

EGYPT



**Service Provision
Assessment Survey
2004**

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This report summarizes the findings of the 2004 Egypt Service Provision Assessment (ESPA) Survey carried out by the Ministry of Health and Population. ORC Macro provided financial and technical assistance for the survey through the USAID-funded MEASURE DHS+ program, which is designed to assist developing countries to collect data on fertility, family planning, and maternal and child health.

Additional information about the ESPA may be obtained from the Ministry of Health and Population, Family Planning Sector, Cairo, Egypt (telephone 20-2-794-4833; fax 20-2-7958097). Additional information about the MEASURE DHS+ project may be obtained by contacting: MEASURE DHS+, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA (telephone 301-572-0200; fax 301-572-0999; e-mail: reports@orcmacro.com; internet: www.measuredhs.com).



Egypt

Service Provision Assessment Survey

2004

Ministry of Health and Population
Cairo, Egypt

El-Zanaty Associates
Cairo, Egypt

ORC Macro
Calverton, Maryland, USA

April 2005



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Recommended citation:

Ministry of Health and Population, El-Zanaty Associates, and ORC Macro. 2005. *Egypt Service Provision Assessment Survey 2004*. Calverton, Maryland, USA: Ministry of Health and Population and ORC Macro.

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Preface

The 2004 Egypt Service Provision Assessment (ESPA 2004) survey was designed to collect information on the provision of reproductive health and child health services in Egypt in order to complement the information obtained through the 2003 Egypt Interim Demographic and Health Survey.

The ESPA 2004 collected information on the preparedness of health facilities in Egypt to provide high-quality care to clients seeking services for family planning, maternal health, child health, and sexually transmitted infections. A representative sample of 659 clinics of all types of facilities, in both government and nongovernmental organization facilities, was assessed.

The survey included, in addition to the resources of the facilities, interviews with service providers, observations of consultations between the providers and clients, and interviews with clients after they were served.

The information included in this report is important for identifying areas of intervention that will help improve the quality of family planning, maternal health, and child health services provided to clients.

The Ministry of Health and Population will ensure that activities in the proposed areas of intervention are implemented.

I am deeply indebted and grateful to all of the ESPA 2004 field and office staff members for their dedicated efforts to make these highly important data available in such a timely fashion.

Finally, I would like to take this opportunity to thank the U.S. Agency for International Development for its financial support for the ESPA 2004.

Professor Dr. Awad Tag El-Din
Minister of Health and Population

Acknowledgments

There were a number of national demographic surveys conducted in Egypt in the 1980s. Information on the utilization of maternal and child health and family planning services data was desired in order to complement the household-based information. In 2002, the first Service Provision Assessment (ESPA 2002) survey was conducted in Egypt. The 2004 Egypt Service Provision Assessment (ESPA 2004) is a followup survey, with similar objectives.¹ The ESPA 2004 was designed to extract information about the general performance of outpatient facilities that provide health services related to child, maternal, and reproductive health needs. In addition, information on health services for selected infectious diseases was sought. Drawing on a representative sample of public facilities and nongovernmental organization facilities, the survey gathered information that points out the strengths and weaknesses of the service delivery environment. The information that the ESPA 2004 elicited on health services at the level of the provider may help policymakers and program administrators develop effective strategies to improve the utilization and coverage of services and prioritize resources in ways that will ensure better health outcomes.

The ESPA 2004 was accomplished through the collaborative efforts of many individuals and institutions. The Ministry of Health and Population (MOHP), under the leadership of Dr. Awad Tag El-Din, contributed to the success of the survey implementation. I would like to acknowledge the contributions of various technical committees at MOHP, the staff of the Management Information System Unit of the MOHP/Family Planning sector, and other professionals who individually and collectively gave comments and advice during the design and development of questionnaires as well as report writing.

Technical assistance was provided by ORC Macro through the worldwide MEASURE DHS+ project. Its contribution throughout the design, implementation, and analysis stages of the ESPA 2004 is appreciated.

Furthermore, I would like to thank the staff of the Population and Health Office, U.S. Agency for International Development, for the financial and technical support they provided to the ESPA 2004.

This survey could not have been conducted in such timely fashion without the combined efforts of the senior office staff of El-Zanaty Associates and the researchers who collected the data from clinics.

Finally, I would like to express my appreciation to all of the facilities, providers, and clients who responded in the survey; without their cooperation, this project would not have been possible.

Fatma El-Zanaty
Technical Director

¹ The HIV/AIDS part of the survey was excluded because of the recent data available from the ESPA 2002.

Critical Findings and Recommendations

- **Current MOHP Health Service Strengthening Activities**

Many of the health service weaknesses identified in the 2004 ESPA, and briefly listed in this critical findings and recommendation summary, have previously been identified by MOHP, and pilot projects have been implemented to address them. These include:

- A Health Sector Reform Strategy that uses a family health model to promote integration of basic services
- Safe motherhood activities that expand services to rural health units and strengthen the availability of emergency obstetric care.
- A major infection control project.

These projects have moved from pilot project to national-level implementation only during the past year. Thus, the impact of activities would not be captured in this nationally representative sample survey. The 2004 ESPA survey findings can be viewed as a baseline for the above activities as they expand nationally.

- **Infrastructure, Services, and Management**

- Facility infrastructure is strong with around 90 percent of facilities having a regular year-round, on-site water supply and a regular supply of electricity.
- A package of maternal, child, and reproductive health services generally needed by families is not commonly available in a single facility, although when services are offered, they are most often available five days a week.
 - Forty-one percent of all health facilities have a full package of maternal, child, and reproductive health services at a minimum frequency, as defined in this survey,² and 14 percent have a full package of services plus 24-hour, facility-based delivery services.
 - Although immunization coverage is high in Egypt (88 percent of children are fully immunized) immunizations are not commonly available at the same time and location as sick child services, resulting in missed opportunities for immunizing sick children who may not be up to date on their immunizations.
 - Delivery services are offered at 26 percent of all facilities. This includes 60 percent of GS hospitals, 50 percent of MCH/urban health centers, and 23 percent of rural health units. Services for emergency obstetric care (caesarean section and blood transfusion) are offered in only 2 of 3 hospitals where delivery services are available, yet support for transportation for emergency obstetric care referrals is not common.

² The services and defined minimum frequency are: curative care for children offered at least five days per week, RTI/STI services at least one day per week, and preventive or elective services (any temporary methods of family planning, antenatal care, immunization, and growth monitoring) at least one day per week.

- **Supervision**

- The system for supervision is strong. Almost all facilities receive external supervision (96 percent) and almost all facilities provide routine supervision to their service providers (90 percent).
- Improvement in the effectiveness of supervision is necessary.
 - Despite documented high levels of supervision, there is low adherence to generally accepted standards for service provision.

- **Infection Control**

- Supplies to prevent provider-client transmission of infection are lacking in most facilities, with only 4 percent of facilities having all items required for infection prevention for that service available at all assessed service sites.
 - Although 88 percent of facilities have a regular water supply, water is available at every assessed service site in only 59 percent of facilities.
 - Hand-washing soap is available at every assessed service site in only 21 percent of facilities.
 - Latex examination gloves were found in all relevant assessed service areas in only 21 percent of facilities.
- Providers rarely wash their hands prior to conducting procedures (only 8 percent were observed washing their hands prior to conducting a pelvic examination).
- Elements indicating that quality sterilization/high-level disinfection procedures can be conducted (functioning equipment, knowledge of correct time and temperature required, an automatic timing device) are present in only 35 percent of facilities.
 - Although 73 percent of GS hospitals have functioning equipment, all elements indicating that quality processing of equipment can be conducted are present in only 47 percent of hospitals.

- **Availability of Basic Medicines**

- Basic medicines for most services are not available at facilities.
 - Prereferral medicines are available at only 13 percent of facilities caring for sick children.
 - Around half of facilities offering ANC do not have folic acid and/or iron tablets. Four in five hospitals offering delivery services have an injectable oxytocic medicine but less than half have a medicine for managing eclampsia.
 - Almost no facilities (2 percent) have medicines available to treat all of the major STIs—trichomoniasis, gonorrhea, chlamydia, and syphilis.
- Overutilization of antibiotics may contribute to the lack of medicines.
 - Among all observed sick children, 59 percent were prescribed antibiotics. This includes children treated for probable viral respiratory illness and nondysentery diarrhea.

- **Systems and Elements to Support Quality**

- Guidelines and protocols for care are not commonly available. they are found most frequently for family planning services (37 percent of facilities offering the service).
- Routine provision of in-service training over the past year is found in only 22 percent of facilities, with family planning services being most likely to provide routine in-service training (23 percent of facilities)

- **Adherence to Common Standards for Service Provision**

- For all services, providing preventive health education, obtaining a full client history, and examination relevant to the client's visit are rarely carried out.
- Use of individual client health records or cards to provide continuity of care is low for curative services.

- **Recommendations**

- Develop and distribute guidelines and protocols (particularly for curative care) adapted to the health situation in Egypt.
- Guidelines for use of antibiotics should be reinforced with service providers.
- Define a basic list of essential emergency medicines for critical services, and ensure that these are available. The medicines should include prereferral medicines for sick children and medicines for managing the complications of pregnancy and delivery.
- Review policies that limit prereferral treatment of seriously ill children.
 - Current MOHP IMCI guidelines define chloramphenicol as the only prereferral medicine, and limit the provision of intravenous rehydration for children to specifically trained physicians. The prereferral criteria in other locations is broader.
- Review policies that limit availability of comprehensive and emergency obstetric care.
 - The most numerous type of health facility is the rural health unit, yet only 1 in 5 provide delivery services. Women who want or need facility-level resources for delivery must travel to an urban health unit or a hospital for even normal delivery services. Assistance with transportation to facilities offering emergency obstetric care is weak.
- Develop strategies to improve the effectiveness of supervision. Supervisory activities should include:
 - Supporting the expectation that guidelines/protocols are available in the service area and that staff are expected to adhere to the standards of practice.
 - Supporting the expectation that critical consumable items will be available in relevant service areas (e.g., soap, latex gloves)

Executive Summary

The 2004 Egypt Service Provision Assessment (ESPA 2004) was conducted in a representative sample of 659 health facilities throughout Egypt. At the request of the United States Agency for International Development (USAID) and the Ministry of Health and Population (MOHP), seven governorates (Cairo, Alexandria, Fayoum, Beni Suef, Menya, Qena, and Aswan) that are part of a USAID-supported pilot project were oversampled to provide key indicators for these areas.

The survey covered general, district, and integrated hospitals (referred to in the report as “general service hospitals”), fever hospitals, maternal and child health/urban health units (MCH/urban HUs), rural health units (rural HUs), mobile units, health offices, and nongovernmental organization (NGO) facilities. The ESPA 2004 used interviews with health service providers and clients, as well as observations of provider-client consultations, to obtain information on the capacity of facilities to provide quality services and the existence of functioning systems to support quality services. The areas addressed were the overall facility infrastructure and resources; specific child health, family planning, and maternal health services; and services for specific infectious illnesses—reproductive tract and sexually transmitted infections (RTI/STIs) and tuberculosis. The objective was to assess the strengths and weaknesses of the infrastructure and systems supporting these services, as well as to assess the adherence to standards in the delivery of curative care for children, family planning, antenatal care (ANC), and consultations for RTI/STIs.

The ESPA 2004 was undertaken jointly by the MOHP and El-Zanaty Associates, with technical assistance provided through ORC Macro under the MEASURE DHS project. USAID provided financial support for the survey.

Facility Infrastructure and Infection Control

Eighty-eight percent of facilities have regular electricity or a generator with fuel.

Almost all facilities have an onsite water source (95 percent), with 88 percent indicating that the water is available year-round and 90 percent indicating that the water is normally supplied through a piped system. Availability of a regular, year round onsite water supply is similar for 2002 and 2004.

Only 23 percent of the facilities have adequate management for hazardous waste.

Large facilities have multiple locations for providing client consultations and examinations, and small facilities often have only one location. Items for infection control were assessed for each service delivery area included in the ESPA 2004. Although water was present in each service area in about half of all facilities (56 percent), soap for hand-washing was rarely present in each assessed service delivery area in a facility (21 percent), a modest improvement since 2002 (15 percent). The percentage of facilities with examination gloves in all required service areas decreased from 39 percent in 2002 to 21 percent in 2004.

When assessing procedures used in the principal location in a facility where equipment to be reused is sterilized or processed with high-level disinfection (HLD) for reuse, 54 percent³ (78 percent in 2002) of

³ When comparing findings from the ESPA 2004 with those from the ESPA 2002, it should be noted that the 2002 report defined functioning equipment as being present if there was capacity to use any method present, regardless of whether the facility reported that it used the method or not. The ESPA 2004 refined the definition, stating that, for the functioning equipment to be counted, the facility had to report that it used the method. The ESPA 2002 result for functioning equipment for methods used is 58 percent (compared with 78 percent for any functioning equipment), similar to the 54 percent found in the ESPA 2004 survey.

facilities (73 percent of general service hospitals but only 21 percent of fever hospitals) had functioning equipment for either HLD or sterilization of reusable equipment. The percentage of facilities with functioning equipment, knowledge of correct processing temperature and time, and an automatic timer was lower in 2004 (35 percent), compared with 2002 (45 percent). Equipment may be processed in different locations within the same facility, depending on the size and organization of a facility. The area where equipment for specific services is processed was assessed (whether it was the main facility processing area or another location) for family planning, delivery, and RTI/STI services. The equipment and knowledge for processing family planning and delivery equipment were somewhat better, with 87 percent of family planning equipment processed in an area with functioning equipment and staff who knew the correct processing time and temperature. This was true for 76 percent of delivery service equipment. Sixty percent of delivery equipment was processed in areas with sterilization equipment and staff with knowledge of the processing time and temperature for sterilization. An additional 16 percent used HLD procedures. HLD does not kill the tetanus spore; therefore, it should not be relied upon as the only means of sterilizing equipment.

Use of new syringes and needles for injections is universal; however, only 71 percent of such needles and syringes were provided by the facility. Sharps boxes were more widely used by providers of immunizations (around 85 percent) than by providers of therapeutic injections (more than 60 percent).

Capacity to adhere to infection control measures at all relevant service delivery areas is weak, with hand-washing soap the item most consistently missing. Only 4 percent of all facilities have all items for infection control in all assessed service delivery areas.

While there are statistically significant decreases from 2002 to 2004 in almost all indicators related to infection control, programmatically, the differences may not be important. Infection control practices remain extremely weak.

Service Availability

MOHP does not expect all facilities to offer all basic health services. For example, district and general hospitals do not routinely offer child immunization services, but integrated hospitals do; mobile units rarely offer immunization, but they offer family planning, ANC, and curative care; and health offices primarily offer child immunization and family planning. Health offices are often located adjacent to hospitals, so services may be conveniently accessed, even if they are not in the same building or under the same manager. In total, half (50 percent) of facilities offer some level of each of the assessed basic child, maternal, and reproductive health services. As expected, MCH/urban HUs and rural HUs are more likely to offer the package of assessed services (about 70 percent). NGO facilities rarely offer child immunization or growth-monitoring services.

Essentially all facilities have at least one physician assigned.

A full package of maternal, child, and reproductive health services is available at a minimum frequency (curative care for children offered at least five days per week, RTI/STI services at least one day per week, and preventive or elective services [any temporary methods of family planning, ANC, immunization, and growth monitoring] at least one day per week) in 41 percent of all health facilities. This package is most commonly found in MCH/urban HUs and rural HUs (73 and 53 percent, respectively). This is a noticeable improvement from 2002.

A full package of maternal, child, and reproductive health services, available at a minimum frequency, and with 24-hour, facility-based delivery services is available at 14 percent of all facilities, including 42 percent of MCH/urban HUs, 13 percent of rural HUs, and 15 percent of general service hospitals. The situation has improved in MCH/HUs from 2002 to 2004.

Facility-based, 24-hour delivery services are less available in 2004 (23 percent) than in 2002 (32 percent).

Hospitals are the primary site where 24-hour emergency service infrastructure support is available, with 52 percent of general service hospitals and 89 percent of fever hospitals having all assessed service components (overnight or inpatient beds; at least two physicians assigned to facility; 24-hour onsite or on-call staffing, with a duty schedule present; access to 24-hour emergency communication; and a client latrine). These percentages in general services hospitals have decreased since 2002 but increased in fever hospitals.

Nationally, a larger proportion of facilities located in Urban Governorates (20 percent) have all of the components to support 24-hour emergency services, as compared with facilities located in Lower or Upper Egypt (11 and 8 percent, respectively).

Facility Management

Thirty-three percent of facilities reported that they had management meetings at least every six months, with half reporting monthly or more frequent meetings; this is a decrease since 2002, when 51 percent of facilities reported having had such meetings. Only 9 percent, however, had any documentation of the meetings. General service hospitals (21 percent), fever hospitals (58 percent), and MCH/urban HUs (14 percent) were more likely to have documentation (such as minutes from meetings) available; however, compared with 2002, only fever hospitals improved recordkeeping of the management meetings.

Nine percent of all facilities (12 percent of general service hospitals) had documentation of functioning quality assurance activities for any service area. This is less than that found in 2002.

Structured in-service training on topics related to the services provided had not been consistently experienced by interviewed providers. At least half of the interviewed health service providers from a facility had received in-service training related to their work during the past 12 months in 22 percent of facilities, with 28 percent of all providers having received in-service training. An additional 33 percent had received related in-service training within the past five years. Providers of family planning and antenatal services were more likely than others to have received related in-service training during the past five years). Routine in-service training has declined from levels seen in 2002, with the decline most noted in MCH/urban HUs and NGO facilities.

Supervision was particularly strong across all government facilities and services, but less so for NGO facilities. Ninety-six percent of facilities had experienced a supervisory visit from officials external to the facility (81 percent of NGO facilities) during the past six months.

At least half of the interviewed health service providers within a facility had been individually supervised during the past six months at 90 percent of the facilities. A notable weakness was seen in NGO facilities, where only half of them received routine supervision. Almost all facilities received external supervision during the six months preceding the survey.

Supervision patterns were similar for providers of the various services assessed, with most reporting being personally supervised at least once per month.

Systems for eliciting community input for facility activities are not widespread. While 22 percent of facilities have routine community participation on some management committee, only 2 percent have any formal means for seeking client feedback.

Thirty percent of facilities have preventive maintenance programs for major equipment, except mobile units (around 80 percent). Only 60 percent of facilities have sources of funding for repair and maintenance of small equipment.

Management of Vaccines, Contraceptives, and Medicine Supplies

Eighty-three percent of facilities that stored vaccines have all of the components for maintaining and monitoring the cold chain. The temperature was not within the accepted range (0° to 8°C) for 8 percent of facilities. This is an improvement since 2002, when 76 percent of facilities had all vaccine storage components available and 17 percent of facilities had not kept the temperature within acceptable range. Health offices had the strongest systems (92 percent) and NGO facilities had the weakest (6 percent) for monitoring and maintaining the cold chain.

Storage conditions for contraceptives are adequate at 89 percent of facilities, but storage conditions for medicines are adequate for only 72 percent of facilities. Medicine storage areas for 19 percent of facilities have evidence of rodents or pests, and 16 percent do not have the medicines off the ground and protected from water.

Among the selected medicines or contraceptives checked, expired items were rarely found (about 3 percent of facilities).

Up-to-date inventories (or daily registers that easily reconciled the stock with the inventory) were present in 84 percent of the facilities storing vaccines, 71 percent of facilities with contraceptive methods, and 60 percent of facilities with medicines. Keeping daily registers up to date improved for vaccines (69 percent in 2002) but deteriorated for medicines (72 percent in 2002).

Service-Specific Findings

Use of individual client cards, important for providing a record of findings and treatments and for continuity of care, varies by service and type of facility. An individual card or other means for supporting continuity of care for sick children, was available in 45 percent of facilities offering sick child services, with MCH/urban HUs most likely to have them (60 percent). Individual records for family planning clients were more widely available (87 percent), with NGO facilities the least likely to have them (58 percent), although use during consultation (the provider referred to information on the card or wrote on the card) was observed for about 70 percent of the clients (66 percent reviewed the card and 76 percent wrote on the card at the end of consultation). Individual records for ANC were widely available in MCH/urban HUs and rural HUs (94 and 78 percent, respectively), but they were available only in 62 percent of the general service hospitals and in one-third of NGO facilities. Use of ANC client cards was observed more often for the followup client (83 percent), than for the first-visit clients (53 percent). Client cards were used for only one in three observations for clients assessed for STIs (27 percent).

Most services were provided under conditions where the clients have visual and auditory privacy. Privacy was available in 85 percent of the RTI/STI client counseling areas, 85 percent of the RTI/STI client examination areas, 79 percent of the family planning client counseling areas, and 84 percent of the family

planning client examination areas. These are two services where privacy is critical to ensure client confidentiality and to encourage sharing of necessary information. However, the client was reassured about confidentiality in only one in six observed consultations of RTI/STI clients.

Any guidelines or protocols that could be used as references by providers for the delivery of specific services—and/or management of health issues related to that service—were not available in the service delivery area for most facilities and for most services assessed. Family planning and sick child services were the most likely to have service guidelines or protocols (about 36 percent). Only 8 percent of facilities had protocols or guidelines for ANC in the service area, 7 percent had protocols for delivery, and 15 percent had guidelines or protocols for RTI/STI diagnosis and treatment in the service area.

Visual aids for client education were available in most family planning service areas (94 percent) and in half of RTI/STI service areas (51 percent), but they were available in only one in four sick child service areas and in one in five ANC service areas. Overall, visual aids were rarely used (3 percent of observed sick child consultations, 7 percent of observed family planning consultations, 1 percent of ANC clients, and none of RTI/STI clients).

Neither basic oral medicines nor prereferral medicines or medicines to manage common complications for clients receiving the services assessed were widely available in the facilities.

Essential advice related to prevention of complications and early identification and help-seeking for problems was rarely provided during the observed sick child or ANC consultations. Side effects of family planning methods were also not consistently explained.

Child Health Services

All basic child health services (curative care, growth monitoring, and immunization) are available at 84 percent of rural HUs and 74 percent of MCH/urban HUs. Although 84 percent of facilities provide consultation services for sick children, fewer provide preventive services such as growth monitoring (62 percent) and immunization (70 percent). Immunization and growth monitoring are most often offered one or two days per week, whereas sick child services are offered at least five days per week in 91 percent of facilities offering any child health services. No major changes were observed in provision of basic child health services since 2002.

Sixty-eight percent of facilities that store child vaccines had all the basic vaccines (vaccine against tuberculosis [BCG], polio, diphtheria-pertussis-tetanus [DPT], and measles), and 63 percent had all basic vaccines as well as hepatitis and measles-mumps-rubella (MMR) vaccines. All types of vaccines are missing from 10 to 20 percent of facilities.

Disposable syringes are universally used for immunization, but only 63 percent of facilities have a sufficient supply of syringes of both BCG and three-milliliter syringes.

Although immunization services are not integrated to allow sick children who are not fully immunized to be immunized at the time they are seeking curative care, the national immunization coverage is very high (88 percent), so this may not be a program priority.

Seventy-seven percent of facilities offering immunization have records showing that they monitor community coverage levels. This is true for only 65 percent of MCH/urban HUs.

MOHP standards specify that most seriously ill children (specifically including those requiring intravenous rehydration) be referred to hospitals. This necessitates that seriously ill children be referred (and that the caretaker follows up on the referral) for quality care.

In Egypt, the only defined prereferral medicine for the Integrated Management of Childhood Illness (IMCI) is chloramphenicol. This is available in only 13 percent of facilities, and is found most commonly in fever hospitals.

MOHP guidelines limit the scope of facilities to provide prereferral treatments common in other countries, where in accordance with IMCI guidelines, programs commonly define prereferral medicines as at least one first-line antibiotic (ampicillin or penicillin) and at least one second-line antibiotic (ceftriaxone or gentamycin), as well as intravenous solution (either normal saline, dextrose and normal saline, or Ringer's lactate) with perfusion sets for treating severe dehydration.

Similar to findings in 2002, one in five (23 percent) facilities offering curative care for sick children, have the package of these other common prereferral medicines. These were found in 69 percent of fever hospitals (51 percent in 2002) and 39 percent of general service hospitals (53 percent in 2002).

All first-line treatment medicines defined for Egypt (ORS solution prepared from packets of oral rehydration salts and oral antibiotics such as amoxicillin or cotrimoxazole for respiratory infections) are available at only two in three facilities. From 2002 to 2004, availability of first-line medicines has increased in hospitals and in facilities in Lower Egypt.

Assessments of sick children for danger signs or symptoms rarely adhere to IMCI guidelines, with a notable lack of a thorough history and physical examination. Similar to findings in 2002, assessments for all danger signs (ability to drink anything, whether child vomits everything, and whether child has convulsions) were rarely carried out (6 percent of observed consultations in 2004 compared with 4 percent in 2002). Regardless of the reason for the consultation, IMCI guidelines call for each child to be evaluated for the major symptoms of cough or respiratory difficulty, diarrhea, and fever. Assessment of the presence of the three major signs and symptoms has also changed little from 2002 to 2004, with all symptoms assessed for one in three (33 percent) observed children in 2004. Despite this, the assessment, reported diagnosis, and prescribed treatments for observed sick children indicated that providers reasonably fit their evaluations to the illness and their perception of its severity. However, in 2004 the median time from starting to completing the assessment of the sick children was six minutes, similar to the findings in 2002 (five minutes). It would be difficult to take a full history of signs and symptoms and to physically assess a child in this time.

Provision of essential information to caretakers about providing more fluid to sick children and about increasing food was given in 41 and 34 percent of observed consultations, respectively. Information on symptoms for which the child should immediately be brought to a facility was provided during 13 percent of observed consultations for sick children. Provision of essential information on continuing to provide food and fluid and on symptoms for immediate return continues to be low, with only 8 percent of the caretakers receiving this information; however, this is a slight improvement over the 3 percent in 2002.

There has been a modest increase in the proportion of sick children who are weighed (50 percent in 2004 and 42 percent in 2002) and for whom the weight is plotted against a standard (25 percent in 2004 and 20 percent in 2002). Assessment of immunization status was not a common component of the evaluation and continues to be low.

Fifty-three percent of children diagnosed with a nonsevere respiratory illness (primarily cough or cold) received or were prescribed antibiotics, and 59 percent of all observed children received an antibiotic. The

appropriateness of current use of antibiotics should be assessed and standards for use should be developed. The proportion of injectable antibiotics compared with oral antibiotics did not appear excessively high (14 percent of injectables).

Antibiotic use since 2002 has increased for the nonsevere cases for most diagnoses. Guidelines with indications for antibiotic use may be warranted.

Although overall use of bronchodilators has not changed from 2002, there is increased use for children whose wheezing was assessed and decreased use (by about half) for cases in which the provider reported there was no wheezing.

Provision of the first dose of oral medication at the facility continues to be a rare practice (3 percent for 2004).

Family Planning Services

The intrauterine device (IUD), injectable progesterone, combined oral pill, and male condoms are the four most commonly offered contraceptive methods, and all four are offered at 84 percent of facilities that offer modern temporary methods of family planning. This rate remained stable from 2002 to 2004. The supply for the four most commonly used methods is reliable: 77 percent of facilities offering these methods had all four methods available on the day of survey.

There has been a shift among the less commonly used methods, with a smaller proportion of facilities in 2004 offering progesterone-only oral pills and emergency contraception, but a slightly larger proportion offering implants. The supply for less frequently used methods is less reliable than that for the more commonly used methods.

Visual aids related to family planning are available in the service delivery area (in 94 percent of facilities, similar to findings in 2002). Among the visual aids available, 82 percent of facilities had trays with samples of methods, 73 percent had teaching aids about specific types of family planning, and 87 percent had information pamphlets for clients to take home. Visual aids related to STIs were available in the family planning service area in 21 percent of the facilities, and information pamphlets on STIs that clients can take home were available in 50 percent of facilities, which is an increase since 2002 (32 percent).

All items for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) are available in the client examination area in 18 percent of facilities. All items are most commonly found in MCH/urban HUs (31 percent) and least commonly found in health offices (4 percent). Latex examination gloves are the items most commonly lacking (missing in two-thirds of all family planning service areas), followed by hand-washing soap and sharps boxes (both items missing in approximately one-third of facilities). From 2002 to 2004, soap provision has improved, with availability increasing from 51 percent in 2002 to 67 percent in 2004. Availability of sharps boxes has not changed. The percentage of facilities with examination gloves decreased from 50 percent (2002) to 30 percent (2004).⁴

⁴ As explained in more details in section 3.4.3, this may reflect more accurate data collection, rather than a change in availability of gloves. Thin, nonlatex disposable gloves are universally available in all service areas where pelvic examinations were conducted, but these are not accepted for infection control. This point was emphasized more during the 2004 ESPA training than it was in 2002.

Diagnosis of and treatment for STIs are provided by family planning service providers in 81 percent of facilities offering family planning. All infrastructure and equipment assessed for conducting a pelvic examination under quality conditions are available in 70 percent of facilities, with an examination light being the item most often lacking.

Among facilities offering a method with estrogen, 11 percent (primarily health offices) have no blood pressure apparatus.

Although 87 percent of facilities have individual client cards available for family planning clients, cards were reviewed by the provider during the family planning consultation for only 66 percent of observed family planning clients. Providers wrote information on the cards after the consultations for 76 percent of observed family planning clients. This is an improvement in practices to support continuity of care since 2002, when the provider was observed checking the client card for only 48 percent of consultations and writing on the card for 65 percent of the observed consultations.

A followup visit was mentioned for 78 percent of observed family planning consultations.

Forty-three percent of first-visit consultation clients were assessed for symptoms of STIs, and 47 percent were asked about chronic illness.

Among all first-visit clients, 65 percent had their blood pressure measured. Among clients receiving a method including estrogen, 70 percent had their blood pressure measured.

Explanations to the client about procedures and adherence to infection control measures (particularly hand-washing and use of latex gloves) are not common for pelvic and IUD procedures. Provider hand-washing prior to starting a procedure is rare (less than one in ten of observed procedures).

No breast examinations were observed conducted on family planning clients, although 6 percent of clients were observed having been taught by providers how to conduct breast self-examination, which was confirmed by 6 percent of clients who indicated that they had been taught breast self-examination either during this visit or a previous visit.

Nineteen percent of women who received either contraceptive pills or injections were observed being given information on how to use the method, side effects, and what to do for problems, as well as information on a followup visit. Among these same women, the proportion was higher when they were asked if they had received these four items of information (30 percent). The women may have been reporting on knowledge or information received previously, rather than information from this specific visit.

The percentage of interviewed clients who reported having been told none or one of the key informational points⁵ increased from 2002 (23 percent) to 2004 (37 percent), while the percentage of clients who reported receiving all key informational points decreased (41 percent in 2002 and 30 percent in 2004). Although the actual observation supported an improvement in the quality of counseling, based on the increased number of key informational points observed being provided to clients, its effectiveness is questionable; even immediately after the consultation, clients had difficulty recalling the key informational points pertaining to the methods they just received. MOHP might like to review the way in which the key informational points are delivered to family planning clients to improve retention.

⁵ The provider was observed counseling on four key points for their method (how to use, possible side effects, what to do for problems, and time for followup visit).

Maternal Health Services

ANC is offered by 87 percent of eligible facilities, with 64 percent offering the service five days per week.

Tetanus toxoid (TT) immunization services are not always available at the same time as ANC. Although 43 percent of facilities indicated they offer TT immunization whenever ANC is offered, on the day of the survey, 75 percent of facilities were offering ANC, but only 25 percent were offering both ANC and TT immunization.

All equipment and medicines for basic ANC assessment (blood pressure apparatus, fetoscope, iron tablets, folic acid tablets, and TT vaccine) were available at only 18 percent of facilities, a slight decrease from 2002, when 22 percent had all items. Folic acid, TT vaccine, and a fetoscope were each missing from 50 to 60 percent of the facilities. There is a noticeable decrease in availability of iron tablets since 2002, when they were available in 73 percent of facilities. Iron tablets are most often lacking in mobile units and NGO facilities.

Medicines for management of common complications of ANC or for postpartum infections were not routinely available. Methyldopa (for hypertension) was available in only 7 percent of general service hospitals.

There has been a slight decrease in the percentage of facilities where ANC service providers diagnose and treat STIs when necessary, from 87 percent in 2002 to 80 percent of facilities in 2004, with only 2 percent of these facilities having a medicine to treat each of the four main STIs (syphilis, gonorrhea, chlamydia, and trichomoniasis). The recommended treatment for gonorrhea is most often lacking.

Around 80 percent of facilities have a standard to routinely check urine protein and glucose and blood for anemia during ANC, although each test is absent from 10 to 30 percent of facilities having the standard.

One in five facilities have the standard and capacity to routinely ascertain blood group and Rh factor for ANC clients.

One in three facilities has the capacity to conduct an ultrasound test, and one in ten reports that this is a standard component of ANC. Routine use of ultrasound has greatly increased in mobile units (26 percent) and MCH/urban HUs (25 percent) since 2002.

Among first-visit ANC clients whose consultation was observed, 41 percent were asked about any medicines they were taking. This is an improvement since 2002 in assessment of medication being taken (29 percent). Forty-four percent were given or prescribed TT immunization, 59 percent had their urine tested (or a test was prescribed), and 42 percent were given (or prescribed) iron tablets.

Among all observed clients, the assessment of current health status was not routinely completed. Counseling on vaginal bleeding (defined as either being counseled about vaginal bleeding as a risk or asked about vaginal bleeding during the examination) was received by one in four clients. This is a substantial improvement over findings in 2002, when 4 percent of clients were counseled about vaginal bleeding as a risk sign (compared with 6 percent in 2004) and 7 percent were asked about vaginal bleeding (compared with 26 percent in 2004). Despite an improvement since 2002, over 85 percent of ANC clients are not receiving the three key components of ANC (assessment of vaginal bleeding, blood pressure, and urine) as defined by MOHP.

Sixty-two percent of women at least five months pregnant were asked about fetal movement, and 62 percent of women at least eight months pregnant had the fetal position assessed (either through palpation or ultrasound); 93 percent had their blood pressure measured.

About 40 percent of first-visit and followup ANC clients received education about nutritional needs during pregnancy. Twelve percent of observed first-visit clients and 18 percent of followup clients were advised on specific risk symptoms for which they should seek help. During the exit interview, one-third of the interviewed clients reported that they had been told about risk factors either during this or a prior visit. Advice on exclusive breastfeeding is not commonly provided. It was observed being provided during 1 to 2 percent of ANC consultations (first visit and followup) and reported by 5 percent of interviewed clients to have been discussed during the current or a prior visit.

Partographs are not commonly used (available in 9 percent of facilities offering delivery services). All assessed basic supplies (a cord-cutting item, cord clamp, any suction apparatus, antibiotic eye ointment for newborn, and skin disinfectant for perineum) were only available in 33 percent of facilities (70 percent of MCH/urban HUs and 33 percent of general service hospitals).

Although, in Egypt, management of complications during pregnancy or labor and delivery is not routinely expected to be provided below the hospital level, facility-supported emergency transportation for referrals is available at only 10 percent of facilities, and caesarean sections are offered at less than half of the general service hospitals.

Emergency medicines for severe preeclampsia or eclampsia were available in only half of the general service hospitals providing delivery services, and injectable antibiotics for sepsis were available in 58 percent of them, with one in ten having both. Equipment to support insufficient labor (forceps or vacuum extractor) is available in less than half of the general service hospitals, and blood transfusion services are available in 62 percent of them.

Reproductive Tract and Sexually Transmitted Infections and Tuberculosis

STI services are reported by 89 percent of all facilities, a large increase from 62 percent reported in 2002. Within facilities reporting RTI/STI services, the services are integrated, with 71 percent of facilities indicating RTI/STI services are available through general outpatient services as well as through ANC and family planning services.

RTI/STI services are often available through family planning and ANC services even when facilities do not offer RTI/STI services as a walk-in service. RTI/STI services are provided by ANC providers in one in four facilities and by family planning providers in about one-third of facilities that reported they provide no routine services for STIs.

Medicines for treating STIs are somewhat less available in 2004 than in 2002. Almost no facilities (2 percent) have medicines available to treat all of the STIs—trichomoniasis, gonorrhea, chlamydia, and syphilis. Only 5 percent of general service hospitals have a medicine available to treat each of these infections, a decrease from 18 percent in 2002.

A treatment for syphilis is most commonly available (56 percent), and a treatment for gonorrhea is least available (2 percent). Medicines to treat other STIs, such as metronidazole for trichomoniasis and tetracycline for chlamydia, were available in about half of all facilities.

Almost all facilities (84 percent) had condoms available, with 50 percent having condoms in the RTI/STI service delivery area. However, education about using condoms for prevention of STIs is almost never provided.

All assessed infrastructure for high-quality pelvic examinations was available in 74 percent of the service areas where RTI/STI clients are normally examined. All items for infection control were available in only 18 percent of these areas, with latex gloves the item most often missing (about two-thirds of the examination areas). Availability of latex gloves has decreased since 2002, when it was 52 percent. Availability of hand-washing soap has improved, with 69 percent of facilities having soap in the RTI/STI service area, compared with 53 percent in 2002.

Almost no providers (8 percent) wash their hands prior to conducting a pelvic examination.

Capacity to provide laboratory confirmation of specific STIs is lacking, with 4 percent of general service hospitals having testing capacity for syphilis and 4 percent (13 percent of fever hospitals) having testing capacity for gonorrhea. Microscopic examination using wet-mount testing was available in 23 percent of general service hospitals and 62 percent of fever hospitals.

Practices to increase case detection (confidentiality policies and partner followup procedures) are not yet policy within the health system and are not common.

Only one in three clients was informed of a relationship between her vaginal infection and sexual activity.

Tuberculosis (TB) followup services were reported more in 2004 (29 percent of facilities) than in 2002 (23 percent). TB services are offered only in general service hospitals and MCH/urban or rural HUs. There was an increase in the proportion of facilities using the Directly Observed Treatment Short-course (DOTS) strategy, from 13 percent in 2002 to 22 percent in 2004. Less than one in five facilities offering TB services had all first-line drugs available on the day of the survey. This includes facilities implementing DOTS, where only 19 percent had all medicines available on the day of the survey.

Abbreviations

AIDS	Acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention
ANC	Antenatal care
ARI	Acute respiratory infection
BCG	Bacillus-Calmette-Guérin (vaccine against tuberculosis)
BEOC	Basic essential obstetric care
CCO	Curative Care Organization
CDD	Control of Diarrheal Diseases
CEOC	Comprehensive essential obstetric care
CSI	Clinical Services Improvement
D&C	Dilatation and curettage
DHS	Demographic and Health Surveys
DOTS	Directly Observed Treatment Short-course
DPT	Diphtheria, pertussis, and tetanus
EDHS	Egypt Demographic and Health Survey
EFPA	Egyptian Family Planning Association
EIDHS	Egypt Interim Demographic and Health Survey
ELISA	Enzyme-linked immunosorbent assay
EmOC	Emergency obstetric care
EOC	Essential obstetric care
EPI	Expanded Program on Immunization
ESPA	Egypt Service Provision Assessment
FHI	Family Health International
FP	Family planning
GS	General service
HIO	Health Insurance Organization
HIV	Human immunodeficiency virus
HLD	High-level disinfection
HM/HC	Healthy Mother/Healthy Child
HSRP	Health Sector Reform Program
HU	Health unit
IEC	Information, education, and communication
IMCI	Integrated Management of Childhood Illness
IUD	Intrauterine device
MCH	Maternal and child health
MMR	Measles-mumps-rubella (vaccine)
MOF	Ministry of Finance
MOHE	Ministry of Higher Education

MOHP	Ministry of Health and Population
MOSA	Ministry of Social Affairs
NACP	National AIDS Control Program
NGO	Nongovernmental organization
OPD	Outpatient department
OPV	Oral polio vaccine
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PVO	Private voluntary organization
QA	Quality assurance
RPR	Reactive protein reagent
RTI	Reproductive tract infection
SC	Sick child
SHIP	Student Health Insurance Program
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
THO	Teaching Hospitals Organization
TST	Time-steam-temperature-sensitive (tape)
TT	Tetanus toxoid
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDRL	Venereal disease research laboratory
WHO	World Health Organization

1.1 Overview

In 2002, the first Egypt Service Provision Assessment survey (ESPA 2002) was conducted. The survey was designed to extract information about the general performance of facilities that offer maternal, child, and reproductive health services, as well as services for specific infectious diseases (reproductive tract or sexually transmitted infections [RTI/STIs], HIV/AIDS, and tuberculosis). The ESPA 2004 is a followup survey, with similar objectives.¹ The same questionnaire, with minor adaptation based on feedback from the ESPA 2002, was used for both surveys. Information to provide a picture of the strengths and weaknesses of the service delivery environment for each assessed service was collected from a representative sample of governmental and nongovernmental facilities. In addition, seven selected governorates were oversampled to provide key indicators for these areas, which are part of a pilot project supported by the U.S. Agency for International Development (USAID). The ESPA 2004 provides the Ministry of Health and Population (MOHP) with information necessary to monitor trends in facility performance. This information can be used when assessing strengths and weaknesses of current strategies to improve maternal, child, and reproductive health.

The ESPA 2004 provides regional- and national-level representative information for both government and specific nongovernmental facilities. Findings can supplement household-based health information from the Egypt Interim Demographic and Health Survey (EIDHS) conducted in 2003, which provides information on the health status and utilization of services by the overall population.

1.2 Institutional Framework and Objectives of the ESPA 2004

The ESPA 2004 was undertaken jointly by the MOHP and El-Zanaty Associates, with technical assistance from ORC Macro under the MEASURE DHS project. The study was funded by USAID.

The primary objectives of ESPA 2004 are the following:

- To describe the preparedness of government and nongovernmental health facilities in Egypt to provide quality child, maternal, and reproductive health services
- To describe the preparedness of government and nongovernmental health facilities in Egypt to provide quality services for specific infectious diseases (RTI/STIs and tuberculosis)
- To identify gaps in the support services, resources, or processes used in providing client services that may impact the ability of facilities to provide quality services
- To describe the processes used by facilities in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed
- To describe the extent to which clients understand what they must do to follow up on the service received so that the best health outcome is achieved
- To provide comparisons on findings between regions in Egypt and, at a national level, between different types of facilities, as well as those managed by different authorities (i.e.,

¹ The HIV/AIDS part of the survey was excluded because of the recent data available from the ESPA 2002.

governmental or nongovernmental), and when relevant, to describe differences in findings for the ESPA 2002 and the ESPA 2004

- To provide USAID with key indicators on findings for seven selected governorates (Cairo, Alexandria, Fayoum, Beni Seuf, Menya, Quena, and Aswan) that were oversampled for these areas which are part of a pilot project supported by USAID. To provide USAID with comparisons on findings between Cairo/Alexandria governorates together and five other governorates together (Fayoum, Beni Suef, Menya, Quena, and Aswan). These findings are available through USAID/Egypt.

1.3 ESPA 2004 Content and Methods for Data Collection

1.3.1 Content of the ESPA 2004

The ESPA 2004 focuses on basic-level health services, particularly those important for women and children. Four high-priority health services, all interrelated to various degrees, were assessed: 1) child health, 2) family planning, 3) maternal health, and 4) specific infectious diseases (RTI/STIs and tuberculosis).

For each assessed service, the presence and functioning of components considered essential for the provision and maintenance of quality health services are assessed. The components are those commonly promoted in programs supported by organizations such as USAID, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and other donors. The ESPA 2004 also assesses the presence of more sophisticated components, such as higher level diagnostic and treatment modalities and support systems for the health services, which are most often introduced after basic-level services have been put into place.

The child health component is designed to assess the availability of preventive services (immunization and growth monitoring) and outpatient care for the sick child, with a focus on the process followed in providing services to the sick child. Guidelines for the Integrated Management of Childhood Illness (IMCI) program set the standard against which service provision is measured.

The family planning component assesses all family planning services that are available, with a focus on the process followed in counseling and providing contraceptive methods to the family planning client.

The maternal health component assesses all maternal health services available, including inpatient delivery and caesarean section, with a focus on the process used in counseling and screening during visits for antenatal care (ANC).

The specific infectious disease component for RTI/STIs assesses the availability of services for diagnosing and treating RTI/STIs, with a focus on the process used in assessing and counseling clients with an RTI/STI. The infectious diseases component also assesses the general availability of tuberculosis diagnostic and treatment programs in sampled health facilities.²

1.3.2 Methods for Data Collection

Four types of data collection tools were used.

² TB diagnosis and prescription of treatment provided primarily by specialized TB chest clinics and hospitals which are not included in the SPA sample.

The first was a *Facility Resources Questionnaire*, designed to obtain information on the facility's preparedness (availability of resources and support services) to provide each of the priority services. Information was collected on the availability of resources, support systems, and infrastructure elements necessary to provide a level of service that meets generally accepted standards. The support services were those that are commonly acknowledged as essential management tools for maintaining health services.

The second was a *Provider Interview*. Providers of health services were interviewed for information on their qualifications (e.g., training, experience, continued in-service training), the supervision they had received, and their perceptions of the service delivery environment.

The third was an *Observation Protocol* tailored to the service being provided. Observations of consultations for sick children, antenatal care, family planning, RTI/STIs, and injection procedures were conducted to assess the extent to which service providers adhered to standards, based on generally accepted practices for good-quality service delivery. Both the process used in conducting specific procedures and examinations and the content of information exchanged between the provider and the client (history, symptoms, and advice) were components of the observation.

The fourth was an *Exit Interview* with the client who was observed receiving a service. The exit interview assessed the client's understanding of the consultation or examination, as well as his or her recollection of the instructions that he or she received about treatment or preventive behavior. The client's perception of the service delivery environment was also elicited.

The data collection instruments were developed to respond to the following basic questions:

1) To what extent are the surveyed facilities prepared to provide the high-priority services? (Availability of resources)

For each of the high-priority services, the Facility Resources Questionnaire and provider interviews were used to collect information on whether a facility had the capacity to provide the service at an acceptable standard of quality.

Capacity is measured by the presence of essential equipment and supplies in a location reasonable for providing a service. The items assessed for quality of services include training and supervision of staff, availability of service delivery guidelines or protocols and of materials for client education; availability and utilization of health information records; the service delivery environment; and facility systems for maintaining equipment and supplies.

2) To what extent do support systems for maintaining or improving the services exist, and how well are they functioning? (Support services)

The support systems assessed are those related to general management, quality assurance, logistics for medicines, equipment maintenance, infection control, and various systems for monitoring activities (such as following service coverage rates and referrals). Facility reports showing the presence of the support system, as well as evidence indicating that the system is functioning, are collected.

The ESPA 2004 also collects data on the basic infrastructure of each facility, which may contribute to a better standard of services or increase clients' utilization. Infrastructure elements assessed include the presence of electricity and water, as well as the availability of amenities and services (types and days of services and staffing levels).

(3) To what extent does the service delivery process follow generally accepted standards? (Care process)

The ESPA 2004 observed consultations between clients and providers to assess whether the process followed in service delivery meets the standards for acceptable content and quality. The observations for outpatient care for sick children, RTI/STI services, family planning services, and antenatal care focus on the information shared between the client and provider and the process the provider follows when assessing the client, conducting procedures, and providing treatments.

An exit interview for each observed client was used to ascertain the client's perspective on information shared and received. This information provides further insight on the quality of the client-provider interaction.

(4) What are the issues that the clients and service providers consider relevant to their satisfaction with the environment in which services are delivered?

Information on issues related to clients' and providers' satisfaction was collected through the client exit interviews and provider interviews.

1.4 Sample

Data were collected from a representative sample of facilities; a sample of health service providers at each facility; and a sample of sick child, family planning, antenatal, and STI clients. In addition, a sample of children receiving injections was selected.

1.4.1 Sample of Facilities

The sample was selected to provide national- and regional-level representation of the health facilities offering maternal, child, and reproductive health services. These included a variety of types of hospitals, health centers, and health units managed by the government (public) or by nongovernmental organizations (NGOs). Private pharmacies and private clinics were not included in the sample. Facilities in the Frontier Governorates were also not included in the survey.

Among public sector facilities, the sample covered hospitals, maternal and child health and urban health units (MCH/urban HUs), rural health units (rural HUs), mobile units, and health offices. General/district and integrated hospitals were selected to represent general service (GS) hospitals. In addition, fever hospitals were also sampled. Although they do not provide the range of services covered by the ESPA 2004, fever hospitals provide health services for sick children and some services for infectious diseases that are of interest to the ESPA 2004 and policymakers. At the request of USAID and MOHP, 7 governorates (Cairo, Alexandria, Fayoum, Beni Suef, Menya, Qena, and Aswan) that are part of a USAID-supported pilot project were oversampled to provide key indicators for these areas.

The total sample size was determined on the basis of funding and logistic considerations, as well as the minimum sample size required for the levels of analysis desired. Using a list of facilities supplied by the MOHP, all facilities of interest were listed by facility type and region—stratifying by governorate—and then systematically selected. The selection was made separately for public and for NGO facilities. The number of facilities in the sample for each region was determined to ensure adequate regional representation of facilities as well as national representation of public and NGO facilities. The final sample contained 659 health facilities, among which 559 were MOHP facilities, with the remainder divided between facilities managed by various NGOs and private, nonprofit facilities.

During data collection, 15 facilities were found to be of different classifications from that indicated on the sampling frame. During data analysis, these facilities were reclassified to reflect their correct facility type.

Data were weighted during analysis to account for the differentials caused by oversampling. Table 1.1 provides information on the weighted percent distribution of facilities included in the sample, as well as the weighted and unweighted number of facilities. Table 1.2 provides this information for the facilities offering each assessed service.

Appendix Table A-1.1 provides additional details on the distribution of the sample by type of facility and geographic location. See section 1.6 for further explanation of the sampling methods and weighting.

Background characteristics	Percent distribution of facilities (weighted)	Number of facilities	
		Weighted	Unweighted
Type of facility			
GS hospital	10	65	68
Fever hospital	2	14	13
MCH/urban health unit	15	97	69
Rural health unit	48	319	304
Mobile unit	8	55	71
Health office	5	33	34
NGO facility	12	76	100
Region			
Urban Governorates	11	73	133
Lower Egypt	49	322	176
Upper Egypt	40	264	350
Total	100	659	659

Service provided	Percent of facilities providing services (weighted)	Number of facilities providing services	
		Weighted	Unweighted
Immunization	70	464	421
Consultation for sick children	84	552	537
Family planning	97	637	637
Antenatal care ¹	85	559	556
Delivery	25	168	176
Services for RTI/STIs ²	89	587	600
Services for tuberculosis	22	148	141

¹ Out of a total of 657 facilities, 87 percent provide ANC services (two fever hospitals were excluded, as fever hospitals do not provide ANC services).
² This may include only laboratory examinations, only preventive measures, or client care.

1.4.2 Sample of Health Service Providers

The sample of health service providers was selected from providers who were present in the facility on the day of the survey and who provided services that were assessed by the ESPA 2004. In facilities with fewer than eight health service providers, all of the providers present on the day of the visit to the unit were interviewed. In facilities with more than eight providers, all providers whose work was observed were interviewed, and a random selection of the providers who were not observed when providing services were interviewed to compile a minimum of eight provider interviews. The selection was carried out to ensure that, if available, at least one provider from each assessed service was interviewed, even if no observation was conducted for that service. A provider is defined as a physician or a nurse who actually provides client services of some type (counseling, health education, or consultation services). Thus, for example, a nurse who only completes registers and who never provides any type of professional client services is not eligible for interview.

Data were weighted during analysis to account for the differentials caused by oversampling or undersampling of providers with a particular qualification in a facility type and region. The results of the ESPA 2004 provider interviews are potentially biased because the staff who were present the day of the survey may not be representative of the staff who normally provide the services of interest in the facility.

Table 1.3 provides information on the weighted proportion of the providers as a percentage of the total number of providers by the type of facility, region, and provider qualification; the weighted number of interviewed providers utilized during analysis; and the unweighted number of interviewed providers. Appendix Table A-1.2 provides information on the weighted and unweighted number of interviewed providers by type of provider and type of facility.

Background characteristics	Percent distribution of interviewed providers (weighted)	Number of interviewed providers	
		Weighted	Unweighted
Type of facility			
GS hospital	32	881	432
Fever hospital	5	129	52
MCH/urban health unit	23	632	441
Rural health unit	30	811	1,285
Mobile unit	2	43	150
Health office	5	126	166
NGO facility	4	114	210
Region			
Urban Governorates	11	303	584
Lower Egypt	54	1,467	810
Upper Egypt	35	966	1,342
Qualification of provider			
Physician, specialist	13	356	390
Physician, generalist	11	306	616
Nurse with midwifery	3	93	101
Nurse	60	1,650	1,549
Midwife	3	94	19
Nurse assistant	2	41	15
Other	7	195	46
Total	100	2,736	2,736

1.4.3 Sample for Observations and Exit Interviews

The sample for observations was opportunistic, meaning that clients were selected for observation as they arrived because there was no way to know how many eligible clients would attend the facility the day of the survey. Where numerous clients were eligible for observation, the rule was to observe a maximum of five clients for each provider of the service, with a maximum of 15 observations in any given facility for each service. In practice, fewer clients than were eligible were observed in some facilities. This occurred primarily where multiple services were provided to clients at the same time in different locations in a facility. Any family planning or ANC client who was also assessed for symptoms of RTI/STIs was observed both for elements related to STI services and for elements related to either family planning or ANC, whichever one was relevant. An attempt was made to interview the caretaker for all observed sick children before leaving the facility and to interview all family planning, ANC, and RTI/STI clients before leaving the facility.

In addition to the above, observers were instructed to complete an observation checklist for five injections³ (either therapeutic or immunization) in all facilities where curative care for children was being provided. They were to attempt to observe therapeutic injections for children, but if clients receiving injections were not readily available, injections for vaccinations as well as injections for adults were accepted.

With regard to child health consultations, when there were several eligible children waiting for service, an effort was made to ensure that children with some illness (rather than injury or skin or eye infections) were selected for observation. When there were several eligible ANC or family planning clients waiting, observers were instructed to select clients for observation, attempting to achieve a ratio of “two new for every one followup case.” The day’s caseload and logistics of organizing observations did not always allow this objective to be met.

The total number of eligible clients who attended the facility on the day a service was observed was also collected to provide information on the proportion of all eligible clients who were observed. In total, among all eligible clients who received services the day of the survey, 30 percent of the sick children were observed, 70 percent of the family planning clients were observed, 80 percent of the ANC clients were observed, and 92 percent of the RTI/STI clients were observed (Appendix Table A-1.3). Information on the total number of clients eligible for observation of injections was not collected. Details on characteristics of the observed clients are presented in the relevant chapters.

The observations were weighted using facility weights to adjust for overrepresentation of facilities (and, subsequently, observations) in the sample. The results of the ESPA 2004 are potentially biased because the clients who were present the day of the survey may not be representative of the clients who normally receive the services of interest in the facility.

Tables 1.4 and 1.5 provide information on the weighted percent distribution of observed consultations, as well as the weighted and actual (unweighted) numbers of observed clients, by type of facility.

Descriptive information on facilities included in the ESPA 2004 is presented in Appendix Tables A-1.4 through A-1.6. The data include the size of catchment populations (Appendix Table A-1.4); median numbers of staff assigned to facilities by provider and facility type (Appendix Table A-1.5); and the median number of years of basic and technical training received by interviewed providers, by type of provider (Appendix Table A-1.6).

³ Injections for contraceptive purposes were assessed with the family planning services.

Table 1.4 Distribution of observed consultations

Percent distribution of observed consultation (weighted) and weighted and unweighted number of observed consultations for curative care for sick children, family planning, antenatal care, and RTI/STIs, by type of facility, Egypt SPA 2004

Background characteristics	Percent distribution of observed consultations (weighted)	Number of observed consultations	
		Weighted	Unweighted
Outpatient care for sick children			
GS hospital	22	468	502
Fever hospital ¹	5	118	112
MCH/urban health unit	23	505	387
Rural health unit	45	977	926
Mobile unit	1	23	35
Health office	1	16	19
NGO facility	2	50	90
Total	100	2,156	2,071
Family planning			
GS hospital	14	276	303
Fever hospital	0	4	5
MCH/urban health unit	23	448	342
Rural health unit	36	690	634
Mobile unit	13	260	345
Health office	4	80	106
NGO facility	9	173	224
Total	100	1,930	1,959
Antenatal care			
GS hospital	13	132	161
Fever hospital ¹	0	0	0
MCH/urban health unit	32	334	289
Rural health unit	39	400	411
Mobile unit	8	79	114
Health office	0	3	5
NGO facility	8	81	113
Total	100	1,029	1,093
RTI/STIs			
GS hospital	17	92	98
Fever hospital	0	0	0
MCH/urban health unit	24	132	128
Rural health unit	18	96	96
Mobile unit	22	120	151
Health office	3	17	26
NGO facility	16	85	123
Total	100	541	622

¹ Fever hospitals do not provide ANC services and, although they do provide RTI/STI services, no clients were identified for observation the day of the survey.

Table 1.5 Distribution of observed therapeutic (or immunization) injections

Percent distribution of observed injections (weighted) and weighted and unweighted number of observed injections, by type of facility, Egypt SPA 2004

Type of facility	Percent distribution of observed injections (weighted)	Number of observed injections	
		Weighted	Unweighted
GS hospital	18	227	217
Fever hospital	1	18	26
MCH/urban health unit	21	272	183
Rural health unit	47	605	586
Mobile unit	1	11	17
Health office	9	119	129
NGO facility	3	35	47
Total	100	1,288	1,205

1.5 Study Implementation

1.5.1 Data Collection Instruments

Data were collected using structured printed instruments. The ESPA 2002 questionnaires were used for the ESPA 2004, with moderate adaptation based on feedback from the ESPA 2002 survey report. These instruments were based on generic questionnaires developed in the MEASURE DHS project and were adapted after consulting with technical specialists from MOHP, USAID, and NGOs knowledgeable about the health services and service program priorities covered by the ESPA 2004.

Operational definitions developed for the health system components that were measured in the ESPA 2002 were revised for the ESPA 2004 after discussions in Egypt. A training manual was also revised and distributed to all data collectors to support standardized data collection. Any differences between definitions used in 2002 and 2004 are discussed in the relevant section of the report.

Because the differences between the ESPA 2002 and 2004 questionnaires were minor and the time between surveys was less than two years, a pretest was not considered to be necessary.

1.5.2 Training and Supervision of Data Collectors

Data collectors were primarily recruited from physicians and demographers experienced in survey implementation and interviewing. Training included practical experience completing all questionnaires in health facilities of different types, as well as role-play for the observation and exit interviews.

1.5.3 Methods for Data Collection

Sixteen teams, each consisting of three interviewers, with one interviewer assigned as the team coordinator, were responsible for data collection. The majority of teams consisted of two physicians and one demographer; however, four teams were composed of three physicians with no demographer. All teams had at least one female interviewer.

Data were collected during May and June 2004. Each team received a list of facilities to be visited. Data collection took one day in most facilities, with two days being allotted to hospitals, if required. In

addition, if one of the observed services was not being offered the day of the survey, the teams returned on a day when the service was offered. If the service was offered, the clients for that day were observed. If the service was offered but no clients came, as occurred occasionally for consultations of sick children and, more often, RTI/STI clients, teams did not revisit the facility.

The team leader was instructed to ensure that the informant for each component of the facility survey was the most knowledgeable person for the particular health service or system component being addressed. Where relevant, the data collector indicated whether a specific item being assessed was observed, was reported available but not observed, or was not available, or whether it was uncertain if the item was available. Equipment, supplies, and resources for specific services were required to be in the relevant service delivery area or in an immediately adjacent room to be accepted as available. Informed consent was taken from the facility director and all respondents for the Facility Resources Questionnaire, from observed and interviewed providers, and from clients for observations and exit interviews.

Data collection teams were supervised throughout the field activities, with each team visited at least twice, to ensure adherence to the survey protocols. Reinterviews were implemented for selected sections of the inventory questionnaire for quality control. In addition, the research teams were connected with the central office and supervisors through mobile phones, so questions could be resolved and clarifications could be shared with all teams.

1.5.4 Process for Data Management and Report Writing

Data management and analysis were carried out according to the following steps:

- **Management of questionnaires.** Completed and verified questionnaires were collected by supervisors and sent to the El-Zanaty Associates office for editing. Two physician supervisors reviewed all “other” responses and recoded responses into categories relevant for data analysis.
- **Data entry.** Data entry was conducted by El-Zanaty Associates staff. CSPRO software developed by ORC Macro and the U.S. Census Bureau was used for data entry. Double-entry of all questionnaires was carried out to catch errors. This operation took place from May through July 2004.
- **Data analysis.** The design of the tabulation plan and the preparation of the programs for the production of statistical tables were carried out from May through September 2004. Data analysis and clarification of questionable results were carried out from October through December 2004. During the data analysis, revisions were made to the analysis plan on the basis of feedback from MOHP and the ESPA 2004 technical advisors to ensure that the analysis was appropriate for the Egyptian health system.
- **Development of final report.** The final report was written with input from ORC Macro technical staff, El-Zanaty Associates, and MOHP officials responsible for services included in the survey.

After the draft report was finalized, a workshop was held with the technical staff of MOHP to present findings and make any corrections, changes, or additional explanations that were required before final publication. This took place during January and February 2005.

1.5.5 Data Analysis

The following conventions were observed during the analysis of the ESPA 2004 data:

- **Assessing the availability of items.** Unless specifically indicated, the ESPA 2004 considered only observed items as available.
- **Observations.** In looking at the observation data, it should be noted that many facilities provide routine services for clients separately from the actual consultation (e.g., taking blood pressures and temperatures). There is often a period between these events and the point at which the primary provider assesses the client. Although ESPA 2004 observers were instructed to follow a client through the entire system, this was not always possible logistically. Thus, when services were observed being provided outside the consultation room on the day of the survey, the observed client was assumed to have received these services. Where this system is used, multiple providers contribute to the services received by each client. The provider who ultimately diagnosed and prescribed was defined as the primary provider.

Observation data assessed whether a practice occurred or a piece of information was shared (process). No attempt was made to verify whether the practice was correct or if the information shared was correct or complete.

- **Provider information.** Not infrequently, providers indicated that they “personally provided” a service that the facility does not offer. It may be that providers indicated services they provide outside the facility. For the ESPA 2004, only providers from facilities that offered the service in question were included in the analysis for that service.
- **Development of aggregate variables.** Aggregating the data into subsets makes it possible to analyze many pieces of information and to see how they relate to the overall capacity to provide services. It also enables monitoring changes in capacity to provide services and changes in adherence to standards, since there may be improvements in some items but not in others. There are not yet generally accepted aggregates of the health information collected in the ESPA 2004. The aggregate variables presented in this report, however, are an initial phase in the process of defining useful health information aggregates. They will be refined as users provide feedback on the aggregate variables found to be useful (or not useful) to policy-makers and program implementers.

1.6 Explanation of Weighted Data

When selecting a sample, there is frequently interest in having data on specific types of services or facilities, where a nationally representative sample will not provide sufficient numbers for meaningful analysis. In designing a sample selection to provide sufficient numbers of subsets of the data, these facilities or services may be either over or under represented in the sample in relation to the proportion that they exist in the nation as a whole. When presenting regional and nationally representative statistics, the data are weighted to compensate for over or under sampling. The weights ensure that, when providing regional or national data, the proportion to which different facilities and services contribute to the total is the same proportion that they exist in the region/nation as a whole.

Example: In Egypt, there was a desire to sample a sufficient number of NGO facilities so that the statistical representation was valid. Thus, although NGO facilities represented only 12 percent of the sampling frame, the actual sample included 100 of these facilities (15 percent of the sample). When adding the NGO facility data to the national total, all 100 facilities are used in calculating the percentage, but each facility is weighted so that, in total, NGO facilities will contribute only 12 percent of the national average, meaning that, on average, each facility counts as 0.76 facility.

Calculations: If 23 percent of the NGO facilities have adequate waste disposal (Table 3.12), this means that 23 of the 100 NGO facilities has adequate waste disposal. Without weighting, this contributes 23 facilities to the national-level numerator and 100 facilities to the national-level denominator when calculating a national average. This would mean that the findings from NGO facilities contribute 15 percent of the total, rather than the 12 percent that reflects the true proportion of the NGO facilities (of the type sampled for this survey) in the country. When weighting data to calculate the national average, the result (1=yes, 0=no) for each facility is multiplied times the weight (on average for NGO facilities $\times 0.75$). Thus, $23 \times 0.76=17.48$ and $100 \times 0.76=76$. The NGO facilities contribute 17.48 facilities to the numerator and 76 facilities to the denominator ($17.48/76=23$ percent) Thus, the proportion of NGO facilities with adequate waste disposal remains the proportion calculated using the data from 100 facilities, but they are represented at their real proportion for the national average.

Summary: On the report tables, we provide the weighted numbers, which provides information on what proportion of the total that comes from this particular type of facility or region. It is important to remember, however, that all facilities in the sample are used when calculating the percentage. So, if a weighted number looks too small to be meaningful, it is essential to review the unweighted number—provided in tables in chapter 1—to know how many actual facilities/interviews contribute to this percentage.

The Egyptian health system faces multiple challenges in improving and ensuring the health and well-being of the Egyptian people. The system faces not only the burden of combating illnesses associated with poverty and lack of education, but it must also respond to emerging diseases and illnesses associated with modern, urban lifestyle. Emerging access to global communications and commerce is raising the expectations of the population for more and better care and for advanced health care technology.

The Egyptian health system has a strong infrastructure of physicians, clinics and hospitals, availability of technology and pharmaceuticals, and excellent physical access to care, with 95 percent of the population being within five kilometers of a medical facility.

A high birth rate combined with a longer life expectancy is increasing the population pressure on the Egyptian health system. By the year 2020, it is estimated that the population of Egypt will have grown to about 92 million.

The Egyptian government is implementing Health Sector Reform Program measures, with the help of external funding and technical assistance, notably from the World Bank, the U.S. Agency for International Development (USAID), and the European Commission. The plan is to provide services using a family health model, where maternal, child, reproductive tract, and infectious disease services are offered as a package of services in one facility. Providers are trained to provide services in an integrated manner, and family health records are maintained.

This chapter provides a brief overview of the health system in Egypt as it relates to health facilities and outpatient services. The chapter provides a context in which to view the findings of the Egypt Service Provision Assessment (ESPA) survey.

Information is presented with respect to—

- General organization of the health system
- The package of health services provided at different facility levels
- Issues related to the health system and quality of care.

2.1 General Organization of the Health System

Egypt has a highly pluralistic health care system. Health services in Egypt are currently managed, financed and provided by various sectors of the government, under different ministries and different laws, operating with variable levels of independence. Services are also provided by the private sector by providers of variable qualification and variable levels of services.

2.1.1 Public Sector

“Public sector” refers to both the governmental and institutional public sectors. Differentiation of the two categories is based on the ownership and the degree of operational independence granted to them by law; however, both categories are considered governmental.

Public Governmental Sector. The Public Governmental Sector represents activities of ministries that receive funding from the Ministry of Finance (MOF). As in many lower- and middle-income countries, the government health services in Egypt are organized as an integrated delivery system in which the financing and provider functions are included under the same organizational structure. This means that government providers receiving budgetary support from the government general revenues (MOF) are also subject to the administrative rules and regulations that govern all civil service organizations. For example, staff are subject to the Civil Service Employment Law, and remuneration is based on the civil service salary scale determined by the Central Agency for Organization and Administration (CAOA). The governmental providers who receive funds primarily from MOF include the Ministry of Health and Population (MOHP), the Ministry of Higher Education (MOHE), the Ministry of Scientific Research, ministries that provide some health services for their employees (agriculture, teachers, railway, electricity, and others), and facilities of the Teaching Hospitals Organization (THO).¹ THO includes nine institutes and nine hospitals distributed throughout Egypt.

Egypt has 14 medical schools (Faculties of Medicine) affiliated with the major universities and 36 university hospitals. University hospitals are regarded as secondary and tertiary care facilities and tend to be much more advanced in terms of technology and medical expertise in comparison with MOHP facilities. These university hospitals are operated under the authority of MOHE.

Government providers are permitted to generate their own income through various means, including charging user fees in special units or departments known as economic departments. Income from these nonbudgetary sources is classified as “self-funding.”

Public Institutional Sector. The Public Institutional Sector is composed of quasi-governmental organizations in which government ministries have a controlling share of decisionmaking, including the Health Insurance Organization (HIO), the Curative Care Organization (CCO), and other public sector organizations providing mainly hospital services. Although the distinction between the government sector and the parastatal or quasi-governmental sector is usually made when describing the Egyptian health sector, both sectors are, in practice, run by the state. From an operational and a financial perspective, the parastatals are governed by their own set of rules and regulations, have separate budgets, and exercise more autonomy in daily operations. However, from a political perspective, MOHP has a controlling share of decisionmaking in parastatal organizations.

CCO is a nonprofit system established in 1964 under the ultimate authority of MOHP. There are six CCOs operating 12 hospitals, accounting for about 4 percent of Egypt’s total hospital beds. These hospitals are located in Cairo, Alexandria, Kalyubia, Damietta, Kafr-El Sheikh, and Port-Said, with none in Upper Egypt.

The Egyptian HIO was created in 1964. It is a parastatal, government-owned entity under MOHP. There are four broad classes of HIO beneficiaries: all employees working in the government sector; some public and private sector employees; pensioners; and widows. In February 1993, the Student Health Insurance Program (SHIP) was introduced to cover 15 million students and school-age children, thus increasing the total beneficiary population from 5 million in 1992 to 20 million in 1995 (Rannan-Eliya, 1997). The 1997 Ministerial Decree 380 extended coverage to newborns (under one year) and by 2002 had increased the eligible beneficiary population to over 30 million.

HIO revenues come from four primary sources. The Social Insurance Organization and the Pensioners Insurance Organization receive contributions as a proportion of employees’ salaries. SHIP receives con-

¹ The Ministry of Defense and the Ministry of Interior also receive a budget to provide health services to their staff, but they are not included in the discussion because of their limited scope.

tributions through a fixed amount from school registration fees and from government subsidy. HIO also receives some revenues in the form of copayments, primarily from government employees.

As a provider of health care, HIO manages 39 hospitals as well as—

- General practitioner clinics inside and outside factories
- 7,141 school health clinics
- 1,040 specialist clinics or polyclinics
- 51 owned and 49 contracted pharmacies

(MOHP, 2003).

2.1.2 Private Sector

The Private Sector includes for-profit and nonprofit organizations and covers everything from traditional midwives, private pharmacies, private doctors, and private hospitals of all sizes. Also in this sector are a large number of nongovernmental organizations (NGOs) providing services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the MOHP as well as the Ministry of Social Affairs (MOSA).

2.1.3 Professional Syndicates

Professional Syndicates are health care providers financed through an insurance scheme consisting of a percapita fee combined with copayment from beneficiaries. The services they may provide are restricted, and there is an agreed upon ceiling per contract period on the amount they may charge.

2.1.4 Other Bodies Influencing Legislation and Health Policy

Other Bodies Influencing Legislation and Health Policy include many professional associations, as well as a number of independent bodies functioning in advisory or legislative capacities to provide input to, review, and/or approve health policies, including the Committee for Health and Environment of the People's Assembly; the Health, Population, and Environment Committee of the Shura Council; and the Supreme Council for Health.

The People's Assembly, or the Parliament, is an elected body consisting of 444 members (in addition to a maximum of 10 members appointed by the President). It is the legislative body, making laws and approving taxes and international agreements. In addition to its legislative function, it has a supervisory monitoring function. Laws, before going to Parliament in its plenary sessions, are referred for preliminary study to the relevant specific committees. There are currently 22 of these committees. One of these is the Committee for Health and Environment. This committee, consisting solely of members of Parliament, often invites “experts” to its meetings for the purpose of obtaining a more comprehensive view of topics under study. The committee influences health policy plans for the future.

The Shura Council was established constitutionally in 1980 and is mainly a “think tank” to advise the Governmental National Policies. The Shura Council's Health, Population, and Environment Committee examines issues relevant to those areas prior to its discussion in the Shura Council's plenary sessions.

Although it does not have a direct legislative role, laws impacting significantly on government policy are required to be discussed by the Shura Council before being passed to the People's Assembly.

2.2 Organization of the Ministry of Health and Population

MOHP operates through functional structures, with administrative and technical personnel at four levels. These are the central level, governorate level (Health Directorates), health district level, and the health care provider level.

2.2.1 Central-Level Organizational Structure

MOHP was formed through a merger of the former Ministry of Health (established in 1936) and the former Ministry of State for population. The MOHP central organizational structure is headed by the Minister of Health and Population, employing almost 5,000 personnel, including professionals and supporting staff, who are in charge of central functions, such as planning, supervision, and program management.

The MOHP is divided into seven broad functional divisions:

- 1) The Minister's Office Affairs Sector
- 2) The Training and Research Sector
- 3) The Health Care and Nursing Sector
- 4) The Preventive Affairs and Endemic Diseases Sector
- 5) The Curative Health Sector
- 6) The Health Regions Sector
- 7) The Central Department for General Secretariat.

The Central Department for General Secretariat is directly accountable to the Minister of Health and Population.

The seven functional divisions embrace 23 central departments and 73 general departments at the central level. The seven sectoral heads report directly to the Minister of Health and Population. In addition, the central department heads for preventive care, laboratories, primary health care, endemic diseases, curative care, research and development, pharmaceuticals, dentistry, family planning, and nursing report directly to the Minister of Health and Population.

In addition to these functional units, the central organization structure includes certain policymaking, planning, and advisory bodies, such as councils, executive committees, and advisory committees. In general, this central structure includes 103 sectoral, central, and general departmental units integrated under the Minister of Health and Population, who constitutionally is the key policy formulator and decision-maker.

2.2.2 Governorate-Level Organizational Structure

The previously described central organizational level is replicated at the governorate level. The governorate-level health directorates are responsible to the Minister of Health and Population on technical functions, but report to the Governorate Executive Council, headed by the Governor, for day-to-day management of activities throughout the governorate.

Egypt has 26 governorates. There are, however, 27 Health Directorates in operation because Luxor has a separate Health Directorate, despite being administratively part of Qena Governorate.

Each Governorate Health Directorate is headed by an Undersecretary or a Director General called “the Director of Health Affairs,” whose functional grade differs according to governorate size. The Director of Health Affairs supervises the Health District Directors.

2.2.3 District-Level Organizational Structure

The district-level organizational structure is simply a replication of that of the governorate, except that the basic functions are implemented on a smaller scale.

Each of the 235 health districts report to their Governorate Health Directorates. Each district has a Director, who is sometimes also the District Hospital Director, supervising a team of physicians, nurse supervisors, and administrators.

2.2.4 MOHP Service Delivery Structure

MOHP is currently the major provider of primary, preventive, and curative care in Egypt, with more than 3,645 health facilities and 66,440 beds spread nationwide. There are no nationwide formal referral systems in the MOHP delivery system. Rather, there are a number of pilot referral systems, in some districts under various health projects.

MOHP service delivery units are organized along a number of different dimensions. These include geographic (rural and urban), structural (health units, health centers, and hospitals), functional (maternal child health centers), or programmatic (immunization and diarrheal disease control).

Specifically, with respect to inpatient services, MOHP is the largest institutional provider of inpatient health care services in Egypt. Hospital services are provided through the following types of facilities:

- Integrated hospitals are small (20 to 60 beds) hospitals providing primary health care and specialized medical services in the rural areas. Integrated hospitals contain well-equipped surgical theaters, x-ray equipment, and laboratories, and they are responsible for serving a catchment population of between 10,000 and 25,000 people.
- District hospitals (100 to 200 beds) provide more specialized medical services and are available in every district. District hospitals are responsible for serving an average catchment population of between 50,000 and 100,000 people in the urban district area. Some districts are significantly larger, covering 300,000 people.
- General hospitals (more than 200 beds) contain all medical specialties. General hospitals are available in every capital of a governorate.
- Integrated, district, and general hospitals were included in the ESPA sample and were categorized as general service hospitals for this report.
- Specialty hospitals are located in urban areas and include such specialties as eye, psychiatric, chest (34), fever (88), heart, ophthalmology (31), tumors, gynecology, and obstetrics. Specialty hospitals are available in all governorates. Fever hospitals are the only type of specialty hospital included in the ESPA sample.

- The private sector has 2,024 inpatient facilities, containing about 22,647 beds. This accounts for approximately 16 percent of the total inpatient bed capacity in Egypt.

2.3 MOHP Public Health Programs

MOHP has attempted to target many health priorities in Egypt through vertical programs that rely heavily on donor assistance. These programs include the following.

2.3.1 Population, Reproductive Health, and Family Planning Programs

As early as 1953, a National Committee for Population Matters was established to review population issues. This committee developed three successive population policies: the first was enacted in 1973; the second was enacted in 1980, which saw the creation of the National Population Council in 1985; and the third was enacted in 1986. In 1991, the National Population Council developed specific objectives for population activities through the introduction of a population strategy. Throughout these years, the population program has continued to develop with varying degree of success and with the support of various donors, principally USAID, UNFPA, and the Social Fund for Development.

Donor assistance has mainly concentrated on providing supplies and technical support. Donors have provided more than 50 percent of the funding for public-sector population program activities and almost 70 percent of the funding for these activities in the private sector.

2.3.2 Control of Diarrheal Diseases and Acute Respiratory Infection Programs

The Control of Diarrheal Diseases (CDD) program and the Acute Respiratory Infection (ARI) program were components of projects supported by USAID. The CDD program is older by a few years and has its own department in MOHP. It has benefited from having been a priority since the 1980s. It was only in the late eighties that the ARI program gained impetus with the development of World Health Organization (WHO) programs focusing on ARI.

Both the CDD and ARI programs have adopted WHO case definitions and case management protocols. In principle, standardized treatments are available in health facilities, and a high proportion of the staff has been trained.

The CDD program has been effective in reducing infant mortality caused by diarrheal diseases; they are now the second leading cause of infant deaths.

2.3.3 Expanded Program on Immunization

The Expanded Program on Immunization (EPI) is probably the most accessible, available, and utilized public health program in Egypt. According to health officials, many parents do not request health services for themselves or their children, but they do have their children immunized. The program has been quite effective in reducing the incidence of some vaccine-preventable diseases, such as diphtheria and poliomyelitis.

2.3.4 Maternal Health

The government of Egypt has demonstrated continued political commitment to improving maternal and child health. In 1994, as host nation of the International Conference on Population and Development, the government of Egypt endorsed a comprehensive approach to women's health with a focus on reducing maternal mortality. Reducing maternal mortality was also a key goal of the National Five-Year Plan (1998-2002) of MOHP.

The national program to reduce maternal mortality is overseen and implemented by the Directorate of Maternal and Child Health Care under the Division/Sector of Primary Health Care of MOHP. MOHP used the conclusions and recommendations of the 1992-1993 National Maternal Mortality Study (NMMS) to design and implement interventions (Maternal Care Program Development and Implementation Process) during the past decade. Particular attention has been paid to improving the quality of delivery care as well as to encouraging appropriate care-seeking behavior. All public health facilities provide maternal and child health (MCH) services.

At the national level, the MCH directorate has defined a package of MCH services, which includes basic and comprehensive essential obstetric care (EOC) for normal delivery and management of obstetric complications. Clinical protocols and service standards for EOC and competency-based training curricula and materials have been developed and officially approved for national use. Quality of care has also been addressed through a series of administrative decrees covering issues such as the presence of senior obstetricians during deliveries, midwife training and licensing, improvement in blood transfusion services, and use of facility-generated revenues for local service improvement.

A Women's Health Project was implemented from 1995 to 2001, funded partially by the Social Fund for Development, in cooperation with MOHP. The project objectives were to upgrade maternity services in almost 300 health units in all governorates, training physicians, nurses, and social change agents to improve competencies in the area of maternal and reproductive health. The goal was both to improve technical competencies and to influence the health beliefs and behaviors of the beneficiaries.

More than 170 maternity centers have been upgraded in the underserved urban and rural areas to provide safe and clean normal delivery services and to be able to refer pregnant women with complications. Seventy-five rural and postnatal care (PNC) units have been upgraded to offer normal delivery care and to improve linkages with referral centers.

2.4 Health Sector Reform Program

The government of Egypt has articulated as its long-term goal the achievement of universal coverage of basic health services for all of its citizens. It has also stated the importance of targeting the most vulnerable population groups as its priority.

In addition to the reform and expansion of social health insurance functions, the Health Sector Reform Program (HSRP) includes the following elements:

- Redefining the role of MOHP to develop regulatory functions, notably to establish quality norms and standards and to establish a mechanism of accreditation and licensure to enforce those standards, and to consolidate the multiple vertical public health programs
- Strengthening the program for training and retaining of family health care physicians, nurses, and allied health professionals; with greater emphasis on preventive health care
- Decentralizing management of the government health delivery system to the governorate and district levels, and introducing greater managerial autonomy at the facility level
- Rationalization of public investment in health infrastructure and health manpower, based on governorate and district health plans, and identifying the actual needs and availability of resources to sustain the investment.

The first phase of the HSRP was developed as a program jointly financed by the Government of Egypt, the World Bank, the European Union, and USAID. In 2000, the African Development Bank joined the financial stakeholders of the program.

Upgrading Health Services I and II as well as Development of Human Resources in the field of Family Medicine are projects that were partially funded by the Social Fund for Development, in cooperation with MOHP in the late 1990s under the umbrella of HSRP.

2.5 Private and Nongovernmental Sector

Private-sector provision of services includes everything from traditional healers and midwives, to private pharmacies, private doctors, and private hospitals of all sizes. Also in this sector are a large number of NGOs providing services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the Ministry of Social Affairs (MOSA).

2.5.1 Private Practices

Physicians represent the most powerful professional group in the health sector. Doctors are permitted to work simultaneously for the government and in the private sector. Those who are employed by the government but run a private practice because of their low salaries account for a large portion of private providers. Many other physicians, however, cannot afford to open their own private clinics and work in more than one nongovernmental religious or private facility in addition to their government jobs.

The Egyptian Health Care Provider Survey (Nandakumar et al., 1999) showed that 89 percent of the physicians with private clinics had multiple jobs. Seventy-three percent of the physicians had two jobs (i.e., they had another job outside their private clinic), 14 percent had three jobs, and 2 percent had four jobs.

MOHP employs 53 percent of physicians with multiple jobs, followed by universities with 14 percent, and HIO with 11 percent. The remaining physicians include well-established and qualified senior physicians who are usually faculty members in the major medical schools or shareholders in modern private hospitals. These physicians have the technology, the resources, and the visibility required to run very successful and profitable private practices.

2.5.2 Private Facilities

After the declaration of an open economic policy in 1974, the private health sector began to grow. Between 1975 and 1990, the total number of private beds rose significantly (Kempres and Oldham, 1992). Private care facilities in Egypt range from hospitals that are large, modern, and sophisticated, to smaller hospitals, day care centers, and polyclinics.

2.5.3 Private Voluntary Organizations

In the private sector, there are also many private voluntary organizations (PVOs) providing care through polyclinics and small hospitals that are usually affiliated with charitable or religious organizations. Among the various PVOs, the mosque clinics, operated by Muslim social agencies, are perceived to be popular and successful providers of ambulatory health care in Egypt and have become the stereotype for nonprofit organizations.

The PVO health sector is financially self-supporting through user fees. Small PVO clinics, however, are generally losing financially on current operations and are vulnerable to service disruption and failure.

2.5.4 Nongovernmental Organizations

NGOs provide many developments, social, and health care services, including reproductive health and family planning services. Reproductive health and family planning services are delivered through the Egyptian Family Planning Association (EFPA), the Clinical Services Improvement (CSI) project, and other NGOs (e.g., mosque health units, church health units, and other NGO clinics). The CSI clinics are funded by USAID as a special program.

According to the 2003 Egypt Interim Demographic and Health Survey, the public sector is providing 56 percent of family planning services in Egypt, and the private sector is providing 44 percent. Classified as private sector, PVOs/NGOs were found to be providing less than 6 percent of family planning services.

MOHP seconds physicians and sometimes nurses to NGOs (if requested) to work either part-time or full-time; however, MOHP has no authority to force these staff to work with the NGOs.

There is a system of supervision and monitoring based on regular followup for the NGO clinics. Supervision is conducted at two levels: supervision from local directors at clinics and supervision from the central staff. The administrative supervision for EFPA is conducted by the staff working in the branch of the EFPA at the governorate level, and the medical supervision is conducted by the Health Directorates at the governorate level.

Although it is feasible to offer outpatient health services under a variety of conditions, there are certain infrastructure and health system components that are believed to encourage and support a consistent level of quality and appropriate utilization of health services.

The first part of this chapter provides information on the presence of infrastructure and resources for supporting quality and appropriate utilization of services. These include the following:

- Availability of a basic package of health services and qualified staff in a facility
- Facility infrastructure supportive of client utilization and quality services
- Facility infrastructure supportive of quality, 24-hour emergency services.

Next, the chapter considers management systems for supporting quality services and appropriate utilization of services. These include the following:

- Systems for addressing management issues
- Staff development activities through supervision and in-service training
- Community input to the facility
- Funding mechanisms to decrease financial barriers to utilization.

The chapter concludes by considering two additional critical systems for supporting quality of services in facilities:

- Logistics systems to support quality maintenance and availability of medicines, vaccines, and contraceptive methods
- Systems and practices for infection control.

3.1 Basic Infrastructure and Resources Supportive of Utilization of Services

3.1.1 Availability of a Range of Services and Qualified Staff

The availability of a basic package of maternal, child, and reproductive health services and the frequency with which the services are offered, as well as the presence of qualified staff, all contribute to client utilization of a facility.

Table 3.1 provides aggregate information and Figure 3.1 provides details on basic services and staff availability. Additional background information describing availability of specific services by type of facility and region are provided in Appendix Tables A-3.1 and A-3.2.

Table 3.1 Availability of basic services and qualified staff to meet client needs					
Percentage of facilities that provide the indicated package of services, at the indicated frequencies, with the indicated qualification of staff, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities with:				Number of facilities (weighted)
	All basic services ¹	All basic services provided at minimum frequencies ²	All basic services at minimum frequencies plus facility-based 24-hour delivery services	All basic services at minimum frequencies, plus facility-based 24-hour delivery services, and at least one physician ³	
Type of facility					
GS hospital ⁴	50	47	15	15	65
Fever hospital	0	0	0	0	14
MCH/urban HU	73	73	42	42	97
Rural HU	70	53	13	13	319
Mobile Unit	0	0	0	0	55
Health Office	3	3	0	0	33
NGO facility	0	0	0	0	76
Region					
Urban Governorates	25	24	14	14	73
Lower Egypt	56	45	11	11	322
Upper Egypt	49	41	18	18	264
Total	50	41	14	14	659

¹ The basic services include outpatient services for sick children and for reproductive tract and sexually transmitted infections, temporary methods of family planning, antenatal care, immunization, and child growth monitoring.

² The services and defined minimum frequency are curative care for children offered at least five days per week, RTI/STI services at least one day per week, and preventive or elective services (any temporary methods of family planning, antenatal care, immunization, and growth monitoring) at least one day per week.

³ In Egypt, only physicians were defined as qualified providers for curative care.

⁴ General service (GS) hospitals include general hospitals (referral sites for district hospitals), district hospitals, and integrated hospitals (supervised by district hospitals).

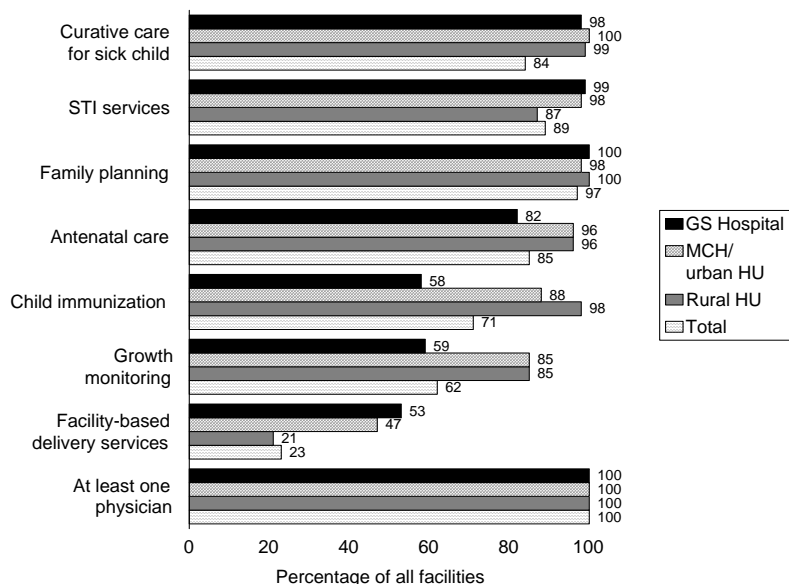
The Egyptian health system is organized with some facility types specializing in specific services, and as such, there are notable differences in the services offered by type of facility. For example, fever hospitals specialize in curative care and do not provide routine preventive services. Health offices primarily provide immunization and family planning services; delivery services are most frequently available in general service (GS) hospitals. Among the GS hospitals, immunization services are provided in integrated hospitals but not in general or district hospitals.

The facilities where the full range of services is expected to be offered are a proportion of the GS hospitals (the integrated hospitals), rural health units (rural HUs), and maternal and child health/urban health units (MCH/urban HUs). Thus, if a facility does not offer all services, it should not be assumed that it is not working to standard. This does mean, however, that clients may have to visit several different facilities to meet all of the basic health needs of their family.

There is a noticeable increase within the last two years in the availability of all basic services at health facilities (50 percent in 2004 [Table 3.1], compared with 35 percent in 2002) and in the number of all basic services provided at defined minimum frequencies (41 percent in 2004, compared with 31 percent in 2002).

Family planning, reproductive tract and sexually transmitted infections (RTI/STI), outpatient care for sick children, and antenatal care are the components of the package of services most widely available (Figure 3.1). Similar to findings in 2002, immunizations and routine growth monitoring services are the least available. Services for RTI/STIs have increased dramatically during the two years (89 percent in 2004, compared with 62 percent in 2002).

Figure 3.1 Availability of services and staff to meet basic client needs (N=659)



Egypt SPA 2004

Rural HUs and MCH/urban HUs are more likely to offer the full range of basic service with the defined minimum frequencies (53 and 73 percent, respectively) than are GS hospitals (47 percent) (Table 3.1). The Urban Governorates are the least likely to have facilities that provided the package of services with the minimum defined.

One explanation for the regional differences is that GS hospitals (frequently located in urban areas) are often adjacent to health offices that provide preventive or elective services. Health offices may provide the child immunization and other preventive or elective services for both facilities, rather than duplicate services. The 2004 Egypt Service Provision Assessment (ESPA 2004) evaluated availability of services by whether facilities stood alone or were adjacent to a health office, in order to gain a better picture of service availability in these cases. It is notable that when GS hospitals or MCH/urban HUs are adjacent to health offices, there is most often a duplication of services rather than a division of services (Appendix Table A-3.1.1). In addition, health offices do not appear to gain infrastructure benefit (water, electricity, or generator) from being adjacent to a GS hospital or MCH/urban HU (Appendix Table A-3.3.1). Thus, while it is possible that the adjacent-facility arrangement helps decrease client load in busy urban GS hospitals and MCH/urban HUs, it does not result in increased availability of a package of services in one location or improved infrastructure for the smaller health office.

There is a decrease in facility-based, 24-hour delivery service from 2002 (32 percent) to 2004 (23 percent). This is especially noticeable for GS hospitals (53 percent in 2004 versus 73 percent in 2002) and among rural HUs (21 percent in 2004 versus 32 percent in 2002).

Only 14 percent of facilities offer all of the basic services at the minimum frequency, plus 24-hour delivery services, with MCH/urban HUs offering the full package more frequently (42 percent) than other types of facilities (Table 3.1). All facilities have at least one physician assigned, with the exception of a small percentage (1 percent) of the mobile units (Appendix Table A-3.1).

3.1.2 Facility Infrastructure Supportive of Client Utilization and Quality Services

Although quality health services can be provided in the most minimal service delivery setting, there are basic client comfort amenities and infrastructure components that contribute to client and staff satisfaction, as well as to the quality and level of services possible. These items may contribute to clients' willingness to use a facility and staff's willingness to work at the facility, and they may facilitate the staff's capacity to follow standards for quality services.

Table 3.2 provides summary information on these items by facility type and region. Appendix Tables A-3.3 and A-3.4 provide details on the availability of items by type of facility and region.

There are no notable changes in the availability of all basic client comfort amenities over the past two years, with six in ten facilities having all assessed elements (Table 3.2) and each of the assessed amenities missing in approximately two in ten facilities (Appendix Table A-3.3). Nongovernmental organization (NGO) facilities and MCH/urban HUs are the most likely to have all amenities, and mobile units are least likely. While they may not have client amenities, the mobile units do ensure that services reach locations where there is no fixed site facility.

Table 3.2 Availability of client comfort amenities and infrastructure components					
Percentage of facilities with the indicated client comfort and infrastructure components, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities with:				Number of facilities (weighted)
	All client comfort amenities ¹	Regular water supply ²	Regular electricity or generator ³	All basic client amenities, regular electric and water supply	
Type of facility					
GS hospital	70	87	84	50	65
Fever hospital	79	95	100	73	14
MCH/urban HU	85	95	95	81	97
Rural HU	54	89	84	42	319
Mobile unit	5	64	90	5	55
Health office	64	90	93	64	33
NGO facility	90	95	97	85	76
Region					
Urban Governorates	79	90	94	76	73
Lower Egypt	60	88	85	46	322
Upper Egypt	58	88	91	52	264
Total	61	88	88	52	659

¹ Functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness

² Year-round water supplied in facility by tap or available within 500 meters of facility

³ Twenty-four-hour regular electricity or a backup generator with fuel

Eighty-eight percent (86 percent in 2002) of facilities have a regular (onsite and nonseasonal) supply of water. Almost all facilities (90 percent) have piped water (data not shown). There is not a large variation in availability of onsite water by season, except for mobile units, where only 64 percent reported year-round water supplied in facility by tap or available within 500 meters of facility (Table 3.2).

Eleven percent of rural HUs, 10 percent of health offices, and 36 percent of mobile units have no regular water supply. No geographical differences were found in the proportion of facilities without a routine water supply.

Eighty-eight percent of facilities have a regular supply of electricity or a backup generator with fuel (Table 3.2).

Among all facilities, only 52 percent have all client amenities and a regular supply of water and electricity, with all items more often found in Urban Governorates (Table 3.2). Availability of all of these basic elements to support services and utilization ranges from 81 percent of MCH/urban HUs to only 5 percent of the mobile units, with the item missing varying by type of facility (Appendix Table A-3.3). This is similar to findings in 2002, when 52 percent of facilities had all these infrastructure and client amenities.

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

It is not expected that all levels of health facilities will provide 24-hour emergency services, but because 24-hour care is essential for managing serious illness and potentially decreasing mortality, it is important to know about the availability of emergency services.¹ For the ESPA 2004, 24-hour emergency services refers to a facility offering emergency onsite treatment, with the capacity to monitor a seriously ill client overnight, until it is possible to refer the client to an inpatient setting if necessary. The ESPA 2004 defined components believed to contribute to a service delivery environment that supports routine availability of 24-hour emergency services and a reasonable quality of service if a seriously ill client must remain overnight

Table 3.3 provides aggregate information for all of the items defined as supporting 24-hour emergency services, by type of facility and region. Figure 3.2 presents information on the availability of individual items for the facilities where 24-hour services might commonly be expected. Appendix Tables A-3.3 and A-3.4 provide details on the assessed items by type of facility and region.

¹ Mobile units and health offices are not eligible to provide 24-hour services and are excluded from this analysis.

Table 3.3 Service and facility infrastructure to support quality 24-hour emergency services			
Percentage of facilities with basic components to support 24-hour emergency services, and basic components to support 24-hour emergency services plus regular water and electricity, by type of facility and region, Egypt SPA 2004			
Background characteristics	Percentage of facilities with:		Number of facilities (weighted) ³
	Basic components to support 24-hour emergency services ¹	Basic components to support 24-hour emergency services plus regular water and electricity ²	
Type of facility³			
GS hospital	52	40	65
Fever hospital	89	84	14
MCH/urban HU	7	7	97
Rural HU	2	1	319
NGO facility	2	2	76
Region			
Urban Governorates	20	18	53
Lower Egypt	11	9	285
Upper Egypt	8	7	233
Total	11	9	571
¹ At least two qualified physicians assigned to facility, duty schedule was observed indicating staff are on site or on call 24 hours a day, availability of overnight beds, a patient latrine, 24-hour emergency communication, and an on-site water source at least sometimes during the year. ² Availability of all basic components to support quality 24-hour emergency services, as well as a year-round on-site water source and a regular source of electricity or backup generator ³ Mobile units (weighted N=55) and health offices (weighted N=33) are not eligible for 24-hour services, and so are excluded from the analysis.			

Overall, 11 percent of facilities have all assessed components for 24-hour emergency services in 2004, compared with 12 percent in 2002.

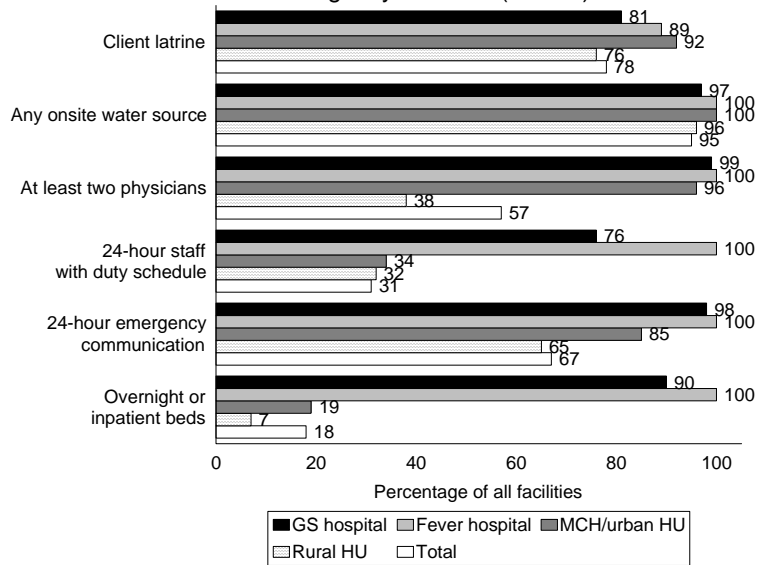
Fifty-two percent of GS hospitals, 89 percent of fever hospitals, and almost no MCH/urban HUs, rural HUs or NGO facilities have all of the defined infrastructure components to support quality 24-hour emergency services (Table 3.3).

The ESPA 2004 defined 24-hour duty staff availability as the facility having some form of observed duty schedule or roster that indicated that staff members were officially on duty or on call. Twenty-four hour staff with a written duty schedule most commonly found in GS and fever hospitals² (76 and 100 percent, respectively) (Appendix Table A-3.3 and Figure 3.2).

It is common for rural HUs to have only one physician, often someone who lives on the premises, with the assumption that this physician is available to provide 24-hour emergency care and that arrangements are made with district officials for another physician to be assigned only if there is a plan for the physician to be away for an extended period of time. Among the rural HUs, 56 percent report that the physician lives on the premises, and 27 percent of physicians living onsite have no duty schedule. With this situation, it is uncertain whether arrangements are routinely made for emergency staff availability if the physician is out of the area for a day or an evening.

² An additional 13 percent of facilities reported that they had 24-hour duty coverage but could not show a schedule.

Figure 3.2 Availability of items to support quality 24-hour emergency services (N=659)



Egypt SPA 2004

More than 95 percent of the GS hospitals, fever hospitals, and MCH/urban HUs have at least two physicians assigned (Figure 3.2). A review of the availability of overnight beds, however, shows that essentially only the GS and fever hospitals are equipped to provide overnight emergency care (Appendix Table A-3.3). Almost all facilities have 24-hour emergency communication.

There are notable regional differences in the availability of staff and furnishings, with facilities in Urban Governorates consistently having greater availability of resources for supporting 24-hour emergency services (18 percent), compared with facilities located in Lower or Upper Egypt (9 and 7 percent, respectively) (Table 3.3).

A nonseasonal onsite source of water and a regular supply of electricity (24-hour electricity with minimum interruption, or a generator with fuel available) are not considered essential but are preferable for providing 24-hour emergency services. Similar to 2002, the proportion of facilities with all elements for providing 24-hour emergency services is 9 percent (Table 3.3) (11 percent in 2002), ranging from 84 percent of fever hospitals to 1 percent of rural HUs.

Key Findings

Basic services

A full package of maternal, child, and reproductive health services is available at a minimum frequency in 41 percent of all health facilities. This package is most commonly found in MCH/urban HUs and rural HUs (73 and 53 percent, respectively). This is a noticeable improvement from 2002.

A full package of maternal, child, and reproductive health services, available at a minimum frequency, and with 24-hour, facility-based delivery services is available at 14 percent of all facilities, including 42 percent of MCH/urban HUs, 13 percent of rural HUs, and 15 percent of GS hospitals. The situation during the last two years has improved in MCH/urban HUs.

Facility-based, 24-hour delivery services are less available in 2004 (23 percent) than in 2002 (32 percent).

Virtually all facilities have at least one physician assigned.

Infrastructure and emergency services

Infrastructure support (client comfort amenities, water, and electricity) are regularly available for 52 percent of facilities, including 50 percent of GS hospitals, 73 percent of fever hospitals, 81 percent of MCH/urban HUs, and 85 percent of NGO facilities.

Almost all facilities have an onsite water source (95 percent), with 88 percent indicating that the water is available year-round.

A majority of facilities (88 percent) have a regular supply of electricity, and about a third of the GS hospitals and approximately half of all fever hospitals have a backup generator as well. A regular supply of electricity is less common in 2004 than in 2002 for GS hospitals (84 percent) and health offices (93 percent), but more common in mobile units (90 percent in 2004).

Hospitals are the primary site where 24-hour emergency service infrastructure support is available, with 52 percent of GS hospitals and 89 percent of fever hospitals having all assessed components. These percentages in GS hospitals have decreased since 2002.

Nationally, a larger proportion of facilities located in the Urban Governorates (20 percent) have all of the components to support 24-hour emergency services, as compared with facilities located in Lower or Upper Egypt (11 and 8 percent, respectively).

3.2 Management Systems to Support and Maintain Quality and Appropriate Utilization of Health Services

Basic management and administrative systems are required to ensure that health services can be consistently provided as planned with an acceptable level of quality.

3.2.1 Management, Quality Assurance, and Referral Systems

Information on the availability of functioning systems for each of the assessed components is shown in Table 3.4. Further information on the components is shown in Figures 3.3 through 3.6 and Appendix Tables A-3.5 and A-3.6.

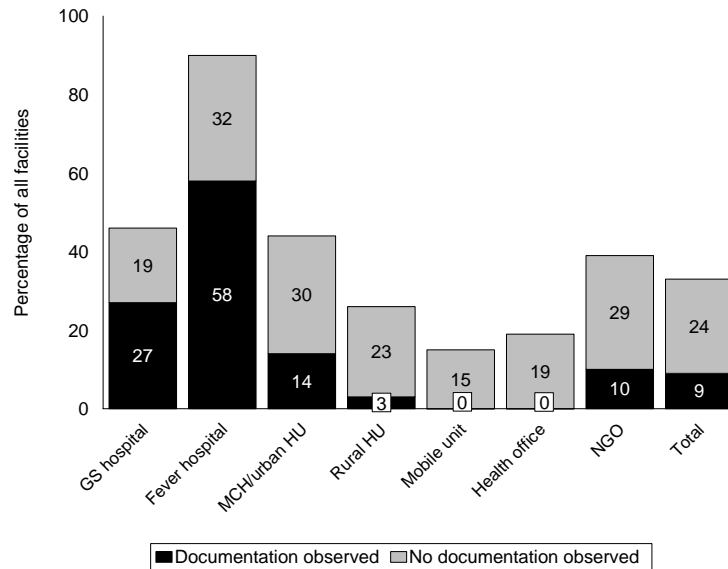
Management

For a well-functioning health facility, a systematic and routine method for addressing management issues is essential. The ESPA 2004 looked for some evidence of functioning management committee meetings—defined as meetings that address facility-level management issues—that are held at least every six months and where there is some official record of proceedings in the form of written notes or records from meetings.

Table 3.4 Management, quality assurance, and referral systems				
Percentage of facilities with documentation of the indicated management system element, by type of facility and region, Egypt SPA 2004				
Background characteristics	Percentage of facilities with:			Number of facilities (weighted)
	Management committee meetings at least every six months and observed documentation of a recent meeting	Facility reports quality assurance activities and documentation observed	Referral form observed ¹	
Type of facility				
GS hospital	27	7	54	65
Fever hospital	58	5	68	14
MCH/urban HU	14	12	60	97
Rural HU	3	9	36	319
Mobile unit	0	1	2	55
Health office	0	10	17	33
NGO facility	10	10	3	76
Region				
Urban Governorates	20	10	35	73
Lower Egypt	7	12	37	322
Upper Egypt	8	5	30	264
Total	9	9	34	659

¹ If the facility was the referral site, it was classified as having a referral form observed.

Figure 3.3 Facilities reporting routine management committee meetings (N=659)



Egypt SPA 2004

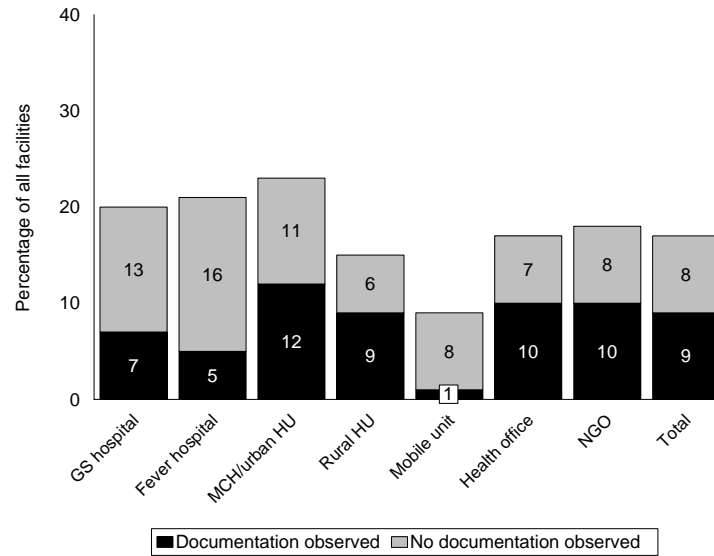
When asked about the frequency of management committee meetings, 33 percent of facilities report having a committee that meets at least every six months (Figure 3.3), with a third of the facilities reporting that they meet monthly or more often (Appendix Table A-3.5). A record of meetings, where decisions are documented and followup on issues that are discussed can be monitored, is considered an indicator of a functioning committee. Only 9 percent of facilities both meet at least every six months and have any minutes or other documentation of meetings available for observation (Figure 3.3 and Table 3.4). GS hospitals, fever hospitals, and MCH/urban HUs are most likely to have documentation of meetings. All assessed management items are reported less often in 2004, when compared with 2002. In 2002, 51 percent had management committees that met at least every six months, and 13 percent both met at least every six months and had documentation of the meetings.

Quality Assurance

Quality assurance (QA) refers to a system for monitoring quality of care, identifying problems, and instituting changes that resolve the problems. QA activities may be a part of basic supervisory systems, but they go beyond supervision. There are various valid approaches for implementing QA. At a minimum, QA requires that there be standards against which services (and systems) are compared to identify quality issues.

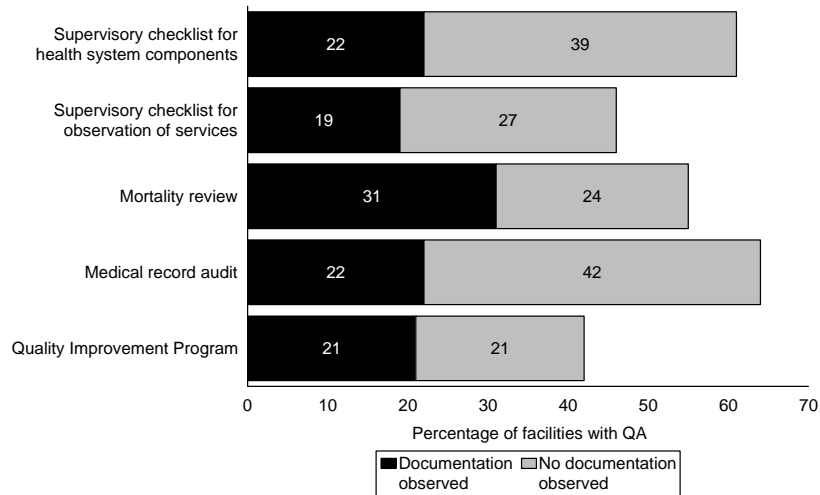
Although 17 percent of facilities indicate that they carried out QA activities, only 9 percent of facilities have any documentation of the QA tools that are used (Figure 3.4). This is lower than findings in 2002, where documentation of QA activities was found at 15 percent of facilities. QA with documentation is most often found in MCH/urban HUs, health offices, and NGO facilities. Documentation of QA activities is found less frequently in facilities in Upper Egypt (5 percent) (Table 3.4). Among the facilities reporting QA activities, 75 percent report that the QA system is facility-wide, and 25 percent indicate that it is implemented for specific services only (data not shown).

Figure 3.4 Facilities reporting quality assurance activities (N=659)



Egypt SPA 2004

Figure 3.5 Reported quality assurance activities (N=111)



Egypt SPA 2004

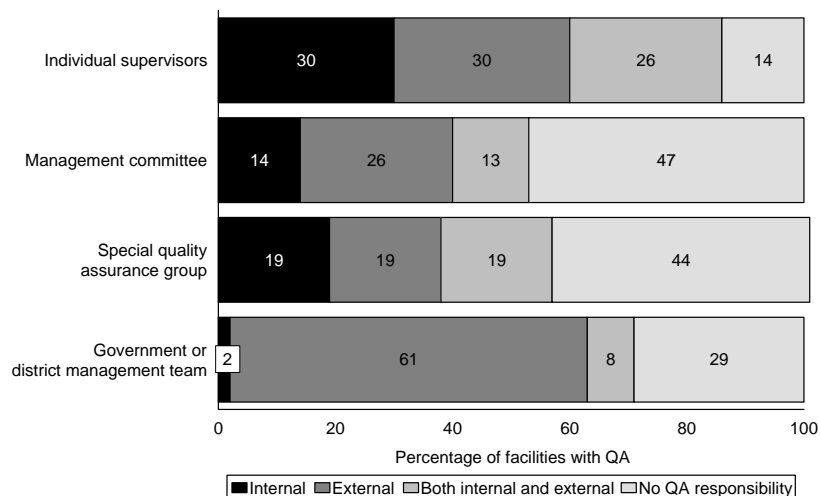
Among facilities implementing QA activities, there are a variety of approaches, with supervisory checklists and medical record audits the most commonly reported activities (Figure 3.5). When asked who is responsible for QA activities, there are also a variety of approaches, with the majority of facilities reporting that QA activities are conducted by district-level persons external to the facility, or both by external and internal persons (Figure 3.6).

Referral Systems

Clients who are referred to other facilities without any formal documentation risk being refused services or having services delayed if the referral facility must assess them as totally new clients. Thus, systematic means to support clients needing services from a higher-level facility in receiving these services is an important aspect of quality of care. If clients are confident that, if needed, they will be assisted in gaining access to higher-level facilities, they may be less likely to bypass lower-level facilities for their health needs. The ESPA 2004 collected information on whether any official, printed form, which at minimum documents the reason for referral and any treatment already provided, is used for referrals. Thirty-four percent of facilities either have an observed referral form or are the referral facility (Table 3.4).³ These include 54 percent of the GS hospitals, 68 percent of fever hospitals, and 60 percent of MCH/urban HUs. Referral facilities or referral forms are more often found in facilities in Lower Egypt (37 percent) than in Upper Egypt (30 percent).

In general, written referral forms were more available in 2004 (34 percent of facilities) than in 2002 (29 percent of facilities).

Figure 3.6 Person(s) or group(s) responsible for implementation and/or review of QA activities, by whether they are internal or external to the facility (N=111)



Egypt SPA 2004

3.2.2 Supportive Management for Providers

The ESPA 2004 collects information to assess the extent to which facilities have supervisory and staff development activities important for supporting quality care.

³ An additional 5 percent of facilities report using a printed referral form but were unable to show the form on the day of the survey (data not shown).

Summary information on supportive management practices at the facility level is provided in Table 3.5, with further details in Appendix Table A-3.7. Details on supervision and in-service training from the perspective of the health service provider are provided in Appendix Table A-3.8.⁴

External Supervision

Supervision from external managers provides an opportunity to ensure that system-wide standards, guidelines, and protocols are followed at the facility level and to promote an “organizational culture” wherein it is expected that these standards and guidelines/protocols will be implemented. It also provides an opportunity to expose staff to a wider scope of ideas and relevant experiences. A facility reporting at least one visit by external supervisors during the past six months is defined as having routine external supervision. Overall, 96 percent of facilities had received external supervision (a supervisory visit from authorities external to the facility) during the past six months (Table 3.5). Activities of the supervisors included checking official registers or records (96 percent), discussing problems (82 percent), and discussing policy issues and/or technical matters (over 65 percent) (data not shown). Seventy-five percent of the facilities said that an external supervisor had observed services being provided, an important means of supporting quality of care.

Findings for 2002 and 2004 are similar, with notable changes being fewer facilities reporting that the supervisors observed service provision (75 percent in 2004 versus 81 percent in 2002).

Supervision of Health Service Providers

In addition to general supervision of facility activities, the work of individual staff must be assessed so that each person’s strengths and weaknesses can be identified and appropriate support can be provided. If at least half of the interviewed health service providers in a facility have been personally supervised at least once during the past six months, the facility is defined as providing routine staff supervision. Findings regarding staff supervision are similar for 2002 and 2004.

Similar to findings in 2002, at least half of the interviewed health service providers were personally supervised during the past six months (Table 3.5) in 90 percent of facilities. Facility-level supervision practices vary by type of facility and by geographic region. Facility-level supervision was weaker for facilities in the Urban Governorates than for those in Lower and Upper Egypt. This may be due to a different mix of facilities: urban areas have a higher proportion of NGO facilities, with these types of facilities having the lowest percentage of regular supervision reported.

In-service Training

To maintain levels of knowledge and technical competence achieved during basic training, it is essential that health service providers be provided continuous exposure to current and new information. It is recognized that health service providers may receive new information and individual instruction related to their work during routine supervisory visits. The ESPA 2004, however, assessed specifically whether the health service provider had received any formal in-service training on topics related to the service offered. If at least half of the interviewed health service providers at a facility have received any in-service training relevant to their service during the past 12 months, the facility is defined as having routine staff development activities. Unlike the almost universal experience of supervision, at least half of the interviewed providers had received in-service training related to their service during the past 12 months in only 22 percent of facilities, with fewer hospitals and MCH/urban HUs having the lowest level of routine

⁴ Information on in-service topics and staff supervision related to a particular service is presented in the report section for each specific service assessed.

in-service training (10 and 12 percent, respectively) (Table 3.5). Routine in-service training has declined from levels seen in 2002 (28 percent), with the decline most noted in MCH/urban HUs and NGO facilities.

Compared with 2002, fewer facilities have all elements defined as routine supportive management practices (the facility has received external supervision during the past six months, and routine supervision and in-service training were found) (19 percent in 2004 versus 25 percent in 2002). Findings of all elements of routine supportive management varied from 38 percent of mobile units to 8 percent of MCH/urban HUs (Table 3.5).

Table 3.5 Supportive management practices at the facility level						
Percentage of facilities that had an external supervisory visit during the past 6 months; percentage where at least half of the interviewed health service providers received the indicated management support, by type of facility and region, Egypt SPA 2004						
Background characteristics	Percentage of facilities with external supervisory visit during the past 6 months	Percentage of facilities where at least half of the interviewed service providers:			Percentage of facilities with all supportive management practices ²	Number of facilities with at least 1 eligible health service provider (weighted) ³
		Received in-service training during past 12 months ¹	Were personally supervised during past 6 months	Were both personally supervised past 6 months and received in-service training past 12 months		
Type of facility						
GS hospital	99	18	97	17	17	65
Fever hospital	100	10	58	10	10	14
MCH/urban HU	98	12	93	8	8	97
Rural HU	99	24	98	22	22	319
Mobile Unit	94	48	88	39	38	55
Health Office	100	14	97	13	13	33
NGO facility	81	17	52	11	11	76
Region						
Urban Governorates	94	26	79	23	23	73
Lower Egypt	98	21	92	18	18	322
Upper Egypt	94	22	92	20	19	264
Total	96	22	90	19	19	659

¹ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

² Facility received external supervision within the past 6 months; at least half of all interviewed health service providers both received in-service training relevant to the services they provided during the past 12 months and were personally supervised during the past 6 months.

³ Interviewed providers who did not personally provide one of the services assessed by the ESPA 2004 (i.e., administrators who might have been interviewed) are excluded.

3.2.3 Management Practices Supporting Community Involvement

It is generally accepted that encouraging community input into aspects of facility functions increases the accountability of the facility to the community it serves and its understanding of the needs of the community, with the expected result being increased appropriate utilization of the facility and subsequent improved health within the population.

Community Representation

Community involvement through routine participation in meetings or activities in 2004 dropped by about half compared with 2002 (22 percent in 2004 compared with 39 percent in 2002), with the most significant decrease occurring among rural HUs (18 percent in 2004 and 41 percent in 2002) and health offices (2 percent in 2004 versus 20 percent in 2002) and in Lower Egypt (22 percent in 2004 versus 44 percent in 2002) (Table 3.6).

Table 3.6 Management practices supporting community feedback and access to facility				
Percentage of facilities that have routine community participation in management meetings, percentage having a system of acquiring client opinion and feedback, and percentage with either mechanism for obtaining community input, by type of facility and region, Egypt SPA 2004				
Background characteristics	Percentage of facilities:			Number of facilities (weighted)
	Where community participation in some management meetings is routine	Where client opinion is elicited and a system for review implemented ¹	That have any mechanism for obtaining community input for services ²	
Type of facility				
GS hospital	48	2	48	65
Fever hospital	62	0	63	14
MCH/urban HU	42	0	42	97
Rural HU	18	3	19	319
Mobile unit	4	0	4	55
Health office	2	0	2	33
NGO facility	10	4	10	76
Region				
Urban Governorates	38	4	38	73
Lower Egypt	22	3	23	322
Upper Egypt	19	0	19	264
Total	22	2	23	659

¹ Some mechanism for eliciting client opinion is reported, and there is documentation indicating that client opinions are reviewed.

² Either community representation at management meetings or a system for eliciting client opinion is in place.

Client Feedback

In 2004 there is a slight increase in facilities reporting they have systems to elicit client feedback (33 percent in 2004 versus 28 percent in 2002) (data not shown); however, a systematic means for reviewing client feedback is rare, found in only 2 percent of facilities in 2004 (Table 3.6) and 3 percent in 2002. Methods for eliciting client opinion include suggestion boxes (16 percent), client survey forms (16 percent, an increase from 11 percent in 2002), and some form (either structured or informal) of client interviews (76 percent) (data not shown).

3.2.4 Funding Mechanisms That Decrease Financial Barriers to Utilization of Health Services

User fees may either have a positive effect on utilization of health facilities (augmenting funds to improve services) or a negative effect (deterring poor clients from using services). User fees with exemption

schemes for vulnerable people often help to augment inadequate facility budgets and, when used to supplement provider salaries, may decrease under-the-table payments that may be expected when health service providers are not paid adequately. However, providing exemptions or discounts for poor clients can result in budget shortages if there is no system for reimbursing these exempted or discounted costs. Other methods that encourage appropriate utilization by poor clients but that also reimburse facilities for client services include insurance plans, credit plans (delayed payment for services received), and charity or equity funds that reimburse the costs of particular subsets of clients to increase their access to care through decreasing their out-of-pocket payments at the time of service utilization.

There are several user fee systems commonly implemented in public and NGO facilities that use a two-tiered approach. One common practice is to provide services either at different times of the day or in different areas of the facility, with one section (or time of day) considered “free” and one section (or time of day) considered “economic.” Clients attending the economic section may pay more out-of-pocket costs (often based on the service provided), but there may be better client amenities, including shorter waiting times. Clients who receive services through the economic section must pay for medicines and tests, while clients who receive free services often pay a small registration fee but no other out-of-pocket costs for services, medicines, or laboratory tests (if they are available at the facility). Access to free section services depends on the economic status of the client.

In Egypt, health insurance may be provided through an employer, or it may be purchased independently. Those people belonging to health insurance plans have specific facilities where they receive services. Any services they receive through the general public sector are not covered by the insurance plan; thus, this is not a source of reimbursement for public sector facilities.

Facility practices regarding user fees and discounting fees are summarized in Table 3.7. Details on types of fee systems utilized are given in Appendix Table A-3.9; items for which user fees are charged in the economic and free sections of facilities are shown in Appendix Table A-3.10; and reported sources of reimbursement for clients with discounted or exempted user fees are available in Appendix Table A-3.11.⁵

⁵ Additional information is presented in subsequent chapters on clients’ out-of-pocket payment for services received and clients’ participation in any health insurance program that might decrease or defer out-of-pocket expenses at the time of service.

Table 3.7 Funding mechanisms utilized in the facilities

Percentage of facilities with routine user fees for curative care, and with both a routine user fee and an external source of reimbursement scheme for clients, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with any routine user fee for curative care for:		Number of facilities offering curative care for children	Percentage of facilities that have both user fees and some external source of reimbursement for clients ¹	Number of facilities (weighted)
	Adults	Children			
Type of facility					
GS hospital	65	37	64	45	65
Fever hospital	68	53	14	42	14
MCH/urban HU	62	27	96	22	97
Rural HU	32	25	316	34	319
Mobile unit	35	16	21	1	55
Health office	23	44	6	0	33
NGO facility	95	92	36	29	76
Region					
Urban Governorates	80	56	54	30	73
Lower Egypt	48	25	273	20	322
Upper Egypt	38	34	225	38	264
Total	48	32	552	28	659

¹ Source of reimbursement is in lieu of out-of-pocket payments by clients and may be from insurance systems, reimbursement from external charities, or other sources of funds (e.g., charities, NGOs) for poor clients.

Practices Related to User Fees

User fees for adult curative services are implemented by almost half of health facilities and by one-third of facilities for the child curative services. The fees are almost universal in NGO facilities for both adult (95 percent) and child (92 percent) curative health services. Health offices are the least likely to report user fees for adult curative care (23 percent), and mobile units are least likely to report fees for child curative care (16 percent) (Table 3.7).

Twenty-eight percent of facilities report that they have user fees but also receive reimbursements for client fees, in lieu of out-of-pocket payments by clients. Systems for reimbursement for client fees are reported more often from facilities in Upper Egypt and Urban Governorates than from facilities in Lower Egypt (Table 3.7), with the most frequently cited source being Health Insurance Organization/Student Health Insurance Program (Appendix Table A-3.11).

Findings on implementation of user fees are substantially different from those in 2002, where 92 percent of facilities reported user fees for adult curative services and 93 percent for children. The question that was asked during both surveys was “Does this facility routinely charge for adult outpatient curative consultation services?” It seems most likely that there was a different understanding of the question when posed in 2002 than in 2004, rather than a major shift in practices at facilities over the two years. Further investigation is required to ascertain which findings best reflect the actual situation.

3.2.5 Maintenance and Repair of Equipment

To provide quality services, a facility must have the means for ensuring that facility equipment and infrastructure are maintained in functioning condition. Some machinery should routinely receive preventive maintenance. Some equipment may require minor repairs or replacement, and buildings and infrastructure require routine maintenance and periodic repair.

Summary information on systems for maintenance and repair or replacement for large and small equipment is provided in Table 3.8. Detailed information on the systems used and people responsible for maintaining equipment in facilities is provided in Appendix Tables A-3.12 and A-3.13; details on systems for building infrastructure maintenance are provided in Appendix Table A-3.14.

An assessment of the actual presence and functioning condition of essential equipment for individual service areas is given in the report section for each specific service assessed. This information provides an indication of the effectiveness of the maintenance and repair systems.

Thirty-one percent of facilities report preventive maintenance programs for major equipment, such as generators or sterilizers (Table 3.8). These systems are most common in hospitals (40 percent for GS hospitals and 37 percent for fever hospitals) and mobile units (78 percent).

Eighty-four percent of all facilities have systems for maintenance and repair of small equipment (such as stethoscopes or sphygmomanometers). Sixty percent of facilities have a system for building maintenance and repair (Table 3.8).

Findings for equipment maintenance and repair are quite similar for 2002 and 2004.

Table 3.8 Facility systems for maintenance and repair of equipment and infrastructure				
Percentage of facilities that have a preventive maintenance program for major equipment, percentage that have a system for repairing or replacing small equipment, and percentage that have a system for maintenance and repair of the building or infrastructure, by type of facility and region, Egypt SPA 2004				
Background characteristics	Percentage of facilities with:			Number of facilities (weighted)
	Preventative maintenance program for major equipment ¹	System for repair or replacement of small equipment ²	System for maintenance and repair of building or infrastructure	
Type of facility				
GS hospital	40	97	71	65
Fever hospital	37	100	84	14
MCH/urban HU	28	89	72	97
Rural HU	25	77	48	319
Mobile unit	78	95	82	55
Health office	28	86	50	33
NGO facility	17	88	73	76
Region				
Urban Governorates	41	91	88	73
Lower Egypt	31	85	67	322
Upper Egypt	27	82	44	264
Total	31	84	60	659
¹ Equipment such as a generator or sterilizer				
² Equipment such as stethoscopes or sphygmomanometers				

Key Findings

Around one-third of facilities hold routine management meetings; however, less than 10 percent have documentation of recent meetings.

QA activities have been introduced into 17 percent of facilities, with MCH/urban HUs, health offices, and NGO facilities more likely to have documentation of tools used for such activities.

Supervision is strong; more than half of all interviewed service providers were personally supervised during the past six months in nine of ten facilities. A notable weakness was seen in NGO facilities, where only half of them received routine supervision. Almost all facilities received external supervision during the six months preceding the survey.

Formal in-service training of the provider is less routinely provided, with at least half of all providers in only one in five facilities receiving related in-service training during the past 12 months. Of those, fewer hospitals and MCH/urban HUs have the lowest level of in-service training.

Systems for eliciting community input for facility activities are not widespread. While 22 percent of facilities have routine community participation on some management committee, only 2 percent have any formal means for seeking client feedback.

Thirty percent of facilities have preventive maintenance programs for major equipment, except mobile units, where around 80 percent have programs. Only 61 percent of facilities have sources of funding for repair and maintenance of small equipment.

3.3 Logistics Systems for Vaccines, Contraceptives, and Medicines (Pharmaceutical Commodities)

To ensure that necessary pharmaceutical commodities are available for daily use, the commodities must be stored under conditions that protect them from damage, monitoring systems must minimize wastage resulting from commodity expiration, and systems must exist to monitor stockage and to ensure timely ordering and resupply of the needed amount of commodities.

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

Information on storage conditions and stock monitoring for vaccines is presented in Table 3.9, and information for contraceptive methods and medicines is shown in Table 3.10. Details for each element assessed for monitoring the cold chain for vaccine storage are shown in Figure 3.8, and details for the vaccine stock monitoring systems are shown in Figure 3.9. Similar information on storage conditions and stock monitoring systems for contraceptive methods and for medicines is provided in Figures 3.10 and 3.11, respectively. Further details on storage conditions are provided in Appendix Tables A-3.15 and A-3.16, and details on commodity ordering systems are given in Appendix Tables A-3.17 through A-3.21.

Facilities often do not update their inventory daily but rather maintain a daily register of distributed items. They then tally the distributed items and update the inventory later, often monthly. Information on the inventory system used for each commodity type is presented in Figure 3.7. If the official inventory record is not up to date, but there is a register where the current inventory can be quickly calculated (and this tallies with the actual commodity stock), the facility is defined as having an up-to-date inventory.

Between 61 and 84 percent of facilities use daily distribution registers and only update inventory records periodically (as opposed to daily) for vaccines, contraceptives, and medicines.

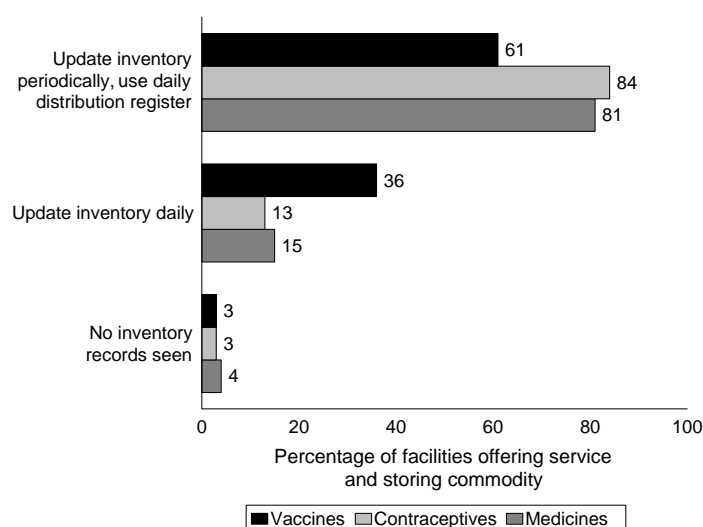
Table 3.9 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with adequate storage temperature and stock monitoring systems in place, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:			Number of facilities with stored vaccines observed (weighted)
	Adequate system for monitoring storage temperature ¹	Number of facilities with stored vaccines (weighted)	Adequate system for monitoring stock ²	
Type of facility				
GS hospital	72	24	56	24
MCH/urban HU	86	89	65	88
Rural HU	85	232	50	217
Health office	92	31	45	31
NGO facility	6	8	64	8
Region				
Urban Governorates	95	34	70	34
Lower Egypt	88	196	54	182
Upper Egypt	75	154	51	152
Total	83	383	54	367

Note: Fever hospitals and mobile units do not store vaccines.
¹ Functioning thermometer in refrigerator, temperature chart up to date, and refrigerator temperature 0° to 8°C at time of survey
² No expired items present, items stored by expiration date, and up-to-date inventory available

Figure 3.7 Inventory system used for stored commodities: vaccines (N=383), contraceptives (N=636), medicines (N=498)



Note: Twenty-two percent of facilities (N=147) had no pharmacy and medicines, and pharmacy practices were not assessed at 14 facilities because access to the facilities was not possible on the day of the survey.

Egypt SPA 2004

3.3.1 Storage and Stock Monitoring Systems for Vaccines

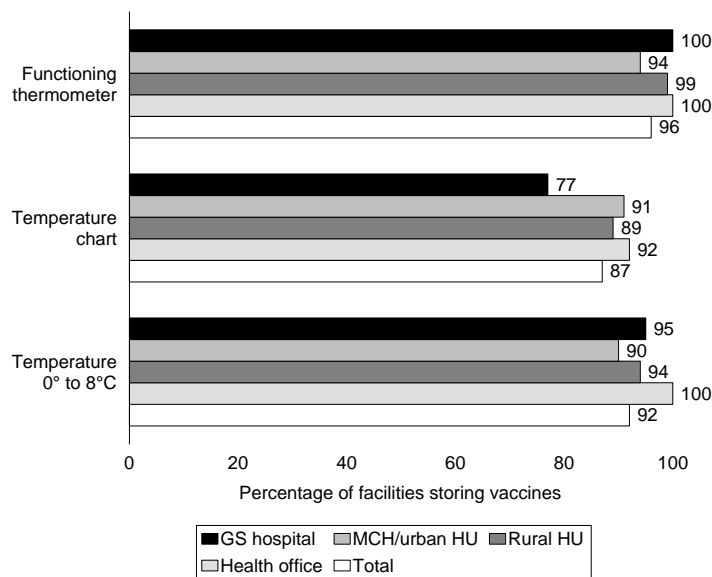
Vaccines must be stored at an appropriate temperature to maintain potency. WHO and UNICEF policy is to monitor the temperature of a refrigerator (or cold box) at a minimum of twice daily and to record the

temperature on a graph as proof of monitoring (WHO, 1998). For evidence of adequate storage conditions, facilities were assessed for 1) presence of a functioning thermometer in the refrigerator, 2) a temperature of 0° to 8°C⁶ at the time of the survey, and 3) a completed temperature graph (completed twice a day) for the past 30 days.

Storage Conditions

Among facilities that store vaccines,⁷ 83 percent have all components for adequate monitoring of the storage temperature (Table 3.9). This is an improvement over the 76 percent observed in 2002. NGO facilities have the weakest systems, with only 6 percent reporting that they have all items for monitoring the storage temperature for vaccines. Details for each element for monitoring the storage temperature are shown in Figure 3.8. Almost all facilities (95 percent) place the vaccine refrigerator so that it is protected from sunlight (Appendix Table A-3.15).

Figure 3.8 Elements for monitoring vaccine storage conditions (N=383)



Egypt SPA 2004

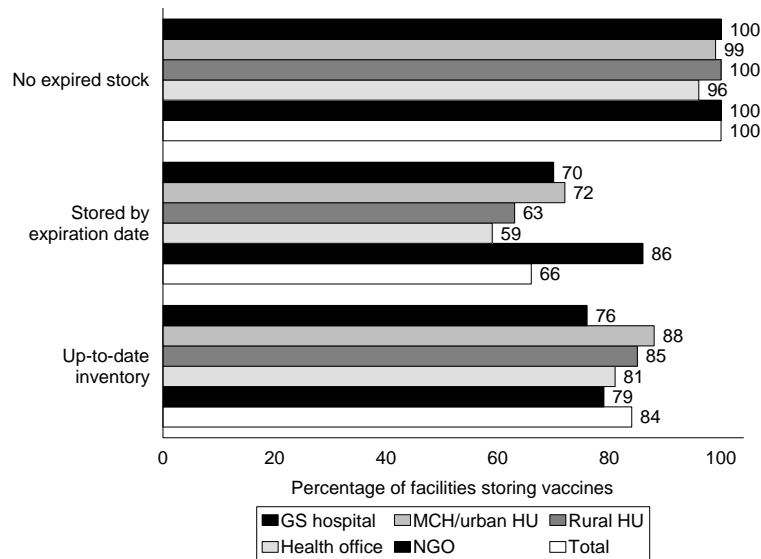
Stock Monitoring Systems

Vaccine stock monitoring systems were assessed for tetanus toxoid, diphtheria-pertussis-tetanus (DPT), measles, hepatitis B (HB), hepatitis-DPT (hep-DTP), and measles-mumps-rubella (MMR) vaccines. Less than 1 percent of facilities have expired vaccines present (Figure 3.9). The practices of storing vaccines by expiration date and maintaining an up-to-date inventory are not systematically utilized across facilities, with 66 percent of facilities storing by expiration date and 84 percent having an up-to-date inventory.

⁶ This is the UNICEF recommendation for vaccine storage at the health center level.

⁷ No fever hospitals or mobile units store vaccines.

Figure 3.9 Elements for monitoring vaccine stock (N=367)



Egypt SPA 2004

The MCH/urban HUs and NGO facilities are more consistent than other types of facilities in maintaining the vaccine management systems (Table 3.9). Two-thirds of the NGO facilities storing vaccines also have all elements for quality monitoring of vaccine stock (Appendix Table A-3.16), although they do not monitor the storage temperature for safe vaccine storage conditions (Appendix Table A-3.15). Stock monitoring systems are weakest in Upper Egypt and strongest for facilities in Urban Governorates (Appendix Table A-3.9).

Since 2002 vaccine stock monitoring has slightly improved, with 54 percent of facilities that store vaccines meeting all conditions for quality monitoring of vaccine stock in 2004, compared with 37 percent in 2002. The largest improvement is in Upper Egypt (51 percent in 2004, compared with 26 percent in 2002).

3.3.2 Storage and Stock Monitoring Systems for Contraceptive Methods and Medicines⁸

To prevent chemical deterioration and contamination, facilities must store medications and contraceptives away from sunlight, under dry conditions, and with protection from contamination by pests or rodents.

Storage Conditions

In general, storage conditions for contraceptives are adequate in 89 percent of facilities (Table 3.10 and Figure 3.10) and for medicines in 72 percent of facilities (Table 3.10 and Figure 3.11). The most common weakness is in protecting commodities from pests and rodents (Appendix Table A-3.16), with 9 percent of the facilities with observed contraceptives and 19 percent of the facilities with observed medicines having evidence of pests or rodents in the storage area. Sixteen percent of the facilities also do not ensure that medicines are off the floor and protected from water. It is not unusual to find contraceptives stored separately from medicines. Among the facilities with observed contraceptive methods, 86 percent have

⁸ Twenty-two percent of facilities had no pharmacy and medicines. In addition, pharmacy practices were not assessed in 14 facilities (2 percent) because there was no access to the pharmacy on the day of the survey.

different storage sites for contraceptive supplies and medicines. Those contraceptives stored separately are stored under somewhat better conditions than those stored with medicines, with only 7 percent having evidence of pests or rodents (compared with 23 percent of those stored with medicines) and only 1 percent not protected from the ground or water (compared with 27 percent of those stored with medicines) (data not shown).

Stock Monitoring Systems

Selected contraceptive methods (the combined oral pill, IUDs, injectables [three monthly], and the condom) and selected medicines (antibiotics and Ringers lactate intravenous solution) were assessed for stock maintenance practices. Three percent of facilities have expired contraceptive methods (Figure 3.10), and 2 percent have expired medicines (Figure 3.11). More than half of the facilities store their contraceptive methods and medicines by expiration date. Up-to-date inventories are maintained for contraceptive methods in 71 percent of facilities and for medicines in 60 percent of facilities. These findings are similar to those from 2002.

There were no consistent changes noted from 2002 to 2004 in monitoring and storage of contraceptive and medical commodities. Overall, 42 and 35 percent of facilities have all assessed components for stock monitoring of contraceptive methods and of medicines, respectively (Table 3.10). In 2002, these percentages were 36 percent for contraceptive methods and 41 percent for medicines. Facilities are consistently weaker in Upper Egypt and stronger in the Urban Governorates for all items assessed.

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

Among facilities storing medicines and clinical methods of contraception, percentage in which good storage conditions were observed and stock monitoring systems were in place, by type of facility and region, Egypt SPA 2004

Background characteristics	Contraceptive methods				Medicines			
	Percentage with all assessed items for system for storing methods ¹	Number of facilities storing contraceptive methods (weighted)	Percentage with all assessed items for system for monitoring stock ²	Number of facilities with stored contraceptive methods observed (weighted) ³	Percentage with all assessed items for system for storing medicines ¹	Number of facilities storing medicines (weighted)	Percentage with all assessed items for system for monitoring stock ²	Number of facilities with stored medicines observed (weighted) ⁴
Type of facility								
GS hospital	95	65	35	65	80	65	33	65
Fever hospital	100	0	100	1	68	14	47	14
MCH/urban HU	87	96	48	96	75	95	46	92
Rural HU	85	317	40	317	69	304	31	298
Mobile unit	95	55	51	55	53	10	19	9
Health office	100	27	41	27	100	6	63	6
NGO facility	92	66	39	66	100	3	100	2
Region								
Urban Governorates	92	67	60	67	78	38	54	38
Lower Egypt	91	311	51	311	73	256	38	249
Upper Egypt	86	249	26	249	69	201	28	198
Total	89	627	42	627	72	496	35	486

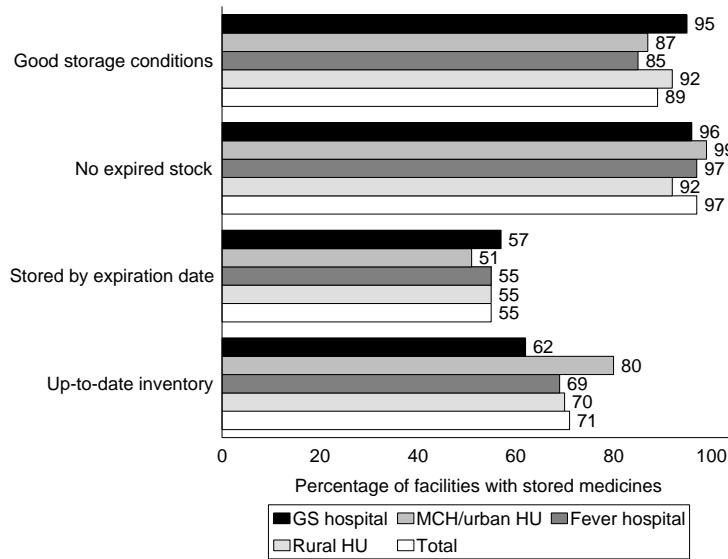
¹ Items are stored in dry location, off the ground, and protected from water, sun, pests and rodents.

² No expired items are present, items are stored by expiration date, and up-to-date inventory is available.

³ Ten facilities providing clinical methods of family planning had no observed contraceptives.

⁴ Access was not available for 14 facilities (2 percent), and 147 facilities (22 percent) had no storage of medicines.

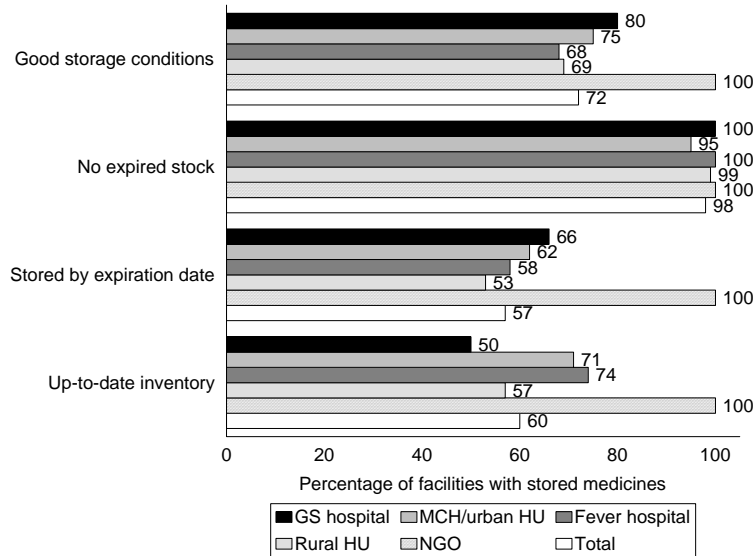
Figure 3.10 Elements for storing and monitoring stock for contraceptives (N=627)



Note: Ten facilities had no observed contraceptives.

Egypt SPA 2004

Figure 3.11 Elements for storing and monitoring stock for medicines (N=486)



Egypt SPA 2004

Key Findings

Though achieving a relatively high level (over 80 percent), problems in monitoring and maintaining a safe temperature for storing vaccines still exist in all types of facilities. NGO facilities are notable, however, in their lack of functioning thermometers in vaccine refrigerators.

Management of stock for all commodities is relatively good, with storage by expiration date and maintenance of an up-to-date inventory existing for more than half of the facilities for all three commodity categories.

3.4 Systems for Infection Control

“Universal precautions” is a term applied to infection control measures used to prevent cross-infection from blood and body fluids. The infection control measures should be utilized by all health workers who may come into contact with blood or other body fluids, under the assumption that anyone may have an infectious condition that can be transmitted through these means unless measures are in place (CDC, 1987; JHPIEGO, 2003).

Infection control was recognized by the Ministry of Health and Population (MOHP) of Egypt as a priority for a long time and, starting in 2002, MOHP developed a comprehensive infection control strategy. This strategy had only begun to be introduced in hospitals in 2004, so the effects of program interventions would not have been captured in this survey.

Summary information on capacity for processing equipment is presented in Table 3.11, and aggregate information on infection and hazardous waste control measures available in service delivery areas is presented in Table 3.12. Details on elements assessed for capacity to process equipment and items for infection control in the service delivery areas are presented in Figures 3.12 through 3.14. Further details are presented in Appendix Tables A-3.22 through A-3.25.

Table 3.11 Capacity for quality processing of equipment for sterilization or high-level disinfection					
Percentage of facilities with the indicated elements to support quality sterilization/high-level disinfection (HLD) of equipment, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities with:				Number of facilities (weighted)
	Equipment	Equipment and knowledge of process time ¹	Equipment, knowledge of process time, and automatic timer ²	Written guidelines or protocols for sterilization or HLD present	
Type of facility					
GS hospital	73	53	47	12	65
Fever hospital	21	11	11	5	14
MCH/urban HU	65	55	47	9	97
Rural HU	49	39	29	13	319
Mobile Unit	75	61	60	7	55
Health Office	11	8	8	3	33
NGO facility	55	46	32	7	76
Region					
Urban Governorates	45	41	35	15	73
Lower Egypt	52	41	31	12	322
Upper Egypt	60	47	39	7	264
Total	54	43	35	11	659

¹ Processing area has functioning equipment and power source for method and reports the correct processing time (or the equipment automatically sets the time) and processing temperature (if applicable) for at least one method. Definitions for capacity for each method assessed were functioning equipment and processing conditions of the following:

- Dry heat sterilization: temperature 160° to 169°C and processed for at least 120 minutes or temperature at least 170°C and processed for at least 60 minutes
- Autoclave: process wrapped items for at least 30 minutes, unwrapped items at least 20 minutes
- Boiling or steaming: process at least 20 minutes
- Chemical disinfection: with chlorine base or glutaraldehyde solution and soaked for at least 20 minutes.

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

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

For syringes and most examination equipment, either sterilization or high-level disinfection (HLD) procedures are sufficient to prevent the spread of infection. For killing the spores that cause illnesses such as tetanus, however, either dry heat sterilization or the autoclave system (or, less frequently used, chemical sterilization⁹) is required. These systems are necessary for processing gloves or surgical equipment that will be reused, including blades and scissors used to cut an umbilical cord.

⁹ Formaldehyde or glutaraldehyde (Cidex).

Table 3.12 Infection control and hazardous waste control

Percentage of facilities that store sterile/HLD items under adequate conditions, that have all items for infection control in service delivery areas, with an adequate disposal system for hazardous waste, and with the MOHP infection control guidelines, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage with sterile storage conditions and processing dates on sterilized items ¹	Number of facilities with stored processed items (weighted)	Percentage with all items for infection control in service delivery areas ²	Percentage with adequate waste disposal system ³	Percentage with infection control guidelines produced by MOHP in any service site ⁴	Percentage with other guidelines for disinfection and sterilization in any service area	Number of facilities (weighted)
Type of facility							
GS hospital	30	40	0	25	6	21	65
Fever hospital	25	3	0	52	5	10	14
MCH/urban HU	12	60	3	35	10	20	97
Rural HU	7	169	4	17	5	23	319
Mobile unit	0	41	12	20	0	11	55
Health office	0	5	2	24	3	15	33
NGO facility	27	52	9	24	1	19	76
Region							
Urban Governorates	27	35	5	47	1	30	73
Lower Egypt	16	161	6	17	4	19	322
Upper Egypt	7	173	3	23	7	18	264
Total	13	369	4	23	5	20	659

¹ Items are wrapped and sealed with TST (time-steam-temperature-sensitive) tape, or items are in sterile or HLD-processed container that clasps shut, and processing time is written.

² Soap and water in all areas, sharps box in all areas (except consultation for sick child), disinfecting solution and latex gloves in family planning, antenatal care, delivery, and RTI/STI service delivery areas

³ Final disposal of contaminated waste is to incinerate, bury, or remove off site, and waste is not visible or is kept under protected conditions on day of survey.

⁴ Infection control guidelines produced in 2003 by MOHP of Egypt

Depending on the size of the facility, different types of equipment may be processed using different methods or in more than one site in the facility. Information presented in this chapter refers to the primary site in the facility where equipment is processed. Information on the processing of equipment used in the family planning, RTI/STI, and delivery service areas is discussed in relevant sections.

Just slightly more than half (54 percent) of facilities had functional equipment (or chemicals for sterilization or HLD processing) for the processing method used,¹⁰ and less (43 percent) had the functional equipment and correct knowledge of the processing time (and temperature, for dry heat sterilization) for the method used. Even fewer, one in three facilities (35 percent), had the equipment, knowledge of processing time, and an automatic timer for the method used (Figure 3.12 and Table 3.11). Availability of equipment with knowledge of correct processing time and temperature and an automatic timer varied from 60 percent of mobile units to 8 percent of health offices.

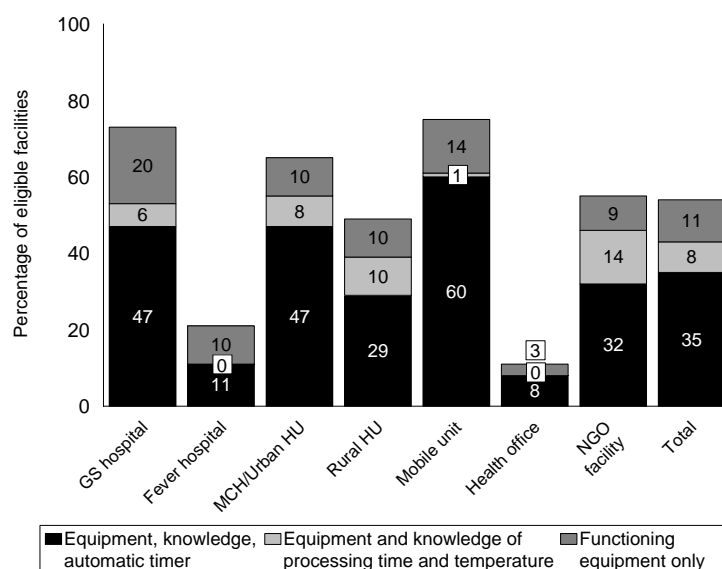
¹⁰ When comparing findings from the ESPA 2004 with those from the ESPA 2002, it should be noted that the 2002 report defined functioning equipment as present if there was capacity to use any method present, regardless of whether the facility reporting it used the method or not. The ESPA 2004 refined the definition, stating that, for the functioning equipment to be counted, the facility had to report that it used the method. The ESPA 2002 result for functioning equipment for methods used is 58 percent (compared with 78 percent for any functioning equipment), similar to the 54 percent found in the ESPA 2004 survey.

At the regional level, Upper Egypt showed a better capacity for quality processing of equipment than the Urban governorates and Lower Egypt.

The percentage of facilities with all three elements (functioning equipment, knowledge of correct processing temperature and time, and an automatic timer) is lower in 2004 (35 percent) than in 2002 (45 percent).¹¹

Written guidelines or protocols for processing equipment were found less often in the area where equipment is processed in 2004 (11 percent) (Table 3.11) than in 2002 (23 percent). When assessing the availability of infection control guidelines anywhere in a facility, the newly developed MOHP infection control guidelines were found in 5 percent of facilities, and other types of infection control guidelines were found in 20 percent of facilities (Table 3.12).

Figure 3.12 Capacity to sterilize or HLD process equipment (any process) (N=659)



Egypt SPA 2004

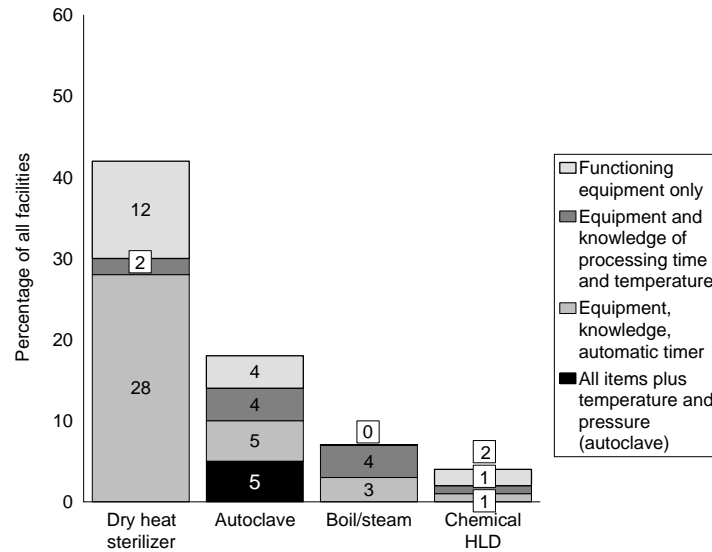
Among the various methods for processing equipment, dry heat sterilization is the most commonly used method and the one for which functioning equipment, knowledge of correct processing temperature and time, and an automatic timer are most often found (28 percent of facilities) (Figure 3.13). This is about the same as in 2002 (29 percent of facilities).

The next most common method is autoclaving, with 5 percent of facilities having a functioning autoclave and staff who could report the correct processing time, temperature, and pressure for correct utilization; an additional 9 percent of facilities had staff with knowledge of correct processing time, but not of temperature and pressure. Although knowledge of temperature and pressure utilized for autoclaves was assessed and was included in the analysis when determining the capacity to carry out autoclave procedures, responses for pressure and temperature should be interpreted cautiously. The respondents in around half of facilities using autoclaves reported that they did not know the pressure and/or the temperature required and did not have an automatic machine (Appendix Table A-3.22).

¹¹ Since the ESPA 2002 only assessed knowledge if the method was used, this is comparable information.

Few facilities (7 percent) boil or steam equipment. Among these, all knew the correct processing time, but 4 percent had no automatic timer.

Figure 3.13 Facilities with indicated elements for processing equipment using indicated method (N=659)



Note: The facility may have more than one method.

Egypt SPA 2004

3.4.2 Appropriate Storage Conditions for Processed Items

The storage conditions that must be observed to maintain sterility or HLD status are 1) storing items in a dry location; 2) either wrapping them in sterile, dry cloth or placing them in a sterile or HLD-processed box that can clasp shut; and 3) writing the date of processing on the item, because the sterile or HLD status cannot be ensured after one week unless the item is also sealed in plastic. Other common storage procedures that may be accepted in some settings (such as keeping unwrapped items in an autoclave or keeping them on a tray covered with a clean cloth) do not ensure the sterile or HLD status.

Among the 56 percent of facilities where there were any sterile or HLD items present, only 13 percent maintain their processed equipment according to the defined standard (Table 3.12). This finding is similar to that of 2002 (10 percent).

A smaller percentage of facilities were identified with stored items in 2004 (56 percent) than in 2002 (85 percent). It is possible that more facilities are using disposable equipment or that there was a difference in the types of equipment identified by data collectors. This finding requires further investigation.

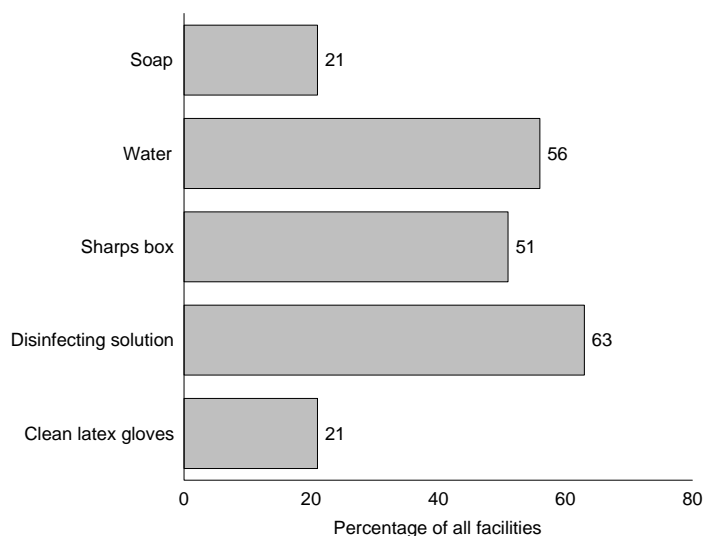
3.4.3 Infection Control in Service Delivery Area

Nosocomial infections (infections that are contracted from the health facility) are always possible and complicate caregiving for any health system. Control measures and constant vigilance are necessary to prevent infections.

All relevant infection control items are available in all assessed service delivery areas in only 4 percent of facilities (Table 3.12), about the same as found in 2002 (5 percent). There has been some improvement in the availability of soap for hand-washing, increasing from 15 percent of facilities in 2002 to 21 percent in 2004 (Figure 3.14).

The percentage of facilities with examination gloves in all required service areas decreased from 39 percent (2002) to 21 percent (2004). However, this may reflect more accurate data collection, rather than a change in availability of gloves. By definition, examination gloves must be latex (either clean or sterile) to be adequate for infection prevention. However, the ESPA 2002 questionnaire simply asked for “gloves.” Although it was clarified to data collectors that thin, nonlatex gloves were not accepted by the ESPA 2004 for infection control, it was discovered late in the training that this type of glove was almost universally available in all service areas where pelvic examinations were conducted. Therefore, for ESPA 2004, the questionnaire specified if gloves were latex or nonlatex, and more explicit emphasis was placed on the difference between latex gloves (accepted by the ESPA 2004 for infection control) and other, nonlatex gloves during the training of data collectors. Information specific to each service delivery site is presented in subsequent chapters.

Figure 3.14 Availability of specific infection control items in all assessed and relevant service delivery areas in a facility (N=659)



Egypt SPA 2004

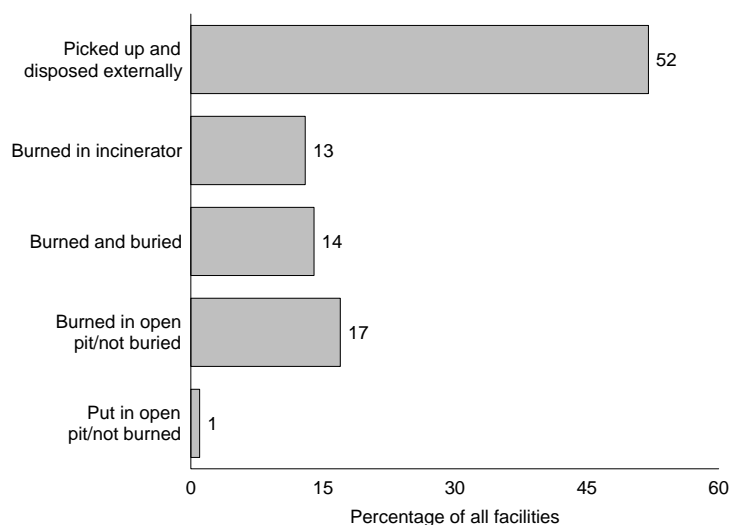
3.4.4 Adequate Disposal of Hazardous Waste

Hazardous waste includes items that may be contaminated by blood or other biological waste and may be infectious if touched (e.g., bandages, used cotton balls, needles, syringes). The most effective means for disposal is incineration and subsequent burial of the remains. Burying items in deep pits is also an effective means of disposal. When assessing whether facilities have adequate systems for disposal of hazardous waste, the most important issue is verifying that there is, in fact, a process for disposal that eliminates the possibility of contamination through contact. If the waste is visible and not protected from animals or people, either before or after being removed, burned, or buried, there is an increased chance that people might inadvertently come in contact with it, risking subsequent infection.

Details on waste disposal methods are provided in Figure 3.15 and Appendix Table A-3.25.

Data collectors were asked to determine which system each facility utilized, and then to go to the location where waste is stored until disposal or to the disposal site to assess if there was nonprocessed waste that was not protected. Only 23 percent (Table 3.12) of the facilities both have an adequate disposal system and were observed to have no unprotected contaminated waste present on the day of the survey, a statistically significant decrease in effective waste disposal conditions (30 percent in 2002).

Figure 3.15 Waste disposal methods for hazardous materials (N=659)



Note: Three percent missing/other

Egypt SPA 2004

Key Findings

While there are statistically significant decreases from 2002 to 2004 in almost all indicators related to infection control, programmatically the differences may not be important. Infection control practices remain extremely weak.

The percentage of facilities where equipment, knowledge of proper processing time and temperature, and an automatic timer are all available has decreased from 45 percent in 2002 to 35 percent in 2004.

Support for consistent adherence to quality sterilization or HLD procedures is lacking in more than two-thirds of facilities overall and in more than half of GS hospitals.

Capacity to adhere to infection control measures at all relevant service delivery areas is weak, with hand-washing soap the item most consistently missing. Only 4 percent of all facilities have all items for infection control in all assessed service delivery areas.

Only 23 percent of the facilities have adequate management for hazardous waste.

3.5 Conditions and Practices for Safe Injections

The ESPA 2004 assessed infection control measures in service areas where injections are provided, and survey staff observed procedures used when administering injections. Observers were asked to observe at least five injections being provided in the facility, with priority given to therapeutic rather than

immunization injections, and for children rather than adults. Injections for family planning purposes are assessed in Chapter 5.

Table 3.13 provides information on observed injection practices by type of injection and client age. Appendix Tables A-3.26 and A-3.27 provide details on service locations and availability of items for infection control for injections. Appendix Table A-3.28 provides details on observed injection practices by type of facility.

In total, 1,205 injections were observed from 352 different facilities.¹² Among the observed clients, 51 percent were younger than five years of age, and 52 percent received immunizations.

Although new needles and syringes were used for all injections (100 percent), only 71 percent of the clients received injections with syringes provided by the facility (as opposed to clients providing their own), which is a decrease from the 86 percent observed in 2002. Facility-provided needles and syringes are least common at NGO facilities (22 percent) and mobile units (32 percent) (Appendix Table A-3.28).

Client age/type of Injection	Percentage of observations				Number of observed injections (weighted)
	New syringe and needle used	Provider observed opening new syringe/needle packet	Facility provided new syringe and needle	Provider disposed of used needle in sharps box	
Client < 5 years	100	94	78	84	653
Therapeutic injection	99	98	40	70	213
Vaccination	100	93	97	90	440
Client 5+ years	100	99	63	70	635
Therapeutic injection	100	98	45	62	417
Vaccination	100	100	97	85	218
Total	100	96	71	77	1,288

There is a significant decrease in facility supplied, new syringes and needles for therapeutic injections for clients age five and older in 2004 (45 percent), compared with the ESPA 2002 (68 percent).

Disposal of used needles in sharps boxes is not universal (77 percent of all observed injections). Sharps boxes are used more often for vaccination injections than for therapeutic injections, regardless of whether the immunization is for a child below five years of age or above five years. The overall use of sharps boxes increased from 73 percent in 2002 to 77 percent in 2004.

¹² These are actual numbers. Data in tables are weighted to provide accurate representation by facility type and governorate.

Key Findings

Use of new syringes and needles for injections is universal.

Although all injections were performed with new needles and syringes, only 71 percent of such needles and syringes were provided by the facility.

Use of facility-provided syringes and needles is almost universal for immunizations (97 percent).

Sharps boxes are more widely used by providers of immunizations (around 85 percent) than by providers of therapeutic injections (more than 60 percent).

4.1 Background**4.1.1 ESPA 2004 Approach to Collection of Child Health Information**

It is estimated by the World Health Organization (WHO) that over 10 million children under five years of age die annually from preventable diseases (WHO 2002-2004). According to WHO, many sick children who are brought to the attention of health providers do not receive adequate assessment and treatment (WHO, 1999b). It is not uncommon for a provider to treat the symptom that is most evident, without conducting a full assessment of the health status of the child. For this reason, WHO and other agencies developed the strategy of Integrated Management of Childhood Illness (IMCI). The strategy promotes using every visit to a health care provider as an opportunity not only to conduct a full assessment of the child's current health and possible underlying problems, but also to provide preventive interventions such as immunization and growth monitoring (for early detection of faltering growth) to prevent or minimize progression to illness.

The ESPA 2004 uses the IMCI guidelines as the basis for assessing child health services, and it uses the national Expanded Program on Immunization (EPI) policy as the basis for assessing childhood immunization services. The Egypt Ministry of Health and Population (MOHP) has adopted the IMCI program. It is, however, in an expansion phase, with only 134 of 245 districts included under IMCI at the time of the survey.

This chapter uses information obtained in the ESPA 2004 to address the following four central questions:

- What is the availability of outpatient services relevant to child health?
- To what extent do facilities offering immunization services for children have the capacity to support quality vaccination services?
- To what extent do the health facilities providing outpatient care for sick children have the capacity to support quality services in adherence to IMCI guidelines?
- To what extent is there evidence that health service providers involved in providing outpatient care for sick children are adhering to standards for quality service provision?

4.1.2 Health Situation of Children in Egypt***Immunization Coverage***

The EPI under MOHP is aimed at ensuring that all children receive one dose of the vaccine against tuberculosis (BCG), three doses of the vaccine against diphtheria-pertussis-tetanus (DPT), three doses of the oral polio vaccine (OPV), and the measles vaccine, before they are one year old. An additional dose of DPT should be received before the age of 18 months. During the mid-1990s, the three-dose vaccine against hepatitis B (HB) was added to the EPI program, and more recently, the measles-mumps-rubella (MMR) vaccine was added.

Community coverage figures indicate that the EPI has been very successful, with virtually all children age 12-23 months receiving at least some of the recommended vaccinations. According to the 2003 Egypt Interim Demographic and Health Survey (EIDHS) (El-Zanaty and Way, 2004), 88 percent of children age

12-23 months are considered fully vaccinated against the six preventable childhood illnesses (i.e., have received BCG, measles vaccine, and three doses of DPT and polio vaccines). Seventy-nine percent of children have received the third dose of the HB vaccine.

Childhood Mortality and Morbidity

The 2003 EIDHS provides household-based child mortality data as well as information on illnesses experienced and health service utilization during the two weeks preceding the household visit for the survey. Key findings include the following:

- The infant mortality rate was estimated at 38 deaths per 1,000 live births in the five years preceding the survey.
- The under-five mortality rate was estimated at 46 deaths per 1,000 live births.
- Seventy percent of children with reported acute respiratory infections (ARI) during the two weeks preceding the survey were reported by their caretaker to have been seen by a health professional.
- Antibiotics were reported to have been given to 73 percent of children whose caretaker said they had symptoms of cough and short, rapid breathing during the two weeks preceding the survey.
- Sixteen percent of children under five years were stunted (low height-for-age), and 4 percent were wasted (low weight-for-height).
- Nineteen percent of children under five years were reported by their caretaker to have had diarrhea in the two weeks preceding the survey (May and June 2003).
- When asked about providing fluids during the child's diarrheal illness, 31 percent of mothers reported that the child was given more fluids.
- Thirty-four percent of the children with diarrhea were reported to have received oral rehydration therapy (ORT) (either oral rehydration salts [ORS] or recommended home fluids [RHF]); altogether, some form of ORT or increased fluids was used to treat 55 percent of diarrheal episodes; 21 percent received antibiotics. A significant proportion of children with diarrhea were reported to have been treated with medicines bought directly from the pharmacy or with home remedies.

4.2 Availability of Child Health Services

Among essential preventive and curative child health services, availability of outpatient care for sick children, routine childhood immunization services (EPI), and routine growth monitoring services were assessed by the ESPA 2004. Table 4.1 provides information on the availability of these services. Appendix Tables A-4.1 and A-4.2 provide further details on frequency of service and community outreach services.¹

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

Availability of each of the three assessed child health services (outpatient care for sick children, routine childhood immunizations, and growth monitoring) and of all services in one facility is similar for 2004 and 2002. All three services are offered in 57 percent of facilities. There have been regional changes, with an increase in availability of the package of services in Lower Egypt (68 percent in 2004 compared with 56 percent in 2002) and a decrease in Upper Egypt (52 percent in 2004, compared with 62 percent in 2002). The package of child health services is offered mainly at the maternal and child health/urban health units (MCH/urban HUs) and rural health units (rural HUs) (Table 4.1). Only 58 percent of general service (GS) hospitals offer child immunization services. The Egyptian health system often locates health offices adjacent to hospitals, so it was expected that services at the two adjacent facilities would complement each other. As noted in Chapter 3, however, GS hospitals that do not offer immunization tend also not to be adjacent to a facility that offers the service (Appendix Table A-3.1.1).

Table 4.1 Availability of child health services					
Percentage of facilities offering the indicated child health services at the facility, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities that provide:				Number of facilities (weighted)
	Outpatient care for sick children	Growth monitoring	Childhood immunization	All basic child health services	
Type of facility					
GS hospital	98	59	58	50	65
Fever hospital	100	11	0	0	14
MCH/urban HU	98	85	86	74	97
Rural HU	99	85	98	84	319
Mobile unit	39	3	0	0	55
Health office	18	40	92	13	33
NGO facility	47	1	1	0	76
Region					
Urban Governorates	73	39	44	30	73
Lower Egypt	85	71	75	68	322
Upper Egypt	85	57	72	52	264
Total	84	62	70	57	659

Health facilities in the Urban Governorates are more specialized than those in Upper or Lower Egypt, with only 30 percent providing all three child health services.

There has been essentially no change at the national level in the availability of childhood immunization services or routine growth monitoring services from 2002 to 2004, with each service available in roughly two in three facilities. There have been changes by facility type, with a smaller proportion of NGO facilities providing sick child services (47 percent in 2004, compared with 60 percent in 2002). Routine growth monitoring continues to be the least frequently offered child health service, with facilities in the Urban Governorates least likely to offer the service (39 percent). Routine growth monitoring services have increased in Lower Egypt (71 percent in 2004, compared with 59 percent in 2002) and among health offices (40 percent in 2004, compared with 23 percent in 2002). Nutritional data from the EIDHS 2003 show that 16 percent of children under five years are stunted and 4 percent are wasted. In view of this, expansion of growth monitoring services might be desirable.

Key Findings

Two in three facilities offer the three assessed child health services (outpatient care for sick children, routine childhood immunizations, and growth monitoring), with the package found most often at MCH/urban HUs (74 percent) and rural HUs (84 percent). These findings are similar to those from 2002, with some improvement noted in availability of the package of services for GS hospitals and facilities in Lower Egypt.

Outpatient care for sick children is the most commonly offered child health service (84 percent of facilities), and growth monitoring is the least offered (62 percent). Given documented levels of malnutrition, increasing availability of growth monitoring services might be desired.

4.3 Capacity to Provide Quality Immunization Services

This section addresses elements that are important for quality immunization services.

4.3.1 Capacity to Maintain the Quality of Vaccines

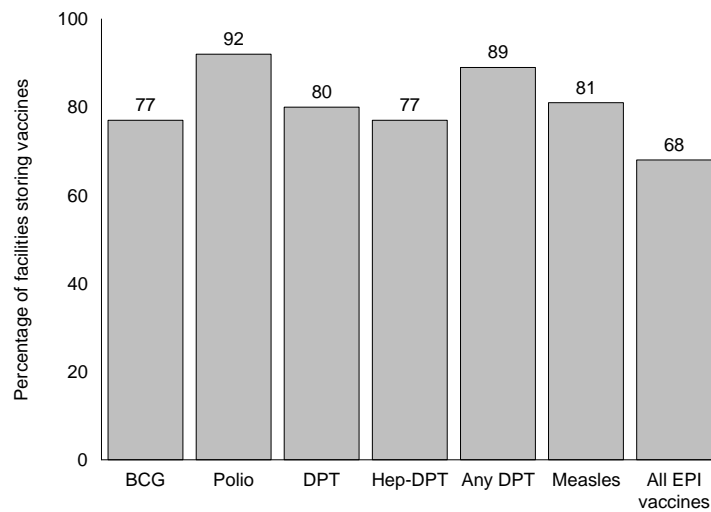
Lack of electricity or other fuel to maintain the cold chain is a common reason why facilities cannot store vaccines. If a facility cannot store vaccines, it must collect them from a central location and maintain their temperature using ice packs and mobile vaccine carriers on the days of service. The logistic considerations for maintaining the cold chain when vaccines cannot be stored frequently result in limited availability of vaccination services. Information on vaccine storage conditions is provided in Chapter 3, with details on elements assessed provided in Table 3.9 and Appendix Table A-3.14.

4.3.2 Availability of Vaccines and Vitamin A

Availability of child vaccines was assessed at eligible facilities (those that store vaccines and provide child immunization services). These results are summarized in Figures 4.1 and 4.2. Additional detail on vaccine availability by facility type and region is found in Appendix Table A-4.3.

Availability of all basic vaccines for the six major childhood diseases, among eligible facilities, is almost the same for 2004 (68 percent) (Figure 4.1) and 2002 (65 percent), although there has been an improvement at eligible GS hospitals, with 89 percent having all vaccines in stock the day of the survey (70 percent in 2002) (Table 4.2). Eligible rural HUs continue to be the least likely to have all vaccines available (60 percent in 2004 and 59 percent in 2002). The specific vaccines are missing from around 10 to 20 percent of facilities (Figure 4.1). The vaccines for the six basic immunizations as well as vaccines for hepatitis B and the MMR vaccine are similarly available (68 and 63 percent of eligible facilities, respectively) (Figures 4.1 and 4.2, respectively).

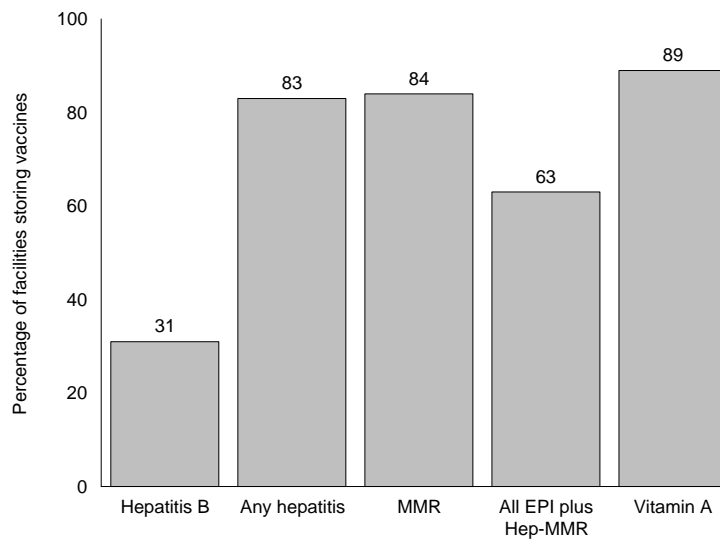
Figure 4.1 Availability of vaccines among facilities offering child vaccination services and storing vaccines (N=363)



Egypt SPA 2004

It is a recommended WHO policy to routinely distribute high-dose vitamin A capsules to children, to provide protection from respiratory infections that are more common when children are depleted in vitamin A. This activity has been added to the EPI program components in many countries. In Egypt, the policy is to provide the high-dose vitamin A at 9 and 18 months of age. Eighty-nine percent of facilities storing vaccines also have vitamin A (Figure 4.2) in their immunization area. This is an increase over 2002, when 79 percent of eligible facilities had vitamin A available in the immunization service area.

Figure 4.2 Availability of additional child vaccines and vitamin A among facilities offering child vaccination services and storing vaccines (N=363)



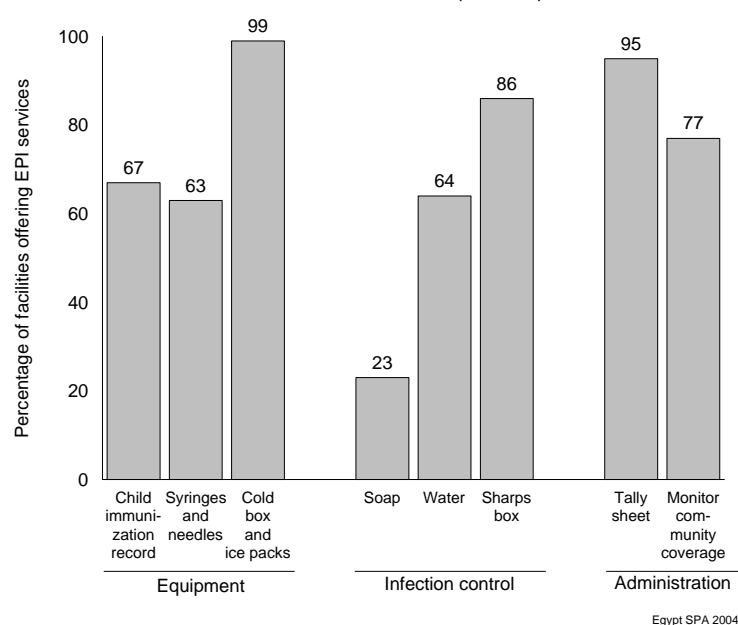
Egypt SPA 2004

4.3.3 Availability of Equipment and Supplies for Vaccination Sessions

Availability of all components assessed for quality immunization services is provided in Table 4.2 and Figure 4.3. Details on item availability for all facilities offering child immunization services are provided by facility type in Appendix Table A-4.4.

All equipment for vaccination sessions is available at 45 percent of facilities that provide child immunization services (including facilities that store vaccines and those that do not store vaccines). This is a decline from the 58 percent with all items in 2002. The availability of individual child immunization records (cards or child health booklets where immunizations are recorded) and an adequate supply of syringes and needles² are the items more frequently lacking in 2004, with each missing in one in three eligible facilities. Practically all of the facilities offering child immunization services (99 percent) have cold boxes and ice packs for transporting vaccines and for maintaining the cold chain during vaccination sessions. Availability of items for infection control has improved, with 21 percent of facilities having all assessed items (soap, water, and sharps box) compared with 14 percent in 2002. Soap and water continue to be the items most often lacking (three in four facilities lack soap, and one in three lack water) (Figure 4.3).

Figure 4.3 Availability of equipment and supplies for immunization services (N=464)



² Disposable needles and syringes are used universally in Egypt.

Table 4.2 Health system components required for childhood immunization services

Percentage of facilities offering child immunization services at the facility and that have all equipment, items for preventing infection, records indicating good administrative practices, and all basic child vaccines, by the type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering child immunization with:				Number of facilities offering child immunization services (weighted) ⁴	Percentage of facilities offering child immunization services and storing vaccines with:		Number of facilities offering child immunization services and storing vaccines (weighted)
	All equipment ¹	All items for infection control ²	Administrative components ³	All equipment, items for infection controls, and administrative components		All basic child vaccines ⁵	All components for providing quality child immunization services (including vaccines) present	
Type of facility								
GS hospital	47	31	79	16	38	89	16	24
MCH/urban HU	48	18	64	2	84	76	2	81
Rural HU	44	20	77	9	311	60	8	230
Health office	54	17	81	16	30	90	13	28
Region								
Urban Governorates	35	33	55	8	32	92	8	31
Lower Egypt	38	23	74	10	241	61	9	181
Upper Egypt	56	16	80	8	191	70	6	150
Total ⁶	45	21	75	9	464	68	8	363

¹ Blank immunization cards, syringes and needles, and cold box with ice packs (or facility reports purchasing ice)

² Soap, water (any source), and sharps container

³ Tally sheet or register where vaccines provided are recorded and documentation of either DPT dropout rate or measles coverage

⁴ All facilities offered immunizations at the facility. In addition some facilities offer the service through village outreach activities.

⁵ Basic child vaccines are BCG, DPT (or Hep-DPT), polio, and measles

⁶ Regional totals and total percentages include data from one NGO facility offering child immunization services and storing vaccines.

4.3.4 Availability of Administrative Components for Monitoring Immunization Activities

The ESPA 2004 looked for evidence of recordkeeping that provides information for monitoring immunization activities.

Measures often used for monitoring immunization coverage include the DPT dropout rate (the difference between the number of children who receive the first dose of DPT and the number among those who completed the three doses of DPT) and immunization coverage rates (the percentage of eligible children who have been fully immunized with a specific vaccine or with all vaccines). Measures of immunization coverage require an estimate of a target population. The ESPA 2004 specifically assesses whether the DPT dropout rate or measles coverage information is available. Seventy-seven percent of facilities have documentation that they monitor either DPT dropout or measles coverage (Figure 4.3).

Ninety-five percent of facilities have an up-to-date register (or tally sheets) for documenting the immunizations provided (Figure 4.3).

Availability of both administrative components to support immunization services is similar for both 2002 and 2004, with both documents available in 75 percent (Table 4.2) of eligible facilities (70 percent in 2002).

Although, with the exception of soap and water, each assessed item individually is available in around three in four facilities, all items are available in fewer than one in ten eligible facilities. There is little regional difference in the proportion of facilities with all items to support quality immunization (all

equipment, items for infection control, and administrative components). Conditions for facilities in the Urban Governorates have deteriorated, with all items available in only 8 percent of facilities (20 percent in 2002) (Table 4.2). Availability of essentially all individual items has declined for these facilities. GS hospitals and health offices tend to be better equipped (16 percent having all items) than other types of facilities. This is an improvement in findings for health offices, where only 7 percent had all assessed elements in 2002.

4.3.5 Injection Practices

Injections for immunizations were observed for infection prevention elements (see section 3.5). Among immunizations observed being provided to children below five years of age (N=440), new needles and syringes were used in all cases, with almost all (97 percent) of the needles and syringes provided by the facility. Observers actually saw the new packet being opened for 93 percent of the observed child immunizations. Cases where the new syringe was not observed being open, but the provider indicated that a new needle and syringe were used, may be cases where multiple syringes were removed from their packets prior to an immunization session to speed up the injection process (Table 3.13). Used needles were disposed of in sharps boxes for 90 percent of observed child immunizations (less than age five).

Key Findings
Eight in ten facilities that offer child immunization services also store vaccines.
Two in three facilities storing vaccines (68 percent) have all basic vaccines for child immunizations. The same proportion has all basic vaccines plus MMR and hepatitis B (63 percent).
Each type of vaccine is missing from around 10 to 20 percent of facilities.
Use of disposable syringes and needles for immunization is universal in Egypt, but only 63 percent of facilities have a sufficient supply of both BCG and three-milliliter syringes.
All items for infection control are available in the immunization service delivery area in only 21 percent of facilities. Soap for hand-washing remains the item most often lacking. Fourteen percent of facilities do not have a sharps box in the immunization area
New, sterile needles and syringes were observed to be used universally for immunizations, and sharps boxes are used for disposing of needles in most (90 percent) of the observed immunizations provided (for children less than age five).
Similar to findings in 2002, fewer than one in ten facilities have all assessed elements to support quality immunization services.

4.4 Capacity to Provide Quality Outpatient Care for Sick Children

To improve the diagnosis of illness and to minimize missed opportunities to provide preventive interventions, IMCI standards recommend that the following be part of any consultation for a sick child:

- Assessing immunization status and providing vaccines that are due
- Assessing nutritional status
- Assessing overall health status

- Ensuring that the child receives the first dose of any antibiotic at the facility and leaves the facility with the necessary medications
- Ensuring that the caretaker knows how to administer the necessary medications or treatments and knows about appropriate foods and how much the child needs both during this sickness and when not sick.

The ESPA 2004 assesses the availability of equipment, supplies, and health system components necessary to adhere to IMCI guidelines and to support quality outpatient care for sick children (WHO, 1999b; WHO 2002). Assessed elements are as follows:

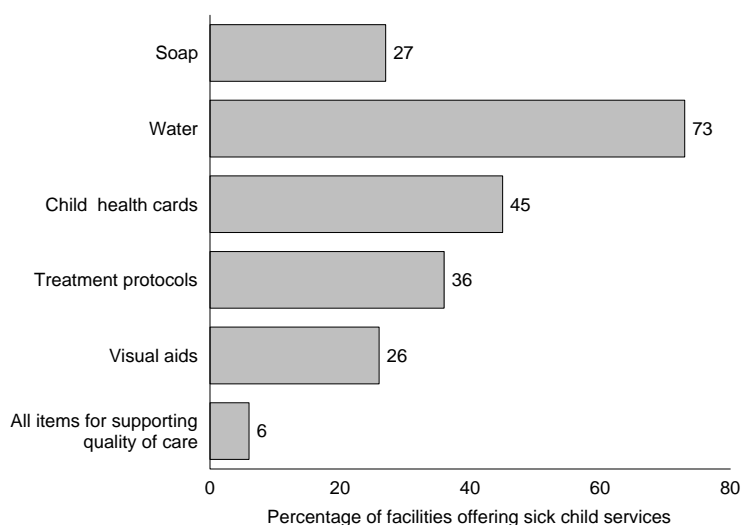
- Infrastructure and resources to support quality assessment and counseling
- Equipment and supplies for adhering to IMCI guidelines for assessment of the sick child
- Essential medicines for treating sick children, in adherence to IMCI guidelines.

4.4.1 Infrastructure and Resources to Support Quality Assessment and Counseling for the Sick Child

Items for supporting quality assessment and counseling that should be in area where sick children receive services are those for infection control, individual child health cards, treatment guidelines or protocols, and visual aids.

Figure 4.4 provides information on availability of individual items for quality of care, and Appendix Tables A-4.5 and A-4.6 provide details on these items by type of facility.

Figure 4.4 Availability of items to support quality of care for sick children (N=552)



Egypt SPA 2004

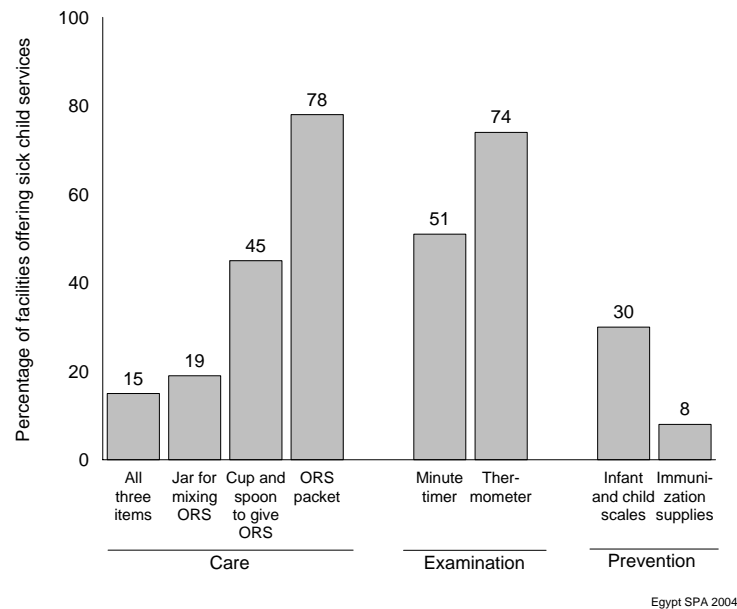
Availability of all items to support counseling for sick children (soap and water, individual child health cards, treatment guidelines or protocols, and visual aids for counseling the caretaker) are available in only 6 percent of facilities where outpatient curative care for sick children is provided (Figure 4.4). There has been an improvement in availability of treatment guidelines or protocols (36 percent in 2004, compared with 24 percent in 2002), with the IMCI chart booklet or wall chart being more readily available (26 percent of facilities in 2004, compared with 17 percent in 2002) (Appendix Table A-4.6). There is little change in availability of other assessed items since 2002. Individual child health charts or records, important for continuity of care, continue to be available in less than half (45 percent) of facilities, and visual aids are available in around one in four (26 percent) facilities.

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

The ESPA 2004 also assesses the availability of the equipment and supplies necessary for evaluating the status of sick children and for providing preventive interventions for adherence to IMCI guidelines.

Figure 4.5 summarizes information on these items. Appendix Table A-4.5 provides details on the items, by facility type, and Appendix Table A-4.7 provides information on the availability of sick child and EPI services on the same day in the same facility.

Figure 4.5 Availability of equipment and supplies for assessing health status of the sick child (N=552)



Among facilities offering sick child services, all items for quality immunization services components (basic vaccines, syringes, cold boxes, items for infection control in the EPI service area, and child immunization cards) are available in only 8 percent of facilities (Figure 4.5). Thus, similar to findings in 2002, most facilities have neither the service delivery pattern nor the capacity to adhere to the IMCI guidelines for using every contact with the facility to provide needed immunizations. There has, however, been an increase in the percentage of facilities reporting that immunization services are available every day when sick child services are offered (15 percent of facilities, compared with 9 percent in 2002), with the increase being noted primarily in facilities in Upper Egypt (23 percent, compared with 1 percent in 2002) (Appendix Table A-4.7). There is no change, however, in the percentage of facilities in which both

immunization services and sick child services were offered on the day of the survey visit (18 percent of facilities).

While 66 percent of eligible facilities have a scale appropriate for weighing an infant (100-gram increments) and 41 percent have a scale appropriate for measuring a child (maximum 250-gram increments), only 30 percent have scales for both infants and children (Figure 4.5). This is a decrease from findings in 2002, when 44 of facilities had both types of scales.

Items for providing oral rehydration onsite, are similarly lacking, with only 15 percent of facilities having a cup and spoon, a jar for mixing, and packets of ORS. This is a decrease from 26 percent having all three items in 2002. Similar to findings in 2002, however, ORS packets are available in 78 percent of facilities.

Although a sick child can be assessed with little equipment, the ESPA 2004 evaluates the presence of elements in the facility (a thermometer and a minute timer for counting respirations) to support the evaluation of sick children. Thermometers are available in three in four facilities (74 percent), and a facility-provided clock or other means for timing one minute (for assessing the severity of respiratory illness) is available in around half (51 percent). IMCI guidelines allow assessment of fever using touch and, in practice, almost all staff members have a wristwatch with a second hand, to enable them to count respirations if necessary, so neither of these items are essential for meeting IMCI guidelines.

4.4.3 Essential Medicines for Treating Sick Children

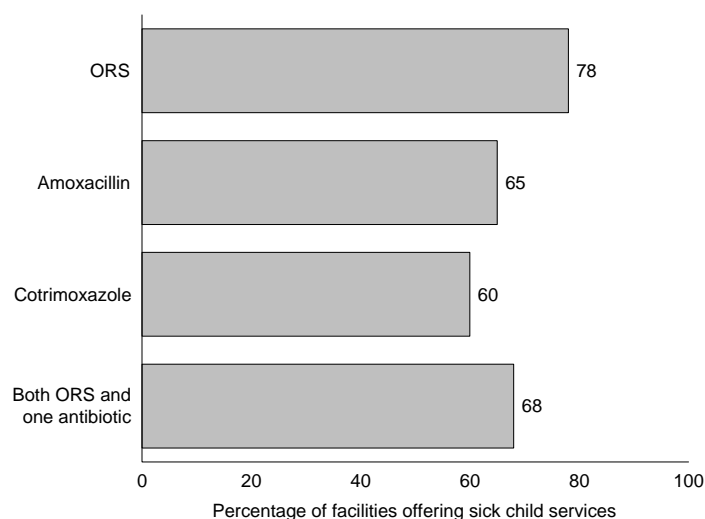
The ESPA 2004 assesses the availability of essential medicines as defined in IMCI guidelines. Summary information on the availability of medicines for sick children is provided in Figures 4.6 through 4.8 and in Table 4.3. Appendix Table A-4.8 provides details on medicines, by type of facility.

IMCI guidelines have defined first-line, prereferral, and other important medications, for treating the sick child. First-line medicines include ORS (solution prepared from packets of oral rehydration salts) and oral antibiotics such as amoxicillin or cotrimoxazole for respiratory infections.

First-Line Medicines

All first-line medicines are available in 68 percent of facilities, with each category of medicine available in around two-thirds of facilities (ORS is slightly more available, at 78 percent of facilities) (Figure 4.6). These findings are similar to those in 2002, when 62 percent of facilities had all first-line medicines. Availability of first-line medicines has increased in hospitals (75 percent in 2004, compared with 59 percent in 2002) and in facilities in Lower Egypt (72 percent in 2004, compared with 63 percent in 2002).

Figure 4.6 Availability of first-line medicines for treating sick children (N=552)



Egypt SPA 2004

Table 4.3 Selected essential components to support quality care for sick children

Percentage of facilities that have all indicated items, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:					Number of facilities offering sick child services (weighted) ⁴
	All essential medicines ¹				Nebulizer	
	First line ²	Prereferral (chloramphenicol only)	Other emergency medicines ³	Oxygen and regulator		
Type of facility						
GS hospital	75	18	39	35	32	64
Fever hospital	68	63	69	26	21	14
MCH/urban HU	78	14	21	43	54	96
Rural HU	74	11	22	33	33	316
Mobile unit	16	0	0	0	0	21
NGO facility	4	3	3	8	12	36
Region						
Urban Governorates	57	19	23	24	29	54
Lower Egypt	72	10	19	31	31	273
Upper Egypt	64	15	28	35	38	225
Total	68	13	23	32	34	552

¹ Twelve percent of facilities either did not have medicine stocks or the ESPA 2004 did not gain access to the pharmacy. For these facilities, if the medicine was not observed in another area, such as a distribution pharmacy, it was classified as not available.

² Oral rehydration salt packet and an oral antibiotic (amoxicillin or cotrimoxazole)

³ At least one first-line injectable antibiotic (ampicillin or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamycin), and intravenous solution (normal saline, Ringer's lactate, or dextrose and saline 0.9%) with perfusion set

⁴ Regional totals and total percentages include data from six health offices providing sick child services.

Prereferral Medicines

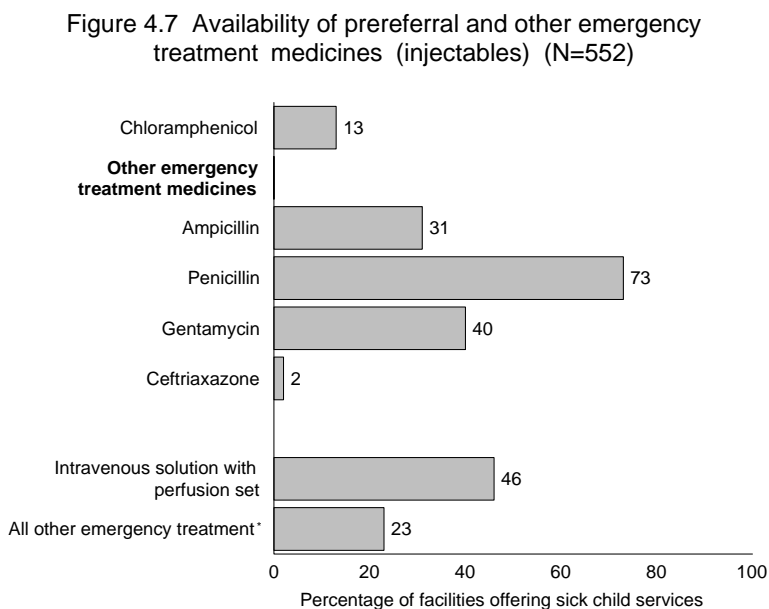
Prereferral medicines are defined as emergency injectable medications for providing urgent treatment before transferring to another facility or admission to the current facility, if necessary. According to Ministry of Health and Population (MOHP) policies at present, only hospitals are authorized to provide rapid rehydration for severely dehydrated children using intravenous solutions.

In Egypt, the only defined prereferral medicine for IMCI is chloramphenicol. This is available in only 13 percent of facilities (Table 4.3) and is found most commonly in fever hospitals.

Other countries commonly defined prereferral medicines as at least one first-line antibiotic (ampicillin or penicillin), at least one second-line antibiotic (ceftriaxone or gentamycin), and intravenous solution (either normal saline, dextrose and normal saline, or Ringer's lactate) with perfusion sets for treating severe dehydration. The availability of these medicines was also assessed.

Similar to findings in 2002, one in five (23 percent) facilities offering curative care for sick children, have the package of other common prereferral medicines (Figure 4.7). These were found in 69 percent of fever hospitals (51 percent in 2002) and 39 percent of GS hospitals (53 percent in 2002) (Table 4.3).

Chloramphenicol and other emergency medicines were least commonly found in facilities in Lower Egypt.



* Ampicillin or penicillin, and gentamycin or ceftriaxone, and intravenous solution

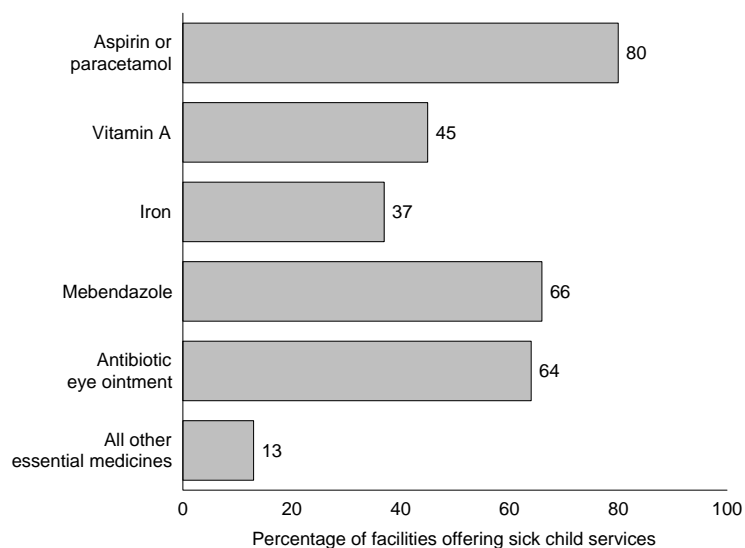
Egypt SPA 2004

Other Essential Medicines

Other essential medicines are those that may be less critical for treating serious illness but are important for treating common symptoms and illnesses of sick children. These include an antipyretic (aspirin or paracetamol), vitamin A and iron supplements, a deworming medication (anthelmintic), and antibiotic eye ointment. Availability of other essential drugs had not changed at the national level (13 percent for both 2002 and 2004), although it has changed for individual medicines, with a slight improvement in

availability of mebendazole and eye ointment (available in two in three facilities) and decreased availability of iron tablets (37 percent of facilities) (Figure 4.8).

Figure 4.8 Availability of other essential medicines (N=552)



Egypt SPA 2004

Specific Respiratory Treatments

Availability of specific treatments for managing respiratory illness is also assessed. Overall, 32 percent of facilities have an oxygen cylinder and a regulator, and 34 percent have a nebulizer (Table 4.3), with availability of each of these items increasing from 19 percent in 2002. These items are most commonly available at MCH/urban HUs (43 percent have oxygen, and 54 percent have nebulizers) and least available at facilities in the Urban Governorates, where oxygen and a regulator are found in 24 percent of facilities and nebulizers are found in 29 percent of facilities.

Key Findings

IMCI guidelines or counseling materials are more available, increasing from 17 percent of facilities in 2002 to 26 percent of facilities.

Although reportedly increasing (15 percent of facilities), child immunization services are not routinely offered on the same day as services for sick children.

Soap for hand-washing and visual aids for instructing caretakers are each missing from three in four facilities.

Although improved since 2002, treatment guidelines or protocols are found in only one in three sick child service sites.

All first-line treatment medicines defined for Egypt are available at only two in three facilities, and prereferral medicines are available at one in ten facilities.

MOHP guidelines limit the scope for facilities to provide prereferral treatments common in other countries.

4.5 Management Practices Supportive of Quality Sick Child Services

Management practices for supporting quality curative care for sick children include documentation and records, practices related to user fees, and staff supervision and development.

Summary information on the availability of these items is presented in Table 4.4. Appendix Table A-4.9 provides sick child client utilization statistics for facilities in the ESPA 2004. Appendix Tables A-4.10 through A-4.12 provide more details on fees and other payment systems utilized by facilities or providers. Figure 4.9 provides summary information on in-service training received by child health service providers. Appendix Tables A-4.13 through A-4.15 provide details on in-service training and supervision from the perspective of the child health service provider.

Background characteristics	Facilities with outpatient care for sick children		Number of facilities offering SC services (weighted)	Percentage where at least half of the interviewed child health service providers:		Number of facilities with interviewed child health service providers (weighted) ³
	Percentage with up-to-date patient register ¹	Percentage with user fees for SC services		Received in-service training during the past 12 months ²	Were personally supervised during the past 6 months	
Type of facility						
GS hospital	51	37	64	7	85	64
Fever hospital	37	53	14	10	58	14
MCH/urban HU	78	27	96	18	97	96
Rural HU	41	25	316	15	98	316
Mobile unit	11	16	21	12	88	19
Health office	63	44	6	26	100	6
NGO facility	10	94	36	0	48	35
Region						
Urban Governorates	59	56	54	13	79	52
Lower Egypt	48	25	273	13	93	272
Upper Egypt	39	35	225	14	93	225
Total	45	32	552	14	92	549

4.5.1 Facility Documentation and Records

Less than half of all facilities providing outpatient care for sick children (45 percent) have an up-to-date register, where there is an entry within the past seven days that documents the child's age and diagnosis (Table 4.4). A lower percentage of facilities in Upper Egypt (39 percent) have an up-to-date register, compared with 59 percent in Urban Governorates.

4.5.2 Practices Related to User Fees

User fees may have a positive effect on utilization of health facilities (augmenting funds to improve services) or a negative effect (deterring poor clients from using services). One in three facilities has charges for sick child consultation services; however, in the Urban Governorates, over half of facilities have charges (Table 4.4).

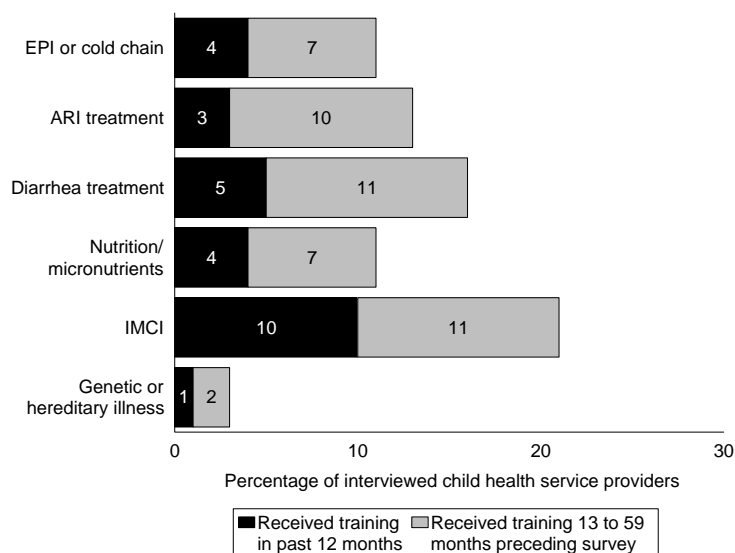
Findings on implementation of user fees are substantially different from those in 2002, where 93 percent of facilities reported user fees for curative child health services. The question that was asked during both surveys was “Does this facility routinely charge for consultation services for the sick child?” It seems most likely that there was a different understanding of the question when posed in 2002 than in 2004, rather than a major shift in practices at facilities over the past two years. Further investigation is required to ascertain which findings best reflect the actual situation.

4.5.3 Supervision and Staff Development

Child health service providers were interviewed from facilities offering any child health services, whether preventive or curative. If at least half of the interviewed child health service providers at a facility have received any structured in-service training (excluding on-the-job training that may be received during discussions with supervisors) relevant to child health during the past 12 months, the facility is defined as providing routine staff development activities. At least half of the interviewed providers had received in-service training related to their service during the past 12 months in only 14 percent of facilities, with almost no regional differences (Table 4.4). This is a slight decrease from the 18 percent found in 2002. Routine provision of in-service training for child health service providers is least commonly found at GS hospitals (7 percent).

During the past 12 months, in-service training related to IMCI was received by 10 percent of providers with an additional 11 percent having received in-service training on IMCI 13 to 59 months preceding the survey (Figure 4.9). These findings are similar to those from 2002. Around 4 percent of providers had received in-service training during the past 12 months that was related to ARI, diarrhea, or micronutrients, with nearly 10 percent having received in-service training on any of the same topics 13 to 59 months preceding the survey (Figure 4.9).

Figure 4.9 In-service training received by interviewed child health service providers, by topic and timing of most recent education (N=1,667)



Egypt SPA 2004

If at least half of the interviewed child health service providers at a facility have been personally supervised during the past six months, the facility is defined as providing routine staff supervision. At least half of the interviewed providers had been personally supervised in the past six months at 92 percent of facilities (Table 4.4). This is essentially the same as found in 2002 (93 percent). Routine supervision continues to be weakest in NGO facilities (48 percent) and in facilities located in the Urban Governorates (79 percent).

Although the proportion of facilities with routine supervision remains stable, the reported frequency of supervision has declined from a median of nine times in the past six months (2002) to six times in the past six months (2004) (Appendix Table A-4.15).

Key Findings

Management practices are similar for 2002 and 2004.

Up-to-date registers for service statistics are found in less than half of facilities, with facilities in the Urban Governorates most likely to have an up-to-date register (59 percent).

Structured in-service training related to child health topics is not routinely provided, with at least half of the interviewed providers in only 14 percent of facilities having received any related in-service training during the past 12 months, a small decrease from 18 percent in 2002.

Twenty-one percent of interviewed providers have received in-service training related to IMCI during the past five years.

Supervision for child health services is strong across all types of government facilities, with at least half of all interviewed child health providers having been personally supervised during the past six months in 92 percent of facilities. The median number of times staff reported being supervised during the past six months has declined from nine (2002) to six (2004).

Supervision of individual providers continues to be weak in NGO facilities, with only 48 percent of NGO facilities routinely supervising their child health service providers.

4.6 Adherence to Guidelines for Sick Child Service Provision

Observed sick child consultations are the basis for assessing whether providers adhere to standards for providing quality service. The observation checklists used are based on IMCI guidelines.

Observers note whether information on a topic is shared (process information), as well as whether procedures are carried out, during provider-client consultations. An assessment of whether the information shared is correct or whether findings are appropriately interpreted is not a component of the observation.

A total of 2,071 sick child consultations were observed at 451 facilities. Among the 2,071 observations, all caretakers participated in exit interviews.³

³ These are actual numbers. Data in tables and figures are weighted to provide accurate representation by facility type and governorate.

Figures 4.10 through 4.14 provide information on practices observed during consultations for sick children. Table 4.5 provides summary information on the assessments and examinations observed and subsequent treatments by the provider, by provider classification of diagnosis or major symptoms. Appendix Tables A-4.16 through A-4.20 provide details on observed practices and information reported from interviewed caretakers of observed sick children.

4.6.1 Full Assessment of Illness

When there are not sufficient numbers of qualified curative care providers, less qualified persons can be trained to provide EPI and growth monitoring services, as well as initial consultation services for sick children. For curative care, however, this assumes that seriously ill children, with illnesses beyond the training of the staff, will be appropriately identified and referred to a better-qualified provider. When reviewing factors that influence quality of care, it is important to know how many facilities depend on referral for the management of severe illnesses. As noted in Chapter 3 (Figure 3.1), almost all of the facilities in Egypt have a physician assigned, thus referral patterns may be different than those found in systems where nonphysicians provide initial curative care.

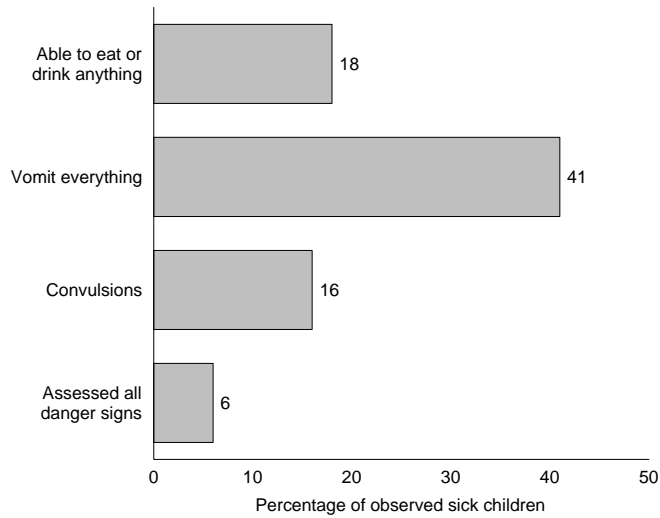
The IMCI components for assessing a sick child provide valid guidelines for quality of care regardless of whether a provider has been trained in the IMCI strategy or not. When interpreting the findings, it is recognized that, even following the IMCI guidelines, a provider will use judgment based on the child's signs and symptoms. For example, a provider seeing a child who appears to have a common cough or cold and who is clearly alert may reasonably not ask about convulsions or whether the child is vomiting everything or not drinking anything. Thus, findings of low percentages for some categories of assessment do not necessarily indicate poor practices.

Major Danger Signs

According to IMCI guidelines, the major danger signs a provider must assess are whether the child is able to breastfeed or drink anything, whether the child vomits everything, whether the child has had convulsions at home or in the facility, and whether the child is lethargic or unconscious.⁴ If there is any doubt about the child's ability to take fluids, the provider should attempt to give the child something orally. Similar to findings in 2002, assessments for all danger signs were rarely carried out (6 percent of observed consultations in 2004, compared with 4 percent in 2002) (Figure 4.10). Eighteen percent of the children were assessed for whether they drank anything, including breast milk, 41 percent for whether they vomited all food and drink, and 16 percent for whether they had convulsions.

⁴ Assessment for lethargy is not a part of the checklist as there is often not an observable component for this assessment.

Figure 4.10 Major danger signs assessed during observed sick child consultations (N=2,156)



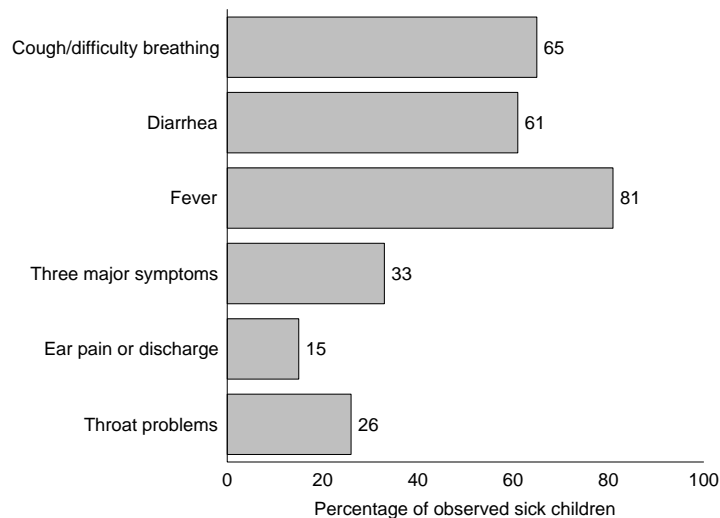
Egypt SPA 2004

Major Signs and Symptoms

Regardless of the reason for the consultation, IMCI guidelines call for each child to be evaluated for the major symptoms of cough, respiratory difficulty, diarrhea, and fever. Information may be shared either when the caretaker of the sick child discusses the reason for the visit (for example, diarrhea or cough) or, if not spontaneously mentioned, whether the provider probes for symptoms.

Assessment of the presence of the three major signs and symptoms has changed little from 2002 to 2004, with all symptoms assessed for 33 percent of observed children in 2004 (Figure 4.11) and 28 percent in 2002. Fever was the symptom most commonly assessed (81 percent), followed by respiratory symptoms (65 percent) and diarrhea (61 percent). Assessment of other symptoms related to common child illnesses, such as ear and throat problems, was less often observed (15 and 26 percent, respectively).

Figure 4.11 Major symptoms assessed during observed sick child consultations (N=2,156)



Egypt SPA 2004

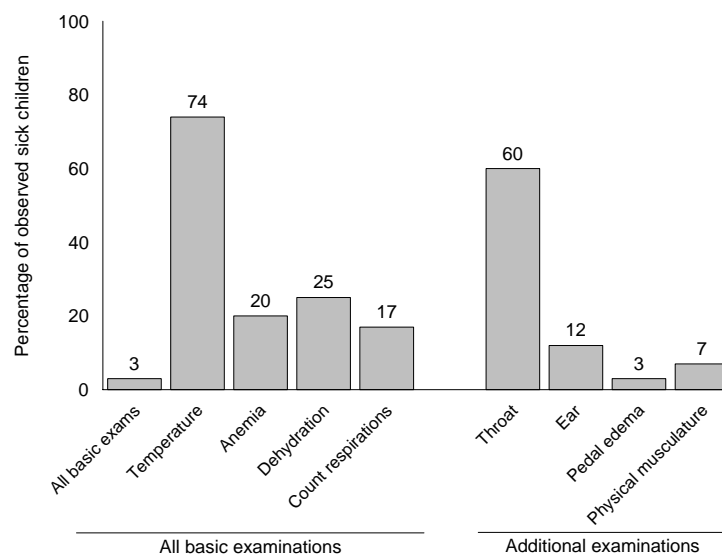
Physical Examination

After information is obtained on the various signs and symptoms of illness, the provider should conduct a physical examination. This should include a hands-on evaluation of the child to verify the presence of fever (by touch or by taking the temperature), to measure the state of dehydration (pinching the abdominal skin), to check visually if the child has anemia, and to count the rate of respirations if a respiratory problem is suspected.

Similar to other observed items, there has been a minimal improvement in examination of the sick child, with the four basic examinations conducted on only 3 percent of observed children (2 percent in 2002). The most commonly observed examination procedure was assessing fever (74 percent) (Figure 4.12), using a thermometer for 56 percent of cases and using touch only for 33 percent of sick children (Appendix Table A-4.16). One in five (20 percent) children was assessed for the presence of anemia, an increase from the 11 percent noted in 2002. Dehydration status was assessed for 25 percent of the children, and the respiratory rate was counted for 17 percent of the children. In addition to the key signs and symptoms, observers also noted that while 60 percent of children had their throat examined using a tongue depressor, only 7 percent were examined with any artificial light to aid in the observation of the back of the throat. In addition, in 12 percent of examinations, providers looked inside and felt behind the ear, 3 percent checked for pedal edema, and 7 percent removed the child's clothing to check the muscular and general physical status. None of the observations included all of these elements of physical examination. The proportion of observed children where each additional examination was conducted is similar for 2002 and 2004.

There were no consistent differences in the elements of the assessment and physical examination of the child between different types of facilities (Appendix Table A-4.16).

Figure 4.12 Elements of physical examination conducted during observed sick child consultations (N=2,156)



Egypt SPA 2004

Assessment of Feeding during Illness

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

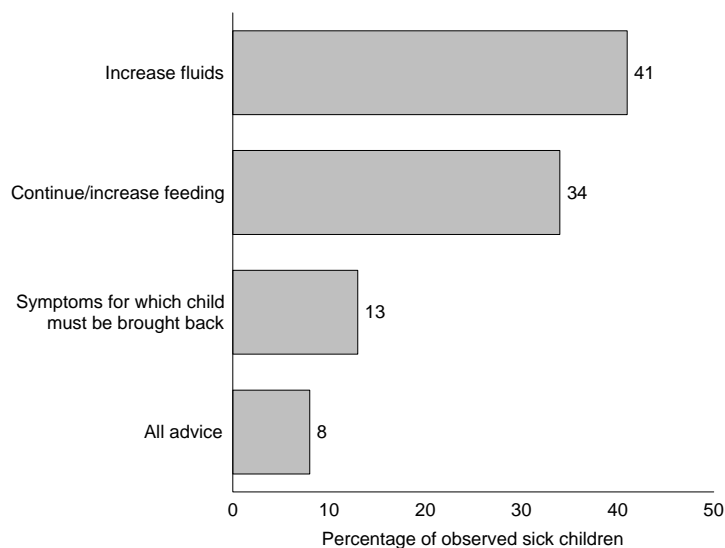
Among all observed sick children, 34 percent were evaluated for feeding practices during the illness, with this more commonly conducted in mobile units and NGO facilities (about 46 percent in both), and 5 percent were specifically checked to see if they would take anything by mouth at the time of the consultation (Appendix Table A-4.16). This is almost double the findings in 2002 when 18 percent of children were assessed for feeding practices and 3 percent were checked at the time of the consultation.

Essential Advice

The IMCI strategy identifies essential advice that the child's caretaker should receive prior to departure. This includes encouraging the caretaker to 1) provide extra fluids to the child during the illness, 2) continue to feed the child, and 3) watch for signs and symptoms for which the child should immediately be brought back to a health care provider.

Advice to increase the quantity of liquids was given in 41 percent of the cases; advice to give the same or increased amount of food or breast milk was given to 34 percent of caretakers; and for 13 percent of the cases, the provider discussed signs and symptoms for which the child should be immediately returned to the facility (Figure 4.13). All three items of advice were provided to only 8 percent of clients. This is a slight improvement over the 3 percent where all advice was provided in 2002.

Figure 4.13 Essential advice provided to caretakers of observed sick children (N=2,156)



Egypt SPA 2004

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

Percentage of observed children diagnosed by the provider with the indicated illness or symptom for whom the indicated assessment, examination, and /or treatment was provided, Egypt SPA 2004

Item	Among children with indicated diagnosis, percentage for whom indicated assessment, examination, and/or treatment was observed									
	Respiratory illness			Febrile illness			Intestinal illness		Other	
	Pneumonia or other severe respiratory problem ¹	Bronchitis	Cough or other respiratory problem without other severe diagnosis	Severe fever	Fever without severe diagnosis or cough	Strep throat	Severe or persistent diarrhea or dysentery or any dehydration with diarrhea	Other diarrhea without other severe diagnosis	All other definitive diagnosis	All observed children ³
IMCI assessment										
Three major symptoms	37	33	43	38	25	31	31	32	16	33
Three major danger signs	4	2	9	0	5	3	5	8	4	6
Assess current eating or drinking	27	28	35	22	42	28	51	42	23	34
Advise both continue feeding and increase food or drink	16	23	26	18	25	30	48	30	11	27
Physical exam										
Temperature	82	69	83	83	65	67	81	68	67	74
Respiratory rate	41	12	32	13	5	9	17	13	14	17
Dehydration	18	12	15	21	24	8	69	43	13	25
Anemia	20	10	28	22	13	12	38	19	15	20
Throat	49	52	70	59	55	86	58	50	44	60
Ear	10	8	16	13	9	10	15	8	11	12
Edema	3	1	6	1	0	1	4	4	3	3
Body muscle	7	3	12	4	3	5	11	8	7	7
Treatment										
Refer/admit	13	1	0	7	0	0	4	1	5	2
Any antibiotic	87	85	53	87	59	94	46	35	30	59
Injectable antibiotic	20	25	10	38	10	26	13	7	3	14
Oral antibiotic	72	71	46	59	52	79	35	29	28	50
Oral bronchodilator	26	28	8	9	0	10	2	1	15	9
Oral medication for symptomatic treatment ²	73	91	90	84	89	91	81	76	55	83
Oral rehydration (ORS)	9	12	10	6	39	8	74	56	8	26
Intravenous fluid	2	0	0	0	0	0	4	0	0	1
Discussed return visit	38	17	26	23	21	22	26	26	25	24
Number of children (weighted) ³	116	382	515	57	189	332	252	531	132	2,156

¹ Pneumonia, bronchopneumonia, or severe bronchitis

² This may be antipyretic, cough medicine, or other general treatment for symptoms.

³ Child may be classified with more than one diagnosis.

4.6.2 Diagnosis-Specific Assessments

After concluding the consultation for the sick child, the observed providers were asked about the diagnosis and major symptoms on which the prescribed treatment was based. This information provides a context for assessing whether the examination and treatment were appropriate according to IMCI guidelines. IMCI guidelines indicate specific symptoms or diagnoses for which antibiotics should be prescribed and when children should be admitted to the facility or referred for a higher level of care.

Although a simple observation does not provide enough information to determine the appropriateness of diagnosis and treatment, there are some items that are expected, based on diagnosis.

Respiratory Illness

Although there are no major changes since 2002 in the proportion of children diagnosed with severe respiratory illness for which danger signs, major symptoms, or current eating and drinking were assessed, there is a slight improvement in the examination and adherence to guidelines for treatment.

The respiratory rate was counted for 41 percent of children diagnosed with a severe respiratory illness (Table 4.5), increasing from 36 percent in 2002. In most of these cases, recourse to antibiotics is warranted, and an increase in use of antibiotics for severe respiratory cases has been observed (87 percent in 2004, compared with 79 percent in 2002) with a slight increase in the proportion receiving injectable antibiotics (20 percent in 2004 and 13 percent in 2002).

Children with severe respiratory illnesses should be examined by a physician and often require hospitalization. Overall, 13 percent (6 percent in 2002) of children diagnosed with severe respiratory illness were referred or admitted (Table 4.5). There are many barriers to clients receiving and/or accepting referrals or admission to facilities that may influence the provider's decisions to refer or not refer. One should, therefore, use this information only as an indicator of a need to conduct a more detailed assessment to determine the quality of care for children with severe respiratory illness.

Although overall use of bronchodilators has not changed from 2002, there is increased use in children whose wheezing was assessed and a decrease, by almost half, in use for cases where the provider reports there is no wheezing. Severe respiratory (pneumonia or bronchopneumonia) or bronchitis cases for whom the provider noted wheezing were prescribed bronchodilator medications four times as often (39 and 50 percent, respectively) as those without wheezing (about 10 percent of cases) (Appendix Table A-4.17).

Diarrhea

Physical assessment and treatment of children with severe diarrhea or diagnosed with any dehydration linked to diarrhea has remained unchanged from 2002 to 2004. Sixty-nine percent were physically assessed for dehydration using the skin-pinch test. Antibiotics are rarely advised for nondysentery-related diarrhea, since using antibiotics inappropriately can prolong the diarrhea. Forty-six percent of the children were given antibiotics, although only 14 percent were classified as having dysentery (data not shown). Among the children classified with severe diarrhea or any dehydration, 74 percent received or were prescribed ORS and 4 percent received intravenous fluids (Table 4.5).

Fever

For children with severe febrile illness, IMCI guidelines recommend the use of antipyretics followed by referral. There is little change noted in the treatment of children with severe febrile illness between 2002 and 2004. Similar to practices in 2002, 7 percent of children with severe febrile illness were referred or admitted (Table 4.5). Almost all of the children with severe febrile illness (84 percent) received oral medication for symptomatic treatment (antipyretic, cough medicine, or other general treatments for symptoms), 87 percent received antibiotics (an increase over 75 percent in 2002), with 38 percent of these receiving injectable antibiotics, almost double the percent receiving injectable antibiotics in 2002 (23 percent).

Streptococcal Throat Infection

Examination and treatment for children diagnosed with streptococcal throat infection has improved slightly from 2002 to 2004, with the throat examined for 86 percent of the cases and antibiotics prescribed for 94 percent (with 26 percent receiving an injectable antibiotic). Antibiotics are usually appropriate for streptococcal throat infections.

Overall Adherence to Standards

From this brief review, it appears that the type of physical examination conducted and treatment provided, including referrals, tends to vary reasonably according to the assessed severity and type of illness. Assessments of symptoms, danger signs, and advice regarding eating and drinking during illness, however, does not consistently vary by severity of illness (Table 4.5).

It was interesting that the median time from starting to completing the assessment of the sick children was six minutes (data not shown), similar to the findings in 2002 (five minutes). It would be difficult to take a full history of signs and symptoms and to physically assess a child in this time.

Among children with nonsevere illnesses or with respiratory or gastrointestinal illnesses that are most often viral in nature, antibiotic use continues to be high. With growing antibiotic resistance worldwide, the use of antibiotics should be reviewed to ensure that they are not being overused for nonsevere viral illnesses.

4.6.3 Other Observed Practices

IMCI guidelines recommend that the first dose of a medicine (particularly an antibiotic) should be provided at the facility so that treatment can begin immediately. This practice also provides an opportunity to reinforce the dosage to the caretaker and to ensure that the child is able to take the medicine. Among children who received any prescription, 3 percent of caretakers reported that the child received the first dose of the prescribed oral medicine at the facility, and 5 percent indicated that the child received an injection (Appendix Table A-4.18). This was supported by observers who noted medicines being administered to 2 percent of the children.

Caretaker education about medicines has improved somewhat, with 79 percent of caretakers observed being told how to give the medicines (63 percent in 2002), although only 6 percent were asked to repeat the instructions to verify that they understood. This finding was supported in exit interviews, where a larger proportion of interviewed caretakers reported being told how to give the medicine (86 percent in 2004 and 72 percent in 2002) and that they felt that they knew how to provide the medicine (86 percent in 2004 and 73 percent in 2002) (Appendix Table A-4.18).

There is an improvement in availability of prescribed medicines from 2002 to 2004, with more caretakers leaving the facility with at least some of the medicines prescribed for their child. Similar to findings in 2002, 30 percent of the caretakers had all prescribed medicines with them; however, 43 percent had some medicines and some prescriptions (22 percent in 2002), and only 28 percent (47 percent in 2002) had only prescriptions. Twenty-one percent (16 percent in 2002) had prescriptions for injections to be filled outside the facility (Appendix Table A-4.18).

The ESPA 2004 observed therapeutic injections provided to children in facilities offering sick child services (the observed children were not necessarily those whose consultation was observed) for infection prevention practices (see section 3.5). Therapeutic injections were observed for 213 children under five years of age (Table 3.13). Among these, new needles and syringes were observed being used for almost

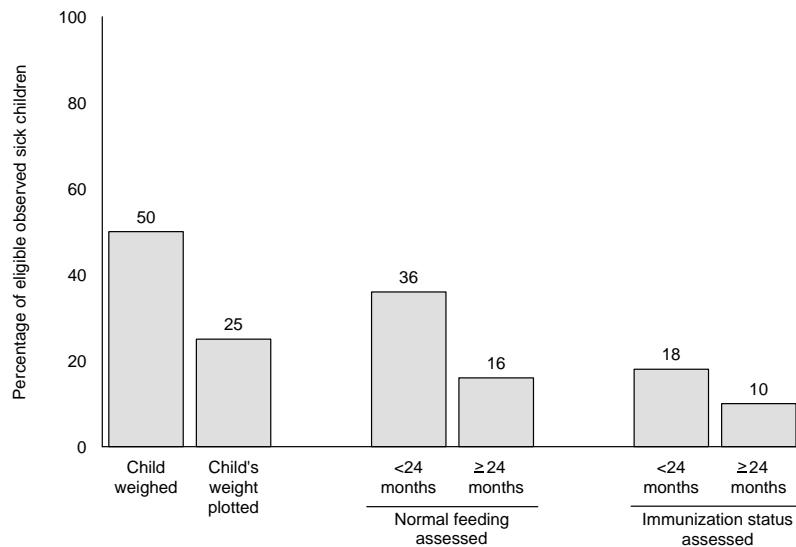
all injections (99 percent in 2004 and 95 percent in 2002). Use of sharps boxes for therapeutic injections has increased from 45 percent in 2002 to 70 percent of observed therapeutic injections in 2004.

4.6.4 Reducing Missed Opportunities for Promoting Child Health Care

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

There has been a modest increase in the proportion of sick children who are weighed (50 percent in 2004 and 42 percent in 2002) (Figure 4.14) and for whom the weight is plotted against a standard (25 percent in 2004 and 20 percent in 2002). Assessment of normal feeding practices for children of all ages has also improved, with normal feeding patterns assessed for 36 percent of children below 24 months of age (26 percent in 2002) and for 16 percent of older children (9 percent in 2002).

Figure 4.14 Observed preventive assessments (N=2,156)
(<24 months N=1,171)



Egypt SPA 2004

Assessment of immunization status for sick children continues to be low, with immunization status observed being assessed for 18 percent of children below 24 months of age (15 percent in 2002) and for 10 percent of older children (7 percent in 2002).

Key Findings

Although providers reasonably adapted their evaluation to their assessment of the type of illness and its severity, complete evaluations, including questioning about signs and symptoms and physical examinations for children diagnosed as having a serious illness, are rarely conducted.

Antibiotic use since 2002 has increased for the nonsevere cases for most diagnoses. Guidelines with indications for antibiotic use may be warranted.

Provision of essential information on continuing to provide food and fluids as well as symptoms for immediate return continues to be low, with only 8 percent of the caretakers receiving this information. Provision of the first dose of oral medication at the facility continues to be a rare practice (3 percent for 2004).

The need to purchase many prescribed medicines outside the facility continues (for 70 percent of the observed clients); however, there has been improvement in the proportion of clients leaving the facility with at least some of their medicines, with the number of clients leaving a facility with only prescriptions falling by half (28 percent in 2004 compared with 47 percent in 2002).

Safe disposal practices for used needles after therapeutic injections improved (70 percent in 2004, compared with 45 percent in 2002).

Opportunities to promote preventive health interventions each time a child is brought to a facility for a consultation are being missed. These preventive practices are not routine policy throughout the health facilities.

4.6.5 Counseling on Child Health Issues and Supporting Continuity of Care

There has been essentially no change from 2002 to 2004 in the use of visual aids during the consultation with the caretaker. Use continues to be almost nonexistent (3 percent) (Table 4.6). It should be recalled that only 26 percent of facilities have any visual aids available for use for child health services (see Figure 4.4).

Appropriate use of child health cards has also not changed since 2002. Frequently, health services are organized in such a way that measurements of temperature, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client record. Although it was noted that one in three facilities collects some of the relevant information outside the consultation room (data not shown), the provider referred to the child health card during only 13 percent of the observations (Table 4.6); thus, they might not have used information from measurements taken by others in their assessment of the child. Only 17 percent of the providers wrote any note on a child health card at the end of the consultation (Table 4.6), thereby leaving no written record for reference during subsequent illnesses or followup visits.

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

Percentage of observations where visual aids were used when providing health education to the caretaker of observed sick children, percentage of observations where the provider referred to the child health card, percentage of observations where the provider wrote on the child health card, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of observations where visual aids were used for health education	Use of individual health card		Number of observed sick children (weighted)
		Percentage of observations where provider referred to card during consultation	Percentage of observations where provider wrote on card after consultation	
Type of facility				
GS hospital	1	5	7	468
Fever hospital	3	0	0	118
MCH/urban HU	2	18	24	505
Rural HU	5	16	21	977
Mobile unit	0	0	0	23
Health office	10	17	17	16
NGO facility	0	4	4	50
Regions				
Urban Governorates	5	8	9	249
Lower Egypt	3	14	22	1,047
Upper Egypt	3	13	14	861
Total	3	13	17	2,156

Key Findings

Little or no progress has been observed from 2002 to 2004 in the use of visual aids when talking with caretakers (3 percent), although visual aids for caretaker education are available in 26 percent of facilities.

Use of individual child health cards to provide continuity of care also continues to be low, with only 13 percent of providers using the card during the consultation and 17 percent writing a note after the consultation. This limits the ability for the provider during this visit, or during subsequent visits, to have all relevant information for provision of continuity of care.

4.7 Caretaker Opinion from Exit Interviews

Prior to leaving the facility, observed caretakers of sick children were interviewed for their opinions on the processes of the consultation, the quality of the providers' services, and the principal problems encountered on the day of the visit. The caretaker was read a list of specific issues commonly related to client satisfaction and was asked to rate the issue as a big or small problem or as no problem.

Caretakers' opinions indicate a slight improvement in the satisfaction with the process of consultation and the quality of providers' services, with fewer feeling they received insufficient explanation about the child's illness (6 percent in 2004 compared with 13 percent in 2002) and a slightly smaller proportion feeling lack of medicine in the facility is a problem (16 percent in 2004, compared with 19 percent in 2002). More caretakers in 2004 reported that they chose the facility because of the physician's efficiency

(41 percent in 2004, compared with 28 percent in 2002), and more also reported that they chose the facility because of a geographical convenience (64 percent in 2004, compared with 59 in 2002). More information on caretaker opinion and personal characteristics is provided in Appendix Tables A-4.21 through A-4.24.

Key Findings
<p>Lack of availability of medicines and supplies, although slightly improved since 2002 (16 percent in 2004, compared with 19 percent in 2002), still was a primary complaint of the caretakers.</p> <p>An overly long waiting time and insufficient explanation about their child's illness were considered big problems by 8 percent of caretakers, indicating a slight improvement since 2002.</p> <p>The efficiency of the physician and the nearness of the facility were two of the main reasons for using the facility for the child's health services, and both factors improved between 2002 and 2004.</p>

5.1 Background

5.1.1 ESPA 2004 Approach to Collection of Family Planning Services Information

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

- Couples may wish to limit family size or delay a desired pregnancy.
- Appropriate spacing of births benefits maternal and child health. Studies have shown that spacing births at least two to three years apart contributes significantly to decreasing infant mortality (Govindasamy et al., 1993; Rutstein, 2000). Although there are fewer studies on the effects of spacing births on maternal health, it is generally accepted that too frequent births result in maternal depletion of essential minerals and vitamins.
- Preventing pregnancies that may worsen chronic or acute illnesses, including HIV/AIDS, benefits women's health.

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

- The availability of a variety of contraception methods to address client preferences and client-specific suitability of method (from the point of view of society and health)
- Counseling and screening of clients for appropriateness of methods
- Client education, using visual aids to increase information retention regarding options, side effects, and appropriate use of the method
- Availability of infrastructure and resources necessary for providing quality family planning services: equipment for client examinations, service guidelines and protocols, trained staff, a service delivery setting that allows client privacy, and procedures for preventing infections
- Availability of other health services relevant for family planning clients. These include education and services for reproductive tract infections and sexually transmitted infections (RTI/STIs) and programs geared toward groups with special needs to improve access and appropriate utilization of family planning services.

To increase the appropriate use of family planning, contraceptive services and counseling should ideally be available wherever maternal health, reproductive health, or child health services are provided.

This chapter uses information obtained in the ESPA 2004 to address the following central questions about the delivery of family planning services:

- What is the availability of family planning services?

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

5.1.2 Family Planning Services in Egypt

The Ministry of Health and Population (MOHP) reproductive health and family planning clinics constitute the majority of all family planning clinics in Egypt. During the past year, in response to a communication from the Minister of Health and Population, all MOHP facilities are encouraged to offer family planning services. This includes categories of facilities (such as fever hospitals) that previously did not offer the service. At the end of 2004, the MOHP reported there were 5,111 family planning clinics run by MOHP. The MOHP family planning clinics include rural health units (rural HUs), maternal and child health/urban health units (MCH/urban HUs), clinics at general service (GS) hospitals (these include general, district, and integrated hospitals), and mobile units.

Use of reproductive health services has been increasing over the years, with modern contraceptive use increasing between 1980 and 2003 from 24 to 60 percent of currently married women age 15-49. Most of the increase took place in the late 1980s, with virtually no change in the overall rate of use between 1991 and 1995, followed by another increase between 1995 and 1997 (El-Zanaty and Way, 2004). The 2003 Egypt Interim Demographic and Health Survey (EIDHS 2003) documented 57 percent of currently married women of reproductive age using modern methods of contraception. The intrauterine device (IUD) is the most widely used method, followed by the oral contraceptive pill (37 and 9 percent, respectively). The majority of the pill users (82 percent) obtain their methods from a private pharmacy. Two-thirds (61 percent) of all IUD users go to public sector facilities.

The Population and Family Planning Program has been relatively effective over time. Total fertility has decreased from 5.3 children per woman (age 15-49 years) in 1979-1980 to 3.2 in 2003. Success has been uneven across the country, with fertility rates higher in rural (3.6) than in urban areas (2.6), and higher in Upper (3.8) than in Lower Egypt (3.1) and in the Urban Governorates (2.3) (El-Zanaty and Way, 2004).

5.2 Availability of Family Planning Services

Methods of family planning differ in how they function, their effectiveness, their side effects, the ease with which they can be administered, and, in view of these issues, their acceptability and desirability to the users. To meet the varying needs and demands for contraception, a variety of methods should be available at a frequency that meets common needs (Curtis and Bright, 1997).

The modern methods most commonly used in Egypt (El-Zanaty and Way, 2004) are—

- IUDs
- Contraceptive pills
- Contraceptive injections.

Other, less commonly used methods include the progesterone implant, male condoms (female condoms are not available), female sterilization, rhythm (natural family planning), diaphragm, spermicides, and emergency contraception. Male sterilization is not available in Egypt, and female sterilization, while offered, is primarily considered for birth control only when a woman has a health condition that makes pregnancy a serious health risk.

Summary information on the availability of family planning services is provided in Table 5.1, and information on the frequency with which family planning services are offered is provided in Table 5.2. Figure 5.1 provides details on the availability of different methods of contraception, and Appendix Tables A-5.1 through A-5.3 provide further details on method availability by type of facility and region.

Table 5.1 Availability of family planning services					
Percentage of all eligible facilities offering the indicated methods of family planning, by type of facility and region, Egypt SPA 2004					
Background characteristics	Facilities eligible for offering family planning (FP) services		Among facilities offering any modern methods of family planning:		
	Percentage offering any modern method of FP ¹	Number of facilities (weighted)	Percentage offering all four of the most common methods ²	Percentage offering counseling on rhythm method	Number of facilities (weighted)
Type of facility					
GS hospital	100	65	95	64	65
Fever hospital	10	14	100	52	1
MCH/urban HU	98	97	92	70	96
Rural HU	100	319	86	70	319
Mobile unit	100	55	87	63	55
Health office ³	86	33	70	62	28
NGO facility	95	76	57	58	72
Region					
Urban Governorates	98	72	70	58	71
Lower Egypt	97	322	93	78	312
Upper Egypt	96	264	76	55	253
Total	97	659	84	67	637
¹ Any of the following: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), implants, IUDs, male condoms, spermicides, diaphragm, or emergency contraceptive. Permanent methods (sterilization) are not included. ² The four most common methods used in Egypt are the IUD, the combined oral pill, the progesterone injection, and the male condom. ³ Often, health offices are located in a hospital or MCH unit. In these cases, family planning services may be offered by the hospital or MCH unit, rather than through the health office.					

5.2.1 Method Availability

A facility that offers all methods of family planning is best able to meet the needs of clients. However, some variation in the methods that facilities offer is expected because of differences in the provider qualifications and training, as well as infrastructure required to provide the methods safely. Methods that can be provided safely with minimal training are pills, injections, and condoms, as well as the rhythm method. Implants and IUDs require a higher level of skill and a more developed infrastructure to provide safely.

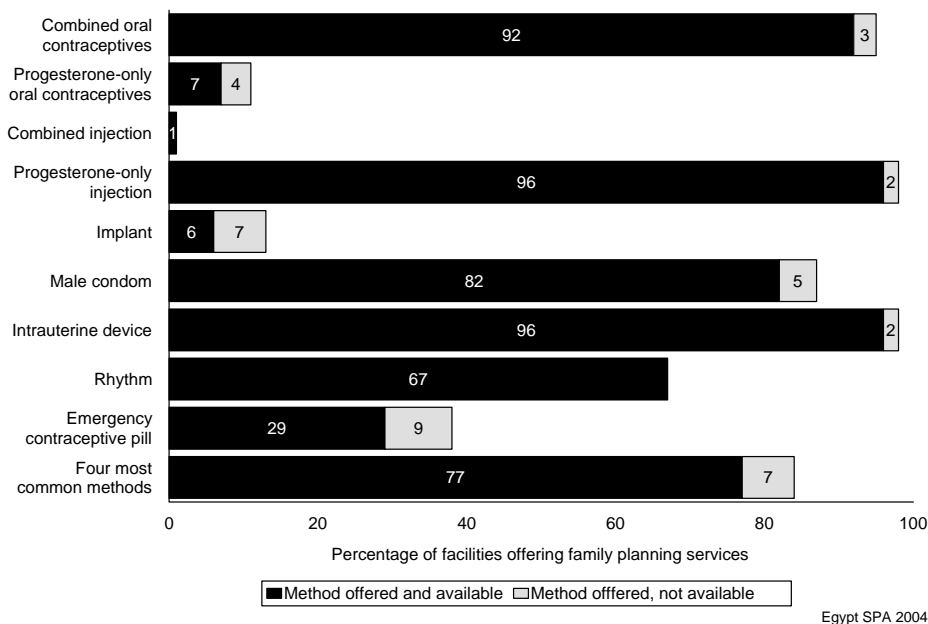
From 2002 to 2004, the proportion of eligible facilities offering a modern method of family planning remained stable,¹ at 97 percent, with 84 percent offering all of the four most common methods (Table 5.1)

¹ In 2004, fever hospitals were beginning to offer family planning services in response to a policy directive from MOHP.

and 77 percent having a supply of all four methods on the day of the survey (Figure 5.1). Sixty-seven percent of facilities offer counseling on the rhythm method, a decrease from 78 percent in 2002. A larger proportion of facilities in Lower Egypt offer the four most common methods (93 percent), compared with those in the Urban Governorates (70 percent). NGO facilities offer less variety in methods, with only 57 percent offering the four most commonly used methods. The proportion of health offices offering the four methods has substantially decreased, from 89 percent in 2002 to 70 percent in 2004. Four percent of facilities report that they offer female sterilization as a method of birth control; this is a slight increase over the 2 percent in 2002, with GS hospitals continuing to be the main service site (25 percent) (Appendix Table A-5.1). Fifteen percent of GS hospitals offered female sterilization in 2002. The percentage of facilities that provide tubal procedures may be higher than this because, in Egypt, tubal ligation is more often provided for medical reasons than for family planning purposes.

Although the proportion of facilities offering the most commonly used methods had remained stable, a shift in the offering of less popular methods, however, has been noted, with the supply of the less frequently used methods, where offered, being a problem both in 2002 and 2004.

Figure 5.1 Method of contraception offered and availability of method on the day of the survey (N=637)



Egypt SPA 2004

The proportion of facilities offering the implant method has increased from 8 percent in 2002 to 13 percent in 2004, although, as in 2002, supply remains a problem, with implants actually available at only half of the facilities where offered, on the day of the survey (Figure 5.1). From 2002 to 2004, although still available across Egypt, Norplant was slowly being replaced by Implanon, a new brand of implant with three-year protection (data not shown). Because of the relatively short period of validity for implant methods, they are not commodities for which a facility should maintain a three-month supply, as per the MOHP logistic strategy for commodity security.

Emergency contraceptive pills are offered at 38 percent of facilities (a decrease from 54 percent in 2002), with one in four facilities lacking an emergency contraceptive method the day of the survey. The progesterone-only pills (which can be used for emergency contraception) are offered at a smaller proportion of facilities (11 percent in 2004, compared with 53 percent in 2002) and also have supply problems. Progesterone-only pills and emergency contraceptive pills are not routinely procured for

MOHP family planning services. The combined injectable method continues to be offered rarely (1 percent of facilities) and primarily by NGO facilities (6 percent) (Appendix Table A-5.1).

5.2.2 Frequency of Services

In addition to providing a range of methods, it is important that family planning services be offered regularly to meet client needs. Similar to findings in 2002, family planning services are offered five days per week by almost all facilities (95 percent) that provide family planning services (Table 5.2). NGO facilities and health offices offer services the least frequently of all facilities.

Table 5.2 Frequency of availability of family planning services				
Percentage of facilities where temporary methods of family planning are offered the indicated number of days per week, by type of facility and region, Egypt SPA 2004				
Background characteristics	Percentage of facilities where family planning (FP) ¹ services are offered:			Number of facilities offering FP services (weighted)
	1-2 days per week	3-4 days per week	5 or more days per week	
Type of facility				
GS hospital	0	0	100	65
Fever hospital	0	0	100	1
MCH/urban HU	0	0	100	96
Rural HU	1	3	97	319
Mobile unit	0	0	100	55
Health office	7	8	85	28
NGO facility	14	14	72	72
Region				
Urban Governorates	4	5	92	71
Lower Egypt	1	3	96	312
Upper Egypt	4	2	94	253
Total	2	3	95	637

¹ Any of the following methods: oral contraceptives (combined or progesterone only), injections (combined or progesterone only), implants, IUDs, male condoms (female condoms are not available), spermicides, diaphragm, or emergency contraceptive

Key Findings

From 2002 to 2004, the proportion of health facilities offering a modern method of family planning remains at 97 percent, with 84 percent offering all four most common methods and 95 percent of facilities offering services at least five days per week.

The supply for the four most commonly used methods is reliable, with 77 percent of facilities offering the four methods (combined oral contraceptives, progesterone injection, male condom, and IUD) and having all four methods available on the day of the survey.

There has been a shift among the less commonly used methods, with a smaller proportion of facilities in 2004 offering progesterone-only oral pills and emergency contraception, but a slightly larger proportion offering implants. The supply for less frequently used methods is less reliable than that for the more commonly used methods.

NGO facilities offer the least variety in methods, with only 57 percent offering the four most commonly used methods.

5.3 Components Supporting Quality Family Planning Services

In order to provide family planning services, adequate infrastructure and resources must be available to support quality counseling and examination of family planning clients. In addition, provision of RTI/STI services, relevant to family planning clients (STI services), and the equipment and supplies for each offered method are important.

5.3.1 Infrastructure and Resources to Support Quality Assessment and Counseling of Family Planning Clients²

For quality counseling for family planning, there is a need for some level of privacy, individual client health cards or records, written service guidelines or protocols, and visual aids.

Aggregate information for items to support quality counseling is provided in Table 5.3, and information on the availability of each specific item for counseling is provided in Figure 5.2. Details on the items assessed for each of the components for counseling are provided in Appendix Table A-5.4, and details on available visual aids and guidelines, by type of facility, are provided in Appendix Table A-5.5.

Family planning is often a sensitive issue for discussion, and providing counseling under conditions where clients can be reasonably assured that the conversation cannot be overheard improves communication and, ultimately, the likelihood that the method provided is suitable for the client. Privacy for counseling is almost universally available, with 86 percent of facilities (Figure 5.2) counseling family planning clients in either a private room (79 percent) or a room where there is a visual screen (7 percent) (Appendix Table A-5.4).

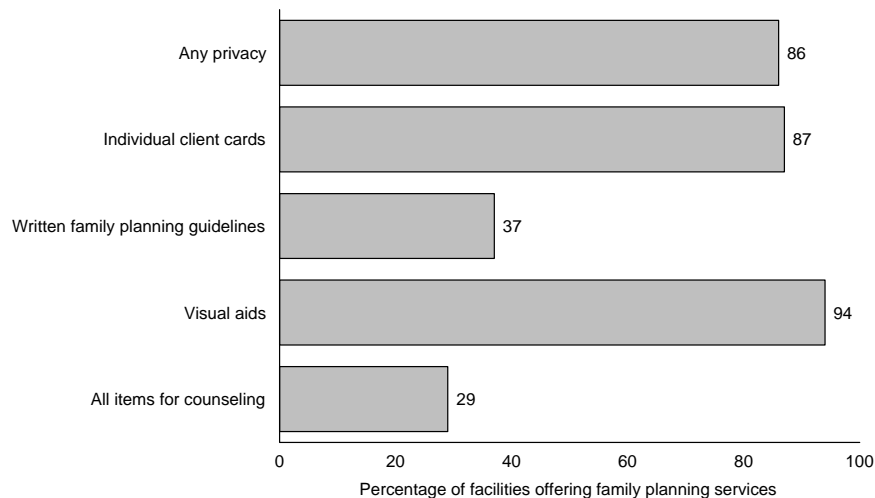
Individual cards or records for family planning clients are important for monitoring a client over time and for ensuring continuity of care. Because facilities often do not keep client records, but rather give them to the clients to keep, the ESPA 2004 assesses the availability of blank cards for new family planning clients. Individual client cards are found at 87 percent of facilities (Figure 5.2).

² Counseling about family planning often takes place in a location different from where procedures (e.g., pelvic examinations, IUD insertions) are conducted; thus, the conditions for counseling are assessed separately from those for procedures.

Written guidelines or protocols for family planning that include information on screening for eligibility for different methods must be available in the family planning service delivery area or in an immediately adjacent area to be considered available for use. Guidelines or protocols are available in the family planning service area in only 37 percent of facilities (Figure 5.2). This is a decrease from 46 percent in 2002.

Visual aids related to family planning are available in the service delivery area in 94 percent of facilities (Figure 5.2), similar to findings in 2002.

Figure 5.2 Items to support quality counseling for family planning (N=637)



Egypt SPA 2004

All assessed items to support quality counseling are available in 29 percent of facilities (Table 5.3), a decline from 37 percent in 2002, due principally to a smaller proportion of facilities having service guidelines or protocols. NGO facilities, mobile units, and facilities in Upper Egypt are least likely to have all items.

5.3.2 Infrastructure and Resources for Examinations

Frequently, a physical examination, often including a pelvic examination, is necessary to determine the suitability of a method, to insert a method, or to evaluate problems with a method. This requires an adequate level of infection control as well as infrastructure and furnishing for examining the client.

Aggregate information for items assessed for infection control and pelvic examinations is provided in Table 5.3, and information on the availability of each specific item for infection control and pelvic examinations is shown in Figure 5.3. Details on the items assessed for each of the components are provided, by type of facility, in Appendix Table A-5.4, and details on processing equipment are given in Appendix Tables A-5.6 through A-5.9.

Infection Control

The ESPA 2004 assesses the presence of items for the control of infections in the area where family planning examinations (such as pelvic examinations) and provision of methods (the implant, IUD, and injection) most often take place. All items for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) are available in the family planning service area in one of five facilities (18 percent) (Table 5.3). All items are present in a higher proportion of facilities in Lower Egypt (one in four) and in MCH/urban HUs (one in three) than in other regions or types of facilities. MOHP infection control guidelines are found in only 4 percent of the family planning service areas (Appendix Table A-5.5).

The items most often lacking are latex gloves (missing in 70 percent of facilities), followed by soap and sharps boxes (both items missing in approximately one-third of facilities) (Figure 5.3). From 2002 to 2004, soap provision has improved, with availability increasing from 51 percent in 2002 to 67 percent in 2004. Availability of sharps boxes has not changed.

The percentage of facilities with latex examination gloves decreased from 50 percent (2002) to 30 percent (2004). As explained in more detail in section 3.4.3, this may reflect more accurate data collection, rather than a change in availability of gloves. Thin, nonlatex disposable gloves are universally available in all service areas where pelvic examinations are conducted, but these are not accepted for infection control. This point was emphasized more during the ESPA 2004 training than it was in 2002.

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

Percentage of facilities with the indicated elements to support quality counseling, examination, and treatment of FP clients, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:					
	All items to support quality counseling ¹	All items for infection control ²	Capacity for sterilization/HLD processing ³	Conditions for quality pelvic examination ⁴	STI treatment provided by FP providers	Number of facilities offering FP (weighted) ⁵
Type of facility						
GS hospital	45	23	61	83	88	65
MCH/urban HU	39	31	84	75	87	96
Rural HU	30	17	51	67	79	319
Mobile unit	6	12	81	65	82	55
Health office	25	4	40	46	64	28
NGO facility	13	11	38	75	86	72
Region						
Urban Governorates	24	11	67	78	93	71
Lower Egypt	38	24	57	63	85	312
Upper Egypt	19	13	56	76	73	253
Total ⁵	29	18	57	70	81	637

¹ Visual privacy, individual client cards, written guidelines or protocols related to family planning, and visual aids related to family planning

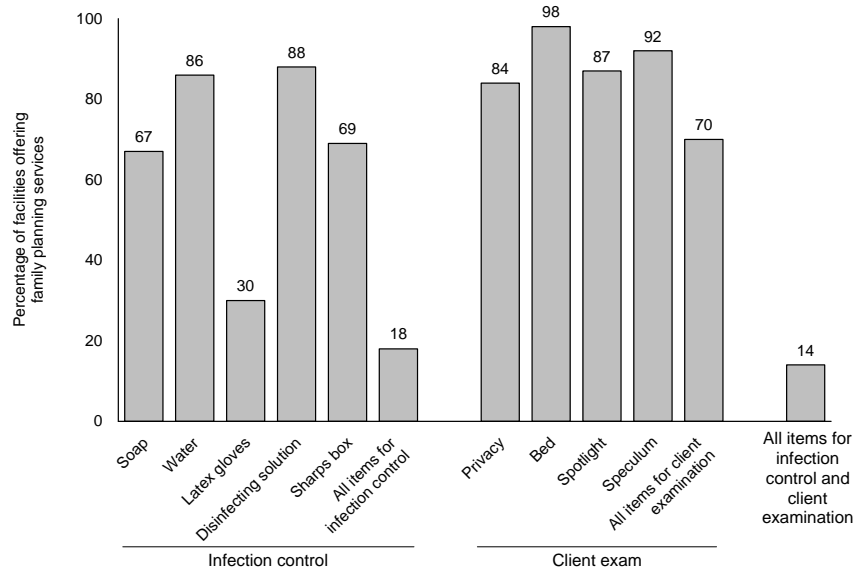
² Soap, water, clean latex gloves, disinfecting solution, and sharps box

³ In location where family planning equipment is processed, equipment and knowledge of minimum processing time for sterilizing or high-level disinfection (HLD) processing are present, and an automatic timing device is available

⁴ Private room (visual and auditory privacy), examination bed, examination light, and vaginal speculum

⁵ One fever hospital offers family planning.

Figure 5.3 Conditions for quality examination of family planning clients (N=637)



Egypt SPA 2004

Equipment for family planning services often requires sterilization or high-level disinfection (HLD) so that it can be reused. Around half of all facilities process equipment specifically in the family planning service area, and the rest send equipment to the main processing area in the facility (Appendix Table A-5.6). Overall, 87 percent of facilities have functioning equipment and a person who knows the proper processing procedure for the sterilization or HLD method used for family planning equipment³ (Appendix Table A-5.7). This is somewhat higher than findings in 2002 (78 percent). An automatic timing device is also important for supporting quality sterilization or HLD processing. When this criteria is added, 57 percent of facilities have the equipment, knowledge, and an automatic timing device (Table 5.3), with the timing device missing most often for facilities where HLD processing (boiling, steaming, or using chemicals) is used.

Examination

Conditions for examination of family planning clients have not changed from 2002 to 2004, with 70 percent of facilities having all items for conducting examinations such as pelvic exams or implant insertions (Table 5.3). The weak areas are a lack of sufficient privacy (16 percent) and lack of a spotlight for visualizing the cervix or implant site (13 percent) (Figure 5.3). Health offices continue to be least likely to have all the equipment and furnishings for client examination (46 percent).

5.3.3 Provision of RTI/STI Treatment for Family Planning Clients

Because they are sexually active, family planning clients are at increased risk for contracting STIs. Consequently, counseling for prevention, as well as diagnosis and treatment, is essential for quality family planning care. It is particularly important to diagnose and treat STIs and other vaginal infections for women who use the IUD, the modern method most commonly used in Egypt. If these services are

³ In Chapter 3, sections 3.4.1 and 3.4.2 provide details on the definitions for adequate sterilization or HLD procedures and for appropriate storage conditions, respectively.

available at the same time and place as family planning services, it is more likely that clients will have the necessary exams and will receive the appropriate treatment for an RTI/STI if needed.

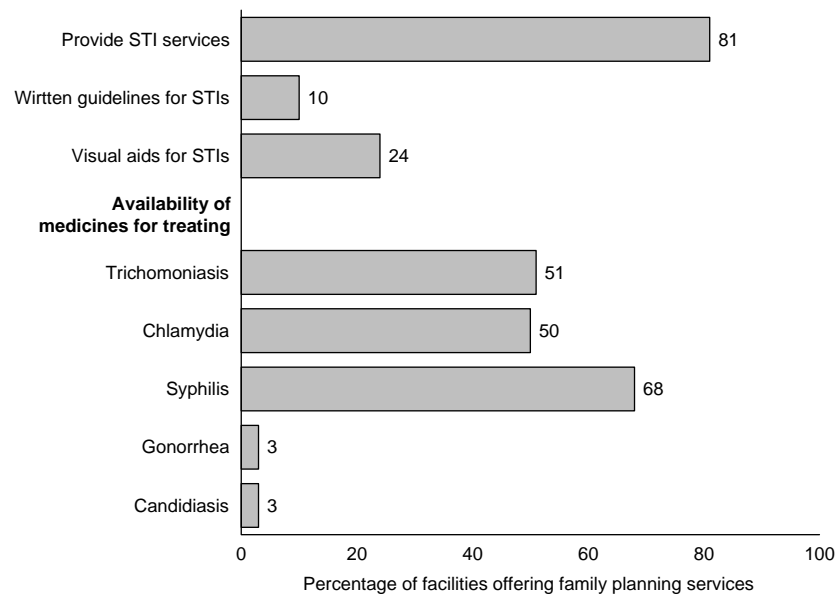
Figure 5.4 provides information on items for RTI/STI services. Appendix Table A-5.10 provides details, by type of facility, on the RTI/STI service items, including medicines for treating specific STIs.

There has been no change since 2002 in the percentage of facilities (81 percent) where family planning service providers diagnose and treat STIs when necessary (Table 5.3 and Figure 5.4). The provision of RTI/STI services by family planning providers was observed, with 38 percent of the 541 observed RTI/STI clients receiving both family planning and RTI/STI services from the family planning service provider (Table A-7.10).

Written guidelines for diagnosis and treatment of STIs are available in the family planning service area in 10 percent of facilities (Figure 5.4), with the World Health Organization (WHO) syndromic approach guidelines found in only 1 percent of facilities (Appendix Table A-5.5). This is lower than in 2002, when 15 percent of facilities had RTI/STI treatment guidelines and 7 percent had WHO guidelines for the syndromic approach. Visual aids for client education related to STIs are available in 24 percent of facilities.

Treatment for each of the three most common STIs is available in half of facilities (Figure 5.4), while medicine for treating gonorrhea and candidiasis (a common infection) is available in only 3 percent of facilities (Figure 5.4). These findings are slightly worse than the 2002 findings.

Figure 5.4 Conditions to support quality STI services for family planning clients (N=637)



Egypt SPA 2004

Key Findings

Privacy for family planning counseling services, individual family planning client cards, and visual aids are commonly available (at around nine in ten facilities).

Guidelines or protocols for family planning, however, are not available in two-thirds of facilities.

All assessed items for infection control are available in the family planning service area in 18 percent of facilities, with latex gloves the most commonly missing item (missing in 70 percent of facilities).

Fifty-seven percent of facilities have all elements for quality sterilization or HLD processing of family planning equipment.

All furnishings and equipment for pelvic examinations are available in 70 percent of facilities.

STI service provision by family planning providers is common (81 percent of facilities), but availability of medicines to treat STIs and common vaginal infections is low. Only 3 percent of facilities offering family planning services have medicines for treating candidiasis or gonorrhea.

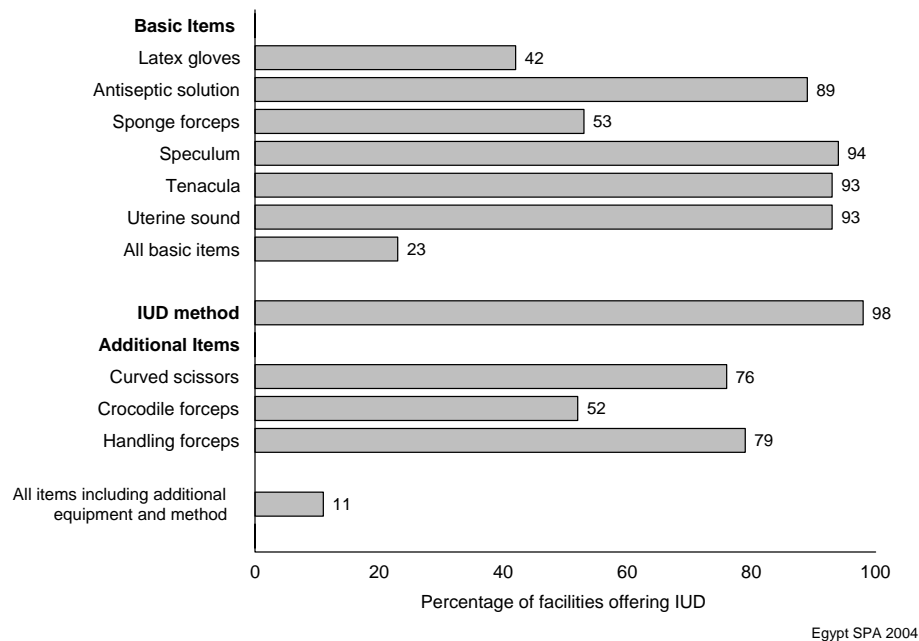
5.3.4 Availability of Equipment and Supplies for Specific Methods

Different contraceptive methods require different equipment to provide the method safely and to monitor the client. Figure 5.5 provides information to assess the availability of items basic to the provision of the IUD. Appendix Tables A-5.11 through 5.13 provide additional details on the availability of equipment and supplies for specific methods, including the IUD and implant methods.

Women receiving family planning methods with estrogen need to be monitored for hypertension. Among facilities providing methods containing estrogen, 89 percent have a blood pressure apparatus and 72 percent have an adult weighing scale (Appendix Table A-5.11). Among those providing injectable contraceptives, 85 percent have sterile needles and syringes (Appendix Table A-5.11). In Egypt, each progesterone injection vial is supplied with a syringe; so it is possible that 2 percent of the facilities without sterile needles and syringes were those facilities without progesterone injection available the day of the survey (Figure 5.1). Why syringes are missing for the other 13 percent is uncertain. It is possible that syringes were used elsewhere. Availability of these items is similar to or slightly lower than findings in 2002.

Among those facilities offering IUDs, 23 percent have the basic equipment necessary for insertion (Figure 5.5). Although this is a decline from 39 percent in 2002, the difference is due primarily to a decrease in availability of latex gloves. As mentioned previously, this probably reflects a more accurate assessment of gloves as latex or nonlatex in 2004. There is also a decline in availability of sponge forceps (53 percent in 2004, compared with 74 percent in 2002). In total, 11 percent of the facilities offering the IUD method have all of the basic equipment for insertion and additional items that were assessed for quality insertion and removal of the IUD (Figure 5.5).

Figure 5.5 Equipment for IUD insertion and removal (N=625)



Key Findings

Blood pressure equipment is available in 89 percent of facilities offering family planning methods containing estrogen.

Although IUDs are one of the most commonly provided contraceptive methods, only 23 percent of facilities have all items necessary for quality IUD insertion.

5.4 Management Practices Supportive of Quality Family Planning Services

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

Summary information on management practices is provided in Table 5.4. Information on topics for in-service training and when training was received is provided in Figure 5.6. Utilization statistics for family planning services are provided in Appendix Table A-5.14. Details on charging practices for family planning services are provided in Appendix Tables A-5.15 through A-5.17. Details on in-service training and supervisory activities from the provider's perspective are provided in Appendix Tables A-5.18 through A-5.20.

5.4.1 Facility Documentation and Records

The ESPA 2004 assesses the availability of up-to-date client registers with information on family planning services provided. This is most often the source of health information system data. A register is defined as up to date if there is an entry within the past seven days, and the entry, at minimum, reports the method or service provided and the client's status (first visit or followup visit). Almost all (91 percent) facilities have an up-to-date register (Table 5.4), with the exception of NGO facilities, where only about half have an up-to-date family planning register.

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

Percentage of facilities with up-to-date family planning (FP) registers, percentage where there are some user fees for family planning services, and percentage with the indicated supportive management practices, by type of facility and region, Egypt SPA 2004

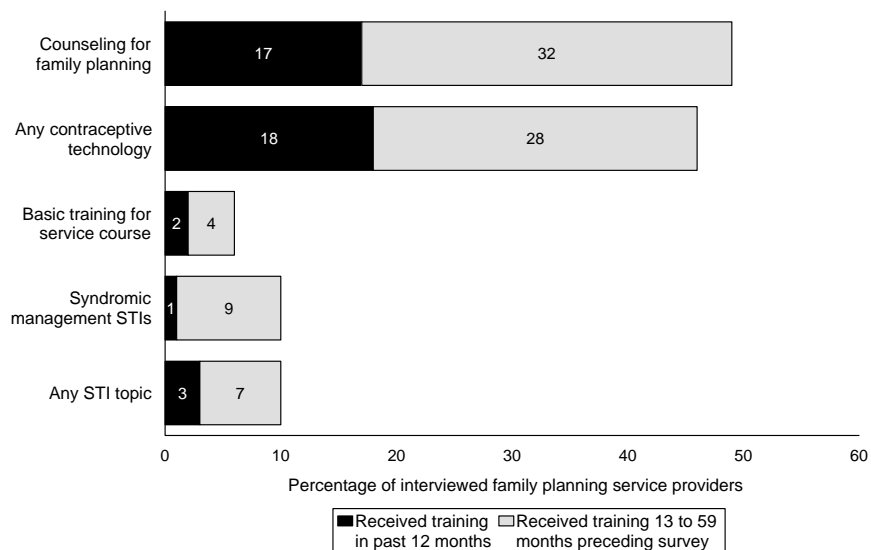
Background characteristics	Facilities that offer family planning services			Percentage of facilities where at least half of the interviewed FP service providers		Number of facilities with interviewed FP service providers (weighted) ³
	Percentage with observed up-to-date patient register ¹	Percentage with user fees for FP services	Number of facilities offering FP (weighted)	Received in-service training during past 12 months ²	Were personally supervised during past 6 months	
Type of facility						
GS hospital	99	97	65	28	96	65
Fever hospital	100	100	1	100	100	1
MCH/urban HU	96	99	96	35	98	96
Rural HU	96	98	319	15	99	319
Mobile unit	95	36	55	39	88	55
Health office	89	84	28	37	100	27
NGO facility	49	97	72	17	57	71
Region						
Urban Governorates	82	92	71	26	83	71
Lower Egypt	93	94	312	19	95	312
Upper Egypt	90	90	253	27	93	251
Total	91	92	637	23	93	635

¹ Register has entry within past seven days and indicates visit status (first or followup) and service provided.

² This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

³ This includes only providers of family planning services in facilities offering family planning services.

Figure 5.6 In-service training received by interviewed family planning service providers, by topic and timing of most recent training (N=1,294)



Egypt SPA 2004

5.4.2 Practices Related to User Fees

Health insurance is not applicable for family planning clients in public sector facilities. Information on user fees is similar for 2002 and 2004. Most facilities (92 percent) have some type of user fees for family planning services (Table 5.4).

5.4.3 Supervision and Staff Development

The types of contraceptive methods that are available and knowledge of the benefits and side effects of methods change over time. In-service training for providers aims to improve the quality of counseling, management of complications or side effects, and judgment and skills in assessing which contraceptive methods are most suitable for clients' needs.

If at least half of the interviewed family planning service providers at a facility have received any structured in-service training (excluding on-the-job training that may be received during discussions with supervisors) relevant to family planning during the past 12 months, the facility is defined as having routine staff development. During the past 12 months, at least half of the interviewed family planning providers had received in-service training related to family planning in only 23 percent of facilities (Table 5.4). Counseling for family planning and contraceptive technology are the topics most often covered, with about 17 percent of the providers having received in-service training in at least one of these subjects during the past 12 months; with an additional one in three providers receiving in-service training during the 13 to 59 months preceding the survey (Figure 5.6). One percent of the interviewed family planning providers had received in-service training on syndromic management of STIs, and 3 percent had received training on any topic related to STIs during the past 12 months, with an additional 7 percent having received in-service training on a topic related to STIs during the 13 to 59 months preceding the survey. The percentage of staff receiving in-service training on topics related to STIs has decreased by half since 2002. A large decrease was noted in the percentage of providers who received an in-service basic training course for family planning during the five years preceding the survey (from 34 percent in 2002 to 6 percent in 2004) (Appendix Table A-5.19). This might be a reflection of a better understanding by interviewers of the definition of this course (the 2002 data collectors may have included preservice training on family planning as "basic training"). It was clarified in 2004 that the basic training course only referred to in-service training.

Supervision of individual staff helps to promote adherence to standards and to identify problems that contribute to poor-quality services. If at least half of the interviewed family planning service providers in a facility have been personally supervised in the past six months, the facility is defined as providing routine staff supervision. Similar to findings in other services, supervision of family planning providers is common, with at least half of the interviewed family planning providers having been supervised during the past six months in 93 percent of facilities (Table 5.4). Among providers who had been supervised, the median number of times they were supervised during the past six months was seven (Appendix Table A-5.20). These findings are similar to those in 2002.

Key Findings
Up-to-date registers are available almost universally (91 percent of facilities), except in NGO facilities, where they are found in only half of facilities.
Formal in-service training for family planning is routinely provided by only one in five facilities.

5.5 Adherence to Standards for Quality Service Provision

Observed family planning client-provider consultations are the basis for assessing whether providers adhere to standards for quality service. The observation checklists used are based on commonly accepted guidelines for screening, counseling, and conducting procedures for family planning clients.

The objective in the observations of the consultations is to note if information on a topic is shared or if an examination is conducted (process information). An assessment of whether the information is correct or whether findings are appropriately interpreted is not a component of the observation.

A total of 1,959 female clients were observed at 523 facilities.⁴ This was the first visit for 31 percent of the women, and 1 percent had no prior pregnancy (Appendix Table A-5.21). Exit interviews were conducted with all observed family planning clients. When two methods were prescribed or received, the client was assessed for knowledge about both their current method and the new method. Clients who left the facility with no method, but had prescriptions for a method, were also assessed for their knowledge about the prescribed method.

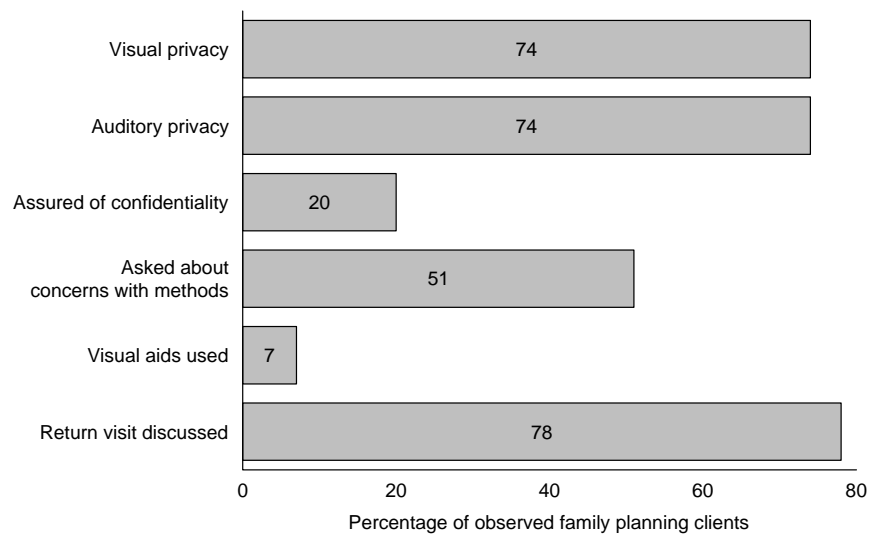
Further details on the observed client status and principal reason for the clinic visit on the day of the survey are provided in Appendix Table A-5.22. Details on the primary method provided, prescribed, or discussed during this visit are provided in Appendix Table A-5.23.

5.5.1 Assessment of Relevant History, Examination, and Counseling

Figure 5.7 provides information on components of family planning related to counseling, Figure 5.8 provides information on elements of the client history that were assessed for first-visit family planning clients, and Figures 5.9 through 5.12 provide information for consultations where clients received specific methods or procedures. Details on elements related to the consultation for first-visit clients are provided in Appendix Tables A-5.24 through A-5.26. Information from observations related to specific methods or examinations is provided in Appendix Tables A-5.27 and A-5.28.

⁴ These are actual numbers. Data in tables and figures are weighted to provide accurate representation by type of facility and governorate.

Figure 5.7 Observed conditions and content for family planning counseling (N=1,930)



Egypt SPA 2004

5.5.2 Counseling and Client Assessment

Counseling was conducted under conditions of both visual and auditory privacy for 74 percent of clients (Figure 5.7). Clients were rarely explicitly assured of the confidentiality of information shared (20 percent). Half of the clients, however, were explicitly asked about concerns about the methods discussed, and 78 percent were advised about a return visit. Visual aids were rarely used (7 percent) during the consultation. Privacy and confidentiality are somewhat improved from 2002, when 65 percent of observed family planning clients had full privacy and 14 percent were explicitly assured of the confidentiality of information shared.

Individual client cards are necessary to monitor a family planning client over time and to document relevant history so that it does not need to be collected multiple times. Frequently, health services are organized in such a way that measurements of blood pressure, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client record. This is the system for 31 percent of facilities (data not shown), similar to what was observed in 2002. An individual client record or chart is important for ensuring that information collected prior to the consultation is available to the provider. Among the observed consultations, the provider reviewed the client card either before or during the consultation for 66 percent of clients and wrote on the card after the consultation for 76 percent of clients (Appendix Table A-5.24). This is an improvement in practices to support continuity of care; in 2002, the provider was observed checking the client card for only 48 percent of consultations and writing on the card for 65 percent of the observed consultations.

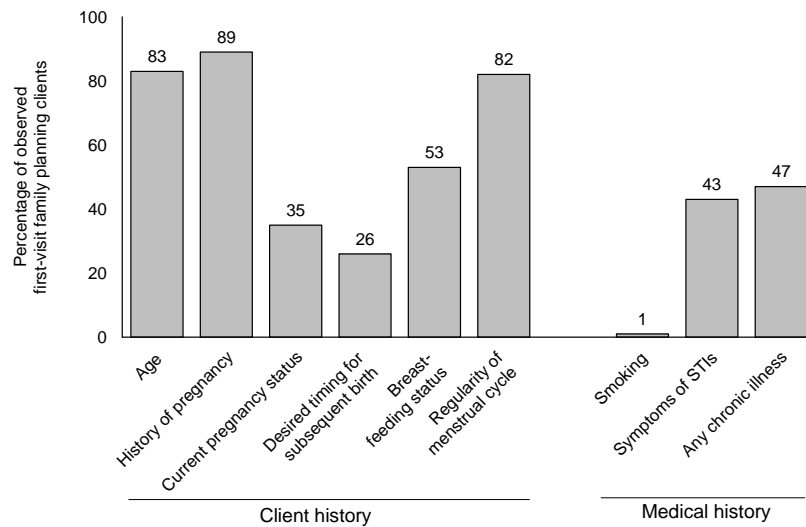
The assessment of relevant history for first-visit family planning clients continues to be incomplete, similar to findings in 2002. Among first-visit family planning clients, the provider should elicit relevant personal and health history that provides the information necessary to make an informed recommendation on contraceptive methods and to screen clients for the safety of specific methods. Client age, prior pregnancy history, and information on the regularity of the menstrual cycle were each assessed for over

80 percent of first-visit clients (Figure 5.8). Current pregnancy status (either ascertained through information sharing or through laboratory testing) and desired timing for the next pregnancy were the least frequently elicited items of client history (35 and 26 percent, respectively). Breastfeeding status, essential to ascertain when determining the suitability of different methods of contraception, was elicited for about half (53 percent) of the women (Figure 5.8). Assessment of the client medical history for risk status relevant to different methods of family planning was also poor. Almost none of the observed clients (1 percent) were asked about smoking, and less than half were asked about symptoms of STIs (43 percent) or chronic illnesses (47 percent). Traditionally smoking has not been common for women in Egypt, so assessment may not have been previously stressed. Recent information, however, suggests an increase in young women in Egypt who smoke, so assessment of smoking is of increasing relevance (MOHP, 1998; Global Youth Tobacco Survey Collaboration Group, 2001).

Finally, an assessment of the husband’s attitude toward family planning or factors related to the husband that might affect the risk for STIs or method choice occurred for only 14 percent of the consultations for observed first-visit clients (Appendix Table A-5.26). Condom use was discussed with none of the clients.

Use of visual aids during the consultation was rare; however, visual aids were used twice as often for first-visit clients (14 percent) than for all clients (7 percent) (Appendix Tables A-5.24 and A-5.26).

Figure 5.8 Observed elements of client history for first-visit family planning clients (N=593)



Egypt SPA 2004

Key Findings

Counseling for family planning clients is conducted under conditions that provide both visual and auditory privacy in 74 percent of facilities. Both counseling conditions and assurance of confidentiality (20 percent) have improved since 2002.

Assessment of relevant client history that might influence whether a family planning method is appropriate is not thorough, with around half or fewer first-visit clients assessed for current pregnancy or breastfeeding status, chronic illnesses, or symptoms of STIs. Almost no client was asked about smoking as a risk factor.

Visual aids are rarely used during counseling (7 percent of all clients).

5.5.3 Method-Specific Assessments and Examinations

First-visit clients usually receive a more complete examination than continuing clients, since examination findings help determine the appropriateness of a method. Among all first-visit clients, 65 percent had their blood pressure measured, 49 percent had their weight measured, 3 percent had their urine checked (usually for pregnancy), and 2 percent had a blood specimen taken (Appendix Table A-5.25).

Among all clients receiving methods with estrogen, where monitoring for hypertension should be a component of care, 66 percent had their blood pressure measured,⁵ and 51 percent had their weight measured (gaining weight may be an indicator of fluid retention and hypertension) (Appendix Table A-5.27).

MOHP is promoting breast examinations as an early detection and prevention measure for breast cancer. Among all observed clients, none received a breast examination, and only 6 percent were taught how to conduct breast self-examination (Appendix Table A-5.28).

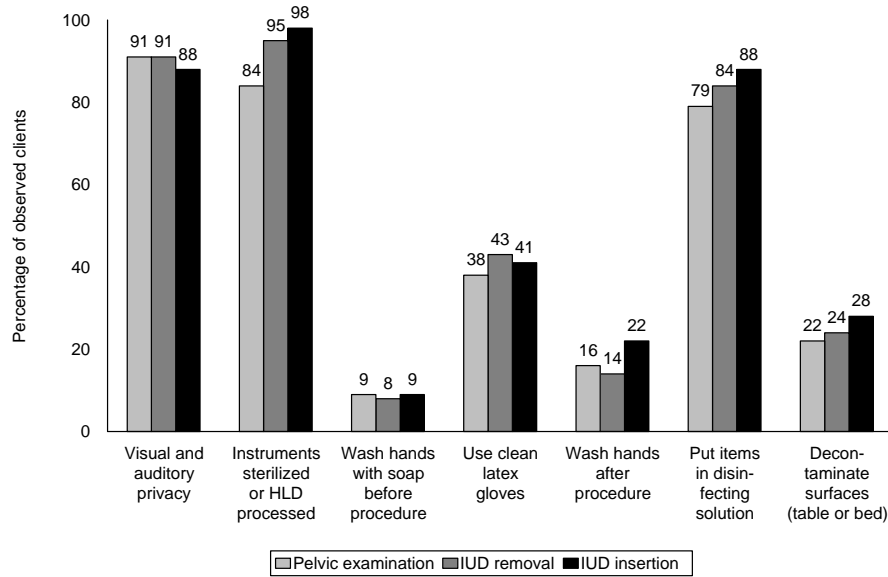
When clients received specific procedures, the observers noted whether critical information was shared, whether the procedure followed defined steps for quality, and whether infection control practices were followed.

Among the women who received pelvic examinations or IUD procedures, almost all (around nine in ten observed procedures) were conducted under conditions of both visual and auditory privacy (Figure 5.9). Sterilized or HLD-processed instruments were almost always used (84 percent for pelvic examinations and 98 percent for IUD insertion). Around one in ten providers washed their hands before the procedure, and two in ten washed their hands after the procedure. Latex gloves were used for only four in ten procedures. As mentioned previously, use of disposable gloves was universal, but these disposable gloves are nonlatex, thin, and easily torn, and are not defined by the ESPA 2004 as sufficient for infection control. Immediately placing items in disinfecting solution was a common practice (for around eight to nine in ten procedures); however, decontaminating the table or bed after the procedure was rare (about 25 percent).

As mentioned previously, it is uncertain if use of latex gloves during these procedures has decreased (around 67 percent in 2002) or if the type of glove was more accurately assessed in 2004.

⁵ If the client was observed in a facility where blood pressure is measured systematically prior to the consultation, the client was assumed to have HAD the blood pressure measured, even if this was not observed for the particular client.

Figure 5.9 Key components for pelvic examination (N=285), IUD insertion (N=384), and IUD removal without reinsertion (N=152)

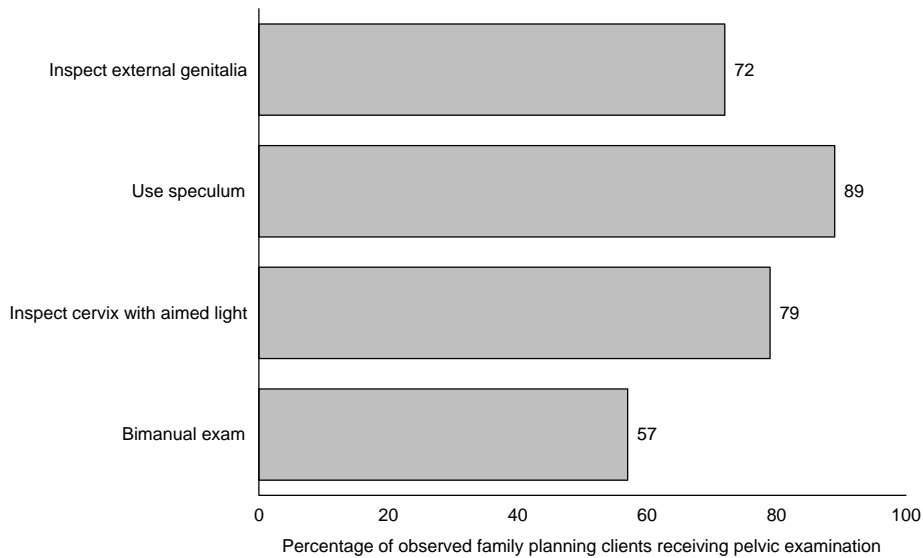


Egypt SPA 2004

Among the 14 observed implant insertion cases, the providers washed their hands before starting for 91 percent of cases, and sterile gloves were utilized in 61 percent of cases (data not shown).

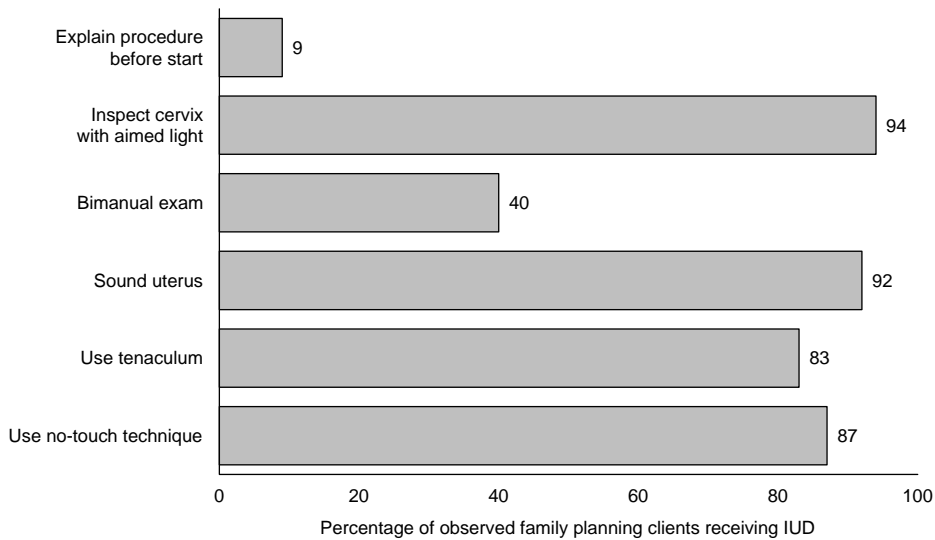
In general, providers did not explain procedures to the clients before starting procedures. Only 6 percent of clients receiving pelvic examinations (data not shown) and 9 percent of clients having IUD insertions were provided explanations before or during procedures. Seventy-nine percent of the pelvic examinations and 94 percent of IUD insertions included a visual inspection of the cervix (using a speculum and an aimed spotlight) (Figures 5.10 and 5.11, respectively). This is an improvement from 2002, when inspection of the cervix was observed for only 46 percent of women receiving IUDs. Bimanual examinations were conducted for 57 percent of women receiving pelvic examinations and 40 percent having IUD insertions, similar to findings in 2002. Among the observed IUD procedures, 92 percent sounded the uterus prior to insertion (a small increase over the 86 percent observed in 2002), 83 percent used a tenaculum, and 87 percent used the no-touch technique for handling the IUD (Figure 5.11).

Figure 5.10 Selected pelvic examination procedures observed (N=285)



Egypt SPA 2004

Figure 5.11 Selected IUD insertion procedures observed (N=384)



Egypt SPA 2004

All providers who were observed providing an injectable contraceptive were observed opening new needle and syringe packets, with 98 percent of these provided by the facility. Sharps containers were used to dispose of the used needles in 79 percent of the cases (data not shown) (a slight increase over 70 percent in 2002).

Key Findings

Adherence to standards for providing specific contraceptive methods safely is not consistent. Only two in three clients receiving estrogen-containing contraceptives have their blood pressure measured.

Explanations to the client about procedures and adherence to infection control measures (particularly hand-washing and use of latex gloves) are not common for pelvic and IUD procedures. Provider hand-washing prior to starting a procedure is rare (less than one in ten observed procedures).

New needles and syringes are used universally for injectable contraceptives.

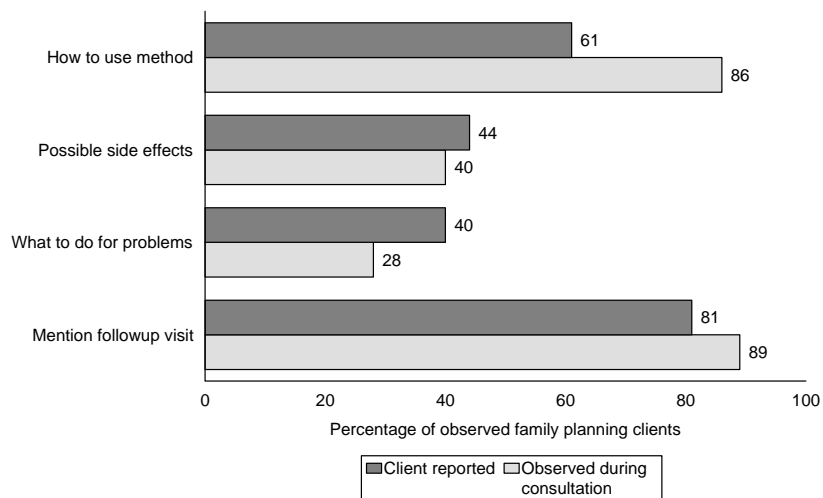
5.5.4 Counseling of Clients

Whether they are new contraceptive users or continuing users, certain information should be reviewed with clients during consultations. The provider should explain or review with the client how to use the method, its possible side effects, what to do for problems, and when the client should return for a followup visit.

Details on components of counseling that were observed and reported by the client are presented in Appendix Tables A-5.29 and A-5.30.

When clients were interviewed after the consultation, there was general consistency between what was observed during the consultation and what the client reported being told about the pill or injectable hormonal methods (Figure 5.12), with the exception of how to use the method. The reason why 25 percent of clients who were observed being told how to use the method reported that they were not told is uncertain. It is possible that they did not understand or were not paying attention. The difference in percentages between the observation and the client reports of counseling on side effects and problems may reflect the client's prior knowledge about the method and the provider's explanations during previous visits.

Figure 5.12 Information provided to hormonal method users, by client report and by observation (N=1,066)



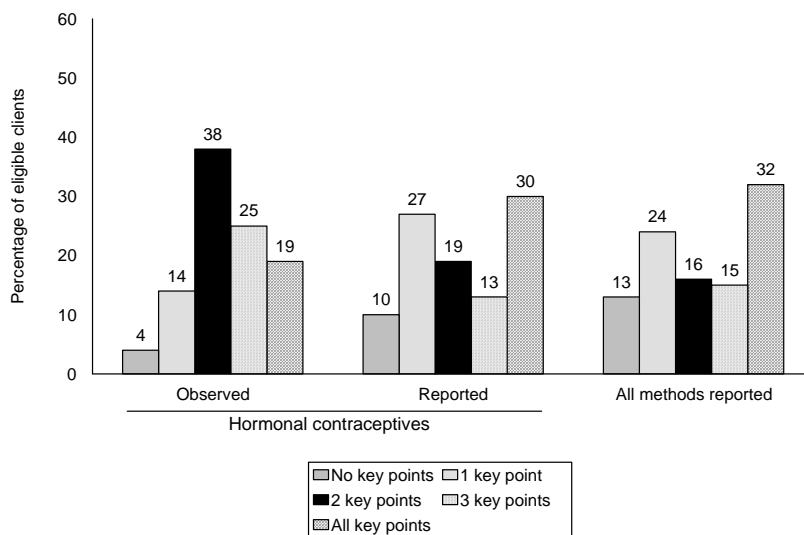
Egypt SPA 2004

Among the 665 women who received an IUD, only 40 percent were observed being instructed to check the string (an improvement from 31 percent in 2002), and 44 percent (39 percent in 2002) were observed being advised about possible heavy bleeding (Appendix Table A-5.30). Eighty percent of IUD users, however, reported that they knew how to check the string, indicating that many continuing clients had previously received this information.

Figure 5.13 shows that for 19 percent of observed clients using hormonal contraceptives (pills or injection), the provider was observed counseling on four key points for their method (how to use, possible side effects, what to do for problems, and time for followup visit). This is an improvement from 13 percent of observed clients using hormonal contraceptives whom the provider was observed counseling on four key points for their method in 2002. Reflecting the same trend, there were fewer consultations where no information on any of the key points was provided (4 percent in 2004 versus 9 percent in 2002).

Client exit interviews showed that about one in three clients who received a prescription or a method reported that they had received all four messages during the consultation, and only 13 percent reported that none of the essential information had been provided to them.

Figure 5.13 Number of key informational points discussed during consultations, by observation and by client report for oral and injectable hormonal contraceptive users (N=1,066), and by client report for all contraceptive method users (N=1,787)



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The percentage of interviewed clients using hormonal contraceptives who reported having been told none or one of the key informational points increased from 2002 (23 percent) to 2004 (37 percent), while the percentage of clients who reported receiving all key informational points decreased (41 percent in 2002 versus 30 percent in 2004). Although the actual observation supported an improvement in the quality of counseling based on the increased number of key informational points observed being provided to clients, its effectiveness is questionable; even immediately after the consultation, clients had difficulty recalling the key informational points pertaining to the methods they just received.

Although only one in three clients using hormonal contraceptive methods could recall all four key points discussed during the observed consultation, almost all (99 percent) (Appendix Table A-5.29) knew the critical information when asked about the contraceptive methods in use (98 percent in 2002), an

indication that the methods may have been discussed on multiple occasions during past visits. Nevertheless, MOHP might like to review the way in which the key informational points are delivered to family planning clients to improve retention. Even though clients may seem knowledgeable about their method, the provider should reinforce the key information at each visit.

Key Findings

Counseling on the four critical points for contraception (how to use contraceptive methods, what the side effects are, how to manage associated problems, and when a followup visit should occur) varied by type of method. Overall, one in three family planning clients reported that they were told all four messages for the method they received or were prescribed.

The consistency with which hormonal method users are being counseled on the four critical points has improved, with one in five clients observed being told all four messages and one in three reporting that they were told the four messages.

Client knowledge on how to use their method was good for most methods, indicating that, although counseling on use, side effects, and problem management may not have occurred on the day of the survey, it likely occurred during prior visits. The MOHP might like to review the way in which the key informational points are delivered to family planning clients to improve retention.

5.6 Client Opinions from Exit Interviews

After the observed consultation, the client was asked to participate in an exit interview during which her opinions on issues commonly related to client satisfaction were sought. Specifically, clients were asked if they had a problem with their method upon their arrival at the facility and whether the provider discussed the problem with them. The client was first asked to identify issues without prompting. Then the client was asked to comment whether specific issues were a big problem, a small problem, or not a problem at all for them.

Details on client opinion are provided in Appendix Tables A-5.31 and A-5.32. Appendix Tables A-5.33 and A-5.34 provide information on the employment and educational backgrounds of the observed and interviewed clients.

Few issues were considered big problems. The areas identified as problems were a long waiting time to see the provider (5 percent). The lack of medicines or supplies, which was a problem in 2002 (6 percent), was a problem for 2 percent of interviewed clients in 2004, similar to the other client service issues (Appendix Table A-5.31).

Half of the interviewed clients (53 percent) indicated that the proximity of the facility was a factor in selecting the facility, and 33 percent said that they selected the facility because the service they needed was available (Appendix Table A-5.32). Clients agreed that other important considerations for choosing the facility were that they were treated well (25 percent), the physician was efficient (24 percent), the facility had a good reputation (18 percent), and a female physician was present (32 percent). The importance of a female physician has increased since 2002 when only 20 percent of interviewed clients said that this was a factor in choosing a facility for family planning services.

6.1 Background

6.1.1 ESPA 2004 Approach to Collection of Maternal Health Information

Maternal health is related not only to the health of a woman, but also has a direct bearing on the health of her newborn. About 15 percent of all pregnant women experience life-threatening complications as a result of their pregnancy (Maternal and Neonatal Health Program, 2001a). Many complications and subsequent poor outcomes for women and infants can be prevented or minimized with early detection of problems and appropriate interventions.

With an international focus on decreasing maternal morbidity and mortality, during recent years there have been shifts in the emphasis placed on some traditional maternal health interventions. Some of the critical thinking and subsequent changes in program emphasis are described below:

- **Antenatal care (ANC):** Because all pregnant women are at risk of developing complications and because many of these complications are unpredictable, it is important to ensure that all pregnant women have access to preventive interventions, early diagnosis and treatment for problems, and emergency care when needed. It is now emphasized that ANC should focus on early detection and skilled and timely interventions for factors having proven impacts on maternal and infant outcomes (Maternal and Neonatal Health Program, 2001a).
- **Delivery care:** Because every delivery may have complications, the emphasis is to promote use of skilled and trained delivery care providers and to ensure that all women have access to lifesaving emergency interventions at the time of labor and delivery. In many countries, deliveries occur at home attended by traditional birth attendants (TBAs). Previously, there were extensive efforts and funds expended toward upgrading the skills of TBAs, but safe motherhood program initiatives have concluded that, in almost all cases, “the level of skill among ‘skilled birth attendants’ is lower than is ‘safe’ for safe motherhood. In-service training cannot improve the skill level of trained providers to the level of competency desired in all skills” (Maternal and Neonatal Health Program, 2001b). With this conclusion has come a shift in the definition of qualified delivery providers to “persons with midwifery skills who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose and manage or refer complicated cases” (Koblinsky, 2000).
- **Postnatal care (PNC):** There is increasing emphasis placed on ensuring that women receive PNC within a few days of delivery for early diagnosis of postpartum complications. PNC also provides an opportunity to counsel the new mother on family planning and on caring for herself and her newborn, as well as to assess the newborn for any problems.
- **Newborn care:** More attention has also been given recently to newborn care, with the increased awareness of the need to discourage some common practices that are detrimental to newborn health and to promote those good practices that contribute to newborn health.

Internationally accepted guidelines define the maternal health services necessary for safe delivery and improved maternal and newborn outcomes as follows (Koblinsky, 1999):

- **Basic essential obstetric care (BEOC):** BEOC includes preventive services as well as medical interventions and procedures that can be provided by well-trained primary care

physicians and nonphysician providers. This includes ANC, with preventive interventions, early detection and treatment of common problems of pregnancy, and the ability to manage simple problems of pregnancy, as well as first aid for complications of pregnancy and labor to minimize the need for emergency interventions.

- **Emergency obstetric care (EmOC):** EmOC specifically covers lifesaving interventions of blood transfusion and surgery.

Together BEOC and EmOC form the basis of what is considered comprehensive essential obstetric care (CEOC). CEOC has been adopted by the Ministry of Health and Population (MOHP) and forms the strategy of programs to improve maternal health.

Maternal and newborn health services represent a wide range of interventions, depending on whether the mother and newborn are healthy or experiencing problems. The ESPA 2004 draws on the findings and recommendations of Safe Motherhood initiatives such as the Maternal and Neonatal Health (MNH) Program and MotherCare, promoted by the World Health Organization (WHO) and other international organizations, to determine which aspects of maternal health to assess.

This chapter uses information obtained in the ESPA 2004 to address the following central questions about maternal health services:

- What is the availability of ANC?
- To what extent do facilities have the capacity to support quality ANC services?
- To what extent is there evidence that health service providers adhere to standards for provision of quality ANC services?
- To what extent is PNC¹ available where ANC is offered, and do facilities have the capacity to support quality PNC services?
- What is the availability of delivery services, and to what extent do facilities have the capacity to support quality delivery services?
- What are the common newborn care practices in facilities providing delivery services?

6.1.2 Maternal Health and the Utilization of Services in Egypt

MOHP has identified maternal health as a priority health issue and has developed a strategy based on CEOC to reduce maternal morbidity and mortality. The U.S. Agency for International Development (USAID) is assisting MOHP, through the Healthy Mother/Healthy Child (HM/HC) program, to implement the strategy.

The national maternal mortality study carried out in 2000 (MOHP, 2001) came to the following conclusions:

- Lack of ANC contributed to 19 percent of maternal deaths, and the poor quality of ANC contributed to 15 percent of maternal deaths.

¹ For the ESPA, any report of offering routine outpatient postnatal examination and services was accepted as PNC. Details on the content of PNC were not collected. Capacity was assessed by whether the facility could identify and manage postpartum infections and whether the newborn weight could be measured.

- Twenty-six percent of maternal deaths in Egypt occurred during delivery or the first 24 hours after delivery.
- Thirty-four percent of direct causes of maternal deaths in Egypt were due to postpartum hemorrhage. In total, 26 percent of deaths occurred postpartum.
- Cardiac diseases were the leading indirect cause of maternal deaths (13 percent), and the most common cardiac problem was rheumatic fever.
- Most (62 percent) maternal deaths occurred in health facilities, 29 percent occurred at home, and 9 percent occurred during transportation, with 93 percent of the women who died having sought medical help for their problems. Of those who delivered in a health facility, a disproportionate number of postpartum hemorrhage and caesarean section deaths occurred in private facilities (37 and 47 percent, respectively), possibly because of lack of blood, poor backup, or delays in transferring patients to hospital.
- Substandard care (poor diagnosis and management) by health providers (in particular, obstetricians and general practitioners) remains the most important avoidable factor, contributing to 54 percent of maternal deaths. Substandard care in the private sector is of particular concern, since deliveries in the private sector have overtaken deliveries in the public sector (36 and 23 percent, respectively) (El-Zanaty and Way, 2004).
- Failure of the woman or her family to recognize danger signs, resulting in a delay in seeking care, was the second most important avoidable factor, contributing to 30 percent of all maternal deaths. Shortage of blood was the most frequently avoidable health facility factor, contributing to 16 percent of maternal deaths.

Through the HM/HC program, MOHP has developed interventions to decrease maternal morbidity and mortality from these causes. Essential obstetric care guidelines have been developed, and there is a focus on competency-based training for physicians and nurses on the new essential obstetric care guidelines and standards of care. MOHP has also been expanding the midwifery training of nurses. The objective is to increase the skills of primary care physicians and nurses trained in midwifery so that they acquire proficiency in the skills necessary to manage normal deliveries and to diagnose and manage or refer complicated cases.

Improvement in maternal health is being achieved. According to the 2000 Maternal Mortality Study (MOHP, 2001)—

- Nationally, maternal mortality has decreased from 174 deaths per 100,000 live births in 1992 and 1993 to 84 deaths per 100,000 live births in 2000.
- There were significant regional differences in maternal mortality. Comparing 1992 and 1993 results with the 2000 results, Metropolitan Egypt had the largest percentage decrease in maternal mortality (79 percent), followed by Upper Egypt (59 percent) and Lower Egypt (29 percent).

The current goal for 2007 is to reduce maternal mortality to 50 or fewer maternal deaths per 100,000 live births.

Finally, the 2003 Egypt Interim Demographic and Health Survey (EIDHS 2003) provides information on levels of utilization of health services during pregnancy. Findings from the EIDHS 2003 include the following (El-Zanaty and Way, 2004):

- Sixty-nine percent of women who had been pregnant during the five-year period preceding the survey had received some type of ANC, an increase since the 2000 Egypt Demographic and Health Survey (EDHS) (53 percent).
- Four ANC visits with services provided by a trained provider (the MOHP definition for ANC) were received by an average of 56 percent of pregnant women, during the five-year period preceding the survey, an increase since the 2000 EDHS (37 percent).
- The proportion of women receiving ANC has increased since 2002 in both urban and rural areas (74 and 45 percent, respectively) (2003 EIDHS).
- Among women receiving ANC, almost two-thirds use private service providers, and one-third use public service providers, the same proportions as found in the 2000 EDHS.
- There has been an increase in the proportion of women using trained delivery service providers, with 69 percent using a trained provider (2003 EIDHS) compared with 61 percent in 2000. Fifty-nine percent of births in 2003 were in a medical facility, an increase from 48 percent in 2000.

6.2 Antenatal Care

6.2.1 Availability of ANC and PNC Services

To support appropriate utilization of ANC, services should be available with sufficient frequency to meet the needs of most pregnant women. Preventive services, such as ANC, are commonly offered only one or two days per week. Although this strategy may facilitate the management of services and personnel, particularly where limited space and equipment are problems, this can create “missed opportunities” for providing ANC. A pregnant woman may be at the facility for another purpose and if she cannot receive the ANC services at the same time, she might be disinclined to return another day specifically for ANC (because of time, financial constraints, or other factors).

Information on the availability of ANC, PNC, and tetanus toxoid (TT) immunization services is provided in Table 6.1. Appendix Table A-6.1 provides information on the availability of various family health services at a facility on the same day as ANC, and Appendix Table A-6.2 provides more detail on the availability of ANC and TT immunization services. Fever hospitals are excluded from the analysis because they are not eligible to provide ANC.

Table 6.1 Availability of antenatal and postnatal care as well as other family health services					
Percentage of facilities offering antenatal care (ANC), postnatal care (PNC), and tetanus toxoid (TT) immunization, and percentage offering all three services, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities offering the indicated services				Number of facilities (weighted)
	ANC	PNC	TT immunization	ANC, PNC, and TT	
Type of facility¹					
GS hospital	82	66	60	56	65
MCH/urban HU	96	91	97	90	97
Rural HU	96	91	93	83	319
Mobile unit	72	16	0	0	55
Health office	5	3	5	3	33
NGO facility	84	26	12	3	76
Region					
Urban Governorates	72	44	37	24	72
Lower Egypt	86	77	72	68	316
Upper Egypt	91	68	73	63	257
Total	87	70	68	61	645
¹ Fever hospitals are not eligible to provide maternity services and so are excluded from analysis of availability of maternity services.					

Most facilities (87 percent) offer ANC, with fewer offering PNC and TT immunization services (around 70 percent each) (Table 6.1). Sixty-one percent of facilities offer all three services, an increase from 2002 when 53 percent offered all three services. Facilities in the Urban Governorates are less likely to offer any of these maternal health services than those in Upper and Lower Egypt.

There has been an increase in availability of PNC since 2002 (when 61 percent of facilities offered the service), with the increase particularly noted in Lower Egypt.

Although two in three facilities offer TT immunization services, less than half (43 percent) report that TT is offered every day ANC is offered (Appendix Table A-6.2).

Facility respondents were asked to provide the number of days per week that ANC and TT are routinely offered. Overall, 64 percent of facilities offer ANC at least five days per week (Appendix Table A-6.2), a slight increase over 57 percent in 2002.

Key Findings

ANC is offered in most eligible facilities (87 percent) and is offered five days per week at two in three facilities.

PNC is more available in 2004 (70 percent of facilities) than in 2002 (61 percent of facilities).

TT is routinely offered the same day as ANC in less than half of facilities.

ANC, PNC, and TT immunization services are all offered at two in three facilities, with MCH/urban HUs and rural HUs offering all three services more frequently than other facilities. Facilities in the Urban Governorates are the least likely to offer any of these maternal health services.

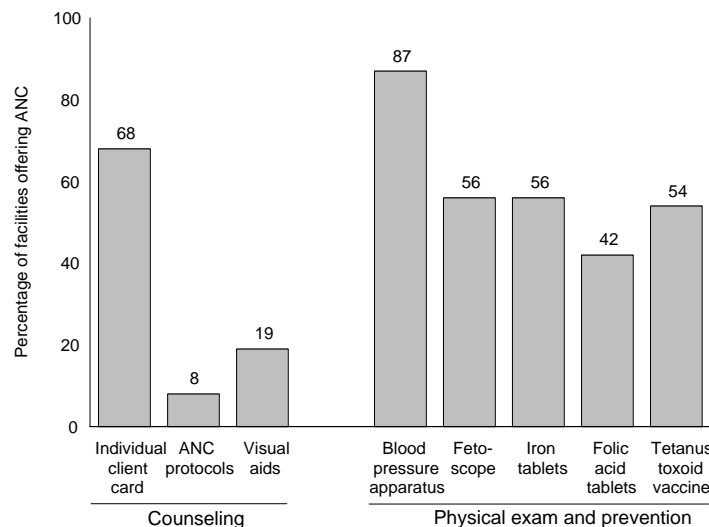
6.3 Capacity to Provide Quality ANC

ANC aims to promote healthy behaviors in pregnant women and to provide early detection and treatment for complications.

6.3.1 Infrastructure and Resources to Support Quality Assessment and Counseling of ANC Clients

Essential items that should be available to support quality assessment and counseling of ANC clients include individual client cards, guidelines or protocols for ANC, and visual aids for client education. Aggregate information on the availability of all items for quality counseling is provided in Table 6.2 by type of facility and region. Summary information on the availability of each of these items is provided in Figure 6.1, with details, by facility type, provided in Appendix Table A-6.3.

Figure 6.1 Availability of items to support quality ANC services (N=559)



Egypt SPA 2004

Individual client cards, important for recording information to allow followup of a woman's pregnancy and health status over time, are available in 68 percent of facilities (Figure 6.1). Written ANC protocols that include management of common problems during pregnancy are available in the ANC service

delivery area in only 8 percent of facilities. Visual aids for ANC client counseling are available in 19 percent of facilities.

In total, 5 percent of facilities have all items assessed for supporting counseling for ANC (Table 6.2). This is less than found in 2002, when 9 percent of facilities had all items. The major contributing factor is a decrease in availability of written guidelines or protocols for ANC (available in 12 percent of facilities in 2002) and availability of visual aids (available in 27 percent of facilities in 2002). Overall facilities in the Urban Governorates and Upper Egypt are least likely to have all items to support counseling for ANC.

Table 6.2 Availability of infrastructure and resources to support quality counseling and examinations for ANC					
Percentage of facilities with all elements to support quality ANC counseling, examinations, and interventions for basic ANC, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities offering ANC services with				Number of facilities offering ANC (weighted) ⁵
	All items to support quality counseling ¹	All items for infection control ²	All items for physical examination ³	All essential supplies for basic ANC ⁴	
Type of facility					
GS hospital	4	3	59	10	54
MCH/urban HU	10	9	42	40	94
Rural HU	5	11	44	19	307
Mobile unit	0	11	72	0	39
NGO facility	0	10	82	0	64
Region					
Urban Governorates	4	6	71	18	52
Lower Egypt	8	13	46	20	272
Upper Egypt	1	6	54	16	234
Total ⁵	5	10	52	18	559
¹ Visual aids for health education, guidelines or protocols for ANC, and individual client card or record					
² Soap and water, clean latex gloves, disinfecting solution, and sharps box					
³ Visual and auditory privacy (private room), examination table, and examination light					
⁴ Iron and folic acid tablets, tetanus toxoid vaccine, blood pressure apparatus, and fetoscope (pinard)					
⁵ Regional totals and total percentages include data from two health offices offering ANC.					

6.3.2 Infrastructure and Resources for Examinations

The ESPA 2004 assesses the availability, in the ANC service area, of furnishing, equipment, and conditions for infection control and for conducting client examinations.

Aggregate information on these elements is provided in Table 6.2, and summary information on specific equipment and supplies is given in Figure 6.1. Appendix Table A-6.3 provides details on each of the items assessed, by facility type.

Infection Control

All items (soap and water for hand-washing, clean latex gloves, disinfecting solution, and a sharps box) are available in the ANC service delivery area in only 10 percent of facilities (Table 6.2), similar to findings in 2002, when this was true for 14 percent of facilities. Facilities in Lower Egypt are far more likely to have all items for infection control (13 percent) than those in Urban Governorates and Upper Egypt (both 6 percent).

Water and sharps boxes are available in the ANC service areas in 79 and 66 percent of facilities, respectively. Similar to findings for other services, soap and clean latex gloves are the infection control items most often lacking. There has been some improvement, with soap present in half of facilities in 2004 (Appendix Table A-6.3), compared with 39 percent in 2002. Clean latex gloves are less available in 2004 (23 percent, compared with 44 percent in 2002), although, as mentioned in other sections, this may reflect a more accurate assessment of latex gloves, compared with other disposable gloves that are universally available but not defined as acceptable for infection control by the ESPA 2004.

Client Examinations

The common physical examinations for ANC include palpating the abdomen, a breast examination, and, when necessary, a pelvic examination.² The basic components assessed for examination of the ANC client are visual and auditory privacy (86 percent), a bed or examination table (91 percent), and an examination light (60 percent) (Appendix Table A-6.3). All three items are found in 52 percent of facilities, most frequently in NGO facilities (82 percent) and facilities in Urban Governorates (71 percent) (Table 6.2). The item most often missing is an examination light. These findings are similar to those in 2002, when 54 percent of facilities had all items for examination.

6.3.3 Essential Equipment and Supplies for Basic ANC

Essential equipment that should be available in the ANC service delivery area includes a functioning blood pressure apparatus (available in 87 percent of facilities) and a fetoscope (available in 56 percent of facilities). Essential supplies that should be available in the facility where ANC is offered are iron tablets (available in 56 percent of facilities), folic acid tablets (42 percent),³ and TT vaccine (54 percent) (Figure 6.1). There is a noticeable decrease in availability of iron tablets since 2002, when they were available in 73 percent of facilities. Iron tablets are most often lacking in mobile units and NGO facilities (Appendix Table A-6.3). All items for basic ANC care are found in only 18 percent of facilities, a slight decrease from 2002, when 22 percent had all items (Table 6.2).

Facilities in Lower Egypt are somewhat more likely than facilities in other regions to have all of the items assessed for quality counseling, infection control, and essential supplies for basic ANC (Table 6.2).

Key Findings
<p>Elements to support quality ANC are commonly lacking, with only 5 percent of facilities having all items for counseling, 10 percent having all items for infection control, and 18 percent having all items essential for providing basic ANC.</p> <p>Nine in ten facilities have a functioning blood pressure apparatus in the ANC service delivery areas, and around half of all facilities are lacking folic acid and/or iron tablets.</p> <p>Availability of ANC guidelines or protocols and visual aids (8 and 19 percent, respectively) has decreased since 2002.</p> <p>Items to support infection control in the ANC service area are lacking. Although availability of soap has increased (half of all facilities) since 2002, clean latex gloves (23 percent) continue to be lacking, and all assessed items are found in the ANC service area in only one in ten facilities.</p>

² Pelvic examinations are not routine components of ANC in Egypt.

³ Forty percent of the facilities had the combined iron and folic acid tablets.

6.3.4 Additional Equipment and Supplies for Quality ANC and PNC Services

The ESPA 2004 assesses the availability of other elements that support quality ANC. These include medicines to treat common infections, diagnostic capacity, and elements to support PNC.

Summary information on each component is provided in Figures 6.2 and 6.3, and aggregated information is given in Table 6.3. Appendix Tables A-6.4 through A-6.9 provide details on each item assessed, by type of facility.

Hypertensive disorder of pregnancy (preeclampsia), anemia, RTI/STIs are conditions that can directly affect both maternal and newborn health. BEOC requires that a facility provide early treatment for the common problems and complications of pregnancy to prevent progression to more serious problems. The standard for treatment of these conditions by ANC service providers may vary depending on ANC guidelines and policies and the qualifications of the service provider.

Table 6.3 Facility practices and resources for diagnosis and management of common problems and complications of pregnancy

Percentage of facilities where ANC service providers can diagnose and treat STIs for ANC clients, percentage with all medicines to manage common complications of pregnancy, and percentage with the indicated diagnostic testing capacity, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage where RTI/STI treatment is provided by ANC providers	Percentage with all medicines for treating pregnancy complications ¹	Percentage with capacity for conducting the indicated diagnostic test				Number of facilities offering ANC (weighted) ⁷	
			Anemia ²	Urine protein ³	Urine glucose ⁴	Blood grouping ⁵		Ultrasound ⁶
Type of facility								
GS hospital	90	1	92	80	62	54	33	54
MCH/ urban HU	89	0	88	81	75	63	61	94
Rural HU	74	0	85	69	63	17	13	307
Mobile unit	81	0	1	1	1	0	93	39
NGO facility	85	2	56	55	51	33	19	64
Region								
Urban Governorates	95	2	68	67	66	51	56	52
Lower Egypt	77	0	80	67	60	30	26	272
Upper Egypt	79	0	76	63	57	23	27	234
Total ⁷	80	0	77	66	59	29	29	559

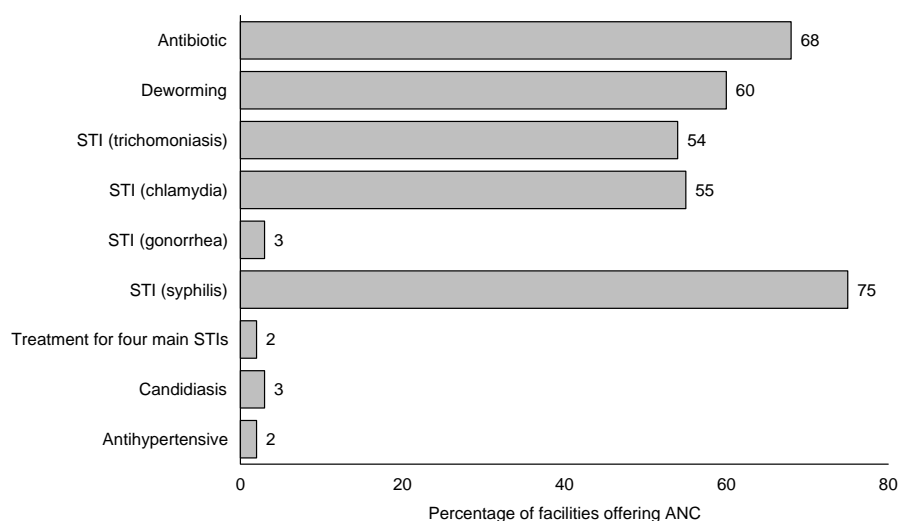
¹ At least one broad-spectrum antibiotic (amoxicillin or cotrimoxazole); at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis; mebendazole (deworming); and nystatin suppository are all present
² Includes any test (hemoglobinometer or calorimeter or centrifuge with capillary tubes, or filter paper methods)
³ Clinistix (Campus e or Campus 9 sticks) or flame, acetic acid, and test tube for testing urine albumin
⁴ Clinistix (Campus 3 or Campus 9 sticks)
⁵ Anti-A, Anti-B, and Anti-D
⁶ Functioning ultrasound machine and provider trained in obstetric ultrasound
⁷ Regional totals and total percentages include data from two health offices offering ANC.

There has been a slight decrease in the percentage of facilities where ANC service providers diagnose and treat STIs, from 87 percent in 2002 to 80 percent in 2004 (Table 6.3). The provision of RTI/STI services by ANC providers was observed, with 8 percent of the 541 observed RTI/STI clients receiving both ANC and RTI/STI services from the ANC service provider (Table A-7.10).⁴ RTI/STI diagnosis and treatment for ANC clients were observed in higher proportions in rural health units (HUs), in NGO facilities, and in facilities in Upper Egypt and the Urban Governorates.

⁴ The STI observations are discussed in Chapter 7.

There are no major changes from 2002 to 2004 in the availability of medicines for treating common problems and complications of pregnancy. Antibiotics for treating urinary tract and postpartum infections, and deworming medicines are available at two in three facilities. However, only 2 percent of facilities have at least one medicine to manage each of the four major STIs (trichomoniasis, chlamydia, syphilis, and gonorrhea), with a medicine for gonorrhea most often lacking (Figure 6.2 and Appendix Table A-6.4). Only 3 percent of facilities have a medicine for candidiasis, a common vaginal infection or STI, and only 2 percent of all facilities (7 percent of general service hospitals) have methyldopa for managing hypertension during pregnancy⁵ (Appendix Table A-6.4). Almost no facilities have all medicines assessed for management of basic infections or health problems during pregnancy (Table 6.3).

Figure 6.2 Medicines for managing common problems and complications of pregnancy (N=559)



Egypt SPA 2004

Laboratory tests for anemia, urine protein (for preeclampsia), and urine glucose (for diabetes) can either identify or facilitate early detection of health conditions that may be exacerbated during pregnancy or that may affect newborn health. It is helpful to know the proportion of facilities that have the standard to routinely offer or provide these tests during pregnancy, as well as the proportion of those that have the laboratory capacity (all equipment and, where applicable, reagents) to conduct the test in-house. Syphilis testing is not a routine component of ANC in Egypt; therefore, information on syphilis testing for ANC was not collected.

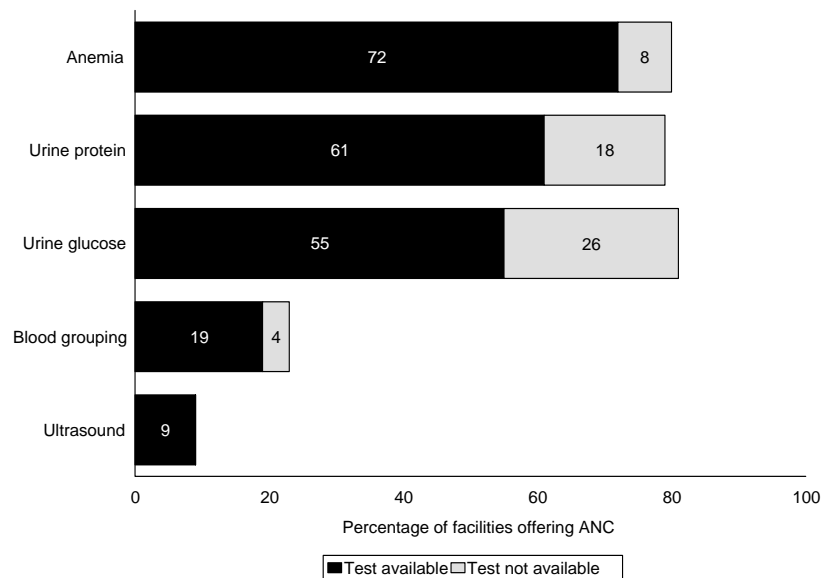
The proportion of facilities with a standard to routinely test ANC clients for anemia, urine protein, and urine sugar has not changed since 2002, with around eight in ten facilities indicating that each of these tests is a routine component of ANC (Figure 6.3). There continues to be a proportion of facilities that report they routinely offer a test, but that do not consistently have the testing capacity. Among facilities with the standard to offer a test, one in ten did not have the capacity to test for anemia on the day of the survey, two in ten for urine protein, and around three in ten for urine glucose.

⁵ In Egypt, methyldopa, for managing hypertension, is to be used for ANC clients only by specialists, and facilities without specialists are expected to refer these cases.

One in four facilities (23 percent) report that they have a standard to routinely ascertain the blood group and Rh factor for ANC clients. This is about half the proportion (44 percent) that reported this was standard for ANC in 2002. The proportion of facilities with both the standard and the capacity to perform these tests, however, has not changed (19 percent).

Finally, routine use of ultrasound is similar, with around one in ten facilities (9 percent) reporting that this is a routine component of ANC (Appendix Table A-6.4). The availability of an ultrasound machine and a trained provider for ultrasound also remains the same, with around one in four facilities (24 percent) having both elements for ultrasound testing (Appendix Table A-6.9). Routine use of ultrasound for ANC has greatly expanded in mobile units (26 percent in 2004, compared with 7 percent in 2002) and MCH/urban HUs (25 percent in 2004, compared with 18 percent in 2002) (2004 data in Appendix Table A-6.4).

Figure 6.3 Availability of ANC tests in facilities where tests are reported to be routine components of ANC (N=559)



Egypt SPA 2004

In Egypt, PNC is often provided through outreach services, with a provider from the facility making home visits for newborns and their mothers. When PNC is received in facilities, however, often the PNC is offered in the same service area as ANC. In addition to supplies assessed for ANC that also are relevant to PNC, there is a need to be able to assess a postpartum woman for infection and to weigh the newborn. A thermometer is available in the ANC service delivery area in 60 percent of facilities, and a functioning infant scale is available in 62 percent (Appendix Table A-6.4). NGO facilities and mobile units are least likely to have an infant scale in the ANC area (16 percent and none, respectively).

Key Findings

The lack of medicines for managing common complications of pregnancy is notable in all facilities, including general service hospitals. Commonly recommended antibiotics are available at two in three facilities.

Eighty percent of facilities diagnose and prescribe treatment for STIs in the ANC service area; however, only 2 percent of these facilities have a medicine to treat each of the four main STIs (syphilis, gonorrhea, chlamydia, and trichomoniasis). The recommended treatment for gonorrhea is most often lacking.

Around 80 percent of facilities have a standard to routinely check urine protein and glucose and blood for anemia during ANC, although each test is absent from 10 to 30 percent of facilities having the standard.

One in five facilities have the standard and capacity to routinely ascertain blood group and Rh factor of ANC clients.

One in three facilities has the capacity to conduct an ultrasound test and one in ten reports that this is a standard component of ANC. Routine use of ultrasound has greatly increased in mobile units (26 percent) and MCH/urban HUs (25 percent) since 2002.

6.4 Management Practices Supportive of Quality ANC and PNC Services

Management practices for supporting quality ANC and PNC services include documentation and records, practices related to user fees, and staff supervision and development.

Table 6.4 provides information on management practices, by type of facility and region, and Figure 6.4 provides summary information on in-service training topics related to ANC that were received during the past five years. Appendix Tables A-6.10 through A-6.12 provide details on utilization of ANC services at facilities included in the ESPA 2004, as well as information on charging practices and out-of-pocket payments. Appendix Tables A-6.13 through A-6.15 provide detailed information on supervision and in-service training from the perspective of the provider, and details on the content of in-service training and supervision for ANC providers.

6.4.1 Facility Documentation and Records

Up-to-date ANC registers that include an entry in the past seven days and indicate, at minimum, if the visit was a first or followup visit are available in 72 percent of facilities (Table 6.4). A register for PNC clients⁶ is present in 57 percent of facilities offering ANC.

⁶ This register may include outreach services (home visits) and/or facility-based services.

Table 6.4 Management practices supportive of quality maternal health services

Percentage of facilities with the indicated records, percentage that have any user fees for ANC, and percentage with the indicated management practices, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering ANC that have:				Number of facilities offering ANC (weighted) ²	Percentage of facilities where at least half of the interviewed ANC service providers		Number of facilities with interviewed ANC providers (weighted) ⁴
	Observed up-to-date patient register ¹		Documen- tation of monitoring ANC coverage	User fees for ANC		Received in-service training during past 12 months ³	Were personally supervised during the past 6 months	
	ANC	PNC						
Type of facility								
GS hospital	74	52	43	29	53	3	92	53
MCH/ urban HU	91	78	37	22	94	8	96	94
Rural HU	87	71	43	5	307	5	98	305
Mobile unit	11	0	0	59	39	10	84	39
NGO facility	11	0	0	99	64	9	59	63
Region								
Urban Governorates	49	28	12	73	52	7	77	52
Lower Egypt	77	72	35	17	272	8	94	271
Upper Egypt	71	47	37	23	234	4	92	233
Total ²	72	57	34	25	559	6	92	556

¹ Register has entry within past seven days and indicates, at minimum, whether this was the first or a followup visit for ANC and number of days postpartum for PNC register.

² Regional totals and total percentages include data from two health offices offering ANC.

³ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

⁴ This includes only providers of ANC in facilities offering ANC services.

Thirty-four percent of facilities have documentation indicating that they monitor the proportion of eligible women in their catchment area who receive ANC services (ANC coverage), with general service (GS) hospitals and rural HUs (43 percent each) more likely than other types of facilities to monitor ANC coverage (Table 6.4). Mobile units and NGO facilities report that they do not monitor ANC coverage. When asked the definition for ANC that the facility uses to calculate ANC coverage, 22 percent of facilities indicate that a woman must have at least four visits (the MOHP standard definition), a decline from 34 percent in 2002 (data not shown). Five percent indicate that they define one visit as acceptable for ANC coverage (similar to 2002, when 3 percent used this definition). The remaining facilities use either two or three visits for calculating ANC coverage.

6.4.2 Practices Related to User Fees

User fees may have a positive effect on utilization of health facilities (augmenting funds to improve services) or a negative effect (detering poor clients from using services). Health insurance does not apply for ANC clients in public sector facilities. One in four facilities have user fees for ANC, with wide variation between types of facilities (from 5 percent of rural HUs to almost all NGO facilities) reporting user fees. User fees are most common in facilities in the Urban Governorates (73 percent) (Table 6.4).

Findings on implementation of user fees are similar for mobile units and NGO facilities for 2002 and 2004, but they are substantially lower in 2004 for other facility types and for facilities in Lower and Upper Egypt. The reasons for this are unclear. Further investigation is required to ascertain whether the

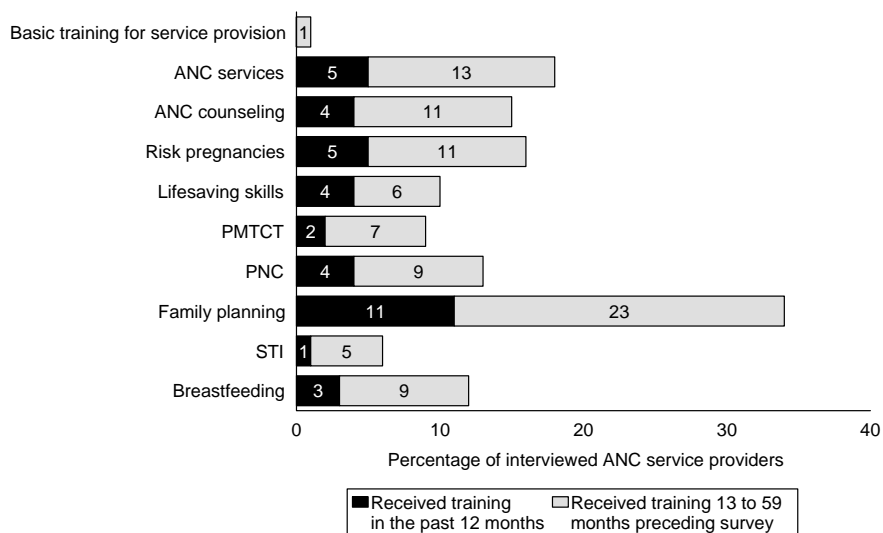
major decrease in implementation of user fees is real or reflects a different understanding by the respondent of the question being asked.

6.4.3 Supervision and Staff Development

If at least half of the interviewed ANC providers at a facility have received any structured in-service training relevant to ANC during the past 12 months (excluding on-the-job training that may be received during discussions with supervisors), the facility is defined as providing routine staff development activities. During the past 12 months, at least half of the interviewed ANC providers had received in-service training related to ANC in only 6 percent of facilities (Table 6.4); this is one-fourth that found in 2002, when routine staff development activities were found for one in four facilities.

The most frequently reported topics of in-service training during the past 12 months were related to family planning (11 percent), with around 4 percent reporting in-service training on other topics specific to ANC, PNC, or STIs (Figure 6.4). An additional one in three providers reported in-service training on topics specific to ANC or PNC during the 13 to 59 months preceding the survey (Appendix Table A-6.13).

Figure 6.4 In-service training received by interviewed ANC service providers, by topic and timing of most recent training (N=1,121)



PMTCT = Prevention of mother-to-child transmission

Egypt SPA 2004

Supervision of individual staff helps to promote adherence to standards and to identify problems that contribute to poor-quality services. Similar to findings in other services, supervision of ANC providers is common, with at least half of the interviewed ANC providers having been personally supervised during the past six months in 92 percent of facilities (Table 6.4). Routine supervision practices for ANC providers are found least often in facilities in the Urban Governorates (77 percent). Among providers who had been supervised, the median number of times they were supervised during the past six months was seven (Appendix Table A-6.15).

Key Findings

While three in four facilities have up-to-date registers for ANC, only around half have PNC registers, and one in three monitor ANC coverage.

Routine provision of in-service training for ANC providers during the past 12 months is found in only 6 percent of facilities, one-fourth of that found in 2002.

Routine supervision of ANC service providers is common across all facilities (92 percent), with the notable exception being NGO facilities (59 percent); routine supervision is least often found in facilities in the Urban Governorates (77 percent).

6.5 Adherence to Standards for Quality ANC Service Provision

Observed ANC client-provider consultations are the basis for assessing whether providers adhere to standards for quality service. The observation checklists used are based on elements of focused ANC as well as additional components of ANC.

The objective in the observations of the consultations is to note if information on a topic is shared or if an examination is conducted (process information). An assessment of whether the information is correct or whether findings are appropriately interpreted is not a component of the observation.

Because ANC services are not provided every day, in some facilities, the survey team made a special effort to schedule the visit on the day when ANC services were offered. If ANC services were not provided on the day of the survey, when possible, the team returned another day specifically for observation of ANC clients.

ANC services were observed for a total of 1093 women in 320 facilities.⁷ Details on characteristics of observed ANC clients are provided in Appendix Table A-6.16. Among the observed ANC clients, this was the first visit for 48 percent of the women. Twenty-eight percent of the observed clients were estimated to be less than five months pregnant, and 21 percent were at least eight months pregnant.⁸ This was the first pregnancy for 38 percent of the clients. An exit interview was obtained from all observed ANC clients.

6.5.1 Appropriate Assessment and Examination for the Visit Number and Gestational Age

Summary information on components of ANC is provided in Figures 6.5 through 6.7. Appendix Tables A-6.17 through A-6.21 provide details on assessments and examinations conducted for ANC clients.

Client History

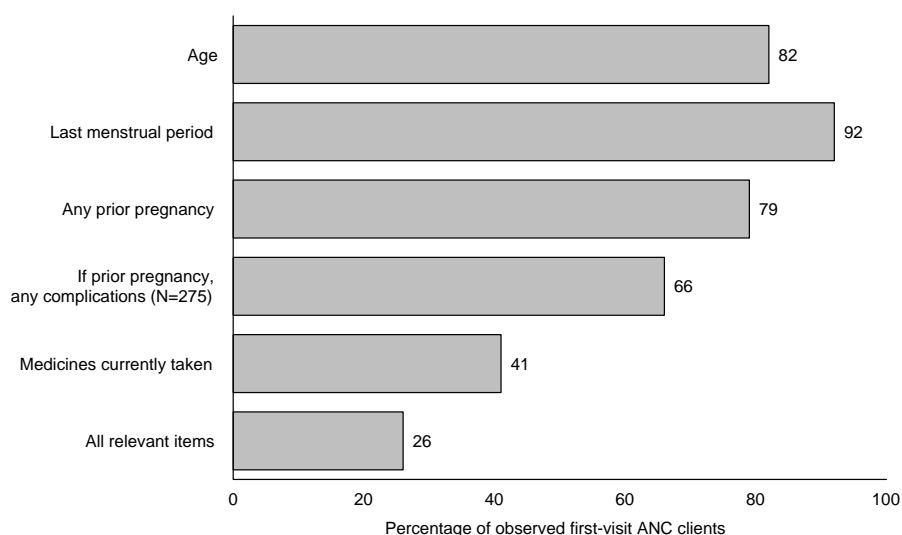
The first ANC visit should include a basic history to assess preexisting risk factors. Age was elicited for 82 percent of first-visit clients, information about the date of last menstrual period for 92 percent, and assessment of any prior pregnancy for 79 percent; 41 percent were asked if they were taking any medications (Figure 6.5). Information about any complications during prior pregnancies was sought for

⁷ These are actual numbers. Data in tables and figures are weighted to provide accurate representation by facility type and governorate.

⁸ Month of pregnancy was noted if information was shared during the observation. The client was also asked during the exit interview. Where there were discrepancies, the observation information was utilized, since the provider assessment of pregnancy status influenced the ANC activities.

66 percent of the first-visit clients who had previously been pregnant. Although there is some improvement in elements of client assessment (in 2002 only 29 percent were asked about medications, and 68 percent were asked their age), overall, a full assessment continues to be conducted for only one in four (26 percent) first-visit ANC clients. More complete histories were noted for clients observed at MCH/urban HUs (all items observed for 34 percent of observations) and at NGO facilities (all items observed for 57 percent of observations) than for clients observed elsewhere (25 percent or less) (Appendix Table A-6.17).

Figure 6.5 Content of client history assessed for first-visit ANC clients (N=489)



Egypt SPA 2004

Monitoring Progress of Pregnancy

All ANC clients should receive certain assessments to monitor the progress of their pregnancy and to identify risk factors. These include assessments of vaginal bleeding, blood pressure, and fetal condition.

All relevant examinations and assessments were conducted for only 15 percent of the ANC clients (Appendix Table A-6.18). While low, this is an improvement over findings in 2002, when only 3 percent of observed clients had all relevant assessments. Vaginal bleeding was assessed for 25 percent of the ANC clients, and blood pressure was measured for 93 percent. Among women five or more months pregnant, 62 percent were asked about fetal movement, and the fetal heart was listened for in 19 percent; among women at least eight months pregnant, fetal position was assessed (either through palpation or ultrasound) for 62 percent. There was no consistent difference by facility type in whether or not assessments were conducted, although MCH/urban HUs and NGO facilities were more likely to perform all relevant assessments.

In addition to the basic examinations, weight was measured for 80 percent of women and activities to allow assessment of gestational age (either palpation, measuring of fundal height, or conducting an ultrasound) were conducted for 49 percent. In total, ultrasound was conducted on 5 percent of women, with the mobile units using it most frequently (22 percent of observed ANC clients), followed by NGO facilities (9 percent) (Appendix Table A-6.18). This represents a substantial decrease in the use of ultrasound since 2002, when 17 percent of observed ANC clients received an ultrasound. It is possible

that the decrease in the use of ultrasound is a result of providers being more discerning about when it is medically appropriate to use the procedure.

Laboratory Testing and Provision of Iron Tablets

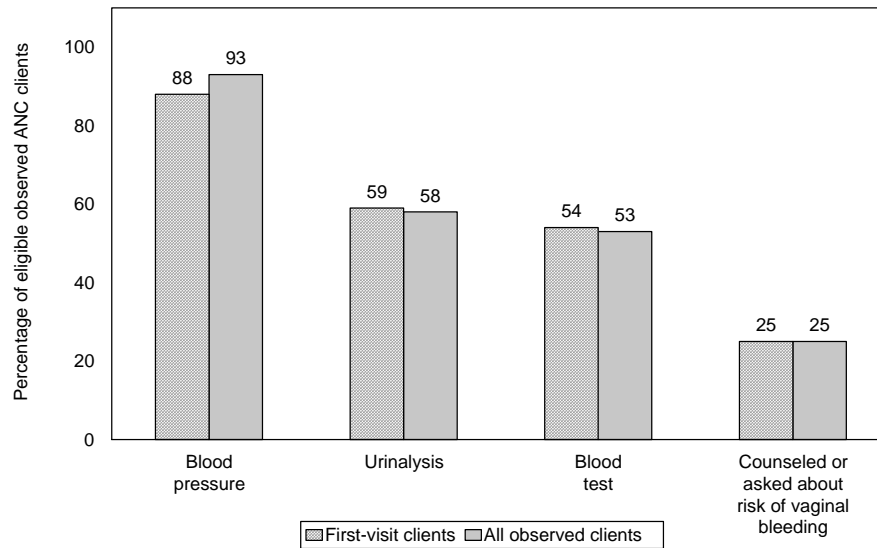
Laboratory facilities and cold chain maintenance capability are required for some screening and preventive interventions. If a facility does not have the capacity to provide the service itself, it should have a referral site that will provide the service to the ANC client.

Over half of all clients received (or were prescribed) a urine test (either urine protein or sugar) and/or a blood test (usually for anemia), and 45 percent received iron tablets (Appendix Table A-6.18), with no major differences between first-visit and followup clients (Appendix Table A-6.17). In addition, 44 percent of first-visit clients (37 percent of all clients) received or were prescribed TT vaccine. These items were components of ANC at MCH/urban HUs and rural HUs more often than they were at other facilities. TT vaccine was least often offered to clients at NGO facilities and mobile units (both about 10 percent).

To meet defined minimum standards for ANC that are promoted in Egypt, each ANC visit should include the following components: 1) counseling on vaginal bleeding as a risk sign for which help should be sought, 2) measuring blood pressure, and 3) a urinalysis (checking for urine protein and glucose). In addition, first-visit clients should have their blood checked (for anemia).

Figure 6.6 provides information on the percentage of observed ANC clients (first-visit and all ANC clients) for whom these elements were part of the services they received. Appendix Tables A-6.17 and A-6.18 provide this information by facility type.

Figure 6.6 ANC content for first-visit ANC clients (N=489) and all observed ANC clients (N=1,029)



Egypt SPA 2004

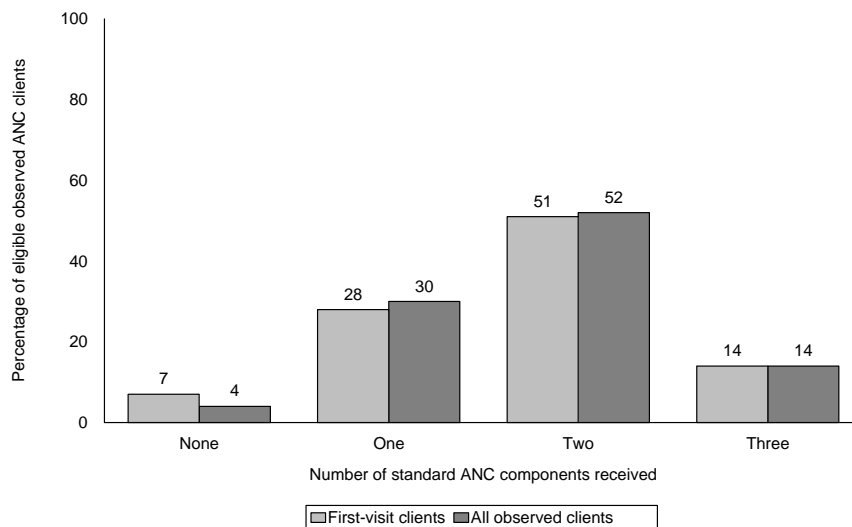
Counseling on vaginal bleeding (defined as either being counseled about vaginal bleeding as a risk or asked about vaginal bleeding during the examination) was received by one in four clients (Figure 6.6). This is a substantial improvement over 2002, when around 4 percent of clients were counseled about vaginal bleeding as a risk sign (compared with around 6 percent in 2004) and around 7 percent were asked about vaginal bleeding (compared with around 26 percent in 2004) (data not shown).

The proportion of first-visit clients having their blood tested has declined to around half (54 percent) from about two in three (60 percent) in 2002. The decline in testing is most notable for GS hospitals, where the percentage of first-visit clients having their blood tested has decreased from 50 percent in 2002 to 26 percent in 2004 ($p < 0.01$).

Overall, one in three observed ANC clients received one of the standard components during the ANC visit, over half received two of the three standard components of ANC, and 14 percent received all three standard components (Figure 6.7), with findings similar for first-visit and all ANC clients.

The percentage of clients receiving all three standard ANC components has increased from around 4 percent in 2002 to 14 percent in 2004 ($p < 0.01$), signifying an improvement in ANC quality. The improvement was most notable in MCH/urban HUs, NGO facilities, and GS hospitals, and in facilities in the Urban Governorates (Appendix Tables A-6.19, A-6.20).

Figure 6.7 Percentage of first-visit ANC clients (N=489) and all observed ANC clients (N=1,029) who received the indicated number of standard ANC components during the observed visit



Egypt SPA 2004

Key Findings

A complete risk-history assessment is received by only one in four first-visit ANC clients. There is some improvement in assessment of medications being taken (41 percent in 2004, compared with 29 percent in 2002).

Basic components for routine ANC care are also not consistently provided, with only 15 percent of clients receiving the components of ANC for which they are eligible.

Laboratory tests to support screening for risk symptoms are utilized for around half of both first-visit and followup ANC clients.

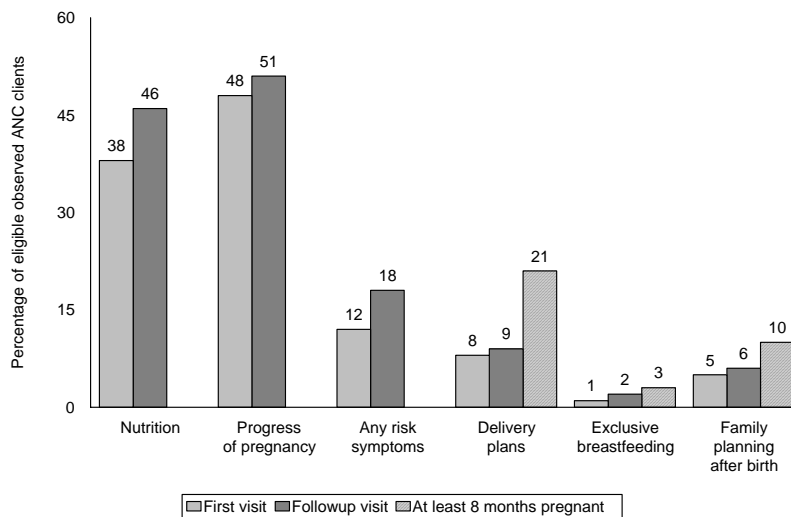
Despite an improvement since 2002, over 85 percent of ANC clients are not receiving the three key components of ANC (assessment of vaginal bleeding, blood pressure, and urine) as defined by MOHP.

6.5.2 Counseling to Promote Healthy Outcomes

Observed and reported components of client counseling are provided in Figures 6.8 and 6.9, respectively. Details on counseling and on client knowledge about risk signs are provided in Appendix Tables A-6.22 through A-6.25. Details on client plans for delivery are provided in Appendix Table A-6.26.

To improve the chances that preventive interventions for pregnancy (iron tablets and tetanus toxoid vaccine) will be effective, clients need to understand why these are important, and how or when they should be taken. Among the women who received (or were prescribed) iron or folic acid tablets, 36 percent were observed receiving an explanation of why the tablets were necessary, and 68 percent were observed receiving information on how to take them (Appendix Table A-6.21). Among those who received or were prescribed TT vaccine, 9 percent were observed being told why it was necessary.

Figure 6.8 Counseling topics discussed during observed first visit (N=489) and followup visit (N=559) and with ANC clients at least 8 months pregnant (N=218), when relevant



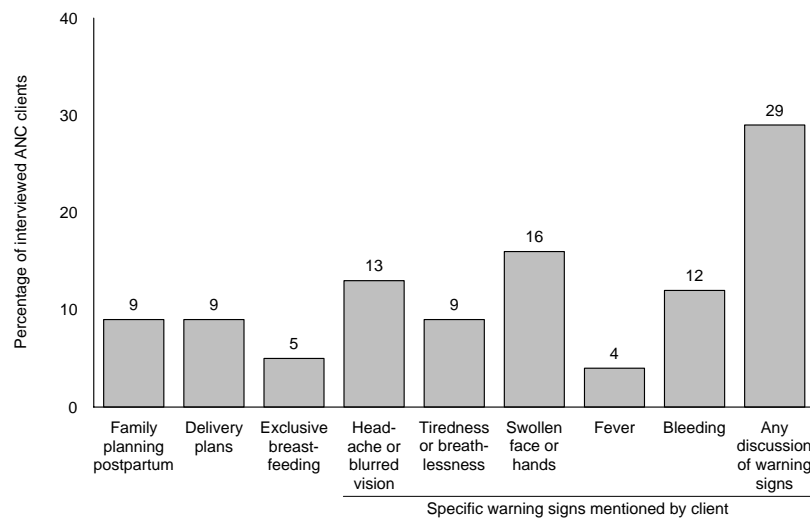
Egypt SPA 2004

Informing a pregnant woman about special nutritional needs during pregnancy and about signs and symptoms that may indicate a problem should be a routine component of ANC counseling. It is not unreasonable, however, to assume that all components of counseling are not discussed during each visit, when a woman makes multiple ANC visits. Thus, the content of counseling for first and followup visits is assessed separately.

Nutritional issues were discussed during the observed consultation with 38 percent of first-visit clients and 46 percent of followup clients, and progress of the pregnancy was discussed with about half of all ANC clients (Figure 6.8).

Risk symptoms, for which a woman should seek help, were rarely observed being discussed (12 percent for first-visit clients and 18 percent for followup clients). While 29 percent of the interviewed clients said that they had been told about warning signs during the current visit or a past visit (an increase from 22 percent in 2002), when asked to name any risk symptoms, only 12 percent mentioned vaginal bleeding (without a prompted responses) (Figure 6.9). Sixteen percent of the women mentioned swollen face or hands, and 13 percent mentioned headache or blurred vision as risk symptoms, with each of the other risk symptoms mentioned by less than 10 percent of the interviewed women.

Figure 6.9 Topics reported by interviewed clients as having been discussed either during this or a previous ANC visit (N=1,029)



Egypt SPA 2004

While, overall, the observed discussion of any particular risk symptom was low (15 percent), this is an improvement when compared with 7 percent observed in 2002; improvements were particularly noted in Lower Egypt, where risk symptoms were observed being discussed with 24 percent of the clients (Appendix Table A-6.23), compared with 10 percent in 2002.

Discussions about plans for delivery were observed with around 9 percent of ANC clients. Plans were more commonly discussed with clients at facilities in the Urban Governorates (19 percent) (Appendix Table A-6.23) and during consultations with clients who were at least eight months pregnant (21 percent) (Figure 6.8). When asked during the exit interview where they planned to deliver, a larger proportion of women in 2004 indicated a plan to deliver at a health facility (47 percent) than in 2002 (37 percent), with 10 percent saying that they planned to deliver at the facility where they were receiving ANC and 37

percent saying that they would go to another facility. Twenty-one percent indicated that they would deliver at home and 32 percent were uncertain (Appendix Table A-6.26).

Counseling on exclusive breastfeeding has not changed since 2002, continuing to be essentially nonexistent. Exclusive breastfeeding was mentioned to only 1 percent of all observed ANC clients, with clients observed in facilities in the Urban Governorates slightly more likely to be counseled on the topic (4 percent). The finding from the observation is supported by reports during exit interviews. When ANC clients were asked if they had ever been instructed about exclusive breastfeeding, only 5 percent said that they had (Figure 6.9), a decrease from 10 percent in 2002, with 3 percent reporting that they had been told to exclusively breastfeed for six months (Appendix Table A-6.24)

Despite the fact that half of all facilities report that counseling about family planning is a routine component of ANC (Appendix Table A-6.4), discussion about the use of family planning after delivery was rarely observed. Family planning was mentioned during only 5 percent of all observed ANC consultations, and was noted only slightly more often when the client was at least eight months pregnant (10 percent) (Figure 6.8). During the exit interview, 9 percent of the interviewed clients mentioned that they had been advised about using family planning postpartum (Figure 6.9). These findings are similar to those from 2002.

Key Findings

Counseling related to nutrition during pregnancy and progress of the pregnancy, the most commonly observed counseling topics, has improved since 2002, with 38 percent of first-visit clients and 46 percent of followup clients being advised about nutrition, and 48 percent of first-visit clients and 51 percent of followup clients being counseled on the progress of their pregnancy.

Although counseling on risk symptoms has also improved since 2002, it continues to be uncommon. Only 15 percent of clients were observed receiving information about risk symptoms, and only one in three reported that the topic had ever been discussed.

Counseling on exclusive breastfeeding is essentially nonexistent. Only 1 percent of clients were observed receiving information about exclusive breastfeeding, and only 5 percent of interviewed clients reported that the topic had ever been discussed.

6.5.3 Supporting Continuity of Care

For quality ANC, continuity of care, which includes monitoring changes between visits, is important. One of the more reliable means for achieving this is to maintain a record of relevant history and findings, as well as interventions or treatments provided. Frequently, health services are organized in such a way that measurements of blood pressure, weight, and other components of a consultation take place prior to the client being seen by the ANC provider responsible for the consultation, and the information is recorded on a client record. Thirty-two percent of facilities were observed to weigh ANC clients and 34 percent to measure blood pressure before the consultation (data not shown). For this information to be available to the provider for use during the assessment, an individual client card must be used. Details on the use of individual client cards are provided in Appendix Table A-6.27.

Individual client cards were used (the provider was noted to look at the card prior to or during the consultation and/or to write on the card after the consultation) during half of the observed first-visit and in over 80 percent of the followup ANC consultations (Appendix Table A-6.27). This is an improvement

since 2002, when the individual client card was used for 65 percent of followup clients. Individual client cards were more often used in the MCH/urban HUs and rural HUs than in other facilities.

6.6 Client Opinions from Exit Interviews

Before they left the facility, observed ANC clients were interviewed for their opinions on the services they received and any problems they encountered on the day of the visit. Similar to findings from other services, there is not much dissatisfaction. The issue of greatest concern was a long waiting time (7 percent), an improvement since 2002, when 11 percent said that the waiting time was a big problem (Appendix Table A-6.29). Lack of medicines or supplies, a big problem for 10 percent of clients in 2002, was only identified by 2 percent of interviewed clients in 2004.

Details on the outcome of ANC visits are provided in Appendix Table A-6.28. Details on client opinion on issues related to service delivery and on why they selected the facility for ANC are provided in Appendix Tables A-6.29 and A-6.30. Appendix Tables A-6.31 and A-6.32 provide additional details on client employment and educational backgrounds.

6.7 Availability of Delivery Services and Capacity to Provide Quality Delivery Care

The availability of emergency obstetric care (EmOC) and the presence of standards, equipment and supplies, and health system components to support quality delivery services are assessed by the ESPA 2004.

It is not uncommon to find that a single facility does not have all resources to provide Comprehensive Essential Obstetric Care (CEOC). It is important, however, that facilities without all resources facilitate a woman's access to the CEOC life-saving interventions when needed.

6.7.1 Availability of Components of CEOC Services

Table 6.5 provides information on the availability of CEOC services that were assessed by the ESPA 2004, by facility type and region. Details on types of emergency transportation systems and the median transportation time using the most common system are provided in Appendix Table A-6.33.

Although 87 percent of facilities offer ANC, only 26 percent offer delivery services, and 24 percent offer both ANC and delivery services (Table 6.5). Delivery services were more widely available in 2002 (35 percent); there is a notable decrease in delivery services in GS hospitals (77 percent in 2002 and 60 percent in 2004) and rural HUs (35 percent in 2002, compared with 23 percent in 2004). Facilities in Lower Egypt are the least likely to offer delivery services (18 percent).

Caesarean sections are offered at 45 percent of GS hospitals (also a decrease from 55 percent in 2002) and at 8 percent of NGO facilities. There are no regional differences in the percentage of facilities offering caesarean sections.

One means of increasing access to EmOC is to offer a means for rapid transfer to a site where the needed service is available. Only 10 percent of facilities have some system for supporting transportation to another facility for obstetric emergencies (Table 6.5). GS hospitals are more likely to have a system for emergency transportation⁹ (47 percent) than other types of health facilities. This is a decrease from 58 percent in 2002. Similar to findings in 2002, facilities that offer facility-based delivery services are more likely to have emergency transportation systems, with 36 percent of facilities that offer delivery services

⁹ Hospitals that are referral centers are counted as having an emergency transportation system, since they can provide all relevant services.

having an emergency transportation system or being a referral hospital (data not shown). This includes 74 percent of the GS hospitals, 48 percent of MCH/urban HUs, 6 percent of rural HUs, and 43 percent of NGO facilities that offer delivery services (data not shown). The lack of a system for emergency transportation from MCH/urban HUs and rural HUs is a particular concern, since the resources to provide emergency interventions are not strong in most HUs. Without a facility-supported emergency transportation system, the woman and family are left to their own devices to arrange for transportation for help during an emergency. Even where a facility does not offer delivery services, but offers ANC, facilitating a woman's access to emergency obstetric care is desirable, given that the 2000 Maternal Mortality Study (MOHP, 2001) documented that 29 percent of maternal deaths occur at home. For many home deliveries, the facility where a woman receives ANC may be the nearest formal health sector site from which emergency help can be sought.

Background characteristics	Percentage of facilities providing indicated services								Number of facilities (weighted)
	Facility-based maternity services					Emergency transportation support for maternity emergencies ²	Services supporting safe home delivery		
	Antenatal care	Normal delivery services ¹	Caesarean section	ANC and normal delivery services	ANC, normal delivery, and caesarean section		Any home delivery services ^{3,4}	Documented official program supportive of TBAs ⁵	
Type of facility⁶									
GS hospital	82	60	45	46	26	47	31	2	65
MCH/urban HU	96	50	0	49	0	24	58	20	97
Rural HU	96	23	1	23	1	2	45	5	319
Mobile unit	72	0	0	0	0	0	0	0	55
Health office	5	0	0	0	0	0	0	0	33
NGO facility	84	9	8	5	4	4	2	0	76
Region									
Urban									
Governorates	72	27	7	25	6	13	26	7	72
Lower Egypt	86	18	6	15	2	9	35	6	316
Upper Egypt	91	35	5	34	4	10	37	5	257
Total	87	26	6	24	3	10	35	6	645

6.7.2 Support for Safe Home Deliveries

In countries where many deliveries take place at home, frequently with the assistance of traditional birth attendants (TBAs), a support system from a facility may increase the chances of having a safe delivery. The common support systems are for facility staff to attend home births, either routinely or for emergencies only, with formal systems for working with TBAs. There is some evidence that TBAs who are linked with the formal health sector are more likely to refer women appropriately and to adopt safer delivery practices (Maternal and Neonatal Health Program, 2002a). The Egypt MOHP encourages facilities to develop programs to link with TBAs and to upgrade the skills of the TBAs.

In assessing TBA support programs, the ESPA 2004 looked for documentation of some official relationship between the TBA and the facility (e.g., minutes or an attendance list from a meeting) to indicate that the relationship is more structured than simply accepting TBA referrals or letting TBAs know they can call for help.

Six percent of facilities have programs with TBAs and have documentation to support that the program is formal and active (Table 6.5). This is a slight decrease from 10 percent in 2002.

Thirty-five percent of facilities provide home delivery services (Table 6.5), with 24 percent reporting that they routinely conducted home deliveries and 11 percent indicating that this is an emergency service only (data not shown). A larger proportion of facilities in Upper and Lower Egypt provide some home delivery service (around 35 percent).

Key Findings

Although ANC is offered in 87 percent of facilities, only 26 percent offer delivery services, and only 6 percent offer caesarean sections.

All three maternity services are offered in 3 percent of all facilities; this includes 26 percent of GS hospitals.

Delivery services remain more available in facilities in Upper Egypt (35 percent) and least available in facilities in Lower Egypt (18 percent), where the proportion of facilities offering the service has decreased from 26 percent in 2002.

Only one in ten facilities provides support for emergency transportation of maternity emergencies to referral facilities.

About 35 percent of facilities in Upper and Lower Egypt provide home delivery services, with 28 percent of facilities in Lower Egypt and 18 percent in Upper Egypt indicating that the service is a routine one, not only for emergencies.

6.7.3 Infrastructure and Resources to Support Quality Delivery Services

In addition to a basic infrastructure that provides privacy and supports prevention of infection, there are multiple types of equipment and medicines that are important for supporting safe deliveries.

Aggregate information on infrastructure, as well as equipment and supplies for basic delivery services, including emergency medicines, is provided in Tables 6.6 and 6.7. Figures 6.10 through 6.12 provide summary information on individual items, and Appendix Tables A-6.34 through A-6.41 provide details on elements assessed for delivery services, with Tables A-6.35 through A-6.38 providing details on sterilization/high-level disinfection (HLD) procedures for delivery equipment. Figure 6.13 provides information on equipment for EmOC, with further details provided in Appendix Tables A-6.42 and A-6.43.

Table 6.6 Availability of elements for quality delivery services					
Percentage of facilities that have all indicated items to support quality delivery services, by type of facility and region, Egypt SPA 2004					
Background characteristics	Percentage of facilities offering delivery services with:				Number of facilities offering delivery services (weighted)
	All items for infection control ¹	Capacity for sterilization/ HLD processing ²	All delivery room infrastructure and furnishings ³	All other elements to support quality ⁴	
Type of facility					
GS hospital	28	65	79	5	39
MCH/urban HU	8	64	93	3	48
Rural HU	19	50	71	0	73
NGO facility	31	66	100	0	7
Region					
Urban Governorates	33	69	91	7	19
Lower Egypt	17	49	85	0	57
Upper Egypt	16	62	75	2	91
Total	18	58	80	2	167
¹ Soap, water, sharps box, disinfecting solution, and clean latex gloves					
² In location where delivery services equipment is processed, equipment and knowledge of minimum processing time for sterilizing or HLD processing and an automatic timing device were available.					
³ Bed, examination light, and visual and auditory privacy					
⁴ Service guidelines or protocols, partographs, and 24-hour delivery provider onsite or on call, with duty schedule observed					

Infection Control

Infection is one of the most common causes of maternal and neonatal morbidity and mortality. Thus, infection control practices are essential for quality delivery care. All items assessed for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) are present in the delivery service area in one of five (18 percent) facilities (Table 6.6), a decrease from one in four facilities in 2002. The item most often lacking is hand-washing soap (available in only 49 percent of facilities) (Appendix Table A-6.34). Latex gloves and a sharps box are also lacking, available in only 52 and 70 percent of facilities, respectively. Over 90 percent of facilities have a regular water supply at the delivery services area. Infection control items are least available in MCH/urban HUs.

The procedures used for sterilizing or HLD-processing equipment used for deliveries are also assessed.¹⁰ Slightly fewer than half (43 percent) of facilities process delivery equipment specifically in the delivery service area, and the rest send equipment to the main processing area in the facility (45 percent) or the family planning service area (12 percent) for processing (Appendix Table A-6.35). Overall, 76 percent of facilities have functioning equipment and a person who knows the proper processing procedure for the sterilization or HLD method used for delivery equipment (Appendix Table A-6.36). This is somewhat higher than findings in 2002 (60 percent). An automatic timing device is also important for supporting quality sterilization or using HLD processing. When this criteria is added, 58 percent of facilities have the equipment, knowledge, and an automatic timing device for sterilization or HLD processing (Table 6.6), with 53 percent using sterilization and 5 percent using HLD (data not shown). HLD processing does not

¹⁰ Chapter 3, sections 3.4.1 and 3.4.2 provide details on the definitions for quality sterilization or HLD procedures and storage conditions.

kill the tetanus spore and thus does not provide a sufficient level of cleanliness for most equipment used for deliveries.

Written guidelines for sterilization or HLD processing are available in the area where delivery equipment is processed for 22 percent of facilities (Appendix Table A-6.36). Guidelines are found more often in facilities in the Urban Governorates (41 percent) than in those in Lower Egypt (24 percent) or Upper Egypt (16 percent).

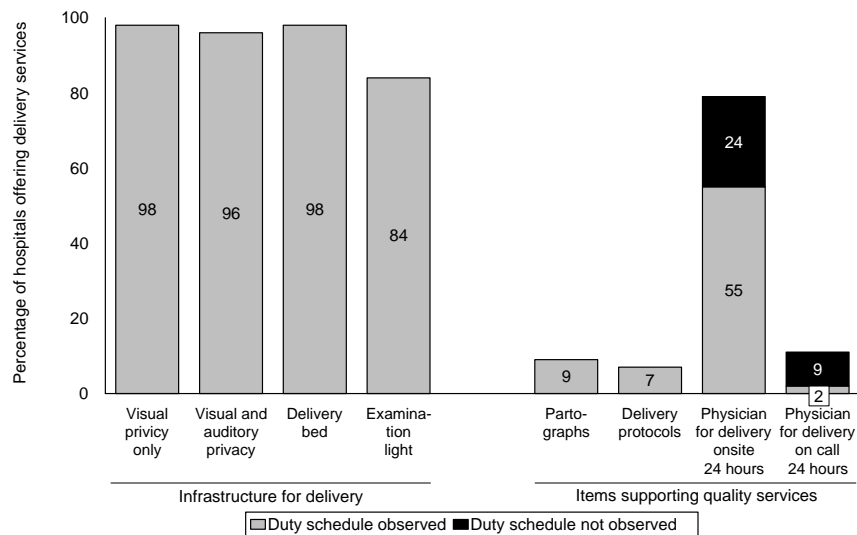
Infrastructure for Delivery

Infrastructure for delivery services has shown little change since 2002. The delivery area in most facilities (98 percent) provides visual privacy (either a private room or a room with a temporary divider), and 96 percent provide both visual and auditory privacy (a private room). Almost all facilities have a bed for delivery (98 percent), and 84 percent have an examination light. Overall, 80 percent of facilities have all of the basic infrastructure and furnishings (Table 6.6), with NGO facilities being the best equipped (100 percent having all items) and rural HUs being the least equipped (71 percent having all items), primarily because of a lack of an examination light (75 percent) (Appendix Table A-6.34).

Elements to Support Quality Delivery Services

The partograph—a document used to monitor an individual woman’s labor—is promoted internationally as a means for improving quality of care. It provides guidelines for monitoring and for early identification of complications (Maternal and Neonatal Health Program, 2002b). Although slight improvements are seen since 2002, partographs remain rarely available in any type of facility (9 percent) (Figure 6.10), although there has been a major improvement in NGO facilities where 14 percent had partographs in 2004 (none had them in 2002) (Appendix Table A-6.34). Guidelines or protocols for deliveries and managing complications of deliveries are also not commonly found, with only 7 percent of all facilities having them in the delivery service area.

Figure 6.10 Items to support quality delivery services (N=167)



Egypt SPA 2004

In Egypt, physicians and nurses with a license to conduct delivery are the principal delivery service providers in facilities. Although 90 percent of facilities report that there is a delivery service provider available 24 hours, either onsite (79 percent) or on call (11 percent), a 24-hour duty schedule is available at only 55 percent of facilities reporting onsite providers and at only 2 percent of facilities with on-call staff (Figure 6.10). An onsite delivery service provider with an observed duty schedule is found in only half (49 percent) of facilities in Upper Egypt, and in two in three facilities in Lower Egypt and the Urban Governorates (Appendix Table A-6.39).

Without an official schedule assigning duty during nights and holidays, the consistency with which a provider will be found during these times is uncertain. In many rural HUs, there is one assigned physician who lives at the facility. In this situation there might, reasonably, be no duty schedule observed; however, staff coverage for when the physician is out of the immediate area for more than a few hours (e.g., visiting another town) is uncertain.

Key Findings
<p>Infection control measures for delivery services are weak, with hand-washing soap and latex gloves available in around half of the delivery service areas.</p> <p>Slightly more than half of facilities have all elements to support quality sterilization of delivery equipment.</p> <p>Partographs and guidelines or protocols to support a routine standard of delivery practice are rarely available (9 and 7 percent of facilities, respectively).</p> <p>Twenty-four-hour delivery services, supported by a night-duty schedule for staff either onsite (55 percent) or on call (2 percent), are available in 57 percent of facilities offering delivery services.</p>

Essential Supplies for Delivery Services

All basic supplies for conducting a normal delivery (an instrument to cut the umbilical cord, umbilical cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineal area) are available in 33 percent of facilities (Table 6.7), an increase from 21 percent in 2002, with the most consistent improvement since 2002 noted in the availability of a suction apparatus and cord ties. The availability of different items varies from 90 percent for skin disinfectant to 57 percent for cord ties/clamps (Figure 6.11).

Table 6.7 Availability of medicines and supplies for normal and complicated delivery services

Percentage of facilities that have all indicated supplies, by type of facility and region, Egypt SPA 2004

Background characteristics	All essential supplies for delivery ¹	Among facilities offering delivery services, percentage with additional medicines and supplies for managing complications of delivery		Number of facilities offering delivery services (weighted)
		Common complications ²	Serious complications ³	
Type of facility				
GS hospital	33	44	12	39
MCH/urban HU	70	20	0	48
Rural HU	10	2	0	73
NGO facility	14	14	14	7
Region				
Urban Governorates	42	28	8	19
Lower Egypt	59	27	3	57
Upper Egypt	15	10	3	91
Total	33	18	3	167

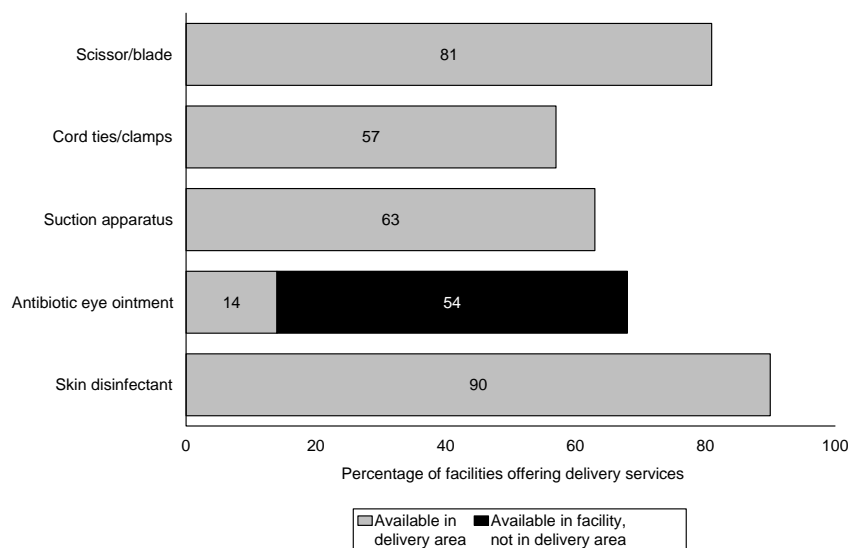
¹ Scissor or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, skin disinfectant.

² Needle and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area; oral antibiotic (cotrimoxazole or amoxicillin) located in pharmacy or delivery room area

³ Injectable anticonvulsant (Valium or magnesium sulfate) in delivery room area; antibiotic (penicillin and ampicillin, or gentamycin) in delivery room area or pharmacy.

MCH/urban HUs are the most likely to have all basic supplies for deliveries, with 70 percent having all items, a major improvement over 44 percent in 2002. There is substantial variation by region in the availability of these essential items, with facilities in Lower Egypt (59 percent) and the Urban Governorates (42 percent) more likely to have all items. This reflects a large improvement in Lower Egypt and a deterioration for facilities in the Urban Governorates since 2002.

Figure 6.11 Essential supplies for delivery (N=167)

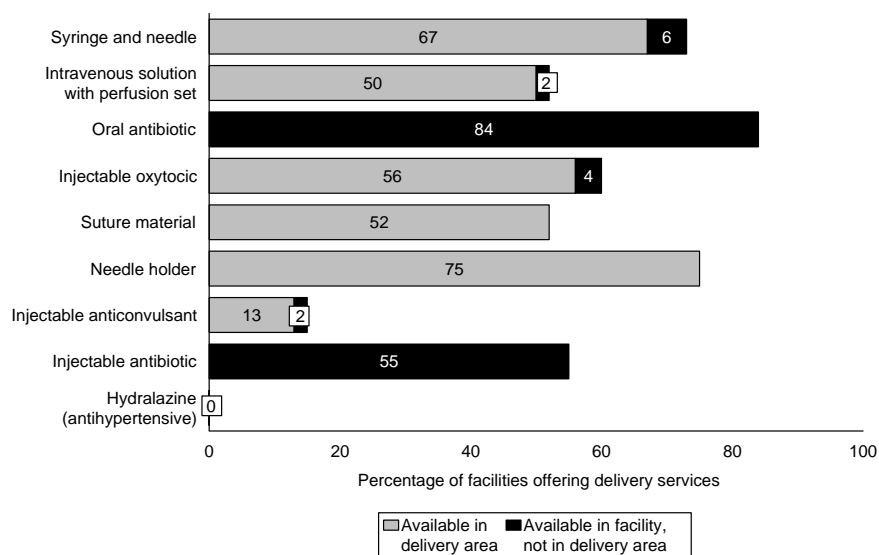


Egypt SPA 2004

Medicines and Supplies for Complications

Medicines and supplies to manage complications of labor and delivery are assessed for all facilities offering delivery services, although in Egypt it is expected that complications will be referred to a GS hospital if there is not a specialist assigned to the facility. Specific items for managing common complications (needles and syringes, intravenous solution and infusion sets, injectable oxytocic medicines, and suture supplies) must be in the delivery room or an immediately adjacent area; during an emergency, the items must be available immediately, and if they are stored in a pharmacy or other location in the facility, they might be locked away and, hence, not available at night. Figure 6.12 provides information on the availability of these items in the delivery area, as well as the additional availability of selected items that are not in the delivery area but are in the facility (most often either in the pharmacy or stock room). All of these items are available in 18 percent of facilities (Table 6.7), primarily in GS hospitals (44 percent) and MCH/urban HUs (20 percent). Items for management of common complications are least available in facilities in Upper Egypt (10 percent). While there are substantial changes since 2002 in the availability of all items, by region, overall, findings are about the same. Each of the essential medicines and supplies is available in half or more of all facilities offering delivery services, with most facilities appropriately storing the relevant items in the delivery service area (Figure 6.12).

Figure 6.12 Additional medicines and supplies for managing complications of delivery (N=167)



Egypt SPA 2004

In addition to medicines for managing common complications, the availability of selected medicines for managing severe complications is assessed. An injectable anticonvulsant for severe preeclampsia and eclampsia is available in the delivery service area in 13 percent of facilities (Figure 6.12), most often in GS hospitals (42 percent) (Appendix Table A-6.40), with a substantial increase in availability in NGO facilities (from 48 percent in 2002 to 74 percent in 2004). Injectable antibiotics for sepsis are available in 55 percent of facilities. Both an anticonvulsant and an injectable broad-spectrum antibiotic are available in only 3 percent of facilities (Table 6.7). This is one-third the availability found in 2002. Hydralazine, commonly used to manage hypertension during labor, is practically unavailable (Figure 6.12), only found in 9 percent of NGO facilities (Appendix Table A-6.40), a decrease from 25 percent of NGO facilities in 2002.

Key Findings

Basic equipment and supplies that should be available for any normal delivery are available in one in three facilities offering delivery services, with large regional variation. Umbilical cord ties or clamps are the items most commonly lacking.

Capacity to manage common or serious complications of labor and delivery is weak in all facilities including GS hospitals.

Forty-four percent of GS hospitals have all basic medicines and supplies for managing common complications of labor and delivery, and only one in ten have medicines for managing eclampsia and sepsis.

An injectable oxytocic medicine is available in the delivery area at 56 percent of facilities, including 83 percent of GS hospitals and 55 percent of MCH/urban HUs.

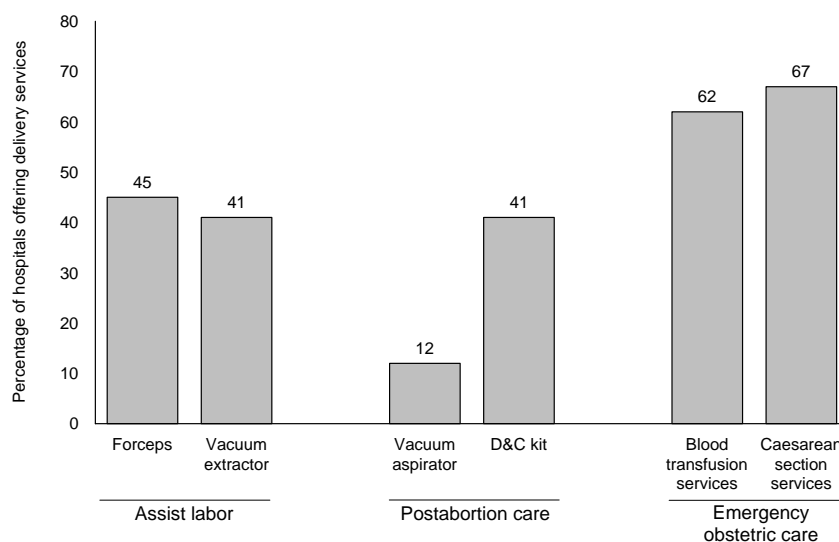
Emergency Equipment

In addition to the previously mentioned equipment and supplies, a facility that manages complicated deliveries should have the capacity to mechanically assist the delivery when contractions are ineffective (using either forceps or a vacuum extractor) and should be able to provide postabortion care by removing retained materials from the uterus, which contribute to hemorrhage and infection (dilatation and curettage [D&C] equipment or a vacuum aspirator). Finally, there is sometimes a need for special equipment to support the newborn. The equipment assessed was a means for providing emergency respiratory support (a resuscitator or ambu bag) and an external heat source to maintain the body heat in a premature newborn (incubator, heat lamp, or other device).

In Egypt, this level of support for complicated deliveries is authorized primarily in GS hospitals, and other facilities that do not have a specialist are expected to refer the clients. There is little change in availability of emergency equipment since 2002. Overall, four in ten GS hospitals have each of these pieces of equipment (Figure 6.13), with six in ten having a heating source for premature infants (Appendix Table A-6.42).

In cases where lifesaving EmOC is required, the capacity to provide a caesarean section and to transfuse blood is essential. Among GS hospitals, six in ten provide caesarean section and blood transfusion services (Figure 6.13).

Figure 6.13 Emergency equipment and services available in general service hospitals offering delivery services (N=39)



Egypt SPA 2004

Key Findings

Equipment for assisting complicated deliveries is available primarily in GS hospitals; thus, referrals are required for most complications.

Among GS hospitals offering delivery services, less than half have equipment to support inefficient labor or to provide postabortion D&C.

Around two-thirds of GS hospitals offer caesarean section and/or blood transfusion services.

6.8 Newborn Care Practices

There has been little change in routine facility practices related to the newborn since 2002. Details on newborn practices, including care of the umbilical cord, are provided in Appendix Table A-6.44.

Using catheter suction to stimulate respirations in newborns who are not breathing is not an uncommon practice; however, this should not be a routine practice, as it may cause injury to the newborn. Seventy-five percent of facilities, including 85 percent of GS hospitals, indicate that they routinely suction the mouth and nose of the newborn with a catheter (Appendix Table A-6.44). Only 33 percent of facilities have a suction bulb for clearing the respiratory path of the newborn (Appendix Table A-6.40).

Hypothermia is a contributing factor to increased morbidity and death for newborns. It can be prevented by avoiding full-immersion bathing the first few hours after birth and, instead, drying the newborn and either immediately giving the infant to the mother for skin-to-skin contact or wrapping the newborn in a warm blanket. Full-immersion bathing is common, with 21 percent of facilities indicating that this practice is routine. MCH/urban HUs report full-immersion bathing more than other facilities (39 percent, compared with 24 percent or less for other facilities) (Appendix Table A-6.44).

Weighing the newborn provides health information for monitoring postnatal care. Birth weight is also an indicator for risk of infant death. Although 86 percent of facilities indicate that they routinely weigh the newborn, not all (77 percent) have a functioning infant scale in the delivery service area (Appendix Table A-6.44).

Vitamin A supplementation in depleted children has been shown to decrease risk of infection and death. Newborns can receive a healthy amount of vitamin A through breast milk; however, pregnant women are also at risk of developing vitamin A deficiency. Eighty percent of facilities indicate that they routinely provide vitamin A to the new mother (Appendix Table A-6.44), an increase from 71 percent in 2002. Only 57 percent of facilities have vitamin A available in the delivery service area, although 77 percent have it available either in the delivery room or in the pharmacy.

When assessing policies and practices for providing oral polio vaccine (OPV) and the vaccine against tuberculosis (BCG) to the newborn, it should be remembered that the full immunization coverage for children in Egypt is estimated at 88 percent (EIDHS 2003). MOHP has recently adopted recommendations from a technical advisory group of international polio experts¹¹ to provide a dose of OPV (considered dose 0) after birth to provide extra protection for the infant. At the time of the ESPA 2002 survey, OPV was reported as being provided to newborns prior to discharge in 19 percent of facilities; in 2004, it has increased to 57 percent, a rapid expansion in implementation of the MOHP policy. It is current MOHP policy to provide BCG vaccine to the newborn within 42 days of birth. When asked, 10 percent of facilities (the same as in 2002) indicate that they provide BCG to the newborn prior to discharge.

MOHP promotes providing vitamin K to the newborn. Nineteen percent of facilities indicate that they routinely provide vitamin K to newborns (Appendix Table A-6.44). Fifty-one percent of facilities have vitamin K available; this suggests that, should it be desirable, this practice could easily be expanded.

Internationally, exclusive breastfeeding is promoted for the first six months of age, with provision of prelacteal liquids discouraged. As noted in section 6.5.2, however, pregnant women are not routinely counseled on exclusive breastfeeding. Prelacteal liquids are not routinely provided (only 9 percent of facilities), although NGO facilities report routinely providing prelacteal liquids more (25 percent) than other facilities. This practice has decreased in GS hospitals, from 31 percent (2002) to 15 percent (2004).

“Rooming in,” where the infant routinely stays with the mother (a practice to support exclusive breastfeeding and mother-child bonding), is routinely practiced in most (96 percent) facilities, a slight increase from 88 percent in 2002.

When asked about care of the umbilical cord, 87 percent of facilities indicate that they apply 70 percent alcohol, 26 percent apply Betadine, and 14 percent use dry dressings only. It is evident that facilities sometimes have more than one care practice for umbilical cords.

¹¹ The Technical Advisory Committee was formed of international polio experts from WHO, UNICEF, USAID, CDC, and Rotary International.

Key Findings

Weighing the infant, providing vitamin A to the mother, and rooming in are practices that are common in Egyptian facilities and are considered supportive of newborn health.

Routine suctioning with a catheter (75 percent of facilities) is a practice that did not decrease since 2002 (72 percent) and should be reassessed and discouraged as a routine procedure

One in four NGO facilities reports routinely providing prelacteal feeds to newborns. This practice should be assessed and potentially discouraged.

6.9 Management Practices Supportive of Quality Delivery Services

Table 6.8 provides information on management practices that are assessed by the ESPA 2004. Appendix Table A-6.45 provides information on user statistics, Appendix Table A-6.46 provides information on user fee practices, and Appendix Tables A-6.47 through A-6.49 provide information on supervision and staff development from the perspective of the provider.

6.9.1 Facility Documentation and Records

A delivery register is defined as being up to date if there is an entry in the past 30 days (assuming there should be at least one birth per month in facilities that provide the service) and if the entry, at a minimum, provides the birth outcome. Fifty-three percent of facilities have an up-to-date delivery register available (Table 6.8).

Table 6.8 Facility-based supportive management practices

Percentage of facilities with the indicated documentation, percentage with user fees, and percentage that provide the indicated supportive management, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering delivery services with:				Number of facilities offering delivery services (weighted)	Percentage of facilities where at least half of the interviewed delivery service providers:		Number of facilities with interviewed providers of delivery services (weighted) ³
	Observed up-to-date patient register ¹	Documentation of monitoring delivery coverage	Facility reviews maternal/newborn deaths or near misses	User fee for delivery		Received in-service training during the past 12 months ²	Were personally supervised during the past 6 months	
Type of facility								
GS hospital	78	11	51	30	39	15	85	35
MCH/urban HU	53	30	33	62	48	26	82	48
Rural HU	42	46	35	28	73	7	98	69
NGO facility	39	0	0	100	7	10	39	6
Region								
Urban Governorates	73	32	36	54	19	11	82	19
Lower Egypt	63	16	36	43	57	24	80	54
Upper Egypt	43	41	37	37	91	10	94	86
Total	53	32	37	41	167	15	88	159

¹ Register has an entry in the past 30 days; entry indicates delivery outcome.

² This refers to structured, in-service sessions and does not include individual instruction received during routine supervision.

³ This includes only providers of delivery services in facilities offering delivery services.

Facilities frequently have catchment populations for whom they provide services. The ESPA 2004 assesses whether the facility has any documentation indicating that it monitors the proportion of deliveries that occur in its catchment area and are attended by facility staff (or, for some program strategies, deliveries that are attended by skilled providers affiliated with the facility). This is a facility's delivery coverage for its catchment population. There has been improvement in monitoring of delivery coverage, with 32 percent of facilities having documentation of this practice, compared with 11 percent in 2002 (Table 6.8).

6.9.2 Systems for Quality Assurance

One quality assurance measure is to systematically review all maternal and newborn deaths or near deaths to develop interventions to decrease or prevent these events. The ESPA 2004 does not assess the quality of these review programs, but it does assess whether facilities have implemented the process. Thirty-seven percent of facilities providing delivery services and over half of GS hospitals indicate that they conduct reviews of maternal or newborn deaths or near deaths, with no difference by other facility types or by region (Table 6.8). This is a decrease from 49 percent of all facilities in 2002, with rural HUs decreasing from 58 percent in 2002 to 35 percent in 2004.

Referral forms, a means for improving effective referrals of obstetric emergencies, are found in 29 percent of facilities (primarily in MCH/urban HUs [54 percent] (Appendix Table A-6.41).

6.9.3 Practices Related to User Fees

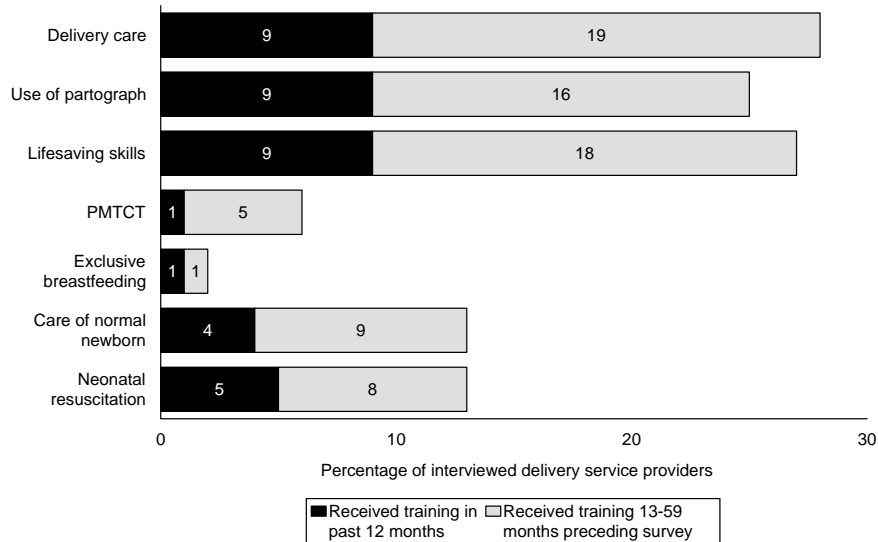
The ESPA 2004 documents the percentage of facilities where user fees are collected for delivery services. Similar to practices in 2002, 41 percent report having user fees for some aspects of deliveries (Table 6.8).

6.9.4 Supervision and Staff Development

Supervision and staff development practices are similar to those found in 2002.

If at least half of the interviewed delivery service providers at a facility have received any structured in-service training relevant to delivery services during the past 12 months (excluding on-the-job training that may be received during discussions with supervisors), the facility is defined as providing routine staff development activities. During the past 12 months, at least half of the interviewed delivery service providers had received in-service training related to delivery services in 15 percent of facilities (Table 6.8), similar to findings in 2002. Topics and timing of the most recent in-service training received by delivery service providers are presented in Figure 6.14.

Figure 6.14 In-service training received by interviewed delivery service providers, by topic and timing of most recent training (N=371)



PMTCT = Prevention of mother-to-child transmission

Egypt SPA 2004

If at least half of the interviewed delivery service providers in a facility have been personally supervised in the past six months, the facility is defined as providing routine staff supervision. More than half of the interviewed delivery service providers in 88 percent of facilities had been personally supervised during the past six months (Table 6.8). Although the percentage of staff receiving supervision is higher in Upper Egypt (94 percent), the frequency of supervision is much higher for providers working in facilities in the Urban Governorates (median number of 19 times during the past six months) than for providers in facilities in Lower Egypt and Upper Egypt (a median of 7 times for each) (Appendix Table A-6.49).

Key Findings

Slightly more than half of facilities have up-to-date delivery registers.

One-third of facilities have documents showing that they monitor community coverage of delivery services, a large increase over 11 percent, found in 2002.

Routine supervision of delivery service providers is almost universal (88 percent of facilities); however routine provision of in-service training is not common (15 percent of facilities).

Communicable Diseases: Services for Reproductive Tract and Sexually Transmitted Infections and Tuberculosis

Chapter 7

7.1 Background

7.1.1 ESPA 2004 Approach to Collection of Information on RTI/STI Services

Sexually transmitted infections (STIs) are a major public health problem throughout the world. These illnesses affect millions of men, women, and children and can cause infertility, serious illness, and even death. STIs have also been shown to increase the risk of transmission of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS) (AIDSCAP/FHI, 1996). Most people infected with STIs do not have symptoms, but they can still transmit the disease to their sexual partners. Pregnant women with STIs are more likely to have low-birth-weight babies, premature babies, and stillbirths (Cotch et al., 1997; AIDSCAP/FHI, 1996). For the 2004 Egypt Service Provision Assessment survey (ESPA 2004), services related to and clients receiving services for reproductive tract infections (RTIs), (whether sexually transmitted or not) are assessed.

As of December 2004, about 40 million people worldwide have been infected with HIV/AIDS (UNAIDS/WHO, 2004). A majority of people infected with HIV do not know that they are infected and, as a result, may unknowingly infect others. These people will die from AIDS if they do not receive appropriate treatment and care. However, with the development of powerful antiretroviral drugs, many people who are HIV positive are living longer, and many infected mothers are giving birth to infection-free babies. Consequently, the role of health systems in addressing the HIV/AIDS epidemic has expanded to include a range of care and support services for people living with HIV/AIDS. Although the prevalence of HIV/AIDS in Egypt is one of the lowest in the region, estimated at 0.03 percent among the general population (MOHP, 2003), the pandemic status of this illness necessitates that vigilance for monitoring and early detection continue to be public health priorities for all countries.

Although sexual contact is not the only means of transmission of HIV/AIDS, it is the most common (UNAIDS/WHO, 2000); thus, preventive measures for STIs are equally relevant to HIV/AIDS.

This chapter uses information obtained in the ESPA 2004 to address the following four central questions:

- What is the availability of RTI/STI services?
- To what extent do the facilities offering RTI/STI services have the capacity to support quality RTI/STI services?
- To what extent is there evidence that health service providers adhere to standards for provision of quality RTI/STI services?

7.1.2 Health Situation Related to RTI/STIs in Egypt

The prevalence of STIs is not believed to be high in Egypt, and as a result, until recently, health services related to STIs have not been a priority area of development. Surveillance for and statistics on the prevalence of STIs are weak, with most published studies on STIs focusing on selected populations. With increasing awareness of the risks of HIV/AIDS and the relationship between STIs and HIV/AIDS, MOHP has developed a new curriculum in 2002 to strengthen the RTI/STI and HIV/AIDS component of

preservice training for health service providers. In addition, health service providers are encouraged to include screening for STIs as a component of health services for clients who are at risk.

The first AIDS case in Egypt was diagnosed in 1986. Subsequently, a National AIDS Program and a National AIDS Committee were established. Since 1986, HIV/AIDS has been classified as a notifiable disease, and blood for transfusions has been screened for HIV/AIDS since 1987.

The current prevalence of HIV/AIDS is estimated at 0.03 percent among the general population and from 0.05 to 0.5 percent among high-risk populations. A recent study of a sample of homosexual men in Cairo also found low prevalence of HIV (just over 1 percent) (El-Rahman, 2004); however, high-risk behaviors were common. El-Rahman noted that many men under 25 had multiple partners and only 19 percent of them consistently used condoms, while some never heard of condoms. El-Rahman suggested that the low rate of condom use combined with almost three in four men over 25 having female sex partners increases the risk of wider transmission of HIV in Egypt (El-Rahman, 2004).

The National AIDS Control Program (NACP) has developed a strategy with the following priorities (MOHP and NACP, 2003):

- Epidemiological surveillance to identify trends and the extent of the problem
- Information, education, and communication (IEC) activities for the public
- IEC activities for prevention of sexual transmission of HIV by decreasing risk behaviors and through early and effective management of STIs
- Screening all blood donations to prevent transmission of HIV through blood
- Prevention of prenatal transmission
- Reducing the impact of HIV infection through supportive care for AIDS patients.

7.2 Availability of RTI/STI Services

The integration of RTI/STI diagnosis and treatment into relevant health services increases opportunities for case detection and followup on treatment. The ESPA 2004 assesses RTI/STI service availability and service delivery conditions. Most commonly, clients seeking health care specifically for symptoms of STIs are seen in a general outpatient department (OPD). Less commonly, there is a specific RTI/STI service area. In addition, however, women seeking services for antenatal care (ANC) or family planning may also require RTI/STI services. Including RTI/STI screening and treatment as a component of these services may increase early detection and improve followthrough on treatment because women may be more comfortable discussing symptoms of STIs during the course of a regular ANC or family planning visit with a provider with whom she is familiar. If she must go elsewhere for RTI/STI services, there is a greater chance that she may decide not to seek followup care.

Table 7.1 provides information on the availability of RTI/STI services of any type and the availability depending on which service the client is using in the facility. Appendix Table A-7.1 provides information on availability of RTI/STI services in facilities reporting that RTI/STI services are not offered as a part of the routine curative care, but where service providers for family planning and ANC report that they offer the service to their clients.

RTI/STI services are defined as any service related to RTI/STIs, including only counseling, only testing, or diagnosis and treatment. RTI/STI services are reported by 89 percent of all facilities (Table 7.1), a large increase from 62 percent reported in 2002. There are few differences in availability of the service by geographic region. Although fever¹ hospitals are a priority for training providers in diagnosing and managing HIV/AIDS (MOHP, 2003), only 42 percent of fever hospitals offer RTI/STI services, less than in 2002 (53 percent). Among facilities reporting RTI/STI services, most (76 percent) offer these services as a part of the general outpatient curative services, with essentially all offering the service at least five days per week (89 percent) (Table 7.1). Integration of RTI/STI services with family planning and ANC services is high, with 84 percent of the facilities offering any RTI/STI services through family planning services and 74 percent offering RTI/STI services through ANC services. Among the facilities that offer RTI/STI services, 71 percent report that the service is available to clients in all three relevant service areas (general outpatient, family planning, and ANC). In small facilities, such as mobile units and rural health units (HUs), one provider who sees all sick adults (routine outpatient services), as well as ANC and family planning clients, may also provide RTI/STI services to any of these clients who need the service.

Table 7.1 Availability of services for RTI/STIs

Percentage of facilities offering services for RTI/STIs; among facilities offering services for RTI/STIs, percentage where RTI/STI services are provided in the indicated service area; and percentage where RTI/STI services are offered five or more days per week, by type of facility and region, Egypt SPA 2004

Background characteristics	Any RTI/STI services	Number of facilities (weighted) ¹	Percentage of facilities where RTI/STI services are available in the indicated service area ¹					Percentage of facilities where services for RTI/STIs are available at least 5 days per week	Number of facilities offering RTI/STI services (weighted)
			General outpatient department (OPD)	Special clinic ²	FP	ANC	OPD, FP, and ANC service areas		
Type of facility									
GS hospital	99	65	83	17	88	74	72	95	65
Fever hospital	42	14	51	49	12	na	0	100	6
MCH/urban HU	98	97	64	36	88	88	80	96	95
Rural HU	87	319	85	15	84	78	75	89	277
Mobile unit	100	55	68	32	82	58	57	97	55
Health office	49	33	44	56	93	9	9	94	16
NGO facility	98	76	64	36	83	73	70	68	74
Region									
Urban Governorates	96	73	41	59	93	74	73	91	70
Lower Egypt	86	322	71	29	89	72	70	90	279
Upper Egypt	91	264	91	9	77	78	71	87	239
Total	89	659	76	24	84	74	71	89	587

¹ Services may be available at multiple sites in the same facility if they are integrated. In small facilities, one service site and one provider may provide services for general outpatients, ANC, and family planning clients.

² RTI/STI services at the public and NGO facilities are utilized primarily by females, so in almost all cases, the special clinic is the gynecologic clinic. Males might receive RTI/STI services in the urology clinic.

FP = Family planning; GS = General service; na = Not applicable; MCH = Maternal and child health; HU = Health unit; NGO = Nongovernmental organization

¹ Fever hospitals provide services for HIV/AIDS patients, but it is not in their mandate to provide services for STI patients, as there are venereal diseases hospitals in the governorates to provide specific STI services.

Key Findings

RTI/STI services are offered by 89 percent of all facilities, a large increase from 62 percent in 2002.

Within facilities reporting RTI/STI services, the services are integrated, with 71 percent of facilities indicating that RTI/STI services are available through general outpatient services as well as through ANC and family planning services.

7.3 Capacity to Provide Quality RTI/STI Services

The ESPA 2004 assesses systems, infrastructure, equipment and supplies for supporting quality RTI/STI services. Although RTI/STI services are provided in multiple sites in large facilities, information for the capacity to provide quality RTI/STI services comes from the general OPD, the main service area for STIs.

Table 7.2 provides information on system components and resources for RTI/STI services. Figures 7.1 to 7.4 provide summary information on items assessed for counseling, diagnosis, and treatment for STIs. Appendix Tables A-7.2 and A-7.3 provide details on items assessed for counseling, physical examinations, and infection control for STIs. Appendix Table A-7.4 provides details on availability of laboratory tests and treatment for STIs.

7.3.1 System Components to Support Utilization of Services

Because a stigma is often associated with having an RTI/STI and the symptoms are not readily apparent in many people, special efforts are needed to promote early diagnosis of RTI/STIs and to encourage clients to seek modern medical help for the symptoms. The ESPA 2004 assessed the existence of program strategies and service delivery components that contribute to the availability and improved utilization of RTI/STI services.

Ensuring clients that information will remain confidential is one essential condition for encouraging the use of services. Adherence to confidentiality standards is supported when a facility has an official written policy that is shared with all staff. For the ESPA 2004, any document or notice that specifies that information related to the client will remain confidential between the provider and the client is accepted as proof of a confidentiality policy. No facilities have a written confidentiality policy for RTI/STI services (data not shown), although 2 percent of NGO facilities report that they have a written policy but were unable to show any documentation. Since confidentiality policies have not yet been introduced through MOHP, it is possible that the NGO facilities have developed their own internal directive on this issue to remind providers or to reassure clients of the importance of confidentiality of information shared.

For effective interruption of RTI/STI transmission, the husband or wife of a client with an RTI/STI should also be tested and, if infected, he or she should be treated. The client with an RTI/STI (all cases observed in the ESPA 2004 were women) should be asked to notify her husband and to ask him to be examined. This is classified as passive followup. If the client feels uncomfortable or ashamed informing her husband that he may be infected, the client may allow local health authorities to contact the husband to inform him of the risk of infection and to advise him to seek care. This is called active followup. Provision of active followup is not MOHP policy.

Forty-seven percent of facilities indicate that they do ask clients to bring their husbands for checkup, with an additional 4 percent reporting that they sometimes conduct active followup as well. This is an increase from findings in 2002, when 36 percent of facilities reported passive followup and 3 percent reported active followup practices.

Table 7.2 Availability of infrastructure and resources to support quality counseling and examinations for RTI/STIs

Percentage of facilities with all indicated components to support counseling, diagnosis, and treatment for RTI/STIs, by type of facility and region, Egypt SPA 2004

Background characteristics	All items to support quality counseling ¹	All conditions to provide quality physical examination ²	Method for diagnosing STIs		Testing capacity for: ⁴					Medicines to treat four major STIs ¹⁰	Number of facilities offering RTI/STI services (weighted)
			Etiologic	Syndromic ³	Syphilis ⁵	Gonorrhea ⁶	Wet mount ⁷	Chlamydia ⁸	HIV/AIDS ⁹		
Type of facility											
GS hospital	7	17	7	97	4	4	23	0	8	5	65
Fever hospital	12	12	50	63	0	13	62	13	75	25	6
MCH/urban HU	12	22	8	98	23	0	29	0	0	1	95
Rural HU	6	14	4	100	2	0	5	1	0	1	277
Mobile unit	3	9	0	100	0	0	0	0	0	0	55
Health office	7	7	0	100	0	0	0	0	0	0	16
NGO facility	1	10	14	100	4	1	13	2	3	1	74
Region											
Urban Governorates	5	8	14	100	15	3	25	1	5	5	70
Lower Egypt	8	20	5	98	6	0	9	1	1	0	279
Upper Egypt	5	11	5	100	3	1	11	1	2	2	239
Total	6	15	6	99	6	1	12	1	2	2	587

¹ Visual and auditory privacy, any RTI/STI service guidelines or protocols, and any visual aids or educational materials

² All infection control items (soap, water, latex gloves, disinfecting solution, and sharps box), visual privacy, examination bed, and examination light

³ This may include diagnosing by symptoms where the syndromic approach algorithms were not followed.

⁴ Capacity to conduct a test does not mean the facility routinely utilizes the test,

⁵ Either venereal disease research laboratory (VDRL) test and functioning microscope, or reactive protein reagent (RPR) test kit

⁶ Gram stain reagents and functioning microscope or culture capacity

⁷ Functioning microscope and slides

⁸ Giemsa stain for chlamydia

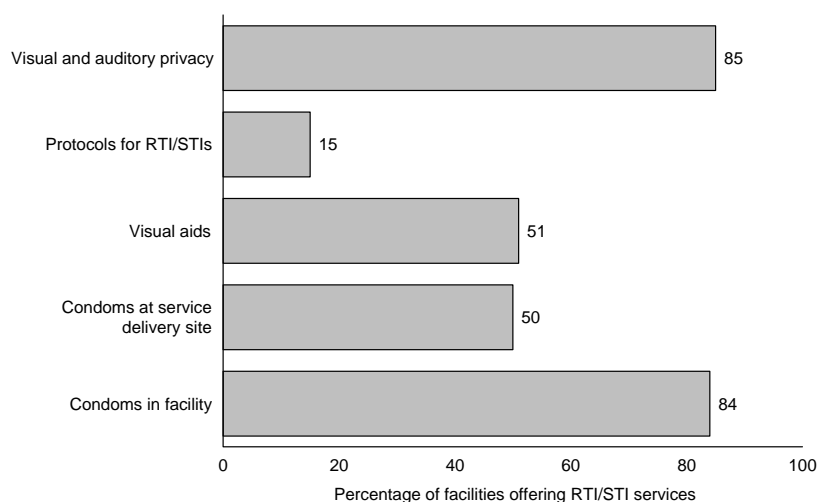
⁹ Enzyme-linked immunosorbent assay (ELISA), Western blot, or rapid test

¹⁰ At least one medicine to treat syphilis, gonorrhea, trichomoniasis, and chlamydia

7.3.2 Infrastructure and Resources to Support Quality Assessment and Counseling

Overall, 6 percent of facilities have all items to support quality counseling (Table 7.2), compared with 10 percent in 2002. With the exception of better privacy for counseling, most other elements have shown a slight decrease. Ensuring complete privacy for counseling for STIs is important to facilitate open communication between the provider and the client. Because counseling for diagnosis and prevention of STIs often takes place in a different location than the physical examination, the conditions for counseling are assessed separately from those for physical examinations. Ensuring auditory and visual privacy is expected to encourage the use of services by the client and adherence to guidelines/protocols and standards by the provider. Without these conditions, the provider may not ask the appropriate questions or make the appropriate examinations. Eighty-five percent of facilities offer counseling for RTI/STI clients under conditions that allow both visual and auditory privacy (Figure 7.1).

Figure 7.1 Items to support quality RTI/STI services (N=587)



Egypt SPA 2004

Fifteen percent of facilities have RTI/STI service guidelines or protocols in the RTI/STI service delivery areas (Figure 7.1), but only 1 percent specifically having guidelines that include the syndromic approach (Appendix Table A-7.2). The syndromic approach is a systematic method for assessing symptoms in a client, and then, based on the symptoms, a specific guideline is followed for which medicines should be prescribed (WHO, 2001). The syndromic approach has not been widely introduced in Egypt; however, the guidelines can be found in a variety of general materials and may have been part of other general guidelines for reproductive health in the facilities where they were found.

About half of all facilities have visual aids for client education related to STIs and around half have condoms in the service delivery area, with 84 percent having condoms anywhere in the facility. The availability of condoms at the service delivery site allows the provider to demonstrate how to use them and to ensure that the client leaves with them.

Key Findings

Practices to increase case detection (confidentiality policies and partner followup procedures) are not yet policy within the health system and are not common.

Guidelines for RTI/STI diagnosis and treatment are available in 15 percent of facilities.

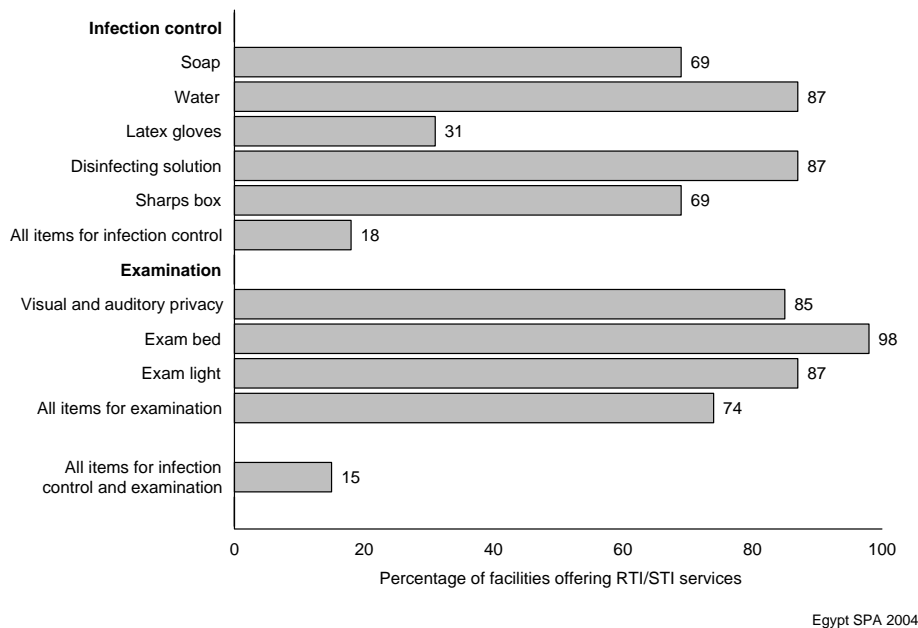
Condoms are available in 84 percent of facilities, although only 50 percent of facilities have condoms in the RTI/STI service area.

7.3.3 Infrastructure and Resources for Examinations and Treatment

Diagnosis and treatment of STIs are supported when there is an adequate infrastructure for a physical exam, laboratory diagnostic support, and medicines for treating specific STIs.

Quality physical examinations require the infection control measures as well as an adequate infrastructure and basic furnishing for client examinations.

Figure 7.2 Items to support quality examinations for RTI/STIs (N=587)



Infection Control

All items for infection control are available in the RTI/STI service area of only 18 percent of facilities (Figure 7.2), compared with 23 percent in 2002, with the difference attributable primarily to a decrease in availability of latex gloves (from 52 percent in 2002 to 31 percent in 2004). As mentioned previously, this may reflect more accurate assessment of the gloves (latex or nonlatex) rather than an actual change in service conditions. Essentially, all facilities have thin, nonlatex disposable gloves available; however, these are not effective for infection control. Availability of hand-washing soap has improved, with 69 percent of facilities having soap in the RTI/STI service area, compared with 53 percent in 2002. All items for infection control are found most commonly in MCH/urban HUs (31 percent) and least often in health offices (7 percent) (Appendix Table A-7.2).

The procedures used for sterilizing or high-level disinfection (HLD) processing of equipment used for RTI/STI services are also assessed.² Around half (46 percent) of facilities process RTI/STI equipment in the main equipment processing area for the facility, and a slightly larger percentage (52 percent) process RTI/STI equipment in the family planning service area. Only 3 percent process the equipment in the area where RTI/STI services are offered (data not shown).

Overall, 88 percent of facilities have functioning equipment and a person who knows the proper processing procedure for the sterilization (64 percent) or HLD method (24 percent) used for RTI/STI equipment (Appendix Table A-7.3). This is somewhat higher than findings in 2002 (78 percent). An automatic timing device is also important for supporting quality sterilization or HLD processing. When this criteria is added, 60 percent of facilities have the equipment, knowledge, and an automatic timing

² In Chapter 3, sections 3.4.1 and 3.4.2 provide details on the definitions for adequate sterilization or HLD procedures and for appropriate storage conditions, respectively.

device for sterilization or HLD processing (data not shown). The timing device is missing most often from facilities using HLD processing (data not shown).

Written guidelines for sterilization or HLD processing are available in the area where RTI/STI service equipment is processed in 25 percent of facilities (Appendix Table A-7.3). Guidelines are found more often in facilities in the Urban Governorates (43 percent).

Client Examinations

A private room (to ensure visual and auditory privacy) is available in 85 percent of the RTI/STI examination areas, and an examination bed and an examination light are each available in about 90 percent of facilities (Figure 7.2), with all furnishings for an examination available in 74 percent of facilities. NGO facilities and GS hospitals are more likely to have all furnishings for examinations (about 83 percent each), and fever hospitals are the least likely (12 percent).

All conditions for quality physical examination, including items for infection control and infrastructure for examination, are available in 15 percent of facilities (Table 7.2).

Key Findings

All items for infection control are found in the RTI/STI service area in only one in five facilities, with MCH/urban HUs (31 percent) being the best prepared for infection control. Overall, the availability of hand-washing soap in the RTI/STI service area has improved substantially, from 53 percent in 2002 to 69 percent in 2004.

Three in four facilities have the infrastructure and furnishing for client examinations.

STI Diagnosis

The World Health Organization (WHO) recommends the use of two approaches in providing RTI/STI services at primary care facilities: etiologic and syndromic approaches (WHO, 2001). The etiologic approach uses laboratory tests for diagnosing STIs. This method is more accurate than syndromic diagnosis; however, laboratory facilities are often not available. The syndromic approach is recommended for facilities with no laboratory. The syndromic approach assesses the presence of specific symptoms and then uses an algorithm to determine treatments to be provided. When neither an etiologic nor a syndromic approach is used, providers often diagnose and prescribe medication on the basis of their clinical judgment and client symptoms (often referred to as clinical diagnosis). Studies have shown that when providers do not have a specific guideline or protocol (such as the syndromic approach) or laboratory results to use when diagnosing and prescribing for STIs, mistreatment is common (Lande, 1993).

Many physician respondents were not familiar with the syndromic approach algorithms and indicated that they use syndromic diagnosis and treatment when they actually practice clinical diagnosis and treatment, not necessarily following the syndromic approach algorithms. Thus, while almost all facilities indicated that they use syndromic methods for diagnosing (Table 7.2), it was clarified that most are referring to clinical diagnosis. Six percent of facilities indicated that they use etiologic diagnostic methods.

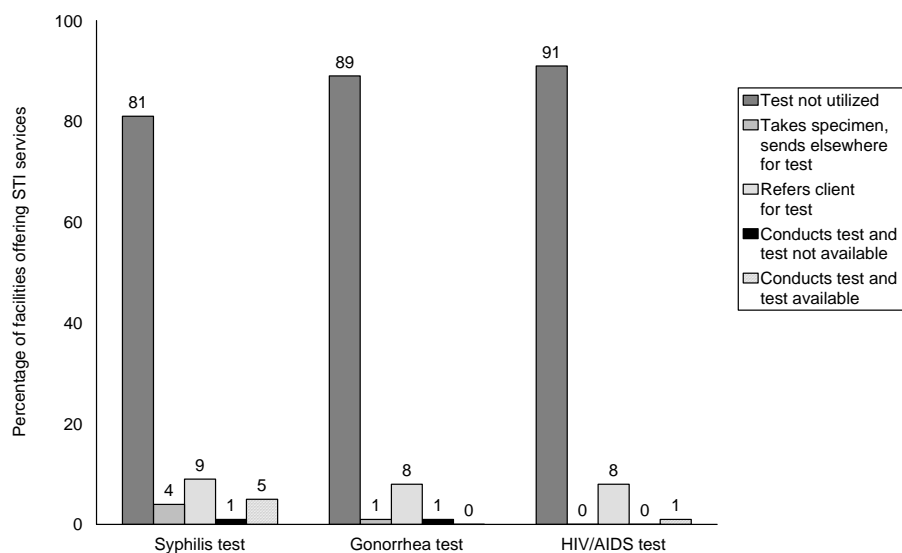
The most reliable means for ensuring that clients receive a desired laboratory test is for the facility to conduct the test in-house. Another alternative is to take the specimen and send it to another facility for testing. The least reliable means is to refer the client to another facility to receive the laboratory test, because there is a likelihood that the client may decide not to take the test at all.

Six percent of facilities have the laboratory capacity to conduct a test for syphilis (Table 7.2), and 12 percent have a microscope for wet-mount examination of a specimen. Testing capacity for HIV/AIDS, for gonorrhea, and for chlamydia is found in around 1 percent of facilities, primarily in hospitals (fever and GS), in MCH/urban HUs, or in NGO facilities. RTI/STI testing capacity is more common in facilities located in Urban Governorates. Only 1 percent of NGO facilities have testing capacity for all five mentioned conditions (Appendix Table A-7.4).

Almost all facilities (94 percent) have vaginal speculums, but few (4 percent) have swab sticks for taking a specimen (Appendix Table A-7.4).

Figure 7.3 provides information on the testing status for each condition, indicating if facilities never test for the condition or if they refer clients elsewhere, send a specimen elsewhere, or conduct the test themselves. Although rarely conducted by the facility providing the RTI/STI services, tests for syphilis are more commonly used for diagnosis (19 percent) than those for gonorrhea (10 percent) or HIV/AIDS (9 percent).

Figure 7.3 Utilization and availability of diagnostic tests for STIs (N=587)



Egypt SPA 2004

STI Treatment

A medicine to treat all of the common STIs³ (trichomoniasis, gonorrhea, chlamydia, and syphilis) is available in only 2 percent of facilities. A treatment for syphilis is most commonly available (56 percent), and a treatment for gonorrhea is least available (2 percent) (Appendix Table A-7.4). GS hospitals are more likely than other facilities to have medicines available; however, only 5 percent have the capacity to treat all of the four above infections (Table 7.2), a decrease from 18 percent in 2002.

³ Metronidazole for trichomoniasis; ceftriaxone or ciprofloxacin for gonorrhea; doxycycline, tetracycline, or erythromycin for chlamydia; and doxycycline, tetracycline, erythromycin, or penicillin for syphilis.

Guidelines or protocols for RTI/STI services are found in the RTI/STI service area in 15 percent of all facilities (Appendix Table A-7.2), most commonly in MCH/urban HUs (27 percent) and health offices (38 percent).

Key Findings

Etiologic diagnostic methods for STIs are not widely used (6 percent of facilities), although they are more commonly reported by fever hospitals (50 percent), NGO facilities (14 percent), and GS hospitals and MCH/urban HUs (over 7 percent each).

Few facilities report that they either conduct tests or refer clients for testing to diagnose syphilis, gonorrhea, or HIV/AIDS.

Medicines for treating STIs are somewhat less available in 2004 than in 2002. Almost no facilities (2 percent) have medicines available to treat the all of the STIs—trichomoniasis, gonorrhea, chlamydia, and syphilis. Only 5 percent of general service hospitals have a medicine available to treat each of these infections.

7.4 Management Practices Supportive of Quality Services

Management practices to support quality RTI/STI services include documentation and records, practices related to user fees, and staff supervision and development.

Summary information on management practices supportive of quality RTI/STI services is provided in Table 7.3. Summary information on topics of in-service training received by providers of RTI/STI services is provided in Figure 7.4. Appendix Tables A-7.5 through A-7.9 provide details on service statistics, charging practices for RTI/STI services, supervision, and provider in-service training.

7.4.1 Facility Documentation and Records

WHO considers recordkeeping and reporting of STIs and RTI/STI service utilization to be key elements in RTI/STI surveillance and necessary for improving RTI/STI program management (WHO, 1999a). A register for RTI/STI services is considered up to date if there is an entry in the past seven days and if symptoms or a diagnosis consistent with RTI/STI are written. Because most RTI/STI services are provided in outpatient departments, these records were checked for entries on clients with RTI/STI symptoms or diagnoses. Only 4 percent of facilities have a register with an entry indicating an RTI/STI diagnosis in the past seven days (Table 7.3). An additional 2 percent of facilities had a register that was observed without an entry in the past seven days.

Specific STIs are classified as notifiable diseases in many countries where the public health system monitors illnesses of public health significance. Statistics on newly diagnosed cases and service utilization provide information for assessing changes in disease patterns. The most common notifiable STIs are syphilis, gonorrhea, and HIV/AIDS.

USAID/Egypt in collaboration with the United States Naval Medical Research Unit (NAMRU)-3 and the Epidemiology and Surveillance Unit (ESU)/MOHP launched the Communicable Diseases Surveillance program for Egypt in early 2001 by developing guidelines for infectious disease surveillance and reporting forms. The system currently collects data on 27 priority infectious diseases (26 identified priority diseases with 1 additional line of “other” unanticipated emerging diseases) (USAID, 2003). This National Electronic Diseases Surveillance System (NEDSS) currently tracks the incidence of the listed notifiable infectious diseases in 13 governorates, and it is planned to extend to the remaining 14 governorates.

Table 7.3 Management practices supportive of quality services for RTI/STIs

Percentage of facilities with the indicated records, percentage that have any user fees for RTI/STI services, and percentage with the indicated supportive management practices, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering RTI/STI services			Number of facilities offering RTI/STI services (weighted)	Percentage of facilities where at least half of the interviewed RTI/STI service providers:		Number of facilities with interviewed providers of RTI/STI services (weighted) ⁴
	With observed, up-to-date patient register ¹	That report specific STIs ²	That have user fees for RTI/STI services		Received in-service training during the past 12 months ³	Were personally supervised during the past 6 months	
Type of facility							
GS hospital	14	4	35	65	9	98	59
Fever hospital	0	63	0	6	0	59	4
MCH/urban HU	10	9	28	95	7	89	95
Rural HU	1	6	27	277	5	99	267
Mobile unit	2	0	10	55	12	89	55
Health office	7	0	9	16	3	100	16
NGO facility	3	4	92	74	3	53	72
Region							
Urban Governorates	16	4	37	70	4	79	70
Lower Egypt	2	7	28	279	10	91	270
Upper Egypt	3	5	40	239	2	92	229
Total	4	6	34	587	6	90	568

¹ Register has entry within past seven days, and symptom or diagnosis indicates probable RTI/STI.
² Facility indicates that it submits reports for specific STI diagnosis to the government.
³ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
⁴ Includes providers offering RTI/STI services in facilities offering RTI/STI services in any clinic assessed in survey (e.g., outpatient, ANC, family planning)

Six percent of facilities, primarily fever hospitals (63 percent), indicate that they submit reports on specific STIs and/or HIV/AIDS (Table 7.3).

7.4.2 Practices Related to User Fees

The effect of a fee for services can be negative (the cost is deemed too high) or positive (free items are often perceived not as good as items that are paid for). Thirty-four percent of facilities indicate that they charged any routine fee for RTI/STI services (Table 7.3), around half of the proportion reporting user fees for RTI/STI services in 2002. The reason for this is unclear. Further investigation is required to ascertain whether the major decrease in implementation of user fees is real or reflects a different understanding by the respondent of the question being asked.

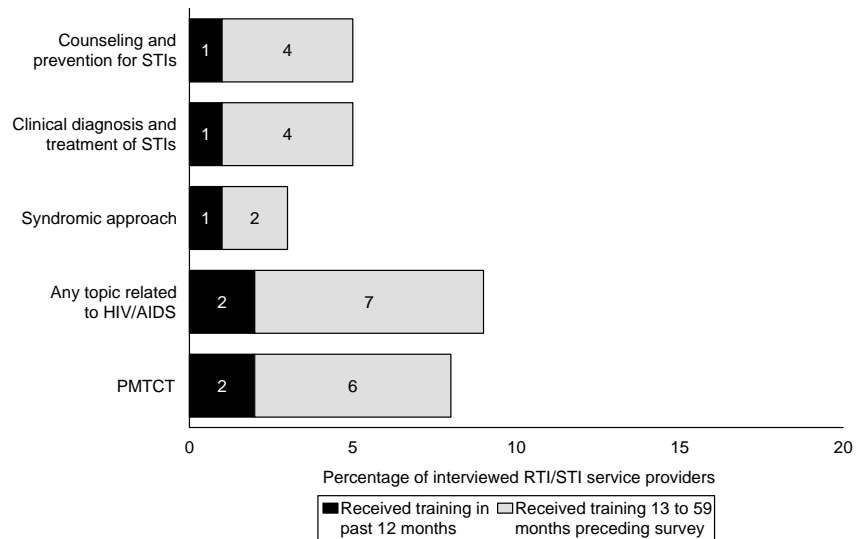
7.4.3 Supervision and Staff Development

If at least half of the interviewed RTI/STI providers in a facility have received in-service training related to RTI/STI services in the past 12 months the facility is defined as providing routine staff development. At least half of the interviewed RTI/STI service providers in 6 percent of facilities had received formal in-service training related to STIs during the past 12 months (Table 7.3), a decrease from 9 percent in 2002. An additional 8 percent of interviewed RTI/STI service providers had received in-service training related to STIs during the past five years. The percentage of providers receiving in-service training on any particular topic was similar for the past 12 months, and for the past five years (Figure 7.4).

If at least half of the RTI/STI service providers in a facility have been personally supervised during the past six months the facility is defined as providing routine supervision. Supervision of individual staff helps to promote adherence to standards and to identify problems that contribute to poor-quality services.

Similar to findings in other services, supervision of RTI/STI service providers is common, with at least half of the interviewed RTI/STI providers having been personally supervised during the past six months in 90 percent of facilities (Table 7.3). Routine supervision practices for RTI/STI service providers are found least often in NGO facilities and fever hospitals. Among providers who had been supervised, the median number of times they were supervised during the past 6 months was seven (Appendix Table A-7.8), with no regional differences.

Figure 7.4 In-service training received by interviewed RTI/STI service providers, by topic and timing of most recent training (N=961)



PMTCT = Prevention of mother-to-child transmission

Egypt SPA 2004

Key Findings

The system for recording service statistics for clients receiving treatments for RTIs or STIs is weak.

Routine provision of in-service training for RTI/STI service providers is not common (6 percent of facilities) and has declined since 2002 (9 percent).

Routine supervision of RTI/STI service providers within facilities is common (90 percent of facilities), except in NGO facilities and fever hospitals.

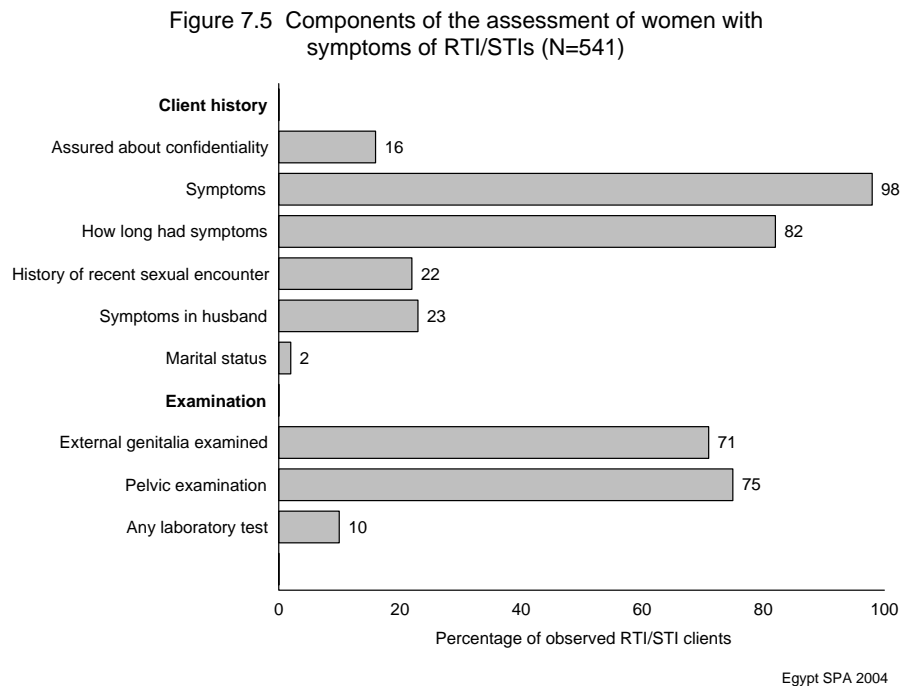
7.5 Adherence to Standards for Quality Service Provision

Observed RTI/STI client-provider consultations are the basis for assessing whether providers adhere to standards for quality service. The observation checklists used are based on generally accepted standards for RTI/STI services (WHO, 2001; AIDSCAP/FHI, 1996).

The objective in the observation of the consultations is to note if information on a topic is shared or if an examination is conducted (process information). An assessment of whether the information is correct or whether findings are appropriately interpreted is not a component of the observation.

All of the observed RTI/STI clients (those who were assessed for symptoms that might be STIs) were female. A total of 622 RTI/STI clients were observed in 262 different facilities.⁴ Among these women, 38 percent were family planning service clients, 8 percent were ANC service clients, and 55 percent came to the facility primarily for the RTI/STI problem (Appendix Table A-7.10). The percentage of observed RTI/STI clients in each different service is almost the same as in 2002. All observed clients participated in the exit interview.

A summary of information shared during the consultation and the types of examinations conducted is provided in Figure 7.5. Appendix Tables A-7.11 through A-7.14 provide details on the content of the observed assessment, physical examinations, and counseling, and Appendix Table A-7.15 provides detailed information on client experience and attitude toward use of condoms.



7.5.1 Assessment of Relevant History

Any client with a possible RTI/STI should be assessed for signs and symptoms as well as social factors that relate to risk of contracting an STI. Only 16 percent of the clients were explicitly assured about the confidentiality of the information shared between herself and the provider (Figure 7.5).

While client symptoms were elicited in almost all observed consultations (98 percent) (Figure 7.5), how long the symptoms had been present was less often asked (82 percent). Among the observed clients, one in five (about 22 percent) was asked about recent sexual contact and/or about symptoms in the husband, and 2 percent were asked about other items, related to the husband, that might signify an increased risk for contracting an STI. Symptoms in the husband were least elicited for clients in GS hospitals (6 percent) and rural HUs (9 percent) (Appendix Table A-7.11). Although proportions remain low, overall, from 2002 to 2004 there has been a large improvement in the proportion of clients for which each of the elements of history was assessed.

⁴ These are actual numbers. Data in tables and figures are weighted to provide accurate representation by facility type and governorate.

7.5.2 Physical Examinations and Laboratory Tests

In addition to assessing the symptoms and social history relevant for diagnosing and treating STIs, a physical examination provides more objective information to improve the probability of an accurate diagnosis. In total, 83 percent of women had some level of physical examination, with 75 percent receiving a pelvic examination and 71 percent having their external genitalia examined (either with or without a pelvic examination) (Appendix Table A-7.11).

Infection Control

Almost no providers washed their hands prior to conducting a pelvic examination (8 percent), although this is an increase over 2002, when this occurred for only 3 percent of cases. Hand-washing is slightly more common after the examination (17 percent). Almost half of all providers were observed wearing clean latex gloves, a decrease from 70 percent observed in 2002 (Appendix Tables A-7.12 and A-7.13). As mentioned previously, this may reflect better identification, in 2004, of latex gloves, compared with the thin, disposable gloves that are universally available but are not appropriate for infection control.

Client Examination

Conditions and practices for pelvic examinations are similar for 2004 and 2002. Almost all pelvic examinations were conducted under conditions where both visual and auditory privacy were assured (91 percent), and the external genitalia were examined for 85 percent of clients (Appendix Table A-7.12). During observations, not all providers who conduct pelvic examinations examine the external genitalia. Some simply do a rapid examination using a speculum or a manual examination for discharge.

Utilization of sterilized or HLD-processed equipment for the pelvic examination was verified for 85 percent of the examinations (with most other equipment of uncertain status because equipment was already prepared before the observer was in the room), and used equipment was placed in decontaminating solution after 80 percent of the pelvic examinations (Appendix Table A-7.13).

Although a speculum was used for 91 percent of the pelvic examinations (Appendix Table A-7.13), the observers noted that the provider carried out actions necessary to inspect the cervix during only 83 percent of the pelvic examinations. Anecdotal evidence showed that the provider frequently did a quick examination using a speculum, but did not aim the light or did not take any time to visualize the condition of the cervix. A bimanual examination was conducted for one in two clients receiving a pelvic examination. There were almost no explanations of the pelvic examination procedure prior to beginning (10 percent), which, although low, is more than observed in 2002 (3 percent).

There were no consistent differences in examination practices by type of facility.

Only 10 percent of clients received or were referred for laboratory examination, with 9 percent receiving a urine test and 3 percent receiving a blood test (Appendix Table A-7.11).

Key Findings

Although there is notable improvement since 2002 in client history and examination procedures, clients receiving RTI/STI services rarely are assessed for a full history relevant to making a diagnosis, and pelvic examination procedures are weak.

Components of a client history and marital status that might indicate risk for STIs are not routinely elicited, although there is notable improvement from 2002 to 2004.

Physical examinations for RTI/STIs are common. Eight in ten clients either had their external genitalia examined or had a pelvic examination.

Almost no providers (8 percent) wash their hands prior to conducting a pelvic examination.

Although almost all pelvic examinations include a speculum exam (91 percent), only 83 percent follow procedures for visualizing the cervix. Bimanual examinations are not common (52 percent of pelvic examinations).

Laboratory examination for the diagnosis is not common (10 percent), with a urine test most commonly performed (9 percent).

7.5.3 Client Counseling and Knowledge

During only 32 percent of the consultations was the relationship between the infection and sexual activity mentioned (Appendix Table A-7.14), an increase from 18 percent in 2002. It is uncertain from the data whether the client actually had an RTI/STI or whether the diagnosis was a nonsexually transmitted vaginal infection. However, 96 percent of the women were prescribed (or received) antibiotics for their infection, and 18 percent also received medicine for their husband (Appendix Table A-7.14). Sixty percent were observed being told how to take the medicine, and for 49 percent of the clients, a followup appointment was mentioned.

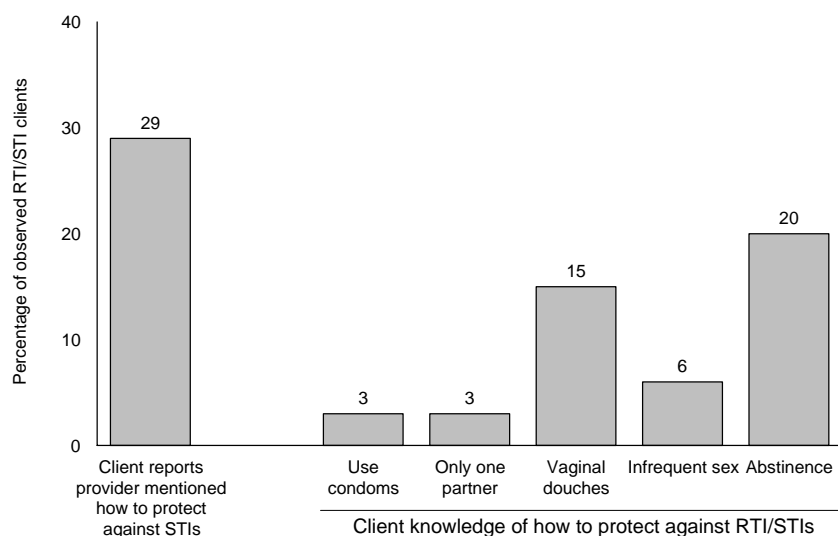
Using condoms as a means for prevention or until treatment is completed was almost never discussed, and condoms were almost never offered to the clients. During only 3 percent of the observations were condoms and HIV/AIDS noted to be mentioned at all (Appendix Table A-7.14). During exit interviews, client reports support the observations, with 2 percent of women reporting the provider talked about condoms during the visit, and 2 percent indicating that they received condoms (Appendix Table A-7.15).

Finally, an individual client health card is important for ensuring that information necessary for followup and for continuity of care is available. Providers recorded information on the individual client card for 27 percent of the observed clients (Appendix Table A-7.14).

During exit interviews with the observed RTI/STI clients, 29 percent reported that the provider gave information on how they could protect themselves against RTI/STIs or HIV/AIDS (Figure 7.6). Clients were then asked (without prompting) to mention ways that they can protect themselves in the future from infections transmitted through sexual activity. Among all interviewed clients, and 3 percent stated that using condoms was a way to protect against STIs or HIV/AIDS, 3 percent stated having only one partner was a means. Fifteen percent, similar to 2002, thought that vaginal douches would protect against STIs, and infrequent sexual activity was mentioned by 6 percent of interviewed clients. Finally, 20 percent mentioned abstinence, a large increase since 2002, when 5 percent stated this was a means to protect against STIs. This method, however, is probably not an option for most married women, who constitute most of the women assessed for STIs during this survey.

Fourteen percent of the interviewed clients reported that they had used condoms with their husband previously (Appendix Table A-7.15).

Figure 7.6 Client reports that provider mentioned how to protect against RTI/STIs; client knowledge of how to protect against RTI/STIs (N=541)



Egypt SPA 2004

Key Findings

Only one in three clients was informed of a relationship between her vaginal infection and sexual activity.

Although 96 percent of the observed clients were prescribed antibiotics, only 18 percent were provided medicines for their husbands. A more thorough study to assess whether cases such as these are STIs, or whether the use of antibiotics for non-STI vaginal infections is appropriate, may be warranted.

Individual client health cards, necessary for followup information and continuity of care, were used in one in three RTI/STI consultations, similar to findings in 2002.

Education about using condoms for prevention of STIs is almost never provided.

Client-reported knowledge on how to protect against STIs is weak and in some cases faulty; however, there is a noticeable increase in mentioning abstinence as a means of protecting against STIs (20 percent in 2004 and 5 percent in 2002). This is probably not a viable option for the women who were interviewed because most of them are married.

7.6 Client Opinion from Exit Interviews

During the exit interview, clients were asked their opinion on issues commonly related to client satisfaction. The client was first asked to identify issues without prompting, and then specific issues were probed, with the client asked to comment if these were big or small problems, or not a problem for them.

Few items were identified as major problems. Among identified problems, 5 percent felt the waiting time was too long (mentioned by 13 percent of clients in GS hospitals), and 3 percent thought that opening hours of the facility were inconvenient. Lack of availability of medicines or supplies, mentioned by 13 percent of interviewed clients in 2002, was mentioned by only 3 percent of clients in 2004 (Appendix Table A-7.16). Clients observed in NGO facilities were more likely to identify opening hours of the facility as a big problem (10 percent).

When asked why they chose the facility for services, 48 percent reported that it was the proximity of the facility. However, 32 percent reported that it was the efficiency of the physician, 48 percent indicated that the presence of a female physician was important (an increase from the 27 percent who mentioned this in 2002), and 21 percent cited the reputation of the facility (or provider). These findings are similar to those mentioned by clients from other observed services, including the noticeable increased preference of a female service provider.

Appendix Table A-7.17 provides details on why the facility was selected. Appendix Tables A-7.18 and A-7.19 provide additional details on client employment and educational background.

7.7 Facility-Level Implementation of Universal Precautions

Because many HIV-infected persons are not aware of their status, the risk of transmission of HIV/AIDS is possible wherever someone might come into contact with infected blood or body secretions, regardless of whether services related to HIV/AIDS are being provided or not. In a high-risk environment such as a health facility, ensuring that no one can become infected inadvertently is critical. An essential step in preventing transmission of HIV/AIDS (as well as hepatitis B or C) is to ensure that any potentially contaminated items are appropriately disinfected, eliminating this avenue for transmission. For this reason, it is recommended that universal precautions should be applied throughout all service delivery areas in all health facilities. Use of sharps containers and procedures for immediately disinfecting used equipment are two of the most critical components for preventing inadvertent transmission.

Although asepsis (absence of infection-causing microorganisms) is a basic concept in medical and paramedical schools, experience indicates that providers who do not work in an environment that actively promotes universal precautions are frequently lax in implementation (Pittet et al., 1999; Williams et al., 1994). Thus, a facility-level strategy to promote adherence to universal precautions is an important factor in improving infection control.

Although there has been improvement since 2002, a lack of soap for hand-washing (found in all relevant service areas in one in five facilities) is evident (Appendix Table A-3.24). Capacity to adequately process equipment for reuse (functioning equipment and knowledge of processing time and temperature) is evident in 43 to 91 percent of all assessed service delivery areas (data in relevant chapters).

Key Findings
Quality of sterilization and HLD processing of equipment within a facility is consistent when it is processed in different areas of facilities. Between 43 and 91 percent of facilities have functioning equipment and knowledge for appropriate processing methods.
Hand-washing soap is a simple intervention that is consistently lacking.

7.8 Resources for Diagnosis and Management of Tuberculosis

Tuberculosis (TB), especially multidrug-resistant TB is a reemerging communicable disease of public health significance. To control TB infection and to prevent its most severe complications, universal vaccination against TB (BCG) at birth is mandatory in many developing countries, including Egypt. Tuberculosis is also one of the most common opportunistic infections for AIDS patients. The Directly Observed Treatment Short-course (DOTS) approach is the WHO-recommended treatment strategy for detection and cure of TB.

The ESPA 2004 looked at the provision of TB services at all facilities. For facilities that provide TB services, the ability to conduct a sputum examination and the availability of medications for short course and standard treatment, as well as prophylactic treatment, were assessed. TB diagnosis and treatment prescription are provided primarily by chest hospitals and chest clinics. Thus, TB services at facilities in this survey would primarily be followup of treatment protocols.

More TB services were reported in 2004 (29 percent of facilities) than in 2002 (23 percent), with TB services offered essentially only in GS hospitals and MCH/urban or rural HUs. There was an increase in the proportion of facilities using the DOTS strategy from 13 percent in 2002 to 22 percent in 2004 (Table 7.4). Among all facilities providing TB services, only 19 percent of those using DOTS and 3 percent of those not using DOTS (16 percent of all facilities offering TB services) have all the medicines for first-line treatment,⁵ with most of the medicines provided as prepackaged individual client packs (Table A-7.20).

Thirteen percent of facilities that offer TB services have a functioning microscope and glass slides for microscopic examination of sputum, twice the proportion found in 2002. However, only GS hospitals have microscopic capacity plus stains for more accurate diagnosis of TB.⁶

Background characteristics	Percentage of facilities providing:			Number of facilities (weighted)
	Any services for TB	TB services through DOTS	TB services not through DOTS	
Type of facility				
GS hospital	36	35	1	65
Fever hospital	16	0	16	14
MCH/urban HU	23	9	14	97
Rural HU	42	36	6	319
Mobile unit	6	0	6	55
Health office	7	0	7	33
NGO facility	1	0	1	76
Region				
Urban Governorates	5	2	3	73
Lower Egypt	30	23	7	322
Upper Egypt	33	27	5	264
Total	29	22	6	659

⁵ Any combination of pyrazinamide, rifampin, ethambutol, and isoniazid

⁶ Stains to conduct the acid-fast bacillus (AFB) or Ziehl-Neelsen test

Key Findings

One in three facilities in 2004 offers TB services, with most using the DOTS approach.

Fewer than one in five facilities offering TB services had all first-line drugs available on the day of the survey. This includes facilities implementing DOTS, where only 19 percent had all medicines available on the day of the survey.

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Chapter 1

Table A-1.1 Description of facility sample frame and final sample selection, by type of facility and region

Number of facilities of each type that were in the sample frame, number selected for the ESPA sample, and percentage of eligible facilities of each type that were included in the ESPA, by region and facility type, Egypt SPA 2004

Facilities included in the facility type category	Number of facilities								Percentage of total for facility type included in ESPA sample
	Urban Governorates		Lower Egypt		Upper Egypt		Total		
	Sample frame	ESPA sample	Sample frame	ESPA sample	Sample frame	ESPA sample	Sample frame	ESPA sample	
Hospital									
General or district hospital	38	9	150	8	171	14	359	31	9
Integrated hospital	2	0	130	15	86	22	218	37	17
Fever hospital	5	1	48	3	49	9	102	13	13
MCH/urban HU									
Maternal child health unit	39	10	93	7	82	15	214	32	15
Urban health unit	107	20	252	5	206	12	565	37	7
Rural HU									
Rural health unit	60	16	1,313	102	1,034	186	2,407	304	13
Mobile unit	74	19	181	14	160	38	415	71	17
Health office	73	18	100	6	73	10	246	34	14
NGO facility									
Egyptian Family Planning Association	58	20	121	8	104	28	283	56	20
Clinical Service Improvement	4	3	49	5	37	6	90	14	16
Other NGO	89	17	49	3	73	10	211	30	14
Number of facilities	549	133	2,486	176	2,075	350	5,110	659	

Table A-1.2 Sample of interviewed health care providers

Number of interviewed health care providers (weighted and unweighted), by type of provider and type of facility, Egypt SPA 2004

Background characteristics	Number of interviewed providers	
	Weighted	Unweighted
Physicians		
GS hospital	256	205
Fever hospital	42	28
MCH/urban health unit	160	192
Rural health unit	110	330
Mobile unit	21	72
Health office	16	50
NGO facility	57	129
Total	662	1,006
Nurses		
GS hospital	577	222
Fever hospital	87	24
MCH/urban health unit	419	234
Rural health unit	515	933
Mobile unit	18	75
Health office	101	106
NGO facility	25	56
Total	1,743	1,650
Auxiliary and other staff¹		
GS hospital	47	5
MCH/urban health unit	53	15
Rural health unit	186	22
Mobile unit	4	3
Health office	8	10
NGO facility	32	25
Total	331	80
Total interviewed staff	2,736	2,736

¹ Includes social workers.

Table A-1.3 Sample of observed and interviewed clients			
Number of children/women attending facility on the day of the survey (eligible), number whose consultation was observed, and percentage of eligible clients who were observed, by type of care and type of facility, Egypt SPA 2004			
Background characteristics	Number of clients present on the day of the survey (eligible for observation)	Actual number of clients observed	Percentage of eligible clients who were observed
CURATIVE CARE FOR SICK CHILDREN			
GS hospital	2286	502	22
Fever hospital ¹	378	112	30
MCH/urban HU	1548	387	25
Rural HU	1892	926	49
Mobile unit	398	35	9
Health office	92	19	21
NGO facility	232	90	39
Total	6,826	2,071	30
FAMILY PLANNING			
GS hospital	505	303	60
Fever hospital ¹	5	5	100
MCH/urban HU	679	342	50
Rural HU	803	634	79
Mobile unit	410	345	84
Health office	106	106	100
NGO facility	289	224	78
Total	2,797	1,959	70
ANTENATAL CARE¹			
GS hospital	161	161	100
MCH/urban HU	510	289	57
Rural HU	459	411	90
Mobile unit	114	114	100
Health office	8	5	63
NGO facility	113	113	100
Total	1,365	1,093	80
STI			
GS hospital	116	98	84
Fever hospital ¹	0	0	0
MCH/urban HU	132	128	97
Rural HU	105	96	91
Mobile unit	151	151	100
Health office	26	26	100
NGO facility	145	123	85
Total	675	622	92
¹ Fever hospitals do not provide ANC services and, while providing RTI/STI services, no clients were identified on the day of the survey.			

Table A-1.4 Facility catchment area

Median population of assigned catchment areas for facilities providing data on a known catchment population, by type of facility and region, Egypt SPA 2004

Background characteristics	Median population in catchment area	Number of facilities (weighted)
Type of facility		
General or district hospital	435,093	8
Integrated hospital	19,072	38
MCH unit	50,093	14
Urban HU	45,003	50
Rural HU	10,135	301
Health office	50,044	31
EFPA, CSI (NGO facility)	282,021	11
Other NGO facility	20,078	2
Region		
Urban Governorates	45,090	33
Lower Egypt	13,146	237
Upper Egypt	12,009	184
Total	13,379	455

Table A-1.5 Staffing patterns for ESPA facilities

Median number of health care providers assigned to outpatient services, by staff qualification and type of facility, Egypt SPA 2004

Type of facility	Median number of providers assigned to each facility ¹				Number of facilities (weighted) ²
	Total staff	Physicians	Qualified nurses	Other	
General or district hospital	136	32	66	3	27
Integrated hospital	23	7	14	3	38
Fever hospital	32	8	25	2	14
MCH unit	19	6	15	3	28
Urban HU	31	8	22	4	69
Rural HU	8	-	6	-	319
Mobil unit	4	2	-	-	55
Health office	12	2	10	-	33
EFPA, CSI (NGO facility)	3	-	-	-	56
Other NGO facility	8	5	-	-	20
Total	9	3	7	-	659

¹ Numbers were provided by facility administrators. Staff who routinely rotate between inpatient and outpatient services are included.

² See Table 1.1 for actual number of facilities included in analysis.

Table A-1.6 Education levels of interviewed health service providers

Median number of years of basic schooling, and median number of years of study for technical qualification, reported by interviewed health service providers, by qualification, Egypt SPA 2004

Qualification	Median number of years of basic education prior to technical training	Median number of years of technical training for qualification	Number of interviewed providers
Doctor, specialist	12	9	356
Doctor, generalist	12	7	306
Nurse with midwifery	10	3	93
Nurse	10	4	1,650
Midwife	10	2	94
Nurse assistant	10	2	41
Other	10	2	195
Total	10	4	2,736

Chapter 3

Table A-3.1 Availability of basic services by type of facility

Percentage of facilities offering the indicated basic outpatient services, facility-based 24-hour delivery services, with at least one physician; and percentage offering all basic services with the minimum defined frequencies and facility-based 24-hour delivery services and at least one physician for curative care, by type of facility, Egypt SPA 2004

Basic services	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Curative care for children	98	100	100	99	40	18	47	84
Any services for RTI/STI	99	42	98	87	100	49	98	89
Temporary methods of family planning	100	10	98	100	100	86	95	97
Antenatal care	82	0	96	96	72	5	84	85
Child immunization	58	0	88	98	0	92	1	71
Growth monitoring	59	11	85	85	3	40	1	62
Percentage of facilities with:								
All basic services at any frequency ¹	50	0	73	70	0	3	0	50
Facility-based 24-hour delivery services	53	5	47	21	0	0	7	23
At least one qualified staff ²	100	100	100	100	99	100	100	100
All services, minimum frequency ³	47	0	73	53	0	3	0	41
All services, minimum frequency and 24-hour delivery services	15	0	42	13	0	0	0	14
All services, minimum frequency, and 24-hour delivery services, and at least one qualified staff	15	0	42	13	0	0	0	14
Number of facilities (weighted)	65	14	97	319	55	33	76	659

¹ Any level of each of the following services offered at the facility: curative care for children, any RTI/STI services, temporary methods of family planning, antenatal care, immunization, and child growth monitoring

² In Egypt, a physician is the level of staff qualified for provision of curative care and caring for complicated cases seen by lower-level providers.

³ Curative services for children provided five days per week, RTI/STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least one day per week

Table A-3.1.1 Availability of basic services by type of facility

Percentage of facilities offering the indicated basic outpatient services, facility-based 24-hour delivery services, with at least one physician; and percentage offering all basic services with the minimum defined frequencies and facility-based 24-hour delivery services and at least one physician for curative care, by type of facility and whether adjacent to another or not, Egypt SPA 2004

Basic services	Percentage of facilities offering services (and proximity to other facilities)					
	GS hospital		Health office		MCH/Urban HU	
	Stand-alone facility	Adjacent to health office or MCH/Urban HU	Stand-alone facility	Adjacent to hospital, MCH center or Urban HU	Stand-alone facility	Adjacent to health office
Curative care for children	95	100	20	17	100	100
Any services for RTI/STI	100	98	38	53	82	100
Temporary methods of family planning	100	100	88	86	100	98
Antenatal care	83	81	7	4	82	98
Child immunization	49	64	100	89	65	91
Growth monitoring	45	68	37	41	71	87
Percentage of facilities with:						
All basic services at any frequency ¹	33	61	0	4	54	76
Facility-based 24-hour delivery services	53	52	0	0	11	52
At least one qualified staff ²	100	100	100	100	100	100
All basic services, minimum frequency ³	28	59	0	4	54	76
All basic services, minimum frequency, and 24-hour delivery services	5	19	0	0	11	47
All services, minimum frequency, and 24-hour delivery services, and at least one qualified staff	5	19	0	0	11	47
Number of facilities (weighted)	26	38	8	24	13	85

¹ Any level of each of the following services offered at the facility: curative care for children, any RTI/STI services, temporary methods of family planning, antenatal care, immunization, and child growth monitoring

² In Egypt, a physician is the level of staff qualified for provision of curative care and caring for complicated cases seen by lower-level providers.

³ Curative services for children provided five days per week, RTI/STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least one day per week

Table A-3.2 Availability of basic services by region

Percentage of facilities offering the indicated basic outpatient services, facility-based 24-hour delivery services, with at least one physician; and percentage offering all basic services with the defined minimum frequencies, facility-based 24-hour delivery services, and at least one physician, by region, Egypt SPA 2004

Basic services	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Curative care for children	73	85	86	84
Any services for RTI/STI	96	86	91	89
Temporary methods of family planning	98	97	96	97
Antenatal care	72	84	89	85
Child immunization	44	75	72	71
Growth monitoring	39	71	57	62
Percentage of facilities with:				
All basic services at any frequency ¹	25	56	49	50
Facility-based 24-hour delivery services	26	16	31	23
At least one qualified staff ²	99	100	100	100
All basic services, minimum frequency ³	24	45	41	41
All services minimum frequency, and 24-hour delivery services	14	11	18	14
All services minimum defined frequency, 24-hour delivery services, and at least one qualified staff	14	11	18	14
Number of facilities (weighted)	73	322	264	659

¹ Any level of each of the following services offered at the facility: curative care for children, any RTI/STI services, temporary methods of family planning, antenatal care, immunization, and child growth monitoring

² In Egypt, a physician is the level of staff qualified for provision of curative care and caring for complicated cases seen by lower-level providers.

³ Curative services for children provided five days per week, RTI/STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least one day per week

Table A-3.3.1 Facility infrastructure supportive of client utilization and quality services by type of facility

Percentage of facilities with client amenities, regular electricity and water supply, items to support quality 24-hour emergency services, by type of facility, Egypt SPA 2004

Items	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Client comfort amenities								
Client latrine	81	89	92	76	26	84	96	78
Protected waiting area	93	95	96	80	17	76	99	80
Clean facility	89	95	93	78	96	91	95	85
All client comfort items ¹	70	79	85	54	5	64	90	61
Facility infrastructure								
No electricity or generator	0	0	0	0	8	0	0	1
Generator observed with fuel	29	47	1	2	15	0	7	7
Regular electricity or generator	84	100	95	84	90	93	97	88
Onsite water	97	100	100	96	70	93	99	95
Regular water supply (onsite and year-round)	87	95	95	89	64	90	95	88
Regular water and electricity ²	74	95	90	76	61	90	93	80
All client amenities, regular water and electricity	50	73	81	42	5	64	85	52
Staff and furnishings								
At least two physicians ³	99	100	96	38	56	50	49	57
Duty staff on site 24 hours ⁴	76	100	34	32	0	0	3	31
Duty staff on-call 24 hours ⁴	0	0	4	1	0	0	0	1
Physician living onsite	60	84	24	56	1	0	5	39
Physician living onsite, no duty roster seen or no duty roster	13	0	13	27	1	0	2	17
Emergency communication ⁵	98	100	85	65	0	66	71	67
Overnight patient beds ⁶	90	100	19	7	0	0	12	18
Basic components supporting 24-hour emergency services ⁷	52	89	7	2	0	0	2	9 ⁹
Basic plus regular water and electricity ⁸	40	84	7	1	0	0	2	8 ⁹
Number of facilities (weighted)	65	14	97	319	55	33	76	659

¹ Clean, functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness

² Year-round, onsite water, and electricity routinely available during service hours or a generator with fuel

³ In Egypt, only physicians were defined as qualified for providing curative care

⁴ A duty schedule or other documentation of official duty status was observed.

⁵ Communication device either in facility or within a 5-minute walk and available 24 hours a day

⁶ Either routine inpatient services or beds for overnight care for emergencies

⁷ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and any onsite water source

⁸ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and regular water and electricity

⁹ Including mobile clinics and health offices

Table A-3.3.2 Facility infrastructure supportive of client utilization and quality services by type of facility and whether adjacent to another facility

Percentage of facilities with client amenities, regular electricity and water supply, items to support quality 24-hour emergency services, by type of facility and whether adjacent to another facility, Egypt SPA 2004

Items	Percentage of facilities offering services (and proximity to other facilities)					
	GS hospital		Health office		MCH/Urban HU	
	Stand-alone facility	Adjacent to health office or MCH/Urban HU	Stand-alone facility	Adjacent to hospital, MCH center or Urban HU	Stand-alone facility	Adjacent to health office
Client comfort amenities						
Client latrine	76	86	88	83	81	94
Protected waiting area	100	87	63	80	96	96
Clean facility	81	96	88	92	100	92
All client comfort items ¹	59	78	40	72	77	86
Facility Infrastructure						
Generator observed with fuel	41	22	0	0	0	1
Regular electricity or generator	91	79	100	91	81	97
Onsite water	91	100	100	91	100	100
Regular water supply (onsite and year-round)	85	88	88	91	89	96
Regular water and electricity ²	77	71	88	91	75	93
All client amenities, regular water and electricity	51	49	40	72	71	83
Staff and furnishings						
At least two physicians ³	100	98	50	51	94	96
Duty staff on site 24 hours ⁴	79	75	0	0	11	38
Duty staff on call 24 hours ⁴	0	0	0	0	11	3
Physician living onsite	68	54	0	0	6	27
Physician living onsite, no duty roster seen or no duty roster	14	13	0	0	0	15
Emergency communication ⁵	94	100	82	61	61	89
Overnight patient beds ⁶	91	91	0	0	6	21
Basic components supporting 24-hour emergency services ⁷	42	61	0	0	6	8 ⁹
Basic plus regular water and electricity ⁸	42	40	0	0	6	8 ⁹
Number of facilities (weighted)	26	38	8	24	13	85

¹ Clean, functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness

² Year-round, onsite water, and electricity routinely available during service hours or a generator with fuel

³ In Egypt, only physicians were defined as qualified for providing curative care

⁴ A duty schedule or other documentation of official duty status was observed.

⁵ Communication device either in facility or within a 5-minute walk and available 24 hours a day

⁶ Either routine inpatient services or beds for overnight care for emergencies

⁷ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and any onsite water source

⁸ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and regular water and electricity

⁹ Including mobile clinics and health offices

Table A-3.4 Facility infrastructure supportive of client utilization and quality services

Percentage of facilities with client amenities, regular electricity and water supply, items to support quality 24-hour emergency services, by region, Egypt SPA 2004

Items	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Client comfort amenities				
Client latrine	88	74	80	78
Protected waiting area	83	80	80	80
Clean facility	99	87	80	85
All client comfort items ¹	79	60	58	61
Facility infrastructure				
No electricity or generator	4	0	1	1
Generator observed with fuel	6	8	7	7
Regular electricity or generator	94	85	91	88
Onsite water	94	95	95	95
Regular water supply (onsite and year-round)	90	88	88	88
Regular water and electricity ⁵	88	77	82	80
All client amenities, regular water and electricity	76	46	52	52
Staff and furnishings				
At least two physicians ³	83	60	47	57
Duty staff on site 24 hours ⁴	28	29	34	31
Duty staff on call 24 hours ⁴	0	1	1	1
Physician living onsite	18	30	56	39
Physician living onsite, no duty roster seen or no duty roster	4	12	25	17
Emergency communication ⁵	67	66	68	67
Overnight patient beds ⁶	18	19	17	18
Basic components supporting 24-hour emergency services ⁷	14	10	7	9 ⁹
Basic plus regular water and electricity ⁸	14	8	6	8 ⁹
Number of facilities (weighted)	73	322	264	659

¹ Clean, functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness

² Year-round, onsite water, and electricity routinely available during service hours or a generator with fuel

³ In Egypt, only physicians were defined as qualified for providing curative care

⁴ A duty schedule or other documentation of official duty status was observed.

⁵ Communication device either in facility or within a 5-minute walk and available 24 hours a day

⁶ Either routine inpatient services or beds for overnight care for emergencies

⁷ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and any onsite water source

⁸ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and regular water and electricity

⁹ Including mobile clinics and health offices

Table A-3.5 Routine management meetings

Percentage of facilities reporting they have routine management meetings at the indicated intervals, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage			Number of facilities (weighted)
	Monthly or more often	Every 2-3 months	Every 4-6 months	
Type of facility				
GS hospital	44	3	0	65
Fever hospital	89	0	0	14
MCH/urban HU	41	2	0	97
Rural HU	27	0	0	319
Mobile unit	14	1	0	55
Health office	19	0	0	33
NGO facility	37	2	1	76
Region				
Urban Governorates	56	2	0	73
Lower Egypt	25	0	0	322
Upper Egypt	33	2	0	264
Total	32	1	0	659

Table A-3.6 Quality assurance activities with documentation observed

Among facilities that report having quality assurance (QA) activities, percentage that both reported that the indicated method for QA is used and had some documentation for the method, by type of facility, Egypt SPA 2004

Type of facility	Percentage						Number of facilities reporting quality assurance activities (weighted)
	Supervisory checklist for health system components	Supervisory checklist for observation of services	Mortality review	Auditing of medical records or registers	Quality assurance committee	Quality improvement program	
GS hospital	15	15	20	20	29	5	13
Fever hospital	25	25	25	25	25	25	3
MCH/urban HU	28	26	37	21	5	12	23
Rural HU	21	18	42	24	25	30	48
Mobile unit	0	0	0	11	11	11	5
Health office	0	0	41	0	0	18	5
NGO facility	34	30	0	34	29	21	13
Total	22	19	31	22	20	21	111

Table A-3.7 Facility level supervision and in-service training for interviewed staff

Percentage of facilities where among all interviewed health service providers, none, at least half, or all of the providers received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities where the indicated percentage of interviewed providers:						Number of facilities with interviewed providers (weighted)
	Received related in-service training during the past 12 months ¹			Were personally supervised during the past 6 months			
	None	At least 50 percent	All	None	At least 50 percent	All	
Type of facility							
GS hospital	23	18	0	0	97	33	65
Fever hospital	53	10	5	11	58	42	14
MCH/urban HU	14	12	0	0	93	49	97
Rural HU	26	24	6	0	98	86	319
Mobile unit	36	48	17	5	88	66	55
Health office	24	14	0	3	97	74	33
NGO facility	75	17	8	33	52	34	76
Region							
Urban Governorates	38	26	6	11	79	47	73
Lower Egypt	29	21	4	2	92	69	322
Upper Egypt	32	22	6	6	92	68	264
Total	31	22	5	5	90	66	659

¹ Structured in-service sessions (does not include individual instruction received during routine supervision)

Table A-3.8 Supportive management practices at the individual provider level

Among interviewed health service providers, percentage who received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage				Number of interviewed health service providers (weighted) ²
	Received in-service training during past 12 months ¹	Personally supervised in past 6 months	Personally supervised during past 6 months and received in-service training during the past 12 months	Most recent in-service training was 13-59 months preceding the survey	
Type of facility					
GS hospital	28	85	26	27	790
Fever hospital	18	72	17	31	126
MCH/urban HU	33	87	28	41	589
Rural HU	27	97	27	34	775
Mobile unit	45	90	38	38	43
Health office	25	96	25	25	110
NGO facility	14	48	8	28	111
Region					
Urban Governorates	32	78	30	31	297
Lower Egypt	29	89	26	29	1,334
Upper Egypt	25	89	24	39	914
Total	28	87	26	33	2,546

¹ Structured in-service sessions (does not include individual instruction received during routine supervision)

² Interviewed providers who do not personally provide any of the assessed services (i.e., managers who might have been interviewed) are excluded.

Table A-3.9 Types of funding options utilized

Among facilities having user fees, percentage where the indicated financing mechanism is utilized, percentage where all fees are publicly posted, and percentage where some fees are publicly posted, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities having indicated system								Number of facilities having any user fees (weighted)
	System for decreasing client out-of-pocket cost				Fee system				
	Economic and free sections	Record available			Fixed fee, varies by type of client	Prepay for multiple visits one service	All fees are posted publicly	Some fees are posted publicly	
		Facility has discount/exemption for some clients	that indicates discount/exemption was provided during prior 7 days	Facility has any system to decrease out-of-pocket costs to client ¹					
Type of facility									
GS hospital	56	69	11	86	11	5	19	14	43
Fever hospital	54	23	15	54	0	0	8	0	9
MCH/urban HU	48	51	4	76	17	2	17	6	60
Rural HU	20	18	3	35	21	1	11	14	103
Mobile unit	0	12	0	12	20	3	23	0	19
Health office	0	7	0	7	72	0	50	29	8
NGO facility	2	63	7	63	62	3	41	3	73
Region									
Urban Governorates	14	58	13	61	34	6	39	9	58
Lower Egypt	32	31	3	53	34	1	19	9	156
Upper Egypt	20	48	3	53	17	2	17	9	101
Total	25	41	5	55	29	2	22	9	315

¹ Facility has either economic/free section, discount/exemption, or both systems

Table A-3.10 Components for which fees are charged under the economic and free service system

Among facilities with user fees, percentage charging for the indicated item under the 'economic' and under the 'free' service delivery system, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage								Number of facilities with client fees (weighted)
	Fixed fee for ticket or consultation		Fixed fee for health card		Charges for medicine		Charges for tests		
	Economic	Free	Economic	Free	Economic ¹	Free ²	Economic ¹	Free ²	
Type of facility									
GS hospital	80	89	10	21	10	16	78	40	43
Fever hospital	92	84	0	0	23	53	84	53	9
MCH/urban HU	84	90	2	30	1	24	84	39	60
Rural HU	54	87	5	24	10	12	20	21	103
Mobile unit	0	38	0	0	0	0	11	20	19
Health office	43	29	0	0	0	0	36	0	8
NGO facility	91	1	2	2	10	0	65	1	73
Region									
Urban Governorates	79	34	6	7	11	6	67	27	58
Lower Egypt	71	75	4	17	7	21	62	33	156
Upper Egypt	62	63	2	23	8	2	30	3	101
Total	69	63	4	17	8	12	52	23	315

¹ It is not uncommon for facilities to provide prescriptions to "economic" clients for medicine or test from outside the facility. If the facility does not provide the medicine or test to the economic section client, it would indicate no charge, even if the client must purchase from outside

² According to government policy, there is no official charge for medicines or tests in the "free" sector. The response that there are charges might indicate that clients must pay for medicines, that test not available in the facility, or the question may not have been fully understood. It is unlikely someone would report that they routinely implement a charging policy that is not sanctioned.

Table A-3.11 Sources of funding for reimbursement for clients receiving services with discount or exemption of fees

Percentage of facilities that receive reimbursements for services to clients, from the indicated reimbursement mechanisms, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities indicating source of reimbursement				No reimbursement system or don't know if reimbursement system	Number of facilities (weighted)
	Charity fund	HIO/SHIP ¹	Ministry of Health and Population	Other		
Type of facility						
GS hospital	23	28	18	2	55	65
Fever hospital	21	21	26	11	58	14
MCH/urban HU	10	12	1	1	79	97
Rural HU	1	33	1	1	66	319
Mobile unit	0	0	1	0	99	55
Health office	0	0	0	0	100	33
NGO facility	15	1	0	16	72	76
Region						
Urban Governorates	16	11	2	6	71	73
Lower Egypt	5	15	3	2	80	322
Upper Egypt	5	32	3	4	62	264
Total	6	21	3	3	72	659

¹ Health Insurance Organization or Student Health Insurance Program

Table A-3.12 Facility systems for maintenance and repair of equipment

Among facilities with preventive maintenance programs for large equipment, percentage that report having on-site staff, external technicians, or both for conducting the repair work; and among facilities with systems for repairing small equipment, percentage that repair equipment on site, using an outside facility or technician, and percentage that have a petty cash fund for repair, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage by persons responsible for preventative maintenance of major equipment ¹			Number of facilities with preventative maintenance for large equipment	Percentage reporting method used for maintenance or replacement of small equipment ²			Number of facilities with system for small equipment repair	Number of facilities (weighted)
	Onsite staff	External technicians	Both onsite and external technicians		Onsite repair	Send outside for repair or replace	Purchase or pay for from funds on hand		
Type of facility									
GS hospital	40	50	9	26	26	58	25	63	65
Fever hospital	15	72	13	5	21	79	21	14	14
MCH/urban HU	8	89	3	27	20	58	33	87	97
Rural HU	0	100	0	80	8	73	15	244	319
Mobile unit	0	88	12	43	6	79	2	52	55
Health office	0	100	0	9	0	60	21	28	33
NGO facility	23	77	0	13	5	64	37	67	76
Region									
Urban Governorates	7	84	8	30	13	59	34	67	73
Lower Egypt	8	89	3	100	17	70	22	273	322
Upper Egypt	9	87	4	72	4	69	15	215	264
Total	8	87	4	203	11	68	21	555	659

¹ Major equipment refers to generators, sterilizers, other large equipment where routine maintenance is recommended to extend the life of the machine.

² Minor equipment refers to stethoscopes, sphygmomanometers, other small equipment where either minor repairs or replacement are common when broken.

Table A-3.13 Source of funding for maintenance and repair of equipment

Among all facilities, percentage with the indicated source(s) of funding for equipment maintenance and repair; and, among those facilities, percentage who report the indicated level of sufficiency for funds, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage where source of funding for maintenance and repairs for equipment was:				Number of facilities (weighted)	Percentage where amount available for equipment maintenance and repair was:			Number of facilities with source of funding (weighted)
	Budget line item	Service improvement box ¹	Both sources of funding	None		Sufficient	Not sure if sufficient	Not sufficient	
Type of facility									
GS hospital	31	80	26	15	65	66	6	28	56
Fever hospital	36	89	36	11	14	59	0	41	12
MCH/urban HU	11	65	9	32	97	71	13	13	66
Rural HU	19	57	12	35	319	59	11	29	206
Mobile unit	23	6	0	70	55	65	11	21	16
Health office	24	10	7	72	33	55	6	17	9
NGO facility	34	15	2	53	76	74	12	9	36
Region									
Urban Governorates	24	43	10	45	73	62	7	26	40
Lower Egypt	34	51	18	33	322	63	11	25	216
Upper Egypt	7	51	2	45	264	66	10	23	145
Total	22	50	11	39	659	64	10	24	401

¹ Money collected from user fees

Table A-3.14 Facility systems for maintenance and repair of building

Among facilities with a system for maintenance and repair of buildings, percentage where authorization for repair is made by the indicated person and percentage where repairs are made by the indicated persons, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage where person responsible for authorizing repair is the: ¹			Percentage where repairs on building or infrastructure are made by:			Number of facilities with system for maintenance and repair (weighted)
	In-charge of facility	In-charge of unit	Other ²	Onsite staff	Persons hired from outside	Both onsite staff and externally hired staff	
Type of facility							
GS hospital	77	23	14	27	35	39	46
Fever hospital	56	37	37	25	37	37	11
MCH/urban HU	79	3	24	7	86	3	70
Rural HU	82	8	14	7	86	6	153
Mobile unit	57	6	43	0	91	2	45
Health office	94	7	35	0	93	7	16
NGO facility	71	4	37	6	89	1	55
Region							
Urban Governorates	72	11	49	5	85	8	64
Lower Egypt	80	11	13	8	84	8	216
Upper Egypt	72	4	29	12	69	13	117
Total	76	9	24	9	80	9	398

¹ More than one person may be responsible for authorizing repairs.

² Other responses were primarily district authorities.

Table A-3.15 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with the indicated elements related to vaccine storage, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities routinely storing vaccines with:					Number of facilities storing vaccines (weighted)	Percentage of facilities where vaccines observed with:			Number of facilities storing vaccines where vaccines were observed (weighted)
	Functioning thermometer in refrigerator	Temperature chart up to date	Temperature 0-8°C at time of survey	Adequate cold chain monitoring system	Refrigerator protected from sun		No expired vaccines present	Vaccines stored by expiration date	Inventory up to date	
Type of facility¹										
GS hospital	100	77	95	72	97	24	100	70	76	24
MCH/urban HU	94	91	90	86	97	89	99	72	88	88
Rural HU	99	89	94	85	95	232	100	63	85	217
Health office	100	92	100	92	90	31	96	59	81	31
NGO facility	14	6	14	6	79	8	100	86	79	8
Region										
Urban										
Governorates	100	95	100	95	100	34	97	72	97	34
Lower Egypt	94	91	90	88	96	196	100	71	80	182
Upper Egypt	98	81	92	75	92	154	100	58	87	152
Total	96	87	92	83	95	383	100	66	84	367

¹ Fever hospitals and mobile units do not store vaccines.

Table A-3.16 Storage conditions and stock monitoring systems for contraceptive methods and for medicines

Among facilities that store clinical methods of contraception and facilities that store medicines, percentage with the indicated elements relating to commodity storage, by type of facility and region, Egypt SPA 2004

Background Characteristics	Among facilities that store commodities, percentage with:								Number of facilities with observed commodities (weighted)
	Proper storage condition				Number of facilities where storage area was observed (weighted)	Proper stock monitoring systems ¹			
	Off the ground and protected from water	Protected from sun	No evidence of pests or rodents	Good storage ²		No expired items present	Stored by expiration date	Inventory up to date	
CONTRACEPTIVE METHODS (CLINICAL)³									
Type of facility									
GS hospital	97	100	97	95	65	96	57	62	65
MCH/urban HU	91	100	90	87	96	99	51	80	96
Rural HU	96	99	87	85	317	97	55	69	317
Mobile unit	97	100	98	95	55	100	59	85	55
Health office	100	100	100	100	27	96	45	65	27
NGO facility	98	100	94	92	66	92	55	70	66
Region									
Urban Governorates	94	98	98	92	67	93	65	84	67
Lower Egypt	95	100	92	91	311	98	67	69	311
Upper Egypt	96	99	88	86	249	96	36	70	249
Total ⁴	96	99	91	89	627	97	55	71	627
MEDICINES⁵									
Type of facility									
GS hospital	83	97	90	80	65	100	66	50	65
Fever hospital	74	100	95	68	14	100	58	74	14
MCH/urban HU	81	98	86	75	95	95	62	71	92
Rural HU	85	94	77	69	304	99	53	57	298
Mobile unit	64	100	88	53	10	94	38	81	9
Health office	100	100	100	100	6	100	63	82	6
NGO facility	100	100	100	100	3	100	100	100	2
Region									
Urban Governorates	85	97	93	78	38	98	73	74	38
Lower Egypt	84	99	81	73	256	98	69	51	249
Upper Egypt	82	91	79	69	201	99	38	69	198
Total	84	96	81	72	496	98	57	60	486

¹ Only selected items were evaluated for the stock maintenance system. Contraceptive items assessed were oral pills, injectable progesterone, IUD, and condoms. Medicines assessed were antibiotics and Ringer's lactate intravenous solution.

² All 3 proper storage conditions (off the ground and protected from water, protected from sun, and no evidence of pests or rodents).

³ The storage area for contraceptive methods was not observed for 10 facilities that store contraceptives.

⁴ Totals include 2 fever hospitals (weighted = 1)

⁵ Twenty-two percent of all facilities did not store medicines and no information on the pharmacy was available for an additional 2 percent of facilities. Storage conditions were observed in 496 facilities, and medicines were actually present in 486 facilities.

Table A-3.17 Reported reliability of ordering system for commodities where order is placed by facility

Among facilities that provide vaccinations, contraceptive methods, or medicines, percentage where decisions on when to order the commodity are made by facility staff, percentage of facilities reporting that their supplies were very reliable, sometimes reliable, or rarely reliable during the prior 3 months, and percentage that received their most recent supply during the past 4 weeks, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities providing commodity in which:				Most recent order received during past 4 weeks	Number of facilities that determine commodity order (weighted)	Number of eligible facilities (weighted)
	Commodity order determined by facility	Receipt of ordered commodity considered:					
		Very reliable	Sometimes reliable	Rarely reliable			
VACCINES							
Type of facility¹							
GS hospital	97	58	36	4	94	37	38
MCH/urban HU	85	81	19	0	97	79	93
Rural HU	96	72	27	1	96	299	313
Health office	100	76	24	0	94	33	33
NGO facility	100	100	0	0	79	8	8
Region							
Urban Governorates	100	96	4	0	97	35	35
Lower Egypt	93	68	30	2	95	237	255
Upper Egypt	94	76	24	0	97	183	195
Total	94	73	25	1	96	455	485
CONTRACEPTIVE METHODS							
Type of facility							
GS hospital	94	66	32	3	93	61	65
MCH/urban HU	94	76	24	0	86	89	96
Rural HU	93	62	37	1	86	298	319
Mobile unit	89	63	33	5	91	49	55
Health office	92	77	23	0	92	26	28
NGO facility	82	81	8	1	73	59	73
Region							
Urban Governorates	93	66	30	1	77	66	71
Lower Egypt	94	67	31	2	91	293	312
Upper Egypt	89	68	30	0	83	225	254
Total^{2,3}	92	67	31	1	86	584	637
MEDICINES⁴							
Type of facility							
GS hospital	65	27	56	16	82	42	65
Fever hospital	95	27	56	17	100	13	14
MCH/urban HU	91	7	73	21	85	86	95
Rural HU	57	32	50	17	62	175	306
Mobile unit	47	56	44	0	78	5	11
Health office	84	0	100	0	67	5	6
NGO facility	80	75	25	0	100	2	3
Region							
Urban Governorates	90	23	61	15	92	33	38
Lower Egypt	60	28	50	19	71	153	256
Upper Egypt	69	21	64	15	70	141	204
Total³	66	24	58	17	73	328	498

¹ Fever hospitals do not provide child immunizations and none of the observed mobile units.

² Totals include data from 2 fever hospitals (weighted = 1)

³ Respondents in one percent of facilities did not know the ordering system.

⁴ Twenty-two percent of facilities (weighted N=147) had no pharmacy and medicines. Pharmacy practices were not assessed in 14 facilities (2 percent) because there was no access to the pharmacy the day of the survey.

Table A-3.18 Reported reliability of ordering system for commodities where order is placed by authority external to facility

Among facilities that provide vaccinations, contraceptive methods, or medicines, percentage in which decisions on when to order the commodity are made by authority external to facility and percentage of facilities reporting that the externally ordered supplies were very reliable, sometimes reliable, or rarely reliable, by type of facility and region, Egypt SPA 2004

Region	Percentage of facilities providing commodity:				Number of facilities where commodity order is determined external to facility (weighted)	Number of eligible facilities (weighted)
	With order determined external to facility	Reporting reliability of receiving ordered stock during the 3 months preceding the ESPA as:				
		Very reliable	Sometimes reliable	Rarely reliable		
VACCINES						
Urban Governorates	0	-	-	-	0	35
Lower Egypt	5	28	72	0	12	255
Upper Egypt	5	86	14	0	10	195
Total	5	54	46	0	23	485
CONTRACEPTIVES						
Urban Governorates	7	56	24	0	5	71
Lower Egypt	6	80	8	11	20	312
Upper Egypt	11	67	29	0	29	254
Total	8	71	21	4	54	637
MEDICINES¹						
Urban Governorates	8	69	31	0	3	38
Lower Egypt	40	22	39	38	102	256
Upper Egypt	30	59	29	11	61	204
Total	33	36	35	27	166	498

Note: Numbers were too small to present percentages by type of facility. Respondents at 4 percent of facilities did not know about the reliability of contraceptive supplies and at 2 percent of facilities did not know about the reliability of medicine supplies.

¹ Twenty-two percent of facilities (weighted N=147) stored no medicines. Pharmacy practices were not assessed in 14 facilities (2 percent) because there was no access to the pharmacy the day of the survey.

Table A-3.19 System for ordering vaccines for facilities placing their own order

Among facilities that provide vaccinations and that order their own supply, percentage reporting they use the indicated criteria for deciding how much to order and when to order, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities providing vaccinations and ordering own supplies in which:														Number of facilities (weighted)
	Amount ordered based on: ¹							Stock orders placed: ¹							
	Maintain- ing a fixed stock	Order same amount each time	Mathematical formula based on utilization	Judgment based on utilization	Other	Don't know/ missing	When stock falls to a pre- determined level	Routinely order:							
								More often than once monthly	Every 4 weeks	Less often than once monthly	When needed	Other	Don't know/ missing		
Type of facility²															
GS hospital	22	0	34	42	0	2	6	56	13	0	19	4	2	37	
MCH/urban HU	13	1	38	48	0	0	7	39	12	0	42	0	0	79	
Rural HU	13	1	54	32	0	0	3	35	31	1	28	1	0	299	
Health office	10	0	47	43	0	0	5	23	29	0	44	0	0	33	
NGO facility	0	21	72	6	0	0	21	0	57	0	21	0	0	8	
Region															
Urban															
Governorates	18	1	42	37	0	1	17	13	22	0	47	0	1	35	
Lower Egypt	21	1	32	45	0	0	4	44	24	1	26	1	0	237	
Upper Egypt	3	0	73	23	0	1	3	31	31	0	34	0	0	183	
Total	13	1	49	36	0	0	4	36	27	1	31	1	0	455	

¹ Multiple responses might apply.

² Fever hospitals do not provide child immunization services.

Table A-3.20 System for ordering contraceptive methods and medicines for facilities placing their own order

Among facilities that provide contraceptive methods and among facilities that store medicines, that order their own supply, percentage that report they use the indicated criteria for determining how much to order and when to order, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities providing vaccinations and ordering own supplies in which:														Number of facilities (weighted)
	Amount ordered based on: ¹							Stock orders placed: ¹							
	Maintain- ing a fixed stock	Order same amount each time	Mathematical formula based on utilization	Judgment based on utilization	Other	Don't know/ missing	When stock falls to a pre- determined level	Routinely order:							
								More often than once monthly	Every 4 weeks	Less often than once monthly	When needed	Other	Don't know/ missing		
CONTRACEPTIVES															
Type of facility															
GS hospital	47	0	52	1	0	0	12	0	59	1	25	0	3	61	
MCH/urban HU	29	8	52	11	0	0	17	2	58	6	16	0	0	89	
Rural HU	38	1	49	12	0	1	17	0	50	3	29	0	1	298	
Mobile unit	40	0	41	19	0	0	21	0	55	4	20	0	0	49	
Health office	27	0	55	18	0	0	16	0	52	4	28	0	0	26	
NGO facility	25	4	32	29	7	3	6	0	50	1	35	1	7	59	
Region															
Urban															
Governorates	8	0	72	15	2	3	13	0	48	2	33	0	4	66	
Lower Egypt	38	4	42	15	1	1	11	1	63	5	18	0	2	293	
Upper Egypt	41	1	47	10	1	0	23	1	40	0	35	0	0	228	
Total ²	36	2	48	13	1	1	16	1	53	3	26	0	1	584	
MEDICINES															
Type of facility															
GS hospital	4	8	22	64	1	0	22	19	33	6	17	3	0	42	
Fever hospital	0	0	33	67	0	0	6	61	17	0	17	0	0	13	
MCH/urban HU	8	0	32	54	0	6	5	3	59	11	20	0	3	86	
Rural HU	4	3	17	71	1	4	5	1	35	34	22	0	1	175	
Mobile unit	0	0	0	100	0	0	0	0	44	0	56	0	0	5	
Health office	0	11	11	45	0	33	0	0	67	11	22	0	0	5	
NGO facility	0	0	0	100	0	0	0	0	25	0	75	0	0	2	
Region															
Urban															
Governorates	5	2	26	60	0	9	8	15	39	6	32	0	0	35	
Lower Egypt	6	4	7	77	1	5	10	5	50	15	19	0	1	153	
Upper Egypt	4	1	36	55	1	3	4	5	32	34	22	1	2	141	
Total	5	3	21	66	1	4	7	6	41	22	22	1	1	328	

¹ Multiple responses might apply.

² Totals include 2 fever hospitals (weighted = 1)

Table A-3.21 System for ordering commodities where order is placed by authorities external to facility

Among facilities providing commodities where stock orders are placed by authorities external to the facility, percentage in which the basis for determining the amount ordered is activity level, a fixed supply is provided, or the basis for deciding how much to order is not known, by type of facility and region, Egypt SPA 2004

Region	Percentage of facilities in which amount provided is based on:			Number of facilities where decision for how much to order is made external to facility (weighted) ¹
	Activity level	Fixed supply	Don't know	
VACCINES				
Urban Governorates	-	-	-	0
Lower Egypt	58	28	14	12
Upper Egypt	93	7	0	10
Total	74	19	8	23
CONTRACEPTIVE METHODS				
Urban Governorates	80	0	20	5
Lower Egypt	89	11	0	20
Upper Egypt	70	23	7	29
Total	78	16	6	54
MEDICINES				
Urban Governorates	47	53	0	3
Lower Egypt	34	20	46	102
Upper Egypt	45	30	25	61
Total	38	24	38	166

¹ Fever hospitals do not provide child immunizations

Table A-3.22 Knowledge and capacity for autoclave processing of equipment

Among facilities with a functioning autoclave machine, percentage where the informant provided the indicated response concerning processing temperature and pressure used for autoclaving, Egypt SPA 2004

Items	Percentage of facilities providing indicated response
Temperature	
Excellent ¹	55
Good ²	4
Don't know/invalid	40
Pressure	
Excellent ³	51
Good ⁴	6
Don't know/invalid	43
Temperature and pressure	
Both excellent	43
Both at least good	4
Don't know/invalid response for temperature or pressure	54
Total number of facilities with functioning autoclave (weighted)	121

¹ Autoclave had automatic temperature control, or response was 120 to 130°C.

² Response was more than 130°C but was less than 361°C (high cutoff point was selected to include any response that appeared valid).

³ Either automatic machine (one facility) or response was PPI of 13-17 or ATM of 1 or 2.

⁴ Response was PPI more than 17 and less than 61, or ATM more than 2 and less than 8 (high cutoff points were selected to include any response that appeared valid).

Table A-3.23 Storage conditions for sterilized or high-level disinfected items

Percentage of facilities with sterilized or disinfected instruments present and, among facilities where sterilized items are present, percentage with specific storage conditions for processed items, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with sterilized or disinfected items present	Number of facilities (weighted)	Among facilities with sterilized items present, percentage in which items stored in indicated manner:				Number of facilities with stored processed items (weighted)
			Sterile/HLD status storage conditions ¹	Clean, but not sterile, storage conditions ²	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilized items	
Type of facility							
GS hospital	61	65	43	67	30	25	40
Fever hospital	21	14	25	50	25	25	3
MCH/urban HU	61	97	13	93	12	10	60
Rural HU	53	319	9	83	7	2	169
Mobile unit	75	55	0	99	0	0	41
Health office	14	33	0	100	0	0	5
NGO facility	68	76	33	64	27	22	52
Region							
Urban Governorates	48	73	33	77	27	22	35
Lower Egypt	50	322	17	80	16	9	161
Upper Egypt	66	264	11	85	7	5	173
Total	56	659	16	82	13	9	369

¹ Items are wrapped and sealed with time-steam-temperature (TST) or are in a sterile/HLD box that clasps shut.

² Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer of autoclave, or sitting in disinfecting solution.

Table A-3.24 Specific items for infection control that were available in all relevant service areas¹

Percentage of facilities where the indicated infection control items were either observed or reported available when the service being assessed was not being offered at the time of the survey in each of the service delivery areas assessed for that facility, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:						Number of facilities (weighted)
	Soap	Water	Sharps box	Disinfectant	Clean latex or sterile gloves	Waste receptacle ²	
Type of facility							
GS hospital	11	52	39	53	10	0	65
Fever hospital	0	42	26	16	10	0	14
MCH/urban HU	11	45	55	45	23	9	97
Rural HU	10	52	56	62	21	8	319
Mobile unit	72	87	57	97	20	20	55
Health office	15	38	67	73	20	7	33
NGO facility	62	79	26	79	27	30	76
Region							
Urban Governorates	40	62	55	75	19	25	73
Lower Egypt	22	58	49	64	25	11	322
Upper Egypt	14	53	51	59	16	6	264
Total	21	56	51	63	21	11	659

¹ Survey criteria required that the item be available in the service delivery room or immediately adjacent, and the item must be observed. If the service was not being provided on the day of the survey, a report that an item was normally available when services were being offered was noted and included in this table. In most cases this added only 0-1 percent. Relevant services and items were: Immunization area: soap, water, sharps box; Injection room: soap, water, sharps box; consultation area for sick children: soap, water; and consultation/examination area for RTI/STI services, family planning, antenatal care, and delivery services: soap, water, sharps box, disinfecting solution, clean latex, or sterile gloves.

² Waste receptacle with plastic liner and lid. This is not a component of the aggregate in Table 3.12 because, while important for injection control, and listed in the MOHP maternity standards, this is not an item that has been commonly introduced.

Table A-3.25 Waste disposal methods for hazardous materials

Percentage of facilities that dispose of hazardous materials through specific methods, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities in which hazardous material:							Number of facilities (weighted)
	Collected and disposed of by external party	Burned in incinerator	Burned and buried	Burned in open pit	Burned but not buried	Thrown in open pit latrine	Other response/missing	
Type of facility								
GS hospital	41	25	20	9	2	2	0	65
Fever hospital	63	32	5	0	0	0	0	14
MCH/urban HU	79	6	2	7	2	2	1	97
Rural HU	29	16	23	13	14	0	4	319
Mobile unit	81	2	3	1	8	1	4	55
Health office	89	3	0	0	7	0	2	33
NGO facility	84	3	5	0	2	3	2	76
Region								
Urban Governorates	87	5	0	1	1	2	3	73
Lower Egypt	43	10	20	10	13	1	4	322
Upper Egypt	53	18	12	9	6	2	1	264
Total	52	13	14	8	9	1	3	659

Table A-3.26 Infrastructure and infection control for the therapeutic injection

Among facilities providing curative care for sick children, percentage where therapeutic injections are provided in the indicated location, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering sick-child care where therapeutic injection service onsite:			Number of facilities assessed for therapeutic injection (weighted)
	With immunization	Not with immunization	No area for therapeutic injections	
Type of facility				
GS hospital	7	64	29	64
Fever hospital	0	58	42	14
MCH/urban HU	23	54	23	96
Rural HU	37	26	36	316
Mobile unit	0	13	87	21
Health office	65	16	18	6
NGO facility	1	30	68	36
Region				
Urban Governorates	11	50	38	54
Lower Egypt	26	31	43	273
Upper Egypt	32	39	30	225
Total	27	36	37	552

Table A-3.27 Infrastructure and infection control for the therapeutic injection service area by items of infection control

Among facilities offering therapeutic injections, percentage with the indicated infection control items, by whether therapeutic injections are provided in the same, or a different service site than immunization services, Egypt SPA 2004

Items	Percentage of facilities offering therapeutic injections:		Total percentage
	With immunization	Not with immunization	
Soap	27	28	28
Water	66	76	72
Sharps box	83	69	75
Syringes 0.5-1 ml	70	25	44
Syringes 2-3 ml	75	48	60
Number of facilities with injection area (weighted)	149	198	347

Table A-3.28 Observed injection practices

Among facilities providing therapeutic or immunization injections, percentage where the indicated injection practice was observed, by type of facility, Egypt SPA 2004

Items	Percentage by type of facility						Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	
New syringe and needle used	100	100	100	100	95	100	100
Provider observed opening new syringe/needle packet	97	100	95	97	100	100	86
Facility provided new syringe and needle	79	51	75	64	32	99	22
Provider disposed of used needle in sharps box	76	65	90	75	16	83	19
Number of observed injections (weighted)	227	18	272	605	11	119	35
							1,288

Chapter 4

Table A-4.1 Availability of child health services at the facility

Among facilities offering outpatient care for sick children, routine growth monitoring services, or routine child immunization services, percentage providing the service at the facility, 1 to 2 days per week, 3 to 4 days per week, or 5 or more days per week, by type of facility and region, Egypt SPA 2004.

Background characteristics	Percentage of facilities offering the service															
	Outpatient care for sick children				Growth monitoring				Child immunization ²				BCG immunization ³			
	Days per week ⁴			Number of facilities (weighted) ¹	Days per week ⁴			Number of facilities (weighted) ¹	Days per week ⁴			Number of facilities (weighted) ¹	Days per week ⁴			Number of facilities (weighted) ¹
1-2	3-4	5+	1-2		3-4	5+	1-2		3-4	5+	1-2		3-4	5+		
Type of facility																
GS hospital	0	0	100	64	54	13	28	39	83	11	0	38	64	3	0	38
Fever hospital	0	0	100	14	0	0	50	1	na	na	na	0	na	na	na	0
MCH/urban HU	1	0	99	96	27	16	57	83	54	22	24	84	91	0	1	81
Rural HU	3	9	88	316	57	1	28	271	80	1	0	311	53	0	0	309
Mobile unit	0	0	97	21	0	0	100	2	na	na	na	0	na	na	na	0
Health office	0	0	100	6	32	15	53	13	19	44	37	30	83	11	3	30
NGO facility	11	15	74	36	0	0	100	1	0	100	0	1	100	0	0	1
Region																
Urban Governorates	0	5	95	54	9	0	89	28	22	16	57	32	89	0	2	32
Lower Egypt	2	6	92	273	51	6	32	230	76	10	1	241	59	1	0	239
Upper Egypt	3	7	90	225	53	7	29	151	74	6	6	191	64	2	1	188
Total	2	6	91	552	49	6	35	409	71	9	7	464	63	1	0	459

na = Not applicable

¹ Number of facilities that provide the service

² Five (1 percent) of these facilities do not provide BCG vaccine, but offer all other child immunizations.

³ All facilities provide all immunizations, including BCG.

⁴ Some facilities offer the service less than one day per week.

Table A-4.2 Availability of child health services through village outreach activities

Among all facilities, percentage offering curative care for sick children, percentage offering growth monitoring, and percentage offering child immunization (EPI) services that may or may not include BCG vaccine, and percentage offering EPI services that include BCG vaccination at least 1 day monthly, through outreach services to villages, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering indicated services through outreach				Number of facilities (weighted)
	Sick child services	Growth monitoring ¹	Child immunization without BCG ¹	All child immunization including BCG ²	
Type of facility					
GS hospital	1	1	6	3	65
Fever hospital	0	0	0	0	14
MCH/urban HU	3	7	10	8	97
Rural HU	0	1	7	3	319
Mobile unit	4	3	0	0	55
Health office	0	0	6	3	33
NGO facility	1	0	0	0	76
Region					
Urban Governorates	2	2	1	1	73
Lower Egypt	1	3	7	4	322
Upper Egypt	0	1	6	2	264
Total	1	2	6	3	659

¹ Oral polio vaccine (OPV), diphtheria-pertussis-tetanus (DPT), and measles

² OPV, DPT, measles, and BCG vaccines offered

Table A-4.3 Availability of child vaccines

Among facilities offering child immunization services and routinely storing vaccines, percentage with the indicated child vaccine observed on the day of the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering immunization services and storing vaccines with vaccine observed											Number of facilities offering child immunization services and storing vaccines (weighted)	
	BCG	Polio	DPT	Hep-DPT	Any DPT	Measles	Hepatitis B	Any hepatitis	MMR	Vitamin A	All basic child vaccines available ¹		All basic child vaccines plus available ²
Type of facility													
GS hospital	92	97	92	87	97	92	34	95	97	83	89	87	24
MCH/urban HU	90	99	89	79	93	92	49	89	92	93	76	75	81
Rural HU	69	88	73	73	85	74	23	78	78	87	60	53	230
Health office	90	100	95	100	100	93	35	100	100	100	90	90	28
NGO facility	100	100	100	100	100	100	0	100	100	0	100	100	1
Region													
Urban Governorates	94	100	98	95	100	97	42	98	98	98	92	92	31
Lower Egypt	75	87	75	76	84	72	21	77	77	90	61	54	181
Upper Egypt	76	96	81	75	93	87	39	88	90	86	70	67	150
Total	77	92	80	77	89	81	31	83	84	89	68	63	363

¹ BCG, polio, DPT or Hep-DPT, and measles.

² All basic child vaccines plus Hepatitis B (or Hep-DPT) and measles, mumps, rubella (MMR).

Table A-4.4 Specific equipment and supplies for child immunization services

Among facilities offering childhood immunization services, percentage with specific equipment and supplies observed, items for infection control, and recordkeeping system components, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering child immunization services with:								Number of facilities offering child immunization services (weighted)
	Equipment and supplies			Items for infection control			Administrative practices		
	Blank immunization cards ¹	Adequate supplies of syringes and needles ^{1,2}	Cold box with ice pack ³	Soap	Water	Sharps box	Register or tally sheet ⁴	Monitoring of community coverage ⁵	
Type of facility									
GS hospital	62	71	100	30	67	90	97	79	38
MCH/urban HU	53	70	100	21	62	84	97	65	84
Rural HU	71	60	99	23	66	84	94	80	311
Health office	74	73	100	17	52	98	97	81	30
Region									
Urban Governorates	51	70	98	34	63	93	96	57	33
Lower Egypt	61	58	99	25	68	83	96	76	241
Upper Egypt	77	69	99	18	59	88	94	82	191
Total⁶	67	63	99	23	64	86	95	77	464

¹ An additional 6 percent of facilities that were not offering EPI services the day of the survey indicated they had child immunization cards, and an additional 7 percent reported they had syringes, but were unable to show them.

² Disposable syringes and needles are universally utilized in Egypt.

³ If a facility reported it purchased ice, this was accepted in place of the ice pack.

⁴ Either a register or tally sheet for recording immunizations provided was observed.

⁵ Measles coverage was documented.

⁶ Regional totals and total percentages include data from one NGO facility that provide immunization services.

Table A-4.5 Availability of specific equipment and supplies for quality assessments of the sick child

Among facilities that provide outpatient care for sick children, percentage with indicated items to support quality of services, to provide preventive services, and to assess the sick child in the service delivery room, by type of facility, Egypt SPA 2004

Items	Percentage by type of facility						Total percentage ³
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Items to support quality							
Soap	37	0	11	26	74	43	27
Water	72	58	69	76	81	67	73
Child health cards	30	16	60	53	0	7	45
Treatment protocols/standards (any)	37	26	57	38	0	1	36
Visual aids for health education	27	21	41	26	0	0	26
All items to support quality of care	8	0	4	8	0	0	6
Preventive measures							
Capacity to provide vaccinations ¹	10	0	2	11	0	0	8
Infant weighing scale	77	26	74	72	8	28	66
Child weighing scale	38	16	48	45	16	28	41
Both infant and child weighing scale	28	16	30	35	8	10	30
All preventive measures	4	0	1	5	0	0	4
Equipment for assessment							
Thermometer	86	68	86	72	0	78	74
Minute timer ²	49	58	70	50	37	25	51
Pitcher for mixing ORS	23	5	27	19	0	1	19
Cup/spoon for giving ORS	45	26	67	47	0	5	45
ORS packet	81	68	88	87	16	4	78
All three oral rehydration therapy (ORT) administration materials	14	5	17	17	0	1	15
All equipment for assessment	7	5	10	13	0	1	10
Additional equipment							
Wooden tongue depressor	71	84	57	57	16	52	58
Light for checking throat	8	0	17	25	11	33	21
Height measuring board	35	16	70	66	0	14	55
Number of facilities offering sick child services (weighted) ³	64	14	96	316	21	36	552

¹ Vaccines, equipment, immunization cards, and infection control items all available. Register and monitoring of coverage were not considered essential for providing vaccines for sick children on the day of survey.

² This represents a minute timer that is facility equipment. In addition to these, many staff had personal watches with second hands that could be used to time for 1 minute.

³ Regional totals and total percentages include data from six health offices offering sick child services.

Table A-4.6 Description of different protocols and teaching materials available

Among facilities providing outpatient care for sick children, percentage where indicated protocol or client educational aid was available, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering sick child services with:					Number of facilities offering sick child services (weighted) ¹
	IMCI chart booklet	IMCI counseling cards for provider	IMCI mother cards	MOHP infection control guidelines	Other infection control guidelines	
Type of facility						
GS hospital	28	23	22	0	1	64
Fever hospital	21	26	16	5	0	14
MCH/urban HU	44	32	31	2	1	96
Rural HU	25	21	23	1	5	316
Mobile unit	0	0	0	0	8	21
NGO facility	0	0	0	1	8	36
Region						
Urban Governorates	21	17	15	1	3	54
Lower Egypt	23	14	21	1	3	273
Upper Egypt	31	31	24	2	5	225
Total ¹	26	21	21	1	4	552

¹ Regional totals and total percentages include data from six health offices offering sick child services.

Table A-4.7 Availability of services for immunization and outpatient care for sick children on the same day

Among all facilities offering outpatient care for sick children, percentage offering child immunization (EPI) every day sick child services are offered, and percentage where both sick child and EPI services were both being offered the day of the survey by type of facility and region. Egypt SPA 2004

Background characteristics	Among facilities offering sick child services, percentage where:		Number of facilities offering sick child services (weighted) ²
	EPI services available every day sick child services are offered	On day of survey, both sick child and EPI services were provided	
Type of facility			
GS hospital ¹	12	19	64
Fever hospital ¹	0	0	14
MCH/urban HU	29	36	96
Rural HU	14	17	316
Mobile unit	0	0	21
NGO facility	1	0	36
Region			
Urban Governorates	22	22	54
Lower Egypt	6	12	273
Upper Egypt	23	24	225
Total	15	18	552

¹ Most hospitals do not offer immunization services but may be adjacent to health offices that provide preventive services.

² Regional totals and total percentages include data from six health offices offering sick child services.

Table A-4.8 Availability of specific medicines for treatment of the sick child

Among facilities that provide outpatient care for sick children, percentage where first-line, prereferral, and other essential medications are available, by type of facility, Egypt SPA 2004

Items	Percentage by type of facility						Total percentage ⁴
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
First-time oral medicines							
ORS solution	81	68	88	87	16	4	78
Antibiotic: amoxicillin	76	95	66	73	3	6	65
Antibiotic: cotrimoxazole	84	53	67	63	21	6	60
Either antibiotic	92	95	85	80	21	6	75
All first-line oral medicines ¹	75	68	78	74	16	4	68
Pre-referral medicines							
Chloramphenicol ²	18	63	14	11	0	3	13
Other emergency treatments							
Antibiotic: ampicillin	50	74	28	32	0	3	31
Antibiotic: penicillin	84	63	84	80	16	4	73
Antibiotic: gentamycin	44	79	58	39	8	4	40
Antibiotic: ceftriaxone	8	21	2	0	0	4	2
Intravenous solution with perfusion set	67	69	39	51	0	4	46
All other emergency treatments ³	39	69	21	22	0	3	23
Other essential medicines							
Aspirin or paracetamol (antipyretic)	92	79	95	86	19	6	80
Vitamin-A (any dose)	54	11	44	52	0	3	45
Iron tablet	38	21	34	43	13	3	37
Mebendazole (deworming)	78	53	74	73	16	4	66
Antibiotic eye ointment	82	16	78	69	16	4	64
All other essential medicines	27	5	12	13	0	3	13
Number of facilities offering sick children services (weighted) ⁴	64	14	96	316	21	36	552

¹ ORS and at least one antibiotic.

² Chloramphenicol is the only pre-referral drug according to IMCI Egypt protocol.

³ At least one first-line injectable antibiotic (ampicillin or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamycin) and intravenous solution (normal saline, Ringer's lactate, or dextrose and saline 0.9%) with perfusion set.

⁴ Regional totals and total percentages include data from six health offices offering sick child services.

Table A-4.9 Facility utilization statistics for outpatient care for sick children

Among facilities providing outpatient care for sick children, the median number of sick-child consultations per month, by type of facility and region, Egypt SPA 2004

Background characteristics	Median monthly number of sick child consultations ¹	Number of facilities providing consultation data (weighted)
Type of facility		
GS hospital	286	48
Fever hospital	126	5
MCH/urban HU	359	76
Rural HU	54	218
Mobile unit	9	5
Health office	2	4
NGO facility	2	8
Region		
Urban Governorates	259	32
Lower Egypt	86	193
Upper Egypt	60	140
Total	79	365

¹ Median value for the average of the number of months out of the past 12 months for which data were available.

Table A-4.10 Information on user fees for outpatient care for sick children

Among facilities offering outpatient care for sick children, percentage where indicated practice for user fees is reported and percentage where the indicated practices exist for publicly posting fees, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage charging for the indicated item					Number of facilities offering sick child services (weighted)	Percentage where fees are posted in public view			Number of facilities having any user fees for sick child services (weighted) ¹
	Fixed fee for health card	Fixed fee for each consult	Charge for medicines and tests	Other routine charges	No charges or don't know		All fees are posted	Some fees posted	No fees posted	
Type of facility										
GS hospital	9	32	2	6	63	64	13	3	84	23
MCH/urban HU	7	17	1	8	73	96	14	0	86	26
Rural HU	9	23	3	0	75	316	9	2	89	80
NGO facility	1	92	25	1	8	36	30	8	62	33
Region										
Urban Governorates	3	51	15	6	44	54	40	10	50	30
Lower Egypt	5	18	3	3	75	273	8	0	92	67
Upper Egypt	11	33	3	1	66	225	11	3	86	78
Total	7	27	4	3	68	552	15	3	82	175

¹ Regional totals and total percentages include data from 7 fever hospitals, three health offices and three mobile units offering sick child services.

Table A-4.11 Health finance program in which observed sick children participate

Among observed sick children, the percentage of caretakers reporting participation in health finance programs, and the types of prepay or other finance plans (program) in which the caretaker reported they participate, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage belonging to any program	Number of interviewed caretakers (weighted)	Percentage belonging to indicated health finance program			Number of interviewed caretakers of sick children belonging to program (weighted)
			HIO or SHIP ¹	Prepay at facility for package of services	Discount or exemption status	
Type of facility						
GS hospital	21	468	99	0	1	96
Fever hospital	9	118	100	0	0	10
MCH/urban HU	21	505	100	0	0	106
Rural HU	23	977	100	0	0	228
Mobile unit	0	23	-	-	-	0
Health office	0	16	-	-	-	0
NGO facility	5	50	80	20	0	3
Region						
Urban Governorates	17	249	96	1	3	42
Lower Egypt	20	1,047	100	0	0	212
Upper Egypt	22	861	100	0	0	189
Total	21	2,156	100	0	0	443

¹ Health insurance organization or the School of Health Insurance Program.

Table A-4.12 Out-of-pocket payments for sick child consultations

Among interviewed caretakers of sick children, percentage who reported that they are part of a program for prepayment or deferring child health costs (program) and percentage who reported paying any out-of-pocket fees for services for the sick child on the day of the survey and, among the caretakers who paid any fees for services for the sick child, median amount (piasters) paid on the day of the survey, by whether the child belongs to a program or not, by type of facility, Egypt SPA 2004

Type of facility	Percentage of interviewed caretakers of sick children reporting:			Number of interviewed caretakers (weighted)	Median out-of-pocket fee (piasters) paid by caretakers who paid anything for child health services on the day of survey		Number of interviewed caretakers providing valid responses for out-of-pocket payments (weighted)	
	Child belongs to the program	Paying out-of-pocket fees for the visit ¹			Belongs to program	Does not belong to program	Belongs to program	Does not belong to program
		Belongs to program	Does not belong to program					
GS hospital	21	97	99	468	100	100	96	370
Fever hospital	9	100	100	118	100	100	10	108
MCH/urban HU	21	95	97	505	99	100	106	398
Rural HU	23	97	97	977	99	100	228	748
Mobile unit	0	-	49	23	-	104	0	22
Health office	0	-	62	16	-	109	0	16
NGO facility	5	80	90	50	498	498	3	46
Total	21	96	96	2,156	99	100	443^a	1,708^a

¹ Includes any amount paid out-of-pocket including consultation, laboratory test, medicines, or other.

^a Numbers do not add to 2,156 due to 5 missed cases with invalid responses.

Table A-4.13 Supportive management for providers of child health services

Among interviewed child health service providers, percentage who received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004.

Background characteristics	Percentage				Number of interviewed child health service providers (weighted) ²
	Received in-service training during past 12 months ¹	Personally supervised in past 6 months	Personally supervised during past 6 months and received in-service training during the past 12 months	Most recent in-service training was 13-59 months preceding survey	
Type of facility					
GS hospital	15	82	13	22	389
Fever hospital	11	71	11	25	119
MCH/urban HU	19	86	18	31	390
Rural HU	20	97	19	26	623
Mobile unit	11	91	5	10	13
Health office	14	97	14	10	77
NGO facility	1	44	1	8	56
Region					
Urban Governorates	21	75	18	23	182
Lower Egypt	17	88	16	23	843
Upper Egypt	16	89	16	28	642
Total	17	87	16	25	1,667

¹ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

² Includes only providers of child health services in facilities offering child health services.

Table A-4.14 In-service training for child health service providers

Among interviewed child health service providers, percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of child health service providers who received in-service training on specific topics												Number of interviewed child health service providers (weighted) ³
	EPI/cold chain		ARI ¹ treatment		Diarrhea treatment		Nutrition/micronutrient deficiencies		IMCI ²		Genetic/hereditary illnesses		
	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	
Type of facility													
GS hospital	3	3	7	8	9	9	7	5	11	6	1	1	389
Fever hospital	0	14	1	10	1	18	1	15	7	6	0	2	119
MCH/urban HU	3	4	2	8	4	10	4	7	9	17	2	2	390
Rural HU	6	10	3	13	5	15	3	9	13	14	1	4	623
Mobile unit	8	1	8	7	8	1	8	2	8	5	2	0	13
Health office	3	4	1	4	0	3	1	1	0	1	1	0	77
NGO facility	0	1	0	5	0	3	0	3	0	3	0	3	56
Region													
Urban Governorates	1	6	3	13	2	7	5	4	7	9	2	3	182
Lower Egypt	6	7	4	10	7	12	5	9	10	10	1	2	843
Upper Egypt	2	7	2	9	3	12	2	6	12	14	1	2	642
Total	4	7	3	10	5	11	4	7	10	11	1	2	1,667

¹ Acute respiratory infection.

² Integrated management of childhood illness.

³ Includes only providers of child health services in facilities offering child health services

Table A-4.15 Supportive supervision for child health service providers

Among interviewed child health service providers, who were personally supervised in the past 6 months, median number of times staff were supervised, and percentage who reported specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2004

Background characteristics	Median number of times staff were supervised in past 6 months	Percentage of providers reporting indicated activities of the supervisor during the last supervisory visit						Number of providers of child health services who were supervised in the past 6 months (weighted) ¹
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Wrote note on unit record	
Type of facility								
GS hospital	6	88	87	80	40	62	79	320
Fever hospital	5	82	88	58	45	49	77	84
MCH/urban HU	6	97	95	91	74	87	87	336
Rural HU	6	99	97	86	74	79	95	601
Mobile unit	7	100	98	95	73	77	93	11
Health office	11	94	91	80	67	68	78	74
NGO facility	5	94	93	76	57	86	87	24
Region								
Urban Governorates	12	96	95	90	73	83	86	136
Lower Egypt	6	93	96	89	68	73	88	746
Upper Egypt	6	97	90	75	57	75	87	570
Total	6	95	94	84	64	75	88	1,452

¹ Includes only providers of child health services in facilities offering child health services

Table A-4.16 Observed assessments, examinations, and treatments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Consultation conducted by physicians	100	100	100	100	100	100	100	100
History: assessment of danger signs								
Inability to eat or drink anything	15	13	22	18	32	21	20	18
Vomiting everything	41	55	40	39	46	38	46	41
Convulsions	9	14	20	18	0	28	3	16
All danger signs	2	3	11	5	0	17	0	6
History: assessment of symptoms								
Cough or difficult breathing	62	66	70	64	61	63	59	65
Diarrhea	63	67	52	66	51	40	50	61
Fever	79	92	77	82	90	76	83	81
All three key symptoms ¹	29	43	30	36	29	24	20	33
Ear pain or discharge	7	12	17	20	5	24	6	15
Throat problems	23	20	34	22	76	27	45	26
All major symptoms ²	2	5	10	5	2	14	0	5
Physical examination								
Felt temperature	38	29	26	32	66	38	53	33
Measured temperature (observed or system)	48	47	71	55	5	48	56	56
Any temperature	71	66	82	71	71	55	81	74
Assessed anemia: Looked at palms	5	7	19	12	0	3	0	11
Assessed anemia: Looked at eye conjunctiva or mucosa of mouth	11	4	16	17	7	3	14	15
Any assessment of anemia	14	8	27	22	7	7	14	21
Assessed dehydration	29	21	18	28	5	10	21	25
Counted respiratory rate per minute	10	8	21	21	10	14	9	17
All key physical checks ³	2	1	3	5	0	0	1	3
Checked throat (tongue depressor no light)	60	78	61	42	44	40	54	53
Checked throat (tongue depressor and light)	2	0	4	12	0	7	13	7
Any check of throat with tongue depressor	62	78	64	54	44	47	67	60
Looked in ear and feel behind ear	8	12	15	13	0	7	10	12
Checked for pedal edema (press both feet)	2	2	2	4	0	0	1	3
Remove clothing and observe musculature	6	5	10	7	0	0	12	7
All physical checks ⁴	0	0	0	0	0	0	0	0
Essential advice								
Increase fluids	34	28	50	39	71	24	68	41
Continue/increase feeding	31	25	39	32	46	20	59	34
Symptoms for immediate return	8	20	13	16	7	0	16	13
All three essential messages	5	10	8	9	7	0	14	8
Drinking/feeding practice during illness								
Feeding/ Breastfeeding practices	26	20	37	38	46	21	47	34
Observed if child can drink or suck	3	4	7	7	0	0	0	5
Both assessments of drinking/feeding status	2	4	4	4	0	0	0	3
Number of observed children (weighted)	468	118	505	977	23	16	50	2,156

¹ Assessed cough, diarrhea, fever.

² Assessed cough, diarrhea, fever, ear symptoms and throat symptoms.

³ Counted respiratory rate, assessed presence of fever (either measured or by touch), and assessed presence of anemia (either palms or mucosa).

⁴ Counted respiratory rate, assessed presence of fever (either measured or by touch), assessed presence of anemia (either palms or mucosa), checked throat (either with or without light), checked ear, checked feet (pedal edema), and checked musculature.

Table A-4.17 Bronchodilator treatments prescribed for children with respiratory diagnosis

Among observed sick children with the indicated diagnosis and indicated wheezing status, percentage who were prescribed a bronchodilator medication, Egypt SPA 2004

Status	Pneumonia or other severe respiratory illness		Bronchitis		Other respiratory illness	
	Percentage receiving bronchodilator	Number with diagnosis (weighted)	Percentage receiving bronchodilator	Number with diagnosis (weighted)	Percentage receiving bronchodilator	Number with diagnosis (weighted)
Wheezing	39	64	50	163	18	23
No wheezing	9	53	12	219	7	491
Total	26	116	28	382	8	515

Table A-4.18 Observed and reported information on prescriptions and medicines provided for the observed sick child

Percent of interviewed caretakers of observed sick children who were given or prescribed oral medicines, who had all medicines some medicines and some prescriptions, and only prescriptions on departure from the facility, percentage who indicated that they were told how to give the medicine at home, and percentage who felt they understood how to provide the medicine, and percentage who stated the child was given a dose of the medicine at the facility, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Observed during consultation								
Caretaker was told about medications	70	68	87	78	97	100	97	79
Caretaker was asked to repeat instructions	4	4	6	7	0	0	6	6
Child received first dose of any medicine at facility	0	3	1	3	0	0	0	2
Antibiotic was prescribed	51	78	45	46	70	72	68	49
Number of observed sick children who received medicines (weighted)	439	109	480	938	22	11	50	2,049
Observed during exit interview								
Caretaker has all medicines	31	34	29	32	13	24	0	30
Caretaker has some medicines and some prescriptions	50	59	35	44	28	14	5	43
Caretaker has only prescriptions	20	7	36	25	60	62	95	28
Child was prescribed an injectable medicine	23	29	17	22	0	5	12	21
Reported by caretaker								
Was told how to give the medicine at home	79	84	92	85	97	73	100	86
Feels comfortable in knowledge of how to provide medicine at home	80	83	90	87	85	95	96	86
Child was provided a dose of oral medicine at the facility	4	4	2	4	0	0	0	3
Child received injectable at the facility	6	2	3	7	0	0	0	5
Number of interviewed caretakers of sick children who received prescription, medicine, or both (weighted)	447	112	491	965	22	11	49	2,098

Table A-4.19 Observed preventive assessments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Preventive measures								
Child weighed	46	25	68	48	0	48	24	50
Weight plotted	13	9	38	27	0	48	0	25
Normal feeding assessed (<24 months)	31	18	36	40	23	25	63	36
Normal feeding assessed (≥24 months)	12	8	20	18	4	15	30	16
Any age normal feeding practices assessed	21	13	29	30	10	21	44	27
Immunization status assessed (<24 months)	12	6	21	21	0	39	0	18
Immunization status assessed (≥24 months)	4	2	17	12	0	0	0	10
Any age immunization status assessed	16	8	44	29	0	52	0	28
Number of observed children < 24 months old (weighted)	240	56	284	555	7	8	21	1,171
Number of observed children ≥24 months old (weighted)	228	63	221	422	16	7	29	985
Number of observed children (weighted)	468	118	505	977	23	16	50	2,156

Table A-4.20 Reported information from interview of caretaker of observed child

Percentage of interviewed caretakers of observed children who, when asked, reported that a provider discussed the indicated items, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Weight or nutritional status of the child	16	10	39	31	0	17	16	28
General feeding practices	13	17	15	20	2	14	3	16
Give food and liquid during the illness	21	24	26	22	46	14	40	23
Was told what the illness was	68	65	75	69	95	90	98	71
Caretaker brought immunization card to facility this visit	6	0	17	12	10	17	0	11
Caretaker reports child <24 months received immunization	5	0	14	6	24	6	0	7
Number of caretakers of children < 24 months (weighted)	240	56	284	555	7	8	21	1,171
Number of caretakers of children ≥24 months (weighted)	228	63	221	422	16	7	29	985
Number of interviewed caretakers (weighted)	468	118	505	977	23	16	50	2,156

Table A-4.21 Client feedback during exit interview

Percentage of interviewed caretakers of observed children who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2004.

Client service issue	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Behavior/attitude of provider	2	1	2	3	0	0	0	2
Inability to discuss problem	6	13	3	4	0	0	0	4
Insufficient explanation about child's illness	8	13	3	5	0	0	0	6
Waiting time to see provider	9	8	9	8	0	0	0	8
Quality of examination and treatment	8	8	3	5	0	0	0	5
Availability of medicines or supplies	18	19	11	17	17	25	0	16
Hours facility is open	2	0	0	1	5	0	0	1
Cleanliness of facility	0	2	0	2	0	0	0	1
Cost of services	0	0	0	1	0	0	0	0
Insufficient visual privacy	1	0	0	1	0	0	0	1
Insufficient auditory privacy	1	0	0	1	0	0	0	1
Time required to complete all parts of the consultation	2	2	2	2	0	0	0	2
Number of interviewed caretakers (weighted)	468	118	505	977	23	16	50	2,156

Table 4.22 Reasons caretakers of observed sick child consultations chose this facility for services

Among interviewed caretakers of observed sick children, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of caretakers of observed sick children agreeing item was a factor in choosing facility							Number of interviewed caretakers (weighted)
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well treated	Facility is nearby	Facility has good reputation	
Type of facility								
GS hospital	1	39	15	35	11	57	21	468
Fever hospital	0	34	1	61	20	24	37	118
MCH/urban HU	2	42	9	37	22	58	16	505
Rural HU	3	41	1	27	23	75	14	977
Mobile unit	8	7	0	46	15	71	22	23
Health office	3	38	0	3	17	86	27	16
NGO facility	5	61	9	8	25	54	22	50
Region								
Urban Governorates	2	46	4	17	20	62	29	249
Lower Egypt	3	43	8	40	19	60	21	1,047
Upper Egypt	1	37	5	28	20	69	12	861
Total	2	41	6	33	20	64	18	2,156

Table A-4.23 Personal characteristics of caretakers of observed sick children, by employment status

Among caretakers of sick children whose consultation was observed and who were interviewed, percent distribution by employment status, and among employed caretakers of sick children, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2004

Background characteristics	Among all caretakers of sick children, percentage who are:		Number of interviewed caretakers (weighted)	Among employed caretakers of sick children, percentage who:							Number of interviewed caretakers who are employed (weighted)
	Employed	Not employed		Work for:			Receive:				
				Family member	Someone else	Self	Salary in cash	Salary in kind	Salary both in cash and in kind	No salary	
Type of facility											
GS hospital	15	85	468	23	70	7	71	2	5	21	71
Fever hospital	14	86	118	25	70	4	66	0	4	30	17
MCH/urban HU	20	80	505	10	84	6	94	0	2	4	103
Rural HU	17	83	977	33	55	12	58	1	8	33	165
Mobile unit	10	90	23	25	0	75	0	0	75	25	2
Health office	3	97	16	0	0	100	100	0	0	0	1
NGO facility	17	83	50	0	94	6	100	0	0	0	8
Region											
Urban Governorates	17	83	249	0	90	10	96	0	0	4	42
Lower Egypt	20	80	1,047	22	70	7	74	2	6	18	211
Upper Egypt	13	87	861	33	53	14	58	0	7	35	115
Total	17	83	2,156	23	67	10	72	1	6	21	367

Table A-4.24 Personal characteristics of caretakers of observed sick children by education, Egypt SPA 2004

Among interviewed caretakers of observed sick children, percentage indicating their education and literacy status as noted below, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed caretakers who have:				Number of interviewed caretakers (weighted)	Percentage of interviewed caretakers with primary or no education who:				Number of interviewed caretakers with primary or no education (weighted)
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write	Can read and write	Missing	
Type of facility										
GS hospital	49	7	8	37	468	81	2	17	0	259
Fever hospital	55	12	4	29	118	87	2	12	0	79
MCH/urban HU	37	7	10	47	505	67	7	24	3	220
Rural HU	52	11	8	29	977	71	3	25	1	611
Mobile unit	64	22	9	5	23	68	6	26	0	20
Health office	23	6	21	50	16	100	0	0	0	5
NGO facility	27	5	15	52	50	80	11	9	0	16
Region										
Urban Governorates	31	8	14	48	249	65	2	33	1	95
Lower Egypt	38	11	5	46	1,047	66	3	29	2	515
Upper Egypt	63	7	11	20	861	81	4	14	0	600
Total	47	9	8	36	2,156	73	3	22	1	1,210

Chapter 5

Table A-5.1 Offered methods of family planning

Percentage of facilities offering each of the indicated methods of family planning, by type of facility, Egypt SPA 2004

Methods offered	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Combined oral contraceptives	100	98	98	96	89	70	95
Progesterone-only oral pill	5	7	10	11	17	27	11
Progesterone-only injectable (two or three monthly)	100	100	100	100	92	84	98
Combined injectable (one monthly)	0	0	0	0	0	6	1
Implants	40	28	3	18	13	5	13
Intrauterine device	100	100	98	100	89	98	98
Male condom	95	94	88	90	89	59	87
Spermicide	0	0	3	0	0	2	2
Diaphragm	0	0	1	0	0	0	0
Rhythm method	64	70	70	63	62	58	67
Female sterilization	25	2	1	4	0	3	4
Emergency contraceptive pill	43	30	47	36	27	5	38
At least two of any temporary modern methods ¹	100	100	100	100	100	88	99
At least four of any temporary modern methods ¹	99	97	92	90	74	57	89
All four most common methods offered ²	95	92	86	87	70	57	84
Number of facilities offering FP (weighted)	65	96	319	55	28	72	637

¹ Among the following methods: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), implants, IUD, condoms (female condom is not available), spermicides, diaphragm, or emergency contraceptive. Permanent methods (sterilization) are not included.

² Combined oral contraceptive (COC) pill, progesterone-only injection (PIN), IUD, and male condom.

Table A-5.2 Availability of offered methods of family planning by type of facility

Among facilities offering the indicated method, percentage where the method was available on the day of the survey, by type of facility, Egypt SPA 2004

Methods	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Combined oral contraceptives	97	98	98	99	96	94	97
Progesterone only oral pill	40	40	67	25	23	77	60
Progesterone only injectable (two or three monthly)	96	100	99	100	96	97	98
Combined injectable (one monthly)	na	na	na	na	na	88	88
Implants	56	61	21	38	43	61	50
Intrauterine device	99	100	98	100	96	92	98
Male condom	92	88	96	97	92	96	94
Spermicide	na	na	na	na	na	0	17
Emergency contraceptive pill	89	79	80	53	71	0	78
Each method offered by a facility was available the day of the survey	69	74	79	74	79	81	77
Four most common methods offered and available	87	88	94	96	90	93	92

na = Not applicable

Table A-5.3 Availability of offered methods of family planning by region

Among facilities offering each of the indicated methods of family planning, percentage where the method was available on the day of the survey, by region, Egypt SPA 2004

Methods	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Combined oral contraceptives	98	99	95	97
Progesterone only oral pill	27	100	63	60
Progesterone only injectable (two or three monthly)	99	99	98	98
Combined injectables (one monthly)	0	100	100	88
Implants	57	46	49	50
IUD	93	99	98	98
Male condom	87	95	95	94
Spermicide	0	20	0	17
Emergency contraceptive pill	48	82	79	78
Each method offered by a facility was available the day of the survey	58	81	77	77
Four most common methods offered and available	84	93	92	92

Table A-5.4 Availability of infrastructure, resources, and systems for quality family planning services

Percentage of facilities where there are items to support quality counseling and items for quality physical examination, by type of facility, Egypt SPA 2004

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Items to support quality counseling							
Private room (complete privacy)	90	74	79	79	56	87	79
Either private room or screen (visual privacy)	93	89	84	92	60	91	86
No privacy	5	9	12	5	39	9	11
Individual client health cards	95	96	92	83	70	58	87
Written FP protocols or guidelines	49	48	39	13	36	17	37
Written RTI/STI protocols or guidelines	15	14	10	9	10	5	10
Visual aids for health education on family planning	100	100	98	95	92	62	94
Visual aids for health education on RTI/STI	37	23	29	8	11	8	24
All items to support quality counseling ¹	45	39	30	6	25	13	29
All items to support quality counseling for FP and for RTI/STI services and education ²	7	1	6	1	2	0	4
Written MOHP infection control guidelines ³	3	10	3	0	3	1	4
Items for infection control							
Soap	83	83	60	73	43	68	67
Water	92	91	84	87	71	86	86
Clean latex gloves	32	42	30	20	23	24	30
Disinfecting solution	88	94	86	97	84	81	88
Sharps box	74	80	75	57	68	30	69
All items for infection control ⁴	23	31	17	12	4	11	18
Waste receptacle ³	33	27	34	21	13	36	31
All items plus waste receptacle for infection control	11	8	9	3	2	7	8
Items for pelvic examination							
Private room (complete privacy)	89	78	85	91	55	91	84
Either private room or screen (visual privacy)	94	93	91	97	65	97	92
No privacy	6	7	8	3	27	3	7
Examination bed ⁵	100	100	98	99	81	99	98
Examination light ⁶	99	98	85	72	68	93	87
Vaginal speculum	95	98	92	93	69	91	92
All furnishings and equipment for pelvic examination ⁷	83	75	67	65	46	75	70
All items for both infection control and pelvic examination	23	23	12	6	4	10	14
Number of facilities offering FP (weighted)	65	96	319	55	28	72	637

¹ Either private room or visual barrier, individual client health cards, written protocols for FP, and any visual aids for FP

² All items to support quality counseling, written RTI/STI protocols or guidelines, and visual aids for health education on RTI/STIs.

³ While important for infection control, and listed in the MoH maternity standards, this is not an item that has been commonly introduced so was not included in the aggregate for infection control.

⁴ Soap, water, clean latex gloves, disinfecting solution, and sharps box.

⁵ Any bed where a woman can lie down flat.

⁶ Examination light, flashlight, or other spotlight source.

⁷ Visual and auditory privacy (private room), examination bed, examination light, and vaginal speculum.

Table A-5.5 Availability of specific teaching and visual aids

Percentage of facilities where the indicated teaching tool or visual aid was available, by type of facility, Egypt SPA 2004

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Visual aids or teaching materials							
About specific methods of family planning	97	83	80	52	55	32	73
About RTI/STIs	32	22	26	7	11	3	21
About HIV/AIDS	5	4	6	6	3	3	5
Posters on family planning	80	83	73	51	61	43	69
Poster about hepatitis	4	2	3	0	0	0	2
Samples of different methods	95	91	85	78	76	55	82
Information for client to take home							
On family planning	97	95	93	85	73	44	87
On RTI/STIs	58	62	55	47	38	14	50
On HIV/AIDS	34	39	32	25	21	6	29
On hepatitis	2	9	0	0	8	0	2
Service protocols or guidelines							
Any reproductive health guidelines or protocols	49	48	39	13	36	17	37
WHO guidelines for syndromic approach	5	0	2	0	0	1	1
MOHP infection control guidelines	3	10	3	0	3	1	4
Number of facilities offering FP (weighted)	65	96	319	55	28	72	637

Table A-5.6 Location in facility where equipment for family planning services is processed for reuse

Percentage of facilities where family planning (FP) equipment is processed for reuse in the indicated location, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities where FP services equipment is processed in indicated area ¹			Number of facilities offering FP (weighted)
	FP service area	Main facility area	Outside facility/no processing FP equipment	
Type of facility				
GS hospital	94	6	0	65
MCH/urban HU	72	28	0	96
Rural HU	52	47	0	319
Mobile unit	27	72	1	55
Health office	64	17	8	28
NGO	31	69	1	72
Region				
Urban Governorates	78	19	2	71
Lower Egypt	63	36	1	312
Upper Egypt	40	59	0	253
Total	56	43	1	637

¹ Main facility area and FP service area may be one location in small facility

Table A-5.7 Level of sterilization/disinfecting capacity available in location where family planning equipment is processed for reuse

Highest level of processing for which the facility had functioning equipment, and knowledge of correct processing time and/or temperature and the percentage with written guidelines, at the site where family planning (FP) equipment is processed for reuse, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with equipment and knowledge of processing time/temperature for the indicated procedures			Percentage of facilities with written guidelines for sterilization or HLD procedures at processing site	Number of facilities offering FP (weighted)
	Dry heat or autoclave ¹	Boil/steam or chemical HLD ²	No procedure ³		
Type of facility					
GS hospital	66	23	11	33	65
MCH/urban HU	83	7	10	28	96
Rural HU	55	33	11	31	319
Mobile unit	82	4	14	14	55
Health office	40	26	34	21	28
NGO	47	35	18	11	72
Region					
Urban Governorates	71	8	21	45	71
Lower Egypt	62	29	9	32	312
Upper Egypt	58	26	16	15	253
Total	61	26	13	27	637

¹ Dry heat: temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 20 minutes, or automatic; autoclave: process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.

² Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes.

³ Either equipment or knowledge was lacking or facility does not process FP equipment.

Table A-5.8 Highest level of sterilization/disinfecting capacity available in family planning service area, for facilities that process equipment for reuse in the family planning service area

Among facilities processing family planning (FP) equipment for reuse in the family planning service area, highest level of processing for which the facility had functioning equipment, and knowledge of correct processing time and/or temperature and the percentage with written guidelines, by type of facility and region, Egypt SPA 2004

Background Characteristics	Among facilities processing family planning equipment in FP service area percentage with equipment and knowledge of processing time/temperature for the indicated procedures			Percentage of facilities with written guidelines for sterilization or HLD procedures at processing site	Number of facilities offering FP and processing equipment in FP service area
	Boil/steam or chemical HLD ²				
	Dry heat or autoclave ¹		No procedure ³		
Type of facility					
GS hospital	66	25	10	35	61
MCH/urban HU	88	7	5	33	69
Rural HU	59	34	7	34	167
Mobile unit	88	0	12	26	15
Health office	53	35	12	27	18
NGO	37	41	22	12	22
Region					
Urban Governorates	83	7	9	52	56
Lower Egypt	64	30	6	32	196
Upper Egypt	58	29	13	21	102
Total	65	26	9	32	354

¹ Sterilization: Dry heat: temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 20 minutes, or automatic; autoclave: process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.

² HLD processing: Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes.

³ Either equipment or knowledge was lacking or facility does not process FP equipment.

Table A-5.9 Details for storing processed equipment in family planning service area

Among facilities that process family planning (FP) equipment in the family planning service area and have processed equipment stored in the family planning service area, percentage where the indicated conditions were observed, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:				Number of facilities processing and storing items in FP service area (weighted) ³
	Sterile storage conditions ¹	Clean storage conditions ²	Processing date indicated on stored items	Sterile storage and processing date	
Type of facility					
GS hospital	7	62	8	4	61
MCH/urban HU	11	76	1	1	69
Rural HU	8	55	1	1	166
Mobile unit	0	82	0	0	15
Health office	0	39	0	0	18
NGO	29	42	21	21	21
Region					
Urban Governorates	8	76	6	4	55
Lower Egypt	11	54	4	3	196
Upper Egypt	4	62	1	0	100
Total	9	60	3	3	351

¹ Items are wrapped and sealed with time-steam-temperature (TST) sensitive tape, or are in a sterile/HLD box that clasps shut

² Items may be wrapped but not sealed, unwrapped on a tray under cloth, unwrapped on a tray in the sterilizer or autoclave, or sitting in disinfecting solution.

³ Many facilities had no equipment stored in the FP service area.

Table A-5.10 Availability of medicines for treating sexually transmitted infections

Percentage of facilities where the indicated medicine is available, and percentage with at least one treatment for each of the four sexually transmitted infections (STIs), by type of facility, Egypt SPA 2004

Medicine (illness treated)	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Provide RTI/STI service	88	87	79	82	64	86	81
Metronidazole (trichomoniasis)	72	69	62	13	19	3	51
Ceftriaxone (gonorrhea)	8	2	0	0	0	2	2
Ciprofloxacin (gonorrhea)	5	0	2	0	0	1	2
Doxycycline (chlamydia, syphilis)	4	0	3	0	0	1	2
Tetracycline (chlamydia, syphilis)	66	54	55	8	14	1	44
Erythromycin (chlamydia, syphilis)	13	25	19	0	8	1	15
Benzathine or Procaine Penicillin (syphilis)	82	78	75	9	17	2	60
At least one medicines for each indicated STI ¹	6	1	1	0	0	1	1
Nystatin suppository (candidiasis)	4	4	3	1	0	1	3
At least one medication for gonorrhea	10	2	2	0	0	2	3
At least one medication for chlamydia	72	68	61	8	14	1	50
At least one medication for syphilis	96	89	83	14	21	2	68
Number of facilities offering FP (weighted)	65	96	319	55	28	72	637

¹ At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis.

Table A-5.11 Availability of equipment and infrastructure for providing specific methods of contraception

Among facilities offering contraceptive methods containing estrogen, injectable methods, intrauterine devices (IUDs), or implants, percentage having the required equipment and infrastructure to provide the method safely, by type of facility, Egypt SPA 2004

Type of facility	Estrogen containing method		Injectables		IUD			Implants			
	Percentage with blood pressure apparatus ¹	Percentage with adult weight scale	Number of facilities offering method with estrogen (weighted)	Percentage with sterile needle and syringe ²	Number of facilities offering injectable method (weighted)	Percentage with items for IUD insertion ³	Percentage with all items for IUD and all quality conditions for pelvic examination ⁴	Number of facilities offering IUD (weighted)	Percentage with items for implant or implanon insertion ⁵	Percentage with all equipment, items for infection control, and infrastructure for implant or implanon insertion ⁶	Number of facilities offering implants (weighted)
GS hospital	89	82	65	90	65	25	11	65	16	16	26
MCH/urban HU	100	76	96	87	96	35	23	96	3	3	27
Rural HU	84	78	319	84	318	21	6	312	0	0	11
Mobile unit	100	23	55	81	55	14	6	55	0	0	10
Health office	79	45	28	74	26	10	4	25	0	0	4
NGO facility	95	75	63	84	61	26	11	71	45	45	4
Total	89	72	628	85	622	23	9	625	8	8	81

¹ Stethoscope and sphygmomanometer.

² Progesterone injectable supplied through the MoHP comes with an individual needle and syringe so this may reflect facilities where a stock of the injectable method was not available the day of the survey (2 percent of facilities). It is uncertain why the remaining 13 percent of facilities were reported as not having needles and syringes. It may be that needles and syringes are occasionally borrowed from the progesterone injectable packet.

³ Clean latex gloves, iodine antiseptic, speculum, forceps for holding gauze to clean cervix, tenacula and uterine sound (or IUD kit that includes a tenacula and uterine sound).

⁴ Equipment for IUD insertion, all infection control items (soap, water, clean latex gloves, disinfecting solution, and sharps box) and visual privacy, an examination bed and an examination light.

⁵ Forceps for grasping Norplant, local anesthetic (Xylocaine), scalpel with blade, sterile needle and syringe, sterile gloves and antiseptic for cleaning skin and sealed Implanon pack with disposable sterile applicator.

⁶ Equipment for implant, all infection control items (soap, water, disinfecting solution, and sharps box) and visual privacy, examination bed, and examination light.

Table A-5.12 Availability of specific items for intrauterine device

Among facilities that offer the intrauterine device (IUD) percentage that have each of the indicated supplies and pieces of equipment to support insertion and removal of IUD, by type of facility, Egypt SPA 2004

Item	Percentage by type of facility						
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	Total percentage
Clean or sterile latex gloves	46	50	44	30	30	29	42
Antiseptic solution	93	96	87	90	80	90	89
Sponge holding forceps	51	58	48	51	45	73	53
Speculum	95	98	94	93	78	93	94
Tenacula	94	98	93	93	78	92	93
Uterine sound	93	98	93	93	74	91	93
All basic items	18	25	25	12	33	20	23
Curved scissors	73	87	75	71	55	77	76
Crocodile forceps	51	62	51	47	42	52	52
Handling forceps	81	95	74	85	48	88	79
IUD method available	99	100	98	100	96	92	98
All items for insertion and removal plus method available	12	21	9	5	4	17	11
Number of facilities offering IUD (weighted)	65	96	312	55	25	71	625

Table A-5.13 Availability of specific items for implant

Among facilities that offer the implant method, percentage that have each of the indicated supplies and pieces of equipment by type of facility, Egypt SPA 2004

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Sterile gloves	38	25	29	51	14	87	35
Antiseptic solution	100	95	95	100	86	100	97
Sponge holding forceps	64	59	73	55	43	100	63
Local anesthetic	84	69	75	78	57	74	75
Sterile syringe and needle	83	81	86	73	14	87	79
Scalpel with blade	53	21	39	33	14	70	37
Two mosquito forceps	75	64	41	44	29	87	61
Any forceps	77	92	66	49	57	87	77
Canula and trochar for inserting implant plus							
Norplant method	11	0	0	0	0	0	4
Sealed Implanon pack	57	61	23	38	43	61	51
All items ¹	16	3	0	0	0	45	8
Number of facilities offering implants (weighted)	26	27	11	10	4	4	81

¹ Sterile gloves, antiseptic solution, sponge holding forceps, local anesthetic, sterile syringe and needle, scalpel with blade, any forceps, any implant method with inserter.

Table A-5.14 Facility utilization statistics for family planning clients

Median number of family planning (FP) consultations per month, by type of facility and region, Egypt SPA 2004

Background characteristics	Median number of family planning consultations ¹	Number of facilities providing consultation data (weighted)
Type of facility		
GS hospital	122	63
MCH/ urban HU	237	94
Rural HU	60	318
Mobile unit	153	52
Health office	116	26
NGO facility	48	56
Region		
Urban		
Governorates	143	64
Lower Egypt	90	303
Upper Egypt	68	242
Total	85	610

¹ Median value for the average of the number of months out of the past 12 months, for which data were available.

Table A-5.15 Information on user fees for family planning services

Percentage of facilities where the indicated practice for user fees is reported, and percentage where the indicated practices exist for publicly posting fees, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage charging for the indicated item						Number of facilities offering FP (weighted)	Percentage where fees are posted in public view			Number of facilities having any user fees for FP (weighted)
	Fixed fee for FP card	Fixed consult fee ¹	Charge for method	Charge for lab tests	Other	No charges/don't know		All fees posted	Some fees posted	No fees posted	
Type of facility											
GS hospital	0	11	97	10	1	3	65	66	5	28	63
MCH/ urban HU	0	4	99	16	0	1	96	78	1	21	95
Rural HU	0	1	97	4	0	2	319	59	1	40	314
Mobile unit	0	3	12	7	23	64	55	19	0	81	20
Health office	0	0	84	2	2	16	28	52	0	48	24
NGO facility	1	93	88	55	5	3	72	41	1	57	70
Region											
Urban											
Governorates	1	27	82	32	8	8	71	58	4	38	65
Lower Egypt	0	11	91	8	2	6	312	64	1	35	294
Upper Egypt	0	12	87	12	2	10	253	53	1	45	228
Total	0	13	88	12	3	8	637	59	1	39	587

¹ More than one fee system may apply.

Table A-5.16 Out-of-pocket payments for family planning services

Among observed and interviewed FP clients, percentage who reported paying any out-of-pocket fees for FP services on the day of the survey and, among the clients who paid any fees for services, median amount (piasters) paid on the day of the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed FP clients paying any out-of-pocket fees	Number of interviewed FP clients (weighted)	Median out-of-pocket payment (piasters) by FP clients who paid anything for FP services day of survey ¹	Number of interviewed FP clients providing valid responses for out-of-pocket payments (weighted) ²
Type of facility				
GS hospital	85	276	107	236
MCH/ urban HU	86	448	108	385
Rural HU	87	690	105	602
Mobile unit	7	260	106	18
Health office	73	80	108	58
NGO facility	92	173	510	159
Region				
Urban Governorates	66	304	200	200
Lower Egypt	80	925	107	742
Upper Egypt	74	700	107	519
Total ²	76	1,930	107	1,462

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

² Regional totals and total percentages include data from 4 observed and interviewed family planning clients from fever hospitals

Table A-5.17 Out-of-pocket payments for clients who received specific family planning procedures

Among observed and interviewed FP clients who received IUD insertion, IUD removal, injectable contraceptive, or a pelvic exam without another procedure, percentage who paid any out-of-pocket fees, and median amount (piasters) paid on the day of the survey, by the main procedure received, Egypt SPA 2004

Procedure	Percentage of clients who paid out-of-pocket fee	Median out-of-pocket fee paid by client receiving indicated procedure ¹	Number of cases who paid out-of-pocket fee	Total number of cases receiving procedure
IUD insertion ²	82	206	309	379
IUD removal	67	108	104	155
Injection	91	106	625	690
Pelvic exam ³	47	109	110	233

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

² May or may not include IUD removal as well

³ Clients who received a pelvic exam but did not also receive IUD procedure, injection, or implant are classified here.

Table A-5.18 Supportive management for providers of family planning services

Among interviewed family planning (FP) service providers, percentage who received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage				Number of interviewed FP service providers (weighted) ^{2,3}
	Received in-service training during past 12 months ¹	Personally supervised in past 6 months	Personally supervised during the past 6 months and received in-service training during the past 12 months	Most recent in-service training was 13-59 months preceding the survey	
Type of facility					
GS hospital	36	88	35	31	393
MCH/urban HU	30	92	27	46	241
Rural HU	20	98	19	33	474
Mobile unit	40	90	33	42	43
Health office	22	96	22	33	52
NGO facility	17	61	11	34	81
Region					
Urban Governorates	24	85	24	41	152
Lower Egypt	28	92	26	32	684
Upper Egypt	28	92	26	37	458
Total³	28	91	26	35	1,294

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.

² Includes only providers of family planning services in facilities offering family planning services.

³ Regional totals and total percentages include data from 11 interviewed family planning providers from fever hospitals

Table A-5.19 In-service training for family planning service providers

Among interviewed family planning (FP) service providers, percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed family planning providers who received in-service training ¹ on specific topics										Number of interviewed FP service providers (weighted) ^{2,3}
	Counseling on family planning		Counseling on any contraceptive technology		Counseling on basic training for service provision		Counseling on syndromic management of STIs		Any counseling or treatment topics for STIs		
	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	
Type of facility											
GS hospital	18	26	27	24	5	4	0	7	1	7	393
MCH/urban HU	18	49	15	45	1	1	2	8	4	6	241
Rural HU	14	29	11	22	2	7	1	11	4	7	474
Mobile unit	29	40	29	39	2	9	7	8	9	6	43
Health office	17	34	12	26	0	0	1	5	1	5	52
NGO facility	11	31	10	28	3	2	1	11	1	11	81
Region											
Urban Governorates	15	45	16	43	0	1	0	4	1	4	152
Lower Egypt	15	28	19	24	3	5	1	10	3	8	684
Upper Egypt	20	35	16	29	2	4	2	7	3	6	458
Total ³	17	32	18	28	2	4	1	9	3	7	1,294

¹ Structured in-service sessions (does not include individual instruction received during routine supervision)

² Includes only providers of family planning services in facilities offering family planning services.

³ Regional totals and total percentages include data from 11 interviewed family planning providers from fever hospitals

Table A-5.20 Supportive supervision for family planning service providers

Among interviewed family planning (FP) service providers, who were personally supervised in the past 6 months, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2004

Background characteristics	Median number of times staff were supervised in past 6 months	Percentage of providers reporting indicated activities of the supervisor during the last supervisory visit						Number of FP service providers who were supervised in the past 6 months (weighted) ^{1,2}
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Wrote note on unit record	
Type of facility								
GS hospital	7	100	91	85	70	82	97	345
MCH/urban HU	7	99	96	90	75	89	98	221
Rural HU	7	99	97	85	73	83	95	465
Mobile unit	7	98	97	89	74	86	93	39
Health office	6	99	99	86	79	85	82	50
NGO facility	6	96	88	81	69	85	88	49
Region								
Urban Governorates	7	99	98	94	82	90	97	129
Lower Egypt	7	99	95	90	76	83	97	630
Upper Egypt	7	99	93	78	66	83	92	421
Total ²	7	99	95	86	73	84	95	1,180

¹ Includes only providers of family planning services in facilities offering family planning services.

² Regional totals and total percentages include data from 11 interviewed family planning providers from fever hospitals

Table A-5.21 Description of observed family planning clients

Among observed family planning (FP) clients, percentage for whom this was the first visit for family planning at this facility, percentage for whom this was a followup visit, and percentage who have no prior pregnancy, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of observed FP clients			Number of observed family planning clients (weighted) ¹
	First visit	Followup visit	No prior pregnancy	
Type of facility				
GS hospital	31	69	0	276
MCH/ urban HU	31	69	1	448
Rural HU	22	78	1	690
Mobile unit	49	51	1	260
Health office	37	63	1	80
NGO facility	33	67	1	173
Region				
Urban Governorates	43	57	2	304
Lower Egypt	26	74	1	925
Upper Egypt	31	69	1	700
Total ¹	31	69	1	1,930

¹ Regional total and total percentages include data from 4 observed family planning clients from fever hospitals

Table A-5.22 Principal reason for visit, and user status for observed family planning clients

Among observed family planning (FP) clients, principal reason they came to the family planning service the day of the survey, and user status, Egypt SPA 2004

Principal reason for visit	Percentage of observed family planning clients with indicated status
Current user at clinic for:	
Re-supply current method/routine visit	42
Elective method change	5
Discuss problem with current method	17
Discuss non-FP health problem	1
Elective discontinuation of FP	6
Other/missing reason for user's visit	2
Nonuser	
Used method in past	17
Never used method	10
Other not determined reason for visit	0
Number of observed FP clients (weighted)	1,930

Table A-5.23 Method of choice for observed family planning clients

Among observed family planning (FP) clients, percentage for whom each of the indicated methods was provided, prescribed, or continued being used at the end of the visit, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage for whom indicated method was the main method either provided, prescribed, or discussed ¹							Number of observed and interviewed family planning clients (weighted) ³
	Oral contraceptive (OC)	Injectable (3 monthly) (PIN)	Injectable (2 monthly) (TIN)	Male condom	IUD	Implant	Other ²	
Type of facility								
GS hospital	17	40	0	2	30	4	1	276
MCH/ urban HU	11	32	0	2	43	2	0	448
Rural HU	19	53	0	2	22	1	0	690
Mobile unit	23	24	0	4	42	2	0	260
Health office	24	30	0	2	35	1	0	80
NGO facility	11	21	0	1	53	0	0	173
Region								
Urban Governorates	13	26	0	4	47	2	0	304
Lower Egypt	17	42	0	3	29	1	0	925
Upper Egypt	18	40	0	1	34	2	0	700
Total ³	17	39	0	2	34	2	0	1,930

¹ Four clients received two methods each (condom and combined pill, condom and IUD, etc.) for RTI/STI prevention and for contraception. An additional six clients received one method and were given a prescription for another method. These were, most often, clients who were using one method until it was feasible to start a new method (e.g., they had an appointment for IUD insertion).

² Other may include emergency contraception or rhythm or female sterilization.

³ Regional total and total percentages include data from 4 observed and interviewed family planning clients from fever hospitals

Table A-5.24 Conditions for counseling of observed family planning clients

Percentage of all observed family planning clients where the counseling portion was conducted under the indicated conditions, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility						Total percentage ²
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Visual privacy assured	72	75	72	76	78	81	74
Auditory privacy assured	72	74	71	76	78	79	74
Client was assured of confidentiality	26	16	18	21	16	27	20
All counseling conditions met ¹	14	4	11	12	1	20	10
Individual client card reviewed during consultation	63	68	72	53	78	52	66
Individual client card written on after consultation	66	81	82	68	86	60	76
Visual aids were used during consultation	11	9	6	3	10	8	7
Return visit was discussed	76	72	83	68	91	86	78
Number of observed FP clients (weighted) ²	276	448	690	260	80	173	1,930

¹ Visual and auditory privacy, confidentiality assured and client was asked about concerns of methods discussed or currently used.

² Include data from 4 observed family planning clients from fever hospitals

Table A-5.25 General assessments, examinations, and interventions for observed first-visit family planning clients

Percentage of observed first-visit family planning (FP) clients for whom the indicated assessment or examination was a component of their consultation, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Client history							
Age	78	87	78	80	91	93	83
Any history of pregnancy	87	88	92	87	91	95	89
Current pregnancy status	32	39	32	35	18	43	35
Desired timing for next child or desire for another child	23	30	17	25	18	49	26
Breastfeeding status	57	63	42	52	47	59	53
Regularity of menstrual cycle	88	85	74	77	93	90	82
All elements of reproductive history ¹	13	21	7	13	4	24	14
Client medical history							
Asked about smoking	0	0	1	1	2	6	1
Asked about symptoms of RTI/STIs	38	46	34	41	58	63	43
Asked about any chronic illnesses	52	50	36	46	57	63	47
All risk-history ²	0	0	0	0	2	6	1
Client examination							
Measure blood pressure	60	70	71	53	80	67	65
Measure weight	49	67	58	18	55	47	49
Take urine specimen	1	1	4	1	2	12	3
Take blood specimen	0	1	1	0	0	12	2
Number of first-visit FP clients (weighted)	85	139	155	126	29	58	593

¹ Age, any history of pregnancy, current pregnancy status, desired timing for next child or desire for another child and regularity of menstrual cycle.

² Asked about smoking, symptoms of STIs and any chronic illness.

Table A-5.26 General assessments, examinations, and interventions for observed first-visit family planning clients

Percentage of observed first-visit family planning (FP) clients for whom the indicated assessment or examination was a component of their consultation, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Counseling topics covered							
Husband attitude toward family planning	16	14	12	11	13	24	14
Husband status ¹	14	1	8	6	13	7	7
Either husband question	22	15	16	15	17	27	18
Discussion related to STIs and condoms							
Use of condoms to prevent STIs discussed	1	1	0	0	0	0	0
Use of condoms as dual method	0	1	0	0	0	0	0
Any discussion related to STIs ²	1	1	1	0	0	1	1
Individual client card reviewed during consultation	51	63	50	46	70	31	52
Individual client card written on after consultation	68	87	80	71	80	49	75
Visual aids were used during consultation	14	22	15	6	6	16	14
Client was assured of confidentiality	17	11	18	23	4	16	16
Number of first-visit FP clients (weighted)	85	139	155	126	29	58	593

¹ Asked if husband has other wife or about husband's absence.

² Risk of STIs discussed or use of condoms to prevent STIs or as dual method discussed.

Table A-5.27 Observed assessments of client who received injections or oral contraceptives with estrogen

Percentage of observed and interviewed family planning (FP) clients who received a contraceptive with estrogen, who had their blood pressure measured, and percentage who had their weight measured, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility						Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Examination specific to estrogen-based contraceptives							
Blood pressure measured	56	71	67	59	71	87	66
Weight measured	50	58	61	28	34	64	51
Number of clients receiving estrogen-based contraceptives (weighted)	43	43	111	55	16	18	289

Table A-5.28 Breast examination

Percentage of observed family planning (FP) clients who received a breast examination, percentage who were taught how to conduct a breast self-examination, and percentage who reported they were taught how to do a breast self-examination, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of observed FP clients			Number of observed and interviewed FP clients (weighted) ¹
	Provider conducted breast examination	Provider taught client how to do breast self-examination	Client reported provider taught how to do breast self-examination	
Type of facility				
GS hospital	0	4	4	276
MCH/ urban HU	1	10	11	448
Rural HU	0	5	5	690
Mobile unit	0	3	4	260
Health office	1	9	10	80
NGO facility	0	8	6	173
Region				
Urban Governorates	0	18	16	304
Lower Egypt	0	6	7	925
Upper Egypt	0	2	2	700
Total ¹	0	6	6	1,930

¹ Includes data from 4 observed and interviewed family planning clients from fever hospitals

Table A-5.29 Observed and reported client counseling related to injectable or oral contraceptives

Percentage of observed and interviewed family planning (FP) clients who received a hormonal contraceptive pill or injection where the indicated counseling item was observed being shared by the provider, or was reported by the client that they were told the information, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility						Total percentage ¹
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Provider was observed to explain the item to the client							
When to take	82	93	84	90	82	86	86
Side effects - menstrual changes	40	51	29	40	61	44	38
Side effects - non-menstrual changes	25	26	17	17	12	27	20
Any side effects	43	52	31	43	61	44	40
What to do if she forgets	35	36	23	29	16	32	28
Mentioned followup visit	87	90	93	71	90	93	89
No key point mentioned	8	3	4	2	5	0	4
1 key point mentioned	12	6	15	25	14	16	14
2 key point mentioned	30	33	46	29	27	35	38
3 key point mentioned	25	36	18	28	39	25	25
All key points mentioned	25	23	17	17	16	23	19
Client reported that the provider shared the indicated information							
Explained how to use the method	60	62	59	67	52	73	61
Explained about possible side effects	45	52	38	47	49	48	44
Explained what to do for problems	45	44	36	42	41	45	40
Mentioned followup visit	82	81	81	77	75	86	81
No key point mentioned	12	13	10	7	7	12	10
1 key point mentioned	26	19	31	30	33	8	27
2 key point mentioned	14	17	21	20	18	29	19
3 key point mentioned	13	15	12	8	19	18	13
All key points mentioned	35	35	26	35	23	33	30
For all pill and injection clients, percentage who knew correct response for question asked about method	99	100	98	99	99	98	99
Number of observed and interviewed FP pill/injection clients (weighted) ¹	157	193	495	121	43	54	1,066

¹ Includes four observed and interviewed FP pill/injection client from fever hospital.

Table A-5.30 Details on observed education provided and client knowledge regarding different methods of contraception other than pills or injections

Among clients who received condoms, IUD, or implants, the percentage who were observed being told critical information about the method, and percentage who, during the exit interview knew the correct response to a critical question asked about using their method, percentage of clients receiving condoms, IUD, or implants who reported they were instructed by the provider on how to use their method, about side effects, what to do for problems, and when to return for followup, Egypt SPA 2004

Components of consultation	Percentage observed and interviewed clients
Condom user: client was observed being told	
Asked about allergy to latex	15
Use one time	28
Leave space at top	71
About lubricant	7
Can use a backup method	28
About dual protection	20
Interviewed client received condom and knows to use condom only once	92
Number of clients receiving condom	46
IUD user : client was observed being told	
To check string	40
About possible heavy bleeding	44
Interviewed client received IUD and knows how to check IUD	80
Number of clients receiving IUD	651
Implant user : client was observed being told	
Implant is good for three/five years	55
Menstrual changes that might occur	51
Initial side effects that might occur	31
Interviewed client received implant and knows how long implant lasts	96
Number of clients receiving implants or prescription for implant	30
Summary of interviewed client responses	
Client knew the correct response for the survey question about their method	82
Client reported provider explained how to use the method	50
Client reported provider explained about possible side effects	58
Client reported provider explained what to do for problems	62
Client reported provider told about a followup visit	68
Client reported all four messages were provided	
No key point mentioned	16
1 key point mentioned	20
2 key points mentioned	11
3 key points mentioned	18
All key points mentioned	36
Number of other family planning clients (weighted) ¹	726

Note: Emergency contraception item is not included as no clients were observed using emergency contraception

¹ Other family planning clients are condom, IUD, and implant, users.

Table A-5.31 Client feedback on services

Percentage of observed and interviewed family planning (FP) clients who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2004

Client service issue	Percentage by type of facility						Total percentage ¹
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Behavior/attitude of provider not good	0	1	0	0	0	0	0
Inability to discuss concerns with provider	3	2	2	1	0	6	2
Explanation about methods or problems not sufficient	3	1	3	1	0	5	2
Poor quality of examination and treatment	2	1	2	0	1	5	2
Waiting time to see provider too long	7	9	3	0	1	6	5
Lack of availability of medicines or supplies	2	3	3	1	0	0	2
Opening hours of facility inconvenient	1	0	2	7	0	1	2
Lack of cleanliness of facility	0	0	2	1	0	0	1
Lack of visual privacy	0	0	1	0	0	0	0
Lack of auditory privacy	0	0	1	0	0	0	0
Cost is too high	0	1	0	0	0	1	0
Time too long between start and completion of consultation	1	1	1	0	0	0	1
Waiting time for laboratory results too long	1	0	0	0	0	2	0
Number of interviewed FP clients (weighted) ¹	276	448	690	260	80	173	1,930

¹ Includes data from 4 observed and interviewed family planning clients from fever hospitals

Table A-5.32 Reasons observed family planning clients chose this facility for services

Among observed and interviewed family planning (FP) clients, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of FP clients agreeing item was a factor in choosing facility								Number of interviewed FP clients (weighted) ¹
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well treated	Has the Gold Star	Facility is nearby	Good reputation	
Type of facility									
GS hospital	19	36	7	35	23	1	53	19	276
MCH/urban HU	45	26	4	34	29	1	40	18	448
Rural HU	15	18	1	36	26	0	71	15	690
Mobile unit	53	18	0	34	19	0	39	19	260
Health office	41	26	0	22	24	3	56	33	80
NGO	56	34	1	23	27	1	32	25	173
Region									
Urban Governorates	49	33	1	15	24	0	47	25	304
Lower Egypt	33	29	3	46	28	1	49	18	925
Upper Egypt	24	15	2	24	22	0	60	16	700
Total ¹	32	24	2	33	25	1	53	18	1,930

¹ Includes data from 4 observed and interviewed family planning clients from fever hospitals

Table A-5.33 Personal characteristics of family planning clients by employment status

Among family planning (FP) clients whose consultation was observed and who were interviewed, percent distribution by employment status, and among employed family planning clients, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2004

Background characteristics	Among all FP clients, percentage who are:		Number of interviewed FP clients (weighted) ¹	Among employed FP clients, percentage who:							Number of interviewed FP clients who are employed (weighted)
	Employed	Not employed		Work for:			Receive:				
				Family member	Someone else	Self	Salary in cash	Salary in kind	Salary both in cash and in kind	No salary	
Type of facility											
GS hospital	14	86	276	42	51	7	51	4	9	36	40
MCH/urban HU	13	87	448	9	70	20	79	0	12	9	58
Rural HU	19	81	690	63	25	12	27	3	7	62	129
Mobile unit	16	84	260	50	34	16	34	5	15	46	42
Health office	11	89	80	0	100	0	100	0	0	0	9
NGO	18	82	173	16	70	15	75	0	8	16	31
Region											
Urban Governorates	15	85	304	2	96	2	99	0	1	0	44
Lower Egypt	19	81	925	50	38	11	40	4	7	49	179
Upper Egypt	12	88	700	44	32	24	38	2	19	42	86
Total ¹	16	84	1,930	42	45	13	48	3	9	40	309

¹ Includes data from 4 observed and interviewed family planning clients from fever hospitals (none was employed)

Table A-5.34 Personal characteristics of family planning clients by education

Among observed and interviewed family planning clients, percentage indicating their education and literacy status as noted below, by type of facility and region, Egypt SPA 2004

Background characteristics	Among interviewed FP clients, percentage with:				Number of interviewed FP clients (weighted) ¹	Percentage of interviewed FP clients with primary or no education who:			Number of interviewed FP clients with primary or no education (weighted)
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write	Can read and write	
Type of facility									
GS hospital	49	7	12	32	276	81	2	17	156
MCH/urban HU	43	9	9	39	448	72	4	24	231
Rural HU	56	9	9	26	690	82	3	15	443
Mobile unit	50	11	10	30	260	76	10	14	157
Health office	40	7	9	44	80	85	0	15	38
NGO	29	8	14	49	173	66	10	23	64
Region									
Urban Governorates	40	7	9	44	304	70	3	28	142
Lower Egypt	41	9	10	40	925	76	4	20	468
Upper Egypt	60	9	11	21	700	82	5	12	480
Total ¹	48	9	10	33	1,930	78	5	18	1,091

¹ Includes data from 4 observed and interviewed family planning clients from fever hospitals, with two clients having primary or no education.

Chapter 6

Table A-6.1 Availability of antenatal care and other family health services on the day of the survey

Percentage of facilities offering antenatal care (ANC) on the day of the survey, and offering ANC and tetanus toxoid (TT) vaccine, ANC and family planning (FP), ANC and curative care for the sick child (SC), ANC and FP and SC services, and ANC and child immunization (EPI), on the day of the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering the indicated services the day of the survey						Number of facilities offering ANC (weighted) ¹
	ANC	ANC and TT vaccine	ANC and FP	ANC and SC	ANC and FP and SC services	ANC and EPI	
Type of facility							
GS hospital	69	14	69	68	68	4	53
MCH/ urban HU	70	42	68	68	68	18	94
Rural HU	70	28	70	62	62	6	307
Mobile unit	99	0	99	50	50	0	39
NGO facility	96	13	96	38	38	0	64
Region							
Urban Governorates	98	24	98	77	77	4	52
Lower Egypt	72	21	72	59	59	5	272
Upper Egypt	73	31	73	57	57	9	234
Total ¹	75	25	75	60	60	7	559

¹ Include data from two health offices offering ANC services.

Table A-6.2 Availability of antenatal care and tetanus vaccine services

Percentage of facilities offering ANC and tetanus toxoid (TT) vaccine the indicated number of days per week and percentage of facilities where TT vaccine is reported offered every day ANC is offered, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:								Number of facilities offering ANC (weighted) ²
	ANC services offered the indicated number of days per week ¹			Not offered	TT services offered the indicated number of days per week ¹			TT every day ANC is offered	
	1-2 days	3-4 days	5+ days		1-2 days	3-4 days	5+ days		
Type of facility									
GS hospital	35	1	63	28	59	1	12	31	53
MCH/ urban HU	19	13	68	0	44	13	43	66	94
Rural HU	41	3	56	4	71	1	22	49	307
Mobile unit	0	0	100	100	0	0	0	0	39
NGO facility	14	16	70	86	1	0	13	13	64
Region									
Urban Governorates	9	7	84	52	23	2	23	25	52
Lower Egypt	29	5	65	16	60	3	18	38	272
Upper Egypt	37	6	57	21	49	3	26	52	234
Total ²	31	6	64	22	52	3	22	43	559

¹ Some facilities offer the services less than one day per week
² Includes data from two health offices offering ANC services.

Table A-6.3 Availability of items to support quality antenatal care services

Percentage of facilities where the indicated items are in the ANC service area or adjacent to the consultation or examination room and the indicated medications are in the facility, by type of facility, Egypt SPA 2004

Items	Percentage by type of facility					Total percentage ¹²
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Items to support quality						
Individual client health cards	62	94	78	7	31	68
Written ANC protocols or guidelines	8	12	9	1	2	8
Written MOHP infection control guidelines	1	2	2	0	1	2
Visual aids for health education	17	38	20	0	4	19
All items to support quality counseling ¹	4	10	5	0	0	5
Group health education sessions	5	8	4	1	0	4
Items for infection control						
Soap	53	46	43	70	71	50
Water	85	69	79	87	85	79
Clean latex gloves	18	25	23	22	23	23
Disinfecting solution	57	54	64	96	82	66
Sharps box	75	80	70	50	29	66
All items for infection control ²	3	9	11	11	10	10
Covered waste receptacle with plastic liner ³	25	25	23	24	39	25
All items for infection control plus waste receptacle	0	3	4	3	8	4
Physical examination						
Visual and auditory privacy ⁴	96	88	81	94	90	86
Visual privacy ⁵	100	95	89	96	97	93
No privacy	0	5	10	4	2	7
Examination bed ⁶	94	91	88	100	99	91
Examination light ⁷	64	45	56	72	93	60
All elements for physical examination ⁸	59	42	44	72	82	52
All elements for physical examination and specific components for infection control present ⁹	4	9	9	13	11	9
Essential supplies for basic ANC						
Blood pressure apparatus	80	88	85	100	96	87
Fetoscope (Pinard)	58	69	50	34	75	56
Iron tablets ¹⁰	67	69	67	9	3	56
Folic acid tablets ¹⁰	38	64	48	3	3	42
Iron and folic acid combined tablet	38	62	47	1	3	40
Tetanus toxoid vaccine	41	90	60	0	13	54
All basic ANC equipment and medicines ¹¹	10	40	19	0	0	18
Number of facilities offering ANC (weighted) ¹²	53	94	307	39	64	559

¹ Individual client health cards, written ANC protocols or guidelines, and visual aids for health education.

² Soap, water, gloves, disinfecting solution for decontaminating reusable items, and sharps box

³ While important for infection control, and listed in the MOH maternity standards, this is not an item that has been commonly introduced and thus was not included in the aggregate for infection control.

⁴ Private room

⁵ Private room or room with screen or curtain that can be pulled for visual privacy.

⁶ May be any type of bed where woman can lie down flat.

⁷ May be examination light, flashlight or other spotlight source

⁸ Visual and auditory privacy, examination light, bed.

⁹ Visual and auditory privacy, examination light, bed, and all infection control items, excluding sharps box.

¹⁰ Iron and folic acid may be separate tablets, or one combined tablet.

¹¹ Blood pressure apparatus, fetoscope, iron and folic acid, tetanus toxoid vaccine.

¹² Regional totals and total percentages include data from two health offices offering ANC services

Table A-6.4 Availability of specific medicines and protocols for antenatal care services

Percentage of facilities with indicated medicines for managing common complications during pregnancy, percentage that routinely provide the indicated medicine or test as a component of ANC, and percentage with a thermometer and an infant scale for PNC, by type of facility and region, Egypt SPA 2004

Items	Percentage by type of facility					Total percentage ⁴
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Medicines for managing common complications during pregnancy						
Antibiotic ¹	91	85	79	14	3	68
Mebendazole (antihelminth)	76	74	72	10	2	60
Metronidazole (trichomoniasis)	73	67	61	19	3	54
Ceftriaxone (gonorrhoea)	8	1	0	0	2	1
Ciprofloxacin (gonorrhoea)	5	0	2	0	2	2
Any medication for gonorrhoea	10	1	3	0	2	3
Doxycycline (chlamydia, syphilis)	5	0	4	0	2	3
Tetracycline (chlamydia, syphilis)	70	53	59	13	2	49
Erythromycin (chlamydia, syphilis)	14	25	20	0	2	16
Any medication for chlamydia	75	67	65	13	2	55
Penicillin (syphilis)	85	84	79	10	2	67
Any medication for syphilis	100	91	88	17	2	75
All medicines for sexually transmitted infections ²	6	1	1	0	2	2
Nystatin suppository	5	5	3	1	2	3
Methyldopa (aldomet)	7	4	2	0	2	2
All medicines for ANC complications ³	1	0	0	0	2	0
Routine ANC service						
Prescribe RTI/STI treatment by ANC providers	90	89	74	81	85	80
Test blood for anemia	88	100	92	0	39	80
Test urine for protein	85	100	91	1	37	79
Test urine for sugar	85	99	93	3	38	81
Test for blood group	31	59	15	0	25	24
Test Rh factor	54	84	42	0	48	48
Test for blood group and Rh factor	29	55	14	0	25	23
Ultrasound investigation	13	25	2	26	5	9
Routine discussion about family planning	43	50	55	54	52	52
Equipment related to postnatal care						
Thermometer	60	62	66	7	62	60
Infant scale	54	71	78	0	16	62
Number of facilities offering ANC (weighted) ⁴	53	94	307	39	64	559

¹ Amoxicillin or cotrimoxazole
² At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis
³ At least one broad-spectrum antibiotic, at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis, mebendazole, and nystatin suppository are all present
⁴ Includes data from two health offices offering ANC

Table A-6.5 Facility capacity to provide anemia screening with antenatal care

Percentage of facilities with the capacity to test for anemia, percentage where the facility has a standard to routinely screen ANC clients for anemia, and percentage where the facility routinely tests ANC clients for anemia and testing capacity for anemia exists, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct anemia test ¹	Facility has standard to screen ANC clients for anemia	Facility has standard to screen ANC clients for anemia and facility has capacity to conduct anemia test	
Type of facility				
GS hospital	92	88	80	53
MCH/ urban HU	88	100	88	94
Rural HU	85	92	83	307
Mobile unit	1	0	0	39
NGO facility	56	39	38	64
Region				
Urban Governorates	68	62	57	52
Lower Egypt	80	85	77	272
Upper Egypt	76	79	69	234
Total	77	80	72	559

¹ Any anemia test. Specific tests assessed where use of hemoglobinometer or calorimeter (did not include presence or absence of drabkin solution), centrifuge and capillary tubes for hematocrit, or any of the blotting paper tests.

² Include data from two health offices offering ANC

Table A-6.6 Facility capacity to provide test for urine protein with antenatal care

Percentage of facilities with the capacity to test urine for protein, percentage where the facility has a standard to routinely screen ANC clients for urine protein, and percentage where the facility has the capacity for urine protein and routinely tests ANC clients for urine protein by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities offering ANC (weighted) ²
	Facility offers ANC and has capacity to conduct urine protein test ¹	Facility has standard to screen ANC clients for urine protein	Facility has standard to screen ANC clients for urine protein and facility has capacity to conduct urine protein test	
Type of facility				
GS hospital	80	85	69	53
MCH/ urban HU	81	100	81	94
Rural HU	69	91	67	307
Mobile unit	1	1	1	39
NGO facility	55	37	35	64
Region				
Urban Governorates	67	63	55	52
Lower Egypt	67	82	64	272
Upper Egypt	63	80	58	234
Total ²	65	79	61	559

¹ Clinistix (Campus 3 or Campus 9 sticks) or flame, acetic acid and test tube for testing urine albumin.

² Regional totals and total percentages include data from two health offices offering ANC.

Table A-6.7 Facility capacity to provide test for urine glucose with antenatal care

Percentage of facilities with the capacity to test urine for glucose, percentage where the facility has a standard to routinely screen ANC clients for urine glucose, and percentage where the facility has the capacity for urine glucose and routinely tests ANC clients for urine glucose by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct urine glucose test ¹	Facility has standard to screen ANC clients for urine glucose	Facility has standard to screen ANC clients for urine glucose and facility has capacity to conduct urine glucose test	
Type of facility				
GS hospital	62	85	55	53
MCH/ urban HU	75	99	74	94
Rural HU	63	93	62	307
Mobile unit	1	3	1	39
NGO facility	51	38	32	64
Region				
Urban Governorates	66	66	55	52
Lower Egypt	60	85	59	272
Upper Egypt	57	79	52	234
Total ²	59	81	55	559

¹ Dipstix (Campus 3 or Campus 9) were assessed.

² Regional totals and total percentages include data from two health offices offering ANC

Table A-6.8 Facility routinely provides blood grouping with Rh factor with antenatal care

Percentage of facilities with the capacity to determine blood group and Rh factor, percentage where the facility has a standard to routinely offer blood grouping and Rh factor determination for ANC clients, and percentage where the facility has a standard to routinely offer the blood grouping and Rh factor determination to ANC clients and laboratory capacity to conduct test exists, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct blood grouping and Rh factor test ¹	Facility has standard to offer blood grouping and Rh factor test to ANC clients	Facility has standard to offer blood group and Rh factor test for ANC clients and facility has capacity to conduct blood grouping and Rh test	
Type of facility				
GS hospital	54	29	26	53
MCH/ urban HU	63	55	45	94
Rural HU	17	14	11	307
Mobile unit	0	0	0	39
NGO facility	33	25	22	64
Region				
Urban Governorates	51	29	24	52
Lower Egypt	30	20	19	272
Upper Egypt	23	24	17	234
Total ²	29	23	19	559

¹ Anti-A, Anti-B, and Anti-D blood grouping materials. Information on glass slides, also important for the test, was missing, however, based on 2002 findings, essentially all facilities with reagents for blood grouping also had glass slides.

² Include data from two health offices offering ANC.

Table A-6.9 Facility capacity to conduct ultrasound examination with antenatal care

Percentage of facilities with an ultrasound machine, percentage with a provider trained in obstetric ultrasound, and percentage with both the ultrasound machine and a trained provider, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ¹
	Facility has ultrasound machine	Facility has trained provider in obstetric ultrasound	Facility has both ultrasound machine and trained provider	
Type of facility				
GS hospital	33	53	33	53
MCH/ urban HU	61	65	61	94
Rural HU	13	9	7	307
Mobile unit	93	76	72	39
NGO facility	19	18	18	64
Region				
Urban Governorates	56	57	52	52
Lower Egypt	26	24	21	272
Upper Egypt	27	27	22	234
Total ¹	29	28	24	559

¹ Regional totals and total percentages include data from two health offices ANC

Table A-6.10 Statistics on utilization of antenatal care and postnatal care services for facilities in ESPA

Median average monthly antenatal care (ANC) clients (new and repeat) and median average monthly postnatal care (PNC) clients for the 12 months preceding the survey, by type of facility, Egypt SPA 2004

Type of facility	Median monthly ANC visits	Number of facilities reporting ANC data ¹ (weighted)	Median monthly PNC visits	Number of facilities reporting PNC data ¹ (weighted)
GS hospital	98	40	113	32
MCH/urban HU	230	94	181	77
Rural HU/Other	54	301	50	251
Mobile unit	22	12	-	1
NGO	9	18	5	6
Total ¹	68	466	65	368

¹ Includes data from two health offices reporting ANC and PNC data

Table A-6.11 Information on user fees for antenatal care service

Percentage of facilities that have user fees for ANC and percentage where the indicated practices exist for publicly posted fees, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities charging for indicated items							Number of facilities providing services (weighted)	Percentage posting fees publicly			Number of facilities having any routine fees for ANC services (weighted) ¹
	Fixed fee for ANC/health card	Fixed fee for each consult	Fixed fee for all ANC services	Fixed fee for all ANC visits plus delivery	Charge for medicines and tests	Other routine charges	No charges or don't know		All fees posted	Some fees posted	No fees posted	
Type of facility												
GS hospital	1	19	0	2	10	6	71	53	22	4	74	16
MCH/urban HU	5	4	2	4	2	13	78	94	17	3	80	21
Rural HU/Other	0	3	0	0	1	1	95	307	14	0	86	14
Mobile unit	0	7	0	0	3	51	41	39	26	0	74	23
NGO	9	88	9	3	33	13	1	64	42	4	54	63
Region												
Urban												
Governorates	13	37	5	6	23	32	27	52	36	7	57	38
Lower Egypt	0	9	1	1	5	8	83	272	37	0	63	46
Upper Egypt	2	17	1	1	3	4	77	234	21	2	77	53
Total ¹	2	15	1	1	6	8	75	559	30	3	67	137

¹ Regional totals and total percentages include data from two health offices offering ANC services

Table A-6.12.1 Out-of-pocket payments for antenatal care services-first-visit clients

Among first-visit ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (piasters) paid on the day of the survey, by type of facility, Egypt SPA 2004

Type of facility	Percentage of interviewed first-visit ANC clients paying any out-of-pocket fees	Number of interviewed first-visit ANC clients (weighted)	Median out-of-pocket payment (piasters) by first-visit ANC clients who paid anything for ANC services day of survey ¹	Number of interviewed first-visit ANC clients providing valid responses for out-of-pocket payments (weighted) ²
GS hospital	63	85	119	53
MCH/urban HU	52	136	110	70
Rural HU	41	160	109	66
Mobile unit	64	66	505	42
NGO facility	96	40	1,000	38
Total	56	489	307	272

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

² Includes data from 3 clients who received ANC from health offices.

Table A-6.12.2 Out-of-pocket payments for antenatal care services-followup clients

Among followup ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (piasters) paid on the day of the survey, by type of facility, Egypt SPA 2004

Type of facility	Percentage of interviewed followup visit ANC clients paying any out-of-pocket fees	Number of interviewed followup visit ANC clients (weighted)	Median out-of-pocket payment (piasters) by followup visit ANC clients who paid anything for ANC services day of survey ¹	Number of interviewed followup visit ANC clients providing valid responses for out-of-pocket payments (weighted)
GS hospital	42	47	114	20
MCH/ urban HU	56	197	107	111
Rural HU	33	240	106	77
Mobile unit	56	14	505	8
NGO facility	88	41	606	36
Total	47	539	108	252

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

Table A-6.13 Supportive management for providers of ANC

Among interviewed antenatal care (ANC) service providers, percentage who received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed ANC providers who:				
	Received in-service training during past 12 months ¹	Personally supervised in past 6 months	Personally supervised during past 6 months and received in-service training during the past 12 months	Most recent in-service training was 13-59 months preceding survey	Number of interviewed ANC providers (weighted) ^{2,3}
Type of facility					
GS hospital	13	84	10	41	226
MCH/ urban HU	28	89	23	31	329
Rural HU	18	98	17	34	472
Mobile unit	44	88	34	32	27
NGO facility	18	63	8	29	65
Region					
Urban Governorates	20	81	17	36	117
Lower Egypt	23	90	18	27	552
Upper Egypt	18	92	16	43	453
Total ²	20	90	17	34	1,121

¹This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.

² Regional totals and total percentages include one provider from health offices where ANC is provided

³ Includes only providers of ANC services in facilities offering ANC services

Table A-6.14.1 Supportive management: In-service training for antenatal care service providers

Among interviewed antenatal care (ANC) service providers, percentage who received in-service training¹ on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed ANC providers who received in-service training on specific topics														Number of interviewed ANC service providers (weighted) ^{4,5}
	Basic training for service provision		ANC service		ANC counseling		Risk pregnancies		Lifesaving skills		PMTCT ²		PNC ³		
	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	
Type of facility															
GS hospital	0	1	4	11	3	11	4	12	5	14	1	11	3	11	226
MCH/ urban HU	0	1	6	15	3	12	8	13	7	3	2	7	4	10	329
Rural HU	0	1	5	13	4	11	4	10	1	5	2	4	4	9	472
Mobile unit	2	4	7	8	7	9	8	8	2	1	6	5	7	7	27
NGO facility	1	2	6	12	6	9	5	13	1	2	2	10	4	6	65
Region															
Urban															
Governorates	0	1	7	14	3	10	4	11	2	4	1	4	3	6	117
Lower Egypt	0	0	5	11	4	9	6	10	4	2	2	8	4	8	552
Upper Egypt	0	3	5	16	4	13	4	13	4	11	1	6	3	12	453
Total⁴	0	1	5	13	4	11	5	11	4	6	2	7	4	9	1,121

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.

² Prevention of mother-to-child transmission (PMTCT) for HIV/AIDS.

³ Postnatal care (PNC)

⁴ Regional totals and total percentages include one provider from health offices where ANC is provided.

⁵ Includes only providers of ANC services in facilities offering ANC services

Table A-6.14.2 In-service training for antenatal care service providers

Among interviewed antenatal care (ANC) service providers, percentage who received in-service training¹ on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed ANC providers who received in-service training on specific topics						Number of interviewed ANC service providers (weighted) ^{2,3}
	Family planning		STI		Breastfeeding		
	12m	13-59m	12m	13-59m	12m	13-59m	
Type of facility							
GS hospital	7	23	1	8	3	11	226
MCH/ urban HU	12	20	0	7	4	9	329
Rural HU	11	23	1	2	2	9	472
Mobile unit	36	38	9	3	2	2	27
NGO facility	15	27	1	9	1	6	65
Region							
Urban							
Governorates	8	31	1	3	5	5	117
Lower Egypt	12	18	2	7	2	9	552
Upper Egypt	12	27	1	4	3	10	453
Total²	11	23	1	5	3	9	1,121

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.

² Regional totals and total percentages include one provider from health offices where ANC is provided.

³ Includes only providers of ANC services in facilities offering ANC services

Table A-6.15 Supportive supervision for antenatal care service providers

Among interviewed antenatal care (ANC) service providers who were personally supervised during the past 6 months, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2004

Background characteristics	Median number of times staff were supervised in past 6 months	Percentage of providers reporting the indicated activities of the supervisor during the last supervisory visit						Number of ANC service providers who were supervised in past 6 months (weighted) ^{1,2}
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Wrote on unit note	
Type of facility								
GS hospital	7	95	84	72	59	77	93	191
MCH/ urban HU	7	97	97	91	77	87	93	292
Rural HU	7	99	96	87	73	79	97	462
Mobile unit	7	97	95	83	68	83	91	24
NGO facility	6	98	88	82	64	82	87	41
Region								
Urban Governorates	10	99	98	93	76	89	94	94
Lower Egypt	7	98	97	93	76	80	99	499
Upper Egypt	7	97	89	74	64	81	89	419
Total ¹	7	98	94	85	71	81	94	1,012

¹ Regional totals and total percentages include one provider from health offices where ANC is provided

² Includes only providers of ANC services in facilities offering ANC services

Table A-6.16 Characteristics of observed antenatal care clients

Among ANC clients whose consultation was observed, percentage for whom this was their first ANC visit, percentage for whom this was a followup ANC visit, percentage who were estimated to be less than 5 months pregnant, at least 5 months pregnant, and at least 8 months pregnant, by type of facility and region, Egypt SPA 2004

Background characteristics	Characteristics of observed ANC clients						Number of observed ANC clients (weighted) ¹
	First ANC visit for this pregnancy	Followup ANC visit ¹	First pregnancy	Month of pregnancy			
				< 5m	≥ 5m	≥ 8m	
Type of facility							
GS hospital	64	36	45	30	70	23	132
MCH/ urban HU	41	59	38	30	70	26	334
Rural HU	40	60	36	22	78	17	400
Mobile unit	83	17	35	33	67	26	79
NGO facility	49	51	33	45	55	18	81
Region							
Urban Governorates	48	52	37	39	61	25	188
Lower Egypt	41	59	37	23	77	22	402
Upper Egypt	53	47	38	29	71	19	439
Total ¹	48	52	38	28	71	21	1,029

¹ Regional totals and total percentages include 3 observed ANC clients from health offices

Table A-6.17 General assessments, examinations, and interventions for observed first-visit ANC clients

Among first-visit antenatal care (ANC) clients whose consultation was observed, percentage where the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Prior history and client characteristics						
Client age	73	87	85	70	92	82
Date of last menstrual period	90	92	92	88	98	92
Any aspects related to prior pregnancy ¹	71	80	82	79	84	79
Any aspects of complications during prior pregnancy (if had prior pregnancy) (N=273)	54	73	75	35	84	66
Medications client currently taking	33	55	21	51	72	41
All relevant elements for client history ²	23	34	13	25	57	26
Laboratory tests and examinations						
Measure blood pressure	69	98	90	80	95	88
Urine test	34	85	73	13	48	59
Blood test	26	81	69	8	34	54
Preventative interventions						
Give or prescribe iron tablets	30	55	40	22	61	42
Give or prescribe tetanus toxoid vaccine	35	47	67	10	11	44
Number first-visit ANC clients (weighted) ³	85	136	160	66	40	489
Among women with prior pregnancies, specific prior complications discussed:						
Stillbirth	18	33	20	1	17	20
Infant mortality first one week after birth	10	33	16	0	8	16
Severe bleeding during labor or postpartum	10	28	8	4	22	14
Assisted delivery	38	60	41	21	66	45
Previous abortion	43	71	69	29	67	59
Number observed first-visit ANC clients with prior pregnancy (weighted) ⁴	44	69	95	39	24	273

¹ This includes any questions that would indicate whether the client had a prior pregnancy.

² Client age, last menstrual period, medicines, any prior pregnancy, and, if there was a prior pregnancy, any questions related to complications during prior pregnancies

³ Three of the observed ANC clients at health office were first-visit clients.

⁴ One of the observed ANC clients at health office was a first-visit client with prior pregnancy.

Table A-6.18 Assessment of current health status for all observed antenatal care clients

Among antenatal care (ANC) clients whose consultation was observed, percentage where the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility					Total percentage ²
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Client questioned regarding						
Vaginal bleeding (asked or counseled)	26	36	12	27	38	25
Fetal movement (at least 5 months pregnant)	51	77	51	75	73	62
Any other problems	66	74	61	79	83	69
Basic physical examination						
Measured blood pressure	77	99	94	81	95	93
Palpated abdomen for fetal position (at least 8 months pregnant)	52	53	46	79	73	55
Either palpated abdomen or ultrasound (at least 8 months pregnant)	60	60	47	92	96	62
Listened for fetal heart (at least 5 months pregnant)	24	23	15	2	37	19
All questions and basic examination ¹	14	28	4	9	25	15
Ultrasound examination	4	4	1	22	9	5
All questions and basic examination plus ultrasound	0	1	0	0	0	0
Additional physical examinations						
Measured weight	61	95	89	25	64	80
Palpated or measured fundal height	46	53	40	53	53	47
Palpate or measure fundal height or ultrasound	49	55	41	57	58	49
Laboratory tests						
Urine test	39	67	70	12	43	58
Blood test	34	63	65	7	34	53
Preventative interventions						
Give or prescribe iron tablets	32	53	44	28	52	45
Give or prescribe tetanus toxoid vaccine	35	36	51	10	7	37
Counseled on risk: vaginal bleeding	26	36	12	27	38	25
Number of observed ANC clients at least 5 months pregnant (weighted)	92	233	312	53	44	735
Number of observed ANC clients at least 8 months pregnant (weighted)	30	87	66	21	14	218
Number of observed ANC clients (weighted) ²	132	334	400	79	81	1,029

¹ Client was questioned regarding vaginal bleeding, fetal movement (if at least 5 months pregnant), blood pressure was measured, abdomen was palpated or ultrasound performed (if at least 8 months pregnant), and provider listened for fetal heart (if at least 5 months pregnant).

² Includes 3 observed first-visit ANC clients from health offices

Table A-6.19 Components of standard antenatal care received by first-visit clients

Among first-visit antenatal care (ANC) clients whose consultation was observed, percentage for whom the indicated number of standard ANC items (measure blood pressure, counsel on risk sign of vaginal bleeding or asking about vaginal bleeding, test urine) were components of this ANC visit, and percentage for whom the three routine components plus a blood test were components of first-visit client assessments, by client status and type of facility, Egypt SPA 2004

Background characteristics	Percentage for whom indicated number of standard ANC activities were provided					Number of observed first-visit ANC clients (weighted) ²
	0	1	2	3	All three elements plus blood test ⁴	
Type of facility						
GS hospital	15	53	23	9	5	85
MCH/ urban HU	1	8	62	29	29	136
Rural HU	6	22	67	5	5	160
Mobile unit	15	50	32	2	1	66
NGO facility	2	32	38	28	23	40
Region						
Urban Governorates	1	12	49	39	35	90
Lower Egypt	6	33	53	7	6	166
Upper Egypt	10	31	50	9	8	234
Total ²	7	28	51	14	13	489

¹ Counsel on vaginal bleeding or ask about vaginal bleeding, measure blood pressure, test urine, and test blood.
² Regional totals and total percentage includes 3 observed first-visit ANC clients from health offices.

Table A-6.20 Components of standard antenatal care received by all observed clients

Among ANC clients whose consultation was observed, percentage for whom the indicated number of components of standard ANC (measure blood pressure, counsel on risk sign of vaginal bleeding, test urine) were components of this ANC visit by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage for whom indicated number of standard ANC activities were provided				Number of observed ANC clients (weighted) ¹
	0	1	2	3	
Type of facility					
GS hospital	12	46	31	11	132
MCH/ urban HU	1	21	55	24	334
Rural HU	3	26	64	7	400
Mobile unit	15	52	30	3	79
NGO facility	4	39	36	22	81
Region					
Urban Governorates	1	19	43	38	188
Lower Egypt	3	28	60	9	402
Upper Egypt	7	36	49	8	439
Total ¹	4	30	52	14	1,029

¹ Regional totals and total percentage includes 3 observed first-visit ANC clients from health offices.

Table A-6.21 Observation of health education for iron tablets and tetanus toxoid vaccine

Among antenatal care (ANC) clients whose consultation was observed and who received the indicated item (or received a prescription for the item), percentage for whom the provider explained why the item was important, percentage for whom the provider explained how to take the medicine, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage receiving iron or folic acid		Number of ANC clients who received iron or folic acid (weighted) ¹	Percentage receiving tetanus toxoid vaccine for whom provider explained purpose	Number of ANC clients who received tetanus toxoid vaccine (weighted) ¹
	Provider explained purpose	Provider explained how to take			
Type of facility					
GS hospital	26	61	43	8	47
MCH/ urban HU	39	75	177	4	122
Rural HU	29	56	174	10	202
Mobile unit	51	77	22	22	8
NGO facility	63	85	42	42	6
Region					
Urban Governorates	52	88	134	9	53
Lower Egypt	30	43	168	11	180
Upper Egypt	30	76	156	6	152
Total ¹	36	68	459	9	385

¹ Regional totals and total percentages include 1 observed ANC client from health offices

Table A-6.22 Observed content of ANC counseling for first visit and followup visit clients

Percentage of first visit and followup visit ANC clients who were observed to receive counseling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, by type of facility, Egypt SPA 2004

Counseling topic	Percentage by type of facility					Total percentage ¹
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
First-visit ANC client						
Nutrition	25	44	33	38	61	38
Progress of pregnancy	41	64	29	56	73	48
Any risk symptoms for seeking help	8	14	10	12	17	12
Specific risk: vaginal bleeding	6	7	4	6	8	6
Specific risk: fever	0	4	3	0	6	3
Specific risk: short breath; excess tired	0	5	6	2	4	4
Specific risk: swelling hands or face	2	6	5	5	2	5
Specific risk: headache or blurred vision	1	5	7	3	9	5
Delivery plans	5	7	5	15	20	8
Exclusive breastfeeding	1	1	0	2	3	1
Family planning after birth	1	2	4	9	11	5
Provider used any visual aids	0	2	4	1	2	2
Number of first-visit ANC clients (weighted) ¹	85	136	160	66	40	489
Followup visit ANC client						
Nutrition	41	56	37	43	50	46
Progress of pregnancy	65	64	33	42	82	51
Any risk symptoms for seeking help	27	22	17	16	3	18
Specific risk: vaginal bleeding	21	7	6	0	3	7
Specific risk: fever	0	2	3	0	0	2
Specific risk: short breath; excess tired	3	7	4	12	0	5
Specific risk: swelling hands or face	18	17	9	4	2	12
Specific risk: headache or blurred vision	21	17	9	0	2	12
Delivery plans	14	10	7	32	8	9
Exclusive breastfeeding	3	1	2	0	4	2
Family planning after birth	3	6	5	4	11	6
Provider used any visual aids	0	1	1	0	0	1
Number of followup visit ANC clients (weighted)	47	197	240	14	41	539

¹ Total percentage includes 3 observed first-visit ANC clients from health offices

Table A-6.23 Observed content of ANC counseling for all clients

Percentage of ANC clients who were observed to receive counseling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, by governorate, Egypt SPA 2004

Counseling topic	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Nutrition	89	36	27	42
Progress of pregnancy	84	40	45	50
Any risk symptoms for seeking help	4	24	12	15
Specific risk: vaginal bleeding	2	7	8	6
Specific risk: fever	0	4	1	2
Specific risk: short breath; excess tired	1	8	2	4
Specific risk: swelling hands or face	1	18	3	9
Specific risk: headache or blurred vision	1	17	5	9
Delivery plans	19	7	6	9
Exclusive breastfeeding	4	2	0	1
Family planning after birth	8	6	3	5
Provider used any visual aids	0	2	1	1
Number of observed ANC clients (weighted)	188	402	439	1,029

Table A-6.24 Reported health education received and knowledge related to warning signs during pregnancy

Percentage of observed and interviewed antenatal care (ANC) clients who stated that a provider had mentioned any warning signs for pregnancy, percentage who named any of the indicated symptoms as warning signs, percentage who indicated what they were told to do if they experienced any warning sign, percentage who stated that a provider had discussed exclusive breastfeeding, the percentage of clients who reported they were advised to exclusively breastfeed for at least 6 months, percentage of clients who said they were asked about their delivery plans, percentage who were told of items to prepare for delivery, and percentage with whom family planning was discussed during this visit or a previous visit, by type of facility, Egypt SPA 2004

Issue discussed during current/ previous visit	Percentage by type of facility					Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	NGO facility	
Counseling on risk signs						
Client said provider mentioned any warning signs	18	33	31	16	28	29
Warning signs mentioned by client						
Bleeding	9	9	15	9	14	12
Fever	0	4	5	2	9	4
Swollen face or hands	10	19	17	11	13	16
Tiredness or breathlessness	1	15	11	1	4	9
Headache or blurred vision	10	16	13	4	10	13
What client was told to do if warning sign occurs						
Seek care at facility	15	28	33	3	22	26
Decrease activity	4	7	1	6	5	4
Change diet	1	2	0	4	3	1
Client reported provider discussed						
Exclusive breastfeeding	1	3	10	3	6	5
Exclusive breastfeeding for 6 months	0	1	5	2	4	3
Delivery plans	11	8	8	12	13	9
Supplies to prepare for delivery	0	0	3	2	2	1
Using family planning after birth	3	6	12	13	11	9
Number of interviewed ANC clients (weighted) ¹	132	334	400	79	81	1,029

¹ Total percentages include 3 interviewed ANC clients from health offices

Table A-6.25 Reported health education received and knowledge

Percentage of observed and interviewed antenatal care (ANC) clients who stated that a provider had mentioned any warning signs for pregnancy, percentage who named any of the indicated symptoms as warning signs, percentage who stated that a provider had discussed exclusive breastfeeding, percentage of clients who said they were asked about their delivery plans, and percentage with whom family planning was discussed during this visit or a previous visit, by governorate, Egypt SPA 2004

Issue discussed during current/ previous visit	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Counseling on risk signs				
Client said provider mentioned any warning signs	17	42	22	29
Warning signs mentioned by client				
Bleeding	2	15	12	12
Fever	0	8	2	4
Swollen face or hands	4	27	11	16
Tiredness or breathlessness	5	19	3	9
Headache or blurred vision	9	19	8	13
What client was told to do if warning sign occurs				
Seek care at facility	9	40	20	26
Decrease activity	8	4	3	4
Change diet	3	1	0	1
Client reported provider discussed				
Exclusive breastfeeding	4	8	4	5
Exclusive breastfeeding for 6 months	1	4	2	3
Delivery plans	13	5	10	9
Supplies to prepare for delivery	0	2	1	1
Using family planning after birth	9	11	7	9
Number of interviewed ANC clients (weighted) ¹	188	402	439	1,029

Table A-6.26 Client plan for place of delivery

Among observed and interviewed antenatal care (ANC) clients, percentage who reported plan for where they will deliver, by type of facility, Egypt SPA 2004

Background characteristics	Percentage of ANC clients who plan to deliver at:				Number of interviewed ANC clients (weighted) ¹
	This facility	Other facility	Home	Don't know	
Type of facility					
GS hospital	25	17	21	38	132
MCH/ urban HU	15	43	6	36	334
Rural HU	4	35	37	24	400
Mobile unit	0	45	17	38	79
NGO facility	6	42	13	39	81
Region					
Urban Governorates	15	35	6	45	188
Lower Egypt	11	47	14	27	402
Upper Egypt	7	29	34	30	439
Total ¹	10	37	21	32	1,029

¹ Regional totals and total percentages include 3 interviewed ANC clients from health offices

Table A-6.27 Use of individual client cards

Among first visit and followup visit antenatal care (ANC) clients, percentage where the provider looked at the client card during the consultation, and where the provider wrote on the client card at the end of the visit, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of ANC consultations where:				Number of first-visit ANC clients (weighted)	Number of followup visit ANC clients (weighted) ¹
	Provider looked at client card during consultation		Provider wrote on client card at end of visit			
	First visit	Followup visit	First visit	Followup visit		
Type of facility						
GS hospital	19	71	21	68	85	47
MCH/ urban HU	86	92	86	84	136	197
Rural HU	65	84	73	88	160	240
Mobile unit	7	11	6	7	66	14
NGO facility	39	69	48	65	40	41
Region						
Urban Governorates	61	83	60	86	90	98
Lower Egypt	50	88	52	79	166	236
Upper Egypt	51	76	57	81	234	204
Total ¹	53	83	56	81	489	539

¹ Regional totals and total percentages include 3 observed first-visit ANC clients from health offices

Table A-6.28 Outcome of observed consultations

Among antenatal care (ANC) clients whose consultations were observed, percentage who went home, were referred elsewhere in the same facility, were admitted to the facility, were referred outside the facility, and whose status was uncertain, at the end of the observed components of the consultation, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of ANC consultations where:					Number of observed ANC clients (weighted) ¹
	Client went home	Client referred, same facility	Client admitted to facility	Client referred elsewhere	Don't know	
Type of facility						
GS hospital	85	13	1	0	0	132
MCH/ urban HU	81	19	0	0	0	334
Rural HU	77	22	0	2	0	400
Mobile unit	99	0	0	1	0	79
NGO facility	93	5	0	2	0	81
Region						
Urban Governorates	94	5	0	1	0	188
Lower Egypt	68	32	0	0	0	402
Upper Egypt	90	8	0	1	0	439
Total ¹	82	17	0	1	0	1,029

¹ Regional totals and total percentages include 3 observed ANC clients from health offices

Table A-6.29 Client feedback on services

Among ANC clients whose consultations were observed, percentage who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2004

Client service issue	Percentage by type of facility					Total percentage ¹
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	NGO facility	
Behavior/attitude of provider not good	1	1	1	0	0	1
Inability to discuss concerns with provider	2	0	2	1	3	1
Not sufficient comment on progress of pregnancy	4	0	1	2	4	1
Poor quality of examination and treatment	4	0	2	1	2	2
Waiting time to see provider too long	14	7	5	3	12	7
Lack of availability of medicines or supplies	2	3	2	0	2	2
Opening hours of facility inconvenient	0	0	2	4	0	1
Lack of cleanliness of facility	0	0	1	0	0	1
Lack of privacy	1	1	1	2	0	1
Cost is too high	0	1	0	0	4	1
Lack of auditory privacy	1	0	1	0	0	1
Time too long between start and complete consultation	0	0	1	0	3	1
Waiting time for laboratory results too long	0	1	1	0	4	1
Number of interviewed ANC clients (weighted) ¹	132	334	400	79	81	1,029

¹ Regional totals and total percentages include 3 interviewed ANC clients from health offices

Table A-6.30 Reasons antenatal care clients chose this facility for services

Among antenatal care (ANC) clients, whose consultations were observed, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of ANC clients agreeing item was a factor in choosing facility								Number of interviewed ANC clients (weighted) ¹
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well-treated	Facility is nearby	Good reputation	Other response	
Type of facility									
GS hospital	13	41	15	28	9	52	18	6	132
MCH/ urban HU	26	25	5	29	26	45	28	5	334
Rural HU	11	21	0	29	28	69	13	6	400
Mobile unit	54	17	0	35	18	38	24	14	79
NGO facility	54	42	1	18	23	30	39	5	81
Region									
Urban Governorates	34	35	1	14	21	39	33	10	188
Lower Egypt	27	28	6	41	30	48	20	5	402
Upper Egypt	15	21	3	23	19	64	19	7	439
Total	23	26	4	29	24	53	22	6	1,029

¹ Regional totals and total percentages include 3 interviewed ANC clients from health offices

Table A-6.31 Personal characteristics of antenatal care clients by employment status

Among antenatal care (ANC) clients whose consultation was observed and who were interviewed, percent distribution by employment status, and among employed ANC clients, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2004

Background characteristics	Among all ANC clients, percentage who are:		Number of interviewed ANC clients (weighted) ¹	Among employed ANC clients, percentage who:							Number of interviewed ANC clients who are employed (weighted)
	Employed	Not employed		Work for:			Receive:				
				Family member	Someone else	Self	Salary in cash	Salary in kind	Salary in cash and in kind	No salary	
Type of facility											
GS hospital	7	93	132	43	57	0	57	0	0	43	9
MCH/ urban HU	7	93	334	0	90	10	90	0	10	0	23
Rural HU	12	88	400	44	49	6	55	4	0	41	48
Mobile unit	13	87	79	0	84	16	84	0	16	0	11
NGO facility	15	85	81	9	91	0	95	0	0	5	12
Region											
Urban Governorates	11	89	188	2	98	0	100	0	0	0	20
Lower Egypt	12	88	402	28	72	0	68	4	0	28	48
Upper Egypt	8	92	439	35	45	20	58	0	11	31	35
Total	10	90	1,029	26	68	7	71	2	4	24	103

¹ Regional totals and total percentages include 3 interviewed ANC clients from health offices (with one client being employed)

Table A-6.32 Personal characteristics of antenatal care clients by education

Among antenatal care (ANC) clients, whose consultations were observed and who were interviewed, percent distribution by education level and, among clients with no or primary education, percent distribution by literacy status, indicating their education and literacy status as noted below, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of all ANC clients:				Number of interviewed ANC clients (weighted)	Percentage of ANC clients with primary or no education who:			Number of interviewed ANC clients with primary or no education (weighted) ¹
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write	Can read and write	
Type of facility									
GS hospital	45	8	11	36	132	72	5	23	70
MCH/ urban HU	35	4	10	51	334	82	2	15	130
Rural HU	46	5	12	37	400	79	3	18	203
Mobile unit	33	6	8	53	79	79	0	21	31
NGO facility	24	6	11	59	81	78	2	20	25
Region									
Urban Governorates	35	10	13	42	188	64	3	32	85
Lower Egypt	28	3	9	60	402	85	3	12	125
Upper Egypt	51	5	11	32	439	81	3	17	249
Total¹	39	5	11	45	1,029	79	3	18	459

¹ Regional totals and total percentages include 3 interviewed ANC clients from health offices (none had primary or no education)

Table A-6.33 Emergency maternity transportation systems

Percentage of facilities with emergency maternity transportation systems, having indicated means of transportation and median transportation time (in minutes) by type of facility and region, Egypt SPA 2004

Background characteristics	Among facilities having emergency transportation, percentage in which means for transport is:				Median transportation time (minutes) to referral facility using most common mode of emergency transportation ⁴	Number of facilities supporting emergency transportation (weighted) ⁵
	Dedicated vehicle ¹	Vehicle at other facility ²	Multipurpose vehicle available at facility	Other arrangement ³		
Type of facility						
GS hospital	73	53	22	14	21	13
MCH/ urban HU	83	57	38	27	8	23
Rural HU	40	48	0	12	21	6
Region						
Urban Governorates	60	53	19	13	11	6
Lower Egypt	92	42	34	26	11	21
Upper Egypt	52	72	20	15	11	18
Total	72	55	27	20	11	44

Note: Emergency maternity transportation systems are any planned program where facility takes some responsibility for ensuring client reaches referral location. Where client must find transport and must pay the total cost, the facilities do not have an emergency transportation system.

¹ Ambulance or other vehicle that stays at the facility.

² Facility calls for dedicated vehicle from other facility to collect emergency patient.

³ Any other plan where the facility arranges for the emergency transport or contributes toward the cost of rental vehicles.

⁴ Transportation time does not vary by season.

⁵ Regional totals and total percentages include data from two NGO facilities that report supporting emergency transportation.

Table A-6.34 Availability of specific equipment and supplies for quality delivery services

Percentage of facilities with the indicated items and infrastructure in the delivery service area, by type of facility, Egypt SPA 2004

Items to support quality services	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Infection control					
Soap	40	46	52	100	49
Water	89	99	90	100	92
Clean latex gloves	69	54	38	91	52
Disinfecting solution	69	47	77	84	67
Sharps box	66	71	75	38	70
All items for infection control ¹	28	8	19	31	18
Covered waste receptacle with plastic liner	17	34	22	24	24
All items for infection control plus waste receptacle	10	7	4	16	7
Infrastructure for delivery					
Visual privacy and auditory privacy	94	100	94	100	96
Visual privacy	96	100	98	100	98
No privacy	4	0	2	0	2
Delivery bed ²	98	100	97	100	98
Examination light ³	86	93	75	100	84
All elements of infrastructure ⁴	79	93	71	100	80
Other items to support quality services					
Blank Partograph	11	14	3	14	9
Protocols for management of complications	15	3	7	0	7
Delivery provider (physician or nurse certified for delivery service) on site 24 hours ⁵	73	59	47	16	55
Delivery provider (physician or nurse certified for delivery service) on call 24 hours	4	4	0	0	2
All other items to support quality ⁶	5	3	0	0	2
Number of facilities offering delivery services (weighted)	39	48	73	7	167

¹ Soap, water, gloves, disinfecting solution for decontaminating reusable items, and sharps box.

² Any type of bed where woman can lie down flat.

³ Examination light, flashlight, or other spotlight source.

⁴ Both visual and auditory privacy, examination bed, and examination light.

⁵ An additional three in ten facilities reported that they did have 24-hour staff either on-site or on-call, but did not have a duty schedule.

⁶ Protocols, partograph, and delivery staff available 24 hours per day with duty schedule observed.

Table A-6.35 Locations where delivery equipment is processed and stored

Percentage of facilities that process delivery equipment and/or store processed equipment for reuse in the indicated location, by type of facility and region, Egypt SPA 2004

Background characteristics	Among facilities offering delivery services, percentage where:						Number of facilities offering delivery services (weighted)
	Equipment is processed in indicated area ¹			Processed equipment is stored in indicated area ¹			
	Delivery service area	Main facility area	Family planning area	Delivery service area	Main facility area	Family planning area	
Type of facility							
GS hospital	76	19	5	77	18	5	39
MCH/urban HU	72	23	5	72	23	5	48
Rural HU/Other	9	70	21	12	66	22	73
NGO	25	66	9	34	57	9	7
Region							
Urban Governorates	29	51	20	32	48	20	19
Lower Egypt	73	18	9	73	18	9	57
Upper Egypt	28	60	12	31	56	13	91
Total	43	45	12	45	42	13	167

¹ Main facility area and delivery processing area may be the same location in small facilities

Table A-6.36 Knowledge and systems for processing of delivery service equipment

Among facilities offering delivery services, highest level of processing for which the facility had functioning equipment, and knowledge of correct processing time and/or temperature and the percentage with written guidelines, at the site where delivery equipment is processed for reuse, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with equipment and knowledge of processing time/temperature for the indicated procedures			Percentage of facilities with written guidelines for sterilization or HLD procedures at processing site	Number of facilities offering delivery services (weighted)
	Dry heat or autoclave ¹	Boil/steam or chemical HLD ²	No procedure ³		
Type of facility					
GS hospital	58	16	26	16	39
MCH/urban HU	67	0	33	22	48
Rural HU/Other	53	29	18	25	73
NGO	100	0	0	16	7
Region					
Urban Governorates	79	0	21	41	19
Lower Egypt	51	12	37	24	57
Upper Egypt	62	22	16	16	91
Total	60	16	24	22	167

¹ Dry heat: temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 20 minutes, or automatic; autoclave: process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.
² Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes.
³ Either equipment or knowledge was lacking or facility does not process delivery equipment.

Table A-6.37 Knowledge and systems for processing delivery service equipment when processing occurs in delivery service area

Among facilities offering delivery services and that process equipment in the delivery service area, highest level of processing for which the functioning equipment is available and the correct processing procedure is known, and the percentage with written guidelines for sterilization or high-level disinfecting procedures, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities where the indicated method was the highest level for which equipment and knowledge of correct processing procedure was available for equipment processed in delivery service area			Percentage of facilities with written guidelines for sterilization or HLD procedures at processing site	Number of facilities offering delivery services and processing equipment in delivery area (weighted)
	Dry heat or autoclave ¹	Boil/steam or chemical HLD ²	No procedure ³		
Type of facility					
GS hospital	59	11	30	14	30
MCH/urban HU	65	0	35	21	35
Rural HU/Other	23	0	77	38	6
NGO	100	0	0	0	2
Region					
Urban Governorates	78	0	22	45	6
Lower Egypt	50	8	42	21	42
Upper Egypt	72	0	28	10	25
Total	60	4	36	19	72

¹ Sterilization: Dry heat: temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 20 minutes, or automatic; autoclave: process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.
² HLD processing: Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes.
³ Either equipment or knowledge was lacking or facility does not process delivery equipment.

Table A-6.38 Details for storing processed equipment in delivery service area

Among facilities that process delivery equipment in the delivery service area and that have processed equipment stored in the delivery service area, percentage where the indicated conditions were observed, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities where indicated conditions were found				Number of facilities processing and storing items in delivery service area (weighted)
	Sterile storage conditions ¹	Clean storage conditions ²	Processing date indicated on stored items	Sterile storage and processing date	
Type of facility					
GS hospital	17	77	14	4	30
MCH/urban HU	41	83	41	23	35
Rural HU/Other	38	35	0	0	6
NGO	100	0	0	0	2
Region					
Urban Governorates	60	91	78	48	6
Lower Egypt	42	63	30	13	42
Upper Egypt	10	90	5	5	25
Total	33	74	25	13	72

¹ Items are wrapped and sealed with time-steam-temperature (TST) sensitive tape or are in a sterile/HLD box that clasps shut.
² Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer or autoclave, or sitting in disinfecting solution.

Table A-6.39 Delivery service providers

Percentage of facilities where a qualified trained delivery provider is available onsite on or call for 24-hour duty to conduct deliveries, and where a duty schedule was observed and where there was no duty schedule, and where a staff member with the indicated qualification most commonly conducts deliveries at night, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with:							Number of facilities offering delivery services (weighted)
	A qualified trained delivery provider available 24 hours, with observed duty schedule		A qualified trained delivery provider available 24 hours, with no observed duty schedule		Provider most commonly on duty to conduct delivery at night ¹			
	Onsite	On call	Onsite	On call	Doctor	Nurse trained in midwifery	Graduate nurse	
Type of facility								
GS hospital	73	4	10	2	13	0	0	39
MCH/urban HU	59	4	11	20	17	6	9	48
Rural HU	47	0	40	3	7	3	3	73
NGO facility	16	0	16	39	58	0	9	7
Region								
Urban Governorates	59	9	9	20	24	21	0	19
Lower Egypt	64	3	9	13	18	0	0	57
Upper Egypt	49	0	36	5	8	2	8	91
Total	55	2	24	9	14	3	4	167

¹ May be more than one type of staff in a facility who routinely conducts night deliveries.

Table A-6.40 Availability of specific equipment and supplies for quality delivery services

Percentage of facilities where indicated supplies are in the delivery room (DR) area or in the facility (DR or pharmacy), by type of facility, Egypt SPA 2004

Equipment and supplies	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Basic medicines and supplies for delivery					
Scissor or blade	86	94	68	100	81
Cord clamp or tie	53	96	33	65	57
Suction apparatus (bulb or machine)	83	88	34	72	63
Suction bulb	36	50	20	25	33
Suction machine	80	78	22	72	54
Antibiotic eye ointment for newborn (delivery room)	6	19	17	0	14
Antibiotic eye ointment for newborn (pharmacy or delivery room)	80	87	55	14	68
Skin disinfectant for perineum	97	94	83	100	90
All basic supplies for delivery ¹	33	70	10	14	33
Additional medicines and supplies for managing common complications of delivery					
Syringes and needles in DR	65	73	63	81	67
Syringes and needles in facility	73	74	71	81	73
Intravenous solution ² and perfusion set in DR	85	70	15	81	50
Intravenous solution ² and infusion set in facility	85	72	18	81	52
Oral antibiotic ³ in facility	92	91	81	14	84
Injectable oxytocic medication in DR	83	55	39	91	56
Injectable oxytocic medication in facility	83	59	44	91	60
Suture material in DR	78	64	26	91	52
Needle holder in DR	84	89	58	100	75
All basic treatment interventions ⁴	44	20	2	14	18
Additional medicines and supplies for managing serious complications					
Valium or magnesium sulfate in DR	42	0	0	74	13
Valium or magnesium sulfate in facility	49	0	0	74	15
Broad spectrum injectable antibiotic in facility	58	44	59	67	55
Ampicillin	46	17	56	14	41
Procaine penicillin	45	47	60	14	51
Gentamycin	38	63	55	14	52
All other medicines for complications ⁵	12	0	0	14	3
Injectable hydralazine in DR	0	0	0	9	0
Number of facilities offering delivery services (weighted)	39	48	73	7	167

¹ Scissor or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, and skin disinfectant for perineum² Accepted Intravenous solutions were Dextrose 5% and normal saline, 0.9% normal saline, or Ringer's lactate.³ Oral amoxicillin, ampicillin, or cotrimoxazole⁴ Needles and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area, oral antibiotic (cotrimoxazole or amoxicillin) located in pharmacy or delivery room area⁵ Injectable anticonvulsant (Valium or magnesium sulfate) in delivery room area, and antibiotic (penicillin and ampicillin, or gentamycin) in delivery room area or pharmacy

Table A-6.41 Additional infrastructure, equipment, and supplies for delivery service

Percentage of facilities with each of the indicated infrastructure, equipment, and diagnostic and treatment items for delivery services, by type of facility, Egypt SPA 2004

Infrastructure, equipment and supplies	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Delivery room conditions					
Tiled floor	84	76	78	91	79
Windows with screens in good condition	46	49	38	34	43
Room free of dust, dirt or spider webs	87	99	87	100	91
Separate labor (pre-delivery) room or recover room (postpartum) present	83	75	31	81	58
Equipment and infrastructure for delivery room					
Air conditioner	38	14	3	81	18
Water heater	41	60	32	81	44
24-hour functioning light source	97	94	89	91	92
Diagnostic and treatment materials					
One full oxygen cylinder	76	51	40	91	54
Oxygen cylinder regulator	72	54	44	91	55
Blood pressure apparatus	84	94	88	100	89
Adult stethoscope	82	96	88	100	90
Fetal heart detector (sonicaid)	58	82	40	58	57
Gel for fetal heart detector	57	71	33	48	50
Neonatal stethoscope	23	13	9	41	15
Fetal stethoscope (Pinard)	60	88	66	65	71
Other materials for delivery services					
Clean Mackintosh oilcloth for delivery	70	94	28	100	60
Sterile gloves	68	71	30	81	53
Sterile Foley catheter size 18/20 (plastic)	65	44	13	81	37
Sterile straight urinary catheter size 18/20 (plastic)	61	49	20	81	40
Skin antiseptic	97	94	83	100	90
Suture material	78	64	26	91	52
Two forceps (Kocher)	79	88	47	100	69
Sterile scissors/blade	86	94	68	100	81
Needle holder	84	89	58	100	75
Injectable hydralazine	0	0	0	9	0
Vitamin K	45	66	43	56	51
Vitamin A	50	57	66	7	57
Additional administrative forms					
Referral forms	13	54	23	0	29
Delivery sheet	61	24	1	54	24
Delivery register	81	80	63	56	72
Number of facilities offering delivery services (weighted)	39	48	73	7	167

Table A-6.42 Equipment and supplies for complications of labor and delivery

Percentage of facilities where the indicated equipment is available, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering delivery services with indicated capacity								Number of facilities offering delivery services (weighted)
	Assist labor		Remove retained products		Blood transfusion services	Caesarean section	Emergency support for newborn		
	Forceps	Vacuum extractor	Vacuum aspirator	D&C kit			Newborn respiratory support ¹	External heat source ²	
Type of facility									
GS hospital	45	41	12	41	62	67	45	60	39
MCH/ urban HU	6	5	5	5	0	0	35	54	48
Rural HU	2	2	0	1	0	2	9	10	73
NGO facility	65	63	0	91	14	91	31	29	7
Region									
Urban Governorates	21	23	0	26	20	26	38	50	19
Lower Egypt	17	17	3	12	23	29	30	39	57
Upper Egypt	14	11	6	15	9	14	21	30	91
Total	16	14	4	15	15	20	26	35	167

¹ Resuscitator or ambu bag.

² Most often an incubator, although heat light would be sufficient.

Table A-6.43 Capacity to conduct caesarean section

Among facilities that offer caesarean section, percentage where the indicated item was available by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering caesarean section, with indicated item									Number of facilities offering caesarean section (weighted)
	Basic item					Additional components			Provider for conducting caesarean section on duty 24 hours	
	Operating table	Operating light	Scrub area adjacent to OR	Sterilized instruments	All basic items observed ¹	Sterile gowns/towels/sheets	Anesthetist	Anesthesia-giving set		
Type of facility										
GS hospital	94	82	87	75 ^a	63	83 ^b	64 ^c	92	75	29
Rural HU	100	100	100	100	100	100	0	100	0	2
NGO facility	100	100	100	69	69	80	43	100	38	6
Region										
Urban Governorates	100	100	100	88	88	88	68	100	48	5
Lower Egypt	92	84	84	75	67	84	67	92	67	20
Upper Egypt	100	85	95	70	55	80	40	95	70	13
Total	96	86	90	75	66	83	58^d	94	65	37

¹ Operating table, operating light, scrub area, and sterilized instruments.

^a An additional 5 percent of facilities reported the sterilized instruments were available but they were not observed.

^b An additional 9 percent of facilities reported the gowns, towels and sheets were present but they were not observed.

^c Duty schedule observed. An additional 21 percent of facilities reported they had an anesthetist but there was not duty schedule.

^d An additional 24 percent of facilities reported they had an anesthetist but there was no duty schedule.

Table A-6.44 Newborn care practices

Percentage of facilities that report the indicated item is a routine component of newborn care, by type of facility, Egypt SPA 2004

Item	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Routine newborn care practices					
Routine suction with catheter	85	97	53	91	75
Full immersion bath within 24-hours after birth	8	39	15	24	21
Weigh newborn	94	92	80	57	86
Infant scale available	71	91	74	38	77
Provide vitamin A to mother	75	100	78	0	80
Vitamin A in delivery area	50	57	66	7	57
Vitamin A in pharmacy or delivery area	75	84	78	14	77
Provide OPV to newborn	41	64	65	0	57
Provide BCG to newborn	5	20	7	0	10
Provide vitamin K to newborn	24	15	18	25	19
Vitamin K in delivery service area	45	66	43	56	51
Provides prelacteal liquids to newborn	15	1	10	25	9
Practices rooming in ¹	97	100	93	100	96
Care for the umbilical cord					
70 percent alcohol	70	89	95	91	87
Betadine	39	14	29	19	26
Dry dressing only	14	24	6	34	14
Number of facilities offering delivery services (weighted)	39	48	73	7	167

¹ Newborn stays with mother

Table A-6.45 Utilization of delivery services by facilities included in the ESPA

Median average monthly home delivery clients, median number of vaginal deliveries, and median number of caesarean sections conducted by facilities having data available on the date of the survey, by type of facility, Egypt SPA 2004

Type of facility	Median monthly vaginal deliveries	Number of facilities reporting vaginal delivery data (weighted)	Median monthly home deliveries	Number of facilities reporting home delivery data (weighted) ¹	Median monthly caesarean sections	Number of facilities reporting caesarean section data (weighted)
GS hospital	22	36	na	5	12	26
MCH/urban HU	3	48	4	29	na	0
Rural HU/other	2	60	5	40	na	2
NGO	na	4	na	0	2	4
Total	3	148	5	74	10	32

¹ Data are from health information system monthly reports available at the facility the day of the survey. Data were collected for the 12 months preceding the survey; however, frequently some months were missing. Information from the number of months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month. na= Not applicable

Table A-6.46 Information on routine charging practices for delivery services

Percentage of facilities with routine charges for delivery services and percentage where each of the indicated fee systems is utilized, and among facilities with routine fees, percent distribution by type of fee posting, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities offering delivery services where fee system involves:					Number of facilities providing services (weighted)	Percentage of facilities with publicly posted fees			Number of facilities having any routine charges for delivery services (weighted)
	Fixed fee for all delivery costs	Fixed fee for ANC plus delivery	Charge for medications and tests	Other routine charges	No charges or don't know		All fees posted	Some fees posted	No fees posted	
Type of facility										
GS hospital	23	0	6	6	70	39	19	0	81	12
MCH/urban HU	57	8	1	5	38	48	21	0	79	30
Rural HU/Other	12	0	0	18	72	73	16	0	84	19
NGO	100	9	33	0	0	7	9	9	81	7
Region										
Urban Governorates	54	7	18	0	46	19	29	0	71	10
Lower Egypt	40	0	0	3	57	57	14	0	86	24
Upper Egypt	21	3	2	17	63	91	18	2	80	33
Total	31	3	3	11	59	167	18	1	81	68

Table A-6.47 Supportive management for providers of delivery services

Among interviewed delivery service providers, percentage who received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed delivery service providers who:				Number of interviewed delivery service providers ²
	Received in-service training during the past 12 months ¹	Were personally supervised in past 6 months	Were both personally supervised during the past 6 months and received in-service training during the past 12 months	Received most recent in-service training 13-59 months preceding the survey	
Type of facility					
GS hospital	8	82	6	33	153
MCH/ urban HU	24	84	10	13	92
Rural HU	9	99	9	32	117
NGO facility	2	28	2	18	9
Region					
Urban Governorates	6	70	4	18	40
Lower Egypt	14	84	6	11	158
Upper Egypt	13	93	11	43	174
Total	12	87	8	27	371

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine

² Includes only providers of delivery services in facilities offering delivery service

Table A-6.48 Supportive management: In-service training for delivery service providers

Among interviewed delivery service providers, percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed service providers who received in-service training on specific topics														Number of interviewed delivery service providers (weighted)
	Delivery care		Use of partograph		Lifesaving skills		PMTCT ¹		Exclusive breastfeeding		Care of normal newborn		Neonatal resuscitation		
	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	
Type of facility															
GS hospital	6	21	7	18	7	20	2	8	0	0	3	12	4	11	153
MCH/ urban HU	23	11	23	6	23	9	0	2	1	1	2	5	2	2	92
Rural HU	2	23	1	22	2	21	0	3	1	2	8	9	8	9	117
NGO facility	0	6	0	6	0	17	2	7	0	0	0	0	0	0	9
Region															
Urban															
Governorates	4	9	4	5	4	7	0	3	0	3	2	6	2	6	40
Lower Egypt	12	11	12	10	12	11	1	3	0	1	0	1	0	1	158
Upper Egypt	7	28	7	25	7	26	1	7	1	1	9	17	9	15	174
Total	9	19	9	16	9	18	1	5	1	1	4	9	5	8	371

¹ Prevention of mother-to-child transmission

Table A-6.49 Supportive supervision for delivery service providers

Among interviewed delivery service providers, who received a supervisory visit during the past 6 months, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2004

	Median number of times staff were supervised in past 6 months	Percentage of providers reporting indicated activities of the supervisor during the last supervisory visit						Number of delivery service providers who were supervised in past 6 months (weighted) ¹
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Wrote on unit note	
Type of facility								
GS hospital	8	96	82	58	58	78	93	125
MCH/ urban HU	7	100	95	96	89	98	90	77
Rural HU	7	100	98	83	56	66	99	116
NGO facility	-	100	46	100	46	61	61	3
Region								
Urban Governorates	19	94	87	91	67	83	85	28
Lower Egypt	7	100	98	87	62	69	95	133
Upper Egypt	7	98	85	65	65	85	95	161
Total	7	99	91	76	64	78	94	321

¹ Includes only providers of delivery services in facilities offering delivery services

Chapter 7

Table A-7.1 Availability of services for RTI/STIs in facilities reporting no services

Among facilities reporting they do not offer services for RTI/STIs, percentage where service providers for antenatal care and family planning indicated they offer RTI/STI diagnosis and treatment to their clients, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities where providers report RTI/STI services are offered to clients attending the indicated service		Number of facilities reporting no RTI/STI services (weighted)
	Family planning services	Antenatal care services	
Type of facility			
GS hospital	100	0	1
Fever hospital	0	0	8
MCH/urban HU	0	0	2
Rural HU	48	42	42
Health office	19	0	17
NGO facility	0	0	2
Region			
Urban Governorates	22	0	3
Lower Egypt	48	39	44
Upper Egypt	10	3	25
Total	34	25	72

Table A-7.2 Availability of system components, infrastructure, and resources to support quality services for RTI/STIs

Percentage of facilities where the indicated systems and items to support quality counseling and examination are present, by type of facility, Egypt SPA 2004

Item	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Items to support utilization of RTI/STI services								
Active partner followup system	8	0	4	5	3	0	1	4
Passive partner followup system	44	49	53	43	55	61	50	47
No followup system for partners	49	51	42	52	42	39	49	49
Items to support quality counseling								
Visual and auditory privacy	91	87	77	85	91	53	89	85
Visual privacy only	95	87	92	91	99	73	94	92
No privacy	5	13	8	9	1	27	6	8
Any guidelines or protocols for RTI/STIs	11	12	27	13	10	38	8	15
Guidelines for syndromic diagnosis RTI/STIs	5	0	0	0	0	0	0	1
Any visual aids or educational materials	47	12	54	62	45	64	14	51
Educational materials specific for HIV/AIDS	6	0	3	3	0	14	0	3
Condoms at service delivery site	55	24	59	47	62	74	31	50
Condoms anywhere in facility	92	24	87	88	90	86	59	84
All items to support quality counseling ¹	7	12	12	6	3	7	1	6
Items for infection control								
Soap	80	12	84	63	73	61	68	69
Water	91	37	91	86	87	97	86	87
Clean latex gloves	28	12	42	32	20	27	27	31
Disinfecting solution for contaminated equipment	80	24	94	87	97	100	80	87
Sharps box	63	37	80	78	57	91	29	69
All items for control of infection ²	17	12	31	18	12	7	11	18
Waste receptacle	29	0	29	32	21	24	35	30
Five or more 2/3 ml disposable syringes with needles	72	50	87	83	81	100	75	81
All items for control of infection, including syringes and waste receptacle	9	0	8	8	3	3	6	7
Items for physical examination								
Visual and auditory privacy ³	88	87	78	86	91	63	92	85
Visual privacy ⁴	94	87	93	92	97	80	97	93
No privacy	6	13	7	8	3	20	3	7
Examination bed ⁵	100	37	100	98	99	100	99	98
Examination light ⁶	96	12	97	84	72	91	92	87
All items for examination	84	12	75	71	70	59	83	74
All items for infection control and physical examination ⁷	17	12	22	14	9	7	10	15
Number of facilities offering RTI/STI services (weighted)	65	6	95	277	55	16	74	587

¹ Visual and auditory privacy (private room), any guidelines or protocols, any visual aids or educational materials, and condoms in RTI/STI service area.

² Soap, water, latex gloves, disinfecting solution, and sharps box.

³ Private room.

⁴ Private room or room with screen or curtain that can be pulled for visual privacy.

⁵ Any type of bed where a woman can lie down flat.

⁶ Examination light, flashlight or other spotlight source.

⁷ All items for infection control, visual and auditory privacy, examination bed, and examination light.

Table A-7.3 Highest level of processing capacity for RTI/STI equipment

Among facilities offering services for RTI/STIs, highest level of processing for which the facility has functioning equipment, and knowledge of correct processing time and/or temperature, and the percentage with written guidelines, at the site where RTI/STI equipment is processed for reuse, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with equipment and knowledge of processing time/temperature for the indicated procedure			Percentage of facilities with written guidelines for sterilization or HLD procedures at processing site	Number of facilities offering RTI/STI services (weighted)
	Dry heat or autoclave ¹	Boil/steam or chemical HLD ²	No procedure ³		
Type of facility					
GS hospital	62	25	13	31	65
Fever hospital	24	0	76	13	6
MCH/urban HU	82	7	11	26	95
Rural HU	59	31	9	30	277
Mobile unit	82	4	14	14	55
Health office	67	26	7	30	16
NGO facility	49	33	18	11	74
Region					
Urban Governorates	70	8	21	43	70
Lower Egypt	67	26	7	29	279
Upper Egypt	58	27	15	16	239
Total	64	24	12	25	587
¹ Dry heat: temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 20 minutes, or automatic; autoclave: process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic. ² Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes. ³ Either equipment or knowledge was lacking or facility does not process FP equipment.					

Table A-7.4 Availability of specific tests and medicines for diagnosis and treatment of sexually transmitted infections

Percentage of facilities with indicated equipment and tests for etiological diagnosis of STIs, and percentage where indicated medicines for treating STIs are available, by type of facility, Egypt SPA 2004

Equipment, test, medicine	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Items for etiologic examination								
Vaginal speculum	97	24	95	92	96	97	96	94
Swab stick for specimen	3	13	1	5	0	0	5	4
Syphilis test capacity ¹	4	0	23	2	0	0	4	6
Gonorrhea test capacity ²	4	13	0	0	0	0	1	1
Chlamydia test capacity ³	0	13	0	1	0	0	2	1
Wet mount testing capacity ⁴	23	62	29	5	0	0	13	12
HIV/AIDS testing capacity ⁵	8	75	0	0	0	0	3	2
All five laboratory tests	0	0	0	0	0	0	1	0
Medicines for treatment								
Metronidazole (trichomoniasis)	71	50	67	62	13	33	3	51
Ceftriaxone (gonorrhea)	7	25	2	0	0	0	2	2
Ciprofloxacin (gonorrhea)	5	0	0	2	0	0	1	2
Doxycycline (chlamydia, syphilis)	4	0	0	4	0	0	1	2
Tetracycline (chlamydia, syphilis)	66	63	53	61	9	30	1	47
Erythromycin (chlamydia, syphilis)	13	13	25	20	0	14	1	15
Penicillin, benzathine (syphilis)	72	50	60	76	6	21	2	56
Penicillin, procaine (syphilis)	54	51	52	54	6	13	1	41
All medicines for sexually transmitted infections ⁶	5	25	1	1	0	0	1	2
Nystatin suppository (candidiasis)	4	0	4	3	1	0	1	3
Number of facilities offering RTI/STI services (weighted)	65	6	95	277	55	16	74	587

¹ Either VDRL test and functioning microscope, or RPR test kit.

² Gram stain reagents and functioning microscope or culture capacity.

³ Giemsa stain for chlamydia

⁴ Functioning microscope.

⁵ Enzyme-linked immunosorbent assay (ELISA), Western blot, or rapid test.

⁶ At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis.

Table A-7.5 Information on user fees for services for RTI/STIs

Among facilities with user fees for RTI/STI services percentage where each of the indicated fee systems is utilized, and percentage publicly posting fees by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage charging for the indicated item					Number of facilities providing services (weighted)	Percentage where fees are posted in public view			Number of facilities having any user fees for RTI/STI services (weighted)
	Fixed fee for health card	Fixed consult fee	Charge for medicines and tests	Other routine charges	No charges/ don't know		All fees posted	Some fees posted	No fees posted	
Type of facility										
GS hospital	0	27	12	0	65	65	34	0	66	22
Fever hospital	0	0	0	0	100	6	-	-	-	0
MCH/urban HU	0	20	8	1	71	95	47	0	53	27
Rural HU	0	24	4	1	72	277	6	1	93	77
Mobile unit	0	9	1	0	90	55	60	0	40	6
Health office	0	6	3	0	91	16	36	0	64	2
NGO facility	0	93	20	4	4	74	37	3	60	71
Region										
Urban Governorates	0	34	15	2	61	70	29	6	65	27
Lower Egypt	0	22	10	1	71	279	43	0	57	80
Upper Egypt	0	39	3	1	59	239	13	1	85	98
Total	0	30	7	1	65	587	27	1	72	205

Table A-7.6 Supportive management of services for RTI/STIs

Among interviewed providers of services for RTI/STIs, percentage who received the indicated supportive management practice, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage				Number of interviewed providers of RTI/STI services (weighted) ¹
	Received in-service training during the past 12 months ¹	Personally supervised in the past 6 months	Personally supervised during the past 12 months and received in-service training during the past 6 months	Most recent in-service training was 13-59 months preceding the survey	
Type of facility					
GS hospital	2	88	1	8	288
Fever hospital	0	83	0	0	15
MCH/urban HU	2	86	2	10	233
Rural HU	3	98	3	4	310
Mobile unit	10	89	7	7	33
Health office	3	100	3	9	16
NGO facility	2	62	2	16	65
Region					
Urban Governorates	2	85	1	6	116
Lower Egypt	4	89	4	6	452
Upper Egypt	1	91	1	10	393
Total	3	89	2	8	961

¹ Includes only providers of RTI/STI services in facilities where RTI/STI services are offered in any assessed clinic

Table A-7.7 Supportive management: In-service training for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of interviewed providers of RTI/STI services who receive in-service training on specific topics										Received training in RTI/STI services during basic pre-service training	Number of interviewed RTI/STI service providers (weighted) ²
	Counseling for and/or prevention of RTI/STIs		Clinical diagnosis and treatment for RTI/STIs		Syndromic approach for diagnosing and treating RTI/STIs		Any course related to HIV/AIDS		Specific course related to PMTCT ¹			
	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m	12m	13-59m		
Type of facility												
GS hospital	1	2	2	2	1	2	1	8	1	8	1	288
Fever hospital	0	0	0	0	0	0	0	0	0	0	0	15
MCH/urban HU	1	8	1	9	1	3	2	6	2	6	4	233
Rural HU	2	2	1	2	1	1	3	4	2	3	6	310
Mobile unit	2	8	4	6	1	3	10	7	5	7	12	33
Health office	3	9	1	7	1	5	3	9	1	8	3	16
NGO facility	1	9	1	10	1	7	2	16	2	12	1	65
Region												
Urban Governorates	2	6	1	5	1	4	2	6	1	5	1	116
Lower Egypt	2	3	2	2	1	2	4	6	3	5	4	452
Upper Egypt	1	6	0	6	0	2	1	9	1	8	4	393
Total	1	4	1	4	1	2	2	7	2	6	4	961

¹ Prevention of mother-to-child transmission (of HIV/AIDS).

² Includes only providers of RTI/STI services in facilities where RTI/STI services are offered in any assessed clinic

Table A-7.8 Supportive supervision for providers of services for RTI/STIs

Among interviewed providers of services for RTI/STIs who were personally supervised in the past 6 months, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2004.

Background characteristics	Median number of times staff were supervised in past 6 months	Among supervised RTI/STI service providers, percentage where indicated activities were conducted during the last supervisory visit					Wrote note on unit record	Number of RTI/STI service providers who received supervision in past 6 months (weighted) ¹
		Checked records	Observed work	Provided feedback	Provided updates	Discussed problems		
Type of facility								
GS hospital	7	99	88	77	67	80	96	254
Fever hospital	4	100	85	62	100	54	100	13
MCH/urban HU	7	96	95	91	72	81	94	201
Rural HU	7	99	97	86	71	81	93	305
Mobile unit	7	98	96	95	75	88	92	29
Health office	13	96	99	97	93	97	97	16
NGO facility	6	97	93	85	67	88	93	40
Region								
Urban Governorates	7	99	99	96	78	87	95	98
Lower Egypt	7	99	97	88	75	82	98	402
Upper Egypt	7	98	88	77	64	78	90	359
Total	7	98	93	84	71	81	94	858

¹ Includes only providers of RTI/STI services in facilities where RTI/STI services are offered in any assessed clinic

Table A-7.9 Utilization of services for RTI/STIs and sources of data on RTI/STIs

Median average monthly number of RTI/STI clients, by type of facility and region, Egypt SPA 2004

Background characteristics	Median average number of RTI/STI clients per month ¹	Number of facilities reporting statistics (weighted) ²
Type of facility		
GS hospital	51	10
Fever hospital	-	3
MCH/urban HU	14	14
Rural HU	4	28
Mobile unit	10	5
Health office	30	2
NGO facility	-	1
Region		
Urban Governorates	29	15
Lower Egypt	5	12
Upper Egypt	6	35
Total	9	62

¹ Data are from health information system monthly reports available at the facility the day of the survey. Data were asked for the 12 months preceding the survey; however, frequently some months were missing. Information from the number of months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

² All facilities did not have data available.

Table A-7.10 Service area where client was observed for RTI/STIs

Among clients who were assessed for possible RTI/STIs and were observed, percentage who had come to the ANC clinic for ANC, percentage who had come to the FP clinic for FP services, and percentage whose primary reason for visiting the facility was for an assessment for reproductive tract infection (RTI) or STI, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of observed RTI/STI clients who came to the facility primarily for:			Number of observed RTI/STI clients (weighted)
	ANC services	FP services	RTI/STI assessment	
Type of facility				
GS hospital	5	29	67	92
MCH/urban HU	9	48	43	132
Rural HU	11	48	41	96
Mobile unit	6	30	63	120
Health office	0	46	54	17
NGO facility	10	29	61	85
Region				
Urban Governorates	11	42	48	140
Lower Egypt	4	36	60	231
Upper Egypt	10	37	53	170
Total	8	38	55	541

Table A-7.11 Observed consultation for clients with symptoms of RTI/STIs

Among observed clients with symptoms of RTI/STIs, percentage who were reassured about confidentiality, percentage for whom the indicated information was asked during the consultation, percentage who had physical examination procedures, and percentage who had laboratory diagnostic tests, by type of facility, Egypt SPA 2004

Components of consultation	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Reassured about confidentiality	20	8	24	16	3	17	16
Client history elicited							
Client symptoms	99	94	99	100	100	96	98
How long symptoms have been present	83	81	81	83	87	81	82
History of recent sexual contact	17	28	16	21	23	28	22
Symptoms in husband	6	31	9	27	33	35	23
Marital status ¹	4	1	2	0	0	6	2
All elements of client history ²	0	0	0	0	0	2	0
Examination							
External genitalia examined	69	70	56	81	58	77	71
Pelvic exam conducted	69	73	59	88	78	81	75
Any physical exam conducted	81	79	65	95	81	97	83
Types of laboratory tests							
Any laboratory test	11	10	9	6	16	15	10
Blood test	3	2	4	2	3	4	3
Urinalysis	9	10	9	5	13	13	9
Microscopic examination of specimen	0	0	0	0	3	1	0
Number of observed female RTI/STI clients (weighted)	92	132	96	120	17	85	541

¹ Married, husband absent, husband has other wife.

² Client symptoms, how long symptoms have been present, history of recent sexual contacts, symptoms in husband, and marital status.

Table A-7.12 Observed physical examination for female clients assessed for RTI/STIs

Among observed female clients assessed for RTI/STIs who had a physical examination, percentage for whom the indicated items were components of the physical examination, by type of facility, Egypt SPA 2004

Components of physical examination	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Conditions during physical examination¹							
Visual privacy assured	90	91	81	98	100	93	92
Visual and auditory privacy assured	90	90	79	98	100	90	91
Provider washed hands with soap prior to examination	16	7	2	4	16	9	8
Provider wore clean latex gloves	48	45	44	50	24	41	45
Genitals were fully exposed	85	89	86	85	72	80	85
Client was lying down	84	89	86	85	72	80	84
Labia were inspected	85	89	83	84	72	79	84
All elements of examination ²	13	1	0	2	0	6	4
Female client had a pelvic examination	86	93	91	93	96	84	90
Number of observed female clients having any physical examination (weighted)	74	104	62	114	13	82	449

¹ These clients may have had only an external examination or may have also had a pelvic examination.

² Visual and auditory privacy assured, provider washed hands with soap prior to examination, provider wore clean latex gloves, genitals were fully exposed, the client was lying down, and labia were inspected.

Table A-7.13 Observed pelvic examination for female RTI/STI clients

Among observed clients assessed for RTI/STIs who had a pelvic examination, percentage for whom the indicated items were components of the examination, by type of facility, Egypt SPA 2004

Components of pelvic examination	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Provider treatment of client							
Visual privacy assured	89	90	87	97	100	91	92
Auditory privacy assured	89	89	84	97	100	88	91
Explained procedure before starting	20	4	14	12	0	7	10
Asked client to relax	48	41	32	39	50	42	41
Infection control procedures							
Provider washed hands with soap prior to examination	19	8	3	2	17	10	8
Provider wore clean gloves	45	46	47	52	25	47	47
Used sterilized or HLD instruments	78	96	77	86	92	80	85
Prepared all instruments before starting	80	95	70	89	92	85	86
Used items placed in decontaminating solutions	70	88	71	87	92	71	80
Provider washed hands after removing gloves	23	21	6	10	50	20	17
Contaminated surfaces wiped with disinfectant	6	36	4	25	42	20	21
Procedures utilized							
Used speculum	77	98	83	95	100	93	91
Explain speculum procedure	10	2	10	10	0	7	7
Inspect cervix	72	98	76	78	80	84	83
Performed bimanual examination	57	50	44	47	79	58	52
Conducted all elements of examination ¹	8	0	1	2	0	7	3
Number of observed clients receiving pelvic examinations (weighted)	64	96	57	106	13	68	404

¹ Used speculum, explained the speculum procedure, used sterilized or HLD instruments, prepared all instruments before starting, inspected the cervix, and performed a bimanual examination.

Table A-7.14 Observed counseling and education for clients assessed for RTI/STIs

Among clients whose consultation for RTI/STIs was observed, percentage for whom the indicated items were components of counseling, by type of facility, Egypt SPA 2004

Components of counseling and education	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Components of counseling							
Any mention of client diagnosis	77	85	69	87	88	91	82
Any mention of relationship between the infection and sexual activity	21	39	19	35	46	39	32
Client received prescription or medication	95	96	96	95	100	97	96
Client received prescription or medication for sexual partner	16	24	2	20	39	18	18
Client instructed about medications	49	65	37	73	62	72	60
Husband referral encouraged	2	2	3	3	0	0	2
Followup appointment discussed	45	48	41	39	55	78	49
Health education-Risk of HIV/AIDS mentioned	0	0	0	1	0	1	0
Components of health education							
Discuss condoms for prevention	2	2	1	4	3	2	2
Instruct how to use condom	0	1	0	4	0	2	1
Offer condoms	2	1	0	4	3	0	2
Any discussion of condoms or HIV/AIDS	2	2	1	6	3	3	3
Wrote on client health card	11	39	26	22	49	32	27
Number of observed RTI/STI consultations (weighted)	92	132	96	120	17	85	541

Table A-7.15 Information from client exit interviews: reported knowledge and experience related to condom use

Among clients whose consultation for RTI/STIs was observed¹ and who were interviewed, percentage for whom the indicated information was reported by the client, Egypt SPA 2004

Information reported by client	Percentage of clients
Client and husband have used condom before	14
Client agrees indicated item may be a major contributing factor to lack of use of condoms	
Embarrassing to purchase	17
Problem with disposal	7
Embarrassing to discuss with husband	13
Reduces own sexual satisfaction	8
Reduces husband's sexual satisfaction	9
Client identified any of the above items as contributing to lack of use of condoms	28
Health workers talked about condoms today	2
Client received condoms today	2
Number of interviewed RTI/STI clients	541
Among clients who reported any items as contributing to lack of use of condoms, percentage who discussed the issue with provider	9
Number of interviewed RTI/STI clients who identified an item as contributing to lack of use of condoms (weighted)	153

¹ All observed and interviewed RTI/STI clients were female

Table A-7.16 Client feedback on services

Among clients whose consultation for an RTI/STI was observed and who were interviewed, percentage who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2004

Big problems identified by client	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Behavior/attitude of provider not good	0	0	2	0	0	0	0
Inability to discuss concerns with provider	2	0	0	0	6	0	0
Insufficient explanation about problem	2	0	0	0	0	0	0
Poor quality of examination and treatment	2	0	6	1	0	0	2
Waiting time to see provider too long	13	4	4	4	0	2	5
Lack of availability of medicines or supplies	2	3	2	5	0	0	3
Opening hours of facility inconvenient	0	0	4	6	0	10	3
Lack of cleanliness of facility	1	0	3	0	0	0	1
Lack of visual privacy	1	0	3	0	0	0	1
Lack of auditory privacy	0	0	3	0	0	0	0
Cost is too high	0	0	0	0	0	1	0
Time too long between start and completion of consultation	4	0	0	0	0	0	1
Number of interviewed RTI/STI clients (weighted)	92	132	96	120	17	85	541

Table A-7.17 Reasons clients observed for RTI/STIs chose this facility for services

Among clients whose consultation for an RTI/STI was observed and who were interviewed, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of RTI/STI clients agreeing item was a factor in choosing facility							Number of interviewed RTI/STI clients (weighted)
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well treated	Facility is nearby	Good reputation	
Type of facility								
GS hospital	28	46	15	22	29	54	18	92
MCH/urban HU	66	28	8	18	24	42	17	132
Rural HU	27	17	0	14	18	67	13	96
Mobile unit	56	27	0	19	25	35	26	120
Health office	58	13	0	13	29	71	52	17
NGO facility	53	50	3	16	24	42	26	85
Region								
Urban Governorates	49	37	3	10	22	41	28	140
Lower Egypt	57	38	7	22	28	50	18	231
Upper Egypt	36	20	4	17	21	50	19	170
Total	48	32	5	18	24	48	21	541

Table A-7.18 Personal characteristics of RTI/STI clients

Among clients whose consultation for an RTI/STI was observed and who were interviewed, percent distribution by employment status, and among employed RTI/STI clients, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2004

Background characteristics	Among all RTI/STI clients, percentage who are:		Number of interviewed RTI/STI clients (weighted)	Among employed RTI/STI clients, percentage who:							Number of RTI/STI clients who are employed (weighted)
	Employed	Not employed		Work for:			Receive:				
				Family member	Someone else	Self	Salary in cash	Salary in kind	Salary both	No salary	
Type of facility											
GS hospital	10	90	92	64	30	7	36	0	7	57	10
MCH/urban HU	8	92	132	0	78	22	100	0	0	0	10
Rural HU	19	81	96	35	36	28	46	9	0	45	18
Mobile unit	11	89	120	38	41	21	54	4	8	34	14
Health office	13	87	17	0	100	0	100	0	0	0	2
NGO facility	25	75	85	12	82	6	85	0	6	9	21
Region											
Urban Governorates	13	87	140	3	97	0	100	0	0	0	18
Lower Egypt	16	84	231	31	50	18	60	5	0	36	37
Upper Egypt	11	89	170	41	31	28	46	3	16	35	19
Total	14	86	541	27	57	16	66	3	4	27	75

Table A-7.19 Education status and literacy status of RTI/STI clients

Among clients whose consultation for an RTI/STI was observed and who were interviewed, percent distribution by education status, and among RTI/STI clients with primary or no education, percent distribution by literacy status, according to type of facility and region, Egypt SPA 2004

Background characteristics	Among interviewed RTI/STI clients, percentage with:				Number of interviewed RTI/STI clients (weighted)	Percentage of interviewed RTI/STI clients with primary or no education who:				Number of RTI/STI clients with primary or no education (weighted)
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write	Can read and write	Missing	
Type of facility										
GS hospital	49	13	16	22	92	82	0	18	0	57
MCH/urban HU	47	9	12	32	132	67	3	29	1	74
Rural HU	54	4	9	32	96	84	4	11	1	56
Mobile unit	49	6	6	39	120	77	7	17	0	66
Health office	23	17	10	51	17	50	0	50	0	7
NGO facility	28	8	14	50	85	77	4	19	0	30
Region										
Urban Governorates	40	9	14	38	140	67	2	31	0	68
Lower Egypt	37	10	11	42	231	71	5	24	0	108
Upper Egypt	61	6	10	24	170	86	4	9	1	113
Total	45	8	11	35	541	76	4	20	1	289

Table A-7.20 Capacity to provide services for tuberculosis

Among facilities providing any tuberculosis services, percentage that have the capacity to test for TB, percentage that have the indicated medicines for treating TB, and percentage that have all medicines for providing first-line and second-line treatment for TB, by type of facility, Egypt SPA 2004

Capacity to provide TB services	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Ability to conduct microscopic sputum exam ¹	27	100	31	6	0	0	0	13
Ability to stain sputum for TB diagnosis ²	19	0	0	0	0	0	0	2
Availability of medicines								
Isoniazid (INH)	14	0	24	1	0	0	0	6
Pyrazinamide	7	0	0	0	0	0	0	1
Rifampin	7	0	24	3	0	100	0	7
Ethambutal	5	0	0	6	0	0	0	5
Remactazid (rifampin & INH)	16	0	0	1	0	0	0	3
Streptomycin	11	0	20	22	0	0	0	19
Pre-packed DOTS TB drugs	26	0	28	13	0	0	0	16
All first-line treatment available ³	26	0	28	13	0	0	0	16
All first- and second-line treatment available ⁴	3	0	0	5	0	0	0	4
Number of facilities providing TB services (weighted)	23	2	22	134	3	2	1	188
Facility has DOTS and all first-line treatment medicines in stock	24	-	73	14	-	-	-	19
Total number of facilities providing TB services and has DOTS	23	0	8	116	0	0	0	148
Facility does not have DOTS and has all first-line treatment medicines in stock	100	0	0	4	0	0	0	3
Total number of facilities providing TB services but does not have DOTS	1	2	14	18	3	2	1	40
¹ Functioning microscope and glass slides								
² Functioning microscope and glass slides plus all stains for AFB or Ziehl-Neelson test								
³ Any combination of pyrazinamide, rifampin, ethambutol, and isoniazid.								
⁴ All first-line medicines plus streptomycin								
DOTS = Directly Observed Treatment Short-course								

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MEASURE Service Provision Assessment

Facility Resources Questionnaire

FACILITY IDENTIFICATION

Name of the facility _____ Facility Location _____ Governorate _____ District _____ Code of the facility _____ Type of Health Facility and Operating Authority Governmental: 11 = General Hospital 21=MCH Center 12=District Hospital 22=Rural health unit 13= Fever Hospital 23=Urban health unit 14= Integrated Hospital 24=Health Office 25=Mobile Unit 26=Other Non-Governmental: 31 =CSI 32= EFPA 33=other non-governmental	QTYPE RES GOV..... DISTRICT..... FACILITY CODE FACILITY TYPE AND OPERATING AUTHORITY
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------

Date: _____ Name of the interviewer _____	DAY MONTH YEAR..... INTERVIEWER CODE..
------------------------------------------------------	-------------------------------------------------------------

Number of questionnaires completed at facility:

Questionnaire Type

1	Sick Child Observations _____	CHILD OBSERVATION		
2	Sick Child Exit Interviews _____	CHILD EXIT		
3	FP Observations _____	FP OBSERVATION		
4	FP Exit Interviews _____	FP EXIT		
5	ANC Observations _____	ANC OBSERVATION		
6	ANC Exit Interviews _____	ANC EXIT		
7	STI Observation _____	STI OBSERVATION		
8	STI Exit Interviews _____	STI EXIT		
9	Provider Interviews _____	PROVIDER INTERVIEWS		
10	Injection Observ _____	INJECTION OBSERVATION		

001	If this facility a hospital or MCH center or urban health unit (see cover page) circle 1 and ask Q 002. If not, circle 2 and go to Q 003.	YES1 NO2	→003
002	Is this facility with or adjacent to a Health Office?	YES1 NO2	
003	If this facility a Health Office(see cover page), circle 1 and ask Q 004. If not, circle 2 and go to Q100	YES1 NO2	→100
004	Is this facility with or adjacent to a hospital, MCH center or urban health unit?	YES1 NO2	

TURN ON AND WAIT UNTIL SATELLITE PAGE CHANGES TO “POSITION”

- 1 WRITE ALTITUDE
- 2 PRESS MARK
- 3 HIGHLIGHT “AVERAGE” AND PRESS ENTER
- 4 HIGHLIGHT WAYPOINT NUMBER AND PRESS ENTER
- 5 ENTER FACILITY CODE (6 DIGITS)
- 6 WAIT 5 MINUTES
- 7 HIGHLIGHT “ SAVE” AND PRESS ENTER
- 8 PAGE TO MAIN MENUE AND HIGHLIGHT “WAYPOINT LIST” AND PRESS ENTER
- 9 HIGHLIGHT YOUR WAYPOINT
- 10 COPY INFORMATION FROM WAYPOINT LIST PAGE- THIS IS THE AVERAGE OF ALL THE SATTELITE READINGS
- 11 BE SURE AND COPY THE WAYPPOINT NAME FROM THE WAYPOINT LIST PAGE TO VERIFY YOU ARE ENTERING THE CORRECT WAYPOINT INFORMATION ON THE DATA FORM

POSITION			
WAYPOINT NAME.....			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ALTITUDE.....			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
LATITUDE.....	<input type="checkbox"/>	<input type="text"/> <input type="text"/>	DEGREES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
LONGITUDE.....	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Section 1a. General Information: Management

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
	<p>FOR OUTPATIENT SERVICES: FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR OUTPATIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely confidential and is not identified with any facility name. We are asking for your help to ensure that the information collected is accurate. If there are sections where someone else is the most appropriate person to provide information, we would appreciate your introducing us to that person. I will ask questions and then for many topics I will ask to see some record related to the question. You may choose to stop the interview at any time.</p> <p>Do you have any questions for me? Do I have your agreement to participate?</p>		
	<p>INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p>	<p>DATE</p>	
100	May I begin the interview?	YES.....1 NO.....2	→ STOP
101	Routinely, how many days each week is the facility open for outpatient adult curative services?	NUMBER OF DAYS <input style="width: 30px; height: 20px;" type="text"/> DON'T KNOW.....8	
101a	Is there a physician who lives onsite at this facility?	YES.....1 NO.....2 NOT APPLICABLE.....3 DON'T KNOW.....8	
102	Is there a physician present (assigned) at the facility at all times (24 hours/day) for emergency services? IF YES, ASK TO SEE DUTY SCHEDULE.	YES, SCHEDULE SEEN1 YES, SCHEDULE NOT SEEN2 NO,.....3	→104 →104
103	Is there a physician available away from the facility, but officially on call at all times after hours for emergency services? IF YES, ASK TO SEE ON CALL DUTY SCHEDULE.	YES, SCHEDULE SEEN1 YES, SCHEDULE NOT SEEN.....2 NO.....3	
104	Does this facility routinely admit inpatients for treatment?	YES.....1 NO2	→106
105	Does this facility have beds for overnight observation?	YES.....1 NO2	
106	Does this facility have routine meetings for reviewing management or administrative issues?	YES.....1 NO2 DON'T KNOW8	→109 →109
107	How often do meetings to discuss the facility management/administrative issues take place?	MONTHLY OR MORE OFTEN.....1 EVERY 2-3 MONTHS.....2 EVERY 4-6 MONTHS.....3 LESS OFTEN THAN EVERY 6 MONTHS4 OTHER6	
108	Is an official record of meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES/NOTES) FROM THE MOST RECENT MEETING	YES, RECORD OBSERVED.....1 YES, REPORTED, NOT SEEN2 NO RECORD MAINTAINED3	
109	Are there any <u>routine</u> meetings about facility activities or management issues that include both facility managers and community members?	YES.....1 NO2 DON'T KNOW8	
110	Does this facility have any system for determining client opinion about the health facility or services? IF YES, CIRCLE ALL METHODS FOR ELICITING CLIENT OPINIONS THAT ARE USED	SUGGESTION BOX A CLIENT SURVEY FORM B CLIENT INTERVIEW C OTHER X (SPECIFY) NO CLIENT FEEDBACK Y DON'T KNOW Z	→113 →113

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
111	Is there a procedure for collecting and reporting on client opinion? IF YES, ASK TO SEE A REPORT OR FORM WHERE DATA IS COMPILED.	YES, REPORT SEEN.....1	YES, NO REPORT SEEN2	NO3		
112	In the past 3 months have any changes been made in the program as a result of client opinion? IF YES, DESCRIBE THE CHANGES MADE.	YES, _____ .1 (SPECIFY)	NO2	DON'T KNOW.....8		
113	Does this facility provide services according to quality criteria? This refers to a <u>routine</u> program for quality assurance.	YES.....1	NO2	DON'T KNOW.....8	→117 →117	
114	Is this system implemented throughout the facility, or is it within specific services only?	THROUGHOUT FACILITY1	ONLY SPECIFIC SERVICES2			
115	Are any of the following methods for quality assurance used? IF YES, ASK TO SEE SOME DOCUMENTATION (REPORT/ MINUTES/ ETC). FOR THE METHOD IMPLEMENTATION.					
	METHOD	METHOD USED				
		1 DOCUME NT SEEN	2 DOCUME NT NOT SEEN	3 METHOD NOT USED	8 NOT DETERMINED	
	1) Supervisory checklist for health system components (e.g. service specific equipment, meds, and records)	1	2	3	8	
	2) Supervisory checklist for health service provision (e.g. Observation Check list)	1	2	3	8	
	3) Facility-wide review of mortality	1	2	3	8	
	4) Periodic audit of medical records or service registers	1	2	3	8	
	5) Quality Assurance committee/team?	1	2	3	8	
	6) Quality Improvement Program (QIP)	1	2	3	8	
	7) Other (SPECIFY)	1	2	3	8	
116	Who is responsible for reviewing findings and taking action from quality activities? CIRCLE ALL THAT APPLY AND INDICATE IF THE PERSON(S) ARE POSTED INTERNAL (IN) TO THE FACILITY OR EXTERNAL (OUT) OR BOTH	1 PERSON S INTERNA L TO FACILITY	2 PERSON S EXTERNA L TO FACILITY	3 BOTH INTERNA L AND EXTERNA L	4 NOT USED	8 DON'T KNO W
	1) Individual Supervisors	1	2	3	4	8
	2) Management Committee	1	2	3	4	8
	3) Special Quality Assurance committee or team.....	1	2	3	4	8
	4) Governorate or district Management Team ...	1	2	3	4	8
	5) Other	1	2	3	4	8
117	When was the last time a supervisor from <u>outside</u> this facility visited the facility?	WITHIN THE LAST 6 MONTHS 1 MORE THAN 6 MONTHS AGO 2 NEVER SUPERVISED FROM OUTSIDE FACILITY 3				→119 →119

NO.	QUESTIONS	CODE CLASSIFICATION			GO TO
		YES	NO	DK	
118	The most recent time within the last 6 months that a supervisor from outside the facility visited, did the supervisor: 1) Check some registers/books?..... 2) Discuss problems?..... 3) Discuss policy/administrative issues?..... 4) Discuss technical protocols or issues related to service delivery practices?..... 5) Hold an official staff meeting?..... 6) Observe individual staff providing services?.... 7) Record observations in supervision book..... 8) Do anything else?	CHECKED REGISTERS..... 1 DISCUSSED PROBLEMS.. 1 DISCUSSED POLICY..... 1 DISCUSSED TECHNICAL MATTERS..... 1 HELD STAFF MEETING..... 1 OBSERVE SERVICE PROVISION..... 1 RECORD IN BOOK..... 1 OTHER_____ 1 (SPECIFY)	2 2 2 2 2 2 2 2	8 8 8 8 8 8 8 8	
119	Is there a standard form used for clients referred to other facilities? ASK TO SEE THE FORM. (IF THE FACILITY IS THE REFERRAL FACILITY, THEN CIRCLE "4" FOR REFERRAL FACILITY.	YES, FORM SEEN..... 1 YES, FORM NOT SEEN..... 2 NO FORM USED..... 3 REFERRAL FACILITY..... 4 DON'T KNOW..... 8			→121 →121 →121
120	Does the referral form have a section requiring client information explaining the reason for the referral?	YES..... 1 NO..... 2 DON'T KNOW..... 8			
121	What is the primary source(s) from which equipment, supplies, other goods required for services are made available for this facility.	GOVERNMENT (MoH)..... A DONORS..... B CLIENT REVENUES..... C OTHER _____ X DON'T KNOW..... Z			
122	What are the primary sources of funds for your facility. BUDGET MEANS AN ANNUAL AMOUNT OF MONEY AVAILABLE TO THE FACILITY FOR NORMAL RUNNING COSTS	ANNUAL BUDGET (MOH)..... A MOH, BUT NOT THROUGH ANNUAL BUDGET..... B ANNUAL BUDGET (DONORS) C DONORS, NOT ANNUAL BUDGET..... D CLIENT REVENUES..... E OTHER _____ X DON'T KNOW..... Z			
123	Does this facility have a specific system for maintenance and repair of the building or infrastructure (e.g. plumbing or electric) ? IF YES, Who authorizes repairs?	IN-CHARGE OF FACILITY..... A IN-CHARGE OF UNIT REQUIRING REPAIR..... B OTHER _____ X (SPECIFY) NO SYSTEM..... Y DON'T KNOW..... Z			→125 →125
124	Who makes repairs for the building or infrastructure?	ON-SITE STAFF..... 1 HIRE FROM OUTSIDE..... 2 BOTH ON-SITE AND OUTSIDE.... 3 OTHER_____ 6 (SPECIFY) DON'T KNOW..... 8			

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO	
125	Does this facility have a program for routine preventive maintenance for major equipment such as a generator or sterilizing equipment? This means the equipment is checked periodically even if there is no problem. IF YES: Who is responsible for the maintenance?	YES, ON-SITE STAFF 1 YES, OUTSIDE SUPPORT 2 YES, BOTH ONSITE AND OUTSIDE 3 NO ROUTINE MAINTENANCE 4 DON'T KNOW 8		
126	What is the system for repairing or replacing small equipment (blood pressure cuffs, stethoscope, etc). (CIRCLE ALL THAT APPLY).	ON-SITE MAINTENANCE A PETTY CASH FOR REPLACING .. B SEND ELSEWHERE FOR REPAIR C OTHER _____ X (SPECIFY) NO SYSTEM Y DON'T KNOW Z		
127	Does this facility have a budget line-item in the current budget, or use funds from service improvement box for equipment maintenance?	YES, BUDGET LINE ITEM A YES, SERVICE IMPROVEMENT BOX B NO Y DON'T KNOW Z	→ 129 → 129	
128	Is the budget and/or funds from the service improvement box adequate to meet normal needs of your facility for maintaining large equipment and repairing or replacing small equipment ?	APPEARS SUFFICIENT 1 UNCERTAIN IF WILL BE SUFFICIENT 2 NOT SUFFICIENT 3 DON'T KNOW 8		
129	Does this facility routinely charge for adult outpatient curative consultation services? IF YES, WHAT SYSTEMS APPLY?	YES, FEE VARIES BY DAY OR TIME OF DAY A YES, ECONOMIC AND FREE SECTION B YES, DISCOUNT OR EXEMPTION FOR SOME CLIENTS C YES, FIXED FEE, VARIES BY TYPE OF CLIENT D YES, PREPAY FOR MULTIPLE VISITS FOR ONE SERVICE E OTHER _____ X (SPECIFY) NO Y DON'T KNOW Z	→ 136 → 136	
130	CIRCLE ALL CHARGING PRACTICES USED	ECONOMIC	FREE SECTION	
	1 Fixed fee for registration ticket or consultation	A	B	Y
	2 Fixed fee health card	A	B	Y
	3 Charge for medications	A	B	Y
	4 Charge for tests	A	B	Y
131	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges? [GO TO AREA AFTER COMPLETING INTERVIEW WITH DIRECTOR]	YES ALL FEES POSTED 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8		
132	CHECK QUESTION 129 C. DOES THE FACILITY OFFER EXEMPTIONS OR DISCOUNTS FOR SOME CLIENTS?	YES 1 NO 2 DON'T KNOW 8	→ 136 → 136	
133	Who is in charge of making the final decision on whether a client receives a discount of exemption?	IN-CHARGE A SOCIAL WORKER B OTHER _____ X DON'T KNOW Z		

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
134	Is there a book or register where discounted fees are collected and exemptions are listed? IF YES, ASK TO SEE THE REGISTER.	YES, REGISTER SEEN..... 1 YES, REGISTER NOT SEEN 2 NO REGISTER 3 DON'T KNOW 8	→ 136 → 136 → 136
135	What is the most recent date for an exemption or discount?	WITHIN 7 DAYS..... 1 >7 DAYS WITHIN 30 DAYS..... 2 MORE THAN 30 DAYS..... 3	
136	Does this facility receive any reimbursement for services to discounted or exempted clients from sources outside of the routine running budget or direct client fees? This may include reimbursement from insurance companies, from charities or communities that reimburse for poor clients, or other systems the facility may participate in. IF YES, INDICATE WHICH PLANS APPLY.	CHARITY FUND FOR POORA INSURANCE/PRE-PAYB HIO/SHIP C MOH FUND..... D OTHER SYSTEM _____X (SPECIFY) NO Y DON'T KNOW Z	
137	Does this facility have an active women's Club? IF YES, ASK TO SEE ANY RECORD OF ACTIVITIES OR SCHEDULE OF ACTIVITIES FOR THE PRIOR MONTH OR THE CURRENT MONTH	YES, DOCUMENT SEEN 1 YES, NO DOCUMENT SEEN 2 NO 3 DON'T KNOW 8	
138	Does this facility have a working phone or short-wave radio for calling outside?	YES 1 NO 2	→ 140
139	Is there a phone or short-wave radio within five minutes time from the facility that staff can use in an emergency? IF YES: Is that phone or short-wave radio available 24 hours a day?	YES, AVAILABLE 24 HOURS 1 YES, NOT AVAILABLE 24 HOURS 2 NO, NONE WITHIN 5 MINUTES ... 3	
140	Does this facility ever have electricity? (from any source)	YES 1 NO 2	→ 142
141	Is the electricity always available during the times when the facility is providing services or is it sometimes interrupted? IF SOMETIMES INTERRUPTED, ASK: On how many days during the past week was the electricity not available for two (2) or more hours?	ALWAYS AVAILABLE..... 0 <input type="checkbox"/> # OF DAYS NOT AVAILABLE PAST WEEK	
142	What is the <u>most commonly used</u> source of water for the facility <u>at this time?</u>	PIPED 10 PROTECTED WELL/ BOREHOLE 20 UNPROTECTED WELL / BOREHOLE 21 RIVER/LAKE /POND..... 30 OTHER _____ _96 (SPECIFY) NO WATER SOURCE 00	→ 145
143	Is water outlet from this source available on-site (that is, within 500m) of the facility?	YES, ON-SITE 1 NO 2	
144	Does this source of water for the facility vary seasonally?	YES 1 NO 2 NO NORMAL SOURCE 3	

145	<p>Now I have some questions about the staff who provide OUTPATIENT services . We want to know the highest technical qualification and the number of staff who are permanently assigned for outpatient services. This may include staff who also rotate to inpatient service. If someone is a specialist physician or nurse, we want to know their basic qualification (e.g. Nurse or Doctor) regardless of specialty or position.</p>																					
	<table border="1"> <thead> <tr> <th data-bbox="256 338 878 380">QUALIFICATION</th> <th data-bbox="878 338 1453 380">TOTAL NUMBER</th> </tr> </thead> <tbody> <tr> <td data-bbox="256 380 878 453">1) OB/GYN PHYSICIAN</td> <td data-bbox="878 380 1453 453">OB/GYN <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 453 878 527">2) FAMILY PLANNING PHYSICIAN</td> <td data-bbox="878 453 1453 527">FAMILY PLANNING <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 527 878 600">3) PEDIATRICIAN</td> <td data-bbox="878 527 1453 600">PEDIATRIC <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 600 878 674">4) FAMILY PHYSICIAN</td> <td data-bbox="878 600 1453 674">FAMILY <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 674 878 747">5) OTHER PHYSICIAN SPECIALIST</td> <td data-bbox="878 674 1453 747">OTHER SPECIALITY <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 747 878 821">6) GENERAL PRACTITIONER</td> <td data-bbox="878 747 1453 821">GENERALIST <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 821 878 894">7) NURSE WITH MIDWIFRY</td> <td data-bbox="878 821 1453 894">NURSE W/ MIDWIFRY <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 894 878 968">8) NURSE</td> <td data-bbox="878 894 1453 968">NURSE <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td data-bbox="256 968 878 1167">9) OTHER (SPECIFY) _____</td> <td data-bbox="878 968 1453 1167">OTHER <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> </tbody> </table>	QUALIFICATION	TOTAL NUMBER	1) OB/GYN PHYSICIAN	OB/GYN <input type="text"/> <input type="text"/> <input type="text"/>	2) FAMILY PLANNING PHYSICIAN	FAMILY PLANNING <input type="text"/> <input type="text"/> <input type="text"/>	3) PEDIATRICIAN	PEDIATRIC <input type="text"/> <input type="text"/> <input type="text"/>	4) FAMILY PHYSICIAN	FAMILY <input type="text"/> <input type="text"/> <input type="text"/>	5) OTHER PHYSICIAN SPECIALIST	OTHER SPECIALITY <input type="text"/> <input type="text"/> <input type="text"/>	6) GENERAL PRACTITIONER	GENERALIST <input type="text"/> <input type="text"/> <input type="text"/>	7) NURSE WITH MIDWIFRY	NURSE W/ MIDWIFRY <input type="text"/> <input type="text"/> <input type="text"/>	8) NURSE	NURSE <input type="text"/> <input type="text"/> <input type="text"/>	9) OTHER (SPECIFY) _____	OTHER <input type="text"/> <input type="text"/> <input type="text"/>	
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8) NURSE	NURSE <input type="text"/> <input type="text"/> <input type="text"/>																					
9) OTHER (SPECIFY) _____	OTHER <input type="text"/> <input type="text"/> <input type="text"/>																					
	<p>10) SUM THE NUMBER OF STAFF REPORTED IN 1-9 AND CHECK: YOU HAVE TOLD ME THAT YOU HAVE ___ (NUMBER OF STAFF) WHO PROVIDE OUTPATIENT SERVICES. IS THIS CORRECT? IF NOT CORRECT, PROBE AND CHANGE 1-10 AS NECESSARY.</p>	<p>YES, NUMBER CORRECT 1 NO 2</p>																				
146	<p>Do have an estimate of the size of the catchment population that this facility serves, that is, the size of the population living in the area served by this facility?</p> <p>IF YES: How many people is that?</p>	<p>CATCHMENT POPULATION</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>NO CATCHMENT AREA... 9999995 DON'T KNOW SIZE OF CATCHMENT POPULATION..... 9999998</p>																				
147	<p>Does the facility have an ESU computer. If Yes, is it functioning? THE ESU COMPUTER IS USED FOR TRACKING 26 PRIORITY INFECTIOUS DISEASES AND IS CONNECTED TO THE CENTRAL ESU IN MOHP.</p>	<p>YES, FUNCTIONING1 YES, NOT FUNCTIONING2 NO3</p>																				

Section 1b. General Information: Resources

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
	ASK TO GO TO THE MAIN AREA WHERE EQUIPMENT IS CLEANED AND STERILIZED OR DISINFECTED AND ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE OF THE PROCESSES USED. I want to ask you about how you process used medical equipment such as surgical equipment, forceps, speculums, or other equipment that must be processed before reusing.		
150	What procedure is used for cleaning contaminated equipment prior to final processing for reuse?	SOAKED IN DISINFECTANT SOLUTION BRUSH SCRUBBED WITH SOAP AND WATER.....1 BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT2 BRUSH SCRUBBED WITH SOAP AND WATER3 SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED4 OTHER6 NONE7 DON'T KNOW8	
151	After cleaning, what is the final process most commonly used for disinfecting or sterilizing medical equipment (e.g., surgical instruments) prior to reuse? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE DIFFERENT METHODS.	DRY HEAT STERILIZATION..... A AUTOCLAVE B STEAM C BOILING D CHEMICAL E PROCESS OUTSIDE FACILITY... F OTHER X NONE Y	→ 159 → 159
GO TO WHERE EQUIPMENT IS STERILIZED AND ASSESS AVAILABILITY OF EQUIPMENT REQUIRED FOR PROCEDURES.			
152	ITEM	(a) AVAILABILITY	(b) FUNCTIONING
		OBSERVED REPORTED AVAILABLE NOT AVAILABLE NOT DETERMINED	YES NO NOT DETER
01	Electric dry heat sterilizer	1→b 2→b 3↓ 8↓	1 2 8
02	Electric autoclave (pressure; wet heat)	1→b 2→b 3↓ 8↓	1 2 8
03	Non-electric autoclave	1→b 2→b 3↓ 8↓	1 2 8
04	Pot with cover (for steaming or boiling)	1 2 3 8	
05	Other method _____ (SPECIFY)	1 2 3 8	
153	Heat source (stove/Cooker w/fuel or power present) For steaming, boiling, or using non-electric autoclave)	1→b 2→b 3↓ 8↓	1 2 8
154	Automatic timer (MAY BE ON MACHINE)	1→b 2→b 3↓ 8↓	1 2 8
155	TST Indicator strips (Tape indicating sterilization)	1 2 3 8	
156	Biological indicator for testing effectiveness of sterilization	1 2 3 8	
157	Written guidelines for disinfection and sterilization	1 2 3 8	

158 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/DISINFECTION AND CHEMICAL DECONTAMINATION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED

	(a) Dry heat sterilization	(b) Autoclave	(c) Boil or steam (high level disinfectant ,HLD)	(d) Chemical decontaminant	(e) Chemical High Level Disinfectant (HLD)	(f) OTHER
01	Method USED1 NOT USED2→b	USED1 NOT USED2→c Temperature AUTOMATIC 666 DON'T KNOW 998	USED1 NOT USED2→d	USED1 NOT USED2→e	USED1 NOT USED2→f	Temperature AUTOMATIC 666 DON'T KNOW 998
02	Temperature (centigrade)	Temperature AUTOMATIC 666 DON'T KNOW 998	Temperature AUTOMATIC 666 DON'T KNOW 998			Temperature AUTOMATIC 666 DON'T KNOW 998
03	PRESSURE	AUTOMATIC 666 DK PRESSURE 998 UNITS OF PRESSURE DK UNITS OF PRESSURE...8 POUNDS/SQ.IN1 ATM PRESSURE2 KILOPASCAL3 MILLIMETER HG4	AUTOMATIC 666 DK PRESSURE 998 UNITS OF PRESSURE DK UNITS OF PRESSURE...8 POUNDS/SQ.IN1 ATM PRESSURE2 KILOPASCAL3 MILLIMETER HG4			AUTOMATIC 666 DON'T KNOW998 UNITS OF PRESSURE DK UNITS OF PRES...8 POUNDS/SQ.IN1 ATM PRESSURE2 KILOPASCAL3 MILLIMETER HG4
04	Minutes-when equipment is not wrapped in cloth	Minutes AUTOMATIC 666 DON'T KNOW 998	Minutes DON'T KNOW 998	Minutes	Minutes	Minutes AUTOMATIC 666 DON'T KNOW 998
05	Minutes when equipment is wrapped	Minutes wrapped AUTOMATIC 666 DON'T KNOW 998	Minutes wrapped DON'T KNOW 998	Minutes wrapped	Minutes wrapped	Minutes wrapped AUTOMATIC 666 DON'T KNOW 998
06	Chemical solution (DISINFECTANT)			CHLOR1 BETADINE2 ALCOHOL3 SAVLON4 OTHER6 DON'T KNOW8	CIDEX/GLUTARAL- DEHYDE/SEPTAID1 CHLOR2 BETADINE3 ALCOHOL4 SAVLON5 OTHER6 DON'T KNOW8	
07	Percent solution (Concentration before diluted)	Percent DK=98	Percent DK=98	Percent DK=98	Percent DK=98	Percent DK=98
08	Mixture, parts disinfectant and water	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED	
159	ASK TO SEE WHERE CENTRALLY PROCESSED ITEMS ARE STORED AFTER PROCESSING, AND INDICATE FOR EACH OF THE BELOW IF THIS WAS OBSERVED OR REPORTED AS A PRACTICE:					
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8	
	2) Stored in sterile container with lid which clasps shut	1	2	3	8	
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8	
	4) On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8	
	5) In container with disinfectant or antiseptic	1	2	3	8	
	6) Other _____ (SPECIFY)	1	2	3	8	
160	Is the date of sterilization for the stored items indicated?	1	2	3	8	
161	Is the storage area for sterilized items clean and dry?	1	2	3	8	
162	Is there a generator for the facility? IF YES, INDICATE IF THE GENERATOR FUNCTIONS OR NOT.	YES, FUNCTIONING 1 YES, NOT FUNCTIONING 2 NO 3 DON'T KNOW 8				→ 164 → 164
163	Is fuel available for the generator? IF YES, ASK TO SEE WHERE THE FUEL IS STORED.	YES, OBSERVED 1 YES, NOT SEEN 2 NO 3 DON'T KNOW 8				
164	Is there a waiting area for clients, where they are protected from sun and rain?	YES 1 NO 2				
165	Is there a toilet (latrine) in functioning condition which is available for use of clients?	YES, OBSERVED 1 YES, NOT SEEN 2 NO 3				→ 167 → 167
166	Is there soap and water available in the toilette?	YES, OBSERVED SOAP & WATER 1 YES, WATER ONLY 2 NO 3				
167	How does this facility dispose of paper waste or common trash (e.g. not contaminated waste)?	BURNED IN INCINERATOR..... 01 COLLECTED AND DISPOSED EXTERNALLY 02 BURNED IN OPEN PIT 03 BURNED AND BURIED 04 BURNED NOT BURIED 05 THROW IN TRASH/OPEN PIT 06 THROW IN PIT LATRINE 07 OTHER 96				
168	How does this facility dispose of potentially contaminated waste and items which are not reused (e.g. bandages, syringes)?	BURNED IN INCINERATOR..... 01 COLLECTED AND DISPOSED EXTERNALLY 02 BURNED IN OPEN PIT 03 BURNED AND BURIED 04 BURNED NOT BURIED 05 THROW IN TRASH/OPEN PIT 06 THROW IN PIT LATRINE 07 OTHER 96				

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
169	INTERVIEWER: ASK TO SEE PLACE USED FOR WASTE DISPOSAL (AND IF APPLICABLE, WHERE CONTAMINATED WASTE IS STORED <u>EXTERNAL</u> TO SERVICE DELIVERY AREA PRIOR TO DISPOSAL) AND INDICATE THE CONDITION THAT APPLIES WHEN YOU CONSIDER BOTH SITES)	WASTE VISIBLE, <u>NOT</u> PROTECTED 1 WASTE VISIBLE,PROTECTED 2 NO WASTE VISIBLE 3 WASTE SITE NOT INSPECTED ... 8	
170	ASSESS GENERAL CONDITION OF FACILITY AND INDICATE IF ANY OF THE ITEMS LISTED WERE NOTED	BROKEN WINDOWS.....A BROKEN DOORS.....B BROKEN WALLS C LEAKING PLUMBING..... D OTHERX NO MAJOR PROBLEMS Y	
171	ASSESS GENERAL CLEANLINESS OF FACILITY ■ A FACILITY IS CLEAN IF THE FLOORS ARE SWEEPED, COUNTERS/TABLES ARE WIPED AND FREE FROM OBVIOUS DIRT OR WASTE. ■ A FACILITY IS NOT CLEAN IF THERE IS OBVIOUS DIRT/WASTE/BROKEN OBJECTS ON FLOORS OR COUNTERS	FACILITY CLEAN 1 FACILITY NOT CLEAN 2	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
209	Do you have a system that allows you to check the amount of each vaccine that is available daily? IF YES, ASK TO SEE THE RECORDS AND INDICATE THE METHOD FOR WHICH YOU OBSERVED RECORDS.	INVENTORY NOT UPDATED DAILY, BUT WITH REGISTER OF DISTRIBUTED VACCINES KEPT DAILY 1 INVENTORY UPDATED DAILY 2 NO INVENTORY RECORDS SEEN 3	

ASK TO SEE THE VACCINES AND VITAMIN A. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. CHECK ALL TO VERIFY IF (A) THEY ARE ARRANGED BY EXPIRY DATE, (B) WERE THERE ANY EXPIRED UNITS PRESENT, AND (C) VERIFY THAT INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY REGISTER OR PRESCRIPTION AND SUBTRACT THESE FROM INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:

210	VACCINE AND VITAMIN-A	(a) AVAILABILITY OF VACCINES 1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED	(b) VALIDITY 1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW	(c) SUPPLY AND INVENTORY (W/REGISTER) SAME 1=YES 2=NO 8=DON'T KNOW
	1) Tetanus Toxoid	1→b 2 3 8	1 2 8	1 2 8
	2) BCG and Dilutant	1→b 2 3 8	1 2 8	1 2 8
	3) Oral Polio (OPV)	1→b 2 3 8	1 2 8	1 2 8
	4) DPT	1→b 2 3 8	1 2 8	1 2 8
	5) Measles & Dilutant	1→b 2 3 8	1 2 8	1 2 8
	6) Hepatitis B	1→b 2 3 8	1 2 8	1 2 8
	7) Hep-DPT ("square)	1→b 2 3 8	1 2 8	1 2 8
	8) MMR	1→b 2 3 8	1 2 8	1 2 8
	9) Vitamin A	1→b 2 3 8	1 2 8	1 2 8

211	Were the vaccines organized according to expiry date "first expire first out" in the fridge/cold box? (VERIFIED WHEN COMPLETING 210)	YES, VERIFIED..... 1 NO 2 DON'T KNOW 8	
212	Does this facility determine the amount of vaccines required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE 2 BOTH (DIFFER BY VACCINE) 3 OTHER 6 (SPECIFY)	→214a
213	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the quantity you receive vary with the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8	→216 →216 →216
214a	When was the last time that you received a routine supply of vaccines ?	WITHIN PRIOR 4 FULL WEEKS....1 WITHIN PRIOR 12 FULL WEEKS...2 MORE THAN 12 WEEKS AGO3 DON'T KNOW.....8	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
214b	<p>Routinely, when you order vaccines, which best describes the system you use to determine how much of each to order:</p> <p>1) Do you review the amount of each vaccine remaining, and order to bring the stock amount to a pre-determined (fixed) amount?</p> <p>2) Do you order the exact same amount each time?</p> <p>3) Do you look at the amount used since the previous order, and plan based on prior utilization and expected future activity?</p> <p>4) Others</p> <p>5) RESPONDENT FAMILIAR WITH ORDERING SYSTEM IS NOT AVAILABLE</p>	<p>ORDER TO MAINTAIN FIXED STOCK LEVEL1</p> <p>ORDER SAME AMOUNT2</p> <p>ORDER BASED ON UTILIZATION.....3</p> <p>OTHER _____...6 (SPECIFY)</p> <p>DON'T KNOW.....8</p>	<p>→ 215a</p> <p>→ 215a</p> <p>→215a</p> <p>→216</p>
214c	<p>When deciding how much of each vaccine to order, based on prior utilization and planned activities, do you have a mathematical formula for calculating how much to use, or do you use your judgment?</p>	<p>MATHEMATICAL FORMULA1</p> <p>JUDGMENT2</p>	
215a	<p>Which of the following best describes the system for deciding when to order vaccines?</p> <p>1) Whenever stock levels fall to a predetermined level</p> <p>2) There is a fixed time that orders are accepted. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS.</p> <p>3) An order is placed at no fixed time, but rather whenever there is a need.</p> <p>4) Other</p>	<p>PREDETERMINED LEVEL1</p> <p>EVERY <input type="text"/> <input type="text"/> WEEKS.....2</p> <p>ORDER AS NEEDED3</p> <p>OTHER _____...6 (SPECIFY)</p>	
215b	<p>If there is a shortage of specific vaccine between routine orders, what is most common procedure followed by this facility?</p> <p>1) Submit special order to normal supplier.</p> <p>2) Tell client to return when vaccine is available.</p>	<p>SPECIAL ORDER.....1</p> <p>CLIENT MUST RETURN.....2</p> <p>NO SHORTAGE.....3</p>	
216	<p>During the past 3 months, how often have you received the amount of vaccines (s) that you order (or that you are suppose to routinely receive)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES..... 2</p> <p>ALMOST NEVER 3</p> <p>D.K.....8</p>	
217	<p>How many vaccine carriers do you have available?</p>	<p>ONE 1</p> <p>TWO OR MORE 2</p> <p>NONE 3</p>	<p>→219</p>

218	Are there ice packs for the vaccine carriers (4-5 per carrier)?	YES, ONE SET 1 YES, TWO OR MORE SETS 2 NO, USE PURCHASED ICE 3 NO 4
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Section 2b. Child Health Services-vaccinations

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
219	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis?	YES 1 NO 2	→ 300

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF CHILD CURATIVE HEALTH SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING PREVIOUSLY, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 220.

READ TO CHILD HEALTH SERVICES INFORMANT (IF DIFFERENT FROM PREVIOUS INFORMANT):

Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about the child health services provided through this facility. Please be assured that the information is completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate?

_____ INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

_____ DATE

220	May I begin the interview?	YES 1 NO 2	→ 300
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	Now, I would like to ask you specifically about child health services. For each of the following services please tell me if the service is offered by your facility, and if yes, how many days per week the service is provided <u>at the facility</u> and days per month in the outreach		
221	CHILD HEALTH SERVICE	(a) # Days per week service provided <u>at facility</u>	(b) # Days per month service provided through outreach (village level)activities
	1) Consultation / curative services for the sick child?	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="text"/> <input type="text"/> 00=NO SERVICE
	2) Growth monitoring or growth promotion (where the <u>healthy child</u> is routinely weighed and weight is charted on growth chart?)	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="text"/> <input type="text"/> 00=NO SERVICE
	3) Immunization services for children? Don't include (BCG)	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="text"/> <input type="text"/> 00=NO SERVICE
	4) BCG Immunization?	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="text"/> <input type="text"/> 00=NO SERVICE
222	CHECK 221a (3) AND INDICATE IF CHILD IMMUNIZATIONS ARE EVER PROVIDED AT THE FACILITY	YES 1 NO 2	→235
223	Are immunization services being offered at the facility today?	YES, ALL 1 YES, ALL BUT BCG 2 NO 3 OTHER 6 (SPECIFY)	
224	Are immunizations offered in the facility or in an adjacent, affiliated facility on every day that sick child consultations are provided? IF YES, RECORD THE ARRANGEMENT UNDER WHICH IMMUNIZATIONS FOR SICK CHILDREN ARE PROVIDED	YES, AT ROUTINE EPI SERVICE.. 1 YES, SPECIAL ARRANGEMENT WITH EPI SERVICE..... 2 YES, OTHER 3 SPECIFY NO 4 DON'T KNOW 8	
225	Does this facility routinely charge for any vaccination services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR EPI CARD.. A YES, FIXED FEE FOR VACCINE SESSION B YES, VARIABLE FEE PER VACCINE C OTHER X (SPECIFY) NO CHARGES Y DON'T KNOW Z	→227 →227

226	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8			
ASK TO SEE THE ROOM WHERE IMMUNIZATIONS ARE PROVIDED					
227	WAS ROOM ALREADY OBSERVED FOR ITEMS IN 228 and 229? IF YES, INDICATE WHICH SECTION INFORMATION FOR THE ROOM IS IN.	YES, INJECTION ROOM [243-244] 1 NOT PREVIOUSLY ASSESSED 2	→230		
FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE SERVICE IS BEING PROVIDED OR IN AN IMMEDIATELY ADJACENT ROOM.					
228	ITEMS REQUIRED TO PROVIDE IMMUNIZATION SERVICES	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED
	1) Safety box for needles	1	2	3	8
	2) 5 or more 0.5 or 1 ml disposable syringes (w/needles).	1	2	3	8
	3) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8
	4) Waste receptacle with lid and plastic liner	1	2	3	8
	5) Hand-washing items (soap)?	1	2	3	8
	6) Water for hand-washing?	1	2	3 →230	8 →230
229	How is water made available for use in the immunization area in the facility <u>today</u> ?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN 3			
230	OTHER ITEMS REQUIRED TO PROVIDE IMMUNIZATION SERVICES	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED
	1) Blank, individual child immunization cards	1	2	3	8
	2) Immunization tally/register sheets	1	2	3	8
231	What is the current estimate for your annual DPT dropout rate?	DPT DROPOUT RATE (%) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998			
232	Do have an estimate of the total number of the target population for child measles 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"/> <input type="text"/> NO CATCHMENT AREA 99995 DON'T KNOW TARGET POPULATION SIZE 99998	→235 →235		
233	What is the current annual estimate for your measles coverage?	MEASLES COVERAGE (%) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998			
234	RECORD THE SOURCE(S) OF INFORMATION FOR % COVERAGE AND DROPOUT RATE ESTIMATES	WRITTEN REPORT A WALL GRAPH B OTHER X (SPECIFY) NO COVERAGE RATES Y SOURCE NOT KNOWN Z			

CHECK TO SEE IF THE FOLLOWING ITEMS ARE PRESENT (AND IN FUNCTIONING CONDITION) IN THE ROOM WHERE SICK CHILD CONSULTATIONS ARE CONDUCTED								
240		(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETERM- INED
	1) Infant Scale	1→b	2→b	3↓	8↓	1	2	8
	2) Child Scale	1→b	2→b	3↓	8↓	1	2	8
	3) Thermometer	1→b	2→b	3↓	8↓	1	2	8
	4) Timer/Watch with second hand	1→b	2→b	3↓	8↓	1	2	8
	5) Oxygen cylinder and regulator	1→b	2→b	3↓	8↓	1	2	8
	6) Nebulizer	1→b	2→b	3↓	8↓	1	2	8
	7) Light for looking in throat	1→b	2→b	3↓	8↓	1	2	8
	8) Wooden tongue depressor	1	2	3	8			
	9) Jar for ORS	1	2	3	8			
	10) Cup and spoon	1	2	3	8			
	11) Height measuring tool	1	2	3	8			

		(a) AVAILABILITY						
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED			
241	PROTOCOLS/TEACHING MATERIALS							
	1) Medical Protocols for treating CHILD ILLNESS	1	2	3	8			
	2) IMCI Chart Booklet	1	2	3	8			
	3) IMCI counseling cards for provider to use	1	2	3	8			
	4) IMCI mothers cards (to give to caretaker)	1	2	3	8			
	5) Other Visual aids for teaching caretaker	1	2	3	8			
	6) Do you have a copy of the MOHP Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
	7) Do you have a copy of the OTHER Infection Control Guidelines? If YES, may I see them?	1	2	3	8			

ASK TO SEE THE ROOM WHERE THERAPEUTIC (TREATMENT) INJECTIONS ARE PROVIDED FOR SICK CHILDREN.

242	WAS ROOM ALREADY OBSERVED FOR ITEMS IN 243 and 244? IF YES, INDICATE WHICH SECTION INFORMATION FOR THE ROOM IS IN.	YES, IMMUNIZATION ROOM [228-229] 1	→245
		NO INJECTION ROOM 2	→245
		NOT PREVIOUSLY SEEN 3	

FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE SERVICE IS BEING PROVIDED OR IN AN IMMEDIATELY ADJACENT ROOM.					
243	ITEMS REQUIRED TO PROVIDE INJECTION SERVICES	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	4 NOT DETERMINED
	1) Safety box for needles	1	2	3	8
	2) 5 or more 0.5 or 1 ml disposable syringes (w/needles).	1	2	3	8
	3) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8
	4) Waste receptacle with lid and plastic liner	1	2	3	8
	5) Hand-washing items (soap)?	1	2	3	8
	6) Water for hand-washing?	1	2	3 → 245	8 → 245
244	How is water made available for use in injection room in the facility <u>today</u> ?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN..... 3			
245	Is there a <u>routine</u> system for providing the first dose of oral antibiotic for the child by someone other than the provider who examines the child? IF YES, ASK TO SEE WHERE THE FIRST DOSE IS PROVIDED.	YES, OBSERVED CHILD RECEIVING DOSE..... 1 YES, REPORTED, NOT SEEN 2 NO 3 DON'T KNOW..... 8			
246	Is there a patient register where information on each child consultation is written? IF YES, ASK TO SEE REGISTER. REGISTER MUST HAVE CHILD AGE AND DIAGNOSIS TO BE VALID.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN..... 2 NO REGISTER KEPT 3			→ 248 → 248
247	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS BUT WITHIN 30 DAYS..... 2 > 30 DAYS 3			
248	How many sick children (below 5 years of age) received consultation services during the previous twelve (12) completed months?	NUMBER OF CHILDREN <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998			→ 250
249	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... <input type="text"/> <input type="text"/>			
250	Are individual child health cards /records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD	YES, OBSERVED CARD 1 YES, CARD NOT SEEN..... 2 NO INDIVIDUAL CARDS 3			
251	Does this facility routinely charge for consultation services for the sick child? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR HEALTH CARD A YES, FIXED FEE EACH CONSULT B YES, CHARGE FOR MEDICATIONS/TESTS C OTHER _____ X (SPECIFY) NO Y DON'T KNOW Z			→ 300 → 300
252	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED..... 1 YES, SOME, NOT ALL FEES POSTED..... 2 NO POSTED FEES 3 DON'T KNOW 8			

Section 3. Family Planning Services

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO																																																								
300	Does this facility ever provide sterilization procedures for women?	YES 1 NO 2																																																									
301	Does this facility offer any other family planning services? This includes clinical methods or counseling on natural family planning.	YES 1 NO 2	→400																																																								
301a	Is this facility currently a Gold Star facility?	YES 1 NO 2																																																									
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF FAMILY PLANNING SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 302.</p> <p>READ TO FAMILY PLANNING SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS):</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely confidential. You may choose to stop the interview at any time.</p> <p>Do you have any questions for me? Do I have your agreement to participate?</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="border-top: 1px solid black; width: 60%; text-align: center;"> <p>INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p> </div> <div style="border-top: 1px solid black; width: 35%; text-align: center;"> <p>DATE</p> </div> </div>																																																											
302	May I begin the interview?	YES 1 NO 2	→400																																																								
303	For each of the methods I will name, tell me if the method of contraceptive is routinely provided at this facility.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">1 YES</th> <th style="width: 10%; text-align: center;">2 NO</th> <th style="width: 20%; text-align: center;">8 DON'T KNOW</th> </tr> </thead> <tbody> <tr><td>1) Combined oral pill</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>2) Progesterone only pill</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>3) Depoprovera (3 monthly)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>3a) Noristerat (2 monthly)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>4) Mesigyna (monthly)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>5) NORPLANT</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>6) Implanon</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>7) Male condom</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>8) IUD</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>9) Emergency contraceptive pill</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>10) Spermicides (tablet or foam)</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>11) Diaphragm</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> <tr><td>12) Counseling on natural family planning</td><td style="text-align: center;">1</td><td style="text-align: center;">2</td><td style="text-align: center;">8</td></tr> </tbody> </table>		1 YES	2 NO	8 DON'T KNOW	1) Combined oral pill	1	2	8	2) Progesterone only pill	1	2	8	3) Depoprovera (3 monthly)	1	2	8	3a) Noristerat (2 monthly)	1	2	8	4) Mesigyna (monthly)	1	2	8	5) NORPLANT	1	2	8	6) Implanon	1	2	8	7) Male condom	1	2	8	8) IUD	1	2	8	9) Emergency contraceptive pill	1	2	8	10) Spermicides (tablet or foam)	1	2	8	11) Diaphragm	1	2	8	12) Counseling on natural family planning	1	2	8	
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<p>ASK TO GO FIRST TO WHERE THE SUPPLIES AND THE RECORDS FOR THE SUPPLIES ARE KEPT AND ASK TO SPEAK WITH THE PERSON RESPONSIBLE FOR THE CONTRACEPTIVE SUPPLIES.</p>																																																											
304	Do you have a system that allows you to check the amount of each contraceptive method that is available daily? IF YES, ASK TO SEE THE RECORDS AND INDICATE THE METHOD FOR WHICH YOU OBSERVED RECORDS.	INVENTORY NOT UPDATED DAILY BUT REGISTER OF DISTRIBUTED METHODS KEPT DAILY 1 INVENTORY UPDATED DAILY 2 NO INVENTORY RECORDS SEEN 3																																																									

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO	
CONTRACEPTIVES: FOR EACH METHOD THAT THE FACILITY OFFER (QUESTION 303) ASK TO SEE THE METHOD AND PROVIDE THE INFORMATION REQUESTED BELOW. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR COMBINED ORAL PILL, DPOPROVERA, AND CONDOMS, CHECK ALL TO VERIFY IF (A) THEY ARE ARRANGED BY EXPIRY DATE, (B) WERE THERE ANY EXPIRED UNITS PRESENT, AND (C) VERIFY THAT INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY REGISTER OR PRESCRIPTION AND SUBTRACT THESE FROM INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:				
305	Contraceptive Methods	(a) AVAILABILITY OF METHODS 1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED	(b) VALIDITY 1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW	(c) SUPPLY AND INVENTORY (w/ REGISTER) SAME 1=YES 2=NO 8=DON'T KNOW
1	Combined Oral Pill	1→b 2↓ 3↓ 8↓	1 2 8	1 2 8
2	Oral Pill (progesterone only)	1 2 3 8		
3	Injectable (3 monthly) Depoprovera	1→b 2↓ 3↓ 8↓	1 2 8	1 2 8
3a	Injectable (2 monthly) Noristerat	1 2 3 8		
4	Injectable(monthly) Mesigyna	1 2 3 8		
5	Norplant	1 2 3 8		
6	Implanon	1 2 3 8		
7	Condom (male)	1→b 2↓ 3↓ 8↓	1 2 8	1 2 8
8	Intrauterine device (IUD)	1 2 3 8	1 2 8	1 2 8
9	Emergency contraceptive pill	1 2 3 8		
10	Spermicide (tablet or foam)	1 2 3 8		
11	Diaphragm	1 2 3 8		
306	WERE THE METHODS ORGANIZED ACCORDING TO EXPIRY DATE, ("FIRST-EXPIRE FIRST-OUT) ON THE SHELVES? (VERIFY WHEN COMPLETING 1,3, 7 and 8 for question 305).	YES, VERIFIED 1 NO 2 DON'T KNOW 8		
307	ARE CONTRACEPTIVE SUPPLIES STORED IN THE GENERAL PHARMACY WITH OTHER MEDICINES?	YES 1 NO 2		→311
OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE CORRECT RESPONSE FOR EACH OF THE FOLLOWING CONDITIONS:				
308	ARE THE METHODS OFF THE FLOOR AND PROTECTED FROM WATER?	YES 1 NO 2 DON'T KNOW 8		
309	ARE THE METHODS PROTECTED FROM THE SUN?	YES 1 NO 2 DON'T' KNOW 8		
310	IS THE ROOM CLEAR OF ANY EVIDENCE OF PESTS (RATS, BATS, ETC.)	YES 1 NO 2 DON'T KNOW 8		

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
311	Do you have the logistic protocol? IF YES, ASK TO SEE THE PROTOCOL	YES, OBSERVED 1 YES, NOT SEEN 2 NOT AVAILABLE 3 DON'T KNOW 8	
312	Does this facility determine the amount of each contraceptive required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE..... 2	→ 314a
313	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL..... 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8	→ 316 → 316 → 316
314a	When was the last time that you received a routine supply of contraceptive methods ?	WITHIN PRIOR 4 FULL WEEKS ... 1 WITHIN PRIOR 12 FULL WEEKS . 2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8	
314b	Routinely, when you order contraceptive methods , which best describes the system you use to determine how much of each to order: 1) Do you review the amount of each contraceptive method remaining, and order to bring the stock amount to a pre-determined (fixed) amount? 2) Do you order the exact same amount each time? 3) Do you look at the amount used since the previous order, and plan based on prior utilization and expected future activity? 4) Others 5) RESPONDENT FAMILIAR WITH ORDERING SYSTEM IS NOT AVAILABLE	ORDER TO MAINTAIN FIXED STOCK LEVEL 1 ORDER SAME AMOUNT..... 2 ORDER BASED ON UTILIZATION..... 3 OTHER _____ ... 6 (SPECIFY) DON'T KNOW 8	→ 315a → 315a → 315a → 316
314c	When deciding how much of each contraceptive method to order, based on prior utilization and planned activities, do you have a mathematical formula for calculating how much to use, or do you use your judgment?	MATHEMATICAL FORMULA 1 JUDGMENT..... 2	
315a	Which of the following best describes the system for deciding when to order contraceptive methods ? 1) Whenever stock levels fall to a predetermined level 2) There is a fixed time that orders are accepted. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. 3) An order is placed at no fixed time, but rather whenever there is a need. 4) Other	PREDETERMINED LEVEL 1 EVERY <input type="text"/> <input type="text"/> WEEKS..... 2 ORDER AS NEEDED..... 3 OTHER _____ ... 6 (SPECIFY)	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO			
315b	If there is a shortage of specific contraceptive method between routine orders, what is most common procedure followed by this facility? 1) Submit special order to normal supplier. 2) Facility purchases from private market 3) Clients must purchase from outside the facility.	SPECIAL ORDER A FACILITY PURCHASE..... B CLIENT PURCHASE..... C NO SHORTAGE.....D				
316	During the past 3 months , have you received the amount of each contraceptive supply that you order (or that you are suppose to routinely receive)?	ALWAYS 1 SOMETIMES 2 ALMOST NEVER..... 3 DON'T KNOW..... 8				
IF YOU ARE NOT IN THE SERVICE DELIVERY AREA FOR FAMILY PLANNING, ASK TO GO TO THE SERVICE DELIVERY AREA AND EXPLAIN THAT YOU WOULD LIKE TO ASK QUESTIONS ABOUT HOW THE SERVICES ARE OFFERED AND SEE THE SERVICE DELIVERY CONDITIONS.						
317	How many days in a week are family planning services provided at the facility.	# DAYS <input type="text"/>				
318	Are family planning services being provided today?	YES..... 1 NO 2				
319	Does this facility have a system where measurements or activities are routinely carried out for FP clients prior to seeing the primary service provider?	YES 1 NO 2 DON'T KNOW 8	→ 321 → 321			
320	IF YES, ASK TO SEE WHERE FAMILY PLANNING CLIENTS ARE SEEN PRIOR TO THE CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.					
	PART OF ROUTINE SERVICES	1 OBSERVED	2 REPORTED DONE, NOT OBSERVED	3 NOT DONE ROUTINELY	8 DON'T KNOW	
	1) Take weight	1	2	3	8	
	2) Take blood pressure	1	2	3	8	
	3) Group health education	1	2	3	8	
	6) Other (SPECIFY) _____	1	2	3	8	
321	If a family planning client has a reproductive tract infection (RTI) or a sexually transmitted infection (STI), is treatment provided from this clinic, or is the client referred to elsewhere?	ROUTINELY TREATS RTI/STI..... 1 REFERS ELSEWHERE..... 2 NO TREATMENT/NO REFERRAL..... 3 TREATS SOME AND REFERS SOME.. 4				
322	ASK TO SEE WHERE <u>COUNSELING</u> FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER 3				

Are any of the following available, in the counseling or the examination room?		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	4 NOT DETERM INED
323	VISUAL AIDS FOR TEACHING				
	1) Samples of different family planning methods	1	2	3	8
	2) About family planning issues (side-effects, how method works, etc.)	1	2	3	8
	3) About STIs	1	2	3	8
	4) About HIV/AIDS	1	2	3	8
	5) About hepatitis	1	2	3	8
	6) Model for demonstrating use of condom	1	2	3	8
	7) Posters on family planning	1	2	3	8
324	INFORMATION BOOKLET/PAMPHLET FOR CLIENT TO TAKE HOME				
	1) On family planning	1	2	3	8
	2) On STIs	1	2	3	8
	3) On HIV/AIDS	1	2	3	8
	4) On Hepatitis	1	2	3	8
325	SERVICE DELIVERY PROTOCOLS				
	1) Reproductive health guidelines / protocols	1	2	3	8
	2) WHO Guidelines for Syndromic Approach diagnosis and treatment of STIs	1	2	3	8
	3) Guidelines for clinical diagnosis of STIs	1	2	3	8
	4) Do you have a copy of the MOHP Infection Control Guidelines? If YES, may I see them?	1	2	3	8
	5) Do you have a copy of the OTHER Infection Control Guidelines? If YES, may I see them?	1	2	3	8

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.		
326	If <u>same examination room</u> has already been observed for items in 327-329 note for which section the room was assessed:	ANTENATAL [410-412].....1 DELIVERY [451-453].....2 STI [510-512].....3 NOT PREVIOUSLY SEEN.....4	→ 330 → 330 → 330
327	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM IF THIS IS THE SAME ROOM AS THAT USED FOR COUNSELING(322),CIRCLE "4"	PRIVATE ROOM.....1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER.....2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER.....3 SAME ROOM FOR COUNSELING.....4	

FAMILY PLANNING SUPPLIES		(a) AVAILABILITY				(b) FUNCTIONS		
328	FACILITY AND EQUIPMENT	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Spotlight source (flashlight or examination light accepted)	1→b	2→b	3↓	8↓	1	2	8
	2) Table for gynecological exam	1	2	3	8			
	3) Clean gloves(latex)	1	2	3	8			
	4) Safety box for needles	1	2	3	8			
	5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8			
	6) Decontamination solution for clinical equipment	1	2	3	8			
	7) Waste receptacle with lid and plastic liner	1	2	3	8			
	8) Hand-washing items (soap)	1	2	3	8			
	9) Water for hand-washing	1	2	3→330	8→330			
329	How is water made available for use in the family planning examination area <u>today</u> ?	PIPED..... 1 BUCKET W/ TAP 2 BUCKET/BASIN..... 3						
SPECIFIC ITEMS FOR FAMILY PLANNING SERVICES		(a) AVAILABILITY				(b) FUNCTIONS		
330	EQUIPMENT (may be in room where measure is taken)	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILAB LE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Blood pressure apparatus	1→b	2→b	3↓	8↓	1	2	8
	2) Stethoscope	1→b	2→b	3↓	8↓	1	2	8
	3) Weighing scale	1→b	2→b	3↓	8↓	1	2	8
331	CHECK 303 (5)(6) AND (8) AND INDICATE IF THE FACILITY OFFERS EITHER THE IUD OR IMPLANT. IF YES, CHECK FOR AVAILABILITY OF EQUIPMENT	YES 1 NO 2						→337
332	EQUIPEMENT AND SUPPLIES FOR BOTH PROCEDURES	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED			
	1) Sterile gloves	1	2	3	8			
	2) Antiseptic solution (e.g.Iodine)	1	2	3	8			
	3) Sponge holding forceps	1	2	3	8			
333	INDICATE IF THE IUD IS OFFERED.			IUD OFFERED..... 1 IUD NOT OFFERED 2				→335
334	MATERIALS FOR IUD	OBSERVED	REPORTED	NOT AVAIL.	NOT DETERMINED			
	1) Speculum	1	2	3	8			
	2) Tenacula	1	2	3	8			
	3) Uterine sound	1	2	3	8			
	4) Curved scissor	1	2	3	8			
	5) Crocodile forceps	1	2	3	8			
	6) handling forceps	1	2	3	8			
335	INDICATE IF NORPLANT/IMPLANON IS OFFERED.			NORPLANT OFFERED A IMPLANON OFFERED B SERVICE IS NOT PROVIDED.Y				→337
	MATERIALS FOR NORPLANT/IMPLANON	OBSERVED	REPORTED	NOT AVAIL.	NOT DETERMINED			

336	1) Local anesthetic (E.g. lidocaine)	1	2	3	8		
	2) Sterile syringe and needle	1	2	3	8		
	3) Canula and trochar for inserting NORPLANT	1	2	3	8		
	4) scalpel with blade	1	2	3	8		
	5) Mosquito forceps (2)	1	2	3	8		
	6) Other forceps for grasping implant (artery forceps or only 1 mosquito forceps	1	2	3	8		
	7) Sealed Implanon Pack(with disposable sterile applicator)	1	2	3	8		
337	After completing an examination, what procedures does this service follow for initial handling of contaminated equipment (such as used speculums, scalpel handles, etc.) that will be reused another time? IF THE UNIT PROCESSES SOME EQUIPMENT AND SENDS OTHER EQUIPMENT ELSEWHERE, INDICATE THE PROCEDURE FOR EQUIPMENT PROCESSED IN THIS SERVICE DELIVERY UNIT.	SOAKED IN DISINFECTANT SOLUTION BRUSH SCRUBBED WITH SOAP AND WATER..... 1 BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT2 BRUSH SCRUBBED WITH SOAP AND WATER.....3 SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED4 OTHER6 NONE7 DON'T KNOW 8					
338	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 "4 " AND CONTINUE	SECTION 1 [Q152-158]..... 1 →344 DELIVERY [Q469-472]..... 2 →344 STI [Q517-520]..... 3 →344 NOT PREVIOUSLY SEEN 4 PROCESS OUTSIDE FACILITY.....5 →344					
339	After cleaning, what is the final process most commonly used for disinfecting or sterilizing equipment prior to reuse? IF MORE THAN ONE METHOD IS USED CIRCLE ALL METHODS THAT THIS UNIT CARRY OUT. AND PROVIDE THE PROCESSING INFORMATION INDICATED IN QUESTION 340.	DRY HEAT STERILIZATION..... A AUTOCLAVE B STEAM STERILIZATION C BOILING D CHEMICAL E PROCESS OUTSIDE FACILITY....F →344 OTHER X NONE Y →344					

GO TO WHERE EQUIPMENT IS STERILIZED AND ASSESS AVAILABILITY OF EQUIPMENT REQUIRED FOR PROCEDURES.								
340	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	NOT DETER
01	Electric dry heat sterilizer	1→b	2→b	3↓	8↓	1	2	8
02	Electric autoclave (pressure; wet heat)	1→b	2→b	3↓	8↓	1	2	8
03	Non-electric autoclave	1→b	2→b	3↓	8↓	1	2	8
04	Pot with cover (for steaming or boiling)	1	2	3	8			
05	Other method _____ (SPECIFY)	1	2	3	8			
06	Heat source (stove/Cooker w/fuel or power present) For steaming, boiling, or using non-electric autoclave)	1→b	2→b	3↓	8↓	1	2	8
07	Automatic timer (MAY BE ON MACHINE)	1→b	2→b	3↓	8↓	1	2	8
340a	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
341	Biological indicator for testing effectiveness of sterilization	1	2	3	8			
342	Written guidelines for disinfection and sterilization	1	2	3	8			

343 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/DISINFECTION AND CHEMICAL DECONTAMINATION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED

	(a) Dry heat sterilization	(b) Autoclave	(c) Boil or steam (high level disinfectant ,HLD)	(d) Chemical decontaminant	(e) Chemical High Level Disinfectant (HLD)	(f) OTHER
01	Method USED 1 NOT USED 2 → b Temperature	USED 1 NOT USED 2 → c Temperature	USED 1 NOT USED 2 → d Temperature	USED 1 NOT USED 2 → e	USED 1 NOT USED 2 → f Temperature	USED 1 NOT USED 2 → 344 Temperature
02	AUTOMATIC 666 DON'T KNOW 998	AUTOMATIC 666 DON'T KNOW 998	AUTOMATIC 666 DON'T KNOW 998			AUTOMATIC 666 DON'T KNOW 998
03		AUTOMATIC 666 DK PRESSURE 998				AUTOMATIC 666 DK PRESSURE 998
04	Minutes when equipment is not wrapped in cloth	Minutes	Minutes	Minutes	Minutes	Minutes
05	Minutes when equipment is wrapped	AUTOMATIC 666 DON'T KNOW 998	AUTOMATIC 666 DON'T KNOW 998	DON'T KNOW 998	DON'T KNOW 998	AUTOMATIC 666 DON'T KNOW 998
06	Chemical solution (DISINFECTANT)					
07	Percent solution (Concentration before diluted)					
08	Mixture, parts disinfectant and water					

NO.	QUESTIONS	CODE CLASSIFICATION			GO TO
344	INDICATE STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (E.G. SPECULUM, FORCEPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN SEEN INDICATE WHICH MODULE THE INFORMATION IS IN.	SECTION 1b [159-161].....	1		→348
		DELIVERY [474-476].....	2		→348
		STI [522-524].....	3		→348
		NOT PREVIOUSLY SEEN.....	4		
345	STORAGE CONDITIONS FOR PROCESSED EQUIPMENT	OBSERVED	REPORTED AVAILABLE	NOT AVAILAB LE	ND
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8
	2) Stored in sterile container with lid which clasps shut	1	2	3	8
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8
	4) On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8
	5) In container w/ antiseptic/disinfectant	1	2	3	8
	6) Other _____ (SPECIFY)	1	2	3	8
346	Is the date of sterilization for the stored items indicated?	1	2	3	8
347	Is the storage area for sterilized items clean and dry?	1	2	3	8
348	Does this facility routinely charge for any family planning consultation services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR FP CARD .A YES, FIXED CONSULT FEE B YES, CHARGE FOR METHOD..... C YES, CHARGE FOR LAB TESTS .D OTHER X (SPECIFY) NO..... Y DON'T KNOW..... Z			→350 →350
349	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED..... 1 YES, SOME,NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW..... 8			
350	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE REGISTER. REGISTER MUST HAVE METHOD AND NEW/CONTINUING STATUS INDICATED FOR EACH CLIENT, TO BE VALID.	YES, REGISTER SEEN..... 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3			→352 →352
351	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS 2 > 30 DAYS..... 3			
352	How many <u>total</u> clients (new and continuing) received family planning services during the previous twelve (12) completed months?	NUMBER OF FP CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
353	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	DON'T KNOW 99998 MONTHS OF DATA..... <input type="text"/> <input type="text"/>			→354
354	Are individual client cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD.	YES, OBSERVED CARD..... 1 YES, CARD NOT SEEN 2 NO INDIVIDUAL CARDS..... 3			

Section 4 Maternal Health Services

SECTION 4a: MATERNITY CARE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																														
400	Does this facility offer antenatal and/or postpartum services? Indicate the services provided from this facility.	YES, ANTENATALA YES, POSTPARTUMB NO, NEITHER SERVICEY	→435																														
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF ANTENATAL CARE. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 403.</p> <p>READ TO ANTENATAL HEALTH SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS):</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely confidential. You may choose to stop the interview at any time.</p> <p>Do you have any questions for me? Do I have your agreement to participate?</p> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="border-bottom: 1px solid black; width: 40%; text-align: center;"> INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) </div> <div style="border-bottom: 1px solid black; width: 40%; text-align: center;"> DATE </div> </div>																																	
401	May I begin the interview?	YES 1 NO 2	→500																														
402	How many days in a week are antenatal care services provided at the facility?	# DAYS <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/>																															
403	Are antenatal care services being provided at the facility today?	YES..... 1 NO 2																															
404	Does this facility have a system where measurements or activities are routinely carried out for ANC clients prior to the consultation?	YES1 NO2 DON'T KNOW8	→406 →406																														
405	<p>IF YES, ASK TO SEE WHERE ANTENATAL CLIENTS ARE SEEN PRIOR TO THE CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 40%;">PART OF ROUTINE SERVICES</th> <th style="width: 10%;">OBSERVED</th> <th style="width: 15%;">REPORTED DONE, NOT OBSERVED</th> <th style="width: 15%;">NOT DONE ROUTINELY</th> <th style="width: 10%;">DON'T KNOW</th> </tr> </thead> <tbody> <tr> <td>1) Take weight</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">8</td> </tr> <tr> <td>2) Take height</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">8</td> </tr> <tr> <td>3) Take Blood Pressure</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">8</td> </tr> <tr> <td>4) Group health education</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">8</td> </tr> <tr> <td>6) Other (SPECIFY) _____</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">8</td> </tr> </tbody> </table>			PART OF ROUTINE SERVICES	OBSERVED	REPORTED DONE, NOT OBSERVED	NOT DONE ROUTINELY	DON'T KNOW	1) Take weight	1	2	3	8	2) Take height	1	2	3	8	3) Take Blood Pressure	1	2	3	8	4) Group health education	1	2	3	8	6) Other (SPECIFY) _____	1	2	3	8
PART OF ROUTINE SERVICES	OBSERVED	REPORTED DONE, NOT OBSERVED	NOT DONE ROUTINELY	DON'T KNOW																													
1) Take weight	1	2	3	8																													
2) Take height	1	2	3	8																													
3) Take Blood Pressure	1	2	3	8																													
4) Group health education	1	2	3	8																													
6) Other (SPECIFY) _____	1	2	3	8																													
<p>Now I would like to know about different services and tests that are routine parts of ANC in this facility. For each item I ask about please tell me if this is a routine part of ANC or not routine.</p>																																	
406	LABORATORY OR OTHER TESTS	YES	NO	DON'T KNOW																													
	1) Test blood for anemia?	1	2	8																													
	2) Test blood group?	1	2	8																													
	2a) Test blood RH factor?	1	2	8																													
	3) Test urine for sugar	1	2	8																													
	4) Test urine for protein?	1	2	8																													

407	TREATMENT AND SERVICES FOR ANC CLIENTS							
	1) Are clients routinely counseled about family planning or birth spacing methods during the third trimester?	1	2	8				
	2) Are tetanus toxoid vaccination services available each day ANC services are provided?	1	2	8				
	3) How many days each week is tetanus toxoid offered at this facility?	DAYS PER WEEK.....						
		NEVER OFFERED		0				
		DON'T KNOW		8				
408	If an ANC client has a reproductive tract infection (RTI) or a sexually transmitted infection (STI), is treatment provided from this clinic, or is the client referred elsewhere?	ROUTINELY TREATS RTI/STI		1				
		REFERRED ELSEWHERE.....		2				
		NO TREATMENT/NOREFERRAL.....		3				
		TREATS SOME AND REFERS SOME.		4				
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.								
409	If <u>same examination room</u> has already been observed for items in 410-412, indicate for which section the room was assessed:	FAMILY PLANNING [327-329]		1				→413
		DELIVERY [451-453]		2				→413
		STI [510-512]		3				→413
		NOT PREVIOUSLY SEEN.....		4				
410	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM.....		1				
		ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER		2				
		ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER		3				
411	ITEMS FOR EXAMINATION FOR ANC/POST NATAL CARE	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Spotlight source (flashlight or examination light accepted)	1→b	2→b	3↓	8↓	1	2	8
	2) Table for gynecological exam	1	2	3	8			
	3) Clean gloves	1	2	3	8			
	4) Safety box for needles	1	2	3	8			
	5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8			
	6) Decontamination solution for clinical equipment	1	2	3	8			
	7) Waste receptacle with lid and plastic liner	1	2	3	8			
	8) Hand-washing items (soap and towel)	1	2	3	8			
	9) Water for hand-washing	1	2	3→413	8→413			
412	How is water made available for use in the antenatal care service area <u>today</u> ?	PIPED.....		1				
		BUCKET W/ TAP		2				
		BUCKET/BASIN.....		3				
413	OTHER EQUIPMENT (may be in room where measure is taken)	(a) AVAILABILITY				(b) FUNCTIONS		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	1) Blood pressure apparatus	1→b	2→b	3↓	8↓	1	2	8
	2) Stethoscope	1→b	2→b	3↓	8↓	1	2	8
	3) Fetal Stethoscope	1→b	2→b	3↓	8↓	1	2	8
	4) Thermometer	1→b	2→b	3↓	8↓	1	2	8
	5) Infant scale	1→b	2→b	3↓	8↓	1	2	8
	6) Ultrasound machine	1→b	2→b	3→416	8→416	1	2	8

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO		
414	Is there a provider trained in using ultrasound who works in this service?	YES.....	1	NO	2	DON'T KNOW.....	8	
415	Is ultrasound routinely conducted for each ANC client?	YES.....	1	NO	2	DON'T KNOW.....	8	
416	PROTOCOLS/TEACHING MATERIALS	Observed	Reported Available	Not Available	Not Determined			
	1) Guidelines/protocols for maternal health care	1	2	3	8			
	2) Teaching aids for ANC	1	2	3	8			
	3) Do you have a copy of the MOHP Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
	4) Do you have a copy of the OTHER Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
417	Does this facility have a formal relationship with traditional birth attendants where training or other types of support are provided to the TBAs?	YES	1	NO	2			→419
418	Is there any documentation available on the TBA program, e.g. lists of affiliated TBAs or TBA training records? IF YES, ASK TO SEE DOCUMENTATION	YES, DOCUMENT SEEN.....	1	YES, DOCUMENT NOT SEEN.....	2	NO DOCUMENTATION	3	
419	Is there a register where client information from ANC visits is recorded? IF YES, ASK TO SEE REGISTER. ANC STATUS (1 ST OR FOLLOW-UP) MUST BE INDICATED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN	1	YES, REGISTER NOT SEEN	2	NO REGISTER KEPT	3	→421 →421
420	How recent is the date of the most recent entry for ANC?	WITHIN THE PAST 7 DAYS	1	> 7 DAYS BUT WITHIN 30 DAYS ..	2	> 30 DAYS.....	3	
421	How many antenatal visits (new and follow-up) took place during the previous twelve (12) complete months?	NUMBER ANC ...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	→423
		VISITS						
		DON'T KNOW	99998					
422	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA.....	<input type="text"/>	<input type="text"/>				
423	Is there a register where client information from postpartum visits (BOTH FOR OUTREACH AND FOR FACILITY PP CARE) is recorded? IF YES, ASK TO SEE REGISTER. DAYS PP AND WHETHER COMPLICATIONS WERE PRESENT OR NOT SHOULD BE INDICATED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN	1	YES, REGISTER NOT SEEN	2	NO REGISTER KEPT	3	→425 →425
424	How recent is the date of the most recent entry for postpartum care?	WITHIN THE PAST 7 DAYS	1	> 7 DAYS.....	2			
425	How many postpartum visits took place during the previous twelve (12) complete months?	NUMBER OF PP VISITS.....	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	→427
		DON'T KNOW	99998					
426	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA.....	<input type="text"/>	<input type="text"/>				

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
427	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment area?	NUMBER OF BIRTHS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998 NO CATCHMENT AREA..... 99995	→431 →431
428	What is the estimate for the annual antenatal coverage rate for this facility?	ANC % COVERAGE <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	→431
429	What is the definition used by this facility when calculating the antenatal coverage for a pregnant women?	AT LEAST 1 VISIT 1 AT LEAST 4 VISITS 2 OTHER 6 (SPECIFY) DON'T KNOW 8	
430	RECORD THE SOURCE OF INFORMATION FOR % ANTENATAL COVERAGE ESTIMATES	WRITTEN REPORT A WALL GRAPH B OTHER X (SPECIFY) NOT KNOWN Z	
431	What is the average number of visits for ANC clients?	AVERAGE NUMBER <input type="text"/> <input type="text"/> DON'T KNOW 98	
432	Are individual ANC cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD?	YES, OBSERVED BLANK CARD .. 1 YES, NO BLANK CARD OBSERVED 2 NO INDIVIDUAL CARDS 3	
433	Does this facility routinely charge for antenatal care consultation? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR ANC/ HEALTH CARD A YES, FIXED FEE EACH CONSULT B YES, FIXED FEE FOR ALL ANC SERVICES C YES, FIXED FEE FOR ALL ANC SERVICES + DELIVERY D YES, CHARGE FOR MEDICATIONS/TESTS E OTHER X (SPECIFY) NO Y DON'T KNOW Z	→435 →435
434	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8	
435	What is the most common means by which women are transported from home to this facility for help during obstetric emergencies? IF MORE THAN ONE MOST COMMON MEANS, CIRCLE ALL THAT APPLY.	PEOPLE CARRY A ANIMAL DRAWN VEHICLE B MOTOR VEHICLE C COMBINATION OF ABOVE D OTHER X (SPECIFY) NEVER RECEIVE OBSTETRIC CASES Y DON'T KNOW Z	→441

436	Does this facility have a procedure for transporting women to another facility if necessary in an obstetric emergency? IF THIS IS THE REFERRAL FACILITY, RECORD "4" FOR "REFERRAL FACILITY".	YES 1 NO 2 REFERRAL FACILITY 4 DON'T KNOW 8	→439 →441 →439				
437	Which of the following emergency transportation procedures are commonly used by this facility? PROVIDE A RESPONSE FOR EACH POSSIBILITY	AVAILABILITY					
		24 Hours	Normal facility hours (<24 Hours)	No set times	Not used		
	1) Emergency vehicle onsite at facility	1	2	3	8		
	2) Multi-use vehicle available at facility. May be used for emergencies	1	2	3	8		
	3) Call other facility to send emergency vehicle	1	2	3	8		
	4) Rental/hire vehicle arrangement when needed (with facility financial support)	1	2	3	8		
438	Is the vehicle available and operational today? If yes, may I see the vehicle?	YES SEEN/FUNCTIONING 1 YES SEEN/NOT FUNCTIONING... 2 VEHICLE AWAY FOR EMERGENCY 3 NOT SEEN 4		→440 →440 →440 →440			
439	What is the most common means by which women are transported from this facility to the nearest referral facility to receive help during an obstetric emergency?	PEOPLE CARRY A ANIMAL DRAWN VEHICLE B MOTOR VEHICLE C COMBINATION OF ABOVE D OTHER X DON'T KNOW Z					
440	How long does it take, using this form of transportation, to get to the nearest referral facility? (NOTE: IF CALL ELSEWHERE TO OBTAIN VEHICLE, RECORD AVERAGE TIME FROM CALL TO PATIENT ARRIVAL AT REFERRAL FACILITY)	MINUTES <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> DON'T KNOW 998					

SECTION 4b: DELIVERY AND NEWBORN CARE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
441	Does this facility offer normal delivery services?	YES 1 NO 2 DELIVERY ROOM BUT NO STAFF 3 ONLY HOME DELIVERIES..... 4	→493 →446 →478
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN DELIVERY SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 432.</p> <p>READ TO DELIVERY SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS):</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely confidential. You may choose to stop the interview at any time.</p> <p>Do you have any questions for me? Do I have your agreement to participate?</p> <p style="text-align: center;">_____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p> <p style="text-align: center;">_____ DATE</p>			
442	May I begin the interview?	YES 1 NO 2	→461
443	Is there a qualified delivery service provider present (assigned) at the facility at all times (24 hours/day) for delivery services? IF YES, ASK TO SEE DUTY SCHEDULE.	YES, SCHEDULE SEEN..... 1 YES, SCHEDULE NOT SEEN 2 NO, 3	→446 →446
444	Is there a qualified delivery service provider available away from the facility, but officially on call at all times after hours for delivery services? IF YES, ASK TO SEE ON CALL DUTY SCHEDULE.	YES, SCHEDULE SEEN..... 1 YES, SCHEDULE NOT SEEN 2 NO 3	
445	During the night-time, what level of provider most commonly is on duty to conduct deliveries? IF DIFFERENT LEVELS ARE COMMONLY AVAILABLE, CIRCLE ALL RELEVANT LEVELS.	DOCTOR.....A NURSE TRAINED IN MIDWIFRY ..B GRADUATE NURSE C OTHERX (SPECIFY) DON'T KNOWZ	
<p>ASK TO SEE THE ROOM WHERE NORMAL DELIVERIES ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE DELIVERY IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.</p>			
446	Is the delivery room floor tiled (Either porcelain or plastic)?	YES..... 1 NO..... 2 DON'T KNOW..... 8	→449
447	Are the screens/ net on windows in good condition to prevent flies/mosquitoes from entering	YES EFFECTIVE NETTING 1 NOT EFFECTIVE NETTING 2 NO WINDOW..... 3	
448	Is the delivery room free of observable dust, dirt, spider webs?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
449	Is there a pre-delivery (labour) room that is separate from the delivery room or postpartum recovery room?	YES..... 1 NO..... 2 DON'T KNOW..... 8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
450	If <u>same examination room</u> has already been observed for items in 451-453 indicate for which section the room was assessed:	FAMILY PLANNING [327-329] 1 ANTENATAL [410-412] 2 STI [510-512] 3 NOT PREVIOUSLY SEEN 4				→454 →454 →454		
451	DESCRIBE THE SETTING FOR THE DELIVERY ROOM	PRIVATE ROOM 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER 3						
452	ITEMS REQUIRED TO PROVIDE DELIVERY SERVICES	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
		1 → b	2 → b	3 ↓	8 ↓	1	2	8
		1) Spotlight source (flashlight or examination light accepted)						
		2) Table for gynecological exam	1	2	3	8		
		3) Clean gloves	1	2	3	8		
		4) Safety box for needles	1	2	3	8		
		5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8		
		6) Decontamination solution for clinical equipment	1	2	3	8		
		7) Waste receptacle with lid and plastic liner	1	2	3	8		
8) Hand-washing items (soap and towel)	1	2	3	8				
9) Water for hand-washing	1	2	3 → 454	8 → 454				
453	How is water made available for use in the delivery area <u>today</u> ?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN 3						

OTHER EQUIPMENT AND SUPPLIES REQUIRED FOR DELIVERY SERVICES	(a) AVAILABILITY				(b) FUNCTIONS		
	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILA BLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
1) Air conditioner	1→b	2→b	3↓	8↓	1	2	8
2) Water Heater	1→b	2→b	3↓	8↓	1	2	8
3) 24-hour functioning light source	1→b	2→b	3↓	8↓	1	2	8
4) 1 full oxygen cylinder	1→b	2→b	3↓	8↓	1	2	8
5) Oxygen cylinder regulator	1→b	2→b	3↓	8↓	1	2	8
6) Blood pressure apparatus	1→b	2→b	3↓	8↓	1	2	8
7) Adult Stethoscope	1→b	2→b	3↓	8↓	1	2	8
8) Fetal Heart Detector (Sonicaid)	1→b	2→b	3↓	8↓	1	2	8
9) Gel for fetal heart detector	1	2	3	8			
10) Neonatal stethoscope	1→b	2→b	3↓	8↓	1	2	8
11) Fetal stethoscope (Pinard)	1	2	3	8			
12) 2 Forceps (Kocher)- sterile	1	2	3	8			
13) Sterile scissors/blade	1	2	3	8			
14) Needle Holder(sterile)	1	2	3	8			
15) Clean Mackintosh oilcloth for delivery table	1	2	3	8			
16) Sterile gloves	1	2	3	8			
17) Sterile Foley catheter size 18 or 20 (plastic)	1	2	3	8			
18) Sterile straight urinary catheter size 18 or 20 (plastic)	1	2	3	8			
19) Suture material w/needle	1	2	3	8			
20) Skin antiseptic (e.g. betadine, chlorhexadine (savlon);dette	1	2	3	8			
MEDICATIONS	Observed	Reported	NA	ND			
21) Intravenous:either Ringers lactate, D5NS, or NS infusion (w/valid expiry date)	1	2	3	8			
21a) D5W(dextrose 5%)	1	2	3	8			
22) IV infusion set w/ cannula	1	2	3	8			
23) Injectable ergometrine/ methergine w/valid expiry date)	1	2	3	8			
24) Syntocin/oxytocin	1	2	3	8			
25) Injectable diazepam or magnesium sulfate	1	2	3	8			
26) Hydralazine (apresoline) INJ	1	2	3	8			
27) Vitamin K (1 mg)	1	2	3	8			
28) Antibiotic Eye drops (NO CHLORAMPHENICOL]	1	2	3	8			
29) Syringes and needles?	1	2	3	8			
30) Vitamin A	1	2	3	8			

	SUPPLIES REQUIRED FOR NEONATAL CARE	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILAB L E	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	31) Resusiteur (Radiant Warmer)	1→b	2→b	3↓	8↓	1	2	8
	32) Suction device for resuscitation (foot or electric power)	1→b	2→b	3↓	8↓	1	2	8
	33) Heat source for baby	1→b	2→b	3↓	8↓	1	2	8
	34) Incubator	1→b	2→b	3↓	8↓	1	2	8
	35) Bag and mask or tube and mask (baby) for resuscitation	1→b	2→b	3↓	8↓	1	2	8
	36) Resuscitation table for baby	1	2	3	8			
	37) Baby scale	1→b	2→b	3↓	8↓	1	2	8
	38) Bulb Mucus extractor	1→b	2→b	3↓	8↓	1	2	8
	39) Pediatric suction catheters	1	2	3	8			
	40) Cord ties	1	2	3	8			
	41) Measuring tape	1	2	3	8			
	42) Towel/blanket to wrap baby	1	2	3	8			
455	PROTOCOLS/EDUCATIONAL MATERIALS							
	1) Essential Obstetric Care Protocols	1	2	3	8			
	2) Basic Essential Obstetric Care Service Standards	1	2	3	8			
	3) Other guidelines for delivery care/emergency care?	1	2	3	8			
	4) Referral Forms	1	2	3	8			
	5) Partographs	1	2	3	8			
	6) Delivery Sheet	1	2	3	8			
	7) Delivery Register	1	2	3	8			
	8) Do you have a copy of the MOHP Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
	9) Do you have a copy of the OTHER Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
456	Is rooming-in the normal practice in this facility? That is, does the baby stay in the same room with the mother?	YES.....1 NO.....2 DON'T KNOW.....8						
457	Does this facility routinely provide Vitamin A to the mother prior to discharge?	YES.....1 NO.....2 DON'T KNOW.....8						
458	Is there routine counseling to newly delivered women to encourage breast-feeding within the first few hours of birth?	YES.....1 NO.....2 DON'T KNOW.....8						

NO.	QUESTIONS	CODE CLASSIFICATION			GO TO			
459	Now I want to ask you about routine practices for the newborn infant at this facility. This means the activity is conducted for essentially all newborns. Indicate for each of the following if it is done routinely for newborns:	1 YES	2 NO	8 DON'T KNOW				
	1) Suction newborn using catheter or bulb mucus extractor	1	2	8				
	2) Weigh newborn	1	2	8				
	3) Give full bath (immerse in water) within first 24 hours (or prior to discharge if less than 24 hours postpartum)	1	2	8				
	4) Give pre-lacteal liquids?	1	2	8				
	5) Give vitamin K (1 mg) prior to discharge?	1	2	8				
	6) Give first dose of OPV prior to discharge?	1	2	8				
	7) Give BCG prior to discharge?	1	2	8				
460	How does this facility routinely care for the umbilical cord?	70% ALCOHOLA BETADINE.....B ANTIBIOTIC OINTMENT.....C DRY DRESSING ONLYD OTHER _____X (SPECIFY) DON'T KNOWZ						
461	Does the facility participate in regular reviews of maternal or newborn deaths or "near miss deaths"?	YES, FOR MOTHERS.....1 YES, FOR NEWBORNS2 YES, FOR BOTH.....3 NO DO NOT PARTICIPATE4						
462	Does this facility handle assisted deliveries, that is using forceps or ventouse (vacuum extractor)?	YES1 NO2			→464			
463	CHECK IF THE FOLLOWING EQUIPMENT IS AVAILABLE IN THE DELIVERY ROOM OR AN IMMEDIATELY ADJACENT ROOM	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Forceps?	1→b	2→b	3↓	8↓	1	2	8
	2) Ventouse (vacuum extractor)?	1→b	2→b	3↓	8↓	1	2	8
464	Is this facility able to perform vacuum aspiration for post-abortion cases when necessary?	YES1 NO2				→466		
465	ASK TO SEE EQUIPEMENT	Observed	Reported Available	Not Available	Not Determined	Yes	No	ND
	1) Manual vacuum aspirator (MVA)	1→b	2→b	3↓	8↓	1	2	8
	2) Dilate and curettage (D&C) kit	1→b	2→b	3↓	8↓	1	2	8
	6) Other (specify)	1→b	2→b	3	8	1	2	8

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
466	<p>After completing an examination, what procedures does this service follow for initial handling of contaminated equipment (such as used 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>SOAKED IN DISINFECTANT SOLUTION BRUSH SCRUBBED WITH SOAP AND WATER..... 1</p> <p>BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT2</p> <p>BRUSH SCRUBBED WITH SOAP AND WATER.....3</p> <p>SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED4</p> <p>OTHER6</p> <p>NONE7</p> <p>DON'T KNOW 8</p>	
467	<p>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 "4 " AND CONTINUE</p>	<p>SECTION 1 [Q152-158] 1</p> <p>FAMILY PLANNING [Q340-343]..... 2</p> <p>STI [Q517-520]..... 3</p> <p>NOT PREVIOUSLY SEEN 4</p> <p>PROCESS OUTSIDE FACILITY.....5</p>	<p>→473</p> <p>→473</p> <p>→473</p> <p>→473</p>
468	<p>After cleaning, what is the final process most commonly used for disinfecting or sterilizing equipment prior to reuse? IF MORE THAN ONE METHOD IS USED CIRCLE ALL METHODS THAT THIS UNIT CARRY OUT. AND PROVIDE THE PROCESSING INFORMATION INDICATED IN QUESTION 469.</p>	<p>DRY HEAT STERILIZATION..... A</p> <p>AUTOClave B</p> <p>STEAM STERILIZATION C</p> <p>BOILING D</p> <p>CHEMICAL E</p> <p>PROCESS OUTSIDE FACILITY....F</p> <p>OTHER X</p> <p>NONE Y</p>	<p>→473</p> <p>→473</p>

GO TO WHERE EQUIPMENT IS STERILIZED AND ASSESS AVAILABILITY OF EQUIPMENT REQUIRED FOR PROCEDURES.								
469	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	NOT DETER
01	Electric dry heat sterilizer	1→b	2→b	3↓	8↓	1	2	8
02	Electric autoclave (pressure; wet heat)	1→b	2→b	3↓	8↓	1	2	8
03	Non-electric autoclave	1→b	2→b	3↓	8↓	1	2	8
04	Pot with cover (for steaming or boiling)	1	2	3	8			
05	Other method _____ (SPECIFY)	1	2	3	8			
06	Heat source (stove/Cooker w/fuel or power present) For steaming, boiling, or using non-electric autoclave)	1→b	2→b	3↓	8↓	1	2	8
07	Automatic timer (MAY BE ON MACHINE)	1→b	2→b	3↓	8↓	1	2	8
469a	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
470	Biological indicator for testing effectiveness of sterilization	1	2	3	8			
471	Written guidelines for disinfection and sterilization	1	2	3	8			

472 FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/DISINFECTION AND CHEMICAL DECONTAMINATION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/BOILING IS REACHED						
	(a) Dry heat sterilization	(b) Autoclave	(c) Boil or steam (high level disinfectant ,HLD)	(d) Chemical decontaminant	(e) Chemical High Level Disinfectant (HLD)	(f) OTHER
01	Method USED.....1 NOT USED.....2→b Temperature	USED.....1 NOT USED.....2→c Temperature	USED.....1 NOT USED.....2→d Temperature	USED.....1 NOT USED.....2→e	USED.....1 NOT USED.....2→f Temperature	USED.....1 NOT USED.....2→473 Temperature
02	Temperature (centigrade)	Temperature	Temperature			
03	Pressure	Pressure	Pressure			
04	Minutes when equipment is not wrapped in cloth	Minutes	Minutes	Minutes	Minutes	Minutes
05	Minutes when equipment is wrapped	Minutes wrapped	Minutes wrapped	Minutes wrapped	Minutes wrapped	Minutes wrapped
06	Chemical solution (DISINFECTANT)	Chemical solution (DISINFECTANT)	Chemical solution (DISINFECTANT)	Chemical solution (DISINFECTANT)	Chemical solution (DISINFECTANT)	Chemical solution (DISINFECTANT)
07	Percent solution (Concentration before diluted)	Percent DK=98	Percent DK=98	Percent DK=98	Percent DK=98	Percent DK=98
08	Mixture, parts disinfectant and water	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
473	INDICATE STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (E.G. speculum, forceps) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN SEEN INDICATE WHICH SECTION THE INFORMATION IS IN.	SECTION 1b [159-161] 1 FAMILY PLANNING [344-347]..... 2 STI [521-524]..... 3 NOT PREVIOUSLY SEEN..... 4				→477 →477 →477
474	STORAGE CONDITIONS FOR PROCESSED EQUIPMENT	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 ND	
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8	
	2) Stored in sterile container with lid which clasps shut	1	2	3	8	
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8	
	4) On tray, covered with cloth or wrapped without TST tape	1	2	3	8	
	5) In container w/ antiseptic/disinfectant	1	2	3	8	
	6) Other (SPECIFY)	1	2	3	8	
475	Is the date of sterilization for the stored items indicated?	1	2	3	8	
476	Is the storage area for sterilized items clean and dry?	1	2	3	8	
477	Does this facility conduct blood transfusion? IF YES, IS THERE A BLOOD BANK OR ARE THERE TRANSFUSION SERVICES ONLY?	YES, BLOOD BANK.....1 YES, TRANSFUSION, NO BLOOD BANK.....2 NO BLOOD TRANSFUSION3				
478	Do facility staff routinely provide home-deliveries or attend home delivery emergencies as a part of the facility service?	YES, ROUTINELY..... 1 YES, EMERGENCY ONLY 2 NO 3				→485
479	Is there bag where supplies for home deliveries are kept? IF YES, ASK TO SEE THE DELIVERY BAG	YES, BAG SEEN..... 1 YES, BAG NOT SEEN 2 NO 3				→481 →481
480	ASK TO SEE THE EMERGENCY DELIVERY BAG AND INDICATE WHETHER THE ITEMS LISTED ARE PRESENT OR NOT.	ITEM PRESENT		NOT PRESENT	NOT DETERMINED	
		STERILE	NOT STERILE			
	1) Sterile instrument package	1	2	3	8	
	2) 1 Scissors (straight) (maybe in packet)	1	2	3	8	
	3) 2 Forceps (Kocher) (maybe in packet)	1	2	3	8	
	4) 1 Fetal Stethoscope		2	3	8	
	5) 1 Mucous Suction Bulb		2	3	8	
	6) 1 Adult Thermometer		2	3	8	
	7) 1 Plastic gown		2	3	8	
	8) 1 Macintosh oilcloth/plastic for under mother		2	3	8	
	9) Sterile dressings, Cotton, Gauze	1	2	3	8	
	10) Betadine solution		2	3	8	
	11) Alcohol		2	3	8	
	12) Antibiotic eye drops [NO CHLORAMPHENICOL]		2	3	8	
	13) Syringe and needle (sterile)	1	2	3	8	
	14) Soap		2	3	8	
	15) Measuring tape		2	3	8	
	16) Newborn scale (hanging)		2	3	8	
	17) 2 pair sterile gloves	1	2	3	8	
	18) Disposable plastic gloves		2	3	8	
	19) Cord clamp/ cord ties		2	3	8	

481	Is there a register where information on home deliveries conducted by facility staff is recorded?	YES, OBSERVED.....1 YES, NOT SEEN2 NO REGISTER3	→483 →483
482	WHAT IS THE MONTH AND YEAR OF THE LAST HOME DELIVERY CONDUCTED THROUGH THIS FACILITY?	MONTH..... <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
483	How many home deliveries were conducted from this facility during the previous twelve (12) completed months?	HOME DELIVERIES <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	→485
484	INDICATE NUMBER OF MONTHS REPRESENTED IN DATA	MONTHS OF DATA <input type="text"/> <input type="text"/>	
485	Is there a register where client information from deliveries conducted by facility staff is recorded? IF YES, ASK TO SEE REGISTER. BIRTH OUTCOME FOR MOTHER AND INFANT MUST BE INCLUDED TO BE VALID.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3	→487 →487
486	How recent is the date of the most recent entry for a delivery conducted at this facility?	WITHIN THE PAST 30 DAYS 1 > 30 DAYS..... 2	
487	How many women delivered at this facility during the previous twelve (12) completed months? (VAGINAL DELIVERIES)	# DELIVERIES ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→489
488	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED .	MONTHS OF DATA..... <input type="text"/> <input type="text"/>	
489	What percentage of deliveries in your catchment area are conducted in this facility? (e.g. your annual coverage rate?).	% COVERAGE <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998 NO CATCHMENT AREA..... 995	→491 →491
490	RECORD THE SOURCE OF INFORMATION FOR DELIVERY COVERAGE ESTIMATE	WRITTEN REPORTA WALL GRAPH.....B OTHERX (SPECIFY) NOT KNOWNZ	
491	Does this facility routinely charge for normal deliveries? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR ALL DELIVERY COSTSA YES, FIXED FEE FOR ANC PLUS DELIVERY B YES, CHARGE FOR MEDICATIONS/ TESTS..... C OTHERX (SPECIFY) NOY DON'T KNOWZ	→493 →493
492	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME,NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8	
493	Does this facility <u>ever</u> perform Caesarean Section?	YES 1 NO 2	→500

ASK TO SEE THE ROOM WHERE CAESAREAN SECTIONS ARE PERFORMED. CHECK WHETHER THE FOLLOWING EQUIPMENT & SUPPLIES ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT ROOM		(a) AVAILABILITY				(b) FUNCTIONS		
494	FACILITY AND EQUIPMENT	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Operating table	1→b	2→b	3↓	8↓	1	2	8
	2) Operating light	1→b	2→b	3↓	8↓	1	2	8
	3) Scrub area adjacent to or in the operating room	1	2	3	8			
	4) Tray, drum, or package with sterilized instruments ready for use	1	2	3	8			
	5) Drum with sterile gowns and towels/sheets for surgery	1	2	3	8			
	6) Anesthesia giving set	1	2	3	8	1	2	8
	7) Anesthetist	1	2	3	8			
495	Does this facility have a provider who can perform a caesarean section present in the facility or on call 24 hours a day (including weekends) . IF YES, ASK TO SEE SCHEDULE.	YES, PRESENT,SCHEDULE SEEN..... 1 YES, PRESENT SCHEDULE NOT SEEN 2 YES, ON CALL, SCHEDULE SEEN..... 3 YES, ON CALL, SCHEDULE NOT SEEN 4 NO 5						
496	How many caesarean sections were conducted at this facility during the past twelve (12) completed months?	NO. CAESAREAN ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>						
		DON'T KNOW 9998 →498						
497	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... <input type="text"/> <input type="text"/>						
498	What is the date of the last caesarean section? TAKE THE DATE FROM A REGISTER OR REPORT FORM.	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99999998						

Section 5. Specific Infections diseases Services					
NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
500	Does this facility offer any services related to diagnosis, treatment or supportive services for RTIs, STIs, or HIV/AIDS or Tuberculosis?	YES	1		→600
		NO	2		
501	<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF STI/HIV/AIDS SERVICES. IF DIFFERENT FROM INDIVIDUAL(S) RESPONDING TO THE PREVIOUS SECTIONS INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 502.</p> <p>READ TO INFORMANT (IF DIFFERENT FROM INFORMANT FOR EARLIER SECTIONS):</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services for sexually transmitted infections, with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely confidential. You may choose to stop the interview at any time.</p> <p>Do you have any questions for me? Do I have your agreement to participate?</p> <p style="text-align: center;">_____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p> <p style="text-align: center;">_____ DATE</p>				
501	May I begin the interview?	YES	1		→600
		NO	2		
502	First I want to ask specifically about services for reproductive tract infections (RTIs) or sexually transmitted infections (STIs). Does this facility offer services for these types of cases?	YES	1		→537
		NO	2		
503	Are services being offered at the facility today for reproductive tract infections?	YES	1		
		NO	2		
504	Are these services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC	1		
		GENERAL OUTPATIENT	2		
505	How many days per week are services for clients with symptoms of reproductive tract infection available in either the special or general clinic?	# DAYS	<input style="width: 40px; height: 20px;" type="text"/>		
506	ASK TO SEE WHERE COUNSELING FOR CLIENTS WITH RTIs or SUSPECTED STI'S IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM	1		
		ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER	2		
		ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER	3		
507	Are any of the following available, in the counseling or the examination room?	1 Observed	2 Reported Available	3 Not Available	4 Not Determined
	Visual Aids for Teaching				
	1) About STIs	1	2	3	8
	2) About HIV/AIDS	1	2	3	8
	3) About Hepatitis	1	2	3	8
	4) Model for demonstrating use of condom	1	2	3	8
	Information Booklet/Pamphlet for Client to take home:				
	5) On STIs	1	2	3	8
	6) On HIV/AIDS	1	2	3	8
	7) On hepatitis	1	2	3	8
	8) Are there Condoms present in the room?	1	2	3	8

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO			
		OBSERVED	REPORTED	NOT AVAILABLE	NOT DETERMINED			
508	Service Delivery Protocols							
	1) Clinical guidelines for diagnosing and treating RTIs or STI?	1	2	3	8			
	2) Guidelines for using syndromic approach for diagnosing and treating RTIs or STI's	1	2	3	8			
	3) Guidelines for diagnosing HIV/AIDS?	1	2	3	8			
	4) Clinical guidelines for treating HIV/AIDS? (e.g. opportunistic infection, anti-retroviral therapy)	1	2	3	8			
	5) Do you have a copy of the MOHP Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
	6) Do you have a copy of the OTHER Infection Control Guidelines? If YES, may I see them?	1	2	3	8			
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR RTIS or STIS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.								
509	If <u>same examination room</u> has already been observed for items in 510-512 indicate for which section the room was assessed:	FAMILY PLANNING [327-329]..... 1 ANTENATAL [410-412]..... 2 DELIVERY [451-453] 3 NOT PREVIOUSLY SEEN 4				→513 →513 →513		
510	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM..... 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER..... 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER..... 3						
ITEMS REQUIRED FOR STI EXAMINATION								
511	ITEMS REQUIRED FOR STI EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Spotlight source (flashlight or examination light accepted)	1→b	2→b	3↓	8↓	1	2	8
	2) Table for gynecological exam	1	2	3↓	8↓			
	3) Clean gloves	1	2	3	8			
	4) Safety box for needles	1	2	3	8			
	5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8			
	6) Decontamination solution for clinical equipment	1	2	3	8			
	7) Waste receptacle with lid and plastic liner							
	8) Hand-washing items (soap)	1	2	3	8			
	9) Water for hand-washing	1	2	3→513	8→513			
512	How is water made available for use in the STI service area <u>today</u> ?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN..... 3						
OTHER EQUIPMENT								
513		1 OBSERVED	2 REPORTED	3 NOT AVAILABLE	8 NOT DETERMINED			
	1) Speculum	1	2	3	8			
	2) Swab sticks	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
514	<p>After completing an examination, what procedures does this service follow for initial handling of contaminated equipment (such as used 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>SOAKED IN DISINFECTANT SOLUTION BRUSH SCRUBBED WITH SOAP AND WATER..... 1</p> <p>BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT2</p> <p>BRUSH SCRUBBED WITH SOAP AND WATER.....3</p> <p>SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED4</p> <p>OTHER6</p> <p>NONE7</p> <p>DON'T KNOW..... 8</p>	
515	<p>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 "4 " AND CONTINUE</p>	<p>SECTION 1 [Q152-158] 1</p> <p>FAMILY PLANNING [Q340-343]..... 2</p> <p>DELIVERY [Q469-472]..... 3</p> <p>NOT PREVIOUSLY SEEN 4</p> <p>PROCESS OUTSIDE FACILITY.....5</p>	<p>→521</p> <p>→521</p> <p>→521</p> <p>→521</p>
516	<p>After cleaning, what is the final process most commonly used for disinfecting or sterilizing equipment prior to reuse? IF MORE THAN ONE METHOD IS USED CIRCLE ALL METHODS THAT THIS UNIT CARRY OUT. AND PROVIDE THE PROCESSING INFORMATION INDICATED IN QUESTION 517.</p>	<p>DRY HEAT STERILIZATION..... A</p> <p>AUTOCLAVE..... B</p> <p>STEAM STERILIZATION C</p> <p>BOILING D</p> <p>CHEMICAL E</p> <p>PROCESS OUTSIDE FACILITY...F</p> <p>OTHER..... X</p> <p>NONE Y</p>	<p>→521</p> <p>→521</p>

GO TO WHERE EQUIPMENT IS STERILIZED AND ASSESS AVAILABILITY OF EQUIPMENT REQUIRED FOR PROCEDURES.								
517	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	NOT DETER
01	Electric dry heat sterilizer	1→b	2→b	3↓	8↓	1	2	8
02	Electric autoclave (pressure; wet heat)	1→b	2→b	3↓	8↓	1	2	8
03	Non-electric autoclave	1→b	2→b	3↓	8↓	1	2	8
04	Pot with cover (for steaming or boiling)	1	2	3	8			
05	Other method _____ (SPECIFY)	1	2	3	8			
06	Heat source (stove/Cooker w/fuel or power present) For steaming, boiling, or using non-electric autoclave)	1→b	2→b	3↓	8↓	1	2	8
07	Automatic timer (MAY BE ON MACHINE)	1→b	2→b	3↓	8↓	1	2	8
517a	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
518	Biological indicator for testing effectiveness of sterilization	1	2	3	8			
519	Written guidelines for disinfection and sterilization	1	2	3	8			

FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/DISINFECTION AND CHEMICAL DECONTAMINATION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/BOILING IS REACHED						
	(a) Dry heat sterilization	(b) Autoclave	(c) Boil or steam (high level disinfectant ,HLD)	(d) Chemical decontaminant	(e) Chemical High Level Disinfectant (HLD)	(f) OTHER
01	Method USED1 NOT USED2→b Temperature	USED1 NOT USED2→c Temperature	USED1 NOT USED2→d Temperature	USED1 NOT USED2→e Temperature	USED1 NOT USED2→f Temperature	USED1 NOT USED2→521 Temperature
02	Temperature (centigrade)	AUTOMATIC666 DON'T KNOW998	AUTOMATIC666 DON'T KNOW998			AUTOMATIC666 DON'T KNOW998
03	Pressure	AUTOMATIC666 DK PRESSURE998	AUTOMATIC666 DK PRESSURE998			AUTOMATIC666 DK PRESSURE998
04	Minutes-when equipment is not wrapped in cloth	Minutes AUTOMATIC666 DON'T KNOW998	Minutes DON'T KNOW998	Minutes	Minutes	Minutes AUTOMATIC666 DON'T KNOW998
05	Minutes when equipment is wrapped	Minutes wrapped AUTOMATIC666 DON'T KNOW998	Minutes wrapped	Minutes	Minutes	Minutes Wrapped AUTOMATIC666 DON'T KNOW998
06	Chemical solution (DISINFECTANT)			CHLOR1 BETADINE2 ALCOHOL3 SAVLON4 OTHER6 DON'T KNOW8	CIDEX/GLUTARAL- DEHYDE/SEPTAID1 CHLOR2 BETADINE3 ALCOHOL4 SAVLON5 OTHER6 DON'T KNOW8	
07	Percent solution (Concentration before diluted)			Percent DK=98	Percent DK=98	
08	Mixture, parts disinfectant and water			Mixture parts a) Disinfectant b) Water DK=998	Mixture parts a) Disinfectant b) Water DK=998	

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
521	INDICATE STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (E.G. speculum, forceps), READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED INDICATE WHICH SECTION THE INFORMATION IS IN.	GENERAL FACILITY [159-161]1 FAMILY PLANNING [344-347]2 DELIVERY [473-476].....3 NOT PREVIOUSLY SEEN4				→525 →525 →525
522	STORAGE CONDITIONS FOR PROCESSED EQUIPMENT	OBSERVED	REPORTED AVAILABLE	NOT AVAILABLE	ND	
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8	
	2) Stored in sterile container with lid which clasps shut	1	2	3	8	
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8	
	4) On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8	
	5) In container w/ antiseptic/disinfectant	1	2	3	8	
	6) Other	1	2	3	8	
523	Is the date of sterilization for the stored items indicated?	1	2	3	8	
524	Is the storage area for sterilized items clean and dry?	1	2	3	8	
525	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY	SYNDROMIC/CLINICALA ETIOLOGIC (LABORATORY).....B				
526	Does this facility have protocols on the following: IF YES, ASK TO SEE A COPY.	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILA BLE.	4 NOT DETERMINED	
	1) Confidentiality Protocol for STI clients?	1	2	3	8	
	2) Informed Consent Protocol for STI testing?	1	2	3	8	
527	Does the facility normally perform partner notification or follow-up for sexually transmitted infections? 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 client to inform or bring their partner(s).	YES, SOMETIMES ACTIVE1 YES, ONLY PASSIVE.....2 NO.....3				→529 →529
528	Do you have a form or register where clients for active follow-up are listed? IF YES, ASK TO SEE.	YES, FORM SEEN1 YES, REGISTER SEEN.....2 YES, FORM/REGISTER NOT SEEN.....3 NO FORM/REGISTER.....4				
529	Is there a register where RTI/STI consultation information is recorded? IF YES, ASK TO SEE REGISTER. CLIENT NAME, AGE, SEX, AND DIAGNOSIS MUST BE INDICATED FOR REGISTER TO BE VALID.	YES, REGISTER SEEN.....1 YES, REGISTER NOT SEEN2 NO REGISTER KEPT3				→532 →532
530	Does the register indicate a specific type of RTI/STI diagnosed?	YES1 NO.....2				
531	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS.....1 >7 BUT WITHIN 30 DAYS2 > 30 DAYS3				
532	RECORD THE NUMBER OF CLIENTS WHO RECEIVED RTI/STI SERVICES DURING THE LAST TWELVE (12) COMPLETED MONTHS	NUMBER OF RTI/STI CLIENTS.... <input type="text"/> <input type="text"/> <input type="text"/>				
533	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	DON'T KNOW 998 MONTHS OF DAT. <input type="text"/> <input type="text"/>				→534
534	Do you submit an official report externally (usually to the MoH or a communicable disease department) for cases of VENERAL DISEASES (SYPHILIS, GONORRHEA) OR HIV/AIDS. IF YES, is the report generated from consultation records or from the laboratory?	YES, CONSULTATION..... 1 YES, LABORATORY 2 YES, BOTH..... 3 NO..... 4 DON'T KNOW 8				

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
535	Does this facility routinely charge for RTI/STI consultation services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR HEALTH CARDA YES, FIXED FEE EACH CONSULT B YES, CHARGE FOR MEDICATIONS/TESTS.....C OTHER _____X (SPECIFY) NOY DON'T KNOWZ				 →537 →537
536	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME,NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8				
537	Does this facility provide treatment for any Tuberculosis patients? If Yes, Does the facility follow DOTS protocol?	YES, DOTS TREATMENT 1 YES, NOT DOTS 2 NO 3				 →538 →538
537a	Does this facility store any TB-DOTS drugs (pre-packed by the pharmacy or outside the pharmacy)? If YES, may I see them?	YES, OBSERVED1 YES,NOT SEEN.....2 NOT AVAILABLE.....3 DON'T KNOW.....8				
538	Does this facility have the capacity to run the following tests? IF NOT: Do you collect the specimen and send it elsewhere for the test or does the client have to go somewhere else for the test?(check section6 for equipment and supplies required for any test conducted in the facility)	1 CONDUCT TEST	2 COLLECT SPEC-IMEN	3 SEND CLIENT ELSE-WHERE	4 TEST NOT UTILIZED	
	1) Syphilis?	1	2	3	4	
	2) Gonorrhea?	1	2	3	4	
	3) Sputum test for Tuberculosis	1	2	3	4	
	4) HIV/AIDS?	1	2	3	4	
	5) CD4 Count? (HIV)	1	2	3	4	
	6) HIV Viral Load?	1	2	3	4	
	7) Bedside Test for STI's?	1	2	3	4	

6. Laboratory Diagnostics

NO	QUESTIONS	CODING CLASSIFICATION	GO TO																												
600	ARE ANY OF THE LABORATORY TESTS RELATED TO STIs OR HIV OR TB (563), OR MCH (406) MARKED WITH THE NUMERAL 1? IF YES: GO TO WHERE LABORATORY TESTS ARE CONDUCTED AND ASK TO SEE THE FOLLOWING EQUIPMENT AND SUPPLIES.	YES,BOTH(STIs and/or TB and MCH)....1 YES, TESTS OTHER THAN MCH.....2 YES, MCH LAB TESTS ONLY, (Q 406).....3 NO LAB TESTS.....4 NO ACCESS TO LAB5	→607 →700 →700																												
601	ITEMS FOR LABORATORY EXAMINATION	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">(a) AVAILABILITY</th> <th colspan="3" style="text-align: center;">(b) FUNCTIONING</th> </tr> <tr> <th style="width: 10%;">OBSERVED PRESENT</th> <th style="width: 10%;">REPORTED AVAILABLE</th> <th style="width: 10%;">NOT AVAILABLE</th> <th style="width: 10%;">NOT DETERMINED</th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 10%;">ND</th> </tr> </thead> <tbody> <tr> <td>1→b</td> <td>2→b</td> <td>3</td> <td>8</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td></td> <td></td> <td>next line.↓</td> <td>next line.↓</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	(a) AVAILABILITY				(b) FUNCTIONING			OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	ND	1→b	2→b	3	8	1	2	8			next line.↓	next line.↓				
(a) AVAILABILITY				(b) FUNCTIONING																											
OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	ND																									
1→b	2→b	3	8	1	2	8																									
		next line.↓	next line.↓																												
01	Microscope	1→b	2→b	3	8	1	2	8																							
02	Centrifuge	1→b	2→b	3	8	1	2	8																							
03	Refrigerator	1→b	2→b	3	8	1	2	8																							
04	Glass slides and covers	1	2	3	8																										
602	HIV/AIDS TESTS		2	3	8																										
01	Rapid test	1	2	3	8																										
02	ELISA + scanner/reader	1→b	2→b	3	8	1	2	8																							
03	Western Blot	1	2	3	8																										
04	CD4	1	2	3	8																										
05	HIV viral load	1	2	3	8																										
06	Other HIV test _____ (SPECIFY TYPE)	1	2	3	8																										
603	SYPHILIS TESTS		2	3	8																										
01	VDRL (syphilis)	1	2	3	8																										
02	RPR (syphilis)	1	2	3	8																										
03	Rotator/ Shaker	1	2	3	8																										
604	GONORRHEA TESTS		2	3	8																										
a				604b.↓																											
01	Chocolate agar (culture medium)	1	2	3	8																										
02	Incubator	1→b	2→b	3	8	1	2	8																							
604	GRAM STAIN		2	3	8																										
b				605.↓																											
04	Crystal violet	1	2	3	8																										
05	Lugol's iodine	1	2	3	8																										
06	Acetone, Ethyl alcohol, other decolorisation	1	2	3	8																										
07	Neutron red, carbol fushin, or other counterstain	1	2	3	8																										
08	Other _____ (SPECIFY TYPE)	1	2	3	8																										
605	CHLAMYDIA TESTS		2	3	8																										
01	Giemsa Stain	1	2	3	8																										
02	Distilled water	1	2	3	8																										
03	Other _____ (SPECIFY TYPE)	1	2	3	8																										

6. Laboratory Diagnostics (continued)

NO	QUESTIONS	CODING CLASSIFICATION				GO TO		
		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED PRESENT	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	ND
606	TUBERCULOSIS TEST		2	3 607.↓				
01	AFB or Ziehl-Neelson test, with stain e.g., methyl blue) present	1	2	3	8			
02	All items for other test for TB (SPECIFY TYPE)	1	2	3	8			
607	URINE TESTS		2	3 608.↓				
01	Any dip sticks for urine protein (with valid expiry date) (Campus 3 or 9)	1	2	3	8			
02	Any dipsticks for urine glucose (Campus 3 or 9)	1	2	3	8			
03	Acetic Acid (albumin)	1	2	3	8			
04	Flame	1→b	2→b	3 next line.↓	8 next line.↓	1	2	8
05	Test tubes	1	2	3	8			
06	Benedict's solution (glucose test)	1	2	3	8			
07	Stove and container for boiling	1→b	2→b	3 next line.↓	8 next line.↓	1	2	8
608	TEST FOR ANEMIA		2	3 609.↓				
01	Hemoglobinometer	1→b	2→b	3 next line.↓	8 next line.↓	1	2	8
02	Colorimeter or spectroscope	1→b	2→b	3 next line.↓	8 next line.↓	1	2	8
03	Drabkin's solution	1	2	3	8			
04	Capillary tubes and a centrifuge	1→b	2→b	3 next line.↓	8 next line.↓	1	2	8
05	Other test (SPECIFY)_____	1	2	3	8			
06	Paper for hemoglobin tests (w/ valid expiry date)	1	2	3	8			
609	Blood Grouping Materials		2	3 700.↓				
01	Anti-A(with valid expiry date)	1	2	3	8			
02	Anti-B(with valid expiry date)	1	2	3	8			
03	Anti-D(Rh factor) (with valid expiry date)	1	2	3	8			

Section 7. Essential Medications And Supplies For Providing Services For Sick Clients Children, Maternal Health Clients , and Clients With some Infectious Diseases

FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR PHARMACEUTICAL SERVICES AT THE OUTPATIENT FACILITY. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF.

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
700	Do you have a system that allows you to check the amount of each medicine that is available daily? IF YES, ASK TO SEE THE RECORDS AND INDICATE THE METHOD FOR WHICH YOU OBSERVED RECORDS.	INVENTORY NOT UPDATED DAILY WITH REGISTER OF DISTRIBUTED MEDICINE KEPT DAILY 1 INVENTORY UPDATED DAILY 2 NO INVENTORY RECORDS SEEN..... 3 NO PHARMACY IN THE FACILITY... 4 NO ACCESS TO PHARMACY 6	→800 →800

ASK TO SEE THE MEDICINE STORE. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR NON-SHADED MEDICINES, CHECK ALL TO VERIFY IF (A) THEY ARE ARRANGED BY EXPIRY DATE, (B) WERE THERE ANY EXPIRED UNITS PRESENT, AND (C) VERIFY THAT INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY REGISTER OR PRESCRIPTION AND SUBTRACT THESE FROM INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:

701	Medications	(a) AVAILABILITY OF MEDICATIONS				(b) VALIDITY			(c) STOCK AND INVENTORY (W/ REGISTER) SAME		
		1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED				1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW			1=YES 2=NO 3=DON'T KNOW		
	Oral										
1	Amoxicillin oral ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
2	Aspirin oral ^{1,2,3}	1	2	3	8						
3	Ciprofloxin PO ³	1→b	2↓	3↓	8↓	1	2	8	1	2	8
4	Cotrimoxazole oral ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
5	Doxycycline PO ^{2,3}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
6	Ergometrine/methergine ²	1↓	2↓	3↓	8						
7	Erythromycin oral ^{2,3}	1	2	3	8						
8	Ethambutol PO ⁴	1	2	3	8						
9	Folic acid ²	1	2	3	8						
10	Iron ^{1,2}	1	2	3	8						
11	Iron with Folic Acid ²	1	2	3	8						
12	Isoniazid ⁴ /inhbex	1	2	3	8						
13	Mebendazole oral ^{1,2}	1	2	3	8						
14	Methyldopa ²	1	2	3	8						
15	Metronidiazole ^{2,3} (FLAGYL)	1	2	3	8						
16	Multivitamins ¹	1	2	3	8						
17	Naladixic acid oral ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
18	Paracetamol oral ¹	1	2	3	8						
19	Penicillin oral ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
20	Pyrazinamide PO ⁴	1	2↓	3	8						
21	Rifampicin ⁴	1	2↓	3	8						
22	Remactazid/Riozid	1	2	3	8						
23	Tetracycline oral ^{2,3}	1→b	2↓	3↓	8↓	1	2	8	1	2	8

24	Vitamin A high dose (200,000 iu) ^{1,2}	1	2	3	8						
25	Vitamin A low dose ^{1,2} (25,000 or 50,000iu)	1	2	3	8						
26	Oral rehydration salts ¹	1	2	3	8						
		(a) AVAILABILITY OF MEDICATIONS 1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED				(b) VALIDITY 1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW			(c) STOCK AND INVENTORY (W/REGISTER) SAME 1=YES 2=NO 8=DON'T KNOW		
	OTHER MEDICINE										
27	Nystatin Vaginal Tablet ³	1	2	3	8						
28	Antibiotic eye Ointment ¹ [NOT CHLORAMPHENICOL]	1	2	3	8						
	INJECTIONS										
29	Ampicillin. ²	1→b	2↓	3↓	8↓	1	2	8	1	2	8
30	Benzathine benzyl pen ^{1,3}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
31	Benzyl Penicillin (Procaine) ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
32	Ceftriaxone ³	1	2	3	8						
33	Diazepam ²	1	2	3	8						
34	Ergometrine/oxytocin ²	1	2	3	8						
35	Gentamycin ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
36	Magnesium sulfate ²	1	2	3	8						
37	Streptomycin ⁴	1	2	3	8						
38	Xylocaine or lidocaine 1% ^{2,5}	1	2	3	8						
39	Chloramphenicol ¹	1	2	3	8	1	2	8	1	2	8
	INTRAVENOUS										
40	Normal Saline ²	1	2	3	8						
41	Dextrose and water ^{1,2}	1	2	3	8						
42	Ringers Lactate ^{1,2}	1	2	3	8	1	2	8	1	2	8
43	D5NS ²	1	2	3	8	1	2	8	1	2	8
	TB DOTS drugs										
44	TB-DOTS drugs ⁴ (pre-packed by the pharmacy)	1→b	2↓	3↓	8↓	1	2	8	1	2	8
45	TB-DOTS drugs ⁴ (pre-packed outside the pharmacy)	1→b	2↓	3↓	8↓	1	2	8	1	2	8

- 1) Child Health
- 2) Maternal Health
- 3) Reproductive tract Infections
- 4) Tuberculosis
- 5) Family Planning

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
702	Were the medications organized according to expiry date "first-expire first-out" on the shelf? (VERIFY WHEN COMPLETING 701(1-45) FOR INDICATED MEDICINES)	YES..... 1 NO..... 2 DON'T KNOW..... 8	
	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE CORRECT RESPONSE FOR EACH OF THE FOLLOWING CONDITIONS:		
703	ARE THE MEDICINES OFF THE FLOOR PROTECTED FROM WATER/DAMPNESS?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
704	ARE THE MEDICINES PROTECTED FROM THE SUN?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
705	IS THE ROOM CLEAR OF ANY EVIDENCE OF PESTS?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
706	Does this facility determine the amount of each medication required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS..... 1 NEED DETERMINED ELSEWHERE 2 DON'T KNOW..... 8	→708a →800
707	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW..... 8	→710 →710 →710
708a	When was the last time that you received a routine supply of medications ?	WITHIN PRIOR 4 FULL WEEKS ... 1 WITHIN PRIOR 12 FULL WEEKS . 2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8	
708b	Routinely, when you order medicines , which best describes the system you use to determine how much of each to order: 1) Do you review the amount of each medicine remaining, and order to bring the stock amount to a pre-determined (fixed) amount? 2) Do you order the exact same amount each time? 3) Do you look at the amount used since the previous order, and plan based on prior utilization and expected future activity? 4) Others 5) RESPONDENT FAMILIAR WITH ORDERING SYSTEM IS NOT AVAILABLE	ORDER TO MAINTAIN FIXED STOCK LEVEL..... 1 ORDER SAME AMOUNT 2 ORDER BASED ON UTILIZATION 3 KNOWLEDGEABLE PERSON IS NOT AVAILABLE..... 5 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	→ 709a → 709a →709a →709a →710
708c	When deciding how much of each medicine to order, based on prior utilization and planned activities, do you have a mathematical formula for calculating how much to use, or do you use your judgment?	MATHEMATICAL FORMULA..... 1 JUDGMENT 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
709a	<p>Which of the following best describes the system for deciding when to order medicines?</p> <p>1) Whenever stock levels fall to a predetermined level</p> <p>2) There is a fixed time that orders are accepted. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS.</p> <p>3) An order is placed at no fixed time, but rather whenever there is a need.</p> <p>4) Other</p>	<p>PREDETERMINED LEVEL..... 1</p> <p>EVERY <input type="text"/> <input type="text"/> WEEKS..... 2</p> <p>ORDER AS NEEDED 3</p> <p>OTHER _____ 6 (SPECIFY)</p>	
709b	<p>If there is a shortage of specific medicines between routine orders, what is most common procedure followed by this facility?</p> <p>1) Submit special order to normal supplier.</p> <p>2) Facility purchases from private market</p> <p>3) Clients must purchase from outside the facility.</p>	<p>SPECIAL ORDER.....A</p> <p>FACILITY PURCHASEB</p> <p>CLIENT PURCHASE C</p> <p>NO SHORTAGE.....D</p>	
710	<p>During the past 3 months, have you received the amount of each medication that you order (or that you are suppose to routinely receive)?</p>	<p>ALWAYS..... 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER..... 3</p> <p>D.K.....8</p>	

Section 8. Supplies

800	SUPPLY ITEM	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED
1	Disinfectant for cleaning surfaces (bleach or other cleaning solution)	1	2	3	8
2	Sterile gloves	1	2	3	8
3	Clean gloves	1	2	3	8
4	Swab containers with sterile swabs or sterile gauze	1	2	3	8
5	Skin antiseptic (iodine or chlorhexidine)	1	2	3	8
6	I.V. giving set	1	2	3	8
7	I.V. canulae	1	2	3	8
8	Injection needles (19 or 21 gauge)	1	2	3	8
9	Sterile syringes (3 or 5 ml)	1	2	3	8

MEASURE Service Provision Assessment

Provider Interview	
FACILITY IDENTIFICATION	
QTYPE OF _____ Name of the facility _____ Facility Location _____ Governorate _____ District _____ Code of the facility _____ Type of Health Facility and Operating Authority Governmental: 11 = General Hospital 21=MCH Center 12=District Hospital 22=Rural health unit 13= Fever Hospital 23=Urban health unit 14= Integrated 24=Health Office 25=Mobile Unit 26=Other Non-Governmental: 31=CSI 32= EFPA 33=other non-governmental	QTYPE SP GOV <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> DISTRICT..... <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> FACILITY CODE <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> <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> <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> FACILITY TYPE <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> AND OPERATING AUTHORITY
Provider Information	
Provider category: 11=OB/GYN Physician ;12=Family Planning Physician; 13=Pediatrician; 14=Family physician; 15=Other physician specialist; 16=General Practitioner; 21=Nurse w/ midwifry; 22=Nurse; 23=Midwife; 24=Nurse asistant; 96=other (_____) (SPECIFY) Sex of Provider: (1=male; 2=female) Provider Code (Use same code for observation component): _____	PROVIDER CATEGORY <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> SEX OF PROVIDER..... <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> PROVIDER CODE..... <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>
INFORMATION ABOUT INTERVIEW	
Date: _____ Name of the interviewer _____ Time interview started: _____	DAY <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> MONTH..... <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> YEAR..... <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle; text-align: center;">2</table> <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle; text-align: center;">0</table> <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle; text-align: center;">0</table> <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle; text-align: center;">4</table> INTERVIEWER CODE.. <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> HOUR..... <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> MINUTES <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>

Provider Interview

100 **OBSERVER:** INTRODUCE YOURSELF TO THE PROVIDER.

Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. I would like to ask you some questions about this subject.

This information is completely confidential. You may choose to stop the interview at any time.

Do you have any questions for me at this time? Do I have your agreement to participate?

 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

 DATE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
1. Provider Training and Experience			
100a	May I continue?	YES.....1 NO.....2	→STOP
101	In what year did you start working in this facility?	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"/>	
102	Now I would like to ask you some questions about your educational background. How many years in total of primary and secondary education did you complete?	YEARS..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
103	What is your current technical qualification?	OB/GYN PHYSICIAN11 FAMILY PLANNING PHYSICIAN12 PEDIATRICIAN.....13 FAMILY PHYSICIAN14 OTHER PHYSICIAN SPECIALIST15 GENERAL PRACTITIONER.....16 NURSE WITH MIDWIFRY21 NURSE22 MIDWIFE23 NURSE ASSISTANT24 OTHER _____ .96 (SPECIFY)	
104	What year did you graduate with this qualification?	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"/>	
105	How many years of study was required for the technical qualification in question 103? (AFTER COMPLETING BASIC EDUCATION DESCRIBED IN Q102)? (If less than 1 year, write "00" in years and indicate number of months).	YEARS..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTHS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→201

2. Child Health Care

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																								
201	Do you currently personally provide child health care services?	YES.....1 NO2	→203																																								
202	For how many years in total have you provided this service? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <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>																																									
203	During the past five years have you received any inservice training on subjects related to child health or illness?	YES.....1 NO2	→301																																								
204	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) EPI/cold chain? B) ARI treatment? C) Diarrhea treatment? D) Nutrition/micro-nutrient deficiencies? E) Integrated Management of Childhood Illness (IMCI)? F) Genetic/hereditary illnesses? W) Other _____?..... (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td></td> <td style="text-align: center;">PRIOR</td> <td style="text-align: center;">PRIOR</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">12mo</td> <td style="text-align: center;">13-59mo</td> <td></td> </tr> <tr> <td style="text-align: center;">EPI/COLD CHAIN</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">ARI</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">DIARRHEA</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">NUTRITION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">IMCI</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">GENETIC/HEREDITY.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">OTHER</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </table>		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		EPI/COLD CHAIN	1	2	3	ARI	1	2	3	DIARRHEA	1	2	3	NUTRITION	1	2	3	IMCI	1	2	3	GENETIC/HEREDITY.....	1	2	3	OTHER	1	2	3	
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OTHER	1	2	3																																								

3. Family Planning

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																												
301	Do you currently personally provide family planning services?	YES.....1 NO2	→303																												
302	For how many years in total have you provided this service? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <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>																													
303	During the past five years have you received any inservice training on subjects related to family planning?	YES.....1 NO2	→401																												
304	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Basic Training for Service Provision (not from medical school)? Additional training aside from Basic Training: B) Family planning counseling? C) Any contraceptive technology (CT)? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td></td> <td style="text-align: center;">PRIOR</td> <td style="text-align: center;">PRIOR</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">12mo</td> <td style="text-align: center;">13-59mo</td> <td></td> </tr> <tr> <td style="text-align: center;">BASIC TRAINING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">FP COUNSELING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">ANY CT.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td style="text-align: center;">OTHER</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </table>		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		BASIC TRAINING	1	2	3	FP COUNSELING	1	2	3	ANY CT.....	1	2	3	OTHER	1	2	3	
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FP COUNSELING	1	2	3																												
ANY CT.....	1	2	3																												
OTHER	1	2	3																												

4. Maternal Health

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																
401	Do you currently personally provide antenatal care or postpartum care, or both?	YES, ANTENATAL1 YES, POSTPARTUM.....2 YES, BOTH.....3 NO, NEITHER.....4	→403																																
402	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>																																	
403	During the past five years have you received any inservice training on subjects related to antenatal or postpartum care?	YES.....1 NO2	→405																																
404	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Basic Training for Service Provision (not from medical school)? Additional training aside from Basic Training: B) Antenatal care? C) Counseling/health education for maternity clients? D) Management of risk pregnancies? E) Mother to child transmission of HIV/AIDS? F) Postnatal care? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES PRIOR 12mo</th> <th style="text-align: center;">YES PRIOR 13-59mo</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>BASIC TRAINING..... 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> <tr> <td>ANTENATAL CARE 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> <tr> <td>COUNSELING/ HEALTH EDUCATION ... 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> <tr> <td>MGMT RISK PREGNANCIES..... 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> <tr> <td>MTC TRANSMISSION.... 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> <tr> <td>POSTNATAL CARE 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> <tr> <td>OTHER _____ 1</td> <td style="text-align: center;">2</td> <td></td> <td style="text-align: center;">3</td> </tr> </tbody> </table>		YES PRIOR 12mo	YES PRIOR 13-59mo	NO	BASIC TRAINING..... 1	2		3	ANTENATAL CARE 1	2		3	COUNSELING/ HEALTH EDUCATION ... 1	2		3	MGMT RISK PREGNANCIES..... 1	2		3	MTC TRANSMISSION.... 1	2		3	POSTNATAL CARE 1	2		3	OTHER _____ 1	2		3	
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POSTNATAL CARE 1	2		3																																
OTHER _____ 1	2		3																																
405	Do you currently personally provide delivery care? By this, I mean conducting the actual delivery?	YES.....1 NO2	→408																																
406	For how many years in total have you conducted deliveries? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>																																	
407	Approximately how many deliveries have you assisted as the principal provider, in the last 6 months? (INCLUDE DELIVERIES CONDUCTED FOR PRIVATE PRACTICE AND FOR FACILITY)	TOTAL DELIVERIES.... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>																																	
408	When was the last time you used a partograph?	NEVER0 IN PAST WEEK1 IN PAST MONTH.....2 IN PAST 6 MONTHS3 6 MONTHS AGO OR LONGER....4 DON'T KNOW.....8																																	
409	During the past five years have you received any inservice training on subjects related to delivery care?	YES.....1 NO2	→411																																

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																												
410	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Care during labor or delivery? B) Use of partograph? C) Life saving skills/emergency complications? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td></td> <td style="text-align: center;">PRIOR</td> <td style="text-align: center;">PRIOR</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">12mo</td> <td style="text-align: center;">13-59mo</td> <td></td> </tr> <tr> <td>DELIVERY CARE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>PARTOGRAPH USE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>LIFE SAVING/EMERG ...</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>OTHER _____</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </table>		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		DELIVERY CARE	1	2	3	PARTOGRAPH USE	1	2	3	LIFE SAVING/EMERG ...	1	2	3	OTHER _____	1	2	3	
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LIFE SAVING/EMERG ...	1	2	3																												
OTHER _____	1	2	3																												
411	Do you currently personally provide newborn care ?	YES.....1 NO2	→413																												
412	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>																													
413	During the past five years have you received any inservice training on subjects related to newborn care?	YES.....1 NO2	→501																												
414	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Care of the normal newborn? B) Neonatal resuscitation? C) Exclusive breast-feeding? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td></td> <td style="text-align: center;">PRIOR</td> <td style="text-align: center;">PRIOR</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">12mo</td> <td style="text-align: center;">13-59mo</td> <td></td> </tr> <tr> <td>NORMAL NEWBORN</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>NEONATAL RESUSCIT ..</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>BREAST FEEDING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>OTHER _____</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </table>		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		NORMAL NEWBORN	1	2	3	NEONATAL RESUSCIT ..	1	2	3	BREAST FEEDING	1	2	3	OTHER _____	1	2	3	
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NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																												
5. SPECIFIC INFECTIOUS DISEASES																															
501	Do you currently personally provide care for clients with reproductive tract infections or sexually transmitted infections? (STIs)? By this, I mean that even if a client comes for another reason, if you suspect an STI, do you provide the care for this problem?	YES.....1 NO2	→503																												
502	For how many years in total have you provided these services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>																													
503	Do you currently personally provide care for clients with tuberculosis?	YES.....1 NO2	→505																												
504	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>																													
505	Do you currently personally provide any preventive services related to HIV/AIDS?	YES.....1 NO2	→508																												
506	What type of preventive services do you provide?	PMTCT A COUNSELING FOR TESTNIG..... B COUNSELING FOR PREVENT C OTHER _____ X (SPECIFY)																													

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
507	For how many years in total have you provided any preventive services related to HIV/AIDS? IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
508	Do you personally provide any care and/or support services for clients who are HIV/AIDS serum positive, or who you suspect may have HIV/AIDS?	YES.....1 NO2	→511
509	Which type of care do you provide? CIRCLE ALL THAT APPLY	INITIAL DIAGNOSIS..... A MEDICAL MANAGEMENT OF OPPORTUNISTIC INFECTIONS .. B ANTI-RETROVIRAL THERAPY C COUNSELING/SOCIAL SUPPORT D OTHER _____ X (SPECIFY)	
510	For how many years in total have you provided any care and/or support services for HIV/AIDS clients? IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
511	During the past five years have you received any inservice training on subjects related to STIs, TB, or HIV/AIDS?	YES.....1 NO2	→600
512	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Did you received training in (SUBJECT) as a part of <u>the pre-service basic training</u> (not from medical school)?		YES NO DK
	a) How to counsel for prevention of STIs	STI COUNSELING1	2 8
	b) Etiological/clinical diagnosis and treatment of STIs	STI CLINICAL DX & TX.....1	2 8
	c) Syndromic diagnosis and treatment of STIs	STI SYNDROMIC DX & TX1	2 8
	d) How to counsel for prevention of HIV/AIDS	PREVENTION OF HIV/AIDS1	2 8
	e) Voluntary counseling and testing	VCT.....1	2 8
	f) Mother to child transmission	MOTHER TO CHILD1	2 8
	g) Counseling on use of condoms	COUNSEL ON CONDOMS1	2 8
	h) Counseling and social support needs for HIV/AIDS infected clients?	COUNSEL/SUPPORT HIV/AIDS...1	2 8
	i) Medical management of HIV/AIDS	MEDICAL MGMT HIV/AIDS1	2 8
	j) Anti-retroviral therapy for HIV/AIDS?	ANTI-RETROVIRAL TX.....1	2 8
	k) Diagnosis of TB	TB DIAGNOSIS1	2 8
	l) Treatment of TB?	TB TREATMENT1	2 8
	m) DOTS strategy	DOTS STRATEGY1	2 8
	n) Preventive therapy for TB in HIV/AIDS patients	PREVENT TB IN AIDS1	2 8

513	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?	YES PRIOR 12mo	YES PRIOR 13-59mo	NO
a)	Counseling for prevention of STIs?	STI COUNSELING/ PREVENTION 1 2 3		
b)	Etiologic/clinical diagnosis and treatment of STIs?	CLINICAL DX & TX..... 1 2 3		
c)	Syndromic diagnosis and treatment of STIs?	SYNDROMIC DX & TX.... 1 2 3		
d)	Counseling for prevention of HIV/AIDS?	PREVENTION HIV/AIDS . 1 2 3		
e)	Voluntary counseling and testing	VCT 1 2 3		
f)	Mother to child transmission	MOTHER TO CHILD TR.. 1 2 3		
g)	Counseling on use of condoms	COUNSEL CONDOMS.... 1 2 3		
h)	Counseling and social support for HIV/AIDS infected clients?	COUNSEL/SUPPORT HIV/AIDS 1 2 3		
i)	Medical management of HIV/AIDS infected clients?	MEDICAL MGMT HIV/AIDS 1 2 3		
j)	Anti-retroviral therapy for HIV/AIDS infected clients?	ANTI-RETROVIRAL TX... 1 2 3		
K)	Preventive treatments for opportunistic infections?	PREVENTIVE TX OI..... 1 2 3		
L)	Diagnosis of opportunistic infections?	DIAGNOSIS OI 1 2 3		
M)	Treating opportunistic infections?	TREAT OI 1 2 3		
N)	Palliative care for HIV/AIDS?	PALLIATIVE CARE..... 1 2 3		
O)	Diagnosis of Tuberculosis	TB DIAGNOSIS 1 2 3		
P)	Treatment of TB	TB TREATMENT 1 2 3		
R)	DOTS strategy	DOTS STRATEGY 1 2 3		
S)	Preventive therapy for TB in HIV/IDS	PREVENT TB/HIV 1 2 3		
w)	Other _____? (SPECIFY)	OTHER _____.. 1 2 3		

Observation of Sick Child Consultation

READ TO PROVIDER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. I would like to observe your consultation with this child in order to better understand how health care is provided in this country.

This information is completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? May I be present at this consultation?

 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

 DATE

100	PERMISSION RECEIVED FROM PROVIDER	YES..... 1 NO 2	→ STOP
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READ TO CHILD'S CARETAKER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children. I would like to observe your consultation with this Provider in order to better understand how health care is provided.

This information is completely confidential and will not affect the level of care you receive here now or in the future. After the consultation, my colleague would like to talk with you about your experiences here today.

You may tell me to stop the interview at any time. Do you have any questions for me? May I be present at this consultation?

 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

 DATE

101	PERMISSION RECEIVED FROM CARETAKER?	YES..... 1 NO 2	→ STOP
102	SEX OF CHILD	MALE 1 FEMALE 2	
103	Visit type (THIS REFERS TO <u>THIS</u> SICKNESS)	FIRST VISIT 1 FOLLOW-UP VISIT 2	

1. Provider Interaction with Child and Caretaker

NO.	QUESTIONS	CODING CLASSIFICATION			
		YES	NO	UNSURE	NA
104	Does the Provider ask about or the Caretaker mention if the child has any of the following major symptoms ?				
	1) Cough or difficult breathing?	1	2	8	
	2) Diarrhea?	1	2	8	
	3) Fever or body hotness?	1	2	8	
	4) Ear pain or discharge?	1	2	8	
	5) Throat problems?	1	2	8	
	6) If the child is unable to drink or breastfeed at all?	1	2	8	
	7) If the child vomits everything?	1	2	8	
	8) If the child has had convulsions with this sickness?	1	2	8	
	9) Did the provider ask about any other problems?	1	2	8	
105	Does the Provider perform any of the following physical examinations ?				
	1) Take temperature using thermometer?	1	2	8	
	2) Feel the child for fever or body hotness?	1	2	8	
	3) Count respiration (breaths)?	1	2	8	
	4) Use stethoscope on chest or back?	1	2	8	
	5) Check skin turgor for dehydration (pinch abdominal skin)?	1	2	8	
	6) Check for pallor by looking at palms?	1	2	8	
	7) Check for pallor by looking at lower lip of mouth?	1	2	8	
	8) Check throat with tongue depressor, using no light?	1	2	8	
	9) Use light and tongue depressor, to check throat?	1	2	8	
	10) Look in ear and feel behind ear?	1	2	8	
	11) Press both feet (checking for edema)?	1	2	8	
	12) Remove or partially remove clothing and check arms and shoulders, thighs and buttocks for muscle/body status?	1	2	8	
	13) Weight the child? IF YES:	1	2→106	8→106	
	14) Plot weight on a growth chart?	1	2	8	5

NO.	QUESTIONS	CODING CLASSIFICATION			
106	Does the Provider ask about or perform other assessments of the child's health?				
	1) Offer the child something to drink or put the child to the breast? (TO VERIFY IF THE CHILD CAN DRINK OR NOT)	1	2	8	
	2) Ask about normal feeding practices when the child is not ill?	1	2	8	
	3) Ask about normal breast feeding practices when the child is not ill?	1	2	8	
	4) Ask about feeding/breast feeding practices for the child during this illness?	1	2	8	
	5) Mention the child's weight or growth to the caretaker, or discuss the growth chart with the caretaker?	1	2	8	
		YES	NO	UN-SURE	NA
	6) Look at the immunization card or ask caretaker about the vaccination history?	1	2	8	
	7) Tell the caretaker where and when to take the child for immunization?	1	2	8	
	8) Look at the child health card either before beginning the consultation or while collecting information from the caretaker or when examining the child? (THIS MAY BE THE VACCINATION CARD OR ANOTHER HEALTH CARD)	1	2	8	
107	Does the Provider provide any of the following advice when counseling the caretaker?				
	1) Counsel the caretaker about feeding and/or breast-feeding the child when not sick?	1	2	8	
	2) Give extra fluids to the child during this sickness?	1	2	8	
	3) Continue feeding the child during this sickness?	1	2	8	
	4) Tell the caretaker what illness(es) the child has?	1	2	8	
	5) Describe signs or symptoms in the child for which the caretaker should <u>immediately</u> bring the child back to the facility?	1	2	8	
108	Was the child referred to another provider (ether inside or outside this facility), or for a laboratory test?	1	2 →110	8 →110	
109	IF YES: Did the provider explain why the referral was made?	1	2	8	
110	Were any oral medications prescribed or provided during the consultation? IF YES: DID A PROVIDER:	1	2 →111	8 →111	
	1) Explain how to administer oral treatment(s)?	1	2	8	5
	2) Ask the caretaker to repeat instructions on how to administer the oral medications?	1	2	8	5
	3) Give the first dose of any oral medicines?	1	2	8	5
	4) Was an oral antibiotic prescribed?	1	2	8	5
	5) Was the child given the first dose of the oral antibiotic by a provider?	1	2	8	5

NO.	QUESTIONS	CODING CLASSIFICATION	
111	Did the Provider use any visual aids when providing health education or counseling the caretaker about the child?	1 2 8	
112	Did the Provider write on the child health card?	YES 1 NO 2 NO CHILD HEALTH CARD USED 3 DON'T KNOW 8	
113	OUTCOME OF CONSULTATION	CHILD SENT HOME 1 CHILD REFERRED TO LAB OR OTHER PROVIDER AT SAME FACILITY 2 CHILD ADMITTED TO SAME FACILITY 3 CHILD REFERRED TO OTHER FACILITY 4 DON'T KNOW 8	
114	Did the provider discuss a return appointment for when the child should be brought back for follow-up?	YES 1 NO 2 DON'T KNOW 8	
115	RECORD TIME CONSULTATION ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	

2. 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.

201 DIAGNOSIS OR MAIN SYMPTOMS (IF NO DIAGNOSIS)		1 SEVERE	2 MODERATE	3 MINOR	4 NO	5 DID NOT ASK	8 UNSURE
RESPIRATORY SYSTEM	A) PNEMUONIA (PNEUMONIA)	1	2		4	5	8
	B) BRONCHO-PNEUMONIA	1	2		4	5	8
	C) BRONCHITIS	1	2	3	4	5	8
	D) COUGH OR COLD ONLY	1	2	3	4	5	8
	E) RESPIRATORY ILLNESS DIAGNOSIS UNCERTAIN	1	2	3	4	5	8
	F) COUGH, DIAGNOSIS UNCERTAIN	1	2	3	4	5	8
Digestive system	I) PERSISTENT DIARRHEA	1	2	3	4	5	8
	J) DIARRHEA	1	2	3	4	5	8
	K) DYSENTERY	1	2	3	4	5	8
	L) OTHER DIGESTIVE _____ (SPECIFY)	1	2	3	4	5	8
DEHYD RATION	M) DEHYADRATION	1	2	3	4	5	8
FEVER	N) FEVER	1	2	3	4	5	8
	O) PROBABLE BACTERIAL FEVER	1	2	3	4	5	8
	P) PROBABLE VIRAL FEVER	1	2	3	4	5	8
	Q) MEASLES	1	2	3	4	5	8
	R) MEASLES WITH EYE OR MOUTH COMPLICATIONS	1	2	3	4	5	8
EAR	S) MASTOIDITIS	1	2	3	4	5	8
	T) ACUTE EAR INFECTION	1	2	3	4	5	8
	U) CHRONIC EAR INFECTION	1	2	3	4	5	8
THROAT	V) STREPTOCOCCAL SORE THROAT	1	2	3	4	5	8
	W) NON-STREPTOCOCCAL SORE THROAT	1	2	3	4	5	8
	X) OTHER THROAT OR EAR DIAGNOSIS _____	1	2	3	4	5	8
X1 OTHER DAGNOSIS _____		1	2	3	4	5	8

202 ASK ABOUT PRESCRIPTION, TREATMENT AND ACTIONS TAKEN FOR ILLNESS AND PROB "ANY THING ELSE"		YES	NO	UNSURE
TREATMENTS FOR VARIETY OF ILLNESSES	A) IMMEDIATE REFERRAL TO OTHER FACILITY	1	2	8
	B) ADMIT TO THIS FACILITY	1	2	8
	C) NO TREATMENT OR REFERRAL	1	2	8
	D) BENZATHINE PENICILLIN INJECTION	1	2	8
	E) OTHER ANTIBIOTIC INJECTION	1	2	8
	F) OTHER INJECTION	1	2	8
	G) ANTIBIOTIC TABLET/SYRUP	1	2	8
	H) ASPIRIN, PARACETAMOL, VITAMINS, COUGH SYRUP, OTHER ORAL MEDICINE FOR SYMPTOMATIC TREATMENT	1	2	8
RESPIRATORY	I) NEBULIZED MEDICATION	1	2	8
	J) ORAL BRONCHODILATOR	1	2	8
	K) DRY EAR BY WICKING	1	2	8
DEHYDRATION	L) HOME ORT	1	2	8
	M) INITIAL ORT IN FACILITY (4 HOURS)	1	2	8
	N) INTRAVENOUS FLUIDS	1	2	8
MEASLES	O) VITAMIN A	1	2	8
	P) FEEDING SOLID FOODS	1	2	8
	Q) FEEDING EXTRA LIQUIDS	1	2	8
	R) FEEDING BREAST MILK	1	2	8
	X) OTHER TREATMENT _____ (SPECIFY)	1	2	8
203	CHECK RESPIRATORY ILLNESSES IN 201. IF ANY CATEGORIES ARE CIRCLED, CLARIFY WITH THE PROVIDER IF THERE WAS WHEEZING OR NOT.	YES, WHEEZING..... 1 NO WHEEZING..... 2 NA.....5 NOT CERTAIN.....8		
204	Did you give or refer the child for an immunization?	PROVIDER GAVE 1 PROVIDER REFERRED.....2 NOT DUE FOR IMMUNIZATION 3 NOTHING ABOUT IMMUNIZATION.....4 DON'T KNOW 8		
205	RECORD TIME OBSERVATION ENDED.	HOUR..... <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>		
206	OBSERVER COMMENT			

Section 1. Visit Information

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT</p> <p>Hello. In order to improve the services offered by this facility, we would like to know about your experience here. All the information given to me will be kept strictly confidential and future care that you receive at this facility will in no way be affected by your participation or non-participation in this interview. You can refuse to answer any question and may stop the interview at any time.</p> <p>Do you have any questions for me at this time? Do I have your agreement to participate?</p> <hr style="width: 80%; margin: 10px auto;"/> <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <div style="text-align: center;"> <p>INTERVIEWER'S SIGNATURE</p> <p>(Indicates respondent's willingness to participate)</p> </div> <div style="text-align: center;"> <p>DATE</p> </div> </div>		
100A	May I begin the interview?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	What is the name of the sick child?	NAME _____	
102	In what month and year was (NAME) born?	MONTH <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> DON'T KNOW MONTH 98 YEAR <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> DON'T KNOW YEAR 9998	→ 104
103	IF CARETAKER DOES NOT KNOW (NAME)'S COMPLETE BIRTH DATE, PROBE: How old is (NAME) in <u>completed</u> months?	AGE IN MONTHS..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	
104	Can you tell me what were main symptoms or problems for which you brought (NAME) to see the doctor today. DETERMINE WHICH MAJOR CATEGORY THE REASON FOR THE VISIT FALLS IN. CIRCLE ALL THAT APPLY.	RESPIRATORY DIFFICULT BREATHING A DIARRHEA/DYSENTERY B FEVER/BODY HOTNESS C SORE THROAT D COUGH E EAR PROBLEM F EYE PROBLEMS G SKIN INFECTION H INJURY I OTHER _____ X (SPECIFY)	
105	Has (NAME) been brought to this facility before for this same episode of sickness?	YES 1 NO 2 DON'T KNOW 8	→ 107 → 107
106	HOW LONG AGO WAS THIS?	WITHIN THE PAST WEEK 1 WITHIN THE PAST MONTH 2 MORE THAN ONE MONTH AGO 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	How many days ago did the problem which you brought (NAME) here begin? RECORD 00 IF LESS THAN ONE DAY	DAYS AGO..... <input type="text"/> <input type="text"/> DON'T KNOW98	
108	Did the Provider tell you what illness (NAME) has?	YES..... 1 NO2 DON'T KNOW8	
109	Were you told about any signs or symptoms for which you must immediately bring the child back? IF NECESSARY, PROBE "were there any serious or danger signs or symptoms for which you were told to Immediately bring (NAME) back? CIRCLE THE SYMPTOM MENTIONED BY THE CARETAKER.	FEVER A DIFFICULT BREATHING B POOR/NOT EATING C POOR/NOT DRINKING..... D BECOMES SICKER E BLOOD IN STOOLF OTHER.....X (SPECIFY) NO Y DON'T KNOWZ	
110	Were you told anything about returning to the facility with (NAME) for follow-up?	YES..... 1 NO2 CHILD REFERRED OR ADMITTED.....3 DON'T KNOW8	→112 →112 →112
111	What were you told about returning for follow-up? CIRCLE ALL RESPONSES MENTIONED BY THE CARETAKER	GAVE A TIME TO RETURN..... A RETURN FOR MORE MEDICATIONS..... B RETURN IF CHILD DOES NOT BECOME BETTER..... C OTHER.....X (SPECIFY) NO Y DON'T KNOWZ	
112	Did the Provider give or prescribe any medicines for (NAME)?	YES,GAVE MEDS 1 YES, GAVE PRESCRIPTION2 GAVE MEDS AND PRESCRIPTION.....3 NO4	→119
113	ASK TO SEE ALL MEDICATIONS WHICH WERE RECEIVED AND ANY PRESCRIPTIONS WHICH HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS/PRESCRIPTIONS SEEN.	HAS ALL MEDS 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS.....2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY3	
114	INDICATE IF ANY OF THE PRESCRIPTIONS ARE FOR THERAPEUTIC INJECTIONS.	YES..... 1 NO2 DON'T KNOW.....8	
115	Did someone at the facility explain to you how to give those medicines to (NAME) at home?	YES..... 1 NO2 DON'T KNOW8	
116	Do you feel comfortable that you know how much of each medication to give (NAME) and how often to give it each day?	YES..... 1 NO2 NOT SURE8	
117	Was (NAME) given a dose of any of these medications [THIS REFERS TO THE MEDICATIONS THE CARETAKER WILL PROVIDE AT HOME] here at the facility already? SPECIFICALLY CHECK FOR ANY ANTIBIOTIC.	YES..... 1 NO2 DON'T KNOW8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
118	Was (NAME) given an injection here at the facility for treating the sickness?	YES..... 1 NO2 DON'T KNOW8	
119	What will you do if (NAME) still has this problem or it becomes worse over the next few days?	RETURN TO FACILITY..... 1 GO TO OTHER FACILITY.....2 GO TO OTHER HEALTH WORKER/HEALER/ PHARMACY3 WAIT4 DON'T KNOW8	
120	Since becoming ill, has the way that (NAME) eats/drinks changed from normal? IF YES, CLARIFY IF THE CHILD IS TAKING MORE OR LESS THAN NORMAL	MORE THAN NORMAL..... 1 SAME AS NORMAL2 LESS THAN NORMAL3 NOT EATING/DRINKING4 DON'T KNOW8	
121	What did the Provider tell you about feeding solid food (NAME) during this illness?	GIVE LESS THAN USUAL..... 1 GIVE SAME AS USUAL2 GIVE MORE THAN USUAL3 GIVE NOTHING/NOT FEED4 DIDN'T DISCUSS.....6 DON'T KNOW8	
122	What did the Provider tell you about giving fluids (or breast milk, if breast fed or formula if formula fed) to (NAME) during this illness?	GIVE LESS THAN USUAL..... 1 GIVE SAME AS USUAL2 GIVE MORE THAN USUAL3 GIVE NOTHING/NOT FEED4 DIDN'T DISCUSS.....6 DON'T KNOW8	
123	Did any Provider today ask you about the types of foods and amounts that you normally feed (NAME) when not sick?	YES..... 1 NO2 DON'T KNOW8	
124	Did anyone at the health facility weight (NAME) today?	YES..... 1 NO2 DON'T KNOW8	
125	Did anyone talk to you about (NAME'S) weight and how s/he is growing?	YES..... 1 NO2 DON'T KNOW8	
126	CHECK QUESTION 102-103. IS THE CHILD 24 MONTHS OLD OR YOUNGER?	YES.....1 NO2	→201
127	Now I want to ask you some questions about (NAME). When (NAME) is not sick, does (NAME) take breastmilk? IF YES, do you normally give other fluids or foods along with the breastmilk?	ONLY BREASTMILK..... 1 BREASTMILK AND LIQUIDS.....2 BREASTMILK AND OTHER FOODS AND LIQUIDS.....3 NO BREASTMILK4 DON'T KNOW8	→129 →129
128	Did any provider today discuss anything specifically about breast feeding, such as how often you should breastfeed (NAME) or what else you should give [NAME]? IF YES, What advise did the provider give you? PROBE TO DETERMINE IF THE CARETAKER RECALLS BEING ADVISED HOW MANY TIMES IN A DAY BREASTMILK SHOULD BE PROVIDED AND WHETHER OTHER OTHER FLUIDS SHOULD BE PROVIDED OR NOT.	EXCLUSIVE BREASTFEED A BREASTFEED AT LEAST 8 TIMES W/I 24 HR..... B ADD OTHER FLUIDS WITH BREASTMILK..... C OTHER X (SPECIFY) NO ADVISE ABOUT BREAST- FEEDING..... Y DON'T KNOWZ	
129	Was (NAME) given a vaccination today?	YES..... 1 NO2 DON'T KNOW8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
130	Do you have the (NAME)'S vaccination card with you?	YES..... 1 NO2	→201
131	ASK TO SEE THE CHILD'S VACCINATION CARD AND CHECK IF THE CHILD RECEIVE A VACCINATION TODAY?	YES, VACCINATED TODAY 1 NOT VACCINATED TODAY2	

132 COMPLETE THE TABLE BELOW USING THE INFORMATION FROM THE CARD. RECORD IN COLUMN 1 WHETHER THE CHILD HAS EVER RECEIVED ANY OF THE FOLLOWING VACCINATIONS. RECORD THE DATE IN COLUMN 2. IF NO DATE IS RECORDED ON THE CARD, ENTER "66" FOR THE DAY AND MONTH AND "6666" FOR THE YEAR.

	CHILD EVER RECEIVED VACCINATION	DATE		
		DAY	MONTH	YEAR
POLIO-0 (AT BIRTH)	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
BCG	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO-1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEP-1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-HEP 1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO-2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEP-2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-HEP 2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO-3	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-3	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEP-3	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>

DPT-HEP 3	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POLIO 4	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEASLES (9 MONTHS)	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMR (18 MONTHS)	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POLIO BOOSTER (18 MONTHS)	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DPT BOOSTER	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VITAMIN A _1 (9m)	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VITAMIN A _2 (18m)	YES.....1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO/NO RECORD.....2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the child health services.							
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw (NAME) for the consultation?	MINUTES..... <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY 000 DON'T KNOW..... 998						
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems							
		SPONTANEOUS		PROMPT				
		BIG	SMALL	BIG	SMALL	NO	DK/NA	
1	Time you waited?	1	2	3	4	5	8	
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8	
3	Time it takes to receive results from tests?	1	2	3	4	5	8	
4	Ability to discuss problems or concerns about your child's health with the health worker?	1	2	3	4	5	8	
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8	
6	Quality of the examination and treatment provided?	1	2	3	4	5	8	
7	Privacy from others seeing exam?	1	2	3	4	5	8	
8	Privacy from others hearing discussion?	1	2	3	4	5	8	
9	Availability of medicines at the facility?	1	2	3	4	5	8	
10	The hours/days of services?	1	2	3	4	5	8	
11	Cleanliness of facility?	1	2	3	4	5	8	
12	How staff treated you?	1	2	3	4	5	8	
13	Cost of services?	1	2	3	4	5	8	
14	Other _____ (SPECIFY)	1	2			5		

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
203	Do you participate in any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility? This includes if you prepay for a package of services or if you received a discounted price or an exemption from paying. IF YES, what type of program do you participate in?	YES, HIO/SHIP A YES, OTHER SYSTEM B YES, PREPAY AT FACILITY FOR PACKAGE OF SERVICES C YES, DISCOUNT/EXEMPT STATUS D OTHER _____ X (SPECIFY) NO Y DON'T KNOW Z	
204	What is the total amount for all staff, services, or treatments which you paid for (NAMEs) consultation today? Please include any money you paid for staff services, laboratory tests, or medicines you received.	1) LAB L.E Piaster [][] [][] PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 2) MEDICINE OR METHOD L.E Piaster [][] [][] PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 3) CONSULT OR PROCEDURE L.E Piaster [][] [][] PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 4) OTHER L.E Piaster [][] [][] PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 5) TOTAL AMOUNT L.E Piaster [][] [][] PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
205	Have you ever visited this facility before? (either as a patient or visiting or accompanying a patient?)	YES 1 NO 2	
206	There are many reasons people choose different health facilities for services. Can you mention some of the reasons you selected this facility for the services you sought today?	FEMALE PHYSICIAN A EFFICIENCY OF THE PHYSICIANS B AVAILIABIITY OF ALL SPECIALITIES C AVAILABILITY OF THE SERVICE D CLIENTS ARE WELL TREATED E HAS THE GOLD STAR F A NEAR BY FACILITY G GOOD REPUTATION H OTHER _____ X (SPECIFY)	

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	What is your relationship to (NAME)?	MOTHER 1 FATHER 2 SIBLING 3 AUNT/UNCLE 4 GRAND FATHER/MOTHER 5 OTHER: _____ ... 6 (SPECIFY)	
301	Could you tell me how old are you?	AGE IN YEARS <input type="text"/> <input type="text"/> DON'T KNOW 98	
302	Have you ever attended school?	YES 1 NO 2	→ 304
303	What is the highest level of school (certificate) you have successfully completed?	NONE 1 PRIMARY 2 PREPARATORY 3 SECONDARY 4 ABOVE SECONDARY 5 UNIVERSITY 6 ABOVE UNIVERSITY 7	→ 306 → 306 → 306 → 306 → 306
304	Have you ever attended any literacy classes?	YES 1 NO 2	
305	Can you read or write?	YES, READ ONLY 1 YES, READ AND WRITE 2 NO 3	
306	Are you currently employed?	YES 1 NO 2	→ 309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER 1 FOR SOMEONE ELSE 2 FOR HERSELF 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH 1 BOTH 2 KIND 3 NOTHING 4	
309	Do you live in a city or a village?	CITY 1 VILLAGE 2	
310	Which governorate do you live in?	_____ <input type="text"/> <input type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	
312	INTERVIEWER COMMENTS		

Observation of Family Planning Consultation

100 **READ TO PROVIDER:** Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide health services with the goal of finding ways to improve service delivery. I would like to observe your consultation with this woman in order to better understand how health care is provided in this country.

This information is completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? May I be present at this consultation?

_____ DATE _____
 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

100a	PERMISSION RECEIVED FROM PROVIDER?	YES	1	➔ STOP
		NO	2	

READ TO CLIENT: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide health services. I would like to observe your consultation with this Provider in order to better understand how health care is provided.

This information is completely confidential and will not affect the level of care you receive here now or in the future. After the consultation, my colleague would like to talk with you about your experiences here today.

You may tell me to stop the interview at any time. Do you have any questions for me? May I stay?

_____ DATE _____
 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

100b	PERMISSION RECEIVED FROM CLIENT?	YES	1	➔ STOP
		NO	2	

1. Client Counseling

NO.	QUESTIONS	CODING CLASSIFICATION		
	OBSERVER: PLEASE COMPLETE THE FOLLOWING ITEMS FOR ALL CLIENTS.			
101	INDICATE WHETHER THE CLIENT HAD ANY PREVIOUS CONTACT WITH A PROVIDER AT THIS FAMILY PLANNING CLINIC.	YES.....	1	
		NO	2	
		NOT DETERMINED	8	
	Client information and history: Indicate below whether the provider asked about /client offered information for each of the following items:			
102	INDICATE IF THE CLIENT HAS EVER BEEN PREGNANT	YES.....	1	
		NO	2	
		DON'T KNOW.....	8	
103	CLIENT HISTORY	YES	NO	UNSURE
	1) Age of client?	1	2	8
	2) Number of living children?	1	2	8
	3) Last delivery date/ Last abortion date?	1	2	8
	4) Age of youngest child?	1	2	8
	5) History of complications with pregnancy?	1	2	8
	6) Current pregnancy status?	1	2	8
	7) Desire for a child or more children?	1	2	8
	8) Desired timing for birth of next child?	1	2	8
	9) Breast feeding status?	1	2	8
	10) Regularity of menstrual cycle?	1	2	8
	11) Smoking?	1	2	8
	12) Symptoms of STIs (e.g. abnormal discharge)?	1	2	8
	13) Chronic illnesses (heart disease, diabetes, hypertension, liver /jaundice problem; breast cancer)?	1	2	8
104	EXAMINATION			
	1) Take Blood pressure?	1	2	8
	2) Take weight?	1	2	8
	3) Take urine specimen?	1	2	8
	4) Take blood specimen?	1	2	8
105	DID THE PROVIDER			
	1) Ensure VISUAL PRIVACY?	1	2	8
	2) Ensure AUDITORY PRIVACY?	1	2	8
	3) Assure CLIENT of CONFIDENTIALITY?	1	2	8
	4) Ask about questions or CONCERNS WITH METHODS discussed or with currently used method?	1	2	8
	DISCUSS:			
	5) Husband/wife attitude toward family planning ?	1	2	8
	6) Husband/wife status: (Husband have more than one wife? Husband away for extended periods of time?)	1	2	8
	7) Discuss risk of STIS?	1	2	8
	8) Discuss use of condoms to prevent STIs?	1	2	8
	9) Discuss using condoms WITH another method (duel method) for preventing STIs?	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
106	INDICATE WHICH METHOD(S) WERE PRESCRIBED DURING THIS VISIT. IF CONDOM WAS PRESCRIBED WITH ANOTHER METHOD, CIRCLE BOTH METHODS. [IF CONTINUING CLIENT RECEIVED REFILL FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUD DURING THIS VISIT, CIRCLE THAT METHOD]	ORAL PILLA CONDOM.....B IUD C SPERMICIDE D DIAPHRAGME INJECTABLEF NORPLANT.....G IMPLANON.....H NATURAL METHODS (RHYTHM) I BREASTFEEDING/LAM J FEMALE STERILIZATIONK EMERGENCY CONTRACEPTION L OTHERX NO METHODY	→108
FOR THE METHOD(S) IN QUESTION 106 INDICATE IF THE RELEVANT INFORMATION INDICATED WAS ASSESSED/DISCUSSED			
107	METHOD	INFORMATION	YES NO UNSURE
	PILLS/ INJECTIONS	1) When to take (PILL DAILY; INJECTION EITHER EVERY 1,2 OR 3 MONTHS)	1 2 8
		2) Changes which may occur with menstruation (decrease; spotting or amenorrhea)	1 2 8
		3) Initial side-effects which may occur (nausea; weight gain, breast tenderness)	1 2 8
		4) What to do if forget pill/do not get injection on time.	1 2 8
	NORPLANT/ IMPLANON	5) Good for 3- 5 years	1 2 8
		6) Changes which may occur with menstruation (decrease; spotting)	1 2 8
		7) Initial side-effects which may occur (nausea; weight gain, breast tenderness)	1 2 8
	EMERGENCY CONTRACEPTION	8) If vomit within 2 hours need another dose	1 2 8
		9) If next period unusually light or not within 4 weeks, return for pregnancy check	1 2 8
	IUD	10) Check string	1 2 8
		11) May have HEAVY BLEEDING/SPOTTING	1 2 8
	STERILIZATION	12) Permanent: -will not become pregnant again	1 2 8
		13) May be slight discomfort at incision site	1 2 8
	CONDOMS	14) Any allergy to latex	1 2 8
		15) Use only one time	1 2 8
		16) Leave space at the top of the condom	
		17) Can use lubricant (water soluble only)	1 2 8
		18) Use as back-up if you fear other method failure	1 2 8
		19) Dual protection (pregnancy and STI)	1 2 8
	SPERMICIDE/ FOAM	20) May cause irritation	1 2 8
		21) Insert before each occurrence of intercourse	1 2 8
	RHYTHM/ PERIODIC ABSTINENCE	22) How to identify fertile period	1 2 8
		23) Should not have intercourse during fertile period without alternate method (condom/spermicide)	1 2 8

NO.	QUESTIONS		CODING CLASSIFICATION			GO TO
	METHOD	INFORMATION	YES	NO	UNSURE	
	LACTATIONAL AMMENORRHEA	24) Slight risk of pregnancy at time shortly before restarting menstruation	1	2	8	
		25) Most effective with exclusive breast-feeding	1	2	8	
		26) Not effective after menstruation begins again	1	2	8	
108	Did the provider refer to or look at the individual client record either prior to or during the consultation?		YES	1		
			NO	2		
			DON'T KNOW	8		
109	Were any visual aids or models used for health education or counseling about different methods?		YES	1		
			NO	2		
			DON'T KNOW	8		
110	DID THE PROVIDER DISCUSS A RETURN VISIT?		YES	1		
			NO	2		
			DON'T KNOW	8		

2. CLINICAL OBSERVATION

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	INDICATE IF ANY CLINICAL PROCEDURE WAS CONDUCTED DURING THIS VISIT.	PELVIC EXAM A IUD INSERTED B IUD REMOVAL C GIVEN INJECTABLE D NORPLANT INSERTED E NORPLANT REMOVAL F IMPLANON INSERTED G IMPLANON REMOVAL H BREAST EXAMINATION I NO PROCEDURE Y	→301
202	INDICATE IF CLINICAL PROVIDER SAME PERSON WHO PROVIDED COUNSELING	YES 1 NO 2	→205a
<p>READ TO PROVIDER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide health services with the goal of finding ways to improve service delivery. I would like to observe the procedure you will conduct. [Mrs. _____] has agreed that she has no objection to my presence. Observing all components of the services provided to [Mrs. _____] will help us better understand the how health services are provided.</p> <p>Any information from this examination is completely confidential. Do you have any questions for me? May I be present during this procedure?</p> <p style="text-align: center;">_____ DATE</p> <p style="text-align: center;">INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p>			
203	PERMISSION RECEIVED FROM PROVIDER	YES 1 NO 2	→STOP
204	Provider performing most of clinical examination	OB/GYN DOCTOR 11 FAMILY PLANNING PHYSICIAN 12 PEDIATRICIAN 13 FAMILY PHYSICIAN 14 OTHER PHYSICIAN SPECIALIST 15 GENERAL PRACTITIONER 16 NURSE W/ MIDWIFERY 21 NURSE 22 OTHER _____ 96 (SPECIFY)	
205	Sex of provider conducting clinical examination	MALE 1 FEMALE 2	
205a	Did the provider examine the breasts?	YES 1 NO 2 DON'T KNOW 8	→206 →206
205b	Did the provider teach the client how to conduct self breast exam?	YES 1 NO 2 DON'T KNOW 8	
206	INDICATE CLINICAL PROCEDURE(S) CONDUCTED DURING THIS VISIT.	PELVIC EXAM A IUD INSERTED B IUD REMOVAL C GIVEN INJECTABLE D NORPLANT INSERTED E NORPLANT REMOVED F IMPLANON INSERTED G IMPLANON REMOVED H NO CLINICAL PROCEDURE Y	→207 →208a →208a →209 →210 →210 →210 →210 →210

PELVIC EXAM

207	DID THE PROVIDER:		YES	NO	N A
	1) ENSURE CLIENT HAS VISUAL PRIVACY?	VISUAL PRIVACY.....	1	2	
	2) ENSURE CLIENT HAS AUDITORY PRIVACY?	AUDITORY PRIVACY	1	2	
	3) EXPLAIN PROCEDURE PRIOR TO BEGINNING?	EXPLAIN PROCEDURE	1	2	
	4) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
	5) USE STERILIZED OR HIGH-LEVEL DISINFECTED INSTRUMENTS ?	DISINFECTED INSTRUMENTS	1	2	
	6) WASH HIS/HER HANDS, USING SOAP, BEFORE THE EXAM?	WASHED HANDS	1	2	
	7) PUT ON NEW OR DISINFECTED GLOVES BEFORE EXAM?	PUT ON GLOVES	1	2	
	8) ASK THE CLIENT TO TAKE SLOW, DEEP BREATHS, AND RELAX ALL MUSCLES?	ASK CLIENT TO RELAX MUSCLES	1	2	
	9) INSPECT THE EXTERNAL GENITALIA?	INSPECT GENITALIA.....	1	2	
	10) (IF USED) EXPLAIN SPECULUM PROCEDURE?	EXPLAIN SPECULUM	1	2	5
	11) INSPECT THE CERVIX AND VAGINAL MUCOSA? (AIM LIGHT INSIDE INSERTED SPECULUM)	INSPECT CERVIX	1	2	5
	12) PERFORM BIMANUAL EXAM (ONE HAND INSIDE VAGINA, OTHER PALPATING UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM.....	1	2	
	13) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER	1	2	
	14) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA.....	1	2	
	15) PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE? (ASK THE PROVIDER)	DECONTAMINATE GLOVES/INSTRUMENTS...	1	2	

Check 206 if there is another procedure skip to it or other wise skip to 301.

IUD INSERTION AND REMOVAL

208a	INDICATE PROCEDURE CONDUCTED	IUD INSERTION.....A IUD REMOVAL.....B			
208b	DID THE PROVIDER:		YES	NO	NA
	1) ENSURE CLIENT HAD VISUAL PRIVACY?	VISUAL PRIVACY	1	2	
	2) ENSURE CLIENT HAD AUDITORY PRIVACY?	AUDITORY PRIVACY.....	1	2	
	3) (NEW CLIENT) RECONFIRM THE METHOD CHOICE?	RECONFIRM CHOICE	1	2	5
	4) EXPLAIN PROCEDURE PRIOR TO BEGINNING?	EXPLAIN PROCEDURE	1	2	
	5) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
	6) USE STERILIZED/HIGH-LEVEL DISINFECTED INSTRUMENTS?	STERILE INSTRUMENTS ..	1	2	
	7) WASH HANDS WITH SOAP <u>BEFORE</u> PUTTING ON GLOVES?	WASH HANDS BEFORE	1	2	
	8) GLOVE HANDS (STERILE GLOVES)?	STERILE GLOVES.....	1	2	
	9) GLOVE HANDS (CLEAN GLOVES)?	CLEAN GLOVES.....	1	2	
	10) SPECULUM EXAM FOR REPRODUCTIVE TRACT INFECTIONS/STIS BEFORE BIMANUAL EXAM?	SPECULUM EXAM	1	2	
	11) CONDUCT BIMANUAL PELVIC EXAM? (ONE HAND INSIDE VAGINA OTHER PALPATE UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM.....	1	2	5
	12) VISUALIZE CERVIX DURING CLEANING? (SHINE LIGHT IN INSERTED SPECULUM)	VISUALIZE CERVIX.....	1	2	
	13) USE TENACULUM?	USE TENACULUM.....	1	2	5
	14) SOUND THE UTERUS <u>BEFORE</u> IUD INSERTION?	SOUND UTERUS.....	1	2	
	15) USE THE NO-TOUCH TECHNIQUE FOR INSERTING THE IUD?	NO-TOUCH TECHNIQUE	1	2	
	16) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER	1	2	
	17) ENSURE NO VAGINA BLEEDING AFTER IUD INSERTION AND BEFORE LEAVING THE EXAMINATION TABLE?	ENSURE NO BLEEDING	1	2	
	18) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA.....	1	2	
	19) PLACE REUSABLE INSTRUMENTS OR GLOVES IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE?	DECONTAMINATE GLOVES/INSTRUMENTS...	1	2	
	20) SHOW REMOVED IUD TO THE CLIENT?	SHOW REMOVED IUD.....	1	2	5
	21) DISCUSS RETURN VISIT AFTER NEXT CYCLE?	DISCUSS RETURN VISIT	1	2	

→301

INJECTABLE

209	WHEN GIVING THE INJECTABLE , DID THE PROVIDER:		YES	NO	N A
	1) (NEW CLIENT) RECONFIRM METHOD CHOICE?	RECONFIRM CHOICE	1	2	5
	2) (NEW CLIENT) VERIFY CLIENT NOT PREGNANT?	NOT PREGNANT.....	1	2	5
	3) (CONTINUING CLIENT) CHECK CLIENT CARD (TO ENSURE GIVING INJECTION AT CORRECT TIME)?	CORRECT TIME.....	1	2	5
	4) WASH HANDS <u>BEFORE</u> INJECTION?	WASH HANDS.....	1	2	
	5) USE NEW NEEDLE AND SYRINGE?	NEW NEEDLE.....	1	2	5
	6) SEE PROVIDER OPEN NEW PACKET WITH NEEDLE AND SYRINGE?	SEE SYRINGE PACKET	1	2	5
	7) STIR/MIX BOTTLE <u>BEFORE</u> DRAWING DOSE? (DEPO)	STIR BOTTLE	1	2	5
	8) CLEAN AND AIR-DRY INJECTION SITE <u>BEFORE</u> INJECTION?	CLEAN AND AIR DRY SITE.....	1	2	
	9) DRAW BACK PLUNGER <u>BEFORE</u> INJECTION?	DRAW BACK PLUNGER	1	2	
	10) MASSAGE INSTEAD OF ALLOWING DOSE TO SELF-DISPERSE?	MASSAGE.....	1	2	
	11) DISPOSE OF SHARPS IN PUNCTURE RESISTANT CONTAINERS?	DISPOSE OF SHARPS.....	1	2	
	12) INDICATE IF 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			

→301

NORPLANT/IMPLANON INSERTION OR REMOVAL

210	INDICATE THE PROCEDURE CONDUCTED	INSERTIONA REMOVALB			
	DID THE PROVIDER:		YES	NO	NA
211	1) RECONFIRM METHOD CHOICE (EITHER INSERTION OR REMOVAL)	RECONFIRM CHOICE.....	1	2	5
	2) VERIFY CLIENT NOT PREGNANT	VERIFY NOT PREGNANT	1	2	5
	3) ENSURE CLIENT VISUAL PRIVACY?	VISUAL PRIVACY.....	1	2	
	4) ENSURE CLIENT AUDITORY PRIVACY?	AUDITORY PRIVACY.....	1	2	
	5) EXPLAIN PROCEDURE PRIOR TO BEGINNING	EXPLAIN PROCEDURE	1	2	
	6) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
	7) USE STERILIZED INSTRUMENTS ?	STERILIZED INSTRUMENTS.	1	2	
	8) WASH HIS/HER HANDS BEFORE BEGINNING PROCEDURE?	WASHED HANDS.....	1	2	
	9) PUT ON STERILE GLOVES AND MAINTAIN STERILITY DURING INSERTION	GLOVES AND STERILITY..	1	2	
	10) CLEAN SKIN WHERE INCISION(INSERTION) WILL BE MADE WITH ANTISEPTIC	ANTISEPTIC.....	1	2	
	11) USE NEW NEEDLE AND SYRINGE FOR LOCAL ANESTHETIC	NEW NEEDLE.....	1	2	
	12) ALLOW TIME FOR LOCAL ANESTHETIC TO TAKE EFFECT PRIOR TO MAKING INCISION(INSERTION)	TIME FOR ANESTHETIC TO WORK.....	1	2	
	13) DISPOSE OF SHARPS IN PUNCTURE RESISTANT CONTAINERS	DISPOSE SHARPS	1	2	
	14) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA.....	1	2	
	15) PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE?	DECONTAMINATE GLOVES/INSTRUMENTS...	1	2	
	16) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER	1	2	
	17) EXPLAIN CARE OF INCISION(INSERTION) AREA	EXPLAIN INCISION CARE .	1	2	
	18) DISCUSS RETURN VISIT TO REMOVE PLASTER?	RETURN VISIT.....	1	2	
212	1) PROVIDE WOMAN WITH CARD STATING DATE IMPLANT WAS INSERTED AND DATE WHEN 5 YEARS OF NORPLANT, OR WHEN 3 YEARS OF IMPLANON IS COMPLETED	PROVIDE CARD	1	2	5
	2) REINFORCE SIDE EFFECTS OF IMRPLANT?	REINFORCE SIDE EFFECTS	1	2	5
213	SHOW EACH STICK REMOVED TO CLIENT AND REASSURE WHEN ALL REMOVED?	SHOW REMOVED NORPLANT	1	2	5
214	INDICATE IF 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			

3. Client's Family Planning Status

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	INDICATE 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	INDICATE PRINCIPAL REASON FOR VISIT.	RESUPPLY/ROUTINE FOLLOWUP 1 WANT METHOD CHANGE- NO PROBLEM 2 DISCUSS PROBLEM WITH CURRENT METHOD 3 DISCUSS OTHER HEALTH PROBLEM (NOT METHOD)..... 4 WANT TO DISCONTINUE FP (NO PROBLEM) 5 OTHER _____ 6 (SPECIFY)	
303	INDICATE OUTCOME OF VISIT.	CONTINUED WITH CURRENT METHOD..... 1 SWITCHED METHOD, RECEIVED TODAY 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	→ 308 → 308 → 307 → 307 → 308
304	INDICATE TIMING OF CLIENT'S MOST RECENT USE OF CONTRACEPTION.	WITHIN PAST 6 MONTHS 1 SIX MONTHS OR MORE AGO..... 2 NOT DETERMINED..... 8	
305	INDICATE OUTCOME OF VISIT.	RESTARTED PRIOR METHOD 1 ADOPTED DIFFERENT METHOD RECEIVED TODAY 2 PLANNED DIFFERENT METHOD, NOT RECEIVED TODAY..... 3 RECEIVED INFORMATION/ COUNSELING ONLY..... 4 NOT DETERMINED..... 8	→ 308 → 308 → 307 → 308 → 308
306	INDICATE OUTCOME OF VISIT.	RECEIVED/PRESCRIBED METHOD..... 1 PLANNED METHOD, NOT RECEIVED TODAY 2 DID NOT DECIDE ON METHOD..... 3	→ 308 → 308
307	WHY WAS METHOD NOT RECEIVED TODAY?	VAGINAL INFECTION A PREGNANCY STATUS UNSURE... B WILL CHECK WITH HUSBAND C METHOD NOT IN STOCK..... D OTHER _____ X (SPECIFY)	
308	Did the provider write in an individual client record or card after the consultation?	YES 1 NO 2 DON'T KNOW 8	

309	TIME OBSERVATION ENDED.	HOUR..... <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>
310	Observer Comment:	

MEASURE Service Provision Assessment

Exit Interview for Family Planning Client

FACILITY IDENTIFICATION

QTYPE OF _____	QTYPEXFP
Name of the facility _____	
Facility Location _____	
Governorate _____	GOV <input type="text"/> <input type="text"/>
District _____	DISTRICT <input type="text"/> <input type="text"/>
Code of the facility	FACILITY CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Type of Health Facility and Operating Authority	
Governmental:	
11 = General Hospital	21=MCH Center
12=District Hospital	22=Rural health unit
13= Fever Hospital	23=Urban health unit
14= Complementary	24=Health Office
	25=Mobile Unit
	26=Other
Non-Governmental:	
31 =CSI	32= EFPA
	33=other non-governmental
	FACILITY TYPE <input type="text"/> <input type="text"/>
	AND OPERATING AUTHORITY

INFORMATION ABOUT INTERVIEW

Date: _____	DAY <input type="text"/> <input type="text"/>
	MONTH <input type="text"/> <input type="text"/>
	YEAR..... <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 4
Name of the interviewer _____	INTERVIEWER CODE.. <input type="text"/> <input type="text"/>
Time observation started: _____	HOUR..... <input type="text"/> <input type="text"/>
	MINUTES <input type="text"/> <input type="text"/>
FP Client Code _____	FP CLIENT CODE..... <input type="text"/> <input type="text"/>

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108	Had you thought about switching methods, and which method to switch to before you came today?	YES 1 NO 2	→110 →112
109	Had you thought about what method you wanted to use to before you came today?	YES 1 NO 2	→112
110	What method was that? (CIRCLE ALL METHODS MENTIONED)	COMBINED PILLA PROGESTIN-ONLY PILLB PILL (TYPE UNSPECIFIED)..... C MALE CONDOM..... D IUDE SPERMICIDE..... F DIAPHRAGM G INJECTABLE DEPO H NORISTERAT I INJECTABLE MESGYNA J NORPLANT IMPLANTK IMPLANON IMPLANT L NATURAL METHODS (RHYTHM) M BREASTFEEDING/LAM N EMERGENCY CONTRACEPTION O FEMALE STERILIZATIONP OTHERX (SPECIFY)	
111	Did the Provider talk about the (method(s) mentioned in question 110)?	YES 1 NO 2 DON'T KNOW 8	
112	What (other) methods did the Provider talk with you about? CIRCLE ALL METHODS MENTIONED	COMBINED PILLA PROGESTIN-ONLY PILLB PILL (TYPE UNSPECIFIED)..... C MALE CONDOM..... D IUDE SPERMICIDE..... F DIAPHRAGM G INJECTABLE DEPO H NORISTERAT I INJECTABLE MESGYNA J NORPLANT IMPLANTK IMPLANON IMPLANT L NATURAL METHODS (RHYTHM) M BREASTFEEDING/LAM N EMERGENCY CONTRACEPTION O FEMALE STERILIZATIONP OTHERX (SPECIFY) NONE Y DON'T KNOW Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
113	<p>What method did you receive or were you given a prescription or referral for?</p> <p>CIRCLE ALL METHODS CLIENT HAS RECEIVED (REC) OR HAS PRESCRIPTION OR REFERRAL (PRES) FOR. IF THE CLIENT IS CONTINUING WITH PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION OR REFERRAL THIS VISIT, CIRCLE "O".</p> <p>IF THE CLIENT DECIDED ON A METHOD BUT WILL START THE METHOD OR RECEIVE THE METHOD LATER, AT THE ADVICE OF THE PROVIDER, CIRCLE THAT METHOD AS "PRES" (PRESCRIBED)</p>	<p style="text-align: right;">REC PRES</p> <p>COMBINED PILLA A PROGESTIN-ONLY PILLB B PILL (TYPE UNSPECIFIED)..... C C MALE CONDOM..... D D IUD.....E E SPERMICIDE.....F F DIAPHRAGM G G INJECTABLE DEPO H H NORISTERAT I I INJECTABLE MESGYNA J J NORPLANT IMPLANTK K IMPLANON IMPLANT L L NATURAL METHODS (RHYTHM) M M BREASTFEEDING/LAM N N EMERGENCY CONTRACEPTION O O FEMALE STERILIZATIONP P NO METHOD REC OR PREC, CONTINUING W/ METHOD IN QUESTION 103 Q A METHOD WAS PRESCRIBED BUT NOT RECEIVED.....R OTHER.....X (SPECIFY) NO METHOD..... Y →201</p>	
114	Does your method (the method in 113) provide any protection against STDs and AIDS?	YES 1 NO 2 DON'T KNOW 8	
115	During your consultation, did the provider: <ol style="list-style-type: none"> 1) Explain how to use the method? 2) Talk about possible side effects? 3) Tell you what to do if you have any problems? 4) Tell you when to return for follow-up? 5) Teach you how to conduct a self breast exam? 	<p style="text-align: right;">YES NO DK</p> <p>HOW TO USE 1 2 8 TALK ABOUT SIDE EFFECTS..... 1 2 8 TELL WHAT TO DO ABOUT PROBLEMS..... 1 2 8 TELL WHEN TO RETURN 1 2 8 TEACH SBE..... 1 2 8</p>	

116	MARK BELOW THE METHOD THAT IS CIRCLED IN 113 AND 103. AFTER ASKING THE CLIENT THE RELEVANT QUESTION		
	1. Pill	How often do you take the pill?	TAKE A PILL ONCE A DAY..... 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	2. IUD	What should you do to make sure that your IUD is in place?	CHECK STRINGS 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	3. Injectable (e.g., Depo Provera)	How long does the Depo Provera injection provide protection against pregnancy?	3 MONTHS 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	3a. Injectable (e.g., Noristerat)	How long does the Noristerat injection provide protection against pregnancy?	2 MONTHS 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	4. Injectable (mesgyna)	How long does the Mesgyna injection provide protection against pregnancy?	1 MONTH..... 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	5. NORPLANT	How long does NORPLANT provide protection against pregnancy?	5 YEARS..... 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	6. IMPLANON	How long does IMPLANON provide protection against pregnancy?	3 YEARS..... 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	7. Female Sterilization	Once you have been sterilized, could you ever become pregnant again?	NO..... 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	8. Condom (Male)	How many times can you use a condom?	ONCE..... 1 OTHER 6 DON'T KNOW..... 8
	9. Spermicide/ Foam	Approximately how long before intercourse should you insert the vaginal tablet?	BETWEEN 15 MINUTES AND 1 HOUR 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8
	10. Periodic Abstinence/Rhythm	How do you recognize the days on which you should <u>not</u> have sexual intercourse?	BODY TEMPERATURE RISES...A MUCUS IN VAGINA.....B DAYS 12-16 OF THE MENSTRUAL CYCLE..... C OTHER _____ X (SPECIFY) DON'T KNOW.....Z
	11. LAM	Can you use this method if your menstrual period has returned?	YES..... 1 NO..... 2 DON'T KNOW..... 8
	12. Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	AT LEAST SIX HOURS (BUT NO LONGER THAN 24 HOURS)..... 1 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the family planning services.							
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES..... <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY..... 000 DON'T KNOW..... 998						
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems							
		SPONTANEOUS		PROMPT				
		BIG	SMALL	BIG	SMALL	NO	DK/NA	
1	Time you waited?	1	2	3	4	5	8	
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8	
3	Time it takes to receive results from tests?	1	2	3	4	5	8	
4	Ability to discuss problems or concerns about the method used with the health worker?	1	2	3	4	5	8	
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8	
6	Quality of the examination and treatment provided?	1	2	3	4	5	8	
7	Privacy from others seeing exam?	1	2	3	4	5	8	
8	Privacy from others hearing discussion?	1	2	3	4	5	8	
9	Availability of medicines at the facility?	1	2	3	4	5	8	
10	The hours/days of services?	1	2	3	4	5	8	
11	Cleanliness of facility?	1	2	3	4	5	8	
12	How staff treated you?	1	2	3	4	5	8	
13	Cost of services?	1	2	3	4	5	8	
14	Other _____ (SPECIFY)	1	2			5		

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Could you tell me how old are you?	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW..... 98	
302	Have you ever attended school?	YES..... 1 NO..... 2	→304
303	What is the highest level of school (certificate) you have successfully completed?	NONE..... 1 PRIMARY..... 2 PREPARATORY..... 3 SECONDARY..... 4 ABOVE SECONDARY..... 5 UNIVERSITY..... 6 ABOVE UNIVERSITY..... 7	→306 →306 →306 →306 →306
304	Have you ever attended any literacy classes?	YES..... 1 NO..... 2	
305	Can you read or write?	YES, READ ONLY..... 1 YES, READ AND WRITE..... 2 NO..... 3	
306	Are you currently employed?	YES..... 1 NO..... 2	→309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER..... 1 FOR SOMEONE ELSE..... 2 FOR HERSELF..... 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH..... 1 BOTH..... 2 KIND..... 3 NOTHING..... 4	
309	Do you live in a city or a village?	CITY..... 1 VILLAGE..... 2	
310	Which governorate do you live in?	_____ <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

No	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	UNSURE	
101	INDICATE WHETHER THIS IS THE CLIENT'S FIRST VISIT FOR ANTENATAL CARE AT THIS FACILITY FOR THIS PREGNANCY. IF THE PROVIDER DOES NOT ASK ABOUT OR THE CLIENT DOES NOT PROVIDE THE INFORMATION, RECORD 8 UNSURE.	YES	NO	UNSURE	
		1	2	8	
102	INDICATE IF THIS IS THE FIRST PREGNANCY FOR THE CLIENT	1	2	8	
DOES THE PROVIDER ASK OR THE CLIENT PROVIDE THE FOLLOWING INFORMATION:					
103	CLIENT HISTORY	YES	NO	UNSURE	
	1) Client AGE?	1	2	8	
	2) Date of LAST MENSTRUAL PERIOD?	1	2	8	
	3) Number of PRIOR PREGNANCIES?	1	2	8	
	PRIOR PREGNANCY HISTORY				
	4) Any PRIOR STILLBIRTH(S)?	1	2	8	
	5) Any INFANT(S) DIED in the first week?	1	2	8	
	6) Any HEAVY BLEEDING During or after delivery with a PRIOR PREGNANCY?	1	2	8	
	7) Any PREVIOUS ASSISTED DELIVERY? (Caesarean-section, ventouse, or forceps)	1	2	8	
8) Any PREVIOUS ABORTIONS?	1	2	8		
104	SYMPTOMS DURING THIS PREGNANCY				
	1) Any BLEEDING during this pregnancy	1	2	8	
	2) If the woman has FELT THE BABY MOVE?	1	2	8	
	3) If there are any OTHER SYMPTOMS OR PROBLEMS the woman thinks might be related to this pregnancy?	1	2	8	
	4) MEDICATIONS woman is currently taking?	1	2	8	
105	WERE ANY OF THE FOLLOWING CLIENT EXAMINATIONS OBSERVED:	YES	NO	UNSURE	
	1) Measure blood pressure?	1	2	8	
	2) Palpate abdomen for fetal presentation/ position?	1	2	8	
	3) Palpate or measure abdomen for fundal (uterine) height?	1	2	8	
	4) Listen to the client's abdomen to hear fetal heartbeat?	1	2	8	
	5) Measure weight of client?	1	2	8	
	6) Examine abdomen by sonar?	1	2	8	
	7) was a urine sample taken or laboratory examination ordered for the client?	1	2	8	
	8) was a blood sample taken or laboratory examination ordered for the client?	1	2	8	
	9) Did the provider look at 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		
	WERE ANY OF THE FOLLOWING TREATMENTS OR COUNSELING PROVIDED:						
106	TREATMENTS	YES	NO	UNSURE			
	1) Prescribe or give iron pills and/or folic acid (IFA)?	1	2→107	8→107			
	2) Explain the purpose of iron/folic?	1	2	8			
	3) Explain how to take iron/folic pills?	1	2	8			
107	1) Prescribe or give tetanus toxoid (TT) injection?	1	2→108	8→108			
	2) Explain the purpose of TT injection?	1	2	8			
108	ADVICE OR COUNSEL ABOUT PREGNANCY						
	1) Quantity and quality of food to eat during pregnancy?	1	2	8			
	2) Mention the following signs and symptoms as risk factors for which the woman should return to the facility?						
	a) Vaginal bleeding?	1	2	8			
	b) Fever?	1	2	8			
	c) Excessive tiredness or breathlessness?	1	2	8			
	d) Swollen hands and face?	1	2	8			
	e) Severe headache or blurred vision?	1	2	8			
	3) Inform the client about the progress of the pregnancy?	1	2	8			
109	DOES THE PROVIDER PROVIDE ADVISE OR COUNSEL ABOUT DELIVERY OR INFANT CARE						
	1) Ask the client where she will deliver?	1	2	8			
	2) Counsel the client to use a skilled health worker during delivery?	1	2	8			
	3) Discuss with client about items to have on hand at home, for delivery?	1	2	8			
110	Advise exclusive breastfeeding for up to 6 months?	1	2	8			
111	Discuss birth control/ family planning, for after delivery?	1	2	8			
112	Ask if the client has any questions and encourage questions?	1	2	8			
113	Use any visual aids during consultation?	1	2	8			
114	Did the Provider write on the woman's health card?	YES1 NO2 NO HEALTH CARD3 DON'T KNOW8					
115	Did the provider discuss when the woman should return for her next visit?	YES1 NO2 DON'T KNOW8					
116	HOW MANY WEEKS PREGNANT IS THE CLIENT? ASK PROVIDER IF THIS QUESTION WAS NOT ASKED DURING CONSULTATION	WEEK OF PREGNANCY <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 KNOW98					

No	QUESTIONS	CODING CLASSIFICATION	GO TO				
117	OUTCOME OF CONSULTATION	CLIENT SENT HOME1 CLIENT REFERRED (TO LAB OR OTHER PROVIDER) AT SAME FACILITY2 CLIENT ADMITTED TO SAME FACILITY3 CLIENT REFERRED TO OTHER FACILITY4 DON'T KNOW8					
118	RECORD TIME CONSULTATION ENDED	HOUR..... <table border="1" data-bbox="1144 436 1261 491"> <tr> <td></td> <td></td> </tr> </table> MINUTES..... <table border="1" data-bbox="1144 495 1261 550"> <tr> <td></td> <td></td> </tr> </table>					
119	OBSERVER COMMENTS:						

Exit Interview for Antenatal Care Clients

Section 1. Visit Information

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT</p> <p>Hello. In order to improve the services offered by this facility, we would like to know about your experience here. All the information given to me will be kept strictly confidential and future care that you receive at this facility will in no way be affected by your participation or non-participation in this interview. You can refuse to answer any question and may stop the interview at any time.</p> <p>Do you have any questions for me at this time? Do I have your agreement to participate?</p> <p style="text-align: center;">_____ DATE _____</p> <p style="text-align: center;">INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p>		
100	May I begin the interview?	CLIENT AGREES 1 CLIENT REFUSES 2	➔ STOP
101	Is this your first pregnancy?	YES 1 NO 2	
102	Is this your first antenatal visit at this facility for this pregnancy?	YES 1 NO 2	
103	How many months pregnant are you?	WEEKS <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>	
104	During this, (or previous) visits, were you given or prescribed iron pills/folic acid? (SHOW THE IFA PILL)	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	➔ 107 ➔ 107
105	During this (or previous) visits, has a Provider explained how to take the Iron pills?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	
106	ASK TO SEE THE IRON PILLS	SAW DRUGS 1 SAW PRESCRIPTION 2 NO DRUG OR PRESCRIPTION 3	
107	During this (or previous) visits, has a provider asked you about whether you received tetanus toxoid or not?	YES ,THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	
108	Have you ever received a tetanus toxoid injection? IF YES, How many times in total during your lifetime have you received a tetanus toxoid injection? THIS MAY BE FROM THIS FACILITY OR ELSEWHERE)	ONCE 1 TWICE 2 THREE OR FOUR 3 FIVE OR MORE 4 NEVER 5 DON'T KNOW 8	
109	Was your urine checked today?	YES 1 NO 2	
110	During this (or previous) visits has a Provider talked with you about any signs of that warn of problems with the pregnancy?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	➔ 113 ➔ 113

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
111	What warning signs or symptoms have been mentioned? (CIRCLE ALL THOSE MENTIONED.) PROBE: Anything else?	BLEEDING A FEVER B SWOLLEN FACE/HAND C TIREDNESS/BREATHLESSNESS D HEADACHE/BLURRED VISION... E OTHER _____ X (SPECIFY)	
112	What did the Provider advise you to do if you experienced any of the warning signs? CIRCLE ALL MENTIONED	SEEK CARE AT THE FACILITY A DECREASE ACTIVITY B CHANGE DIET C OTHER _____ X (SPECIFY)	
113	During this (or previous) visits has a Provider given you advice on the importance of exclusive breastfeeding, i.e. about give your baby nothing apart from breast milk?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	→115 →115
114	For how many months, did the provider recommend that you breastfeed exclusively?	MONTHS..... <input type="text"/> <input type="text"/> DON'T KNOW 98	
115	During this or previous visits did a provider discuss family planning methods or birth spacing methods for use after this birth?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	
116	During this or previous visits, did the Provider talk to you about where you plan to delivery?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	
117	Have you decided where you will have your delivery? 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 DON'T KNOW 8	
118	During this (or previous) visits has a Provider discussed supplies you should have at home or other preparations you should make for the delivery?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	→120 →120
119	ASK CLIENT TO MENTION SOME OF THE SUPPLIES OR PREPARATIONS FOR DELIVERY WHICH HAVE BEEN MENTIONED. CIRCLE ALL THAT APPLY. PROBE: Are there any other items? Anything else you have been advised to prepare before delivery?	SOAP A STERILE BLADE B SCISSOR C TIES FOR UMBILICAL CORD... D PLASTIC FOR UNDER WOMAN E PLAN FOR TRANSPORTATION TO FACILITY F OTHER _____ X (SPECIFY)	
120	ASK TO SEE THE CLIENTS ANC CARD AND INDICATE IF THERE IS A NOTE INDICATING ANY FINDINGS FROM THE EXAMINATION TODAY?	YES, FINDINGS RECORDED 1 YES, CARD, FINDINGS NOT RECORDED 2 NO CARD 3 DON'T KNOW 8	→201 →201
121	CHECK THE ANC CARD OR TETANUS IMMUNIZATION CARD AND INDICATE IF THERE IS ANY NOTE OR RECORD OF THE WOMAN HAVING RECEIVED TETANUS TOXOID	YES, 1 TIME 1 YES, 2 OR MORE TIMES..... 2 PRESCRIBED TODAY 3 NO 4 DON'T KNOW 8	

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the maternal health services.							
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES..... <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY..... 000 DON'T KNOW..... 998						
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems							
		SPONTANEOUS		PROMPT				
		BIG	SMALL	BIG	SMALL	NO	DK/NA	
1	Time you waited?	1	2	3	4	5	8	
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8	
3	Time it takes to receive results from tests?	1	2	3	4	5	8	
4	Ability to discuss problems or concerns about your pregnancy with the health worker?	1	2	3	4	5	8	
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8	
6	Quality of the examination and treatment provided?	1	2	3	4	5	8	
7	Privacy from others seeing exam?	1	2	3	4	5	8	
8	Privacy from others hearing discussion?	1	2	3	4	5	8	
9	Availability of medicines at the facility?	1	2	3	4	5	8	
10	The hours/days of services?	1	2	3	4	5	8	
11	Cleanliness of facility?	1	2	3	4	5	8	
12	How staff treated you?	1	2	3	4	5	8	
13	Cost of services?	1	2	3	4	5	8	
14	Other _____ (SPECIFY)	1	2				5	

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Could you tell me how old are you?	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW..... 98	
302	Have you ever attended school?	YES..... 1 NO..... 2	→304
303	What is the highest level of school (certificate) you have successfully completed?	NONE..... 1 PRIMARY..... 2 PREPARATORY..... 3 SECONDARY..... 4 ABOVE SECONDARY..... 5 UNIVERSITY..... 6 ABOVE UNIVERSITY..... 7	→306 →306 →306 →306 →306
304	Have you ever attended any literacy classes?	YES..... 1 NO..... 2	
305	Can you read or write?	YES, READ ONLY..... 1 YES, READ AND WRITE..... 2 NO..... 3	
306	Are you currently employed?	YES..... 1 NO..... 2	→309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER..... 1 FOR SOMEONE ELSE..... 2 FOR HERSELF..... 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH..... 1 BOTH..... 2 KIND..... 3 NOTHING..... 4	
309	Do you live in a city or a village?	CITY..... 1 VILLAGE..... 2	
310	Which governorate do you live in?	_____ <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

104	EXAMINATION CONTINUED:				
	7) WERE LABIA SEPARATED AND INSPECTED TO INSPECT FOR LESIONS/DISCHARGE?	LABIA SEPARATED AND INSPECTED.....	1	2	5
	FOR MALE CLIENT NOT CIRCUMCISED:				
	8) WAS FORESKIN RETRACTED TO INSPECT FOR LESIONS/DISCHARGE?	FORESKIN RETRACTED...	1	2	5
105	IF CLIENT IS FEMALE: INDICATE WHETHER PROVIDER CONDUCTED A PELVIC EXAM.	YES1 NO2 MALE CLIENT3			→107 →107
106	PELVIC EXAM				
	DID THE PROVIDER:		YES	NO	NA
1	ENSURE CLIENT VISUAL PRIVACY?	VISUAL PRIVACY	1	2	
2	ENSURE CLIENT AUDITORY PRIVACY?	AUDITORY PRIVACY	1	2	
3	EXPLAIN PROCEDURE PRIOR TO BEGINNING?		1	2	
4	PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
5	USE STERILIZED OR HIGH-LEVEL DISINFECTED INSTRUMENTS ?(ASK THE SERVICE PROVIDER)	DISINFECTED INSTRUMENTS	1	2	
6	WASH HIS/HER HANDS BEFORE THE EXAM?	WASHED HANDS.....	1	2	
7	PUT ON NEW OR DISINFECTED GLOVES <u>BEFORE</u> EXAM?	PUT ON GLOVES.....	1	2	
8	ASK THE CLIENT TO TAKE SLOW, DEEP BREATHS, AND RELAX ALL MUSCLES?	ASK CLIENT TO RELAX MUSCLES.....	1	2	
9	INSPECT THE EXTERNAL GENITALIA?	INSPECT GENITALIA.....	1	2	
10	(IF USED) EXPLAIN SPECULUM PROCEDURE?	EXPLAIN SPECULUM.....	1	2	5
11	INSPECT THE CERVIX AND VAGINAL MUCOSA? (AIM LIGHT INSIDE INSERTED SPECULUM)	INSPECT CERVIX	1	2	
12	PERFORM BIMANUAL EXAM (ONE HAND INSIDE VAGINA, OTHER PALPATING UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM	1	2	
13	WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER.....	1	2	
14	WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA	1	2	
15	PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE? (ASK THE PROVIDER)	DECONTAMINATE GLOVES/INSTRUMENTS .	1	2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																				
107	Was a specimen taken or a laboratory examination ordered for the client?	YES.....1 NO.....2 DON'T KNOW.....8	→110 →110																				
108	IF YES, WERE ANY OF THE FOLLOWING TYPES OF TESTS MENTIONED? 1) BLOOD TEST? 2) URINE ANALYSIS? 3) MICROSCOPIC EXAMINATION OF SPECIMEN OF VAGINAL OR URETHRAL DISCHARGE? 4) HIV/AIDS TEST?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">UNSURE</th> </tr> </thead> <tbody> <tr> <td>BLOOD TEST.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>URINE ANALYSIS... </td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>MICROSCOPIC EXAM OF DISCHARGE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>HIV/AIDS TEST.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table>		YES	NO	UNSURE	BLOOD TEST.....	1	2	8	URINE ANALYSIS...	1	2	8	MICROSCOPIC EXAM OF DISCHARGE	1	2	8	HIV/AIDS TEST.....	1	2	8	
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URINE ANALYSIS...	1	2	8																				
MICROSCOPIC EXAM OF DISCHARGE	1	2	8																				
HIV/AIDS TEST.....	1	2	8																				
109	Did the provider at any time ask for the client's agreement or permission for ordering or taking a specimen to check for infection or specifically mention a STI (e.g. syphilis or HIV/AIDS)?	YES..... 1 NO..... 2 DON'T KNOW..... 8																					
110	Did the provider discuss the diagnosis with the client?	YES..... 1 NO..... 2																					
111	Did the provider mention any relationship between the infection and sexual activity?	YES..... 1 NO..... 2 DON'T KNOW..... 8																					
112	Did the provider give the client a prescription or medications?	YES..... 1 NO..... 2	→115																				
113	Did the provider give the client a prescription or medications for the sexual partner?	YES..... 1 NO..... 2 DON'T KNOW..... 8																					
114	Did the provider instruct the client on the importance of completing the full course of treatment?	YES..... 1 NO..... 2																					
115	Was the client encouraged to refer his/her partner(s) for treatment?	YES..... 1 NO..... 2																					
116	Did the provider give a follow-up date to return for re-examination?	YES..... 1 NO..... 2																					
117	Were any visual aids used for client education about STIs or HIV/AIDS?	YES..... 1 NO..... 2																					
118	Was the risk of HIV/AIDS mentioned?	YES..... 1 NO..... 2																					
119	Did the provider: 1) Talk about the role of condoms in prevention of STIs and HIV/AIDS transmission? 2) Instruct the client on how to use Condom? 3) Demonstrate how to put on condom? 4) Offer condoms to the client?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>DISCUSS CONDOMS AND STI/HIV PREVENTION... </td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>INSTRUCT HOW TO USE CONDOM</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>DEMONSTRATE HOW TO PUT ON CONDOM... </td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>PROVIDE CONDOM</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table>		YES	NO	DK	DISCUSS CONDOMS AND STI/HIV PREVENTION...	1	2	8	INSTRUCT HOW TO USE CONDOM	1	2	8	DEMONSTRATE HOW TO PUT ON CONDOM...	1	2	8	PROVIDE CONDOM	1	2	8	
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DEMONSTRATE HOW TO PUT ON CONDOM...	1	2	8																				
PROVIDE CONDOM	1	2	8																				
120	Did the Provider write on the client's health card?	YES.....1 NO.....2 NO HEALTH CARD USED3 DON'T KNOW.....8																					

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO				
121	RECORD TIME OBSERVATION ENDED.	HOUR MINUTES <table border="1" data-bbox="1219 180 1320 275" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					
122	OBSERVER COMMENTS						

Exit Interview for RTI/STI Clients

Section 1. Visit Information

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT</p> <p>Hello. In order to improve the services offered by this facility, we would like to know about your experience here. All the information given to me will be kept strictly confidential and future care that you receive at this facility will in no way be affected by your participation or non-participation in this interview. You can refuse to answer any question and may stop the interview at any time.</p> <p>Do you have any questions for me at this time? Do I have your agreement to participate?</p> <p style="text-align: center;">_____ INTERVIEWER'S SIGNATURE (Indicates respondent' willingness to participate)</p> <p style="text-align: center;">_____ DATE</p>		
100a	May I begin the interview?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	Did the health worker give you a diagnosis for your problem today, that is, did he/she tell you what is causing the problem?	YES 1 NO 2 DON'T KNOW 8	
102	Were you given a prescription or medications today?	YES 1 RECEIVED INJECTION BUT NO OTHER MEDICATIONS OR PRESCRIPTION 2 NO 3	→ 105 → 105
103	ASK TO SEE ALL MEDICATIONS WHICH WERE RECEIVED AND ANY PRESCRIPTIONS WHICH HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS OR PRESCRIPTIONS SEEN	HAS ALL MEDS 1 HAS SOME MEDS, SOME PRESCRIPTIONS NOT SUPPLIED 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY 3	
104	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	
105	Did the health worker talk to you about how to protect yourself against reproductive tract infections or HIV/AIDS?	YES 1 NO 2 DON'T KNOW 8	
106	What are some of the ways that you can protect yourself from reproductive tract infections transmitted through sexual activity?	USE CONDOMS A HAVE ONLY ONE PARTNER B OTHER X (SPECIFY) DON'T KNOW Z	

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO				
107	Have you ever used condoms before?	YES.....	1					
		NO	2					
108	Some people do not want to use condoms. I would like to hear your opinion on reasons that some people would not want to use condoms or issues that might inhibit people from using condoms? FOR EACH ITEM MENTIONED, ASK: Do you think that is a big or a small problem for using condoms? PROBE WITHOUT PROVIDING ANY ANSWERS. AFTER IT APPEARS THE RESPONDENT HAS NO MORE ANSWER, ASK: I want to ask you about your opinion now about some other reasons people may <u>not</u> use a condom. As I mention each item, 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 big problem, a small problem, or not a problem for you to when deciding whether to use condoms or not..							
	POSSIBLE PROBLEMS WITH USING CONDOMS		SPONTANEOUS		PROMPT			
	1)	It is embarrassing to purchase/obtain condoms?	BIG	SMALL	BIG	SMALL	NO	DK
	2)	Disposal of the condom is a problem	1	2	3	4	5	8
	3)	It is embarrassing to discuss use of condom with partner?	1	2	3	4	5	8
	4)	The condom reduces your own [RESPONDENT] sexual satisfaction?	1	2	3	4	5	8
	5)	The condom reduces partner's sexual satisfaction?	1	2	3	4	5	8
	6)	OTHER _____ (SPECIFY)	1	2			5	
109	Did you discuss any of the issues related to using condoms that were mentioned above with the provider?	YES.....	1					→111
		NO	2					
		NA.....	8					
110	Did the provider talk to you about condoms or mention condoms today?	YES.....	1					
		NO	2					
		DON'T KNOW.....	8					
111	Were you given any condoms today?	YES.....	1					
		NO	2					→113
112	Did a provider demonstrate to you how the condom is used?	YES.....	1					
		NO	2					
113	Did you receive a blood test or did the health worker take a specimen for laboratory examination today?	YES.....	1					
		NO	2					→201
114	Did the health worker explain to you what the laboratory test was for? IF YES, What was the test for?	YES, INFECTION/STI.....	A					
		YES, HIV/AIDS	B					
		YES, OTHER _____ (SPECIFY)	X					
		NO	Y					
		DON'T KNOW.....	Z					

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the health services.							
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES..... <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY..... 000 DON'T KNOW..... 998						
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems							
		SPONTANEOUS		PROMPT				
		BIG	SMALL	BIG	SMALL	NO	DK/NA	
1	Time you waited?	1	2	3	4	5	8	
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8	
3	Time it takes to receive results from tests?	1	2	3	4	5	8	
4	Ability to discuss problems or concerns about your health with the health worker?	1	2	3	4	5	8	
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8	
6	Quality of the examination and treatment provided?	1	2	3	4	5	8	
7	Privacy from others seeing exam?	1	2	3	4	5	8	
8	Privacy from others hearing discussion?	1	2	3	4	5	8	
9	Availability of medicines at the facility?	1	2	3	4	5	8	
10	The hours/days of services?	1	2	3	4	5	8	
11	Cleanliness of facility?	1	2	3	4	5	8	
12	How staff treated you?	1	2	3	4	5	8	
13	Cost of services?	1	2	3	4	5	8	
14	Other _____ (SPECIFY)	1	2			5		

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
203	Do you participate in any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility? This includes if you prepay for a package of services or if you received a discounted price or an exemption from paying. IF YES, what type of program do you participate in?	YES, HIO/SHIP A YES, OTHER SYSTEM B YES, PREPAY AT FACILITY FOR PACKAGE OF SERVICES C YES, DISCOUNT/EXEMPT STATUS D OTHER _____ X (SPECIFY) NO Y DON'T KNOW Z	
204	What is the total amount for all staff, services, or treatments which you paid for (NAMEs) consultation today?*	1) LAB L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
	Please include any money you paid for staff services, laboratory tests, or medicines you received.	2) MEDICINE OR METHOD L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
		3) CONSULT OR PROCEDURE L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
		4) OTHER L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
		5) TOTAL AMOUNT L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
205	Have you ever visited this facility before? (either as a patient or visiting or accompanying a patient?)	YES 1 NO 2	
206	There are many reasons people choose different health facilities for services. Can you mention some of the reasons you selected this facility for the services you sought today?	FEMALE PHYSICIAN A EFFICIENCY OF THE PHYSICIANS B AVAILIABIITY OF ALL SPECIALITIES C AVAILABILITY OF THE SERVICE D CLIENTS ARE WELL TREATED E HAS THE GOLD STAR F A NEAR BY FACILITY G GOOD REPUTATION H OTHER _____ X (SPECIFY)	

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Could you tell me how old are you?	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW..... 98	
302	Have you ever attended school?	YES..... 1 NO..... 2	→ 304
303	What is the highest level of school (certificate) you have successfully completed?	NONE..... 1 PRIMARY..... 2 PREPARATORY..... 3 SECONDARY..... 4 ABOVE SECONDARY..... 5 UNIVERSITY..... 6 ABOVE UNIVERSITY..... 7	→ 306 → 306 → 306 → 306 → 306
304	Have you ever attended any literacy classes?	YES..... 1 NO..... 2	
305	Can you read or write?	YES, READ ONLY..... 1 YES, READ AND WRITE..... 2 NO..... 3	
306	Are you currently employed?	YES..... 1 NO..... 2	→ 309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER..... 1 FOR SOMEONE ELSE..... 2 FOR HERSELF..... 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH..... 1 BOTH..... 2 KIND..... 3 NOTHING..... 4	
309	Do you live in a city or a village?	CITY..... 1 VILLAGE..... 2	
310	Which governorate do you live in?	_____ <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

1	INDICATE TYPE OF INJECTION BEING PROVIDED	VACCINATION..... 1 CURATIVE 2			
2	INDICATE ROUTE OF INJECTION	INTRAMUSCULAR 1 INTRADERMAL OR SUB-CUTANEOUS..... 2 I.V.....3 DON'T KNOW 8			
3	INDICATE SOURCE OF SYRINGE	FACILITY STOCK 1 PATIENT PROVIDED 2 DON'T KNOW 8			
4	INDICATE AGE OF CLIENT RECEIVING INJECTION	CHILD < 5 YEARS 1 OTHER 6 (specify)			
	WHEN GIVING THE INJECTION DID THE PROVIDER:		YES	NO	NA
5	WASH HANDS <u>BEFORE</u> INJECTION?	WASH HANDS	1	2	
6	PREPARE INJECTION IN AREA WITH CLEAN TABLE OR TRAY TO SET ITEMS ON?	CLEAN PREPARATION AREA	1	2	
7	USE NEW SYRINGE AND NEEDLE FROM A STERILE SEALED PACKET?	NEW SYRINGE AND NEEDLE	1	2	
8	DID YOU SEE THE PROVIDER OPEN THE NEW PACKET WITH SYRINGE AND NEEDLE?	SEE OPEN PACKET	1	2	
9	REMOVE NEEDLE FROM MULTIPLE DOSE VIAL EACH TIME?	REMOVE NEEDLE	1	2	5
10	CLEAN SKIN WITH ANTISEPTIC?	CLEAN SKIN	1	2	
11	DRAW BACK PLUNGER <u>BEFORE</u> INJECTION?	DRAW BACK PLUNGER....	1	2	5
12	USE SCOOP TECHNIQUE TO RECAP NEEDLE ?	SCOOP RECAP	1	2	
13	RECAP NEEDLE USING TWO HANDS?	TWO-HAND RECAP	1	2	
14	NOT RECAP NEEDLE?	NO-RECAP	1	2	
15	DISPOSE OF NEEDLES IN PUNCTURE RESISTANT SAFETY CONTAINERS?	DISPOSE OF SHARPS.....	1	2	

