIM A</p> <p>REQUIRED PRE-ART CLINIC VISITS B</p> <p>MADE ON TIME B</p> <p>TREATMENT ASSISTANT IDENTIFIED C</p> <p>OTHER X</p> <p>(SPECIFY) _____</p> <p>NO ADHERENCE CRITERIA APPLIE . . Y</p>																																																																																				
914	<p>Is a total lymphocyte count (TLC) always done prior to starting ART? IF YES, What is the most common practice for providing the test?</p>	<p>YES, CONDUCTED IN THIS FACILIT . . 1</p> <p>YES, CLIENT GOES ELSEWHERE . . 2</p> <p>YES, BLOOD SENT ELSEWHERE . . 3</p> <p>NO 4</p>	→ 916																																																																																			

NO.	QUESTIONS	CODING CATEGORIES	GO TO		
915	After the initial TLC test, do you retest for a follow up level? IF YES, Is retesting done only if it is indicated by the patient's condition, or is it done periodically. IF PERIODICALLY, ASK: How often is follow-up testing done?	ONLY IF INDICATED BY PATIENT CONDITION 01 EVERY MONTH 02 EVERY 2-3 MONTHS 03 EVERY 4-6 MONTHS 04 EVERY YEAR 05 ONCE ONLY, WITHIN 1 MONTH 06 OTHER 96 (SPECIFY) NO FOLLOW-UP 95			
916	Is a CD4 T Cell count always determined prior to starting ART? IF YES, What is the most common practice for providing the test?	YES, CONDUCTED IN THIS FACILITY 1 YES, CLIENT REFERRED OUTSIDE 2 YES, BLOOD SENT OUTSIDE 3 NO 4	→ 918		
917	After the initial CD4 T cell count, do you retest for a follow up level? IF YES, Is retesting done only if it is indicated by the patient's condition, or is it done periodically. IF PERIODICALLY, ASK: How often is follow-up testing done?	ONLY IF INDICATED BY PATIENT CONDITION 01 EVERY MONTH 02 EVERY 2-3 MONTHS 03 EVERY 4-6 MONTHS 04 EVERY YEAR 05 ONCE ONLY, WITHIN 1 MONTH 06 OTHER 96 (SPECIFY) NO FOLLOW-UP 95			
918	Is an HIV RNA Viral load level always done prior to starting ART? IF YES, What is the most common practice for providing the test? READ EACH RESPONSE.	YES, CONDUCTED IN THIS FACILITY 1 YES, CLIENT REFERRED OUTSIDE 2 YES, BLOOD SENT OUTSIDE 3 NO 4	→ 920		
919	After the initial HIV RNA Viral load level, do you retest for a follow up level? IF YES, Is retesting done only if it is indicated by the patient's condition, or is it done periodically. IF PERIODICALLY, ASK: How often is follow-up testing done?	ONLY IF INDICATED BY PATIENT CONDITION 01 EVERY MONTH 02 EVERY 2-3 MONTHS 03 EVERY 4-6 MONTHS 04 EVERY YEAR 05 ONCE ONLY WITHIN 1 MONTH 06 OTHER 96 (SPECIFY) NO FOLLOW-UP 95			
920	For each of the following tests, please tell me if the test is conducted routinely, selectively, or never, before starting ART.				
		TEST CONDUCTED			
		ROUTINELY	SELECTIVELY	NEVER	DK
01	Hemoglobin/hematocrit	1	2	3	8
02	Full blood count	1	2	3	8
03	Pregnancy test for women	1	2	3	8
04	Serum electrolytes (including serum creatinine)	1	2	3	8
05	Urinalysis	1	2	3	8
06	Liver function tests (Serum transaminases)	1	2	3	8
07	TB sputum test	1	2	3	8
08	Chest X-ray	1	2	3	8
09	Any other routine tests _____ (SPECIFY)	1	2	3	8

NO.	QUESTIONS	CODING CATEGORIES				GO TO
921	When a client is started on ART, are any of the following types of counseling offered? IF YES, RECORD WHETHER THE COUNSELING IS ALWAYS OR SOMETIMES OFFERED.	ALWAYS	SOMETIMES	NEVER	DON'T KNOW	
01	Pre-treatment medication counseling?	1	2	3	8	
02	Follow-up counseling to discuss adherence to ART medicines?	1	2	3	8	
03	Follow-up counseling to discuss adherence to medication plan in presence of significant others?	1	2	3	8	
922	CHECK Q921 IF THERE IS ANY COUNSELING RELATED TO ART, (01) OR (02) OR (03) = 1 OR 2	YES	1	NO	2	→ 925
923	Who provides the counseling for ART medicines? CIRCLE ALL THAT APPLY. IF NONE OF THE RESPONSES IN 921 ARE CODED '1', CIRCLE 'Y', "NO COUNSELING".	PRESCRIBING PHYSICIAN/MO/AMO OR CLINICAL OFFICER A OTHER CONSULTANT/PHYSICIAN/CLINICAL OFFICER B REG NURSE/NURSING OFFICER ... C N. MIDWIFE/PHN/TRAINED NRS ... D TRAINED COUNSELOR E PHARMACIST F COMMUNITY/PLHA WORKER G OTHER X (SPECIFY) _____ NO COUNSELING Y				→ 925
924	Have all of the people you just mentioned, who provide counseling for ART medicines been trained in counseling for adherence to ART?	YES	1	NO	2	
		DON'T KNOW	8			
925	Are there any fees assessed for any services or items related to ARV treatment?	YES	1	NO	2	→ 927
926	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE			(b) AMOUNT IN [TSHS]	
		YES	NO	NA		
01	FEE FOR ART CLIENT CARD/CHART	1→ b	2 02 ↙	3 02 ↙	<input type="text"/>	
02	FEE FOR CONSULTATION SERVICE	1→ b	2 03 ↙	3 03 ↙	<input type="text"/>	
03	FEE FOR ARV MEDICINE	1→ b	2 04 ↙	3 04 ↙	<input type="text"/>	
04	FEE FOR LAB TEST CD4 COUNT	1→ b	2 927 ↙	3 927 ↙	<input type="text"/>	
927	WAS INFORMATION FOR OPD QRE 221 OR IPD Q321, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY COLLECTED FOR THIS CLINIC/UNIT?	YES	1	NO	2	→ 930
928	Are there any guidelines or 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?	SOME GUIDELINES/PROTOCOLS AVAILABLE 1 SOME GUIDELINES/PROTOCOLS AVAILABLE- NONE SEEN 2 NO GUIDELINES OR PROTOCOLS 3				→ 932

NO.	QUESTIONS	CODING CATEGORIES				GO TO
929	First I want to ask about some of the national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(a)		(b)		
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	National Guidelines for the clinical management of HIV and AIDS	1 → b	2 → b	3 02 ↙	4 02 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
02						
03	National Infection Prevention and control guidelines for health care services in Tanzania	1 → b	2 → b	3 04 ↙	4 04 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
04	National Guidelines for Voluntary Counseling and Testing	1 → b	2 → b	3 05 ↙	4 05 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
05	Guidelines for management of HIV/AIDS for Frontline workers	1 → b	2 → b	3 06 ↙	4 06 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
06	National guidelines for prevention of mother to child transmission of HIV(PMTCT)	1 → b	2 → b	3 07 ↙	4 07 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
07	Guidelines for Home Based Care Services	1 → b	2 → b	3 08 ↙	4 08 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
08	Guidelines for home based care services in Tanzania	1 → b	2 → b	3 09 ↙	4 09 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
09	A Guideline for counselors in Tanzania with special emphasis on HIV/AIDS/SIDs counseling	1 → b	2 → b	3 10 ↙	4 10 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
10	Guidelines and Standards for Counseling and Supervision	1 → b	2 → b	3 930 ↙	4 930 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
930	Other than the previously mentioned national guidelines, are there any other protocols or guidelines for counseling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES 1 NO OTHER PROTOCOLS/ GUIDELINES 2				→ 932

NO.	QUESTIONS	CODING CATEGORIES				GO TO
931	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a)			(b)	
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL NOT SEEN	NOT AVAIL.	DATE ON MANUAL month year
01	Other protocols/guidelines for pretest counseling?	1 → b	2 → b	3 02 ↙	4 02 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
02	Other protocols/guidelines for post test counseling for both positive and negative test results?	1 → b	2 → b	3 03 ↙	4 03 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
03	Is there any written policy that all clients receiving HIV tests must be offered pretest counseling or information, and post test counseling?	1 → b	2 → b	3 04 ↙	4 04 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
04	Is there any policy on HIV testing procedures, that is what test should be done, and when?	1 → b	2 → b	3 05 ↙	4 05 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 → b	3 06 ↙	4 06 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
06	Is there a written informed consent document for the client?	1 → b	2 → b	3 07 ↙	4 07 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
07	Any other informed consent policy?	1 → b	2 → b	3 08 ↙	4 08 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
08	Is there a written policy on confidentiality for the client that specifically states one will be told the HIV test result without the permission of the client?	1 → b	2 → b	3 09 ↙	4 09 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
09	Any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client?	1 → b	2 → b	3 932 ↙	4 932 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
932	Where is information for patients receiving ART through this clinic/unit 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 CHART/ RECORD D COMPUTER E NO RECORD KEPT Y				→ 945
933	SKIM THE REGISTER FOR ALL NEW ENTRIES 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				
934	ASK TO SEE CLIENT INDIVIDUAL RECORDS. RANDOMLY SELECT 10 INDIVIDUAL CLIENT RECORDS/CHARTS/CARDS AND INDICATE WHICH INFORMATION IS PRESENT ON ALL 10 CARDS.	TREATMENT SUPPORTER A DATE OF ENROLLMENT IN ART B ELIGIBILITY CRITERIA C ARV REGIME BEING USED D NONE OF ABOVE ITEMS Y				
935	ASK TO SEE THE REGISTER/CLIENT CHART/ 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				→ 945

NO.	QUESTIONS	CODING CATEGORIES	GO TO
936	How many patients are currently receiving ART through this clinic/unit?	TOTAL NUMBER OF CLIENTS ON ART .. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000	
937	How many female patients are currently receiving ART through this clinic/unit?	TOTAL NUMBER OF FEMALE CLIENTS ON ART <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998	
938	How many children below 18 months of age are currently receiving ART through this clinic/unit?	TOTAL NUMBER OF < 18 MONTH CHILDREN ON ART <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998	
939	Since the beginning of the ART services, how many clients have been lost to follow-up or are defaulters. This is the number who began ART and no longer receive ART and you do not know their status (transferred or died).	NUMBER ART CLIENTS LOST TO FOLLOW-UP <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998	
940	Among ART clients who began treatment before January 2006, how many were late to pick up their medicines, to avoid missing a dose, during the past 6 months.	NUMBER OF IRREGULAR ART CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998 ART PROGRAM OPERATING < 6M 9995	
941	During the past 12 full months, how many ART clients have died?	NUMBER OF CLIENTS DIED <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998	→ 943
942	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/>	
943	During the past 12 full months, how many ART clients have been lost to follow-up?	NUMBER OF CLIENTS LOST TO FOLLOW-UP <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998	→ 945
944	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/>	
945	Are reports regularly compiled on the numbers of clients receiving ART?	YES 1 NO 2	→ 948
946	How frequently are the compiled reports submitted to someone outside of this clinic/unit?	YES, MONTHLY OR MORE OFTEN ... 1 YES, EVERY 2-3 MONTHS 2 YES, EVERY 4-6 MONTHS 3 YES LESS OFTEN THAN EVERY 6 MONTHS 4 NEVER 5	→ 948
947	To whom do you send these reports? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/CBOH/TACAID: C REGIONAL LEVEL (MOH/CBOH/ NAC) D NATIONAL LEVEL (MOH/CBOH/TACAID E DONOR AGENCY F OTHER X (SPECIFY) _____	

NO.	QUESTIONS	CODING CATEGORIES	GO TO				
948	Is an individual client chart/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 CHART/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, CHART/RECORD AVAILABLE IN OTHER CLINIC/UNIT, THIS FACILITY 3 ENTER CLINIC/UNIT NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NO 4					
949	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	→ 951				
950	Does the appointment system indicate if the client kept the appointment or not?	YES 1 NO 2					
951	Does this facility provide nutrition rehabilitation services for HIV/AIDS patients? NUTRITIONAL REHABILITATION REFERS TO EDUCATION ABOUT EATING WELL, EARLY IDENTIFICATION OF DEFICIENCIES, PROVID- ING 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 COUNSELING A TEACH EARLY IDENTIFICATION OF DEFICIENCIES B PROVIDE VITAMINS C PROVIDE FORTIFIED PROT. SUPP. D PROVIDE HIGH PROTEIN FOODS E PROVIDE OTHER DIET SUPPLEMENT X _____ (SPECIFY) NO SERVICES Y					
COMMUNITY BASED SERVICES							
952	Does this facility have links with community based health workers or volunteers? 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 CARE C YES, CLIENT TREATMENT SUPPORT D YES, PRETEST COUNSELING E YES, PREVENTIVE EDUCATION F YES, ADHERENCE COUNSELING 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	→ 958				
953	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: What method do you use?	YES, REFERRAL SLIP OBSERVED 01 YES, REFERRAL SLIP NOT OBSERVED 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD 04 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 05 WRITE NOTE/LETTER (UNSTRUCTURED) 06 OTHER 96 _____ (SPECIFY) NO METHOD USED 98					

NO.	QUESTIONS	CODING CATEGORIES	GO TO
954	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, What method is used?	YES, REFERRAL SLIP OBSERVED 01 YES, REFERRAL SLIP NOT OBSERVED 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 03 WRITE ON PRESCRIPTION FORM/LETTERHEAD 04 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 05 WRITE NOTE/LETTER (UNSTRUCTURED) 06 OTHER 96 (SPECIFY) _____ NO METHOD USED 98	
955	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	
956	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 OR REPORT	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
957	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	
958	Are the support and care services provided by this facility/clinic/unit supported by external agency?	YES 1 SPECIFY _____ NO 2 DK 8	
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE			

SECTION J: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES			
Facility Number: <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div>		QRE TYPE J	
Interviewer Code: <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div>			
1000	INDICATE THE SERVICE SETTING FOR THIS SECTION	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> Line # Unit # </div>	
1001	<div> MANAGING AUTHORITY GOVERNMENT-PUBLIC 1 GOVERNMENT-NOT PUBLIC (MILITARY, ETC) 2 PARASTATAL 3 FAITH BASED ORGANIZATION 4 PRIVATE/PARASTATAL 5 OTHER 6 <div style="text-align: center; margin-top: 5px;">(SPECIFY) _____</div> </div>		
1002	HOW ARE THE PMTCT SERVICES FOR THIS CLINIC/UNIT PROVIDED?	SEPARATE PMTCT SERVICES 1 PMTCT AND VCT SERVICES TOGETHER 2 PMTCT WITH ANC SERVICES 3 PMTCT WITH ANC AND DELIVERY (ONE SYSTEM) 4 PMTCT WITH DELIVERY 5	
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT PMTCT SERVICES PROVIDED IN THIS CLINIC/UNIT.			
<p>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 HIV/AIDS-RELATED SERVICES IN THE DEPARTMENT. IF IN AGREEMENT, READ THE INTRODUCTORY CONSENT FORM BELOW</p> <p>IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q1003 BELOW AND GO ON TO Q1005.</p>			
<p>Now I will read a statement explaining the survey and asking your consent for responding to survey questions.</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the National Bureau of Statistics to assist the government in knowing more about health services. Now I will read a statement explaining the survey.</p> <p>Your facility was randomly selected to participate in this study. We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded, or shared. The information about your facility may be used by the MOH and organizations supporting services in your facility, for planning service improvement or further studies of health services. The data collected from your facility may also be provided to researchers for analyses, however, the name of your facility will not be provided, and any reports that use your facility data will only present information in aggregate form so that your facility can not be identified.</p> <p>We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate your introducing us to that person.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>Interviewer's signature _____</div> <div>Date _____</div> </div> <p>SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>			
1003	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CATEGORIES				GO TO																																																																																																																													
1005	<p>First, I would like to identify clinical staff (such as nurses or doctors) or other staff (such as counselors, social workers, and laboratory technicians) who provide services related to HIV/AIDS, TB, malaria, or STIs, who are assigned to this clinic/unit who are present today.</p> <p>Please give me the names and main service responsibility of the 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 CLINIC/UNIT. DO NOT DUPLICATE HIV/AIDS SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.</p>																																																																																																																																		
	<div>RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.</div> <div>STAFF LIST COMPLETED YES 1 NO 2</div>																																																																																																																																		
1006	<p>How many months have PMTCT services been offered from this clinic/unit? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.</p>	MONTHS <input type="text"/> <input type="text"/> <input type="text"/>																																																																																																																																	
1007	<p>For each service I will mention, please tell me if providers in this clinic/unit offer the service or refer the client for the service, either in this facility or outside, for prevention of mother to child transmission of HIV.</p>																																																																																																																																		
	<table border="1"> <thead> <tr> <th rowspan="3">SERVICE</th><th colspan="3">SERVICE OFFERED IN THIS FACILITY</th><th rowspan="3">REFER CLIENTS OUTSIDE FACILITY</th><th rowspan="3">NO SERVICE OR REFERRAL</th></tr> <tr> <th colspan="2">OUTPATIENT</th><th rowspan="2">INPATIENT SERVICE ONLY</th></tr> <tr> <th>OFFERED THIS CLINIC/UNIT</th><th>REFER TO OTHER CLINIC/UNIT THIS FACILITY</th></tr> </thead> <tbody> <tr><td>01 Offer HIV testing</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>02 Offer group pretest information or counseling</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>03 Offer individual HIV pretest information or counseling</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>04 Offer individual HIV post-test counseling</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>05 Offer couple counseling for women who are HIV positive</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>06 Offer counseling on infant feeding to HIV positive women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>07 Offer counseling on maternal nutrition to HIV positive women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>08 Offer counseling on family planning</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>09 Offer family planning services</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>10 Offer counseling on condom use for dual protection</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>11 Distribute condoms to PMTCT clients</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>12 Offer ARV prophylaxis for pregnant women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>13 Offer ARV prophylaxis for newborn</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>14 Provide breast-milk substitutes for newborns of HIV positive women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>15 Offer follow up counseling for HIV positive women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>16 Offer ARV therapy (long-term treatment) for HIV positive women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>17 Offer ARV therapy for family members of HIV positive women</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>18 Offer women-to-women support groups</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>19 Offer PMTCT services with delivery services</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> </tbody> </table>	SERVICE	SERVICE OFFERED IN THIS FACILITY			REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL	OUTPATIENT		INPATIENT SERVICE ONLY	OFFERED THIS CLINIC/UNIT	REFER TO OTHER CLINIC/UNIT THIS FACILITY	01 Offer HIV testing	1	2	3	4	5	02 Offer group pretest information or counseling	1	2	3	4	5	03 Offer individual HIV pretest information or counseling	1	2	3	4	5	04 Offer individual HIV post-test counseling	1	2	3	4	5	05 Offer couple counseling for women who are HIV positive	1	2	3	4	5	06 Offer counseling on infant feeding to HIV positive women	1	2	3	4	5	07 Offer counseling on maternal nutrition to HIV positive women	1	2	3	4	5	08 Offer counseling on family planning	1	2	3	4	5	09 Offer family planning services	1	2	3	4	5	10 Offer counseling on condom use for dual protection	1	2	3	4	5	11 Distribute condoms to PMTCT clients	1	2	3	4	5	12 Offer ARV prophylaxis for pregnant women	1	2	3	4	5	13 Offer ARV prophylaxis for newborn	1	2	3	4	5	14 Provide breast-milk substitutes for newborns of HIV positive women	1	2	3	4	5	15 Offer follow up counseling for HIV positive women	1	2	3	4	5	16 Offer ARV therapy (long-term treatment) for HIV positive women	1	2	3	4	5	17 Offer ARV therapy for family members of HIV positive women	1	2	3	4	5	18 Offer women-to-women support groups	1	2	3	4	5	19 Offer PMTCT services with delivery services	1	2	3	4	5					
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NO.	QUESTIONS	CODING CATEGORIES			GO TO	
1008	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, AS TO SEE WHERE THIS INFORMATION IS RECORDED AND ANSWER THE FOLLOWING QUESTIONS.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 RECORDED IN INDIVIDUAL CLIENT CHART/RECORD, NOT COMPILED FOR REPORTING 3 NO 4			→ 1010 → 1010 → 1010	
1009	RECORD THE FOLLOWING INFORMATION FOR ANC CLIENTS. IT MAY BE NECESSARY TO REVIEW ANC AS WELL AS PMTCT RECORDS TO COLLECT THE INFORMATION.	(a) RECORD/REGISTER OBSERVED REPORTED NOT SEEN NOT AVAIL			(b) NUMBERS FROM OBSERVED RECORDS NUMBER OF CLIENTS MONTHS OF DATA	
01	TOTAL ANC CLIENTS RECEIVING PRIMARY PREVENTIVE COUNSELING (EITHER GROUP OR INDIVIDUAL) PAST 12 MONTHS	1 → b	2 → 02	3 → 02	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
02	TOTAL HIV POSITIVE WOMEN RECEIVING PRIMARY PREVENTIVE COUNSELING PAST 12 MONTHS	1 → b	2 → 03	3 → 03	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
03	TOTAL HIV POSITIVE WOMEN RECEIVING COUNSELING ON FAMILY PLANNING PAST 12 MONTHS	1 → b	2 → 04	3 → 04	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
04	TOTAL HIV POSITIVE WOMEN RECEIVING INFANT FEEDING COUNSELING PAST 12 MONTHS	1 → b	2 → 05	3 → 05	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
05	TOTAL HIV POSITIVE WOMEN RECEIVING COUPLES COUNSELING PAST 12 MONTHS	1 → b	2 → 1010	3 → 1010	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
1010	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC UNIT 1 YES, OTHER LOCATION IN FACILITY 2 NO 3			→ 1014 → 1014	
1011	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED, COMPLETE 1 YES, OBSERVED, NOT COMPLETE 2 YES, REPORTED NOT SEEN 3 NO 4				
1012	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				

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1013	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. What are the key components of the youth friendly services that are offered in this clinic/unit? ASK FOR EACH ITEM. CIRCLE ALL THAT APPLY.	SERVICES IN SEPARATE ROOM A DISCOUNT FEES B NO FEES C EDUCATION/COUNSELING D OTHER X (SPECIFY)				
1014	WAS INFORMATION FOR OPD QRE 221 OR IPD Q321, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY ASKED FROM THIS RESPONDENT?	YES 1				→ 1017
		NO 2				
1015	Are there any guidelines or 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?	SOME GUIDELINES/PROTOCOLS AVAILABLE 1 SOME GUIDELINES/PROTOCOLS AVAILABLE- NONE SEEN 2 NO GUIDELINES OR PROTOCOLS 3				→ 1019
1016	First I want to ask about some of the national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(b)				
		COM- PLETE	OBSERVED, INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	National Guidelines for the clinical management of HIV and AIDS	1 → b	2 → b	3 02 ←	4 02 ←	
02						
03	National Infection Prevention and control guidelines for health care services in Tanzania	1 → b	2 → b	3 04 ←	4 04 ←	
04	National Guidelines for Voluntary Counseling and Testing	1 → b	2 → b	3 05 ←	4 05 ←	
05	Guidelines for management of HIV/AIDS for Frontline workers	1 → b	2 → b	3 06 ←	4 06 ←	
06	National guidelines for prevention of mother to child transmission of HIV(PMTCT)	1 → b	2 → b	3 07 ←	4 07 ←	
07	Guidelines for Home Based Care Services	1 → b	2 → b	3 08 ←	4 08 ←	
08	Guidelines for home based care services in Tanzania	1 → b	2 → b	3 09 ←	4 09 ←	
09	A Guideline for counselors in Tanzania with special emphasis on HIV/AIDS/STDs counseling	1 → b	2 → b	3 10 ←	4 10 ←	
10	Guidelines and Standards for Counseling and Supervision	1 → b	2 → b	3 1017 ←	4 1017 ←	
1017	Other than the previously mentioned national guidelines, are there any other protocols or guidelines for counseling and testing or other related topics?	YES, OTHER PROTOCOLS/ GUIDELINES 1 NO OTHER PROTOCOLS/ GUIDELINES 2				→ 1019

NO.	QUESTIONS	CODING CATEGORIES				GO TO
		(a)			(b)	
		OBSERVED, COM- PLETE	INCOM- PLETE	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON MANUAL YEAR
1018	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:					
01	Other protocols/guidelines for pretest counseling?	1 → b	2 → b	3 ↙ 02 ↙	4 ↙ 02 ↙	<input type="text"/>
02	Other protocols/guidelines for post test counseling for both positive and negative test results?	1 → b	2 → b	3 ↙ 03 ↙	4 ↙ 03 ↙	<input type="text"/>
03	Is there any written policy that all clients receiving HIV tests must be offered pretest counseling or information, and post test counseling?	1 → b	2 → b	3 ↙ 04 ↙	4 ↙ 04 ↙	<input type="text"/>
04	Is there any policy on HIV testing procedures, that is what test should be done, and when?	1 → b	2 → b	3 ↙ 05 ↙	4 ↙ 05 ↙	<input type="text"/>
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 → b	3 ↙ 06 ↙	4 ↙ 06 ↙	<input type="text"/>
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 → b	3 ↙ 07 ↙	4 ↙ 07 ↙	<input type="text"/>
07	Any other informed consent policy?	1 → b	2 → b	3 ↙ 08 ↙	4 ↙ 08 ↙	<input type="text"/>
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 → b	3 ↙ 09 ↙	4 ↙ 09 ↙	<input type="text"/>
09	Any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client?	1 → b	2 → b	3 ↙ 10 ↙	4 ↙ 10 ↙	<input type="text"/>
10	Any other guidelines for PMTCT services?	1 → b	2 → b	3 ↙ 1019 ↙	4 ↙ 1019 ↙	<input type="text"/>
1019	Does this clinic/unit have a counselor who has been trained for both pretest and post test counseling? 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				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1020	DESCRIBE THE SETTING WHERE CLIENT COUNSELING 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 NO PRIVACY 4	
1021	How is pretest counseling or information provided?	INDIVIDUAL ONLY 1 GROUP ONLY 2 BOTH INDIVIDUAL AND GROUP ... 3 NO PRETEST COUNSELING 4	→ 1024 → 1025
1022	Are there records of the group pretest information sessions? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS AND RECORD THE NUMBER OF SESSIONS THAT HAVE BEEN HELD.	YES, <input type="text"/> <input type="text"/> <input type="text"/> NUMBER OF SESSIONS NO RECORDS ON GROUP COUNSELING 995	→ 1024
1023	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>	
1024	Which staff most commonly provide pre test HIV counseling for clients in this clinic/unit? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	VCT/CT COUNSELORS FROM OUTSIDE UNIT 1 TRAINED UNIT STAFF PROVIDE COUNSELING 2 TRAINED AND UNTRAINED UNIT STAFF, DEPENDING ON TIME AND STAFF AVAILABILITY . 3 BOTH OUTSIDE STAFF AND TRAINED UNIT STAFF PROVIDE COUNSELING, DEPENDING ON TIME AND STAFF AVAILABILITY . 4 CLIENTS ALWAYS SENT TO ANOTHER CLINIC/UNIT FOR PRE-TEST COUNSELING 5	
1025	Which staff most commonly provide post-test HIV counseling for clients in this clinic/unit with negative results? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	VCT/CT COUNSELORS FROM OUTSIDE UNIT 1 TRAINED UNIT STAFF PROVIDE COUNSELING 2 BOTH OUTSIDE STAFF AND TRAINED UNIT STAFF PROVIDE COUNSELING, DEPENDING ON TIME AND STAFF AVAILABILITY . 3 CLIENTS ALWAYS SENT TO ANOTHER CLINIC/UNIT FOR POST-TEST COUNSELING 4 NO POST TEST COUNSELING FOR NEGATIVE RESULTS. 5	
1026	Which staff most commonly provide post-test HIV counseling for clients in this clinic/unit with positive results? PROBE FOR RESPONSE THAT IS MOST ACCURATE.	VCT/CT COUNSELORS FROM OUTSIDE UNIT 1 TRAINED UNIT STAFF PROVIDE COUNSELING 2 BOTH OUTSIDE STAFF AND TRAINED UNIT STAFF PROVIDE COUNSELING, DEPENDING ON TIME AND STAFF AVAILABILITY . 3 CLIENTS ALWAYS SENT TO ANOTHER CLINIC/UNIT FOR POST-TEST COUNSELING 4 NO POST TEST COUNSELING ... 5	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1029	ARE ALL SURFACE AREAS IN THE BLOOD DRAWING AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2	
1030	How many days each week are HIV tests available in this facility for pregnant women?	DAYS PER WEEK <input type="text"/> DON'T KNOW 8	
1031	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 5 (SPECIFY)	
1032	Are all HIV positive women instructed to bring the child for an HIV test? IF YES, ASK WHETHER ALL PMTCT CLIENTS ARE INSTRUCTED OR ONLY THOSE DELIVERING AT THE FACILITY.	YES, FOR ALL HIV POSITIVE WOMEN YES, FOR FACILITY DELIVERIES ONLY 2 NO 3	→ 1034
1033	At what age are the women instructed to bring the child for HIV testing? INDICATE AGE IN MONTHS	AGE (IN MONTHS) INFANT TO BE BROUGHT FOR HIV TESTING <input type="text"/> <input type="text"/> DON'T KNOW98	
1034	Does this clinic/unit actually prescribe or provide the antiretroviral medicine to HIV positive women for PMTCT? IF YES, ASK: What is the ARV regime used? CIRCLE ALL THAT APPLY.	NEVIRAPINE ALONE A ZIDOVUDINE ALONE B ZIDOVUDINE AND LAMIVUDINE TOGETHER C ZIDOVUDINE AND NEVIRAPINE ... D OTHER X SPECIFY NO ARV AVAILABLE FROM THIS CLINIC/UNIT FOR PMTCT Y	→ 1039
1035	What is the practice for providing the ARV prophylaxis to the HIV positive woman?	GIVE TO ANC WOMAN FOR SELF ADMINISTRATION AT TIME OF LABOUR. A GIVEN TO CHW/TBA TO GIVE TO WOMAN AT HOME DURING LABOUR B ONLY PROVIDE TO WOMEN WHO DELIVER IN FACILITY, AT TIME OF DELIVERY C OTHER X (SPECIFY)	→ 1037
1036	What is the most common practice for when the ARV is provided to the HIV positive client or to the CHW/TBA?	SAME DAY HIV STATUS IS CONFIRMED. 0 PROVIDED AT SPECIFIC STAGE OF PREGNANCY. INDICATE MONTHS OF PREGNANCY <input type="text"/>	
1037	Which ARV is used for the newborn for PMTCT?	NEVIRAPINE 1 ZIDOVUDINE (or AZT) 2 OTHER 6 (SPECIFY)	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1038	What is the practice for providing the ARV prophylaxis to the newborn of the HIV positive woman?	GIVE TO ANC WOMAN FOR SELF ADMINISTRATION TO NEWBORN AFTER BIRTH A GIVEN TO CHW/TBA TO GIVE AT HOME AFTER BIRTH B INSTRUCT MOTHER TO BRING CHILD TO FACILITY FOR ARV AROUND 72 HOURS AFTER BIRTH C OTHER X (SPECIFY) NO ARV PROPHYLAXIS FOR NEWBORN Y	
1039	Now I would like to look at ANC records, including those that provide information on any PMTCT counseling 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	→ 1042 → 1042
1040	RECORD THE TOTAL NUMBER OF FIRST VISIT ANC CLIENTS DURING THE PAST 12 MONTHS.	NUMBER OF FIRST VISIT ANC CLIENTS <input type="text"/>	
1041	INDICATE NUMBER OF MONTHS OF DATA AVAILABLE IN PREVIOUS QUEST.	MONTHS OF DATA <input type="text"/>	
1042	Are there any records or registers that provide numbers of ANC clients receiving pre or post test counseling 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 VCT STATISTICS BUT NOT SPECIFIC FOR ANC 2 NO 3	→ 1045 → 1045

NO.	QUESTIONS	CODING CATEGORIES			GO TO	
1043	ASK TO SEE ANY RECORD OR REGISTER OF ANC CLIENTS WHO RECEIVED ANY HIV TEST OR COUNSELING SERVICES DURING 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	UNIT ONLY RECORDS CLIENT ID AND TEST RESULT, NO WRITTEN RECORDS OF COUNSELING OR RECEIPT OF TEST RESULTS	1 → b	2 → 02	3 → 02	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> 06
02	TOTAL ANC CLIENTS RECEIVING INDIVIDUAL PRE-TEST COUNSELING	1 → b	2 → 03	3 → 03	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
03	TOTAL ANC CLIENTS RECEIVING POST-TEST COUNSELING	1 → b	2 → 04	3 → 04	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
04	TOTAL ANC CLIENTS WHO RECEIVED HIV TEST RESULTS	1 → b	2 → 05	3 → 05	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
05	TOTAL ANC CLIENTS WITH POSITIVE HIV TESTS WHO RECEIVED TEST RESULTS	1 → b	2 → 06	3 → 06	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
06	TOTAL ANC CLIENTS WITH POSITIVE HIV TEST	1 → b	2 → 07	3 → 07	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
07	TOTAL ANC CLIENTS WHO RECEIVED HIV TEST	1 → b	2 → 1044	3 → 1044	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
1044	WHAT IS THE MOST RECENT DATE RECORDED FOR HIV TEST COUNSELING?	WITHIN PAST 30 DAYS 1 MORE THAN 30 DAYS 2 NO DATE RECORDED 3 NO COUNSELING RECORDED 4			→ 1047	
1045	Is there a system where you can link the HIV test result with the client who received pre and post test counseling? IF YES, ASK TO SEE HOW THE SYSTEM WORKS	YES, OBSERVED 1 YES, REPORTED NOT SEEN 2 NO 3 SEROSTATUS NOT ASSESSED 4			→ 1049	
1046	Is there a system for linking the counseling 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				

NO.	QUESTIONS	CODING CATEGORIES			GO TO	
1047	AMONG THE WOMEN FOR WHOM TESTING INFORMATION WAS AVAILABLE (Q1043) INDICATE IF INFORMATION ON RECEIVING ARV, AND ON THEIR NEWBORN IS AVAILABLE. IF INFORMATION ONLY AVAILABLE IN DELIVERY AREA, CIRCLE '2'.	(a) RECORD/REGISTER OBSERVED REPORTED NOT SEEN NOT AVAIL			(b) NUMBERS FROM OBSERVED RECORDS NUMBER OF CLIENTS MONTHS OF DATA	
01	NUMBER OF HIV POSITIVE WOMEN WHO WERE PROVIDED ARV FOR PMTCT	1 → b	2 → 02	3 → 02	<input type="text"/>	<input type="text"/>
02	NUMBER OF NEWBORNS OF HIV POSITIVE WOMEN WHO WERE PROVIDED ARV	1 → b	2 → 03	3 → 03	<input type="text"/>	<input type="text"/>
03	NUMBER OF INFANTS BORN TO HIV POSITIVE WOMEN	1 → b	2 → 04	3 → 04	<input type="text"/>	<input type="text"/>
04	NUMBER OF HIV POSITIVE INFANTS.	1 → b	2 → 05	3 → 05	<input type="text"/>	<input type="text"/>
05	TOTAL NUMBER OF BIRTHS FOR ALL WOMEN	1 → b	2 → 1048	3 → 1048	<input type="text"/>	<input type="text"/>
1048	Is there any record of HIV positive pregnant women who begin ARV treatment? IF YES, ASK TO SEE THE RECORD/REGISTER	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 WOMEN REFERRED TO ART OUTSIDE THIS CLINIC/UNIT NO FURTHER FOLLOW-UP THIS CLINIC/UNIT 3 NO 4 ART TREATMENT NOT AVAILABLE 5				
1049	Are any reports regularly compiled on the pregnant women or infants in this clinic who receive testing or counseling services related to HIV/AIDS? IF YES, CLARIFY WHETHER THE REPORTS PROVIDE INFORMATION ON PREGNANT WOMEN AND CIRCLE THE RESPONSE THAT BEST REFLECTS THE PRACTICE.	YES, REPORTS COMBINE PREGNANT AND NON-PREGNANT CLIENTS 1 YES, PREGNANT CLIENTS REPORTED SEPARATELY 2 YES, FOR CONFIRMED HIV/AIDS ONLY PREGNANT CLIENTS SPECIFIED 3 YES, FOR CONFIRMED HIV/AIDS ONLY PREGNANCY STATUS NOT SPECIFIED 4 NO 5			→ 1053	
1050	Which statistics do you submit for pregnant women receiving PMTCT services? CIRCLE ALL THAT APPLY	NUMBER OF PREGNANT WOMEN RECEIVING PRETEST COUNSELING .. A RECEIVING POSTTEST COUNSELING B TESTED FOR HIV C SERO POSITIVE FOR HIV D RECEIVING ARV FOR PMTCT E INFANTS OF HIV POSITIVE WOMEN WHO ARE TESTED FOR HIV F RECEIVING ARV FOR PMTCT G				
1051	How frequently are any of the compiled reports submitted to someone outside of this clinic/unit?	MONTHLY OR MORE OFTEN 1 EVERY 2-3 MONTHS 2 EVERY 4-6 MONTHS 3 LESS OFTEN THAN EVERY 6 MONTHS . 4 NEVER 5			→ 1053	

NO.	QUESTIONS	CODING CATEGORIES			GO TO																						
1052	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/CBOH/TACAIDS) C REGIONAL LEVEL (MOH/CBOH/TACAIDS) D NATIONAL LEVEL (MOH/CBOH/TACAIDS) E DONOR AGENCY F OTHER X _____(SPECIFY)_____																									
1053	Are there any fees assessed for any services or items related to PMTCT services?	YES 1 NO 2			→ 1055																						
1054	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	<table border="1"> <thead> <tr> <th colspan="3">(a) FEE</th> <th rowspan="2">(b) AMOUNT IN TSH</th> </tr> <tr> <th>YES</th> <th>NO</th> <th>NA</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Fee for HIV test</td> <td>1→b 2 02 ↓</td> <td>3 02 ↓</td> <td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td> </tr> <tr> <td>02</td> <td>Fee for antiretroviral prophylaxis for mother</td> <td>1→b 2 03 ↓</td> <td>3 03 ↓</td> <td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td> </tr> <tr> <td>03</td> <td>Fee for antiretroviral prophylaxis for newborn</td> <td>1→b 2 1055 ↓</td> <td>3 1055 ↓</td> <td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td> </tr> </tbody> </table>			(a) FEE			(b) AMOUNT IN TSH	YES	NO	NA	01	Fee for HIV test	1→b 2 02 ↓	3 02 ↓	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	02	Fee for antiretroviral prophylaxis for mother	1→b 2 03 ↓	3 03 ↓	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	03	Fee for antiretroviral prophylaxis for newborn	1→b 2 1055 ↓	3 1055 ↓	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
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1055	Is an individual client chart/record/card maintained for clients who receive services through this clinic/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 A BLANK OR CURRENT CHART/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, ONLY AVAILABLE IN OTHER FACILITY AREA 3 ENTER CLINIC/UNIT NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER 6 _____(SPECIFY)_____																									
1056	Are there delivery services in this facility, where PMTCT clients can receive services? IF YES ASK: Is there any system for linking the PMTCT clients from ANC to women who deliver in this facility and receive PMTCT? 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- REQUIRES SEPARATE IPD AND PMTCT QRE 2 NO DELIVERY SERVICES 3			→ GO TO DELIVERY UNIT & CONT. QRE → END → END																						
1057	Is the HIV serostatus routinely assessed for all women who deliver in the facility? IF YES, 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)_____																									
1058	Is pretest counseling routinely offered to women in labour whose HIV status is unknown?	YES 1 NO 2			→ 1061																						
1059	Who provides the pretest counseling for women in labour. CIRCLE ALL THAT APPLY.	TRAINED PMTCT COUNSELOR COMES TO UNIT A TRAINED UNIT STAFF PROVIDE COUNSELING B NOT ALWAYS COUNSELED BY TRAINED STAFF C PRETEST COUNSELING NOT ROUTINE ... D																									

NO.	QUESTIONS	CODING CATEGORIES			GO TO	
1060	What is the most common practice for providing post-test counseling to HIV positive women who were tested when admitted for delivery?	TRAINED PMTCT COUNSELOR COMES TO UNIT A TRAINED UNIT STAFF PROVIDE COUNSELING B NOT ALWAYS COUNSELED BY TRAINED STAFF C POST TEST COUNSELING NOT ROUTINE D				
1061	Are there any guidelines for HIV test counseling in the delivery unit? IF YES, ASK TO SEE THE GUIDELINES AND INDICATE IF THEY SPECIFY BOTH PRE AND POST TEST COUNSELING.	YES, NATIONAL PMTCT GUIDELINES OBSERVED 1 YES, NATIONAL VCT GUIDELINES OBSERVED 2 YES, OTHER GUIDELINES REPORTED NOT SEEN 3 NO, GUIDELINES NOT AVAILABLE 4				
1062	Are records on HIV test counseling available in this clinic/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 COUNSELING 1 REPORTED RECORDS KEPT WITH PMTCT/VCT CLINIC/UNIT 2 RECORDED IN CLIENT INDIVIDUAL CHART/RECORD ONLY 3 COUNSELING NOT ROUTINELY RECORDED 4				
1063	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				
1064	Is there a register or record where the HIV positive 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 THE SAME REGISTER KEPT FOR ANC PMTCT RECIPIENTS)	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3			→ 1066 → 1066	
1065	ASK TO SEE RELEVANT RECORDS FOR THE DATA REQUESTED BELOW FOR THE PAST 12 MONTHS AND RECORD THE CORRECT RESPONSE.	(a) RECORD/REGISTER OBSERVED REPORTED NOT SEEN NOT AVAIL			(b) NUMBERS FROM OBSERVED RECORDS NUMBER OF CLIENTS MONTHS OF DATA	
01	TOTAL DELIVERIES IN THE FACILITY	1 → b	2 → 02	3 → 02	<input type="text"/>	<input type="text"/>
02	TOTAL HIV POSITIVE WOMEN DELIVERING IN THE FACILITY	1 → b	2 → 03	3 → 03	<input type="text"/>	<input type="text"/>
03	TOTAL HIV POSITIVE WOMEN DELIVERING IN THE FACILITY AND RECEIVING ARV PROPHYLAXIS	1 → b	2 → 1066	3 → 1066	<input type="text"/>	<input type="text"/>
1066	Other than previously observed guidelines, do you have any guidelines or protocols 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				

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1067	<p>What delivery practices are implemented in this unit, to decrease mother to child transmission of HIV/AIDS? DO NOT READ RESPONSES. PROMPT THE RESPONDENT BY ASKING: For example, have you changed any delivery practices because of the risk of HIV/AIDS?</p> <p>CIRCLE ALL THAT ARE MENTIONED.</p>	<p>NO ROUTINE EPISIOTOMY A MINIMIZE INSTRUMENT DELIVERY B HIBITANE VAGINAL CLEANSING C MINIMIZE VAGINAL EXAM D MINIMIZE ARTIFICIAL RUPTURE MEMBRANES E CAESAREAN SECTION F ARV PROPHYLAXIS IF HIV POSITIVE .. G AVOID MILKING CORD/IMMEDIATE CLAMP CORD H AVOID SUCTION I ENCOURAGE EXCLUSIVE BREAST FEEDIN J OTHER X (SPECIFY) NONE Y DON'T KNOW Z</p>			
1068	<p>ASK TO SEE THE DELIVERY ROOM AND INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT AREA</p>	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER	1 → 03	2	3	
02	WATER IN BUCKET OR BASIN (WITHOUT TAP)	1	2	3	
03	HAND-WASHING SOAP	1	2	3	
04	SINGLE-USE HAND DRYING TOWELS	1	2	3	
05	SHARPS CONTAINER	1	2	3	
06	DISPOSABLE LATEX GLOVES	1 → 08	2	3	
07	DISPOSABLE NON-LATEX GLOVES	1	2	3	
08	ALREADY MIXED DECONTAMINATION SOLUTION	1 → 10	2	3	
09	DISINFECTANT (NOT YET MIXED)	1	2	3	
10	CONDOMS	1	2	3	
11	RAPID TEST FOR HIV	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	DISPOSABLE SYRINGES	1	2	3	
14	EXAMINATION TABLE	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 → END	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE					

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT **Observation of Sick-Child Consultation**

1. Facility Identification

Name of the facility: _____ QTYPE

O	S	C
---	---	---

Location of the facility: _____

FACILITY NUMBER

--	--	--

2. Provider Information

<p>Provider category:</p> <table style="width: 100%;"> <tr> <td>Consultant 01</td> <td>Nurse Midwife 13</td> </tr> <tr> <td>Medical Doctor 08</td> <td>Public Health Nurse 14</td> </tr> <tr> <td>Medical Officer 09</td> <td>Trained Nurse 15</td> </tr> <tr> <td>Ast. Med. Officer (AMO) .. 10</td> <td>Aux. Nurse/Med Attnd. ... 16</td> </tr> <tr> <td>Clinical Officer 11</td> <td>Clinical Assistant 31</td> </tr> <tr> <td>RN/Nursing Officer ... 12</td> <td></td> </tr> <tr> <td colspan="2">Other _____ 96 (SPECIFY)</td> </tr> </table> <p>Sex of provider: (1=Male; 2=Female)</p> <p>SERIAL (SL) NUMBER FROM STAFF LISTING SHOULD BE USED. USE SAME NUMBER FOR STAFF INTERVIEW AND OBSERVATION</p>	Consultant 01	Nurse Midwife 13	Medical Doctor 08	Public Health Nurse 14	Medical Officer 09	Trained Nurse 15	Ast. Med. Officer (AMO) .. 10	Aux. Nurse/Med Attnd. ... 16	Clinical Officer 11	Clinical Assistant 31	RN/Nursing Officer ... 12		Other _____ 96 (SPECIFY)		<p>PROVIDER CATEGORY <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>SEX OF PROVIDER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr></table></p> <p>PROVIDER SL NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p>					
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Other _____ 96 (SPECIFY)																				

3. Information About Observation

<p>Date: _____</p> <p>Name of the observer: _____</p> <p>Client code: _____</p>	<p>DAY <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>MONTH <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>YEAR <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td></tr></table></p> <p>OBSERVER CODE <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>CLIENT CODE <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p>												

4. Observation of Sick-Child Consultation			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CHILD'S 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.</p> <p>READ TO PROVIDER: Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health facilities 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 health care for sick children is provided in this facility. Information from this observation is confidential. Neither your name or that of the client will be recorded. The information acquired during this observation, however, may be used by the MOH or organizations supporting services in this facility, for planning service improvements or further studies of health services. Information from this observation may be provided to researchers for analyses, however, the information will be provided in such a way that neither you, this facility, nor the client can be identified. Any reports that use information from this observation will only present information in aggregate form as an additional safeguard for confidentiality.</p> <p>Do you have any questions for me? Do you understand that if, at any point you feel uncomfortable you can ask me to leave? Do I have your permission to be present at this consultation?</p> <p style="text-align: right;">Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES 1 NO 2	→ STOP
	<p>READ TO CARETAKER: Hello, I am _____. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. I would like to be present while you are receiving services today, in order to better understand how health care is provided.</p> <p>We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility in particular, but rather are trying to gain a picture of the overall situation in order to improve services. Information from this observation may be provided to researchers for analyses, but 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.</p> <p>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.</p> <p>After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do you understand that if, at any point you feel uncomfortable, you can ask me to leave? Do I have your permission to be present at this consultation?</p> <p style="text-align: right;">Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CARETAKER.	YES 1 NO 2	→ STOP
102	RECORD THE TIME THE OBSERVATION STARTED <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>		
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	Cough or difficult breathing (e.g. fast breathing)	1	2	8	
02	Diarrhea	1	2	8	
03	Fever or body hotness	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)	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	Look in child's ear	1	2	8	
09	Feel behind child's ear	1	2	8	
10	Undress child to examine (up to shoulders/ down to ankles)	1	2	8	
11	Press both feet to check for edema	1	2	8	
12	Assessed for suspected symptomatic HIV infection	1	2	8	
13	Weigh the child IF YES:	1	2 → 108	8 → 108	
14	Plot weight on growth chart	1 → 108	2	8	
15	Compare child's weight to standard weight	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
108	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH BY DOING ANY OF THE FOLLOWING.	YES	NO	DK		
01	Offer 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	8		
02	Ask about normal feeding practices when the child is not ill	1	2	8		
03	Ask about normal breastfeeding practices when the child is not ill	1	2	8		
04	Ask about feeding or breastfeeding practices for the child during this illness	1	2	8		
05	Mention the child's weight or growth to the caretaker, or discuss the growth chart with the caretaker	1	2	8		
06	Look at the child's immunization card or ask the caretaker about child's vaccination history	1	2	8		
07	Ask if child received Vitamin A	1	2	8		
08	Look 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	8		
109	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING WHEN COUNSELING THE CARETAKER.	YES	NO	DK	NA	
01	Provide general information about feeding or breast-feeding the child even when not sick	1	2	8		
02	Tell the caretaker to give extra fluids to the child during this sickness	1	2	8		
03	Tell the caretaker to continue feeding the child during this sickness	1	2	8		
04	Tell the caretaker what illness(es) the child has	1	2	8		
05	Describe signs or symptoms in the child for which the caretaker should immediately bring the child back	1	2	8		

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
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/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 BUT NOT PRESCRIBED FOR HOME TREATMENT TREATMENT.	YES	NO	DK	
01	Prescribe or provide oral medications during consultation	1	2 → 112	8 → 112	
02	Explain how to administer oral treatment(s)	1	2	8	5
03	Ask the caretaker to repeat the instructions for the medications	1	2	8	5
04	Give the first dose of the oral treatment	1	2	8	5

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
112	RECORD WHETHER A PROVIDER USED ANY VISUAL AIDS WHEN PROVIDING INDIVIDUAL HEALTH EDUCATION OR COUNSELING TO THE CARETAKER ABOUT THE CHILD.	YES 1	NO 2	DK 8	
113	RECORD WHETHER THE MAIN PROVIDER REFERRED TO THE CHILD'S HEALTH CARD/ BOOK BEFORE OR DURING THE CONSULTATION.	YES 1 NO 2 NO HEALTH CARD/BOOK USED 3 DON'T KNOW 8	→ 115		
114	RECORD WHETHER THE MAIN PROVIDER WROTE ON THE CHILD'S HEALTH CARD/ BOOK.	YES 1 NO 2 NO HEALTH CARD/BOOK 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.	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>			

6. Diagnosis and Classification and Treatment						
ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS. EXPLAIN THAT FOR ANY DIAGNOSIS OR SYMPTOM YOU WANT TO KNOW IF THE PROBLEM WAS SEVERE, MODERATE, OR MINOR. THEN ASK ABOUT THE TREATMENT PRESCRIBED OR PROVIDED. PROMPT IF NECESSARY.						
DIAGNOSIS OR MAIN SYMPTOMS (IF NO DIAGNOSIS)		1 SEVERE	2 MOD- ERATE	3 MINOR	4 NO	8 DON'T KNOW
201	RESPIRATORY SYSTEM					
	1) PNEUMONIA	1	2		4	8
	2) BRONCHO-PNEUMONIA	1	2		4	8
	3) BRONCHIAL SPASM/ASTHMA	1	2	3	4	8
	4) UPPER RESPIRATORY INFECTION (URI)	1	2	3	4	8
	5) RESPIRATORY ILLNESS, DIAGNOSIS UNCERTAIN	1	2	3	4	8
	6) COUGH, DIAGNOSIS UNCERTAIN	1	2	3	4	8
202	DIGESTIVE SYSTEM					
	1) PERSISTENT DIARRHEA	1	2	3	4	8
	2) DIARRHEA	1	2	3	4	8
	3) DYSENTERY	1	2	3	4	8
	4) AMEBIASIS	1	2	3	4	8
	5) OTHER DIARRHEA _____ (SPECIFY)	1	2	3	4	8
203	DEHYDRATION					
	1) DEHYDRATION	1	2	3	4	8
204	MALARIA					
	1) MALARIA (CLINICAL DIAGNOSIS)	1	2	3	4	8
	2) MALARIA (BLOOD SMEAR)	1	2	3	4	8
	3) PROBABLE MALARIA (BY SYMPTOMS)	1	2	3	4	8
205	FEVER					
	1) FEVER	1	2	3	4	8
	2) MEASLES	1	2	3	4	8
	3) MEASLES WITH COMPLICATIONS	1	2	3	4	8
206	EAR					
	1) MASTOIDITIS	1	2	3	4	8
	2) ACUTE EAR INFECTION	1	2	3	4	8
	3) CHRONIC EAR INFECTION	1	2	3	4	8
207	THROAT					
	1) STREPTOCOCCAL SORE THROAT	1	2	3	4	8
	2) NON-STREPTOCOCCAL SORE THROAT	1	2	3	4	8
	3) OTHER THROAT _____ OR EAR DIAGNOSIS (SPECIFY)	1	2	3	4	8
208	OTHER					
	1) OTHER DIAGNOSIS _____ (SPECIFY)	1	2	3	4	8

209	CHECK RESPIRATORY ILLNESSES IN 201. IF CODES 1, 2 OR 3 ARE CIRCLED, CLARIFY WITH THE PROVIDER IF THERE WAS WHEEZING OR NOT.	YES, WHEEZING 1 NO WHEEZING 2 NOT APPLICABLE 5 NOT CERTAIN 8	
	ASK ABOUT PRESCRIPTION, TREATMENT AND ACTIONS TAKEN FOR ILLNESS AND PROBE "ANYTHING ELSE?"	YES NO DK	
210	1 NO TREATMENT	1 → 217 2 8	
211	TREATMENT FOR VARIOUS ILLNESSES		
	1) BENZATHINE PENICILLIN INJECTION	1 2 8	
	2) OTHER ANTIBIOTIC INJECTION	1 2 8	
	3) OTHER INJECTION	1 2 8	
	4) ANTIBIOTIC TABLET/SYRUP	1 2 8	
	5) CO-TRIMOXAZOLE/AMOXICILLIN	1 2 8	
	6) PARACETAMOL	1 2 8	
	7) ZINC (for Diarrhea) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (SPECIFY DOSE in mg)	1 2 8	
	8) VITAMINS	1 2 8	
	9) COUGH SYRUPS/OTHER MEDICATION FOR SYMPTOMATIC TREATMENT	1 2 8	
212	RESPIRATORY		
	1) NEBULIZED OR INHALER	1 2 8	
	2) INJECTABLE BRONCHODILATOR (ADRENALINE)	1 2 8	
	3) ORAL BRONCHODILATOR	1 2 8	
	4) DRY EAR BY WICKING	1 2 8	
213	MALARIA		
	1) INJECTABLE QUININE, FANSIDAR (SP) OR ARTEMETHER	1 2 8	
	2) INJECTABLE CHLOROQUINE	1 2 8	
	3) OTHER INJECTABLE ANTIMALARIAL	1 2 8	
	4) ORAL ANTIMALARIAL	1 2 8	
	5) ORAL CHLOROQUIN	1 2 8	
	6) ORAL FANSIDAR (SP)	1 2 8	
	7) ORAL ARTEMISININ	1 2 8	
	8) ORAL AMODIAQUINE	1 2 8	
	9) ORAL ARTEMETER	1 2 8	
	10) OTHER ORAL ANTIMALARIAL (SPECIFY) _____	1 2 8	
214	DEHYDRATION		
	1) HOME ORT	1 2 8	
	2) INITIAL ORT IN FACILITY (4 HOURS)	1 2 8	
	3) INTRAVENOUS FLUIDS	1 2 8	

215	MEASLES	YES	NO	DK	
	1) VITAMIN A	1	2	8	
	2) FEEDING SOLID FOODS	1	2	8	
	3) FEEDING EXTRA LIQUIDS	1	2	8	
	4) FEEDING BREAST MILK	1	2	8	
216	1 OTHER TREATMENT _____ (SPECIFY)	1	2	8	
217	Did you give or refer the child for an immunization? IF NO: Why not?	PROVIDER GAVE 1 PROVIDER REFERRED 2 NOT DUE FOR IMMUNIZATION/ COMPLETED IMMUNIZATIC.... 3 VACCINE NOT AVAILABLE4 CHILD TOO SICK 5 NOT DAY FOR IMMUNIZATION 6 DID NOT CHECK FOR IMMUNIZATION 7			
218	RECORD THE TIME THE OBSERVATION ENDED.		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Observer's comments: 					

3. Information About Visit			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>READ TO CARETAKER: Hello, I am _____. As my colleague mentioned, we are representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today.</p> <p>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.</p> <p>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. If, at any point, you would prefer I leave please feel free to tell me</p> <p>Do you have any questions for me? Do I have your permission to continue with the interview?</p> <div style="text-align: right; margin-top: 20px;"> _____ Interviewer's signature Date (Indicates respondent's willingness to participate) </div>		
100	May I begin the interview?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	RECORD THE TIME THE INTERVIEW STARTED	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> : <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	
102	What is the name of the sick child?	NAME	
103	What month and year was [NAME] born?	MONTH <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> DON'T KNOW MONTH 98 YEAR <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> DON'T KNOW YEAR 9998	
104	WERE YOU ABLE TO ASCERTAIN THE COMPLETE BIRTH DATE OF THE CHILD?	YES 1 NO 2	
105	How old is [NAME] in completed months?	AGE IN MONTHS <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	
106	Did you bring [NAME] to the facility today because he or she had any of the following problems?	<div style="text-align: right; margin-bottom: 5px;"> <u>YES</u> <u>NO</u> </div> 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?	EYE PROBLEMS A SKIN SORE/PROBLEMS B INJURY C OTHER NON-SERIOUS W OTHER SERIOUS X <div style="text-align: center; margin-top: 5px;">(SPECIFY)</div> NO OTHER REASON Y	
108	Has [NAME] been brought to this facility before for this same sickness?	YES 1 NO 2 DON'T KNOW 8	→ 110 → 110

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
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 <input type="text"/> <input type="text"/> DON'T KNOW 98	
111	Did the provider tell you what illness [NAME] has?	YES 1 NO 2 DON'T KNOW 8	
112	What will you do if [NAME] does not get completely better or becomes worse?	RETURN TO FACILITY 1 GO TO OTHER FACILITY 2 GO TO OTHER HEALTH WORKER/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 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 CHILD ADMITTED D ROUTINE IMMUNIZATION E 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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
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	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 how often to give it? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	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	Now I want to ask you some questions about [NAME]. When not sick, what types of food or fluid does [NAME] normally take?	ONLY BREASTMILK 1 OTHER MILKS 2 BREASTMILK AND LIQUIDS . 3 BREASTMILK AND OTHER FOODS AND LIQUIDS 4 NO BREASTMILK 5 DON'T KNOW 8	
122	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	
123	Did anyone at the health facility weigh [NAME] today?	YES 1 NO 2	
124	Did anyone talk to you today about [NAME]'s weight and how [NAME] is growing?	YES 1 NO 2	
125	Since becoming ill, has the way that [NAME] drinks changed from normal? IF YES: CLARIFY WHETHER THE CHILD IS CONSUMING MORE OR LESS THAN NORMAL.	MORE THAN NORMAL 1 SAME AS NORMAL 2 LESS THAN NORMAL 3 NOT DRINKING 4 NOT CERTAIN 8	
126	Since becoming ill, has the way that [NAME] eats changed from normal? IF YES: CLARIFY WHETHER THE CHILD IS CONSUMING MORE OR LESS THAN NORMAL.	MORE THAN NORMAL 1 SAME AS NORMAL 2 LESS THAN NORMAL 3 NOT EATING 4 HAS NOT BEGUN SOLIDS ... 5 NOT CERTAIN 8	
127	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	
128	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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																																														
129	Was [NAME] given a vaccination today?	YES 1 NO 2 DON'T KNOW 8																																																																															
130	Do you have [NAME]'s vaccination card with you?	YES 1 NO 2	→ 133																																																																														
131	ASK TO SEE THE CHILD'S VACCINATION CARD. INDICATE WHETHER THE RECORD SHOWS THAT THE CHILD WAS VACCINATED TODAY.	YES 1 NO 2																																																																															
132	CHECK THE CHILD'S HEALTH CARD AND INDICATE IN COLUMN "A" WHETHER THE CHILD HAS EVER RECEIVED ANY OF THE FOLLOWING VACCINATIONS. ALSO CHECK THE DATE THAT EACH OF THE VACCINATIONS WAS GIVEN AND WRITE THE DATE IN COLUMN "B". IF NO DATE IS RECORDED ON THE CARD, ENTER 66 FOR THE DAY AND MONTH AND 6666 FOR THE YEAR.																																																																																
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133	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	→ 135																																																																														
134	01 Were you given any paper or record to take with you for the referral?	YES NO DK 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																																																																															
135	Did you see another health provider or traditional healer before coming here? CIRCLE ALL THAT APPLY	YES, OTHER PROVIDER A YES, TRADITIONAL HEALER B NO Y																																																																															

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..... <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY000 DON'T KNOW998	
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 large or small problems for you.		
		NO PROB- LARGE SMALL LEM DK	
01	Time you waited	WAIT 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 problem you had today that I did not mention	____ 1 2 3 8 (SPECIFY)	
203	Are you a part of any prepayment plan (such as 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	<p>What is the total amount you paid for all services or treatments you received at this facility today?</p> <p>Please include any money you paid for services, laboratory tests, or medicines.</p>	<p>1) TOTAL AMOUNT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>PAID NO MONEY 000000 DON'T KNOW 999998</p> <p>2) LAB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3) MEDICINE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4) CONSULT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>5) OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
206	Is this the closest health facility to your home?	<p>YES 1 → 208 NO 2 DON'T KNOW 8 → 208</p>	
207	<p>What was the main reason you did not go to the nearest facility?</p> <p>IF CARETAKER MENTIONS SEVERAL REASONS, PROBE FOR THE MOST IMPORTANT, OR MAIN REASON.</p>	<p>INCONVENIENT OPERATING HOURS01 BAD REPUTATION02 DON'T LIKE PERSONNEL ..03 NO MEDICINE04 PREFERS TO REMAIN ANONYMOUS05 IT IS MORE EXPENSIVE06 REFERRAL07 OTHER96 (SPECIFY) DON'T KNOW98</p>	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	<p>YES 1 NO 2</p>	

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 OTHER 6 (SPECIFY)	
301	How old were you at your last birthday?	AGE IN YEARS <input type="text"/> <input type="text"/>	
302	Have you ever attended school?	YES 1 NO 2	→ 305
303	What is the highest level of school you attended?	INFORMAL 1 PRIMARY 2 MIDDLE 3 SECONDARY 4 HIGHER 5	→ 305
304	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
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	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>	
307	Interviewer's comments:		

Sample List for Sick Child Observation

Date

DAY		MONTH		YEAR			

FAC #		

IF THERE ARE MORE THAN 25 CHILDREN YOU MAY INDICATE THE TOTAL NUMBER HERE

--	--

	INITIALS OF CHILD	AGE (MONTHS)	SYMPTOM	
			SICK	INJURY
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

1. Facility Identification																													
<p style="text-align: right;">QTYPE O F P</p> <p>Name of the facility: _____</p> <p>Location of the facility: _____</p> <p>FACILITY NUMBER </p>																													
2. Provider Information																													
<p>Provider category:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Consultant</td> <td style="width: 10%; text-align: center;">01</td> <td style="width: 30%;">NurseMidwife ...</td> <td style="width: 10%; text-align: center;">13</td> </tr> <tr> <td>Medical Doctor</td> <td style="text-align: center;">08</td> <td>Public Health Nurse</td> <td style="text-align: center;">14</td> </tr> <tr> <td>Medical Officer</td> <td style="text-align: center;">09</td> <td>Trained Nurse</td> <td style="text-align: center;">15</td> </tr> <tr> <td>Ast. Med. Officer (AMO)</td> <td style="text-align: center;">10</td> <td>Aux. Nurse/Med Attnd.</td> <td style="text-align: center;">16</td> </tr> <tr> <td>Clinical Officer</td> <td style="text-align: center;">11</td> <td>Clinical Assistant</td> <td style="text-align: center;">31</td> </tr> <tr> <td>RN/Nursing Officer</td> <td style="text-align: center;">12</td> <td></td> <td></td> </tr> <tr> <td colspan="2" style="padding-top: 10px;">Other _____</td> <td style="text-align: center; vertical-align: bottom;">96</td> <td></td> </tr> </table> <p style="text-align: center; margin-top: 5px;">SPECIFY</p> <p>Sex of provider: (1=Male; 2=Female)</p> <p>SERIAL (SL) NUMBER FROM STAFF LISTING SHOULD BE USED. USE SAME NUMBER FOR STAFF INTERVIEW AND OBSERVATION</p>	Consultant	01	NurseMidwife ...	13	Medical Doctor	08	Public Health Nurse	14	Medical Officer	09	Trained Nurse	15	Ast. Med. Officer (AMO)	10	Aux. Nurse/Med Attnd.	16	Clinical Officer	11	Clinical Assistant	31	RN/Nursing Officer	12			Other _____		96		<p>PROVIDER CATEGORY </p> <p>SEX OF PROVIDER </p> <p>PROVIDER SL NUMBER </p>
Consultant	01	NurseMidwife ...	13																										
Medical Doctor	08	Public Health Nurse	14																										
Medical Officer	09	Trained Nurse	15																										
Ast. Med. Officer (AMO)	10	Aux. Nurse/Med Attnd.	16																										
Clinical Officer	11	Clinical Assistant	31																										
RN/Nursing Officer	12																												
Other _____		96																											
3. Information About Observation																													
<p>Date: _____</p> <p>Name of the observer: _____</p> <p>Client code: _____</p>	<p>DAY </p> <p>MONTH </p> <p>YEAR </p> <p>OBSERVER CODE </p> <p>CLIENT CODE </p>																												

4. Observation of Family Planning Consultation			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>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.</p> <p>READ TO PROVIDER: Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health facilities 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.</p> <p>Information from this observation is confidential. Neither your name or that of the client will be recorded. The information acquired during this observation, however, may be used by the MOH or organizations supporting services in this facility, for planning service improvements or further studies of health services. Information from this observation may be provided to researchers for analyses, however, the information will be provided in such a way that neither you, this facility, nor the client can be identified. Any reports that use information from this observation will only present information in aggregate form as an additional safeguard for confidentiality.</p> <p>Do you have any questions for me? Do you understand that if, at any point you feel uncomfortable, you can ask me to leave? Do I have your permission to be present at this consultation?</p> <p style="text-align: right;">Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES 1 NO 2	→ STOP
	<p>READ TO CLIENT: Hello, I am _____. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. I would like to be present while you are receiving services today, in order to better understand how health care is provided.</p> <p>We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility in particular, but rather are trying to gain a picture of the overall situation in order to improve services. Information from this observation may be provided to researchers for analyses, but 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.</p> <p>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.</p> <p>After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do you understand that if, at any point you feel uncomfortable, you can ask me to leave? Do I have your permission to be present at this consultation?</p> <p style="text-align: right;">Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)</p>		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES 1 NO 2	→ STOP
102	RECORD THE TIME THE OBSERVATION STARTED		<div style="border: 1px solid black; display: inline-block; width: 30px; height: 30px; text-align: center; vertical-align: middle;"> </div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 30px; text-align: center; vertical-align: middle;"> </div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 30px; text-align: center; vertical-align: middle;"> </div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 30px; text-align: center; vertical-align: middle;"> </div>

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 CLINIC.	1	2	8		
02	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	Current pregnancy status	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	Take the client's blood pressure	1	2	8		
02	Weigh the client	1	2	8		
03	Ask the client about smoking	1	2	8		
04	Ask the client about symptoms of STIs (e.g., abnormal discharge)	1	2	8		
05	Ask the client about chronic illnesses (heart disease, diabetes, hypertension, liver or jaundice problem, breast cancer)	1	2	8		
06	Look 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	Ensure visual privacy	1	2	8	
02	Ensure auditory privacy	1	2	8	
03	Assure the client orally of confidentiality	1	2	8	
04	Ask 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 partners for client or for client's partner; partner's absence)	1	2	8	
03	Risk of STIs	1	2	8	
04	Use of condoms to prevent STIs	1	2	8	
05	Using condoms as well as or along with another method (dual method) to attempt to prevent STIs	1	2	8	
109	<p>INDICATE WHICH METHOD(S) WERE PROVIDED OR PRESCRIBED DURING THIS VISIT. IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.</p> <p>[IF CLIENT IS CONTINUING CLIENT WHO RECEIVED REFILLS FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUD DURING THIS VISIT, CIRCLE THE METHOD THAT WAS REPLENISHED]</p>	COMBINED PILL A PROGESTIN-ONLY PILL B PILL (TYPE UNSPECIFIED) C MALE CONDOM D FEMALE CONDOM E IUD F SPERMICIDE G DIAPHRAGM H INJECTABLE DEPO PROVERA I INJECTABLE NORIGYNON J IMPLANT K NATURAL METHODS (RHYTHM) L BREASTFEEDING/LAM M VASECTOMY N FEMALE STERILIZATION ... O EMERGENCY CONTRACEPTION P 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 INDICATED WAS ASSESSED OR DISCUSSED.	YES	NO	DK	NA
	PILLS OR INJECTIONS				5 → 05
01	When to take (pill daily; injection either every month or every 3 months)	1	2	8	
02	Changes that may occur with menstruation (decreased flow, 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	
	CONDOMS				5 → 10
05	Client cannot use if allergic to latex	1	2	8	
06	Can be used only one time	1	2	8	
07	Some lubricants may be used (male condom—water soluble only; female condom—any lubricant)	1	2	8	
08	Use as backup if client fears other method will fail	1	2	8	
09	Dual protection (from pregnancy and against STI)	1	2	8	
	IUD				5 → 12
10	User should regularly check string after menstruation	1	2	8	
11	May cause heavy bleeding or spotting	1	2	8	
	SPERMICIDE/FOAM				5 → 14
12	May cause irritation	1	2	8	
13	Insert before each occurrence of intercourse	1	2	8	
	IMPLANT				5 → 17
14	Good for 5 years	1	2	8	
15	Changes that may occur with menstruation (decreased flow, spotting)	1	2	8	
16	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
	RHYTHM METHOD or PERIODIC ABSTINENCE				5 → 19
17	How to identify a woman's fertile period	1	2	8	
18	No intercourse during woman's fertile period without alternative method (condom/spermicide)	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	DK	NA
	LAM				5 → 22
19	Slight risk of pregnancy during the time shortly before menstruation resumes	1	2	8	
20	Most effective with exclusive breastfeeding without menstruation	1	2	8	
21	Not effective after menstruation begins again	1	2	8	
	VASECTOMY/FEMALE STERILIZATION				5 → 25
22	Permanent: cannot impregnate or become pregnant again	1	2	8	
23	Slight discomfort at incision site may occur	1	2	8	
24	Male must use condom or some other method for the next 20 ejaculations or for 3 months	1	2	8	5
	EMERGENCY CONTRACEPTION				5 → 111
25	If vomit within 2 hours, need another dose	1	2	8	
26	If next period is unusually light or fails to occur within 4 weeks, return for pregnancy check	1	2	8	
27	First dose to be taken within 72 hours of contact	1	2	8	
28	Second dose should be taken 12 hours after first dose	1	2	8	
29	Regimen not to be repeated/taken more than three times in any one month	1	2	8	
111	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD.	YES 1 NO 2 NO HEALTH CARD USED ... 3 DON'T KNOW 8			
112	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING 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 IUD, INJECTABLE METHOD, OR IMPLANT.	YES 1 NO 2	→ 301
202	INDICATE WHETHER CLINICAL PROVIDER IS PERSON WHO PROVIDED COUNSELING.	YES 1 NO 2	→ 206
	<p>READ TO PROVIDER: Hello, I am representing the Ministry of Health. We are carrying out a survey 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.</p> <p>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.</p> <p>Do you have any questions for me? Do I have your permission to be present during this procedure?</p> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> <p>_____ Date</p>		
203	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES 1 NO 2	→ STOP
204	RECORD THE TYPE OF PROVIDER PERFORMING MOST OF THE CLINICAL EXAMINATION.	CONSULTANT 01 MEDICAL DOCTOR 08 MEDICAL OFFICER 09 ASST. MED. OFFICER (AMO) 10 CLINICAL OFFICER 11 RN/NURSING OFFICER 12 NURSE MIDWIFE 13 PUBLIC HEALTH NURSE 14 TRAINED NURSE 15 AUX. NURSE/MED ATTND. . 16 CLINICAL ASSISTANT 31 OTHER 96 (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 IUD INSERTED/REMOVED .. B INJECTABLE GIVEN C IMPLANT INSERTED/ REMOVED D	

6. Pelvic Examination

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
207A	CHECK Q206: WAS A PELVIC EXAMINATION CONDUCTED?	YES	1	NO	2 → 208A
207	RECORD WHETHER THE FOLLOWING OCCURRED DURING OR AFTER THE EXAMINATION	YES NO NA			
01	ENSURE THAT CLIENT HAD VISUAL PRIVACY	VISUAL PRIVACY	1	2	
02	ENSURE THAT CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY	1	2	
03	EXPLAIN PROCEDURE BEFORE STARTING	EXPLAIN PROCEDURE BEFOREHAND	1	2	
04	PREPARE ALL INSTRUMENTS BEFORE STARTING PROCEDURE	PREPARED INSTRUMENTS	1	2	
05	USE STERILIZED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILIZED/HLD INSTRUMENTS	1	2	
06	WASH HIS/HER HANDS WITH SOAP BEFORE STARTING PROCEDURE	WASHED HANDS	1	2	
07	PUT ON NEW OR DISINFECTED LATEX GLOVES BEFORE STARTING PROCEDURE	PUT ON GLOVES	1	2	
08	ASK THE CLIENT TO TAKE SLOW DEEP BREATHS AND RELAX MUSCLES	ASK CLIENT TO RELAX MUSCLES	1	2	
09	INSPECT THE EXTERNAL GENITALIA	INSPECT GENITALIA	1	2	
10	EXPLAIN SPECULUM PROCEDURE (IF USED)	EXPLAIN SPECULUM	1	2	5
11	INSPECT THE CERVIX AND VAGINAL MUCOSA (USE SPECULUM AND LIGHT)	INSPECT CERVIX	1	2	5
12	PERFORM A BIMANUAL EXAMINATION (ONE HAND IN VAGINA OTHER PALPATING ABDOMEN)	BIMANUAL EXAM	1	2	
13	WASH HANDS AFTER REMOVING GLOVES	WASH HANDS AFTER	1	2	
14	WIPE CONTAMINATED SURFACES WITH DISINFECTANT	DISINFECT AREA	1	2	
15	PLACE REUSABLE GLOVES OR INSTRUMENTS IN CHLORINE SOLUTION IMMEDIATELY AFTER THE PROCEDURE.	DECONTAMINATE GLOVES OR INSTRUMENTS	1	2	

7. IUD Insertion and/or Removal

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
208A	CHECK 206: WAS AN IUD EITHER INSERTED OR REMOVED?	YES 1 NO 2	→ 210A
208	INDICATE PROCEDURE CONDUCTED.	IUD INSERTION A IUD REMOVAL B	
209	RECORD WHETHER THE FOLLOWING OCCURRED DURING OR AFTER THE EXAMINATION	YES NO NA	
01	ENSURE THAT CLIENT HAD VISUAL PRIVACY	VISUAL PRIVACY 1 2	
02	ENSURE THAT CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY 1 2	
03	EXPLAIN PROCEDURE BEFORE STARTING	EXPLAIN PROCEDURE BEFOREHAND 1 2	
04	(FOR NEW CLIENT) RECONFIRM CLIENT CHOICE OF METHOD	RECONFIRM CHOICE 1 2 5	
05	(FOR NEW CLIENT, CONFIRM CLIENT NOT PREGNANT	CONFIRM CLIENT NOT PREGNANT 1 2 5	
06	PREPARE ALL INSTRUMENTS BEFORE STARTING PROCEDURE	PREPARED INSTRUMENTS 1 2	
07	USE STERILIZED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILIZED/HLD INSTRUMENTS 1 2	
08	WASH HIS/HER HANDS WITH SOAP BEFORE STARTING PROCEDURE	WASHED HANDS 1 2	
09	PUT ON NEW OR DISINFECTED LATEX GLOVES BEFORE STARTING PROCEDURE	PUT ON GLOVES 1 2	
10	PERFORM A SPECULUM EXAM (FOR RTI OR STI) BEFORE CONDUCTING BIMANUAL EXAMINATION	SPECULUM EXAM 1 2 5	
11	PERFORM A BIMANUAL EXAMINATION (ONE HAND IN VAGINA OTHER PALPATING ABDOMEN)	BIMANUAL EXAM 1 2 5	
12	INSPECT THE CERVIX AND VAGINAL MUCOSA (USE SPECULUM AND LIGHT)	VISUALIZE CERVIX 1 2 5	
13	USE A TENACULUM	USE TENACULUM 1 2 5	
14	SOUND THE UTERUS BEFORE INSERTING IUD	SOUND UTERUS 1 2 5	
15	USE THE NO-TOUCH TECHNIQUE FOR INSERTION	NO-TOUCH TECHNIQUE 1 2 5	
16	WASH HANDS AFTER REMOVING GLOVES	WASH HANDS AFTER 1 2	
17	ASK CLIENT TO WAIT AND REST FOR 15 MINUTES AFTER INSERTION OF IUD	ASK CLIENT TO WAIT 1 2	
18	WIPE CONTAMINATED SURFACES WITH DISINFECTANT	DISINFECT AREA 1 2	
19	PLACE REUSABLE GLOVES OR INSTRUMENTS IN CHLORINE SOLUTION IMMEDIATELY AFTER THE PROCEDURE.	DECONTAMINATE GLOVES OR INSTRUMENTS 1 2	
20	WAS THE CLIENT INSTRUCTED TO REGULARLY CHECK THE STRING AFTER MENSTRUATION?	INSTRUCTED CHECK STRING 1 2 5	
21	WAS THE CLIENT TOLD THAT SHE MAY EXPERIENCE HEAVY BLEEDING OR SPOTTING WITH THE IUD?	TOLD ABOUT BLEEDING/SPOTTING 1 2 5	

8. Injectable Contraceptive

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
210A	CHECK Q206: WAS A CONTRACEPTIVE INJECTION GIVEN?	YES 1 NO 2			→ 212A
210	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:	YES	NO	NA	
01	(With a new client) Reconfirm the client's choice of method	RECONFIRM CHOICE	1	2	5
02	(With a new client) Verify that client was not pregnant	CONFIRM CLIENT NOT PREGNANT	1	2	5
03	(Continuing client) Check the client's card to ensure giving injection at correct time	ENSURE CORRECT TIMING	1	2	5
04	Wash his or her hands with soap before giving the injection	WASHED HANDS	1	2	
05	(If using reusables) Use newly reprocessed needle and syringe	USE NEW/CLEAN NEEDLE	1	2	5
06	Remove needle from multiple dose vial each time	REMOVE NEEDLE	1	2	5
07	Stir or mix the bottle <i>before</i> drawing dose (DEPO)	STIR BOTTLE	1	2	5
08	Clean and air-dry the injection site <i>before</i> injection	CLEAN AND AIR-DRY THE SITE	1	2	
09	Draw back plunger <i>before</i> giving injection	DRAW BACK PLUNGER	1	2	
10	Allow dose to self-disperse instead of massaging the site	NO MASSAGE	1	2	
11	Dispose of sharps in puncture-resistant containers	DISPOSE OF SHARPS	1	2	
211	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. Implant 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 NA	
01	Reconfirm the client's choice of method	RECONFIRM CHOICE 1 2 5	
02	Verify that client was not pregnant	CONFIRM CLIENT NOT PREGNANT 1 2 5	
03	Ensure that the client had visual privacy	VISUAL PRIVACY 1 2	
04	Ensure that the client had auditory privacy	AUDITORY PRIVACY 1 2	
05	Explain the procedure before starting it	EXPLAIN PROCEDURE BEFOREHAND 1 2	
06	Prepare all instruments before the procedure	PREPARED INSTRUMENTS 1 2	
07	Use sterilized or high-level disinfected instruments	STERILIZED/HLD INSTRUMENTS 1 2	
08	Wash his or her hands with soap, <i>before</i> the procedure	WASHED HANDS 1 2	
09	Put on sterile gloves and maintain sterility during insertion	GLOVES AND STERILITY 1 2	
10	Clean skin where incision will be made with antiseptic	USE ANTISEPTIC 1 2	
11	Use sterile towel to protect area	USE STERILE TOWEL 1 2	
12	Use new or sterilized needle and syringe for local anesthetic	USE STERILE NEEDLE 1 2	
13	Allow time for local anesthetic to take effect prior to making incision	ALLOW TIME FOR ANESTHETIC TO WORK 1 2	
14	Dispose of sharps in puncture-resistant containers	DISPOSE OF SHARPS 1 2	
15	Wipe contaminated surfaces with disinfectant	DISINFECT AREA 1 2	
16	Place reusable gloves and instruments in a chlorine solution immediately after completing the procedure	DECONTAMINATE GLOVES OR INSTRUMENTS 1 2	
17	Wash hands <i>after</i> removing gloves	WASH HANDS AFTER 1 2	
18	Explain care of incision area and removal of the bandage	EXPLAIN INCISION CARE 1 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
		YES NO NA	
19	Discuss return visit to remove plaster	DISCUSS RETURN 1 2	
20	Provide woman with card stating date implant was inserted and date when 5 years of implant would be completed	PROVIDE CARD 1 2 5	
21	WAS THE CLIENT INSTRUCTED THAT THE IMPLANT IS GOOD FOR 3-5 YEARS?	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	
214	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	

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT **Exit Interview for Family Planning Client**

1. Facility Identification

Name of the facility: _____ Location of the facility: _____	QTYPE <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">X</td> <td style="width: 20px; height: 20px; text-align: center;">F</td> <td style="width: 20px; height: 20px; text-align: center;">P</td> </tr> </table>	X	F	P
X	F	P		
FACILITY NUMBER	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			

2. Information About Interview

Date: _____ Name of the interviewer: _____ Client code: _____	DAY <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> MONTH <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> YEAR <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> INTERVIEWER CODE <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> CLIENT CODE: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>												

3. Information About Visit			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>READ TO CLIENT: Hello, I am _____. As my colleague mentioned, we are representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today.</p> <p>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.</p> <p>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. If, at any point, you would prefer I leave please feel free to tell me.</p> <p>Do you have any questions for me? Do I have your permission to continue with the interview?</p> <p>_____ Interviewer's signature Date (Indicates respondent's willingness to participate)</p>		
100	May I begin the interview?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	RECORD THE TIME THE INTERVIEW STARTED	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div> : <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div>	
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 IUD F SPERMICIDE G DIAPHRAGM H INJECTABLE DEPO-PROVERA I INJECTABLE NORIGYNON J IMPLANT K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) L BREASTFEEDING/LAM M VASECTOMY N FEMALE STERILIZATION O EMERGENCY CONTRACEPTION P OTHER X (SPECIFY)	
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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
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 IUD F SPERMICIDE G DIAPHRAGM H INJ PROGESTERONE (2-3M) I INJ NORIGYNON (1M) J IMPLANT K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) L BREASTFEEDING/LAM M VASECTOMY N FEMALE STERILIZATION O EMERGENCY CONTRACEPTION P 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	<p>What (other) family planning methods did the provider talk with you about?</p> <p>CIRCLE ALL METHODS MENTIONED.</p>	COMBINED PILL A PROGESTIN-ONLY PILL B PILL (TYPE UNSPECIFIED) . C MALE CONDOM D FEMALE CONDOM E IUD F SPERMICIDE G DIAPHRAGM H INJ PROGESTERONE (2-3M) I INJ NORIGYNON (1M) J IMPLANT K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . L BREASTFEEDING/LAM M VASECTOMY N FEMALE STERILIZATION O EMERGENCY CONTRACEPTION P OTHER X (SPECIFY) NONE Y	
116	<p>What family planning method did you either receive or get a prescription or referral for?</p> <p>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.</p> <p>CHECK PACKET OR PRESCRIPTION TO CONFIRM TYPE OF PILL OR INJECTION</p>	<div style="display: flex; justify-content: space-between;"> <u>REC</u> <u>PRES</u> </div> 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 SPERMICIDE G G DIAPHRAGM H H INJ PROGESTERONE (2-3M) I I INJ NORIGYNON (1M) J J IMPLANT K K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . L L BREASTFEEDING/LAM M M VASECTOMY N N FEMALE STERILIZATION O O EMERGENCY CONTRACEPTION P P CONTINUING WITH METHOD IN QUESTION 106 Y Y OTHER X X (SPECIFY) NO METHOD Z Z <div style="text-align: right;"> 201 201 </div> <p>[ONLY SKIP TO 201 IF BOTH "Z" ARE CIRCLED, IE, NO METHOD EITHER RECEIVED OR PRESCRIBED]. OTHERWISE CONTINUE TO Q117</p>	
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	<div style="display: flex; justify-content: space-around;"> YES NO DK </div>	
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 and 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	IUD	What should you do to make sure that your IUD is in place?	CHECK STRING 1 OTHER 2 DON'T KNOW 8	
05	Spermicide	Approximately how long before intercourse should you insert the vaginal tablet?	BETWEEN 15 MINUTES AND 1 HOUR 1 OTHER 2 DON'T KNOW 8	
06	Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	AT LEAST 6 HOURS (BUT NO LONGER THAN 24 HOURS) 1 OTHER 2 DON'T KNOW 8	
07	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	
08	Injectable (Norigynon) (monthly)	How long does the Norigynon injection provide protection from pregnancy?	1 MONTH 1 OTHER 2 DON'T KNOW 8	
09	Implant	How long does your implant provide protection against pregnancy?	3-5 YEARS 1 OTHER 2 DON'T KNOW 8	
10	Natural method (RHYTHM)	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 X DON'T KNOW Z	
11	Breastfeeding/LAM	Can you use this method if your menstrual period has returned?	YES 1 NO 2 DON'T KNOW 8	
12	Male sterilization (Vasectomy)	After you have been sterilized (and after the first 3 months), can you make a woman pregnant again?	NO 1 OTHER 2 DON'T KNOW 8	
13	Female sterilization	After you have been sterilized, could you ever become pregnant again?	NO 1 OTHER 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 <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>													
		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 large or small problems for you.														
		<table style="width: 100%; text-align: center;"> <tr> <td></td> <td></td> <td></td> <td>NO PROB- LEM</td> <td>DK</td> </tr> <tr> <td></td> <td><u>LARGE</u></td> <td><u>SMALL</u></td> <td></td> <td></td> </tr> </table>							NO PROB- LEM	DK		<u>LARGE</u>	<u>SMALL</u>		
			NO PROB- LEM	DK											
	<u>LARGE</u>	<u>SMALL</u>													
01	Time you waited	WAIT	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 any problem or method of family planning	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 or methods 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 treatment	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 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	<p>What is the total amount you paid for all services or treatments you received at this facility today?</p> <p>Please include any money you paid for services, laboratory tests, or medicines.</p>	<p>1) TOTAL AMOUNT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>PAID NO MONEY 000000</p> <p>DON'T KNOW 999998</p> <p>2) LAB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3) MEDI-CINE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4) CON-SULT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>5) OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
206	Is this the closest health facility to your home?	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→ 208</p> <p>→ 208</p>
207	What was the main reason you did not go to the nearest facility?	<p>INCONVENIENT OPERATING HOURS 01</p> <p>BAD REPUTATION 02</p> <p>DON'T LIKE PERSONNEL 03</p> <p>NO MEDICINE 04</p> <p>PREFERS TO REMAIN ANONYMOUS 05</p> <p>IT IS MORE EXPENSIVE 06</p> <p>REFERRAL 07</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p> <p>DON'T KNOW 98</p>	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	<p>YES 1</p> <p>NO 2</p>	

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 <input type="text"/> <input type="text"/>	
302	Have you ever attended school?	YES 1 NO 2	→ 305
303	What is the highest level of school you attended?	INFORMAL 1 PRIMARY 2 MIDDLE 3 SECONDARY 4 HIGHER 5	→ 305
304	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
305	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 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.	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>	
307	Interviewer's comments:		

Sample List for Family Planning Client Observation

Date

--	--	--	--	--	--	--	--

DAY
MONTH
YEAR

--	--	--

FAC #

IF THERE ARE MORE THAN 25 CLIENTS YOU MAY SIMPLY INDICATE THE TOTAL
 NUMBER OF FIRST VISIT AND TOTAL NUMBER OF FOLLOW-UP VISITS

--	--

	NAME	FIRST VISIT	FOLLOW-UP
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT **Observation of Antenatal-Care Consultation**

1. Facility Identification

<p>Name of the facility: _____</p> <p>Location of the facility: _____</p> <p>FACILITY NUMBER</p>	<p>QTYPE <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px; text-align: center;">O</td><td style="width: 20px; height: 20px; text-align: center;">A</td><td style="width: 20px; height: 20px; text-align: center;">N</td></tr></table></p> <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	O	A	N			
O	A	N					

2. Provider Information

<p>Provider category:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Consultant</td> <td style="width: 33%;">01</td> <td style="width: 33%;">Nurse Midwife . . .</td> <td style="width: 33%;">13</td> </tr> <tr> <td>Medical Doctor</td> <td>08</td> <td>Public Health Nurse</td> <td>14</td> </tr> <tr> <td>Medical Officer</td> <td>09</td> <td>Trained Nurse</td> <td>15</td> </tr> <tr> <td>Ast. Med. Officer (AMO)</td> <td>10</td> <td>Aux. Nurse/Med Attn.</td> <td>16</td> </tr> <tr> <td>Clinical Officer</td> <td>11</td> <td>Clinical Assistant</td> <td>31</td> </tr> <tr> <td>RN/Nursing Officer</td> <td>12</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Other _____</td> <td></td> <td>96</td> </tr> <tr> <td colspan="4" style="text-align: center;">(SPECIFY)</td> </tr> </table> <p>Sex of provider: (1=Male; 2=Female)</p> <p>SERIAL (SL) NUMBER FROM STAFF LISTING SHOULD BE USED. USE SAME NUMBER FOR STAFF INTERVIEW AND OBSERV.</p>	Consultant	01	Nurse Midwife . . .	13	Medical Doctor	08	Public Health Nurse	14	Medical Officer	09	Trained Nurse	15	Ast. Med. Officer (AMO)	10	Aux. Nurse/Med Attn.	16	Clinical Officer	11	Clinical Assistant	31	RN/Nursing Officer	12			Other _____			96	(SPECIFY)				<p>PROVIDER CATEGORY <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>SEX OF PROVIDER <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>PROVIDER SL NUMBER <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p>					
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RN/Nursing Officer	12																																					
Other _____			96																																			
(SPECIFY)																																						

3. Information About Observation

<p>Date: _____</p> <p>Name of the observer: _____</p> <p>Client code: _____</p>	<p>DAY <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>MONTH <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>YEAR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>OBSERVER CODE <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>CLIENT CODE <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p>											

4. Observation of Antenatal-Care Consultation			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>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.</p> <p>READ TO PROVIDER: Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health facilities 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.</p> <p>Information from this observation is confidential. Neither your name or that of the client will be recorded. The information acquired during this observation, however, may be used by the MOH or organizations supporting services in this facility, for planning service improvements or further studies of health services. Information from this observation may be provided to researchers for analyses, however, the information will be provided in such a way that neither you, this facility, nor the client can be identified. Any reports that use information from this observation will only present information in aggregate form as an additional safeguard for confidentiality.</p> <p>Do you have any questions for me? Do you understand that if, at any point you feel uncomfortable, you can ask me to leave? Do I have your permission to be present at this consultation?</p> <p style="text-align: right;">_____ Interviewer's signature Date (Indicates respondent's willingness to participate)</p>		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES 1 NO 2	→ STOP
	<p>READ TO CLIENT: Hello, I am _____. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. I would like to be present while you are receiving services today, in order to better understand how health care is provided.</p> <p>We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility in particular, but rather are trying to gain a picture of the overall situation in order to improve services. Information from this observation may be provided to researchers for analyses, but 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.</p> <p>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.</p> <p>After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do you understand that if, at any point you feel uncomfortable, you can ask me to leave? Do I have your permission to be present at this consultation?</p> <p style="text-align: right;">_____ Interviewer's signature Date (Indicates respondent's willingness to participate)</p>		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES 1 NO 2	→ STOP
102	RECORD THE TIME THE OBSERVATION STARTED	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div> : <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center; line-height: 20px;"> </div>	
103	CLIENT STATUS. (OBSERVER TO COMPLETE)	YES NO DK	
01	RECORD WHETHER THIS IS CLIENT'S FIRST VISIT FOR ANTENATAL CARE AT THIS FACILITY FOR THIS PREGNANCY.	1 2 8	
02	RECORD WHETHER THIS IS THE CLIENT'S FIRST PREGNANCY.	1 2 8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:	YES	NO	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	8	
02	Infant(s) who died in the first week of life	1	2	8	
03	Heavy bleeding, during or after delivery	1	2	8	
04	Previous assisted delivery (caesarean section, ventouse, or forceps)	1	2	8	
05	Previous abortions	1	2	8	
106	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY:				
01	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	Whether there are any other symptoms or problems the client thinks might be related to this pregnancy	1	2	8	
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				
03	Palpate the client's abdomen for fetal presentation (or conduct ultrasound)	1	2	8	
04	Palpate the client's abdomen for uterine height (or conduct ultrasound)	1	2	8	
05	Listen to the client's abdomen for fetal heartbeat	1	2	8	
06	Perform or refer for anemia test	1	2	8	
07	Perform or refer for urine test	1	2	8	
08	Perform or refer the client for a syphilis test	1	2	8	
09	Perform or refer for HIV test	1	2	8	
10	Provide or refer for counseling related to HIV test	1	2	8	
11	Look 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
108	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENTS OR COUNSELING:	YES	NO	DK	
01	Prescribe or give iron pills or folic acid (IFA) or both	1	2 05 ↙	8 05 ↘	
02	Explain the purpose of iron or folic acid	1	2	8	
03	Explain how to take iron or folic-acid pills	1	2	8	
04	Explain side effects of iron pills	1	2	8	
05	Prescribe or give a tetanus toxoid (TT) injection	1	2 07 ↙	8 07 ↘	
06	Explain the purpose of the TT injection	1	2	8	
07	Prescribe or give anti-malarial prophylaxis	1	2 13 ↙	8 13 ↘	
08	Explain the purpose of the preventive treatment with malaria medications	1	2	8	
09	Explain how to take the anti-malarial medications	1	2	8	
10	Explain possible side effects of malaria pills	1	2	8	
	DIRECT OBSERVATION:				
11	Observed that the 1st dose of IPT is given in the facility	1	2	8	
12	Importance of a second dose of IPT explained	1	2	8	
13	Importance of using ITN explained explicitly	1	2	8	
14	Given voucher for ITN	1	2 109 ↙	8 109 ↘	
15	Explanation is given about using the voucher for ITN	1	2	8	
16	Cash value of the voucher (2750 shillings) explained	1	2	8	
17	Explained where she can use the voucher to buy an ITN	1	2	8	
18	Explained she will have to pay extra money to get an ITN	1	2	8	
109	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT PREPARATIONS:	YES	NO	DK	
01	Discuss quantity or quality of food to eat during pregnancy	1	2	8	
	Mention the following signs and symptoms as risk factors for which the woman should return to the facility:	YES	NO	DK	
02	Vaginal bleeding	1	2	8	
03	Fever	1	2	8	
04	Excessive tiredness or breathlessness	1	2	8	
05	Swollen hands and face	1	2	8	
06	Severe headache or blurred vision	1	2	8	
07	Inform the client about the progress of the pregnancy	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	Ask the client where she will deliver	1 2 8	
02	Advise the client to use a skilled health worker during delivery	1 2 8	
03	Discuss with client what items to have on hand at home for delivery (including for delivery at home), e.g., sterile blades	1 2 8	
04	Discussed importance of immunization for the newborn	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 (OR BIRTH CONTROL) 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 COUNSELING 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.	WEEK OF PREGNANCY <input type="text"/> <input type="text"/> DON'T KNOW 98	
117	RECORD THE OUTCOME OF THE CONSULTATION. [RECORD THE OUTCOME AT THE TIME THE OBSERVATION CONCLUDED]	CLIENT SENT HOME 1 CLIENT REFERRED (TO LABORATORY OR OTHER PROVIDER) AT SAME FACILITY 2 CLIENT ADMITTED TO SAME FACILITY 3 CLIENT REFERRED TO OTHER FACILITY 4 DON'T KNOW 8	
118	RECORD THE TIME THE OBSERVATION ENDED.	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>	
119	Observer's comments:		

1. Facility Identification

	QTYPE	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">X</td> <td style="width: 33%; text-align: center;">A</td> <td style="width: 33%; text-align: center;">N</td> </tr> </table>	X	A	N
X	A	N			
Name of the facility: _____					
Location of the facility: _____					
FACILITY NUMBER		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; height: 40px;"></td> <td style="width: 33%; height: 40px;"></td> <td style="width: 33%; height: 40px;"></td> </tr> </table>			

<p>Date: _____</p> <p>Name of the interviewer: _____</p> <p>Client code: _____</p>	DAY	<div></div> <div></div>
	MONTH	<div></div> <div></div>
	YEAR	<div></div> <div></div>
	INTERVIEWER CODE	<div></div> <div></div>
CLIENT CODE	<div></div> <div></div>	

3. Information About Visit			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>READ TO CLIENT: Hello, I am _____. As my colleague mentioned, we are representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today.</p> <p>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.</p> <p>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. If, at any point, you would prefer I leave please feel free to tell me.</p> <p>Do you have any questions for me? Do I have your permission to continue with the interview?</p> <p>_____ Interviewer's signature Date (Indicates respondent's willingness to participate)</p>		
100	May I begin the interview now?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	RECORD THE TIME THE INTERVIEW STARTED. <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>		
102	Do you have an antenatal-care card/book, or an immunization 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	→ 105 → 105
103	CHECK ANTENATAL-CARE CARD/BOOK, OR IMMUNIZATION CARD. INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS TOXOID.	YES, 1 TIME 1 YES, 2 OR MORE TIMES 2 NO 3 DON'T KNOW 8	
104	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD?	WEEKS <input type="text"/> <input type="text"/>	→ 106
105	How many weeks pregnant do you think you are? IF RESPONSE IS IN MONTHS, CALCULATE WEEKS, USING 4 WEEKS PER MONTH.	WEEKS <input type="text"/> <input type="text"/>	
106	Is this your first pregnancy?	YES 1 NO 2	
107	Is this your first antenatal visit at this facility for this pregnancy?	YES 1 NO 2	
108	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 A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	→ 110 → 113 → 113
109	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	
110	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	
111	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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
112	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	
113	During this or previous visits, has a provider given or prescribed any anti-malarial pills for you? SHOW THE CLIENT CAPSULES OF CHLOROQUINE AND FANSIDAR.	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	→ 115 → 116 → 116
114	ASK TO SEE THE CLIENT'S ANTI-MALARIAL PILLS.	SAW PILLS 1 SAW PRESCRIPTION 2 NO PILLS OR PRESCRIPTION SEEN 3	
115	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	
116	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	
117	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 <input type="text"/> <input type="text"/> NEVER 96 DON'T KNOW 98	
118	During this visit or previous visits, has a provider discussed things you should have in preparation for your delivery? This may include planning in case of emergency, things you should bring to a facility, or things you should prepare at home for home delivery.	YES 1 NO 2	
119	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	EMERGENCY TRANSPORT ..A MONEY B DISINFECTANT C STERILE BLADE/SCISSORS TO CUT CORD D OTHER X (SPECIFY) DON'T KNOW Z	
120	Do you have money set aside for the delivery? IF YES, PROBE	YES, ENOUGH 1 YES, BUT NOT ENOUGH 2 NO 3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
121	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	→ 125 → 125
122	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	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	
123	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)	
124	Do you know any danger signs during/after delivery? IF YES: What danger signs do you know?	BLEEDING A FEVER B GENITAL INJURIES C NONE Y	
125	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	
126	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	→ 128 → 128
127	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?	MONTHS <input type="text"/> <input type="text"/> DON'T KNOW 98	
128	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	
129	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 IN A PRIVATE HOME 3 OTHER 6 (SPECIFY)(SPECIFY) DON'T KNOW 8	
130	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 us to improve 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 <input type="text"/> <input type="text"/> <input type="text"/> 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 large or small problems for you.		
		NO PROB- LARGE SMALL LEM DK	
01	Time you waited	WAIT 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 your pregnancy or any problems	EXPLAIN PROB. OR PREGNANCY 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 treatment	COST 1 2 3 8	
13	Any problem you had today that I did not mention	_____ 1 2 3 8 (SPECIFY)	
203	Are you a part of any prepayment plan (such as 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	<p>What is the total amount you paid for all services or treatments you received at this facility today?</p> <p>Please include any money you paid for services, laboratory tests, or medicines.</p>	<p>1) TOTAL AMOUNT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>PAID NO MONEY 000000</p> <p>DON'T KNOW 999998</p> <p>2) LAB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3) MEDICINE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4) CONSULT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>5) OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
206	Is this the closest health facility to your home?	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→ 208</p> <p>→ 208</p>
207	What was the main reason you did not go to the nearest facility?	<p>INCONVENIENT OPERATING HOURS 01</p> <p>BAD REPUTATION 02</p> <p>DON'T LIKE PERSONNEL ... 03</p> <p>NO MEDICINE 04</p> <p>PREFERS TO REMAIN ANONYMOUS 05</p> <p>IT IS MORE EXPENSIVE 06</p> <p>REFERRAL 07</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p> <p>DON'T KNOW 98</p>	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	<p>YES 1</p> <p>NO 2</p>	

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 <input type="text"/> <input type="text"/>	
302	Have you ever attended school?	YES 1 NO 2	→ 305
303	What is the highest level of school you attended?	INFORMAL 1 PRIMARY 2 MIDDLE 3 SECONDARY 4 HIGHER 5	→ 305
304	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
305	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 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.	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>	
307	Interviewer's comments:		

Sample List for Antenatal Care Client Observation

Date

DAY		MONTH		YEAR			

FAC #		

IF THERE ARE MORE THAN 25 CLIENTS YOU MAY SIMPLY INDICATE THE TOTAL
NUMBER OF FIRST VISIT AND TOTAL NUMBER OF FOLLOW-UP VISITS

--	--

	NAME	FIRST VISIT	FOLLOW-UP
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

1. Facility Identification		
Name of the facility:	QTYPE	<div> <div>O</div> <div>S</div> <div>I</div> </div>
Location of the facility:		
FACILITY NUMBER	<div> <div></div> <div></div> <div></div> </div>	

Provider category:		
Consultant	01	Nurse Midwife 13
Medical Doctor	08	Public Health Nurse .. 14
Medical Officer	09	Trained Nurse 15
Ast. Med. Officer (AMO)	10	Aux. Nurse/Med Attnd. 16
Clinical Officer	11	Clinical Assistant .. 31
RN/Nursing Officer	12	
Other _____		96
SPECIFY		
Sex of provider: (1=Male; 2=Female)		
SERIAL (SL) NUMBER FROM STAFF LISTING SHOULD BE USED.		
USE SAME NUMBER FOR STAFF INTERVIEW AND OBSERV.		

<p>Date: _____</p> <p>Name of the observer: _____</p> <p>Service where client is observed</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">ANC</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 30%;">SC</td> <td style="width: 10%; text-align: center;">3</td> </tr> <tr> <td>FP</td> <td style="text-align: center;">2</td> <td>STI</td> <td style="text-align: center;">4</td> </tr> </table> <p>Client code: _____</p>	ANC	1	SC	3	FP	2	STI	4	<table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">DAY</td> <td style="width: 20%; text-align: center;"> <table border="1" style="border-collapse: collapse; width: 40px; height: 30px;"> <tr><td></td></tr> </table> </td> </tr> <tr> <td>MONTH</td> <td style="text-align: center;"> <table border="1" style="border-collapse: collapse; width: 40px; height: 30px;"> <tr><td></td></tr> </table> </td> </tr> <tr> <td>YEAR</td> <td style="text-align: center;"> <table border="1" style="border-collapse: collapse; width: 80px; height: 30px;"> <tr><td></td><td></td></tr> </table> </td> </tr> </table> <p>OBSERVER CODE</p> <table border="1" style="border-collapse: collapse; width: 60px; height: 30px; margin-left: 40px;"> <tr><td></td><td></td></tr> </table> <p>SERVICE WHERE OBSERVATION OCCURRED</p> <table border="1" style="border-collapse: collapse; width: 40px; height: 30px; margin-left: 40px;"> <tr><td></td></tr> </table> <p>CLIENT CODE</p> <table border="1" style="border-collapse: collapse; width: 60px; height: 30px; margin-left: 40px;"> <tr><td></td><td></td></tr> </table>	DAY	<table border="1" style="border-collapse: collapse; width: 40px; height: 30px;"> <tr><td></td></tr> </table>		MONTH	<table border="1" style="border-collapse: collapse; width: 40px; height: 30px;"> <tr><td></td></tr> </table>		YEAR	<table border="1" style="border-collapse: collapse; width: 80px; height: 30px;"> <tr><td></td><td></td></tr> </table>							
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YEAR	<table border="1" style="border-collapse: collapse; width: 80px; height: 30px;"> <tr><td></td><td></td></tr> </table>																							

4. Observation of STI Client Consultation			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>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.</p> <p>BE AS DISCREET AS POSSIBLE DURING THE ASSESSMENT. DO NOT TAKE PART IN THE INTERACTION BETWEEN THE PROVIDER AND THE CLIENT. TRY TO SIT BEHIND THE CLIENT AND TO ONE SIDE, SO YOU WILL NOT BE SITTING DIRECTLY IN FRONT OF THE PROVIDER. FOR EACH OF THE ITEMS BELOW, CIRCLE THE ANSWER THAT BEST EXPRESSES YOUR ASSESSMENT OF WHAT HAPPENED DURING THE INTERACTION.</p> <p>READ TO PROVIDER: Hello. I am [NAME OF OBSERVER]. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health facilities with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to understand how services are provided in this facility.</p> <p>Information from this observation is confidential. Neither your name or that of the client will be recorded. The information acquired during this observation, however, may be used by the MOH or organizations supporting services in this facility, for planning service improvements or further studies of health services. Information from this observation may be provided to researchers for analyses, however, the information will be provided in such a way that neither you, this facility, nor the client can be identified. Any reports that use information from this observation will only present information in aggregate form as an additional safeguard for confidentiality.</p> <p>Do you have any questions for me? Do I have your permission to be present at this consultation?</p> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> <p>_____ Date</p>		
100	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES 1 NO 2	→ STOP
	<p>READ TO CLIENT: Hello, I am _____. I am representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. I would like to be present while you are receiving services today, in order to better understand how health care is provided.</p> <p>We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility in particular, but rather are trying to gain a picture of the overall situation in order to improve services. Information from this observation may be provided to researchers for analyses, but 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.</p> <p>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.</p> <p>Do you have any questions for me? Do I have your permission to be present at this consultation?</p> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> <p>_____ Date</p>		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES 1 NO 2	→ STOP
102	RECORD THE TIME THE OBSERVATION STARTED	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	DK	
103	RECORD WHETHER THE PROVIDER ADVISED 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	→ 109 → 110 → 110		
107	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING ACTIONS IN REGARD TO PRIVACY AND HYGIENE (FOR MALE CLIENTS)				
			YES	NO	DK NA
01	Ensure the client's visual privacy	VISUAL PRIVACY	1	2	8
02	Ensure the client's auditory privacy	AUDITORY PRIVACY	1	2	8
03	Explain the procedure to the client before beginning	EXPLAIN PROCEDURE FIRST	1	2	8
04	Wash hands with soap before conducting the examination	WASH HANDS BEFORE	1	2	8
05	Wear clean latex gloves	WEAR GLOVES	1	2	8
06	Make sure the client's genitalia were fully exposed	FULLY EXPOSED	1	2	8
07	FOR MALE CLIENTS NOT CIRCUMCISED: Retract foreskin to inspect for lesions or discharge	RETRACT FORESKIN	1	2	8 5
08	Place reusable gloves and instruments in a disinfectant solution immediately after complete procedure	DECONTAMINATE GLOVES AND INSTRUMENTS	1	2	8 5
09	Wash hands with soap after removing his/her gloves.	WASH HANDS AFTER	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
108	SKIP Q109 IF CLIENT IS MALE <input type="checkbox"/>					110
109	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING DURING THE PHYSICAL EXAMINATION FOR THE FEMALE CLIENT:	YES NO DK NA				
01	Ensure the client's visual privacy	VISUAL PRIVACY	1	2	8	
02	Ensure the client's auditory privacy	AUDITORY PRIVACY	1	2	8	
03	Explain the procedure to the client before beginning	EXPLAIN PROCEDURE FIRST	1	2	8	
04	Wash his/her hands with soap before the examination.	WASH HANDS BEFORE	1	2	8	
05	Put on new or disinfected latex gloves before the examination	PUT ON GLOVES	1	2	8	
06	Have client lie down during the examination	HAVE CLIENT LIE DOWN	1	2	8	
07	Separate and inspect labia for lesions or discharge	SEPARATE AND INSPECT LABIA	1	2	8	
08	Explain the speculum procedure (if pertinent)	EXPLAIN SPECULUM	1	2	8	5
09	Prepare all instruments before the examination	PREPARE INSTRUMENTS	1	2	8	5
10	Use sterilized (or high-level disinfected) instruments	DISINFECT INSTRUMENTS	1	2	8	5
11	Ask the client to take slow, deep breaths and relax all muscles	ASK CLIENT TO RELAX MUSCLES	1	2	8	
12	Inspect the cervix and vaginal mucosa (by aiming a light inside the inserted speculum)	INSPECT CERVIX	1	2	8	
13	Perform a bimanual exam (one hand inside the vagina and the other palpating the uterus through the abdomen)	BIMANUAL EXAMINATION	1	2	8	
14	Wash hands with soap after removing his/her gloves.	WASH HANDS AFTER	1	2	8	
15	Wash contaminated surface with disinfectant	DISINFECT AREA	1	2	8	
16	Place reusable gloves and instruments in a disinfectant solution immediately after complete procedure	DECONTAMINATE GLOVES AND INSTRUMENTS	1	2	8	5
110	RECORD WHETHER A SPECIMEN WAS TAKEN OR A LABORATORY EXAMINATION WAS ORDERED FOR THE CLIENT.	YES NO DON'T KNOW	1 2 8			→ 113 → 113
111	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	Test for HIV or AIDS	HIV/AIDS	1	2	8	
112	DID THE PROVIDER AT ANY TIME ASK THE CLIENT FOR PERMISSION TO TEST FOR AN INFECTION THAT MIGHT BE SEXUALLY TRANSMITTED OR ASK TO TEST FOR A SPECIFIC STI SUCH AS SYPHILIS OR HIV/AIDS?	YES 1 NO 2 DON'T KNOW 8				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
113	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	
114	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	→ 116 → 116
02	Give the client a prescription or medication(s) for the client's sexual partner	YES 1 NO 2 DON'T KNOW 8	
115	RECORD WHETHER THE PROVIDER INSTRUCTED THE CLIENT ON THE IMPORTANCE OF COMPLETING THE FULL COURSE OF TREATMENT	YES 1 NO 2 DON'T KNOW 8	
116	RECORD WHETHER THE CLIENT WAS ENCOURAGED TO REFER HIS/HER SEXUAL PARTNER(S) FOR TREATMENT	YES 1 NO 2 DON'T KNOW 8	
117	RECORD WHETHER THE PROVIDER GAVE THE CLIENT A FOLLOW-UP DATE ON WHICH TO RETURN FOR A REEXAMINATION	YES 1 NO 2 DON'T KNOW 8	
118	RECORD WHETHER ANY VISUAL AIDS WERE USED FOR CLIENT EDUCATION ABOUT STIs OR HIV/AIDS	YES 1 NO 2 DON'T KNOW 8	
119	RECORD WHETHER THE RISK OF HIV/AIDS WAS MENTIONED	YES 1 NO 2 DON'T KNOW 8	
120	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING IN REGARD TO STIs AND PROPHYLACTICS	YES NO DK	
01	Talk about the role of condoms in preventing STIs and HIV/AIDS transmission	DISCUSS CONDOMS 1 2 8	
02	Instruct the client on how to use condoms	INSTRUCT 1 2 8	
03	Demonstrate how to put on a condom	DEMONS- TRATE 1 2 8	
04	Offer condoms to the client	OFFER 1 2 8	
121	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD	YES 1 NO 2 NO HEALTH CARD 3 DON'T KNOW 8	

DIAGNOSIS AND CLASSIFICATION AND TREATMENT

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
201	<p>EXPLAIN TO THE PROVIDER THAT YOU WANT TO ASK A FEW QUESTIONS ABOUT THE DIAGNOSIS AND THE TREATMENT PROVIDED/PRESCRIBED FOR THE CLIENT.</p> <p>Which of the following best describes the diagnosis you made for this client? READ EACH RESPONSE AND CIRCLE A RESPONSE FOR EACH CATEGORY THAT APPLIES.</p> <p align="center">YES NO DK</p>				
01	Bacterial vaginosis	1	2	8	
02	Cervicitis	1	2	8	
03	Candidiasis	1	2	8	
04	Trichomoniasis	1	2	8	
05	Chlamydia	1	2	8	
06	Genital ulcers	1	2	8	
08	Genital herpes	1	2	8	
09	Gonorrhea	1	2	8	
10	Syphilis	1	2	8	
11	Chancroid	1	2	8	
12	Non-specific vaginal discharge	1	2	8	
13	Non-specific urethral discharge/urethritis	1	2	8	
14	Other _____ (SPECIFY)	1	2	8	
202	<p>Which treatment did you prescribe or give the client? DO NOT READ RESPONSES. ACCEPT EITHER ORAL RESPONSE OR WRITTEN PRESCRIPTIONS OF PROVIDER.</p> <p align="center">YES NO</p> <p align="center">IF YES, WRITE DOSE: MG/DAY AND NO. DAYS</p>				
01	ACYCLOVIR, ORAL	1	<input type="checkbox"/>	2	
02	AMOXICILLIN, ORAL	1	<input type="checkbox"/>	2	
03	CEFTRIAXONE, INJ	1	<input type="checkbox"/>	2	
04	CIPROFLOXACIN, ORAL	1	<input type="checkbox"/>	2	
05	CLOTTRIMAZOLE, SUPP.	1	<input type="checkbox"/>	2	
06	DOXYCYCLINE, ORAL	1	<input type="checkbox"/>	2	
08	ERYTHROMYCIN, ORAL	1	<input type="checkbox"/>	2	
09	FAMCICLOVIR, ORAL	1	<input type="checkbox"/>	2	
10	METRONIDAZOLE, ORAL	1	<input type="checkbox"/>	2	
11	MICONAZOLE, SUPP	1	<input type="checkbox"/>	2	
12	NYSTATIN, SUPP	1	<input type="checkbox"/>	2	
13	NYSTATIN, ORAL	1	<input type="checkbox"/>	2	
14	PENICILLIN, BENZATHINE INJ	1	<input type="checkbox"/>	2	
15	SPECTINOMYCIN, INJ	1	<input type="checkbox"/>	2	
16	OTHER _____ SPECIFY ALL OTHER TREATMENTS	1	<input type="checkbox"/>	2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
203	WAS A PRESCRIPTION WRITTEN FOR CONDOMS?	YES 1 NO 2	
204	RECORD THE TIME WHEN THE OBSERVATION ENDED	<div> <div></div> <div></div> <div>.</div> <div></div> <div></div> </div>	
Observer's comments:			

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT **Exit Interview for STI Client**

1. Facility Identification

Name of the facility: _____ Location of the facility: _____ FACILITY NUMBER	QTYPE <table border="1" style="display: inline-table; text-align: center; width: 80px;"> <tr> <td style="width: 30px;">X</td> <td style="width: 30px;">S</td> <td style="width: 30px;">I</td> </tr> </table> <table border="1" style="display: inline-table; text-align: center; width: 80px;"> <tr> <td style="width: 30px;"> </td> <td style="width: 30px;"> </td> <td style="width: 30px;"> </td> </tr> </table>	X	S	I			
X	S	I					

2. Information About Interview

Date: _____ Name of the interviewer: _____ Client Code: _____	<table style="width: 100%;"> <tr> <td style="width: 80%;">DAY</td> <td><table border="1" style="display: inline-table; text-align: center; width: 40px;"> <tr><td> </td></tr> <tr><td> </td></tr> </table></td> </tr> <tr> <td>MONTH</td> <td><table border="1" style="display: inline-table; text-align: center; width: 40px;"> <tr><td> </td></tr> <tr><td> </td></tr> </table></td> </tr> <tr> <td>YEAR</td> <td><table border="1" style="display: inline-table; text-align: center; width: 60px;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table></td> </tr> </table> INTERVIEWER CODE <table border="1" style="display: inline-table; text-align: center; width: 40px;"> <tr><td> </td></tr> </table> CLIENT CODE: <table border="1" style="display: inline-table; text-align: center; width: 40px;"> <tr><td> </td></tr> </table>	DAY	<table border="1" style="display: inline-table; text-align: center; width: 40px;"> <tr><td> </td></tr> <tr><td> </td></tr> </table>			MONTH	<table border="1" style="display: inline-table; text-align: center; width: 40px;"> <tr><td> </td></tr> <tr><td> </td></tr> </table>			YEAR	<table border="1" style="display: inline-table; text-align: center; width: 60px;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table>					
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3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>READ TO CLIENT: Hello, I am _____. As my colleague mentioned, we are representing the Ministry of Health and the National Bureau of Statistics. We are doing a survey of health services in health facilities. In order to improve the services this facility offers, we would like to ask you some questions about your experience here today.</p> <p>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.</p> <p>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. If, at any point, you would prefer I leave please feel free to tell me.</p> <p>Do you have any questions for me? Do I have your permission to continue with the interview?</p> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> <p>_____ Date</p>		
100	May I begin the interview now?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	RECORD THE TIME THE INTERVIEW STARTED <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>		
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 a prescription or medications today?	YES 1 RECEIVED INJECTION BUT NO OTHER MEDICATIONS OR PRESCRIPTIONS 2 NO 3	→ 106 → 106
104	ASK TO SEE ALL MEDICATIONS THAT THE CLIENT RECEIVED AND ANY PRESCRIPTIONS NOT YET FILLED 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 6 (SPECIFY) DON'T KNOW 8	
106	Did a health worker talk to you about how to protect yourself against sexually transmitted infections 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 X (SPECIFY) DON'T KNOW Z	
108	Did the health worker offer you an HIV/AIDS test or ask you to have one done, or did you ask to have an HIV/AIDS test?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
109	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	→ 111
110	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	
111	Have you ever used condoms?	YES 1 NO 2	
112	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 large problem, a small problem, or not a problem for you to decide whether to use condoms.		
	How great a problem is each of the following about condoms	<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; justify-content: space-between;"> <div>LARGE</div> <div>SMALL</div> </div> <div> <div>NO</div> <div>PROB-</div> <div>LEM</div> <div>DK</div> </div> </div> </div>	
01	Embarrassing to purchase or obtain condoms	EMBARRASSING TO OBTAIN 1 2 3 8	
02	Difficult to dispose of	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	
113	Did you discuss with the health worker any of the issues related to using condoms that we just referred to?	YES 1 NO 2	
114	Did the health worker talk to you about condoms or mention condoms today?	YES 1 NO 2 DON'T KNOW 8	
115	Were you given any condoms today?	YES 1 NO 2	

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 us to improve 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 <input type="text"/> <input type="text"/> <input type="text"/> 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 large or small problems for you.		
		NO PROB- LEM DK LARGE SMALL	
01	Time you waited	WAIT 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 your sickness or any problems	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 treatment	COST 1 2 3 8	
13	Any problem you had today that I did not mention	_____ 1 2 3 8 (SPECIFY)	
203	Are you a part of any prepayment plan (such as 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	<p>What is the total amount you paid for all services as treatments you received at this facility today?</p> <p>Please include any money you paid for services, laboratory tests, or medicines.</p>	<p>1) TOTAL AMOUNT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>PAID NO MONEY 000000</p> <p>DON'T KNOW 999998</p> <p>2) LAB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3) MEDICINE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4) CONSULT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>5) OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
206	Is this the closest health facility to your home?	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→ 208</p> <p>→ 208</p>
207	What was the main reason you did not go to the nearest facility?	<p>INCONVENIENT OPERATING HOURS 01</p> <p>BAD REPUTATION 02</p> <p>DON'T LIKE THE PERSONNEL 03</p> <p>NO MEDICINE 04</p> <p>PREFERS TO REMAIN ANONYMOUS 05</p> <p>IT IS MORE EXPENSIVE . . . 06</p> <p>REFERRAL 07</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p> <p>DON'T KNOW 98</p>	
208	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	<p>YES 1</p> <p>NO 2</p>	

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 <input type="text"/> <input type="text"/>	
302	Have you ever attended school?	YES 1 NO 2	→ 305
303	What is the highest level of school you attended?	INFORMAL 1 PRIMARY 2 MIDDLE 3 SECONDARY 4 HIGHER 5	→ 305
304	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
305	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 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 WHEN THE INTERVIEW ENDED	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>	
307	Interviewer's comments:		

Sample List for STI Client Observation

Date

DAY		MONTH		YEAR			

FAC #		

IF THERE ARE MORE THAN 25 CLIENTS YOU MAY SIMPLY INDICATE THE TOTAL
NUMBER OF MALE AND FEMALE CLIENTS

--	--

	NAME	GENDER		SYMPTOM/DIAGNOSIS
		MALE	FEMALE	
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
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25				

HEALTH WORKER INTERVIEW			
			QRE K
Facility Number:	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	CLINIC/UNIT CODE	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
			Line # Unit #
Interviewer Code:	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	Provider SL Number:	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
DATE:	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	Provider Sex: (1=MALE; 2=FEMALE)
DAY MONTH YEAR			
		Provider Status: (1=Assigned; 2=Seconded)	
Number of ANC Observations Associated with Provider		<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
Number of FP Observations Associated with Provider		<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
Number of Sick Child Observations Associated with Provider		<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
Number of STI Observations Associated with Provider		<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
<p>READ THE FOLLOWING CONSENT FORM</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and National Bureau of Statistics to assist the government in knowing more about how services are provided in health facilities.</p> <p>Now I will read a statement explaining the survey.</p> <p>Your facility was randomly 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 and organizations supporting services in your facility, for planning service improvements or further studies of services. The information you share may also be provided to researchers for analyses, however, any reports that use your data will only present information in aggregate form so that neither you nor your facility can be identified.</p> <p>You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?</p> <p>_____ Interviewer's signature Date</p> <p>SIGNATURE OF INTERVIEWER INDICATES INFORMED CONSENT WAS PROVIDED.</p>			
100	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP
1. Education and Experience			
NO.	QUESTIONS	CODING CLASSIFICATION	
102	May I begin the interview now?	YES 1 NO 2	→ STOP
103	What year did you start working in this facility?	YEAR <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	
104	Now I would like to ask you some questions about your educational background. How many years of primary and secondary education did you complete in total?	YEARS <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	

NO.	QUESTIONS	CODING CLASSIFICATION	
105	What is your current technical qualification?	CONSULTANT 01 MEDICAL DOCTOR 08 MEDICAL OFFICER 09 ASST. MED OFFICER (AMO) 10 CLINICAL OFFICER 11 RN/NURSING OFFICER 12 NURSE MIDWIFE 13 PUBLIC HEALTH NURSE 14 TRAINED NURSE 15 AUX. NURSE/MED ATTENDANT 16 PHARMACIST 17 PHARM. TECHNICIAN 18 PHARMACY ASSISTANT 19 LAB. TECHNOLOGIST 20 LAB. TECHNICIAN 21 LAB ASSISTANT 22 NUTRITIONIST/NUTR. TECH 23 HEALTH EDU. OFFICER 24 RECORD TECH/STATS CLERK 25 HEALTH ADMIN. OFFICER 26 SOCIAL WORKER 27 HIV/AIDS COUNSELOR 28 OTHER COUNSELOR 29 PATHOLOGIST 30 CLINICAL ASSISTANT 31 OTHER STAFF PROVIDING CLIENT SERVICES 96 SPECIFY _____	
106	What year did you graduate with this qualification? IF NO TECHNICAL QUALIFICATION, ASK: What year did you complete any basic training for your current position? IF NO BASIC TRAINING, WRITE 0000.	YEAR	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
107	How many years of study were required for this qualification (AFTER COMPLETING THE BASIC EDUCATION DESCRIBED IN Q104)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS FOR YEARS AND INDICATE THE NUMBER OF MONTHS.	YEARS	<input type="text"/> <input type="text"/> MONTHS <input type="text"/> <input type="text"/>
108	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	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
109	What was your age at your last birthday?	AGE AT LAST BIRTHDAY (YRS) .	<input type="text"/> <input type="text"/>

NO.	QUESTIONS	CODING CLASSIFICATION														
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 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	Universal precautions?	1	2	3												
02	Any other training related to infection prevention?	1	2	3												
03	Health Information Systems (HIS) or reporting requirements for any service?	1	2	3 3												
04	Confidentiality and rights to non-discrimination practices for People Living with HIV/AIDS (PLHA)?	1	2	3												
201	Are you a manager or in-charge for any clinical services?	YES 1 NO 2														
202	Do you provide any client services other than conducting laboratory tests?	YES 1 ONLY LAB TESTS ... 2 NO CLIENT SERVICES OR LAB TESTS ... 3		→ 701 → STOP												
203	Now I want to ask you about services you personally provide. For each service I mention, tell me if you provide the service, and then I want to know if you have received any pre or in-service training related to the topic and during the past 3 years, even if you don't currently provide the service. Remember, I am asking about service provided as a part of your current position for this facility.															
	Do you ever provide services for [READ TOPIC]. IF INDICATED, ASK: How long have you provided this service, either in this facility or in another service setting? IF LESS THAN 1 YEAR WRITE '00'.	<table border="1"> <thead> <tr> <th colspan="2">a</th><th colspan="2">b</th></tr> <tr> <th>YES</th><th>NO</th><th colspan="2"></th></tr> </thead> <tbody> <tr> <td colspan="2"></td><td colspan="2"></td></tr> </tbody> </table>			a		b		YES	NO						
a		b														
YES	NO															
01	Diagnosis and/or treatment of STIs?	1 → b	2 ↓ 02	<table border="1"><tr><td></td><td></td></tr></table>												
02	Diagnosis and/or treatment of malaria ?	1	2													
03	Diagnosis, treatment, or follow-up for tuberculosis? IF YES, ASK: do you [READ FOLLOWING LIST OF SERVICES]	1 → b	2 ↓ 09	<table border="1"><tr><td></td><td></td></tr></table>												
04	Diagnose tuberculosis based on clinical symptoms?	1	2													
05	Diagnose tuberculosis based on sputum?	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	Do you provide any services that are designed to be Youth Friendly, that is, that have a specific aim to encourage adolescent utilization?	1	2													

NO.	QUESTIONS	CODING CLASSIFICATION		
204	Now I want to ask about any in-service or preservice training you have received during the past 3 years on any of the topics I have just mentioned. During the past three years have you received any preservice or in-service training on [READ TOPIC]? 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	Diagnosing and treating sexually transmitted infections (STIs)?	1	2	3
02	The WHO syndromic management for STIs?	1	2	3
03	Any topic related to malaria? IF YES, ASK: Did the training cover any of the following topics?	1	2	3 → 07
04	Diagnosis and treatment of malaria?	1	2	3
05	Specifically diagnosing and treating malaria in children?	1	2	3
06	Intermittent Preventive Treatment (IPT) of malaria for pregnant women?	1	2	3
07	Any topic related to tuberculosis? IF YES, ASK: Did the training cover any of the following topics?	1	2	3 → 205
08	Diagnosing tuberculosis (TB) using sputum test?	1	2	3
09	Diagnosing TB using clinical symptoms?	1	2	3
10	Prescribing treatment for TB?	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
205	Any topic specific to youth friendly services? This includes addressing psychological or health issues of particular relevance to adolescents?	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION		
3. Child Health Services				
301	In your current position, and as a part of your work for this facility, do you ever 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 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>		
303	During the past three years have you received any pre-service or in-service training on subjects related to child health or illness?	YES 1 NO 2	→ 401	
304	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	EPI/cold chain	1	2	3
02	ARI treatment	1	2	3
03	Diarrhea treatment	1	2	3
04	Malaria treatment for children	1	2	3
05	Nutrition/micronutrient deficiencies	1	2	3
06	Breast feeding (including exclusive breast-feeding)	1	2	3
07	Complementary feeding of infant	1	2	3
08	Integrated Management of Childhood Illness (IMCI)	1	2	3
09	Other training specific to 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 ever 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 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>		
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	
404	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	General counseling for family planning?	1	2	3
02	Clinical issues related to providing family planning methods?	1	2	3
03	Symptom updates related to family planning methods	1	2	3
04	Symptom management for family planning methods	1	2	3
05	Topics specific for family planning for HIV infected women?	1	2	3
06	Other family planning topics? _____	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION		
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	→ 503
		NO	2	
502	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	Prevention of mother to child transmission for HIV/AIDS	1	2	3
02	Nutrition counseling for newborn of mother with HIV/AIDS	1	2	3
03	Optimal 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 ever personally provide any antenatal or postpartum care? IF YES, INDICATE WHICH SERVICE IS PROVIDED.	YES, ANTENATAL	1	→ 505
		YES, POSTPARTUM	2	
		YES, BOTH	3	
		NO, NEITHER	4	
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 BOXED CELLS.	YEARS	<div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; vertical-align: middle;"></div>	
505	During the past three years have you received any pre-service or in-service training on subjects related to antenatal or postpartum care?	YES	1	→ 507
		NO	2	
506	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	ANC counseling (preventive or symptomatic management)	1	2	3
02	ANC services or screening	1	2	3
03	Complications of pregnancy	1	2	3
04	Symptom management for pregnancy	1	2	3
05	Management of risk pregnancies	1	2	3
06	Postpartum care	1	2	3
07	Counseling for prevention of mother to child transmission of HIV?	1	2	3
08	Antiretroviral treatment for prevention of mother to child transmission (PMTCT) of HIV?	1	2	3
09	Nutritional counseling for the newborn of mothers with HIV/AIDS?	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION		
		YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
10	Nutrition counseling for the pregnant woman with HIV/AIDS?	1	2	3
11	Other training for antenatal or postpartum care: _____ (SPECIFY)	1	2	3
507	In your current position, and as a part of your work for this facility, do you ever personally provide delivery services? By that I mean conducting the actual deliveries of newborns.	YES 1 NO 2		→ 511
508	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 <input type="text"/> <input type="text"/>		
509	During the past 6 months, approximately how many deliveries have you conducted as the principal provider (include deliveries conducted for private practice and for facility)?	TOTAL DELIVERIES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
510	When was the last time you used a partograph?	NEVER 1 IN PAST WEEK 2 IN PAST MONTH 3 IN PAST 6 MONTHS 4 OVER 6 MONTHS AGO 5 DON'T KNOW 8		
511	During the past three years have you received any pre-service or in-service training on subjects related to delivery care?	YES 1 NO 2		→ 513
512	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	Care during labor or delivery	1	2	3
02	Use of partograph	1	2	3
03	Essential obstetric care/Life saving skills	1	2	3
04	Lifesaving skills/emergency complications	1	2	3
05	Post abortion care	1	2	3
06	Optimal delivery care for preventing maternal to child transmission (PMTCT) of HIV/AIDS?	1	2	3
07	Other training related to delivery services _____ (SPECIFY)	1	2	3
513	In your current position, and as a part of your work for this facility, do you ever personally provide care for the newborn?	YES 1 NO 2		→ 515
514	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 <input type="text"/> <input type="text"/>		
515	During the past three years have you received any pre-service or in-service training on subjects related to newborn care?	YES 1 NO 2		→ 601

NO.	QUESTIONS	CODING CLASSIFICATION			
516	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS	
01	Care of the normal newborn/neonatal care	1	2	3	
02	Neonatal resuscitation	1	2	3	
03	Exclusive breastfeeding	1	2	3	
04	Nutrition for the newborn of the HIV infected woman	1	2	3	
05	Other training related to newborn health: _____ (SPECIFY)	1	2	3	
6. HIV/AIDS SERVICES					
601	Now I want to ask you about services specifically related to HIV/AIDS. IF INDICATED, ASK HOW LONG THE PROVIDER HAS BEEN PROVIDING THE SERVICE. IF LESS THAN ONE YEAR, WRITE '00'.	<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">a</div> <div style="text-align: center;">b</div> </div> <div style="display: flex; justify-content: space-between;"> <div>YES</div> <div>NO</div> <div>DURATION</div> </div>			
01	Do you provide any counseling related to HIV testing? IF YES, ASK: How long? Now, do you provide:	1 → b	2 ↓ 602	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>	
02	Pre-test counseling?	1	2		
03	Post-test counseling for HIV positive clients?	1	2		
04	Follow-up counseling for HIV, after the initial post-test counseling or emotional support?	1	2		
602	Do you provide education to patients and families on prevention of HIV/AIDS?	1	2		
01	Do you provide counseling on care and support of the HIV/AIDS infected person who is seriously ill?	1	2		
02	Do you provide nutrition counseling to HIV/AIDS infected clients?	1	2		
03	Do you yourself actually prescribe the HIV test for clients?	1	2		
603	Do you provide any services related to prevention of mother to child transmission of HIV/AIDS? IF YES: How long?	1 → b	2 ↓ 604		<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>
01	Do you provide nutrition counseling for the newborn of the HIV infected woman?	1	2		
02	Do you counsel HIV positive women about family planning?	1	2		
03	Do you ever provide or prescribe the preventive antiretroviral therapy for prevention of mother to child transmission?	1	2		
604	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 provide:	1 → b	2 ↓ 605		<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>
01	Clinical management of HIV/AIDS-related neurological disorders?	1	2		
02	Diagnosis and/or treatment of opportunistic infections?	1 → b	2 ↓ 04		<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>
03	Prescribe antiretroviral therapy (ART)?	1 → b	2 ↓ 05		<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>
04					

NO.	QUESTIONS	CODING CLASSIFICATION			
		a		b	
		YES	NO	DURATION	
05	Provide medical follow-up for clients on antiretroviral therapy?	1	2		
06	Provide adherence counseling 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	Prescribe, counsel, or provide nutritional rehabilitation for HIV/AIDS patients?	1	2		
10	Provide pediatric AIDS care?	1	2	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div>	
11	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?	1 → b	2 ↓ 12		
12	Do you either provide home based care, or provide training or support for others who provide home based care?	1	2		
605	Do you ever provide counseling or prescriptions for post-exposure prophylaxis (PEP)?	1	2		
606	Now I want to know about preservice or in-service training you have received during the past 3 years on any of the topics I have just mentioned. First I want to know about specific trainings, then, I want to know if you received any other training on the topics I mention. Did you attend [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 training for HIV/AIDS counselors (6 weeks)	1	2	3	
02	Refreshing training on HIV/AIDS counseling (2 weeks)	1	2	3	
03	Comprehensive Care and Treatment course (6 days)	1	2	3	
04	HIV/AIDS Training of trainers course (TOT), (2 weeks)	1	2	3	
05	Supervisors training course for counselors at district and regional level (VCT) (2 weeks)	1	2	3	
06	Basic training for home based care providers (3 weeks)	1	2	3	
07	Health facility home based providers training (3 weeks)	1	2	3	
08	Community based home based care providers training course (3 weeks)	1	2	3	
09	Syndromic STI care management training (2 weeks)	1	2	3	
10	Syphilis screening training (4 days)	1	2	3	
11	Indent system training on STI commodities	1	2	3	
12	Peer health education training (7 days)	1	2	3	
13	Youth friendly health service training (YFS) (2 weeks)	1	2	3	
14	HMIS training (2 weeks) (1 week in Zanzibar)	1	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION		
607	Other than any previously mentioned trainings , during the past 3 years, have you received any training related to any aspect of HIV/AIDS prevention, counseling, or care and support?	YES	1	701
		NO	2	
608	IF YES, Ask: Did any other pre or in-service education provide information about [READ TOPIC]? IF YES, ASK: was this during the past 1 year? MULTIPLE TOPICS MAY HAVE BEEN COVERED IN ONE TRAINING. MAKE SURE RESPONDENT ONLY REPORTS ON TRAINING THAT WAS A NOT A PART OF PREVIOUSLY RECORDED TRAINING COURSES.	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO TRAINING WITHIN PAST 3 YEARS
01	HIV pre-test counseling?	1	2	3
02	HIV post-test counseling?	1	2	3
03	HIV testing procedures, that is, which tests to order, and when?	1	2	3
04	Follow-up counseling, after the initial post-test counseling or emotional support for HIV/AIDS clients?	1	2	3
05	Educational needs of patients and families about HIV/AIDS care?	1	2	3
06	General nutritional counseling for HIV/AIDS clients?	1	2	3
07	Primary prevention of HIV, such as behavior change education, partner counseling, condom promotion and distribution?	1	2	3
08	Tuberculosis INH preventive therapy for HIV/AIDS clients?	1	2	3
09	Cotrim preventive therapy (CPT) for HIV/AIDS clients for pneumonia?	1	2	3
10	Clinical management of HIV/AIDS-related neurological disorders?	1	2	3
11	Diagnosis and treatment of opportunistic infections?	1	2	3
12	Prescribing antiretroviral therapy (ART)?	1	2	3
13	Ordering or prescribing laboratory tests for monitoring of ART?	1	2	3
14	Nutritional rehabilitation for HIV/AIDS patients?	1	2	3
15	Any topic specific to pediatric AIDS care?	1	2	3
16	Training on provision of palliative care, to manage symptoms of the seriously ill HIV/AIDS client?	1	2	3
17	Ordering or prescribing Post-exposure prophylaxis (PEP)?	1	2	3
18	Training on nursing care or training caregivers to provide care for HIV/AIDS patients? This might include training related to home-based care.	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION		
7. Laboratory services				
701	In your current position, and as a part of your work for this facility, do you ever personally actually conduct laboratory tests for tuberculosis or HIV/AIDS? CIRCLE 'NO' IF THE PROVIDER ONLY COLLECTS SPECIMENS.	YES	1	800
		NO	2	
702	Do you conduct any of the following laboratory tests?	^a PROVIDES SERVICE YES NO		
01	Checking sputum for tuberculosis?	1	2	
02	Any of the blood tests for HIV?	1	2	
03	Any of the laboratory tests for monitoring antiretroviral therapy?	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	800
		NO	2	
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 or hepatitis prior to transfusion?	1	2	3
05	Tests for monitoring ART	1	2	3
06	Other _____ (SPECIFY)	1	2	3
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		<input type="text"/> <input type="text"/>
801	I want to know if you can estimate how much of your time each week is spent providing services or performing tasks related to HIV/AIDS. This includes such services as counseling, testing, providing clinical care and support, providing social support services, as well as record keeping and documentation related to HIV/AIDS. When you add up all the time you spend, on average, during a normal week either providing services or performing tasks 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		<input type="text"/> <input type="text"/> <input type="text"/>

NO.	QUESTIONS	CODING CLASSIFICATION																																													
802	<p>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? By formal training I mean training where there was a structured session. This may have been conducted by this facility or external to the facility. I am interested in actual days of training. For example, a one week training usually entails 5 actual days of training, a four week training usually entails 20 days of training. IF THE TRAINING WAS LESS THAN ONE FULL DAY, ENTER 001. PROBE IF NECESSARY.</p> <p>IF NO DAYS OF TRAINING, ENTER 000</p>	NUMBER OF DAYS OF HIV/AIDS RELATED TRAINING <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>																																													
803	<p>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?</p> <p>IF YES, ASK: When was the most recent time?</p>	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 → 806 → 806																																												
804	How many times in the past six months has your work been supervised?	NUMBER OF TIMES <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>																																													
805	The last time you were personally supervised, did your supervisor do any of the following:	<table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> <tbody> <tr> <td>01 Deliver supplies</td><td>DELIVERED SUPPLIES</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>02 Check your records or reports</td><td>CHECKED RECORD</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>03 Observe your work</td><td>OBSERVED</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>04 Provide any feedback (either positive or negative) on your performance</td><td>FEEDBACK</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>05 Give you verbal feedback that you were doing your work well</td><td>VERBAL PRAISE</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>06 Provide any written comment that you were doing your work well</td><td>WRITTEN PRAISE</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>07 Provide updates on administrative or technical issues related to your work</td><td>UPDATES</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>08 Discuss problems you have encountered</td><td>DISCUSS</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		YES	NO	DK	01 Deliver supplies	DELIVERED SUPPLIES	1	2	8	02 Check your records or reports	CHECKED RECORD	1	2	8	03 Observe your work	OBSERVED	1	2	8	04 Provide any feedback (either positive or negative) on your performance	FEEDBACK	1	2	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	UPDATES	1	2	8	08 Discuss problems you have encountered	DISCUSS	1	2	8	
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806	<p>Do you have a written job description of your current job or position in this facility?</p> <p>IF YES, ASK: May I see it?</p>	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																																													

NO.	QUESTIONS	CODING CLASSIFICATION
	Finally, I would like to ask you a few additional questions about HIV/AIDS and working with clients who may have HIV/AIDS	
900	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 ANTIRETROVIRAL OR REFERRAL FOR ARVs I OTHER _____ X (SPECIFY) NOTHING Y DON'T KNOW Z
901	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
902	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 noninvasive exams on clients suspected of HIV	1 2 5 8
04	Extra precautions been taken in the sterilization 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
903	Have you ever heard the word "unyanyapaa" (stigma)?	YES 1 NO 2 → 910
904	Does stigma occur in health facilities?	YES 1 NO 2 → 906 UNCERTAIN/DON'T KNOW 8 → 906

NO.	QUESTIONS	CODING CLASSIFICATION			
905	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 STERILIZATION 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)			
906	Does stigma occur outside health facilities?	YES 1 NO 2 → 910 UNCERTAIN/DON'T KNOW 8 → 910			
907	Where have you observed or heard stigma occur?	HOUSEHOLD/FAMILY A COMMUNITY B WORKPLACE C PLACES OF WORSHIP D PLACES OF ENTERTAINMENT . . . E OTHER _____ X (SPECIFY)			
908	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)			
909	If you ever saw any of the above types of stigma happening to a client because s/he is a PLHA, would you be willing to report to higher authorities?	YES 1 NO 2 DON'T KNOW 8			
910	I don't want to know the result, but have you ever had an HIV test?	YES 1 NO 2 → 912			
911	The last time you had an HIV test, did you yourself ask for the test, was it offered to you and you accepted, or was it required?	ASK SELF 1 WAS OFFERED 2 WAS REQUIRED 8			
912	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 between? HELP THE RESPONDENT TO ESTIMATE A PERCENTAGE.	CONDOM <table border="1"><tr><td></td><td></td><td></td></tr></table> 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.					

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PROV. SL NUM	CLIN/UNIT NUMBER				Provider first name or initials	Qual- ification Code	ART	Any HIV counseling testing, PMTCT, VCT	SERVICE PROVIDED				Conduct lab tests	INTERVIEWED	
									Treatment		ANC FP Delivery	Other client services		Check if staff interview conducted	
	line	unit	HIV/AIDS related illnesses	Malaria STI TB					Yes individual						
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