

COVER SHEET			
1. Facility Identification			
001	NAME OF FACILITY _____		
002	LOCATION OF FACILITY _____		
003	REGION	<input style="width: 20px; height: 20px;" type="text"/>	
004	DISTRICT	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
006	DIVISION/SUB-COUNTY	DIVISION (URBAN)	1
		SUB-COUNTY (RURAL)	2
007	FACILITY NUMBER	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
008	TYPE OF FACILITY NATIONAL REFERRAL HOSPITAL 01 REGIONAL REFERRAL HOSPITAL 02 GENERAL HOSPITAL 03 OTHER HOSPITAL 04 HEALTH CENTER IV 05 HEALTH CENTER III 06 HEALTH CENTER II 07 OTHER _____ 96 <div style="text-align: center;">(SPECIFY)</div>		
010	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER _____ 6 <div style="text-align: center;">(SPECIFY)</div>		
2. Information about Interview			
011	Date	DAY	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
		MONTH	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
		YEAR	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
012	Name of the interviewer _____	INTERVIEWER CODE	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
013	INTERVIEWER VISITS: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;">Visit 1</div> <div style="text-align: center;">Visit 2</div> <div style="text-align: center;">Visit 3</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> DATE _____ TEAM LEADER _____ </div> <div style="width: 45%;"> _____ _____ </div> </div>		
014	RESULT CODES: 1 = COMPLETED 2 = RESPONDENT NOT AVAILABLE 3 = REFUSED 4 = PARTIALLY COMPLETED 6 = OTHER		
		RESULT CODE	<input style="width: 20px; height: 20px;" type="text"/>

3. GPS READING

- 1 TURN MACHINE ON AND WAIT UNTIL SATELITE PAGE CHANGES TO "POSITION"
- 2 WRITE ALTITUDE
- 3 PRESS "MARK"
- 4 HIGHLIGHT "AVERAGE" AND PRESS "ENTER"
- 5 HIGHLIGHT "WAYPOINT NUMBER" AND PRESS "ENTER"
- 6 ENTER 3-DIGIT FACILITY NUMBER
- 7 WAIT 5 MINUTES
- 8 HIGHLIGHT "SAVE" AND PRESS "ENTER"
- 9 PAGE TO MAIN MENU, HIGHLIGHT "WAYPOINT LIST" AND PRESS "ENTER"
- 10 HIGHLIGHT YOUR WAYPOINT
- 11 COPY INFORMATION FROM WAYPOINT LIST PAGE: THIS IS THE "AVERAGE" OF ALL THE SATELITE READINGS
- 12 BE SURE TO COPY THE WAYPOINT NAME FROM THE WAYPOINT LIST PAGE TO VERIFY THAT YOU ARE ENTERING THE CORRECT WAYPOINT INFORMATION ON THE DATA FORM

015	WAYPOINT NAME (FACILITY NUMBER)	<input type="text"/> <input type="text"/> <input type="text"/>
016	ELEVATION	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

017 LATITUDE	N/S a <input type="text"/> DEGREES/DECIM. b <input type="text" value="0"/> <input type="text"/> c <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
018 LONGITUDE	E/W a <input type="text" value="E"/> DEGREES/DECIM. b <input type="text" value="0"/> <input type="text"/> <input type="text"/> c <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

4. NUMBER OF OBSERVATION/EXIT & PROVIDER QUESTIONNAIRES COMPLETED AT FACILITY:

1	PROVIDER INTERVIEWS	<input type="text"/> <input type="text"/>
2	ANC OBSERVATION	<input type="text"/> <input type="text"/>
3	FP OBSERVATION	<input type="text"/> <input type="text"/>
4	SICK CHILD OBSERVATION	<input type="text"/> <input type="text"/>
5	STI OBSERVATION	<input type="text"/> <input type="text"/>
6	INJECTIONS	<input type="text"/> <input type="text"/>

019 CHECKED BY MONITOR/SUPERVISOR:	<input type="text"/>
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							
			Sec 12 or 13 OPD or IPD	Sec 14 HMIS	Sec 15 LAB	Sec 16 PHARM	Sec 17 TB	Sec 18 VCT	Sec 19 ART	Sec 20 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

21= MCH Clinic

06= Tuberculosis (TB)

15= Emergency/Casualty

96= Other OPD _____

07= VCT/ CT (may be stand alone)

08= PMTCT

16= Social Services Department/ home-based care/
community services (not HIV/AIDS specific)

(SPECIFY)

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							
			Sec 12 or 13	Sec 14	Sec 15	Sec 16	Sec 17	Sec 18	Sec 19	Sec 20
			OPD or IPD	HMIS	LAB	PHARM	TB	VCT	ART	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)
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	21= MCH Clinic
06= Tuberculosis (TB)	15= Emergency/Casualty	96= Other OPD _____
07= VCT/CT (may be stand alone)		(SPECIFY)
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 ped)	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)	

FACILITY NUMBER:				INTERVIEWER CODE:								
LIST ALL PROVIDERS WHO ARE PRESENT TODAY IN THIS UNIT. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND CHECK THE SERVICES THE PROVIDER OFFERS. CHECK IF PROVIDER INTERVIEWED FOR INDIVIDUAL HEALTH WORKER INTERVIEW												
PROV. SL NUM					Qual- ification Code	ART	Any HIV counseling testing, PMTCT, VCT	SERVICE PROVIDED				INTERVIEWED
								Treatment		ANC FP Delivery	Other client services	
	CLIN/UNIT NUMBER line unit	Provider first name or initials	HIV/AIDS related illnesses	Malaria STI TB								
01												
02												
03												
04												
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01 ANAESTHESIOLOGIST/ANAESTH	12 REGISTERED NURSE	23 NUTRITIONIST
02 CLINICAL OFFICER ANAESTHETIST	13 REGISTERED MIDWIFE/DBL. TRAINED NURSE	24 HEALTH EDUCATOR
03 NURSE ANAESTHETIST	14 COMPREHENSIVE NURSE	25 STATISTICIAN
04 OB/GYNAECOLOGIST	15 PUBLIC HEALTH NURSE	26 RECORDS CLERK
05 SURGEON	16 NURSING ASSISTANT	27 HOSPITAL ADMINISTRATOR
06 PEDIATRICIAN	17 NURSING AIDE	28 SOCIAL WORKER
07 OTHER PHYSICIAN SPECIALIST	18 PHARMACIST	29 HIV/AIDS COUNSELOR
08 MEDICAL OFFICER	19 PHARMACY DISPENSER	30 OTHER COUNSELOR
09 CLINICAL OFFICER	20 LABORATORY TECHNOLOGIST	31 PATHOLOGIST
10 ENROLLED NURSE	21 LABORATORY TECHNICIAN	96 OTHER CLINICAL STAFF
11 ENROLLED MIDWIFE	22 LABORATORY ASSISTANT	

FACILITY NUMBER:								INTERVIEWER CODE:					
<p>LIST ALL PROVIDERS WHO ARE PRESENT TODAY IN THIS UNIT. WRITE THE NUMBER THAT CORRESPONDS TO THE PROVIDER QUALIFICATION, AND CHECK THE SERVICES THE PROVIDER OFFERS. CHECK IF PROVIDER INTERVIEWED FOR INDIVIDUAL HEALTH WORKER INTERVIEW</p>													
PROV SL NUM.					Qual- ification Code	ART	Any HIV counseling testing, PMTCT, VCT	SERVICE PROVIDED					INTERVIEWED
	CLIN/UNIT NUMBER		Provider first name or initials	HIV/AIDS related illnesses				Malaria STI TB	ANC FP Delivery	Other client services	Conduct lab tests	CHECK IF HW INTERVIEW CONDUCTED	
	line	unit											
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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>		.		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>				
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								Treatment	Malaria	ANC FP Delivery	Other client services	
	HIV/AIDS related illnesses	STI TB										
	CLIN/UNIT NUMBER	line	unit	Provider first name or initials								
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05	SURGEON				16	NURSING ASSISTANT				27	HOSPITAL ADMINISTRATOR	
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10	ENROLLED NURSE				21	LABORATORY TECHNICIAN				96	OTHER CLINICAL STAFF	
11	ENROLLED MIDWIFE				22	LABORATORY ASSISTANT						

SECTION 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 Uganda 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 by these researchers, 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 style="width: 60%;"> <p>_____ Interviewer's signature (Indicates respondent's willingness to participate)</p> </div> <div style="width: 35%;"> <p>_____ Date</p> </div> </div>			
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	

2. Information About Services																																																																												
NO.	QUESTIONS	CODING CLASSIFICATION		GO TO																																																																								
102	How many days each week is the facility routinely open for outpatient curative services?	NUMBER OF DAYS <input type="text"/> DON'T KNOW 8																																																																										
103	Does a trained health provider live on the facility premises?	YES 1 NO 2																																																																										
104	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																																																																								
105	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																																																																								
106	Is this facility part of a network, where one of the network facilities always offers 24-hour emergency service? IF YES, ASK TO SEE SOME SCHEDULE OR NOTICE TO INFORM CLIENTS	YES, SCHEDULE/NOTICE OBSERVED 1 YES, SCHEDULE/NOTICE NOT SEEN 2 NO 3																																																																										
107	<p>Now I have some questions about staffing for this facility. Please tell me how many staff with this qualification are currently assigned to this facility and whether they are male or female staff. Then please tell me how many of these staff are part-time, both male and female. Finally, tell me the number present today, both part-time and full-time. 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.</p> <p>IF THE SEX OF THE STAFF IS NOT KNOWN, WRITE THE TOTAL NUMBER IN COL. (a).</p> <table border="1"> <thead> <tr> <th></th> <th>QUALIFICATION</th> <th>(a) ACTUAL # MALE (FT & PT)</th> <th>(b) ACTUAL # FEMALE (FT & PT)</th> <th>(c) ACTUAL # PART-TIME (M & F)</th> <th>(d) PRESENT TODAY (MALE/ FEMALE)</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Anaesthesiologist/ Anaesthetist</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>02</td> <td>Clinical Officer Anaesthetist</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>03</td> <td>Nurse Anaesthetist</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>04</td> <td>Obstetrician/ Gynaecologist</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>05</td> <td>Surgeon</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>06</td> <td>Pediatrician</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>07</td> <td>Other Physician Specialist/Consultant</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>08</td> <td>Medical Officer</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>09</td> <td>Other Clinical Officer</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>10</td> <td>Enrolled Nurse</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>11</td> <td>Enrolled Midwife</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>					QUALIFICATION	(a) ACTUAL # MALE (FT & PT)	(b) ACTUAL # FEMALE (FT & PT)	(c) ACTUAL # PART-TIME (M & F)	(d) PRESENT TODAY (MALE/ FEMALE)	01	Anaesthesiologist/ Anaesthetist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	02	Clinical Officer Anaesthetist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	03	Nurse Anaesthetist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	04	Obstetrician/ Gynaecologist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	05	Surgeon	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	06	Pediatrician	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	07	Other Physician Specialist/Consultant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	08	Medical Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	09	Other Clinical Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	10	Enrolled Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	11	Enrolled Midwife	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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12	Registered Nurse	<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"/>	
13	Registered Midwife/ Double-trained Nurse	<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"/>	
14	Comprehensive Nurse	<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"/>	
15	Public Health Nurse	<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"/>	
16	Nursing 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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
17	Nursing Aide	<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"/>	
18	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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
19	Pharmacy Dispenser	<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"/>	
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"/>	<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"/>	<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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
23	Nutritionist	<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"/>	
24	Health Educator	<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"/>	
25	Statistician	<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"/>	
26	Records 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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
27	Hospital Administrator	<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"/>	
28	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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
29	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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
30	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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
31	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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
32	Supplies 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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
33	Stores 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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	
34	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"/>	
35	All other 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"/>	
36	SUM THE NUMBER OF STAFF REPORTED IN EACH COLUMN	<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"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																												
	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 (01-35) AS NECESSARY.																																																														
108	INDICATE IF THE STAFF INFORMATION WAS PROVIDED BY SEX FOR ALL CATEGORIES	YES, ALL 1 SOME, NOT ALL 2 NO 3																																																													
109	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	→ 112																																																												
110	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="4">SERVICES</th></tr> <tr> <th></th><th colspan="2">(a)</th><th colspan="2">(b)</th></tr> <tr> <th></th><th colspan="2">HIV/AIDS</th><th colspan="2">OTHER</th></tr> <tr> <th></th><th colspan="4">ONLY</th></tr> </thead> <tbody> <tr> <td>MEDICAL OFFICER . . .</td><td><input type="text"/></td><td><input type="text"/></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><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><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><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><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><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><td><input type="text"/></td><td><input type="text"/></td></tr> <tr> <td>(SPECIFY)</td><td colspan="4"></td></tr> </tbody> </table>		SERVICES					(a)		(b)			HIV/AIDS		OTHER			ONLY				MEDICAL OFFICER . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	CLINICAL OFFICER . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NURSE . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COUNSELOR . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	LAB TECH/ ASSISTANT . . .	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	COMMUNITY WORKER	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	OTHER	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(SPECIFY)					
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OTHER	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																											
(SPECIFY)																																																															
111	SUM THE NUMBER OF SECONDED STAFF IN Q110 WHO WORK WITH THE FACILITY.	TOTALS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																																													
112	How many staff (either regular or seconded) work here who are foreign? PROBE, IF NECESSARY	NUMBER OF FOREIGN STAFF <input type="text"/> <input type="text"/> DON'T KNOW 9 8																																																													

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
113	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 <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> NO CATCHMENT AREA 9999995 DON'T KNOW SIZE OF CATCHMENT POPULATION 9999998	
114	Does this facility routinely provide inpatient care?	YES 1 NO 2	→ 116
115	Does this facility have beds for overnight observation?	YES 1 NO 2	→ 117
116	INDICATE HOW MANY BEDS OF EACH TYPE THE FACILITY HAS	NUMBER OF BEDS 1) OVERNIGHT <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> 2) ROUTINE INPATIENT <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>	
117	Does this facility have routine meetings for reviewing managerial or administrative matters?	YES 1 NO 2 DON'T KNOW 8	→ 121 → 121
118	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	→ 121
119	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	→ 121 → 121
120	SCAN THE RECORD OR MINUTES AND CIRCLE THE LETTER FOR ANY OF THE LISTED TOPICS THAT ARE MENTIONED IN THE SCANNED RECORDS/MINUTES.	ISSUES RELATED TO: ROUTINE SERVICE PROVISION . A QUALITY OF SERVICES B ROUTINE HEALTH INFORMATION . C STAFFING ISSUES D EMPLOYMENT CONDITIONS (E.G., SALARY, DUTY SCHEDULE, BENEFITS) E EQUIPMENT AND SUPPLIES . . . F FINANCES OR BUDGET G NONE OF THE ABOVE Y	
121	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	→ 124 → 124
122	How often are <i>routine</i> 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	→ 124

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
123	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	
124	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	→ 127 → 127
125	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	
126	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	
127	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 NO 2 DON'T KNOW 8	→ 131 → 131
128	Is this system implemented throughout the facility or only in specific services?	THROUGHOUT FACILITY 1 ONLY SPECIFIC SERVICES . . . 2	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
129	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.					
		<div style="text-align: center;">METHOD USED</div> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">DOCUMENT OBSERVED</div> <div style="text-align: center;">DOCUMENT REPORTED, NOT SEEN</div> <div style="text-align: center;">METHOD NOT USED</div> <div style="text-align: center;">DON'T KNOW</div> </div>				
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	
130	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 ACTIVE 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
131	Is this facility a part of any accreditation or certification program that is implemented by or from persons outside of the facility? IF YES, SPECIFY THE TYPE OF PROGRAM	YES, YELLOW STAR (Quality of Care Strategy) 1 YES, UGANDA CATHOLIC MEDICAL BUREAU 2 YES, BOTH YELLOW STAR AND UGANDA CATHOLIC MED. BUR . . 3 YES, _____ 6 (OTHER) NO 7	
132	Is there an infection control committee or a person assigned specifically for infection control? IF YES, CLARIFY THE TYPE OF INFECTION CONTROL (IC) COMMITTEE/STAFF	YES, MULTIDEPARTMENTAL COMMITTEE 1 YES, STAFF MEMBER ASSIGNED SOLELY FOR IC 2 NO SPECIAL IC COMMITTEE OR STAFF 3	→ 136
133	Do any of the infection control committee members/person have a qualification (or the equivalent qualification of [READ EACH QUALIFICATION LISTED AS A RESPONSE AND CIRCLE IF THE RESPONSE IS 'YES'.])	MEDICAL OFFICER A NURSE/MIDWIFE B PHARMACIST C LAB. TECHNOLOGIST D OTHER HEALTH PROFESSIONAL . . E NONE OF THE ABOVE Y	
134	Have any members of the infection control committee or the person assigned for infection control, received any specific training related to infection control and activities they are responsible for? IF YES, ASK IF THE TRAINING WAS PROVIDED BY THE FACILITY STAFF OR FROM OUTSIDE.	INFECTION CONTROL TRAINING (FACILITY BASEC..... A INFECTION CONTROL TRAINING (EXTERNAL) B INJECTION SAFETY TRAINING (FACILITY BASEC..... C INJECTION SAFETY TRAINING (EXTERNAL) D NO SPECIAL TRAINING Y DON'T KNOW Z	
135	Is there any documentation of meetings or reports or actions (including required data reporting from units) by the infection control committee or of staff training related to infection control? ASK ABOUT EACH RESPONSE LISTED, IF YES, ASK TO SEE THE DOCUMENTATION AND CIRCLE ALL TYPES THAT WERE OBSERVED	REPORT OF MEETING A REPORT TO PERSONS OUTSIDE COMMITTEE B DATA REPORTS RELATED TO INFECTION CONTROL ISSUES C DOCUMENTS REPORTED, NONE S..... D INSERVICE TRAINING TO STAFF ABOUT INFECTION CONTROL ISSUES E NO DOCUMENTATION Y	
136	Now I would like to ask you a few questions about external supervision this facility may have received. 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	→ 138 → 138

390 APPENDIX D

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
141	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 2 OR USER-FEES 2	→ 145
142	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 DIAGNOSIS 1 2 8	
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/ EXEMPTIONS 1 2 8	
08	Is there a system for clients to pre-pay for multiple visits for curative care?	PRE-PAY FOR MULTIPLE 1 2 8	
143	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	
145	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 (PVT OR PUBLIC) 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	
146	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	→ 148 → 148
147	Is fuel available today? ACCEPT REPORTED RESPONSE FROM KNOWLEDGEABLE RESPONDENT.	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
148	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? This might include providing a loan or cost-sharing with the patient or family	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	
149	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	→ 151 → 151
150	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	
151	Does this facility ever obtain electricity from a source other than a generator?	YES, CENTRAL SUPPLY 1 YES, SOLAR OR OTHER SOURCE. ... 2 YES, BOTH CENTRAL SUPPLY AND SOLAR 3 NO 4	→ 155
152	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	→ 154
153	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	
154	CHECK TO SEE IF THE ELECTRICITY IS FUNCTIONING NOW.	YES, FUNCTIONING 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
155	What is the most commonly used source of water for hand washing for the facility <i>at this time</i> ?	PIPED INTO FACILITY 01 PIPED ONTO FACILITY GROUNDS . . 02 PUBLIC TAP/STANDPIPE 03 TUBEWELL/BOREHOLE 04 PROTECTED DUG WELL 05 UNPROTECTED DUG WELL 06 PROTECTED SPRING 07 UNPROTECTED SPRING 08 RAINWATER 09 BOTTLED WATER 10 CART W/SMALL TANK/DRUM 11 TANKER TRUCK 12 SURFACE WATER (RIVER/DAM/LAKE/POND) 13 OTHER 96 (SPECIFY) DON'T KNOW 98 NO WATER SOURCE 00	→ 159
156	Is water outlet from this source available onsite (that is, within 500m of the facility?) REPORTED RESPONSE IS ACCEPTABLE	YES, ONSITE 1 NO 2	
157	Does the availability of water from this source vary by season?	YES 1 NO 2	
158	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES 1 NO 2	
159	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	→ 161 → 161 → 161 → 161
160	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	
161	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	→ 163
162	Is there ever access to email/internet within the facility? (REPORTED RESPONSE IS ACCEPTABLE)	YES 1 NO 2	
163	AT THIS TIME CHECK Q101 TO SEE IF THE FACILITY OFFERS HIV/AIDS RELATED SERVICES	YES 1 NO 2	→ 175
164	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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
165	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	
166	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	→ 175
167	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	→ 175
168	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	
169	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
170	What is the PEP regimen that is most commonly prescribed?	2-Drug Combinations: ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC) 01 STAVUDINE (d4T) + LAMIVUDINE (3TC) 02 STAVUDINE (d4T) + DIDANOSINE (ddI) 03 3-Drug Combinations ANY OF 1, 2 or 3 plus EFAVIRENZ (EFZ) 04 ANY OF 1, 2 or 3 plus NELFINAVIR (NFV) 05 ANY OF 1, 2 or 3 plus LOPINAVIR-RITONAVIR (LPV/r) 06 OTHER 96 (SPECIFY)	
171	ASK TO GO TO THE MAIN PLACE IN THE FACILITY WHERE PEP MEDICINES ARE STORED, AND INDICATE IF MEDICINES ARE AVAILABLE	PEP MEDICINES STORED SAME AREA AS ARVs FOR TREATMENT 1 YES, PEP MEDS STORED ELSEWHERE 2 NO PEP MEDICINES IN FACILITY .. 3	→ 175 → 175

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
180	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.							
	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			

181							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 Disinfection (HLD)	(6) Initial decontamination							
A Method	USED 1 NOT USED . . . 2 → 2	USED 1 NOT USED . . . 2 → 3	USED . . . 1 NOT USED . . . 2 → 4	USED 1 NOT USED . . . 2 → 5	USED 1 NOT USED . . . 2 → 6	USED 1 NOT USED . . . 2 → 182							
B Temperature (centigrade)	TEMPERATURE [][] AUTOMATIC 666 DON'T KNOW . . . 998	TEMPERATURE [][] AUTOMATIC 666 DON'T KNOW . . . 998											
C Pressure		PRESSURE [][] 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	JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE . . . 04 ALCOHOL 05 CHLORHEXIDINE . . . 06 GLUTARALDEHYDE . . . 07 CHLORINE TABS . . . 08 DON'T KNOW . . . 98					JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE . . . 04 ALCOHOL 05 CHLORHEXIDINE . . . 06 GLUTARALDEHYDE . . . 07 CHLORINE TABS . . . 08 DON'T KNOW . . . 98							
H Percent solution before dilution	PERCENT [][] DON'T KNOW . . . 98					PERCENT [][] DON'T KNOW . . . 98							
I Mixture, parts solution or tablets and water	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000					MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000							

HEPATITIS B VACCINE & HOME BASED MANAGEMENT OF FEVER (HBMF) STRATEGY			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I have a few questions about Hepatitis B vaccine for workers in this facility and also about protective equipment for waste handlers. I will then ask a few questions about the Home Based Management of Fever (HBMF) strategy. If for any of these questions you don't consider yourself the most appropriate to answer the questions, I will appreciate you introducing me to the most appropriate person to help me answer those questions.		
190	To the best of your knowledge, have ALL health workers in this facility received the vaccine against Hepatitis B? IF YES, PROMPT FOR "ALL" OR NOT	YES, ALL HEALTH WORKERS 1 YES, BUT NOT ALL HEALTH WORKERS 2 NO 3 DON'T KNOW 8	
190a	Have ALL waste handlers in this facility received the vaccine against Hepatitis B? IF YES, PROMPT FOR "ALL" OR NOT	YES, ALL WASTE HANDLERS 1 YES, BUT NOT ALL WASTE HANDLERS 2 NO 3 DON'T KNOW 8	
190b	Is protective equipment available for waste handlers in this facility? IF YES, ASK: What protective equipment are those? PROBE AND CIRCLE ALL THAT APPLY	RUBBER-COATED INDUSTRIAL GLOVES A LEATHER GLOVES B GOULASHES/INDUSTRIAL STRENGTH BOOTS. C SAFETY GLASSES D HARD HATS E FACE SHIELDS F DUST MASKS G APRONS H OTHER X _____ (SPECIFY) DON'T KNOW Y NO PROTECTIVE EQUIPMENT Z	
191	Now I would like to ask a few questions about the home based management of fever strategy. Does this facility participate in the home based management of fever (HBMF) strategy?	YES 1 NO 2 DON'T KNOW 8	→END →END
192	When did this facility start the HBMF strategy? Please give me the month and year	MONTH <input type="text"/> <input type="text"/> DON'T KNOW 9 8 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9 9 9 8	
193	What drug regimen does this facility use for the HBMF strategy?	HOMAPAK ONLY 1 ACTs (COARTEM) ONLY 2 BOTH HOMAPAK AND ACTs 3 OTHER 6 _____ (SPECIFY)	
194	How many villages (LCIs) are served by this facility for the HBMF strategy?	# OF LCIs <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9 9 9 8	
195	How many Community Medicine Distributors (CMDs) have been trained by this facility since the start of the HBMF strategy? PROBE FOR AN APPROXIMATE NUMBER	# OF TRAINED CMDs <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9 9 9 9 8	
196	How many CMDs that were trained are still active?	# OF ACTIVE CMDs <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9 9 9 9 8	
197	Are records maintained for patients who are seen and treated by CMDs associated with this facility? IF YES, ASK TO SEE THE RECORDS AND INDICATE WHAT TYPE OF INFORMATION IS AVAILABLE.	YES, OBSERVED 1 YES, REPORTED NOT SEEN 2 NO RECORDS MAINTAINED 3	→END →END

HEPATITIS B VACCINE & HOME BASED MANAGEMENT OF FEVER (HBMF) STRATEGY			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
198	REVIEW THE RECORDS/REGISTERS AND INDICATE WHICH INFORMATION IS AVAILABLE		
01	TOTAL # OF PATIENTS/CASES TREATED BY CDMs BETWEEN JULY 2006 AND JUNE 2007	<div> <div></div><div></div><div></div><div></div><div></div> </div> DON'T KNOW 9 9 9 9 8	
02	TOTAL # OF PATIENTS/CASES TREATED BY CDMs DURING THIS PERIOD WHO RECEIVED TREATMENT WITHIN 24HRS OF ONSET OF SYMPTOMS	<div> <div></div><div></div><div></div><div></div><div></div> </div> DON'T KNOW 9 9 9 9 8	
03	TOTAL # OF PATIENTS/CASES TREATED OR REFERRED BY CDMs DURING THIS PERIOD WHO RECOVERED	<div> <div></div><div></div><div></div><div></div><div></div> </div> DON'T KNOW 9 9 9 9 8	
04	TOTAL # OF PATIENTS/CASES TREATED OR REFERRED BY CDMs DURING THIS PERIOD WHO DIED	<div> <div></div><div></div><div></div><div></div><div></div> </div> DON'T KNOW 9 9 9 9 8	

2a. Vaccine Logistical System			
	Facility Number: <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div>	Interviewer Code: <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div>	
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>	YES, CHILDREN ONLY 1 YES, PREGNANT WOMEN ONLY 2 BOTH CHILDREN AND PREGNANT WOMEN 3 NO IMMUNIZATION SERVICES EVER PROVIDED 4	<div style="text-align: right;">Section → 2b (Q230)</div>
	<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 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 style="width: 60%;"> Interviewer's signature (Indicates respondent's willingness to participate) </div> <div style="width: 35%;"> Date </div> </div>		
201	May I begin the interview now?	YES 1 NO 2	<div style="text-align: right;">→ STOP</div>
202	Does this facility routinely store any vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided? KEEPING VACCINES 1-2 DAYS ONLY FOR IMMEDIATE USE IS NOT CONSIDERED AS STORING VACCINES	YES, STORES VACCINES 1 STORES NO VACCINES 2	<div style="text-align: right;">→ 210</div>
203	ASK TO GO WHERE VACCINES ARE STORED, AND EXPLAIN: I want to find out about your system for keeping vaccines. What type of equipment do you usually use to store your vaccines? CIRCLE ALL THAT APPLY	ELECTRIC REFRIGERATOR A KEROSENE REFRIGERATOR B GAS REFRIGERATOR C SOLAR REFRIGERATOR D COLD BOX E	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
204	INDICATE THE TEMPERATURE INSIDE THE REFRIGERATOR OR COLD BOX. IF MORE THAN ONE SYSTEM/STORAGE EQUIPMENT IS USED, SELECT THE ONE WHERE DPT-HB IS STORED AND CHECK THE TEMPERATURE	TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/> NOT OBSERVED 94 → 206 THERMOMETER NOT FUNCTIONING 95 → 206 NO THERMOMETER 96 → 206	
205	INDICATE WHETHER TEMPERATURE INSIDE COOLING UNIT IS ABOVE OR BELOW 0 (ZERO) DEGREES CENTIGRADE. FOR 0 DEGREES, CIRCLE 1.	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 → 208 NO 3 → 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 GO TO THE MAIN AREA WHERE VACCINES ARE STORED AND COLLECT INFORMATION ON VALIDATION OF THE LISTED VACCINES		VALIDATION OF COMMODITY											K MONTHS OF DATA REVIEWS WED 0-6 MO
		A PRODUCT NORMALLY CARRIED OR STOCKED AT THIS FACILITY	B VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY	C ITEMS STORED BY DATE OF EXPIRATION	D STOCK CARD AVAILABLE	E NUMBER AVAILABLE MATCHES STOCK RECORD	F VARIATION STOCK AND STORE	G ANY ZERO BALANCE OBSERVED FOR THE PAST 6 MONTHS	H REVIEW INFORMATION (RECORDED ON STOCK CARDS ONLY)* FOR THE PAST 6 MONTHS AND		I RECORD AMOUNT DISBURSED	J BALANCE TODAY	
									AMOUNT RECEIVED	AMOUNT DISBURSED			
PRODUCT & UNIT OF COUNT		Y=Yes N=No If NO, skip to next line item	Y=Yes N=No O=Stockout U=** If stockout, skip to next line item	Y=Yes N=No	Y=Yes N=No If NO, skip to next line item	Y=Yes N=No to G							
01	DPT-HB + Hib (Doses)	Y	N	Y	N	O	U	Y	N	Y	N		
02	ORAL POLIO VACCINE (OPV) (Doses)	Y	N	Y	N	O	U	Y	N	Y	N		
03	MEASLES AND DILUENT (Doses)	Y	N	Y	N	O	U	Y	N	Y	N		
04	BCG AND DILUENT (Doses)	Y	N	Y	N	O	U	Y	N	Y	N		
05	VITAMIN A CAPSULES	Y	N	Y	N	O	U	Y	N	Y	N		
06	RUBELLA (Doses)	Y	N	Y	N	O	U	Y	N	Y	N		
07	TETANUS TOXOID (Doses)	Y	N	Y	N	O	U	Y	N	Y	N		
*If information is not recorded on Stock cards/records, record 9998. Do not collect information from multiple receipts													
**U=Not All Checked, but at least one of the items randomly checked was valid													
ITEM		# OF DOSES PER VIAL/AMPOULE											
01. DPT-HB + Hib (VIAL)		2											
02. ORAL POLIO (VIAL OR AMPOULE)		20											
03. MEASLES (VIAL OR AMPOULE)		10											
04. BCG (VIAL OR AMPOULE)		20											
05. TETANUS TOXOID		20											
NOTE: MULTIPLE VIAL POLICY APPLIES TO ONLY ORAL POLIO VACCINE (OPV) AND TETANUS TOXOID (TT); IMPLYING, ONCE OPENED THEY CAN BE KEPT IN FRIDGE FOR UP TO 1 MONTH. REMAINING DOSES OF OPV AND TETANUS TOXOID ONCE OPENED IN AN OUTREACH MUST BE DISCARDED													

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
210	When was the last time that you received a routine supply of vaccines, either that you ordered, or that is part of your routine supply system?	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8	
211	Does this facility determine the quantity of vaccines needed 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	→214 →217
212	Do you always receive a standard fixed amount for each vaccine received or does the quantity you receive vary according to recent need or activity level?	QUANTITY BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8	
213	CHECK Q211 TO SEE IF '3' (BOTH) IS CIRCLED. YES <input type="checkbox"/> NO <input type="checkbox"/>		217
214	Routinely, when you order vaccines, which best describes the system you use to determine how much of each to order? Do you: - Review the amount of each vaccine remaining, and order to bring the stock amount to a pre-determined (fixed) amount? - Order exactly the same quantity each time, regardless of the existing stock? - Review the amount of each vaccine used since the previous order, and plan based on prior consumption and expected future activity? - Other _____ (SPECIFY) - Don't know	ORDER TO MAINTAIN FIXED STOCK 1 ORDER SAME AMOUNT 2 ORDER BASED ON CONSUMPTION 3 OTHER 6 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
215	<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>	
216	On average, how long does it take to receive your supplies after you have placed an order?	<p>UNDER 4 WEEKS 1</p> <p>BETWEEN 4 TO 8 WEEKS 2</p> <p>OVER 8 WEEKS 3</p>	
217	During the past 6 months, have you always, not always, but often, or almost never received the amount of vaccines that you ordered (or that you are supposed to routinely receive)?	<p>ALWAYS 1</p> <p>OFTEN 2</p> <p>ALMOST NEVER 3</p>	
218	How many vaccine carriers do you have available?	<p>ONE 1</p> <p>TWO OR MORE 2</p> <p>NONE 3</p>	→ 220
219	Are there ice packs for the vaccine carriers (four or five per carrier)?	<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>	
220	What type of injection equipment is used during routine immunization sessions at this facility?	<p>SINGLE-USE A</p> <p>STERILIZABLE B</p> <p>AUTO-DISABLE 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
230	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis, or outreach in schools for primary school children?	YES 1 NO 2	→END
<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 Q231. 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	
231	May I begin the interview?	YES 1 NO 2	→END

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
232	<p>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</i>, and how many days per month outreach services are provided (if any).</p> <p>In addition, please tell me if any of the services is provided as an outreach at schools for primary school children.</p>			
	CHILD HEALTH SERVICE (USE A 4-WEEK MONTH TO CALCULATE # OF DAYS FOR OUTREACH)	(a) FACILITY SERVICE	(b) OUTREACH (VILLAGE LEVEL SERVICES)	(c) OUTREACH AT SCHOOLS
01	Routine series of immunizations for children (DPT-HB+Hib, polio)	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
02	Routine series of immunizations for children (Measles)	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
03	BCG immunizations	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
04	Routine Vitamin A supplementation	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
05	Rubella	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
06	Tetanus Toxoid Booster	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
07	Deworming	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
08	Vision screening	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
09	Consultation or curative services for a sick child	# OF DAYS PER MONTH NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
10	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 NO SERVICE 00	# OF DAYS PER MONTH NO SERVICE 00	# OF TIMES PER YEAR NO SERVICE 00
232a	CHECK 232 AND INDICATE WHETHER ANY OF THE LISTED 01-10 SERVICES ARE OFFERED AS OUTREACH TO SCHOOLS YES <input type="checkbox"/> NO <input type="checkbox"/>			233
232b	Is parental consent required for any of these school-based outreach services?	YES 1 NO 2		
233	CHECK 232 (01a and 02a) AND INDICATE WHETHER ROUTINE CHILD IMMUNIZATIONS ARE EVER PROVIDED AT THE FACILITY (EITHER 01a OR 02a OR BOTH MUST BE CIRCLED) YES <input type="checkbox"/> NO <input type="checkbox"/>			251a
234	Are routine immunizations for children available at the facility today?	YES 1 NO 2		
235	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 2 NO 3 DON'T KNOW 8		
236	Is there a waiting area for clients receiving child immunization services where they are protected from sun and rain?	YES 1 NO 2		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
237	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	→240
238	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	Fee for the child immunization chart or record?	IMMUNIZATION 1 2 8 CHART/RECORD	
02	Fee for syringes provided by the facility?	SYRINGES 1 2 8	
03	Fee for immunization services?	IMMUNIZATION 1 2 8 SERVICE	
04	Fee for any vaccines?	VACCINE 1 2 8	
239	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	
240	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 [268] 1 YES, DATA PROVIDED IN EXAMINATION ROOM [265] 2 NO, DATA NOT YET COLLECTED 3	→242 →242

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
241	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	
01	RUNNING WATER (PIPED)	1 04 ↙	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	VACUTAINER	1	2	3	
242	OTHER ITEMS REQUIRED FOR IMMUNIZATION SERVICES	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Immunization practice in Uganda (1st Edition 2000) (National guidelines)	1	2	3	8
02	Blank, individual child immunization cards	1	2	3	8
03	Tally sheets or register sheets	1	2	3	8
04	Permanent register or summary sheets for recording immunizations	1	2 244 ↙	3 244 ↙	8 244 ↙

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
243	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		
244	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		
245	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	→ 247 → 247	
246	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		
247	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		
248	CONDITION OF CHILD IMMUNIZATION AREA	YES NO		
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1 2		
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1 2		
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1 2		
04	WALLS: REASONABLY CLEAN			
05	DOORS: NO OR MINOR DAMAGE	1 2		
06	WALLS: NO OR MINOR DAMAGE	1 2		
07	ROOF: NO OR MINOR DAMAGE	1 2		
249	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2		
250	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2 NO SHARPS CONTAINER 3		
251	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES . . . 1 YES, IN UNCOVERED CONTAINER 2 NO 3		
251a	Is there a routine "well baby" clinic where children are assessed for growth and development, and screened for early signs of disease available in this facility? By this I mean growth monitoring . CHECK Q232.10: IF GROWTH MONITORING IS AVAILABLE, THAT MEANS WELL BABY CLINICS ARE AVAILABLE SOMEPLACE IN FACILITY.	YES, IN ANOTHER LOCATION . . . 1 YES, THIS LOCATION 2 NO WELL BABY CLINIC IN FACILITY 3	→ 252	

NO.	QUESTIONS	CODING CLASSIFICATION					GO TO		
	GO TO THE AREA WHERE WELL BABY/GROWTH MONITORING SERVICES ARE PROVIDED (IF DIFFERENT FROM WHERE IMMUNIZATION SERVICES ARE OFFERED) AND SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT WELL BABY CLINICS.								
251b	How many days in a month are well baby services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	NUMBER OF DAYS <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							
251c	Are well-baby services being offered at this facility today?	YES 1 NO 2							
251d	Do you routinely check the immunization status of all infants (less than 12 months) you see at this well-baby clinic and immunize those infants who are missing some shots?	YES 1 NO 2					→ 252		
251e	Do you routinely have any of the following vaccines at well-baby clinics?. ASK TO SEE EACH ITEM	YES, OBSERVED	YES, REPORTED NOT SEEN	YES, BUT NOT AVAILABLE NOW	NO, NOT USED	DON'T KNOW			
01	DPT-HB + Hib	1	2	3	4	8			
02	ORAL POLIO VACCINE (OPV)	1	2	3	4	8			
03	MEASLES AND DILUENT	1	2	3	4	8			
04	BCG AND DILUENT	1	2	3	4	8			
05	VITAMIN A CAPSULES	1	2	3	4	8			
06	RUBELLA	1	2	3	4	8			
07	TETANUS TOXOID	1	2	3	4	8			
08	OTHER _____ (SPECIFY)	1	2	3	4	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
252	CHECK Q232(09a): DOES FACILITY PROVIDE SICK-CHILD CONSULTATIONS? YES <input type="checkbox"/> NO <input type="checkbox"/>		→ END
253	How many staff assigned to this unit have received training on IMCI guidelines?	# OF STAFF TRAINED IN IMCI <input type="text"/> NONE 00 DON'T KNOW 98	
254	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	
255	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	→258
256	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	Fee for the child health chart or record?	IMMUNIZATION CARD/RECORD 1 2 8	
02	Fee for the consultation service?	FEE FOR CONSULT 1 2 8	
03	Different fee depending on the child's diagnosis?	VARY BY DIAGNOSIS 1 2 8	
04	Fees for medications?	MEDICINES 1 2 8	
05	Fees for laboratory tests?	TESTS 1 2 8	
06	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	
257	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	
258	Is there a waiting area for clients receiving child health services where they are protected from sun and rain?	YES 1 NO 2	
259	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	→261 →261

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
260	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
261	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			
262	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			
263	Does this facility ever use blood tests to verify the diagnosis of malaria?	YES 1 NO 2			

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
264	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				

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
265	ITEMS FOR INFECTION CONTROL AND EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 04 ↙	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↙	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	VACUTAINER	1	2	3	

NO.	QUESTIONS				CODING CLASSIFICATION	GO TO
266	ASK TO SEE THE FOLLOWING MATERIALS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	IMCI Laminated forms	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	
06	Management of Un-complicated Malaria (3rd edition-2005)	1	2	3	8	
07	Uganda Clinical Guidelines	1	2	3	8	
267	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 [241] ... 1 YES, DATA PROVIDED IN : EXAMINATION ROOM [265] .. 2 NO, DATA NOT YET COLLECTED 3 NO THERAPEUTIC INJ. 4				→269 →269 →269

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
268	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 FOR INFECTION CONTROL AND INJECTIONS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 04 ↙	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	VACUTAINER	1	2	3	
269	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			→273 →273
270	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS ... 1 MORE THAN 7 DAYS OLD ... 2			
271	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			→273
272	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98			

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
273	Are there ever any meetings where service statistics for child health are discussed with staff from this clinic/unit, such as looking at changes in patterns or other items relevant to client services?	YES 1 NO 2		
274	Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH A WRITTEN REPORT/MINUTES .. B OTHER X (SPECIFY) NO OBSERVED EVIDENCE ... Y		→ 276
275	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.	WITHIN THE PAST 3 MONTHS ... 1 MORE THAN 3 MONTHS AGO .. 2 DON'T KNOW 8		
276	Are individual health records or charts maintained for sick children, such as the MF5 forms ? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN .. 2 NO 3		
277	Are curative child health services available at the facility today?	YES 1 NO 2		
278	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		
279	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		
280	CONDITION OF CHILD CURATIVE CARE SERVICE AREA AND AREA FOR THERAPEUTIC INJECTIONS	YES	NO	
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2	
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2	
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2	
04	WALLS: REASONABLY CLEAN			
05	DOORS: NO OR MINOR DAMAGE	1	2	
06	WALLS: NO OR MINOR DAMAGE	1	2	
07	ROOF: NO OR MINOR DAMAGE	1	2	
281	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2		
282	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2 NO SHARPS CONTAINER 3		
283	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES 1 YES, IN UNCOVERED CONTAINER 2 NO 3		

3a. Family Planning Services			
	Facility Number: 	Interviewer Code: 	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	Does this facility offer any family planning services—including clinical methods or counseling on natural family planning or sterilizations?	YES 1 NO 2	→END
<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. READ THE FOLLOWING TO NEW RESPONDENTS:</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the 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 style="width: 60%;"> Interviewer's signature _____ (Indicates respondent's willingness to participate) </div> <div style="width: 35%;"> Date _____ </div> </div>			
302	May I begin the interview now?	YES 1 NO 2	→END
303	How many days in a month are family planning services offered at this facility? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	NUMBER OF DAYS DON'T KNOW 98	
304	Are family planning services being offered at this facility today?	YES 1 NO 2	
305	Is there a waiting area for clients receiving family planning services where they are protected from sun and rain?	YES 1 NO 2	
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	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
307	Which of the following methods of contraception is provided, prescribed, or do you provide counseling about in this facility? If there are routine fees for any of the methods that are either provided, prescribed or counseled please tell me the amount of the fee.	IF METHOD IS EITHER PROVIDED, PRESCRIBED OR COUNSELLED AND THERE IS A FEE, ENTER AMOUNT OF FEE IN BOX. ENTER 000000 IF NO FEE ENTER 999998 IF UNABLE TO DETERMINE FEE				
		PROVIDED	PRESCRIBED /COUNSELED	AMOUNT IN USH	NOT OFFERED	
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) (eg. DEPO)	1	2		3	
05	Male condom	1	2		3	
06	Female condom	1	2		3	
07	Intrauterine device (IUD)	1	2		3	
08	Implant (6 rod, 1 rod, Implanon, Jadelle)	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	MoonBeads for Standanrd Days Method (SDM)	1	2			
14	Male sterilization (Vasectomy)	1	2		3	
15	Female sterilization (Tubal Ligation)	1	2		3	
16	Others _____ (SPECIFY)	1	2		3	
308	CHECK Q306: IS "1" CIRCLED INDICATING CLIENTS HAVE OUT-OF-POCKET CHARGES OR USER FEES? YES <input type="checkbox"/> NO <input type="checkbox"/>					311
309	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
310	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				
311	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				→313 →313
312	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	
313	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				
314	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 (such as flip charts and leaflets) 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
315	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	
316	Are any of the following guidelines or protocols for delivery of services available in the counseling room or the examination room?					
01	The National Policy Guidelines and Service Standards for Repro Health Services (2001 or 2006)	1	2	3	8	
02	Uganda Clinical Guidelines (2003)	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	
317	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				→ 321 → 321
318	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS .. 1 MORE THAN 7 DAYS OLD .. 2				
319	RECORD THE TOTAL NUMBER OF FAMILY PLANNING VISITS (NEW AND CONTINUING) DURING THE PAST 12 COMPLETED MONTHS.	TOTAL FP VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998				→ 320a
320	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q319.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98				
320a	RECORD THE NUMBER OF NEW CLIENTS , WHO RECEIVED FAMILY PLANNING SERVICES DURING THE PAST 12 COMPLETED MONTHS	NEW CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998				→ 321
320b	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q320a.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
321	Are there ever any meetings where service statistics for family planning are discussed with staff from this clinic/unit, such as looking at changes in patterns or other items relevant to client services?	YES 1 NO 2	
322	Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH A WRITTEN REPORT/MINUTES . B OTHER _____ . X (SPECIFY) NO OBSERVED EVIDENCE .. Y	→ 324
323	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.	WITHIN THE PAST 3 MONTHS .. 1 MORE THAN 3 MONTHS AGO .. 2 DON'T KNOW 8	
324	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	
325	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.		
326	IF THE SAME EXAMINATION ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN 327, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	ANTENATAL [Q438] 1 DELIVERY [Q536] 2 STI [Q628] 3 NOT PREVIOUSLY SEEN 4	→ 328 → 328 → 328

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
327	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.				
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
01	RUNNING WATER (PIPED)	1 04 ↙	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↙	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	VACUTAINER	1	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
328	OTHER EQUIPMENT	(a) AVAILABILITY		(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES NO DON'T KNOW
01	Spotlight for pelvic exam. Flashlight/torch or exam light acceptable	1 → b	2 → b	3 02 ↙	8 02 ↙	1 2 8
NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.						
02	Blood pressure apparatus	1 → b	2 → b	3 03 ↙	8 03 ↙	1 2 8
03	Stethoscope	1 → b	2 → b	3 329 ↙	8 329 ↙	1 2 8
329	CHECK Q307(07) and (08): IS "1" CIRCLED FOR EITHER QUESTION, INDICATING THE FACILITY PROVIDES IUD OR IMPLANT? YES <input type="checkbox"/> NO <input type="checkbox"/>					335
330	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	
331	CHECK Q307(07): IS "1" CIRCLED, INDICATING THAT THE FACILITY PROVIDES IUD? YES <input type="checkbox"/> NO <input type="checkbox"/>					333
332	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	Tenaculum	1	2	3	8	
05	Uterine sound	1	2	3	8	
333	CHECK Q307(08): IS "1" CIRCLED, INDICATING THAT THE FACILITY PROVIDES IMPLANT? YES <input type="checkbox"/> NO <input type="checkbox"/>					335

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
334	NOTE THE AVAILABILITY OF THE FOLLOWING ITEMS:					
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 Implant 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	
335	CHECK Q307: IS "14" OR "15" (OR BOTH) CIRCLED, INDICATING THAT THE FACILITY PROVIDES MALE OR FEMALE STERILIZATION (OR BOTH)? YES <input type="checkbox"/> NO <input type="checkbox"/>					→ 343
336	GO TO WHERE STERILIZATION PROCEDURES TAKE PLACE AND NOTE THE AVAILABILITY OF THE FOLLOWING	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	NOT APPLICABLE
	MALE STERILIZATION					5 → 04
01	NSV ringed forceps	1	2	3	8	
02	NSV dissecting forceps	1	2	3	8	
03	Local anesthetic (such as lidocaine)	1	2	3	8	
	FEMALE STERILIZATION					5 → 337
04	Uterine elevator	1	2	3	8	
05	Tubal hook	1	2	3	8	
06	Sedative	1	2	3	8	
07	Atropine	1	2	3	8	
08	Opioid analgesic	1	2	3	8	
09	Local anesthetic (such as lidocaine)	1	2	3	8	
337	Is there a register where male/female sterilization information is recorded? IF YES, ASK TO SEE THE REGISTER.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3				→ 343 → 343
338	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY FOR EITHER MALE OR FEMALE STERILIZATION?	WITHIN THE PAST 30 DAYS 1 MORE THAN 30 DAYS AGO 2 DON'T KNOW 8				
339	RECORD THE NUMBER OF MALE STERILIZATIONS DONE DURING THE PAST 12 MONTHS	TOTAL MALE STERILIZATIONS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998 NO MALE STERILIZATION 9995				→ 341 → 341
340	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q339	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98				
341	RECORD THE NUMBER OF FEMALE STERILIZATIONS DONE DURING THE PAST 12 MONTHS	TOTAL FEMALE STERILIZATIONS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998 NO FEMALE STERILIZATION 9995				→ 343 → 343
342	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q341	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98				

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
343	ASSESS CONDITION OF FP SERVICE AREA	YES	NO	
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2	
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2	
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2	
04	WALLS: REASONABLY CLEAN			
05	DOORS: NO OR MINOR DAMAGE	1	2	
06	WALLS: NO OR MINOR DAMAGE	1	2	
07	ROOF: NO OR MINOR DAMAGE	1	2	
344	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES	1 NO 2	
345	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2 NO SHARPS CONTAINER	3	
346	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES .. 1 YES, IN UNCOVERED CONTAINER . 2 NO 3		
347	Are syringes for client injections or drawing blood ever reused? IF YES, ASK: What is the final method most commonly used sterilizing syringes prior to reuse? CIRCLE ALL THAT APPLY. IF NO: CIRCLE 'Y' FOR NEVER REUSE SYRINGES	DRY-HEAT STERILIZATION .. A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E OTHER X (SPECIFY) NEVER REUSE SYRINGES Y		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
348	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	→ 357 → 351
349	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	→ 351 → 351
350	SCAN THE GUIDELINE AND CIRCLE ALL COMPONENTS THAT ARE MENTIONED OR COVERED	SOAKING TIME A PERCENT OF CHEMICAL USED ... B PROPORTIONS TO MIX C BRUSH SCRUB D NONE OF THE ABOVE Y	
351	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 [Q179-181] 1 DELIVERY [Q585-587] 2 NOT PREVIOUSLY SEEN 3 PROCESS OUTSIDE FACILITY 4 SECTION 1 [Q179-181], HOWEVER COMPLETED IN FP AREA 5 NO EQUIPMENT PROCESSED ... 7	→ 354(6) → 354(6) → 354(6) → 354(6) → 354(6)
352	What is the final method 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 AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E PROCESSED OUTSIDE FACILITY F OTHER X (SPECIFY)	→ 354(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.										
353	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 sterilization or HLD	1	2	3	8						

354 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIMEPROCESSED 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 Disinfection (HLD)	(6) Initial decontamination																																				
A	Method USED 1 NOT USED .. 2 → 2	USED 1 NOT USED .. 2 → 3	USED 1 NOT USED .. 2 → 4	USED 1 NOT USED .. 2 → 5	USED 1 NOT USED .. 2 → 6	USED 1 NOT USED .. 2 → 355																																				
B	Temperature (centigrade)	TEMPERATURE [][] AUTOMATIC 666 DON'T KNOW ... 998																																								
C	Pressure	TEMPERATURE [][] AUTOMATIC 666 → 2E DON'T KNOW 998 → 2E																																								
D	Units of pressure	PRESS- URE [][] AUTOMATIC 666 → 2E DON'T KNOW 998 → 2E																																								
E	Minutes-when equipment is not wrapped in cloth	UNITS OF PRESSURE: KG/SQ CM .. 1 ATM PRESSURE .. 2 KILOPASCAL ... 3 MILLIMETER HG .. 4	MINUTES [][][] AUTOMATIC 666 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	<table border="0"> <tr> <td>JIK</td> <td>01</td> <td>JIK</td> <td>01</td> </tr> <tr> <td>CHLORINE</td> <td>02</td> <td>CHLORINE</td> <td>02</td> </tr> <tr> <td>H2O2</td> <td>03</td> <td>H2O2</td> <td>03</td> </tr> <tr> <td>POVIDONE IODINE</td> <td>04</td> <td>POVIDONE IODINE</td> <td>04</td> </tr> <tr> <td>ALCOHOL</td> <td>05</td> <td>ALCOHOL</td> <td>05</td> </tr> <tr> <td>CHLORHEXIDINE</td> <td>06</td> <td>CHLORHEXIDINE</td> <td>06</td> </tr> <tr> <td>GLUTARALDEHYDE</td> <td>07</td> <td>GLUTARALDEHYDE</td> <td>07</td> </tr> <tr> <td>CHLORINE TABS</td> <td>08</td> <td>CHLORINE TABS</td> <td>08</td> </tr> <tr> <td>DON'T KNOW</td> <td>98</td> <td>DON'T KNOW</td> <td>98</td> </tr> </table>					JIK	01	JIK	01	CHLORINE	02	CHLORINE	02	H2O2	03	H2O2	03	POVIDONE IODINE	04	POVIDONE IODINE	04	ALCOHOL	05	ALCOHOL	05	CHLORHEXIDINE	06	CHLORHEXIDINE	06	GLUTARALDEHYDE	07	GLUTARALDEHYDE	07	CHLORINE TABS	08	CHLORINE TABS	08	DON'T KNOW	98	DON'T KNOW	98
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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>DON'T KNOW</td> <td>98</td> <td>DON'T KNOW</td> <td>98</td> </tr> </table>					PERCENT	[][]	PERCENT	[][]	DON'T KNOW	98	DON'T KNOW	98																												
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I	Mixture, parts solution or tablets and water	<table border="0"> <tr> <td>MIXTURE PARTS/L</td> <td>[][]</td> <td>MIXTURE PARTS/L</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/L	[][]	MIXTURE PARTS/L	[][]	a) DISINFECTANT	[][]	a) DISINFECTANT	[][]	b) WATER	[][]	b) WATER	[][]	DK	000	DK	000																				
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NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
355	ASK TO SEE WHERE PROCESSED EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED, PRIOR TO REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION OR CLINIC/UNIT THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "3" AND CONTINUE.	SECTION 1 [Q182] 1 DELIVERY [Q589] 2 NOT PREVIOUSLY SEEN 3				→ 357 → 357
356	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	
357	DID YOU NOTICE OR OBSERVE ANYTHING THAT WOULD SUGGEST THAT AN ATTEMPT IS BEING MADE TO STERILIZE OR PROCESS INJECTION EQUIPMENT SUCH AS NEEDLES AND SYRINGES FOR RE-USE? IF YES, CIRCLE ALL RESPONSES THAT APPLY	USED INJECTION EQUIPMENT IN STERILIZER, AUTOCLAVE, BOILER OR DISH OF WATER ... A USED INJECTION EQUIPMENT IN DRAWERS B BULGING OR DISCOLORED SYRINGES C NO EVIDENCE OF ATTEMPT Y OTHER _____ X (SPECIFY)				

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
370	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 371. 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 (Indicates respondent's willingness to participate) Date _____</p>			
371	May I begin the interview now?	YES 1 NO 2	→ STOP

372 GO TO THE MAIN AREA WHERE CONTRACEPTIVES ARE STORED AND COLLECT INFORMATION ON VALIDATION OF THE LISTED CONTRACEPTIVE COMMODITIES												VALIDATION OF COMMODITY											
A		B		C		D		E		F		G		H		I		J		K			
PRODUCT NORMALLY CARRIED OR STOCKED AT THIS FACILITY		VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY		ITEMS STORED BY DATE OF EXPIRATION		STOCK CARD AVAILABLE		NUMBER AVAILABLE MATCHES STOCK RECORD		VARIATION STOCK AND STORE		ANY ZERO BALANCE OBSERVED FOR THE PAST 6 MONTHS		REVIEW INFORMATION (RECORDED ON STOCK CARDS ONLY)* FOR THE PAST 6 MONTHS AND RECORD		AMOUNT RECEIVED		AMOUNT DISBURSED		BALANCE TODAY		MONTHS OF DATA REVIEWED 0-6 MO	
Y=Yes N=No If NO, skip to next line item		Y=Yes N=No U=** If stockout, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item		Y=Yes N=No If NO, skip to next line item	
PRODUCT & UNIT OF COUNT																							
01 Combined oral pill (Cycle)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
02 Progestin-only pill (Cycle)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
03 Combined injectable (monthly)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
04 Progestin-only inj. (2-3 monthly)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
05 Condoms (male) (Unit)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
06 Condoms (female) (Unit)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
07 Intrauterine device (IUD) (UNIT)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
08 Implant (UNIT)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
09 Spermicide		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
10 Diaphragm (Unit)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
11 MoonBeads for SDM (Cycle)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	
12 Emergency contraceptive pills (Tabs)		Y N		Y N O U		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N		Y N	

*If information is not recorded on Stock cards/records, record 9998. Do not collect information from multiple receipts

**U=Not All Checked, but at least one of the items randomly checked was valid

373	Are contraceptive supplies stored in the same location as other medicines?	YES 1 NO 2	→ 375		
374	OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OF EACH OF THE FOLLOWING CONDITIONS				
01	ARE ALL THE METHODS OFF THE FLOOR?	YES 1 NO 2			
02	ARE ALL THE METHODS PROTECTED FROM WATER?	YES 1 NO 2			
03	ARE ALL THE METHODS PROTECTED FROM THE SUN?	YES 1 NO 2			
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC).	YES 1 NO 2			
374a	ASK IF THERE IS A THERMOMETER FOR THE ROOM AND RECORD THE TEMPERATURE AT THE TIME OF THE SURVEY	TEMPERATURE <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> CENTEGRADE NOT OBSERVED 94 THERMOMETER NOT FUNCTIONING 95 NO THERMOMETER PRESENT 96			→ 374c → 374c → 374c
374b	INDICATE WHETHER TEMPERATURE IN THE ROOM IS ABOVE OR BELOW ZERO (0) DEGREES. FOR ZERO DEGREES CIRCLE "1"	POSITIVE 1 NEGATIVE 2			
374c	LOOK AT THE STORAGE AREA AND CIRCLE ALL THAT APPLY	STORAGE AREA CAN BE LOCKED A THERE IS LIMITED ACCESS B DOORS SOLID C WINDOWS HAVE BARS OR SHUTTERS D NONE OF THE ABOVE Y			
375	When was the last time that you received a routine supply of contraceptives, either that you ordered, or that is part of your routine supply system?	WITHIN PRIOR 4 WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO .. 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8			
376	Does this facility determine the quantity of each contraceptive method that it needs 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 METHOD) 3 DON'T KNOW 8	→ 379 → 381		

377	Do you always receive a standard fixed quantity of each method or does the quantity you receive vary according to recent need or activity level?	QUANTITY BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY ... 2 DON'T KNOW 8	
378	CHECK Q376 TO SEE IF '3' (BOTH) IS CIRCLED. YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 381
379	Routinely, when you order contraceptive methods, which best describes the system you use to determine how much of each to order? Do you: <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 consumption and expected future activity? - Other _____ (SPECIFY) DON'T KNOW 	ORDER TO MAINTAIN FIXED STOCK 1 ORDER SAME AMOUNT 2 ORDER BASED ON CONSUMPTION 3 OTHER 6 DON'T KNOW 8	→ 381
380	Which of the following best describes the routine system for deciding when to order contraceptive methods? Do you: <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 	PREDETERMINED LEVEL 1 FIXED TIME 2 EVERY <input type="text"/> <input type="text"/> WEEKS ORDER WHEN NEEDED 3 OTHER 6 DON'T KNOW 8	
381	On average, how long does it take to receive your supplies after you have placed an order?	UNDER 4 WEEKS 1 BETWEEN 4 TO 8 WEEKS 2 OVER 8 WEEKS 3	
382	If there is a shortage of a specific method between routine orders, what is the most common procedure followed by this facility? <ul style="list-style-type: none"> - Submit special order to normal supplier - Facility purchases from private market - Clients must purchase from outside the facility - Facility borrows from neighboring facility - None of the above 	SPECIAL ORDER 1 FACILITY PURCHASE 2 CLIENT PURCHASE OUTSIDE 3 FACILITY BORROWS 4 NONE OF THE ABOVE 5	
383	During the past 6 months, have you always, not always, but often, or almost never received the amount of each method that you ordered (or that you are supposed to routinely receive)?	ALWAYS 1 OFTEN 2 ALMOST NEVER 3	

4. Antenatal and Postpartum 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
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	→ 441
<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 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 month are antenatal-care services provided at the facility? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	NUMBER OF DAYS <input type="text"/> <input type="text"/> DON'T KNOW 98	
403	Are antenatal-care services being provided at the facility today?	YES 1 NO 2	
404	Is there a waiting area for clients receiving antenatal or postpartum care services where they are protected from sun and rain?	YES 1 NO 2	
405	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	→ 408

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
406	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for antenatal care services:	FOR ANY ITEM WHERE THERE IS A FEE, INDICATE THE AMOUNT IN THE BOXES, OR 999998 IF FEE NOT KNOWN				
		<div style="display: flex; justify-content: space-between;"> YES AMOUNT IN USH NO DON'T KNOW </div>				
01	Fee for the client health card?	ANC CARD/RECORD	1	<input type="text"/>	2	8
02	Fee for registration?	REGISTRATION	1	<input type="text"/>	2	8
03	Fee for a "resident" provider consultation service?	RESIDENT PROVIDER CONSULTATION	1	<input type="text"/>	2	8
04	Fee for a "consultant" consultation service?	CONSULTANT CONSULTATION	1	<input type="text"/>	2	8
05	Fees for Iron and/or Folic acid tablets?	IRON/FOLIC ACID	1	<input type="text"/>	2	8
06	Fees for laboratory tests for urine protein?	URINE PROTEIN	1	<input type="text"/>	2	8
07	Fees for laboratory tests for anemia?	ANEMIA	1	<input type="text"/>	2	8
08	Is there a fixed fee for ALL ANC services?	FIXED FEE	1	<input type="text"/>	2	8
09	Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS	1	<input type="text"/>	2	8
10	Is there a system for clients to pre-pay for multiple visits for care during pregnancy?	PRE-PAY FOR MULTIPLE	1	<input type="text"/>	2	8
407	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				
408	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				→410 →410
409	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	
410	Which of the following activities are performed as part of routine ANC services, that is, each client has this test at least once. INDICATE CORRECT RESPONSE FOR (B) FOR EACH TEST CONDUCTED	<div style="display: flex; justify-content: space-between;"> <div>(a) ROUTINE TESTING</div> <div>(b) ITEMS FOR TEST AVAILABLE ANC UNIT TODAY</div> </div>				
		YES	NO	DON'T KNOW	YES	NO
01	Blood test for anemia	1→ b	2→ 02	8→ 02	1	2
02	Blood test for syphilis	1→ b	2→ 03	8→ 03	1	2
03	Blood group	1→ b	2→ 04	8→ 04	1	2
04	Test for RH factor	1→ b	2→ 05	8→ 05	1	2
05	Urine test for protein	1→ b	2→ 06	8→ 06	1	2
06	Urine test for glucose	1→ b	2→ 411	8→ 411	1	2

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
411	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 treatment (IPT)	1	2	8	
02	Counseling about family planning	1	2	8	
03	Counseling about HIV/AIDS	1 PMTCT QRE	2	8	
04	Voluntary testing for HIV/AIDS	1 PMTCT QRE	2	8	
05	Preparations to make for delivery	1	2 → 413	8 → 413	
412	What routine advice is given to pregnant women about preparations to make for delivery? For each of the following, tell me whether or not women are advised or counseled:				
		YES	NO	DON'T KNOW	
01	TO PLAN FOR TRANSPORTATION	1	2	8	
02	TO SET ASIDE EMERGENCY FUNDS	1	2	8	
03	ON SUPPLIES TO BRING TO FACILITY	1	2	8	
04	ON SUPPLIES TO HAVE AT HOME	1	2	8	
05	ON ADVANTAGES OF DELIVERY IN FACILITY	1	2	8	
413	Is tetanus toxoid vaccination available all days antenatal care services are offered?	YES 1 NOT ALL ANC DAYS 2 TT NEVER OFFERED 3			→ 416
414	How many days each week are tetanus toxoid vaccinations offered at this facility?	DAYS PER WEEK <input type="text"/> LESS OFTEN THAN ONCE/WEEK ... 0 DON'T KNOW 8			
415	Is tetanus toxoid immunization available today?	YES 1 NO 2			
416	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			
417	Is there a register where information on antenatal care clients' visits is recorded? IF YES, ASK TO SEE THE REGISTER(S) WHERE ANC CLIENT INFORMATION IS RECORDED	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3			→ 422 → 422
418	SCAN THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE THE RESPONSE FOR EACH TYPE OF INFORMATION ROUTINELY RECORDED FOR ANC CLIENTS. SEARCH ALL APPLICABLE REGISTERS/RECORDS MAINTAINED ROUTINELY.	CLIENT VISIT (FIRST OR FOLLOW-UP) A IPT PROVIDED FOR MALARIA B TETANUS TOXOID PROVIDED C NONE OF THE ABOVE Y			
419	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS 1 MORE THAN 7 DAYS OLD 2			
420	RECORD THE TOTAL NUMBER OF ANTENATAL VISITS (1ST AND FOLLOW-UP) DURING THE PREVIOUS 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			→ 421a

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
421	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
421a	RECORD THE NUMBER OF FIRST VISIT ANC CLIENTS WHO RECEIVED SERVICES DURING THE PREVIOUS 12 COMPLETED MONTHS	NUMBER OF NEW CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 999998	→ 422
421b	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
422	What is the minimum number of ANC visits recommended by this clinic/unit for a normal, uncomplicated pregnancy?	ONE 1 TWO 2 THREE 3 FOUR 4 MORE THAN 4 5 NO FIXED NUMBER/DEPENDS .. 6 DON'T KNOW 8	
423	What percent of ANC clients routinely receive ANC services at least two times in the past 12 months? RECORD THE PERCENTAGE.	PERCENT WITH AT LEAST 2 ANC VISITS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	→ 425
424	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	
425	Now I would like to ask you a few questions about postpartum (PP) care or services Does this facility offer postpartum services? IF YES, ASK: Is there a register where client information from postpartum (PP) visits is recorded?	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN .. 2 NO REGISTER KEPT 3 NO PP SERVICES 4	→ 430 → 430 → 430
426	SCAN THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE THE RESPONSE FOR EACH TYPE OF INFORMATION ROUTINELY RECORDED FOR PNC CLIENTS. SEARCH ALL APPLICABLE REGISTERS/RECORDS MAINTAINED ROUTINELY.	DELIVERY DATE OR DAYS PP A ANY/NO COMPLICATIONS B TEMPERATURE C NONE OF THE ABOVE Y	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
427	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS 1 MORE THAN 7 DAYS OLD 2	
428	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	→ 430
429	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
430	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	→ 433 → 433
431	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	→ 433
432	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	
433	Are there ever any meetings where service statistics for ANC or PNC are discussed with staff from this clinic/unit, such as looking at changes in patterns or other items relevant to client services?	YES 1 NO 2	
434	Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH A WRITTEN REPORT/MINUTES .. B OTHER X (SPECIFY) NO OBSERVED EVIDENCE Y	→ 436
435	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.	WITHIN THE PAST 3 MONTHS 1 MORE THAN 3 MONTHS AGO 2 DON'T KNOW 8	
436	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	
437	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 Q438 INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q327] 1 DELIVERY [Q536] 2 STI [Q628] 3 NOT PREVIOUSLY SEEN 4	→ 439 → 439 → 439

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
438	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.				
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	RUNNING WATER (PIPED)	1 04 ↙	2	3	8
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	8
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	8
04	HAND-WASHING SOAP	1	2	3	8
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	8
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	8
07	SHARPS CONTAINER	1	2	3	8
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	8
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	8
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	8
11	DISINFECTANT (NOT YET MIXED)	1	2	3	8
12	DISPOSABLE NEEDLES	1	2	3	8
13	AUTO-DISABLE SYRINGES	1	2	3	8
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	8
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↙	2	3	8
16	AUDITORY PRIVACY	1	2	3	8
17	VISUAL PRIVACY	1	2	3	8
18	EXAMINATION TABLE	1	2	3	8
19	VACUTAINER	1	2	3	8

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
439	EQUIPMENT AND SUPPLIES	(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
NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.								
02	Blood pressure apparatus	1 → b	2 → b	3 03 ↙	8 03 ↙	1	2	8
03	Stethoscope	1 → b	2 → b	3 04 ↙	8 04 ↙	1	2	8
04	Fetal stethoscope (Pinard)	1 → b	2 → b	3 05 ↙	8 05 ↙	1	2	8
05	Adult weighing scale	1 → b	2 → b	3 06 ↙	8 06 ↙	1	2	8
06	Vaginal speculum (s)	1	2	3	8			
07	Vaginal speculum (m)	1	2	3	8			
08	Vaginal speculum (l)	1	2	3	8			
POSTPARTUM/NEWBORN								
09	Thermometer	1 → b	2 → b	3 10 ↙	8 10 ↙	1	2	8
10	Infant scale	1 → b	2 → b	3 11 ↙	8 11 ↙	1	2	8
11	Facility provided minute timer	1 → b	2 → b	3 12 ↙	8 12 ↙	1	2	8
12	Personal watch with second hand	1 → b	2 → b	3 13 ↙	8 13 ↙	1	2	8
13	Individual chart/record for infant	1	2	3	8			
14	Vitamin K	1	2	3	8			
15	Vitamin A	1	2	3	8			
MEDICINES FOR IPT								
		a				b		
		OBSERVED		REPORTED AVAILABLE, NOT SEEN	NOT AVAILABLE	STOCK OUT IN THIS SERVICE AREA IN LAST SIX MONTHS		
ALL UNITS VALID	AT LEAST ONE UNIT VALID	YES	NO			DK		
16	FANSIDAR	1 → b	2 → b	3 17 ↙	4 17 ↙	1	2	8
17	CHLOROQUINE	1 → b	2 → b	3 18 ↙	4 18 ↙	1	2	8
18	OTHER _____ (SPECIFY)	1 → b	2 → b	3 440 ↙	4 440 ↙	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
440	NOTE THE AVAILABILITY OF PROTOCOLS AND TEACHING MATERIALS.				
01	The National Policy Guidelines and Service Standards for Reproductive Health (May 2001)	1	2	3	8
02	Essential Maternal & Neonatal Care Clinical Guidelines for Uganda (July 2001)	1	2	3	8
03	Uganda Clinical Guidelines (2003)	1	2	3	8
04	Any other Guidelines or protocols for antenatal care	1	2	3	8
05	Any other guidelines or protocols for IPT?	1	2	3	8
06	Any other guidelines or protocols for family planning?	1	2	3	8
07	Guidelines for Syndromic Approach for STIs	1	2	3	8
08	Other guidelines or protocols for diagnosing or treating STIs	1	2	3	8
09	Visual aids for client education on subjects related to pregnancy or antenatal care	1	2	3	8
10	Other guidelines for postpartum care	1	2	3	8
11	Other guidelines for newborn health care	1	2	3	8
FOR THE NEXT QUESTIONS, DETERMINE THE MOST KNOWLEDGEABLE PERSON TO PROVIDE THE INFORMATION. THE BEST RESPONDENT MAY BE WITH ANC SERVICES OR WITH DELIVERY SERVICES, DEPENDING ON THE FACILITY.					
441	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			→ 445
442	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			
443	Please tell me how many TBAs report to this facility? ENTER "00" FOR "NONE"	# OF TBAs REPORTING <input type="text"/> DON'T KNOW 98			
444	Does anyone from this facility supervise the activities of the TBAs?	YES 1 NO 2 DON'T KNOW 8			
445	Do (the) TBAs refer women to this facility?	YES 1 NO 2			
446	Does the facility or ANC unit have safe delivery kits (MAMA KITS) for sale or to provide women for home births? IF YES, ASK TO SEE ONE	YES, OBSERVED 1 YES, IN STORES/PHARMACY 2 YES, REPORTED, NOT SEEN 3 NO 4			
447	Are there any community based systems to help women with obstetric emergencies either to come to the facility, or to transfer from this facility to another? IF YES, CLARIFY THE SITUATION	YES, ONLY TO BRING TO THIS FACILITY ... 1 ONLY TO TRANSFER ELSEWHERE ... 2 BOTH TO BRING HERE AND FOR TRANSFER ELSEWHERE 3 NO 4 DON'T KNOW 8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																
448	What is the most common means of transport used by women coming from their homes to this facility for help during obstetric emergencies? IF THERE IS MORE THAN ONE MOST COMMON MEANS, CIRCLE THE NUMBER FOR ALL THAT APPLY.	AMBULANCE A PRIVATE CAR/BUS B PUBLIC CAR/BUS C MOTORCYCLE (PVT OR PUBLIC) D BICYCLE E PEOPLE CARRY/PUSH OR PULL PATIENT F ANIMALS CARRY/PULL PATIENTS G OTHER X (SPECIFY) NEVER RECEIVE EMERGENCY Y DON'T KNOW Z																																	
449	Does this facility ever attempt to refer a woman outside the facility for emergency obstetric care?	YES 1 NO 2	→ 452																																
450	Please tell me if this facility has any of the following systems to support emergency obstetric referrals.	<table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>DON'T KNOW</th></tr> </thead> <tbody> <tr> <td>01 Are there any funds set aside to help clients with emergency transportation?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>02 Does the facility hire a vehicle locally to provide emergency obstetric transportation?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>03 Is there a community health insurance scheme that provides support for emergency obstetric referrals?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>04 Is fuel set aside for emergency obstetric referrals?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>05 Is there a revolving fund system for transportation for emergency obstetric referrals? This might include providing a loan or cost-sharing with the patient or family</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>06 Does the facility radio or phone another facility to send transportation for emergency obstetric referrals?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>07 Is there any other system? IF YES, SPECIFY _____</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		YES	NO	DON'T KNOW	01 Are there any funds set aside to help clients with emergency transportation?	1	2	8	02 Does the facility hire a vehicle locally to provide emergency obstetric transportation?	1	2	8	03 Is there a community health insurance scheme that provides support for emergency obstetric referrals?	1	2	8	04 Is fuel set aside for emergency obstetric referrals?	1	2	8	05 Is there a revolving fund system for transportation for emergency obstetric referrals? This might include providing a loan or cost-sharing with the patient or family	1	2	8	06 Does the facility radio or phone another facility to send transportation for emergency obstetric referrals?	1	2	8	07 Is there any other system? IF YES, SPECIFY _____	1	2	8	
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07 Is there any other system? IF YES, SPECIFY _____	1	2	8																																
451	How long does it take to get to the nearest referral facility with the most commonly used type of transportation? 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 <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998 02 WET SEASON MINUTES <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998																																	
451a	CHECK Q400. IS "Y" CIRCLED, INDICATING THE FACILITY DOES NOT OFFER ANC OR POST PARTUM CARE?	YES, "Y" CIRCLED 1 Y NOT CIRCLED 2	→ END																																

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
452	ASSESS CONDITION OF ANC SERVICE AREA	YES	NO	
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2	
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2	
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2	
04	WALLS: REASONABLY CLEAN	1	2	
05	DOORS: NO OR MINOR DAMAGE	1	2	
06	WALLS: NO OR MINOR DAMAGE	1	2	
07	ROOF: NO OR MINOR DAMAGE	1	2	
453	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2		
454	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2 NO SHARPS CONTAINER 3		
455	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES 1 YES, IN UNCOVERED CONTAINER .. 2 NO 3		
456	Are ARVs for PMTCT kept or managed in this ANC service site? IF YES, ASK TO SEE THE ARVS	YES 1 ARVs NOT KEPT IN THIS SITE 2 NO PMTCT SERVICES FROM THIS ANC SERVICE AREA 8		→END →END
457	ARVS FOR PMTCT	a		b
		OBSERVED	REPORTED AVAILABLE, NOT SEEN	STOCK OUT IN THIS SERVICE AREA IN LAST SIX MONTHS
		ALL UNITS VALID	AT LEAST ONE UNIT VALID	YES NO DK
01	ZIDOVUDINE (AZT)	1 → b	2 → b	3 02 ↙ 4 02 ↙ 1 2 8
02	LAMIVUDINE (3TC)	1 → b	2 → b	3 03 ↙ 4 03 ↙ 1 2 8
03	NEVIRAPINE (NVP)	1 → b	2 → b	3 04 ↙ 4 04 ↙ 1 2 8
04	NEVIRAPINE SYRUP	1 → b	2 → b	3 05 ↙ 4 05 ↙ 1 2 8
05	OTHER _____ (SPECIFY)	1 → b	2 → b	3 06 ↙ 4 06 ↙ 1 2 8

5. Delivery and Newborn Care																																							
Facility Number: <input type="text"/>		Interviewer Code: <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	→ 556 → 556																																				
<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 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	Do skilled attendants/midwives routinely provide home deliveries or attend home delivery emergencies as a part of the facility's services?	YES, ROUTINELY 1 YES, EMERGENCY ONLY 2 NO 3	→ 505																																				
503	Is there a home delivery bag or kit for use by skilled attendants/midwives? IF YES, ASK TO SEE THE BAG/KIT.	YES, BAG SEEN 1 YES, BAG NOT SEEN 2 NO 3	→ 505 → 505																																				
504	INDICATE WHETHER THE ITEMS LISTED ARE IN THE DELIVERY BAG OR NOT.	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr><td>01 Soap</td><td>1</td><td>2</td></tr> <tr><td>02 Scissor or blade</td><td>1</td><td>2</td></tr> <tr><td>03 Clamp or umbilical tie</td><td>1</td><td>2</td></tr> <tr><td>04 Ergometrine oral</td><td>1</td><td>2</td></tr> <tr><td>05 Ergometrine inj. with syringe and needle</td><td>1</td><td>2</td></tr> <tr><td>06 Decontaminant</td><td>1</td><td>2</td></tr> <tr><td>07 IV Fluid with infusion set</td><td>1</td><td>2</td></tr> <tr><td>08 Sutures</td><td>1</td><td>2</td></tr> <tr><td>09 Dissecting forceps</td><td>1</td><td>2</td></tr> <tr><td>10 Clean gloves</td><td>1</td><td>2</td></tr> <tr><td>11 Cotton wool</td><td>1</td><td>2</td></tr> </tbody> </table>		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	
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11 Cotton wool	1	2																																					

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO				
505	Do skilled attendants/midwives or providers routinely provide home-based PNC as part of their facility services?	YES, ROUTINELY 1 YES, EMERGENCY ONLY 2 NO 3	→ 510a				
506	How many PNC/post-delivery visits are made to households where deliveries took place?	ONE 1 TWO 2 THREE 3					
507	What is the content of the PNC/post-delivery visit?	EXAMINE MOTHER AND CHILD TO IDENTIFY DANGER SIGNS A COUNSEL MOTHER ON MATERNAL AND NEWBORN TOPICS B DELIVER IRON TABLETS AND VITAMIN A C OTHER X (SPECIFY) _____ NONE OF THE ABOVE Y					
508	Is there a record of the number of home-based PNC visit by midwives/providers from this facility? IF "YES", ASK: May I see the record?	YES 1 NO 2 DON'T KNOW 8	→ 510a → 510a				
509	INDICATE THE NUMBER OF HOME-BASED PNC VISITS MADE BY PROVIDERS FROM THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS	# OF HOME PNC VISITS <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					→ 510a
510	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					
510a	CHECK Q500: IS "3" CIRCLED, INDICATING THAT THE FACILITY OFFERS SERVICES FOR HOME DELIVERIES ONLY AND NO SERVICES FOR FACILITY BASED NORMAL DELIVERIES?	YES 1 NO 2	→ 523				
511	Does the facility provide 24 hour coverage for delivery services?	YES 1 NO 2	→ 514				
512	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	→ 514				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																														
513	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 OFFICER B CLINICAL OFFICER C REGISTERED NURSE D REGISTERED MIDWIFE E ENROLLED NURSE F ENROLLED MIDWIFE G COMPREHENSIVE NURSE H NURSING ASSISTANT I NURSING AIDE J OTHER X (SPECIFY) DON'T KNOW Z																															
514	During normal working hours, what level of provider is most commonly available to conduct complicated deliveries?	OBSTETRICIAN/ GYNECOLOGIST A MEDICAL OFFICER B CLINICAL OFFICER C REGISTERED NURSE D REGISTERED MIDWIFE E ENROLLED NURSE F ENROLLED MIDWIFE G COMPREHENSIVE NURSE H NURSING ASSISTANT I NURSING AIDE J OTHER X (SPECIFY) DON'T KNOW Z																															
515	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	→ 517a																														
516	Please tell me if any of the following user-fee or charging practices are ever applied by this facility for antenatal care services:	FOR ANY ITEM WHERE THERE IS A FEE, INDICATE THE AMOUNT OR 999998 IF THE FEE IS NOT KNOWN <table border="1"> <thead> <tr> <th></th><th>YES</th><th>AMOUNT IN US\$</th><th>NO</th><th>DON'T KNOW</th></tr> </thead> <tbody> <tr> <td>01 Is there a fixed fee for normal delivery?</td><td>FEE FOR DELIVERY 1</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td><td>2</td><td>8</td></tr> <tr> <td>02 Is there a fixed fee for the package of ANC and delivery services?</td><td>FIXED ANC + DELIVERY FEE 1</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td><td>2</td><td>8</td></tr> <tr> <td>03 Are there any fees or charges for medicines?</td><td>MEDICINES 1</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td><td>2</td><td>8</td></tr> <tr> <td>04 Are there fees for laboratory or other diagnostic tests?</td><td>TESTS 1</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td><td>2</td><td>8</td></tr> <tr> <td>05 Are discounts or exemptions from fees allowed for some clients?</td><td>DISCOUNT/ EXEMPTIONS 1</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td><td>2</td><td>8</td></tr> </tbody> </table>			YES	AMOUNT IN US\$	NO	DON'T KNOW	01 Is there a fixed fee for normal delivery?	FEE FOR DELIVERY 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8	02 Is there a fixed fee for the package of ANC and delivery services?	FIXED ANC + DELIVERY FEE 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8	03 Are there any fees or charges for medicines?	MEDICINES 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8	04 Are there fees for laboratory or other diagnostic tests?	TESTS 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8	05 Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8
	YES	AMOUNT IN US\$	NO	DON'T KNOW																													
01 Is there a fixed fee for normal delivery?	FEE FOR DELIVERY 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8																													
02 Is there a fixed fee for the package of ANC and delivery services?	FIXED ANC + DELIVERY FEE 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8																													
03 Are there any fees or charges for medicines?	MEDICINES 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8																													
04 Are there fees for laboratory or other diagnostic tests?	TESTS 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8																													
05 Are discounts or exemptions from fees allowed for some clients?	DISCOUNT/ EXEMPTIONS 1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2	8																													
517	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																															
517a	Are women in labor expected to bring along supplies and medications? IF YES: What are they expected to bring?	STERILE GLOVES A CLOTHES FOR BABY B SANITARY PADS C NEEDLES AND SYRINGES D CORD LIGATURES E BASIN F RAZOR BLADES G COTTON WOOL H PLASTIC SHEETS I LOOSE DRESS FOR B-FEEDING J OTHER (SPECIFY) X NO Z																															
518	Is there a register where client information from attended births is recorded? IF YES, ASK TO SEE THE REGISTER.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 525 → 525																														

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
519	SCAN THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE THE RESPONSE FOR EACH TYPE OF INFORMATION ROUTINELY RECORDED FOR DELIVERIES. SEARCH ALL APPLICABLE REGISTERS/RECORDS MAINTAINED ROUTINELY.	BIRTH OUTCOME FOR INFANT A MATERNAL OUTCOME B TYPE OF DELIVERY C MOTHER AGE D GESTATIONAL AGE E IF ANC RECEIVED F HIV STATUS OF MOTHER G NEWBORN WEIGHT H IF PARTOGRAPH USED I NONE OF ABOVE Y	
520	HOW RECENT IS THE DATE OF THE MOST RECENT BIRTH ATTENDED BY FACILITY STAFF?	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> DK 98 DK 98	
521	How many women delivered at this facility during the previous 12 completed months? (EXCLUDE CESAREAN 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	→ 523
522	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
523	How many home-deliveries were assisted by staff from this facility during the previous 12 complete months?	NUMBER OF DELIVERIES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998 NO HOME DELIVERIES 99995	→ 525 → 525
524	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
524a	CHECK Q500 AGAIN: IS "3" CIRCLED, INDICATING THAT THE FACILITY OFFERS SERVICES FOR HOME DELIVERIES ONLY AND NO SERVICES FOR FACILITY-BASED NORMAL DELIVERIES? IF YES: SKIP TO Q556 IF NO: CIRCLE "2" AND PROCEED TO NEXT QUE.	YES 1 NO 2	→ 556
525	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	→ 527 → 527
526	RECORD THE SOURCE OF INFORMATION FOR THE ESTIMATED DELIVERY COVERAGE.	WRITTEN REPORT A GRAPH/CHART B OTHER X (SPECIFY) _____ SOURCE NOT KNOWN Z	
527	Are there ever any meetings where service statistics for delivery services are discussed with staff from this clinic/unit, such as looking at changes in patterns or other items relevant to client services?	YES 1 NO 2	
528	Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH A WRITTEN REPORT/MINUTES B OTHER X (SPECIFY) _____ NO OBSERVED EVIDENCE Y	→ 530
529	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.	WITHIN THE PAST 3 MONTH 1 MORE THAN 3 MONTHS AGO 2 DON'T KNOW 8	
530	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	→ 532

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO		
531	How often are reviews of maternal and/or infant deaths and/or near misses carried out?	EVERY <input type="text"/> <input type="text"/> WEEKS WHEN CASE OCCURS 53 DON'T KNOW 98			
532	Please tell me the total number of beds in the maternity ward/unit in this facility	1) # OF BEDS IN MATERNITY <input type="text"/> <input type="text"/> <input type="text"/> NO SPECIFIC MATERNITY BEDS 000 NO FACILITY-BASED DELIVERIES 995	→ 534 → 556		
533	Please tell me the total number of general beds available for delivery	2) # GENERAL BEDS AVAILABLE FOR DELIVERY <input type="text"/> <input type="text"/> <input type="text"/>			
534	ASK TO SEE THE ROOM(S) WHERE WOMEN IN LABOR STAY UNTIL TIME FOR DELIVERY AND INDICATE THE SITUATION FOR PRIVACY	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY 2 VISUAL PRIVACY ONLY 3 NO PRIVACY 4 NO SEPARATE LABOR ROOM 5			
535	ASK TO SEE THE ROOM(S) WHERE DELIVERIES TAKE PLACE. IF THE SAME ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q536, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FAMILY PLANNING [Q327] 1 ANTENATAL [Q438] 2 STI [Q628] 3 NOT PREVIOUSLY SEEN 4 SAME AS FOR LABOR 5	→ 537 → 537 → 537		
536	NOTE THE AVAILABILITY AND CONDITION OF SUPPLIES AND EQUIPMENT REQUIRED FOR DELIVERY SERVICES. EQUIPMENT MAY BE IN DELIVERY ROOM OR AN ADJACENT ROOM.				
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	RUNNING WATER (PIPED)	1 <input type="checkbox"/> 04 <input type="checkbox"/>	2	3	8
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 <input type="checkbox"/> 04 <input type="checkbox"/>	2	3	8
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	8
04	HAND-WASHING SOAP	1	2	3	8
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	8
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	8
07	SHARPS CONTAINER	1	2	3	8
08	DISPOSABLE LATEX GLOVES	1 <input type="checkbox"/> 10 <input type="checkbox"/>	2	3	8
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	8
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 <input type="checkbox"/> 12 <input type="checkbox"/>	2	3	8
11	DISINFECTANT (NOT YET MIXED)	1	2	3	8
12	DISPOSABLE NEEDLES	1	2	3	8
13	AUTO-DISABLE SYRINGES	1	2	3	8
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	8
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 <input type="checkbox"/> 18 <input type="checkbox"/>	2	3	8
16	AUDITORY PRIVACY	1	2	3	8
17	VISUAL PRIVACY	1	2	3	8
18	EXAMINATION TABLE	1	2	3	8
19	VACUTAINER	1	2	3	8

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
537	OTHER SUPPLIES AND EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONING
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES NO DON'T KNOW
	01 Spotlight for pelvic exam (flashlight/torch or exam light acceptable)	1→ b	2→ b	3 02 ↙	8 02 ↙	1 2 8
	02 24-hour functioning light source (lantern acceptable)	1→ b	2→ b	3 03 ↙	8 03 ↙	1 2 8
	03 Skin antiseptic (such as Chlorhexidine, Savlon, or Dettol)	1	2	3	8	
	04 Intravenous infusion set	1	2	3	8	
	05 Syringes and needles	1	2	3	8	
	06 Suture material with needle	1	2	3	8	
	07 Sterile scissors or blade	1	2	3	8	
	08 Needle holder	1	2	3	8	
	09 Sterile gloves	1	2	3	8	
	10 Cord clamp or ties	1	2	3	8	
	11 Thermometer	1	2	3	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
538	MEDICATIONS IN DELIVERY SERVICE AREA	(a) AVAILABILITY				(b) AT LEAST ONE VALID
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES NO DON'T KNOW
		1 → b	2 ↘ 02 ←	3 ↘ 02 ←	8 ↘ 02 ←	1 2 8
		1 → b	2 ↘ 03 ←	3 ↘ 03 ←	8 ↘ 03 ←	1 2 8
		1 → b	2 ↘ 04 ←	3 ↘ 04 ←	8 ↘ 04 ←	1 2 8
		1 → b	2 ↘ 05 ←	3 ↘ 05 ←	8 ↘ 05 ←	1 2 8
		1 → b	2 ↘ 06 ←	3 ↘ 06 ←	8 ↘ 06 ←	1 2 8
		1 → b	2 ↘ 07 ←	3 ↘ 07 ←	8 ↘ 07 ←	1 2 8
		1 → b	2 ↘ 08 ←	3 ↘ 08 ←	8 ↘ 08 ←	1 2 8
		1 → b	2 ↘ 09 ←	3 ↘ 09 ←	8 ↘ 09 ←	1 2 8
		1 → b	2 ↘ 10 ←	3 ↘ 10 ←	8 ↘ 10 ←	1 2 8
		1 → b	2 ↘ 11 ←	3 ↘ 11 ←	8 ↘ 11 ←	1 2 8
		1 → b	2 ↘ 12 ←	3 ↘ 12 ←	8 ↘ 12 ←	1 2 8
		1 → b	2 ↘ 13 ←	3 ↘ 13 ←	8 ↘ 13 ←	1 2 8
		1 → b	2 ↘ 14 ←	3 ↘ 14 ←	8 ↘ 14 ←	1 2 8
		1 → b	2 ↘ 15 ←	3 ↘ 15 ←	8 ↘ 15 ←	1 2 8
		1 → b	2 ↘ 539 ←	3 ↘ 539 ←	8 ↘ 539 ←	1 2 8

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
539	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 to wipe baby	1	2	3	8			
10	Blanket to wrap baby	1	2	3	8			
11	Vitamin K (Inj)	1	2	3	8			
540	GUIDELINES/ PROTOCOLS							
01	Essential maternal & Neonatal care clinical Guidelines for Uganda	1	2	3	8			
02	Other guidelines for normal delivery	1	2	3	8			
03	Guidelines for emergency obstetric care	1	2	3	8			
04	Blank partographs ANY PARTOGRAPH REGARDLESS OF WHETHER IT IS SEPARATE PAPERS OR ON THE MOTHERS CARD	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
541	CHECK Q539(02) IF INCUBATOR IS AVAILABLE IN UNIT YES, OBSERVED OR REPORTED <input type="checkbox"/> NO <input type="checkbox"/>		→ 543a
542	Is there someone in the unit who has received technical training to operate the incubator?	YES 1 NO 2 DON'T KNOW 8	
	Now I will ask you a few questions about the management of 3rd stage of labor. For each of the following practices for managing 3rd stage of labor, please tell me if this is: i) a routine practice, or ii) selectively done (depending on the condition of the client or the provider conducting the delivery), or iii) it is never carried out.		
543a	Administer uterotonic drug, that is either <i>ergometrine or oxytocin</i>	ROUTINE 1 SELECTIVE 2 NEVER 3	→ 543c → 543c
543b	How many minutes after birth is the drug usually administered?	IMMEDIATELY/WITHIN 1 MINUTE 1 WITHIN 5 MINUTES 2 NO SPECIFIC PRACTICE 3 OTHER 6 (SPECIFY)	
543c	Apply controlled cord traction?	ROUTINE 1 SELECTIVE 2 NEVER 3	→ 543e → 543e
543d	Can you describe the technique used when applying cord traction? DOES THE PROVIDER INDICATE THAT COUNTER TRACTION IS APPLIED TO THE UTERUS? DO NOT PROMPT!!	YES 1 NO 2 DON'T KNOW 8	
543e	Massage fundus through the abdomen?	ROUTINE 1 SELECTIVE 2 NEVER 3	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO			
544	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					
545	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	Suction the newborn by means of bulb	1	2	8				
03	Weigh the newborn	1	2	8				
04	Give full bath (immerse newborn in water) within 24 hours of birth	1	2	8				
05	Give the newborn prelacteal liquids	1	2	8				
06	Give the newborn OPV prior to discharge	1	2	8				
07	Give the newborn BCG prior to discharge	1	2	8				
546	How is the umbilical cord treated? ASK FOR EACH ITEM IF IT IS APPLIED AND CIRCLE ALL PRACTICES THAT ARE ROUTINELY USED	APPLY SALTY WATER A APPLY ALCOHOL B APPLY OTHER ANISEPTIC C APPLY NOTHING TO CORD D WRAP WITH DRY DRESSING E OTHER (SPECIFY)..... X						
547	How is the newly delivered placenta managed prior to final disposal? ASK TO SEE ANY CONTAINER THAT IS USED. CIRCLE ALL TYPES OF CONTAINERS REPORTED AND OBSERVED FOR IMMEDIATE PLACEMENT OF PLACENTA	PUT IN CONTAINER COVERED LEAKPROOF A UNCOVERED LEAKPROOF B DOUBLE PLASTIC BAGS C NOT LEAKPROOF D OTHER (SPECIFY) X						
548	What is the most common method used for final disposal of the placenta? CIRCLE ALL THAT APPLY.	GIVE TO FAMILY A DISPOSE WITH OTHER INFECTIOUS WASTE OF FACILITY B DISPOSE SEPARATE FROM OTHER WASTE BURN C BURY D OTHER X (SPECIFY)						
549	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		→ 552			
550	CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.							
		(a) AVAILABILITY			(b) FUNCTIONING			
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Ventouse (vacuum extractor)	1 → b	2 → b	3 551 ↙	8 551 ↙	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO			
551	Has an assisted delivery been conducted in this facility within the past 3 months?	YES	1					
		NO	2					
		DON'T KNOW	8					
552	Is this facility able to extract retained products of conception when necessary? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES	1					
		NO	2	→ 555				
553	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	3 554 ↙	8 554 ↙	1	2	8
554	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					
555	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			(b) PROVIDED IN PAST 3 MONTHS			
		YES	NO	DK	YES	NO	DK	
01	Parenteral antibiotic	1 → b	2 02 ↙	8 02 ↙	1	2	8	
02	Parenteral oxytocic drugs	1 → b	2 03 ↙	8 03 ↙	1	2	8	
03	Parenteral anti-convulsants for pregnancy-induced hypertension	1 → b	2 04 ↙	8 04 ↙	1	2	8	
04	Manual removal of placenta	1 → b	2 556 ↙	8 556 ↙	1	2	8	
556	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	→ 558		
557	Has blood transfusion been performed for maternity care by this facility during the past 3 months?	YES	1					
		NO	2					
		DON'T KNOW	8					
558	Does this facility ever perform caesarean sections?	YES	1					
		NO	2	→ 566				
558a	Is there a routine fee for caesarean sections? IF YES: Please tell me the amount of the fee. IF AMOUNT OF FEE NOT KNOW, PUT 99999998	YES			1			
		<div style="border: 1px solid black; display: inline-block; width: 150px; height: 20px; margin: 5px 0;"></div>						
		NO FEE FOR FOR CS			2			

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
559	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.							
		(a) AVAILABILITY				(b) FUNCTIONING		
	EQUIPMENT AND SUPPLIES FOR CAESAREAN SECTION	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Operating table	1 → b	2 → b	3 02 ↙	8 02 ↘	1	2	8
02	Operating light	1 → b	2 → b	3 03 ↙	8 03 ↘	1	2	8
03	Anesthesia giving set/ equipment or instrument	1 → b	2 → b	3 04 ↙	8 04 ↘	1	2	8
04	Scrub area adjacent to or in the operating room	1	2	3	8			
05	Tray, drum, or package with sterilized instruments ready for use	1	2	3	8			
06	Emergency source of light	1 → b	2 → b	3 07 ↙	8 07 ↘	1	2	8
07	Suction machine	1 → b	2 → b	3 560 ↙	8 560 ↘	1	2	8
560	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						
561	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						
562	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				→ 566 → 566		
563	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				→ 565		
564	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98						
565	What is the date of the last caesarean section? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	MONTH <input type="text"/> <input type="text"/> DON'T KNOW 989998 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>						

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
566	Does this facility have a health worker or provider who can repair obstetric fistulae?	YES	1			
		NO	2		→ 574	
		DON'T KNOW	8		→ 574	
567	Does this facility have any providers (medical officers and above) trained to competence for simple repair of fistulae?	YES	1			
		NO	2			
		DON'T KNOW	8			
568	Does this facility have any providers (medical officers and above) trained to competence for complex repair of fistulae?	YES	1			
		NO	2			
		DON'T KNOW	8			
569	Does this facility have any providers (medical officers and above) trained to competence as fistula repair trainers ?	YES	1			
		NO	2			
		DON'T KNOW	8			
570	Is there a register where fistula repair data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED	1			
		YES, REPORTED, NOT SEEN	2		→ 574	
		NO	3		→ 574	
571	RECORD THE NUMBER OF FISTULAE REPAIRED AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF FISTULAE				
		DON'T KNOW	9998		→ 573	
572	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA				
		DON'T KNOW	98			
573	What is the date of the last fistula repair? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	MONTH	YEAR			
		DON'T KNOW	989998			
574	Does this facility ever perform male circumcisions? IF YES, ASK: Is the circumcision done for infants only, adults only or for both infants and adults?	YES, INFANTS ONLY	1			
		YES, ADULTS ONLY	2			
		YES, BOTH INFANTS AND ADULTS	3			
		NO MALE CIRCUMCISION	4		→ 578a	
		DON'T KNOW	8		→ 578a	
574a	Is there a fee for male circumcision? IF YES, ASK: Please tell me the amount. If the fee varies for infant and adult circumcision, please tell me the fee for adult male circumcision. IF THERE IS A FEE, HOWEVER THE AMOUNT IS NOT KNOWN, ENTER 9999998	1			
		NO FEE FOR MALE CIRCUMCISION	2			
574b	GO TO WHERE MALE CIRCUMCISION PROCEDURES TAKE PLACE AND NOTE THE AVAILABILITY OF THE FOLLOWING ITEMS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	LOCAL ANAESTHETIC WITHOUT ADRENALINE	1	2	3	8	
02	STERILE GLOVES	1	2	3	8	
03	STRAPPINGS	1	2	3	8	
04	STITCH SCISSORS	1	2	3	8	
05	DISSECTING FORCEPS	1	2	3	8	
06	SURGICAL BLADE AND HANDLE	1	2	3	8	
07	ARTERY FORCEPS	1	2	3	8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
574c	Does this facility have a health worker who can perform male circumcision present in the facility or on call 24 hours a day?	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	
575	Is there a register where male circumcision data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 578a → 578a
576	RECORD THE NUMBER OF MALE CIRCUMCISIONS AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF CIRCUMCISIONS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→ 578a
577	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
578	WHAT IS THE DATE OF THE LAST MALE CIRCUMCISION? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	WITHIN PAST 1 WEEK 1 WITHIN PAST 1 MONTH 2 WITHIN PAST 3 MONTHS 3 DON'T KNOW 8	
CERVICAL SCREENING AND TREATMENT			
578a	Does this facility offer any services for identifying cervical dysplasia, that is, cervical screening services to detect precancerous lesions?	YES 1 NO 2 DON'T KNOW 3	→ 579 → 579
578b	How many days of the month are cervical screening services provided at the facility? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	# OF DAYS <input type="text"/> <input type="text"/> DON'T KNOW 98	
578c	Are cervical screening services being provided at the facility today?	YES 1 NO 2	
578d	What cervical screening methods are used in this facility?	PAP SCREENING A VISUAL INSPECTION B HPV TEST C OTHER X (SPECIFY) _____	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
578e	CHECK Q578d IF PAP SCREENING IS USED FOR SCREENING IN THE FACILITY YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 578i
578f	Is there a register where cervical screening data is recorded? IF YES, ASK: May I see the register please?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 578i → 578i
578g	RECORD THE NUMBER OF PAP SCREENING AT THIS FACILITY DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF PAP SCREEN DON'T KNOW 9998	→ 578i
578h	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA DON'T KNOW 98	
578i	If a woman is identified with cervical precancers, how are they most commonly managed at this facility?	TREATED AT THIS FACILITY A REFERRED TO ANOTHER FACILITY B WITHIN DISTRICT C OUTSIDE DISTRICT X OTHER _____ (SPECIFY)	
578j	ASK TO GO TO THE AREA WHERE CERVICAL SCREENING AND/OR TREATMENT IS DONE AND NOTE THE AVAILABILITY OF THE FOLLOWING IN THE SERVICE DELIVERY ROOM OR AN ADJACENT ROOM.		
	EQUIPMENT AND SUPPLIES FOR EXAMINATION AND/OR TREATMENT	(a) AVAILABILITY OBSERVED REPORTED, NOT SEEN NOT AVAILABLE DON'T KNOW (b) FUNCTIONING YES NO DON'T KNOW	
01	Cryotherapy unit with gas	1 → b 2 → b 3 02 8 02	1 2 8
02	Operating light (Spotlight or torch)	1 → b 2 → b 3 03 8 03	1 2 8
03	Colposcope	1 → b 2 → b 3 04 8 04	1 2 8
04	Lugol's iodine	1 2 3 8	
05	Cotton swabs	1 2 3 8	
06	Vaginal speculum (s)	1 2 3 8	
07	Vaginal speculum (m)	1 2 3 8	
08	Vaginal speculum (l)	1 2 3 8	
09	Guidelines/protocols for identifying and treating cervical dysplasia	1 2 3 8	
10	Visual aids for counseling clients on screening procedures	1 2 3 8	
11	Any information for clients to take home	1 2 3 8	
579	AT THIS POINT, CHECK IF EITHER Q500 OR Q558 IS "1" [FACILITY OFFERS DELIVERY SERVICES]	YES 1 NO 2	→ SEC 6
580	Are syringes for client injections or drawing blood ever reused? IF YES, ASK: What is the final method most commonly used sterilizing syringes prior to reuse? CIRCLE ALL THAT APPLY. IF NO: CIRCLE "Y" FOR NEVER REUSE SYRINGES	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E OTHER _____ (SPECIFY) X NEVER REUSE SYRINGES Y	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
581	<p>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?</p> <p>IF THE UNIT PROCESSES SOME EQUIPMENT AND SENDS OTHER EQUIPMENT ELSEWHERE, INDICATE THE PROCEDURE FOR EQUIPMENT PROCESSED IN THIS SERVICE DELIVERY UNIT</p> <p>IF VAGINAL DELIVERIES ARE CONDUCTED IN A DIFFERENT ROOM THAN CAESAREAN SECTION DELIVERIES, ASSESS THE PROCESSING EQUIPMENT FOR VAGINAL DELIVERIES.</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 SOAK 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 06</p> <p>(SPECIFY)</p> <p>NO EQUIPMENT EVER REUSED 07 → 589a</p> <p>DON'T DECONTAMINATE 95 → 584</p>	
582	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 → 584</p> <p>NO 3 → 584</p>	
583	SCAN THE GUIDELINE AND CIRCLE ALL COMPONENTS THAT ARE MENTIONED OR COVERED	<p>SOAKING TIME A</p> <p>PERCENT OF CHEMICAL USED B</p> <p>PROPORTIONS TO MIX C</p> <p>BRUSH SCRUB D</p> <p>NONE OF THE ABOVE Y</p>	
584	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.	<p>SECTION 1 [Q179-181] 1 → 587(6)</p> <p>FAMILY PLANNING [Q352-354] 2 → 587(6)</p> <p>NOT PREVIOUSLY SEEN 3</p> <p>PROCESS OUTSIDE FACILITY 4 → 587(6)</p> <p>SECTION 1 [Q179-181], HOWEVER COMPLETED IN DELIVERY AREA. ... 5 → 587(6)</p> <p>NO EQUIPMENT PROCESSED 7</p>	
585	What is the final method 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.	<p>DRY-HEAT STERILIZATION A</p> <p>AUTOCLAVING B</p> <p>BOILING C</p> <p>STEAM STERILIZATION D</p> <p>CHEMICAL METHOD E</p> <p>PROCESSED OUTSIDE FACILITY F → 587(6)</p> <p>OTHER X</p> <p>(SPECIFY)</p>	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
586	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	

587							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 Disinfection (HLD)	(6) Initial decontamination							
A	Method	USED 1 NOT USED ... 2 → 2	USED 1 NOT USED ... 2 → 4	USED 1 NOT USED ... 2 → 5	USED 1 NOT USED ... 2 → 6	USED 1 NOT USED ... 2 → 588							
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	<div> <div>JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE 04 ALCOHOL 05 CHLORHEXIDINE 06 GLUTARALDEHYDE 07 CHLORINE TABS 08 DONT KNOW 98</div> <div>JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE 04 ALCOHOL 05 CHLORHEXIDINE 06 GLUTARALDEHYDE 07 CHLORINE TABS 08 DONT KNOW 98</div> </div>											
H	Percent solution before dilution	PERCENT [][] DONT KNOW 98	PERCENT [][] DONT KNOW 98	PERCENT [][] DONT KNOW 98	PERCENT [][] DONT KNOW 98	PERCENT [][] DONT KNOW 98							
I	Mixture, parts solution or tablets and water	<div> MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000 </div> <div> MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000 </div>											

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
588	ASK TO SEE WHERE PROCESSED EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED, PRIOR TO REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION OR CLINIC/UNIT THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "3" AND CONTINUE. CONTINUE.	SECTION 1 [Q182] 1 FAMILY PLANNING [Q356] 2 NOT PREVIOUSLY SEEN 3				→ 589a → 589a
589	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	
589a	DID YOU NOTICE OR OBSERVE ANYTHING THAT WOULD SUGGEST THAT AN ATTEMPT IS BEING MADE TO STERILIZE OR PROCESS INJECTION EQUIPMENT SUCH AS NEEDLES AND SYRINGES FOR RE-USE? IF YES, CIRCLE ALL RESPONSES THAT APPLY	USED INJECTION EQUIPMENT IN STERILIZER, AUTOCLAVE, BOILER OR DISH OF WATER. A USED INJECTION EQUIPMENT IN DRAWERS B BULGING OR DISCOLORED SYRINGES C NO EVIDENCE OF ATTEMPT Y				
590	ASSESS CONDITION OF DELIVERY SERVICE AREA	YES	NO			
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2			
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2			
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2			
04	WALLS: REASONABLY CLEAN	1	2			
05	DOORS: NO OR MINOR DAMAGE	1	2			
06	WALLS: NO OR MINOR DAMAGE	1	2			
07	ROOF: NO OR MINOR DAMAGE	1	2			
591	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES NO	1 2			
592	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES NO NO SHARPS CONTAINER	1 2 3			
593	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES YES, IN UNCOVERED CONTAINER NO	1 2 3			

6. Services for Reproductive Tract and Sexually Transmitted Infections																												
Facility Number: <input type="text"/>		Interviewer Code: <input type="text"/>																										
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																									
600	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	→ END																									
<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>																												
601	May I begin the interview now?	YES 1 NO 2	→ STOP																									
602	Are services for STI clients being offered at this facility today?	YES 1 NO 2																										
603	Are STI services primarily offered in a special STI clinic or through general outpatient services?	SPECIAL STI CLINIC 1 GENERAL OUTPATIENT 2																										
604	How many days in the month are STI services available in either the special/the general clinic? USE A 4-WEEK MONTH TO CALCULATE DAYS	NUMBER OF DAYS <input type="text"/>																										
604a	Does this facility have any routine user-fees or charges for any services related to STI 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	→ 605																									
604b	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	FOR ANY ITEM WHERE THERE IS A FEE, INDICATE THE AMOUNT IN THE BOXES. IF FEE NOT KNOWN, ENTER 999998 <table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>AMOUNT IN US\$</th> <th>NO</th> <th>DON'T KNOW</th> </tr> </thead> <tbody> <tr> <td>FEE FOR HEALTH CARD</td> <td>1</td> <td><input type="text"/></td> <td>2</td> <td>8</td> </tr> <tr> <td>FEE FOR CONSULTATION</td> <td>1</td> <td><input type="text"/></td> <td>2</td> <td>8</td> </tr> <tr> <td>FEE FOR LAB TESTS</td> <td>1</td> <td><input type="text"/></td> <td>2</td> <td>8</td> </tr> <tr> <td>FEE FOR MEDICINES</td> <td>1</td> <td><input type="text"/></td> <td>2</td> <td>8</td> </tr> </tbody> </table>			YES	AMOUNT IN US\$	NO	DON'T KNOW	FEE FOR HEALTH CARD	1	<input type="text"/>	2	8	FEE FOR CONSULTATION	1	<input type="text"/>	2	8	FEE FOR LAB TESTS	1	<input type="text"/>	2	8	FEE FOR MEDICINES	1	<input type="text"/>	2	8
	YES	AMOUNT IN US\$	NO	DON'T KNOW																								
FEE FOR HEALTH CARD	1	<input type="text"/>	2	8																								
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FEE FOR MEDICINES	1	<input type="text"/>	2	8																								

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
605	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY.	SYNDROMIC APPROACH A ETIOLOGIC (LAB) B CLINICAL JUDGMENT C				
606	FOR EACH OF THE FOLLOWING LABORATORY TESTS, ASK: Does this service use any laboratory test for diagnosing [THE INDICATED ILLNESS]? 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?					
	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	1	2	3	4	8
04	Chlamydia	1	2	3	4	8
607	Does this clinic/unit have a protocol or guideline 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, BOTH FORM AND REGISTER OBSERVED 3 YES, FORM/REGISTER REPORTED, NOT SEEN 4 NO 5	
610	Is there a register where information is recorded on STI consultations? IF YES, ASK TO SEE THE REGISTER. MAY BE GENERAL OPD REGISTERS.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 616 → 616
611	SKIM THE REGISTER FOR THE PAST 3 MONTHS AND CIRCLE IF THE INDICATED INFORMATION IS ROUTINELY RECORDED FOR CLIENTS RECEIVING SERVICES THIS CLINIC/UNIT	CLIENT NAME A CLIENT AGE B CLIENT SEX C DIAGNOSIS/MAIN SYMPTOM D NONE OF THE ABOVE Y	
612	Were there any diagnoses noted that indicated a client had an STI or reproductive tract infection? IF YES, CIRCLE WHICH OF THE INDICATED INFORMATION WAS OBSERVED FOR ANY CLIENTS	SYMPTOM (DISCHARGE/PAIN) A GENERAL DIAGNOSIS (STI/RTI) B SPECIFIC TYPE OF STI/RTI C OTHER INDICATION OF RTI/STI X (SPECIFY) _____ NONE OF THE ABOVE Y	→ 616
613	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY FOR A PROBABLE STI OR RTI?	WITHIN THE PAST 7 DAYS 1 MORE THAN 7 DAYS OLD 2	
614	RECORD THE NUMBER OF CLIENTS WHO RECEIVED STI SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF STI CLIENTS .. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→ 616
615	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/> DON'T KNOW 98	
616	Are there ever any meetings where service statistics for adult health are discussed with staff from this clinic/unit, such as looking at changes in patterns or other items relevant to client services?	YES 1 NO 2	
617	Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.	OBSERVED WALL CHART/GRAPH A WRITTEN REPORT/MINUTES B OTHER X (SPECIFY) _____ NO OBSERVED EVIDENCE Y	→ 619
618	ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED	WITHIN THE PAST 3 MONTHS 1 MORE THAN 3 MONTHS AGO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
619	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 STI syndromes, or specific STIs such as syphilis, 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			
620	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			
	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.					
621	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	
622	SERVICE DELIVERY STANDARDS/PROTOCOLS					
01	Sexually Transmitted Infections Treatment Guidelines for use by operational level health workers in Uganda (2003)	1	2	3	8	
02	Etiologic (laboratory) diagnosis of STIs	1	2	3	8	
03	Any other Treatment protocols for STIs	1	2	3	8	
04	Syndromic approach guidelines (treatment chart)	1	2	3	8	
05	Guidelines for diagnosing HIV/AIDS	1	2	3	8	
623	Is there a policy (or guideline) that all STI clients should be offered an HIV test? IF YES, ASK TO SEE THE POLICY OR GUIDELINE	1	2	3	8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
624	Are all STI clients routinely referred for HIV testing?	YES 1 ONLY IF CLIENT SUSPECTED TO BE HIV+ .. 2 NO 3	→ 626
625	Where are the clients sent for HIV testing? PROBE FOR A SPECIFIC UNIT WITHIN FACILITY, OR SPECIFIC LOCATION OUTSIDE FACILITY TO BE NAMED	LOCATION NAMED INSIDE FACILITY 1 OUTSIDE FACILITY 2 DON'T KNOW SPECIFIC LOCATION 8	
626	Are individual client health records or charts used? IF YES, ASK TO SEE EITHER A USED OR NEW CLIENT HEALTH CARD/CHARD/RECORD.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
627	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 628, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	FP [Q327] 1 ANTENATAL [Q438] 2 DELIVERY [Q536] 3 NOT PREVIOUSLY SEEN 4 COUNSELING AND EXAM IN SAME ROOM [Q620] 5	→ 629 → 629 → 629

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
628	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.							
	ITEMS FOR INFECTION CONTROL AND CONDITIONS FOR EXAMINATION	(a) AVAILABILITY						
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	RUNNING WATER (PIPED)	1 04 ↙	2	3	8			
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	8			
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	8			
04	HAND-WASHING SOAP	1	2	3	8			
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	8			
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	8			
07	SHARPS CONTAINER	1	2	3	8			
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	8			
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	8			
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	8			
11	DISINFECTANT (NOT YET MIXED)	1	2	3	8			
12	DISPOSABLE NEEDLES	1	2	3	8			
13	AUTO-DISABLE SYRINGES (3 or 5 ml)	1	2	3	8			
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	8			
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↙	2	3	8			
16	AUDITORY PRIVACY	1	2	3	8			
17	VISUAL PRIVACY	1	2	3	8			
18	EXAMINATION TABLE	1	2	3	8			
19	VACUTAINER	1	2	3	8			
629	OTHER SUPPLIES AND EQUIPMENT REQUIRED FOR EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	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	Vaginal speculum (s)	1	2	3	8			
04	Vaginal speculum (m)	1	2	3	8			
05	Vaginal speculum (l)	1	2	3	8			
06	Swab sticks for taking specimen	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
630	ASSESS CONDITION OF FP SERVICE AREA	YES	NO	
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2	
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2	
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2	
04	WALLS: REASONABLY CLEAN			
05	DOORS: NO OR MINOR DAMAGE	1	2	
06	WALLS: NO OR MINOR DAMAGE	1	2	
07	ROOF: NO OR MINOR DAMAGE	1	2	
631	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES	1	
		NO	2	
632	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES	1	
		NO	2	
		NO SHARPS CONTAINER	3	
633	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES	1	
		YES, IN UNCOVERED CONTAINER	2	
		NO	3	

SECTION 12: HIV/AIDS OUTPATIENT CARE																		
Facility Number: 		QRE TYPE 12																
Interviewer: Code 																		
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.																		
1200	INDICATE WHICH OUTPATIENT CLINIC/UNIT THE DATA IN THIS QUESTIONNAIRE REPRESENTS	<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>																
1201	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER _____ 6 <div style="text-align: center; font-size: small;">(SPECIFY)</div>																	
1202	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 Q1206, Q1208 & Q1210</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>PMTCT Q1205</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TB Q1218 (01, 02, 03)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>ART Q1225 (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 Q1206, Q1208 & Q1210	1	2	PMTCT Q1205	1	2	TB Q1218 (01, 02, 03)	1	2	ART Q1225 (07, 08)	1	2
	APPLICABLE & COMPLETED	NOT APPLICABLE																
(V)CT Q1206, Q1208 & Q1210	1	2																
PMTCT Q1205	1	2																
TB Q1218 (01, 02, 03)	1	2																
ART Q1225 (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 Q1203 BELOW AND GO ON TO Q1204.																		
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 Uganda 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 prepared by these researchers 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				
1210	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 → 1212				
1211	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					
1212	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	→ 1214 → 1214				
1213	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					
1214	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					
1215	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 LINE AND C/U 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> YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS.... 4 OTHER 6 SPECIFY NO INDIVIDUAL CLIENT CHART/ RECORD 7					

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1216	Is there a written policy document or statement 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 CLIENTS. . . 1 YES, OBSERVED WRITTEN POLICY OR NATIONAL VCT GUIDELINES . . . 2 YES, REPORTED, NOT SEEN 3 NO 4				→ 1218
1217	Does the policy specify that no one can be informed of the HIV/AIDS status without the client's consent?	YES 1 NO 2				
1218	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 malaria?	1	2	3	4	
05	Do providers assigned to this clinic/unit prescribe treatment for sexually transmitted infections (STI)?	1	2 1220 ↙	3 1220 ↙	4 1220 ↙	
1219	Are all STI clients routinely referred for HIV testing?	YES 1 ONLY IF CLIENT SUSPECTED TO BE HIV+ 2 NO 3				
1220	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				→ 1224

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1221	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	<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 style="text-align: center;">OBSERVED</div> <div style="text-align: center;">REPORTED AVAIL. NOT SEEN</div> <div style="text-align: center;">NOT AVAIL.</div> <div style="text-align: center;">DATE ON OBSERVED MANUAL (YEAR)</div> </div>			
01	Uganda National Policy on HIV Counseling and Testing	1 → b	2 02 ↙	3 02 ↙	<input type="text"/>
02	Policy Guidelines for Prevention of Mother to Child Transmission	1 → b	2 03 ↙	3 03 ↙	<input type="text"/>
03	National Antiretroviral Treatment and Care guideline for Adult and Children	1 → b	2 04 ↙	3 04 ↙	<input type="text"/>
04	Comprehensive HIV Care (IMAI): Acute Care Guide	1 → b	2 05 ↙	3 05 ↙	<input type="text"/>
05	Comprehensive HIV Care (IMAI): Chronic HIV Care Guide	1 → b	2 06 ↙	3 06 ↙	<input type="text"/>
06	Comprehensive HIV Care: Home Based Care Trainers' Guide for Health Workers	1 → b	2 07 ↙	3 07 ↙	<input type="text"/>
07	Uganda Clinical Guidelines	1 → b	2 08 ↙	3 08 ↙	<input type="text"/>
08	Sexually Transmitted Infections Treatment Guidelines for Use by Operational Level Health Workers	1 → b	2 09 ↙	3 09 ↙	<input type="text"/>
09	Nutritional Care and Support for People Living with HIV/AIDS in Uganda	1 → b	2 10 ↙	3 10 ↙	<input type="text"/>
10	Tuberculosis Control & Community-based DOTS as an essential component of District Health Systems	1 → b	2 11 ↙	3 11 ↙	<input type="text"/>
11	Tuberculosis Case Management Desk Aide	1 → b	2 12 ↙	3 12 ↙	<input type="text"/>
12	Management of uncomplicated Malaria	1 → b	2 13 ↙	3 13 ↙	<input type="text"/>
13	Infection Control: Policies and Procedures	1 → b	2 14 ↙	3 14 ↙	<input type="text"/>
14	Injection Safety and Appropriate Health Care Waste Management: Participants Notes	1 → b	2 15 ↙	3 15 ↙	<input type="text"/>
15	Standards for Injection Safety and Health Care Waste Management Practices	1 → b	2 1222 ↙	3 1222 ↙	<input type="text"/>
1222	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 → 1224			

NO.	QUESTIONS	CODING CATEGORIES			GO TO
		(a)			(b)
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON MANUAL (YEAR)
1223	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:				
01	Other protocols/guidelines for infection control [MUST MENTION HAND WASHING AND SHARPS]	1 → b	2 02 ↙	3 02 ↙	<input type="text"/>
02	Other protocols/guidelines for injection safety	1 → b	2 03 ↙	3 03 ↙	<input type="text"/>
03	Other protocols/guidelines on waste management	1 → b	2 04 ↙	3 04 ↙	<input type="text"/>
04	Other protocols/guidelines for diagnosis or treatment of malaria?	1 → b	2 05 ↙	3 05 ↙	<input type="text"/>
05	Other protocols/guidelines for STI diagnosis or treatment?	1 → b	2 06 ↙	3 06 ↙	<input type="text"/>
06	Any other guidelines for post-exposure prophylaxis?	1 → b	2 07 ↙	3 07 ↙	<input type="text"/>
07	Any other guidelines on nutrition for people living with HIV/AIDS?	1 → b	2 122 ↙	3 122 ↙	<input type="text"/>

NO.	QUESTIONS	CODING CATEGORIES					GO TO					
1224	Do providers assigned to this clinic/unit ever provide any curative or preventive care services for HIV/AIDS infected clients?	YES 1 NO, HIV/AIDS CLIENTS ARE REFERRED ELSEWHERE IN THIS FACILITY 2 → 1232 NO, HIV/AIDS CLIENTS ARE REFERRED TO OTHER FACILITY 3 → 1232 NEVER PROVIDE THESE SERVICES OR REFER CLIENTS WITH HIV/AIDS FOR SERVICES 4 → 1232 PROVIDE NO CLINICAL OR SOCIAL SERVICES FOR HIV/AIDS CLIENTS 5 → 1251										
1225	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 <table border="1"> <thead> <tr> <th>PROVIDE SERVICE THIS CLINIC</th><th>REFER TO OTHER CLINIC</th><th>INPATIENT SERVICE ONLY</th><th>REFER CLIENTS OUTSIDE FACILITY</th><th>NO SERVICE OR REFERRAL</th></tr> </thead> </table>					PROVIDE SERVICE THIS CLINIC	REFER TO OTHER CLINIC	INPATIENT SERVICE ONLY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL	
PROVIDE SERVICE THIS CLINIC	REFER TO OTHER CLINIC	INPATIENT SERVICE ONLY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL								
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 and/or provide medical follow-up for ART clients	1 ART QRE ↙	2	3	4	5						
08	Provide other 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						
1226	How many days per month is palliative care offered from this clinic/unit? USE A 4-WEEK MONTH TO CALCULATE NUMBER OF DAYS	DAYS PER MONTH <table border="1"><tr><td></td><td></td></tr></table> SERVICE NOT AVAILABLE 00 <table border="1"><tr><td></td><td></td></tr></table>										

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1227	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	Primary preventive treatment, that is, before the client is ill, for opportunistic infections such as Cotrimoxazole treatment (CPT).	1	2	3	4	5
02	Preventive treatment for TB (IPT)	1	2	3	4	5
03	Testing or screening for tuberculosis?					
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
1228	Is there any record of clients receiving CPT? IF YES, ASK TO SEE THE RECORD AND INDICATE IF CLIENT SEX IS RECORDED.	YES, OBSERVED, SEX RECORDED 1 YES OBSERVED, SEX NOT RECORDED 2 RECORD REPORTED, NOT SEEN 3 ONLY RECORDED IN INDIVIDUAL CLIENT CHART 4 INFORMATION NOT RECORDED 5 CPT NOT OFFERED 6				
1229	Is there any record of clients receiving Isoniazid (INH) for TB preventive treatment, that is IPT? IF YES, ASK TO SEE THE RECORD AND INDICATE IF CLIENT SEX IS RECORDED.	YES, OBSERVED, SEX RECORDED 1 YES OBSERVED, SEX NOT RECORDED 2 RECORD REPORTED, NOT SEEN 3 ONLY RECORDED IN INDIVIDUAL CLIENT CHART 4 INFORMATION NOT RECORDED 5 IPT NOT OFFERED 6				
1230	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 → 1232				
1231	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)	
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON MANUAL (YEAR)	
01	Other protocols/guidelines for the clinical management of HIV/AIDS infection/treatment of OIs in adults	1 → b	2 02 ↙	3 02 ↙	[][][][]	
02	Other protocols/guidelines for the clinical management of HIV/AIDS infection/treatment of OIs in children	1 → b	2 03 ↙	3 03 ↙	[][][][]	
03	Protocols/guidelines on micronutrient supplementation	1 → b	2 04 ↙	3 04 ↙	[][][][]	
04	Protocols/guidelines on advanced nutritional support, such as fortified protein supplement to treat or prevent severe malnutrition?	1 → b	2 05 ↙	3 05 ↙	[][][][]	
05	Protocols/guidelines on provision of symptomatic or palliative care [MUST MENTION PAIN CONTROL]	1 → b	2 06 ↙	3 06 ↙	[][][][]	
06	Protocols/guidelines on preventive therapy other than TB, such as cotrimoxazole to prevent pneumonia?	1 → b	2 07 ↙	3 07 ↙	[][][][]	
07	Protocols/guidelines on preventive therapy for tuberculosis	1 → b	2 08 ↙	3 08 ↙	[][][][]	
08	Other protocols/guidelines on community or home-based care for HIV/AIDS clients	1 → b	2 1232 ↙	3 1232 ↙	[][][][]	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1232	Do providers assigned to this clinic/unit ever provide or refer HIV infected clients for support services or counseling for helping them and their families to live with HIV/AIDS?	YES 1 NO 2				→ 1234
1233	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
1234	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				→ 1242
1235	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				→ 1237 → 1237

NO.	QUESTIONS	CODING CATEGORIES	GO TO																												
1243	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 OR COMPUTER 1 CENTRAL FACILITY LOCATION (RECORDS OR COMPUTERIZED) 2 NO RECORD MAINTAINED 3	→ 1248 → 1251																												
1244	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. 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.	<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 KAPOS'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) 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 KAPOS'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) 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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1245	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"/>																													
1246	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
1247	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	
1248	Are reports regularly compiled on the number of visits by clients who seek treatment from this clinic/unit?	YES 1 NO 2	→ 1251
1249	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	→ 1251
1250	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/UAC/MEP) C REGIONAL LEVEL (MOH/UAC/MEP) D NATIONAL LEVEL (MOH/UAC/MEP) E DONOR AGENCY F OTHER X (SPECIFY) _____	
1251	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	→ 1259 → 1259 → 1259
1252	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	
1253	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES	YES, OBSERVED 1 YES, REPORTED NOT SEEN 2 NO 3	
1254	What is the PEP regimen that is most commonly prescribed?	2-Drug Combinations: ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC) 01 STAVUDINE (d4T) + LAMIVUDINE (3TC) ... 02 STAVUDINE (d4T) + DIDANOSINE (ddl) ... 03 3-Drug Combinations ANY OF 1, 2 or 3 plus EFAVIRENZ (EFZ) ... 04 ANY OF 1, 2 or 3 plus NELFINAVIR (NFV) ... 05 ANY OF 1, 2 or 3 plus LOPINAVIR-RITONAVIR (LPV/r) 06 OTHER 96 (SPECIFY) _____	
1255	Are any PEP drugs stored in this clinic/unit? IF YES, ASK TO SEE THE PEP DRUGS	YES 1 NO 2	→ 1259

NO.	QUESTIONS	CODING CATEGORIES			GO TO
	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				
1263	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	CONDOMS	1	2	3	
20	RAPID TEST FOR HIV	1	2	3	
21	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
22	VACUTAINER	1	2	3	

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1264	Is there a procedure room in this clinic/unit that is different from the room just assessed? IF YES, ASK TO SEE AND INDICATE IF THE ITEMS LISTED BELOW ARE AVAILABLE	YES 1 NO 2			→ 1266
1265	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
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13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	CONDOMS	1	2	3	
20	RAPID TEST FOR HIV	1	2	3	
21	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
22	VACUTAINER	1	2	3	
1266	Is this the main outpatient clinic/unit?	YES 1 NO 2			→ 1271

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1267	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			→ 1271
1268	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10	2	3	
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10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	CONDOMS	1	2	3	
20	RAPID TEST FOR HIV	1	2	3	
21	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
22	VACUTAINER	1	2	3	
1269	INDICATE WHICH UNIT THE FOLLOWING INFORMATION IS FOR. IF NO ELIGIBLE UNIT REMAINS, CIRCLE '3'.	DERMATOLOGY 1 DENTAL 2 NO ELIGIBLE UNITS 3			→ 1271

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1270	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
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17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	CONDOMS	1	2	3	
20	RAPID TEST FOR HIV	1	2	3	
21	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
22	VACUTAINER	1	2	3	
1271	<p>Are syringes for client injections or drawing blood ever reused? IF YES, ASK:</p> <p>What is the final method most commonly used sterilizing syringes prior to reuse? CIRCLE ALL THAT APPLY.</p> <p>IF NO, CIRCLE 'Y' FOR "NEVER REUSE SYRINGES"</p>	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E OTHER X (SPECIFY) NEVER REUSE SYRINGE Y			

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)								
1277	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 or HLD	1	2	3	8			

1278 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 Disinfection (HLD)	(6) Initial decontamination
A	Method USED 1 NOT USED ... 2 → 2	USED 1 NOT USED ... 2 → 3	USED 1 NOT USED ... 2 → 4	USED 1 NOT USED ... 2 → 5	USED 1 NOT USED ... 2 → 6	USED 1 NOT USED ... 2 → 1278a
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	<div> <div> JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE 04 ALCOHOL 05 CHLORHEXIDINE 06 GLUTARALDEHYDE 07 CHLORINE TABS .. 08 DON'T KNOW 98 </div> <div> JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE 04 ALCOHOL 05 CHLORHEXIDINE 06 GLUTARALDEHYDE 07 CHLORINE TABS .. 08 DON'T KNOW 98 </div> </div>				
H	Percent solution before dilution PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98
I	Mixture, parts solution or tablets and water MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000

NO.	QUESTIONS	CODING CATEGORIES				GO TO			
1278a	ASK TO SEE WHERE PROCESSED EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED, PRIOR TO REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION OR CLINIC/UNIT THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "5" AND CONTINUE.	SECTION 1 (Q182)	1	→ 1279a					
		SECTION 3 (Q356)	2	→ 1279a					
		SECTION 5 (Q589)	3	→ 1279a					
		OTHER C/U. <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>					4	→ 1279a	
		NOT PREVIOUSLY SEEN	5						
1279	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 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				
1279a	DID YOU NOTICE OR OBSERVE ANYTHING THAT WOULD SUGGEST THAT AN ATTEMPT IS BEING MADE TO STERILIZE OR PROCESS INJECTION EQUIPMENT SUCH AS NEEDLES AND SYRINGES FOR RE-USE? IF YES: CIRCLE ALL RESPONSES THAT APPLY	USED INJECTION EQUIPMENT IN STERILIZER, AUTOCLAVE, BOILER OR DISH OF WATER ... A USED INJECTION EQUIPMENT IN DRAWERS B BULGING OR DISCOLORED SYRINGES C NO EVIDENCE OF ATTEMPT Y							
1280	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 clinic/unit finally dispose of sharp items, or what is the final disposal process for filled sharps boxes?	BURN IN INCINERATOR: 2-CHAMBER INDUSTRIAL (800-1000+° c 02 1-CHAMBER DRUM/BRICK 03 OPEN BURNING FLAT GROUND-NO PROTECTION ... 04 PIT OR PROTECTED GROUND 05 DUMP WITHOUT BURNING FLAT GROUND-NO PROTECTION ... 06 COVERED PIT OR PIT LATRINE 07 OPEN PIT-NO PROTECTION 08 PROTECTED GROUND OR PIT 09 REMOVE OFFSITE STORED IN COVERED CONTAINER... 10 → 1282 STORED IN OTHER PROTECTED ENVIRONMENT 11 → 1282 STORED UNPROTECTED .. 12 → 1282 OTHER 96 (SPECIFY) NEVER HAVE SHARPS WASTE ... 95 → 1282							

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1281	Are the burned/dumped sharps routinely buried? IF YES, CHECK TO SEE IF THE WASTE IS COMPLETELY COVERED BY THE BURIAL.	YES, WASTE COMPLETELY COVERED 1 YES, WASTE PARTIALLY COVERED ... 2 NO BURIAL OF BURNED/DUMPED SHARPS 3	
1282	Now I would like to ask you a few questions about the waste disposal practices for infectious waste such as used bandages. How does this clinic/unit finally dispose of infectious wastes such as these?	SAME AS FOR SHARP ITEMS 01 BURN IN INCINERATOR: 2-CHAMBER INDUSTRIAL (800-1000+° c 02 1-CHAMBER DRUM/BRICK 03 OPEN BURNING FLAT GROUND-NO PROTECTIO..... 04 PIT OR PROTECTED GROUND 05 DUMP WITHOUT BURNING FLAT GROUND-NO PROTECTION 06 COVERED PIT OR PIT LATRINE 07 OPEN PIT-NO PROTECTION 08 PROTECTED GROUND OR PIT 09 REMOVE OFFSITE STORED IN COVERED CONTAINER.... 10 STORED IN OTHER PROTECTED ENVIRONMENT 11 STORED UNPROTECTED 12 OTHER 96 (SPECIFY) NEVER HAVE INFECTIOUS WASTE..... 95	→ 1284 → 1284 → 1284 → 1284 → 1284
1283	Is the burned/dumped infectious waste routinely buried? IF YES, CHECK TO SEE IF THE WASTE IS COMPLETELY COVERED BY THE BURIAL.	YES, WASTE COMPLETELY COVERED... 1 YES, WASTE PARTIALLY COVERED ... 2 NO BURIAL OF BURNED/DUMPED INFECTIOUS WASTE 3	
1284	ARE THERE ANY UNPROTECTED SHARPS OR INFECTIOUS WASTE OBSERVED EITHER AT THE FINAL DISPOSAL SITE OR ON THE FACILITY GROUNDS? THIS INCLUDES SYRINGES, NEEDLES, AND BANDAGES.	YES 1 NO, OR NOT APPLICABLE 2	
1285	CHECK Q1280 AND 1282 , IS 10 OR 11 OR 12 CIRCLED (ANY WASTE REMOVED OFFSITE FOR DISPOSAL?) YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 1287
1286	How is the waste that is collected and removed offsite finally disposed?	INCINERATED 1 TAKEN TO LOCAL DUMP: BURNED AND BURIED 2 BURNED BUT NOT BURIED 3 BURIED UNBURNED 4 OTHER 6 (SPECIFY) DON'T KNOW 8	

NO.	QUESTIONS	CODING CATEGORIES		GO TO
1287	ASSESS CONDITION OF SERVICE AREA	YES	NO	
01	FLOOR SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2	
02	COUNTERS/TABLES/CHAIRS WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2	
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2	
04	WALLS: REASONABLY CLEAN	1	2	
05	DOORS: NO, OR MINOR DAMAGE	1	2	
06	WALLS: NO, OR MINOR DAMAGE	1	2	
07	ROOF: NO, OR MINOR DAMAGE	1	2	
1288	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES	1	
		NO	2	
1289	WAS THE SHARPS CONTAINER OVERFLOWING OR WAS THE CONTAINER PIERCED/BROKEN?	YES	1	
		NO	2	
		NO SHARPS CONTAINER	3	
1290	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES	1	
		YES, IN UNCOVERED CONTAINER ..	2	
		NO	3	

SECTION 13: INPATIENT CARE																		
Facility Number: 		QRE TYPE 13																
Interviewer Code: 																		
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.																		
1300	INDICATE WHICH INPATIENT UNIT THE DATA IN THIS QUESTIONNAIRE REPRESENTS	<div style="display: flex; justify-content: center; gap: 10px;"> <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: center; gap: 10px; font-size: small;"> Line # Unit # </div>																
1301	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">MANAGING AUTHORITY</td> <td style="width: 20%; text-align: right;">1</td> </tr> <tr> <td>GOVERNMENT</td> <td style="text-align: right;">2</td> </tr> <tr> <td>PRIVATE</td> <td style="text-align: right;">6</td> </tr> <tr> <td>OTHER _____</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: center;">(SPECIFY)</td> </tr> </table>			MANAGING AUTHORITY	1	GOVERNMENT	2	PRIVATE	6	OTHER _____		(SPECIFY)						
MANAGING AUTHORITY	1																	
GOVERNMENT	2																	
PRIVATE	6																	
OTHER _____																		
(SPECIFY)																		
1302	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 Q1306, Q1308 & Q1310</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>'PMTCT Q1305</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TB Q1316 (01, 02, 03)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>'ART Q1324 (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 Q1306, Q1308 & Q1310	1	2	'PMTCT Q1305	1	2	TB Q1316 (01, 02, 03)	1	2	'ART Q1324 (07, 08)	1	2
	APPLICABLE & COMPLETED	NOT APPLICABLE																
'(V)CT Q1306, Q1308 & Q1310	1	2																
'PMTCT Q1305	1	2																
TB Q1316 (01, 02, 03)	1	2																
'ART Q1324 (07, 08)	1	2																
<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 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 Q1303 BELOW AND GO ON TO Q1304.</p>																		
<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 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 prepared by the unit 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;"> <div style="width: 60%;"> Interviewer's signature _____ </div> <div style="width: 35%;"> Date _____ </div> </div> <p>SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>																		

NO.	QUESTIONS	CODING CATEGORIES		GO TO								
1311	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										
1312	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										
1313	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 ENTER 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> 3 YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER 6 SPECIFY _____ NO INDIVIDUAL CLIENT CHART/RECORD 7										
1314	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 CLIENTS. . 1 YES, OBSERVED WRITTEN POLICY .. 2 YES, REPORTED, NOT SEEN 3 NO 4		→ 1316								
1315	Does the policy specify that no one can be informed of the HIV/AIDS status without the client's consent?	YES 1 NO 2										
1316	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.	<table border="1" style="width: 100%; text-align: center;"> <tr> <th colspan="2">SERVICE OFFERED IN THIS FACILITY</th> <th colspan="2">NO SERVICE THIS FACILITY</th> </tr> <tr> <td>PROVIDE SERVICE THIS CLINIC</td> <td>SERVICE BY PROVIDERS FROM OTHER CLINIC/UNIT THIS FACILITY</td> <td>REFER CLIENTS OUTSIDE FACILITY</td> <td>NO SERVICE OR REFERRAL</td> </tr> </table>		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	
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 malaria?	1 2 3 4										
05	Do providers assigned to this unit prescribe treatment for sexually transmitted infections (STI)?	1 2 1318 ↙	3 1318 ↙ 4 1318 ↙									

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1317	Are all STI clients routinely referred for HIV testing?	YES	1		
		ONLY IF SUSPECTED TO BE HIV+ ...	2		
		NO	3		
1318	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			→ 1322
1319	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?	(a) OBSERVED REPORTED AVAIL. NOT SEEN NOT AVAIL.			(b) DATE ON OBSERVED MANUAL YEAR
01	Uganda National Policy on HIV Counseling and Testing	1 →b	2 02	3 02	<input type="text"/>
02	Policy Guidelines for Prevention of Mother to Child Transmission	1 →b	2 03	3 03	<input type="text"/>
03	National Antiretroviral Treatment and Care guideline for Adult and Children	1 →b	2 04	3 04	<input type="text"/>
04	Comprehensive HIV Care (IMAI): Acute Care Guide	1 →b	2 05	3 05	<input type="text"/>
05	Comprehensive HIV Care (IMAI): Chronic HIV Care Guide	1 →b	2 06	3 06	<input type="text"/>
06	Comprehensive HIV Care: Home Based Care Trainers' Guide for Health Workers	1 →b	2 07	3 07	<input type="text"/>
07	Uganda Clinical Guidelines	1 →b	2 08	3 08	<input type="text"/>
08	Sexually Transmitted Infections Treatment Guidelines for Use by Operational Level Health Workers	1 →b	2 09	3 09	<input type="text"/>
09	Nutritional Care and Support for People Living with HIV/AIDS in Uganda	1 →b	2 10	3 10	<input type="text"/>
10	Tuberculosis Control & Community-based DOTS as an essential component of District Health Systems	1 →b	2 11	3 11	<input type="text"/>
11	Tuberculosis Case Management Desk Aide	1	2 12	3 12	<input type="text"/>
12	Management of uncomplicated Malaria	1 →b	2 13	3 13	<input type="text"/>
13	Infection Control: Policies and Procedures	1 →b	2 14	3 14	<input type="text"/>
14	Injection Safety and Appropriate Health Care Waste Management: Participants Notes	1 →b	2 15	3 15	<input type="text"/>
15	Standards for Injection Safety and Health Care Waste Management Practices	1 →b	2 1320	3 1320	<input type="text"/>

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1320	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			→ 1322
1321	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a)			(b)
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	Other protocols/guidelines for infection control [MUST MENTION HAND WASHING AND SHARPS]	1 →b	2 02↵	3 02↵	<input type="text"/>
02	Other protocols/guidelines for injection safety	1 →b	2 03↵	3 03↵	<input type="text"/>
03	Other protocols/guidelines on waste management	1 →b	2 04↵	3 04↵	<input type="text"/>
04	Other protocols/guidelines for diagnosis or treatment of malaria?	1 →b	2 05↵	3 05↵	<input type="text"/>
05	Other protocols/guidelines for STI diagnosis or treatment	1 →b	2 06↵	3 06↵	<input type="text"/>
06	Any other guidelines for post-exposure prophylaxis?	1 →b	2 07↵	3 07↵	<input type="text"/>
07	Any other guidelines on nutrition for people living with HIV/AIDS?	1 →b	2 1322↵	3 1322↵	<input type="text"/>
1322	Do providers assigned to this clinic/unit ever provide any curative or preventive care services for HIV/AIDS infected clients?	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 PROVIDE NO CLINICAL OR SOCIAL SERVICES FOR HIV/AIDS CLIENTS 5			→ 1330 → 1330 → 1330 → 1348(03)
1323	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
1324	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 TO		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? [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 and/or provide medical follow-up for ART clients	1 ART QRE	2	3	4	5
08	Provide other 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
1325	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	Primary preventive treatment, that is, before the client is ill, for opportunistic infections such as Cotrimoxazole Preventive Treatment (CPT).	1	2	3	4	5
02	Preventive treatment for TB (INH)	1	2	3	4	5
03	Testing or screening for tuberculosis?	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
1326	Is there any record of clients receiving CPT? IF YES, ASK TO SEE THE RECORD AND INDICATE CLIENT SEX IS RECORDED.	YES, OBSERVED, SEX RECORDED 1 YES OBSERVED, SEX NOT RECORDED 2 RECORD REPORTED, NOT SEEN 3 ONLY RECORDED IN INDIVIDUAL CLIENT C 4 INFORMATION NOT RECORDED 5 CPT NOT OFFERED 6				
1327	Is there any record of clients receiving INH for TB preventive treatment? YES, ASK TO SEE THE RECORD AND INDICATE IF IF CLIENT SEX IS RECORDED.	YES, OBSERVED, SEX RECORDED 1 YES OBSERVED, SEX NOT RECORDED 2 RECORD REPORTED, NOT SEEN 3 ONLY RECORDED IN INDIVIDUAL CLIENT C 4 INFORMATION NOT RECORDED 5 IPT NOT OFFERED 6				
1328	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				→ 1330
1329	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)	
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR	
01	Other protocols/guidelines for the clinical management of HIV/AIDS infection/treatment of OIs in adults	1 → b	2 02 ↙	3 02 ↙		
02	Other protocols/guidelines for the clinical management of HIV/AIDS infection/treatment of OIs in children	1 → b	2 03 ↙	3 03 ↙		
03	Protocols/guidelines on micronutrient supplementation	1 → b	2 04 ↙	3 04 ↙		
04	Protocols/guidelines on advanced nutritional support, such as fortified protein supplement to treat or prevent severe malnutrition?	1 → b	2 05 ↙	3 05 ↙		
05	Protocols/guidelines on provision of symptomatic or palliative care? [MUST MENTION PAIN CONTROL]	1 → b	2 06 ↙	3 06 ↙		
06	Protocols/guidelines on preventive therapy other than TB, such as cotrimoxazole to prevent pneumonia?	1 → b	2 07 ↙	3 07 ↙		
07	Protocols/guidelines on preventive therapy for tuberculosis	1 → b	2 08 ↙	3 08 ↙		
08	Other protocols/guidelines on community or home-based care for HIV/AIDS clients	1 → b	3 1330 ↙	3 1330 ↙		

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1330	Do providers assigned to this clinic/unit ever provide or refer HIV infected clients for support services or counseling for helping them and their families live with HIV/AIDS?	YES	1		→1332	
		NO	2			
1331	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			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
1332	Is there a record maintained of client referrals outside this UNIT? IF YES, ASK TO SEE DOCUMENTS WHERE REFERRALS ARE RECORDED.	YES, OBSERVED			1	→ 1339
		YES, REPORTED, NOT SEEN			2	
		RECORDED ON CLIENT CHART ONLY			3	
		NO			4	
		NO, NEVER REFER IN OR OUTSIDE FACILITY			5	
1333	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	→ 1335
		YES, REPORTED, NOT SEEN			2	
		NO FORM USED			3	
		NEVER REFER WITHIN FACILITY			4	→ 1335

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1334	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	
1335	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	→ 1337 → 1337 → 1339
1336	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	→ 1338 → 1338 → 1338
1337	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	
1338	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	
1339	CHECK Q1324 AND RECORD IF ANY RESPONSES ARE '1', INDICATING THIS UNIT PROVIDES CLINICAL SERVICES FOR HIV/AIDS.	YES 1 NO 2	→ 1348

NO.	QUESTIONS	CODING CATEGORIES	GO TO																																												
1340	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	→ 1345 → 1348																																												
1341	<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></th><th>NUMBER OF ADMISSIONS/DISCHARGES</th><th></th></tr> </thead> <tbody> <tr> <td>1</td><td>ORAL CANDIDIASIS/MOUTH SORES</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td><td rowspan="13"></td></tr> <tr> <td>2</td><td>CRYPTOCOCCAL MENINGITIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>3</td><td>TOXOPLASMOSIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>4</td><td>KAPOS'I'S SARCOMA</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>5</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>TUBERCULOSIS</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>12</td><td>OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO) LYMPHADENOPATHY</td><td><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>13</td><td>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	KAPOS'I'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) 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
1342	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"/>	
1343	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"/>	
1344	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	
1345	Are reports regularly compiled on the number of admissions/discharges of clients for this unit?	YES 1 NO 2	→ 1348
1346	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	→ 1348
1347	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/UAC/MEP) C REGIONAL LEVEL (MOH/UAC/MEP) D NATIONAL LEVEL (MOH/UAC/MEP) E DONOR AGENCY F OTHER X _____ (SPECIFY)	
1348	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	
1349	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	
1350	Were bednets observed for the beds of patients in this unit? IF YES, INDICATE IF THE BEDNETS ARE PROVIDED BY THE FACILITY, OR IF THE PATIENT MUST PROVIDE THEIR OWN BEDNET	YES, PROVIDED BY FACILITY AND OBSERVED ALL PATIENT BEDS ... 1 OBSERVED SOME PATIENT BEDS ... 2 YES, PROVIDED BY PATIENTS 3 NO 4	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1351	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	→ 1359 → 1359 → 1359
1352	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	
1353	Are there any written protocols/guidelines for post-exposure prophylaxis available in this site? IF YES, ASK TO SEE THE PROTOCOLS/ GUIDELINES	YES, OBSERVED 1 YES, REPORTED NOT SEEN 2 NO 3	
1354	What is the PEP regimen that is most commonly prescribed?	2-Drug Combinations: ZIDOVUDINE (ZDV) + LAMIVUDINE (3TC)... 01 STAVUDINE (d4T) + LAMIVUDINE (3TC) 02 STAVUDINE (d4T) + DINADOSINE (ddI) 03 3-Drug Combinations ANY OF 1, 2 or 3 plus EFAVIRENZ (EFZ) 04 ANY OF 1, 2 or 3 plus NELFINAVIR (NFV) 05 ANY OF 1, 2 or 3 plus LOPINAVIR-RITONAVIR (LPV/r) 06 OTHER 96 (SPECIFY)	
1355	Are any PEP drugs stored in this UNIT? IF YES, ASK TO SEE THE PEP DRUGS	YES 1 NO 2	→ 1359
1356	RECORD WHICH MEDICINES ARE PRESENT FOR PEP	ZIDOVUDINE (ZDV or AZT) A LAMIVUDINE (3TC) B STAVUDINE (d4T) C DINADOSINE (ddI) D EFAVIRENZ (EFZ) E NELFINAVIR (NFV) F LOPINAVIR-RITONAVIR (LPV-r) G OTHER ARV H (SPECIFY) OTHER ARV I (SPECIFY) OTHER ARV J (SPECIFY) NONE Y	→ 1359
1357	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)	
1358	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
1362	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			→ 1364
1363	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	CONDOMS	1	2	3	
20	RAPID TEST FOR HIV	1	2	3	
21	SPINAL TAP KIT (LUMBAR PUNCTURE)	1	2	3	
22	VACUTAINER	1	2	3	
1364	Are syringes for client injections or drawing blood ever reused? IF YES, ASK: What is the final method most commonly used sterilizing syringes prior to reuse? CIRCLE ALL THAT APPLY. IF NO, CIRCLE 'Y' FOR "NEVER REUSE SYRINGES"	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E OTHER X (SPECIFY) NEVER REUSE SYRINGE Y			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1365	<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	 → 1372a → 1368
1366	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	 → 1368 → 1368
1367	SCAN THE GUIDELINE AND CIRCLE ALL COMPONENTS THAT ARE MENTIONED OR COVERED	SOAKING TIME A PERCENT OF CHEMICAL USED B PROPORTIONS TO MIX C BRUSH SCRUB D NONE OF THE ABOVE Y	
1368	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"/> NON UNIT (E.G., CENTRAL PROCESSING, THEATER, THIS FACILITY) 3 SEND TO OTHER FACILITY 4 OTHER 6 (SPECIFY) NO ITEMS EVER PROCESSED 7	 → 1371(6) → 1371(6) → 1371(6) → 1371(6)
1369	<p>What is the final method most commonly used for disinfecting or sterilizing medical equipment (such as speculums and/or surgical instruments) before they are reused?</p> <p>IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE METHOD(S) USED FOR METAL EQUIPMENT SUCH AS SPECULUMS OR FORCEPS.</p>	DRY-HEAT STERILIZATION A AUTOCLAVING B BOILING C STEAM STERILIZATION D CHEMICAL METHOD E PROCESSED OUTSIDE FACILITY F OTHER X (SPECIFY)	 → 1371(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)									
1370	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 sterilization or high-level disinfection (HLD)	1	2	3	8				

1371 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 Disinfection (HLD)	(6) Initial decontamination	
A	Method USED 1 NOT USED ... 2 → 2	USED 1 NOT USED ... 2 → 3	USED 1 NOT USED ... 2 → 4	USED 1 NOT USED ... 2 → 5	USED 1 NOT USED ... 2 → 6	USED 1 NOT USED ... 2 → 1371a	
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	<div> <div> JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE 04 ALCOHOL 05 CHLORHEXIDINE 06 GLUTARALDEHYDE 07 CHLORINE TABS 08 DON'T KNOW 98 </div> <div> JIK 01 CHLORINE 02 H2O2 03 POVIDONE IODINE 04 ALCOHOL 05 CHLORHEXIDINE 06 GLUTARALDEHYDE 07 CHLORINE TABS 08 DON'T KNOW 98 </div> </div>					
H	Percent solution before dilution PERCENT [][] DON'T KNOW 98	PERCENT [][] DON'T KNOW 98					PERCENT [][] DON'T KNOW 98
I	Mixture, parts solution or tablets and water MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000	MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000					MIXTURE PARTS/L a) DISINFECTANT [][] b) WATER [][] DK 000

NO.	QUESTIONS	CODING CATEGORIES				GO TO		
1371a	ASK TO SEE WHERE PROCESSED EQUIPMENT SUCH AS SPECULUMS AND FORCEPS ARE STORED, PRIOR TO REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION OR CLINIC/UNIT THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "7" AND CONTINUE.	SECTION 1 (Q182)	1		→ 1372a			
		SECTION 3 (Q356)	2		→ 1372a			
		SECTION 5 (Q589)	3		→ 1372a			
		OTHER C/U <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>					4	→ 1372a
		NOT PREVIOUSLY SEEN	5					
1372	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 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			
1372a	DID YOU NOTICE OR OBSERVE ANYTHING THAT WOULD SUGGEST THAT AN ATTEMPT IS BEING MADE TO STERILIZE OR PROCESS INJECTION EQUIPMENT SUCH AS NEEDLES AND SYRINGES FOR RE-USE? IF YES, CIRCLE ALL RESPONSES THAT APPLY	USED INJECTION EQUIPMENT IN STERILIZER, AUTOCLAVE, BOILER OR DISH OF WATER ... A USED INJECTION EQUIPMENT IN DRAWERS B BULGING OR DISCOLORED SYRINGES C NO EVIDENCE OF ATTEMPT Y						
1373	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 clinic/unit finally dispose of sharp items, or what is the final disposal for filled sharps boxes?	BURN IN INCINERATOR: 2-CHAMBER INDUSTRIAL (800-1000+° C) 02 1-CHAMBER DRUM/BRICK 03 OPEN BURNING FLAT GROUND-NO PROTECTION 04 PIT OR PROTECTED GROUND 05 DUMP WITHOUT BURNING FLAT GROUND-NO PROTECTION 06 COVERED PIT OR PIT LATRINE 07 OPEN PIT-NO PROTECTION 08 PROTECTED GROUND OR PIT 09 REMOVE OFFSITE STORED IN COVERED CONTAINER 10 → 1375 STORED IN OTHER PROTECTED ENVIRONMENT 11 → 1375 STORED UNPROTECTED 12 → 1375 OTHER 96 (SPECIFY) NEVER HAVE SHARPS WASTE 95 → 1375						
1374	Are the burned/dumped sharps routinely buried? IF YES, CHECK TO SEE IF THE WASTE IS COMPLETELY COVERED BY THE BURIAL.	YES, WASTE COMPLETELY COVERED 1 YES, WASTE PARTIALLY COVERED ... 2 NO BURIAL OF BURNED/DUMPED SHARPS 3						

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1375	<p>Now I would like to ask you a few questions about the waste disposal practices for infectious waste such as used bandages.</p> <p>How does this clinic/unit finally dispose of infectious wastes such as these?</p>	<p>SAME AS FOR SHARP ITEMS 01</p> <p>BURN IN INCINERATOR:</p> <p>2-CHAMBER INDUSTRIAL (800-1000+°C) 02</p> <p>1-CHAMBER DRUM/BRICK 03</p> <p>OPEN BURNING</p> <p>FLAT GROUND-NO PROTECTION 04</p> <p>PIT OR PROTECTED GROUND 05</p> <p>DUMP WITHOUT BURNING</p> <p>FLAT GROUND-NO PROTECTION 06</p> <p>COVERED PIT OR PIT LATRINE 07</p> <p>OPEN PIT-NO PROTECTION 08</p> <p>PROTECTED GROUND OR PIT 09</p> <p>REMOVE OFFSITE</p> <p>STORED IN COVERED CONTAINER 10</p> <p>STORED IN OTHER PROTECTED ENVIRONMENT 11</p> <p>STORED UNPROTECTED 12</p> <p>OTHER 96</p> <p>(SPECIFY)</p> <p>NEVER HAVE INFECTIOUS WASTE ... 95</p>	<p>→ 1377</p> <p>→ 1377</p> <p>→ 1377</p> <p>→ 1377</p> <p>→ 1377</p> <p>→ 1377</p> <p>→ 1377</p>
1376	<p>Is the burned/dumped infectious waste routinely buried?</p> <p>IF YES, CHECK TO SEE IF THE WASTE IS COMPLETELY COVERED BY THE BURIAL.</p>	<p>YES, WASTE COMPLETELY COVERED ... 1</p> <p>YES, WASTE PARTIALLY COVERED ... 2</p> <p>NO BURIAL OF BURNED/DUMPED INFECTIOUS WASTE 3</p>	
1377	<p>ARE THERE ANY UNPROTECTED SHARPS OR INFECTIOUS WASTE OBSERVED EITHER AT THE FINAL DISPOSAL SITE OR ON THE FACILITY GROUNDS? THIS INCLUDES SYRINGES, NEEDLES, AND BANDAGES.</p>	<p>YES 1</p> <p>NO, OR NOT APPLICABLE 2</p>	
1378	<p>CHECK Q1373 AND 1375, IS 10 OR 11 OR 12 CIRCLED (ANY WASTE REMOVED OFFSITE FOR DISPOSAL?)</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>		→ 1380
1379	<p>How is the waste that is collected and removed offsite finally disposed?</p>	<p>INCINERATED 1</p> <p>TAKEN TO LOCAL DUMP:</p> <p>BURNED AND BURIED 2</p> <p>BURNED BUT NOT BURIED 3</p> <p>BURIED UNBURNED 4</p> <p>OTHER 6</p> <p>(SPECIFY)</p> <p>DON'T KNOW 8</p>	

NO.	QUESTIONS	CODING CATEGORIES		GO TO
1380	ASSESS CONDITION OF SERVICE AREA	YES	NO	
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2	
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2	
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2	
04	WALLS: REASONABLY CLEAN	1	2	
05	DOORS: NO OR MINOR DAMAGE	1	2	
06	WALLS: NO OR MINOR DAMAGE	1	2	
07	ROOF: NO OR MINOR DAMAGE	1	2	
1381	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES	1	
		NO	2	
1382	WAS THE SHARPS CONTAINER OVERFLOWING OR WAS THE CONTAINER PIERCED/BROKEN?	YES	1	
		NO	2	
		NO SHARPS CONTAINER	3	
1383	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES	1	
		YES, IN UNCOVERED CONTAINER ...	2	
		NO	3	
1384	Now I would like to ask you few questions about availability of adult and pediatric beds and bed nets ASK TO SEE THE WARD AND COUNT THE NUMBER OF BEDS, WITH AND WITHOUT BED NETS FOR THIS WARD			
		OBSERVED PRESENT	NOT AVAILABLE	
01	How many adult beds are in this ward?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	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	

SECTION 14. HEALTH MANAGEMENT INFORMATION SYSTEM			
Facility Number: 		QRE TYPE 14	
Interviewer Code: 		 	
		Line # Unit #	Parent Line #
1400	INDICATE WHICH HMIS UNIT THIS DATA REPRESENTS	OUTPATIENT ONLY 1 INPATIENT ONLY 2 BOTH IN AND OUTPATIENT 3	
1401	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER 6 <div style="text-align: center; font-size: small;">(SPECIFY) _____</div>		
FIND THE PERSON IN CHARGE OF THE HMIS REPORTS. IF HE/SHE IS NOT PRESENT, ASK TO SPEAK WITH THE PROVIDER MOST KNOWLEDGEABLE ABOUT HIV/AIDS HMIS REPORTS PREPARED BY THE FACILITY			
<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 Q1402 BELOW AND GO ON TO Q1403.</p> <p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR THE FACILITY SERVICE DATA, 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 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 types of HIV/AIDS- related statistics and reports compiled by this facility. We will ask to see various reports and records for HIV/AIDS related 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 use your facility d 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 _____		Date _____	
SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.			
1402	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO		
1403	Are you the primary person responsible for compiling routine health information reports? IF NO, ASK TO SPEAK WITH THE PRIMARY RESPONSIBLE PERSON.	YES 1 NO, PRIMARY PERSON NOT PRESENT 2 NO, THERE IS NO ONE ASSIGNED TO COMPILE REPORTS 3	→ 1405 → 1405		
1404	What is the technical background for the person primarily responsible for compiling routine health information reports?	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)			
1405	What is your technical background? 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)			
1406	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	→ 1409		
1407	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. IF # OF DAYS CIRCLE "1" IF # OF MONTHS CIRCLE "2"	NUMBER OF DAYS/MONTHS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> DAYS 1 MONTHS 2			
1408	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			
1409	How many years have you been responsible for HMIS records/reports in this facility? RECORD '00' FOR LESS THAN ONE YEAR	YEARS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			
1410	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	→ 1415		
1411	Who do you train in HMIS?	STAFF IN HMIS UNIT 1 STAFF IN SERVICE UNITS 2 STAFF IN HMIS AND SERVICE UNITS 3			
1412	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	→ 1415		
1413	Was the training on strategic information for HIV/AIDS, formal or informal? IF BOTH, RECORD 'FORMAL'.	FORMAL 1 INFORMAL 2			
1414	How long was the most recent training on strategic information for HIV/AIDS?	DAYS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>			

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1415	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	
05	Standard case definitions on priority diseases for surveillance	1	2	3	
06	District Database	1	2	3	
07	Health Unit procedure manual	1	2	3	
1416	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
1417	ASK TO SEE A COPY OF THE LAST 3 FULL MONTHS ROUTINE HEALTH INFORMATION REPORTS THAT WERE SUBMITTED OUTSIDE OF THE FACILITY	OBSERVED 3 MONTHS REPORTS 1 OBSERVED AT LEAST 1 MONTH REPORT 2 NO REPORTS OBSERVED 3 NEVER SUBMIT REPORTS OUTSIDE 4			→1419 →1419
1418	ASK TO SEE A COPY OF THE LAST 3 FULL MONTH ROUTINE HEALTH INFORMATION REPORTS THAT WERE COMPILED FOR THE FACILITY	OBSERVED 3 MONTHS REPORTS 1 OBSERVED AT LEAST ONE MONTH REPORT 2 NO REPORTS OBSERVED 3 DO NOT COMPILE REPORTS 4			
1419	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 → 1422	3 → 1424	4 → 1424
1420	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"/>			
1421	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>			
1422	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			→ 1424
1423	To whom outside the facility, are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOH/UAC/MEP) C REGIONAL LEVEL (MOH/UAC/MEP) D NATIONAL LEVEL (MOH/UAC/MEP) E DONOR AGENCY F OTHER X (SPECIFY) _____			

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1424	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 → 1427	3 → 1429	4 → 1429
1425	RECORD THE NUMBER OF NEWLY DIAGNOSED HIV CASES DURING THE PAST 12 MONTHS	NEW HIV CASES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
1426	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>			
1427	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			→ 1429
1428	To whom are the reports sent? CIRCLE ALL THAT APPLY.	DISTRICT LEVEL (MOH/UAC/MEP) C REGIONAL LEVEL (MOH/UAC/MEP) D NATIONAL LEVEL (MOH/UAC/MEP) E DONOR AGENCY F OTHER X (SPECIFY) _____			
1429	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

NO.	QUESTIONS	CODING CATEGORIES		GO TO
1430	INDICATE CLIENT INFORMATION FOR WHICH THE FOLLOWING QUESTION IS COMPLETED.	OUTPATIENT CLIENTS ONLY	1	
		INPATIENT CLIENTS ONLY	2	
		BOTH OUTPATIENT AND INPATIENT	3	
1431	RECORD THE NUMBER OF CLIENT VISITS 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.			
		(A) NUMBER OUTPATIENT VISITS	(B) INPATIENT ADMISSIONS/DISCHARGES	
1	ORAL CANDIDIASIS/MOUTH SORES	<input type="text"/> <input type="text"/> <input type="text"/> <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"/> <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"/> <input type="text"/> <input type="text"/> <input type="text"/>	
4	KAPOS'I'S SARCOMA	<input type="text"/> <input type="text"/> <input type="text"/> <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"/> <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"/> <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"/> <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"/> <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"/> <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"/> <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"/> <input type="text"/> <input type="text"/> <input type="text"/>	
12	OTHER NON-SPECIFIC DIAGNOSIS COMMON TO HIV/AIDS ILLNESSES PYREXIA/FEVER UNKNOWN ORIGIN (PUO) LYMPHADENOPATHY	<input type="text"/> <input type="text"/> <input type="text"/> <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"/> <input type="text"/> <input type="text"/> <input type="text"/>	
1432	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN THE PREVIOUS QUESTION	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
1433	RECORD THE TOTAL NUMBER OF OUTPATIENT VISITS AND INPATIENT ADMISSIONS/ DISCHARGES FOR ALL HIV AND NON-HIV DIAGNOSES, FOR THE TIME PERIOD INDICATED IN Q1431	TOTAL OPD VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	TOTAL IPD ADMISSIONS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1434	<p>Finally, I want to know about any activities where the data collected and compiled is reviewed for improving services.</p> <p>Are there ever any meetings where service statistics are discussed among management or with clinic/unit staff, such as looking at changes in patterns or other items relevant to client services?</p>	<p>YES 1</p> <p>NO 2</p>	→ END
1435	<p>Is there any evidence of looking at service data for evaluating or monitoring data? IF YES, ASK TO SEE ANY REPORTS, WALL GRAPHS OR CHARTS THAT SHOW SERVICE DATA HAS BEEN REVIEWED. CIRCLE ALL RELEVANT TYPE OF REPORTS OBSERVED.</p>	<p>OBSERVED</p> <p>WALL CHART/GRAPH A</p> <p>WRITTEN REPORT/MINUTES B</p> <p>OTHER X</p> <p>(SPECIFY)</p> <p>NO OBSERVED EVIDENCE Y</p>	→ END
1436	<p>ASSESS THE MOST RECENT DATE WHERE THERE IS EVIDENCE OF DATA BEING REVIEWED.</p>	<p>WITHIN THE PAST 3 MONTHS 1</p> <p>MORE THAN 3 MONTHS AGO 2</p> <p>DON'T KNOW 8</p>	
<p>THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE</p>			

SECTION 15: LABORATORY AND OTHER DIAGNOSTICS										
Facility Number: 		QRE TYPE 15								
Interviewer: Code 		<div style="display: flex; justify-content: space-between; align-items: center;"> <div>CLINIC/UNIT CODE</div> <div style="border: 1px solid black; padding: 2px;"> 1 9 </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 2px;"> <div>Line #</div> <div>Unit #</div> <div>Parent Line #</div> </div>								
1500	INDICATE SETTING FOR LAB	LAB IN FACILITY 1 AFFILIATED EXTERNAL LAB 2 AREA LOCKED/NO ACCESS 3 FACILITY HAS NO LAB 4	→ STOP							
1501	Does this lab provide services for both outpatients and inpatients, or does it provide services for outpatients only, or inpatients only? . . .	OUTPATIENT ONLY 1 INPATIENT ONLY 2 BOTH OUT- AND INPATIENTS 3								
1502	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER 6 <div style="text-align: center; font-size: small;">(SPECIFY) _____</div>									
1503	CHECK QUESTION Q1500. IS THE RESPONSE '3', NO ACCESS?	YES 1 NO 2	→ STOP							
1504	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;"> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center; font-size: small;">APPLICABLE & COMPLETED</th> <th style="width: 20%; text-align: center; font-size: small;">NOT APPLICABLE</th> </tr> <tr> <td>VCT (Q1529)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </table>		APPLICABLE & COMPLETED	NOT APPLICABLE	VCT (Q1529)	1	2		
	APPLICABLE & COMPLETED	NOT APPLICABLE								
VCT (Q1529)	1	2								
<p>START DATA COLLECTION IN THE MAIN LABORATORY. FOR EACH OF THE LABORATORY PROCEDURES OF INTEREST, GO TO THE MAIN LOCATION IN THE FACILITY WHERE THE TEST/INFORMATION IS LOCATED. IF A TEST/INFORMATION IS NOT IN THAT LOCATION, ASK IF IT IS ANYWHERE ELSE IN THE FACILITY, AND GO THERE TO COMPLETE THE QUESTIONNAIRE. 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 Q1505 BELOW AND GO ON TO Q1506.</p>										

Hello. My name is _____. We are here on behalf of the Ministry of Health, and the 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.

1505	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP
NO.	QUESTIONS	CODING CATEGORIES	GO TO
1506	How many days in a week is the lab open to serve clients?	NUMBER OF DAYS OPEN <input type="text"/>	
1507	<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 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
1508	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	REPORTED AVAILABLE NOT SEEN	NOT AVAILABLE	YEAR ON OBSERVED MANUAL
01	Infection Control: Policies and Procedures	1 → b	2 02 ↙	3 02 ↙	
02	Injection Safety and Appropriate Health Care Waste Management: Participants Notes	1 → b	2 03 ↙	3 03 ↙	
03	Standards for Injection Safety and Health Care Waste Management Practices	1 → b	2 04 ↙	3 04 ↙	
04	Laboratory Guidelines and Standard Operating Procedures (Volume 1)	1 → b	2 05 ↙	3 05 ↙	
05	Laboratory Guidelines and Standard Operating Procedures (Volume 2)	1 → b	2 06 ↙	3 06 ↙	
06	Other guidelines for blood safety	1 → b	2 07 ↙	3 07 ↙	
07	Other guidelines for universal /standard precautions for healthcare workers	1 → b	2 08 ↙	3 08 ↙	
08	Other infection prevention guidelines	1 → b	2 09 ↙	3 09 ↙	
09	Other guidelines for post-exposure (HIV/AIDS) prophylaxis for healthcare workers	1 → b	2 10 ↙	3 10 ↙	
10	Other guidelines for laboratory procedures related to TB microscopic diagnostic procedures	1 → b	2 11 ↙	3 11 ↙	
11	Any other standard operating procedures (SOPs) for laboratory work?	1 → b	2 1509 ↙	3 1509 ↙	
HIV TESTING					
1509	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			→ 1524
1510	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	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON MANUAL YEAR
01	Uganda National Policy on HIV Counseling and Testing	1 → b	2 02 ↙	3 02 ↙	
02	Other protocols/guidelines for HIV testing procedures (who to test, which test to use)	1 → b	2 03 ↙	3 03 ↙	
03	Any written guidelines on how to conduct HIV test (may be manufacturers instructions)	1 → b	2 04 ↙	3 04 ↙	
04	Written guidelines on confidentiality and disclosure of HIV test results	1 → b	2 1511 ↙	3 1511 ↙	

NO.	QUESTIONS	CODING CATEGORIES						GO TO	
1511	Now I would like to see the equipment and the reagents necessary to conduct various tests.								
	For each of the following tests or equipment, I would like to know if it is used, if it is functioning today, and if relevant, if all items to conduct the test are available today	(a) TEST CONDUCTED		(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 1512↵	1	2	3 1512↵			
1512	Do you have any record of HIV test results for tests conducted in this laboratory? IF YES, ASK TO SEE THE RECORDS FOR THE PAST 12 MONTHS			YES 1 NO 2			→ 1514		
1513	INDICATE IF THE SPECIFIED INFORMATION IS AVAILABLE AND IF SO, RECORD THE INDICATED CLIENT NUMBERS FOR THE PAST 12 MONTHS.	(a)			(b)				
		RECORD AVAILABLE AND OBSERVED			NUMBERS FROM OBSERVED RECORDS				
		REPORTED, NO YES NOT SEEN RECORD			NUMBER OF CLIENTS		MONTHS OF DATA		
01	TOTAL CLIENTS RECEIVING HIV TEST	1→ b	2 02↵	3 02↵	[][][][]		[][]		
02	TOTAL CLIENTS WITH POSITIVE HIV TEST RESULT	1→ b	2 03↵	3 03↵	[][][][]		[][]		
03	TOTAL CLIENTS OR PROVIDERS WHO WERE PROVIDED TEST RESULTS	1→ b	2 04↵	3 04↵	[][][][]		[][]		
04	TOTAL CLIENTS WITH POSITIVE TESTS WHERE RESULTS WERE PROVIDED	1→ b	2 1514↵	3 1514↵	[][][][]		[][]		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1514	Is there an established system for external quality control for the HIV tests conducted by this laboratory? IF YES, PROBE FOR SYSTEM USED. CIRCLE ALL THAT APPLY	YES, PROFICIENCY PANEL A YES, EXTERNAL INSPECTION/ OBSERVATION OF TECHNIQUE ... B SEND BLOOD FOR RETESTING ... C NOT ROUTINE, BUT SOMETIMES ... D NO EXTERNAL QUALITY CONTROL ... Y	→ 1517 → 1517 → 1517 → 1520
1515	CHECK PREVIOUS QUESTION. IS "C" CIRCLED? IF YES ASK: How do you determine when to send a blood sample for retesting?	YES, SEND EVERY FIXED NUMBER OF TESTS 1 YES, SEND EVERY FIXED PERCENT OF TESTS 2 YES, BUT NO FIXED NUMBER 3 DO NOT SEND BLOOD ELSEWHERE 4	→ 1517 → 1520
1516	Please tell me how you decide when to send a blood sample for retesting.	RECORD CORRECT NUMBER/PERCENT FOR Q1515 <input type="text"/>	
1517	Is there a record of the results from the external quality check? IF YES, ASK TO SEE THE RECORD OR REPORT WHERE THE RESULTS ARE RECORDED.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 1520 → 1520
1518	What is the most recent date for an external quality check test result or error rate?	WITHIN PAST ONE MONTH 1 WITHIN PAST 2-6 MONTHS 2 MORE THAN 6 MONTHS 3	
1519	What is the most recent error rate that is recorded by external quality control?	PERCENT ERROR RATE <input type="text"/> DON'T KNOW 98	
1520	Is there any other system used for quality control of laboratory tests for HIV/AIDS?	INTERNAL QUALITY CONTROL 1 OTHER 2 DESCRIBE NO 3	→ 1522
1521	Is there a record of the results from the internal/ other quality check? IF YES, ASK TO SEE THE RECORD OR REPORT WHERE THE RESULTS ARE RECORDED.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	

NO.	QUESTIONS	CODING CATEGORIES			GO TO																												
1522	Are there any fees assessed for any services or items related to HIV/AIDS tests?	YES	1																														
		NO	2		→ 1524																												
1523	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	<table border="1"> <thead> <tr> <th colspan="3">(a) FEE</th> <th>(b) AMOUNT IN USHS.</th> </tr> <tr> <th>YES</th> <th>NO</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 ↙ 05 ↙</td> <td>3 ↙ 05 ↙</td> <td></td> </tr> <tr> <td>1 → b</td> <td>2 ↙ 1524 ↙</td> <td>3 ↙ 1524 ↙</td> <td></td> </tr> </tbody> </table>			(a) FEE			(b) AMOUNT IN USHS.	YES	NO	NA		1 → b	2 ↙ 02 ↙	3 ↙ 02 ↙		1 → b	2 ↙ 03 ↙	3 ↙ 03 ↙		1 → b	2 ↙ 04 ↙	3 ↙ 04 ↙		1 → b	2 ↙ 05 ↙	3 ↙ 05 ↙		1 → b	2 ↙ 1524 ↙	3 ↙ 1524 ↙		
(a) FEE			(b) AMOUNT IN USHS.																														
YES	NO	NA																															
1 → b	2 ↙ 02 ↙	3 ↙ 02 ↙																															
1 → b	2 ↙ 03 ↙	3 ↙ 03 ↙																															
1 → b	2 ↙ 04 ↙	3 ↙ 04 ↙																															
1 → b	2 ↙ 05 ↙	3 ↙ 05 ↙																															
1 → b	2 ↙ 1524 ↙	3 ↙ 1524 ↙																															
01	FEE FOR RAPID TEST																																
02	FEE FOR ELISA TEST																																
03	FEE FOR CD4 TEST																																
04	FEE FOR PCR TEST																																
05	FEE FOR COMPLETE BLOOD COUNT																																
1524	Do you send blood outside the facility for HIV diagnostic testing?	YES	1																														
		NO	2		→ 1529																												
1525	For which HIV test do you send blood outside?	ELISA	A																														
		WESTERN BLOT	B																														
		PCR	C																														
		OTHER	X																														
		SPECIFY																															
1526	Do you have a record with the result of the HIV/AIDS tests conducted elsewhere? IF YES, ASK TO SEE THE REGISTER	YES, OBSERVED	1																														
		YES, REPORTED, NOT SEEN	2																														
		NO	3		→ 1528																												
1527	Does the register indicate if the client or the provider has received the results?	YES, OBSERVED	1																														
		YES, REPORTED, NOT SEEN	2																														
		NO	3																														
1528	After receiving the results, how are the results provided to the client?	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT A LAB TELLS CLIENT VERBALLY ONLY B LAB PROVIDES RESULTS TO HEALTHWORKER/CLINIC/UNIT AND THEY TELL CLIENT C OTHER X (SPECIFY) DON'T KNOW Z																															
1529	Is any pre or post HIV test counseling ever provided to clients in the laboratory area?	YES	1		Q:VCT																												
		NO	2																														
1530	Do you send blood outside the facility for CD4 count, total lymphocyte count or viral load testing? CIRCLE ALL THAT APPLY	YES, CD4	A																														
		YES, TLC	B																														
		YES, VIRAL LOAD	C																														
		NONE OF THE ABOVE	Y		→ 1533																												
1531	Do you have a record with results of the tests conducted elsewhere? IF YES, ASK TO SEE THE RECORD WITH RESULTS OF ANY OF THE ABOVE TESTS SENT ELSEWHERE.	YES, OBSERVED	1																														
		YES, REPORTED, NOT SEEN	2																														
		NO	3																														
1532	After receiving the results, how are the results provided to the client?	LAB PROVIDES WRITTEN COPY OF RESULTS TO CLIENT A LAB TELLS CLIENT VERBALLY ONLY B LAB PROVIDES RESULTS TO HEALTHWORKER WHO TELLS CLIENT C OTHER X (SPECIFY) DON'T KNOW Z																															

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1533	Does this laboratory or unit regularly compile reports of newly diagnosed HIV cases?	YES 1 NO 2			→ 1538
1534	How frequently are the compiled reports submitted to someone outside 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			→ 1536
1535	Where, or to whom does the laboratory send reports? I'm referring to where they are directly sent from the laboratory. CIRCLE ALL THAT APPLY	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR ... B DISTRICT LEVEL (MOH/UAC/MEP) ... C REGIONAL LEVEL (MOH/UAC/MEP) ... D NATIONAL LEVEL (MOH/UAC/MEP) ... E DONOR AGENCY F MAIN FACILITY LABORATORY G OTHER _____ X (SPECIFY)			
1536	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"/> <input type="text"/> REPORT NOT SEEN 99996			→ 1538
1537	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>			
1538	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			→ 1540
1539	HIV RESULTS ARE RECORDED SEPARATELY FOR:	YES	NO	NOT APPLICABLE	
01	VCT	1	2	5	
02	PMTCT/VCT	1	2	5	
03	Surveillance	1	2	5	
04	Blood bank or blood for transfusion	1	2	5	
05	General or specialty outpatient clinic/units (except VCT or PMTCT)	1	2	5	
06	In-patient units, either by separate units or as total in-patient units	1	2	5	
07	By sero-status, irrespective of source	1	2	5	

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1540	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	VACUTAINER	1	2	3	
1541	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2			
1542	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 Q1540.	YES, SAME AREA 1 DIFFERENT AREA 2 NO BLOOD DRAWN 3			→ 1544 → 1544

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1543	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 (PIPED)	1 04 ↙	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↙	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	VACUTAINER	1	2	3	
ASK TO SPEAK WITH THE PERSON MOST KNOWLEGABLE ABOUT OVERALL LABORATORY PRACTICES. IF PRACTICES VARY BETWEEN LABORATORIES, THEN ASSESS THE DECONTAMINATION, STOCK AND EQUIPMENT MANAGEMENT INFORMATION FOR THE MAIN AREA.					
1544	Is there a functioning autoclave for the laboratory?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 YES, NOT FUNCTIONING 3 NO 4			
1545	Does the laboratory decontaminate any 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			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1546	What is the final procedure for disposing of hazardous laboratory waste? PROBE TO ARRIVE AT THE USUAL PRACTICE FOR THE LAB	BURN IN INCINERATOR: 2-CHAMBER INDUSTRIAL (800-1000+° C) .. 02 1-CHAMBER DRUM/BRICK 03 OPEN BURNING FLAT GROUND-NO PROTECTION 04 PIT OR PROTECTED GROUND 05 DUMP WITHOUT BURNING FLAT GROUND-NO PROTECTION 06 COVERED PIT OR PIT LATRINE 07 OPEN PIT-NO PROTECTION 08 PROTECTED GROUND OR PIT 09 REMOVE OFFSITE STORED IN COVERED CONTAINER 10 STORED IN OTHER PROTECTED ENVIRONMENT 11 STORED UNPROTECTED 12 OTHER 96 (SPECIFY)	
1547	Is there a program for routine preventive maintenance for the laboratory 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	
1548	When was the last time that you received a routine supply of test kits or reagents, either that you ordered or that is part of your routine supply system?	WITHIN PRIOR 4 WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO 3 NO ROUTINE SUPPLY SYSTEM ... 4 DON'T KNOW 8	
1549	Does this facility determine the quantity of each test kit or reagent that it needs and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE 2 BOTH (DEPENDS ON KIT/REAGENT) 3 DON'T KNOW 8	→ 1552 → 1554
1550	Do you always receive a standard fixed amount for each test kit or reagent received or does the quantity you receive vary according to recent need or activity level?	QUANTITY BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8	
1551	CHECK Q1549 TO SEE IF '3' (BOTH) IS CIRCLED (DEPENDS ON KIT/REAGENT) YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 1554
1552	Routinely, when you order test kits and reagents, which best describes the system you use to determine how much of each to order? Do you: <ul style="list-style-type: none"> - Review the amount 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 used since the previous order, and plan based on prior consumption and expected future activity? - Other _____ (SPECIFY) - Don't know 	ORDER TO MAINTAIN FIXED STOCK 1 ORDER SAME AMOUNT 2 ORDER BASED ON CONSUMPTION 3 OTHER 6 DON'T KNOW 8	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1553	<p>Which of the following best describes the routine system for deciding when to order test kits and reagents? 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>	
1554	<p>If there is a shortage of a specific test kit or reagent 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 receive test from outside the facility. - Facility borrows from neighboring facility - Test is not offered to client that day 	<p>SPECIAL ORDER 1</p> <p>FACILITY PURCHASE 2</p> <p>CLIENT PURCHASE OUTSIDE .. 3</p> <p>FACILITY BORROWS 4</p> <p>TEST IS NOT OFFERED 5</p>	
1555	<p>During the past 6 months, have you always, not always, but often, or almost never received the amount of each test kit and reagent that you ordered (or that you are supposed to routinely receive)?</p>	<p>ALWAYS 1</p> <p>OFTEN 2</p> <p>ALMOST NEVER 3</p>	

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	NOT AVAILABLE	YES	NO	DON'T KNOW
1556	Now I would like to see specific equipment necessary for other tests Is the following equipment available, and is it functioning today?								
01	ANY HEMATOLOGY TESTS	1	2						
		1557							
02	Hematology analyzer/Coulter (for total lymphocyte count, full blood count, platelet count,)	1→b	2	1 → c	2 → c	3	1	2	8
		03				03	1557		
03	Hemoglobinometer (Shali's apparatus)	1→b	2	1 → c	2 → c	3	1	2	8
		05				05			
04	0.1% HCL for Shali's apparatus			1	2	3			
05	Hemoglobinometer (Lovibond apparatus)	1→b	2	1 → c	2 → c	3	1	2	8
		07				07			
06	20% Ammonia solution for Lovibond app.			1	2	3			
07	Colorimeter or spectrophotometer	1→b	2	1 → c	2 → c	3	1	2	8
		09				09			
08	Drabkin's solution (for colorimeter)			1	2	3			
09	Centrifuge for hematocrit	1→b	2	1 → c	2 → c	3	1	2	8
		11				11			
10	Capillary tubes for hematocrit			1	2	3			
11	Litmus paper for hemoglobin test (with valid expiration date)	1→b	2	1	2	3			
		12							
12	Other anemia test _____ (SPECIFY)	1→b	2	1	2	3			
		1557							
1557	01 SYPHILIS TESTS	1	2						
		1559							
02	VDRL	1→b	2	1	2	3			
		04							
03	Rotator or shaker			1 → c	2 → c	3	1	2	
						04			
04	Rapid plasma reagin test (RPR)	1→b	2	1	2	3			
		1558							
1558	Do you have any record of syphilis test results? IF YES, ASK TO SEE THE RECORD.			YES, RECORD OBSERVED 1	YES, REPORTED, NOT SEEN 2	NO RECORD 3			

NO.	QUESTIONS	CODING CATEGORIES				GO TO
BLOOD TRANSFUSION AND SCREENING						
1559	Does this facility ever conduct blood typing and cross matching? IF YES, ASK TO SEE THE REAGENTS BELOW.	YES 1 NO 2				→1561
1560		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		
04	Anti-D Reagent (valid expiration date)	1	2	3		
05	Incubator (37 degrees Celsius)	1	2	3		
06	Coomb's reagent	1	2	3		
1561	Is blood ever transfused in this facility?	YES 1 NO 2				→1567
1562	Is blood ever stored anywhere in the facility prior to transfusion? IF YES, ASK TO SEE THE FRIDGE THAT IS USED AND INDICATE THE STORAGE CONDITIONS	BLOOD/PLASMA STORED ALONE 1 BLOOD STORED W/ MEDS/VACCINES. ... 2 BLOOD STORED WITH LAB REAGENTS. ... 3 NO BLOOD EVER STORED 4 UNABLE TO OBSERVE 8				
1563	Does any place in this facility do blood screening for infectious diseases prior to transfusion? IF THE FACILITY RECEIVES BLOOD THAT IS ALREADY SCREENED, RESPONSE "2" APPLIES	YES 1 BLOOD SCREENED OUTSIDE FACILITY 2 NO SCREENING TESTS DONE 3				→1567
1564	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	
1565	Do you ever send blood outside for any of the previously mentioned tests?	YES 1 NO 2				→1567
1566	INDICATE IF THERE IS AN OBSERVE RECORD OF RESULTS FOR TEST CONDUCTED OUTSIDE	(a) SEND BLOOD OUTSIDE FOR TEST		(b) RECORD OF TEST RESULTS OBSERVED		
		YES	NO	YES	NO	
01	Syphilis	1→ b	2↓	1	2	
02	Hepatitis B	1→ b	2↓	1	2	
03	Hepatitis C	1→ b	2↓	1	2	
04	HIV	1→ b	2↓	1	2	
1567	DO INFECTION PREVENTION CONDITIONS NEED TO BE ASSESSED FOR THIS LABORATORY AREA?	YES 1 NO, LABORATORY ALREADY ASSESSED 2				→1570

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1568	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	VACUTAINER	1	2	3	
1569	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODILY FLUIDS?	YES 1 NO 2			
1570	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2 NO SHARPS CONTAINER 3			→ 1572
1571	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2			
1572	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES 1 YES, IN UNCOVERED CONTAINER 2 NO 3			

NO.	QUESTIONS	CODING CATEGORIES						GO TO	
BIOCHEMISTRY									
1573	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 fxn tests)	1→b 2↓ 02←		1→ c	2 → c	3 02←	1 1574←	2	8
02	Other means for serum glucose	1→b 2↓ 1574←		1→ c	2 → c	3 1574←	1	2	8
1574	URINE TESTS	1 2↓ 1575←							
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↓ 1575←		1→ c	2 → c	3 1575←	1	2	8
1575	Pregnancy test	1→b 2↓ 1576←		1	2	3			
1576	Do you ever send blood or urine outside for any of the previously mentioned tests?	YES 1 NO 2					→1578		
1577	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				
1578	DO INFECTION PREVENTION CONDITIONS NEED TO BE ASSESSED FOR THIS LABORATORY AREA?	YES 1 NO, LABORATORY ALREADY ASSESSED 2					→1584		

NO.	QUESTIONS	CODING CATEGORIES			GO TO
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	
1579	ASSESS THE LABORATORY AREA. FOR INFECTION PREVENTION CONDITIONS. INDICATE IF ITEMS LISTED BELOW ARE AVAILABLE IN THE LABORATORY, OR IMMEDIATELY ADJACENT				
01	RUNNING WATER (PIPED)	1 04 ↘	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↘	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10 ↘	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↘	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↘	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	VACUTAINER	1	2	3	
1580	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2 NO SHARPS CONTAINER 3			
1581	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2			
1582	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES 1 YES, IN UNCOVERED CONTAINER 2 NO 3			
1583	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	
MICROBIOLOGY									
1584	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→	2→ 02→	1 → c	2 → c	3 → 02→	1	2	8
02	Refrigerator	1→b 2→	2→ 03→	1 → c	2 → c	3 → 03→	1	2	8
03	Incubator	1→b 2→	2→ 04→	1 → c	2 → c	3 → 04→	1	2	8
04	Test tubes	1→b 2→	2→ 05→	1	2	3			
05	Centriguge for CSF microbiology	1→b 2→	2→ 06→	1 →	2 →	3 → 06→	1	2	8
06	Glass slides and covers	1→b 2→	2→ 1585→	1	2	3			
1585	MALARIA TESTS	1	2→ 1586→						
01									
02	Giemsa stain	1→b 2→	2→ 03→	1	2	3			
03	Field stain	1→b 2→	2→ 04→	1	2	3			
04	Rapid test (test strips, ICT, paracheck, etc)	1→b 2→	2→ 05→	1	2	3			
05	Acridine Orange (AO microscope, and acridine orange stain)	1→b 2→	2→ 06→	1	2	3			
06	Other test for malaria (SPECIFY)	1→b 2→	2→ 1586→	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
1586	Indian ink stain	1→b 1587←	2	1	2	3			
1587 01	GONORRHEA TESTS	1 1588←	2						
02	Chocolate agar (culture medium)	1→b 03←	2	1	2	3			
03	Oxidase reagent	1→b 04←	2	1	2	3			
04	Thayer-Martin or Modified TM or Vancomycin-free selective medium (VFMS)	1→b 1588←	2	1	2	3			
1588 01	GRAM STAIN	1 1589←	2						
02	Crystal violet or Gentian violet			1	2	3			
03	Lugol's iodine			1	2	3			
04	Acetone or Acetone alcohol			1	2	3			
05	Neutral red, carbol fuchsin, or other counterstain			1	2	3			
1589 01	CHLAMYDIA TEST	1 1590←	2						
02	Giemsa stain	1→b 03←	2	1	2	3			
03	Other test for chlamydia (SPECIFY)	1→b 1590←	2	1	2	3			
1590	Urine microscopy	1→b 1591←	2	1	2	3			
1591 01	STOOL MICROSCOPY	1 1592←	2						
02	Formal saline	1→b 03←	2	1	2	3			
03	Iodine solution	1→b 1592←	2	1	2	3			
1592 01	TUBERCULOSIS TEST	1 1592d←	2						
02	Ziehl-Neelson test for AFB	1 06←	2						
03	Carbol Fuchsin	1→b 04←	2	1	2	3			
04	20% Sulphuric Acid	1→b 05←	2	1	2	3			
05	Methyl blue	1→b 06←	2	1	2	3			
06	New rapid test for TB	1→b 07←	2	1	2	3			
07	Culture media for TB (Lowenstein-Jensen; Ogawa and Middlebrook, BACTEC or MGIT)	1→b 08←	2	1	2	3			
08	All items for other tests for TB (SPECIFY)	1→b 1592d←	2	1	2	3			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1592d	Is there a system for external quality control for the TB Sptom smears assessed by this laboratory? IF YES, PROBE FOR SYSTEM USED. CIRCLE ALL THAT APPLY	YES, EXTERNAL INSPECTION/ OBSERVATION OF TECHNIQUE . A SEND SLIDE FOR RE-READING . B OTHER _____ . X (SPECIFY) NO EXTERNAL QUALITY CONTROL Y	→1592j
1592e	CHECK PREVIOUS QUESTION. IS "B" CIRCLED? IF "YES" ASK: When you send slides for re-reading, how do you determine when to send them? That is do you send them every fixed number of slides or every fixed percentage of slides? IF "NO": CIRCLE "4" AND SKIP	YES, SEND EVERY FIXED NUMBER OF SLIDES 1 YES, SEND EVERY FIXED PERCENT OF SLIDES 2 YES, BUT NO FIXED NUMBER . 3 DO NOT SEND SLIDE ELSEWHERE 4	→1592g →1592g
1592f	Please tell me how you decide when to send a TB slide for re-reading.	RECORD CORRECT NUMBER FOR 1 OR 2 <input type="text"/> <input type="text"/> <input type="text"/> IN Q1592e	
1592g	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	→1592j →1592j
1592h	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	
1592i	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	
1592j	Is there any other system used for quality control of TB sputum slides?	INTERNAL QUALITY CONTROL 1 OTHER _____ 2 DESCRIBE NO 3	→1593b
1593a	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	
1593b	Does this laboratory conduct sensitivity testing for tuberculosis drugs? IF YES ASK IF ALL COMPONENTS ARE AVAILABLE TODAY.	YES, ALL COMPONENTS PRESENT .. 1 YES, NOT AVAILABLE TODAY 2 NO SENSITIVITY TESTING 3	→1593d
1593c	Is there a written guideline or protocol for TB drug sensitivity testing methods? IF YES, ASK TO SEE IT.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	
1593d	Does this facility ever send sputum outside the facility for testing?	YES 1 NO 2	
1593e	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	→1593g →1593g
1593f	When was the last entry in the register for TB test results?	WITHIN 30 DAYS 1 MORE THAN 30 DAYS AGO 2	
1593g	Do you ever send blood outside for any of the previously mentioned tests?	YES 1 NO 2	→1594c

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1594	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	
1594c	DO INFECTION PREVENTION CONDITIONS NEED TO BE ASSESSED FOR THIS LABORATORY AREA?	YES 1 NO, LABORATORY ALREADY ASSESSED 2				→ 1594i
1594d	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 (PIPED)	1 04 ↙	2	3		
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04 ↙	2	3		
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3		
04	HAND-WASHING SOAP	1	2	3		
05	SINGLE-USE HAND DRYING TOWELS	1	2	3		
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3		
07	SHARPS CONTAINER	1	2	3		
08	DISPOSABLE LATEX GLOVES	1 10 ↙	2	3		
09	DISPOSABLE NON-LATEX GLOVES	1	2	3		
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12 ↙	2	3		
11	DISINFECTANT (NOT YET MIXED)	1	2	3		
12	DISPOSABLE NEEDLES	1	2	3		
13	AUTO-DISABLE SYRINGES	1	2	3		
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3		
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18 ↙	2	3		
16	AUDITORY PRIVACY	1	2	3		
17	VISUAL PRIVACY	1	2	3		
18	VACUTAINER	1	2	3		

NO.	QUESTIONS	CODING CATEGORIES		GO TO																					
1594e	ARE ALL SURFACE AREAS IN THE LAB AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2																							
1594f	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2																							
1594g	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES 1 NO 2 NO SHARPS CONTAINER 3																							
1594h	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES 1 YES, IN UNCOVERED CONTAINER 2 NO 3																							
1594i	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		→ 1595																					
PATHOLOGY																									
1594j	Do you have all items today, for performing.	ARE ALL ITEMS FOR TEST AVAILABLE? <table border="1"> <thead> <tr> <th colspan="2">AVAILABLE TODAY</th> <th rowspan="2">NORMALLY AVAILABLE NOT TODAY</th> <th rowspan="2">NO TEST THIS FACILITY</th> <th rowspan="2">DON'T KNOW</th> </tr> <tr> <th>OBSERVED</th> <th>REPORTED, NOT SEEN</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>PAP smears?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>8</td> </tr> <tr> <td>02</td> <td>Histology?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>8</td> </tr> </tbody> </table>			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
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																			
1595	FOR THE BELOW CIRCLE THE RESPONSE THAT BEST REFLECTS THE OVERALL SITUATION FOR ALL LABORATORY AREAS THAT WERE VISITED.	YES	NO																						
01	FLOOR: SWEEPED, NO OBVIOUS DIRT OR WASTE	1	2																						
02	COUNTERS/TABLES/CHAIRS: WIPED CLEAN- NO OBVIOUS DUST OR WASTE	1	2																						
03	BROKEN EQUIPMENT, PAPERS, BOXES AROUND MAKING AREA CLUTTERED AND DIRTY	1	2																						
04	WALLS: REASONABLY CLEAN																								
05	DOORS: NO OR MINOR DAMAGE	1	2																						
06	WALLS: NO OR MINOR DAMAGE	1	2																						
07	ROOF: NO OR MINOR DAMAGE	1	2																						
08	ROOMS: CAN BE LOCKED	1	2																						

NO.	QUESTIONS	CODING CATEGORIES						GO TO
1596	Does this facility perform diagnostic X-rays? IF YES, ASK TO GO TO WHERE THE EQUIPMENT IS LOCATED.	YES 1 NO 2 → END INFORMATION ALREADY COLLECTED 3 INFORMATION IN LAB QRE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> → END						
1597	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				
03	ULTRASOUND EQUIPMENT	1 → c	2 → c	3 04 →	1	2	8	
04	CT SCAN	1 → c	2 → c	3 END →	1	2	8	
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE								

SECTION 16: MEDICINES AND SUPPLIES												
Facility Number: 		Interviewer Code 										
		QRE TYPE 16										
		CLINIC/UNIT CODE 20										
		<div style="display: flex; justify-content: space-between; font-size: small;"> Line # Unit # Parent Line # </div>										
1600	INDICATE WHICH CLIENTS HAVE ACCESS TO MEDICINES REPORTED IN THIS QRE.	<div style="font-size: x-small;"> OUTPATIENT ONLY 1 INPATIENT ONLY 2 BOTH IN AND OUTPATIENT 3 AREA LOCKED/NO ACCESS 4 NO MEDICINES STORED IN FACILITY 5 </div>	→STOP									
1601	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER 6 <div style="text-align: center; font-size: x-small;">(SPECIFY) _____</div>											
1602	CHECK QUESTION Q1600. IS THE RESPONSE "4", NO ACCESS?	<div style="font-size: x-small;"> YES 1 NO 2 </div>	→STOP									
1603	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; font-size: x-small;">APPLICABLE & COMPLETED</th> <th style="width: 20%; text-align: center; font-size: x-small;">NOT APPLICABLE</th> </tr> </thead> <tbody> <tr> <td style="font-size: x-small;">(V)CT Q1605 (A)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td style="font-size: x-small;">ART (Q1605 (B)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		APPLICABLE & COMPLETED	NOT APPLICABLE	(V)CT Q1605 (A)	1	2	ART (Q1605 (B)	1	2	
	APPLICABLE & COMPLETED	NOT APPLICABLE										
(V)CT Q1605 (A)	1	2										
ART (Q1605 (B)	1	2										
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 Q1604 BELOW AND GO ON TO Q1605.</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 Uganda 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 the 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="margin-top: 20px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Interviewer's signature _____ SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED. </div> <div style="width: 45%;"> Date _____ </div> </div> </div>												

1604	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→STOP
NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
1605	Is counseling related to HIV/AIDS ever provided by staff from this medicine storage or dispensing 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
1606	Is there a register or stock cards where the amount of each medicine received, the amount disbursed, and the amount present today (stock balance) is recorded? IF YES, ASK: May I see the records?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→1608a
1606a	How often do you update or reconcile your inventory/stock records?	EVERY <input type="text"/> <input type="text"/> DAYS 1 THE DAY ITEMS ARE RECEIVED OR DISBURSED 2 NEVER 8	
1607	Is the stock maintenance system computerized?	YES 1 NO 2	
1608	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN Q1606 OR Q1607.	STOCK RECORDS UPDATED DAY ITEM RECEIVED/DISBURSED 1 STOCK RECORDS NOT ALWAYS UPDATED WHEN ITEM DIS- BURSED, BUT RECORD OF RECEIVED/DISTRIBUTED ITEMS OBSERVED 2 OTHER 6 (SPECIFY) _____	
1608a	Who is the principal person responsible for managing medical supplies at this facility? By this I mean the person responsible for ordering, receiving and controlling medical supplies.	PHARMACIST 1 DISPENSER 2 FACILITY IN-CHARGE 3 SUPPLIES OFFICER 4 STORE ASSISTANT 5 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								
1609	GENERAL MEDICINES	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
		CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY	NEVER AVAIL- ABLE	YES	NO
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
		CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY			
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	Dipyrrone (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	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS			
		OBSERVED AVAILABLE			NOT OBSERVED			YES	NO	DK	
		CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY				NEVER AVAIL- ABLE
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			YES	NO	DK
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY	NEVER AVAIL- ABLE			
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 (20,000 IU)		2 → b	3 86 ↘	4 86 ↘	5 86 ↘	6 86 ↘	1	2	8
86	Vitamin A (100,000 IU)		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 1610 ↘	4 1610 ↘	5 1610 ↘	6 1610 ↘	1	2	8

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
1610	ANTIMALARIALS	(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	NEVER AVAIL- ABLE	YES	NO	DK
01	Artemisinin (Tabs) (Artesunate, Cotexin, Arinate)	1 → b	2 → b	3 02 ↙	4 02 ↙	5 02 ↙	6 02 ↙	1	2	8
02	Artemether-Lumefantrine (Tabs) (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 (Tabs)	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	Quinine Mixture	1 → b	2 → b	3 07 ↙	4 07 ↙	5 07 ↙	6 07 ↙	1	2	8
07	Chloroquine (Tabs)	1 → b	2 → b	3 08 ↙	4 08 ↙	5 08 ↙	6 08 ↙	1	2	8
08	Chloroquine (Syrup)	1 → b	2 → b	3 09 ↙	4 09 ↙	5 09 ↙	6 09 ↙	1	2	8
09	Chloroquine (inj)	1 → b	2 → b	3 10 ↙	4 10 ↙	5 10 ↙	6 10 ↙	1	2	8
10	Amodiaquine (Tabs)	1 → b	2 → b	3 11 ↙	4 11 ↙	5 11 ↙	6 11 ↙	1	2	8
11	Homapak (Red)	1 → b	2 → b	3 12 ↙	4 12 ↙	5 12 ↙	6 12 ↙	1	2	8
12	Homapak (Green)	1 → b	2 → b	3 13 ↙	4 13 ↙	5 13 ↙	6 13 ↙	1	2	8
13	Homapak (Blue)	1 → b	2 → b	3 14 ↙	4 14 ↙	5 14 ↙	6 14 ↙	1	2	8
14	Other _____ (SPECIFY)	1 → b	2 → b	3 1610a ↙	4 1610a ↙	5 1610a ↙	6 1610a ↙	1	2	8
1610a	CHECK Q1610.02 ABOVE ON COARTEM. IS "1" CIRCLED IN COL. B INDICATING STOCKOUT IN LAST 6 MONTHS? IF YES, ASK: Was there any time during the Last 6 months when you had a stockout of Coartem lasting for 1 week or longer?				YES, STOCKOUT LASTED 1 WEEK OR LONGER 1 STOCKOUT LASTED LESS THAN 1 WEEK 2 NO STOCKOUT ANYTIME IN LAST 6 MONTHS 3					

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES								
1611	TUBERCULOSIS	(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	NEVER AVAIL- ABLE	YES	NO	DK
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	Rifampicin (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 + rifampicin (Rifina) (Adult formulation)		2 → b	3 07 ↙	4 07 ↙	5 07 ↙	6 07 ↙	1	2	8
07	Isoniazid + rifampicin (Rifina) (Pediatric formulation)		2 → b	3 08 ↙	4 08 ↙	5 08 ↙	6 08 ↙	1	2	8
08	Isoniazid+rifampicin+ pyrazinamide (RHZ, Rifater)		2 → b	3 09 ↙	4 09 ↙	5 09 ↙	6 09 ↙	1	2	8
09	Isoniazid + ethambutol (EH)		2 → b	3 10 ↙	4 10 ↙	5 10 ↙	6 10 ↙	1	2	8
10	4FDC (combination INH, Ethambutol, pyrazinamide, rifampicin)		2 → b	3 11 ↙	4 11 ↙	5 11 ↙	6 11 ↙	1	2	8
11	Other _____ (SPECIFY)		2 → b	3 1612 ↙	4 1612 ↙	5 1612 ↙	6 1612 ↙	1	2	8
1612	INTRAVENOUS SOLUTION	(a) AVAILABILITY OF MEDICINES						(b) OUT OF STOCK IN LAST SIX MONTHS		
		OBSERVED AVAILABLE			NOT OBSERVED					
	CHECK INVENTORY	ALL VALID	AT LEAST ONE VALID	AVAILABLE BUT NONE VALID	REPORTED AVAILABLE, NOT SEEN	NOT AVAIL- ABLE TODAY	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 1613 ↙	4 1613 ↙	5 1613 ↙	6 1613 ↙	1	2	8
1613	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 1614 ↙	4 1614 ↙	5 1614 ↙	6 1614 ↙	1	2	8

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES			
1614	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OR EACH OF THE FOLLOWING CONDITIONS.				
01	ARE ALL THE MEDICINES OFF THE FLOOR?	YES 1 NO 2			
02	ARE ALL THE MEDICINES PROTECTED FROM WATER?	YES 1 NO 2			
03	ARE ALL THE MEDICINES PROTECTED FROM THE SUN?	YES 1 NO 2			
04	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (ROACHES, ETC)	YES 1 NO 2			
1615	Does the pharmacy separate damaged and/or expired items from the usable products, and remove them from the inventory? IF YES, ASK TO SEE EVIDENCE OF EACH OF THE INDICATED PRACTICES AND ALL THAT WERE OBSERVED.	YES, DAMAGED/EXPIRED ITEM REMOVED FROM INVENTORY A REMOVED FROM SHELVES AND NO EXPIRED ITEMS PRESENT B EXPIRED ITEMS OBSERVED C NO Y			
1616	ASK IF THERE IS A THERMOMETER FOR THE ROOM AND RECORD THE TEMPERATURE AT THE TIME OF THE SURVEY	TEMPERATURE <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> CENTEGRADE NOT OBSERVED94 → 1617 THERMOMETER NOT FUNCTIONING95 → 1617 NO THERMOMETER PRESENT96 → 1617			
1616a	INDICATE WHETHER TEMPERATURE IN THE ROOM IS ABOVE OR BELOW ZERO (0) DEGREES. FOR ZERO DEGREES CIRCLE "1"	POSITIVE1 NEGATIVE2			
1617	Is there a functioning refrigerator, separate from one used for vaccines, that is used to store some medicines, or reconstituted vials? IF YES, ASK TO SEE THE REFRIGERATOR	OBSERVED, FUNCTIONING 1 OBSERVED, NOT FUNCTIONING 2 REPORTED, NOT SEEN 3 USE VACCINE FRIDGE 4 NO REFRIGERATOR FOR MEDICINES 5			
1618	LOOK AT THE STORAGE AREA AND CIRCLE ALL THAT APPLY	STORAGE AREA CAN BE LOCKED A THERE IS LIMITED ACCESS B DOORS SOLID C WINDOWS HAVE BARS OR SHUTTERS D NONE OF THE ABOVE Y			
1619	When was the last time that you received a routine supply of medicines, either that you ordered, or that is part of your routine supply system?	WITHIN PRIOR 4 WEEKS 1 BETWEEN 4-12 WEEKS 2 MORE THAN 12 WEEKS AGO 3 NO ROUTINE SUPPLY SYSTEM 4 DON'T KNOW 8			

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
1620	Does this facility determine the quantity of each medicine that it needs and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE 2 BOTH (DIFFERS BY MEDICINE) 3 DON'T KNOW 8	→ 1623 → 1626
1621	Do you always receive a standard fixed quantity of medicine or does the quantity you receive vary according to recent need or activity level?	QUANTITY BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8	
1622	CHECK Q1620 TO SEE IF "3" (BOTH) IS CIRCLED. YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 1626
1623	Routinely, when you order medicines, which best describes the system you use to determine how much of each to order? Do you: - Review the amount of each medicine remaining, and order to bring the stock amount to a pre-determined (fixed) amount? - Order exactly the same quantity each time, regardless of the existing stock? - Review the amount of each medicine used since the previous order, and plan based on prior consumption and expected future activity? - Other _____ (SPECIFY) - Don't know	ORDER TO MAINTAIN FIXED STOCK 1 ORDER SAME AMOUNT 2 ORDER BASED ON CONSUMPTION 3 OTHER 6 DON'T KNOW 8	
1624	Which of the following best describes the routine system for deciding when to order medicines? Do you: - Place order whenever stock levels fall to a predetermined level? - 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	PREDETERMINED LEVEL 1 FIXED TIME 2 EVERY <input type="text"/> <input type="text"/> WEEKS ORDER WHEN NEEDED 3 OTHER 6 DON'T KNOW 8	
1625	On average, how long does it take to receive your supplies after you have placed an order?	UNDER 4 WEEKS 1 BETWEEN 4 TO 8 WEEKS 2 OVER 8 WEEKS 3	
1626	If there is a shortage of a specific medicine between routine orders, what is the most common procedure followed by this facility? - Submit special order to normal supplier - Facility purchases from private market - Clients must purchase from outside the facility - Facility borrows from neighboring facility - None of the above	SPECIAL ORDER 1 FACILITY PURCHASE 2 CLIENT PURCHASE OUTSIDE 3 FACILITY BORROWS 4 NONE OF THE ABOVE 5	→ 1628
1627	During the past 6 months, have you always, not always, but often, or almost never received the amount of each medicine that you ordered (or that you are supposed to routinely receive)?	ALWAYS 1 OFTEN 2 ALMOST NEVER 3	

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES	
1644	<p>Which of the following best describes the routine system for deciding when to order ARVs? 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>	
1645	On average, how long does it take to receive your ARV supplies after you have placed an order?	<p>UNDER 4 WEEKS 1</p> <p>BETWEEN 4 TO 8 WEEKS 2</p> <p>OVER 8 WEEKS 3</p>	
1646	<p>If there is a shortage of a specific ARV 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 - Facility borrows from neighboring facility 	<p>SPECIAL ORDER 1</p> <p>FACILITY PURCHASE 2</p> <p>CLIENT PURCHASE OUTSIDE .. 3</p> <p>FACILITY BORROWS 4</p>	
1647	During the past 6 months, have you always, not always, but often, or almost never received the amount of each ARV that you ordered (or that you are supposed to routinely receive)?	<p>ALWAYS 1</p> <p>OFTEN 2</p> <p>ALMOST NEVER 3</p>	

NO	MEDICATION/SUPPLY ITEM	CODING CATEGORIES					
1648	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 or 3 ml)	1 →b	2 03 ↙	3 03 ↙	1	2	8
03	Disposable syringes 5 ml	1 →b	2 04 ↙	3 04 ↙	1	2	8
04	Autodisable syringes	1 →b	2 05 ↙	3 05 ↙	1	2	8
05	Infusion sets for intravenous solution	1 →b	2 06 ↙	3 06 ↙	1	2	8
06	Cannulae for intravenous	1 →b	2 07 ↙	3 07 ↙	1	2	8
07	Clean non-latex, gloves	1 →b	2 08 ↙	3 08 ↙	1	2	8
08	Clean latex gloves	1 →b	2 09 ↙	3 09 ↙	1	2	8
09	Sterile latex gloves	1 →b	2 10 ↙	3 10 ↙	1	2	8
10	Spinal tap/lumbar puncture kits	1 →b	2 11 ↙	3 11 ↙	1	2	8
11	Disinfectant for cleaning surfaces (bleach or other cleaning solution such as chlorine or chlorhexidine)	1 →b	2 12 ↙	3 12 ↙	1	2	8
12	Hand-washing soap	1 →b	2 13 ↙	3 13 ↙	1	2	8
13	Insecticide treated bed net	1 →b	2 14 ↙	3 14 ↙	1	2	8
14	Sharps boxes/containers	1 →b	2 1649 ↙	3 1649 ↙	1	2	8

1649 GO TO THE MAIN AREA WHERE MEDICINES ARE STORED AND COLLECT INFORMATION ON VALIDATION OF THE LISTED MEDICINES		VALIDATION OF COMMODITY										
		A	B	C	D	E	F	G	H	I	J	K
		PRODUCT NORMALLY CARRIED OR STOCKED AT THIS FACILITY	VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY Y=Yes N=No O=Stockout U=** If stockout, skip to next line item	ITEMS STORED BY DATE OF EXPIRATION Y=Yes N=No	STOCK CARD AVAILABLE Y=Yes N=No If NO, skip to next line item	NUMBER AVAILABLE MATCHES STOCK RECORD Y=Yes N=No If Y, skip to next line item	VARIATION STOCK AND STORE	ANY ZERO BALANCE OBSERVED FOR THE PAST 6 MONTHS Y=Yes N=No	REVIEW INFORMATION (RECORDED ON STOCK CARDS ONLY)* FOR THE PAST 6 MONTHS AND			MONTH S OF DATA REVIE WED 0- 6 MO
									AMOUNT RECEIVED	AMOUNT DISBURSED	BALANCE TODAY	
PRODUCT & UNIT OF COUNT												
01	Coartem Tabs: 20mg/120mg (6 Tab Blisters)	Y	N	Y	N	Y	N	Y	N			
02	Coartem Tabs: 20mg/120mg (12 Tab Blisters)	Y	N	Y	N	Y	N	Y	N			
03	Coartem Tabs: 20mg/120mg (18 Tab Blisters)	Y	N	Y	N	Y	N	Y	N			
04	Coartem Tabs: 20mg/120mg (24 Tab Blisters)	Y	N	Y	N	Y	N	Y	N			
05	Fansidar Tabs: 25mg/500mg (Tabs)	Y	N	Y	N	Y	N	Y	N			
06	Quinine Inj: 600mg/2ml (Ampoule)	Y	N	Y	N	Y	N	Y	N			
07	Ciprofloxacin Tabs: 500mg (Tabs)	Y	N	Y	N	Y	N	Y	N			
08	Doxycycline Tabs: 100mg (Tabs)	Y	N	Y	N	Y	N	Y	N			
09	Benzathine Penicillin Inj: 2.4mU (Vial)	Y	N	Y	N	Y	N	Y	N			
10	Procaine Penicillin Inj: 4MU (Vial)	Y	N	Y	N	Y	N	Y	N			
11	Cotrimoxazole Tabs: 120/480mg (Tabs)	Y	N	Y	N	Y	N	Y	N			
12	Cotrimoxazole Syr: 240mg/5mL (Bottle)	Y	N	Y	N	Y	N	Y	N			
13	Amoxicillin Caps: 250mg (Capsule)	Y	N	Y	N	Y	N	Y	N			
14	Amoxicillin Syrup: 250mg/5mL (Bottle)	Y	N	Y	N	Y	N	Y	N			
15	Gentamycin Inj: 40mg/mL (Ampoule)	Y	N	Y	N	Y	N	Y	N			
16	Metronidazole Tabs: 200mg (Tabs)	Y	N	Y	N	Y	N	Y	N			
17	Erythromycin Tabs: 250mg (Tabs)	Y	N	Y	N	Y	N	Y	N			
18	Nalidixic Acid: 500mg (Tabs or Caps)	Y	N	Y	N	Y	N	Y	N			
19	Oxytocin Inj: 10IU/mL (Ampoule)	Y	N	Y	N	Y	N	Y	N			
20	Chloramphenicol Inj: 1G (Vial)	Y	N	Y	N	Y	N	Y	N			

*If information is not recorded on Stock cards/records, record 9998. Do not collect information from multiple receipts

**U=Not All Checked, but at least one of the items randomly checked was valid

1650 GO TO THE MAIN AREA WHERE ARVS ARE STORED AND COLLECT INFORMATION ON VALIDATION OF THE LISTED ARVS. IF NO ARVS ARE STOCKED, END THE INTERVIEW		VALIDATION OF COMMODITY											MONTHS OF DATA REVIEW ED 0-6 MO				
		A	B	C	D	E	F	G	H		I	J		K			
									REVIEW INFORMATION (RECORDED ON STOCK CARDS ONLY)* FOR THE PAST 6 MONTHS AND	RECORD							
															AMOUNT RECEIVED	AMOUNT DISBURSED	
		PRODUCT NORMALLY CARRIED OR STOCKED AT THIS FACILITY	VALID EXPIRATION DATE ON PRESENT TODAY Y=Yes N=No O=Stockout U=** If stockout, skip to next line item	ITEMS STORED BY DATE OF EXPIRATION Y=Yes N=No	STOCK CARD AVAILABLE Y=Yes N=No If NO, skip to next line item	NUMBER AVAILABLE MATCHES STOCK RECORD Y=Yes N=No If Y, skip to G	VARIATION STOCK AND STORE	ANY ZERO BALANCE OBSERVED FOR THE PAST 6 MONTHS Y=Yes N=No	AMOUNT RECEIVED	AMOUNT DISBURSED	BALANCE TODAY						
PRODUCT & UNIT OF COUNT																	
NrRTI																	
01	Zidovudine (ZDV, AZT) (100 mg Capsules)	Y	N	Y	N	Y	N	Y	N	Y	N						
02	Zidovudine (ZDV, AZT) (300 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
03	Zidovudine (ZDV, AZT) Syrup (50mg/5ml) Bottle	Y	N	Y	N	Y	N	Y	N	Y	N						
04	Abacavir (ABC) (300 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
05	Abacavir (ABC) Syrup (20 mg/ml) Bottle	Y	N	Y	N	Y	N	Y	N	Y	N						
06	Didanosine (ddl) (25 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
07	Didanosine (ddl) (50 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
08	Didanosine (ddl) (100 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
09	Didanosine (ddl) (200 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
10	Didanosine (ddl) (200 mg Capsules)	Y	N	Y	N	Y	N	Y	N	Y	N						
11	Didanosine (ddl) (250 mg Capsules)	Y	N	Y	N	Y	N	Y	N	Y	N						
12	Didanosine (ddl) (200 mg Capsules)	Y	N	Y	N	Y	N	Y	N	Y	N						
13	Lamivudine (3TC) (150 mg Tablets)	Y	N	Y	N	Y	N	Y	N	Y	N						
14	Lamivudine (3TC) Syrup (50mg/5ml) Bottle	Y	N	Y	N	Y	N	Y	N	Y	N						
15	Stavudine (d4T) 15 mg Capsules	Y	N	Y	N	Y	N	Y	N	Y	N						
16	Stavudine (d4T) 20 mg Capsules	Y	N	Y	N	Y	N	Y	N	Y	N						
17	Stavudine (d4T) 30 mg Capsules	Y	N	Y	N	Y	N	Y	N	Y	N						
18	Stavudine (d4T) 40 mg Capsules	Y	N	Y	N	Y	N	Y	N	Y	N						
19	Stavudine Syrup (1 mg/ml) powder	Y	N	Y	N	Y	N	Y	N	Y	N						
NrRTI																	
20	Tenofovir (Disoproxil Fumerate) (300 mg Tabs)	Y	N	Y	N	Y	N	Y	N	Y	N						

	A PRODUCT NORMALLY CARRIED OR STOCKED AT THIS FACILITY	B VALID EXPIRATION DATE ON ALL UNITS PRESENT TODAY Y=Yes N=No O=Stockout U=** If stockout, skip tonext line item	C ITEMS STORED BY DATE OF EXPIRATION Y=Yes N=No	D STOCK CARD AVAILABLE Y=Yes N=No If NO, skip to next line item	E NUMBER AVAILABLE MATCHES STOCK RECORD Y=Yes N=No If Y, skip to G	F VARIATION STOCK AND STORE	G ANY ZERO BALANCE OBSERVED FOR THE PAST 6 MONTHS Y=Yes N=No	H REVIEW INFORMATION (RECORDED ON STOCK CARDS ONLY)* FOR THE PAST 6 MONTHS AND		I RECORD		J BALANCE		K MONTHS OF DATA REVIEW ED 0-6 MO
								AMOUNT RECEIVED	AMOUNT DISBURSED	AMOUNT RECEIVED	AMOUNT DISBURSED	BALANCE TODAY	BALANCE TODAY	
PRODUCT														
NNRTI														
21 Nevirapine (NVP) (200mg Tablets)	Y N	Y N O U	Y N	Y N	Y N		Y N							
22 Nevirapine(NVP) Syrup (50 mg/5ml) Bottle	Y N	Y N O U	Y N	Y N	Y N		Y N							
23 Efavirenz (EFZ) 50 mg Capsules	Y N	Y N O U	Y N	Y N	Y N		Y N							
24 Efavirenz (EFZ) 200 mg Capsules	Y N	Y N O U	Y N	Y N	Y N		Y N							
25 Efavirenz (EFZ) 600 mg Tablets	Y N	Y N O U	Y N	Y N	Y N		Y N							
26 Efavirenz (EFZ) Syrup (30mg/ml) Bottle	Y N	Y N O U	Y N	Y N	Y N		Y N							
PROTEASE INHIBITORS														
27 Indinavir (400 mg Capsules)	Y N	Y N O U	Y N	Y N	Y N		Y N							
28 Ritonavir (Norvir) (100 mg Capsules)	Y N	Y N O U	Y N	Y N	Y N		Y N							
29 Saquinavir (Invirase) (200 mg Capsules)	Y N	Y N O U	Y N	Y N	Y N		Y N							
30 Saquinavir (Invirase) (500 mg Tablets)	Y N	Y N O U	Y N	Y N	Y N		Y N							
COMBINED-3DRUGS														
31 [3TC/d4T](30)/NVP Tablets	Y N	Y N O U	Y N	Y N	Y N		Y N							
32 [3TC/d4T](40)/NVP Tablets	Y N	Y N O U	Y N	Y N	Y N		Y N							
COMBINED - 2 DRUGS														
33 [AZT+3TC] Combivir	Y N	Y N O U	Y N	Y N	Y N		Y N							
34 Lopinavir-Ritonavir (LPV/r) Tablet	Y N	Y N O U	Y N	Y N	Y N		Y N							
35 Lopinavir-Ritonavir (LPV/r) Syrup 60 ml Bottle	Y N	Y N O U	Y N	Y N	Y N		Y N							
*If information is not recorded on Stock cards/records, record 9998. Do not collect information from multiple receipts														
**U=Not All Checked, but at least one of the items randomly checked was valid														

SECTION 17: TUBERCULOSIS DIAGNOSIS AND TREATMENT			
Facility Number: <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>		QRE TYPE <div style="border: 1px solid black; padding: 2px 5px; font-weight: bold;">17</div>	
Interviewer Code: <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>			
1700	INDICATE THE SERVICE SETTING FOR THIS SECTION	<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="margin-left: 5px;">Line # Unit #</div>	
1701	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER _____ 6 <div style="text-align: center; margin-top: 5px;">(SPECIFY)</div>		
<p>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> <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 Q1702 BELOW AND GO ON TO Q1703.</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and the 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 use 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> <div style="margin-top: 20px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">Interviewer's signature _____</div> <div style="width: 45%;">Date _____</div> </div> <p>SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p> </div>			
1702	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1703	<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	
1704	<p>What is the most common method used by providers in this clinic/unit (OR AFFILIATED OPD) for diagnosing TB?</p> <p>IF PROVIDERS IN THIS UNIT MAKE THE FINAL DIAGNOSIS, REGARDLESS OF WHERE THE TEST IS DONE, AND MAKE THE DECISION ON STARTING THE CLIENT ON ANTI-TB DRUGS, ONE OF RESPONSE 1-5 MUST APPLY.</p>	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 ELSEWHERE WITHIN FACILITY 6 REFER ELSEWHERE OUTSIDE FACILITY 7	→ 1710 → 1710 → 1707 → 1707
1705	How many sputum tests are required before diagnosing a client with TB?	ONE 1 TWO 2 THREE 3 NO FIXED NUMBER/DEPENDS ON CLIENT 4 OTHER 6 (SPECIFY)	
1706	<p>Where is the sputum test performed?</p> <p>IF CLIENT OR SPUTUM ARE SENT TO OTHER FACILITY FOR TESTING, ASK TO SEE A RECORD FOR THE RESULTS THAT WERE RETURNED SO CLINIC/UNIT CAN MAKE DIAGNOSIS AND INITIATE TREATMENT.</p>	THIS FACILITY 1 EXTERNAL FACILITY RECORD OF TEST RESULTS OBSERVED 2 RECORD OF TEST RESULTS IN LAB 3 RECORDS REPORTED, NOT SEEN 4	→ 1710 → 1708 → 1708 → 1708
1707	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	
1708	<p>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?</p> <p>IF YES, ASK: May I see a copy of the form?</p>	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO FORM USED 3 NEVER REFER OUTSIDE FACILITY 4 DON'T KNOW 8	→ 1710 → 1710
1709	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
1710	WAS INFORMATION FOR OPD Q1221 OR IPD Q1319, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY COLLECTED FOR THIS CLINIC/UNIT?	YES	1	→ 1711 (03)	
		NO	2		
1711	Do you have any guidelines/protocols for the diagnosis and treatment of tuberculosis? IF YES, ASK: May I see the guidelines/ protocols?	(a)			(b)
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
01	TB Control and Community-based DOTS as an essential component of District Health Systems	1 → b	2 02 ↙	3 02 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
02	TB Case Management Desk Aide	1 → b	2 03 ↙	3 03 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
03	Other guidelines for TB diagnosis and treatment	1 → b	2 04 ↙	3 04 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
04	Other guidelines for follow-up of TB clients	1 → b	2 1712 ↙	3 1712 ↘	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
1712	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	→ 1715	
		NO	2		
1713	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	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
1714	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA	<input type="text"/> <input type="text"/>		
1715	Is this facility included in the national DOTS program?	YES	1		
		NO	2		
1716	What treatment strategy is followed by providers in this clinic/unit for TB treatment?	DIRECT OBSERVE 2M, FU 6M 01 DIRECT OBSERVE 6M 02 DIRECT OBSERVE 8M 03 FOLLOW UP CLIENTS ONLY AFTER FIRST 2M DIRECT OBSERVATION ELSEWHERE 04 → 1723 DIAGNOSE AND TREAT WHILE INPATIENT. DISCHARGE TO OTHER CLINIC/UNIT FOR F/UP ... 05 → 1723 PROVIDE FULL TREATMENT, WITH NO ROUTINE DIRECT OBSERVATION PHASE 06 → 1722 DIAGNOSE, PRESCRIBE/PROVIDE MEDICINES ONLY, NO F/UP 07 → 1723 DIAGNOSE ONLY, NO TREATMENT OR PRESCRIPTION OF MEDICINE 08 → END			
1717	What is the strategy for the direct observed treatment (DOT) 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) _____			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1718	CHECK 1717. IS C OR D (OR BOTH) CIRCLED INDICATING OUTREACH OR COMMUNITY WORKERS OR FAMILY DIRECTLY OBSERVE CLIENTS DURING TREATMENT OR UNTIL CLIENT IS SPUTUM NEGATIVE?	YES 1 NO 2	→ 1720
1719	Do you have a reporting format that the outreach or 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	
1720	Do you have a record or register that show the clients who are currently on DOTS ? IF YES, ASK TO SEE THE REGISTER/RECORD	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 1722 → 1722
1721	Is the record/register up-to-date for the prior week for all clients receiving their DOTS TB medications?	YES 1 NO 2	
1722	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	→ 1729
1723	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	
1724	Do you have a register or list of clients currently being followed by this unit for TB treatment, including those being treated on DOT and no direct observation?	YES, REGISTER OR LIST OBSERVED 1 ONLY HAVE DOTS CLIENTS 2 NO 3	→ 1728
1725	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	→ 1728
1726	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 <div><div></div><div></div><div></div><div></div></div>	
1727	RECORD THE NUMBER OF FEMALE CLIENTS CURRENTLY ON TB TREATMENT BY THIS CLINIC/UNIT.	NUMBER OF FEMALE CLIENTS DON'T KNOW 9998 <div><div></div><div></div><div></div><div></div></div>	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1728	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	
1729	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	→ 1734 → 1734
1730	Where are the clients sent for HIV testing? PROBE FOR A SPECIFIC UNIT WITHIN FACILITY, OR SPECIFIC LOCATION OUTSIDE FACILITY TO BE NAMED	LOCATION NAMED INSIDE FACILITY 1 OUTSIDE FACILITY 2 DON'T KNOW SPECIFIC LOCATION 8	
1731	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	→ 1734 → 1734
1732	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	
1733	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA	
1734	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	→ 1736
1735	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 DON'T KNOW 9998	
1736	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)	
1737	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
1738	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

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1739	BULK JAR MEDICINES FOR TUBERCULOSIS	a				b
		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	Rifampicin		2 → b	3 05 ↙	4 05 ↙	1 2 8
05	Streptomycin		2 → b	3 06 ↙	4 06 ↙	1 2 8
06	Isoniazid + rifampicin (Rifina) (Adult formulation)		2 → b	3 07 ↙	4 07 ↙	1 2 8
07	Isoniazid + rifampicin (Rifina) (Pediatric formulation)		2 → b	3 08 ↙	4 08 ↙	1 2 8
08	Isoniazid + rifampicin + pyrazinamide (RHZ, Rifater)		2 → b	3 09 ↙	4 09 ↙	1 2 8
09	Isoniazid + ethambutol (EH)		2 → b	3 10 ↙	4 10 ↙	1 2 8
10	4FDC (combination INH, Ethambutol, pyrazinamide, rifampicin)		2 → b	3 11 ↙	4 11 ↙	1 2 8
11	Other _____ (SPECIFY)		2 → b	3 END ↙	4 END ↙	1 2 8
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE						

SECTION 18: COUNSELING AND TESTING			
Facility Number: <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>		QRE TYPE <div style="border: 2px solid black; padding: 2px; font-weight: bold; font-size: 1.2em;">18</div>	
Interviewer Code: <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>			
1800	INDICATE THE SERVICE SETTING FOR THIS SECTION.	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> Line # Unit #	
1801	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER 6 <div style="text-align: center;">(SPECIFY) _____</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 Q1802 BELOW AND GO ON TO Q1803.</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 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>			
<div style="display: flex; justify-content: space-between; border-top: 1px solid black; margin-top: 10px;"> Interviewer's signature _____ Date _____ </div> <p style="margin-top: 5px;">SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>			
1802	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→ STOP

NO	QUESTIONS	CODING CATEGORIES	GO TO
1803	<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 SERVICE PROVIDERS WHO ARE LISTED FOR A SERVICE AREA THAT WAS PREVIOUSLY ASSESSED.</p>	<p>STAFF LIST COMPLETED</p> <p>YES 1</p> <p>NO 2</p>	
1804	<p>RESPONDENT MUST BE INTERVIEWED FOR TRAINING AND EXPERIENCE.</p>	<p>DAYS PER WEEK <input type="text"/></p> <p>NO COUNSELING SERVICES 0</p>	→1814
1805	<p>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>	<p>MONTHS <input type="text"/><input type="text"/><input type="text"/></p>	
1806	<p>How many months have counseling services been offered from this clinic/unit? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.</p>	<p>YES, PRESENT TODAY 1</p> <p>YES, NOT PRESENT TODAY 2</p> <p>NO 3</p>	
1807	<p>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>	<p>PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY 1</p> <p>OTHER ROOM WITH AUDITORY AND VISUAL PRIVACY 2</p> <p>VISUAL PRIVACY ONLY 3</p> <p>NO PRIVACY 4</p>	
1808	<p>DESCRIBE THE SETTING WHERE CLIENT COUNSELING RELATED TO HIV/AIDS IS PROVIDED</p>	<p>INDIVIDUAL ONLY 1</p> <p>GROUP ONLY 2</p> <p>BOTH INDIVIDUAL AND GROUP ... 3</p> <p>NO PRETEST COUNSELING 4</p>	<p>→1811</p> <p>→1812</p>
1809	<p>How is pretest counseling or information provided?</p>	<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>	→1811
1810	<p>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>	<p>MONTHS OF DATA <input type="text"/><input type="text"/></p>	

NO	QUESTIONS	CODING CATEGORIES	GO TO
1811	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	
1812	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	
1813	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	
1814	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	→ 1818 → 1818 → 1818

NO	QUESTIONS	CODING CATEGORIES			GO TO
1815	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 MONTHS OF DATA
01	RAPID TEST USED BY UNIT AND 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"/> <input type="text"/> <input type="text"/>
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"/> <input type="text"/> <input type="text"/>
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"/> <input type="text"/> <input type="text"/>
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"/> <input type="text"/> <input type="text"/>
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"/> <input type="text"/> <input type="text"/>
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"/> <input type="text"/> <input type="text"/>
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"/> <input type="text"/> <input type="text"/>
09	TOTAL CLIENTS RECEIVING HIV TEST	1 → b	2 1816 ↙	3 1816 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
1816	WHAT IS THE MOST RECENT DATE REDORDED FOR ANY COUNSELING?	WITHIN PAST 30 DAYS 1 MORE THAN 30 DAYS 2 NO DATE RECORDED 3 NO RECORD FOR COUNSELING . 4			→ 1818
1817	Is there a client number or other identifier for clients receiving pre and post test counseling?	YES 1 NO 2			
1818	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 SERVICES 0			→ 1822
1819	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
1820	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	
1821	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	
1822	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	→ 1825
1823	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	→ 1825
1824	To whom are the reports sent? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR B DISTRICT LEVEL (MOH/UAC/MEP) .. C REGIONAL LEVEL(MOH/UAC/MEP) .. D NATIONAL LEVEL(MOH/UAC/MEP) .. E DONOR AGENCY F OTHER X (SPECIFY)	
1825	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 RAPID TEST ONSITE-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				
1826	CHECK Q1825 AND CIRCLE CORRECT RESPONSE TO RIGHT	BLOOD DRAWN IN THIS CLINIC/UNIT (A OR E OR F CIRCLED) 1 BLOOD FOR HIV TEST DRAWN OUTSIDE FACILITY (ONLY H OR X CIRCLED) ... 2 ANY OTHER RESPONSE 3			→ 1834 → 1833				
1827	ASK TO SEE WHERE BLOOD IS DRAWN FOR THE HIV TEST AND INDICATE IF THE ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q1828. IF YES, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	DATA RECORDED IN OPD/IPD QRE 1 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>							→ 1833
1828	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 (PIPED)	1 04	2	3					
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3					
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3					
04	HAND-WASHING SOAP	1	2	3					
05	SINGLE-USE HAND DRYING TOWELS	1	2	3					
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3					
07	SHARPS CONTAINER	1	2	3					
08	DISPOSABLE LATEX GLOVES	1 10	2	3					
09	DISPOSABLE NON-LATEX GLOVES	1	2	3					
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3					
11	DISINFECTANT (NOT YET MIXED)	1	2	3					
12	DISPOSABLE NEEDLES	1	2	3					
13	AUTO-DISABLE SYRINGES	1	2	3					
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3					
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3					
16	AUDITORY PRIVACY	1	2	3					
17	VISUAL PRIVACY	1	2	3					
18	EXAMINATION TABLE	1	2	3					
19	CONDOMS	1	2	3					
20	RAPID TEST FOR HIV	1	2	3					
21	VACUTAINER	1	2	3					

NO	QUESTIONS	CODING CATEGORIES	GO TO
1829	ARE ALL SURFACE AREAS IN THE BLOOD DRAWING AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES 1 NO 2	
1830	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES 1 NO 2	
1831	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED OR BROKEN?	YES 1 NO 2 NO SHARPS CONTAINER ... 3	
1832	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES ... 1 YES, IN UNCOVERED CONTAINER ... 2 NO 3	
1833	CHECK Q1825. 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.		
1834	WAS INFORMATION FOR OPD QRE 1221 OR IPD Q1319, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY ASKED FROM THIS RESPONDENT?	YES 1 NO 2	→ 1837
1835	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	→ 1839

NO	QUESTIONS	CODING CATEGORIES			GO TO
		(a)			(b)
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR
1836	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]?				
01	Uganda National Policy on HIV Counseling and Testing	1 → b	2 ↵ 02↵	3 ↵ 02↵	<input type="text"/>
02	Policy Guidelines for Prevention of Mother to Child Transmission	1 → b	2 ↵ 03↵	3 ↵ 03↵	<input type="text"/>
03	National Antiretroviral Treatment and Care guideline for Adult and Children	1 → b	2 ↵ 04↵	3 ↵ 04↵	<input type="text"/>
04	Comprehensive HIV Care (IMAI): Acute Care Guide	1 → b	2 ↵ 05↵	3 ↵ 05↵	<input type="text"/>
05	Comprehensive HIV Care (IMAI): Chronic HIV Care Guide	1 → b	2 ↵ 06↵	3 ↵ 06↵	<input type="text"/>
06	Comprehensive HIV Care: Home Based Care Trainers' Guide for Health Workers	1 → b	2 ↵ 07↵	3 ↵ 07↵	<input type="text"/>
07	Uganda Clinical Guidelines	1 → b	2 ↵ 08↵	3 ↵ 08↵	<input type="text"/>
08	Sexually Transmitted Infections Treatment Guidelines for Use by Operational Level Health Workers	1 → b	2 ↵ 09↵	3 ↵ 09↵	<input type="text"/>
09	Nutritional Care and Support for People Living with HIV/AIDS in Uganda	1 → b	2 ↵ 10↵	3 ↵ 10↵	<input type="text"/>
10	Tuberculosis Control & Community-based DOTS as an essential component of District Health Systems	1 → b	2 ↵ 11↵	3 ↵ 11↵	<input type="text"/>
11	Tuberculosis Case Management Desk Aide	1 → b	2 ↵ 12↵	3 ↵ 12↵	<input type="text"/>
12	Management of uncomplicated Malaria	1 → b	2 ↵ 13↵	3 ↵ 13↵	<input type="text"/>
13	Infection Control: Policies and Procedures	1 → b	2 ↵ 14↵	3 ↵ 14↵	<input type="text"/>
14	Injection Safety and Appropriate Health Care Waste Management: Participants Notes	1 → b	2 ↵ 15↵	3 ↵ 15↵	<input type="text"/>
15	Standards for Injection Safety and Health Care Waste Management Practices	1 → b	2 ↵ 1837↵	3 ↵ 1837↵	<input type="text"/>

NO	QUESTIONS	CODING CATEGORIES				GO TO
1837	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 → 1839				
1838	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	(a) OBSERVED REPORTED AVAIL. NOT SEEN NOT AVAIL. (b) DATE ON OBSERVED MANUAL YEAR				
01	Other protocols/guidelines for pretest counseling?	1 → b	2 02	3 02	<input type="text"/>	
02	Other protocols/guidelines for post test counseling for both positive and negative test results?	1 → b	2 03	3 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 04	3 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 05	3 05	<input type="text"/>	
05	HIV Laboratory Manual for the Processing of samples, use of HIV test kits, and data management?	1 → b	2 06	3 06	<input type="text"/>	
06	Is there a written informed consent document for the client to sign or keep?	1 → b	2 07	3 07	<input type="text"/>	
07	Any other informed consent policy?	1 → b	2 08	3 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 09	3 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 10	3 10	<input type="text"/>	
10	Any other guidelines for post-exposure prophylaxis? (PEP)	1 → b	2 1839	3 1839	<input type="text"/>	
1839	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 C/U NUMBER <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			
1840	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC/UNIT 1 YES, OTHER LOCATION IN FACILITY 2 NO 3	→ 1844 → 1844
1841	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED 1 YES, REPORTED NOT SEEN 2 NO 3	
1842	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	
1843	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES AND ASK : 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)	
1844	Are family planning services routinely provided for all HIV positive clients?	YES, ALWAYS 1 YES, SOMETIMES 2 NO 3	→ 1848
1845	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	→ 1848 → 1848
1846	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	
1847	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			
1848	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
1849	When clients are referred to community based health workers or volunteers, do you have a formal system for making the referral, such as a referral slip or other means? IF YES: ASK: What method do you use?	YES, REFERRAL SLIP OBSERVED .. 01 YES, REFERRAL SLIP REPORTED, NOT SEEN 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD 04 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 05 WRITE NOTE/LETTER (UNSTRUCTURED) 06 OTHER 96 (SPECIFY) NO METHOD USED 95	
1850	When community based health workers refer clients to the facility, is there a formal system for making the referral such as a referral slip or other means? IF YES, ASK: What method is used?	YES, REFERRAL SLIP OBSERVED .. 01 YES, REFERRAL SLIP REPORTED, NOT SEEN 02 PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 03 WRITE ON PRESCRIPTION FORM/ LETTERHEAD 04 PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 05 WRITE NOTE/LETTER (UNSTRUCTURED) 06 OTHER 96 (SPECIFY) NO METHOD USED 95	
1851	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	
1852	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	
1853	When was the most recent training session for community health workers who are linked with this facility?	WITHIN PAST 30 DAYS 1 WITHIN PAST 2--6 MONTHS 2 WITHIN PAST 7-12 MONTHS 3 MORE THAN 12 MONTHS AGO 4 NO TRAINING 5 DON'T KNOW 8	
1854	When was the most recent meeting with community health workers who are linked with this facility?	WITHIN PAST 30 DAYS 1 WITHIN PAST 2--6 MONTHS 2 WITHIN PAST 7-12 MONTHS 3 MORE THAN 12 MONTHS AGO 4 NO TRAINING 5 DON'T KNOW 8	
THANK YOUR RESPONDENT FOR THE TIME AND HELP PROVIDED AND PROCEED TO THE NEXT DATA COLLECTION SITE			

SECTION 19: ANTIRETROVIRAL THERAPY			
Facility Number: <div style="display: inline-block; width: 60px; height: 25px; border: 1px solid black; margin-left: 10px;"></div>		QRE TYPE <div style="display: inline-block; width: 40px; height: 25px; border: 1px solid black; text-align: center; font-weight: bold;">19</div>	
Interviewer Code: <div style="display: inline-block; width: 40px; height: 25px; border: 1px solid black; margin-left: 10px;"></div>			
1900	INDICATE THE SERVICE SETTING FOR THIS SECTION	<div style="display: inline-block; width: 60px; height: 25px; border: 1px solid black; margin-left: 10px;"></div> <div style="display: flex; justify-content: flex-end; font-size: small;"> <div style="border-bottom: 1px solid black; width: 40px; margin-right: 5px;"></div> <div style="border-bottom: 1px solid black; width: 40px; margin-right: 5px;"></div> <div style="border-bottom: 1px solid black; width: 40px; margin-right: 5px;"></div> <div style="border-bottom: 1px solid black; width: 40px;"></div> </div> <div style="display: flex; justify-content: flex-end; font-size: x-small;"> <div style="margin-right: 10px;">Line #</div> <div>Unit #</div> </div>	
1901	MANAGING AUTHORITY <div style="display: flex; justify-content: space-between; font-size: small;"> GOVERNMENT 1 </div> <div style="display: flex; justify-content: space-between; font-size: small;"> PRIVATE 2 </div> <div style="display: flex; justify-content: space-between; font-size: small;"> OTHER _____ 6 </div> <div style="text-align: center; font-size: x-small;">(SPECIFY)</div>		
ENSURE THAT YOUR RESPONDENT IS THE PERSON PRESENT TODAY WHO IS MOST KNOWLEDGEABLE ABOUT ART 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 Q1902 BELOW AND GO ON TO Q1903.</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 style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div> <p>Interviewer's signature Date SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED.</p>			
1902	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	→STOP

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1903	<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 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>	
1904	How many days each week are ART services available in this clinic/unit?	DAYS PER WEEK <input type="text"/>	
1905	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"/>	
1906	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	→ 1908 → 1908
1907	What is the qualification of the person in charge of ARV services?	CONSULTANT/SPECIALIST 01 MEDICAL OFFICER 02 CLINICAL OFFICER 03 ENROLLED NURSE/MIDWIFE 04 REGISTERED NURSE/MIDWIFE 05 COMPREHENSIVE NURSE 06 PHARMACY WORKER (ANY QUAL) ... 07 OTHER 96 (SPECIFY) _____	
1908	<p>Which ARV drugs are prescribed in this clinic/unit?</p> <p>CIRCLE ALL THAT APPLY.</p> <p>AFTER THE RESPONSE, READ THE NAME OF EACH ARV THAT IS NOT MENTIONED, TO VERIFY THAT IT 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 STAVUDINE + LAMIVUDINE & NEVIRAPINE, CIRCLE "F, E AND H)</p>	<p>NsRTI</p> COMBIVIR (AZT+3TC) A ZIDOVUDINE (ZDV, AZT) B ABACAVIR (ABC) C DIDANOSINE (ddI) D LAMIVUDINE (3TC) E STAVUDINE (d4T) OR (D3T) F <p>NtRTI</p> (TENOFOVIR [DISOPROXIL FUMARATE/VIREAD]) G <p>NNRTI</p> NEVIRAPINE (NVP) H EFAVIRENZ (EFZ) I <p>PROTEASE INHIBITORS (INDINAVIR [CRIVAN], NELFINAVIR [VIRACEPT], RITONAVIR [NORVIR], SAQUINAVIR [INVIRASE]) J LOPINAVIR-RITONAVIR (LPV/r) K OTHER X (SPECIFY) _____ </p>	
1909	What is the most commonly prescribed first-line ART regimen?	STAVUDINE (d4T) + LAMIVUDINE (3TC) plus NEVIRAPINE (NVP) 1 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) plus NEVIRAPINE (NVP) 2 STAVUDINE (d4T) + LAMIVUDINE (3TC) plus EFAVIRENZ (EFV) 3 ZIDOVUDINE (AZT) + LAMIVUDINE (3TC) plus EFAVIRENZ (EFV) 4 NO ROUTINE FIRST-LINE REGIMEN 6	

NO.	QUESTIONS	CODING CATEGORIES					GO TO																																																																																																
1910	<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"></td></tr> <tr> <td colspan="7">ELIGIBILITY CRITERIA</td></tr> <tr> <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 colspan="2">DOCTOR OPINION</td></tr> <tr> <td>01</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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</td><td>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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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																																																																																																
1911	<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?</p> <p>READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.</p>	<p>GEOGRAPHIC CRITERIA A</p> <p>PROOF OF CAPACITY TO ATTEND 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>																																																																																																					
1912	<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?</p> <p>READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.</p>	<p>CONSISTENT USE OF COTRIM A</p> <p>REQUIRED PRE-ART CLINIC VISITS 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>																																																																																																					
1913	<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 FACILITY. . 1</p> <p>YES, CLIENT GOES ELSEWHERE. . . . 2</p> <p>YES, BLOOD SENT ELSEWHERE. . . . 3</p> <p>NO 4</p>	→ 1915																																																																																																				

NO.	QUESTIONS	CODING CATEGORIES				GO TO
1914	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				
1915	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				→ 1917
1916	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				
1917	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				→ 1919
1918	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				
1919	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					
1920	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						
04	Prevention counseling	1	2	3	8						
1921	CHECK Q1920 IF THERE IS ANY COUNSELING RELATED TO ART, (01) OR (02) OR (03) OR (04)= 1 OR 2	YES 1 NO 2				→ 1924					
1922	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 OR CLINICAL OFFICER A OTHER CONSULTANT/PHYSICIAN/ CLINICAL OFFICER B REG NURSE/NURSING OFFICER ... C N. MIDWIFE/PHN/TRAINED NRS ... D TRAINED COUNSELOR E PHARMACY STAFF F COMMUNITY/PLHA WORKER G OTHER X (SPECIFY) _____ NO COUNSELING Y				→ 1924					
1923	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									
1924	Are there any fees assessed for any services or items related to ARV treatment?	YES 1 NO 2				→ 1926					
1925	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 [UGS]						
		YES	NO	NA							
01	FEE FOR ART CLIENT CARD/CHART	1→ b	2 02 ↙	02 ↘	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
02	FEE FOR CONSULTATION SERVICE	1→ b	2 03 ↙	03 ↘	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
03	FEE FOR ARV MEDICINE	1→ b	2 04 ↙	04 ↘	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
04	FEE FOR LAB TEST CD4 COUNT	1→ b	2 1925a ↙	1925a ↘	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
1925a	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									
1926	WAS INFORMATION FOR OPD QRE 1221 OR IPD Q1319, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY COLLECTED FOR THIS CLINIC/UNIT?	YES 1 NO 2				→ 1929					
1927	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				→ 1931					

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1928	First I want to ask about some of the national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]? LIST ANY NATIONAL GUIDELINES RELATED TO INDICATED TOPICS	<div>(a)</div> <div>OBSERVED REPORTED AVAIL NOT AVAIL.</div> <div>NOT SEEN</div>			<div>(b)</div> <div>DATE ON OBSERVED MANUAL</div> <div>YEAR</div>
01	Uganda National Policy on HIV Counseling and Testing	1 → b	2 ↘ 02 ↙	3 ↘ 02 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
02	Policy Guidelines for Prevention of Mother to Child Transmission	1 → b	2 ↘ 03 ↙	3 ↘ 03 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
03	National Antiretroviral Treatment and Care guideline for Adult and Children	1 → b	2 ↘ 04 ↙	3 ↘ 04 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
04	Comprehensive HIV Care (IMAI): Acute Care Guide	1 → b	2 ↘ 05 ↙	3 ↘ 05 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
05	Comprehensive HIV Care (IMAI): Chronic HIV Care Guide	1 → b	2 ↘ 06 ↙	3 ↘ 06 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
06	Comprehensive HIV Care: Home Based Care Trainers' Guide for Health Workers	1 → b	2 ↘ 07 ↙	3 ↘ 07 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
07	Uganda Clinical Guidelines	1 → b	2 ↘ 08 ↙	3 ↘ 08 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
08	Sexually Transmitted Infections Treatment Guidelines for Use by Operational Level Health Workers	1 → b	2 ↘ 09 ↙	3 ↘ 09 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
09	Nutritional Care and Support for People Living with HIV/AIDS in Uganda	1 → b	2 ↘ 10 ↙	3 ↘ 10 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
10	Tuberculosis Control & Community-based DOTS as an essential component of District Health Systems	1 → b	2 ↘ 11 ↙	3 ↘ 11 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
11	Tuberculosis Case Management Desk Aide	1 → b	2 ↘ 12 ↙	3 ↘ 12 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
12	Management of uncomplicated Malaria	1 → b	2 ↘ 13 ↙	3 ↘ 13 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
13	Infection Control: Policies and Procedures	1 → b	2 ↘ 14 ↙	3 ↘ 14 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
14	Injection Safety and Appropriate Health Care Waste Management: Participants Notes	1 → b	2 ↘ 15 ↙	3 ↘ 15 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
15	Standards for Injection Safety and Health Care Waste Management Practices	1 → b	2 ↘ 1929 ↙	3 ↘ 1929 ↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

NO.	QUESTIONS	CODING CATEGORIES			GO TO
1929	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			→ 1931
1930	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <div style="text-align: center;">(a)</div> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">OBSERVED</div> <div style="text-align: center;">REPORTED AVAIL NOT SEEN</div> <div style="text-align: center;">NOT AVAIL.</div> </div> </div> <div style="width: 35%;"> <div style="text-align: center;">(b)</div> <div style="text-align: center;">DATE ON MANUAL</div> </div> </div>			
01	Other protocols/guidelines for eligibility for ART	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"/>
02	Other protocols/guidelines for prescribing ART	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"/>
03	Other protocols/guidelines on adherence counseling for ART	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"/>
04	Other protocols/guidelines on nutrition for ART clients	1 → b	2 <input type="checkbox"/> 05 <input type="checkbox"/>	3 <input type="checkbox"/> 05 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
05	Other protocols/guidelines on laboratory follow-up for ART	1 → b	2 <input type="checkbox"/> 1931 <input type="checkbox"/>	3 <input type="checkbox"/> 1931 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
1931	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			→ 1946
1932	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			
1933	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			
1934	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			→ 1946
1935	How many patients are currently receiving ART through this clinic/unit are adults? ADULTS ARE 14 YEARS AND OLDER	TOTAL NUMBER OF ADULTS ON ART .. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000			
1936	How many patients currently receiving ART through this clinic are children? CHILDREN ARE THOSE UNDER 14 YEARS	TOTAL NUMBER OF CHILDREN ON ART <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000			

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1937	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	
1938	How many women who were identified through testing when pregnant or at delivery, such as PMTCT clients are currently receiving ART through this clinic/unit?	TOTAL NUMBER OF PMTCT CLIENTS ON ART <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NONE 0000 DON'T KNOW 9998	
1939	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	
1940	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	
1941	Among ART clients who began treatment before JUNE 2007, 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	
1942	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	→ 1944
1943	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/>	
1944	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	→ 1946
1945	INDICATE MONTHS OF DATA IN PREVIOUS QUESTION.	MONTHS OF DATA <input type="text"/> <input type="text"/>	

NO.	QUESTIONS	CODING CATEGORIES	GO TO				
1946	Are reports regularly compiled on the numbers of clients receiving ART?	YES 1 NO 2	→ 1949				
1947	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	→ 1949				
1948	To whom do you send these reports? CIRCLE ALL THAT APPLY.	RECORDS CLERK A FACILITY DIRECTOR/SUPERVISOR... B DISTRICT LEVEL (MOH/UAC/MEP) ... C REGIONAL LEVEL (MOH/UAC/MEP)... D NATIONAL LEVEL (MOH/UAC/MEP) ... E DONOR AGENCY F OTHER X (SPECIFY) _____					
1949	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, CHART/RECORD AVAILABLE IN OTHER CLINIC/UNIT, THIS FACILITY 3 ENTER CLINIC/UNIT <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> NUMBER YES, ONLY AVAILABLE WITH CENTRAL RECORDS/STATISTICS 4 OTHER 6 (SPECIFY) _____ NO INDIVIDUAL CLIENT CHART/RECORD 7					
1950	Do you have a system for making individual client appointments for follow-up? IF YES, ASK TO SEE ANY RECORDS INDICATING THE SYSTEM FUNCTIONS.	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 1952				
1951	Does the appointment system indicate if the client kept the appointment or not?	YES 1 NO 2					
1952	Does this facility provide nutrition rehabilitation services for HIV/AIDS patients? NUTRITIONAL REHABILITATION REFERS TO EDUCATION ABOUT EATING WELL, EARLY IDENTIFICATION OF DEFICIENCIES, PROVIDING FORTIFIED PROTEIN SUPPLEMENT (FPS). IF YES, ASK: Which of the following are routine components of nutritional rehabilitation services? READ EACH RESPONSE AND CIRCLE ALL THAT APPLY.	NUTRITIONAL 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					

NO.	QUESTIONS	CODING CATEGORIES	GO TO
COMMUNITY BASED SERVICES			
1953	<p>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?</p> <p>CIRCLE ALL THAT APPLY</p>	<p>YES, DISTRIBUTE ARVS A</p> <p>YES, REFER FOR ART ELIGIBILITY B</p> <p>YES, HOME CARE C</p> <p>YES, CLIENT TREATMENT SUPPORT D</p> <p>YES, PRETEST COUNSELING E</p> <p>YES, PREVENTIVE EDUCATION F</p> <p>YES, ADHERENCE COUNSELING G</p> <p>YES, EMOTIONAL/SOCIAL SUPPORT H</p> <p>YES, DEFAULTER FOLLOW-UP I</p> <p>YES, NOT HIV/AIDS RELATED J</p> <p>YES, OTHER HIV/AIDS RELATED X</p> <p>_____ (SPECIFY)</p> <p>NO Y</p>	→ 1959
1954	<p>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?</p> <p>IF YES: What method do you use?</p>	<p>YES, REFERRAL SLIP OBSERVED 01</p> <p>YES, REFERRAL SLIP NOT OBSERVED 02</p> <p>PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 03</p> <p>WRITE ON PRESCRIPTION FORM/ LETTERHEAD 04</p> <p>PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 05</p> <p>WRITE NOTE/LETTER (UNSTRUCTURED) 06</p> <p>OTHER 96</p> <p>_____ (SPECIFY)</p> <p>NO METHOD USED 98</p>	
1955	<p>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?</p> <p>IF YES, What method is used?</p>	<p>YES, REFERRAL SLIP OBSERVED 01</p> <p>YES, REFERRAL SLIP NOT OBSERVED 02</p> <p>PATIENT SENT WITH MEDICAL CHART/RECORD/CARD 03</p> <p>WRITE ON PRESCRIPTION FORM/ LETTERHEAD 04</p> <p>PROVIDER GIVES VERBAL REPORT TO SITE (MAY ACCOMPANY CLIENT) 05</p> <p>WRITE NOTE/LETTER (UNSTRUCTURED) 06</p> <p>OTHER 96</p> <p>_____ (SPECIFY)</p> <p>NO METHOD USED 98</p>	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
1956	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	
1957	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	
1958	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	
1959	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 20: 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 <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black; text-align: center; font-weight: bold;">20</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>			
2000	INDICATE THE SERVICE SETTING FOR THIS SECTION	<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; margin-right: 5px;"></div> <div style="display: inline-block; width: 40px; height: 20px; border: 1px solid black;"></div>	<div style="display: flex; justify-content: space-around; font-size: small;"> Line # Unit # </div>
2001	MANAGING AUTHORITY GOVERNMENT 1 PRIVATE 2 OTHER 6 <div style="text-align: center; margin-top: 5px;">(SPECIFY) _____</div>		
2002	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.			
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 IF THE RESPONDENT HAS ALREADY BEEN INTERVIEWED FOR A PREVIOUS SECTION, CIRCLE NUMBER 1 (YES) IN Q2003 BELOW AND GO ON TO Q2004.			
<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 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 style="width: 60%;"> Interviewer's signature _____ SIGNATURE OF INTERVIEWER INDICATING INFORMED CONSENT WAS PROVIDED. </div> <div style="width: 35%;"> Date _____ </div> </div>			
2003	Do I have your agreement to participate? Thank you. Let's begin now.	YES 1 NO 2	
		→ STOP	

NO.	QUESTIONS	CODING CATEGORIES			GO TO																																																																																																																										
2004	<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 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>																																																																																																																													
2005	<p>How many months have PMTCT services been offered from this clinic/unit? IF EXACT MONTHS ARE UNCERTAIN, PROBE FOR AN ESTIMATE.</p>	<p>MONTHS <input type="text"/> <input type="text"/> <input type="text"/></p>																																																																																																																													
2006	<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>																																																																																																																														
		<p>SERVICE OFFERED IN THIS FACILITY</p> <table border="1"> <thead> <tr> <th rowspan="2">SERVICE</th><th colspan="2">OUTPATIENT</th><th rowspan="2">INPATIENT SERVICE ONLY</th><th rowspan="2">REFER CLIENTS OUTSIDE FACILITY</th><th rowspan="2">NO SERVICE OR REFERRAL</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	OUTPATIENT		INPATIENT SERVICE ONLY	REFER CLIENTS OUTSIDE FACILITY	NO SERVICE OR REFERRAL	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
2007	When the various services offered for PMTCT are provided, is this recorded anywhere so that you can see what services a pregnant woman has received? IF YES, 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				→ 2009 → 2009 → 2009
2008	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			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	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"/>
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"/>
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"/>
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"/>
05	TOTAL HIV POSITIVE WOMEN RECEIVING COUPLES COUNSELING PAST 12 MONTHS	1 → b	2 → 2009	3 → 2009	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
2009	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC UNIT 1 YES, OTHER LOCATION IN FACILITY 2 NO 3				→ 2013 → 2013
2010	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED 1 YES, REPORTED NOT SEEN 2 NO 3				
2011	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				
2012	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)				

NO.	QUESTIONS	CODING CATEGORIES			GO TO								
2013	WAS INFORMATION FOR OPD QRE 1221 OR IPD Q1319, AVAILABLE GUIDELINES/ PROTOCOLS PREVIOUSLY ASKED FROM THIS RESPONDENT?	YES	1	→ 2016									
		NO	2										
2014	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			→ 2018								
2015	First I would like to ask about national guidelines. ASK ABOUT EACH GUIDELINE/PROTOCOL Do you have [NAME OF GUIDELINE]? LIST ANY NATIONAL GUIDELINES RELATED TO INDICATED TOPICS	<table border="1"> <thead> <tr> <th colspan="3">(a)</th><th>(b)</th></tr> <tr> <th>OBSERVED</th><th>REPORTED AVAIL. NOT SEEN</th><th>NOT AVAIL.</th><th>DATE ON OBSERVED MANUAL YEAR</th></tr> </thead> </table>			(a)			(b)	OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR	
(a)			(b)										
OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON OBSERVED MANUAL YEAR										
01	Uganda National Policy on HIV Counseling and Testing	1 → b	2 02 ↙	3 02 ↙	<input type="text"/>								
02	Policy Guidelines for Prevention of Mother to Child Transmission	1 → b	2 03 ↙	3 03 ↙	<input type="text"/>								
03	National Antiretroviral Treatment and Care guideline for Adult and Children	1 → b	2 04 ↙	3 04 ↙	<input type="text"/>								
04	Comprehensive HIV Care (IMAI): Acute Care Guide	1 → b	2 05 ↙	3 05 ↙	<input type="text"/>								
05	Comprehensive HIV Care (IMAI): Chronic HIV Care Guide	1 → b	2 06 ↙	3 06 ↙	<input type="text"/>								
06	Comprehensive HIV Care: Home Based Care Trainers' Guide for Health Workers	1 → b	2 07 ↙	3 07 ↙	<input type="text"/>								
07	Uganda Clinical Guidelines	1 → b	2 08 ↙	3 08 ↙	<input type="text"/>								
08	Sexually Transmitted Infections Treatment Guidelines for Use by Operational Level Health Workers	1 → b	2 09 ↙	3 09 ↙	<input type="text"/>								
09	Nutritional Care and Support for People Living with HIV/AIDS in Uganda	1 → b	2 10 ↙	3 10 ↙	<input type="text"/>								
10	Tuberculosis Control & Community-based DOTS as an essential component of District Health Systems	1 → b	2 11 ↙	3 11 ↙	<input type="text"/>								
11	Tuberculosis Case Management Desk Aide	1 → b	2 12 ↙	3 12 ↙	<input type="text"/>								
12	Management of uncomplicated Malaria	1 → b	2 13 ↙	3 13 ↙	<input type="text"/>								
13	Infection Control: Policies and Procedures	1 → b	2 14 ↙	3 14 ↙	<input type="text"/>								
14	Injection Safety and Appropriate Health Care Waste Management: Participants Notes	1 → b	2 15 ↙	3 15 ↙	<input type="text"/>								
15	Standards for Injection Safety and Health Care Waste Management Practices	1 → b	2 2017 ↙	3 2017 ↙	<input type="text"/>								
2016	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			→ 2018								

NO.	QUESTIONS	CODING CATEGORIES			GO TO
		(a)			(b)
		OBSERVED	REPORTED AVAIL. NOT SEEN	NOT AVAIL.	DATE ON MANUAL YEAR
2017	ASK ABOUT ANY GUIDELINES OTHER THAN THOSE PREVIOUSLY RECORDED, THAT COVER THE FOLLOWING TOPICS:				
01	Other protocols/guidelines for pretest counseling?	1→b	2 02↙	3 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 03↙	3 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 04↙	3 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 05↙	3 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 06↙	3 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 07↙	3 07↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
07	Any other informed consent policy?	1→b	2 08↙	3 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 09↙	3 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 10↙	3 10↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
10	Any other guidelines on how to prescribe the ART for the HIV positive woman?	1→b	2 11↙	3 11↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
11	Any other guidelines on storage and stock management for the ARVs?	1→b	2 12↙	3 12↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
12	Any other guidelines specifying counseling on family planning for the HIV positive woman?	1→b	2 13↙	3 13↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
13	Any other guidelines specifying counseling on infant feeding for the HIV positive woman?	1→b	2 14↙	3 14↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
14	Any other guidelines specifying general nutrition counseling for people living with HIV/AIDS?	1→b	2 15↙	3 15↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
15	Any other guidelines for Post Exposure Prophylaxis (PEP)?	1→b	2 2018↙	3 2018↙	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2018	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
2019	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	
2020	How is pretest counseling or information provided?	INDIVIDUAL ONLY 1 GROUP ONLY 2 BOTH INDIVIDUAL AND GROUP 3 NO PRETEST COUNSELING 4	→ 2023 → 2024
2021	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	→ 2023
2022	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN PREVIOUS QUESTION	MONTHS OF DATA <input type="text"/> <input type="text"/>	
2023	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	
2024	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	
2025	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				
2026	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 RAPID TEST ONSITE-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) CLIENT NEVER OFFERED HIV TEST Y					
2027	CHECK Q2026 AND CIRCLE CORRECT RESPONSE TO RIGHT	BLOOD DRAWN IN THIS CLINIC/UNIT (A OR E OR F CIRCLED) 1 BLOOD FOR HIV TEST DRAWN OUTSIDE FACILITY (ONLY H OR X CIRCLED) ... 2 ANY OTHER RESPONSE 3	→ 2035 → 2034				
2028	ASK TO SEE WHERE BLOOD IS DRAWN FOR THE HIV TEST AND INDICATE IF THE ROOM HAS ALREADY BEEN OBSERVED FOR ITEMS IN Q2029. IF YES, INDICATE WHICH SECTION THE DATA ARE RECORDED IN.	DATA RECORDED IN OPD/IPD QRE 1 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> DATA NOT PREVIOUSLY RECORDED 2					→ 2034

NO.	QUESTIONS	CODING CATEGORIES			GO TO
2029	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 (PIPED)	1 04	2	3	
02	OTHER RUNNING WATER (BUCKET WITH TAP OR POUR PITCHER)	1 04	2	3	
03	WATER IN BUCKET OR BASIN (WATER REUSED)	1	2	3	
04	HAND-WASHING SOAP	1	2	3	
05	SINGLE-USE HAND DRYING TOWELS	1	2	3	
06	WASTE RECEPTACLE WITH LID AND PLASTIC LINER	1	2	3	
07	SHARPS CONTAINER	1	2	3	
08	DISPOSABLE LATEX GLOVES	1 10	2	3	
09	DISPOSABLE NON-LATEX GLOVES	1	2	3	
10	ALREADY MIXED DECONTAMINATION SOLUTION	1 12	2	3	
11	DISINFECTANT (NOT YET MIXED)	1	2	3	
12	DISPOSABLE NEEDLES	1	2	3	
13	AUTO-DISABLE SYRINGES	1	2	3	
14	DISPOSABLE SYRINGES (3 OR 5 ML)	1	2	3	
15	PRIVATE ROOM (AUDITORY AND VISUAL PRIVACY)	1 18	2	3	
16	AUDITORY PRIVACY	1	2	3	
17	VISUAL PRIVACY	1	2	3	
18	EXAMINATION TABLE	1	2	3	
19	CONDOMS	1	2	3	
20	RAPID TEST FOR HIV	1	2	3	
21	VACUTAINER	1	2	3	
2030	ARE ALL SURFACE AREAS IN THE BLOOD DRAWING AREA CLEAN OF BLOOD OR OTHER BODY FLUIDS?	YES NO		1 2	
2031	WERE ANY USED NEEDLES OR OTHER SHARPS OBSERVED OUTSIDE OF A SHARPS CONTAINER?	YES NO		1 2	
2032	WAS THE SHARPS CONTAINER OVERFLOWING, OR WAS THE CONTAINER PIERCED/BROKEN?	YES NO NO SHARPS CONTAINER		1 2 3	
2033	WERE ANY BANDAGES OR OTHER NON-SHARP INFECTIOUS WASTE OBSERVED OUTSIDE OF A COVERED TRASH CONTAINER?	YES, ON FLOOR/SURFACES YES, IN UNCOVERED CONTAINER . NO		1 2 3	
2034	How many days each week are HIV tests available in this facility for pregnant women?	DAYS PER WEEK DONT KNOW	<input type="text"/> 8		

NO.	QUESTIONS	CODING CATEGORIES	GO TO
2035	What is the most common procedure followed, for offering HIV testing to pregnant women? RECORD THE RESPONSE THAT BEST REFLECTS THE PRACTICE. PROBE IF NECESSARY.	OFFERED WHEN VOLUNTARILY REQUESTED BY PREGNANT WOMAN 1 OFFERED TO ALL ANC CLIENTS AT FIRST VISIT 2 OFFERED SELECTIVELY TO ANC CLIENTS AT FIRST VISIT, BASED ON SOCIAL/MEDICAL HISTORY ... 3 OTHER 6 (SPECIFY)	
2036	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	→ 2038
2037	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	
2038	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 LAMIVUDIN C ZIDOVUDINE AND NEVIRAPIN D OTHER X (SPECIFY) NO ARV AVAILABLE FROM THIS CLINIC/UNIT FOR PMTCT Y	→ 2043
2039	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 CORPS/VHW 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)	→ 2041
2040	What is the most common practice for when the ARV is provided to the HIV positive client or to the CORPS/VHW ?	SAME DAY HIV STATUS IS CONFIRMED. 0 PROVIDED AT SPECIFIC STAGE OF PREGNANCY. INDICATE MONTHS OF PREGNANCY <input type="text"/>	
2041	Which ARV is used for the newborn for PMTCT?	NEVIRAPINE 1 ZIDOVUDINE (or AZT) 2 NEVIRAPINE + ZIDOVUDINE 3 OTHER 6 (SPECIFY)	
2042	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 CORPS/VHW TO GIVE AT HOME AFTER BIRTH B INSTRUCT MOTHER TO BRING CHILD TO FACILITY FOR ARV AROUND 72 HOURS AFTER BIRTH C GIVEN IMMEDIATELY TO BABY BEFORE DISCHARGE D OTHER X (SPECIFY) NO ARV PROPHYLAXIS FOR NEWBORN Y	

NO.	QUESTIONS	CODING CATEGORIES		GO TO
2043	Now I would like to look at ANC records, including those that provide information on any PMTCT counseling and testing services			→ 2046 → 2046
	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		
2044	RECORD THE TOTAL NUMBER OF FIRST VISIT ANC CLIENTS DURING THE PAST 12 MONTHS.	NUMBER OF FIRST VISIT ANC CLIENTS	<div><div></div><div></div><div></div><div></div></div>	
2045	INDICATE NUMBER OF MONTHS OF DATA AVAILABLE IN PREVIOUS QUESTION.	MONTHS OF DATA	<div><div></div><div></div></div>	
2046	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		→ 2049 → 2049

NO.	QUESTIONS	CODING CATEGORIES			GO TO	
2047	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	RAPID TEST USED BY UNIT AND 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"/> 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"/>
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"/>
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"/>
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"/>
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"/>
07	TOTAL ANC CLIENTS WHO RECEIVED HIV TEST	1 → b	2 → 2048	3 → 2048	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
2048	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			→ 2051	
2049	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			→ 2054	
2050	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	
2051	AMONG THE WOMEN FOR WHOM TESTING INFORMATION WAS AVAILABLE (Q2047) INDICATE IF INFORMATION ON RECEIVING ARV, AND ON THEIR NEWBORN IS AVAILABLE. COLLECT INFORMATION FROM OUTPATIENT AREA ONLY. IF INFORMATION ONLY AVAILABLE IN DELIVERY AREA CIRCLE "2" AND INFORMATION WILL BE COLLECTED IN Q2070.	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	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"/> <input type="text"/> <input type="text"/>	<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"/> <input type="text"/> <input type="text"/>	<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"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
04	NUMBER OF HIV POSITIVE INFANTS.	1 → b	2 → 05	3 → 05	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
05	TOTAL NUMBER OF BIRTHS FOR ALL WOMEN	1 → b	2 → 2052	3 → 2052	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
2052	Is there any record of HIV positive pregnant women who were referred for ARV treatment? IF YES, ASK TO SEE THE RECORD.	YES, OBSERVED 1 YES REPORTED NOT SEEN 2 NO 3				
2053	Is there any record of HIV positive pregnant women who started 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				
2054	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			→ 2058	
2055	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				
2056	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			→ 2058	

NO.	QUESTIONS	CODING CATEGORIES				GO TO
2065	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 Y				
2066	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				
2067	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				
2068	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				
2069	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				→ 2071 → 2071
2070	ASK TO SEE RELEVANT RECORDS FOR THE DATA REQUESTED BELOW FOR THE PAST 12 MONTHS AND RECORD THE CORRECT RESPONSE.	(a) RECORD/REGISTER			(b) NUMBERS FROM OBSERVED RECORDS	
		OBSERVED	REPORTED NOT SEEN	NOT AVAIL	NUMBER OF CLIENTS	MONTHS OF DATA
		1 → b	2 → 02	3 → 02	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
		1 → b	2 → 03	3 → 03	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
		1 → b	2 → 04	3 → 04	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
		1 → b	2 → 2071	3 → 2071	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
2071	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				

612 APPENDIX D

HEALTH WORKER INTERVIEW			
Facility Number: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>		CLINIC/UNIT CODE <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Line # Unit # </div>	
Interviewer Code: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>		Provider SL Number: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	
DATE: <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> DAY MONTH YEAR </div>		Provider Sex: (1=MALE; 2=FEMALE) <input style="width: 30px;" type="text"/> Provider Status: (1=Assigned; 2=Seconded) <input style="width: 30px;" type="text"/>	
Number of ANC Observations Associated with Provider <input style="width: 30px;" type="text"/>		Number of FP Observations Associated with Provider <input style="width: 30px;" type="text"/>	
Number of Sick Child Observations Associated with Provider <input style="width: 30px;" type="text"/>		Number of STI Observations Associated with Provider <input style="width: 30px;" type="text"/>	
Number of INJECTIONS Associated with Provider <input style="width: 30px;" type="text"/>			
<div style="display: flex; justify-content: space-between;"> <div> INDICATE IF PROVIDER WAS PREVIOUSLY INTERVIEWED IN OTHER FACILITY. IF YES, RECORD NAME AND FACILITY NUMBER OF WHERE HE/SHE WAS INTERVIEWED </div> <div> YES, PREVIOUSLY INTERVIEWED 1 <div style="display: flex; align-items: center;"> <div style="border-bottom: 1px solid black; width: 150px; margin-right: 5px;"></div> <div style="font-size: small;">NAME & NUMBER OF FACILITY</div> <div style="margin-left: 10px;"> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> </div> <div style="margin-left: 10px;">→ STOP</div> </div> </div> <div> NO, NOT PREVIOUSLY INTERVIEWED 2 </div> </div>			
<p>READ THE FOLLOWING CONSENT FORM</p> <p>Hello. My name is _____. We are here on behalf of the Ministry of Health and Bureau of Statistics to assist the government in knowing more about how services are provided in health facilities. 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> <div style="border-top: 1px solid black; margin-top: 10px;"> <div style="display: flex; justify-content: space-between; width: 80%;"> Interviewer's signature Date </div> </div> <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	
101	May I begin the interview now?	YES 1 NO 2	→ STOP
102	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 <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	

NO.	QUESTIONS	CODING CLASSIFICATION	
103	What is your current technical (or medical) qualification?	CONSULTANT 01 MEDICAL OFFICER 08 CLINICAL OFFICER 09 ENROLLED NURSE 10 ENROLLED MIDWIFE 11 REGISTERED NURSE 12 R MIDWIFE/DBL. TRAINED NURSE 13 COMPREHENSIVE NURSE 14 PUBLIC HEALTH NURSE 15 NURSING ASSISTANT 16 NURSING AIDE 17 PHARMACIST 18 PHARMACY DISPENSER 19 LAB. TECHNOLOGIST 20 LAB. TECHNICIAN 21 LAB ASSISTANT 22 NUTRITIONIST 23 HEALTH EDUCATOR 24 STATISTICIAN 25 RECORDS CLERK 26 HOSPITAL ADMINISTRATOR 27 SOCIAL WORKER 28 HIV/AIDS COUNSELOR 29 OTHER COUNSELOR 30 PATHOLOGIST 31 OTHER STAFF PROVIDING CLIENT SERVICES 96 SPECIFY _____	
104	What year did you graduate (or complete) with this qualification? IF NO TECHNICAL QUALIFICATION, ASK: What year did you complete any basic training for your current position? IF NO BASIC TRAINING, CIRCLE "0000" AND SKIP.	YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NO TECHNICAL QUALIFICATION AND NO BASIC TRAINING .. 0000	→ 106
105	How many years of study were required for this qualification? In other words, how long was your technical training after completing basic education? 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"/>	
106	In what year did you start working in this facility?	YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
107	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"/>	
108	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 (of Infection Control)?	1	2	3								
02	Waste management-that is disposal of sharps and contaminated waste?	1	2	3								
03	Any other training related to infection prevention?	1	2	3								
04	Any training related to Injection safety?	1	2	3								
05	Health Management Information Systems (HMIS) or reporting requirements for any service?	1	2	3 3								
06	Confidentiality and rights to non-discrimination practices for People Living with HIV/AIDS (PLHA)?	1	2	3								
200a	As part of your services in this facility, have you received any dose of Hepatitis B vaccine? IF YES, ASK: How many doses have you received so far?	YES, ONE DOSE 1 YES, TWO DOSES 2 YES, THREE DOSES . . 3 NO 4										
201	Are you a manager or in-charge for any clinical services?	YES 1 NO 2										
202	Do you provide any client/clinical 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.											
		<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">DURATION IN YEARS</th></tr> </thead> </table>			a		b		YES	NO	DURATION IN YEARS	
a		b										
YES	NO	DURATION IN YEARS										
01	Diagnosis and/or treatment (i.e., management) 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 tests or analysis?	1	2									
06	Prescribe treatment for tuberculosis?	1	2									
07	Provide follow-up treatment for tuberculosis?	1	2									
08	Participate in the Direct Observation Treatment Short-course (DOTS) strategy?	1	2									
09	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 pre-service 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 pre-service 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 syndromic management for STIs?	1	2	3
03	Drug resistance to STI treatment medications	1	2	3
04	Any topic related to malaria? IF YES, ASK: Did the training cover any of the following topics?	1	2	3 → 08
05	Diagnosis and treatment of malaria?	1	2	3
06	Specifically diagnosing and treating malaria in children?	1	2	3
07	Intermittent Preventive Treatment (IPT) of malaria for pregnant women?	1	2	3
08	Any topic related to tuberculosis? IF YES, ASK: Did the training cover any of the following topics?	1	2	3 → 205
09	Diagnosing tuberculosis (TB) using sputum test?	1	2	3
10	Diagnosing TB using clinical symptoms?	1	2	3
11	Prescribing treatment for TB?	1	2	3
12	The DOTS (Direct observed treatment-short-course) strategy?	1	2	3
13	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	→504a
		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 BOXES	YEARS	<input type="text"/>	<input type="text"/>
504a	Do you personally provide any PMTCT services? IF YES, INDICATE WHICH OF THE LISTED SERVICES ARE PROVIDED	PREVENTIVE COUNSELING ..	A	
		HIV TEST COUNSELING ..	B	
		CONDUCT HIV TEST ..	C	
		PROVIDE ARV TO MOTHER ..	D	
		PROVIDE ARV TO/FOR INFANT ..	E	
		NO PMTCT SERVICES ..	Y	
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	Any topic related to pregnancy and AIDS or PMTCT?	1	2	3 →507
08	Counseling for prevention of mother to child transmission of HIV?	1	2	3
09	Antiretroviral treatment for prevention of mother to child transmission (PMTCT) of HIV?	1	2	3
10	Nutritional counseling for the newborn of mothers with HIV/AIDS?	1	2	3
11	Guidelines to follow when dispensing the preventive ARV to HIV positive women?	1	2	3
12	Record keeping, or other management of the ARVs for PMTCT?	1	2	3
13	Nutrition counseling for the pregnant woman with HIV/AIDS?	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION		
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	→ 511
		NO	2	
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	→ 513
		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	→ 513
		NO	2	
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	→ 515
		NO	2	
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	→ 601
		NO	2	

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 YES </div> <div style="text-align: center;"> b NO </div> <div style="text-align: center;"> b DURATION IN YEARS </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	
03	Do you provide nutrition counseling to HIV/AIDS infected clients?	1	2	
04	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	
01	Do you provide nutrition counseling for the newborn of the HIV infected woman?	1	2	
03	Do you counsel HIV positive women about family planning?	1	2	
04	Do you ever provide or prescribe the preventive antiretroviral therapy for prevention of mother to child transmission?	1	2	

NO.	QUESTIONS	CODING CLASSIFICATION											
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:	<table border="1"> <thead> <tr> <th colspan="2">a</th> <th>b</th> </tr> <tr> <th>YES</th> <th>NO</th> <th>DURATION IN YEARS</th> </tr> </thead> <tbody> <tr> <td>1 → b</td> <td>2 ↓ 605</td> <td><input type="text"/><input type="text"/></td> </tr> </tbody> </table>			a		b	YES	NO	DURATION IN YEARS	1 → b	2 ↓ 605	<input type="text"/> <input type="text"/>
a		b											
YES	NO	DURATION IN YEARS											
1 → b	2 ↓ 605	<input type="text"/> <input type="text"/>											
01													
02	Clinical management of HIV/AIDS-related neurological disorders?	1	2										
03	Diagnosis and/or treatment of opportunistic infections?	1 → b	2 ↓ 04	<input type="text"/> <input type="text"/>									
04	Prescribe antiretroviral therapy (ART)?	1 → b	2 ↓ 05	<input type="text"/> <input type="text"/>									
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										
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	<input type="text"/> <input type="text"/>									
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										
605a	Do your clients who are HIV positive actively participate in the services that you provide or the services that they receive? IF YES, ASK: How do they actively participate?	SUPPORT GROUPSA DELIVER MEDS FOR OTHER CLIENTS WHO ARE TOO SICK TO ATTEND CLINICB OTHER _____X (SPECIFY) NO ACTIVE PARTICIPATION .. Y NO SERVICES TO HIV CLIENTS Z											

NO.	QUESTIONS	CODING CLASSIFICATION		
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 (or comprehensive) training for HIV/AIDS counselors (3 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), (8 weeks)	1	2	3
05	Supervisors training course for counselors at district and regional level (VCT) (6 days)	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	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 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	Cotrimoxazole 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 prior to transfusion?	1	2	3
05	Blood screening for Hepatitis B prior to transfusion?	1	2	3
06	Tests for monitoring ART such as TLC and serum creatinine.	1	2	3
800	Now I want to ask you a few more questions about your work in this facility. In an average week, how many hours do you work in this facility? IF WEEKS ARE NOT CONSISTENT, ASK THE RESPONDENT TO AVERAGE OUT HOW MANY HOURS PER MONTH AND THEN DIVIDE THIS BY 4.	AVERAGE HOURS PER WEEK WORKING IN THIS FACILITY		
801	I want to know if you can estimate how much of your 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		
		DON'T KNOW/NOT CERTAIN 998		

NO.	QUESTIONS	CODING CLASSIFICATION				
802	During the past 12 months, if you add together all of the formal training you have received related to HIV/AIDS, how many days is this? 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. IF NO DAYS OF TRAINING, ENTER 000	NUMBER OF DAYS OF HIV/AIDS RELATED TRAINING	<table border="1"><tr><td></td><td></td><td></td></tr></table>			
803	Now I would like to ask you some questions about supervision you have personally received. This supervision may have been from a supervisor either in this facility, or from outside the facility. Do you receive technical support or supervision in your work? IF YES, ASK: When was the most recent time?	YES, IN THE PAST 3 MONTHS 1 YES, IN THE PAST 4-6 MONTHS 2 YES, IN THE PAST 7-12 MONTHS 3 YES, MORE THAN 12 MONTHS AGO 4 NO 5	→ 806 → 806 → 806			
804	How many times in the past six months has your work been supervised?	NUMBER OF TIMES	<table border="1"><tr><td></td><td></td></tr></table>			
805	The last time you were personally supervised, did your supervisor do any of the following:	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 07			
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			
806	Do you have a written job description of your current job or position in this facility? IF YES, ASK: May I see it?	YES, OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO 3				
807	Are there any opportunities for promotion in your current job?	YES 1 NO 2 UNCERTAIN/DON'T KNOW 8				

NO.	QUESTIONS	CODING CLASSIFICATION	
808	Do you personally receive any salary supplement, that is, money outside of your routine salary, that is related to your work in this facility?	YES 1 NO 2	→ 810
809	Which type of salary supplement do you receive?	MONTHLY OR DAILY SALARY SUPPLEMENT A PERDIEM WHEN ATTENDING TRAINING B DUTY ALLOWANCE C PAYMENT FOR EXTRA ACTIVITIES (NOT ROUTINELY PROVIDED) .. D OTHER X (SPECIFY) _____	
810	In your current position, have you ever received any non-monetary incentives for the work you do? This might include such things as discounts for medicines or other items, uniforms or other clothing, food, training, or other things like this.	YES 1 NO 2	→ 812
811	Describe any incentives that you have received. CIRCLE ALL THAT APPLY.	UNIFORMS, BACKPACKS, CAPS ETC. A DISCOUNT MEDICINES, FREE TICKETS FOR CARE, VOUCHERS, etc. B TRAINING C FOOD RATION D SUBSIDIZED HOUSING E MONETARY BONUS (IRREGULAR) F OTHER X (SPECIFY) _____	
812	Among the various things related to your working situation that you would like to see improved, can you tell me the three that you think would most improve your ability to provide care and support services for HIV/AIDS? CIRCLE ONLY THREE ITEMS. IF THE PROVIDER MENTIONS MORE THAN THREE ITEMS, ASK THE PROVIDER TO PRIORITIZE TO ONLY THREE. IF THE PROVIDER DOES NOT MENTION THREE ITEMS, PROBE FOR ANY OTHERS IN AN ATTEMPT TO HAVE THREE ANSWERS.	MORE SUPPORT FROM SUPERVISOR A MORE KNOWLEDGE/ TRAINING B MORE SUPPLIES/STOCK C BETTER QUALITY EQUIPMENT/ SUPPLIES D LESS WORKLOAD (i.e. MORE STAFF) E BETTER WORKING HOURS F MORE INCENTIVES (SALARY, PROMOTION, HOLIDAYS) G TRANSPORTATION FOR PATIENTS WHO ARE REFERRED H PROVIDING ART I INCREASED SECURITY J BETTER FACILITY INFRASTRUCTURE K MORE AUTONOMY /INDEPENDENCE L EMOTIONAL SUPPORT FOR STAFF (COUNSELING/ GROUP SOCIAL ACTIVITIES) .. M OTHER W (SPECIFY) _____ OTHER X (SPECIFY) _____	

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																																								
900a	Have you had any needle stick injuries in the last 6 months?	YES 1 NO 2 DON'T KNOW 8																																								
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																																									
		<table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>NA</th><th>DK</th></tr> </thead> <tbody> <tr> <td>01 Testing a client for HIV infection without their consent</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> <tr> <td>02 Requiring some clients to be tested for HIV before scheduling surgery</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> <tr> <td>03 Using latex gloves for performing noninvasive exams on clients suspected of HIV</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> <tr> <td>04 Extra precautions been taken in the sterilization of instruments used on HIV-positive patients</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> <tr> <td>05 Health providers gossiping about a client's HIV status</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> <tr> <td>06 Because a patient is HIV-positive a senior health provider pushing the client to a junior provider</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> <tr> <td>07 An HIV-positive patient receiving less care/attention than other patients</td><td>1</td><td>2</td><td>5</td><td>8</td></tr> </tbody> </table>		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
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903	Have you ever heard the word stigma?	YES 1 NO 2 → 910																																								
904	Does stigma occur in health facilities?	YES 1 NO 2 UNCERTAIN/DON'T KNOW 8 → 906 → 906																																								

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 O A N</p>
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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: 40%;">Registered Midwife</td> <td style="width: 10%; text-align: center;">13</td> </tr> <tr> <td>Medical Officer</td> <td style="text-align: center;">08</td> <td>Comprehensive Nurse</td> <td style="text-align: center;">14</td> </tr> <tr> <td>Clinical Officer</td> <td style="text-align: center;">09</td> <td>Public Health Nurse</td> <td style="text-align: center;">15</td> </tr> <tr> <td>Enrolled Nurse</td> <td style="text-align: center;">10</td> <td>Nursing Assistant</td> <td style="text-align: center;">16</td> </tr> <tr> <td>Enrolled Midwife</td> <td style="text-align: center;">11</td> <td>Nursing Aide</td> <td style="text-align: center;">17</td> </tr> <tr> <td>Registered Nurse</td> <td style="text-align: center;">12</td> <td></td> <td></td> </tr> </table> <p>Other _____ 96 (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 OBSERV.</p>	Consultant	01	Registered Midwife	13	Medical Officer	08	Comprehensive Nurse	14	Clinical Officer	09	Public Health Nurse	15	Enrolled Nurse	10	Nursing Assistant	16	Enrolled Midwife	11	Nursing Aide	17	Registered Nurse	12			<p>PROVIDER CATEGORY </p> <p>SEX OF PROVIDER </p> <p>PROVIDER SL NUMBER </p>
Consultant	01	Registered Midwife	13																						
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Enrolled Midwife	11	Nursing Aide	17																						
Registered Nurse	12																								

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>
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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 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;"> </div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center;"> </div> : <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; text-align: center;"> </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 spontaneous abortions	1	2	8	
06	Previous induced 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 fundal height (or conduct ultrasound)	1	2	8	
05	Listen to the client's abdomen for fetal heartbeat	1	2	8	
06	Examine the client's breasts	1	2	8	
07	Conduct vaginal examination/exam of perineal area	1	2	8	
08	Perform or refer for anemia test	1	2	8	
09	Perform or refer for urine test	1	2	8	
10	Perform or refer the client for a syphilis test	1	2	8	
11	Perform or refer for HIV test	1	2	8	
12	Provide or refer for counseling related to HIV test	1	2	8	
13	Look at the client's health card (either before beginning the consultation or while collecting information or examining the client)	1	2	8	
14	Discuss any aspect related to having ever received a tetanus toxoid injection	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 IPT-1 or IPT-2	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 the malaria tablets	1	2	8	
	DIRECT OBSERVATION:				
11	Dose of IPT-1 or IPT-2 is ingested in presence of provider	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	Client given an ITN free of charge	1	2	8	
15	Client purchased ITN from provider	1	2	8	
16	Explanation is given about using the 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	Client indicated that she plans to deliver in a facility	1 2 8	
03	Advise the client to use a skilled health worker during delivery	1 2 8	
04	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	
05	Mention planning for transportation during labor (either to place of delivery or for emergency care during home-delivery)	1 2 8	
06	Mention setting aside money for emergencies at time of delivery	1 2 8	
07	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:		

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT **Exit Interview for Antenatal-Care Client**

1. Facility Identification

	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;">A</td> <td style="width: 20px; height: 20px; 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="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: _____	<table style="width: 100%;"> <tr> <td style="width: 70%;">DAY</td> <td style="width: 30%; text-align: center;"> <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> </td> </tr> <tr> <td>MONTH</td> <td style="text-align: center;"> <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> </td> </tr> <tr> <td>YEAR</td> <td style="text-align: center;"> <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> </td> </tr> </table> INTERVIEWER CODE <table border="1" style="display: inline-table; border-collapse: collapse; vertical-align: middle;"> <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; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>	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>								
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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 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"/>	
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	→ 106 → 106
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, 2-4 TIMES 2 YES, 5 OR MORE TIMES 3 NO 4 DON'T KNOW 8	
104	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD?	WEEKS <input type="text"/> INFORMATION NOT AVAILABLE 98	
105	DOES THE CARD INDICATE THE CLIENT HAS RECEIVED IPT?	YES, 1 DOSE 1 YES, 2 DOSES 2 NO 3 DON'T KNOW 8	
106	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"/> DON'T KNOW 98	
107	Is this your first pregnancy?	YES 1 NO 2	
108	Is this your first antenatal visit at this facility for this pregnancy?	YES 1 NO 2	
109	During this visit, or previous visits, did the provider give you iron pills, folic acid or iron with folic acid, or give you a prescription for them? SHOW THE CLIENT AN IRON PILL, A FOLIC-ACID PILL, OR A COMBINED PILL.	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	→ 111 → 114 → 114
110	ASK TO SEE THE CLIENT'S IRON/FOLIC ACID/IRON WITH FOLIC ACID PILLS.	SAW PILLS 1 SAW PRESCRIPTION 2 NO PILLS OR PRESCRIPTION SEEN 3	
111	During this visit or previous visits, has a provider explained to you how to take the iron pills?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	
112	During this or previous visits, has a provider discussed with you the side effects of the iron pill?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
113	Please tell me any side effects of the iron pill that you know of.	NAUSEA A BLACK STOOLS B CONSTIPATION C OTHER X (SPECIFY) DON'T KNOW Z	
114	During this or previous visits, has a provider given, or prescribed any anti-malaria tablets for you? SHOW THE CLIENT TABLETS OF FANSIDAR (OR OTHER APPROPRIATE MED).	YES, THIS VISIT 1 YES, PREVIOUS VISIT 2 YES, BOTH PREVIOUS VISIT AND THIS VISIT 3 NO 4 DON'T KNOW 8	→ 116 → 117 → 117
114a	Did provider ask you to take the tablet in front of him or her? IF YES, ASK: Did you take it?	YES, I TOOK IT 1 YES, BUT I DID NOT TAKE 2 NO, PROVIDER DID NOT ASK 3	→ 117
115	ASK TO SEE THE CLIENT'S ANTI-MALARIAL TABLETS.	SAW PILLS 1 SAW PRESCRIPTION 2 NO PILLS OR PRESC SEEN 3	
116	Did a provider explain to you how to take the anti-malarial tablets?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	
117	Do you own an ITN, that is a net that has been treated with a chemical to protect you from mosquito bites?	YES 1 NO 2 DON'T KNOW 8	
118	Did you sleep under an ITN last night?	YES 1 NO 2	
119	During this visit or previous visit, did a provider offer you an ITN free of charge or offer to sell you one? IF THERE IS AN INDICATION THAT THE CLIENT WILL PICK UP OR BUY THE ITN ELSEWHERE WITHIN THE FACILITY, THAT COUNTS AS PROVIDER GIVING OR CLIENT PURCHASING FROM PROVIDER	YES, OFFERED FREE THIS VISIT 1 YES OFFERED FREE PREVIOUS VISIT 2 YES, OFFERED TO SELL THIS VISIT 3 YES, OFFERED TO SELL PREVIOUS VISIT 4 NO, NOT OFFERED 5	
120	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	
121	Have you ever received a tetanus toxoid (TT) injection, including one you may have received today? IF YES, ASK: 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	
122	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	
123	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 GLOVES E COTTON WOOL F CLOTHS FOR BABY G OTHER X (SPECIFY) DON'T KNOW Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
124	Do you have money set aside for the delivery? IF YES, PROBE: Is the money enough?	YES, ENOUGH 1 YES, BUT NOT ENOUGH 2 NO 3	
125	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	→ 129 → 129
126	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	
127	What did the provider advise you to do if you experienced any of the danger 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)	
128	Do you know any danger signs during/after delivery? IF YES: What danger signs do you know?	BLEEDING A FEVER B GENITAL INJURIES C OTHER X (SPECIFY) NONE Y	
129	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	
130	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	→ 132 → 132
131	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	
132	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	
133	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) DON'T KNOW 8	
134	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? IF CLIENT ARRIVED AT THE FACILITY BEFORE FACILITY OFFICIALLY OPENED, THAT TIME DOES NOT COUNT AS WAITING TIME	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 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	What was the main reason you did not go to the nearest facility?	<p>INCONVENIENT OPERATING HOURS 01 BAD REPUTATION 02 DON'T LIKE PERSONNEL ... 03 NO MEDICINE 04 PREFERS TO REMAIN ANONYMOUS 05 IT IS MORE EXPENSIVE 06 REFERRAL 07 OTHER _____ 96 (SPECIFY) 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 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"/> DON'T KNOW 98	
302	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 2 NO 3	
303	Have you ever attended school? IF YES, ASK: Was your schooling formal or informal?	YES, FORMAL 1 YES, INFORMAL 2 NO SCHOOLING 3	→ 306 → 306
304	What is the highest level of school you attended?	PRIMARY 1 SECONDARY 2 TERTIARY 3 UNIVERSITY 4	
305	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
	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 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			
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25			

1. Facility Identification																																				
Name of the facility: _____ Location of the facility: _____		QTYPE <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">O</td> <td style="width: 20px; height: 20px;">F</td> <td style="width: 20px; height: 20px;">P</td> </tr> </table>	O	F	P																															
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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; width: 30px; height: 30px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> : <div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></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>	<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 </p>			→ 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 → 14
	10 Good for up to 12 years				
	11 Should return to the clinic 3-6 weeks post insertion or after first menses				
	12 Common side effects that may occur (heavy bleeding for first few months post insertion, spotting, or mild abdominal cramps)	1	2	8	
	13 Should return to clinic if side effectss continue	1	2	8	
	SPERMICIDE/FOAM				5 → 16
	14 May cause irritation	1	2	8	
	15 Insert before each occurrence of intercourse	1	2	8	
	IMPLANT				5 → 20
	16 Good for 3-5 years (Implanon-3 yrs, Jadelle-5 yrs)	1	2	8	
	17 Changes that may occur with menstruation (irregular bleeding, spotting)	1	2	8	
	18 Initial side effects that may occur (nausea, weight gain, and breast tenderness)	1	2	8	
	19 Should return to clinic if side effectss continue	1	2	8	
	RHYTHM METHOD or PERIODIC ABSTINENCE				5 → 22
	20 How to identify a woman's fertile period	1	2	8	
	21 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 → 25
22	Slight risk of pregnancy during the time shortly before menstruation resumes	1	2	8	
23	Most effective with "exclusive breastfeeding" without menstruation	1	2	8	
24	Not effective after menstruation begins again	1	2	8	
	VASECTOMY				5 → 30
25	Partner is protected from pregnancy after 3 months	1	2	8	
26	Use of a back-up method for the next 3 months	1	2	8	
27	Procedure intended to be permanent; slight risk of failure	1	2	8	
28	Warning signs that may occur after surgery (severe pain, tenderness, bleeding)	1	2	8	
29	Should return to clinic if experience warning signs	1	2	8	
	FEMALE STERILIZATION				5 → 34
30	Protect from pregnancy immediately	1	2	8	
31	Procedure intended to be permanent, slight risk of failure	1	2	8	
32	Warning signs that may occur after surgery (severe pain, light-headedness, fever, bleeding, missed periods)	1	2	8	
33	Should return to clinic if experience warning sign	1	2	8	
	EMERGENCY CONTRACEPTION				5 → 111
34	If vomit within 2 hours, need another dose	1	2	8	
35	If next period is unusually light or fails to occur within 4 weeks, return for pregnancy check	1	2	8	
36	First dose to be taken within 72 hours of contact	1	2	8	
37	Second dose should be taken 12 hours after first dose	1	2	8	
38	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, IMPLANT OR MALE OR FEMALE STERILIZATION.	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 OFFICER 08 CLINICAL OFFICER 09 ENROLLED NURSE 10 ENROLLED MIDWIFE 11 REGISTERED NURSE 12 REGISTERED MIDWIFE 13 COMPREHENSIVE NURSE .. 14 PUBLIC HEALTH NURSE 15 NURSING ASSISTANT 16 NURSING AIDE 17 OTHER 96 (SPECIFY)	
205	RECORD THE SEX OF THE PROVIDER CONDUCTING THE CLINICAL EXAMINATION OR PROCEDURE.	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 MALE STERILIZATION E FEMALE STERILIZATION ... F	

6. Pelvic Examination

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
207A	CHECK Q206: WAS A PELVIC EXAMINATION CONDUCTED?	YES	1		→ 208A
		NO	2		
207	RECORD WHETHER THE FOLLOWING OCCURRED DURING/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	5
05	USE STERILIZED OR HIGH LEVEL DISINFECTED INSTRUMENTS	STERILIZED/HLD INSTRUMENTS	1	2	5
06	WASH HIS/HER HANDS WITH SOAP AND RUNNING WATER BEFORE PUTTING ON GLOVES.	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 WITH SOAP AND RUNNING WATER 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/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 AND RUNNING WATER BEFORE PUTTING ON GLOVES	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 WITH SOAP AND RUNNING WATER 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 CLIENT TOLD THAT IUD IS GOOD FOR UP TO 12 YEARS?	GOOD FOR UP TO 12 YEARS 1 2 5		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO		
			YES	NO	NA
21	WAS CLIENT INSTRUCTED TO RETURN TO THE CLINIC 3 TO 6 WEEKS POST INSERTION OR AFTER FIRST MENSES?	INSTRUCTED TO RETURN IN 3 TO 6 WEEKS	1	2	5
22	WAS THE CLIENT INSTRUCTED TO REGULARLY CHECK THE STRING AFTER MENSTRUATION?	INSTRUCTED CHECK STRING	1	2	5
23	WAS THE CLIENT TOLD THAT SHE MAY EXPERIENCE SIDE EFFECTS? (HEAVY BLEEDING FOR 1ST FEW MONTHS, SPOTTING, OR MILD ABDOMINAL CRAMPS?)	TOLD ABOUT SIDE EFFECTS	1	2	5
24	WAS THE CLIENT INSTRUCTED TO RETURN TO THE CLINIC IF SIDE EFFECTS CONTINUED?	RETURN TO CLINIC	1	2	5
25	WAS THE CLIENT PROVIDED WITH A CARD STATING THE DATE IUD WAS INSERTED AND THE FOLLOW-UP DATE?	CARD PROVIDED	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 and running water before giving the injection	WASHED HANDS	1	2	
05	Prepare injection in area with clean table or tray to set items on	PREPARE IN CLEAN LOCATION	1	2	
06	(If using reusables) Use newly reprocessed needle and syringe	USE NEW/CLEAN NEEDLE	1	2	5
07	(If using disposables) Use new syringe and needle from a sterile sealed pack	USE NEW/CLEAN NEEDLE	1	2	5
08	Saw the provider open the new packet with syringe and needle	SAW OPEN PACKET	1	2	5
09	Remove needle from multiple dose vial each time	REMOVE NEEDLE	1	2	5
10	Stir or mix the bottle <i>before</i> drawing dose (DEPO)	STIR BOTTLE	1	2	5
11	Clean and air-dry the injection site <i>before</i> injection	CLEAN AND AIR-DRY THE SITE	1	2	
12	Draw back plunger <i>before</i> giving injection	DRAW BACK PLUNGER	1	2	
13	Allow dose to self-disperse instead of massaging the site	NO MASSAGE	1	2	
14	Use scoop technique to recap needle	SCOOP TECHNIQUE	1	2	
15	Recap needle using two hands	TWO-HAND RECAP	1	2	
16	Did not recap needle	NO RECAP	1	2	
17	Immediately dispose of sharps in puncture-resistant safety container or remove needle with needle cutter/puller and dispose of syringe in safety container that is not overflowing or pierced or broken	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 and running, water before wearing gloves	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 with soap and running water <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	
24	WAS THE CLIENT INSTRUCTED TO RETURN TO THE CLINIC IF SIDE EFFECTS CONTINUED?	RETURN TO CLINIC 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	

10. Client's Family Planning Status			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
AFTER THE CONSULTATION, COMPLETE THE FOLLOWING INFORMATION			
301	RECORD THE CLIENT'S FAMILY PLANNING STATUS AT THE BEGINNING OF THE CONSULTATION.	CURRENT USER 1 NONUSER, USED IN PAST .. 2 NONUSER, NO PAST USE .. 3 NOT DETERMINED 8	→ 304 → 306 → 306
302	RECORD THE CLIENT'S PRINCIPAL REASON FOR THE VISIT.	RESUPPLY/ROUTINE FOLLOW-UP 1 DISCUSS PROBLEM WITH METHOD 2 DESIRE TO CHANGE METHOD (NO PROBLEM) 3 DESIRE TO DISCONTINUE FP (NO PROBLEM) 4 DISCUSS OTHER PHYSICAL PROBLEM 5	
303	RECORD THE OUTCOME OF THE VISIT. (FOR CURRENT USER)	CONTINUED WITH CURRENT METHOD 1 SWITCHED METHOD 2 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, CONTINUED USE OF CURRENT METHOD 3 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, DISCONTINUED CURRENT METHOD 4 DECIDED TO STOP USING FAMILY PLANNING 5	→ 307 → 307 → 307 → 307 → 308
304	RECORD THE CLIENT'S MOST RECENT USE OF CONTRACEPTION. (NON-USER, USED IN THE PAST)	WITHIN PAST 6 MONTHS. . . . 1 SIX MONTHS OR MORE AGO . . 2 NOT DETERMINED 8	
305	RECORD THE OUTCOME OF THE VISIT. (NON-USER, USED IN THE PAST)	RESTARTED PRIOR METHOD 1 ADOPTED DIFFERENT METHOD 2 PLANNED DIFFERENT METHOD, NOT RECEIVED TODAY . . . 3 RECEIVED INFORMATION/ COUNSELING ONLY 4 NOT DETERMINED 8	→ 307 → 307 → 307 → 308 → 308
306	RECORD THE OUTCOME OF THE VISIT. (NON-USER, NO PAST USE)	ACCEPTED TO START METHOD 1 DID NOT DECIDE ON METHOD 2	→ 308
307	DID CLIENT LEAVE FACILITY WITH METHOD? IF NO: RECORD THE REASON THE CLIENT DID NOT RECEIVE METHOD.	YES, LEFT WITH METHOD .. 1 NO, METHOD NOT IN STOCK .. 2 NO, REQUIRES APPOINTMENT 3 NO, DELAY RECEIVING DUE TO HEALTH PROBLEM . . . 4 NO, PREGNANCY STATUS UNCERTAIN 5 OTHER _____ 6 (SPECIFY)	
308	INDICATE WHETHER THE PROVIDER WROTE IN OR ON AN INDIVIDUAL CLIENT'S RECORD OR CARD AFTER THE CONSULTATION.	YES 1 NO 2 NO INDIVIDUAL CARD USED . . 3 DON'T KNOW 8	
309	RECORD THE TIME THE OBSERVATION ENDED	<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>	
310	Observer's comments:		

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; vertical-align: middle;"> <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;"> <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; vertical-align: middle;"> <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; vertical-align: middle;"> <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; 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> INTERVIEWER CODE <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> CLIENT CODE: <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>												

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 <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>		
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 PROGESTIN (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/REF) FOR. IF THE CLIENT IS CONTINUING USING A METHOD IN Q106 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;"> <div> COMBINED PILL A PROGESTIN-ONLY PILL B PILL (TYPE UNSPECIFIED) C MALE CONDOM D FEMALE CONDOM E IUD F SPERMICIDE G DIAPHRAGM H INJ PROGESTIN (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 CONTINUING WITH METHOD IN QUESTION 106 Y OTHER X (SPECIFY) NO METHOD Z </div> <div style="text-align: right;"> <u>REC</u> <u>PRES/REF</u> A A B B C C D D E E F F G G H H I I J J K K L L M M N N O O P P Y Y X X Z Z 201 201 </div> </div> <p>[SKIP TO 201 ONLY 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-between;"> <div>YES</div> <div>NO</div> <div>DK</div> </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(S) 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 are the common side effects of an IUD?	HEAVY BLEEDING 1ST FEW MONTHS, SPOTTING OR CRAMPING 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)	At what point is your partner protected against pregnancy?	AFTER 3 MONTHS 1 OTHER 2 DON'T KNOW 8	
13	Female sterilization	After you have been sterilized, for how long are you protected against pregnancy?	Intended to be permanent; only slight risk or failure 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"/> <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) MEDI-CINE <input type="text"/> <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"/> <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 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"/> DON'T KNOW 98	
302	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 2 NO 3	
303	Have you ever attended school? IF YES, ASK: Was your schooling formal or informal?	YES, FORMAL 1 YES, INFORMAL 2 NO SCHOOLING 3	→ 306 → 306
304	What is the highest level of school you attended?	PRIMARY 1 SECONDARY 2 TERTIARY 3 UNIVERSITY 4	
305	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
	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 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 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 border="0" style="width: 100%;"> <tr> <td>Consultant</td> <td>01</td> <td>Registered Midwife ...</td> <td>13</td> </tr> <tr> <td>Medical Officer</td> <td>08</td> <td>Comprehensive Nurse ..</td> <td>14</td> </tr> <tr> <td>Clinical Officer</td> <td>09</td> <td>Public Health Nurse ..</td> <td>15</td> </tr> <tr> <td>Enrolled Nurse</td> <td>10</td> <td>Nursing Assistant</td> <td>16</td> </tr> <tr> <td>Enrolled Midwife</td> <td>11</td> <td>Nursing Aide</td> <td>17</td> </tr> <tr> <td>Registered Nurse</td> <td>12</td> <td></td> <td></td> </tr> </table> <p>Other _____ 96 (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	Registered Midwife ...	13	Medical Officer	08	Comprehensive Nurse ..	14	Clinical Officer	09	Public Health Nurse ..	15	Enrolled Nurse	10	Nursing Assistant	16	Enrolled Midwife	11	Nursing Aide	17	Registered Nurse	12			<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>					
Consultant	01	Registered Midwife ...	13																											
Medical Officer	08	Comprehensive Nurse ..	14																											
Clinical Officer	09	Public Health Nurse ..	15																											
Enrolled Nurse	10	Nursing Assistant	16																											
Enrolled Midwife	11	Nursing Aide	17																											
Registered Nurse	12																													

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 able or 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) using a timer	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
		YES	NO	DK	
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	YES	NO	DK	
01	Give a written prescription during consultation	1	2	8	
02	Provide oral medication during consultation	1	2	8	
	DID THE PROVIDER EXPLAIN:				
03	How much of the medicine to take each time (dose)	1	2	8	
04	How many times each day the medicine should be taken (frequency)	1	2	8	
05	How many days the medicine should be taken (duration)	1	2	8	
06	Ask the caretaker to repeat the instructions for the medications	1	2	8	
07	Give the first dose of the oral treatment	1	2	8	

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; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></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 MILD	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	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 (DIAGNOSED BY SYMPTOMS)	1	2	3	4	8
	2) MALARIA (DIAGNOSED BY MICROSCOPY IN LAB)	1	2	3	4	8
	3) MALARIA (DIAGNOSED BY RDT AT SITE)	1	2	3	4	8
	4) 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	TREATMENTS GIVEN OR PRESCRIBED	1 2 → 8 → 217 217	
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) CO-TRIMOXAZOLE TABLETS	1 2 8	
	5) CO-TRIMOXAZOLE SYRUP	1 2 8	
	6) AMOXICILLIN CAPSULES	1 2 8	
	7) AMOXICILLIN SYRUP	1 2 8	
	8) OTHER ANTIBIOTIC TABLET/SYRUP	1 2 8	
	9) PARACETAMOL	1 2 8	
	10) ZINC (for Diarrhea) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (SPECIFY DOSE in mg)	1 2 8	
	11) VITAMINS	1 2 8	
	12) COUGH SYRUPS/OTHER MEDICATION FOR SYMPTOMATIC TREATMENT	1 2 8	
212	RESPIRATORY		
	1) NEBULIZER 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 OR FANSIDAR (SP) OR ARTEMETHER	1 2 8	
	2) INJECTABLE CHLOROQUINE	1 2 8	
	3) OTHER INJECTABLE ANTIMALARIAL	1 2 8	
	4) ORAL COARTEM (ARTEMETHER + LUMEFANTRINE)	1 2 8	
	5) ORAL ARTESUNATE + AMODIAQUINE	1 2 8	
	6) ORAL ARTESUNATE + FANSIDAR (SP)	1 2 8	
	7) ORAL ARTESUNATE + MEFLOROQUINE	1 2 8	
	8) ORAL AMODIAQUINE + FANSIDAR (SP)	1 2 8	
	9) ORAL ARTESUNATE	1 2 8	
	10) ORAL FANSIDAR	1 2 8	
	11) ORAL AMODIAQUINE	1 2 8	
	12) ORAL CHLOROQUINE	1 2 8	
	13) HOMAPAK	1 2 8	
	14) OTHER ORAL ANTIMALARIAL	1 2 8	
	_____ (SPECIFY)		

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?	YES 1 REFERRED FOR IMMUNIZATION 2 NOT DUE FOR IMMUNIZATION/ COMPLETED IMMUNIZATIO... 3 VACCINE NOT AVAILABLE 4 CHILD TOO SICK 5 NOT DAY FOR IMMUNIZATION 6 DID NOT CHECK FOR IMMUNIZATION 7		
218	RECORD THE TIME THE OBSERVATION ENDED.	<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> . <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>		
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> <p style="text-align: right;">_____ 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; 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> 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> DON'T KNOW 98																									
106	Did you bring [NAME] to the facility today because he or she had any of the following problems?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;"><u>YES</u></th> <th style="width: 20%; text-align: center;"><u>NO</u></th> </tr> </thead> <tbody> <tr> <td>01 Cough or difficult breathing</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>02 Diarrhea</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>03 Fever/body hotness at home</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>04 Vomiting everything</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>05 Feeding problems</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>06 Convulsions</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>07 Excessive sleepiness</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		<u>YES</u>	<u>NO</u>	01 Cough or difficult breathing	1	2	02 Diarrhea	1	2	03 Fever/body hotness at home	1	2	04 Vomiting everything	1	2	05 Feeding problems	1	2	06 Convulsions	1	2	07 Excessive sleepiness	1	2	
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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 (SPECIFY) NO OTHER REASON Y																									

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO		
108	Has [NAME] been brought to this facility before for this same sickness or illness?	YES 1 NO 2 DON'T KNOW 8	→ 110 → 110		
109	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 <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			
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 4	→ 126		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
116	ASK TO SEE ALL MEDICATIONS THAT THE CARETAKER RECEIVED AND ANY PRESCRIPTIONS THAT HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.	HAS ALL MEDS 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY ... 3	
117	DOES THE CARETAKER HAVE OBSERVED ANTIMALARIA MEDICATIONS? IF YES, INDICATE IF LEAVING WITH FULL TREATMENT	YES, FULL TREATMENT ... 1 YES, PARTIAL TREATMENT . 2 NO 3 DON'T KNOW 8	→ 120
118	EXPLAIN: I want to ask you specifically about this medicine (SHOW ANTIMALARIAL DRUG). Do you know what this medicine is for?	MENTIONS MALARIA 1 MENTIONS FEVER 2 MENTIONS BOTH FOR MALARIA AND FEVER ... 3 NO (OR WRONG) RESPONSE 4	
119	Can you tell me how you will give this medicine? What I want to know is how much you will give each time, how many times each day you will give the medicine, and finally, how many days in total, you will give the medicine. INTERVIEWER CHECK RESPONSE AGAINST COUNTRY ADAPTED NOTE	CORRECT RESPONSE 1 INCORRECT RESPONSE ... 2 DON'T KNOW 8	
120	DOES THE CARETAKER HAVE OTHER MEDICINES THAT THE CHILD IS TO TAKE AT HOME?	YES 1 NO 2	→ 126
121	Did a provider at the facility explain to you how to give these medicines to [NAME] at home? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	YES 1 NO 2 DON'T KNOW 8	
122	Do you feel confident that you know how much of each medication to give [NAME] each day? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	YES 1 NO 2 DON'T KNOW 8	
123	Do you feel confident that you know how many times each day (or how often) to give each medicine? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	YES 1 NO 2 DON'T KNOW 8	
124	Do you feel comfortable or confident that you know for how many days to give each medicine? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	YES 1 NO 2 DON'T KNOW 8	
125	Has [NAME] been given a dose of any of these medications here at the facility already?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
126	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	
CHECK THE ABOVE QUESTIONS (119, 121, 122, 123 AND 124). IF THE CARETAKER DID NOT KNOW HOW TO GIVE THE MEDICINES (RESPONSE '2' OR '8') SUGGEST THE CARETAKER RETURN TO THE PROVIDER OR THE PHARMACY FOR CLARIFICATION ON HOW TO GIVE THE MEDICINES.			
127	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, ONLY OTHER FOODS & LIQUIDS .. 5 DON'T KNOW 8	
128	Did any provider ask you today about the types of foods and amounts that you normally feed [NAME] when [NAME] is not sick?	YES, TYPE ONLY 1 YES, AMOUNT ONLY 2 YES, BOTH TYPE & AMOUNT 3 NO 4 CANNOT REMEMBER 8	
129	Did anyone at the health facility weigh [NAME] today?	YES 1 NO 2	
130	Did anyone talk to you today about [NAME]'s weight and how [NAME] is growing?	YES 1 NO 2	
131	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	
132	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	
133	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	
134	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																																				
135	Was [NAME] given a vaccination today?	YES 1 NO 2 DON'T KNOW 8																																					
136	Do you have [NAME]'s vaccination card with you?	YES 1 NO 2	→ 139																																				
137	ASK TO SEE THE CHILD'S VACCINATION CARD. INDICATE WHETHER THE RECORD SHOWS THAT THE CHILD WAS VACCINATED TODAY.	YES 1 NO 2																																					
138	<p>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.</p> <table border="1"> <thead> <tr> <th></th><th>HAS CHILD EVER RECEIVED VACCINATION?</th><th>DATE</th></tr> <tr> <th></th><th></th><th>DAY MONTH YEAR</th></tr> <tr> <th></th><th>a</th><th>b</th></tr> </thead> <tbody> <tr> <td>01</td><td>POLIO-0 YES 1→ b NO OR NO RECORD .. 2→ 02</td><td><input type="text"/><input type="text"/> <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>BCG YES 1→ b NO OR NO RECORD .. 2→ 03</td><td><input type="text"/><input type="text"/> <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>POLIO-1 YES 1→ b NO OR NO RECORD .. 2→ 04</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>04</td><td>POLIO-2 YES 1→ b NO OR NO RECORD .. 2→ 05</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>05</td><td>POLIO-3 YES 1→ b NO OR NO RECORD .. 2→ 06</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>06</td><td>DPT-HB + Hib-1 YES 1→ b NO OR NO RECORD .. 2→ 07</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>07</td><td>DPT-HB + Hib-2 YES 1→ b NO OR NO RECORD .. 2→ 08</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>08</td><td>DPT-HB + Hib-3 YES 1→ b NO OR NO RECORD .. 2→ 09</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> <tr> <td>09</td><td>MEASLES YES 1→ b NO OR NO RECORD .. 2→ 139</td><td><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></td></tr> </tbody> </table>				HAS CHILD EVER RECEIVED VACCINATION?	DATE			DAY MONTH YEAR		a	b	01	POLIO-0 YES 1→ b NO OR NO RECORD .. 2→ 02	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	02	BCG YES 1→ b NO OR NO RECORD .. 2→ 03	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	03	POLIO-1 YES 1→ b NO OR NO RECORD .. 2→ 04	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	04	POLIO-2 YES 1→ b NO OR NO RECORD .. 2→ 05	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	05	POLIO-3 YES 1→ b NO OR NO RECORD .. 2→ 06	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	06	DPT-HB + Hib-1 YES 1→ b NO OR NO RECORD .. 2→ 07	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	07	DPT-HB + Hib-2 YES 1→ b NO OR NO RECORD .. 2→ 08	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	08	DPT-HB + Hib-3 YES 1→ b NO OR NO RECORD .. 2→ 09	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	09	MEASLES YES 1→ b NO OR NO RECORD .. 2→ 139	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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04	POLIO-2 YES 1→ b NO OR NO RECORD .. 2→ 05	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																					
05	POLIO-3 YES 1→ b NO OR NO RECORD .. 2→ 06	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																					
06	DPT-HB + Hib-1 YES 1→ b NO OR NO RECORD .. 2→ 07	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																					
07	DPT-HB + Hib-2 YES 1→ b NO OR NO RECORD .. 2→ 08	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																					
08	DPT-HB + Hib-3 YES 1→ b NO OR NO RECORD .. 2→ 09	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																					
09	MEASLES YES 1→ b NO OR NO RECORD .. 2→ 139	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																					
139	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	→ 141																																				
140	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																																					
141	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 services for sick children.		
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- LEM DK LARGE SMALL	
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"/> DON'T KNOW 98	
302	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 2 NO 3	
303	Have you ever attended school? IF YES, ASK: Was your schooling formal or informal?	YES, FORMAL 1 YES, INFORMAL 2 NO SCHOOLING 3	→ 306 → 306
304	What is the highest level of school you attended?	PRIMARY 1 SECONDARY 2 TERTIARY 3 UNIVERSITY 4	
305	What is the highest grade you completed at that level?	GRADE <input type="text"/> <input type="text"/>	
	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 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		
Name of the facility:	QTYPE	<div>O</div> <div>S</div> <div>I</div>
Location of the facility:		
FACILITY NUMBER	<div></div> <div></div> <div></div>	

Provider category: Consultant 01 Registered Midwife ... 13 Medical Officer 08 Comprehensive Nurse 14 Clinical Officer 09 Public Health Nurs 15 Enrolled Nurse 10 Nursing Assistant 16 Enrolled Midwife 11 Nursing Aide 17 Registered Nurse 12		PROVIDER CATEGORY <input type="text"/> <input type="text"/>
Other 96 SPECIFY		
Sex of provider: (1=Male; 2=Female)		SEX OF PROVIDER <input type="text"/>
SERIAL (SL) NUMBER FROM STAFF LISTING SHOULD BE USED. USE SAME NUMBER FOR STAFF INTERVIEW AND OBSERV.		PROVIDER SL NUMBER <input type="text"/> <input type="text"/>

<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: 50%;">ANC 1</td> <td style="width: 50%;">SC 3</td> </tr> <tr> <td>FP 2</td> <td>STI 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;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </td> </tr> <tr> <td>MONTH</td> <td style="text-align: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </td> </tr> <tr> <td>YEAR</td> <td style="text-align: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </td> </tr> <tr> <td>OBSERVER CODE</td> <td style="text-align: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </td> </tr> <tr> <td>SERVICE WHERE OBSERVATION OCCURRED</td> <td style="text-align: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </td> </tr> <tr> <td>CLIENT CODE</td> <td style="text-align: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </td> </tr> </table>	DAY	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	MONTH	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	YEAR	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	OBSERVER CODE	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	SERVICE WHERE OBSERVATION OCCURRED	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	CLIENT CODE	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>
ANC 1	SC 3																
FP 2	STI 4																
DAY	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>																
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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
10	Obtain client's consent for examination prior to conducting examination.	OBTAIN CONSENT	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
17	Obtain client's consent for examination prior to conducting examination.	OBTAIN CONSENT	1	2	8	
18	Have an assistant of the same sex as client present during examination	SAME-SEX ASSISTANT	1	2	8	
110	RECORD WHETHER A SPECIMEN WAS TAKEN OR A LABORATORY TEST 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	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
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	
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> <table> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> </table>		YES	NO	DK					
	YES	NO	DK							
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						
07	Genital herpes	1	2	8						
08	Gonorrhea	1	2	8						
09	Syphilis	1	2	8						
10	Chancroid	1	2	8						
11	Non-specific vaginal discharge	1	2	8						
12	Non-specific urethral discharge/urethritis	1	2	8						
13	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> <table> <thead> <tr> <th></th><th>YES</th><th colspan="2">IF YES, WRITE DOSE: MG/DAY AND NO. DAYS</th><th>NO</th></tr> </thead> </table>		YES	IF YES, WRITE DOSE: MG/DAY AND NO. DAYS		NO				
	YES	IF YES, WRITE DOSE: MG/DAY AND NO. DAYS		NO						
01	ACYCLOVIR, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
02	AMOXICILLIN, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
03	CEFTRIAXONE, INJ	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
04	CIPROFLOXACIN, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
05	CLOTRIMAZOLE, SUPP.	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
06	DOXYCYCLINE, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
07	ERYTHROMYCIN, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
08	FAMCICLOVIR, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
09	METRONIDAZOLE, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
10	MICONAZOLE, PESSARIES	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
11	NYSTATIN, PESSARIES	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
12	NYSTATIN, ORAL	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
13	PENICILLIN, BENZATHINE INJ	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
14	SPECTINOMYCIN, INJ	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						
15	OTHER _____ SPECIFY ALL OTHER TREATMENTS	1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2						

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
203	WAS A PRESCRIPTION WRITTEN FOR CONDOMS, OR WERE CONDOMS OFFERED TO THE CLIENT?	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: 40px;"><tr><td>X</td><td>S</td><td>I</td></tr></table> <table border="1" style="display: inline-table; text-align: center; width: 60px;"><tr><td> </td><td> </td><td> </td></tr></table>	X	S	I			
X	S	I					

2. Information About Interview

Date: _____ Name of the interviewer: _____ Client Code: _____	DAY <table border="1" style="display: inline-table; text-align: center; width: 40px;"><tr><td> </td><td> </td></tr></table> MONTH <table border="1" style="display: inline-table; text-align: center; width: 40px;"><tr><td> </td><td> </td></tr></table> YEAR <table border="1" style="display: inline-table; text-align: center; width: 60px;"><tr><td> </td><td> </td><td> </td><td> </td></tr></table> INTERVIEWER CODE <table border="1" style="display: inline-table; text-align: center; width: 40px;"><tr><td> </td><td> </td></tr></table> CLIENT CODE: <table border="1" style="display: inline-table; text-align: center; width: 40px;"><tr><td> </td><td> </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 (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="text-align: right;">NO PROB- LEM DK</div> <div style="text-align: center;">LARGE SMALL</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.		
		<div> <div></div> <div> <div>LARGE</div> <div>SMALL</div> <div>NO PROB- LEM</div> <div>DK</div> </div> </div>	
01	Time you waited	WAIT 1 2 3 8	
02	Ability to discuss problems or concerns about your illness 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 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 NO 2 DON'T KNOW 8</p>	<p>→ 208 → 208</p>
207	What was the main reason you did not go to the nearest facility?	<p>INCONVENIENT OPERATING HOURS 01 BAD REPUTATION 02 DON'T LIKE THE PERSONNEL 03 NO MEDICINE 04 PREFERS TO REMAIN ANONYMOUS 05 IT IS MORE EXPENSIVE . . . 06 REFERRAL 07 OTHER _____ 96 (SPECIFY) 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 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 style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> DON'T KNOW 98	
302	Do you know how to read or how to write?	YES, READ ONLY 1 YES, READ AND WRITE 2 NO 3	
303	Have you ever attended school? IF YES, ASK: Was your schooling formal or informal?	YES, FORMAL 1 YES, INFORMAL 2 NO SCHOOLING 3	→ 306 → 306
304	What is the highest level of school you attended?	PRIMARY 1 SECONDARY 2 TERTIARY 3 UNIVERSITY 4	
305	What is the highest grade you completed at that level?	GRADE <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	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 style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> : <input style="width: 20px;" type="text"/> <input style="width: 20px;" 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										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										

MEASURE *DHS* + SERVICE PROVISION ASSESSMENT

Observation of Injections

1. Facility Identification

Name of the facility: _____

QTYPE

O	I	N
---	---	---

Location of the facility: _____

FACILITY NUMBER

--	--	--

2. Provider Information

Provider category:

Consultant	01	Registered Midwife ...	13
Medical Officer	08	Comprehensive Nurse	14
Clinical Officer	09	Public Health Nurs	15
Enrolled Nurse	10	Nursing Assistant	16
Enrolled Midwife	11	Nursing Aide	17
Registered Nurse	12		

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY

--	--

Sex of provider: (1=Male; 2=Female)

SEX OF PROVIDER

--

SERIAL (SL) NUMBER FROM STAFF LISTING SHOULD BE USED.
USE SAME NUMBER FOR STAFF INTERVIEW AND OBSERVATION

PROVIDER SL NUMBER

--	--

3. Information About Observation

Date: _____

DAY

--	--

MONTH

--	--

YEAR

--	--	--	--

Name of the observer: _____

OBSERVER CODE

--	--

Client code:

CLIENT CODE

--	--

4. Observation of Injections			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>BEFORE OBSERVING THE PROCEDURE, 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 injection procedure for this client in order to understand how injections 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>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 □□:□□		

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
103	WHAT IS THE AGE OF THE CLIENT?	UNDER 5 YEARS OLD 1 OVER 5 YEARS OLD 2 DON'T KNOW 8				
104	WHAT TYPE OF INJECTION WAS IT?	THERAPEUTIC 1 IMMUNIZATION 2 FAMILY PLANNING 3 DON'T KNOW 8				
105	WHAT WAS THE MODE OF DELIVERY?	INTRAMUSCULAR 1 INTRAVENOUS 2 SUBCUTANEOUS 3 INTRADERMAL 4 DON'T KNOW 8				
106	WHO PROVIDED THE SYRINGE AND NEEDLE?	FACILITY PROVIDED FREE ... 1 FACILITY PROVIDED AT A COST 2 CLIENT PROVIDED 3 DON'T KNOW 8				
107	WAS IT AN AUTO-DISABLE SYRINGE AND NEEDLE?	YES 1 NO 2 DON'T KNOW 8				
108	DID THE PROVIDER DO ANY OF THE FOLLOWING WHILE GIVING THE INJECTION?	YES	NO	DK	NA	
01	WASH HAND WITH SOAP AND WATER BEFORE THE PROCEDURE?	1	2	8		
02	PREPARE THE INJECTION IN AN AREA WITH CLEAN TABLE OR TRAY TO SET ITEMS ON?	1	2	8		
03	USE NEW SYRINGE AND NEEDLE FROM A STERILE SEALED PACK?	1	2	8		
04	WERE THE SYRINGE AND NEEDLE FROM SEPARATE PACKS?	1	2	8		
05	REMOVE NEEDLE FROM MULTIPLE-DOSE VIAL EACH TIME?	1	2	8	5	
06	CLEAN SKIN WITH ANTISEPTIC?	1	2	8	5	
07	DRAW BACK PLUNGER BEFORE INJECTION?	1	2	8		
08	RECAP NEEDLE?	1	2 ↓ 11	8 ↓ 11		
09	USE SCOOP TECHNIQUE TO RECAP NEEDLE?	1	2	8		
10	USE BOTH HANDS TO RECAP NEEDLE?	1	2	8		
11	IMMEDIATELY DISPOSE OF NEEDLE WITH SYRINGE IN A PUNCTURE RESISTANT SAFETY CONTAINER OR REMOVE NEEDLE WITH A NEEDLE CUTTER/PULLER AND DISPOSE OF SYRINGE IN A SAFETY CONTAINER THAT IS NOT OVERFLOWING, PIERCED OR BROKEN?	1	2	8		

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
	DID THE PROVIDER DO ANY OF THE FOLLOWING WHILE GIVING THE INJECTION?	YES	NO	DK	NA	
12	WAS THERE ANY RECONSTITUTION OF MEDICINES FOR THIS INJECTION?	1	2 ↓ 14	8 ↓ 14		
13	WAS THE RECONSTITUTION DONE USING NEW STERILE DEVICES, SEPARATE FROM WHAT IS USED FOR THE INJECTION?	1	2	8		
14	IF A GLASS AMPOULE (OR VIAL WITH METAL CAP) WAS USED, DID THE PROVIDER USE A CLEAN BARRIER SUCH AS A SPONGE, COTTON, GAUZE OR FILE TO PROTECT HIS/HER FINGERS WHEN BREAKING THE AMPOULE OR REMOVING THE METAL CAP?	1	2	8	5	
15	DID THE PROVIDER USE, EXPLAIN OR REFER TO ANY COMMUNICATION/IEC MATERIALS WITH THE CLIENT?	1	2	8		
16	ARE THERE REMINDERS, POSTERS OR JOB AIDS POSTED IN THE INJECTION AREA THAT PROMOTE REDUCING THE USE OF INJECTIONS, SAFE INJECTION ADMINISTRATION, OR SAFE DISPOSAL OF USED INJECTION EQUIPMENT?	1	2	8		
109	RECORD THE TIME THE OBSERVATION 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>				