KENYA

Service Provision Assessment Survey 2004

Maternal & Child Health, Family Planning and STIs

Kenya
Service Provision Assessment Survey
2004

National Coordinating Agency for
Population and Development
Nairobi, Kenya

Ministry of Health
Nairobi, Kenya

Central Bureau of Statistics
Nairobi, Kenya

ORC Macro
Calverton, Maryland, USA

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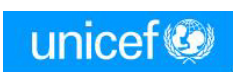

This report summarizes the findings of the 2004 Kenya Service Provision Assessment (KSPA) carried out by the National Coordinating Agency for Population and Development (NCAPD), and the Ministry of Health (MOH), with logistic support from the Central Bureau of Statistics (CBS). ORC Macro provided technical assistance through the MEASURE DHS project for this USAID, DFID, and UNICEF-funded project designed to collect information on health facility infrastructure, resources, and management systems, and on services for child health, family planning, maternal health, and selected communicable diseases. The survey also provides information on the capacity of health facilities to provide quality HIV/AIDS services. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the donor organisations.

Additional information about the KSPA 2004 may be obtained from the National Coordinating Agency for Population and Development, the Chancery, 4th Floor, Valley Road, Nairobi, Kenya (Telephone: 020 711-600/1; Fax: 020 710-281). Additional information about the MEASURE DHS project may be obtained from ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (Telephone: 301-572-0200 and Fax: 301-572-0999, e-mail: reports@orcmacro.com)

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[1] See the 2004 Kenya HIV/AIDS SPA final report for the HIV/AIDS findings and the survey instruments (Muga et al., 2005).

Tables and Figures

Foreword

The 2004 Kenya Service Assessment (KSPA) is a follow-up to the 1999 KSPA, conducted in conjunction with the 2003 Kenya Demographic and Health Survey (KDHS). The information from the KSPA gives an indication of our progress towards attaining the Millennium Development Goals (MDGs).

The KSPA was designed to provide national and sub-national information on the availability and quality of services from a representative sample of 440 health facilities. These facilities included hospitals, health centres, dispensaries, maternities, clinics and VCT centres. The managing authorities of these facilities included the government, NGOs, and private and faith-based organisations (FBOs). The facilities were stratified by province and by district.

The services of interest to the KSPA included child health, family planning, maternal health (antenatal and delivery care), STIs, TB, and HIV/AIDS. There was a deliberate over-sampling of the facilities offering VCT, ART and PMTCT services.

The survey included interviews with the service providers, observations of a sample of consultations between the health providers and clients seeking these services, and interviews with clients after they were served. The preliminary findings were first reviewed with the health service providers, programme managers, and policymakers in preparation for national dissemination of the study report.

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

In the National Health Sector Strategic Plan (NHSSP), reproductive health has been identified as one of the priority packages that the Ministry of Health will address. This KSPA report is therefore an important tool in the nation's efforts to address reproductive health concerns. Areas of intervention that may make a difference have been proposed and are included as recommendations.

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

Prof. Peter Anyang' Nyong'o
Minister for Planning and National Development

Acknowledgments

The 2004 KSPA was accomplished through the collaborative efforts of staff from the Ministry of Health (MOH), the National Coordinating Agency for Population and Development (NCAPD), the Central Bureau of Statistics (CBS), and ORC Macro under the MEASURE DHS project. USAID, DFID and UNICEF provided financial support, while the Central Bureau of Statistics assisted in technical and logistical support.

We wish to acknowledge contributions from the various authors, members of the various technical committees, and other professionals who individually and collectively gave comments and advice in the process of writing the report.

We are especially grateful to the project co-coordinators for their contribution to the success of the project. We also recognize the contribution of ORC Macro throughout the design, implementation, and analysis of the KSPA 2004.

Finally, we wish to thank all the staff members of the various agencies who, in one way or another, contributed to the success of the exercise.

Of particular note and acknowledgement is the assistance offered in designing the survey instruments and in collecting, processing and analyzing the information. In this regard, we are truly grateful to the representatives from collaborating government ministries, universities, local and international NGOs, UNICEF, USAID, participants, and individuals.

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Key Findings

The 2004 Kenya Service Provision Assessment Survey (KSPA 2004) was conducted in a representative sample of 440 health facilities throughout Kenya. The survey covered all levels of facilities from dispensaries to hospitals and included government, private for-profit, non-governmental (NGO) and faith based organisation (FBO) managed facilities. The KSPA 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, child health, family planning, maternal health services and services for specific infectious diseases (STIs, TB and HIV/AIDS). There was a special module on HIV/AIDS.

The objectives of the survey 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 sick children, family planning (family planning), antenatal care (ANC), and consultations for STIs.

The KSPA 2004 was undertaken jointly by the National Coordinating Agency for Population and Development (NCAPD), the Ministry of Health (MOH) and the Central Bureau of Statistics (CBS), with technical assistance from ORC Macro under the MEASURE DHS project. The United States Agency for International Development (USAID), the British Department for International Development (DfID) and the United Nations Children's Fund (UNICEF) provided financial support for the survey.

Facility-Level Infrastructure, Resources and Systems

- Over half of all facilities offer the full package of services. The service most widely available are curative care for sick children, growth monitoring, child immunisation and adult STI services. Antenatal care and family planning services are slightly less available. Facility-based delivery services are available in just a third of all facilities, available in over 90 percent of hospitals. Almost all facilities had at least one qualified provider available. 24-hour emergency services are available in 57 and 59 percent of hospitals and maternities, respectively.

- Regular electricity or back-up generator is available in about half of facilities, mostly in hospitals and VCT facilities. Regular year-round water is available in only a quarter of facilities, however, client comfort amenities (client latrine, protected waiting area, basic level of cleanliness) are available in about 9 in 10 facilities.

- Routine Management committee meetings are held at least once every 6 months in about two-thirds of facilities, however, documentation of such meetings are missing in most facilities. Routine Management board meetings are held in less than half of facilities. Quality Assurance (QA) activities are not routinely carried out in most facilities and documentation of QA activities are missing as well in most facilities that report QA activities.

- Almost 9 in 10 facilities have routine external supervision at least once every 6 months, mostly government and NGO-managed facilities and about three-fourths of facilities provide routine in-service training to their staff.

- Only a small percentage of facilities had all items for infection control in service delivery areas with soap and disinfecting solutions the items usually missing, thus contributing to overall weak-

ness. Waste disposal is also inadequate in most facilities, particularly in health centres, dispensaries and in government facilities.

- Approximately three-fourths of facilities storing vaccines have adequate systems for monitoring vaccine storage temperature however 22 percent of facilities did not have refrigerator temperature in recommended range of 0°-8°C on the day of the survey. Among facilities storing contraceptive methods, 92 percent had adequate storage conditions, where items are stored in dry location, off the ground and protected from water, sun pests and rodents.

- Guidelines/protocols and visual aids are missing in most service areas and are not observed being used by providers in most facilities. The exception is the availability of visual aids in family planning service delivery areas. Guidelines for disinfection and sterilisation are missing in most service areas where items are sterilised or disinfected

- Community participation in management meetings and client feedback is rare, with less than half of government facilities having community participation in some management meetings.

Child Health Services

- More than three-fourths of facilities offer the child health services of curative care, immunisation, and growth monitoring, with curative care being the most frequently offered child health service. Child immunisation is lowest in facilities in Nairobi province and private for-profit facilities are the least likely to offer immunisation services.

- Among facilities offering immunisation services and storing vaccines, 85 percent had all basic EPI vaccines available, and almost all those facilities that only offer immunisation services (but do not store vaccines) had adequate supplies of syringes and needles, and cold box with ice packs. Three-fourths had all assessed items for infection control (soap, water and sharps box) in the immunisation area with soap most often missing.

- Treatment guidelines of any kind (including IMCI treatment guidelines) are available in only 22 percent of facilities offering curative care for sick children. IMCI counselling cards for providers and IMCI mother cards are each available in only 5 percent of facilities. Similarly, visual aids for client education are lacking, available in less than 30 percent of facilities. Only 9 percent of interviewed child health providers had received any in-service training related to IMCI in the past 12 months.

- All first-line medicines are available in 83 percent of facilities however pre-referral medicines are less available, found in only a quarter of facilities offering outpatient care for sick children. Fansidar (SP) is more available as a first-line antimalarial medicine compared to amodiaquine.

Family Planning Services

- Three-fourths of facilities offer some modern method of family planning. The combined oral pill, progestin-only injection and the male condom are the most widely offered methods in Kenya, available in almost 9 in 10 facilities. The majority of facilities offering these methods had them available on the day of the survey. Nine in 10 facilities offering family planning methods offer them 5 or more days per week.

- Infrastructure and resources considered important for family planning counselling (privacy, individual client cards, written family planning guidelines and family planning-related visual aids) are all available in just 1 in 5 facilities, with family planning guidelines most lacking. Visual aids, though widely available in family planning service sites, are rarely used by providers during family planning counselling sessions, observed being used during only 14 percent of family planning consultations.

- All items for infection control (hand-washing supplies, latex gloves, disinfecting solution and sharps box) are available in family planning service areas of 4 in 10 facilities. The items most lacking are disinfecting solution and soap. Less than 10 percent of facilities offering family planning have all items for client pelvic examination.

- In-service training received by family planning service providers is uncommon, with less than a third having received any such training in the past 3 years.

Maternal Health Services

- Antenatal care (ANC) services are offered in four out of five facilities in Kenya, however, ANC, postnatal care (PNC) and tetanus toxoid vaccine services are available in only a third of all facilities.

- Three-fourths of facilities offering ANC services have service providers who can diagnose and treat STIs, however just a quarter of these facilities have at least one medicine to treat each of the four major STIs (trichomoniasis, chlamydia, syphilis and gonorrhoea). Medicine for treating gonorrhoea is most often lacking.

- Only 36 percent of interviewed ANC clients reported being counselled on warning/danger signs during pregnancy and 51 percent were counselled on delivery plans.

- Two in five facilities offer normal delivery services, and 39 percent of facilities offering delivery services have blank partographs. Only 13 percent have medicines for managing serious delivery complications, and 56 percent have newborn respiratory support (infant sized Ambu bag).

- Only six percent of interviewed providers of normal delivery services were able to mention all four signs/symptoms of postpartum haemorrhage (PPH) and 12 percent were able to mention all four expected interventions.

STI, TB and HIV/AIDS Services

- STI services are available in approximately 9 in 10 facilities and are well integrated into ANC and family planning services. The primary location of STI services is the general outpatient department (OPD), with specialized STI service sites being rare. STI services are available five or more days a week in almost all facilities offering the services. However, only about one-fourth of facilities have at least one medicine available for treating each of the four major STIs, and medicines for treating gonorrhoea and candidiasis are the most lacking.

- About one- third of facilities offering STI services have all items to support quality STI counselling. STI guidelines are usually available; however, visual aids and condoms are commonly miss-

ing. They are available in the STI service sites of only 52 and 60 percent of facilities, respectively.

- The majority of facilities use the syndromic approach to diagnose and treat STIs. Discussions of any kind about condoms or HIV/AIDS were held during 70 percent of all STI client consultations and approximately 60 percent were counselled on risks of HIV/AIDS. Though condoms were offered to 21 percent of all STI clients, only 17 percent were counselled on its proper use.

- About one-third of facilities have all items for infection control at STI service sites, with disinfecting solution and soap the items most often missing

- Less than half of facilities offer any TB services, with 27 percent using the Directly Observed Treatment Short-Course (DOTS) strategy. Approximately two-thirds of those offering TB services have all first-line medicines, but only one-fourth have both first- and second-line medicines.

- While a third of all facilities have an HIV testing system only about one-fourth provide any PMTCT services. Antiretroviral therapy (ART) and post-exposure prophylaxis (PEP) are among the least offered HIV/AIDS services.

Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Antiretroviral treatment
ARV	Antiretroviral
BCG	Bacille de Calmette et Guérin
BEOC	Basic essential obstetric care
CBS	Central Bureau of Statistics
CEOC	Comprehensive essential obstetric care
DfID	Department for International Development
DHS	Demographic and Health Surveys
DOTS	Directly Observed Treatment, Short-course
DPT	Diphtheria, pertussis, and tetanus
EmOC	Emergency obstetric care
EPI	Expanded Programme on Immunisation
FHR	Foetal heart rate
FP	Family planning
HIV	Human immunodeficiency virus
HLD	High-level disinfection
IM	Intramuscular
IMCI	Integrated Management of Childhood Illnesses
IUD	Intrauterine device
IV	Intravenous
KSPA	Kenya Service Provision Assessment
MOH	Ministry of Health
MTCT	Mother-to-child transmission
NCAPD	National Coordinating Agency for Population and Development
NGO	Non-governmental organisation
OPV	Oral polio vaccine
ORC	Opinion Research Corporation
ORS	Oral rehydration salts
PEP	Post-exposure prophylaxis
PLHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
QA	Quality assurance
RPR	Rapid plasma reagin
RTI	Reproductive tract infection
SC	Curative care for sick children
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
TT	Tetanus toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
VDRL	Venereal disease research laboratory
WHO	World Health Organisation

Chapter 1 Survey Methodology

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1.1 Overview

The Kenya Service Provision Assessment of 2004 (KSPA 2004) survey is a follow-up of the Service Provision Assessment conducted in Kenya in 1999. The KSPA provides the Government with information necessary to monitor trends in facility performance. This information can be used to assess strengths and weaknesses of current strategies to improve maternal, child, and reproductive health, as well as services for sexually transmitted infections (STIs) and HIV/AIDS.

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 (STIs, HIV/AIDS, and tuberculosis). The KSPA 2004 survey instruments are based on the KSPA 1999 instruments, but were designed to collect more comprehensive information. In addition, the KSPA 2004 added a complete module on HIV/AIDS. In effect, the KSPA 2004 is a combination of the maternal and child health (MCH) SPA, which has been conducted in several countries, and the more specialised HIV/AIDS SPA. 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 facilities managed by the public sector, the private sector, faith-based organisations (FBOs) and non-governmental organisations (NGOs) from all eight provinces of the country.

The KSPA 2004 provides national- and provincial-level representative information for all types of facilities. Findings can supplement household-based health information from the Kenya Demographic and Health Survey (KDHS) conducted in 2003, which provides information on health, fertility, nuptiality and utilisation of services by the overall population.

1.2 Institutional Framework and Objectives of the KSPA

The KSPA 2004 was conducted by the National Coordinating Agency for Population and Development (NCAPD), an agency within the ministry of Planning and National Development; the Ministry of Health (MOH); and the Central Bureau of Statistics (CBS). ORC Macro provided technical assistance under the MEASURE DHS Project. The survey was funded by the United States Agency for International Development (USAID), the Department for International Development (DfID), and the United Nations Children's Fund (UNICEF).

The objectives of the 2004 KSPA were to

- Describe the preparedness of health facilities in Kenya to provide quality child, maternal, reproductive health, STI, tuberculosis, and HIV/AIDS services;
- Identify gaps in support services, resources, and processes used in providing client services that may affect facilities' capacity to provide quality services;
- Describe the tasks used in providing child, maternal and reproductive health services and the extent to which accepted standards for quality service provision are followed;
- Describe clients' perceptions of services and assess whether they understand instructions and follow-up advice received so that the best health outcome is achieved;
- Collect baseline information on health facilities' capacity to provide basic- and advanced-level HIV/AIDS care and support services, and their capacity to maintain record-keeping systems for monitoring HIV/AIDS preventive, diagnostic, care and support services;

- Compare findings among provinces, different types of facilities, and facilities managed by different authorities, and describe trends in findings between the KSPA 1999 and the KSPA 2004.

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

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

For each of the high-priority services, the Facility Inventory Questionnaire and provider interviews were used to collect information on whether a facility has 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 facility characteristics assessed for quality of services include training and supervision of staff, availability of service delivery protocols and of materials for client education, availability and utilisation of health information records, the service delivery environment, and facility systems for maintaining equipment and supplies.

The survey assessed support systems for general management, quality assurance, logistics for medicines, equipment maintenance, infection control, and systems for monitoring activities (such as tracking service coverage rates and referrals). Interviewers asked whether a facility had these support systems in place, but also recorded data on whether or not those systems were functioning.

A facility's basic infrastructure can affect the standard of health services provided and influence how likely clients are to use the facility. The KSPA 2004 collected data on whether or not facilities had electricity, water, and client amenities; recorded what services the facility offered on which days of the week; and assessed staffing levels.

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

KSPA interviewers observed consultations between clients and providers to assess whether the process followed in service delivery meets standards for acceptable content and quality. Observers sat in on consultations for sick children, STI services, family planning services, and antenatal care. They recorded what information was shared between the client and provider and what process the provider followed when assessing the client, conducting procedures, and providing treatment. Facilities were asked to provide a sample of records on monitoring labour, to determine the extent to which established standards for delivery care were followed.

Each observed client was asked to participate in an exit interview, to ascertain the client's perception of information shared and services received. This information provides further insight on the quality of the client-provider interaction.

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

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

Although the KSPA 2004 is a follow-up to the KSPA 1999, several factors limit direct comparison of the 1999 and 2004 findings:

1. The selection of health facilities for KSPA 1999 was tied to some extent to the 1998 KDHS clusters. This means that all health facilities in the country did not have an equal chance of being sampled. The 2004 KSPA used a random sample of health facilities, which insured that all facilities in the country had an equal chance of being sampled, in proportion to representation by facility and province.
2. The KSPA 2004 used more detailed questionnaires that collected slightly different information to conform to international standards.
3. North Eastern province was not included in the KSPA 1999 but was covered in 2004.
4. Stand-alone VCT facilities were included in 2004 but not in 1999.

1.3 KSPA 2004 Content and Methods for Data Collection

1.3.1 Content of the KSPA 2004

The KSPA 2004 focussed on basic-level health services, particularly those important for women and children. Four high-priority health services, all interrelated to some extent, were assessed: child health, family planning, maternal health, and specific infectious diseases (STIs, HIV/AIDS, and tuberculosis).

For each of these four areas, the survey assessed whether components considered essential for quality health services were present and functioning. The components assessed are those commonly promoted in programmes supported by the Government and development partners. The KSPA 2004 also assessed whether more sophisticated components were present, such as higher-level diagnostic and treatment modalities, and support systems for the health services that are most often introduced after basic-level services have been put in place.

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

The ***family planning component*** focuses on the process followed in counseling and providing contraceptive methods to the family planning client.

The ***maternal health component*** assessed counselling and screening during antenatal care (ANC) visits, the environment available during labour and delivery, and postnatal care.

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

1.3.2 Methods for Data Collection

Five main types of data collection tools were used:

1. In the ***Facility Inventory Questionnaire***, interviewers collected information on the availability of resources, support systems, and infrastructure elements necessary to provide a level of service that generally meets accepted standards. The support services assessed were those that are commonly acknowledged as essential management tools for maintaining health services.

2. In the ***Health Provider Interview***, interviewers asked providers about their qualifications (training, experience, and continued in-service training), the supervision they had received, and their perceptions of the service delivery environment.

3. The ***Observation Protocol*** was tailored to the service being provided. For sick child, antenatal care, family planning, and STI consultations, the observer assessed the extent to which service providers adhered to standards of care, based on generally accepted practices for good-quality service delivery. The observations included 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).

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

5. The ***HIV/AIDS Services*** module assessed how inpatient and outpatient HIV/AIDS clients were handled, from the counselling and testing stage through the treatment, referral, and follow-up stages. Interviewers also asked for records and statistics on HIV/AIDS clients.

Together with the above-mentioned tools, which have been used in other SPA surveys, several Kenya-specific instruments were also used:

1. The ***Maternal Health Statistics summary sheet*** summarized information on complications, procedures, and outcomes for maternity clients.

2. The ***District Health Management Team (DHMT) questionnaire*** sought information about DHMTs' management of facilities, staff training, operations, budgeting, and record keeping.

3. The ***Normal delivery record review*** was used to collect information on the quality of care provided during normal labour and delivery.

4. The ***Maternal Health Worker Knowledge questionnaire*** assessed the health worker's knowledge of various symptoms that pregnant women experience and what actions need to be taken in response to those symptoms.

1.4 Sampling

Data were collected from a representative sample of facilities, a sample of health service providers at each facility, and a sample of sick children (SC), family planning (FAMILY PLANNING), antenatal (ANC), and STI clients.

1.4.1 Sample of Facilities

The sample used for the KSPA 2004 was obtained from a list of 4,742 health facilities in Kenya provided by the Ministry of Health. The list included hospitals, health centres, maternities, clinics, dispensaries and stand-alone VCT facilities, with different managing authorities, including government, non-governmental organisations (NGOs), private for-profit, and faith-based organisations (FBOs). The two national referral hospitals and all eight provincial general hospitals were purposely included in the sample. The rest of the facilities were sampled in such a way as to provide national and provincial representation. A sample size of 453 facilities was selected for the survey, based on logistic considerations, as well as the minimum sample size required for the desired analysis (margin of error of 10 percent). Since information on HIV/AIDS services constituted a separate interest, and given that these services were expected to be offered in only a fraction of facilities, facilities offering PMTCT and VCT services were oversampled to provide sufficient numbers for analysis. Thus, the KSPA final sample covered approximately 11 percent of all facilities, and for PMTCT and VCT services, sampling covered 34 and 42 percent, respectively of all available services.

Data were weighted during analysis to account for the differentials caused by oversampling and to represent the actual distribution of facilities in the country. Tables 1.1 and 1.2 provide information on the weighted percent distribution of facilities included in the sample, as well as the weighted and unweighted number of facilities. All other tables in the report bear the weighted numbers of facilities only; Tables 1.1 and 1.2 should be used to determine the actual number of facilities assessed by the SPA. Appendix Table A-1.1.1 gives additional details on the distribution of the sample by type of facility and province.

Interviewers were not able to survey several of the sampled facilities. Some declined to be assessed, some were closed for renovations, and some had ceased operation. These facilities were replaced with the nearest facility of the same type, under the same managing authority, and in the same district. In all, 440 facilities were assessed.

Table 1.1 Distribution of facilities by type of facility, managing authority and province

Percent distribution of facilities (weighted) and number of facilities (weighted and unweighted) by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percent distribution of facilities (weighted)	Number of facilities	
		Weighted	Unweighted
Type of facility			
Hospital	6	28	172
Health centre	28	125	51
Maternity	5	20	46
Clinic	2	8	67
Dispensary	56	249	69
Stand-alone VCT	2	10	35
Managing authority			
Government	56	246	175
NGO	5	21	35
Private (for-profit)	14	63	143
Faith-based organisation	25	110	87
Province			
Nairobi	9	41	61
Central	11	50	62
Coast	11	49	57
Eastern	19	83	60
North Eastern	2	8	29
Nyanza	12	54	57
Rift Valley	29	126	62
Western	7	29	52
Total	100	440	440

Table 1.2 Percentage of facilities providing specific services

Percentage of facilities providing specific services (weighted) and number of facilities (weighted and unweighted) providing services, by service provided, Kenya SPA 2004

Service provided	Percentage of facilities providing services (weighted)	Number of facilities providing services	
		Weighted	Unweighted
Child immunisation	81	356	328
Consultation for sick children	95	418	393
Family planning	73	323	323
Antenatal/postnatal care	79	348	324
Delivery	37	164	256
Services for sexually transmitted infections[1]	92	403	391
Total	-	440	440

[1] This may include only laboratory examinations, only preventive measures, or client care.

1.4.2 Sample of Health Service Providers

A health service provider is defined as one who actually provides client services of some type, such as counseling, health education, consultation services, or laboratory and imaging services. For example, health workers were not eligible for observation or interview if they only complete registers and never provide any type of professional client services. The sample of health service providers was selected from providers who were present in the facility on the day of the survey and who provided services that were assessed by the KSPA. The ideal was to interview an average of eight providers in a facility. In facilities with fewer than eight health providers, all of the providers present on the day of the visit were interviewed. In facilities with more than eight providers, an average of eight providers were interviewed, including all providers whose work was observed. If interviewers observed fewer than eight providers, they also interviewed a random selection of the remaining health providers, to obtain an average of eight provider interviews.

Data were weighted during analysis to account for the differentials caused by oversampling or undersampling of providers with a particular qualification in a facility type and province. It should be pointed out that in a few cases, the staff present on the day of the survey may not be representative of the staff who normally provide the services being assessed.[1]

Table 1.3 provides general information on the weighted proportion of the providers interviewed as a percentage of the total number of providers assigned to facilities and present at the time of the survey, by background characteristics and provider qualification. It also gives the weighted and unweighted number of interviewed providers utilized for the analysis. Appendix Table A-1.2 provides additional information on the weighted and unweighted number of interviewed providers, by type of provider and type of facility.

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

Table 1.3 Distribution of interviewed providers

Percent distribution of interviewed providers (weighted) and number of interviewed providers (weighted and unweighted), by type of facility, managing authority, province and qualification of provider, Kenya SPA 2004

Background characteristics	Percent distribution of interviewed providers (weighted)	Number of interviewed providers	
		Weighted	Unweighted
Type of facility			
Hospital	47	978	1,338
Health centre	24	503	208
Maternity	7	137	164
Clinic	1	18	166
Dispensary	20	418	122
Stand-alone VCT	1	27	83
Managing authority			
Government	59	1,230	1,067
NGO	3	54	133
Private (for-profit)	16	334	475
Faith-based organisation	22	463	406
Province			
Nairobi	17	351	390
Central	11	220	258
Coast	12	246	292
Eastern	18	369	263
North Eastern	1	17	108
Nyanza	12	248	239
Rift Valley	24	496	283
Western	6	134	248
Qualification of provider			
Consultant	0[1]	9	28
Medical doctor	1	31	67
Clinical officer	7	145	290
Registered nurse	7	145	294
Registered midwife	8	162	228
Enrolled nurse	16	326	373
Enrolled midwife	26	534	395
Nurse aide	13	281	40
Lab technician/technologist	7	151	240
Trained counsellor (full time)	4	92	94
Other/missing [2]	10	206	32
Total	100	2,081	2,081

[1] Percentage smaller than 1.
[2] Other providers include social workers and nutritionists.

1.4.3 Sample for Observations and Exit Interviews

The sample for observations was opportunistic, meaning clients were selected for observation as they arrived, since it was not possible to know how many eligible clients would attend the facility on the day of the survey. Where numerous clients were present and eligible for observation, the rule was to observe a maximum of five clients for each provider of the service, with a maximum of 15 observations in any given facility for each service. In practice, however, at some facilities, interviewers observed fewer clients than were eligible for observation. This occurred primarily where multiple services were being offered to clients at the same time in different locations in a facility. Any family planning or ANC client who was also assessed for STI symptoms was observed both for elements related to STI services and elements related to either FAMILY PLANNING or ANC, whichever one was relevant. Interviewers attempted to give an exit interview to all observed clients (or sick child caretakers) before they left the facility.

For child health consultations, only children who were suffering from an illness (rather than an injury or a skin or eye infection) were selected for observation. When several eligible ANC or FAMILY PLANNING clients were waiting, interviewers tried to select two new clients for every one follow-up case. The day's caseload and logistics of organizing observations did not always allow them to meet this objective.

Table 1.4 gives the weighted percent distribution of observed consultations, as well as the weighted and unweighted numbers of observed clients, by service. The total (weighted) number of clients observed during the survey for each of the services was as follows: 1,379 sick children, 539 FAMILY PLANNING clients, 967 ANC clients, and 116 STI clients. Details on these clients' characteristics are presented in the relevant chapters of this report.

The observations were weighted using facility weights to adjust for overrepresentation of facilities, and subsequently observations, in the sample. It should be pointed out that in a few cases, the clients present on the day of the survey might not be representative of the clients who normally receive the services being assessed.[2]

Appendix Tables A-1.4 through A-1.6 describe the facilities included in the KSPA 2004. This includes the size of the facilities' catchment population (Appendix Table A-1.4), the median number 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 that interviewed providers had received, by type of provider (Appendix Table A-1.6).

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

Table 1.4 Distribution of observed consultations

Percent distribution of observed consultations (weighted) and number of observed consultations for curative care for sick children, family planning, antenatal care, and sexually transmitted infections (weighted and unweighted), by type of facility, Kenya SPA 2004

Background characteristics	Percent distribution of observed consultations (weighted)	Number of observed consultations	
		Weighted	Unweighted
OUTPATIENT CARE FOR SICK CHILDREN			
Type of facility			
Hospital	7	102	625
Health centre	39	539	216
Maternity	2	26	52
Clinic	1	14	115
Dispensary	51	696	199
Stand-alone VCT	0	1	4
Total	100	1,379	1,211
FAMILY PLANNING			
Type of facility			
Hospital	12	64	413
Health centre	48	259	99
Maternity	2	13	29
Clinic	1	3	28
Dispensary	37	199	52
Stand-alone VCT	0	1	7
Total	100	539	628
ANTENATAL CARE			
Type of facility			
Hospital	11	105	636
Health centre	40	386	157
Maternity	3	32	61
Clinic	1	5	42
Dispensary	45	437	104
Stand-alone VCT	0	2	10
Total	100	967	1,010
SEXUALLY TRANSMITTED INFECTIONS			
Type of facility			
Hospital	15	18	128
Health centre	44	52	24
Maternity	2	2	3
Clinic	1	2	11
Dispensary	37	43	12
Stand-alone VCT	0	0	0
Total	100	116	178

1.5 Survey Implementation

1.5.1 Data Collection Instruments

The KSPA 2004 survey instruments were based on generic questionnaires developed by the MEASURE DHS project and were adapted after consulting with technical specialists from the Government of Kenya, USAID, and NGOs knowledgeable about the health services and service programme priorities covered by the KSPA. All questionnaires were drafted in English. The client exit interview questionnaires were also translated into 12 local languages.

The survey instruments were pre-tested in 12 facilities over a two-week period in July 2004. A total of 23 interviewers, comprised of 11 nurses and 12 social scientists, underwent a one-week intensive training session in Nakuru, then conducted data collection in facilities in Nairobi, Machakos, Nakuru, and Kajiado. The observations and experiences gathered from the pre-test were used to improve the instruments for the main survey.

Some operational definitions developed for the KSPA 1999 were revised for the KSPA 2004. A training manual was also developed to support standardized data collection. Any differences between definitions used in 1999 and 2004 are discussed in the relevant chapters of this report.

1.5.2 Training and Supervision of Data Collectors

Data collectors were primarily recruited from among clinical officers, nurses, and social scientists experienced in survey implementation and interviewing. Data collectors were trained for three weeks (22 August through 11 September 2004) for the main survey. Training included classroom lectures, practical experience in completing survey instruments in different types of health facilities, and role-plays for the observation and exit interviews. NCAPD field officers and team leaders, who were reporting to the NCAPD headquarters, as well as two technical advisors, supervised the teams during data collection. Four nurse (and clinical officer) interviewers were selected as regional field supervisors to assist in supervising the teams.

1.5.3 Data Collection

Data collection began on 18 September 2004 and ended on 10 January 2005. A total of 17 teams of three or four interviewers (each with at least 2 nurses and one social scientist) were responsible for data collection. One interviewer in each team was selected to be the team leader, with the responsibility of final questionnaire checking before leaving the field. Each team was given a list of facilities to visit, with the facilities' name and location. Information on the intended visits was relayed to the sampled facilities before the visit, so that they could prepare to receive the interviewers. To this end, NCAPD field officers acted as liaisons between the data collection teams and the facilities to be visited. They also organized transport for the teams and ensured that enough questionnaires were available.

Data collection took one day in small facilities, while in larger facilities it took several days. In addition, if one of the services of interest was not being offered on the day of the survey, the teams returned on a day when the service was being offered, to observe and interview the clients that came that day. However, if the service was offered but no clients came, the teams did not revisit the facility.

The team leader ensured that the respondent for each component of the facility inventory was the most knowledgeable person for the particular health service or system component being assessed. Where relevant, the data collector indicated whether a specific item being assessed was observed, reported available but not observed, or not available, or whether it was uncertain if the item was available. Equipment, supplies, and resources for specific services were only recorded as available if they were in the relevant ser-

vice delivery area or in an immediately adjacent room. Informed consent was obtained from the facility in-charge, all respondents for the facility inventory questionnaire, and observed and interviewed providers and clients.

Quality control was ensured throughout the data collection period by holding monthly meetings to review progress and address any emerging issues. The technical advisors undertook field spot checks on a regular basis. There was regular telephone communication between the technical advisors and the data collectors. In addition, several teleconferences were held between NCAPD and ORC Macro to update on the progress and sort out any emerging problems.

1.5.4 Process for Data Management and Report Writing

Data management and analysis were carried out as follows:

Field sorting and editing. After completing data collection in each facility, the teams held sessions to sort and edit the questionnaires before handing them over to the field supervisors or NCAPD field officers for transmission to the NCAPD headquarters.

Data sorting and editing at headquarters. Once the questionnaires for each facility were received at headquarters, they were first sorted to ensure that they were in the correct order and none was missing. They were then edited to eliminate any mistakes that would prevent the computer from accepting information during data entry. In cases where there was a problem with the questionnaires from a facility, the data collection team was consulted so that the problem could be rectified.

Data entry. Nine data operators entered the data under the supervision of two NCAPD staff. CSPro software developed by ORC Macro and the U.S. Census Bureau was used for data entry. All questionnaires were entered twice to ensure that the data had been accurately keyed in. The data entry took place from September 2004 through January 2005.

Data processing. The design of the tabulation plan and the preparation of the programmes for producing statistical tables were carried out from January through February 2005. Data analysis, including clarification of unclear information, was carried out from March through May 2005. During data analysis, the analysis plan was revised on the basis of feedback from the NCAPD and the KSPA technical advisors to ensure that the analysis was appropriate for the Kenyan health system.

Development of the final report. The final report was written with input from ORC Macro, NCAPD, the Ministry of Health, the Central Bureau of Statistics, and the University of Nairobi, between June and August 2005.

1.5.5 Data Analysis

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

Assessing the availability of items. Unless specifically indicated, the KSPA considered only observed items as available.

Observations. When looking at the data on observed consultations, it should be noted that many facilities provide routine services for clients separately from the actual consultation (such as 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 KSPA interviewers were instructed to follow a client through the entire system, this was not always possible. Thus, when observers saw that services were being provided outside the consultation room on the day of the survey, the observed client was assumed to have received

these services. Where this system is used, multiple providers contribute to the services received by each client. The provider who ultimately diagnosed and prescribed was defined as the primary provider.

Observers assessed whether a practice occurred or a piece of information was shared. They did not attempt to verify whether the practice was correct or if the information shared was correct or complete.

Provider information. Frequently, providers indicated that they "personally provided" a service that the facility did not offer. It may be that providers indicated services they provide outside the facility. For the KSPA, only providers from facilities that offer 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 analysts to monitor changes in a facility's capacity to provide services and in its 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 KSPA. The aggregate variables presented in this report, however, represent an initial phase in the process of defining useful health information aggregates. They will be refined as users provide feedback on which aggregate variables are useful to policymakers and programme implementers.

Chapter 2 Overview of the Health System in Kenya

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This chapter provides an overview of the health system in Kenya as a context in which to view the findings of the 2004 Kenya Service Provision Assessment (KSPA 2004) survey. It presents information on the background of the Kenya Health Policy Framework and the general organisation of the healthcare system.

Health is defined here in its broad sense, being not only the absence of disease but also general mental, physical, and social well-being. In this definition, the environment in which people live—including access to nutritious food, safe water, sanitation, education and social cohesion—also determines health.

2.1 Historical Background of Kenya Health Framework

In 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. It spells out the long-term strategic imperatives and the agenda for Kenya's health sector. To operationalise the document, the Ministry of Health (MOH) developed the Kenya Health Policy Framework Implementation Action Plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) in 1997 to spearhead and oversee the implementation process. A rationalisation programme within the MOH was also initiated. The above policy initiatives aimed at responding to the following constraints: decline in health sector expenditure, inefficient utilisation of resources, centralized decisionmaking, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth.

The 1999 National Census estimated Kenya's population to be 28.7 million, of whom 56 percent was less than 20 years of age. In 2004, the population was estimated at 32.8 million. Life expectancy is on the decline, at 48 years for women and 47 for men, and expected to fall further due to the rising incidence and prevalence of HIV/AIDS. There is also a steady decline in the fertility rate, from 8.1 in 1978 to 5.4 in 1992, and to 4.9 in 2003 (but up from 4.7 in 1998). According to the 2003 Kenya Demographic and Health Survey (KDHS 2003), more married women are using modern contraceptive methods. The prevalence rate has risen from 18 percent in 1989 to 27 percent in 1993, 32 percent in 1998, and 33 percent in 2003.

Overall morbidity and mortality remain high, particularly among women and children. An infant mortality rate (IMR) of 62 in 1993 increased by 12 percentage points to 74 in 1998 and was not significantly different (at 77) in 2003. The under-five mortality rate also rose from 110 deaths per 1,000 live births in the period 1993-1998 to 115 in the 1998-2003 period. Maternal mortality in 2003 was estimated to be 414 maternal deaths per 100,000 live births, which is a decline from the 590 deaths estimated for 1998, but also with large sampling errors, which makes comparing the rates over time uncertain.

Malaria is the leading cause of outpatient morbidity in Kenya, accounting for one-third of all new cases reported. After malaria, the most common illnesses seen in outpatient clinics are diseases of the respiratory system, skin diseases, diarrhoea, and intestinal parasites. Other frequent health problems include accidental injuries, urinary tract infections, eye infections, rheumatism, and other infections. Combined, these ten leading conditions account for nearly four-fifths of the total outpatient cases reported. This pattern has persisted for the past decade. Recurrent outbreaks of highland malaria and widespread emergence of drug resistance strains have aggravated the problem of malaria.

In 2003, full immunisation coverage declined to under 60 percent (from 65 percent in 1998 and 78 percent in 1993), with the percentage of children receiving no vaccinations at all increasing from 3 percent in 1998 to 6 percent in 2003. The major causes of this decrease in coverage are the declining availability, access to, and quality of public health services; the increasing level of poverty is a main underlying factor. In addition, because fewer people are dying from immunisable diseases, the focus on immunisation services has reduced, and funding has decreased.

The challenge facing the government is to reverse this decline. The National Development Plan of 2002-2008 states that the health care system in its current form (at the time of the National Plan's preparation) does not operate efficiently. Some of the areas targeted in the plan include drugs, personnel, and facility utilisation. Drugs, which account for 14 percent of the health budget, were deemed to be the most promising area for improvement, particularly in drugs' selection and quantification. Staffing norms for key cadres would be developed for deployment purposes. The plan also calls for formulating a health manpower policy, to develop and retain human resources in the sector.

2.1.1 The First Health Sector Strategic Plan (1999-2004)

The development of the first National Health Sector Strategic Plan (NHSSP-I) for the period 1999-2004 was a follow-up to the Ministry of Health's efforts to translate the policy objectives into an implementable programme (MOH, 1999a). In addition to taking into account past constraints, the document involved key stakeholders in the planning process from the start through consultative workshops within the Ministry itself and with other stakeholders, such as development partners, public sector, districts, and provinces, the private sectors, NGOs, religious groups, professional organisations, communities, and users of health services, as well as teaching and research institutions. The end product thus incorporated the views and priorities of all these groups.

2.1.2 Findings of the External Evaluation of NHSSP-I

The NHSSP-I was evaluated in September 2004 by an external team of independent consultants. The evaluation found that

> *"...despite having well focused national health policies and reform agenda whose overriding strategies were focused on improving health care delivery services and systems through efficient and effective health management systems and reform, the overall implementation of NHSSP-I (1999-2004) did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socio economic development as expected by the plan". This may be attributed to a set of factors, most of which are inter-related, such as*
>
> - *Absence of a legislative framework to support decentralisation;*
> - *Lack of well articulated, prioritized and costed strategic plan;*
> - *Inadequate consultations amongst MOH staff themselves and other key stakeholders involved in the provision of health care services;*
> - *Lack of institutional coordination and ownership of the strategic plan leading to inadequate monitoring of activities;*
> - *Weak management systems;*
> - *Low personnel morale at all levels; and*
> - *Inadequate funding and low level of resource accountability.*

As a result, the efforts made under NHSSP-I did not contribute toward improving Kenyans' health status. Rather, health indicators showed a downward trend. Infant and child mortality rates increased. The use of

health services in public facilities declined; in 1990 there were 0.6 new consultations per person, while in 1996, there were only 0.4 new consultations per person. The doctor-to-population ratio declined from the 1980s to the 1990s. The public sector's contributions to healthcare stagnated, going from US$12 per person in 1990 to US$6 per person in 2002. In more general development terms, poverty levels also increased, going from 47 percent in 1999 to 56 percent in 2002.

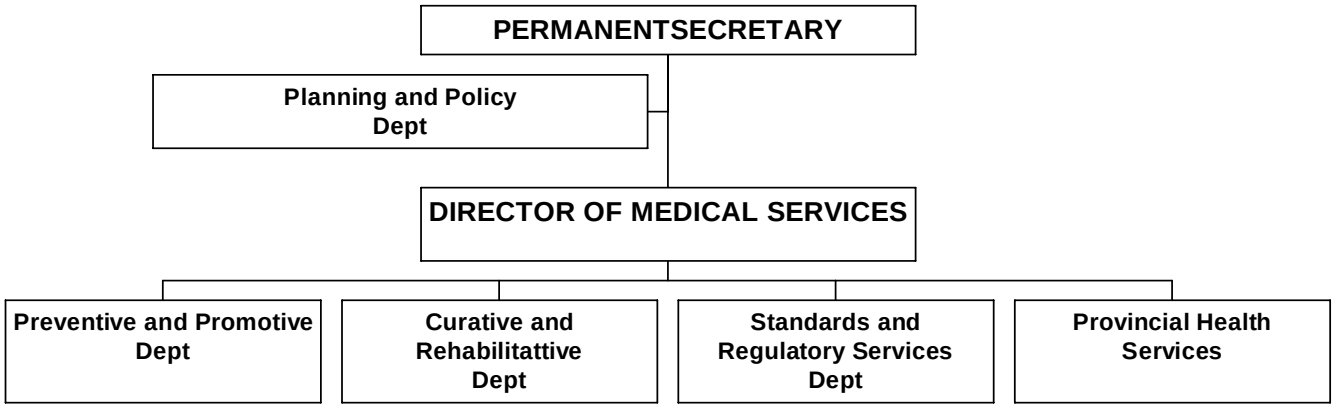
2.2 Organisation of the Health Care System

This section presents a brief overview of the organisation of the health care system in Kenya.

2.2.1 Organisation of the Ministry of Health

The Department of Preventive and Promotive Services (Figure 2.1) is responsible for the Reproductive and Child Health Programme, the Malaria Control Programme, the National AIDS/STI Control Programme, the Occupational Health Programme, the Parasite Diseases Control Programme, and others, with Maternal, Child Health, and Family Planning services included under the Reproductive and Child Health Unit.

Figure 2.1 Ministry of Health organisational diagram



2.2.2 The Health Care System

The health sector comprises the public system, with major players including the MOH and parastatal organisations, and the private sector, which includes private for-profit, NGO, and FBO facilities. Health services are provided through a network of over 4,700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities.

The public health system consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres, and dispensaries.

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

Provincial hospitals act as referral hospitals to their district hospitals. They also provide very specialized care. The provincial level acts as an intermediary between the national central level and the districts. They

oversee the implementation of health policy at the district level, maintain quality standards, and coordinate and control all district health activities. Similar private hospitals at the provincial level include Aga Khan Hospitals in Kisumu and Mombasa.

District hospitals concentrate on the delivery of health care services and generate their own expenditure plans and budget requirements based on guidelines from headquarters through the provinces.

The network of *health centres* provides many of the ambulatory health services. Health centres generally offer preventive and curative services, mostly adapted to local needs.

Dispensaries are meant to be the system's first line of contact with patients, but in some areas, health centres or even hospitals are effectively the first points of contact. Dispensaries provide wider coverage for preventive health measures, which is a primary goal of the health policy.

The government health service is supplemented by privately owned and operated hospitals and clinics and faith-based organisations' hospitals and clinics, which together provide between 30 and 40 percent of the hospital beds in Kenya.

2.2.3 Kenya Health Service

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

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

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

At the sub-district level, both preventive and curative services are provided by the health centres as well as dispensaries and outreach services to the communities within the catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household level with the introduction of the community package.

Non-governmental organisations, faith-based organisations and the private sector. Although several health-oriented NGOs operate throughout the country, the population covered by these NGO health services cannot be easily determined. The MOH and external donors support the health services offered by NGOs and the private sector in several ways. Depending on their comparative advantage, NGOs, FBOs, and community-based organisations (CBOs) undertake specific health services. The MOH provides support to mission health facilities by training their staff as well as seconding staff to these facilities and offering drugs and vaccines.

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

Modalities exist for MOH supervision and monitoring of NGO, FBO and other private-sector facilities. The NGOs and private facilities work with communities in collaboration with the DHMT. The commu-

nity programmes report to the DHMBs, which reports to the headquarters through the Provincial Health Management Boards. Their activities are guided by MOH standards and protocols.

2.3 Health Facilities

Tables 2.1 and 2.2 show the distribution of health facilities and hospital beds and cots by province. As seen in Table 2.1, the overall number of health facilities increased between 2001 and 2002. Although there was a decline in the number of hospital beds/cots per 100,000 population between 2003 and 2004, there has been a drastic increase from the numbers for 2001 and 2002.

Table 2.1 Health facilities and hospital beds and cots, 2001-2002

Number of health facilities in Kenya, and number of hospital beds and cots available, Kenya SPA 2004

Facility type	2001	2002
Hospitals/maternities	500	514
Health centres	611	634
Dispensaries	3,310	3,351
Total	4,421	4,499
Number of beds and cots	58,080	60,657
Number of beds and cots per 100,000 population	18.9	19.2

Source: Health Management Information System, Ministry of Health, 2005

Table 2.2 Health facilities and hospital beds and cots by province, 2003-2004

Number of health facilities in Kenya, and number of hospital beds and cots available, by province, Kenya SPA 2004

	Number of institutions								Hospital beds & cots			
	2003				2004				2003		2004	
Province	Hospitals	Health centres	Dispen-saries	Total	Hospitals	Health centres	Dispen-saries	Total	Number of beds/cots	Number per 100,000 population	Number of beds/cots	Number per 100,000 population
Nairobi	58	54	381	493	71	61	395	527	5,528	21.6	5,528	20.1
Central	65	89	372	526	69	95	392	556	8,542	22.9	8,543	21.2
Nyanza	64	42	334	440	72	37	344	453	8,871	31.4	8,871	30.3
N/Eastern	65	80	692	837	64	79	695	838	8,261	15.4	8,261	16.1
R/Valley	8	12	68	88	13	14	74	101	1.954	14.2	1,954	13.6
Eastern	98	117	333	548	102	118	336	556	12,871	23.2	12,871	26.3
Western	100	161	1006	1267	98	196	1080	1,374	12,832	16.5	12,951	15.4
Coast	68	94	196	358	73	91	198	362	6,992	19.4	6,992	18.0
Total	526	649	3,382	4,557	562	691	3,514	4,767	65,851	19.5	65,971	18.1

Source: Health Management Information System, Ministry of Health, 2005

2.3.1 Dispensaries

The dispensaries are at the lowest level of the public health system and are the first point of contact with patients. They are staffed by enrolled nurses, public health technicians, and dressers (medical assistants). The enrolled nurses provide antenatal care and treatment for simple medical problems during pregnancy such as anaemia, and occasionally conduct normal deliveries. Enrolled nurses also provide basic outpatient curative care.

2.3.2 Health Centres

Health centres are staffed by midwives or nurses, clinical officers, and occasionally by doctors. They provide a wider range of services, such as basic curative and preventive services for adults and children, as well as reproductive health services. They also provide minor surgical services such as incision and drainage. They augment their service coverage with outreach services, and refer severe and complicated conditions to the appropriate level, such as the district hospital.

2.3.3 District Hospitals

District hospitals are the facilities for clinical care at the district level. They are the first referral hospital and form an integral part of the district health system.

A district hospital should provide the following:

- Curative and preventive care and promotion of health of the people in the district;
- Quality clinical care by a more skilled and competent staff than those of the health centres and dispensaries;
- Treatment techniques such as surgery not available at health centres;
- Laboratory and other diagnostic techniques appropriate to the medical, surgical, and outpatient activities of the district hospital;
- Inpatient care until the patient can go home or back to the health centre;
- Training and technical supervision to health centres, as well as resource centre for health centres at each district hospital;
- Twenty-four hour services;
- The following clinical services:
  - Obstetrics and gynaecology;
  - Child health;
  - Medicine;
  - Surgery, including anaesthesia;
- Accident and emergency services;
- Non-clinical support services;
- Referral services;
- Contribution to the district-wide information generation, collection planning, implementation and evaluation of health service programmes.

2.3.4 Provincial Hospitals

Provincial hospitals form a secondary level of health care for their location. They provide services to a geographically well-defined area. Provincial hospitals are an integral part of the provincial health system. They provide specialized care, involving skills and competence not available at district hospitals, which makes them the next level of referral after district hospitals. Their personnel include medical professionals, such as general surgeons, general medical physicians, paediatricians, general and specialized nurses, midwives, and public health staff.

Provincial hospitals should provide clinical services in the following disciplines:

- Medicine;
- General surgery and anaesthesia;
- Paediatrics;
- Obstetrics and gynaecology;

- Dental services;
- Psychiatry;
- Accident and emergency services;
- Ear, nose and throat;
- Ophthalmology;
- Dermatology;
- ICU (intensive care unit) and HDU (high dependency unit) services.

They should also provide the following services:

- Laboratory and diagnostic techniques for referrals from the lower levels of the health care system;
- Teaching and training for health care personnel such as nurses and medical officer interns;
- Supervision and monitoring of district hospital activities;
- Technical support to district hospitals such as specific outreach services.

2.3.5 Teaching and Referral Hospitals

Moi Referral and Teaching Hospital and Kenyatta Hospital are the referral and teaching hospitals in Kenya. They are centres of excellence and provide complex health care requiring more complex technology and highly skilled personnel. They have a high concentration of resources and are relatively expensive to run. They also support the training of health workers at both pre-service and in-service levels.

Teaching and referral hospitals have the following functions:

Health care. Referral hospitals provide complex curative tertiary care. They also provide preventive care and participate in public health programmes for the local community and the total primary health care system. Referrals from the districts and provinces are ultimately received and managed at the referral hospitals. The referral hospitals have a specific role in providing information on various health problems and diseases. They provide extra-mural treatment alternatives to hospitalisation, such as day surgery, home care, home hospitalisation and outreach services.

Quality of care. Teaching hospitals should provide leadership in setting high clinical standards and treatment protocols. The best quality of care in the country should be found at teaching and referral hospitals.

Access to care. Patients may only have access to tertiary care through a well-developed referral system.

Research. With their concentration of resources and personnel, teaching and referral hospitals contribute in providing solutions to local and national health problems through research, as well as contributing to policy formulation.

Teaching and training. Teaching is one of the primary functions of these hospitals. They provide both basic and post-graduate training for health professionals.

2.3.6 Private Maternity and Nursing Homes

Private maternity homes fall under the governance of the Kenya Registered Midwives Association (KRMA). Some maternity and nursing homes are run by other health care professionals, such as doctors and clinical officers. Working in close collaboration with the Reproductive Health and Child Health Divisions of the Ministry of Health, they offer reproductive and family planning services. In addition, some child welfare activities are carried out on their premises by health staff of public health facilities.

2.3.7 Private Clinics

These provide mostly curative services and are operated by FBOs, NGOs, nurses/midwives, clinical officers and doctors.

2.3.8 Voluntary Counselling and Testing (VCT) facilities

VCT facilities provide HIV/AIDS counselling and testing services. They may be managed by the government, NGOs, FBOs, or private for-profit enterprises.

2.4 The Second Health Sector Strategic Plan (NHSSP-II): 2005-2010

In a renewed effort to improve health service delivery, the Ministry of Health and stakeholders have reviewed the NHSSP-I service delivery system in order to devise a new strategy for making it more effective and accessible to as many people as possible (MOH, 2004a). The recommended changes are contained in the Second Health Sector Strategic Plan. This plan proposes to improve service delivery by using the following levels of care delivery (see Figure 2.2).

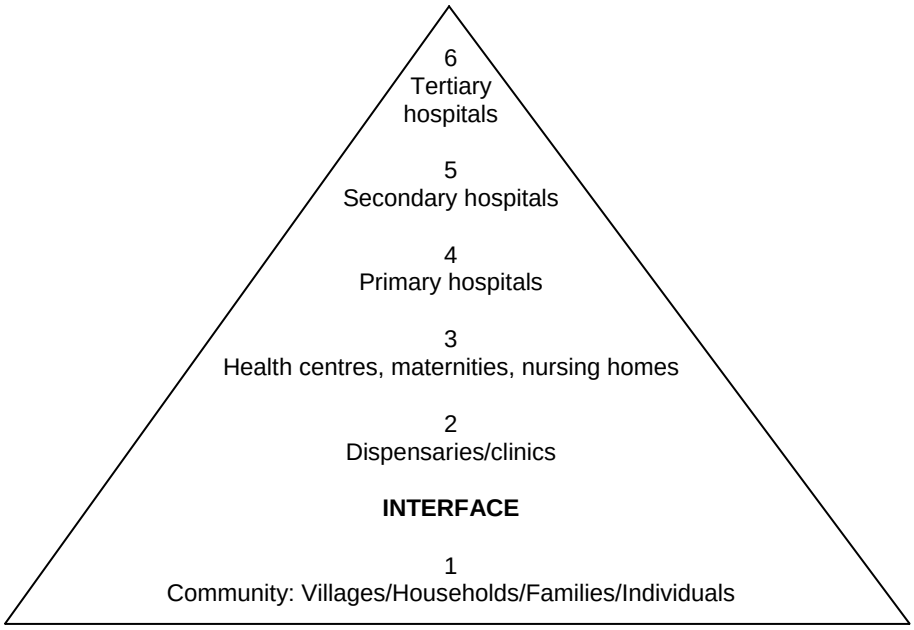
Level 1, the community level, is the foundation of the service delivery priorities. Once the community is allowed to define its own priorities and once services are provided that supports such priorities, real ownership and commitment can be expected. Important gains can be reached to reverse the downward trend in health status at the interface between the health services and the community. Village Health Committees (VHC) will be organised in each community through which households and individuals can participate and contribute to their own health and that of their village.

Levels 2 and 3 (dispensaries, health centres, and maternity/nursing homes) will handle Kenya Essential Package for Health (KEPH) activities related predominantly to promotive and preventive care, but also various curative services.

Levels 4-6 (primary, secondary and tertiary hospitals) will undertake mainly curative and rehabilitative activities of their service delivery package. They will address to a limited extent preventive/promotive care.

In this way, the existing vertical programmes will come together to provide services to the age groups at these various levels. The plan adopts a broader approach—a move from the emphasis on disease burden to the promotion of individual health based on the various stages of the human cycle: pregnancy and the newborn (up to two weeks of age); early childhood (two weeks to five years); late childhood (6-12 years); youth and adolescence (13-24 years); adulthood (25-59); and the elderly (60+ years).

Figure 2.2 Levels of health care delivery in the Kenya Essential Package for Health (KEPH)



2.5 Health Manpower

Table 2.3 presents the number of health providers, both registered and in training, in comparison to the population.

Table 2.3 Number of medical personnel registered and in training, 2003-2004

Number of registered medical personnel and medical personnel in training, by year and type of personnel, Kenya SPA 2004

	Registered medical personnel				Medical personnel in training	
	2003		2004			
Personnel	Number	Number per 100,000 population	Number	Number per 100,000 population	2003/2004	2004/2005
Doctors	4,813	15	5,016	16	1,818	2,177
Dentists	772	3	841	3	141	147
Pharmacists	1,881	6	2,570	8	295	266
Pharmacists and pharmacy technologists	1,405	4	1,620	5	132	142
Bsc. Nursing	-	-	280	1	302	349
Registered nurses	9,869	33	10,210	32	1,281	1,342
Enrolled nurses	30,212	100	30,562	96	3,940	4,015
Clinical officers	4,804	16	4,953	16	406	425
Public health officers	1,216	4	1,314	4	282	296
Public health technicians	5,627	19	5,861	18	289	307
Total	60,509	192	63,227	198	9,086	9,455

Source: Health Management Information System, Ministry of Health, 2005

The total number of registered medical personnel increased slightly (by 4.3 percent) from 60,599 in 2003 to 63,277 in 2004. The number of medical personnel per 100,000 population improved from 192.1 in

2003 to 197.6 in 2004, and the number of medical personnel undergoing training increased by 4.1 percent, from 9,086 in 2003 to 9,455 in 2004.

2.6 Public Health Programmes

The MOH is focusing on a number of health priorities in Kenya, and specific health programmes have been developed to address these priorities.

2.6.1 Reproductive and Child Health

The Ministry of Health has sanctioned the existence and free unfettered operation of the Reproductive Health and Child Health Divisions. The Divisions have provided an annual report based on data from provincial, district, sub-district and rural health facilities.

The components of the reproductive health programmes are as follows (MOH, 1996):

- Safe motherhood, including antenatal, safe delivery, and postnatal care, especially breastfeeding, infant health and women's health;
- Family planning;
- Prevention and treatment of unsafe abortions and post-abortion care;
- Prevention and treatment of reproductive tract infections, including sexually transmitted diseases and HIV/AIDS;
- Prevention and treatment of infertility;
- Management of cancer, including prevention and management of cervical cancers;
- Discouragement of harmful traditional practices that affect the reproductive health of men and women, such as female genital mutilation;
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, preconception care, and sexual health;
- Gender and reproductive rights.

The reproductive health care system, which was designed for adults, is currently being modified to meet the needs of adolescents as well.

The Child Health Division constitutes all child health activities aimed at promoting and maintaining the optimal growth and development of children age 0-18 years. Its specific responsibilities are:

- To ensure survival, growth and development of children age 0-5 years;
- To promote health in all children, pre-school and school-age, including adolescents (up to 18 years), both in and out of school;
- To promote good nutrition to children, expectant and nursing mothers, the sick, and the general population, including elimination of micronutrient deficiencies;
- Promotion of child's rights and child protection.

The following strategies are applied to ensure quality child health:

Early childhood:

- Integrated Management of Childhood Illnesses (IMCI) 0-5 years
- Comprehensive school health programme 6-18 years

Neonatal health care:

- Nutrition programme;
- Promotion of exclusive breastfeeding for six months and timely intervention of complementary feeding;
- Immunisation;
- Growth promotion and nutrition rehabilitation;
- Curative care for minor ailments and injuries;
- Promotion of family/household practices that have greatest impact on child health;
- Child rights promotion.

School health services:

- Screening and examination of school children and food vendors;
- Immunisation and micronutrient supplementation;
- Health education on current public health issues;
- Management of minor ailments and injuries;
- Introduction of life skills and moral values including reproductive health;
- Maintenance of a hygienic school environment;
- School deworming;
- Referrals.

Adolescent health:

- Referrals identification and management of common health problems affecting adolescents;
- Provision of services focused on adolescents, including counselling, information, education and communication (IEC), and reproductive health issues in general;
- Referrals.

2.7 Health Insurance

Table 2.4 shows a breakdown of National Hospital Insurance Fund resources by receipts, benefits and contributions net of benefits for the 1999/2000-2003/2004 financial years. Total receipts rose by 4.6 percent (from Ksh. 2,523.9 million in 2002/2003 to Ksh. 2639.5 million in 2003/2004). Benefits accrued to members, however, dropped by 13.3 percent (from Ksh. 822 million in 2002/2003 to Ksh. 713 million in 2003/2004). Contributions net of benefits continued to rise throughout the five-year period (from Ksh. 1,286 million in 1999/2000 to Ksh. 1,926.2 million in 2003/2004).

Table 2.4 National Hospital Insurance Fund resources, 1999/2000-2003/2004

Kenya National Hospital Insurance Fund resources, including receipts, benefits, and contributions net of benefits, Kenya SPA 2004

Financial year	Receipts (millions)	Benefits (millions)	Contributions net of benefits (millions)
1999/2000	1,694.3	497.9	1,196.4
2000/2001	2,147.7	710.0	1,437.7
2001/2002	2,143.9	591.4	1,552.5
2002/2003	2,523.9	822.0	1,701.9
2003/2004	2,639.5	713.3	1,926.2

Source: MOH, National Hospital Insurance Fund, 2005

2.8 Financing the Health Sector

Adequate resources are critical to sustainable provision of health services. The Kenya policy framework of 1994 identified several methods of health services financing, including taxation, user fees, donor funds, and health insurance. These methods have evolved into important mechanisms for funding health services in the country. They should reflect the cost of service provision as well as the ability of the population to pay. In the non-governmental sector, health services are financed primarily through the revenue collected from fees and insurance premiums charged to service users. These are based on costs of service provision and on ability to pay.

2.8.1 Current Financing Trends, Policies, and Expenditures

Over the past decade, real financing allocations to the public sector have declined or remained constant. Reviews of public expenditures and budgets in Kenya show that total health spending constitutes about 8 percent of the total government expenditure and that recurrent expenditures have been consistently higher than the development expenditures, both in absolute terms, and as a percentage of the GDP. Per capita total health spending stands at about Ksh. 500 (US$6.2), far below the WHO's recommended level of US$34 per capita.

The per capita expenditure falls short of the Government of Kenya's commitment to spend 15 percent of its total budget on health, as agreed in the Abuja Declaration. The under-financing of the health sector has thus reduced its ability to ensure an adequate level of service provision to the population.

The GOK funds the health sector through budgetary allocations to the MOH and related government departments. However, tax revenues are unreliable sources of health finance, because of macroeconomic conditions such as poor growth, national debt, and inflation, which often affect health allocations. A manifestation of the health budget shortfalls is the widespread lack of adequate drugs and pharmaceuticals, staff shortages, and poor maintenance of equipment, transport, and facilities.

Over the past two decades, the GOK has pursued a policy of cost sharing to bridge the gap between actual budgets and the level of resources needed to fund public health sector activities. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. In 2002-03, cost sharing contributed over 8 percent of the recurrent expenditure and about 21 percent of the non-wage recurrent budget of the MOH.

However, because of the worsening poverty situation in the country, the MOH has changed its cost sharing policy and replaced it with a "10/20" policy, in which dispensaries and health centres are not to charge user fees for curative care other than 10 or 20 Ksh for client cards.

In addition, the MOH is planning to introduce in the coming years a National Social Health Insurance Fund (NSHIF). This is a social health insurance scheme to which everyone would contribute without exemption. For administrative purposes, contributions should be per head and not per family, although current entitlements in the National Hospital Insurance Fund also include family members of the insured. For those too poor to pay, the government would pay for them. In its tenth year of phased implementation, the scheme would be targeted to give comprehensive health care to 80 percent of the population. The sources of funding would include payroll harmonisation, general taxation, informed sector contributions, donations and grants. The scheme is outlined in Sessional Paper No. 2 of 2004 (Ministry of Health, 2004c).

The health budget allocation has continued to be skewed in favour of tertiary and secondary care facilities, which absorb 70 percent of health expenditures. Yet primary care units, being the first line of contact with the population, provide the bulk of health services and are cost effective in dealing with the disease conditions prevalent in communities.

Health personnel expenditures are high, compared to expenditures on drugs, pharmaceuticals, and other medical inputs such as medical equipment and supplies. Personnel spending accounts for about 50 percent of the budget, leaving 30 percent for drugs and medical supplies, 11 percent for operations and maintenance (O&M) at the facility level and 10 percent for other recurrent expenses. Expenditures for curative care constitute more than 48 percent of the total MOH budget.

The GOK works closely with development partners to raise money for the health sector. Donor contributions to the health sector have been on the increase, rising from 8 percent of the health budget in 1994-95 to 16 percent in the fiscal 2001-2002. In some years, donor contributions accounted for over 90 percent of the development budget of the MOH.

In summary, the Ministry of Health Public Expenditure Review (Ministry of Health, 2004b) reported that the flow of funding to health facilities, especially at the primary care level, is poor. Leakages amount to 22 percent of the user fee revenue collected. The review advised allocating more resources to community-based facilities, where health resources have been shown to be most effective in dealing with prevailing disease conditions and in promoting and improving people's health.

2.8.2 Ministry of Health Total Expenditures

Budgetary allocations to the MOH between 2000 and 2005 have increased steadily (Ksh. 12 billion in 2000-01 to Ksh. 23 billion in 2004-05). Table 2.5 shows MOH expenditures for both the Recurrent Account and the Development Account. Recurrent expenditures have increased both in absolute terms and as a proportion of total GOK spending and GDP, while development expenditures are somewhat variable, reflecting fluctuations in donor spending (Ministry of Health, 2005b).

Table 2.5 Ministry of Health expenditures

Kenya Ministry of Health expenditures, for the Recurrent and Development Accounts, in Ksh and US$ (millions), by year, Kenya SPA 2004

	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
Recurrent Account	11,041	12,715	14,405	15,438	15,952
Development Account	1,032	2,519	945	1,003	7,659
Total	12,072	15,234	15,351	16,441	23,611
Per capita Ksh	395.49	488.44	481.97	506.05	712.67
Per capita US$	5.05	6.28	6.29	6.52	9.10
MINISTRY OF HEALTH EXPENDITURES AS PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURES					
Recurrent Account	7.67	8.23	8.69	7.76	7.22
Development Account	4.49	17.18	5.12	2.77	8.83
Total	7.23	9.01	8.33	6.99	7.67
MINISTRY OF HEALTH EXPENDITURES AS PERCENTAGE OF GDP					
Recurrent Account	1.32	1.38	1.40	1.41	1.29
Development Account	0.12	0.27	0.09	0.09	0.62
Total	1.44	1.65	1.49	1.51	1.91

Source: MOH, 2005b

2.9 General Recommendations for Future Health Sector Planning (2005-2010)

The overall thrust for future planning in the health sector should be to firmly address the downward spiral of deteriorating health status. The goal should be to reduce health inequalities and to reverse the downward trend in the impact and outcome indicators. These health inequalities exist between urban and rural

populations and between districts and provinces (66 percent of the population of Western Province is below the poverty line, compared with 46 percent in Central Province). They are related to gender, education and disability. The goal to reduce health inequalities can only be achieved effectively by involving the population itself in decisions on priority setting and consequently in the allocation of the resources. This requires a fundamental change in the existing governance structures in order to allow such a community ownership to take place.

Future planning needs to recognize that "reversing the trends" cannot be achieved by the government health sector alone. Active involvement and partnership with other stakeholders in the provision of care is needed. A functioning health system should be established that relies upon collaboration and partnership with all stakeholders whose policies and services have an impact on health outcomes.

The system should give a frame for sector-wide approach arrangement and bring flexibility for rapid disbursement of budgetary resources. A human resource plan will need to be developed to better staff the lower health facilities for effective primary health care. The new plan should strengthen monitory evaluation and reporting system. Additional resources should be dedicated to commodity security, especially for vaccines, reproductive health commodities, and essential drugs.

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

Chapter 3 Facility-Level Infrastructure, Resources, and Systems

Dr. Josephine Kibaru, Christopher Ndayara Omolo, Nzomo Mulatya

This chapter reports on facility-level infrastructure and availability of resources and critical systems to support provision of quality services in health facilities, and access to the general health care system in the country. Although it is feasible to offer health services under a variety of conditions, there are certain infrastructure and health system components that are believed to be necessary for a consistent level of quality and appropriate utilisation of health services.

The chapter is divided into three parts. The first part provides information on whether facilities have the infrastructure and resources to support quality services and appropriate service utilisation. These include the following:

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

The first part of the chapter also reports on facilities' catchment area and staffing pattern.

The second part of the chapter considers management components for supporting quality services and appropriate utilisation of services. These include the following:

- Systems for addressing management issues;
- Staff development activities through supervision and in-service training;
- Community participation;
- Funding mechanisms to decrease financial barriers to utilisation.

Finally, the chapter considers 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 to Support Utilisation of Services and Accessibility

3.1.1 Availability of Services and Human Resources and Accessibility of Health Care System

The availability of basic health services, the frequency with which the services are offered, the presence of qualified staff, and the accessibility of the health care system all contribute to client utilisation of a health facility. Table 3.1 and Figure 3.1 provide details on basic services and staff availability, while Tables 3.1.2 and 3.1.3 provide aggregate information on facility catchment area and staffing patterns. Additional information describing what specific services are available, by type of facility and province, is provided in Appendix Tables A-3.1 and A-3.2.

Availability of Basic Services and Qualified Staff

The Kenya health care service delivery system is comprised of a network of facilities providing both preventive and curative health services. Only some hospitals, health centres, and maternities are expected to

offer the full range of basic services (outpatient services for sick children and for STIs, temporary methods of family planning, antenatal care, immunisation, and child growth monitoring). If a facility does not offer all services, it should not be assumed that the facility is working below standard. It does mean, however, that clients may have to visit several different facilities to meet all of their family's basic health needs.

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, managing authority and province, Kenya SPA 2004

	Percentage of facilities with:				
Background characteristics	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 qualified curative care provider[3]	Number of facilities (weighted)
Type of facility					
Hospital	66	53	50	50	28
Health centre	65	54	34	34	125
Maternity	52	46	42	42	20
Clinic	30	28	6	6	8
Dispensary	55	39	3	3	249
Stand-alone VCT	4	4	4	4	10
Managing authority					
Government	69	58	19	19	246
NGO	66	29	27	27	21
Private (for-profit)	24	19	16	16	63
Faith-based organisation	46	28	9	9	110
Province					
Nairobi	40	39	21	21	41
Central	60	40	12	12	50
Coast	57	45	12	12	49
Eastern	42	37	17	17	83
North Eastern	46	46	13	13	8
Nyanza	84	75	29	29	54
Rift Valley	56	35	11	11	126
Western	64	50	22	22	29
Total	57	44	16	16	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] The basic services consist of outpatient services for sick children and for adult sexually transmitted infections, temporary methods of family planning, antenatal care, immunisation, and child growth monitoring.

[2] The services and defined minimum frequencies are the following: curative care for children offered at least five days per week, STI services offered at least one day per week, and preventive or elective services (any temporary methods of family planning, antenatal care, immunisation, and growth monitoring) offered at least one day per week.

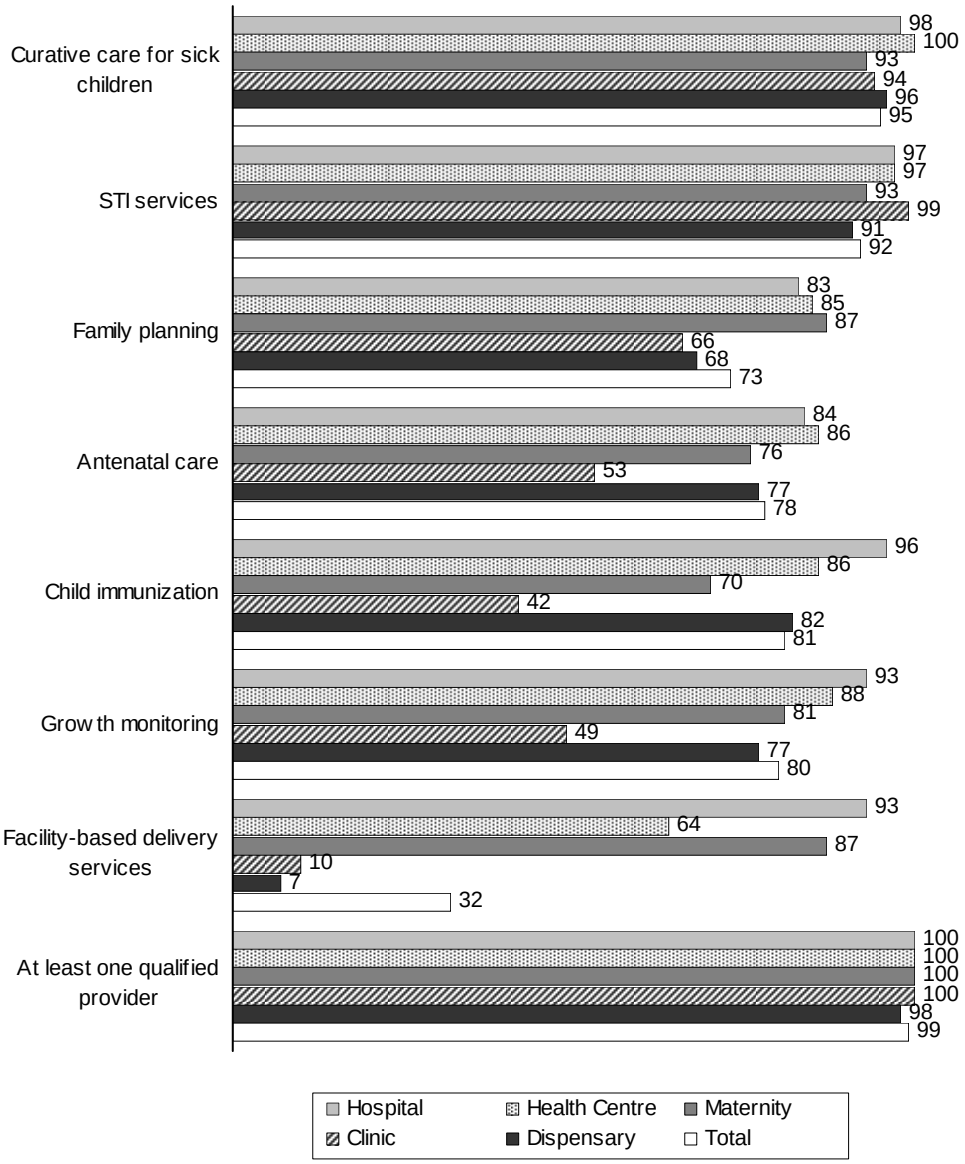
[3] Qualified providers of curative care are enrolled and registered nurses, enrolled and registered midwives, clinical officers and medical doctors.

In general, 57 percent of facilities offer the full range of services, with hospitals (66 percent) and health centres (65 percent) more likely than dispensaries (55 percent) and maternities (52 percent) to provide these services (Table 3.1). Because of their specialized nature, stand-alone VCT facilities are less likely to provide these services. Approximately 4 in 10 facilities offer these services at the KSPA defined minimum frequencies. Hospitals and health centres are more likely to offer the full range of basic services at

the defined minimum frequencies (53 and 54 percent, respectively) than are other types of facilities. Similarly, government-managed facilities (58 percent) and facilities in Nyanza province (75 percent) are more likely to provide services at the defined frequencies. Only 16 percent of facilities offer the full range of basic services at the minimum frequencies, as well as provide 24-hour delivery services, with hospitals and maternities more likely (50 and 42 percent, respectively) than other types of facilities (Table 3.1). This may be a reflection of the current nationwide shortage of specialized health care providers.

The services most widely available are curative care for sick children and STI services. All facilities, however, have at least one qualified provider available (Figure 3.1).

Figure 3.1 Availability of staff to meet basic client needs
(N=440)



Kenya SPA 2004

Services are widely available to meet basic client needs for curative care for sick children and for STI services; other services are less widely available. Facility-based delivery services are available in 32 percent of all facilities (including clinics and dispensaries, which are not expected to offer these services) (Figure 3.1). A considerable proportion of health centres also offer facility-based delivery services. Quite a substantial percentage of dispensaries (23 percent) do not offer growth monitoring and antenatal care services (Figure 3.1).

Catchment Area

Although overall coverage and physical access to health care services seem quite good in Kenya, with almost 80 percent of the population living within 5 kilometres of a facility (KDHS 1993), the KSPA 2004 findings indicate that facilities have the challenge of serving very large populations. The median population in a hospital catchment area is more than 100,000, while dispensaries, which have limited staff, serve a catchment population of around 8,000 (Table 3.1.1). Wide provincial differentials are notable, with facilities in Nairobi province having a catchment population seven times higher than the average catchment population in Eastern and Rift Valley provinces.[1] Government- and FBO-managed facilities also seem to serve much larger catchment populations than facilities managed by other authorities. It is possible that the catchment areas of government and non-government facilities overlap, since government catchment areas are constructed to serve the entire population, whereas non-governmental facilities define their own catchment areas, usually without coordinating with the MOH.

Table 3.1.1 Facility catchment areas

Median population of assigned catchment areas for facilities providing data on a known catchment population, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Median population in catchment area	Number of facilities (weighted)
Type of facility		
Hospital	100,539	17
Health centre	19,898	85
Maternity	7,989	8
Clinic	10,973	3
Dispensary	7,937	174
Stand-alone VCT	150,400	3
Managing authority		
Government	13,001	193
NGO	7,906	14
Private (for-profit)	3,371	30
Faith-based organisation	10,406	53
Province		
Nairobi	55,581	7
Central	8,688	28
Coast	13,514	31
Eastern	7,555	58
North Eastern	13,577	8
Nyanza	20,405	35
Rift Valley	7,428	99
Western	10,977	24
Total	10,578	290

Staffing

Different kinds of health facilities have different staffing patterns. Unsurprisingly, hospitals and higher-level facilities are better staffed, with more qualified staff than lower-level facilities. The findings presented in Tables 3.1.2 and 3.1.3 demonstrate that there are shortages of health professionals in Kenyan facilities. Dispensaries have a median of one enrolled midwife while health centres have a median of one enrolled nurse and one enrolled midwife. Hospitals have a median of three doctors.

[1] These differences reflect population densities as well as resources available. It is up to health planners to ensure that the size and diversity of facilities match the area's population density and geophysical characteristics.

Table 3.1.2 Staffing patterns

Median number of health care providers assigned to facilities, by type of provider and type of facility, Kenya SPA 2004

Type of facility	Median number of providers assigned to each facility[1]										Number of facilities (weighted)
	Total staff	Doctor	Clinical officer	Regis-tered nurse	Regis-tered midwife	Enrolled nurse	Enrolled midwife	Any nursing/ midwife staff	Other technical	Other staff	
National referral hospital	1,570	37	45	17	161	18	258	451	175	843	0
Provincial hospital	396	17	23	33	28	49	180	293	49	15	1
Other hospital	55	3	3	2	3	4	6	21	9	11	27
Health centre	11	-	1	-	-	1	1	5	2	3	125
Maternity	10	1	1	-	-	-	2	4	2	3	20
Clinic	4	-	-	-	-	-	-	2	2	1	8
Dispensary	4	-	-	-	-	-	1	2	-	1	249
Stand-alone VCT	7	-	-	-	-	-	-	-	5	1	10

[1] Numbers were provided by facility administrators

Table 3.1.3 Staffing patterns for KSPA facilities

Median number of lab technicians, pharmacists, and social workers assigned to outpatient services, by type of provider and type of facility, Kenya SPA 2004

Type of facility	Median number of providers assigned to each facility		
	Lab technologist/ technician	Pharmacist/ pharmaceutical technologist	Social worker/ counsellor
National referral hospital	87	27	17
Provincial hospital	21	8	14
Other hospital	4	2	2
Health centre	1	-	-
Maternity	2	-	-
Clinic	1	-	-
Stand-alone VCT	-	-	4

3.1.2 Facility Infrastructure Supportive of Client Utilisation and Quality Services

In theory, quality health services can be provided in the most minimal service delivery setting. However, clients and staff are more likely to be satisfied with the facility if basic comfort amenities and infrastructure components are available, such as a functioning latrine, a comfortable waiting area, and a regular water supply. These components also help staff provide higher-quality services. Table 3.2 provides summary information on these infrastructure elements by facility type and province, and Appendix Tables A-3.3 and A-3.4 provide more details on their availability.

As Table 3.2 indicates, about 9 in 10 facilities have the assessed client comfort amenities, with each assessed element missing in very few facilities (1 to 7 percent) (Appendix Table A-3.3). Twenty-six percent of all facilities have a regular water supply. This varies by the type of facility, from 23 percent in health centres to 47 percent in stand-alone VCT facilities. Almost half of all facilities have regular electricity or a functioning generator with fuel. Hospitals, stand-alone VCT facilities, NGO-managed facilities, and facilities in Nairobi are most likely to have regular electricity or a functioning generator.

Only one-fourth of facilities have all the client comfort amenities and infrastructure elements that the KSPA assessed, including a regular water supply and regular electricity. Stand-alone VCT facilities (40 percent) and NGO-managed facilities (49 percent) were most likely to have all these elements, as were facilities in Nairobi province (48 percent).

Table 3.2 Service and facility infrastructure

Percentage of facilities with the indicated infrastructure elements, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with: All client comfort amenities[1]	Regular water supply[2]	Regular electricity or generator[3]	All basic client amenities, plus regular electric and water supply	Number of facilities (weighted)
Type of facility					
Hospital	86	37	89	34	28
Health centre	90	23	51	18	125
Maternity	91	36	74	36	20
Clinic	88	39	51	35	8
Dispensary	89	24	37	24	249
Stand-alone VCT	88	47	80	40	10
Managing authority					
Government	86	25	43	23	246
NGO	98	49	85	49	21
Private (for-profit)	91	33	65	32	63
Faith-based organisation	94	20	39	19	110
Province					
Nairobi	86	53	75	48	41
Central	98	32	57	32	50
Coast	78	4	41	3	49
Eastern	84	27	52	23	83
North Eastern	79	17	56	15	8
Nyanza	90	7	21	7	54
Rift Valley	93	36	50	35	126
Western	99	9	18	9	29
Total	89	26	47	24	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness
[2] Year-round water supplied in facility, or available within 500 meters of facility
[3] Electricity routinely available during service hours or a backup generator with fuel

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

Twenty-four-hour care can save lives when clients have serious illnesses or maternity complications. Not all types of health facilities are expected to provide 24-hour emergency services. However, because 24-hour care is so important, it is useful to assess all facilities' capacity to provide services 24 hours a day. For purposes of the KSPA 2004, a facility is said to have basic 24-hour emergency services if it offers emergency on-site 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. This means the facility must have at least two qualified providers, a duty schedule indicating staff are on site or on call 24 hours a day, available overnight beds, a patient latrine, 24-hour emergency communication, and an on-site water source at least sometimes during the year.

Table 3.3 provides information on facilities that meet these requirements. It also shows which facilities meet these requirements and have a regular supply of water and electricity. Figure 3.2 presents information on the availability of individual items, for the facilities where 24-hour services might commonly be expected.

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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with: Basic components to support 24-hour emergency services[1]	Basic components to support 24-hour emergency services, plus regular water and electricity[2]	Number of facilities (weighted)
Type of facility			
Hospital	57	34	28
Health centre	20	9	125
Maternity	59	31	20
Clinic	6	1	8
Dispensary	6	5	249
Stand-alone VCT	4	4	10
Managing authority			
Government	11	7	246
NGO	55	39	21
Private (for-profit)	29	14	63
Faith-based organisation	12	4	110
Province			
Nairobi	16	15	41
Central	11	10	50
Coast	18	3	49
Eastern	13	11	83
North Eastern	8	0	8
Nyanza	21	4	54
Rift Valley	17	10	126
Western	21	9	29
Total	16	9	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] At least two qualified providers 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 electricity routinely available during service hours or backup generator with fuel

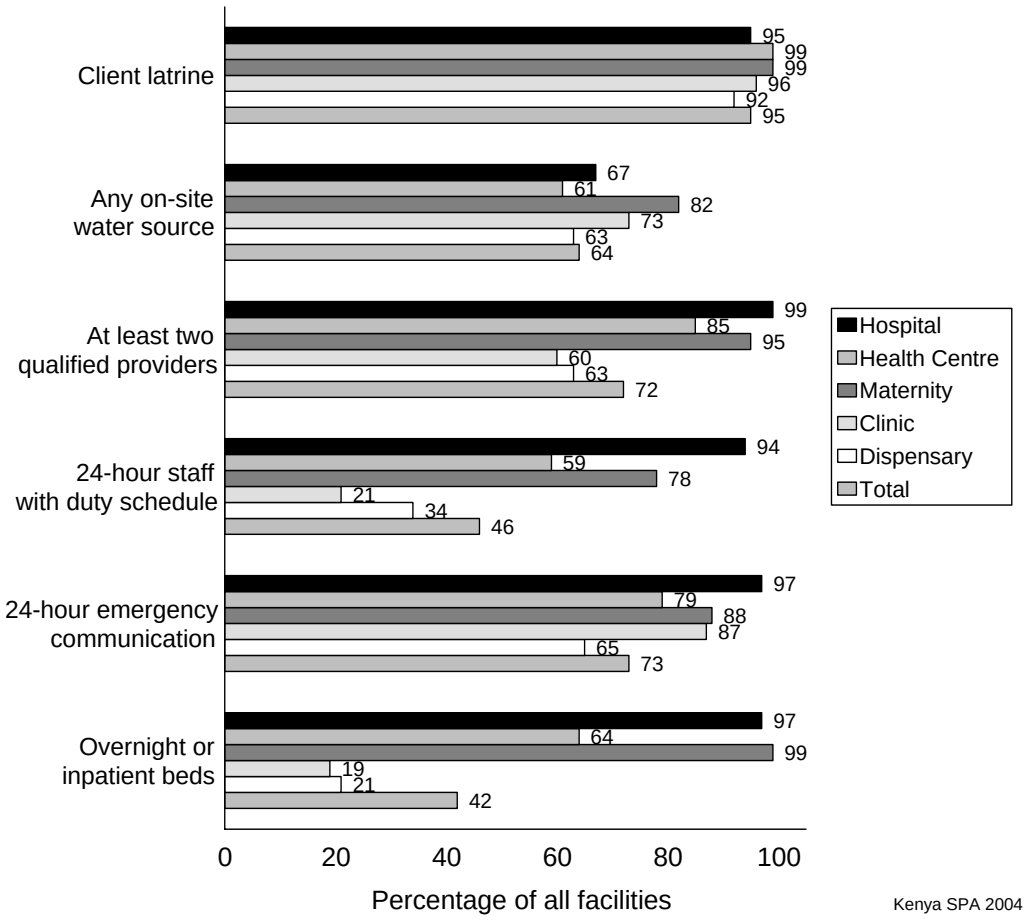
Overall, only 16 percent of facilities have all the basic components to support 24-hour emergency services. This includes clinics, dispensaries, and stand-alone VCT facilities, which are not expected to provide 24-hour emergency services. When clinics, dispensaries and stand-alone VCT facilities are excluded from the analysis, the proportion of facilities having all the assessed basic components for 24-hour emergency services is 57 percent of hospitals, 59 percent of maternities and 20 percent of health centres (Table 3.3). This brings the national average to only 31 percent (table not shown), despite the fact that according

to the Ministry of Health categorisation, all these facility types are expected to be able to offer 24-hour services. Hospitals in particular most often lacked an on-site water source, which kept them from meeting the criteria for quality 24-hour service. Interestingly, although dispensaries, clinics and stand-alone VCT facilities are not expected to offer 24-hour services, some of them do indeed have the needed components (Table 3.3). NGO-managed facilities are the most likely to have all the items needed to support 24-hour emergency services. There are no clear provincial differences, although facilities in North Eastern province were least likely to meet the 24-hour criteria (8 percent).

According to the KSPA definition, a regular source of water (non-seasonal and on site) and a regular supply of electricity (24-hour electricity with minimum interruption, or a generator with fuel available) are not considered essential for providing 24-hour emergency services. However, they are certainly preferable. The basic 24-hour components described above, plus regular water and electricity, are available at only 1 in 10 facilities (Table 3.3). Hospitals and maternities are most likely to have all these infrastructure components (34 and 31 percent, respectively); similarly, NGO-managed facilities are more likely than others to have them. Almost no facilities in North Eastern province have all these components.

The KSPA 2004 defined 24-hour duty staff availability as the facility having some form of observed duty schedule or roster that indicated that staff was officially on duty or on call. Twenty-four-hour staff availability with a written duty schedule is most commonly found in hospitals and maternities (94 and 78 percent, respectively) (Figure 3.2).

Figure 3.2 Availability of items to support quality 24-hour emergency services (N=440)



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More than 90 percent of hospitals and maternities have at least two qualified providers assigned to them (Figure 3.2). A review of the availability of overnight beds shows that essentially only hospitals and maternities are adequately equipped to provide overnight emergency care (Appendix Table A-3.3). It is common for health centres to have qualified providers who live on the premises, with the assumption that they are available to provide 24-hour emergency care to clients, and that arrangements are made with district officials for another qualified provider to be assigned if the regular providers plan to be away for an extended period of time. Among health centres, 76 percent report having qualified providers living on site; 9 percent of these providers have no duty schedule (Table A-3.3). It is not clear whether arrangements are routinely made for emergency staff availability if some of the service providers are out of the facility for a day or an evening. It is, however, notable that 85 percent of health centres have at least two qualified providers to provide 24-hour services (Figure 3.2), although only 20 percent of health centres have the defined basic infrastructure components to support 24-hour emergency services. Approximately three-fourths of all facilities have 24-hour emergency communication, with almost all hospitals and 88 percent of maternities having access to emergency communication.

Key Findings

Basic Services

A full package of basic services is available in 57 percent of health facilities, and is available at the KSPA defined minimum frequency in 44 percent of facilities. This package is most commonly found in hospitals and health centres (53 and 54 percent, respectively)

A full package of maternal, child, STI and reproductive health services, available at the defined minimum frequency, together with 24-hour facility-based delivery services, is available at only 16 percent of all facilities. This includes 50 percent of hospitals, 42 percent of maternities, and 34 percent of health centres.

Facility-based 24-hour delivery services are available in almost all hospitals, in 87 percent of maternities, and in 64 percent of health centres in the country**.**

Infrastructure and Emergency Services

Infrastructure support (all client comfort amenities, water, and electricity) are regularly available in almost a quarter of all facilities.

Approximately two-thirds of all facilities have an on-site water source; however, only a quarter have water available year-round.

Almost half of facilities have a regular supply of electricity or backup generator. This figure rises to 89 percent in hospitals and 80 percent in stand-alone VCT facilities.

Hospitals and maternities are the primary sites where 24-hour emergency service infrastructure support is available (57 and 59 percent, respectively)

At the national level, facilities located in North Eastern province are least likely to have the assessed components to support 24-hour emergency services.

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

Basic management and administrative systems are required to ensure that health services can 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

To function well, a health facility must have a systematic and routine method for addressing management issues. A "facility management system" means an established system for considering management or administrative issues. These may be meetings to discuss scheduling or day-to-day issues, or meetings to discuss broader management aspects such as financing, utilisation, or plans for health-related campaigns. They must, however, be regularly scheduled meetings with specific staff having defined areas of responsibility. The KSPA 2004 sought information for some evidence of functioning management committee meetings held at least every six months, and asked for some official documentation of proceedings. A committee was considered to be functioning if there was a record of meetings with documented decisions and follow-up on issues that are discussed. Service delivery at the district level is managed through the District Health Management Teams (DHMTs).

Overall, about 7 in 10 facilities report having routine management committees that meet at least every six months. This is similar to the KSPA 1999 findings, where 66 percent of facilities reported regular management committee meetings. Almost 4 in 10 facilities said they meet monthly or more often, one-fourth reported that they meet every 2-3 months, and 6 percent said they meet every 4-6 months (Figure 3.3, Appendix Table A-3.5).

Thirty-four percent of facilities meet at least every six months and have documentation of recent meetings (Table 3.4, Figure 3.3). Hospitals (50 percent) and stand-alone VCT facilities (56 percent) are most likely to have both regular meetings and documentation, compared to other types of facilities. Similarly, facilities in Eastern province (59 percent) are more likely than those in other provinces, particularly those in Nairobi and North Eastern provinces (19 and 18 percent, respectively), to have management committee meetings at least every six months and have documentation of the most recent meetings (Table 3.4).

Table 3.4 Management, quality assurance, and referral systems

Percentage of facilities with documentation of the indicated management system element, by type of facility, managing authority and province, Kenya SPA 2004

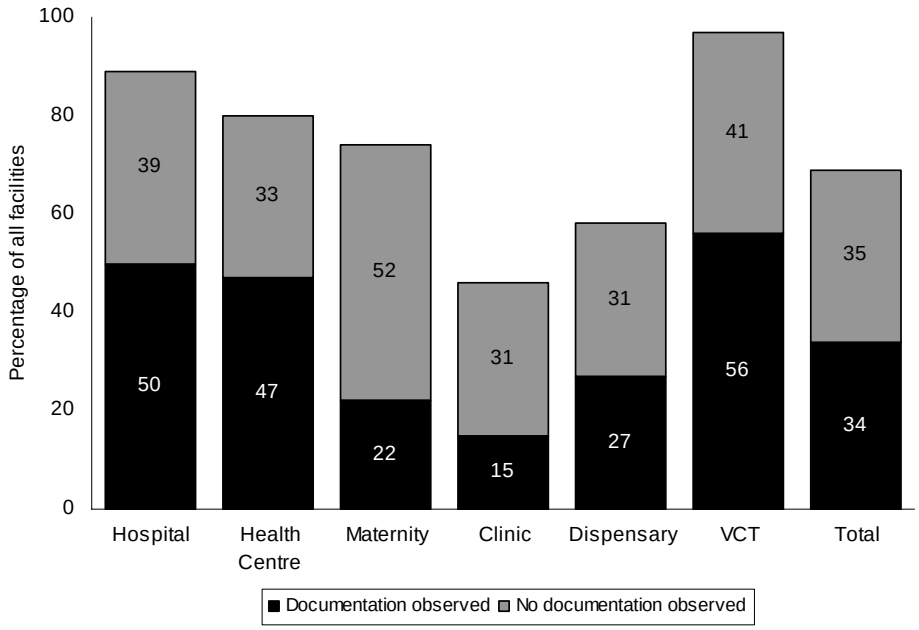
Background characteristics	Percentage of facilities with: Management committee meetings at least every 6 months, and documentation of a recent meeting was observed	Facility reports QA[1] activities and documentation was observed	Referral form observed[2]	Number of facilities (weighted)
Type of facility				
Hospital	50	38	44	28
Health centre	46	35	18	125
Maternity	22	26	12	20
Clinic	15	15	27	8
Dispensary	27	26	11	249
Stand-alone VCT	56	29	61	10
Managing authority				
Government	41	27	10	246
NGO	28	57	35	21
Private (for-profit)	22	27	39	63
Faith-based organisation	27	32	14	110
Province				
Nairobi	19	29	49	41
Central	27	7	16	50
Coast	31	37	13	49
Eastern	59	58	17	83
North Eastern	18	7	1	8
Nyanza	40	16	5	54
Rift Valley	26	25	13	126
Western	30	26	17	29
Total	34	30	16	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] Quality Assurance

[2] If the facility was the referral site, it was classified as having a referral form observed. If the facility routinely sends the client record or file with the client for referral, this is classified as having a referral form observed.

Figure 3.3 Facilities reporting routine management committee meetings (N=440)



Quality Assurance

Quality assurance (QA), which refers to a system for monitoring quality of care, identifying problems, and instituting changes to resolve the identified problems, is very important in the provision of health care. Quality assurance requires an established standard against which quality is measured; there must also be systematic means whereby results are assessed and interventions developed. Activities for quality assurance might include medical record audits, supervisory checklists with client care issues, a supervisor observing consultations, or holding meetings to discuss client care problems or trends in client utilisation data from a health management information system (HMIS).

Table 3.4 and Figures 3.4 and 3.5 provide information on how many facilities reported conducting quality assurance, and which quality assurance activities they reported. The different activities or approaches assessed are as follows:

- **A supervisory checklist for health systems** which looks for the presence of equipment and supplies, completeness of HMIS accounts, and other process indicators.
- **A supervisory checklist for health service provision** which indicates specific content for patient assessment, treatment or consultation. This is often used for observing care provision.
- **Facility-wide review of mortality,** which refers to a structured system for reviewing the care of each client who dies. There will normally be a committee established for this purpose.
- **Medical record/register audit,** which refers to checking medical records for the presence of specific items or information. These may be simply the presence or absence of specific items, or may be more detailed to assess if protocols were followed.

Less than half (46 percent) of health facilities in the country report quality assurance activities; 30 percent have documentation of their QA activities. Hospitals and health centres are more likely to report quality assurance activities (67 and 57 percent, respectively) and also to have documentation of QA activities (38 and 35 percent, respectively) (Figure 3.4). NGO-managed facilities are more likely than others to report

QA activities and have documentation (Table 3.4). As with management committee meetings, facilities in Eastern provinces are more likely than facilities in other provinces (58 percent) to report QA activities and also have documentation.

The most common QA activities are having a supervisory checklist for health system components (61 percent of facilities reporting QA, with 37 percent having documentation) and conducting medical record audits (55 percent, with 33 percent having documentation) (Figure 3.5).

Figure 3.4 Facilities reporting quality assurance activities (N=201)

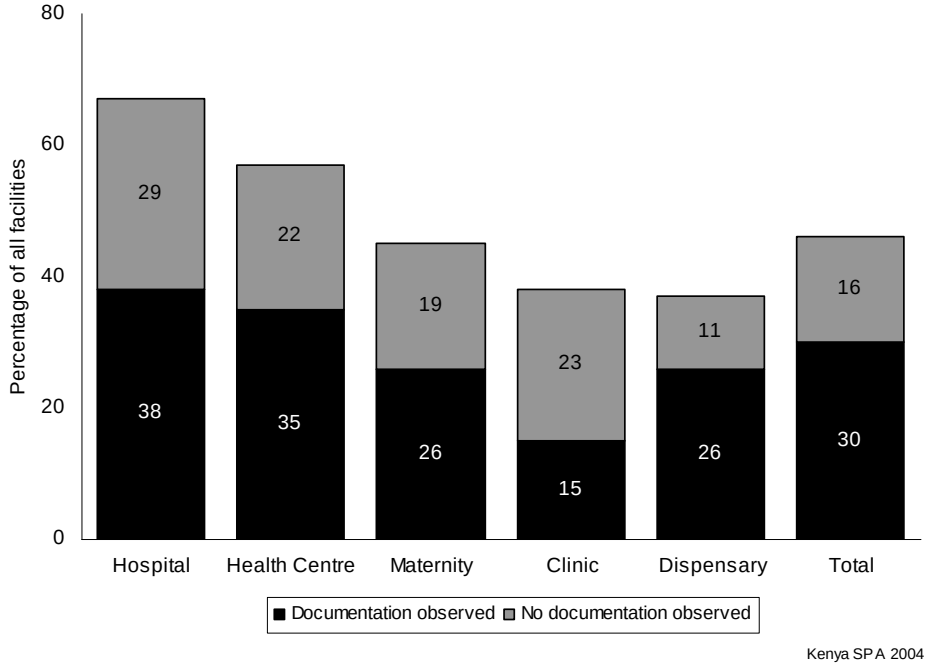
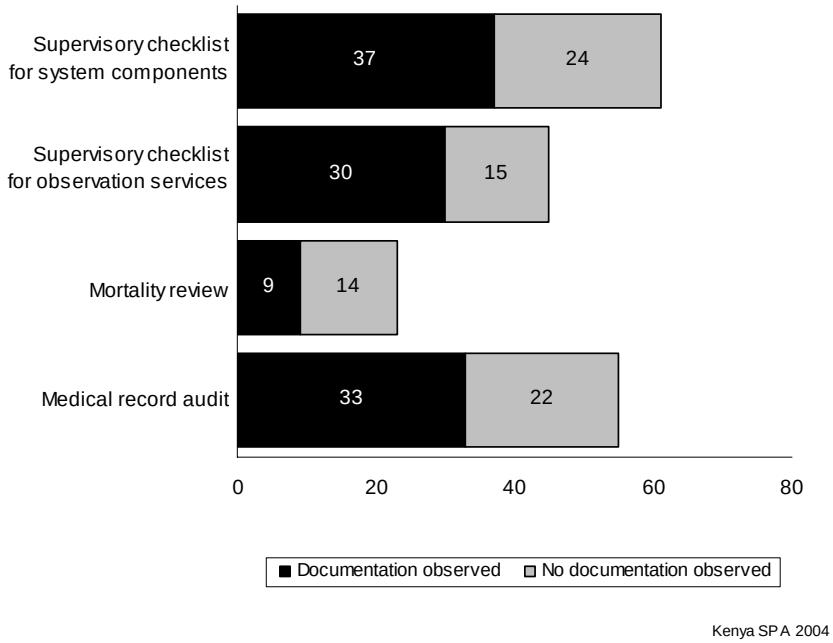


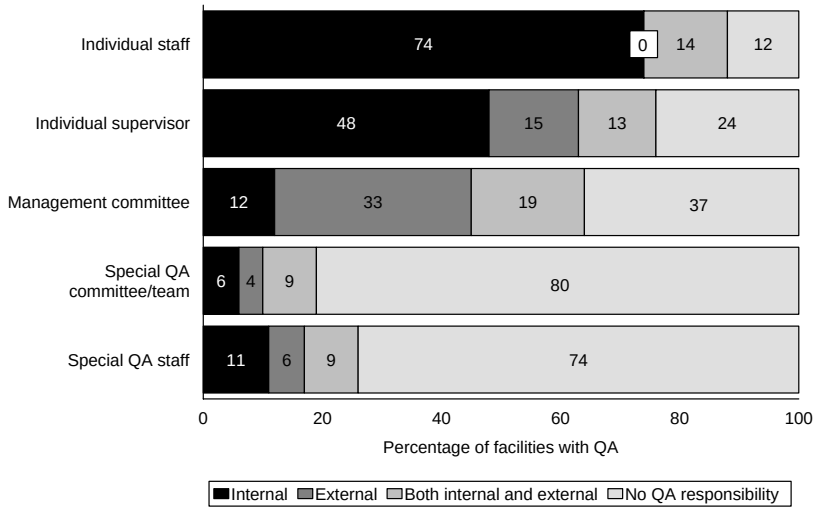
Figure 3.5 Reported quality assurance activities (N=201)



Only 23 percent of facilities reporting QA activities conduct a facility-wide review of mortality. However, among hospitals, where this is most applicable, 63 percent report conducting mortality reviews, with 37 percent having documentation to substantiate this (data not shown). Among maternities, 22 percent report conducting a mortality review, but only 11 percent have supporting documentation.

Among facilities with QA activities, the people reported as responsible for QA included those based inside as well as outside the facility. Figure 3.6 presents data on who implements and reviews facilities' QA activities. When asked about individual staff members, three-fourths of facilities report that QA activities are conducted by individual staff members based within the facility, and 12 percent report that individual staff members have no QA responsibility. When asked about management committees, 12 percent of facilities report that an internal management committee is responsible for QA, while 33 percent have an external management committee that conducts QA activities.

Figure 3.6 Percentage of facilities with indicated person(s) or group(s) responsible for implementation and/or review of QA activities, by whether they are based internal or external to the facility (N=201)



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Referral Systems

When clients are referred to another facility without any formal documentation, they risk being refused services, or having services delayed if the referral facility must assess them as totally new clients. Thus, having a systematic means to refer clients to a higher-level facility is an important aspect of quality of care. If clients are confident that they will be assisted in gaining access to higher-level facilities when needed, they may be less likely to bypass lower-level facilities for their health needs. The KSPA 2004 collected information on whether facilities have any official, printed forms which at minimum document the reason for referral and list any treatment already provided.

Only 16 percent of facilities either have an observed referral form, or are the referral facility (Table 3.4). Hospitals and stand-alone VCT facilities (44 and 61 percent, respectively), 35 percent of NGO-managed and 39 percent of private for-profit facilities have formal client referral forms. At the provincial level, almost half of facilities in Nairobi province have an observed referral form, or are the referral facility. However, in North Eastern province, referral forms are almost non-existent, available in only 1 percent of facilities.

3.2.2 Supportive Management for Providers

The KSPA 2004 collected information on whether facilities have supervisory and staff development activities, which are important for supporting quality care. Summary information on supportive management practices at the facility level is provided in Table 3.5, with further details provided in Appendix Tables A-3.7 and A-3.8.

External Supervision

Supervision from external managers provides an opportunity to ensure that system-wide standards and protocols are followed at the facility level and to promote an "organisational culture" wherein it is expected that these standards and protocols will be implemented. It also provides an opportunity to expose staff to a wider scope of ideas and relevant experiences, including on-job-training (OJT) for some providers. External supervision can also act as a motivator to service providers, especially if the supervisor is supportive. A facility reporting at least one visit by external supervisors during the past six months is defined for KSPA purposes as having routine external supervision. Overall, 87 percent of facilities have routine external supervision, with government- and NGO-managed facilities being more likely (91 percent each) than others to have such supervision. At the provincial level, facilities in Nairobi have the weakest routine external supervision (54 percent), compared with facilities in Western and Nyanza provinces (96 percent each).

In-Service Training

To maintain the levels of knowledge and technical competence they achieved during basic training, health service providers must continually be exposed to current and new information. The KSPA assessed whether health service providers had received any formal or structured in-service training on topics related to the service offered. It is recognized that health service providers may receive new information and individual instruction related to their work during routine supervisory visits, but the KSPA did not assess this type of instruction.

If at least half of the interviewed health service providers at a facility had received any in-service training relevant to their service in the 12 months preceding the survey, the KSPA defines the facility as having routine staff development activities. Overall, three-fourths (76 percent) of facilities satisfied these criteria. Stand-alone VCT facilities and hospitals are more likely than other facility types to conduct routine staff development (91 p and 85 percent, respectively). NGO facilities have slightly more staff development activities (84 percent), and facilities in Nairobi and Coast provinces have a slight edge over facilities in other provinces, each at 83 percent (Table 3.5).

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 had been personally supervised at least once during the past six months, the KSPA defined the facility as providing routine staff supervision. Over 80 percent of facilities met the KSPA criteria for routine staff supervision. Maternities and clinics have the weakest routine staff supervision (60 and 67 percent, respectively). The level of individual supervision is higher in health centres (89 percent). Supervision in NGO facilities is universal and is lowest in private facilities at 65 percent. At the provincial level, facilities in Nairobi and Central provinces are weakest in supervision (72 percent each), compared with Nyanza (95 percent).

The survey results also give details of facilities that conduct regular in-service training in addition to routine staff supervision. Overall, 67 percent of facilities meet both these supportive management criteria.

Table 3.5 Supporting management practices at the facility level

Percentage of facilities that had an external supervisory visit during the past 6 months, and percentage where at least half of the interviewed health service providers received the indicated management support, by type of facility, managing authority and province, Kenya 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 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 in past 6 months and received in-service training past 12 months		
Type of facility						
Hospital	78	85	72	65	54	28
Health centre	87	75	89	67	56	125
Maternity	77	66	60	45	39	20
Clinic	68	70	67	54	47	8
Dispensary	89	75	85	68	63	249
Stand-alone VCT	84	91	85	83	77	10
Managing authority						
Government	91	80	91	73	67	246
NGO	91	84	99	84	75	21
Private (for-profit)	62	66	65	44	24	63
Faith-based organisation	88	70	76	63	61	110
Province						
Nairobi	54	83	72	56	41	41
Central	91	79	72	53	52	50
Coast	86	83	77	70	64	49
Eastern	93	63	86	61	55	83
North Eastern	89	65	80	59	58	8
Nyanza	96	78	95	73	71	54
Rift Valley	85	77	87	74	62	126
Western	96	77	90	74	72	29
Total	87	76	84	67	59	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[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 KSPA (i.e., administrators who might have been interviewed) are excluded.

3.2.3 Management Practices Supporting Community Involvement

Encouraging community input into a facility's functions makes the facility more accountable to the community it serves and helps it understand the community's needs. This in turn results in better health-seeking behaviour, which improves the health of the population.

Community Representation

Overall, 44 percent of facilities have routine community participation in some management meetings (Table 3.6). However, such involvement is minimal in maternities (4 percent). Community participation in management meetings for NGO-managed facilities and in facilities in the North Eastern province is relatively strong (63 and 67 percent, respectively). Only 49 percent of government-managed facilities report community involvement in management meetings, despite the fact that government policy requires every facility to have a management committee or board, for community ownership.

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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities: Where community participation in 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]	Number of facilities (weighted)
Type of facility				
Hospital	37	17	45	28
Health centre	42	10	44	125
Maternity	4	4	6	20
Clinic	15	7	17	8
Dispensary	49	8	49	249
Stand-alone VCT	52	28	65	10
Managing authority				
Government	49	13	50	246
NGO	63	17	66	21
Private (for-profit)	26	4	27	63
Faith-based organisation	39	2	41	110
Province				
Nairobi	28	10	31	41
Central	24	0	25	50
Coast	35	9	43	49
Eastern	48	22	49	83
North Eastern	67	12	67	8
Nyanza	53	7	53	54
Rift Valley	47	7	47	126
Western	65	1	65	29
Total	44	9	45	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[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

The KSPA 2004 also assessed whether facilities have a system for acquiring client opinion and feedback. The findings show that very few facilities—only 9 percent—have such a system (Table 3.6). Twenty-eight percent of stand-alone VCT facilities elicit client opinion and have a system to review it; this is the largest proportion among all types of facilities. Among facilities with different managing authorities, only 2 and 4 percent of faith-based organisation and private for-profit facilities, respectively, elicit client opinion and have a system for reviewing it. Such systems exist in only 1 percent of facilities in Western Province and are non-existent in Central Province.

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

User fees may have either a positive effect on utilisation of health facilities (by increasing the funds available to the facility) or a negative effect (by deterring poor clients from using services). User fees with ex-

emption schemes for vulnerable people often help to augment inadequate facility budgets. However, providing exemptions or discounts for poor clients can result in budget shortages if there is no system for reimbursing these exempted or discounted costs. Other methods that encourage appropriate utilisation by poor clients but that also reimburse facilities for client services include insurance plans, credit plans (delayed payment for services received today), 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 utilisation. In any case, health facilities should clearly display their fees for services, which is a quality of care standard that improves accountability, reduces the likelihood of corruption, and helps the client calculate the costs they will incur in seeking such services.

Health insurance may be provided through an employer or it may be purchased independently. People belonging to health insurance plans may have specific facilities where they receive services. Any services that insured clients receive through the general public sector are usually not covered by the insurance plan, which means that except for the National Health Insurance Fund (NHIF), health insurance is not usually a source of reimbursement for public sector facilities.

Table 3.7 summarizes facilities' funding options. Details on these funding options and components for which facilities charge fees appear in Appendix Tables A-3.9 and A-3.10.

Practices Related to User Fees and Additional Sources of Funding

As of June-July 2004, according to government policy, dispensaries and health centres are not to charge user fees for curative care, apart from clients having to pay for client cards. The KSPA findings, however, do not show that facilities have adopted this new policy. Approximately 9 in 10 facilities routinely have some form of user fees for adult curative services (Table 3.7), and as indicated in Appendix Table A-3.10, about half of all health centres and dispensaries still do charge for client consultations. Overall, half of all facilities with client user fees charge for a client chart or record, while 53 percent charge for consultation. Less than half of NGO-managed facilities report routine user fees for adult curative care. Contrary to expectation, routine user fees for adult curative care are not charged by all private for-profit facilities; only 80 percent routinely charge these fees.

Among facilities charging some form of user fees for adult curative services, 42 percent report that they have an additional source of funding (Appendix Table A-3.9). Hospitals, NGO-managed facilities and facilities in the North Eastern province are most likely to have additional sources of funding outside of routine running budget or direct client fees used in the facility. The source of additional funding is usually the central government and donors (Appendix Table A-3.9).

3.2.5 Maintenance and Repair of Equipment

To provide quality services, a facility must have the means to ensure that facility equipment and infrastructure are 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. For purposes of the KSPA 2004, infrastructure refers to such things as buildings and roads within the facility complex.

Summary information on systems for maintenance and repair or replacement for large and small equipment is provided in Table 3.8. Detailed information on what systems are used and which people are responsible for maintaining facilities' equipment is provided in Appendix Tables A-3.11 and A-3.12.

Some 4 in 10 facilities report preventive maintenance programmes for major equipment such as generators or sterilisers (Table 3.8); among hospitals, the facilities most likely to have major equipment requiring maintenance, 76 percent have such programmes. These systems are also common in NGO-managed

Table 3.7 Facility funding mechanism

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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities: With any routine user fee for adult curative care[1]	With any external source of reimburse-ment for clients	With both user fees and some external source of reimbursement for clients[2]	Number of facilities (weighted)
Type of facility				
Hospital	95	69	64	28
Health centre	92	38	34	125
Maternity	96	27	23	20
Clinic	93	19	18	8
Dispensary	84	42	37	249
Stand-alone VCT	36	69	25	10
Managing authority				
Government	90	42	38	246
NGO	46	55	43	21
Private (for-profit)	80	29	13	63
Faith-based organisation	89	46	46	110
Province				
Nairobi	85	41	36	41
Central	89	40	40	50
Coast	99	4	4	49
Eastern	88	45	34	83
North Eastern	88	66	55	8
Nyanza	93	51	50	54
Rift Valley	74	50	43	126
Western	100	38	38	29
Total	86	42	37	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Includes charges for client cards/charts or record, and for consultations
[2] 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., NGOs) for poor clients.

facilities (81 percent) and in facilities in the Eastern province (75 percent). Among facilities with preventive maintenance programmes for large equipment, 24 percent have on-site staff responsible for the programme, while 67 percent employ external technicians (Appendix Table A-3.11).

With regards to small equipment such as stethoscopes and sphygmomanometers, 87 percent of facilities have systems for repair or replacement. This is widespread among facilities of all types, managing authorities, and provinces. Facilities use different methods for maintaining or replacing small equipment, including on-site repair, sending equipment outside for repair or replacement, and purchasing or paying for new equipment from funds on hand. Thirteen percent of facilities report on-site repair, while 67 percent send equipment outside for repair or replacement.

Less than half of facilities have a system for maintaining and repairing their building or infrastructure (Table 3.8); hospitals (81 percent) are most likely to have such a system. NGO-managed facilities and

private for-profit facilities are also relatively likely to have such a system. There is not much differential at the provincial level, though facilities in Nyanza province are the least likely to have a system for maintenance and repair of building or infrastructure.

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

Percentage of facilities that have a preventive maintenance programme 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, managing authority and province, Kenya SPA 2004

	Percentage of facilities with:			
Background characteristics	Preventative maintenance programme for major equipment[1]	System for repair or replacement of small equipment[2]	System for maintenance and repair of building or infrastructure	Number of facilities (weighted)
Type of facility				
Hospital	76	96	81	28
Health centre	35	93	41	125
Maternity	51	93	57	20
Clinic	26	87	45	8
Dispensary	41	86	35	249
Stand-alone VCT	29	27	50	10
Managing authority				
Government	40	93	38	246
NGO	81	83	76	21
Private (for-profit)	48	90	63	63
Faith-based organisation	34	75	30	110
Province				
Nairobi	38	86	47	41
Central	40	93	36	50
Coast	47	80	41	49
Eastern	75	92	57	83
North Eastern	50	98	50	8
Nyanza	18	93	23	54
Rift Valley	27	86	37	126
Western	52	71	50	29
Total	42	87	41	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Equipment such as a generator or steriliser
[2] Equipment such as stethoscopes or sphygmomanometers

Key Findings

About two-thirds of facilities hold routine management meetings; however, only about one-third have documentation of a recent meeting.

Nationally, only 46 percent of health facilities report quality assurance (QA) activities, and 30 percent have documentation of the QA tools used.

Eighty-seven percent of all facilities report receiving external supervision during the past six months. A notable weakness was in Nairobi province, where only 54 percent of facilities report at least one visit by external supervisors during the six months before the survey.

Formal in-service training for health providers is provided on a routine basis, with three in four facilities having at least half of all providers receive related in-service training during the past 12 months.

Systems for eliciting community input for facility activities are not widespread. Less than half of facilities have routine community participation in management committee meetings, and only 9 percent have any formal means for seeking client feedback.

Seventy-six percent of hospitals have preventive maintenance programmes for major equipment, and 87 percent of facilities have systems for repair or replacement 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, facilities must make sure that the commodities are stored under conditions that protect them from damage, they must have monitoring systems to minimize waste resulting from commodity expiration, and systems must exist to monitor stock and to ensure timely ordering and re-supply of the needed commodities.

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 3.7, and details for the vaccine stock monitoring systems are shown in Figures 3.8 and 3.9. Similar information on storage conditions and stock monitoring systems for contraceptive methods and medicines is provided in Figures 3.10 and 3.11. 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.

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, managing authority and province, Kenya SPA 2004

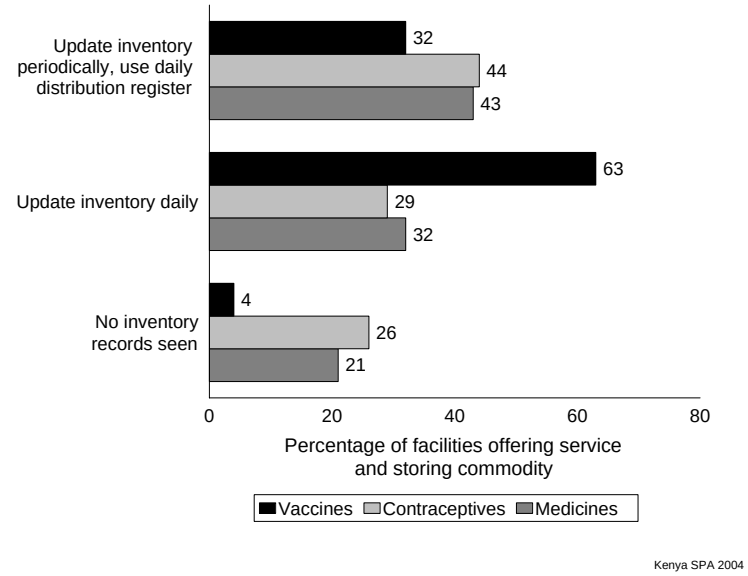
Background characteristics	Percentage of facilities with: Adequate system for monitoring storage temperature[1]	Adequate system for monitoring stock[2]	Number of facilities with stored vaccines observed (weighted)[3]
Type of facility			
Hospital	76	90	25
Health centre	77	70	100
Maternity	70	70	14
Clinic	77	56	3
Dispensary	72	81	178
Managing authority			
Government	74	79	189
Private (for-profit)	56	83	29
Faith-based organisation	80	76	95
Province			
Nairobi	98	49	26
Central	90	98	37
Coast	89	91	35
Eastern	51	84	54
North Eastern	99	87	7
Nyanza	26	63	45
Rift Valley	84	70	88
Western	90	91	27
Total[3]	73	77	320

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[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
[3] Totals include data from six NGO facilities (weighted).

All commodities were assessed to ensure the presence of a valid expiration date on at least one unit. For selected vaccines, contraceptive methods, and medicines, the entire stock was assessed for 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.

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 32 and 44 percent of facilities use daily distribution registers and only update inventory records periodically (as opposed to daily) for vaccines, contraceptives and medicines.

Figure 3.7 Inventory system used for stored commodities: vaccines (N=332), contraceptives (N=298), and medicines (N=429)



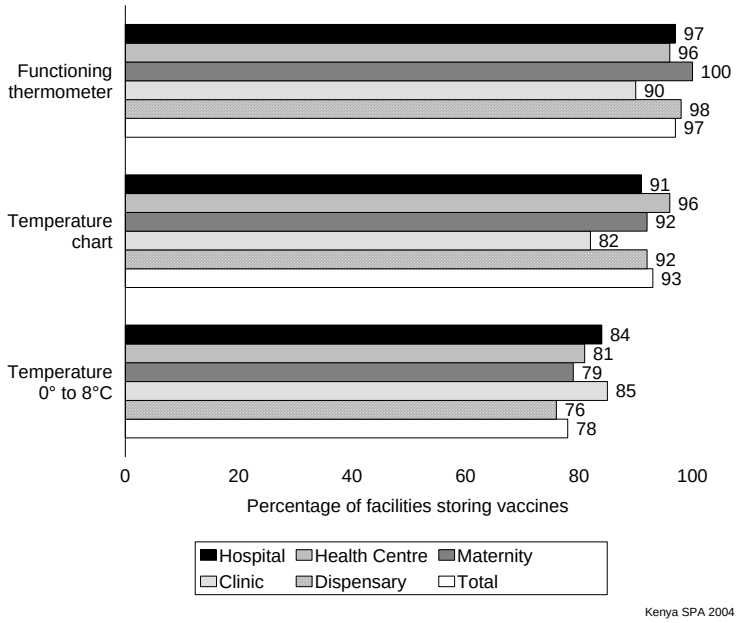
3.3.1 Storage and Stock Monitoring Systems for Vaccines

Vaccines must be stored at an appropriate temperature to maintain potency. WHO and UNICEF policy is to monitor the refrigerator or cold box temperature at least twice daily and to record the temperature on a graph as proof of monitoring (WHO, 1998). To assess facilities' vaccine storage conditions, KSPA observers checked for (1) the presence of a functioning thermometer in the refrigerator, (2) a temperature of 0° to 8°C at the time of the survey, and (3) a completed temperature graph (completed twice a day) for the prior 30 days.

Storage Conditions

Among facilities that routinely store vaccines, 73 percent have all the necessary components for adequate temperature monitoring (Table 3.9). Private for-profit facilities and facilities in Nyanza province have the weakest systems, with only 56 and 26 percent respectively having all the needed items for monitoring storage temperature (Table 3.9). Figure 3.8 gives details for each element that a facility needs for monitoring storage temperature. In general, 97 percent of facilities have a functioning thermometer and 93 percent have a temperature chart, and in 78 percent of facilities, a temperature of 0° to 8°C (the UNICEF recommendation for vaccine storage at the health centre level) was found at the time of the survey. This implies that 22 percent of health facilities do not adhere to the standard requirements for maintaining a proper vaccine storage temperature. Almost all facilities do place the vaccine refrigerator so that it is protected from sunlight (Appendix Table A-3.13).

Figure 3.8 Elements for monitoring vaccine storage conditions (N=320)



Stock Monitoring Systems

Vaccine stock monitoring systems were assessed using the tetanus toxoid (TT); diphtheria, pertussis, and tetanus (DPT); measles; hepatitis B; hepatitis-DPT (Hep-DPT); and measles, mumps, and rubella (MMR) vaccines. Very few facilities have expired vaccines present (Figure 3.9). The practice of storing vaccines by expiration date and maintaining an up-to-date inventory is widespread, with 9 in 10 facilities storing vaccines by expiration date and 86 percent having an up-to-date inventory.

Hospitals are more consistent than other types of facilities (90 percent) in maintaining vaccine monitoring systems (Table 3.9). Among the provinces, Nairobi has the weakest stock monitoring system, with 49 percent having an adequate system (Table 3.9).

3.3.2 Storage and Stock Monitoring Systems for Contraceptive Methods and Medicines

To prevent chemical deterioration and contamination, facilities must store medications and contraceptives away from sunlight, under dry conditions, and in an area protected from rodent or pest infestation.

Storage Conditions

In general, storage conditions for contraceptives are adequate in 92 percent of facilities (Table 3.10 and Figure 3.10) and for medicines in 86 percent of facilities (Table 3.10 and Figure 3.11). Five percent and 10 percent of the facilities do not ensure that contraceptives and medicines, respectively, are off the floor and protected from water (Table A-3.14).

Stock Monitoring Systems

The KSPA assessed stock monitoring practices for selected contraceptive methods (combined oral pill, IUDs, three-month injectables, and condoms) and selected medicines (antibiotics and Ringers lactate

Figure 3.9 Elements for monitoring vaccine stock (N=320)

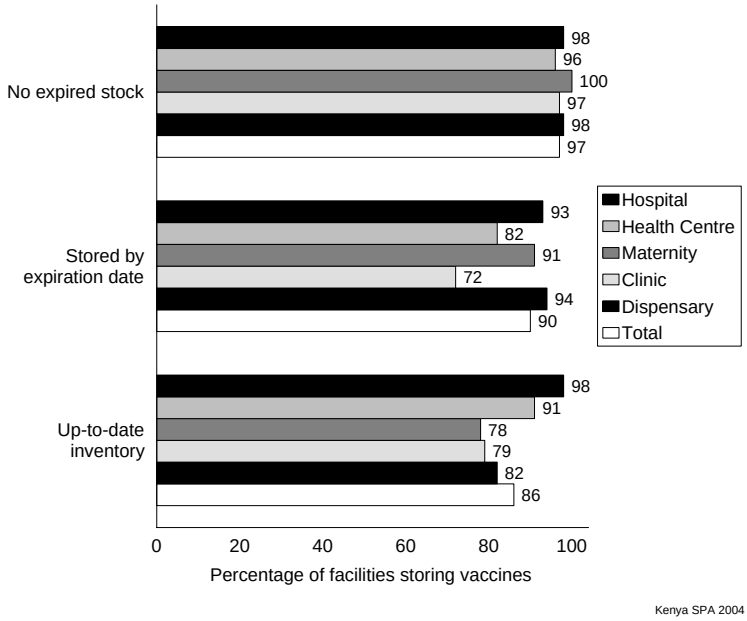


Table 3.10 Storage conditions and stock monitoring systems for contraceptives and medicines

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, managing authority and province, Kenya SPA 2004

Background characteristics	Contraceptive methods			Medicines		
	Percentage with all assessed items for system for storing methods[1]	Percentage with all assessed items for system for monitoring stock[2]	Number of facilities with stored contraceptive methods observed (weighted)	Percentage with all assessed items for system for storing medicines[1]	Percentage with all assessed items for system for monitoring stock[2]	Number of facilities with stored medicines observed (weighted)[3]
Type of facility						
Hospital	89	64	22	91	38	28
Health centre	100	66	103	91	50	125
Maternity	85	39	17	94	31	19
Clinic	92	53	5	89	24	7
Dispensary	88	63	151	83	33	249
Managing authority						
Government	90	66	209	79	46	245
NGO	99	16	14	99	14	16
Private (for-profit)	90	54	36	97	19	59
Faith-based organisation	100	68	39	96	33	109
Province						
Nairobi	99	35	18	91	72	38
Central	99	54	35	90	39	50
Coast	89	87	35	80	24	48
Eastern	83	75	53	78	53	80
North Eastern	89	45	6	67	37	8
Nyanza	87	48	49	89	17	53
Rift Valley	100	64	81	91	25	122
Western	87	60	22	92	67	29
Total[3]	92	62	298	86	38	429

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Items are stored in dry location, off the ground, and protected from water, sun, pests and rodents.
[2] No expired items present, items stored by expiration date and up-to-date inventory available.
[3] Totals include data from one stand-alone VCT centre (weighted).

intravenous solution). While 62 percent of facilities have all the assessed stock monitoring components for contraceptive methods, only 38 percent meet the KSPA criteria for monitoring medicine stocks (Table 3.10). In both cases, maternities and clinics are least likely to meet the KSPA stock monitoring criteria (Table 3.10). Similarly, NGO and private for-profit facilities have weaker stock monitoring systems than the other managing authorities.

One percent of facilities had expired contraceptive methods on the day of the survey (Figure 3.10), and 22 percent had expired medicines (Figure 3.11). All facility types had some expired medicines, but dispensaries and hospitals (25 and 21 percent, respectively) were more likely to have expired medicines than other facility types. More than 80 percent of facilities store their vaccines and contraceptive methods by expiration date (Figure 3.9 and 3.10). Up-to-date inventories are maintained for contraceptive methods in 72 percent of facilities and for medicines in 45 percent of facilities (Figures 3.10 and 3.11).

Figure 3.10 Elements for storing and monitoring stock for contraceptives (N=298)

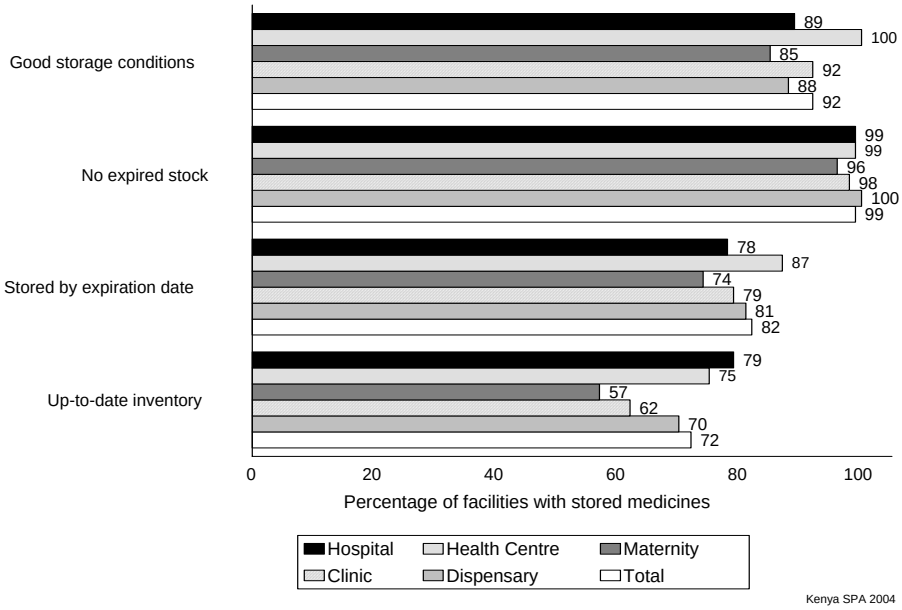
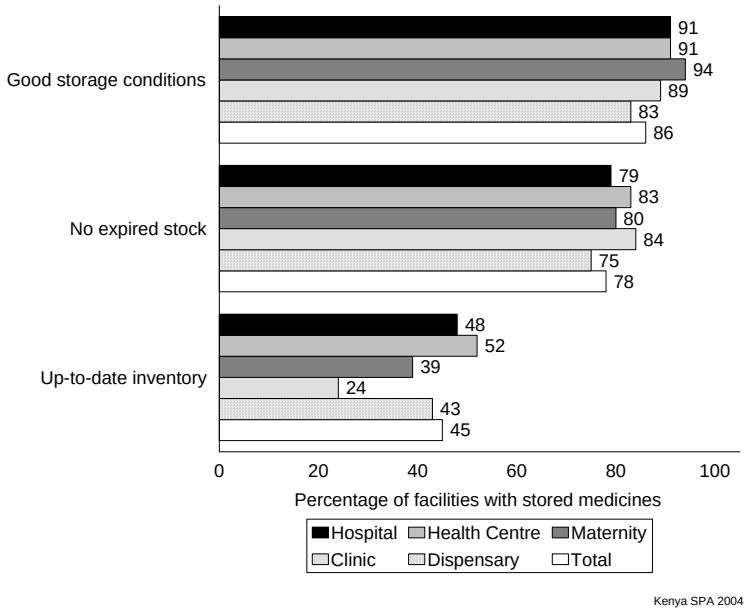


Figure 3.11 Elements for storing and monitoring stock for medicines (N=429)



Key Findings

Three-fourths of facilities that store vaccines have all the necessary components for adequately monitoring storage temperature. This implies that problems in monitoring and maintaining a safe temperature for storing vaccines still exist in all types of facilities. Monitoring and maintenance of cold chain is weakest in private for-profit facilities.

Systems for stock monitoring for vaccines and contraceptives are adequate in 77 and 62 percent, respectively, of all facilities.

Systems for stock monitoring of vaccines are weakest in Nairobi province (49 percent) and strongest in Central province (98 percent). Similarly, the system for stock monitoring of contraceptives is weak in Nairobi province (35 percent) and strong in Coast province (87 percent).

Management of stock for vaccines and contraceptives is relatively good; more than 70 percent of facilities store these commodities by expiration date and maintain an up-to-date inventory. However, maintenance of an up-to-date inventory for medicines is sub-standard (45 percent of all facilities).

About 2 in 10 facilities have expired medicines in stock.

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. These universal precautions should be exercised by all health workers who may come into contact with contaminated fluids, under the assumption that anyone may have an infectious condition (CDC, 1987; JHPIEGO, 2003).

Conditions for infection control were assessed in service delivery areas included in the KSPA 2004. These include conditions under which hand-washing by the health care provider between seeing different

clients, could be reasonably expected, and presence of a secure box in which sharp items such as disposable needles—which may be contaminated with HIV or hepatitis or other blood-borne infections—can be securely disposed.

Summary information on facilities' capacity to process equipment for reuse is presented in Table 3.11, and aggregate information is presented in Table 3.12 on equipment processing capacity and infection control measures available in service delivery areas. Details are presented in Figures 3.12 through 3.14 on the individual elements that the KSPA defined as necessary for processing equipment and maintaining infection control in the service delivery areas. Further details are available in Appendix Tables A-3.22 through A-3.25.

Table 3.11 Capacity for quality processing of equipment for sterilisation or high-level disinfection

Percentage of facilities with the indicated elements to support quality sterilisation/high-level-disinfection (HLD) of equipment, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with: Equipment or appropriate chemical	Equipment and knowledge of process time[1]	Equipment, knowledge of process time, and automatic timer[2]	Written guidelines for sterilisation or HLD present	Number of facilities (weighted)
Type of facility					
Hospital	92	81	61	32	28
Health centre	56	43	22	24	125
Maternity	74	56	26	19	20
Clinic	55	48	14	7	8
Dispensary	59	56	8	4	249
Stand-alone VCT	6	6	4	4	10
Managing authority					
Government	51	42	11	10	246
NGO	74	66	48	12	21
Private (for-profit)	68	56	21	23	63
Faith-based organisation	71	70	19	11	110
Province					
Nairobi	58	45	31	14	41
Central	76	67	6	9	50
Coast	54	46	24	29	49
Eastern	47	41	8	17	83
North Eastern	31	22	6	25	8
Nyanza	67	62	7	8	54
Rift Valley	55	52	15	1	126
Western	94	74	46	26	29
Total	60	52	16	12	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[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 sterilisation: 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 at least 30 minutes, unwrapped items at least 20 minutes
- Boiling or steaming: process at least 10 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 sterilisation or HLD equipment.

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

For syringes and most examination equipment, either sterilisation or high-level disinfection (HLD) procedures are sufficient to prevent the spread of infection. However, to effectively kill the spores that cause illnesses such as tetanus, either dry-heat sterilisation or an autoclave system (or the less frequently used chemical sterilisation[2]) is required. These systems are necessary for processing gloves or surgical equipment that will be reused, including for example blades and scissors used to cut an umbilical cord.

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, that have an adequate disposal system for hazardous waste, and that have infection control guidelines, by type of facility, managing authority and province, Kenya SPA 2004

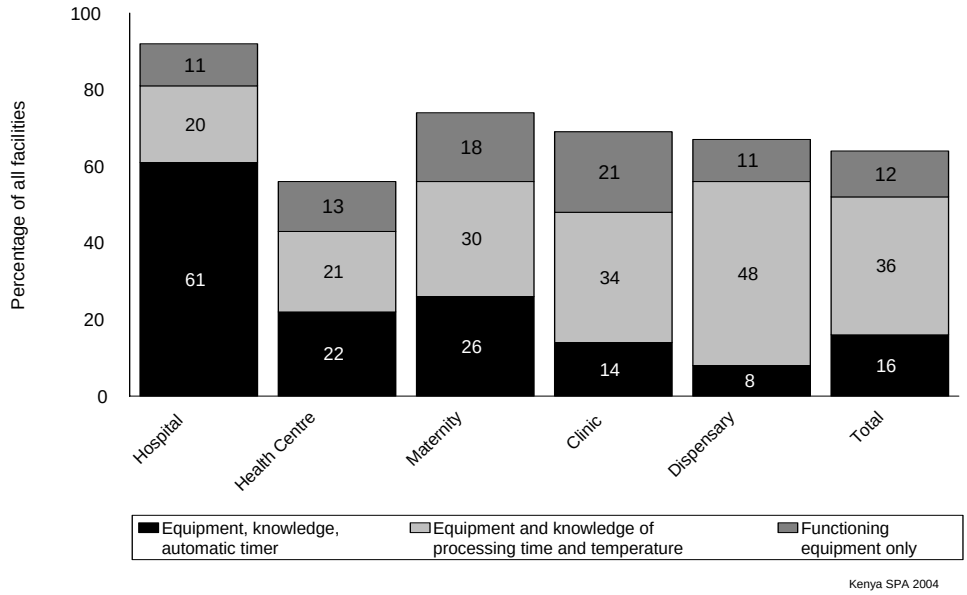
Background characteristics	Percentage with sterile storage conditions and processing dates on sterilised items[1]	Number of facilities with stored processed items (weighted)	Percentage with all items for infection control in service delivery areas[2]	Percentage with adequate waste disposal system[3]	Percentage with guidelines for disinfection and sterilisation in any service area	Number of facilities (weighted)
Type of facility						
Hospital	62	27	2	63	35	28
Health centre	16	105	5	29	24	125
Maternity	31	19	5	60	19	20
Clinic	16	6	23	49	9	8
Dispensary	15	186	22	36	4	249
Stand-alone VCT	45	1	2	54	4	10
Managing authority						
Government	13	186	18	29	10	246
NGO	27	16	2	75	12	21
Private (for-profit)	49	52	12	50	24	63
Faith-based organisation	16	90	10	43	11	110
Province						
Nairobi	66	34	2	64	14	41
Central	9	47	30	18	10	50
Coast	7	33	14	52	29	49
Eastern	9	72	15	58	17	83
North Eastern	14	5	1	43	25	8
Nyanza	15	53	23	26	8	54
Rift Valley	28	72	12	25	1	126
Western	16	29	1	28	26	29
Total	20	344	14	38	12	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Items are wrapped and sealed with time-steam-temperature-sensitive (TST) 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 STI client examination 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.

[2] Formaldehyde or glutaraldehyde (Cydex)

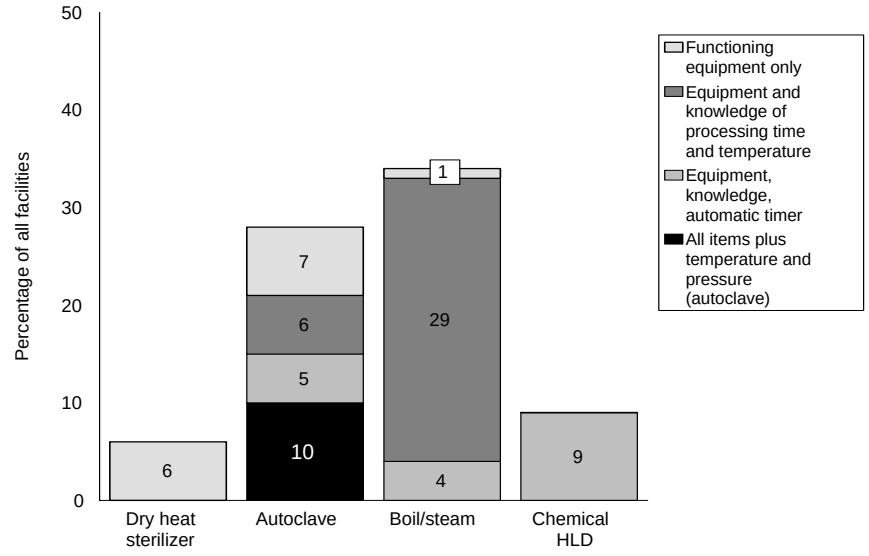
Depending on the size of the facility, different types of equipment may be processed using different methods or in more than one site in the facility. The information presented in this chapter refers to the primary site in the facility where equipment is processed. Sixty percent of facilities have functioning equipment (or chemicals for sterilisation or HLD processing) for the processing method used, and 52 percent have the functional equipment and correct knowledge of the processing time (and temperature, for dry heat sterilisation) for the method used. When an automatic timer is added to the assessment (where applicable), the proportion drops dramatically (to 16 percent). The great majority of hospitals (92 percent) and about three-fourths of health centres have functioning equipment. NGO-managed facilities have a slight edge over other facilities in this area. The availability of functional equipment varies from 31 percent in North Eastern province to 94 percent of facilities in Western province (Figure 3.12 and Table 3.11). Written guidelines for sterilisation/HLD processing (in any service area) were found in only 12 percent of facilities.

Figure 3.12 Capacity to sterilise or HLD process equipment (any process) (N=440)



Among the various methods for processing equipment, boiling/steaming is the most commonly used method and the one for which KSPA observers most often found functioning equipment and knowledge of the correct processing time (33 percent of facilities) (Figure 3.13). However, only 9 percent also had an automatic timer. The next most common processing method is autoclaving; 10 percent of facilities had a functioning autoclave, an automatic timer, and staff who could report the correct processing time, temperature, and pressure for correct utilisation.

Figure 3.13 Facilities with indicated elements for processing equipment using indicated method (N=440)



Note: Facility may have more than one method

Kenya SPA 2004

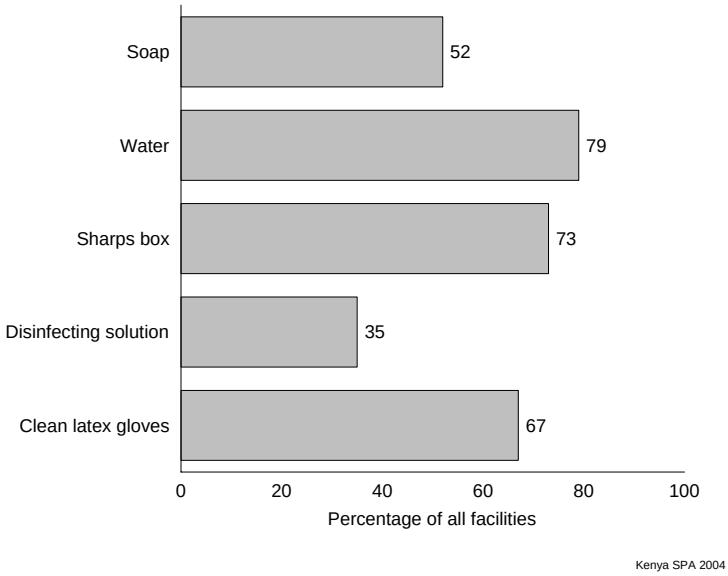
3.4.2 Appropriate Storage Conditions for Processed Items

After sterilising equipment, facilities must be able to store it under sterile conditions. 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 container that can clasp shut; and 3) writing the processing date on the item, because the sterile/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 sterile/HLD status. Among facilities that store processed items, only 20 percent do so under sterile conditions and with processing dates on processed items. Hospitals and facilities in Nairobi (62 and 66 percent, respectively), and private for-profit facilities to some extent (49 percent), are most likely to store processed items under appropriate conditions (Table 3.12).

3.4.3 Infection Control in Service Delivery Area

Nosocomial infections (infections that are contracted from the health facility) are always possible and complicate care giving for any health system. Control measures and constant vigilance are necessary to prevent infections. Only 14 percent of facilities had all relevant infection control items available in all assessed service delivery areas (Table 3.12). Figure 3.14 presents a summary of which specific infection control items were available in all the assessed and relevant service delivery areas in a facility. Soap and clean latex gloves were available in 52 and 67 percent, respectively, of service delivery areas.

Figure 3.14 Availability of specific infection control items in all assessed and relevant service delivery areas in a facility (N=440)



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 (such as bandages, used cotton balls, needles, and 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 disposing 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 systems are provided in Appendix Table A-3.25.

Data collectors were asked to determine which system each facility used, and then to go to the location where waste is stored prior to disposal, or to the disposal site itself, to assess if there were non-processed wastes that were not protected. Only 38 percent (Table 3.12) of the assessed facilities have an adequate waste disposal system. A larger proportion of hospitals, maternities, and stand-alone VCT facilities (63, 60, and 54 percent, respectively) are equipped to handle waste safely. Unfortunately, government-managed facilities are least likely to have an adequate waste disposal system (29 percent); NGO-managed facilities were most likely (75 percent) (Table 3.12). At the provincial level, only one-fourth of all facilities in Rift Valley province have adequate waste disposal systems, compared to 64 percent in Nairobi province.

Key Findings

Sixty percent of facilities have functional equipment for the processing method they use for infection control. However, only 16 percent also have an automatic timer and staff who know the correct processing time.

Boiling/steaming is the most commonly used method for sterilising/disinfecting equipment; facilities are also most likely to have functioning equipment and staff who know the correct processing temperature and time for boiling/steaming.

Among facilities that store sterile or HLD items, only 20 percent store them according to the defined standards.

Only 38 percent of facilities had an adequate disposal system; this percentage varies from 29 percent for health centres to 63 percent for hospitals.

Government-managed facilities are least likely to have an adequate waste disposal system (29 percent); NGO facilities are much more likely to have an adequate system (75 percent).

Only one-fourth of all facilities in Rift Valley province have an adequate waste disposal system, compared with 64 percent in Nairobi province.

Chapter 4 Child Health Services

Dr. Annah Wamae, Dr. Richard Muga, Fred Otieno, Lydia Karimurio

4.1 Background

4.1.1 KSPA Approach to Collecting Child Health Information

The World Health Organisation (WHO) estimates that over 10 million children under 5 years of age die annually from preventable diseases. According to WHO, many sick children who are brought to see a health provider 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 child's health status and acting to prevent further diseases. For this reason, WHO and other agencies developed the Integrated Management of Childhood Illnesses (IMCI) strategy. This 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 immunisation and growth monitoring (for early detection of faltering growth) to prevent or minimize progression to illness.

The IMCI strategy aims to reduce morbidity and mortality among children less than five years of age, through implementation of three components:

1. Improving health workers' skills through training and supportive supervision;
2. Improving health systems to include equipment, supplies, organisation of work, and referral systems, among others;
3. Improving childcare at the community and household level in line with key family practices.

The first component helps first-level health workers assess and appropriately treat the five major childhood illnesses in a holistic approach. Kenya is in the expansion phase of implementation of the IMCI strategy, having started in three districts, Embu, Kajiado, and Vihiga. The programme is currently being rolled out to districts not included in the early implementation phase, as well as to areas not yet covered in the districts already implementing IMCI. At the time of the survey, only 24 out of 71 districts were implementing IMCI at the health facility level, and even then, only in some areas; an estimated 7 percent of all health facilities implement the IMCI strategy. Therefore, most Kenyan health workers are not expected to be using the IMCI approach. However, many of the elements in the IMCI protocol are already part of Kenya's standards and policy on the delivery of child health services. WHO recommends that 60 percent of health workers seeing children under five in health facilities be trained in IMCI case management to ensure a critical mass for quality management of sick children's health.

The utilisation of the IMCI framework in this assessment is expected to provide useful baseline IMCI measures which can be used later to judge progress in implementing the strategy across Kenyan health facilities. Therefore, the IMCI protocol is used whenever possible in looking at the delivery of child health services at the health facility level.

This chapter uses information obtained in the KSPA 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 immunisation 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?

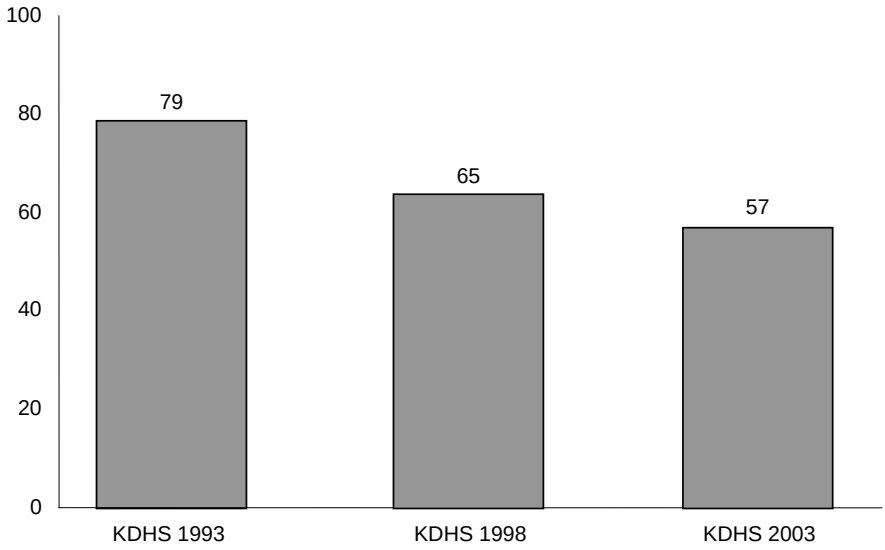
4.1.2 Health Situation of Children in Kenya

Vaccine Coverage

Immunisation against vaccine-preventable diseases is key in reducing child morbidity and mortality levels. The Kenya Expanded Programme of Immunisation (KEPI) under the Ministry of Health is aimed at ensuring that all children are fully immunised by their first birthday. Children should receive one dose of tuberculosis vaccine (BCG); three doses of the vaccine against diphtheria, pertussis, tetanus, Hepatitis B, and Haemophilus influenza b (DPT-HepB-Hib, or pentavalent); three doses of polio vaccine (OPV), and one dose of measles vaccine. However, only 57 percent of children age 12-23 months have received all these immunisations, compared with the KEPI target of 80 percent (KDHS 2003). Moreover, immunisation coverage rates have decreased between 1993 and 2003 (Figure 4.1). Community coverage figures are expected to improve as the country implements the Reach Every District (RED) strategy.

Recent findings show that fewer detected measles cases test positive for the wild measles virus, while rubella cases are on the increase (service statistics). This may be an indication to consider adding mumps and rubella to the measles vaccine (i.e. using the measles-mumps-rubella, or MMR, vaccine) to protect more children. The yellow fever vaccine is indicated in only four districts in the Rift Valley province (Koibatek, Keiyo, Baringo, and Marakwet).

Figure 4.1 Percentage of children age 12-23 months immunised against the eight KEPI target illnesses, Kenya DHS 1993, 1998 and 2003



Nutritional Status and Care Seeking

Malnutrition is an underlying factor in about 70 percent of the illnesses that cause death among children under five. The KDHS 2003 found that about a third of children under five in Kenya are stunted or too short for their age. Specifically, 30 percent were stunted, 11 percent were severely stunted, and 20 percent were underweight. The findings further show that of all children suffering from fever and/or symptoms of acute respiratory infections, 46 percent were taken to health facility/provider for treatment. However, a

significant percentage were not taken for treatment, showing the need to improve on care-seeking behaviour among Kenyan communities.

Childhood Mortality and Morbidity

The 2003 KDHS provides household-based child mortality data, as well as information on what illnesses children experienced and whether they received health care during the two weeks preceding the household survey visit. Key findings include the following:

- The infant mortality rate was estimated at 77 deaths per 1,000 live births in the five years preceding the survey.
- The under-five mortality rate was estimated at 115 deaths per 1,000 live births.
- Forty-six percent of children with reported acute respiratory infections (ARI) and/or fever during the two weeks before the survey were reported by their caretaker to have been seen by a health professional.
- Antibiotics were reported to have been given to 18 percent of children whose caretaker said they had symptoms of cough and short, rapid breathing during the two weeks before the survey.
- Sixteen percent of children under five were reported by their caretaker to have had diarrhoea in the two weeks preceding the survey.
- When asked about providing fluids during the child's diarrhoeal illness, 34 percent of caretakers reported that they had given the child more fluids.
- The recommended treatment for diarrhoeal diseases (other than dysentery, where antibiotics are recommended) is fluid replacement. Twenty-nine percent of children with diarrhoea were reported to have received oral rehydration therapy, either with oral rehydration salts or recommended home solutions. Altogether, some form of oral rehydration therapy was used to treat 51 percent of diarrhoea episodes; 22 percent received syrups or tablets of some sort. A significant proportion of children with diarrhoea were reported to have been treated with medicines bought directly from the pharmacy or with home remedies.
- Fifteen percent of children under five slept under mosquito nets the night before the survey, while only five percent slept under insecticide-treated nets.
- Forty-two percent of children under five years of age were reported as having had fever and/or convulsions in the two weeks preceding the survey. Of those, 27 percent took anti-malarial drugs; however, only 11 percent received antimalarial medicines within one day of symptoms.
- Eleven percent of children under 15 do not live with either of their parents and are therefore considered fostered. Nine percent and four percent had lost their fathers and mothers, respectively, while 2 percent had lost both parents.

4.2 Availability of Child Health Services

Among the essential preventive and curative child health services, the KSPA assessed the availability of outpatient curative care for sick children, routine childhood immunisation services (under the Expanded Programme of Immunisation, or EPI), and routine growth monitoring services. 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]

Health services in Kenyan facilities are relatively integrated; about 8 in 10 facilities offer all three of the above basic child health services. Childhood immunisation is provided in 83 percent of facilities (com-

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

pared with 86 percent in 1999), growth monitoring in 81 percent (compared with 90 percent in 1999), and outpatient curative care for sick children in 97 percent (compared to 88 percent in 1999). Hospitals and FBO-managed facilities are more likely than other facility types to provide all the basic services. Facilities in Nairobi and Eastern province are least likely to offer all these services.

Outpatient curative care is the most commonly provided of the three basic services. It is almost universally available across all types of facilities, managing authorities and provinces, apart from Nairobi province, where a slightly smaller proportion of facilities offer this service for sick children.

Table 4.1 Availability of child health services

Percentage of facilities offering the indicated child health services at the facility, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities that provide: Outpatient care for sick children	Growth monitoring	Childhood immunisation	All basic child health services	Number of facilities (weighted)
Type of facility					
Hospital	98	93	96	92	28
Health centre	100	88	86	83	125
Maternity	93	81	70	66	20
Clinic	94	49	42	37	8
Dispensary	96	77	82	76	249
Managing authority					
Government	97	81	85	79	245
NGO	100	89	89	89	16
Private (for-profit)	94	63	50	49	61
Faith-based organisation	100	92	95	91	109
Province					
Nairobi	88	69	69	66	37
Central	95	79	83	78	50
Coast	100	91	79	79	49
Eastern	95	62	73	56	81
North Eastern	99	89	94	88	8
Nyanza	100	94	94	94	54
Rift Valley	100	85	87	84	124
Western	98	94	94	94	29
Total	97	81	83	78	430

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

Maternities and clinics are least likely to offer childhood immunisation services (70 and 42 percent, respectively); private for-profit facilities and facilities in Nairobi province are also relatively unlikely to provide childhood immunisation. Facilities in Western, Nyanza and North Eastern provinces (94 percent each) are most likely to provide this service. The low proportion of facilities offering immunisation services in Nairobi may be explained by the fact that most facilities in Nairobi are referral facilities; many are also privately owned and do not offer basic routine services.

Routine growth monitoring is offered at similar or slightly lower levels than child immunisation, especially at dispensaries and in the Eastern province. Given the documented levels of malnutrition in the country (KDHS 2003), increasing the availability of growth monitoring services for early identification of nutrition problems and interventions to address the causes of malnutrition should be considered. Moreover, the absence of immunisation services in some health facilities results in unacceptably high missed opportunities for immunisation and vitamin A supplementation.

Key Findings

Eight in ten facilities offer all three basic child health services (outpatient curative care for sick children, immunisations, and growth monitoring). Outpatient curative care for sick children is the most commonly offered child health service (97 percent of facilities), and growth monitoring the least offered service (81 percent). There has been a small decrease in the availability of preventive services for children since 1999.

Childhood immunisation services are least available in Nairobi health facilities (69 percent) compared to Western, Nyanza and North Eastern (94 percent). This is a decline from 1999, when 88 percent of facilities in Nairobi and 100 percent in Western province offered childhood immunisation.

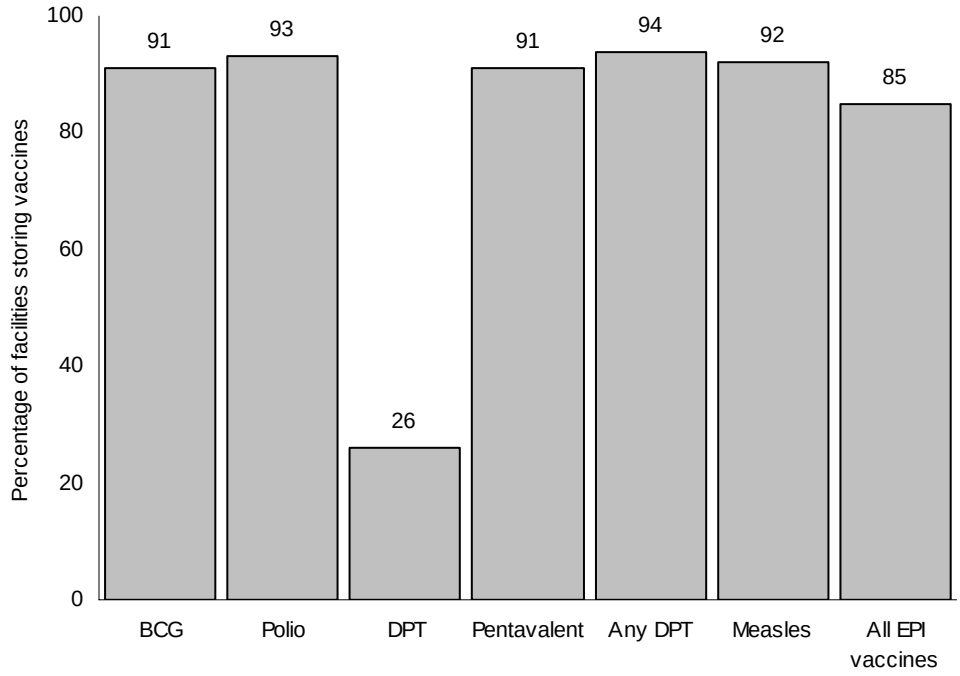
Private for-profit facilities are least likely to offer immunisation services (50 percent), compared with 95 percent of faith-based organisations.

4.3 Capacity to Provide Quality Immunisation Services

The following section addresses elements that are important for quality immunisation services:

- capacity to maintain the quality of vaccines;
- availability of vaccines and vitamin A;
- availability of equipment and supplies for vaccination sessions; and
- availability of administrative components for monitoring immunisation activities.

Figure 4.2 Availability of vaccines among facilities offering child vaccination services and storing vaccines (N=331)



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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 facilities cannot, or do not, 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.

In general, of all facilities with stored vaccines observed, 73 percent have an adequate system for monitoring storage temperature, while 77 percent adequately monitor stocks. Regarding monitoring storage temperature, private for-profit facilities and facilities in Nyanza province (56 and 26 percent, respectively) are least likely to have an adequate system. Just over half of facilities in Nairobi province do not have adequate vaccine stock monitoring systems (Table 3.9).

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 immunisation services). These results are summarized in Figures 4.2 and 4.3. Additional detail on vaccine availability by facility type and province is found in Appendix Table A-4.3.

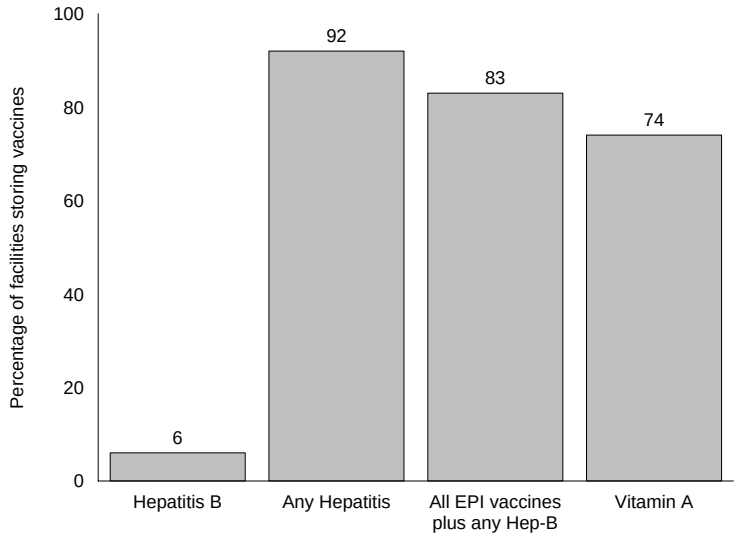
All basic EPI vaccines for the eight major childhood diseases are available in 85 percent of eligible facilities (Figure 4.2, Table A-4.3). The individual vaccines are consistently available in most eligible health facilities (at over 90 percent). Most facilities are replacing DPT only (available in 26 percent of facilities) with the pentavalent vaccine (DPT-HepB-Hib), which is available in 91 percent of facilities.

Forty percent of facilities had all components for providing quality child immunisation, including vaccines, in stock on the day of the survey (Table 4.2). Among the different categories of eligible health facilities, there is notable variation in the percentage that have all vaccines; maternities are highest, at 91 percent, and clinics are lowest, at 77 percent. Each type of vaccine is missing in 6 to 9 percent of facilities (Figure 4.2). Data on availability of the vaccines for the six basic immunisations plus hepatitis B and Hib are similarly available (91 percent of eligible facilities) in Appendix Table A-4.3.

Yellow fever vaccine is indicated in only four districts in Rift Valley province (Baringo, Koibatek, Keiyo and Marakwet) and is therefore not expected to be available in most facilities. Only half of eligible facilities in these four districts actually have the yellow fever vaccine available (data not shown). Availability of hepatitis B vaccine is high (92 percent), as it is a component of the widely available pentavalent vaccine (Figure 4.3).

It is a recommended WHO policy to routinely distribute high-dose vitamin A capsules to children. Vitamin A is essential for the functioning of the immune system and for healthy growth and development. Vitamin A also provides protection from respiratory infections (as well as night blindness); these conditions are more common when children are deficient in vitamin A. Vitamin A supplementation has been added to the EPI programme in many countries. In Kenya, the policy is to provide high-dose vitamin A starting at 6 months of age and then every 6 months up to the age of 5 years. Seventy-four percent of facilities offering sick child services have vitamin A available in the facility (Figure 4.3).[2]

Figure 4.3 Availability of additional child vaccines among facilities offering child vaccination services and storing vaccines (N=331)



4.3.3 Availability of Equipment and Supplies for Vaccination Sessions

Information on the availability of all the components assessed for quality immunisation services is provided in Table 4.2 and Figure 4.4. Details on item availability by facility type are available Appendix Table A-4.4.

[2] Vitamin A was assessed in the pharmacy but not in the child health service delivery area.

Equipment

All equipment for vaccination sessions—blank immunisation cards, syringes and needles, and cold box with ice pack—is available at 81 percent of facilities that offer child immunisation services and store vaccines. Fewer government facilities and facilities in Nyanza have all these basic items (71 percent and 60 percent, respectively) (Table 4.2). Blank immunisation cards were missing in a few facilities but were available in 83 percent of eligible health facilities, while syringes, needles, and cold boxes with ice packs were more readily available (99 and 98 percent, respectively). The availability of cold boxes and ice packs in almost all the facilities offering child immunisation services supports the maintenance of cold chain during transportation and vaccination sessions (Table A-4.4).

Infection Control

Infection control is critical to providing quality care, including immunisation services. Among eligible facilities, 75 percent had all three infection control items (soap, water, and sharps box) (Table 4.2). Hospitals have a slight edge over other facility types in this area. Similarly, facilities in Nairobi and Central provinces were most likely to have all infection control items (92 percent each) and facilities in North Eastern province were the least likely (37 percent). Water and sharps boxes are the most commonly available of the three infection control items, available at 91 percent and 95 percent of facilities, respectively (Appendix Table A-4.4).

Table 4.2 Health system components required for childhood immunisation services

Percentage of facilities offering facility-based child immunisation services that have all equipment, items for infection control, records indicating good administrative practices, and all basic child vaccines, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering child immunisation with:				Number of facilities offering child immunisation services (weighted)[4]	Percentage of facilities offering child immunisation services and storing vaccine with:		Number of facilities offering child immunisation services and storing vaccines (weighted)
	All equipment[1]	All items for infection control[2]	Administrative components[3]	All equipment items for infection control, and administrative components		All basic child vaccines[5]	All components for providing quality child immunisation services (including vaccines) present	
Type of facility								
Hospital	86	79	81	60	27	83	52	25
Health centre	76	72	88	54	107	79	41	107
Maternity	94	69	70	53	14	91	48	14
Clinic	76	72	42	29	3	77	29	3
Dispensary	82	76	72	44	204	89	37	182
Managing authority								
Government	71	70	75	41	208	80	34	200
NGO	88	77	95	60	14	100	11	6
Private (for-profit)	92	83	54	43	30	91	39	29
Faith-based organisation	96	80	85	64	104	93	54	95
Province								
Nairobi	93	92	91	76	25	92	76	25
Central	93	92	52	50	41	68	34	41
Coast	80	71	89	61	39	81	50	35
Eastern	63	70	76	53	59	77	45	59
North Eastern	87	37	87	28	8	92	28	7
Nyanza	60	78	94	44	50	99	48	45
Rift Valley	94	66	66	33	107	91	16	91
Western	79	84	100	68	27	85	62	27
Total	81	75	77	48	356	85	40	331

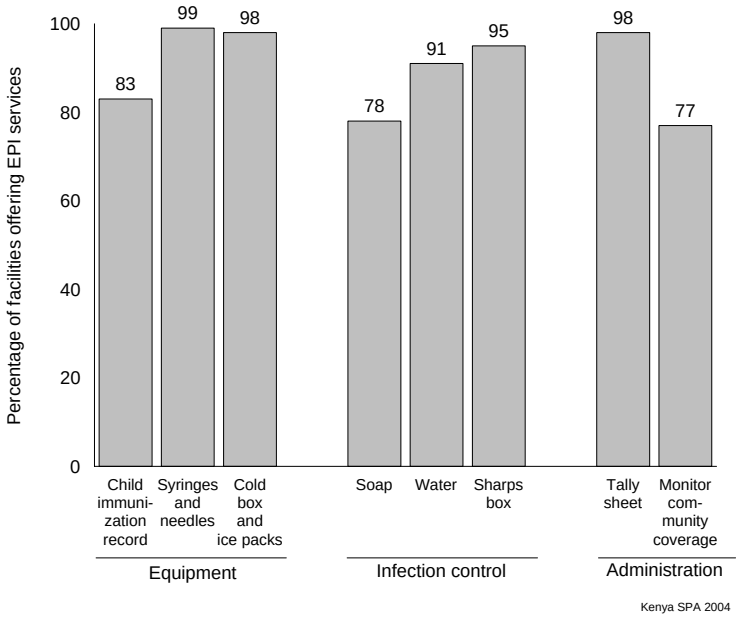
Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Blank immunisation cards, syringes and needles, and cold box with ice packs (or facility reports purchasing ice).
[2] Soap, water (any 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 immunisations at the facility. Some facilities also offer immunisations through village outreach activities.
[5] Basic child vaccines are BCG, any DPT, polio, and measles.

4.3.4 Availability of Administrative Components for Monitoring Immunisation Activities

The KSPA 2004 looked for evidence that facilities were keeping records that could provide information for monitoring immunisation activities.

Measures often used for monitoring immunisation coverage include the DPT dropout rate (the difference between the number of children who receive the first dose of DPT and the number who complete all three doses) and vaccine coverage rates. Measures of immunisation coverage require an estimate of a target population. The KSPA 2004 specifically assessed whether DPT dropout rates or measles coverage information was available. Almost all facilities have registers (or tally sheets) for documenting immunisations provided, whereas a smaller proportion have documentation of monitoring community coverage (either measles coverage or DPT dropout rates) (Appendix Table A-4.4, Figure 4.5). NGO-managed facilities and facilities in Nairobi, Nyanza, and Western provinces have better immunisation monitoring information than other facilities.

Figure 4.4 Availability of equipment and supplies for immunisation services (N=356)



Key Findings

Eighty-three percent of facilities offering child immunisation services and storing vaccines have all basic (EPI) child vaccines in stock, plus hepatitis B vaccine.

Each type of vaccine is missing from 6-9 percent of facilities.

Use of disposable syringes and needles for immunisation is universal in Kenya.

All items for infection control are available in the immunisation service delivery area in three-fourths of facilities. Soap for hand-washing is the item least often found (78 percent), and five percent of facilities do not have a sharps box in the immunisation area.

Two in five facilities have all the components needed to support quality immunisation services, according to the KSPA definition.

Availability of all KSPA-assessed immunisation items varies among categories of health facilities. All three components for high quality immunisation, equipment, items for infection control, and evidence of record-keeping were found in 60 percent of hospitals, but in only 29 percent of clinics; they were present in 64 percent of FBO facilities, but in only 40 percent of government facilities.

4.4 Capacity to Provide Quality Outpatient Care for Sick Children

To improve the diagnosis of illnesses 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 immunisation status and providing vaccines that are due;
- Assessing nutritional status and counselling caretakers on identified problems;
- Assessing overall health status;
- Ensuring that the child receives the first dose of any prescribed drugs, including antibiotics, at the facility, and leaves the facility with the necessary medications;

- Ensuring that the caretaker knows how to administer the necessary medications or treatments, knows about appropriate foods, and knows how much the child needs both during this sickness and when not sick;
- Ensuring that the caretaker knows signs of when to return the child immediately and for the scheduled follow-up.

The KSPA 2004 assessed 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:

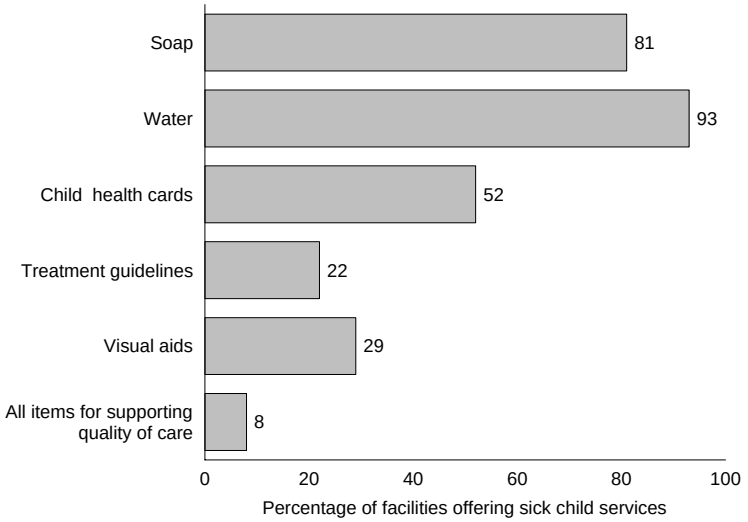
- Infrastructure and resources to support quality assessment and counselling;
- Equipment and supplies for adhering to IMCI guidelines for assessment of the sick child;
- Essential medicines for treating sick children, in adherence to IMCI guidelines;
- IMCI job aids (chart booklet, recording form, and mother's/caretaker's cards).

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

To support quality assessment and counselling, the following should be readily available in areas where sick children receive services: soap and water for infection control, individual child health cards, treatment protocols, and visual aids. Figure 4.5 provides information on the availability of these items, with further details in Appendix Tables A-4.5 and A-4.6.

All of the above items are available in only 8 percent of eligible facilities (Figure 4.5, Appendix Table A-4.5). Treatment guidelines (necessary for quick reference) are available in only 22 percent of the facilities, and hospitals are more likely to have them (33 percent) than other facility types. Individual child health cards or records, important for continuity of care, are available in just over half of facilities; visual aids are available in approximately three in ten facilities.

Figure 4.5 Availability of items to support quality of care for sick children (N=417)



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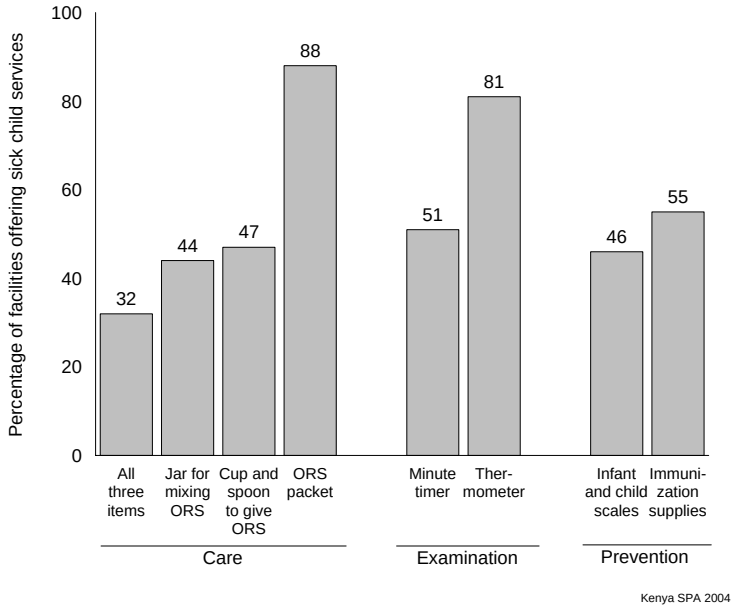
Because the government is promoting IMCI, one might expect items related to IMCI (such as IMCI charts and booklets, IMCI counselling cards for providers, and IMCI caretaker cards) to be widely available in facilities. Surprisingly, only 11 percent of facilities offering curative care for sick children have IMCI charts or booklets, and only 5 percent have IMCI counselling cards for providers and for caretakers (Appendix Table A-4.6).

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

The KSPA also assessed 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 4.6 summarizes information on these items. Appendix Table A-4.5 provides details 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 4.6 Availability of equipment and supplies for assessing health status of the sick child (N=417)



Among facilities offering sick child services, 55 percent had all items for quality immunisation services (basic vaccines, syringes, cold boxes, items for infection control in the EPI service area, and child immunisation cards) (Figure 4.6, Appendix Table A-4.5). This means about half of facilities have the service delivery pattern or the capacity to adhere to the IMCI guidelines of using every contact with the facility to provide needed immunisations. Thirty-four percent of facilities report providing immunisation services every day sick child services are offered; however, 58 percent were actually providing both services on the day of the survey (Appendix Table A-4.7). Differentials by management authority show that government facilities are more likely to offer the two services together (43 percent) than facilities managed by other authorities.

While 72 percent of eligible facilities have a scale appropriate for weighing an infant (100 gram gradation), and 58 percent have a scale appropriate for weighing older children (maximum 250 gram gradation), only 46 percent have both infant and child weighing scales (Figure 4.6, Appendix Table A-4.5).

Items for providing oral rehydration therapy on site are similarly lacking, with only 32 percent of facilities having all three necessary items (a cup and spoon, a jar for mixing, and packets of oral rehydration salts [ORS]). However, ORS packets are available in 88 percent of facilities.

Although a sick child can be assessed with little equipment, certain minimum standards are considered to be necessary for quality care. The KSPA 2004 assessed whether facilities had a thermometer and some type of minute timer for counting respirations. Thermometers are available in 8 in 10 facilities, and facility-provided timers are available in about half of the facilities.

4.4.3 Essential Medicines for Treating Sick Children

The KSPA 2004 also assessed the availability of the essential medicines defined in the IMCI guidelines. Summary information on the availability of medicines for sick children is provided in Figures 4.7 through 4.9 and in Table 4.3. Appendix Table A-4.8 provides details on available medicines by type of facility.

IMCI guidelines have defined first-line, pre-referral, and other important medications for treating the sick child. First-line medicines include packets of oral rehydration salts for diarrhoeal diseases, oral antibiotics such as amoxicillin or cotrimoxazole for respiratory infections, and antimalarial medicines such as SP (fansidar) and amodiaquine.

First-line Medicines

All the first-line medicines (ORS, at least one antimalarial, and at least one antibiotic) are available in 83 percent of facilities, with hospitals, health centres, and dispensaries more likely than others to have all first-line medicines (Appendix Table A-4.8, Figure 4.7). Cotrimoxazole is more widely available as a first-line antibiotic in Kenyan facilities than amoxicillin. Similarly, Fansidar (sulfadoxine-pyrimethamine) is more readily available as a first-line antimalarial than amodiaquine.

Figure 4.7 Availability of first-line medicines for treating sick children (N=417)

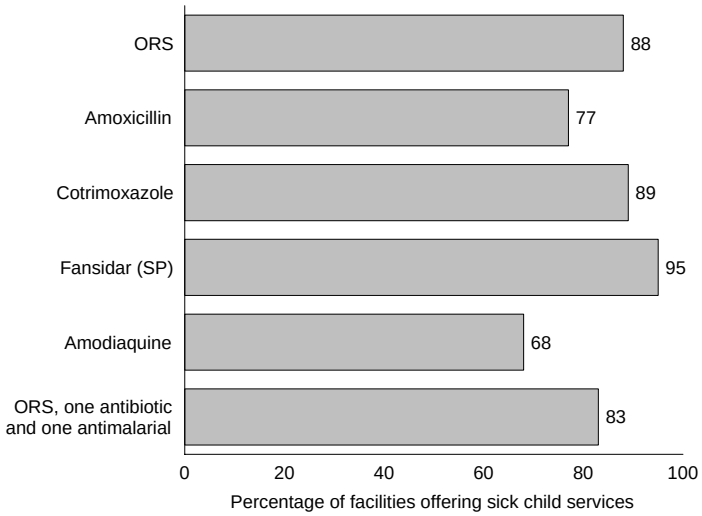


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Table 4.3 Selected essential components to support quality care for sick children

Percentage of facilities that have all indicated items, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with essential medicines: All first-line medicines[1]	All pre-referral medicines[2]	All other medicines[3]	Number of facilities offering SC services (weighted)
Type of facility				
Hospital	89	56	36	28
Health centre	87	29	42	125
Maternity	57	59	28	19
Clinic	54	27	24	7
Dispensary	83	13	29	238
Managing authority				
Government	93	13	29	236
NGO	98	54	25	16
Private (for-profit)	69	45	19	57
Faith-based organisation	66	28	50	108
Province				
Nairobi	97	17	42	32
Central	92	4	23	47
Coast	90	32	49	48
Eastern	76	21	40	76
North Eastern	90	12	58	8
Nyanza	63	26	41	53
Rift Valley	87	21	19	124
Western	75	52	32	28
Total	83	23	33	417

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] ORS, at least one oral antibiotic (amoxicillin or cotrimoxazole) and at least one antimalarial (Fansidar or amodiaquine).
[2] At least one first-line injectable antibiotic (ampicillin or penicillin) and one second-line injectable antibiotic (ceftriaxone or gentamycin), or injectable chloramphenicol, an intravenous solution (normal saline, Ringers lactate, or dextrose and saline 0.9 percent) with perfusion set and injection quinine.
[3] Aspirin, vitamin A, iron tablets, mebendazole, and an antibiotic eye ointment.

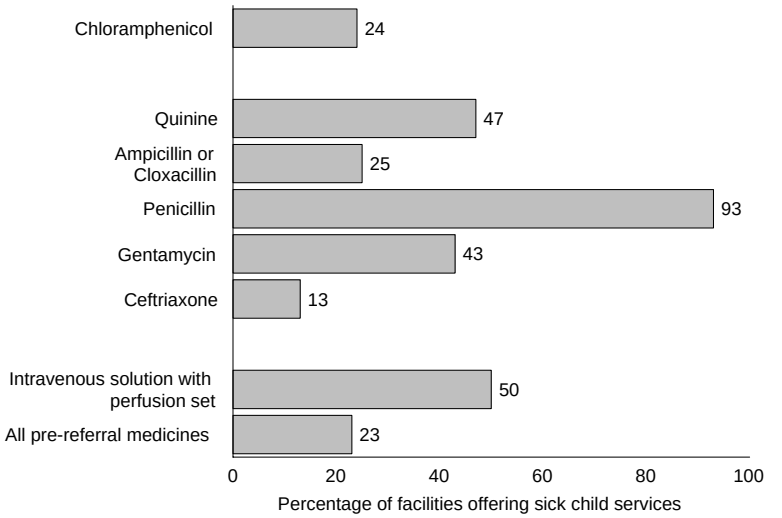
Pre-referral Medicines

Pre-referral medicines are emergency injectable medications and intravenous solution (with perfusion set) for providing urgent treatment and rehydration before admitting the sick child or referring to another facility, if necessary. It should be noted that according to Ministry of Health policies, hospitals, health centres, and dispensaries are authorized to provide rapid rehydration for severely dehydrated children using intravenous solutions if they have facilities and skills.

In Kenya, a facility is defined as having all pre-referral medicines if it satisfies the following criteria: at least one first-line injectable antibiotic (ampicillin or penicillin) and at least one second-line injectable antibiotic (ceftriaxone or gentamycin), or injectable chloramphenicol, injectable quinine, and an intravenous solution (normal saline, Ringers lactate, or dextrose and saline 0.9 percent) with perfusion set. According to the KSPA 2004 findings, less than 3 in 10 facilities offering outpatient care for sick children have all these pre-referral medicines (Figure 4.8, Table 4.3). They are available mostly in hospitals and maternities (56 and 59 percent, respectively). NGO and private for-profit facilities are also more likely

than other facilities to have all pre-referral medicines (54 and 45 percent, respectively), and facilities in Western province are slightly more likely to have them than those in other provinces. Government facilities are the least likely to have all pre-referral medicines for sick children. Chloramphenicol is available in just a quarter of facilities, and quinine is available in less than half of facilities. Penicillin is almost universally available (Figure 4.8). Only half of all eligible facilities have intravenous solutions with perfusion sets.

Figure 4.8 Availability of pre-referral and other emergency treatment medicines (injectables) (N=417)



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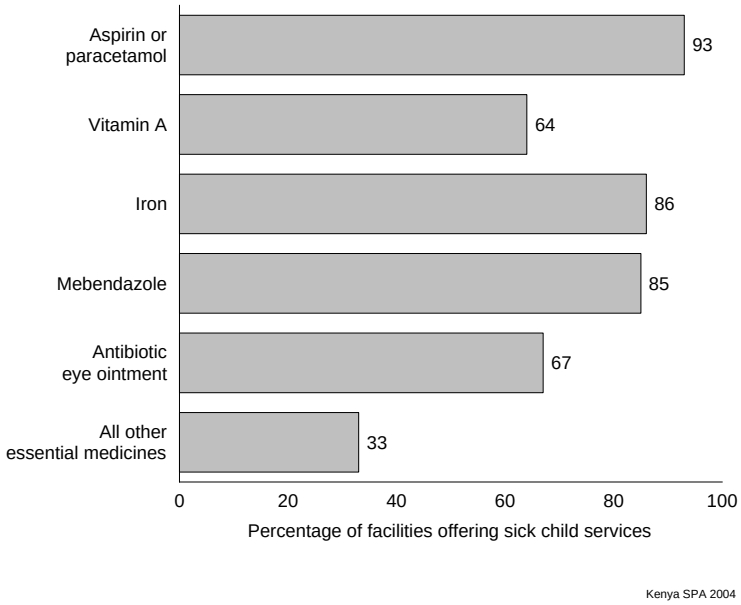
Other Essential Medicines and Vitamin A

In addition to first-line and pre-referral medicines, the KSPA assessed the availability of a few other essential medicines, less critical for treating serious illness, but important for treating common symptoms and illnesses of sick children. These include an antipyretic (paracetamol or aspirin), vitamin A, iron tablets or supplements, de-worming medicines (anthelmintic), and antibiotic eye ointment. All these other essential medicines are available in 33 percent of health facilities (Table 4.3, Figure 4.9). Aspirin or paracetamol is almost universally available, whereas vitamin A was found in two-thirds of facilities.

Figure 4.9 Availability of other essential medicines (N=417)



Key Findings

IMCI treatment guidelines for sick children are available in 22 percent of facilities offering sick child services, while treatment protocols are found in only 1 in 5 facilities

One-third of facilities offer child immunisation services every day that sick child services are offered.

Soap for hand washing is absent in one in five facilities, and visual aids for instructing caretakers are missing from seven in ten facilities.

All first-line treatment medicines are available in 8 out of 10 facilities, but pre-referral medicines are only available in one-third of facilities—mostly NGO-managed facilities, private for-profit facilities, and facilities in Nairobi province.

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 utilisation statistics, and Appendix Tables A-4.10 through A-4.12 provide more details on fees and other payment systems. Figure 4.10 summarizes information on in-service training received by child health service providers, and 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.

4.5.1 Facility Documentation and Records

An up-to-date register is defined as a register that has an entry within the past seven days and that indicates the child's age and diagnosis or symptom. About nine in ten facilities providing outpatient curative care for sick children have an up-to-date register (Table 4.4). Clinics were somewhat less likely to have

up-to-date registers, but otherwise, there is not much variation by facility type. NGO-managed facilities are more likely to have up-to-date registers than facilities under other managing authorities. At the provincial level, facilities in Central province are less likely to have an up-to-date register (76 percent, compared with 98 percent in Western province).

4.5.2 Practices Related to User Fees

In Kenya, the Ministry of Health policy on user fees is to offer free services for all children under five years of age, in order to make these services accessible. User fees may have either a positive effect on utilisation of health facilities (by increasing the funds available to the facility) or a negative effect (by deterring poor clients from using services). In any case, posting of user fees is an element of quality of care, since it increases accountability and makes clients aware of costs associated with services. In spite of the recent policy on free health services for children under five, 4 in 10 facilities charge some form of user fee for sick child services (Table 4.4), including 15 percent of government-managed facilities. Of those that charge any user fees, 14 percent charge for client charts or records, 21 percent charge for actual consultations by resident providers, and 14 percent charge user fees for consultations by consultants (Appendix Table A-4.10). Maternities and clinics, private for-profit and FBO facilities, and facilities in Nairobi are most likely to charge for client consultations. Government facilities are less likely to charge for client consultations than facilities under other managing authorities.

Table 4.4 Management practices supportive of quality child health services

Percentage of facilities with the indicated records, percentage with any user fees for consultation services for the sick child (SC), and percentage where interviewed providers of child health services received the indicated supportive management practice, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Among 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 any user fees for SC services		Received in-service training during the past 12 months[2]	Were personally supervised during past 6 months	
Type of facility						
Hospital	81	58	28	9	70	28
Health centre	84	39	125	12	85	122
Maternity	84	78	19	30	69	19
Clinic	75	92	7	25	68	7
Dispensary	89	37	238	30	87	238
Managing authority						
Government	90	15	236	15	90	236
NGO	98	48	16	4	99	16
Private (for-profit)	83	72	57	31	69	57
Faith-based organisation	79	84	108	39	76	105
Province						
Nairobi	81	68	32	17	72	32
Central	76	38	47	13	77	47
Coast	92	40	48	17	71	48
Eastern	87	54	76	12	87	76
North Eastern	90	17	8	44	80	8
Nyanza	97	58	53	35	94	50
Rift Valley	83	25	124	34	87	124
Western	98	39	28	14	93	28
Total	87	42	417	23	84	414

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Register has entry within past seven days that indicates child's age and diagnosis or symptom.
[2] This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.
[3] Includes only providers of child health services in facilities offering child health services.

4.5.3 Staff Development and Supervision

Staff Development

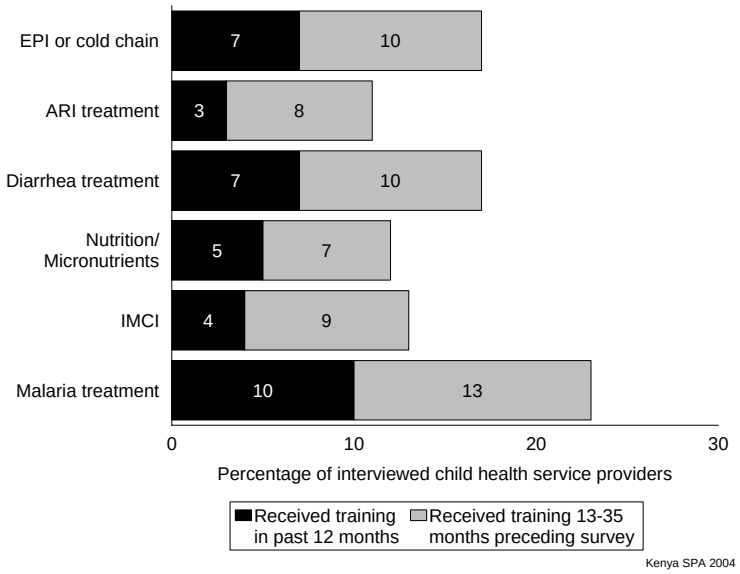
In facilities offering any child health services, whether preventive or curative, child health service providers were interviewed on training received (excluding on-the-job training). If at least half of the interviewed providers at a facility had received any structured in-service training on child health issues in the past 12 months, the facility is considered to be providing routine staff development activities.

Among facilities with interviewed child health service providers, only 23 percent are considered to be providing routine staff development activities, under the KSPA definition. Hospitals and health centres (9 percent and 12 percent, respectively) and NGO-managed and government facilities (4 percent and 15 percent, respectively) provide fewer routine staff development activities than other types of facilities (Table

4.4). At the provincial level, facilities in the North Eastern province stand out, with 44 percent providing routine staff development activities.

Overall, only 15 percent of interviewed child health providers had received structured in-service training in the 12 months preceding the survey (Appendix Table A-4.12). Interestingly, providers in dispensaries (31 percent) and those in the North Eastern province (37 percent) are more likely than others to have received some in-service training. Training was mostly on the treatment of malaria (10 percent of providers), with only 4 percent receiving training related to IMCI in the 12 months preceding the survey, though an additional 9 percent had received this training more than a year before the survey (Figure 4.10, Appendix Table A-4.13).

Figure 4.10 In-service training received by interviewed child health service providers, by topic and timing of most recent education (N=1,410)



Supervision

If at least half of the interviewed child health service providers at a facility had been personally supervised in the past six months, the facility is considered to be providing routine staff supervision. Overall, 84 percent of facilities meet the KSPA criteria for providing routine staff supervision (Table 4.4). A smaller proportion of hospitals, maternities, and clinics meet the criteria (70, 69 and 68 percent, respectively) whereas, contrary to the findings for routine staff development activities, routine staff supervision is strongest and almost universal in government and NGO-managed facilities (90 and 99 percent, respectively), and weaker in private for-profit facilities (69 percent).

On individual supervision, 65 percent of interviewed child health service providers report having been personally supervised in the six months preceding the survey (Appendix Table A-4.12), with staff reporting that they were supervised an average of four times during that period (Appendix Table A-4.14). Although the number of times staff was supervised varies minimally by province, it was highest for providers in Nairobi province (12 times) and lowest in Nyanza and Rift Valley (3 times)

Key Findings

Up-to-date registers for service statistics are found in 87 percent of facilities; almost all facilities in Western province had registers for service statistics.

Structured in-service training related to child health topics is not routinely provided. Only 23 percent of facilities had provided such training in the past 12 months to at least half of their interviewed providers.

Four in ten facilities charge some form of user fees for sick child services. Two in 10 charge for actual consultations by resident providers, and just over 1 in 10 facilities charge for consultations by consultants. Few government facilities charge user fees for consultations.

Only 4 percent of providers have received in-service training related to IMCI during the 12 months preceding the survey.

Routine supervision for child health service providers was reported in 84 percent of facilities, with most providers supervised 4 times during the past 6 months. It was less common in private for-profit facilities (69 percent) and facilities in Coast province (71 percent).

4.6 Adherence to Guidelines for Sick Child Service Provision

To assess whether providers adhere to standards for providing quality service, trained KSPA personnel observed sick child consultations. The observation checklists they used are based on IMCI guidelines.

The observers noted what information the provider shared and whether recommended procedures were carried out. They did not assess whether the information shared was correct, or whether findings were appropriately interpreted. Figures 4.11 through 4.15 show what practices were observed during sick child consultations. Table 4.5 summarizes the providers' assessments, examinations, and subsequent treatments, 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 by interviewed caretakers of observed sick children.

4.6.1 Full Assessment of Illnesses

When there are not enough qualified curative care providers, less qualified persons can be trained to provide EPI and growth monitoring services, as well as initial consultation services for sick children. For curative care, however, this assumes that seriously ill children, with illnesses beyond the training scope of 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. Almost all facilities in Kenya have at least one qualified health provider, as shown in Figure 3.1 (Chapter 3).

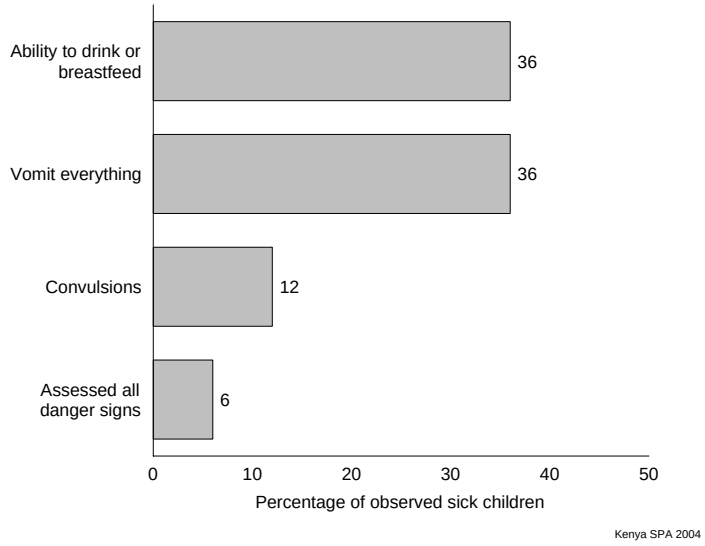
The IMCI programme in Kenya is being expanded and now covers approximately 7 percent of primary health care facilities (Wamae, 2005). The IMCI components for assessing a sick child provide valid guidelines for quality of care, regardless of whether a provider has been trained in the IMCI strategy or not. When interpreting the findings, it is important to recognize that, even when following the IMCI guidelines, providers should use their judgment, based on the child's signs and symptoms.

General Danger Signs

According to the IMCI guidelines, a provider should check for the following general danger signs: whether the child is able to drink or breastfeed, whether the child vomits everything, whether the child

has had convulsions at home or a convulsion is observed in the facility, and whether the child is lethargic or unconscious[3]. If there is any doubt about the child's ability to drink, the provider should attempt to give the child something orally. In general, 36 percent of the children were assessed for whether they could drink or breastfeed (compared with 51 percent in 1999), and 36 percent for whether they vomited everything (compared with 44 percent in 1999) (Appendix Table A-4.15). An additional 12 percent were assessed for convulsions (compared with 24 percent in 1999). Overall, 6 percent of children were assessed for all three danger signs, as compared to 20 percent in 1999. Comparing findings within facility types, it is clear that apart from maternities, where a larger proportion of facilities than in 1999 assessed whether a child vomits everything, every other assessment in all facility types showed a downward trend. These findings suggest a decline in the quality of sick child assessment in the last five years.

Figure 4.11 General danger signs assessed during observed sick child consultations (N=1,378)



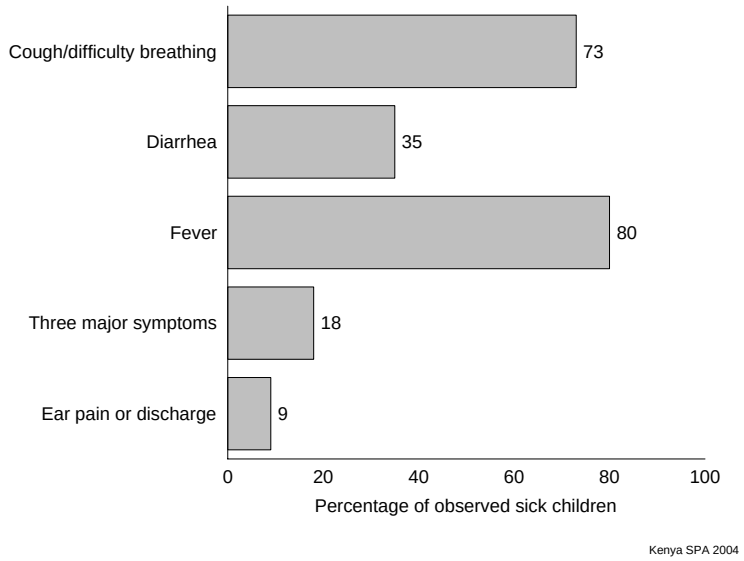
Major Signs and Symptoms

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

Providers checked for all three major symptoms in about 20 percent of consultations (Figure 4.12). Fever was the symptom most commonly assessed; providers checked for fever in 80 percent of consultations, compared to 76 percent in 1999. They checked for respiratory symptoms in 73 percent of consultations, and diarrhoea in 35 percent. Only 9 percent of consultations included an assessment of ear problems, a common childhood illness.

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

Figure 4.12 Major symptoms assessed during observed sick child consultations (N=1,378)



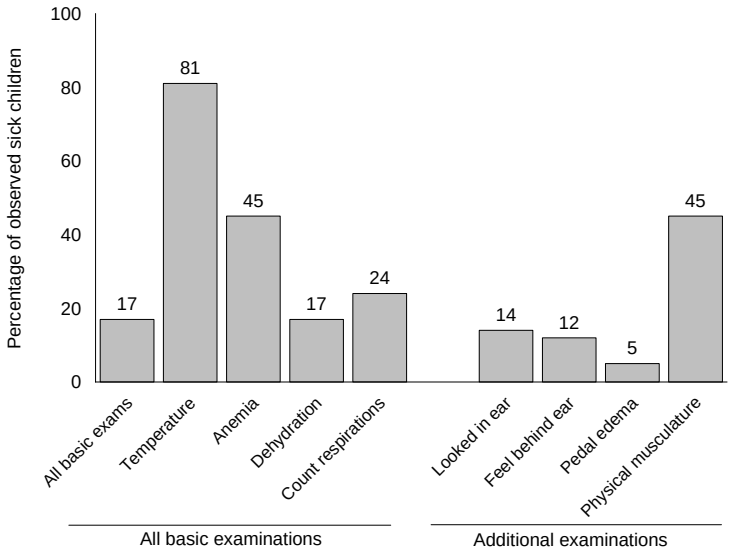
Physical Examination

After obtaining information on the various signs and symptoms of illness, the provider should conduct a physical examination. This should include a hands-on evaluation of the child to 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 anaemia, and to count the rate of respirations if a respiratory problem is suspected.

There has been only minimal improvement in sick child examination practices since 1999, with all the key physical examinations (counting respiratory rate and assessing for fever, dehydration, and anaemia) being conducted during only 17 percent of observed consultations (Figure 4.13, Appendix Table A-4.15). Providers in maternities are more likely to conduct all the recommended examinations than providers in other types of facilities. The most commonly observed examination practice was the assessment of fever (81 percent)(Figure 4.13), observed mostly in consultations in clinics and maternities (91 and 94 percent, respectively). Providers checked for anaemia much more often in 2004 (45 percent of consultations) than they did in 1999 (18 percent) (Appendix Table A-4.15). Anaemia assessment was mostly observed in hospitals (63 percent) and maternities (81 percent). This apparently remarkable improvement may be partially explained by the fact that the 1999 KSPA only considered providers as having checked for anaemia if they examined the palms and nail beds. In 2004, checking the conjunctiva also counted as an anaemia assessment.

Providers checked for dehydration in 17 percent of consultations and counted the child's respiratory rate in 24 percent. They looked inside the ear and felt behind it in 14 percent and 12 percent of consultations, respectively, and they assessed for pedal oedema in 5 percent of consultations (compared with 13 percent in 1999). Providers checked the sick child's muscular and general nutritional and physical status in 45 percent of consultations. More information on complete physical examinations, including all basic and additional examinations, is available in Appendix Table A-4.15. There were no consistent differences among facility types in the elements of the assessment and physical examination of the child.

Figure 4.13 Elements of physical examination conducted during observed sick child consultations (N=1,378)



Kenya 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 the illness contributes to further malnutrition. Aggravating this cycle is the tendency for sick children to eat and drink less and the not uncommon practice of caretakers to limit the sick child's consumption of food and liquids.

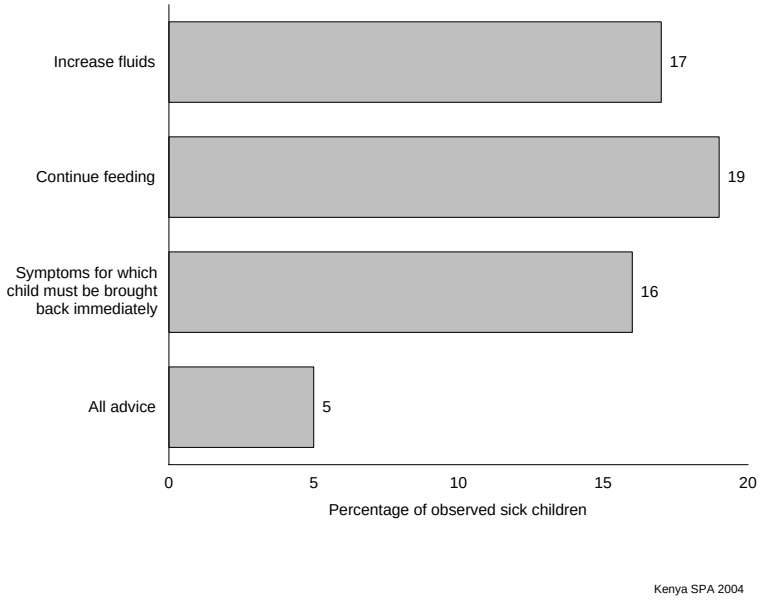
During observed sick child consultations, providers asked about normal feeding practices during illness 34 percent of the time, regardless of age of the child (Table A-4.17). This was more common in hospitals and maternities than in other facility types.

Essential Advice

The IMCI strategy identifies essential advice that the child's caretaker should receive before leaving the health facility. This includes encouraging the caretaker to 1) give the child extra fluids 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.

Providers advised caretakers to increase the quantity of liquids in 17 percent of the observed consultations, and in 19 percent of consultations, they advised caretakers to give the child at least the same amount of food or breast milk as usual (Figure 4.14). They provided information on signs and symptoms for which the sick child should be immediately returned to the facility during 16 percent of the consultations. Only 5 percent of sick child consultations included all three pieces of advice.

Figure 4.14 Essential advice provided to caretakers of observed sick children (N=1,378)



4.6.2 Diagnosis-Specific Assessments

After the sick child consultation, the observer asked the provider about the child's diagnosis, major symptoms, and prescribed treatment. 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, certain interventions can reasonably be expected for a given diagnosis. The KSPA 2004 does not evaluate the appropriateness of specific actions of providers.

Respiratory Illness

Children with severe respiratory illnesses should be thoroughly examined by a provider and hospitalized if indicated. In most of these cases, recourse to antibiotics is warranted. Among children diagnosed with pneumonia or other severe respiratory illnesses, the provider checked temperature in 85 percent of cases and counted respiratory rate in 46 percent (Table 4.5). Overall, providers referred or hospitalized 15 percent of these children, and put 93 percent of them on some form of antibiotic (41 percent received an injectable and 73 percent an oral antibiotic).

Among children diagnosed with bronchitis, providers checked temperature in 75 percent of cases, and as many as 98 percent were put on antibiotics—more than among children diagnosed with pneumonia. When children were diagnosed with cough or other respiratory problems, without another serious symptom such as fever or difficult/short breathing, providers were very likely to prescribe antibiotics (87 percent), even those such cases are most often viral in nature. This may mean that providers in Kenya prescribe antibiotics even when it is not medically indicated. With growing antibiotic resistance worldwide, rational use of antibiotics should be encouraged to ensure that these drugs are not overused.

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

Among observed children diagnosed by the provider with the indicated illness or symptom, percentage for whom the indicated assessment, examination, and/or treatment was provided, Kenya SPA 2004

	Among children with indicated diagnosis, percentage for whom indicated assessment, examination, and/or treatment was observed									
	Respiratory illness			Febrile illness			Intestinal illness		Other	
Item	Pneumonia or other severe respiratory infection[1]	Bronchitis (mild to moderate)	Cough or other respiratory problem without other severe diagnosis	Severe fever	Fever without severe diagnosis or cough	Malaria	Severe or persistent diarrhoea or dysentery or any dehydration w/diarrhoea	Other diarrhoea without other severe diagnosis	All other definitive diagnosis	All observed children
IMCI assessment										
Three major symptoms	18	4	20	33	20	21	39	28	11	18
Three general danger signs	5	13	5	7	5	7	1	7	7	6
Current eating/drinking	29	47	34	42	24	41	30	50	26	37
Advise continue feeding/ increase food or drink	31	20	23	32	36	26	48	33	19	26
Physical exam										
Temperature	85	75	76	100	79	85	89	73	81	81
Respiratory rate	46	24	22	24	24	24	20	26	20	24
Dehydration	33	4	13	27	19	19	46	22	11	17
Anaemia	46	43	44	38	49	52	58	39	34	45
Ear	11	3	9	10	13	9	13	7	11	9
Oedema	3	3	6	10	7	7	4	6	8	5
Body muscle	65	55	42	59	41	43	45	38	41	45
Treatment										
Refer/admit	15	1	7	11	5	7	20	9	12	9
Any antibiotic	93	98	87	66	86	62	80	88	71	73
Injectable antibiotic	41	32	18	23	16	16	11	6	30	19
Oral antibiotic	73	92	82	57	80	56	70	86	68	67
Antimalarial	39	48	44	58	58	94	50	58	5	54
Oral bronchodilator	20	43	6	0	2	4	4	4	3	7
Oral medication for symptomatic treatment[2]	69	81	79	83	88	82	51	64	67	73
Oral rehydration (ORS)	17	1	8	7	11	15	76	44	0	14
Intravenous fluid	0	0	0	1	0	0	2	0	0	0
Described signs or symptoms for immediately seeking help	25	21	13	21	14	15	23	13	24	16
Discussed follow-up visit	32	15	34	46	33	42	35	39	47	36
Number of children (weighted)[3]	156	57	606	59	189	743	99	190	77	1,378

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[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.

Fever

For children with severe febrile illness, IMCI guidelines recommend the use of antimalarials and antipyretics (especially in high malaria risk areas), followed by referral to appropriate facilities for further treatment. All children diagnosed with severe fever had their temperature taken, compared with about 85 percent of children who were diagnosed with malaria-related fever or who had a fever with no accompanying serious symptoms (Table 4.5). About 1 in 10 children diagnosed with severe fever were either re-

ferred or admitted, and 66 percent received some form of antibiotics (23 percent received injectable antibiotics and 57 percent oral antibiotics). Approximately 4 in 5 of the children received oral medication for symptomatic treatment (an antipyretic, cough medicine, or other general treatments for symptoms).

Malaria

Examination and treatment for children diagnosed with malaria appears to have improved since 1999. Temperature was assessed for 85 percent of malaria cases, and anaemia was assessed in 52 percent. Overall, 94 percent of children diagnosed with malaria received some form of antimalarial (Table 4.5). About 2 in 10 received injectable quinine, Fansidar, or artemether; about 8 in 10 were put on an oral antimalarial; and only 1 percent received injected chloroquine (table not shown). About one-third received an antibiotic, while 8 in 10 received oral medication for symptomatic treatment.

Diarrhoea

Observers recorded the physical assessment and treatment of children diagnosed with intestinal illnesses. There were two categories of diagnoses: 1) severe or persistent diarrhoea or dysentery, or any dehydration with diarrhoea, and 2) other diarrhoea without another severe diagnosis (Table 4.5). Providers assessed dehydration in 46 percent of children in the first category, whereas only 22 percent of children in the second category were checked for dehydration. In the 1999 KSPA, all diarrhoea was combined into one category, and 45 percent of the observed children were assessed for dehydration. Twenty percent of children with the first, more severe, type of diarrhoea were either admitted or referred to a higher-level facility, compared with 9 percent of children in the second category.

Antibiotics are rarely indicated for non-dysentery-related diarrhoea, since using antibiotics inappropriately can prolong the episode. As many as 80 percent of children with severe diarrhoea (just over half of whom had dysentery or amoebiasis) were prescribed antibiotics; among children in the second category, 88 percent received antibiotics. These findings further indicate that antibiotics may be over-prescribed in Kenya. ORS was prescribed for 76 percent of children with severe diarrhoea, and 2 percent received intravenous fluids, while 44 percent of children with less severe diarrhoea were put on ORS.

Overall Adherence to Standards

From this brief review it appears that the type of physical examination conducted and treatment provided, including referrals, tend 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, do not vary accordingly by severity of illness (Table 4.5).

4.6.3 Other Observed Practices

IMCI guidelines recommend that the first dose of any prescribed medicine, particularly antibiotics, 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 prescriptions, 14 percent were observed receiving the first dose of the prescribed medicine at the facility. This practice was least common in hospitals (9 percent) than in other facility types (Appendix Table A-4.16).

Providers educated caretakers about medicines in 54 percent of cases, although caretakers were not often asked to repeat the instructions back to providers to verify that they understood (11 percent). During exit interviews, however, a much larger proportion of interviewed caretakers reported being told how to give the medicine (96 percent) and said they felt that they knew how to provide the medicine (98 percent) (Ap-

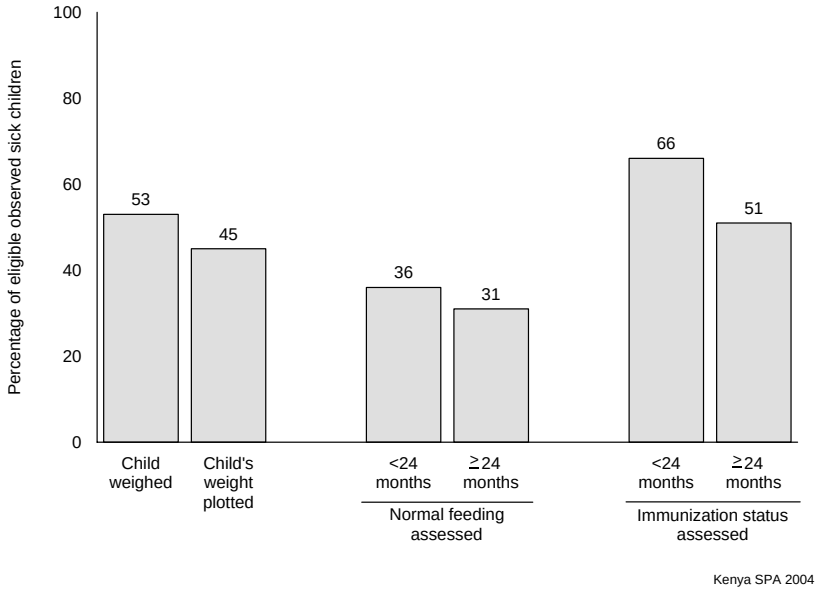
pendix Table A-4.16). It is also possible they received instructions at the pharmacy when collecting medicines.

4.6.4 Reducing Missed Opportunities for Promoting Child Health Care

The IMCI approach recommends evaluating children's growth, to provide an objective assessment of their current nutritional status and to detect any chronic latent nutritional problems. Growth monitoring includes comparing the child's current weight with a standard (based on either height or age), eliciting information on feeding patterns to determine whether the 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 for feeding practices call for exclusive breastfeeding until six months of age, followed by the introduction of locally available foods based on a balanced nutritional plan, with continued breastfeeding until two years of age.

About half of sick children were weighed. However, providers only plotted the weight against a standard in 45 percent of cases (Figure 4.15). They assessed normal feeding practices in 34 percent of all consultations, 36 percent of consultations for children under 24 months, and 31 percent of consultations for older children.

Figure 4.15 Observed preventive assessments (N=1,360)
(<24 months N=844)



Assessment of immunisation status for sick children was low; providers checked immunisation status for 66 percent of children under 24 months of age and 51 percent of older children.

Key Findings

Assessment for general danger signs in sick children is poor. Providers assessed whether children could drink or breastfeed in 36 percent of cases, and asked whether they were vomiting everything in 36 percent of cases. Twelve percent were assessed for convulsions. Only 6 percent were assessed for all three danger signs.

Ninety-three percent of children diagnosed with severe respiratory illness received an antibiotic; 41 percent received injectable antibiotics. However, 87 percent of children with non-severe respiratory conditions also received antibiotics, contrary to current recommendations.

Providers seldom provided caretakers with essential information. Only 5 percent of caretakers received all of the three IMCI-recommended counsels (increased fluids, increased food intake, and list of symptoms for which the child must be brought back immediately).

Children rarely received the first dose of oral medication at the facility (14 percent).

Fifty-four percent of caretakers were observed being told how to administer medicines at home, though only 11 percent were asked to repeat the instructions to the provider to check their understanding. Ninety-six percent, however, reported that they had received the information, with most reporting they understood how to give medicines to the child.

Opportunities to promote preventive health interventions each time a child is brought to a facility for a consultation are being missed. Assessments of immunisation, weight, and feeding practices for children under 24 months occurred in 66 percent, 53 percent and 36 percent of cases, respectively. This is particularly important given the decrease in overall immunisation coverage and existing levels of chronic malnutrition documented in the KDHS 2003.

4.6.5 Counselling on Child Health Issues and Supporting Continuity of Care

The use of visual aids during consultations was almost nonexistent, at 2 percent (Table 4.6). This is not surprising, considering the fact that only 29 percent of facilities have any visual aids available for use for child health services (Figure 4.5).

Supporting Continuity of Care

Frequently, health services are organised in such a way that a client's temperature and weight are measured, other routine services are provided, and the information is recorded on a client card or record, before the provider responsible for the consultation sees the client. Although it was noted that one in three facilities collect some of this relevant information outside the consultation room (data not shown), the provider referred to the sick child's health card during 73 percent of the observed consultations (Table 4.6). Thus, 27 percent of the providers might not have used information from measurements taken by others in their assessment of the child. Providers in Western province facilities were most likely to refer to a client card during consultation. Most providers did write notes on the sick child's health card at the end of the consultation (Table 4.6).

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

Percent 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's health card, and percentage of observations where the provider wrote on the child's health card, by type of facility, managing authority and province, Kenya 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				
Hospital	3	75	96	102
Health centre	2	69	95	539
Maternity	5	70	93	26
Clinic	0	62	96	14
Dispensary	2	75	98	696
Managing authority				
Government	3	79	97	978
NGO	0	27	74	49
Private (for-profit)	2	85	98	111
Faith-based organisation	0	49	98	240
Province				
Nairobi	1	72	100	188
Central	6	66	91	149
Coast	0	80	100	167
Eastern	0	60	95	273
North Eastern	0	81	97	15
Nyanza	2	68	99	174
Rift Valley	3	79	96	327
Western	5	95	100	85
Total	2	73	97	1,378

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

Key Findings

Providers almost never used visual aids during consultations (2 percent), although visual aids for caretaker education are available in 29 percent of facilities.

Use of individual child health cards to provide continuity of care was relatively high, with 73 percent of providers referring to the card during the consultation and 97 percent writing a note on the card after the consultation. This increases accountability of health care, as well as the likelihood that the provider will have all relevant information for continuity of care, both during the current visit and on subsequent visits.

4.7 Caretaker Opinion from Exit Interviews

Before leaving the facility, KSPA interviewers asked observed caretakers of sick children for their opinions on the consultation process, the quality of the providers' services, and the principal problems en-

countered on the day of the visit. The interviewer read the caretakers a list of specific issues commonly related to client satisfaction and asked them to rate each issue as a big problem, a small problem, or no problem.

Caretakers' responses to these interviews indicate that most were told how to administer prescribed medicines at home (96 percent) and felt comfortable giving the medicine (98 percent). As expected, some were dissatisfied enough with aspects of their experience in the facility that they considered them to be big problems, though usually in small percentages. For example, 20 percent considered the time they waited to see the provider to be a big problem, and 17 percent considered lack of availability of medicines to be a big problem (Appendix Table A-4.19). Only 7 percent of the caretakers felt they did not receive sufficient explanation about their child's illness.

When asked about their choice of health facility, 25 percent of interviewed caretakers indicated that the facility they visited was not closest to their home. The most common reasons cited for not visiting the nearest facility to their home were that the nearest facility was more expensive (27 percent), had a bad reputation (12 percent), or lacked medicines (12 percent). Appendix Tables A-4.19-A-4.21 provide additional information on caretakers' opinions and personal characteristics.

Key Findings

The major complaints from caretakers were the waiting time to see a provider (20 percent) and lack of medicines (17 percent).

Only a small proportion considered it to be a big problem that they had not received enough information about their child's illness (7 percent) and that the facility's operating hours were inconvenient (8 percent).

Twenty-five percent of the children were not taken to the facility nearest to their home, with cost (27 percent), a bad reputation (12 percent), and lack of medicines (12 percent) the most commonly cited reasons.

Chapter 5 Family Planning Services

Samuel Ogola, Karugu Ngatia and Dr. Marsden Solomon

5.1 Background

The Kenya Service Provision Assessment 2004 (KSPA 2004) collected information on the availability of family planning (FP) services, on clients' perceptions of their experience in the facility, and on services received. This chapter provides detailed information gathered from family planning clients as they left the service facility, on their knowledge of a variety of topics related to their encounter with the provider, and on the family planning method they were prescribed or are currently using. It also looks at the components supporting quality family planning services, management practices supportive of quality services, and providers' adherence to standards for quality service provision. This information is also useful in assessing how family planning services are delivered and can be used to improve programmes to meet the needs revealed by the 2003 Kenya Demographic and Health Survey (KDHS 2003).

5.1.1 KSPA Approach to Collection of Family Planning Service Information

The 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 part 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);
- Counselling and screening of clients for appropriateness of methods;
- Client education, using visual aids to increase information retention regarding options, side effects, and appropriate use of the method;
- Availability of infrastructure and resources necessary for providing quality family planning services: equipment for client examinations, guidelines and protocols, trained staff, a service delivery setting that allows client privacy, and procedures for preventing infections; and
- Availability of other health services relevant for family planning clients. These include education and services for sexually transmitted infections (STIs) and programmes geared toward groups with special needs to improve access and appropriate utilisation of family planning services.

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

This chapter uses information obtained in the KSPA 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 Kenya

The Kenya family planning programme was launched in 1967. The programme has made substantial progress in expanding the use of modern contraception in Kenya in the more than 30 years since family planning was integrated into the maternal and child health services of the Ministry of Health, whose facilities offer most family planning services in Kenya. Family planning services are integrated into the MCH/FP clinics at dispensaries, health centres, and district and provincial hospitals. There are also family planning clinics in referral hospitals and mobile units.

Use of modern contraceptive methods by currently married women age 15-49 increased from 27 percent in 1993 to 33 percent in 1998 (KDHS 1993 and 1998). The injection is the most widely used method, followed by the combined oral contraceptive pill (15 percent and 10 percent, respectively). Pill users obtain their methods from either public sources (48 percent) or private medical sources (46 percent); very few get them from other private outlets such as shops and friends or relatives. More than 60 percent of all injection users get their injections at public sector facilities.

The family planning programme in Kenya has been relatively effective over time. The proportion of women using public sources has declined steadily from 68 percent in 1993 to 53 percent in 2003, while the proportion getting methods from private medical sources has similarly increased, from 25 percent to 41 percent in the same period (KDHS 1993 and 2003). As more sources are now available for users to obtain their services and methods, maintaining quality of care is increasingly important. Discontinuation is still an important problem in Kenya; nearly 40 percent of users discontinue their family planning method within 12 months. Pill users are most likely to stop using their method, with 46 percent discontinuing in the first year (KDHS 2003). Another issue related to quality of care is informed choice. Less than half of all users were informed about the side effects of their current method and of other methods they could use (KDHS 2003).

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 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).

According to the KDHS 2003, the modern methods most commonly used in Kenya are contraceptive injections, contraceptive pills, and female sterilisation. Other, less commonly used methods include implants, condoms, male sterilisation, intrauterine devices (IUDs), periodic abstinence (natural family planning), the diaphragm, spermicides, and emergency contraception (KDHS, 2003). In an effort to understand the context in which modern methods of contraception are used in the country, the KSPA asked facilities about the availability of family planning services.

Table 5.1 summarizes information on the availability of family planning services in Kenyan health facilities, and Table 5.2 shows how frequently these services are offered. 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, managing authority and province, Kenya SPA 2004

Background characteristics	Temporary methods of family planning (FP)		Percentage offering male or female sterilisation	Number of eligible facilities offering temporary or permanent methods of family planning (weighted)
	Percentage offering any modern method of family planning[1]	Percentage offering counselling on rhythm method		
Type of facility				
Hospital	83	48	46	28
Health centre	85	50	3	125
Maternity	87	40	17	20
Clinic	66	37	3	8
Dispensary	68	31	0	249
Managing authority				
Government	85	42	5	245
NGO	88	85	5	16
Private (for-profit)	59	33	11	61
Faith-based organisation	58	27	2	109
Province				
Nairobi	49	33	6	37
Central	83	53	4	50
Coast	73	45	10	49
Eastern	77	39	3	81
North Eastern	68	37	0	8
Nyanza	91	31	4	54
Rift Valley	72	33	4	124
Western	78	47	8	29
Total	75	38	5	430

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] Any of the following: contraceptive pills (combined or progestin-only), injections (combined or progestin-only), implants, intrauterine devices (IUDs), male condoms, spermicides, diaphragm, or emergency contraceptive.

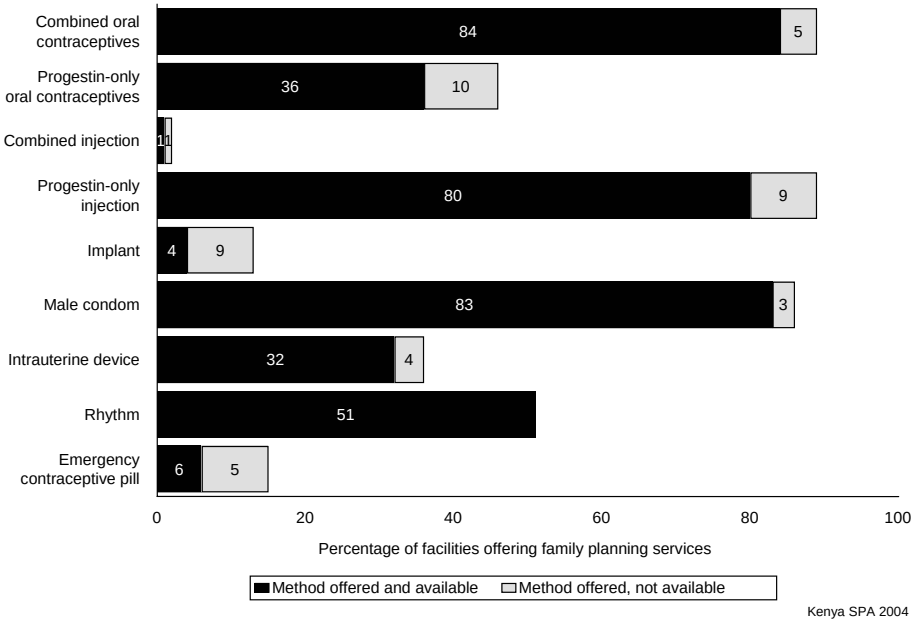
Contraceptive Method Mix and Method Availability

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

Over the last five years, the proportion of eligible facilities offering any modern method of family planning has declined from 88 percent to 75 percent. The proportion of facilities offering counselling on the rhythm method, however, remained stable at 38 percent. Hospitals, maternities and health centres, and government and NGO facilities, are more likely to offer at least one temporary modern method of family planning. Facilities in Nyanza and Central provinces are also more likely to offer family planning methods than facilities in other provinces (Table 5.1).

The most commonly offered family planning methods in Kenyan facilities are the combined oral contraceptive, progestin-only injections, and the male condom, offered by almost 9 in 10 facilities (Figure 5.1). Most facilities that offer these methods had them available on the day of the survey. Surgical sterilisation as a family planning method is not commonly offered; only 5 percent of facilities (including 46 percent of hospitals) reported that they offer either male or female sterilisation. About 7 in 10 facilities offer at least four temporary family planning methods (Appendix Table A-5.1); dispensaries are less likely to offer a wide range of methods, with 59 percent offering at least four methods.

Figure 5.1 Temporary methods of contraception offered and availability of method on the day of the survey (N=322)



The proportion of facilities offering the implant method has increased slightly, from 8 percent in 1999 to 13 percent in 2004, although, as in 1999, supply remains a problem; only half of the facilities offering implants actually had them available on the day of the survey (Figure 5.1).

Emergency contraception is not technically considered a family planning method, but rather is considered a backup for unprotected sexual intercourse. Just 11 percent of facilities offer emergency contraceptive pills, and almost half of these did not have an emergency contraceptive method available on the day of the survey. Progestin-only pills, which can be used for emergency contraception, are also offered in 46 percent of facilities (a decrease from 77 percent in 1999), but there are supply problems with this method as well. The combined injectable method continues to be offered rarely (2 percent of facilities) and primarily by hospitals (10 percent). However, the progestin-only injection is available in 90 percent of facilities (Table A-5.1).

Frequency of Services

In addition to providing a range of methods, it is important that facilities offer family planning services regularly enough to meet client needs. As in 1999, almost all facilities that provide family planning services offer them five or more days per week (Table 5.2). Faith-based facilities and those in the Eastern Province offer family planning services less frequently than other facilities.

Table 5.2 Frequency of availability of family planning services

Percentage of facilities where any temporary methods of family planning (FP) are offered the indicated number of days per week, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities where family planning services are offered:[1] 1-2 days per week	3-4 days per week	5 or more days per week	Number of facilities offering family planning services (weighted)
Type of facility				
Hospital	5	3	92	24
Health centre	5	0	95	107
Maternity	1	2	96	18
Clinic	0	3	97	5
Dispensary	5	0	88	169
Managing authority				
Government	3	0	97	209
NGO	12	0	88	14
Private (for-profit)	1	3	96	36
Faith-based organisation	12	0	70	63
Province				
Nairobi	9	3	88	18
Central	12	0	88	42
Coast	1	0	99	35
Eastern	14	1	79	62
North Eastern	0	0	100	6
Nyanza	1	0	99	49
Rift Valley	0	0	91	89
Western	0	0	100	22
Total[2]	5	0	91	322

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] Any of the following methods: oral contraceptives (combined or progestin-only), injections (combined or progestin-only), implants, intrauterine devices (IUDs), condoms, spermicides, diaphragm, emergency contraceptive or rhythm.

[2] Percentages may not add up to 100 percent since some facilities offer family planning services less frequently than once a week

Key Findings

Ninety-one percent of facilities offer temporary modern methods of contraception at least five days per week. They are most likely to offer progestin-only injections, pills, and the male condom.

The proportion of health facilities offering any temporary modern methods of family planning declined to 75 percent in 2004 from 88 percent in 1999.

About 7 in 10 facilities offer at least four commonly used family planning methods (such as combined oral contraceptives, progestin-only injection, male condom, and progestin-only oral contraceptives). Dispensaries are less likely to have such a wide range of methods; only 59 percent offer at least four methods.

5.3 Components Supporting Quality Family Planning Services

In order to provide family planning services, facilities must have adequate infrastructure and resources available to support quality counselling and examination of family planning clients; they should also have the equipment and supplies needed to provide each family planning method they offer. In addition, because family planning clients are sexually active, it is important to have STI services available to them.

5.3.1 Infrastructure and Resources to Support Quality Assessment and Counselling of Family Planning Clients

To provide quality counselling to family planning clients, facilities should be able to provide some level of privacy, individual client health cards or records, written family planning guidelines or protocols, and family planning-related visual aids. Since counselling about family planning often takes place in a location different from where procedures (such as pelvic examinations and IUD insertions) are conducted, the conditions for counselling are assessed separately from those for procedures. Table 5.3 provides aggregate information on items to support quality counselling; information on the availability of each specific item needed for counselling is provided in Figure 5.2. Appendix Table A-5.4 gives details on the items assessed for each of the components for counselling, and Appendix Table A-5.5 provides details on available visual aids and guidelines, by type of facility.

Only 22 percent of facilities have all four of the above items (Table 5.3, Figure 5.2); this is principally because many facilities do not have written family planning guidelines. These items are almost unavailable in all facilities in Central and North Eastern provinces (Table 5.3).

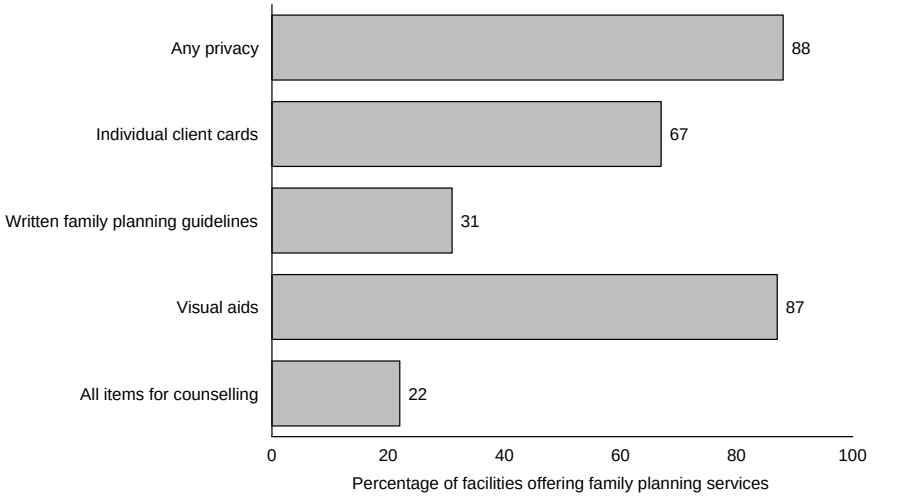
Family planning is often a sensitive issue for discussion. Providing counselling under conditions where clients can be reasonably assured that the conversation cannot be overheard improves communication and ultimately the likelihood that the method provided is suitable for the client. Privacy for counselling is almost universally available, with 88 percent of facilities (Figure 5.2, Table A-5.4) counselling family planning clients under conditions where both visual and auditory privacy are possible. Clinics are least likely to assure this kind of privacy (74 percent).

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 store client records, but rather give them to the clients to keep, the KSPA assessed the availability of blank cards for new family planning clients. Blank individual client cards were found at 67 percent of facilities (Figure 5.2). Maternities were least likely to have blank client cards (53 percent) (Table A-5.4).

The KSPA assessed whether facilities had written family planning guidelines or protocols, with information on eligibility screening and correct procedures for different methods. The guidelines were only considered available for use if they were in the family planning service delivery area or an immediately adjacent area. Only 3 in 10 facilities had family planning guidelines or protocols available (Figure 5.2).

Visual aids, which are important elements for good family planning counselling, are available in the service delivery area in 87 percent of facilities (Figure 5.2).

Figure 5.2 Items to support quality counselling for family planning
(N=322)



Kenya SPA 2004

5.3.2 Infrastructure and Resources for Examinations

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

Table 5.3 provides aggregate information on items for infection control and pelvic examinations; Figure 5.3 gives information on the availability of each specific item needed for infection control and pelvic examinations. Details on the specific items assessed are provided, by type of facility, in Appendix Table A-5.4, and details on processing equipment are available in Appendix Tables A-5.6 through A-5.9.

Infection Control

The KSPA 2004 assessed the presence of items for infection control in areas where family planning examinations (such as pelvic examinations) and provision of methods (the implant, IUD, and injection) most often take place. Items assessed for infection control were hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box; all these items are available in the family planning service area in about 4 in 10 facilities. More facilities in Eastern province have all these items available (69 percent); as do about half of hospitals and dispensaries. However, only 5 percent of NGO-managed facilities have all the items needed for infection control (Table 5.3).

Facilities most often lack disinfecting solution and soap; these items are missing in 48 percent and 28 percent of facilities, respectively (Figure 5.3).

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 counselling, examination, and where providers offer STI treatment to family planning clients, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with:					Number of facilities offering family planning services (weighted)
	All items to support quality counselling[1]	All items for infection control[2]	Capacity for sterilisation/HLD processing[3]	Conditions for quality pelvic examination[4]	STI treatment provided by family planning providers	
Type of facility						
Hospital	30	48	47	30	29	24
Health centre	21	31	26	10	62	107
Maternity	16	32	26	20	55	18
Clinic	28	42	11	23	88	5
Dispensary	23	48	5	2	74	169
Managing authority						
Government	22	47	13	8	65	209
NGO	18	5	71	3	61	14
Private (for-profit)	19	32	25	25	68	36
Faith-based organisation	26	35	10	1	69	63
Province						
Nairobi	41	40	45	27	44	18
Central	3	50	15	8	59	42
Coast	57	50	23	11	58	35
Eastern	15	69	1	1	63	62
North Eastern	2	2	3	2	61	6
Nyanza	18	39	6	11	71	49
Rift Valley	23	20	24	6	70	89
Western	20	33	18	9	91	22
Total	22	41	16	8	66	322

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

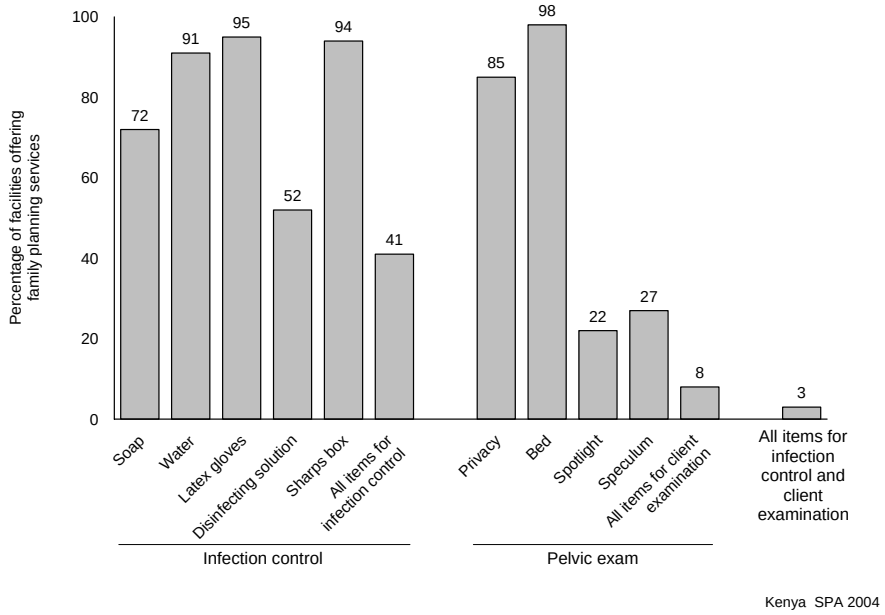
[1] Visual privacy, individual client cards, written guidelines related to family planning, and visual aids related to family planning

[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 sterilising or HLD processing and an automatic timing device were available.

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

Figure 5.3 Conditions for quality examination of family planning clients (N=322)



Equipment for family planning services often requires sterilisation or high-level disinfection (HLD) so that it can be reused. According to Kenya standards, this means facilities must have functioning equipment, knowledge of the minimum processing time for sterilising (or HLD processing), and an automatic timer, available in the location where family planning equipment is processed. Overall, only 16 percent of the facilities meet these criteria (Table 5.3). These are mainly hospitals, NGO-managed facilities, and, to some extent, facilities in Nairobi province (Table 5.3). Seventy-eight percent of facilities send equipment to the main processing area in the facility for processing, and 17 percent process items in the family planning service delivery area (Table A-5.6). As noted in Figure 3.13, the most common weakness in processing capacity in facilities' central processing location is the lack of an automatic timer for boiling, which is the most commonly used HLD method.

Examination

The KSPA 2004 assessed items needed for conducting quality pelvic examination for family planning clients. The items assessed are a private room (for both visual and auditory privacy), an examination bed and spotlight, and the availability of a vaginal speculum. Fewer than 1 in 10 facilities in Kenya have all these items (Table 5.3). Hospitals, private for-profit facilities, and facilities in Nairobi province were most likely to have these items. The weak areas are lack of a vaginal speculum (73 percent) and lack of a spotlight (78 percent) (Figure 5.3).

5.3.3 Provision of STI Treatment for Family Planning Clients

Family planning clients, because they are sexually active, may be at increased risk of contracting STIs. Consequently, counselling for STI prevention, as well as diagnosis and treatment, are essential components of quality family planning care. It is particularly important to diagnose and treat STIs and other vaginal infections for women who use the IUD. Figure 5.4 provides information on items needed to provide STI services to family planning clients. Table A-5.9 provides details, by type of facility, on the STI service items, including medicines for treating specific STIs.

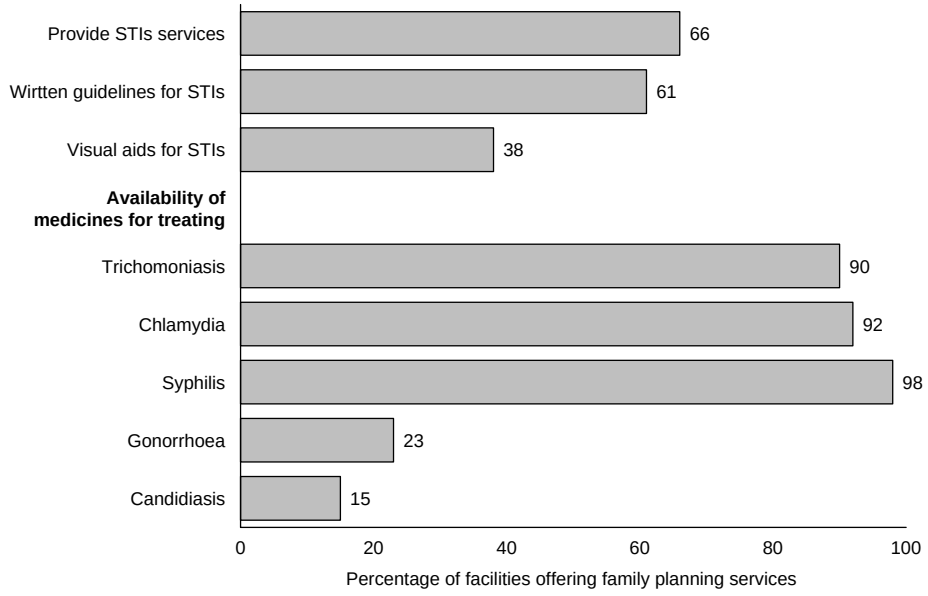
In two-thirds of facilities where family planning services are provided, providers diagnose and treat STIs (Table 5.3, Figure 5.4). Hospitals and facilities in Nairobi province are the least likely to have family planning providers diagnosing and treating STIs. This may be due to the fact that STI services in these facilities are considered more specialized and are organised separately, with different providers than for family planning.

Written guidelines for diagnosing and treating STIs are available in the family planning service area in 61 percent of facilities (Figure 5.4), with the World Health Organisation (WHO) syndromic approach guidelines found in 60 percent of facilities (Appendix Table A-5.5). Among the different facility types, dispensaries are the most likely to have these guidelines (70 percent).

Only 20 percent of facilities have STI-related visual aids for client education, (Table A-5.5), with hospitals most likely to have them available (33 percent).

Medicines for treating trichomoniasis, chlamydia, and syphilis are almost universally available in facilities offering family planning services (Figure 5.4), while medicines for gonorrhoea and candidiasis (a more common infection) are available in only 23 percent and 15 percent of facilities, respectively (Figure 5.4).

Figure 5.4 Conditions to support quality STI services for family planning clients (N=322)



Kenya SPA 2004

Key Findings

Privacy for family planning counselling services and visual aids are commonly available (about 9 in 10 facilities). Guidelines and protocols for family planning, however, are not available in almost two-thirds of facilities.

All assessed items for infection control are available in the family planning service area in 41 percent of facilities, with disinfecting solution the most commonly missing item (missing in 48 percent of facilities)

Only 16 percent of facilities have the capacity for quality sterilisation or HLD processing of family planning equipment.

All the furnishings and equipment needed for quality pelvic examinations are available in only 8 percent of facilities.

Medicines for treating trichomoniasis, chlamydia, and syphilis are universally available in facilities offering family planning services (about 9 in 10), while medicines for candidiasis and gonorrhoea are less available (15 and 23 percent, respectively).

5.3.4 Availability of Equipment and Supplies for Specific Methods

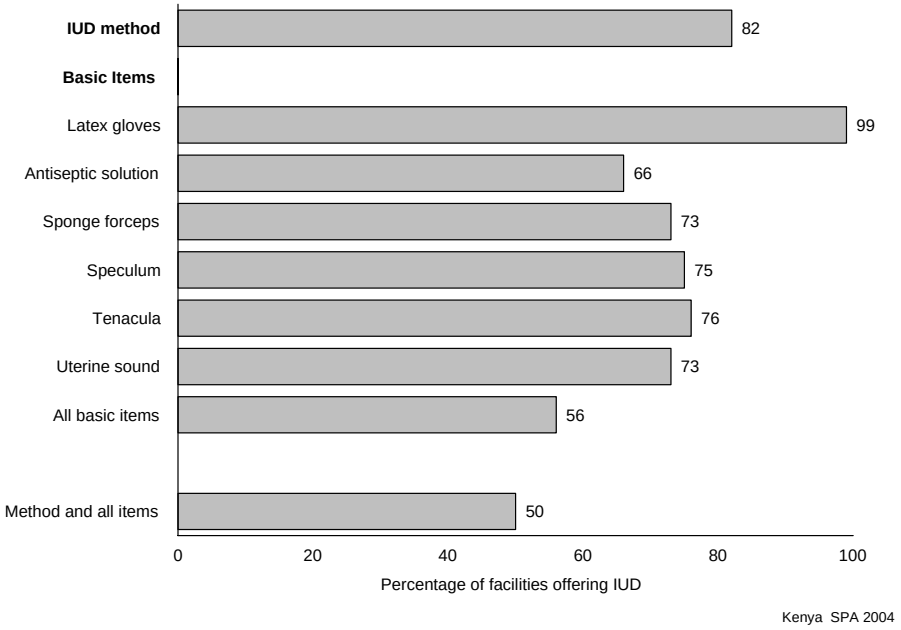
To provide different contraceptive methods safely, and to monitor the client, facilities need a variety of equipment. Figure 5.5 shows what items facilities have available for providing IUDs. Appendix Tables A-5.10 through 5.12 provide additional detail on the availability of equipment and supplies for specific methods, including the IUD and implant methods.

Among facilities offering IUDs, 82 percent have the IUDs themselves, 56 percent have all the basic equipment necessary for insertion and removal, and only 50 percent have both the IUD itself and all the basic items (Figure 5.5). Only 11 percent of the facilities have IUDs and all basic items, and also satisfy all KSPA-defined conditions[1] for quality insertion and removal of IUDs (Table A-5.10). Latex gloves, one of the basic items, are universally available in all facilities offering IUDs (Figure 5.5, Table A-5.10).

Women receiving oestrogen-containing family planning methods benefit from blood pressure and weight monitoring. Among facilities providing methods containing oestrogen, 80 percent have a blood pressure apparatus and 92 percent have an adult weighing scale (Table A-5.10). Almost all maternities and clinics have a blood pressure apparatus, but many health centres do not. Among facilities providing injectable contraceptives, 96 percent have sterile needles and syringes (Appendix Table A-5.10). It should be noted that in Kenya, each progestin injection vial is supplied with a syringe; so it is possible that the 4 percent of facilities without sterile needles and syringes were facilities that did not have progestin injections available the day of the survey (Figure 5.1).

[1] Conditions here refer to all infection control items, visual privacy, an examination bed, an examination light and the method

Figure 5.5 Equipment for IUD insertion and removal (N=117)



Key Findings

Blood pressure equipment is available in 80 percent of facilities offering family planning methods containing oestrogen, and 92 percent of such facilities have a weighing scale.

Sterile needle and syringes were available in almost all the facilities offering injectable contraceptive methods.

Fifty percent of the facilities that report offering IUDs have the method and all the basic items needed for IUD insertion. However, only 11 percent have the method, all the basic items, and all the conditions necessary for quality IUD insertion and removal.

Latex gloves are universally available in facilities offering IUDs.

5.4 Management Practices That Support 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. Figure 5.6 shows topics for in-service training and when providers received training. Utilisation statistics for family planning services are provided in Appendix Table A-5.13. Information on user fees charged for family planning services is provided in Appendix Tables A-5.14 through A-5.16. Details on in-service training and supervisory activities from the provider's perspective are provided in Appendix Tables A-5.17 to A-5.19.

5.4.1 Facility Documentation and Records

The KSPA assessed whether facilities had up-to-date family planning client registers; such registers are most often the source of data for health information systems. A register was defined as up-to-date if there was an entry within the past seven days, and the latest entry reported the method or service provided and

the client's status (first visit or follow-up visit). Seventy-six percent of family planning facilities had an up-to-date register (Table 5.4); these were most commonly government and NGO-managed facilities (88 percent and 98 percent, respectively). Registers were less commonly found in private for-profit facilities (38 percent). Facilities in North Eastern province were also unlikely to keep up-to-date client registers, which were available in only half of facilities.

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, percentage with the indicated supportive management practices, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Facilities that offer family planning services		Number of facilities offering family planning services (weighted)	Percentage of facilities where at least half of the interviewed family planning service providers:		Number of facilities with interviewed family planning service providers (weighted)[3]
	Percentage with observed up-to-date client register[1]	Percentage with user fees for family planning services		Received in-service training during past 12 months[2]	Were personally supervised during past 6 months	
Type of facility						
Hospital	72	60	24	29	70	23
Health centre	85	44	107	32	84	107
Maternity	57	94	18	36	78	16
Clinic	56	93	5	37	64	5
Dispensary	73	49	169	35	93	157
Managing authority						
Government	88	42	209	29	88	201
NGO	98	31	14	18	99	14
Private (for-profit)	38	95	36	42	76	34
Faith-based organisation	52	62	63	49	85	59
Province						
Nairobi	84	72	18	54	89	18
Central	81	57	42	38	80	41
Coast	71	54	35	43	69	35
Eastern	64	58	62	23	97	58
North Eastern	49	11	6	24	68	5
Nyanza	82	57	49	31	95	48
Rift Valley	78	44	89	33	83	80
Western	85	28	22	30	98	22
Total	76	51	322	34	87	308

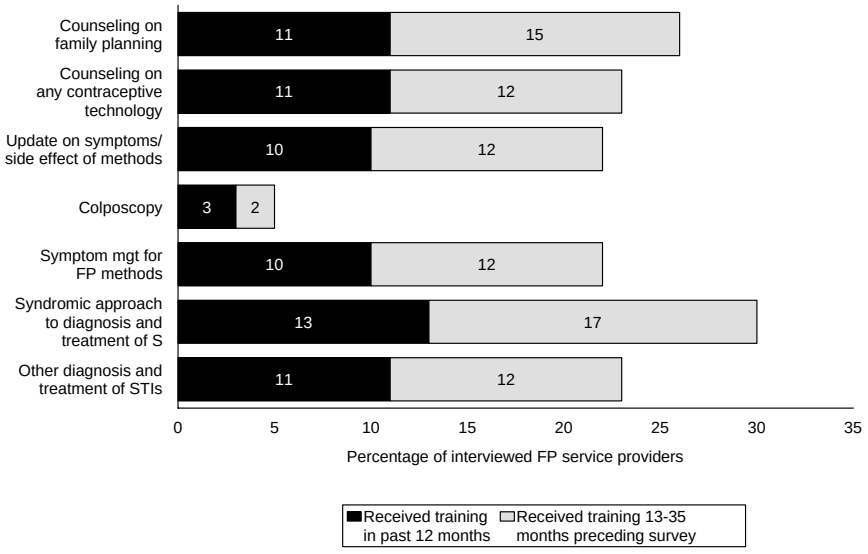
Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Register has entry within past seven days and indicates visit status (first or follow-up) and service provided.
[2] This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
[3] Includes only providers of family planning services in facilities offering family planning services.

5.4.2 Practices Related to User Fees

According to government policy, family planning services in government facilities should be free. However, government facilities can and do charge a registration fee for the client card, while private facilities usually charge a consultation fee. There should be no charge for any government-supplied contraceptive method administered, whether in government or private facilities. The KSPA found that about half of facilities offering family planning charge some type of user fee for family planning services. This is com-

mon in maternities and clinics (94 percent and 93 percent, respectively), and, not surprisingly, in private for-profit facilities (95 percent). It is also common in facilities in Nairobi province (72 percent) (Table 5.4). When offering family planning counselling sessions, approximately 2 in 10 facilities charge fees, with hospitals, maternities and clinics most likely to do so (36 percent, 40 percent, and 46 percent, respectively). Twelve percent of government facilities charge for family planning counselling, and, rather surprisingly, less than half of private for-profit facilities do (Table A-5.14). A rather small proportion of government and NGO-managed facilities (8 and 6 percent, respectively) charge for the actual methods; however, this varies by facility type, with maternities, clinics, and private for-profit and FBO facilities more likely to charge clients for family planning methods.

Figure 5.6 In-service training received by interviewed family planning service providers, by topic and timing of most recent training (N=853)



5.4.3 Staff Development and Supervision

Staff Development

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

A facility is defined as having routine staff development activities 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. Overall, 34 percent of facilities meet these criteria for providing routine staff development activities. Staff in primary-level facilities and maternities, in facilities in Nairobi province, and in FBO-managed facilities are more likely to receive this training (Table 5.4). The most common in-service training topics covered are counselling on family planning and on any contraceptive technology, updates on symptoms/side effects, and the syndromic approach to diagnosis and treatment (Figure 5.6). More details can be found in Table A-5.17.

Supervision

Supervision of individual staff members 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 the findings for other services, supervision of family planning providers is common, with 87 percent of facilities meeting the criteria for providing routine staff supervision (Table 5.4). Family planning providers who were supervised in the six months prior to the survey reported that their supervisors universally checked records, observed their work, discussed problems, provided feedback, and gave verbal praises. The supervisors rarely delivered supplies or gave written praises during the visits.

Key Findings

Up-to-date registers are available in three-fourths of facilities, commonly in government and NGO-managed facilities, and rarely in private for-profit facilities.

Only a third of facilities provide routine staff training for family planning providers, but approximately 9 in 10 facilities provide routine staff supervision.

5.5 Adherence to Standards for Quality Service Provision

To assess whether providers adhere to standards for quality service, KSPA personnel observed family planning client-provider consultations. The observation checklists used are based on commonly accepted guidelines for screening, counselling, and conducting procedures for family planning clients; they collected information on whether the consultation process answered the following questions:

- Did providers discuss essential topics relevant to determining the appropriateness of the various methods discussed, and did providers conduct the physical examinations needed to screen clients for method appropriateness?
- Did the conditions and procedures followed for provision of specific methods meet the criteria defined for quality?

The observers noted what information the provider shared and whether an examination was conducted. They did not assess whether the information was correct, or whether findings were appropriately interpreted.

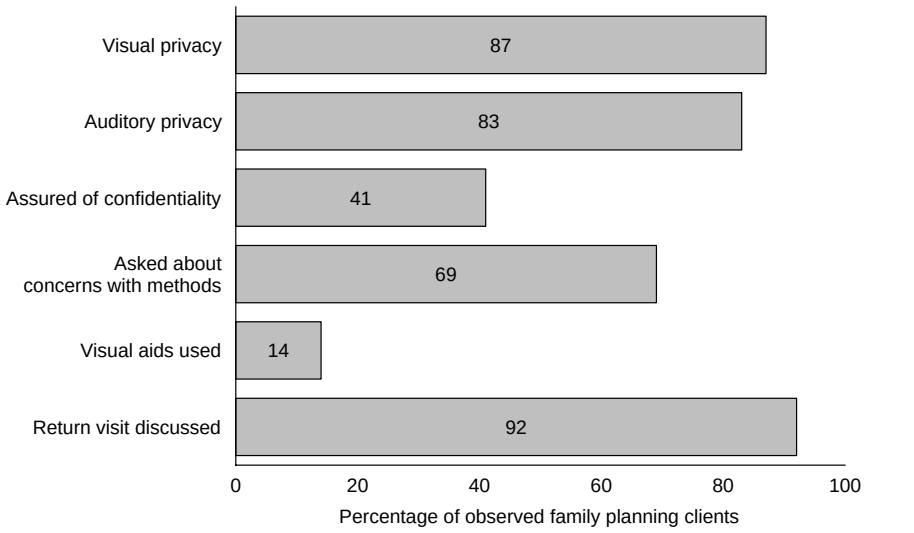
A total of 537 female clients were observed at 322 facilities. This was the first visit for 29 percent of the women; 71 percent were follow-up clients. Five percent of clients had never been pregnant (Appendix Table A-5.20). Exit interviews were conducted with all observed family planning clients. When two methods were prescribed or received, the client was assessed for knowledge about both. 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 clients' status and their principal reason for visiting the clinic are provided in Appendix Table A-5.21. Appendix Table A-5.22 gives details on the primary method provided, prescribed or discussed during this visit.

5.5.1 Assessment of Relevant History, Examination, and Counselling

Figure 5.7 provides information on components related to counselling, Figure 5.8 provides information on what client history elements the provider assessed for first-visit family planning clients, and Figure 5.9 gives information on consultations where clients received hormonal methods or procedures. Details on consultations 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.

Figure 5.7 Observed conditions and content for family planning counselling (N=537)



Kenya SPA 2004

5.5.2 Counselling and Client Assessment

Privacy is very important for quality family planning counselling. Eighty-seven percent of observed family planning counselling sessions were conducted under conditions where there was visual privacy; 83 percent of clients had auditory privacy (Figure 5.7). In only 41 percent of counselling sessions were clients explicitly assured that the information they shared was confidential. Providers explicitly asked clients about concerns with their methods in about 7 in 10 sessions. Return visits were discussed during 92 percent of sessions. Providers rarely used visual aids during family planning consultations (14 percent).

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 organised 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 card. This means an individual client card or chart is also important for ensuring that information collected before the consultation is available to the provider. During the observed family planning consultations, the provider reviewed the client card for 81 percent of clients and wrote on the card after the consultation for 95 percent of clients (Appendix Table A-5.23). These practices are less frequent in maternities than in other facility types.

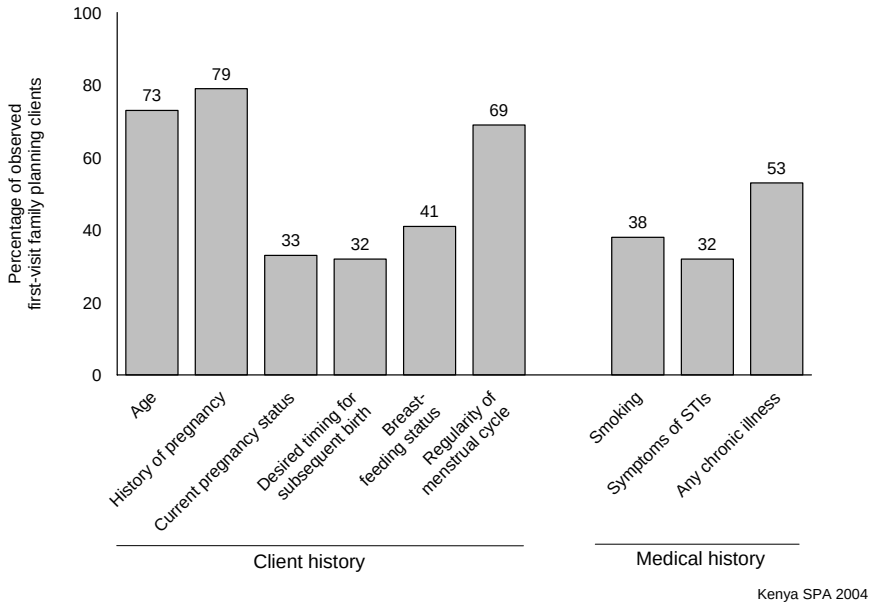
During a client's first visit, providers are expected to elicit relevant personal and health history that will provide the information they need to make an informed recommendation on contraceptive methods; they should also screen clients for the appropriateness of specific methods. Providers asked the client's age and

prior pregnancy history during 70 percent of first visits (Figure 5.8). They were least likely to check on current pregnancy status (either by asking the client or through laboratory testing) and desired timing for the next pregnancy (33 percent and 32 percent, respectively). Knowing a client's breastfeeding status is essential when determining the suitability of different methods of contraception, but providers only asked 41 percent of clients whether they were breastfeeding (Figure 5.8). Relatively few providers assessed clients' medical history to determine their risk status for different family planning methods. About 4 in 10 of the observed first-visit clients were asked whether they smoke, and about 3 in 10 were asked whether they had symptoms of STIs. A little over half were assessed for chronic illnesses. Traditionally, smoking has not been common for women in Kenya, so assessment may not have been stressed in provider training, but smoking is a particularly important risk factor for certain methods.

Providers asked only 35 percent of first-visit clients about their husband's attitude toward family planning or about other factors related to the husband that might affect the client's STI risk or method choice (Appendix Table A-5.25). Providers discussed condom use to prevent STIs with 34 percent of first-visit clients, and they discussed condoms as a dual family planning method during 11 percent of first visits. Considering the current drive toward reducing HIV/AIDS rates, these percentages are rather low.

Use of visual aids during first visits is rare; it was most common in hospitals (56 percent) (Appendix Table A-5.25).

Figure 5.8 Observed elements of client history for first-visit family planning clients (N=154)



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Key Findings

Visual and auditory privacy during family planning counselling existed in 87 percent and 83 percent of counselling sessions, respectively; however, providers verbally assured clients of the confidentiality of their consultations less than half the time.

Providers do not thoroughly assess relevant client history that might influence whether a family planning method is appropriate. Less than half of first-visit clients were assessed for current pregnancy or breastfeeding status, chronic illnesses, and risk factors such as STI symptoms or smoking.

Visual aids, though available in 87 percent of facilities, are rarely used during family planning counselling sessions.

5.5.3 Method-Specific Assessments and Examinations

For clients receiving methods with oestrogen, whether oral or injectable, monitoring for hypertension should be a component of care, as should weight monitoring; gaining weight may be an indicator of fluid retention and a factor in hypertension. Among these clients, 71 percent had their blood pressure measured[2] and 87 percent had their weight measured (Appendix Table A-5.26).

5.5.4 Counselling of Clients

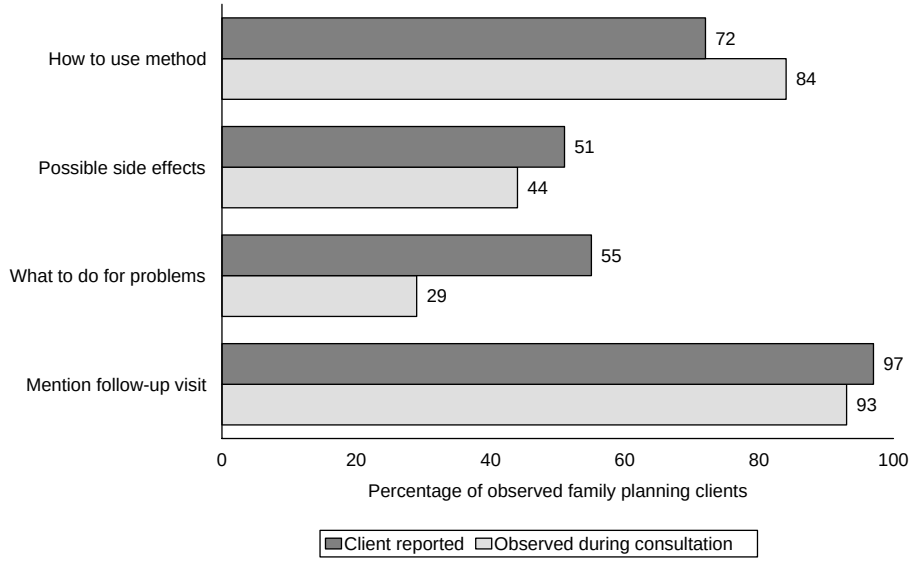
Whether they are new contraceptive users or continuing users, clients should receive certain information during consultations. The provider should explain or review with the client how to use the method, the possible side effects, what to do for problems, and when the client should return for a follow-up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

Details on components of counselling that were observed and reported by clients are presented in Appendix Tables A-5.27 and A-5.28.

KSPA data can be used to compare what was observed during a consultation to the client's exit interview about the same consultation (Figure 5.9). Client reports were most likely to agree with the observed data on whether the provider mentioned possible side effects of the method and discussed a follow-up visit. Data on other areas was more inconsistent. For example, whereas 84 percent of providers were observed discussing with clients how to use their method, a smaller percentage (72 percent) of clients reported that this happened during the consultation. On the contrary, as opposed to 29 percent of cases when the provider was observed discussing what to do in case of problems, 55 percent of clients actually reported this to have taken place. Clients may have received this information during prior visits or at the pharmacy when receiving their methods.

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

Figure 5.9 Information provided to hormonal method users, by client report and by observation (N=516)



Kenya SPA 2004

Key Findings

Among all clients receiving methods with oestrogen, where monitoring for hypertension should be a component of care, 71 percent had their blood pressure measured.

There were some inconsistencies between client reports and observation of the information provided to hormonal method users; however, at most half of clients either reported or were observed being counselled about possible side effects or what to do for problems.

5.6 Client Opinion from Exit Interviews

After the observed consultation, the client was asked to participate in an exit interview during which the interviewer asked for her opinions on issues commonly related to client satisfaction. 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 on whether specific issues were a big problem, a small problem, or not a problem at all for them.

Few issues were considered big problems, and usually only by a small proportion of interviewed clients. Long waiting time to see the provider was a big problem for 23 percent of clients. Fewer clients (6 percent) considered lack of medicines or supplies to be a big problem, while only 4 percent considered the operating hours of the facility to be a problem (Appendix Table A-5.29).

Further details on client opinion are provided in Appendix Tables A-5.29 and A-5.30. Appendix Table A-5.31 provides information on the educational backgrounds of observed and interviewed clients.

When asked if this was the nearest facility to their home, about 2 in 10 of the interviewed clients said that it was not. These were more likely to be clients at maternities (69 percent) and those who were attending private for-profit facilities (53 percent). Similarly, clients in facilities in Nairobi province (49 percent) are more likely to visit facilities not nearest to them. The main reasons clients gave for not attending the nearest facilities to where they live were that those facilities were more expensive (23 percent) and lacked medicine (15 percent) (Appendix Table A-5.30).

Chapter 6 Maternal Health Services

Pamela Godia, Helton Jilo, George Kichamu, Luwei Pearson, Kennedy Ongwae, Paul Kizito, Richard Muga, Alfredo Fort

6.1 Background on Maternal Health Care in Kenya

This chapter provides an overview of the Kenyan maternal and newborn health services environment. Maternal health data are primarily derived from four modules of the KSPA: the facility inventory, the health worker interview, the antenatal care observation, and the antenatal care client exit interview. Additional information was also derived from the maternal health provider knowledge questionnaire, the normal delivery record review questionnaire, and the maternity statistics form. The chapter highlights the key aspects of maternal and newborn care, including the availability of staff and services for antenatal care, safe delivery, post-partum care, and obstetric complications.

Maternal Health Status and Health Care Utilisation

Complications related to pregnancy and childbirth are among the leading causes of morbidity and mortality among Kenyan women. Recent estimates suggest that there are 414 maternal deaths per 100,000 live births, representing a 1 in 25 lifetime risk of dying from a maternal-related cause (KDHS 2003). Hospital-based studies suggest that the majority of these deaths are due to obstetric complications, including haemorrhage, sepsis, eclampsia, obstructed labour, and unsafe abortion. Unsafe abortion practices alone are thought to cause at least a third of all maternal deaths.

Kenyan women's use of maternal health services is higher than in other African countries. The KDHS 2003 found that 88 percent of women make at least one antenatal care visit, 31 percent make two or three visits, and more than 52 percent make four or more visits. However, the majority of these women seek antenatal care relatively late in pregnancy; the median gestation at first visit is 5.9 months.

The 2003 KDHS also showed that 52 percent of mothers received two or more doses of tetanus toxoid vaccine during pregnancy, while 34 percent received one dose. The remaining 14 percent of mothers did not receive any tetanus immunisation.

Delivery within a health facility or with a skilled attendant is much less common than antenatal care. Only 42 percent of women have a skilled attendant present at delivery, while 28 percent of women deliver with a traditional birth attendant (TBA); slightly over one-fifth deliver with a relative, and nearly one-tenth of women deliver entirely alone. The majority of the deliveries with a skilled attendant occur in health facilities. Overall, 26 percent of all deliveries occur in public health facilities, and three out of five births occur at home.

These aggregate figures conceal wide provincial disparities, however. Delivery at home, for example, is more than twice as common in rural as in urban areas, and the proportion of births with a skilled attendant ranges from only 29 percent in Western province to 79 percent in Nairobi (KDHS 2003).

Maternal Health Policy Framework

Maternal health services in Kenya began as part of an integrated MCH programme in 1972, but it was not until the inauguration of the Safe Motherhood Initiative in Nairobi in 1987 that specific programmes to reduce maternal mortality and improve maternal health were established. Early efforts focused on training TBAs to screen high-risk pregnancies for complications; efforts are now directed towards providing women with access to skilled care during pregnancy and delivery.

The National Reproductive Health Strategy for 1997 (Ministry of Health, 1996) has two principal maternal health objectives: to reduce maternal mortality to 170 per 100,000 live births by the year 2010, and to increase professionally attended deliveries to 90 percent in the same time period. The objective is to help health facilities in various areas manage pregnancy-related complications, unsafe abortion, and newborn care, and to establish a functional referral system.

Organisation of Maternal Health Services

Maternal health services are provided by facilities at every level of the Kenyan healthcare system. Dispensaries, the lowest-level facilities in the public health sector, are staffed by enrolled nurses and public health technicians. They provide antenatal care, treat simple medical problems in pregnancy such as anaemia, and occasionally conduct normal deliveries. Health centres provide the next level of services. They are staffed by midwives/nurses and clinical officers, and provide a wider range of services, including deliveries. Health centres should be able to provide basic first aid for obstetric complications but are not equipped for surgery or for managing delivery complications such as obstructed labour. District hospitals (and some sub-district hospitals) are the lowest level of health facility equipped to carry out caesarean sections**.**

Clinics and maternities also provide a wide range of maternal health services. Although there are some public-sector clinics and maternities, most are private establishments, and the types of services they provide vary widely. Some clinics provide only antenatal care, while others, particularly the larger establishments or polyclinics, also provide delivery care and surgery. Most maternities provide normal delivery care, and some are equipped to carry out caesarean sections.

Doctors, clinical officers, and registered and enrolled midwives and nurses make up the professional labour force of skilled attendants. Although clinical officers have less obstetric training than doctors, some of them provide obstetric care on a regular basis. Registered nurses and midwives (KRN/M, KRCN) have three years of pre-service training and form the senior level of the nursing cadre. In general, they fill a teaching, administrative, or supervisory role. Enrolled nurses and midwives (KEN/M, KECN) have two years of pre-service training and comprise the majority of the labour force in all facilities.

Although providing women with access to a skilled attendant at birth is a key element in the National Reproductive Health Strategy, there are major problems with the availability and distribution of health sector manpower. There are recognized shortages of doctors, clinical officers and nurses across the country, particularly in rural areas and at facilities below the hospital level. More than half of all health personnel and four-fifths of doctors are based at urban facilities (Ministry of Health, 1996). The National Health Sector Strategic Plan (NHSSP) of 2005-2010 has specific action strategies that will be undertaken to address these persistent staff shortages. Efforts are currently being made to address the shortfall.

6.1.1 KSPA Approach to Collecting Maternal Health Information

Maternal health is not just a women's issue; the mother's health 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. Many complications and subsequent poor outcomes for women and infants can be prevented or minimized by early detection of problems and appropriate interventions.

With an international focus on decreasing maternal morbidity and mortality, some of the traditional maternal health interventions have been re-examined in recent years, with subsequent changes in programme emphasis.

Antenatal care (ANC): All pregnant women are at risk of developing complications, many of which are unpredictable. It is therefore important to ensure that all pregnant women have access to preventive inter-

ventions, early diagnosis and treatment, and emergency care when needed. It is now emphasized that ANC should focus on birth preparedness, early detection of complications, and skilled and timely interventions to avoid adverse maternal and neonatal outcomes.

Delivery care: Every delivery may have complications; therefore emphasis should be towards the use of skilled and trained delivery care providers and ensuring that all women have access to life-saving emergency interventions at the time of labour and delivery. In many countries, 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 programme initiatives have shown that in almost all cases, the level of skill among 'skilled traditional birth attendants' is lower than is considered 'safe' for safe motherhood. In-service training for TBAs cannot improve their skills to the level of competency needed.

A skilled attendant, as defined by the World Health Organisation (WHO) and other international bodies, is a 'health professional—such as a midwife, doctor, clinical officer, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth, and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns'.

Postnatal care (PNC): There is an increasing emphasis on ensuring that women receive PNC within 48 hours 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 an increased awareness of the need to discourage some common practices that are detrimental to newborn health and to promote those practices that contribute to improved newborn health.

Internationally accepted guidelines define the maternal health services necessary for safe delivery and improved maternal and newborn outcomes as follows:

Basic essential obstetric care (BEOC) includes preventive services as well as medical interventions and procedures that can be provided to pregnant women by well-trained primary care physicians and non-physician providers. This includes ANC with early detection and treatment of common problems of pregnancy, as well as first aid for complications of pregnancy and labour.

Comprehensive essential obstetric care (CEOC) includes basic essential obstetric care services, together with blood transfusions and caesarean sections.

Emergency obstetric care involves a set of interventions called 'signal functions' that should be available in a facility that provides emergency care for women with pregnancy-related complications. These signal functions must be performed at a facility in order for that facility to be recognized as an emergency obstetric care (EmOC) facility. A facility can either be classified as a basic EmOC or a comprehensive EmOC facility.

The **basic EmOC signal functions** are administration of parenteral antibiotics, oxytocic drugs and anticonvulsants; manual removal of placenta; manual vacuum aspiration of retained products of conception; and assisted vaginal delivery.

Comprehensive emergency obstetric care (comprehensive EmOC) includes the six basic signal functions, plus performing caesarean section and blood transfusion. Comprehensive EmOC has been adopted by the Ministry of Health and forms part of the strategy of programmes 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 KSPA 2004 draws on the findings and recommendations of Safe Motherhood initiatives such as the Maternal and Neonatal Health Project, promoted by WHO and other international organisations to determine which aspects of maternal health to assess.

This chapter uses information obtained in the KSPA 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 PNC[1] available where ANC is offered, and to what extent 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?
- What is the maternal health provider knowledge on signs and basic interventions of common maternal complications?

6.1.2 Maternal Health and the Utilisation of Services in Kenya

The Ministry of Health (MOH) and the National Coordinating Agency for Population and Development (NCAPD) have identified maternal health as a priority health issue and have developed a strategy based on CEOC to reduce maternal morbidity and mortality. Through the Health Sector Strategic Plan, the MOH has developed interventions to reduce maternal morbidity and mortality from these causes. Essential obstetric care protocols have been developed, and there is a focus on competency-based training for physicians and nurses on the new essential obstetric care protocols and standards of care. The MOH has also been expanding midwifery training for nurses. The objective is to increase the skills of primary care physicians and nurses trained in midwifery so that they can become "skilled birth attendants" by acquiring proficiency in the skills necessary to manage normal deliveries and to diagnose and manage or refer complicated cases.

Some improvement in maternal health is being achieved. According to the 2003 KDHS, the national maternal mortality rate has declined from 590 maternal deaths per 100,000 live births in 1998 to 414 maternal deaths per 100,000 live births in 2003. However, Millennium Development Goal (MDG) No. 5 is to reduce maternal mortality rate to 175 maternal deaths per 100,000 live births or less. Much still needs to be done to achieve the MDG target.

6.2 Availability of Antenatal and Postnatal Care and Capacity to Provide Quality Services

ANC is designed to promote healthy behaviours and preparedness during pregnancy, childbirth, and after delivery, and also to provide early detection and treatment for complications.

[1] For the KSPA, 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.

6.2.1 Availability of Antenatal and Postnatal Care Services

Information on the availability of ANC, PNC, and tetanus toxoid (TT) vaccine is provided in Table 6.1. Appendix Table A-6.1 provides information on whether facilities offer various family health services on the same day they offer ANC, and Appendix Table A-6.2 gives more details on the availability of ANC and TT vaccines.

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), tetanus toxoid vaccine (TT), and percentage offering all three services, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering the indicated services				Number of facilities (weighted)
	ANC	PNC	TT vaccine	ANC, PNC and TT	
Type of facility					
Hospital	84	53	96	50	28
Health centre	86	51	94	47	125
Maternity	76	44	82	41	20
Clinic	53	21	52	18	8
Dispensary	77	24	79	24	249
Managing authority					
Government	81	40	86	38	245
NGO	88	74	89	74	16
Private (for-profit)	59	23	66	22	61
Faith-based organisation	87	24	88	24	109
Province					
Nairobi	68	31	70	31	37
Central	79	46	84	46	50
Coast	78	19	84	18	49
Eastern	81	45	83	44	81
North Eastern	82	41	89	41	8
Nyanza	96	30	96	29	54
Rift Valley	75	28	81	26	124
Western	82	53	94	48	29
Total	79	35	84	33	430

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

Seventy-nine percent of facilities offer ANC services; one-third offer PNC, and eighty-four percent provide TT vaccine. One-third of facilities provide all three services (Table 6.1). There has been a decline in availability of ANC since 1999, when 86 percent of facilities offered the service. Approximately three-fourths of facilities offer ANC services five or more days per week, and 26 percent offer these services one or two days per week (Table A-6.2). Similarly, TT services are usually offered five or more days a week, and almost all facilities offer TT every day ANC is offered.

The provincial differentials show that nearly all the facilities in Nyanza province provide ANC services, followed by North Eastern and Western provinces (82 percent). Nairobi province has the lowest proportion of facilities providing ANC services. Seventy-four percent of NGO facilities provide all the three services, compared with 22 percent of private for-profit facilities (Table 6.1); private facilities most often lack ANC.

Key Findings

ANC is offered in four out of five facilities and in nearly all facilities in Nyanza province.

All the three services (ANC, PNC, tetanus toxoid vaccine) are available in only one-third of the facilities.

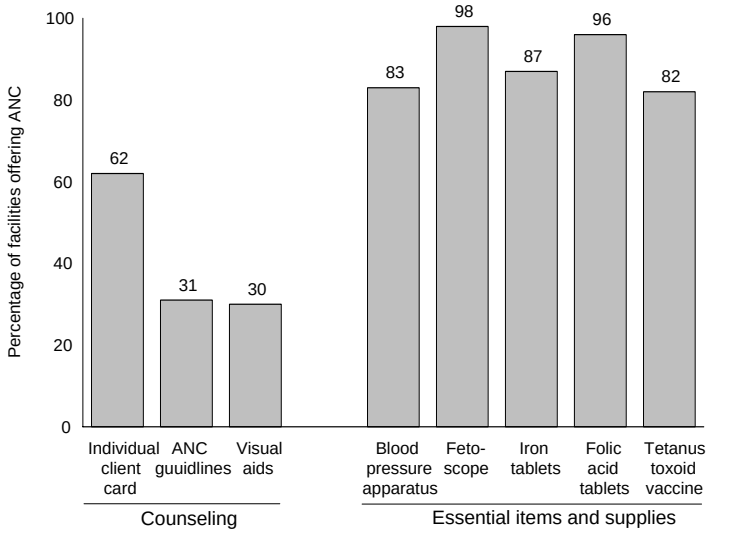
6.2.2 Infrastructure and Resources to Support Quality Assessment and Counselling of ANC Clients

To support quality assessment and counselling of ANC clients, facilities should have individual client cards, guidelines or protocols for ANC, and visual aids for client education. Table 6.2 and Figure 6.1 present information on the availability of these items. More details are available, including a breakdown by facility type, in Appendix Table A-6.3.

An individual ANC card is used for monitoring maternal and foetal condition during pregnancy and for keeping track of the type of care/treatment given. It is important for identifying risk factors for referral, assessing quality of care, ensuring standardisation of antenatal care, and helping in planning purposes (Population Council, 2002a). Individual client cards are available in 62 percent of facilities (Figure 6.1).

Written ANC guidelines or protocols which include details pertaining to the management of common problems during pregnancy are available in 31 percent of facilities; visual aids for ANC client counselling are available in just 30 percent.

Figure 6.1 Availability of items to support basic ANC services (N=347)



Kenya SPA 2004

Overall, only 1 in 10 facilities have all three items for supporting quality ANC (individual client cards, ANC guidelines, and visual aids), with facilities in Rift Valley, North Eastern and Central provinces least likely to have all the items (Table 6.2).

Table 6.2 Availability of antenatal care and resources to support quality counselling and examinations for ANC/PNC

Percentage of facilities with all elements to support quality ANC/PNC counselling, examinations and interventions for basic ANC/PNC, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering ANC services with: All items to support quality counselling[1]	All items for infection control[2]	All items for physical examination[3]	All essential equipment and supplies for basic ANC[4]	Number of facilities offering ANC (weighted)
Type of facility					
Hospital	16	42	46	70	25
Health centre	19	30	14	50	111
Maternity	13	40	50	56	16
Clinic	7	36	41	43	4
Dispensary	4	41	18	59	191
Managing authority					
Government	10	40	5	52	202
NGO	3	5	60	18	14
Private (for-profit)	7	42	54	53	36
Faith-based organisation	13	33	32	74	95
Province					
Nairobi	8	39	38	63	25
Central	1	47	27	47	39
Coast	19	36	14	65	38
Eastern	20	65	15	49	66
North Eastern	1	8	1	92	7
Nyanza	16	36	25	55	51
Rift Valley	0	21	20	55	96
Western	17	17	10	75	25
Total	10	37	20	57	347

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Visual aids for health education, guidelines 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 foetoscope (Pinard).

6.2.3 Infrastructure and Resources for Examinations

The KSPA 2004 assessed whether facilities had the necessary supplies, equipment, and conditions for infection control and for conducting client examinations in the ANC service area.

Aggregate information on these elements is provided in Table 6.2, 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.

Infection Control

All items necessary for infection control (soap and water for hand washing, clean latex gloves, disinfecting solution, and a sharps box) are available in the ANC service delivery area in 37 percent of facilities offering ANC (Table 6.2). Facilities in North Eastern, Western, and Rift Valley provinces are less likely to have all items for infection control than those in other provinces. Water and sharps boxes are available in the ANC service areas in about 9 in 10 facilities (90 and 93 percent, respectively) (Table A-6.3).

Client Examinations

The common physical examinations for ANC include palpating the abdomen, breast examination and, when indicated, a pelvic examination.[2] The basic components for examining ANC clients are visual and auditory privacy, a bed or examination table, and an examination light. Eighty-eight percent of facilities that offer ANC are able to ensure clients both visual and auditory privacy, and all facilities (99 percent) have either a bed or an examination table. However, only about 2 in 10 facilities have an examination light (Appendix Table A-6.3). All three items are available in 20 percent of facilities, mostly in NGO-managed facilities (60 percent) and in facilities in Nairobi province (38 percent) (Table 6.2). Facilities in North Eastern and Western provinces are the least likely to have all three items. Government-managed facilities are less likely than other facilities to have all three items for quality client examination (5 percent). The item most often missing in all facilities is an examination light.

6.2.4 Essential Equipment and Supplies for Basic ANC

A functioning blood pressure apparatus and a foetoscope are essential equipment that should be available in the ANC service delivery area; essential ANC supplies that should be available in the facility are iron tablets, folic acid tablets, and TT vaccine. All the essential equipment and supplies are available in only 6 in 10 facilities (Table 6.2); however, each individual item is available in over 80 percent of facilities (Figure 6.1). Provinces where facilities are most likely to have all the essential supplies and items are Western (75 percent), North Eastern (92 percent) and Coast (65 percent). Facilities in Central (47 percent) and Eastern (49 percent) province are the least likely to have them (Table 6.2).

Key Findings

Elements to support quality ANC are commonly lacking; only 1 out of 10 facilities has all the items needed for counselling, 37 percent have all items for infection control, and 57 percent have all the items essential for providing basic ANC.

ANC guidelines and visual aids are available in 31 percent and 30 percent of facilities respectively; 4 in 10 facilities did not have client ANC cards available

Four out of five facilities have a functioning blood pressure apparatus in the ANC service delivery area, and 4 percent and 13 percent of facilities lack folic acid and iron tablets, respectively.

6.2.5 Additional Equipment and Supplies for Quality ANC and PNC Services

Other elements that support quality ANC and PNC include diagnostic capacity and medicines to treat common infections. Figures 6.2 and 6.3 provide summary information on the medicines and laboratory tests available in facilities, with aggregate information available in Table 6.3. Appendix Tables A-6.4 through A-6.9 provide details on each item assessed, by type of facility.

[2] Pelvic examination is not a routine component of ANC in Kenya.

Table 6.3 Facility practices and resources for diagnosis and management of common problems and complications of pregnancy

Percentage of facilities where ANC/PNC service providers can diagnose and treat STIs for ANC/PNC clients, percentage with all medicines to manage common complications of pregnancy, percentage with the indicated diagnostic testing capacity, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage where 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)
			Anaemia[2]	Urine protein[3]	Urine glucose[4]	Syphilis[5]	
Type of facility							
Hospital	46	8	86	86	83	88	25
Health centre	68	8	45	36	36	45	111
Maternity	80	9	80	76	72	78	16
Clinic	90	8	51	62	62	66	4
Dispensary	82	0	20	29	31	35	191
Managing authority							
Government	68	4	25	20	20	25	202
NGO	86	0	20	21	21	44	14
Private (for-profit)	85	8	88	88	86	88	36
Faith-based organisation	84	2	41	58	62	68	95
Province							
Nairobi	58	3	79	73	73	79	25
Central	79	0	24	38	38	52	39
Coast	65	2	50	26	25	33	38
Eastern	77	6	32	38	37	38	66
North Eastern	76	0	26	16	16	20	7
Nyanza	72	2	20	12	19	31	51
Rift Valley	78	5	34	46	46	50	96
Western	93	5	46	45	45	41	25
Total	75	4	36	38	39	44	347

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] At least one broad-spectrum antibiotic (amoxicillin or cotrimoxazole); at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia infection, and syphilis; mebendazole or albendazole (for deworming); aldomet for hypertension; nystatin suppository; and antimalarials all present.

[2] Includes any test (haemoglobinometer or calorimeter or centrifuge with capillary tubes, or filter paper methods).

[3] Clinistix (Campus 3 or Campus 9 sticks) or flame, acetic acid, and test tube for testing urine albumin.

[4] Clinistix (Campus 3 or Campus 9 sticks).

[5] Venereal disease research lab (VDRL) test with functioning microscope or rapid plasma reagin (RPR)

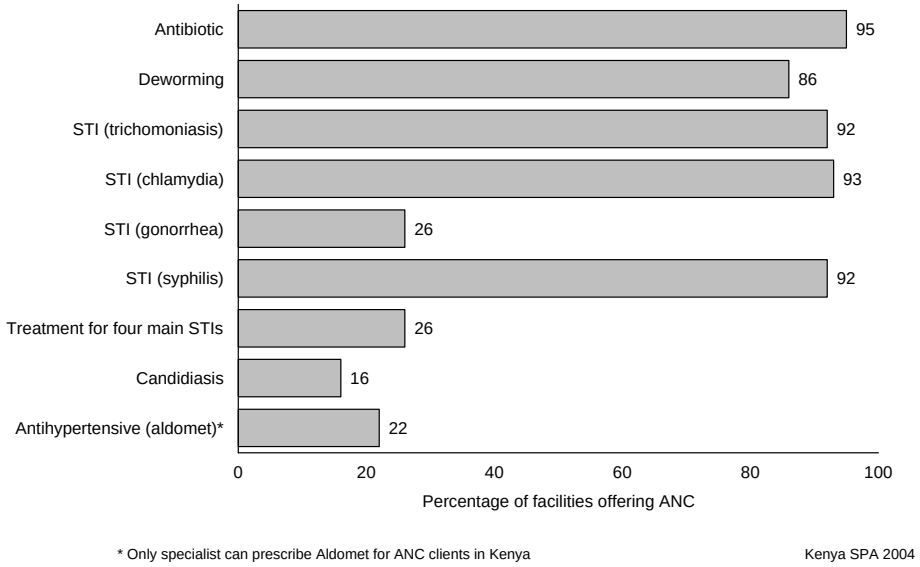
Pre-eclampsia (a hypertensive disorder of pregnancy), anaemia, sexually transmitted infections (STIs), and vaginal infections can directly affect both maternal and newborn health. Basic Essential Obstetric Care (BEOC) requires that a facility provide early treatment for complications of pregnancy to prevent progression to more serious conditions. The standard for treatment may vary depending on ANC guidelines and policies and the qualifications of the service provider.

In three-fourths of facilities offering ANC, STI treatment is offered to ANC clients (Table 6.3). Rather surprisingly, hospitals and government-managed facilities (46 and 68 percent, respectively) are the least likely to have ANC providers treat STIs, and similarly, ANC service providers in facilities in Nairobi are least likely to treat STIs. Only 26 percent of facilities have at least one medicine to treat each of the four major STIs (trichomoniasis, chlamydia, syphilis, and gonorrhoea), with medicine for gonorrhoea most often lacking (Figure 6.2 and Appendix Table A-6.4). Only one out of four facilities has at least one

medication for gonorrhoea. Nearly all facilities have at least one medication to treat chlamydia (93 percent) and syphilis (92 percent). However, only 16 percent of facilities have medicine for candidiasis, a common vaginal or sexually transmitted infection.

About 1 in 5 ANC facilities have methyldopa (Aldomet) for managing hypertension during pregnancy[3] (Appendix Table A-6.4). A mere four percent of facilities have all medicines expected to be available for managing basic infections and health problems during pregnancy: at least one broad-spectrum antibiotic (amoxicillin or cotrimoxazole); at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia infection, and syphilis; mebendazole or albendazole (for deworming); methyldopa (Aldomet) for hypertension; nystatin suppositories and antimalarials (Table 6.3).

Figure 6.2 Medicines for managing common problems and complications of pregnancy (N=347)



* Only specialist can prescribe Aldomet for ANC clients in Kenya

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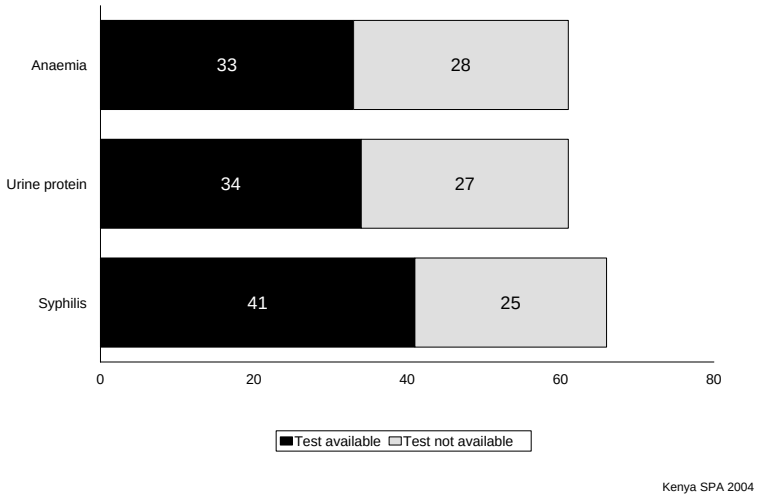
The KSPA 2004 also assessed whether facilities have the capacity to test ANC/PNC clients for anaemia, urine protein, and urine glucose, and to diagnose and treat syphilis.

Among facilities providing ANC/PNC services, only thirty-six percent have the capacity to test for anaemia, 38 percent for urine protein and 39 percent for urine glucose (Tables 6.3, A-6.5-A-6.8). Hospitals and maternities (as expected), private for-profit facilities, and facilities in Nairobi are more likely than others to have the capacity to conduct these tests. Figure 6.3 shows how many facilities routinely screening ANC clients for these conditions, and which ones actually have the capacity to conduct the necessary tests. About 4 in 10 facilities routinely screen ANC clients for syphilis and have the capacity to conduct a syphilis testing; these are mostly hospitals, private for-profit facilities, and facilities in Nairobi (Table A-6.8). All facilities offering ANC had antimalarials available, and of those, 84 percent routinely provide preventive antimalarials as a component of ANC services (Table A-6.4).

[3] In Kenya, methyldopa (Aldomet), for managing hypertension, is to be used for ANC clients only by specialists, and facilities without specialists are expected to refer these cases.

Figure 6.3 Availability of ANC tests in facilities where tests are reported to be routine components of ANC (N=347)



Key Findings

The lack of all medicines for managing common pregnancy-related conditions is notable in all types of facilities. However, commonly recommended antibiotics are available in 95 percent of facilities.

Three out of four facilities diagnose and prescribe treatment for STIs in the ANC service area; however, only 26 percent of these facilities have medicines to treat each of the four main STIs (syphilis, gonorrhoea, chlamydia, and trichomoniasis). The recommended treatment for gonorrhoea is most often lacking.

Thirty-eight percent of facilities have the capacity to routinely check urine protein, and 2 out of 5 facilities have the capacity to measure urine glucose.

6.3 Management Practices Supportive of Quality ANC and PNC Services

Management practices for supporting quality ANC and PNC services include documentation and records, posting user fees, and staff supervision and development.

Table 6.4 provides information on management practices, and Figure 6.4 provides summary information on in-service training on ANC. Appendix Tables A-6.9 through A-6.11 provide details on utilisation, user fees, and out-of-pocket payments for ANC services, and Appendix Table A-6.12 provides information on supportive management for providers of ANC. Appendix Tables A-6.13 and A-6.14 provide detailed information on in-service training and supervision.

6.3.1 Facility Documentation and Records

Among facilities offering ANC, 82 percent have up-to-date registers that include an entry in the past seven days and indicate whether the client was visiting for the first time (Table 6.4). Only 5 percent of facilities offering ANC have an up-to-date register for PNC clients. This low percentage can be explained by the fact that PNC as a component of maternal and child care has received very little attention in Kenya, especially the maternal component, which affects both maternal and child morbidity and mortality (Population Council et al., 1999). Women do not always receive early postpartum care in Kenyan facilities; health care providers appear reluctant to provide this care, especially in busy units. Most men are not even aware that women need postpartum care and believe it is only for the baby (Warren and Liambila, 2004).

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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering ANC that have:				Number of facilities offering ANC (weighted)	Percentage of facilities where at least half of the interviewed ANC service providers:		Number of facilities with interviewed ANC providers (weighted)[3]
	Observed up-to-date patient register[1]		Documentation of monitoring ANC coverage	User fees for ANC		Received in-service training during past 12 months[2]	Were personally supervised during the past 6 months	
	ANC	PNC						
Type of facility								
Hospital	83	10	18	80	25	61	71	24
Health centre	93	9	14	67	111	47	82	111
Maternity	74	8	16	100	16	62	81	16
Clinic	52	5	5	100	4	53	65	4
Dispensary	78	3	12	61	191	52	91	184
Managing authority								
Government	89	8	9	53	202	52	87	194
NGO	98	3	58	43	14	19	100	14
Private (for-profit)	49	1	18	76	36	63	82	36
Faith-based organisation	78	2	13	95	95	51	83	95
Province								
Nairobi	76	11	2	87	25	34	71	25
Central	71	13	8	77	39	43	74	39
Coast	83	9	19	67	38	50	72	38
Eastern	86	6	20	69	66	72	98	66
North Eastern	83	1	32	20	7	33	80	7
Nyanza	85	3	3	84	51	49	95	51
Rift Valley	82	0	17	52	96	45	84	88
Western	90	5	1	57	25	63	95	25
Total	82	5	13	67	347	51	86	339

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Register has entry within past seven days and indicates, at minimum, whether this was the first or a follow-up visit for ANC and number of days postpartum for PNC register.
[2] This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
[3] Includes only providers of ANC in facilities offering ANC services.

Of the facilities offering ANC services, 13 percent have documentation indicating that they monitor their ANC coverage rate (the proportion of eligible women in their catchment area who receive ANC services). While about 6 in 10 NGO-managed facilities monitor ANC coverage, only 1 in 10 government-managed facilities do so, and barely any facilities in Nairobi, Nyanza, and Western provinces have documentation showing that they monitor coverage rates (2, 3 and 1 percent, respectively).

6.3.2 Practices Related to User Fees

User fees may have either a positive effect on utilisation of health facilities (by increasing the funds available to the facility) or a negative effect (by deterring poor clients from using services). Posting user fees is a good standard for quality of care, since clients are able to know exactly the cost of services. Approximately two-thirds of facilities charge some form of user fees for ANC. All maternities and clinics charge user fees, and facilities in Nairobi and Nyanza provinces are more likely than facilities in other provinces

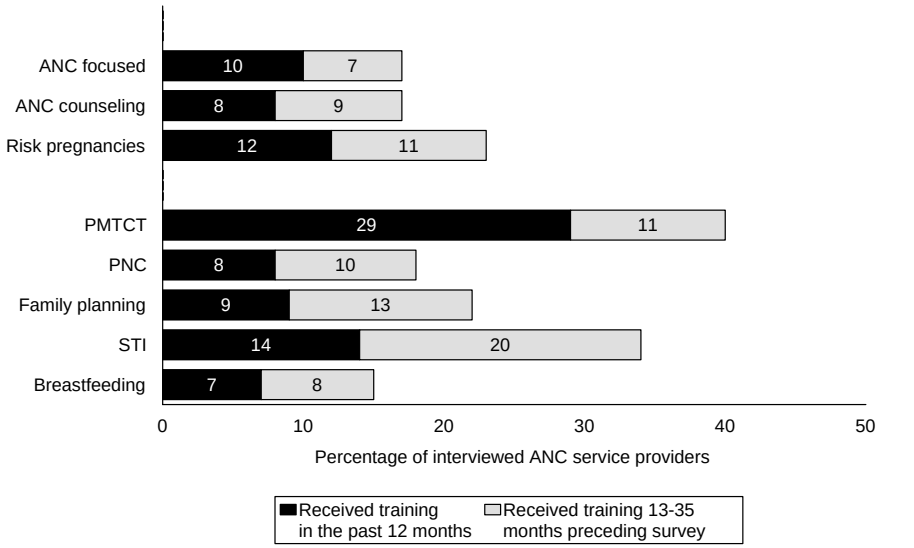
to charge fees for ANC services (87 and 84 percent, respectively). Only 20 percent of facilities in North Eastern province charge some user fees, despite the fact that fewer facilities in this province offer ANC services (Table 6.4). Approximately 2 in 10 facilities charge user fees specifically for client consultations by resident providers; these are mostly private for-profit facilities, FBO-managed facilities, and facilities in Nairobi province (Table A-6.11). A very small proportion of facilities (mostly private for-profit and FBO-managed) charge for client consultations by consultants, and about one-fourth charge user fees for laboratory tests and iron tablets. About 4 in 10 facilities have fixed fees for all ANC services.

6.3.3 Staff Development and Supervision

The KSPA defines a facility as providing routine staff development activities if at least half of the interviewed ANC providers said they had received 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). Half (51 percent) of all facilities meet these criteria for providing routine staff development activities (Table 6.4). The facilities most likely to have routine staff development activities are hospitals and maternities (61 and 62 percent, respectively). NGO-managed facilities and facilities in Nairobi and North Eastern provinces are least likely to provide routine staff development.

The most frequently reported in-service training topics are STIs and prevention of mother-to-child HIV transmission (PMTCT) (29 and 14 percent, respectively) (Figure 6.4).

Figure 6.4 In-service training received by interviewed ANC service providers, by topic and timing of most recent training (N=1,041)



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Supervising individual staff members helps promote adherence to standards and also helps identify problems that contribute to poor quality services. As found with other services, supervision of ANC providers is common; 86 percent of facilities met the KSPA criteria for routine staff supervision (at least half of the interviewed ANC providers had been personally supervised during the past six months) (Table 6.4).[4] Rou-

[4] The assessment is not able to determine how complete or supportive the supervision is, and whether it is only for administrative matters or includes any coaching/learning component.

tine supervision for ANC providers is less frequent in hospitals and clinics (71 percent and 65 percent, respectively) and in facilities in Nairobi, Coast and Central provinces (71, 72 and 74 percent, respectively).

Key Findings

While 82 percent of facilities have up-to-date ANC registers, only 5 percent have PNC registers; 13 percent have documentation indicating they monitor ANC coverage rates.

Half of the facilities assessed have routine staff development activities, and about nine out of ten facilities have routine staff supervision, including nearly all facilities in Eastern province.

6.4 Adherence to Standards for Quality ANC Service Provision

To assess whether providers adhere to standards for providing quality service, KSPA personnel observed ANC client-provider consultations. The observation checklists used are based on elements of focused ANC. The observers noted whether providers shared information on a topic and whether an examination was conducted. They did not assess whether the information was correct or whether findings were appropriately interpreted.

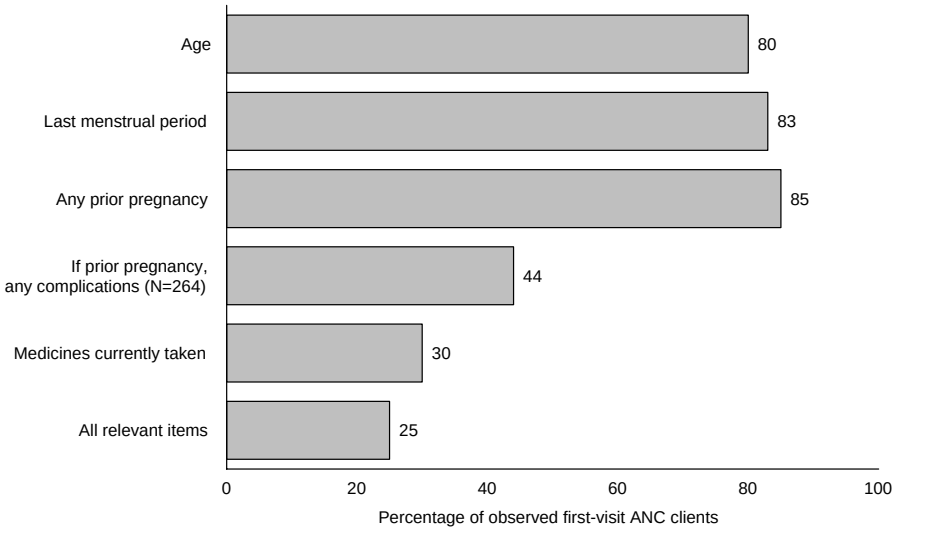
6.4.1 Appropriate Assessment and Examination for ANC clients

Summary information on components of ANC is provided in Figures 6.5, 6.6 and 6.7. Appendix Tables A-6.17 to A-6.21 provide details on assessments and examinations conducted for ANC clients.

Client History

At a first ANC visit, the provider should elicit a basic medical history to assess pre-existing risk factors. The information most often elicited by providers was age, date of last menstrual period, and information about any prior pregnancies. These questions were asked of 80 percent, 83 percent, and 85 percent, respectively, of first-visit ANC clients (Figure 6.5). These findings are similar to those from the 1999 KSPA. All the relevant client history items were assessed in only 1 out of 4 of first-visit consultations.

Figure 6.5 Content of client history assessed for first-visit ANC clients (N=357)



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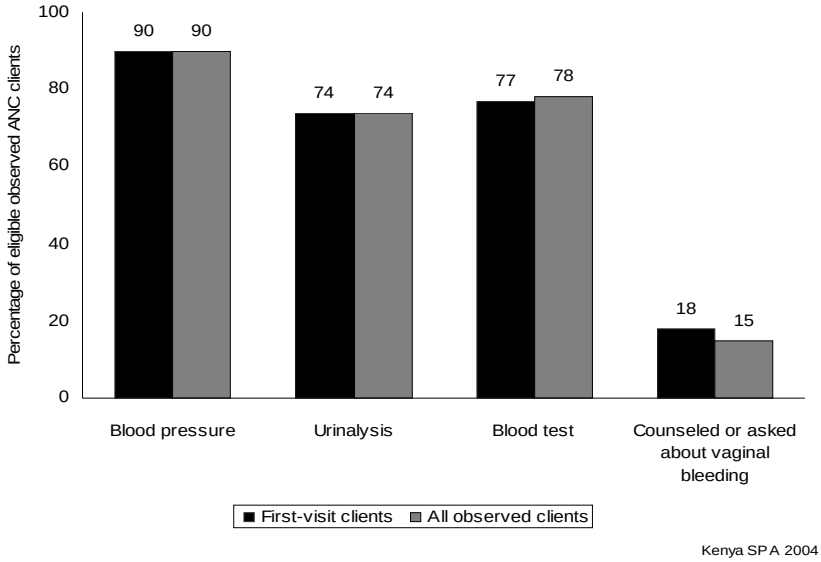
Monitoring Progress of Pregnancy

All ANC clients should receive periodic assessments to monitor the progress of their pregnancy and to identify risk factors. These include assessments of vaginal bleeding, blood pressure, and foetal condition. Figure 6.6 provides information on the percentage of observed ANC clients (whether first or follow-up visits) who received these elements as part of their visit. 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=357) and all observed clients (N=913)



Laboratory Testing and Provision of Iron Tablets

Laboratory facilities and cold chain maintenance capability are required for facilities to be able to provide certain 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.

To meet defined minimum standards for ANC, each ANC visit should include the following components: counselling on vaginal bleeding as a risk factor for which help should be sought, measuring blood pressure, and urinalysis to check for urine protein and glucose. First-visit clients should also have their blood checked for anaemia.

Counselling on vaginal bleeding (defined as either being counselled about vaginal bleeding as a risk or asked about vaginal bleeding during the examination) was provided to 18 percent of all first-visit clients (compared to 15 percent of all clients) (Figure 6.6). This is an improvement over the findings from 1999, when only 1 out of 10 clients was counselled about vaginal bleeding; however, these rates are still highly insufficient, given the life-threatening potential of the complication. Blood pressure was measured during 90 percent of consultations, for both first-visit and follow-up clients. Three-fourths of first-visit clients receive a blood test for anaemia. Providers were more likely to measure blood pressure, conduct urinalysis, and provide blood tests than they were to counsel clients about vaginal bleeding (Figure 6.6).

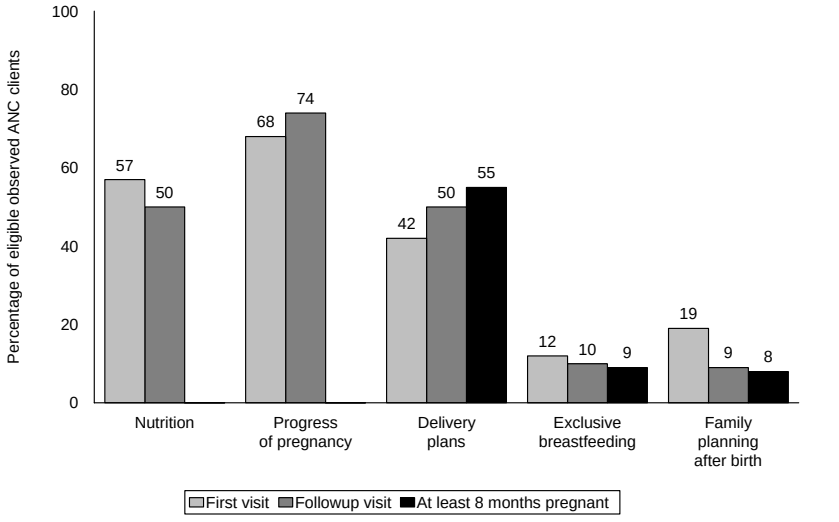
Key Findings

Only one-fourth of first-visit ANC clients were assessed for all of the relevant medical history items (age, last menstrual period, any prior pregnancy, complications in prior pregnancy, and medications currently taken).

6.4.2 Counselling to Promote a Healthy Outcome

Observed and reported components of client counselling are presented in Figures 6.7 and 6.8. Details on counselling and client knowledge about risk signs are available in Appendix Tables A-6.21 and A-6.22. Details on client plans for delivery are provided in Appendix Table A-6.23.

Figure 6.7 Counselling topics discussed during first visit (N=357) and follow-up visit (N=556) and with ANC clients at least 8 months pregnant (N=432), when relevant



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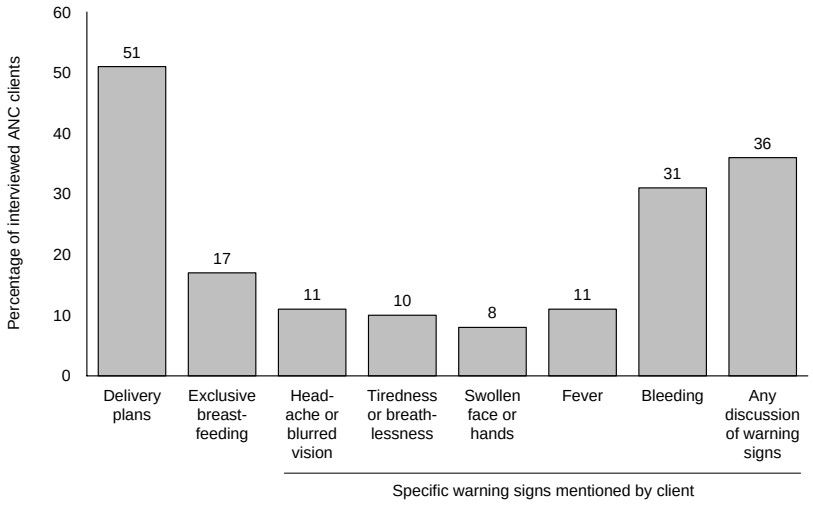
ANC providers are expected to routinely counsel their clients about special nutritional needs during pregnancy and about signs and symptoms that may indicate a problem. It is not unreasonable, however, to assume that all components of counselling may not be discussed during each visit, when a woman makes multiple ANC visits. Thus, the content of counselling for first and follow-up visits is assessed separately.

Nutritional issues were discussed during the observed consultation in 57 percent of first visits and in 50 percent of follow-up visits. Discussions on the progress of the pregnancy were held with 68 percent of first-visit clients and with 74 percent of follow-up clients (Figure 6.7). This is an improvement from 1999, when nutritional issues during pregnancy were discussed with only 34 percent of first-visit clients and with 42 percent of follow-up clients.

The Client Perspective

All interviewed ANC clients were asked about topics that the provider discussed with them, either during the current visit to the facility, or during a previous visit. Half of the interviewed clients said they had discussed plans for delivery with their provider (Figure 6.8). However, only 17 percent said they had discussed exclusive breastfeeding.

Figure 6.8 Topics reported by interviewed clients as having been discussed during either this or a previous ANC visit (N=900)



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Interviewed clients were also asked to mention specific warning signs that the provider had discussed with them during the current visit or any prior visit. While 36 percent said they had been told about warning/danger signs or symptoms, when asked to name any of these danger signs, few could mention the most important ones (Figure 6.8): just 3 in 10 mentioned vaginal bleeding, 8 percent mentioned swollen face or hands, and 11 percent mentioned headache or blurred vision.

Key Findings

Counselling on nutrition during pregnancy and progress of the pregnancy was observed during 57 percent of first visits and half of follow-up visits.

Thirty-six percent of interviewed ANC clients reported that they had been counselled on warning signs during pregnancy. Few clients could spontaneously mention these signs.

There is a general lack of counselling on exclusive breastfeeding and family planning, except for women near delivery.

6.4.3 Supporting Continuity of Care

For quality ANC, it is important to provide continuity of care, including monitoring changes between visits. One of the more reliable ways to achieving this is to maintain a record of relevant history and findings, as well as interventions or treatments provided. Frequently, health services are organised in such a way that a client's blood pressure and weight are measured and the information is recorded on the client's record before the ANC provider sees the client. Approximately 7 in 10 first-visit ANC clients were weighed and 9 in 10 had their blood pressure measured before or during the consultation (Table A-6.16). For such information to be available to the provider for use, an individual client card must be used. Details on the use of individual client cards are provided in Appendix Table A-6.24.

During 94 percent of first visits and 97 percent of follow-up consultations, the provider was observed to look at the individual client card during the consultation. By the end of all first-visit consultations, providers had written on the client's card. This was also the case in 98 percent of follow-up visits (Appendix

Table A-6.24). It is, of course, not possible to know through these observations whether the notes taken were relevant or accurate.

About 8 in 10 observed ANC clients went home after their consultation, and 14 percent were referred elsewhere in the same facility. None were admitted to the facility; 3 percent were referred to another facility.

6.5 Client Opinion of Service Provision

Before leaving the facility, observed ANC clients were asked their opinion of the services they received and about any problems they encountered on the day of the visit. The most common concern was the long waiting time, but only 2 in 10 clients considered this a big problem (Appendix Table 6.26). Another area of concern was lack of privacy, both visual and auditory.

Interviewed clients who reported that the facility was not the closest to their home were asked if specific factors were important in determining why they did not visit the facility closest to their home. Some reasons cited were that the closest facility was more expensive (17 percent) and that the closest facility had a bad reputation (12 percent). Six percent of interviewed clients had been referred and therefore had had to bypass the closest facility (Appendix Table A-6.27).

6.6 Availability of Delivery Services and Capacity to Provide Quality Delivery Care

The KSPA assessed the availability of emergency obstetric care and the presence of standards, equipment and supplies, and health system components to support quality delivery services. Specific items that were assessed include the following:

- Availability of delivery services;
- Home delivery care practices;
- Infrastructure and resources to support quality delivery services;
- Practices related to signal functions; and
- Documentation of delivery procedures and outcomes.

6.6.1 Availability of Delivery Services

Table 6.5 provides information on the availability of maternal health services, as well as details on the availability of emergency transport and services supporting safe home delivery (domiciliary care). Information on median travel time using the most common transport system is provided in Appendix Table A-6.29.

Although about 8 in 10 facilities offer ANC, only about 38 percent of facilities offer normal delivery services; one-third offer both ANC and normal delivery services (Table 6.5). Hospitals are, as expected, most likely to offer delivery services; NGO-managed facilities are more likely than others to offer delivery services. FBO- and government-managed facilities, and facilities in Central province, are least likely to offer these services. The percentage of facilities offering normal delivery services remains relatively similar to that observed in 1999.

Caesarean sections are offered by only 7 percent of eligible facilities, logically provided mostly by hospitals (76 percent). Rather surprisingly, only 3 percent of government-managed facilities offer caesarean sections (a decline from 15 percent in 1999), compared with 23 percent of private for-profit facilities. Among eligible hospitals, 67 percent of those providing caesarean sections are government-managed, 78 percent are NGO-managed, and 86 percent are private for-profit facilities (data not shown).

Table 6.5 Availability of maternal health services

Percentage of facilities that offer the indicated services and percentage with documentation of activities with traditional birth attendants (TBAs), by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of facilities providing indicated services								
	Facility-based maternity services						Services supporting safe home delivery		
Background characteristics	Ante-natal care	Normal delivery services	Cae-sarean section	ANC and normal delivery services	ANC, normal delivery, and caesarean section	Emergency transportation support for maternity emergencies[1]	Any home delivery services[2]	Documented official programme supportive of TBAs[3]	Number of facilities (weighted)[4]
Type of facility									
Hospital	84	95	76	81	65	91	10	8	28
Health centre	86	64	3	56	3	42	5	4	125
Maternity	76	87	23	68	18	59	3	0	20
Dispensary	77	15	0	14	0	9	4	5	249
Managing authority									
Government	81	35	3	30	3	16	4	7	245
NGO	88	87	5	86	5	87	50	12	16
Private (for-profit)	59	48	23	36	20	37	3	0	61
Faith-based organisation	87	33	6	31	5	37	2	1	109
Province									
Nairobi	68	30	7	28	7	34	1	5	37
Central	79	18	7	18	7	33	0	0	50
Coast	78	27	7	20	5	26	7	7	49
Eastern	81	32	9	30	7	22	1	11	81
North Eastern	82	35	6	29	6	29	9	17	8
Nyanza	96	49	6	47	6	26	1	6	54
Rift Valley	75	45	6	38	5	21	10	1	124
Western	82	69	6	54	6	46	8	0	29
Total[4]	79	38	7	33	6	27	5	5	430

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Any system where the facility provides some support for emergency transportation to referral site, or the facility is the referral site.
[2] This may be either a routine service or service only for emergency cases.
[3] Any official activity with TBAs for which the facility has any documentation.
[4] Totals include one clinic (weighted)

One way of increasing access to emergency obstetric care is to offer rapid transport to a facility where the needed service is available. Without a facility-supported emergency transportation system, the expectant mother and family are forced to use their own means of transport during an emergency. Even when a facility does not offer delivery services, but does offer ANC, it is desirable to have emergency transport available. 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.

Among all facilities, only 27 percent have a system of emergency transportation[5] to another facility for obstetric emergencies (Table 6.5). Hospitals are more likely (91 percent) than other facility types to have

[5] Facilities that are referral facilities are counted as having an emergency transportation system, since they can provide all relevant services.

an emergency transportation support for maternity emergencies, as are NGO-managed facilities (87 percent). Approximately 4 in 10 maternities do not have emergency transport services available. Among those facilities supporting emergency obstetric transport, 62 percent have an ambulance or other facility-based vehicle, 19 percent have other arrangements to support cost, and 5 percent are themselves referral sites (Table A-6.29)

Among facilities offering delivery services, however, 52 percent have an emergency transportation system in place for obstetric emergencies (data not shown). This is a modest improvement since 1999, when 47 percent of facilities providing delivery services had a driver and vehicle.

6.6.2 Domiciliary Care Practices

In countries where a large proportion of deliveries take place at home, frequently with the assistance of traditional birth attendants (TBAs), a support system from a health facility may increase a woman's chances of having a safe delivery. Research has also shown that every pregnancy is risky, and therefore every pregnant woman should receive skilled care during delivery. The concept of domiciliary care operates on the understanding that skilled care can be provided at the community level. The common support systems are for facility staff to attend home births, either routinely or for emergencies only. Retired midwives in the community can also be used to provide skilled care to women during delivery and have formal systems for working with the health system and other community resource persons including TBAs.

The KSPA 2004 findings indicate that only 5 percent of facilities have services supporting safe home delivery; these are mostly NGO-managed facilities (Table 6.5). No maternity offers this outreach service. Finally, a very small proportion of facilities have documentation of official support for traditional birth attendants (5 percent).

Key Findings

Although ANC is offered in four out of five facilities, only half of them offer normal delivery services, and about 1 in 10 (including 76 percent of hospitals) offer caesarean sections.

All three maternal health services (ANC, normal delivery, and caesarean section) are offered in only 6 percent of facilities, although they are offered in two-thirds of hospitals.

Normal delivery services are most widely available in Western province facilities (69 percent) and least available in the Central province (18 percent).

About one-fourth of all facilities and 52 percent of facilities offering delivery services provide support for emergency transportation of maternity emergencies to referral facilities.

Only 5 percent of all facilities assessed provide any home delivery service, but half of NGO facilities do provide it.

6.6.3 Infrastructure and Resources to Support Quality Delivery Services

In addition to a basic infrastructure that provides privacy and supports infection control, several types of equipment and medicines are needed to support safe deliveries.

Tables 6.6 and 6.7 provide aggregate information on infrastructure, equipment, and supplies for basic delivery services, including emergency medicines. Figures 6.10 through 6.12 summarize the individual items available, 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 sterilisation/high-level disin-

fecting (HLD) procedures for delivery equipment. Figure 6.12 provides information on equipment for emergency obstetric care, with further details 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering delivery services with: All items for infection control[1]	Capacity for sterilisation/ HLD processing[2]	All delivery room infrastructure and furnishings[3]	All other elements to support quality[4]	Number of facilities offering delivery services (weighted)[5]
Type of facility					
Hospital	54	56	62	21	27
Health centre	35	30	22	7	80
Maternity	45	21	50	1	18
Dispensary	37	32	11	0	38
Managing authority					
Government	46	27	20	8	86
NGO	16	72	17	1	14
Private (for-profit)	48	37	60	5	29
Faith-based organisation	27	31	30	9	35
Province					
Nairobi	47	47	59	20	11
Central	78	23	46	10	9
Coast	40	87	45	24	13
Eastern	56	8	43	5	26
North Eastern	50	10	38	3	3
Nyanza	41	12	45	1	26
Rift Valley	29	33	11	2	55
Western	22	62	6	11	20
Total[5]	40	34	29	7	164

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[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 sterilising or HLD processing, and an automatic timing device were available
[3] Bed, examination light, and visual and auditory privacy.
[4] Guidelines, partographs, and 24-hour delivery provider on site or on call, with duty schedule observed.
[5] Totals include one clinic (weighted)

Infection Control

Infection is one of the most common causes of maternal and neonatal morbidity and mortality. Infection control practices are therefore essential for quality delivery care. Among facilities offering delivery services, 4 in 10 had all the items assessed for infection control available in the delivery service area (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) (Table 6.6). Hospitals are more likely than other facilities to have all infection control items, although this proportion is still low at only 54 percent. NGO-managed facilities are least likely to have infection control items (16 percent). Central province facilities are more likely than facilities in other provinces to have these infection control items (78 percent). The items most often lacking in all these facilities were disinfecting solution (missing in 33 percent of facilities) and hand-washing soap (missing in 41 percent of facilities) (Appendix Table A-6.30). Over 90 percent of facilities, however, have clean latex gloves.

Among facilities offering delivery services, only one-third have the capacity for sterilisation/HLD processing (Table 6.6); the remainder either lack equipment or knowledge, or the facility simply does not sterilise/disinfect delivery equipment (Table A-6.32). As expected, it is mostly hospitals (56 percent) and NGO-managed facilities (72 percent) that have the capacity for sterilisation/HLD processing (Table 6.6).

The procedure used for sterilising/HLD processing equipment used for deliveries was also assessed.[6] Among the 34 percent of facilities with the capacity for sterilisation/HLD processing, 31 percent use dry heat or autoclave, and 3 percent either boil/steam or use chemical HLD (Appendix Table A-6.32). Only 12 percent of facilities process delivery equipment specifically in the delivery service area, and the remaining 86 percent send equipment to the main processing area in the facility (Appendix Table A-6.31).

Only 1 in 4 facilities have written guidelines for sterilisation or HLD processing available in the area where delivery equipment is processed (Appendix Table A-6.32). Guidelines are most often found in Coast province facilities (84 percent), compared with just 2 percent of facilities in Rift Valley province.

Infrastructure for Delivery

Items to support quality delivery services were also assessed (Table 6.6 and Figure 6.9). A bed, an examination light, and privacy (both visual and auditory) are considered the basic delivery room infrastructure and equipment. Overall, only 29 percent of facilities have all these basic items (Table 6.6). The best equipped facilities are hospitals and maternities (62 percent and 50 percent, respectively) and private for-profit facilities (60 percent). Similarly, facilities in Nairobi are more likely to have all the basic infrastructure and equipment. The delivery area in most facilities (91 percent) provides both visual and auditory privacy (Figure 6.9). Almost all facilities (98 percent) have a delivery bed; however, only 31 percent have an examination light.

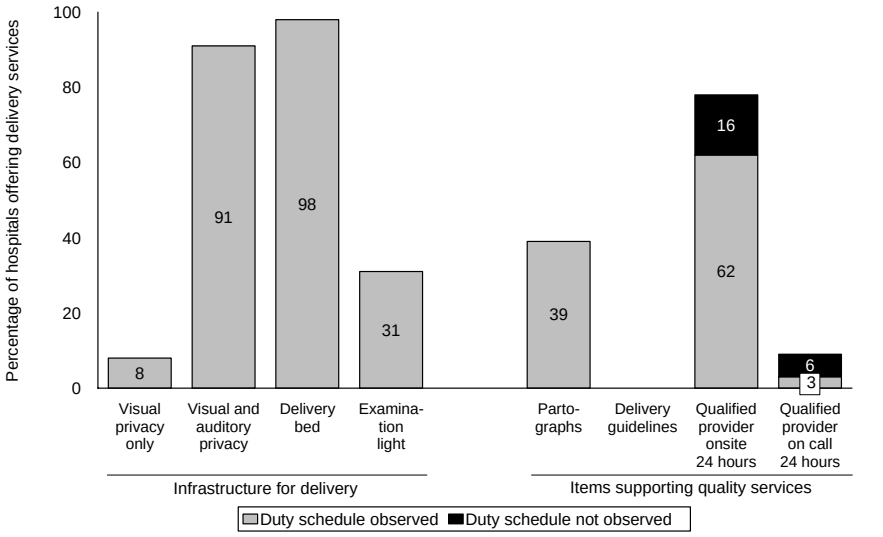
Elements to Support Quality Delivery Services

The partograph—a document used to monitor an individual woman's labour—is promoted internationally as a means for improving quality of care by helping providers take appropriate and timely decisions, based on the progress of labour at every stage. It provides guidelines for the early identification of complications. Only 4 in 10 eligible facilities have blank partographs available (Figure 6.9); this finding is similar to data from 1999. Regarding actual use of the partograph, only 38 percent of interviewed providers offering delivery services had used a partograph within the month preceding the interview. Eleven percent had never used a partograph to monitor labour (data not shown).

Delivery guidelines, necessary for managing delivery complications, are also not commonly available; only 7 percent of facilities offering delivery services had guidelines available in the delivery service area (Figure 6.9). In Kenya, general practitioners, obstetricians, and nurses/midwives are the principal facility-based delivery service providers. Although about 8 in 10 facilities report that there is a delivery service provider on site 24 hours a day, 16 percent did not have a duty schedule to document that claim. A much smaller percentage of facilities (9 percent) report a qualified provider on call 24 hours a day, and 3 percent have a duty schedule to document that a provider is on call (Figure 6.9).

[6] Chapter 3, sections 3.4.1 and 3.4.2 provide details on the definitions for adequate sterilisation or HLD procedures and storage practices.

Figure 6.9 Items to support quality delivery services
(N=164)



Kenya SPA 2004

Key Findings

Infection control measures for delivery services are weak, with only 4 out of 10 facilities having all the five internationally recommended items.

About 3 in 10 facilities have all the elements needed to support quality sterilisation of delivery equipment.

Partographs and protocols to support quality delivery standards are available in only 39 percent and 7 percent of facilities, respectively.

Two out of three facilities have a qualified trained provider available 24 hours a day (on site or on call), with an observed duty schedule.

Monitoring of Normal Deliveries

It is very important to monitor all deliveries in order to ensure the well-being of both the foetus and the mother. Table 6.7 provides information on critical practices for monitoring normal facility-based deliveries. The recommended standard practice is to monitor foetal heart rate, maternal pulse rate, and uterine contractions every 30 minutes, and to check maternal blood pressure every 4 hours.

Information gathered from clients' delivery records or charts showed that foetal heart rate and uterine contractions were monitored or checked every 30 minutes for only 1 in 5 normal deliveries, while blood pressure measurement was recorded every 4 hours in only 14 percent of cases. Pulse rate measurements every 30 minutes were least likely to be recorded (8 percent). Overall, all four critical practices were documented for only 5 percent of all reviewed normal delivery records. Only 17 percent of hospitals and 10 percent of maternities had documentation of all four critical practices (Table 6.7). Interestingly, no other facilities (health centres, clinics or dispensaries) had any records indicating that all four critical practices were carried out.

Table 6.7 Documentation of critical practices for monitoring normal deliveries

Percentage of recent normal deliveries where the client records document certain monitoring practices. Kenya SPA 2004

Background characteristics	Percentage of reviewed records with the indicated items documented					Number of normal delivery records reviewed (weighted)
	Foetal heart rate measured every 30 minutes	Assessment of contractions every 30 minutes	Blood pressure measured every 4 hours	Pulse measured every 30 minutes	All critical practices carried out	
Type of facility						
Hospital	45	45	39	22	17	129
Health centre	15	13	6	3	0	330
Maternity	31	28	29	18	10	74
Clinic	10	22	4	0	0	4
Dispensary	2	2	2	0	0	132
Managing authority						
Government	13	15	10	4	2	350
NGO	26	32	9	19	8	29
Private for-profit	41	29	26	17	12	134
FBO	15	17	13	5	4	157
Province						
Nairobi	46	42	25	22	9	55
Central	16	22	31	9	4	43
Coast	33	20	17	6	5	65
Eastern	21	22	15	4	3	84
North Eastern	13	8	5	4	1	14
Nyanza	31	32	22	19	13	93
Rift Valley	7	6	5	3	2	222
Western	17	19	9	5	2	93
Total	20	19	14	8	5	670

Essential Supplies for Delivery Services

All basic supplies for conducting a normal delivery (scissor or blade, cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineum) are available in the delivery area in only 36 percent of facilities (Table 6.8). Hospitals and maternities (63 percent and 56 percent, respectively), and also private for-profit facilities (59 percent) and facilities in Nairobi province (56 percent) are more likely to have all the supplies compared to others. These findings indicate that cord ties/clamps are less widely available; availability has decreased from 72 percent in 1999 to 64 percent in 2004. Availability of different individual items in the delivery area varies from 77 percent for skin disinfectant to 56 percent for antibiotic eye ointment to (Figure 6.10).

Table 6.8 Availability of medicines and supplies for normal and complicated delivery services

Percentage of facilities that have all indicated supplies, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	All essential supplies for delivery[1]	Among facilities offering delivery services, percentage with additional medicines and supplies for:		Number of facilities offering delivery services (weighted)[4]
		Common complications[2]	Serious complications[3]	
Type of facility				
Hospital	63	59	25	27
Health centre	36	22	7	80
Maternity	56	36	10	18
Dispensary	6	6	20	38
Managing authority				
Government	22	20	2	86
NGO	42	16	2	14
Private (for-profit)	59	48	14	29
Faith-based organisation	47	25	43	35
Province				
Nairobi	56	48	16	11
Central	40	81	8	9
Coast	43	21	9	13
Eastern	31	43	3	26
North Eastern	35	23	13	3
Nyanza	44	23	14	26
Rift Valley	23	9	18	55
Western	49	23	15	20
Total[4]	36	26	13	164

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

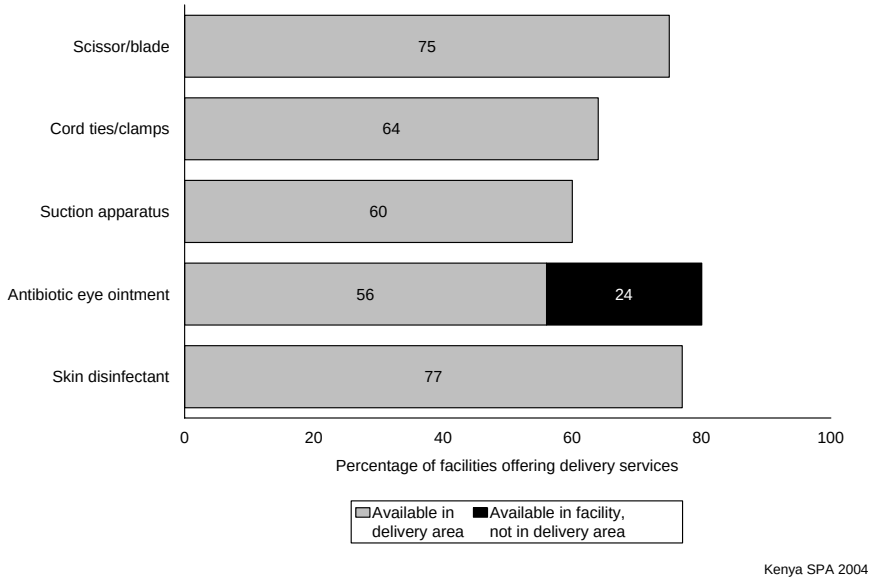
[1] Scissor or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, skin disinfectant.

[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 gentamicin) in delivery room area or pharmacy.

[4] Totals include one clinic (weighted)

Figure 6.10 Essential supplies for delivery (N=164)

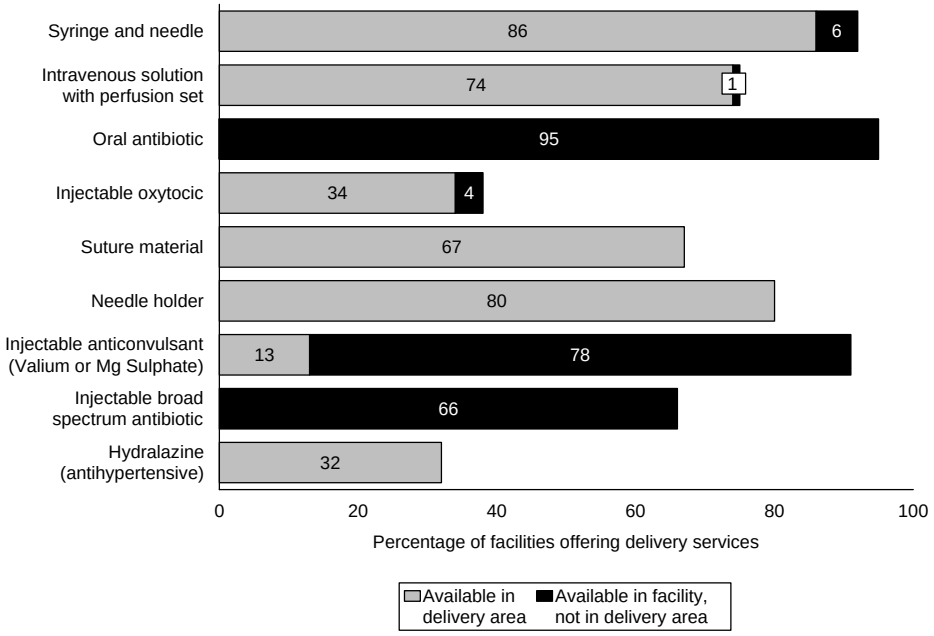


Medicines and Supplies for Complications

Table 6.8 provides information on the availability of essential supplies for normal delivery and additional medicines and supplies to handle common and serious delivery complications. Figure 6.11 provides detailed information on these additional medicines and supplies.

All items for managing common delivery complications are available in one out of every four facilities offering delivery services (Table 6.8), primarily in hospitals and maternities (59 percent and 36 percent, respectively) and in private for-profit facilities (48 percent). These items are most widely available in facilities in the Central province (81 percent) and least available in facilities in Rift Valley province (9 percent).

Figure 6.11 Additional medicines and supplies for managing complications of delivery (N=164)



Kenya SPA 2004

The KSPA also assessed whether facilities offering delivery services had selected medicines and supplies for managing serious complications. The standards for maternal care in Kenya indicate that every pregnant woman or woman in puerperium seeking health care should be attended to by a skilled health care provider within 30 minutes of arrival at a health facility. This implies that all the supplies needed for emergencies should be readily available. The Kenyan maternal care standards call for EmOC facilities to have an emergency tray of drugs available, with anticonvulsants, anti-hypertensives, and oxytocics, among others (Population Council, 2002b).

These additional medicines and supplies for managing serious complications were available in 13 percent of facilities offering delivery services. FBO-managed facilities are most likely to have these medicines and supplies (Table 6.8). Injectable anticonvulsants, used to treat severe pre-eclampsia and eclampsia, are available in the delivery service area in 13 percent of facilities, though an additional 78 percent have them elsewhere in the facility (Figure 6.11).

Injectable antibiotics for treating sepsis are available in two-thirds of facilities, but none had them in the delivery area. Hydralazine, commonly used to manage hypertension during labour, is found in the delivery area of only 32 percent of facilities.

Provider Knowledge of Signs of Postpartum Haemorrhage

KSPA interviewers spoke with the most experienced maternal health provider present on the day of the survey in each facility that offered maternal health services. They used the maternal health provider questionnaire to assess the provider's knowledge of common signs of postpartum haemorrhage and obstructed labour. Interviewed providers were expected to spontaneously name signs they should look for to assess the severity of any postpartum haemorrhage. The expected responses included signs of shock (dizziness or low blood pressure), amount of external bleeding, un-contracted uterus, and retained products of conception/placenta. Table 6.9 provides information on providers' knowledge of these signs and of immediate intervention steps to alleviate the problem.

Only 6 percent of interviewed midwives spontaneously named all four categories of signs of postpartum haemorrhage. More midwives in maternities (23 percent), private for-profit facilities (13 percent) and facilities in Nairobi province (31 percent) were able to name all four signs and symptoms spontaneously. Sixty percent of interviewed midwives spontaneously named signs of shock, 55 percent named uncontracted uterus, and 53 percent named the amount of external bleeding as signs for assessing the severity of the haemorrhage. Forty-one percent spontaneously named retained products/placenta.

Provider Knowledge of Interventions for Postpartum Haemorrhage

When asked to name interventions for postpartum haemorrhage, 70 percent of midwives spontaneously mentioned massaging the uterus, and 76 mentioned giving an injection of ergometrine intramuscularly or intravenously. They were less likely to mention emptying the patient's urinary bladder (46 percent) and giving intravenous fluids (44 percent). In all, only 12 percent of all interviewed midwives were able to spontaneously name all four expected interventions for postpartum haemorrhage. Unlike naming signs and symptoms for assessing the severity of postpartum haemorrhage, more midwives in hospitals than in other types of facilities were able to name all expected interventions. However, more midwives in Nairobi than in other provinces were still able to name all four interventions compared to midwives in other provinces. Not a single midwife interviewed in dispensaries, NGO facilities, or the North Eastern province was able to mention all four interventions.

Table 6.9 Knowledge of signs of postpartum haemorrhage and of immediate interventions

Percentage of interviewed midwives who spontaneously described the indicated signs of postpartum haemorrhage and interventions for postpartum haemorrhage, Kenya SPA 2004

Background characteristics	Percentage mentioning indicated signs of postpartum haemorrhage					Percentage mentioning indicated interventions for postpartum haemorrhage[1]					Number of interviewed midwives (weighted)
	Uncontracted uterus	Signs of shock[2]	Amount of external bleeding	Retained products/ placenta	All four signs & symptoms	Massage fundus	Empty woman's bladder	Ergometrine IM or IV[3]	Start intravenous fluids	All four interventions	
Type of facility											
Hospital	64	72	61	44	12	73	50	79	66	24	27
Health centre	55	67	43	41	2	72	43	74	60	17	86
Maternity	65	66	66	53	23	69	40	79	57	20	18
Clinic	75	45	53	61	16	62	68	81	31	15	2
Dispensary	48	45	60	35	4	67	49	76	10	0	65
Managing authority											
Government	55	70	48	37	5	77	45	76	44	14	115
NGO	41	28	62	4	1	38	58	99	5	0	14
Private for-profit	49	64	65	46	13	69	34	74	70	18	30
FBO	65	40	55	60	3	62	52	70	36	7	40
Province											
Nairobi	94	60	49	76	31	60	64	99	79	40	11
Central	81	88	36	79	16	94	45	87	35	23	9
Coast	73	44	46	46	3	60	31	50	42	4	25
Eastern	60	60	59	32	3	93	56	86	60	15	35
North Eastern	26	56	28	44	0	35	0	44	50	0	3
Nyanza	34	56	43	42	3	35	38	82	21	1	35
Rift Valley	41	57	57	25	2	78	51	69	40	14	56
Western	68	79	68	51	11	80	44	82	50	15	25
Total	55	60	53	41	6	70	46	76	44	12	198

[1] Postpartum haemorrhage resulting from an atonic or un-contracted uterus
[2] Dizziness or low blood pressure
[3] Ergometrine is commonly used for the management of post-partum haemorrhage, and is either given intramuscularly or intravenously

Key Findings

Basic equipment and supplies that should be available for any normal delivery are available in 1 of 3 facilities offering delivery services, with minimal provincial variation.

Capacity to manage common or serious complications of labour and delivery is weak in all facilities, including hospitals.

Thirty-nine percent of facilities offering delivery services have blank partographs, and thirty-eight percent of providers offering delivery services had used a partograph within one month of the survey.

Three out of five hospitals have all the basic medicines and supplies for managing common complications of labour and delivery, whereas only 1 in 4 has medicines for managing serious complications.

An injectable oxytocic medicine is available in the delivery area in only one-third of all facilities assessed.

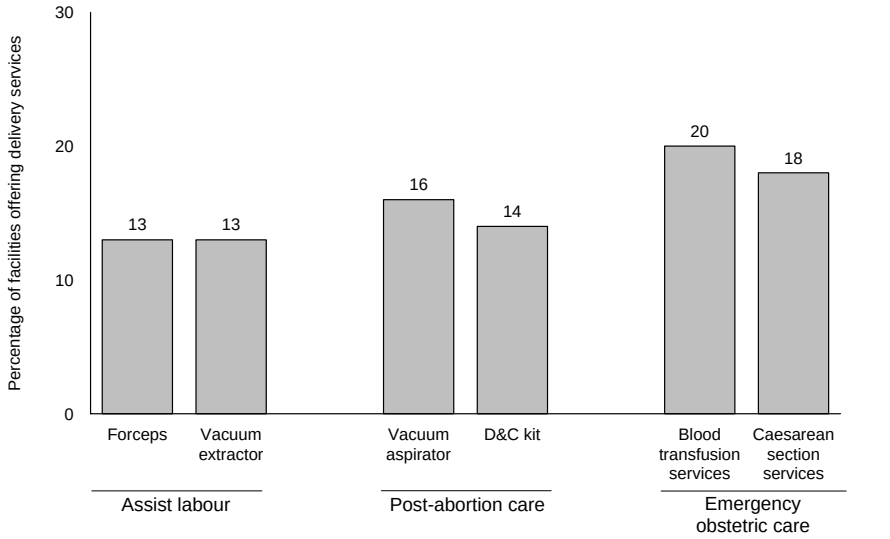
Only 6 percent of providers mentioned all four signs of postpartum haemorrhage; 12 percent mentioned all four interventions to manage postpartum haemorrhage.

Emergency Equipment

In addition to the previously mentioned equipment and supplies, a facility that manages complicated deliveries should have the capacity to offer comprehensive essential obstetric care. In Kenya, support for complicated deliveries is authorized primarily in hospitals and maternities that can perform a caesarean section. Facilities that do not have the capacity to provide the service are expected to refer the clients.

In cases where life-saving emergency obstetric care is required, the capacity to provide a caesarean section (CS) and to transfuse blood is essential. Overall, among facilities offering delivery services, only around 2 in 10 provide CS or blood transfusion services (Figure 6.12). Among eligible hospitals, 8 in 10 provide caesarean section and around 9 in 10 provide blood transfusion services (Table A-6.36); this is very similar to the findings in 1999, when 79 percent of hospitals offering delivery services provided caesarean section and 86 percent provided blood transfusion services. The number of maternities providing these services has declined since 1999; only 26 percent provide CS (compared with 50 percent in 1999) and 46 percent provide blood transfusion services (compared with 65 percent in 1999). Among government-managed facilities, only 1 in 10 can provide caesarean section or blood transfusion services.

Figure 6.12 Emergency equipment and services available in facilities providing delivery services (N=164)



Kenya SPA 2004

Key Findings

Among government-managed facilities, less than one in ten has the capacity to perform assisted vaginal delivery.

Only one in ten government facilities offering delivery services can provide caesarean section or blood transfusion services, whereas almost half of private for-profit facilities offering delivery services can provide caesarean section or blood transfusion services.

Assisted Vaginal Delivery

Assisted vaginal delivery in Kenya is a procedure performed only by obstetricians, and therefore not frequently performed. If required, it should involve as little trauma as possible (for example, by using a plastic cap vacuum extractor at low pressure). The practice is not banned (MOH/KOGS, 2001).

Among facilities offering delivery services, 13 percent have the capacity to provide assisted vaginal delivery by means of forceps, and another 13 percent by means of vacuum extraction (Figure 6.12). Rather surprisingly, 31 percent of dispensaries have the capacity to provide forceps delivery (Table A-6.36). FBO-managed facilities and facilities in Nyanza are more likely than other facilities to provide this service. In the case of vacuum extraction, hospitals and FBO-managed facilities are most likely to provide this service.

Post-abortion Care

The ability to provide care to a woman after an abortion is vital to prevent any further complications. To remove any retained products of conception, facilities should be able to provide manual vacuum aspiration or dilatation and curettage (D&C). Information on the availability of these services is found in Figure 6.12 and Appendix Table A-6.36. Among facilities offering delivery services, only 16 percent have a vacuum aspirator, and 14 percent have a D&C kit. As expected, hospitals and maternities are most likely to have this equipment. Private for-profit facilities are more likely to have a vacuum aspirator (32 percent), while NGO facilities are least likely to have either a vacuum aspirator (4 percent) or D&C kit (5 percent). Facilities in Coast province are most likely to have a vacuum aspirator (59 percent), compared with facilities in Rift Valley and Eastern provinces (6 percent and 5 percent, respectively).

6.7 Newborn Care Practices

The perinatal mortality rate (PNMR) in Kenya is 40 deaths per 1,000 births (KDHS 2003), with the Coast province having the highest rate and Western province the lowest. The KSPA 2004 assessed newborn care practices and the availability of equipment and supplies for newborn care. Facilities sometimes need special equipment to support the newborn. KSPA observers noted whether facilities had a emergency respiratory support unit (resuscitaire or Ambu bag) and an external heat source to maintain the infant's body heat, especially in a premature newborn (incubator, heat lamp, or other device). Details on emergency support for newborns and on newborn care practices (excluding care of the umbilical cord) are provided in Figure 6.13 and Appendix Tables A-6.36 and A-6.38.

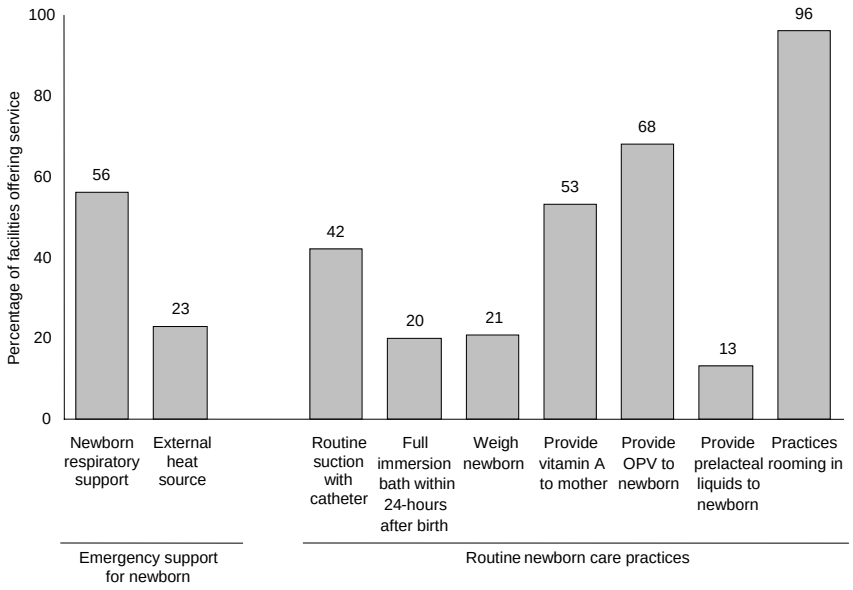
Only 39 percent of eligible facilities had an Ambu bag for newborn respiratory support in 1999, but close to 6 in 10 facilities had this support for newborns in 2004 (Figure 6.13). Hospitals are most likely to have this emergency respiratory support available, and NGO-managed facilities were most unlikely to have it. Almost all facilities in the Central province (93 percent) have a respiratory support system for the newborn (Table A-6.36).

Figure are very similar for an external heat source for newborns. On average, only 23 percent of all facilities have an external heat source; most hospitals (72 percent) and facilities in the Central province (78 percent) have an external heat source for newborns. NGO-managed facilities, again, are the least likely to have this equipment (Appendix Table A-6.36)

Using catheter suction to stimulate respiration in newborns who are not breathing is a common practice in many facilities. However, this should not be a routine practice, as it may cause injury to the newborn and risk mother-to-child transmission of HIV. Approximately 4 in 10 facilities report routinely using catheter suction (Figure 6.13, Appendix Table A-6.38).

Hypothermia contributes to increased morbidity and mortality of newborns. This can be prevented by avoiding a full-immersion bath 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 relatively uncommon, with 20 percent of facilities indicating that this practice is routine. The practice is more common in hospitals and in maternities (33 percent and 42 percent, respectively) than in other facility types (Figure 6.13, Appendix Table A-6.38).

Figure 6.13 Emergency support and routine practices for newborns (N=164)



Weighing the newborn provides health information for monitoring postnatal care, as low birth weight is a risk indicator of infant death. Although 9 out of 10 facilities indicate that they routinely weigh the newborn, only 8 out of 10 have a functioning infant weighing scale in the delivery service area (Figure 6.13, Appendix Table A-6.38).

Vitamin A supplementation in poorly nourished children has been shown to decrease the risk of infection and death. Newborns can receive a healthy amount of vitamin A through breast milk; however, pregnant women are also at risk of developing vitamin A deficiency, and therefore need vitamin A supplementation after delivery. About half of facilities indicate that they routinely provide vitamin A to new mothers, and half have it available in the delivery area of the facility. Eighty percent of facilities have vitamin A available either in the delivery room or in the pharmacy.

Oral polio virus (OPV) vaccination is provided to newborns in 68 percent of the assessed facilities, and BCG vaccine is provided in 66 percent of the facilities.

Internationally, exclusive breastfeeding is promoted for the first six months of age, and providing prelacteal liquids is discouraged. As noted in the section in Chapter 6 on antenatal care (Figure 6.7), pregnant women are not routinely counselled on exclusive breastfeeding. Prelacteal liquids are routinely provided in 13 percent of facilities.

“Rooming in,” where the infant routinely stays with the mother (a practice that supports exclusive breastfeeding and mother-child bonding), is routinely practiced in most facilities (96 percent).

Key Findings

Emergency support for newborns is lacking in most facilities. Hospitals and facilities in Central province are most likely to have emergency newborn support capacity, and NGO-managed facilities are least likely to have this capacity

Weighing the infant, providing vitamin A to the mother, and rooming in are practices that are common in Kenya and are considered supportive of newborn health.

Routine suctioning with a catheter is a practice that is being carried out routinely in some facilities, especially maternities (53 percent) and hospitals (46 percent); this should be re-assessed and discouraged as a routine practice.

One out of five hospitals report routinely providing prelacteal liquids to newborns.

6.8 Management Practices Supportive of Quality Delivery Services

Tables 6.4 and 6.10 provide information on management practices related to childbirth that were assessed by the KSPA 2004. Appendix Table A-6.42 provides information on supportive management for providers of delivery services. Appendix Table A-6.34 provides information on availability of delivery service providers, Appendix Table A-6.41 provides information on routine charging practices for delivery services, and Appendix Tables A-6.42 through A-6.44 provide information on supervision and staff development from the provider's perspective.

6.8.1 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. Seventy-six percent of facilities offering delivery services have an up-to-date delivery register available (Table 6.10). Hospitals and facilities in the Central province (92 percent each) are most likely to have up-to-date registers. NGO-managed facilities are least likely (44 percent) to have up-to-date registers.

Facilities frequently have catchment populations for whom they are responsible for providing services. The KSPA 2004 assessed whether facilities have any documentation indicating that they monitor the proportion of deliveries that occur in their catchment area under skilled care (or, for some programme strategies, deliveries that are attended by skilled providers affiliated with the facility). Only 14 percent of facilities offering delivery services have documentation on monitoring delivery coverage in their catchment areas (Table 6.10). Despite the low overall percentages, facilities in Coast, Central, and Eastern provinces are much more likely to monitor delivery coverage (49, 47, and 31 percent, respectively).

Table 6.10 Facility-based supportive management practices in relation to childbirth

Percentage of facilities with the indicated documentation, percentage with user fees, and percentage that provide the indicated supportive management, by type of facility, managing authority and province, Kenya 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)[3,4]
	Observed up-to-date patient register[1]	Documentation of monitoring delivery coverage	Reviews of 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								
Hospital	92	12	60	96	27	43	70	27
Health centre	80	22	12	76	80	26	86	80
Maternity	82	10	24	99	18	49	67	18
Dispensary	52	0	37	43	38	29	100	38
Managing authority								
Government	76	22	18	61	86	36	85	86
NGO	44	3	5	42	14	16	99	14
Private (for-profit)	81	9	33	98	29	36	69	29
Faith-based organisation	84	3	54	99	35	26	92	35
Province								
Nairobi	79	1	33	71	11	45	71	11
Central	92	47	33	100	9	19	82	9
Coast	78	49	43	77	13	45	67	13
Eastern	67	31	11	68	26	39	94	26
North Eastern	60	6	16	26	3	25	62	3
Nyanza	78	6	40	87	26	30	89	26
Rift Valley	74	3	20	66	55	19	86	55
Western	84	0	35	83	20	53	90	20
Total[4]	76	14	27	74	164	32	85	164

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[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. Topics are birth or delivery services related.
[3] Includes only providers of delivery services in facilities offering delivery services.
[4] Totals include one clinic (weighted)

6.8.2 Systems for Quality Assurance, Including Maternal Death Reviews

One measure of quality assurance for delivery services is to systematically review all maternal and newborn deaths or near-misses, in order to identify avoidable factors leading to these deaths. This helps to develop interventions that prevent the occurrence of future deaths. The KSPA 2004 did not assess the quality of these review programmes, but did enquire whether facilities implemented the process or not. Overall, only 27 percent of facilities providing delivery services indicated that they conduct reviews of maternal or newborn deaths or near-misses (Table 6.10). The practice is most common in hospitals (60 percent) and in FBO-managed facilities (54 percent). Facilities in Eastern and North Eastern provinces are less likely to conduct these reviews.

6.8.3 Practices Related to User Fees

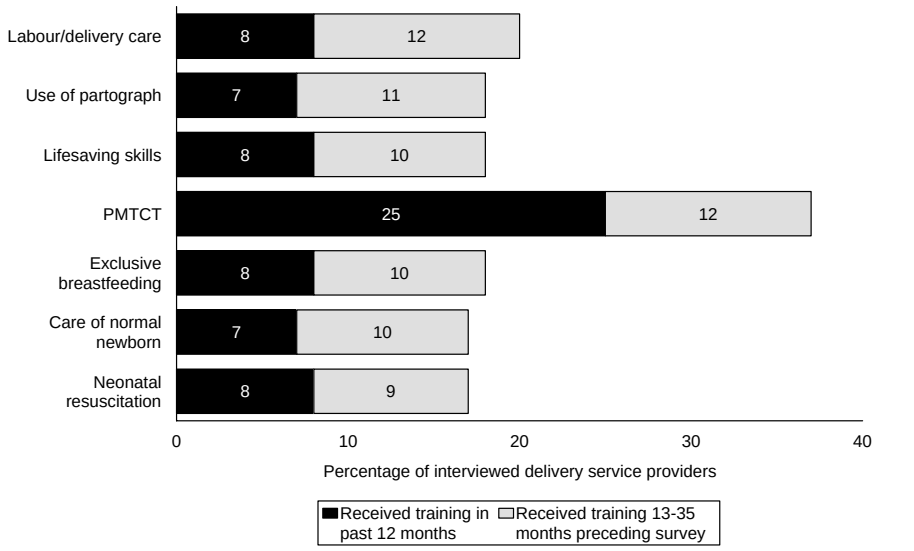
The KSPA 2004 documented the percentage of facilities that collect user fees for delivery-related services. Seventy-four percent of all facilities offering delivery services charge some form of user fee (Table 6.10), with almost all hospitals and maternities, and all private for-profit and FBO-managed facilities, doing so. Similarly, all facilities in Central province charge user fees, while only a quarter of facilities in

North Eastern province do. While 73 percent of facilities charge user fees specifically for normal delivery services, 19 percent charge a fixed fee covering both ANC and normal delivery services (Appendix Table A-6.41). About one-third have specific fees for medicines, and one-fourth charge for laboratory tests.

6.8.4 Staff Development and Supervision

A facility is defined as providing routine staff development activities when at least half of the interviewed delivery service providers at that facility have received any structured in-service training relevant to delivery services during the past 12 months (excluding on-the-job training/coaching that may be received during discussions with supervisors). Just 3 in 10 facilities meet these criteria for providing routine staff development activities (Table 6.10). Hospitals and maternities are slightly more likely than other types of facilities to provide routine staff development (43 percent and 49 percent, respectively); the same is true of government and private for-profit facilities (36 percent). Figure 6.14 shows what topics were covered in the most recent in-service training received, and when it was offered. Staff members were more likely to be trained in PMTCT than in any other topic.

Figure 6.14 In-service training received by interviewed delivery service providers, by topic and timing of most recent training (N=881)



Kenya SPA 2004

A facility is defined as providing routine staff supervision when at least half of the interviewed delivery service providers have been personally supervised in the past six months. Eighty-five percent of facilities meet these criteria for provide routine staff supervision (Table 6.10).

Key Findings

Three out of four facilities have up-to-date delivery registers.

One out of ten facilities have documents showing they monitor community coverage of delivery services.

Almost three out of ten facilities offering delivery services conduct reviews of maternal of newborn deaths or near-misses.

Routine supervision of delivery service providers is almost universal (85 percent of facilities), but routine in-service training is not common (32 percent of facilities).

6.8.5 Youth-friendly Services

Most youth who need sexual and reproductive health care are not comfortable accessing existing services, because these services are not "youth-friendly" and may not meet their need. In addition, providers are often biased and untrained, and do not feel comfortable serving sexually active youth. There has been a recent effort to sensitize all staff at health care facilities on the provision of “youth-friendly” services (YFS) that are geared towards making youth feel comfortable and welcome to seek health care. More information on the availability of YFS is provided elsewhere in this report; however, it bears mentioning in this section that only 2 percent of facilities in Kenya provide any youth-friendly services related to ANC (data not shown).

6.9 Availability of Emergency Obstetric Care

6.9.1 The Signal Functions for EmOC

Outcome indicators of maternal health, such as the maternal mortality ratio, require large numbers of observations in the denominator, and are amenable to change only in the long term (4-5 years). In recognition of this fact, Columbia University and UNICEF developed a series of tools to measure “process indicators” that are easier to collect and interpret, and susceptible to changes in a shorter period (UNICEF et al., 1997). The indicators developed were called the UN Process Indicators for Emergency Obstetric Care (EmOC) and measured certain types of obstetric services that were understood to have a direct bearing on maternal outcomes, including mortality and morbidity. The assessment of UN process indicators for EmOC follows two main steps. The first step is based on a set of certain critical services or “signal functions” proven to significantly reduce maternal deaths and improve birth outcomes for the newborn. These signal functions include:

1. Administration of parenteral antibiotics
2. Administration of parenteral oxytocic drugs
3. Administration of parenteral anticonvulsants for pre-eclampsia/eclampsia
4. Manual removal of placenta
5. Removal of retained products of conception
6. Assisted vaginal delivery
7. Blood transfusions
8. Surgery (caesarean delivery)

The second main step for assessing the UN process indicators of EmOC involves categorising health facilities on the basis of their EmOC signal function status as Basic Emergency Obstetric Care (BEmOC) facilities or Comprehensive Emergency Obstetric (CEmOC) facilities. Internationally, if a health facility provides the first six functions described above, it qualifies as a Basic EmOC facility (BEmOC). If a fa-

cility provides all eight functions, it qualifies as a Comprehensive EmOC facility (CEmOC). For purposes of the KSPA, a facility providing the first five of six signal functions qualifies as a BEmOC facility (known as BEmOC "minus one"). Further, a facility that qualifies as BEmOC and performs Caesarean delivery and blood transfusions qualifies as a CEmOC facility (or CEmOC "minus one").

The KSPA used the proportion of facilities that provided normal delivery (38 percent in total) as the subset with which to examine the availability of EmOC services. This amounted to 164 facilities. However, since clinics and dispensaries are not really expected to provide emergency obstetric services, these facilities are left out for subsequent analysis.

Table 6.11 shows the percentage of facilities in the KSPA sample (among those offering delivery services) that reported having carried out the "signal functions" for EmOC in the three months preceding the survey.

Table 6.11 Signal functions for emergency obstetric care

Among facilities offering delivery services (excluding dispensaries and clinics), percentage reporting the indicated procedure/intervention was carried out at least once during the past 3 months, Kenya SPA 2004

	Percentage who applied/carried out										
Background characteristics	Parenteral antibiotics	Parenteral oxytocics	Parenteral anticon-vulsants/ sedatives	Manual removal of placenta	Removal of retained products	Assisted vaginal delivery (AVD)	Blood trans-fusion	Caesarean section	Basic EmOC-1 (minus AVD)[1]	Compre-hensive EmOC-1 (minus AVD)[2]	Number of facilities (weighted)
Type of facility											
Hospital	85	81	61	69	48	24	63	76	32	26	27
Health Centre	18	12	10	19	8	0	0	0	0	0	80
Maternity	42	33	26	41	29	10	14	22	16	0	18
Managing authority											
Government	24	16	17	30	18	2	11	12	6	5	69
NGO	72	66	12	67	14	7	12	8	5	2	6
Private (for-profit)	45	38	26	37	26	16	19	32	14	4	28
Faith-based organisation	52	52	42	29	19	10	26	32	14	10	21
Province											
Nairobi	25	25	21	21	13	9	15	24	7	1	11
Central	41	45	29	42	26	3	31	41	17	14	9
Coast	50	52	42	42	65	5	17	19	16	9	13
Eastern	17	17	11	13	8	6	13	14	6	6	22
North Eastern	38	23	35	35	16	13	23	13	16	10	3
Nyanza	23	14	12	21	21	7	14	14	8	5	22
Rift Valley	43	33	16	48	9	8	14	23	7	3	32
Western	59	42	56	42	25	2	12	11	10	7	13
Total	36	30	23	33	20	7	16	19	9	6	125

[1] Facility applied the first six procedures (left-to-right) in the three months preceding the survey.
[2] Facility applied all Basic EmOC procedures, plus blood transfusion and caesarean section, in the three months preceding the survey.

Almost four in ten facilities report having the capacity to administer parenteral antibiotics, 33 percent report having the capacity for manual removal of the placenta, and 30 percent report administering parenteral oxytocics. Facilities are less likely to use parenteral anticonvulsants/sedatives (23 percent) and perform removal of retained products, caesarean sections and blood transfusions (between 16 and 20 percent). The function least often performed is assisted vaginal delivery (AVD). As noted above, AVD is a procedure performed only by specialists and is therefore not carried out in many facilities.

As expected, health centres are least able to provide critical emergency obstetric services, in particular removal of retained products. Regionally, there are differentials worth noting in the Eastern province and in some cases in the Nyanza and Rift Valley provinces.

Overall, fewer than one in ten facilities in Kenya is able to offer Basic Emergency Obstetric Care "minus one", and even fewer (6 percent) offer Comprehensive Emergency Obstetric Care "minus 1". When analyzed by type of facility, only one-third of hospitals and 16 percent of maternities provide BEmOC-1; no health centre qualifies for BEmOC-1. Further, only slightly more than one-fourth of hospitals are able to provide CEmOC-1, and no other type of facility in Kenya is capable of this level of service. These results demonstrate the urgent need to upgrade facilities to offer these critical services to women.

6.9.2 Assessment of the UN Process Indicators for EmOc

Once the proportion of facilities that offer basic or comprehensive EmOC is known, then a simple calculation can be made to apply the proportions to the total number of facilities within each region, in order to arrive at the number of facilities that offer EmOC[7] (Table 6.12).

Table 6.12 Coverage rates for emergency obstetric care

Number of hospitals, maternities, and health centres in Kenya offering Basic and Comprehensive Emergency Obstetric Care ("minus 1"), derived from the proportions of BEmOC-1 and CEmOC-1 facilities surveyed, by province, Kenya SPA 2004

Province	Population	Number of hospitals, maternities, and health centres	Percentage providing BEmOC-1	Number providing BEmOC-1[1]	Coverage of BEmOC-1 (per 500,000 population)[2]	Percentage providing CEmOC-1[1]	Number providing CEmOC-1	Coverage of CEmOC-1 (per 500,000 population)[2]
Nairobi	2,656,997	224	7	16	3.0	1	2	0.4
Central	4,012,433	183	17	31	3.9	14	26	3.2
Coast	2,866,931	239	16	38	6.7	9	22	3.8
Eastern	5,070,098	326	6	20	1.9	6	20	1.9
North Eastern	1,358,301	32	16	5	1.9	10	3	1.2
Nyanza	4,857,210	292	8	23	2.4	5	15	1.5
Rift Valley	8,169,849	425	7	30	1.8	3	13	0.8
Western	3,816,448	161	10	16	2.1	7	11	1.5
Total	32,808,267	1,882	9	179	2.7	6	111	1.7

[1] Number of facilities in country × percentage found to be offering service ÷ 100
[2] Number of facilities in country calculated to be offering service ÷ population × 500,000

Nationally, coverage rates for basic and comprehensive EmOC are 2.7 and 1.7 facilities per 500,000 population, respectively. Overall coverage for basic EmOC is below the recommended level of 4 per 500,000 people in most provinces. The Coast (6.7 per 500,000) and Central (3.9 per 500,000) provinces achieve or surpass the recommended level. The overall coverage for comprehensive EmOC is nearly 2 facilities per 500,000 population, more than the recommended level of 1 per 500,000 people. However, when examining the data by region, large differentials are apparent, such as a rate of nearly 4 facilities per 500,000 in Coast province, compared with 0.4 in Nairobi province.

[7] Because the KSPA uses a random sample of facilities, covering 55 percent of hospitals, 21 percent of maternities, and 4 percent of health centres, an assumption is made that the capacity found in the sampled facilities will also exist in the remaining non-sampled facilities.

The rates obtained here may be considered crude, since they are calculated for large areas and may hide greater gaps in smaller geopolitical areas. For example, within the Coast province, facilities may be concentrated in a small area (such as the tourist area) leaving relatively large pockets of population without coverage. Still, these differences speak of the need to upgrade facilities in several regions of the country, in particular in the Rift, Eastern, and North Eastern provinces.

It is important to highlight that this is the first time a nationwide facility survey has been used to derive signal functions and the UN indicators. Other indicators will be available as further analysis of data is conducted.

Chapter 7 Communicable Diseases: Services for Sexually Transmitted Infections, HIV/AIDS and Tuberculosis

Dr. Robert K. Ayisi, Mr. Robert C. B. Buluma, and Mr. Boaz Cheluget

7.1 Background

7.1.1 KSPA Approach to Collection of Information on STI Services

Sexually transmitted infections (STIs) and reproductive tract infections (RTIs) other than HIV/AIDS are a major public health problem throughout the world. They affect millions of men, women, and children, and lead to infertility, serious illness, and even death in some cases. STIs have also been shown to increase the risk of transmission of HIV, the virus that causes AIDS (AIDSCAP/FHI, 1996). Some 80 percent of women and 10 percent of men infected with STIs are asymptomatic, 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). Sexually transmitted infections in Kenya declined after the introduction and training of clinicians and the supply of free STI drugs between 1995 and 2001 (Cheluget et al., 2004); however, since then, the country has been experiencing an increase in STIs.

The consequences of STIs and RTIs on reproductive health can be severe and life-threatening. They include pelvic inflammatory disease (PID), infertility in both women and men, ectopic pregnancy, and adverse pregnancy outcomes including miscarriage, stillbirth, preterm birth, and congenital infection. STIs and RTIs are also known to increase the risk of HIV transmission. Although most STIs and RTIs can affect both men and women, the consequences in women are more common and more severe than in men. In fact, STIs and RTIs and their complications are among the most important causes of illness and death among women in poor regions of the world (MOH, 2005a).

According to the UNAIDS/WHO global report of 2004 on HIV/AIDS, about 40 million people are infected with HIV/AIDS globally. Of these, 70 percent live in sub-Saharan Africa, and more than 40 percent—17.1 million—are women. The report indicates that about 20 million of those infected have died since the first case of AIDS was detected about 20 years ago. With the advent of HIV/AIDS, tuberculosis (TB), especially multi drug-resistant tuberculosis (MDR-TB), is re-emerging as a communicable disease of public health significance. This is because TB is also one of the most common opportunistic infections for AIDS patients. There are more than 6.5 million new cases of tuberculosis worldwide and more than 2 million deaths from the disease each year.

Although sexual contact is not the only means of transmission of HIV/AIDS, it is the most common (UNAIDS/WHO, 2000); therefore, preventive measures for STIs are equally relevant to the control of HIV/AIDS.

It is therefore of the utmost importance that the health care system in a country diagnose and treat the most common STIs. This chapter uses data from the KSPA 2004 to address the following six central questions:

- To what extent are STI services available?
- To what extent do facilities offering STI services have the capacity to support quality STI and HIV/AIDS services?
- To what extent is there evidence that health service providers adhere to standards for provision of quality STI and HIV/AIDS services?

- Do facilities have management practices supportive of quality STI and HIV/AIDS services?
- What do clients feel about the STI and HIV/AIDS services offered?
- Does the facility have resources for diagnosing and managing tuberculosis?

7.1.2 The Health Situation Related to STIs, RTIs, and HIV/AIDS in Kenya

"Reproductive tract infection" (RTI) is a broad term that includes sexually transmitted infections (STIs) as well as other infections that are not transmitted through sexual contact. WHO estimates that over 340 million new cases of four curable STIs (gonorrhoea, chlamydia, syphilis, and trichomoniasis) occurred in 1999. The epidemiology of STIs and RTIs in Kenya is poorly understood because of inadequate reporting and poor data management in health institutions. Data available from the Kenya National AIDS Control Programme for the period 1990-2001 indicates that the prevalence of genital discharge was between 11 and 28 percent, and the prevalence of genital ulcer diseases was 20-37 percent.

The prevalence of STIs was believed to be low in Kenya in the 1970s, and as a result, until recently, health services related to STIs have not been a priority area of development. STI surveillance and statistics on STI prevalence are weak, with most published studies on STIs focusing on select populations. With increased awareness of the risks for HIV/AIDS and the relationship between STIs and HIV/AIDS, the National AIDS and STI Control Programme (NASCOP) has developed national guidelines for the control of STIs and HIV/AIDS, to strengthen the pre-service and in-service training for health service providers.

The first AIDS case in Kenya was diagnosed in 1984 (MOH and NACC, 2001); a National AIDS Programme and a National AIDS Committee were subsequently established. Since 1986, HIV/AIDS has been classified as a notifiable disease, and blood for transfusion has been screened for HIV/AIDS since 1987. The prevalence of HIV in Kenya peaked at about 10 percent in the late 1990s (data from National AIDS Control Council, reconciled with DHS data). HIV prevalence in Kenya is currently estimated at 6.7 percent among the general population and at 8.7 percent among high-risk populations (KDHS 2003). At the beginning of the HIV/AIDS epidemic, there was a limited range of services available for testing and treatment, with virtually no organised care and support system for the infected and the affected. Currently, the National AIDS Control Programme of Kenya in the Ministry of Health has rolled out more than 600 voluntary counselling and testing (VCT) centres and about 755 sites for the prevention of mother-to-child HIV transmission (PMTCT), and there are currently over 200 centres in the country offering antiretroviral therapy (ART). Treatment for STIs should be available in all health facilities in Kenya, down to the health centre level. Health facilities are providing more and more HIV/AIDS services, which increases the need to monitor the availability and quality of the services being offered. The increased workload that this causes was not anticipated (Kinoti and Picazo, 2003) and thus remains a challenge.

Kenya has a National AIDS Strategic Plan (KNASP) for the years 2000-2005 and 2005-2010 (NACC, 2005). There is also a National Health Sector-specific strategy for the period 1999-2004, and plans for 2005-2010 are advanced.

The KNASP 2005-2010 has identified three priority areas in response to the HIV/AIDS epidemic in the country:

- Preventing new infections;
- Improving quality of life; and
- Mitigating the socio-economic impact of HIV/AIDS.

These strategic plans provide a roadmap on prevention to continue reducing the incidence of new HIV infections. They also provides a strategy for expanded ARV treatment. It is estimated that HIV prevalence

will decrease from 7 percent in 2003 to 5.5 percent by 2009-10. Goals for the STI programme area include ensuring that 90 percent of patients diagnosed with STIs are offered HIV testing, ensuring that 90 percent are offered appropriate symptomatic treatment, and making treatment of STIs an important entry point for the ART programme.

7.1.3 Health Situation Related to Tuberculosis in Kenya

Each year, there are more than 6.5 million new cases of tuberculosis and more than 2 million deaths from tuberculosis worldwide. Tuberculosis is the seventh most important cause of global premature mortality and disability, and is projected to remain one of the ten leading causes of disease burden even in the year 2020. Because of a powerful interaction between tuberculosis and HIV, the tuberculosis incidence rate is rising in sub-Saharan Africa and may rise in Asia. Increasing drug resistance, which could lead to worse treatment outcomes, has also been reported. Using the directly observed therapy, short-course (DOTS) strategy, cure rates of 80 percent to 90 percent have been achieved for passively diagnosed cases of smear-positive pulmonary tuberculosis. Analyses of national programmes in Malawi, Tanzania, and Mozambique and in ten provinces of China have shown that this strategy is both effective and cost-effective. Based on the successes of these programmes, the World Health Organisation (WHO) adopted DOTS as its strategy for global tuberculosis control. Since WHO championed the DOTS strategy, uptake by national programmes has unfortunately been slow; WHO reports that only 11 percent of people with new smear-positive pulmonary tuberculosis cases are enrolled in DOTS programmes worldwide (Murray and Salomon, 1998).

WHO tuberculosis monitoring and evaluation has shown a dramatic resurgence of TB in much of Southern and East Africa since 1980. This is primarily because of the HIV epidemic, and it affects other countries, not only those in sub-Saharan Africa. People who are infected with HIV are much more likely to develop active tuberculosis than those who are not. Because sub-Saharan Africa has the highest rates of HIV in the world, HIV-related tuberculosis has its greatest impact in this region.

In Kenya, as elsewhere, HIV began to spread in the early 1980s. The notification rate of TB in Nairobi remained fairly constant into the late 1980s, at about 65 per 100,000 per year. By 1995, the HIV prevalence among women receiving antenatal care in Nairobi had reached 17 percent, and the tuberculosis notification rate had increased fourfold to 250 per 100,000 per year. Since then, HIV prevalence has remained steady, while the tuberculosis notification rate has continued to increase to its current alarming level of about 773 per 100,000 per year (National Leprosy and TB Control Programme).

Finally, it is worth noting that the prevalence of HIV/AIDS depends strongly on both gender and age, and this has important implications for tuberculosis. Data from the Kisii District in Kenya show a substantial increase in HIV prevalence among both men and women, especially in the 25-34 age group, precisely those who are most likely to be infected with HIV. A study in Kisumu shows that the tuberculosis notification rates peak about 6 years after the age at which HIV prevalence peaks (WHO, 2005).

This chapter presents KSPA data on STI and TB services offered throughout the country, which will help programme planners and policymakers understand where the need for quality services is greatest.

7.2 Availability of STI Services

Integrating STI diagnosis and treatment into relevant health services increases opportunities for case detection and follow-up on treatment. The KSPA assessed 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 are specific STI clinics or service areas. Clients, particularly women, seeking services for ANC or family planning may also require STI services. Including STI screening and treatment as a component of these services may therefore increase early detection

and improve follow-through 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 STI services, there is a greater chance that she may decide not to seek follow-up care.

Table 7.1 provides information on the availability of STI services. Appendix Table A-7.1 provides information on whether facilities have the indicated systems and items needed to support quality counselling and examination.

Table 7.1 Availability of services for sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs), among these percentage where STI services are provided in the indicated service area and STI services offered five or more days per week, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Any STI services	Number of facilities (weighted)	Percentage of facilities where STI services are available in the indicated service area[1]					Percentage of facilities where services for STIs are available at least 5 days per week	Number of facilities offering STI services (weighted)[3]
			Primary location				OPD, family planning, and ANC service areas		
			General outpatient	Special clinic[2]	Family planning	ANC			
Type of facility									
Hospital	97	28	77	23	25	45	18	99	28
Health centre	97	125	94	6	54	65	37	97	121
Maternity	93	20	96	4	52	75	48	100	19
Clinic	99	8	97	1	59	50	33	100	8
Dispensary	91	249	100	0	55	70	51	95	227
Managing authority									
Government	91	246	94	6	61	63	53	100	224
NGO	76	21	99	1	52	74	51	100	16
Private (for-profit)	94	63	98	1	41	61	29	100	59
Faith-based organisation	95	110	99	1	42	77	31	86	104
Province									
Nairobi	83	41	90	10	24	46	14	100	34
Central	88	50	98	2	55	70	47	91	45
Coast	99	49	99	1	42	56	41	93	48
Eastern	88	83	98	1	54	71	41	100	73
North Eastern	86	8	97	3	48	79	46	100	7
Nyanza	98	54	90	10	65	72	51	100	54
Rift Valley	91	126	98	2	54	65	44	93	115
Western	99	29	93	7	71	89	70	100	29
Total[3]	92	440	96	4	53	67	44	96	403

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] STI services at the public and NGO facilities are utilized primarily by females, so in almost all cases the special clinic is the gynaecologic clinic. Males might receive STI services in urology clinic.
[3] Totals include one stand-alone VCT (weighted)

STI services may include counselling only, testing only, or diagnosis and treatment. Availability of STI services is reported in 92 percent of health facilities (Table 7.1). Among facilities offering STI services, 96 percent offer them as part of the general outpatient curative services, and 4 percent have special STI clinics. Almost all facilities offer STI services at least five days per week (Table 7.1). STI services are also integrated within family planning services in 53 percent of facilities, and within ANC services in 67 percent of facilities. Among facilities that offer STI services, 44 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 dispensaries and health centres, the only provider available sees all patients for all services and also provides STI services to those clients that need them.

NGO-managed facilities (76 percent) and facilities in Nairobi (83 percent) are less likely than other facilities to offer STI services.

Key Findings

STI services are offered in 9 of 10 facilities and are integrated within ANC, family planning, and general curative care services in around half of these. Specialized STI services are rare.

NGO-managed facilities and facilities in Nairobi are slightly less likely to offer STI services than other facilities.

7.3 Capacity to Provide Quality STI Services

The KSPA 2004 assessed systems, infrastructure, equipment, and supplies for supporting quality STI services. Although STI services are provided in multiple sites in large facilities, information on whether facilities have the capacity to provide quality STI services comes from the general OPD, which is the main STI service area.

Table 7.2 provides information on whether facilities have the infrastructure and resources to support counselling and examinations for STI services. Figures 7.1, 7.2 and 7.3 summarize information on items to support quality STI services, diagnosis, and utilization and availability of diagnostic tests for STIs. Appendix Tables A-7.1 to A-7.3 provide details on system components, infrastructure and resources, specific tests and medicines for diagnosis and treatment, user fees, and supportive management services for STIs. Appendix Table A-7.5 provides details on in-service training for providers of STIs, and Appendix Table A-7.6 gives information on supportive supervision for providers of STIs.

7.3.1 System Components to Support Utilization of Services

As a result of the stigma that is frequently associated with having an STI, as well as the lack of symptoms in many people having STIs, special efforts are needed to promote early diagnosis and to encourage clients to seek modern medical help for STI symptoms. The KSPA 2004 assessed the existence of programme strategies and service delivery components that contribute to the availability and improved utilization of STI services.

To effectively interrupt STI transmission, partners of clients with STIs must also be tested, and treated if they are found to be infected. The client should be asked to notify the partner and ask him or her to be examined; this process is referred to as passive follow-up. Under certain circumstances, the local health authorities may take the initiative to contact the partner and inform him or her about the possibility of being infected with an STI and recommending the appropriate course of action. This is known as active follow-up. Passive follow-up is the most widely used system of client notification, with 67 percent of facilities reporting that they use it, compared to 18 percent of facilities using active follow-up. Fifteen percent of facilities have no follow-up system in place (Appendix Table A-7.1).

7.3.2 Infrastructure and Resources to Support Quality Assessment and Counselling

To support quality counselling for STIs, complete privacy is needed, in order to facilitate open communication between the provider and the client. This is expected to encourage the use of services by the client,

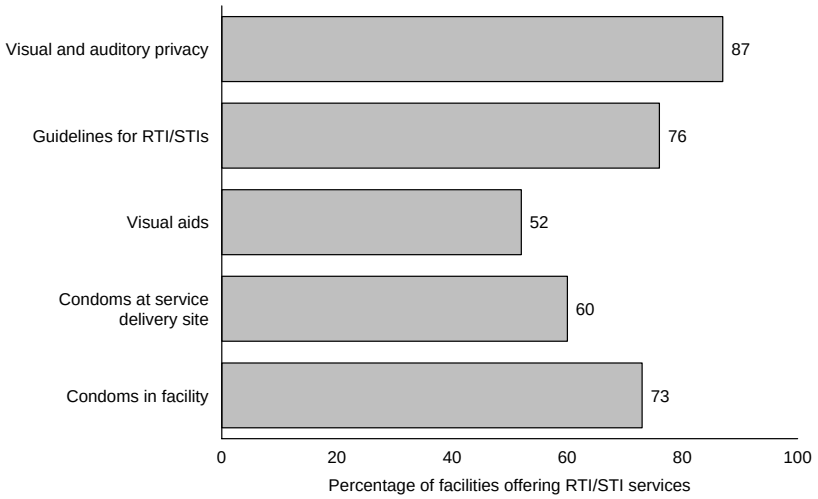
and also the adherence to protocols and standards by the provider. Without these conditions, the provider may not ask the appropriate questions or make the appropriate examinations. Since counselling for diagnosis and prevention of STIs often takes place in a different location than the physical examination, the conditions for counselling are assessed separately from those for physical examinations.

Approximately 9 in 10 facilities provide counselling for STIs under conditions that allow both visual and auditory privacy (Figure 7.1). Another 9 percent have conditions assuring visual privacy but not auditory privacy, and 3 percent do not assure privacy of any kind (Appendix Table A-7.1).

Seventy-six percent of facilities have STI guidelines in the STI service delivery areas (Figure 7.1), and 72 percent specifically have the WHO guidelines for syndromic STI diagnosis and management (Appendix Table A-7.1). The syndromic approach is a systematic method for assessing symptoms in a client, and a specific protocol for which medicines should be prescribed, based on the symptoms observed (WHO, 2001). The syndromic approach was widely implemented in Kenya in the early 1990s with support from the World Bank. It involved training care providers, printing and distributing IEC material, purchasing and distributing STI drugs and test kits, and distributing advocacy materials and condoms. The guidelines for syndromic STI diagnosis and management 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. Health centres are most likely to have the WHO guidelines compared with other types of facilities.

Only about half of facilities have visual aids for client education related to STIs, and an even smaller proportion (31 percent) have any educational materials specific to HIV/AIDS (Appendix Table A-7.1).

Figure 7.1 Items to support quality STI/RTI services (N=403)



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Having condoms available at the service delivery site allows the provider to readily demonstrate how to use them, and to ensure that the client leaves with them. Condoms are not universally available in STI service delivery areas; only about 6 in 10 facilities have condoms in the service delivery area, whereas approximately 7 in 10 have them somewhere in the facility (Figure 7.1).

Overall, about one-third of eligible facilities have all items to support quality counselling (Table 7.2). These items include all the items described above: privacy (both visual and auditory), availability of STI guidelines, and visual aids for client education. There is not much variation by facility type, but NGO-managed facilities and facilities in Nairobi province are less likely to have these items.

Table 7.2 Availability of infrastructure and resources to support quality counselling and examinations for sexually transmitted infections

Percentage of facilities with all indicated components to support counselling, diagnosis, and treatment for STIs, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	All items to support quality counselling[1]	All conditions to provide quality physical examination and infection control[2]	Method for diagnosing STIs			Testing capacity for:[4]					Medicines to treat four major STIs[10]	Number of facilities offering STI services (weighted)[11]
			Etiologic	Syndromic[3]	Clinical	Syphilis[5]	Gonorrhoea[6]	Wet mount[7]	Chlamydia[8]	HIV/AIDS[9]		
Type of facility												
Hospital	33	19	89	75	43	90	81	96	15	88	55	28
Health centre	35	12	69	80	57	46	23	61	0	14	30	121
Maternity	26	29	73	52	65	75	53	77	1	41	46	19
Clinic	21	14	73	60	65	60	43	71	0	26	41	8
Dispensary	30	3	37	82	64	29	16	37	0	11	13	227
Managing authority												
Government	44	5	35	82	62	23	12	36	0	9	19	224
NGO	8	6	49	87	96	49	29	51	0	28	7	16
Private (for-profit)	16	25	81	65	52	66	56	68	4	37	52	59
Faith-based organisation	16	6	74	81	59	64	35	73	1	28	21	104
Province												
Nairobi	11	8	91	69	78	67	55	73	2	39	53	34
Central	20	18	56	90	57	46	34	44	1	15	6	45
Coast	48	16	40	62	78	34	25	34	1	20	19	48
Eastern	36	13	53	80	61	37	30	49	0	12	34	73
North Eastern	18	1	36	39	56	33	9	39	0	18	22	7
Nyanza	40	1	42	96	39	30	11	44	1	10	24	54
Rift Valley	24	2	51	79	57	42	16	58	1	23	17	115
Western	48	8	52	83	77	39	27	53	1	18	26	29
Total[11]	31	8	53	79	61	41	25	51	1	19	24	403

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] Visual and auditory privacy, any guidelines 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 refers specifically to following the WHO syndromic approach algorithms.

[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 rapid plasma reagin (RPR) test kit

[6] Gram stain reagents and functioning microscope or culture capacity

[7] Functioning microscope and slides

[8] Giemsa stain for Chlamydia, with functioning microscope and slides

[9] ELISA, Western Blot, or Rapid test

[10] At least one medicine to treat syphilis, gonorrhoea, trichomoniasis, and Chlamydia

[11] Totals include one stand-alone VCT (weighted)

Key Findings

Only 3 in 10 facilities have all items to support quality STI counselling.

Most facilities provide STI counselling under conditions that ensure both visual and auditory privacy, and STI guidelines are available in three-fourths of service delivery areas.

Visual aids and educational materials for STIs and HIV/AIDS are not widely available in STI service delivery sites.

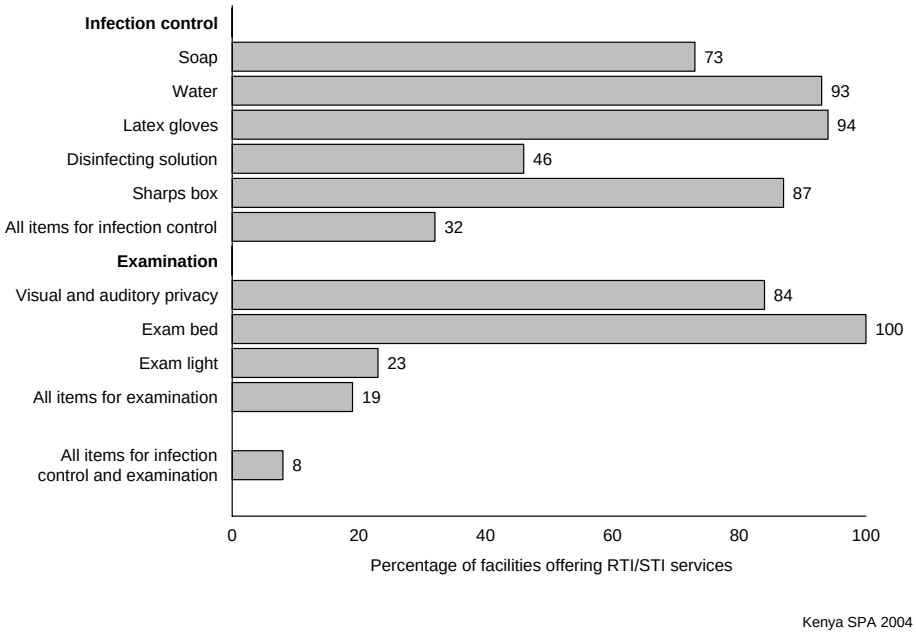
More than one-fourth of facilities providing STI services do not have condoms available, either in the service delivery area or anywhere in the facility.

7.3.3 Infrastructure and Resources for Examinations and treatment

Facilities can better diagnose and treat STIs when they have an adequate infrastructure for physical examination, laboratory diagnostic support, and medicines for treating specific STIs.

Quality physical examination requires infection control measures and adequate infrastructure and basic equipment for client examinations.

Figure 7.2 Items to support quality examination for STIs/RTIs (N=403)



Infection Control

All items for infection control are available in the STI service area in only 32 percent of facilities (Figure 7.2). Water and latex gloves are almost universally available, whereas soap and sharps boxes are found less frequently. The item missing in most facilities is disinfecting solution, available in less than half of facilities. Maternities are more likely to have all items for infection control (48 percent) than other types of facilities (Table A-7.1).

Waste receptacles are available in only one-third of facilities. In general, a mere 14 percent of facilities offering STI services have the necessary items for infection control as well as waste receptacles.

Physical Examinations

For providers to conduct a quality physical examination, necessary items and conditions include privacy (both visual and auditory) and the availability of an examination bed and examination light. All the items and conditions necessary to provide quality physical examinations are available in only 2 in 10 facilities. Hospitals (51 percent) are more likely than other types of facilities to have all these items and conditions (Figure 7.2, Table A-7.1). Eighty-four percent of facilities are able to provide client examination under conditions of both visual and auditory privacy, while examination beds are universally available. The item most commonly missing is an examination light, available in only 23 percent of facilities; this brings down the composite indicator (Figure 7.2).

In general, just 8 percent of facilities have all the needed items for infection control and quality physical examinations.

Key Findings

All items for infection control in the STI service area are rarely available; maternities seem best prepared for infection control. Facilities are most often missing disinfecting solution.

One in five facilities have all items for physical examination, with hospitals most commonly having all items.

Only about one of every ten facilities has all items for both infection control and for quality physical examinations for STIs.

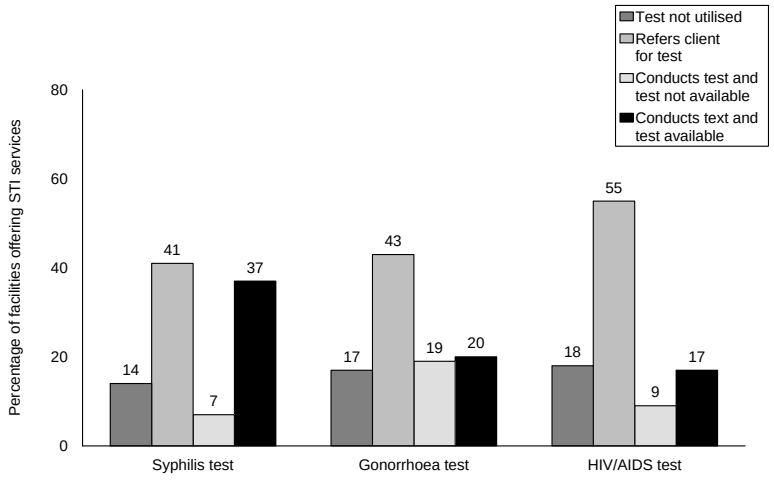
STI Diagnosis

The World Health Organisation (WHO) recommends the use of two approaches in diagnosing and providing STI services at the primary care facility level: the etiologic approach and the syndromic approach (WHO, 2001). The etiologic approach uses laboratory tests for diagnosing STIs and is obviously more accurate than syndromic diagnosis. However, laboratory facilities are often unavailable. The syndromic approach is recommended for facilities with no laboratory. This 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 based on their clinical judgment and client symptoms (often referred to as clinical diagnosis). Studies have shown that when providers do not have a specific protocol (such as the syndromic approach) or laboratory results to use when diagnosing and prescribing for STIs, wrong treatment is commonly given (Lande, 1993).

Health facilities in Kenya use various methods for diagnosing STIs. About 8 in 10 facilities use the syndromic method and 6 in 10 use the clinical method for diagnosing STIs (Table 7.2). Approximately half of facilities report using the etiologic method to diagnose STIs, mostly in private facilities and in Nairobi; the etiologic method is least common in government facilities and dispensaries and in the North Eastern province. Only 1 percent of facilities have the capacity to test for chlamydia, compared with 41 percent that can test for syphilis, 25 percent for gonorrhoea, and 19 percent for HIV/AIDS.

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 the client may decide not to take the test at all. 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.

Figure 7.3 Utilisation and availability of diagnostic tests for STIs (N=403)



Note: One percent take specimen and send elsewhere for STI tests.

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Having the capacity to conduct a test does not mean a facility routinely utilizes the test. As evident from Figure 7.3, syphilis testing is more commonly offered than other tests. Although 44 percent of facilities report conducting the test in house, only 37 percent had tests available on the day of the survey. Gonorrhoea and HIV/AIDS testing is less common. Although 26 percent of facilities report conducting HIV/AIDS testing in-house, only 17 percent had the test available on the day of the survey. Occasions where facilities report they conduct a test but tests were not available on the day of the survey (for example, 9 percent in the case of HIV testing, and 19 percent for gonorrhoea) may reflect stock-outs of test equipment or reagents, or a lack of precise knowledge on the part of the respondents on the availability of such specific testing equipment.

STI Treatment

Only 24 percent of facilities have at least one medicine for treating each of the four major STIs (syphilis, gonorrhoea, trichomoniasis, and chlamydia). Hospitals and maternities, private for-profit facilities, and facilities in Nairobi are more likely than others to have this capacity (Table 7.2); NGO-managed facilities, dispensaries, and facilities in the Central province are much less likely. The medicines most widely available are metronidazole for treating trichomoniasis (available in 88 percent of facilities), benzathine penicillin for treating syphilis (in 86 percent of facilities), and doxycycline for treating chlamydia and syphilis (in 85 percent of facilities) (Appendix Table A-7.2). Medicines for treating gonorrhoea and candidiasis are available in less than 20 percent of facilities.

Key Findings

The syndromic diagnostic approach for STIs is the most widely used method in most facilities in Kenya, followed by the clinical and etiological methods.

About 4 in 10 facilities have the capacity for syphilis testing, with test materials available on the day of the survey.

Only one-fourth of facilities in Kenya have medicines to treat each of the four major sexually transmitted infections.

7.4 Management Practices Supportive of Quality Services

Management practices to support quality STI services include documentation practices related to user fees and staff supervision and development.

Table 7.3 summarizes information on management practices that support quality STI services. Summary information on topics of in-service training received by STI service providers is provided in Figure 7.4. Appendix Tables A-7.5 through A-7.9 provide details on service statistics, charging practices for STI services, supervision, and in-service training.

7.4.1 Facility Documentation and Records

WHO considers recordkeeping and reporting on STIs and STI service utilization to be key elements in STI surveillance, necessary for improving STI programme management (WHO, 1999a). A register for STI services is considered up-to-date if there is an entry during the past seven days, and if symptoms or a diagnosis consistent with STI is recorded. Because most STI services are provided in outpatient departments, these records were checked for entries on clients with STI symptoms or diagnoses.

Only about half of facilities have an up-to-date register: mostly health centres, NGO-managed facilities, and facilities in Western province (Table 7.3). Facilities in North Eastern and Nairobi provinces are least likely to have updated registers. Approximately one-fourth of facilities providing STI services have records with entries more than seven days old. This is more frequent among dispensaries and FBO-managed facilities, which might also indicate that these facilities provide STI services less frequently.

Table 7.3 Management practices supportive of quality services for sexually transmitted infections

Percentage of facilities with the indicated records, percentage that have any user fees for STI services, and percentage with the indicated supportive management practices, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering STI services: Observed client register with probable STI client recorded: Entry within past 7 days	Observed client register with probable STI client recorded: Most recent entry > 7 days ago	Percentage of facilities offering STI services: That have user fees for STI services	Number of facilities offering STI services (weighted)	Percentage of facilities where at least half of the interviewed STI service providers: Received in-service training during the past 12 months[1]	Were personally supervised during the past 6 months	Number of facilities with interviewed providers of STI services (weighted)[2,3]
Type of facility							
Hospital	52	17	67	28	80	70	27
Health centre	63	16	67	121	75	86	121
Maternity	27	17	86	19	89	76	19
Clinic	29	21	90	8	81	66	8
Dispensary	39	35	60	227	65	84	220
Managing authority							
Government	61	25	51	224	70	90	216
NGO	71	13	38	16	88	100	16
Private (for-profit)	23	17	79	59	75	69	59
Faith-based organisation	24	38	89	104	65	75	104
Province							
Nairobi	26	24	81	34	67	68	34
Central	52	18	67	45	46	70	44
Coast	48	29	78	48	92	71	48
Eastern	54	30	81	73	64	85	73
North Eastern	23	22	22	7	50	75	7
Nyanza	37	10	70	54	78	94	54
Rift Valley	47	34	48	115	72	90	107
Western	58	32	46	29	75	91	29
Total[3]	46	27	65	403	70	83	395

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
[2] Includes providers offering STI services in facilities offering STI services in any clinic assessed in survey (e.g., outpatient, ANC, family planning)
[3] Totals include one stand-alone VCT (weighted)

7.4.2 Practices Related to User Fees

User fees may have either a positive effect (because free services can be perceived as inferior to items that are paid for) or a negative effect (by deterring poor clients from using services). Sixty-five percent of facilities indicate they routinely charge some form of user fees for STI services (Table 7.3). Maternities and clinics (86 percent and 90 percent, respectively), private for-profit and FBO facilities (79 percent and 89 percent, respectively) and facilities in Nairobi and Eastern provinces (81 percent each) are more likely to charge some form of user fee.

As indicated in Appendix Table A-7.3, 27 percent of facilities charge specifically for client consultations, whereas 31 percent charge only for medicines, and 28 percent charge only for tests (Table A-7.3). Mater-

nities (61 percent) and clinics (57 percent) are more likely to charge for consultations. Similarly, private and FBO-managed facilities, and facilities in Nairobi, are more likely to charge for client consultations than other facilities.

7.4.3 Staff Development and Supervision

Staff Development

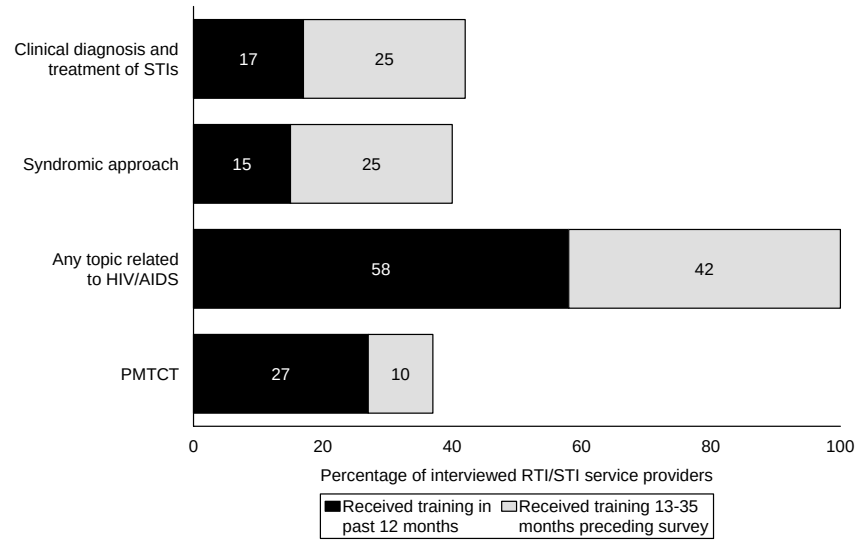
A facility is considered to provide routine staff development activities if at least half of its interviewed STI providers have received in-service training related to STI services in the past 12 months. Seventy percent of the facilities meet this criterion (Table 7.3). Maternities, NGO-managed facilities, and facilities in Coast province are most likely to have routine staff development activities.

Fifty-eight percent of interviewed STI service providers received some form of HIV/AIDS-related training in the 12 months preceding the survey, while 15 percent received training related to the syndromic approach (Figure 7.4).

Supervision

If at least half of the STI service providers in a facility have been personally supervised during the past six months, the facility is defined as providing routine supervision. Supervising individual staff helps to promote adherence to standards and to identify problems that contribute to poor quality services. Routine supervision is offered in 83 percent of facilities (Table 7.3). All NGO-managed facilities meet this criterion, compared to 69 percent of private for-profit facilities. Facilities in Nairobi are the least likely to routinely supervise STI service providers. Providers were supervised an average of four times in the six months preceding the survey (Appendix Table A-7.6).

Figure 7.4 In-service training received by interviewed STI/RTI service providers, by topic and timing of most recent training (N=957)



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Key Findings

Just about half of facilities offering STI services have up-to-date client registers.

Seven in 10 facilities provide routine staff training, and about 8 in 10 facilities provide routine staff supervision. Supervision is weakest in Nairobi province.

About two-thirds of facilities charge some form of user fees for STI services, but only about one-fourth charge specifically for client consultations. Government facilities rarely charge for consultation, medicine, or tests.

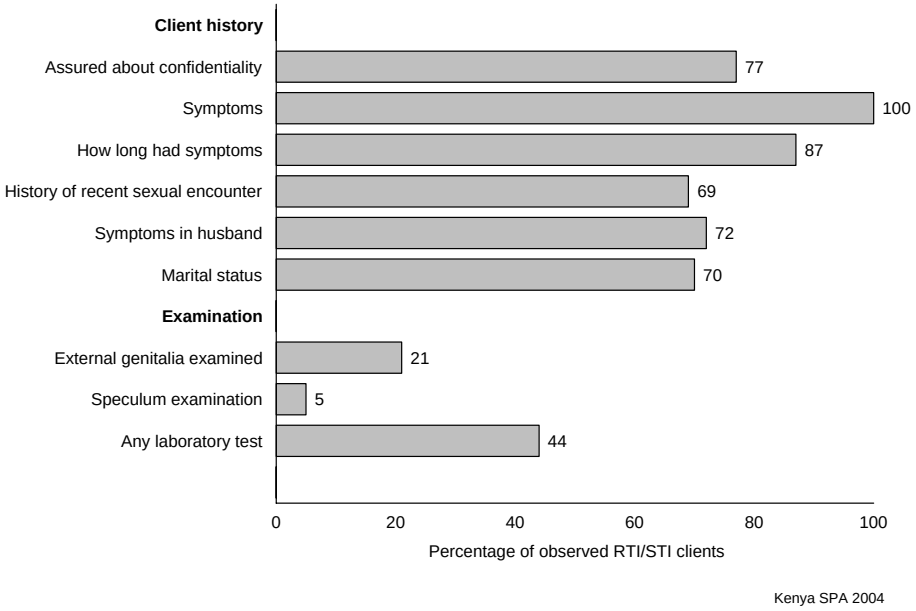
7.5 Adherence to Standards for Quality Service Provision

To assess whether providers adhere to standards for quality service, KSPA personnel observed STI client-provider consultations. The observation checklists they used are based on generally accepted standards for STI services (WHO, 2001; AIDSCAP/FHI, 1996). The observers noted what information was shared on a topic or if an examination was actually conducted. They did not assess whether the information was correct or whether findings were appropriately interpreted.

A total of 166 STI clients (38 males and 78 females) were observed being assessed for symptoms that might be STIs. Of all observed STI clients, 80 percent were assured of confidentiality; providers asked all of them about their symptoms. Additional information on client history, types of laboratory tests, and examination is available in Appendix Table A-7.8.

Figure 7.5 summarizes what information was shared during the consultation and which types of examinations were conducted for female clients. Appendix Tables A-7.9 through A-7.14 provide details on the content of the observed assessment, physical examinations, and counselling.

Figure 7.5 Components of the assessment of women with symptoms of STIs/RTIs (N=78)



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7.5.1 Assessment of Relevant History

Any client with a possible STI should be assessed for signs and symptoms, as well as social factors that relate to the risk of contracting an STI. Providers explicitly assured 77 percent of female clients that the shared information was confidential (Figure 7.5).

Client symptoms were elicited during all observed female client consultations; providers were slightly less likely to ask about the duration of symptoms (87 percent) (Figure 7.5). Among the observed female clients, most were asked about a recent sexual encounter, their marital status, and about symptoms in their husbands (nearly 70 percent each).

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. Providers only examined the external genitalia of about 1 in 5 female clients, and a speculum examination was conducted for a mere 5 percent of clients. Providers relied much more often on laboratory tests (44 percent) (Figure 7.5).

Infection Control

Appendix Table A-7.9 gives details on infection control procedures followed by providers performing a pelvic examination on female STI clients. Almost all providers wore clean gloves while performing a pelvic examination. Similarly, 93 percent of the providers washed their hands after removing the gloves. However, only 36 percent of the providers washed their hands with soap prior to conducting an examination.

Client Examination

Conditions and practices for quality pelvic examinations are almost universal in health facilities. During pelvic examinations, all providers assured clients of visual privacy. Similarly, auditory privacy was assured in 98 percent of client examinations. Ninety-seven percent of providers explained procedures to their clients before starting the pelvic examination (Appendix Table A-7.9).

Use of sterilised or high-level disinfected (HLD) equipment for the pelvic examination was observed in only 32 percent of examinations. Only 23 percent of examinations were conducted with instruments that had been properly prepared beforehand (sterilised, placed on a tray, and covered). Similarly, only 26 percent of used equipment was placed in decontaminating solution after pelvic examinations. Worse still, in only 24 percent of examinations were contaminated surfaces wiped with disinfectant after the examination (Appendix Table A-7.9)..

Key Findings

Almost all providers wear clean gloves to perform pelvic examination and 93 percent washed hands after removing gloves. However, only 36 percent of providers wash their hands with soap before the examination.

Pelvic examinations are performed under visual and auditory privacy in almost all facilities.

Use of sterilised equipments for pelvic examination is low.

7.5.3 Client Counselling

Providers mentioned or discussed the relationship between an STI and sexual activity during 89 percent of all observed STI consultations (Appendix Table A-7.10). Almost all observed STI clients received either medication or a prescription, but only 12 percent were given medication or a prescription for their sexual partner. Hospitals are more likely than other facility types to provide medicine or prescriptions for sexual partners; other facilities rarely do this (Appendix Table A-7.10). Ninety-one percent of clients were observed being told how to take the medicine, and a follow-up appointment was discussed with 85 percent clients. Unfortunately, only 3 out of 5 STI clients were counselled on the risk of HIV/AIDS.

Discussions of any kind about condoms or HIV/AIDS were observed in 70 percent of all STI consultations. Using condoms for prevention was discussed in about half of consultations, but condoms were then offered to only 21 percent of clients, and only 17 percent were instructed on how to use condoms (Appendix Table A-7.10).

Using an individual client health card is important for ensuring that information is available for follow-up and continuity of care. Providers recorded information on the individual client health card for almost all observed clients (Appendix Table A-7.10).

7.5.4 Client Opinion from Exit Interviews

During client exit interviews, clients whose consultations were observed were asked about their experiences on that day with the provider. When asked whether they had ever used a condom, 38 percent said they and their partner had used condoms in the past (Appendix Table A-7.11).

Only 7 percent of clients reported that the provider talked about condoms during the visit, and only 13 percent said they had received condoms during the visit (Appendix Table A-7.11). These percentages are even lower than those reported from observations. It is possible that some clients were embarrassed and thus denied having been counselled about condoms.

When asked about issues that may contribute to lack of condom use in general, 47 percent identified possible items. Of those, 22 percent said a major contributing factor is that condoms are embarrassing to purchase. Other factors identified by clients are shown in Appendix Table A-7.11. These include problems with disposal (7 percent) and embarrassment about discussing them with their partner (18 percent). Among clients who reported any of the above items as contributing to lack of condom use, about 59 percent said they had discussed those issues with the provider.

During the exit interview, clients were also 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 problems, small problems, or not a problem for them. Few items were identified as big problems, and by relatively few clients. Among identified problems, 26 percent felt that the waiting time was a big problem, and 13 percent said the operating hours of the facility were a big problem (Appendix Table A-7.12). Only 3 percent of clients mentioned lack of medicines or supplies. A few interviewed clients mentioned insufficient visual and auditory privacy (5 and 7 percent, respectively) as big problems.

Clients were also asked whether the facility was the nearest to them, and if not, why they did not visit the nearest facility. Interestingly, almost half of the STI clients said that this was not the closest facility to their home. The main reasons why they did not go to the nearest facility were that they did not like the personnel (17 percent), that medicines were unavailable (22 percent), and that the other facility is more expensive (29 percent). Fourteen percent had been referred to the facility and therefore had had to bypass the nearest facility to their home (Appendix Table A-7.13).

Key Findings

The relationship between STIs and sexual activities is commonly mentioned during STI consultations, but only slightly over half of STI clients are counselled on the risks of HIV/AIDS.

Discussion of using condoms for protection was observed in just over half of STI client consultations. While just over 20 percent of clients were offered condoms by the provider, fewer than 20 percent were instructed on how to use them.

7.6 Availability of HIV/AIDS Services

Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that lead to death. This is a serious public health and socioeconomic problem in many countries around the world.

The principal mode of transmission of HIV in Kenya is through heterosexual contact (MOH and NACC, Kenya 2001). This is followed in importance by perinatal transmission, whereby the mother passes the HIV virus to the child during pregnancy, at the time of birth, or through breastfeeding. Health personnel are at an increased risk of acquiring the HIV infection if they inadvertently come in contact with bodily fluids while they are providing services. Therefore, they should not only know how to prevent this exposure but also how to get immediate attention if such potentially harmful contact were to occur.

In general, it is of the utmost importance that the health system in a country provides services for the situations described above. Table 7.4 shows the availability of HIV/AIDS-related services in health facilities throughout the country. The services described in this section are: voluntary counselling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT), antiretroviral therapy (ART), and post-exposure prophylaxis (PEP).

In general, 35 percent of facilities offer both HIV counselling and testing (VCT) as a package at least one day a week, making VCT the most widely available HIV/AIDS service in health facilities in Kenya (Table 7.4). Not surprisingly, 9 in 10 hospitals and all stand-alone VCT facilities offer the service. Facilities in Nairobi province are most likely to offer this service, and NGO-managed and private for-profit facilities are more likely than government and FBO-managed facilities to offer VCT services.

Prevention of mother-to-child transmission (PMTCT) services are offered in only 24 percent of facilities. One might expect a greater proportion of maternities to offer PMTCT services, but surprisingly, only 35 percent do; by comparison, 74 percent of hospitals offer PMTCT.

The HIV/AIDS-related services least offered in Kenyan facilities are ART and PEP, offered in 7 percent and 13 percent of facilities, respectively. PEP is available in 4 percent of facilities, and 9 percent of facilities use referral sites to offer the service (Table 7.4).

Table 7.4 Availability of HIV/AIDS services

Percentage of facilities offering the indicated HIVAIDS-related services by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage									Number of facilities (weighted)
	VCT			PMTCT	ART[1]	PEP[1]				
	Counselling services at least one day a week	Testing services at least one day a week	Both services at least one day a week	Service at facility	Service at facility	Availability at facility[2]	Referred to another facity[2]	Not available	Total	
Type of facility										
Hospital (all types)	89	91	89	74	52	39	7	54	100	28
Health centre	47	46	46	36	12	4	8	88	100	125
Maternity	50	46	45	35	6	0	4	96	100	20
Clinic	36	36	36	16	6	7	4	89	100	8
Dispensary	21	22	21	12	0	0	9	91	100	249
Stand-alone VCT	100	100	100	6	6	6	55	39	100	10
Managing authority										
Government	31	32	31	24	5	1	3	96	100	246
NGO	47	47	47	28	21	18	19	63	100	21
Private (for-profit)	50	50	48	34	15	7	30	63	100	63
Faith-based organisation	36	35	35	17	6	6	11	84	100	110
Province										
Nairobi	73	73	73	55	19	18	27	55	100	41
Central	30	35	30	14	4	3	5	92	100	50
Coast	40	40	40	37	10	2	13	85	100	49
Eastern	38	38	38	24	12	2	12	86	100	83
North Eastern	12	12	12	7	2	1	2	97	100	8
Nyanza	19	19	19	15	5	3	2	95	100	54
Rift Valley	30	31	30	16	3	3	7	90	100	126
Western	43	36	36	30	5	1	2	96	100	29
Total	36	36	35	24	7	4	9	87	100	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] ART is Anti-Retroviral Therapy (for AIDS); PEP is post exposure prophylaxis
[2] PEP available to staff of facility anywhere in the facility
[3] Staff referred to another facility to receive PEP

7.6.1 Systems for Testing and Providing HIV Test Results

Voluntary counselling and testing (VCT) is now acknowledged as an effective and essential strategy for both HIV prevention and AIDS care. The need for VCT is partly driven by the high prevalence rates reported in Kenya. Scientific evidence has shown that high quality counselling and knowledge of HIV status helps individuals assess their level of risk, develop realistic plans to reduce risk, and increase safer sex practices. HIV-negative persons become more empowered to remain disease-free, while those who are HIV-infected assess their options for treatment and positive living with HIV/AIDS. One of the major strategies in the battle against HIV/AIDS is to encourage people to get tested for the HIV virus so that those who test positive can take precautions to reduce its spread.

The KSPA 2004 assessed facilities to determine what systems were in place for testing and providing results for HIV tests to clients. Table 7.5 shows the percentage of facilities with an HIV testing system, and which systems facilities use for providing clients with their results.

Table 7.5 System for testing and for providing results for HIV test, Kenya SPA 2004

Percentage of facilities with an HIV testing system and, among these, the percentage using the indicated system for providing HIV test results, and with the indicated documents, Kenya SPA 2004

Background characteristics	Percentage of facilities with HIV testing system[1]	Number of facilities	Facilities with the means for providing HIV test with: HIV test available in facility or affiliated lab[2]	HIV test available or observed record for testing conducted outside facility	Informed consent policy for HIV testing observed in all relevant service sites[3]	Observed register with HIV test results	Observed record for clients receiving HIV test results	All items for indicator[4]	Number of facilities with HIV testing system	Number of service sites with HIV testing system[5]
Type of facility										
Hospital	92	28	98	99	18	57	53	10	26	112
Health centre	48	125	98	100	57	71	71	31	60	148
Maternity	53	20	81	91	15	62	46	2	11	30
Clinic	36	8	92	92	33	89	89	24	3	5
Dispensary	22	249	91	91	59	92	74	29	54	77
Stand-alone VCT	100	10	100	100	89	100	100	83	10	11
Managing Authority										
Government	33	246	94	94	57	76	76	35	81	199
NGO	47	21	100	100	72	94	94	68	10	16
Private (for-profit)	52	63	93	96	44	62	32	7	33	90
Faith-based organisation	36	110	96	99	36	88	82	23	40	78
Province										
Nairobi	77	41	100	100	32	96	96	27	31	70
Central	36	50	84	85	30	65	50	4	18	42
Coast	40	49	100	100	34	45	44	4	20	82
Eastern	38	83	98	98	87	66	64	45	32	72
North Eastern	13	8	100	100	49	66	66	9	1	2
Nyanza	19	54	99	99	14	86	67	4	10	30
Rift Valley	31	126	100	100	67	93	75	46	39	64
Western	43	29	62	78	35	73	68	32	13	22
Total	37	440	95	96	50	77	69	28	164	383

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] The facility either conducts the test (any type of HIV test anywhere in the facility, including ANC clinics), has an affiliated external laboratory where tests are conducted, or has an agreement with an external testing site from where the test results are expected to be returned to the facility.

[2] The facility has rapid test anywhere in the facility (including VCT and PMTCT service sites), has functioning ELISA equipment with all items necessary to conduct a test, or has all items for Western Blot or PCR tests available.

[3] Availability of national guidelines for VCT at a service site counts as having informed consent policy for HIV testing.

[4] Facility has testing capability on or offsite and has all documentation available

[5] There may be several locations within the same facility where the same service is offered. Each such location is defined as a service site.

Just 37 percent of facilities have an HIV testing system, meaning the facility either conducts the test (any type of HIV test anywhere in the facility, including ANC clinics), has an affiliated external laboratory where tests are conducted, or has an agreement with an external testing site from which the test results are expected to be returned to the facility. The vast majority of hospitals have a testing system, whereas only a little over half of maternities have such a system. Further, private for-profit facilities and facilities in Nairobi are more likely to have an HIV testing system.

Of the facilities with a testing system, 95 percent have the HIV test available in the facility or affiliated laboratory, and only 1 percent of facilities with a testing system rely on an external non-affiliated testing site (Table 7.5). Among facilities with an HIV testing system, all VCT facilities and almost all hospitals and health centres conduct the HIV test on site; facilities in North Eastern province are least likely to test

on site. Among facilities with an HIV testing system, all NGO-managed facilities and all facilities in Nairobi, Coast, North Eastern, and Rift Valley provinces have the HIV test available on site.

The weakest components of HIV testing systems are recordkeeping and having protocols and guidelines available. Only 50 percent of facilities have an informed consent policy for HIV testing in all relevant service sites. Further, 77 percent have registers with HIV test results, and only 69 percent have records for clients receiving HIV test results. Overall, only 28 percent of facilities with a testing system have all necessary documentation available. VCT facilities and NGO-managed facilities are more likely to have the necessary informed consent policy documents and other documentation compared to others. Facilities in Nairobi province are more likely than facilities elsewhere to have registers recording test results and showing that clients received test results (Table 7.5)

7.6.2 Availability of PMTCT Services

Current strategies on HIV/AIDS in Kenya are geared towards improving the health of the HIV-infected mother and reducing the rate of transmission to children during pregnancy, labour, delivery, and breastfeeding, as outlined in the National HIV/AIDS Strategic Plan of 2000 (MOH, 1999b).

To achieve these goals, it is critical to increase the level of general knowledge of transmission of the virus from mother to child and reduce the risk of transmission by use of anti-retroviral drugs (2003 KDHS). The four components of PMTCT are 1) counselling and testing, 2) ARV prophylaxis to prevent transmission, 3) counselling on infant feeding, and 4) family planning counselling and/or referral. Table 7.6 shows the availability of PMTCT services in health facilities across the country.

Overall, only 24 percent of health facilities offer any PMTCT services, with hospitals and facilities in Nairobi more likely to offer the service. Among facilities offering PMTCT, 87 percent offer HIV counselling and testing services, with almost all hospitals, private for-profit, FBO-managed facilities, and all eligible facilities in Nairobi and Eastern provinces offering counselling and testing services.

Antiretroviral (ARV) prophylaxis for preventing mother-to-child transmission of HIV is offered in 58 percent of facilities offering PMTCT services. Hospitals, private for-profit facilities, and facilities in Central province are most likely to provide this component of PMTCT. Counselling on infant feeding is available in more PMTCT facilities (85 percent) than ARV prophylaxis. One might expect these components to be widely available in maternities, but only 70 percent of maternities offer ARV prophylaxis, and about two-thirds offer counselling on infant feeding (Table 7.6). Eighty-eight percent of PMTCT facilities offer family planning counselling and/or referral.

In addition to the four basic components of PMTCT, if a facility also offers antiretroviral therapy (ART) to HIV-positive women and their families, that facility is considered to offer "PMTCT+" services. Only 15 percent of PMTCT facilities offer ARV therapy for HIV-positive women and family members, and only 14 percent of PMTCT facilities meet the criteria for providing PMTCT+ services.

Table 7.6 Availability of PMTCT and PMTCT+ services

Percentage of facilities offering PMTCT services, and among facilities offering PMTCT, percentage offering the indicated component of PMTCT services, Kenya SPA 2004

Background characteristics	Percentage of facilities providing any PMTCT services	Number of facilities (weighted)	Percentage of facilities offering the indicated component of PMTCT[1]: Counselling and testing services[2] (V)CT	ARV prophylaxis to prevent MTCT[3]	Infant feeding counselling[4]	Family planning counselling and/or referral[5]	All four items for minimum package PMTCT	ARV therapy for HIV+ women and family members[6]	All items for PMTCT+[7]	Number of facilities offering PMTCT services (weighted)	Number of programme sites for PMTCT (weighted)[8,9]
Type of facility											
Hospital (all types)	74	28	98	89	95	91	82	53	48	21	45
Health centre	36	125	86	57	85	91	57	10	10	45	67
Maternity	35	20	81	70	67	85	53	3	3	7	13
Clinic	16	8	75	51	93	81	39	12	12	1	2
Dispensary	12	249	82	36	82	81	36	0	0	31	33
Managing authority											
Government	24	246	86	51	79	89	51	15	15	60	94
NGO	28	21	40	37	94	94	37	3	3	6	10
Private (for-profit)	34	63	94	90	89	96	83	11	11	21	31
Faith-based organisation	17	110	98	53	98	70	46	24	18	19	26
Province											
Nairobi	55	41	100	82	100	79	78	13	13	22	31
Central	14	50	95	96	100	98	92	25	21	7	11
Coast	37	49	78	61	61	97	61	20	20	18	27
Eastern	24	83	100	38	78	80	36	10	10	20	27
North Eastern	7	8	100	17	100	100	17	17	17	1	1
Nyanza	15	54	98	47	87	100	43	21	21	8	16
Rift Valley	16	126	68	63	99	94	60	15	11	21	32
Western	30	29	68	11	68	72	11	8	7	9	14
Total[9]	24	440	87	58	85	88	56	15	14	106	160

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] PMTCT is the Prevention of Mother-To-Child Transmission of HIV. Indicated services offered in the facility either as an outpatient or inpatient service

[2] Group (or individual) pre-test information or counselling, or individual post-test counselling, and testing services

[3] Antiretroviral prophylaxis for HIV positive women and newborns

[4] The objective is to assess the mother's personal circumstances in order to help her select the best feeding option for her baby

[5] Counselling and referral on family planning offered to HIV positive women

[6] Antiretroviral therapy offered to HIV positive women and their eligible HIV positive family members

[7] PMTCT + refers to provision of the minimum package of PMTCT services plus ARV therapy (sum of all previous columns)

[8] There may be several locations within the same facility where PMTCT services are offered. Each such location is defined as a service site

[9] Totals include one stand-alone VCT (weighted)

Key Findings

Just over one-third of facilities offer VCT services at least one day per week; other HIV/AIDS services (including PMTCT, ART, and PEP) are less widely available.

One-third of facilities have an HIV testing system, almost all of which offer the test in the facility or in an affiliated laboratory.

Hospitals and facilities in Nairobi province are most likely to have an HIV testing system.

One-fourth of facilities offer PMTCT services, ART services are available in only 7 percent of facilities, and PEP services for health personnel are available in 13 percent of health facilities.

Hospitals, private for-profit facilities, and facilities in Nairobi province are most likely to offer PMTCT services. The KSPA-defined minimum package of services is offered in slightly more than half of facilities offering PMTCT.

Highlighting the scarcity of antiretroviral therapy in Kenya, only 14 percent of facilities offer "PMTCT+" services (primarily hospitals).

7.7 Resources for Diagnosis and Management of Tuberculosis

Tuberculosis (TB), especially multi drug-resistant tuberculosis (MDR-TB), is a re-emerging communicable disease of public health significance. In order to control TB infection and to prevent its most severe complications, universal BCG vaccination at birth is mandatory in many developing countries, including Kenya. 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 TB. The KSPA 2004 assessed TB services provided at all facilities, the capacity to conduct a sputum test, and the availability of medications for short-course, standard, and prophylactic treatments.

TB services are available in 44 percent of facilities; more hospitals (91 percent) than other facilities offer TB services (Table 7.7). About half of private and government facilities offer TB services, and facilities in Western province (81 percent) are more likely than facilities elsewhere to offer these services. Of all facilities, 27 percent offer TB treatment using the DOTS strategy, and an additional 17 percent offer alternative TB regimes.

7.7.1 TB Diagnosis

Among facilities offering any TB services, 63 percent have a functioning microscope and glass slides for conducting microscopic sputum examinations, and 55 percent have the capacity to stain sputum for diagnosis (Appendix Table A-7.15)

7.7.2 Availability of TB medicines

Among facilities providing any TB services, 73 percent have first-line medicines available (any combination of pyrazinamide, rifampin, ethambutol, and isoniazid) (Appendix Table A-7.15). Only 26 percent have first-line and second-line medicines (first-line medicines plus streptomycin). Of all facilities providing TB treatment using the DOTS strategy, 89 percent have all first-line treatment medicines in stock.

Table 7.7 Availability of services for tuberculosis

Percentage of facilities that provide the indicated TB services, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities providing: Any services for TB	TB services through DOTS[1]	TB services not through DOTS	Number of facilities (weighted)
Type of facility				
Hospital	91	78	13	28
Health centre	65	45	20	125
Maternity	46	4	42	20
Clinic	21	9	12	8
Dispensary	30	16	14	249
Stand-alone VCT	0	0	0	10
Managing authority				
Government	54	38	16	246
NGO	13	11	2	21
Private (for-profit)	51	7	44	63
Faith-based organisation	23	17	5	110
Province				
Nairobi	32	24	8	41
Central	35	25	9	50
Coast	69	42	28	49
Eastern	45	40	5	83
North Eastern	33	32	1	8
Nyanza	40	17	23	54
Rift Valley	34	18	16	126
Western	81	31	50	29
Total	44	27	17	440

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Directly observed treatment, short-course (WHO's strategy for TB control)

Key Findings

Less than half of all facilities in the country offer TB services (mostly hospitals and health centres).

Twenty-seven percent of facilities use the DOTS strategy, and an additional 17 percent provide an alternative TB treatment strategy.

Approximately three-fourths of facilities providing TB services have first-line medicines available, but only one-fourth have first-line medicines plus streptomycin available.

Nine in ten facilities utilizing the DOTS strategy have all first-line medicines in stock.

7.8 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 fluids, regardless of whether services related to HIV/AIDS are being provided or not. In a high-risk environment such as a health facility, it is critical to ensure that no one is unintentionally exposed to the virus. An essential step

in preventing transmission of HIV/AIDS (as well as hepatitis B and C) is to ensure that any potentially contaminated items are appropriately disinfected, which eliminates this avenue for transmission. Therefore, it is recommended that universal precautions 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.

A few related indicators from Chapter 3 are presented here. Among all assessed facilities, water (either running or in a bucket) was available in all relevant service sites in less than 79 percent of facilities (see Appendix Table A-3.22). Chlorine solution was found in MCH and STI sites in a much smaller proportion of facilities (35 percent). The most widely available infection control items are latex gloves (found in 67 percent of all relevant service areas), sharps boxes (73 percent), and soap (52 percent). Only 14 percent of facilities have all the indicated items for infection control present in all relevant service sites; dispensaries and clinics are most likely to have all the items (Table 3.12).

Overall, 60 percent of facilities have functioning equipment for sterilisation or high-level disinfection (HLD) (see Table 3.11). VCT facilities are the least likely to have these items, most probably because they use disposable equipment such as disposable needles and syringes.

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Appendix A Weighting of Facilities in KSPA 2004

When selecting a sample, very frequently there is interest in having data on specific types of services or facilities where a nationally representative sample alone 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 over- or under-represented in the sample in relation to the proportion that exist in the nation as a whole. To compensate for over- or under-sampling, when presenting statistics that are meant to be nationally representative, the data are weighted. The weights ensure that such actual proportions of facilities and services as exist in reality appear in the data. Thus, if a type of facility or service is over-sampled, so that twice as many were included in the sample as should be, for nationally representative results, the results for the over-sampled services or facilities will be weighted down by 50 percent. In this particular survey, the number of hospitals actually assessed (172) corresponds to 39 percent of the total sample. However, the real proportion of hospitals to all facilities as per the national list of facilities—i.e., the sampling frame for the Service Provision Assessment—is 6 percent. Thus, the number of hospitals was weighted down to 28, which reflects the actual percentage.

The weighted numbers are provided in the tables in the report and give information on what proportion of the total comes from this particular type of facility or province. It is important to know, however, that all facilities in the sample are used during analyses and in calculating percentages. So, if a weighted number looks too small to be meaningful, it is important to review the unweighted number to know how many actual facilities/interviews contribute to the particular percentage. For example, in a sample of 100 facilities, if clinics represent 3 percent of all facilities, the weighted number of facilities shown will be “3”. If, in fact, 20 clinics were sampled so that data could be provided for clinics alone, the data from these 20 clinics would be used to calculate the percentage that is shown for the “3” weighted clinics.

Appendix B Additional Tables

Chapter 1

Table A-1.1.1 Distribution of facility sample frame and final sample selection by province

Number of facilities of each type that were in the sample frame, number selected for the survey sample, and percentage of eligible facilities of each type that were included in the sample, by type of facility and province, Kenya SPA 2004

	Province															
	Nairobi		Central		Coast		Eastern		North Eastern		Nyanza		Rift Valley		Western	
Type of facility[1]	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample
Hospital	23	14	37	26	29	18	50	24	11	11	41	24	86	29	26	26
Health centre	174	10	126	3	183	6	259	6	19	4	177	5	316	9	102	8
Maternity	27	3	19	10	26	10	17	4	1	1	74	9	23	2	31	7
Clinic	20	12	6	6	13	13	16	10	4	4	16	11	7	7	4	4
Dispensary	154	4	351	13	274	8	532	12	52	9	272	6	908	11	149	6
Stand-alone VCT	41	18	6	4	5	2	21	4	1	0	10	2	21	4	2	1
Total	439	61	545	62	530	57	895	60	88	29	590	57	1,361	62	314	52

[1] Not uncommonly, facility classifications may change due to service upgrades or downgrades. Often, such changes are not reflected in official facility databases in a timely manner. The survey identified several facilities with a classification that was different from that provided in the sample frame, which resulted in some numbers in the sample being greater than some numbers in the frame. Whenever the number of facilities in the SPA sample was more than the number in the sample frame, the frame was adjusted to be equal to the number of facilities in the sample, implying all these facilities in the sample frame were selected for the survey. The number of facilities in the sample frame shown in this table reflects numbers after accounting for any discrepancies. A total of 20 such discrepancies were corrected in 5 provinces.

Table A-1.1.2 Distribution of facility sample frame and final sample selection by managing authority

Number of facilities of each type that were in the sample frame, number selected for the survey sample, and percentage of eligible facilities of each type that were included in the sample, by type of facility and managing authority, Kenya SPA 2004

	Managing authority							
	Government		NGO		Private (for-profit)		Faith-based organisation	
Type of facility[1]	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample	Sample frame	SPA sample
Hospital	128	87	8	5	61	40	98	40
Health centre	538	36	75	3	591	4	152	8
Maternity	5	1	1	1	199	39	13	5
Clinic	1	1	6	6	58	51	10	9
Dispensary	1596	45	108	1	353	4	635	19
Stand-alone VCT	15	5	66	19	9	5	17	6
Total	2,283	175	264	35	1,271	143	952	87

[1] Information not available to show where adjustments were made by managing authority whenever there were discrepancies as described in Table A-1.1.1

Table A-1.1.3 Distribution of facility sample frame and final sample selection

Number of facilities of each type that were in the sample frame, number selected for the survey sample, and percentage of eligible facilities of each type that were included in the sample, by type of facility, Kenya SPA 2004

	Total	
Type of facility[1]	Sample frame	SPA sample
Hospital	303	172
Health centre	1,356	51
Maternity	218	46
Clinic	86	67
Dispensary	2,692	69
Stand-alone VCT	107	35
Total	4,762	440

[1] Not uncommonly, facility classifications may change due to service upgrades or downgrades. Often, such changes are not reflected in official facility databases in a timely manner. The survey identified several facilities with a classification that was different from that provided in the sample frame, which resulted in some numbers in the sample being greater than some numbers in the frame. Whenever the number of facilities in the SPA sample was more than the number in the sample frame, the frame was adjusted to be equal to the number of facilities in the sample, implying all these facilities in the sample frame were selected for the survey. The number of facilities in the sample frame shown in this table reflects numbers after accounting for any discrepancies. A total of 20 such discrepancies were corrected in 5 provinces.

Table A-1.2.1 Sample of interviewed health care providers

Number of interviewed health care providers (weighted and unweighted), by type of provider and type of facility, Kenya SPA 2004

Background characteristics	Number of interviewed providers	
	Weighted	Unweighted
Physicians/clinical officers		
Hospital	99	269
Health centre	49	37
Maternity	11	31
Clinic	3	39
Dispensary	22	7
Stand-alone VCT	1	2
Total	184	385
Nurses		
Hospital	246	490
Health centre	127	57
Maternity	14	41
Clinic	2	32
Dispensary	82	43
Stand-alone VCT	0	4
Total	471	667
Midwives		
Hospital	354	405
Health centre	149	70
Maternity	60	46
Clinic	3	35
Dispensary	126	51
Stand-alone VCT	4	16
Total	696	623
Auxiliary and other staff[1]		
Hospital	279	174
Health centre	178	44
Maternity	52	46
Clinic	10	60
Dispensary	187	21
Stand-alone VCT	23	61
Total	730	406
Total interviewed staff	2,081	2,081

[1] Includes social workers.

Table A-1.2.2 Sample of interviewed nurses and midwives

Number of interviewed nurses and midwives (weighted and unweighted), by type of provider and type of facility, Kenya SPA 2004

	Number of interviewed providers	
Background characteristics	Weighted	Unweighted
Registered nurses		
Hospital	90	228
Health centre	25	24
Maternity	6	19
Clinic	1	10
Dispensary	23	12
Stand-alone VCT	0	1
Total	145	294
Registered midwives		
Hospital	111	172
Health centre	31	22
Maternity	6	13
Clinic	1	9
Dispensary	13	6
Stand-alone VCT	1	6
Total	162	228
Enrolled nurses		
Hospital	156	262
Health centre	102	33
Maternity	9	22
Clinic	1	22
Dispensary	59	31
Stand-alone VCT	0	3
Total	326	373
Enrolled midwives		
Hospital	243	233
Health centre	118	48
Maternity	54	33
Clinic	2	26
Dispensary	113	45
Stand-alone VCT	3	10
Total	534	395
Total interviewed staff	1,167	1,290

Table A-1.3 Sample of observed consultations

Number of children/women whose consultation was observed, by type of care and type of facility, Kenya SPA 2004

Type of facility	Actual number of clients observed
CURATIVE CARE FOR SICK CHILDREN	
Hospital	625
Health centre	216
Maternity	52
Clinic	115
Dispensary	199
Stand-alone VCT	4
Total	1,211
FAMILY PLANNING	
Hospital	413
Health centre	99
Maternity	29
Clinic	28
Dispensary	52
Stand-alone VCT	7
Total	628
ANTENATAL CARE	
Hospital	636
Health centre	157
Maternity	61
Clinic	42
Dispensary	104
Stand-alone VCT	10
Total	1,010
STI	
Hospital	128
Health centre	24
Maternity	3
Clinic	11
Dispensary	12
Stand-alone VCT	0
Total	178

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, managing authority and province, Kenya SPA 2004

Background characteristics	Median population in catchment area	Number of facilities (weighted)
Type of facility		
Hospital	100,539	17
Health centre	19,898	85
Maternity	7,989	8
Clinic	10,973	3
Dispensary	7,937	174
Stand-alone VCT	150,400	3
Managing authority		
Government	13,001	193
NGO	7,906	14
Private (for-profit)	3,371	30
Faith-based organisation	10,406	53
Province		
Nairobi	55,581	7
Central	8,688	28
Coast	13,514	31
Eastern	7,555	58
North Eastern	13,577	8
Nyanza	20,405	35
Rift Valley	7,428	99
Western	10,977	24
Total	10,578	290

Table A-1.5.1 Staffing patterns for SPA facilities: health care providers

Median number of health care providers assigned to outpatient services by type of provider and type of facility, Kenya SPA 2004

	Median number of providers assigned to each facility[1]										Number of facilities (weighted)
Type of facility	Total staff	Doctor	Clinical officer	Registered nurse	Registered midwife	Enrolled nurse	Enrolled midwife	Any nursing/ midwife staff	Other technical	Other staff	
National referral hospital	1,570	37	45	17	161	18	258	451	175	843	0
Provincial hospital	396	17	23	33	28	49	180	293	49	15	1
Other hospital	55	3	3	2	3	4	6	21	9	11	27
Health centre	11	-	1	-	-	1	1	5	2	3	125
Maternity	10	1	1	-	-	-	2	4	2	3	20
Clinic	4	-	-	-	-	-	-	2	2	1	8
Dispensary	4	-	-	-	-	-	1	2	-	1	249
Stand-alone VCT	7	-	-	-	-	-	-	-	5	1	10
Total	6	-	-	-	-	-	1	3	1	2	440

[1] Numbers were provided by facility administrators

Table A-1.5.2 Staffing patterns for SPA facilities: other technical health care providers

Median number of selected other technical health care providers assigned to outpatient services by type of provider and type of facility, Kenya SPA 2004

	Median number of selected technical health care providers assigned to each facility		
Type of facility	Lab technologist/ technician	Pharmacist/ pharmaceutical technologist	Social worker/ counselor
National referral hospital	87	27	17
Provincial hospital	21	8	14
Other hospital	4	2	2
Health centre	1	-	-
Maternity	2	-	-
Clinic	1	-	-
Stand-alone VCT	-	-	4

Table A-1.6 Education levels of interviewed health service providers

Median number of years of basic schooling, and median number of years study for technical qualification, reported by interviewed health service providers, by type of provider, Kenya SPA 2004

Type of provider	Median number of years of basic education prior to technical training	Number of interviewed providers with information for basic education (weighted)	Median number of years of technical training for qualification	Number of interviewed providers with information for technical training (weighted)	Number of interviewed providers (weighted)
Qualification of provider					
Consultant	13	9	6	9	9
Medical doctor	12	31	5	31	31
Clinical officer	12	145	3	144	145
Registered nurse	11	145	2	145	145
Registered midwife	11	162	3	162	162
Enrolled nurse	11	326	2	326	326
Enrolled midwife	11	534	2	534	534
Nurse aide	11	281	0	281	281
Lab technician/technologist	11	151	2	151	151
Trained counselor (full time)	12	92	-	92	92
Other/missing	11	206	2	166	206
Total	11	2,080	2	2,041	2,081

Chapter 3

Table A-3.1.1 Availability of basic services by type of facility

Percentage of facilities offering basic services, by specific services and indicated packages of services, with the frequency and staffing indicated, Kenya SPA 2004

	Percentage by type of facility						
Services	Hospital	Health centre	Maternity	Clinic	Dispensary	Stand-alone VCT	Total
Services							
Curative care for children	98	100	93	94	96	4	95
Any service for sexually transmitted infections	97	97	93	99	91	6	92
Temporary methods of family planning	83	85	87	66	68	4	73
Antenatal care	84	86	76	53	77	4	78
Child immunisation	96	86	70	42	82	4	81
Growth monitoring	93	88	81	49	77	4	80
Packages of services available							
All basic services at any frequency[1]	66	65	52	30	55	4	57
Facility-based 24-hour delivery services	93	64	87	10	7	4	32
At least one qualified staff[2]	100	100	100	98	99	23	98
All services, minimum frequency[3]	53	54	46	28	39	4	44
All services, minimum frequency and 24-hour delivery services	50	34	42	6	3	4	16
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	50	34	42	6	3	4	16
Number of facilities (weighted)	28	125	20	8	249	10	440

[1] Any level of each of the following services offered at the facility: curative care for children, any STI services, temporary methods of family planning, antenatal care, immunisation, and child growth monitoring

[2] Qualified staff (providers of curative care) include: enrolled and registered nurses, enrolled and registered midwives, clinical officers and medical doctors.

[3] Curative services for children provided five days per week, STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunisation, and growth monitoring) provided at least one day per week

Table A-3.1.2 Availability of outreach services from facility

Among all facilities, percentage offering indicated service by type of facility, managing authority, and province, Kenya SPA 2004

Background characteristics	Outreach services							Number of facilities (weighted)
	ANC	Family planning	Immunisation	Adult curative care	Child curative care	Tetanus toxoid	HIV Testing	
Type of facility								
Hospital	37	29	49	30	33	22	9	28
Health centre	14	5	25	8	13	4	1	125
Maternity	8	8	12	10	10	4	0	20
Clinic	9	11	10	10	12	5	5	8
Dispensary	20	7	31	13	14	15	3	249
Stand-alone VCT	0	0	0	4	4	0	66	10
Managing authority								
Government	17	7	32	8	11	7	1	246
NGO	3	4	3	5	5	1	19	21
Private (for-profit)	6	7	7	5	6	4	3	63
Faith-based organisation	32	10	39	28	28	26	8	110
Province								
Nairobi	0	4	11	3	3	0	6	41
Central	1	1	2	2	2	1	0	50
Coast	16	17	23	22	22	16	3	49
Eastern	22	11	28	18	18	11	2	83
North Eastern	15	7	32	25	25	8	0	8
Nyanza	12	3	41	2	2	8	2	54
Rift Valley	26	2	35	14	17	14	8	126
Western	47	30	55	25	42	29	6	29
Total	19	8	29	12	14	11	4	440

Table A-3.2 Availability of basic services by province

Percentage of facilities offering basic services, by specific services and indicated packages of services, with the frequency and staffing indicated, by province, Kenya SPA 2004

	Percentage of facilities by province								
Services	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total
Services									
Curative care for children	80	94	99	92	99	98	98	97	95
Any service for sexually transmitted infections	83	88	99	88	86	98	91	99	92
Temporary methods of family planning	46	83	72	75	68	90	71	77	73
Antenatal care	62	78	77	79	82	94	73	82	78
Child immunisation	64	82	79	71	94	92	85	93	81
Growth monitoring	64	78	90	61	89	93	83	94	80
Packages of services available									
All basic services at any frequency[1]	40	60	57	42	46	84	56	64	57
Facility-based 24-hour delivery services	28	18	27	32	22	48	32	53	32
At least one qualified staff[2]	95	100	93	97	100	98	98	100	98
All services, minimum frequency[3]	39	40	45	37	46	75	35	50	44
All services, minimum frequency and 24-hour delivery services	21	12	12	17	13	29	11	22	16
All services, minimum frequency, and 24-hour delivery services, and at least one qualified staff	21	12	12	17	13	29	11	22	16
Number of facilities (weighted)	41	50	49	83	8	54	126	29	440

[1] Any level of each of the following services offered at the facility: curative care for children, any STI services, temporary methods of family planning, antenatal care, immunisation, and child growth monitoring

[2] Qualified staff (providers of curative care) include: enrolled and registered nurses, enrolled and registered midwives, clinical officers and medical doctors

[3] Curative services for children provided five days per week, STI services offered at least one day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunisation, and growth monitoring) provided at least one day per week

Table A-3.3 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, Kenya SPA 2004

Items to support quality 24-hour emergency services	Percentage by type of facility						
	Hospital	Health centre	Maternity	Clinic	Dispensary	Stand-alone VCT	Total
Client comfort amenities							
Client latrine	95	99	99	96	92	88	95
Protected waiting area	99	100	95	100	98	100	99
Clean facility	92	90	92	92	94	98	93
All client comfort items[1]	86	90	91	88	89	88	89
Facility infrastructure							
No electricity or generator	4	23	15	30	52	14	38
Generator observed with fuel	73	9	30	14	10	20	15
Regular electricity or generator	89	51	74	51	37	80	47
Onsite water	67	61	82	73	63	74	64
Regular water supply (onsite and year-round)	37	23	36	39	24	47	26
Regular water and electricity[2]	37	23	36	39	24	47	26
All client amenities, regular water and electricity	34	18	36	35	24	40	24
Staff and furnishings							
At least two qualified staff[3]	99	85	95	60	63	18	72
Duty staff on site 24 hours[4]	93	52	77	15	29	9	41
Duty staff on-call 24 hours[4]	1	7	1	6	5	10	5
Qualified staff living onsite	98	76	90	30	53	23	63
Qualified staff living onsite, no duty roster seen or no duty roster	4	9	12	7	5	0	6
Emergency communication[5]	97	79	88	87	65	93	73
Overnight patient beds[6]	97	64	99	19	21	6	42
Basic components supporting 24-hour emergency services[7]	57	20	59	6	6	4	16
Basic plus regular water and electricity[8]	34	9	31	1	5	4	9
Number of facilities (weighted)	28	125	20	8	249	10	440

[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] Qualified staff (providers of curative care) include: enrolled and registered nurses, enrolled and registered midwives, clinical officers and medical doctors
[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 qualified providers 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 qualified providers 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

Table A-3.4 Facility infrastructure supportive of client utilization and quality services by province

Percentage of facilities with client amenities, regular electricity and water supply, items to support quality 24-hour emergency services, by province, Kenya SPA 2004

Items to support quality 24-hour emergency services	Percentage by province								
	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total
Client comfort amenities									
Client latrine	86	100	80	95	79	100	99	100	95
Protected waiting area	100	100	100	95	100	99	100	100	99
Clean facility	87	99	84	94	87	90	94	100	93
All client comfort items[1]	86	98	78	84	79	90	93	99	89
Facility infrastructure									
No electricity or generator	10	20	52	36	30	55	38	56	38
Generator observed with fuel	29	11	8	10	8	10	22	9	15
Regular electricity or generator	75	57	41	52	56	21	50	18	47
Onsite water	69	43	46	65	62	77	67	79	64
Regular water supply (onsite and year-round)	53	32	4	27	17	7	36	9	26
Regular water and electricity[2]	53	32	4	27	17	7	36	9	26
All client amenities, regular water and electricity	48	32	3	23	15	7	35	9	24
Staff and furnishings									
At least two qualified staff[3]	93	76	59	77	46	62	67	92	72
Duty staff on site 24 hours[4]	29	27	45	52	34	44	38	52	41
Duty staff on-call 24 hours[4]	13	0	0	6	20	1	9	0	5
Qualified staff living onsite	42	50	66	77	69	67	65	52	63
Qualified staff living onsite, no duty roster seen or no duty roster	0	11	1	0	15	14	10	0	6
Emergency communication[5]	95	90	61	80	73	46	74	58	73
Overnight patient beds[6]	32	23	41	32	24	58	48	63	42
Basic components supporting 24-hour emergency services[7]	16	11	18	13	8	21	17	21	16
Basic plus regular water and electricity[8]	15	10	3	11	0	4	10	9	9
Number of facilities (weighted)	41	50	49	83	8	54	126	29	440

[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] Qualified staff (providers of curative care) include: enrolled and registered nurses, enrolled and registered midwives, clinical officers and medical doctors
[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 qualified providers 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 qualified providers 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

Table A-3.5.1 Routine management meetings

Percentage of facilities reporting they have routine management meetings at the indicated intervals, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage			Number of facilities (weighted)
	Monthly or more often	Every 2-3 months	Every 4-6 months	
Type of facility				
Hospital	66	21	2	28
Health centre	42	34	4	125
Maternity	53	14	7	20
Clinic	40	4	2	8
Dispensary	29	22	7	249
Stand-alone VCT	82	15	0	10
Managing authority				
Government	42	28	3	246
NGO	50	4	8	21
Private (for-profit)	43	10	8	63
Faith-based organisation	22	29	11	110
Province				
Nairobi	40	21	13	41
Central	52	12	5	50
Coast	39	20	0	49
Eastern	31	42	0	83
North Eastern	23	14	7	8
Nyanza	37	21	16	54
Rift Valley	37	16	6	126
Western	33	54	2	29
Total	38	25	6	440

Table A-3.5.2 Routine management board meetings

Percentage of facilities reporting they have routine management board meetings at the indicated intervals, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage			Number of facilities (weighted)
	Monthly or more often	Every 2-3 months	Every 4-6 months	
Type of facility				
Hospital	15	33	16	28
Health centre	15	25	6	125
Maternity	13	5	3	20
Clinic	17	3	0	8
Dispensary	12	17	13	249
Stand-alone VCT	37	24	7	10
Managing authority				
Government	14	25	7	246
NGO	43	7	2	21
Private (for-profit)	7	4	8	63
Faith-based organisation	13	19	21	110
Province				
Nairobi	37	6	19	41
Central	11	18	13	50
Coast	20	13	0	49
Eastern	12	16	6	83
North Eastern	2	25	0	8
Nyanza	3	33	13	54
Rift Valley	15	17	13	126
Western	1	48	6	29
Total	14	20	10	440

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, Kenya 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 medical records or registers	Other	
Background characteristics						
Hospital	28	36	36	36	2	19
Health centre	21	29	13	41	0	71
Maternity	14	33	15	46	0	9
Clinic	28	22	0	26	0	3
Dispensary	54	29	0	25	4	93
Stand-alone VCT	31	28	3	24	0	6
Total	37	30	9	33	2	201

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, managing authority and province, Kenya SPA 2004

	Percentage of facilities where the indicated percentage of interviewed providers:[1]						
	Received related in-service training during the past 12 months[2]			Were personally supervised during the past six months			Number of facilities with interviewed providers (weighted)
Background characteristics	None	At least 50 percent	All	None	At least 50 percent	All	
Type of facility							
Hospital	3	67	18	7	60	13	28
Health centre	13	50	25	3	49	40	125
Maternity	20	43	24	17	44	17	20
Clinic	20	24	46	26	35	33	8
Dispensary	18	24	52	11	23	61	249
Stand-alone VCT	6	13	78	15	6	79	10
Managing authority							
Government	13	42	38	4	37	54	246
NGO	15	15	69	0	21	78	21
Private (for-profit)	20	40	26	21	42	22	63
Faith-based organisation	18	19	52	14	24	52	110
Province							
Nairobi	4	44	39	10	63	9	41
Central	19	37	42	24	23	50	50
Coast	14	49	34	9	31	47	49
Eastern	21	25	38	5	43	43	83
North Eastern	22	17	48	12	19	61	8
Nyanza	10	27	51	3	40	55	54
Rift Valley	20	35	42	9	23	64	126
Western	2	36	42	1	29	61	29
Total	15	34	41	9	34	50	440

[1] Interviewed providers who did not personally provide one of the services assessed by the KSPA (i.e., administrators who might have been interviewed) are excluded.
[2] 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage receiving indicated supportive management practices				Number of interviewed health service providers (weighted)[2]
	Received in-service training during past 12 months[1]	Personally supervised in past six months	Personally supervised during past 6 months and received in-service training during past 12 months	Most recent in-service training was 13-35 months preceding the survey	
Type of facility					
Hospital	71	60	46	15	209
Health centre	67	70	49	17	456
Maternity	67	60	46	9	71
Clinic	67	60	46	9	19
Dispensary	65	72	50	16	432
Stand-alone VCT	83	86	75	9	23
Managing authority					
Government	69	71	51	13	709
NGO	78	90	70	14	58
Private (for-profit)	60	55	37	14	183
Faith-based organisation	66	67	47	23	260
Province					
Nairobi	72	62	45	17	224
Central	65	59	38	8	110
Coast	69	61	49	12	158
Eastern	62	68	46	12	210
North Eastern	61	68	45	12	19
Nyanza	69	73	53	24	123
Rift Valley	67	75	55	17	277
Western	68	81	56	17	89
Total	67	68	49	15	1,210

[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 for adult curative care, percentage where the indicated financing mechanism is utilized, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Client can prepay for multiple visits one service	Additional sources of funding[1]										Facility has any additional sources of funding[1]	Fees are posted publicly		Number of facilities having any user fees (weighted)
		Central govern-ment	Local govern-ment	NHIF	NSHI	Charity	Employer of client	Insurance	Donors	Revolving fund	Other		All fees	Some fees	
Type of facility															
Hospital	3	22	0	43	4	2	12	10	13	1	5	68	44	10	27
Health centre	3	28	4	0	0	0	0	0	15	3	0	37	30	6	115
Maternity	4	0	0	21	0	2	4	6	5	0	0	24	18	5	19
Clinic	0	2	0	2	2	2	4	4	13	0	4	19	17	11	7
Dispensary	0	27	0	0	0	4	0	0	13	0	4	44	24	7	208
Stand-alone VCT	0	18	0	0	0	0	0	0	69	6	6	69	80	0	4
Managing authority															
Government	0	35	2	2	0	0	0	0	7	2	2	42	35	4	222
NGO	0	22	0	4	0	2	4	2	93	2	4	94	28	0	10
Private (for-profit)	3	0	0	15	1	0	5	7	0	0	1	17	27	11	50
Faith-based organisation	4	14	0	3	1	9	1	0	29	0	5	51	11	11	99
Province															
Nairobi	4	16	5	5	0	11	3	5	26	1	1	42	52	0	34
Central	0	41	0	3	1	0	0	0	1	0	0	45	10	1	45
Coast	0	0	0	3	0	0	1	1	3	0	0	4	23	8	49
Eastern	0	12	0	2	0	7	1	0	7	0	12	39	43	7	73
North Eastern	0	61	0	5	0	0	1	1	9	0	0	63	7	4	7
Nyanza	6	40	0	7	1	1	1	1	9	7	1	54	27	9	51
Rift Valley	0	29	3	5	0	0	1	1	33	0	0	58	21	9	93
Western	0	33	0	5	0	0	1	0	5	0	0	38	19	9	29
Total	1	25	1	4	0	2	1	1	14	1	3	42	27	7	380

[1] Sources of funding outside of routine running budget or direct client fees used in the facility.

Table A-3.10 Components for which fees are charged

Among facilities with user fees for adult curative care, percentage charging for the indicated item, by type of facility, managing, authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities charging for the indicated item: Client chart or record	Consultation	Number of facilities with client fees (weighted)
Type of facility			
Hospital	58	62	27
Health centre	48	53	115
Maternity	41	73	19
Clinic	27	74	7
Dispensary	52	50	208
Stand-alone VCT	18	82	4
Managing authority			
Government	60	38	222
NGO	52	98	10
Private (for-profit)	19	86	50
Faith-based organisation	43	66	99
Province			
Nairobi	51	77	34
Central	62	27	45
Coast	23	84	49
Eastern	45	45	73
North Eastern	47	43	7
Nyanza	64	38	51
Rift Valley	51	57	93
Western	62	53	29
Total	50	53	380

Table A-3.11 Facility systems for maintenance and repair of equipment

Among facilities with preventive maintenance programmes for large equipment, percentage where indicated persons are responsible for maintenance, and among facilities with systems for repairing small equipment, percentage where the indicated system is used for repair, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities where indicated persons are responsible for performing 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
	On-site staff	External technicians	Both onsite and external technicians		On-site repair	Send outside for repair or replace	Purchase or pay for from funds on hand	
Type of facility								
Hospital	65	26	8	22	61	25	45	27
Health centre	18	78	4	44	11	67	36	116
Maternity	21	77	2	10	25	34	62	19
Clinic	7	76	16	2	10	42	66	7
Dispensary	19	70	11	102	7	77	23	213
Stand-alone VCT	0	62	38	3	17	32	67	3
Managing authority								
Government	31	57	12	98	7	83	17	228
NGO	2	83	15	17	14	75	21	17
Private (for-profit)	15	81	3	30	23	38	72	56
Faith-based organisation	22	76	3	38	22	41	47	83
Province								
Nairobi	31	50	19	15	30	40	59	35
Central	9	90	1	20	10	68	38	47
Coast	20	76	4	23	23	57	39	39
Eastern	25	68	7	62	15	74	18	76
North Eastern	22	75	2	4	3	80	17	8
Nyanza	33	65	2	10	5	83	20	51
Rift Valley	33	43	24	34	8	65	36	109
Western	6	94	0	15	14	69	19	21
Total	24	67	9	183	13	67	32	385

[1] Major equipment refers to generators, sterilisers, and other large equipment where routine maintenance is recommended to extend the life of the machine.
[2] Minor equipment refers to stethoscopes, sphygmomanometers, and other small equipment where either minor repairs or replacement are common when broken.

Table A-3.12 Facility systems for maintenance and repair of building

Among facilities with system for maintenance and repair of buildings, percentage where the indicated person is responsible for performing repairs, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage where repairs on building or infrastructure are made by:			Number of facilities with system for maintenance and repair (weighted)
	On-site staff	Persons hired from outside	Both on-site staff and externally hired	
Type of facility				
Hospital	72	18	10	23
Health centre	3	69	28	52
Maternity	41	59	0	11
Clinic	11	83	6	4
Dispensary	22	69	9	87
Stand-alone VCT	14	64	22	5
Managing authority				
Government	21	56	23	93
NGO	3	83	15	16
Private (for-profit)	19	79	3	40
Faith-based organisation	47	49	4	34
Province				
Nairobi	41	37	22	19
Central	12	85	3	18
Coast	11	87	2	20
Eastern	27	56	17	47
North Eastern	9	89	2	4
Nyanza	24	45	31	13
Rift Valley	29	54	18	46
Western	13	85	2	15
Total	24	62	14	182

Table A-3.13 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities routinely storing vaccines with:					Percentage of facilities where vaccines observed with:			Number of facilities with stored vaccines observed (weighted)
	Functioning thermometer in refrigerator	Tempera-ture chart up-to-date	Temperature 0-8º C at the time of survey	Adequate cold chain monitoring system	Refrigerated or protected from sun	No expired vaccines present	Vaccines stored by expiration date	Inventory up-to-date	
Type of facility									
Hospital	97	91	84	76	95	98	93	98	25
Health centre	96	96	81	77	100	96	82	91	100
Maternity	100	92	79	70	100	100	91	78	14
Clinic	90	82	85	77	95	97	72	79	3
Dispensary	98	92	76	72	100	98	94	82	178
Managing authority									
Government	98	97	77	74	99	98	90	89	189
NGO	100	48	100	48	100	100	18	98	6
Private (for-profit)	98	67	61	56	98	100	91	91	29
Faith-based organisation	95	95	85	80	100	95	94	78	95
Province									
Nairobi	99	99	99	98	99	100	61	88	26
Central	99	100	90	90	98	100	99	99	37
Coast	99	90	98	89	100	99	91	100	35
Eastern	92	99	52	51	100	92	91	85	54
North Eastern	100	100	99	99	87	94	88	99	7
Nyanza	91	88	38	26	100	100	91	63	45
Rift Valley	100	86	89	84	100	96	92	81	88
Western	100	95	96	90	100	100	91	99	27
Total	97	93	78	73	99	97	90	86	320

Table A-3.14 Storage conditions and stock monitoring systems for contraceptive methods and 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, managing authority and province, Kenya SPA 2004

Background characteristics	Proper storage condition				Proper stock monitoring systems[1]			Number of facilities with stored commodities observed (weighted)
	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	
CONTRACEPTION								
Type of facility								
Hospital	97	99	92	89	99	78	79	22
Health centre	100	100	100	100	99	87	75	103
Maternity	90	99	92	85	96	74	57	17
Clinic	98	98	92	92	98	79	62	5
Dispensary	91	100	95	88	100	81	70	151
Managing authority								
Government	93	100	96	90	99	84	73	209
NGO	100	100	99	99	100	97	19	14
Private (for-profit)	94	99	95	90	98	76	73	36
Faith-based organisation	100	100	100	100	100	74	81	39
Province								
Nairobi	99	100	100	99	100	68	66	18
Central	100	100	99	99	100	81	64	35
Coast	90	100	90	89	100	89	90	35
Eastern	83	100	98	83	100	75	91	53
North Eastern	100	100	89	89	100	68	77	6
Nyanza	98	100	89	87	98	69	59	49
Rift Valley	100	100	100	100	100	99	65	81
Western	88	100	99	87	95	74	66	22
Total	95	100	96	92	99	82	72	298
MEDICINES[3]								
Type of facility[4]								
Hospital	96	100	95	91	79		48	28
Health centre	92	100	100	91	83		52	125
Maternity	98	100	94	94	80		39	19
Clinic	97	100	93	89	84		24	7
Dispensary	87	99	95	83	75		43	249
Managing authority								
Government	84	99	95	79	80		54	245
NGO	100	100	99	99	51		14	16
Private (for-profit)	99	100	97	97	77		22	59
Faith-based organisation	96	100	100	96	78		44	109
Province								
Nairobi	91	100	100	91	99		72	38
Central	95	95	100	90	80		49	50
Coast	87	100	86	80	80		24	48
Eastern	78	100	99	78	84		53	80
North Eastern	89	100	78	67	95		37	8
Nyanza	99	100	90	89	85		29	53
Rift Valley	91	100	100	91	57		42	122
Western	92	100	100	92	100		67	29
Total	90	99	96	86	78		45	429

[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 Ringers lactate intravenous solution.
[2] All proper storage conditions (off the ground and protected from water, protected from sun, and no evidence of pests or rodents).
[3] Information not collected on storage of medicines by expiration date
[4] Totals include data from one stand-alone VCT (weighted)

Table A-
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 the 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities where commodity order is determined by facility	Number of eligible facilities (weighted)	Receipt of ordered commodity considered: Very reliable	Sometimes reliable	Rarely reliable	Most recent order received during past 4 weeks	Number of facilities that determine commodity order (weighted)
VACCINES							
Type of facility							
Hospital	92	28	60	25	13	87	26
Health centre	88	111	55	32	9	93	98
Maternity	90	14	43	25	19	82	13
Clinic	97	3	43	37	17	93	3
Dispensary	93	204	44	43	7	79	190
Managing authority							
Government	92	208	45	40	8	86	193
NGO	99	14	72	3	25	100	14
Private (for-profit)	60	35	46	35	10	90	21
Faith-based organisation	99	104	53	39	8	77	103
Province							
Nairobi	94	26	77	3	16	97	24
Central	100	41	67	27	0	85	41
Coast	99	39	71	18	2	98	38
Eastern	80	63	22	52	18	82	51
North Eastern	99	8	82	18	0	75	8
Nyanza	91	50	33	60	5	98	46
Rift Valley	92	107	48	45	4	69	98
Western	90	27	32	28	40	90	25
Total	92	361	49	38	9	84	330
CONTRACEPTION							
Type of facility							
Hospital	92	22	46	42	12	58	20
Health centre	96	103	40	36	21	68	98
Maternity	89	17	33	31	34	47	15
Clinic	98	5	47	46	7	69	5
Dispensary	98	151	59	36	5	63	148
Managing authority							
Government	96	209	51	41	8	67	201
NGO	100	14	58	4	38	98	14
Private (for-profit)	93	36	30	26	43	54	33
Faith-based organisation	99	40	57	31	4	38	39
Province							
Nairobi	100	18	36	36	29	80	18
Central	93	35	47	53	0	63	33
Coast	91	35	28	40	31	54	32
Eastern	100	53	48	42	9	83	53
North Eastern	92	6	42	54	2	16	5
Nyanza	96	49	58	29	6	60	46
Rift Valley	99	81	71	19	10	54	80
Western	93	22	5	68	27	71	21
Total	96	298	50	36	13	63	288
MEDICINES							
Type of facility							
Hospital	76	28	52	38	9	77	21
Health centre	64	125	57	30	11	84	80
Maternity	98	19	42	38	19	77	18
Clinic	99	7	60	26	15	79	7
Dispensary	63	249	29	53	15	65	156
Managing authority							
Government	44	245	30	57	12	65	108
NGO	100	16	36	50	14	98	16
Private (for-profit)	99	59	49	37	13	87	59
Faith-based organisation	93	109	48	31	17	68	101
Province							
Nairobi	73	38	38	26	31	95	27
Central	51	50	25	62	13	62	26
Coast	67	48	25	63	12	88	32
Eastern	78	80	57	35	1	92	63
North Eastern	69	8	62	28	9	57	6
Nyanza	60	53	67	27	6	82	32
Rift Valley	67	122	31	50	19	45	82
Western	57	29	22	44	34	70	17
Total	66	429	40	44	14	73	284

Table A-3.16 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 province, Kenya SPA 2004

Background characteristics	Percentage with order determined external to facility	Number of eligible facilities (weighted)	Percentage of facilities providing commodity: Reporting reliability of receiving ordered stock during the 3 months preceding the SPA as Very reliable	Sometimes reliable	Rarely reliable	Most recent order received during past four weeks	Number of facilities where commodity order is determined external to facility (weighted)
VACCINES							
Province							
Nairobi	6	26	100	0	0	100	2
Central	0	41	100	0	0	100	0
Coast	1	39	0	100	0	100	0
Eastern	13	63	100	0	0	49	8
North Eastern	1	8	100	0	0	0	0
Nyanza	9	50	17	8	75	100	4
Rift Valley	8	107	10	86	4	96	9
Western	10	27	15	85	0	100	3
Total	7	361	45	41	14	83	26
CONTRACEPTION							
Province							
Nairobi	0	18	-	-	-	-	0
Central	7	35	0	0	0	100	3
Coast	9	35	0	0	0	100	3
Eastern	0	53	-	-	-	-	0
North Eastern	8	6	0	0	0	0	0
Nyanza	2	49	0	0	0	100	1
Rift Valley	1	81	0	0	0	51	1
Western	7	22	0	0	0	74	2
Total	3	298	0	0	0	87	10
MEDICINES							
Province							
Nairobi	27	38	32	34	35	49	10
Central	49	50	72	28	0	100	24
Coast	33	48	19	81	0	77	16
Eastern	22	80	23	77	0	73	17
North Eastern	31	8	43	25	32	64	3
Nyanza	40	53	20	59	21	60	21
Rift Valley	33	122	19	81	0	53	40
Western	43	29	1	53	46	22	12
Total	34	429	28	61	10	64	145

Note: Numbers were too small to present percentages by type of facility and managing authority.

Table A-3.17 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, managing authority and province, Kenya SPA 2004

	Percentage of facilities providing vaccinations and ordering own supplies in which:								
	Amount ordered based on:[1]			Stock orders placed:[1]					
					Routinely order:				
Background characteristics	Maintain a fixed stock	Order same amount each time	Order based on utilization	When stock falls to a predeter-mined level	More often than once monthly	Every four weeks	Less often than once monthly	When needed	Number of facilities (weighted)
Type of facility									
Hospital	37	1	60	14	2	16	1	26	26
Health centre	42	0	55	10	0	9	0	35	98
Maternity	32	0	56	16	2	17	0	22	13
Clinic	29	4	64	15	3	7	0	38	3
Dispensary	35	6	54	16	0	20	2	15	190
Managing authority									
Government	33	2	58	17	0	17	2	22	193
NGO	3	0	97	3	0	57	0	37	14
Private (for-profit)	47	1	44	8	3	15	0	18	21
Faith-based organisation	47	7	45	13	0	9	0	23	103
Province									
Nairobi	42	0	54	9	0	16	0	29	24
Central	57	0	37	12	0	1	0	24	41
Coast	60	0	31	3	1	1	0	26	38
Eastern	19	8	64	9	0	43	0	12	51
North Eastern	15	0	78	21	0	27	1	35	8
Nyanza	36	0	61	13	1	9	9	29	46
Rift Valley	32	8	57	23	0	14	0	19	98
Western	27	0	73	18	0	26	0	29	25
Total[2]	37	4	55	14	0	16	1	23	330

[1] Multiple responses might apply.
[2] Totals may be less than 100 percent due to other responses or missing data.

Table A-3.18 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 deciding how much to order and when to order, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities providing contraceptive methods and medicines and ordering own supplies in which: Amount ordered based on:[1] Maintain a fixed stock	Order same amount each time	Order based on utilization	Stock orders placed:[1] When stock falls to a predeter-mined level	Routinely order: More often than once monthly	Every 4 weeks	Less often than once monthly	When needed	Number of facilities (weighted)
CONTRACEPTION									
Type of facility									
Hospital	20	2	78	19	2	6	17	33	20
Health centre	16	0	84	18	0	6	17	43	98
Maternity	26	0	73	22	0	3	5	42	15
Clinic	9	0	91	30	2	7	4	48	5
Dispensary	22	5	73	26	2	8	4	32	148
Stand-alone VCT	50	0	50	50	0	0	0	0	0
Managing authority									
Government	23	0	77	22	1	9	11	33	201
NGO	4	0	96	4	0	0	1	92	14
Private (for-profit)	14	0	86	17	0	5	12	52	33
Faith-based organisation	13	19	68	40	0	0	3	25	39
Province									
Nairobi	34	0	66	10	0	9	6	41	18
Central	28	0	72	14	8	0	21	30	33
Coast	22	0	78	16	0	2	9	51	32
Eastern	16	0	83	9	0	24	16	34	53
North Eastern	12	0	84	14	0	2	4	65	5
Nyanza	32	0	68	29	0	0	1	38	46
Rift Valley	5	10	85	38	1	5	10	31	80
Western	29	0	71	25	0	6	3	37	21
Total[2]	20	3	78	23	1	7	10	37	288
MEDICINES									
Type of facility									
Hospital	23	1	75	41	16	3	1	37	21
Health centre	19	0	81	37	21	0	0	43	80
Maternity	30	4	65	39	10	0	0	49	18
Clinic	28	0	71	43	5	0	1	47	7
Dispensary	18	5	76	32	31	0	0	36	156
Stand-alone VCT	21	0	79	14	0	0	0	64	1
Managing authority									
Government	11	8	81	36	32	1	0	31	108
NGO	4	0	96	33	59	1	0	6	16
Private (for-profit)	39	1	59	47	2	0	0	49	59
Faith-based organisation	21	0	79	27	26	0	0	47	101
Province									
Nairobi	35	0	65	37	47	0	1	13	27
Central	14	0	85	63	21	1	0	15	26
Coast	13	0	87	37	11	0	0	53	32
Eastern	14	0	86	17	14	0	0	69	63
North Eastern	28	9	60	30	32	11	2	24	6
Nyanza	20	2	78	19	23	0	0	58	32
Rift Valley	20	10	70	44	34	0	0	21	82
Western	33	0	67	40	22	1	0	37	17
Total[2]	20	3	77	35	25	0	0	39	284

[1] Multiple responses might apply.
[2] Totals may be less than 100 percent due to other responses or missing data.

Table A-3.19 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 commodity, Kenya SPA 2004

Commodity	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)
	Activity level	Fixed supply	Don't know/missing	
Vaccines	78	22	0	26
Contraception	73	19	8	10
Medicines	31	69	0	145[a]

Note: Numbers too small to show by background characteristics.
[a] Facilities were government managed (primarily health centres and dispensaries).

Table A-3.20 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, Kenya SPA 2004

Background characteristics	Percentage of facilities providing indicated response
Temperature	
Excellent[1]	74
Good[2]	4
Don't know/invalid	23
Pressure	
Excellent[3]	49
Good[4]	8
Don't know/invalid	43
Temperature and pressure	
Both excellent	46
Both al least good	8
Don't know/invalid response for temperature or pressure	46
Total number of facilities with functioning autoclave (weighted)	118

[1] Autoclave had automatic temperature control, or response was 120 to 130° C.
[2] Response was more that 130° C but was less than 361° C (high cutoff point was selected to include any response that appeared valid).
[3] Either automatic machine 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-3.21 Storage conditions for sterilised or high-level disinfected items

Percentage of facilities with sterilised or disinfected instruments present and, among facilities where sterilised items are present, percentage with specific storage conditions for processed items, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with sterilised or disinfected items present	Number of facilities (weighted)	Among facilities with sterile/HLD equipment present, percentage in which indicated conditions were found[1]: Sterile/HLD status storage conditions[2]	Clean, but not sterile, storage conditions[3]	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilised items	Number of facilities with stored processed items (weighted)
Type of facility							
Hospital	97	28	87	38	65	62	27
Health centre	84	125	57	32	21	16	105
Maternity	97	20	65	39	33	31	19
Clinic	80	8	47	38	17	16	6
Dispensary	75	249	58	45	15	15	186
Stand-alone VCT	8	10	45	18	45	45	1
Managing authority							
Government	76	246	52	45	14	13	186
NGO	76	21	96	4	28	27	16
Private (for-profit)	82	63	76	41	55	49	52
Faith-based organisation	82	110	62	35	18	16	90
Province							
Nairobi	83	41	89	54	66	66	34
Central	94	50	56	48	9	9	47
Coast	67	49	60	52	18	7	33
Eastern	87	83	48	31	9	9	72
North Eastern	56	8	26	39	16	14	5
Nyanza	98	54	48	22	16	15	53
Rift Valley	57	126	67	39	28	28	72
Western	99	29	76	50	25	16	29
Total	78	440	60	40	22	20	344

[1] More than one storage condition may apply.
[2] Items are wrapped and sealed with time-steam-temperature (TST) tape or are in a sterile/HLD box that clasps shut and storage area is dry and clean.
[3] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser of autoclave, in a box or cabinet, and storage area is dry and clean, or sitting in disinfecting solution and storage area is clean.

Table A-3.22 Specific items for infection control that were available in all relevant service areas

Percentage of facilities where the indicated infection control items were either observed or reported available when the service being assessed was not being offered at the time of the survey in each of the service delivery areas assessed for that facility[1], by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with: Soap	Water	Sharps box	Disinfectant	Clean latex or sterile gloves	Waste receptacle[2]	Number of facilities (weighted)
Type of facility							
Hospital	50	75	66	22	10	10	28
Health centre	40	76	65	32	50	15	125
Maternity	46	72	71	34	30	30	20
Clinic	60	85	69	38	82	19	8
Dispensary	61	84	82	39	86	15	249
Stand-alone VCT	2	4	4	4	2	2	10
Managing authority							
Government	42	75	79	37	73	9	246
NGO	57	59	8	12	26	12	21
Private (for-profit)	58	81	70	40	50	24	63
Faith-based organisation	71	89	76	33	70	26	110
Province							
Nairobi	29	77	54	23	55	24	41
Central	64	59	75	44	81	21	50
Coast	55	85	78	30	72	16	49
Eastern	58	84	74	57	76	6	83
North Eastern	3	22	78	21	58	2	8
Nyanza	71	77	69	46	67	10	54
Rift Valley	51	90	77	21	64	19	126
Western	28	61	79	25	39	19	29
Total	52	79	73	35	67	15	440

[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: Immunisation area: soap, water, sharps box; Injection room: soap, water, sharps box; consultation area for sick children: soap, water; and consultation/examination area for 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 infection control, and listed in guidelines and protocols, this is not an item that has been commonly introduced.

Table A-3.23 Waste disposal methods for hazardous materials

Percentage of facilities that dispose of hazardous materials through specific methods, by type of facility, managing authority and, province, Kenya SPA 2004

Background characteristics	Percentage of facilities in which hazardous material: Removed offsite	Burned in incinerator	Burned and buried	Burned and not buried or burned and removed offsite	Buried/not burned or thrown in open pit latrine	Thrown in trash/ open pit	Thrown in pit latrine	Number of facilities (weighted)
Type of facility								
Hospital	4	69	4	1	15	5	1	28
Health centre	5	25	13	0	41	6	10	125
Maternity	14	65	4	1	12	4	0	20
Clinic	28	21	12	6	15	5	12	8
Dispensary	1	21	20	2	46	4	6	249
Stand-alone VCT	42	23	5	0	21	4	5	10
Managing authority								
Government	1	16	24	0	46	7	6	246
NGO	22	55	1	0	19	1	2	21
Private (for-profit)	17	42	12	1	7	2	20	63
Faith-based organisation	1	38	5	4	50	1	1	110
Province								
Nairobi	21	51	0	0	13	14	0	41
Central	6	13	5	0	52	0	23	50
Coast	10	17	39	0	33	0	0	49
Eastern	1	26	47	0	20	0	6	83
North Eastern	2	23	24	1	49	0	0	8
Nyanza	1	27	8	8	45	9	1	54
Rift Valley	1	29	0	0	58	3	9	126
Western	0	28	12	0	35	20	5	29
Total[1]	4	27	16	1	40	5	7	440

[1] Totals may not add up to 100 percent due to other responses or missing data

Table A-3.24 Infrastructure and infection control for the therapeutic injection

Among facilities providing curative for sick children, percentage where therapeutic injections as provided in the indicated location, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering sick-child care where therapeutic injection service in site: With immunisation	Not with immunisation	Number of facilities assessed for therapeutic injection (weighted)
Type of facility			
Hospital	47	53	27
Health centre	53	47	124
Maternity	51	49	18
Clinic	31	69	7
Dispensary	62	38	238
Managing authority			
Government	50	50	235
NGO	88	12	16
Private (for-profit)	41	59	56
Faith-based organisation	77	23	108
Province			
Nairobi	43	57	31
Central	43	57	47
Coast	45	55	48
Eastern	51	49	76
North Eastern	69	31	8
Nyanza	82	18	53
Rift Valley	64	36	123
Western	55	45	28
Total	57	43	415

Table A-3.25 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 immunisation services, Kenya SPA 2004

Infection control items	Percentage of facilities offering therapeutic injections: With immunisation	Not with immunisation	Total
Soap	79	76	78
Water	93	92	92
Sharps box	95	90	93
Syringes 2-3 ml	98	91	95
Number of facilities with injection area (weighted)	237	177	415

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, routine child immunisation services, and BCG immunisation, percentage providing the service at the facility the indicated number of days per week, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering the service															
	Outpatient care for sick children				Growth monitoring				Child immunisation				BCG immunisation			
	Days per week[2]			Number of facilities (weighted)[1]	Days per week[2]			Number of facilities (weighted)[1]	Days per week[2]			Number of facilities (weighted)[1]	Days per week[2]			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																
Hospital	10	1	89	28	27	1	65	26	25	1	68	27	43	3	49	27
Health centre	12	0	88	125	34	3	62	111	27	3	69	107	51	4	40	107
Maternity	9	0	91	19	38	7	46	16	43	8	44	14	71	8	16	14
Clinic	6	0	94	7	27	3	67	4	42	4	51	3	60	4	15	3
Dispensary	13	1	86	238	40	0	49	192	41	0	44	204	57	0	24	200
Managing authority																
Government	11	0	89	236	30	0	65	197	24	0	71	208	48	2	43	204
NGO	2	0	98	16	26	0	19	14	26	0	19	14	38	2	2	14
Private (for-profit)	11	0	89	57	59	10	25	39	32	13	24	30	54	4	11	30
Faith-based organisation	17	3	80	108	44	0	50	99	61	0	33	104	70	0	15	104
Province																
Nairobi	1	1	98	32	48	1	50	25	49	1	49	25	75	0	22	25
Central	14	0	86	47	41	0	52	39	38	0	55	41	59	1	34	41
Coast	19	7	75	48	37	6	56	44	28	7	64	39	46	7	46	39
Eastern	6	0	94	76	33	1	65	50	29	1	70	59	54	0	46	59
North Eastern	0	0	100	8	9	0	91	7	7	0	93	8	14	4	82	8
Nyanza	9	0	91	53	27	2	63	51	28	2	61	50	59	2	29	46
Rift Valley	15	0	85	124	42	0	42	105	44	0	34	107	54	0	14	107
Western	23	0	77	28	32	0	63	27	37	0	57	27	49	6	35	27
Total	12	1	87	417	37	1	55	349	36	1	54	356	55	2	31	351

[1] Number of facilities that provide the service
[2] 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 routine growth monitoring, and percent offering child immunisation (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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering indicated services through outreach				Number of facilities (weighted)
	Sick child services	Growth monitoring	Child immunisation without BCG[1]	All child immunisation including BCG[2]	
Type of facility					
Hospital	32	37	40	26	28
Health centre	19	26	26	19	125
Maternity	9	9	11	5	20
Clinic	7	7	7	1	8
Dispensary	15	22	26	13	249
Managing authority					
Government	14	24	27	14	245
NGO	4	3	3	3	16
Private (for-profit)	6	7	7	4	61
Faith-based organisation	30	34	38	25	109
Province					
Nairobi	0	0	0	0	37
Central	1	1	1	0	50
Coast	28	29	29	28	49
Eastern	18	17	28	12	81
North Eastern	19	17	19	17	8
Nyanza	24	34	34	23	54
Rift Valley	16	32	32	16	124
Western	30	41	50	28	29
Total	17	23	26	15	430

[1] Oral polio vaccine (OPV), any DPT (DPT or pentavalent), and measles but no BCG vaccine.
[2] OPV, any DPT, measles, and BCG vaccines offered.

Table A-4.3 Availability of child vaccines

Among facilities offering child immunisation services and routinely storing vaccines, percentage with the indicated child vaccine observed on the day of the survey, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of facilities offering immunisation services and storing vaccines with vaccine observed												
Background characteristics	BCG	Polio	DPT	Pentavalent	Any DPT	Mea-sles	Hepatitis B	Any hepatitis	Yellow fever	All basic child vaccines available[1]	All basic child vaccines plus hepatitis available[2]	Tetanus toxoid in area with vaccines	Number of facilities offering child immunisation services and storing vaccines (weighted)
Type of facility													
Hospital	88	93	25	95	95	94	21	96	8	83	83	97	25
Health centre	90	90	23	85	92	84	5	85	0	79	72	87	107
Maternity	97	94	31	97	97	100	3	97	0	91	91	95	14
Clinic	77	97	42	90	100	97	23	100	0	77	77	100	3
Dispensary	91	94	27	94	94	95	4	94	6	89	89	95	182
Managing authority													
Government	88	89	27	87	91	89	3	87	2	80	77	89	200
NGO	100	100	30	100	100	100	2	100	0	100	100	100	6
Private (for-profit)	95	98	43	97	98	98	40	99	3	91	91	99	29
Faith-based organisation	94	99	19	98	98	95	1	98	9	93	93	99	95
Province													
Nairobi	99	100	9	99	100	94	10	100	0	92	92	100	25
Central	78	81	63	84	84	90	1	84	6	68	68	90	41
Coast	98	98	20	98	98	82	2	98	0	81	81	99	35
Eastern	85	85	15	78	85	86	1	78	0	77	70	85	59
North Eastern	99	100	10	100	100	93	0	100	0	92	92	99	7
Nyanza	99	100	41	93	100	100	2	93	0	99	92	93	45
Rift Valley	91	96	18	96	96	93	15	96	10	91	91	93	91
Western	92	90	23	96	96	100	2	96	0	85	85	100	27
Total	91	93	26	91	94	92	6	92	4	85	83	93	331

[1] BCG, polio, any DPT and measles.
[2] All basic child vaccines plus any Hepatitis B

Table A-4.4 Specific equipment and supplies for child immunisation services

Among facilities offering child immunisation services, percentage with specific equipment and supplies observed, items for infection control, and record keeping system components, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering child immunisation services with:								Number of facilities offering child immunisation services (weighted)
	Equipment and supplies			Items for infection control			Administrative practices		
	Blank child immunisation record	Adequate supplies of syringes and needles	Cold box with ice pack[1]	Soap	Water	Sharps box	Register or tally sheet[2]	Monitoring of community coverage[3]	
Type of facility									
Hospital	86	98	99	82	91	95	97	81	27
Health centre	78	100	99	72	89	97	100	88	107
Maternity	94	100	100	71	82	100	100	70	14
Clinic	89	87	91	79	92	81	87	42	3
Dispensary	84	98	98	81	93	94	98	72	204
Managing authority									
Government	74	98	98	70	90	98	98	75	208
NGO	100	100	88	77	77	77	100	95	14
Private (for-profit)	94	98	99	86	90	96	98	54	30
Faith-based organisation	96	100	100	91	97	91	100	85	104
Province									
Nairobi	100	99	93	93	99	100	100	91	25
Central	93	100	100	92	93	100	100	52	41
Coast	80	99	99	71	92	99	99	89	39
Eastern	63	92	100	77	91	85	92	76	59
North Eastern	87	100	100	37	63	94	100	87	8
Nyanza	69	100	91	87	90	91	99	94	50
Rift Valley	94	100	100	67	93	96	100	66	107
Western	79	100	100	93	85	100	100	100	27
Total	83	99	98	78	91	95	98	77	356

[1] If a facility reported it purchased ice, this was accepted in place of the ice pack.
[2] Either a register or tally sheet for recording immunisations provided was observed.
[3] Measles coverage or DPT dropout rate was documented

Table A-4.5 Availability of specific equipment and supplies for quality assessment of the sick child

Among facilities that provide outpatient care for sick children, percentage with indicated items to support quality of services, to provide preventative services, and to assess the sick child in the service delivery room, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Items	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Items to support quality						
Soap	81	74	73	88	85	81
Water	93	89	89	97	95	93
Child health cards	55	57	69	53	48	52
Treatment guidelines/standards (any)	33	22	12	18	22	22
Visual aids for health education	39	21	24	16	33	29
All items to support quality of care	13	9	7	0	7	8
Preventive measures						
Capacity to provide vaccinations[1]	68	53	46	25	56	55
Infant weighing scale	74	76	69	42	71	72
Child weighing scale	68	57	70	48	57	58
Both infant and child weighing scale	60	47	56	24	44	46
All preventive measures	41	32	36	9	21	26
Equipment for assessment						
Thermometer	84	78	84	96	81	81
Minute timer[2]	55	51	60	59	50	51
Pitcher for mixing ORS	45	32	27	40	51	44
Cup/spoon for giving ORS	43	42	34	54	51	47
ORS packet in facility (pharmacy or sick child service area)	90	92	64	56	88	88
All three Oral dehydration therapy (ORT)	35	28	18	20	34	32
All equipment for assessment	21	15	16	16	20	19
Number of facilities offering sick child services (weighted)	28	125	19	7	238	417

[1] Vaccines, equipment, immunisation 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 either a minute timer that is facility equipment or a staff member who is present with a personal watch with second hand that could be used to time for 1 minute.

Table A-4.6 Description of different guidelines and teaching materials available

Among facilities providing outpatient care for sick children, percentage where indicated guideline or client educational aid was available, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering sick child services with: IMCI chart booklet	IMCI counseling cards for provider	IMCI mother cards	Clinical guidelines	Medical protocols for children's illnesses	Number of facilities offering sick child services (weighted)
Type of facility						
Hospital	20	13	9	28	21	28
Health centre	10	5	4	21	15	125
Maternity	0	0	1	11	7	19
Clinic	6	0	0	18	4	7
Dispensary	11	4	6	22	3	238
Managing authority						
Government	12	6	4	23	9	236
NGO	11	1	0	14	22	16
Private (for-profit)	15	0	14	26	4	57
Faith-based organisation	6	5	5	16	6	108
Province						
Nairobi	21	16	17	9	13	32
Central	1	1	1	7	1	47
Coast	34	8	8	54	28	48
Eastern	1	1	1	13	2	76
North Eastern	16	13	13	31	20	8
Nyanza	8	7	6	31	7	53
Rift Valley	8	1	6	14	2	124
Western	24	14	1	42	23	28
Total	11	5	5	21	8	417

Table A-4.7 Availability of services for immunisation and outpatient care for sick children on the same day

Among all facilities offering outpatient care for sick children, percentage offering child immunisation (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, managing authority and province, Kenya SPA 2004

Background characteristics	Among facilities offering sick child services, percentage where:		Number of facilities offering sick child services (weighted)
	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			
Hospital	33	82	28
Health centre	28	74	125
Maternity	18	52	19
Clinic	19	29	7
Dispensary	40	49	238
Managing authority			
Government	43	67	236
NGO	17	39	16
Private (for-profit)	8	28	57
Faith-based organisation	32	57	108
Province			
Nairobi	33	35	32
Central	35	64	47
Coast	35	72	48
Eastern	41	60	76
North Eastern	41	67	8
Nyanza	45	68	53
Rift Valley	23	46	124
Western	42	79	28
Total	34	58	417

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 the first-line, pre-referral, and other essential medications are available, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Medicines	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
First-line oral medicines						
Oral rehydration solution (ORS)	90	92	64	56	88	88
Antibiotic: amoxicillin	94	71	75	78	79	77
Antibiotic: cotrimoxazole	92	92	77	73	89	89
Either antibiotic	99	92	85	86	94	93
Antimalarial: Fansidar	97	100	68	84	94	95
Antimalarial: amodiaquine	94	75	72	71	62	68
Either Fansidar or amodiaquine	99	100	86	87	98	98
All first-line oral medicines[1]	89	87	57	54	83	83
Pre-referral medicines						
Injectable quinine	87	52	80	60	37	47
Injectable chloramphenicol	82	34	45	22	11	24
Injectable ampicillin or cloxacillin	56	17	49	33	23	25
Injectable penicillin	96	94	91	93	91	93
Injectable gentamycin	94	41	83	79	33	43
Injectable ceftriaxone	47	24	23	14	2	13
Intravenous solution with perfusion set	65	45	79	42	49	50
All pre-referral medicines[2]	56	29	59	27	13	23
Other essential medicines						
Aspirin or paracetamol (antipyretic)	98	99	90	90	90	93
Vitamin-A (any dose)	49	69	48	38	66	64
Iron tablet	89	85	66	64	88	86
Mebendazole (deworming)	85	83	61	75	89	85
Antibiotic eye ointment	85	69	72	75	63	67
All other essential medicines	36	42	28	24	29	33
Number of facilities offering sick child services (weighted)	28	125	19	7	238	417

[1] ORS, at least one oral antibiotic and at least one antimalarial (Fansidar or amodiaquine).
[2] [(At least one first-line injectable antibiotic (ampicillin or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamycin)) or injectable chloramphenicol], intravenous solution (normal saline, Ringers lactate, or dextrose and saline 0.9 percent) with perfusion set and injection quinine.

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, managing authority and province, Kenya SPA 2004

Background characteristics	Median monthly number of sick-child consultations[1]	Number of facilities providing consultation data (weighted)
Type of facility		
Hospital	188	23
Health centre	180	106
Maternity	27	16
Clinic	30	6
Dispensary	86	222
Managing authority		
Government	172	210
NGO	216	15
Private (for-profit)	48	47
Faith-based organisation	50	99
Province		
Nairobi	186	26
Central	202	42
Coast	164	45
Eastern	91	67
North Eastern	160	5
Nyanza	69	52
Rift Valley	84	107
Western	171	28
Total	99	372

[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, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities charging for the indicated item: Client chart or record	Consultation by resident provider	Consultation by consultant	No charges or don't know	Number of facilities offering sick child services (weighted)
Type of facility					
Hospital	18	31	25	42	28
Health centre	15	14	23	61	125
Maternity	20	63	23	22	19
Clinic	22	53	30	8	7
Dispensary	13	19	7	63	238
Managing authority					
Government	10	5	0	85	236
NGO	3	16	34	52	16
Private (for-profit)	8	40	36	28	57
Faith-based organisation	29	46	29	16	108
Province					
Nairobi	29	40	13	32	32
Central	21	11	12	62	47
Coast	3	33	9	60	48
Eastern	12	20	17	46	76
North Eastern	0	13	3	83	8
Nyanza	33	24	25	42	53
Rift Valley	6	11	11	75	124
Western	16	33	13	61	28
Total	14	21	14	58	417

Table A-4.11 Out-of-pocket payments for sick child consultations

Among interviewed caretakers of sick children, percentage who reported that they are part of a programme for prepayment or deferring child health costs (programme) 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 (KSH) paid on the day of the survey, by whether the child belongs to a programme or not, by type of facility, Kenya SPA 2004

Type of facility	Percentage of interviewed caretakers of sick children reporting: They belong to programme	Payment of any out-of-pocket fees this visit[1]: Belongs to programme	Payment of any out-of-pocket fees this visit[1]: Does not belong to programme	Number of interviewed caretakers (weighted)	Median out-of-pocket fees (KSH) paid by caretakers who paid anything for child health services on the day of survey: Belongs to programme	Median out-of-pocket fees (KSH) paid by caretakers who paid anything for child health services on the day of survey: Does not belong to programme	Number of interviewed care-takers providing valid responses for out-of-pocket payments (weighted): Belongs to programme	Number of interviewed care-takers providing valid responses for out-of-pocket payments (weighted): Does not belong to programme
Hospital	16	7	47	95	171	76	7	43
Health centre	10	3	25	529	206	86	16	132
Maternity	18	18	70	25	258	185	4	17
Clinic	16	13	72	13	204	140	2	10
Dispensary	9	4	36	679	94	69	26	242
Total	10	4	33	1,341	140	83	55	444

[1] Includes any amount paid out-of-pocket including consultation, laboratory test, medicines, or other.

Table A-4.12 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage receiving indicated supportive management practices: Received in-service training during the 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 13-35 months preceding survey	Number of interviewed child health service providers (weighted)[2]
Type of facility					
Hospital	15	54	11	15	608
Health centre	7	69	7	12	432
Maternity	14	79	11	5	93
Clinic	18	61	11	13	10
Dispensary	31	77	27	8	266
Managing authority					
Government	14	62	12	9	821
NGO	7	64	7	14	26
Private (for-profit)	18	67	13	7	258
Faith-based organisation	19	68	14	25	305
Province					
Nairobi	18	66	15	11	200
Central	10	47	8	3	147
Coast	11	57	9	10	196
Eastern	9	70	7	10	221
North Eastern	37	64	32	9	10
Nyanza	17	74	14	19	204
Rift Valley	24	60	20	16	322
Western	9	84	8	9	109
Total	15	65	13	12	1,410

[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-4.13 In-service training for child health providers

Among interviewed child health providers, percentage who received in-service training on specific topics during the past 12 months or 13-35 months preceding the survey, by type of facility, managing authority and province, Kenya SPA 2004

	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		Malaria treatment		Nutrition/ micronutrient deficiencies		Breast-feeding		Complementary feeding		IMCI[2]		
Background characteristics	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility																	
Hospital	5	8	4	9	6	15	9	14	8	8	10	9	9	8	6	7	608
Health centre	3	11	2	5	2	6	4	12	2	5	3	12	3	5	2	11	432
Maternity	5	11	2	9	6	6	4	12	1	10	7	7	7	5	1	8	93
Clinic	12	6	10	14	10	17	10	13	6	15	11	15	6	15	6	6	10
Dispensary	20	11	3	8	16	8	23	9	4	6	6	5	5	3	5	8	266
Managing authority																	
Government	6	7	3	6	7	7	9	8	4	6	6	6	6	5	4	6	821
NGO	5	14	2	10	2	16	2	14	1	13	3	14	4	7	1	9	26
Private (for-profit)	6	11	4	7	7	8	11	8	5	9	9	7	9	6	3	8	258
Faith-based organisation	10	17	4	11	6	20	10	29	6	7	8	17	6	9	6	16	305
Province																	
Nairobi	7	14	7	10	10	8	7	10	7	10	10	8	9	7	5	9	200
Central	7	4	2	4	3	4	5	3	2	4	5	2	5	3	4	2	147
Coast	4	6	2	6	4	7	5	6	5	5	6	6	5	3	4	5	196
Eastern	5	10	3	8	3	10	5	11	3	8	5	9	5	9	3	11	221
North Eastern	16	14	12	12	15	15	15	14	13	15	25	9	24	8	18	11	10
Nyanza	6	16	2	8	5	10	10	22	7	6	9	21	9	9	6	18	204
Rift Valley	12	10	2	8	14	18	20	19	5	6	8	6	6	4	4	4	322
Western	5	5	2	7	2	9	4	9	3	8	2	10	3	7	1	11	109
Total	7	10	3	8	7	10	10	13	5	7	7	9	6	6	4	9	1,410

[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-4.14 Supportive supervision for child health service providers

Among interviewed child health 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, managing authority and province, Kenya 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]
		Deliver supplies	Checked records	Observed work	Provided feedback	Verbal praise	Written praises	Provided updates	Discussed problems	Other	
Type of facility											
Hospital	4	51	93	90	89	84	31	63	89	19	330
Health centre	5	45	98	85	78	71	32	70	90	8	296
Maternity	3	36	98	96	47	47	18	47	54	1	74
Clinic	3	40	93	87	85	82	47	73	81	5	6
Dispensary	4	74	96	94	93	89	53	79	93	8	204
Managing authority											
Government	4	60	95	89	87	82	37	68	90	12	511
NGO	4	41	97	95	95	94	74	60	97	13	17
Private (for-profit)	6	27	98	94	56	51	24	72	76	3	173
Faith-based organisation	5	58	95	86	94	87	38	63	90	16	209
Province											
Nairobi	12	52	92	88	92	87	27	74	93	7	132
Central	4	58	92	92	92	81	60	60	88	13	69
Coast	7	39	97	90	58	49	26	89	95	11	111
Eastern	6	71	100	91	93	88	41	59	91	23	155
North Eastern	4	73	93	88	86	83	55	61	90	10	7
Nyanza	3	32	94	92	68	66	24	50	71	14	152
Rift Valley	3	64	97	93	88	83	38	70	87	7	193
Western	5	47	96	73	91	89	41	76	92	3	91
Total	4	53	96	89	83	78	35	68	87	11	910

[1] Includes only providers of child health services in facilities offering child health services

Table A-4.15 Observed assessments, examinations, and treatments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Consultation conducted by physicians	81	38	29	44	8	26
History: assessment of danger signs						
Inability to eat or drink anything	41	33	56	41	36	36
Vomiting everything	44	34	48	47	37	36
Convulsions	18	14	13	13	9	12
All danger signs	11	9	6	9	3	6
History: assessment of symptoms						
Cough or difficult breathing	79	74	59	77	72	73
Diarrhea	41	39	42	49	31	35
Fever	80	80	81	86	79	80
All three key symptoms[1]	27	24	19	37	12	18
Ear pain or discharge	13	11	12	15	7	9
All major symptoms[2]	8	5	3	6	1	3
Physical examination						
Felt temperature	74	51	77	71	52	54
Measured temperature (observed or system)	58	57	85	82	71	65
Any temperature	88	74	94	91	86	81
Assessed anemia: Looked at palms	29	13	39	22	10	13
Assessed anemia: Looked at eye conjunctiva or mucosa of mouth	60	43	78	54	38	43
Any assessment of anemia	63	45	81	57	40	45
Assessed dehydration	35	15	32	33	14	17
Counted respiratory rate per minute	39	22	53	47	21	24
All key physical checks[3]	28	15	49	31	14	17
Looked in ear	21	14	34	21	13	14
Feel behind ear	21	12	25	17	10	12
Checked for pedal edema (press both feet)	11	5	13	7	4	5
Remove clothing and observe musculature	50	48	50	48	42	45
All physical checks[4]	4	2	6	3	0	1
Essential advice						
Increase fluids	20	16	22	18	17	17
Continue/increase feeding	29	20	38	31	16	19
Symptoms for immediate return	21	14	27	28	15	16
All three essential messages	10	3	9	6	6	5
Drinking/feeding practice during illness						
Feeding/Breastfeeding practices	41	31	46	39	36	34
Observed if child can drink or suck	12	6	8	9	8	8
Both assessments of drinking/feeding status	10	4	3	4	4	5
Number of observed children (weighted)	102	539	26	14	696	1,378

[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 ear, checked feet (pedal edema), and checked musculature.

Table A-4.16 Observed and reported information on prescriptions and medicines provided for the observed sick child

Percentage 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Observed during consultation						
Caretaker was told about medications	36	47	74	77	60	54
Caretaker was asked to repeat instructions	7	11	17	21	12	11
Child received first dose of any medicine at facility	9	10	28	27	18	14
Antibiotic was prescribed	77	78	71	66	71	74
Number of observed sick children who received medicines (weighted)	83	501	22	13	631	1,250
Observed during exit interview						
Caretaker has all medicines	57	63	80	80	66	64
Caretaker has some medicines and some prescriptions	28	32	15	17	31	31
Caretaker has only prescriptions	15	4	6	2	2	4
Child received or was prescribed an injectable medicine	29	33	41	29	25	29
Report by caretaker						
Was told how to give the medicine at home	90	96	87	86	97	96
Feels comfortable in knowledge of how to provide medicine at home	93	97	88	97	99	98
Number of interviewed caretakers of sick children who received prescription, medicine, or both (weighted)	76	489	20	12	621	1,217
Child was provided a dose of oral medicine at the facility	22	28	30	23	25	26
Child received injectable at the facility	29	33	46	31	27	30
Number of interviewed caretakers of sick children (weighted)	78	495	22	12	631	1,239

Table A-4.17 Observed preventative 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Preventive measures						
Child weighed	75	48	64	48	54	53
Weight plotted	70	48	63	37	39	45
Normal feeding assessed (<24 months)	44	36	60	46	33	36
Normal feeding assessed (≥24 months)	40	29	27	26	31	31
Any age normal feeding practices assessed	42	33	49	37	32	34
Immunisation status assessed (<24 months)	82	66	58	54	64	66
Immunisation status assessed (≥24 months)	61	58	42	28	46	51
Any age immunisation status assessed	74	63	53	43	57	60
Number of observed children < 24 months old (weighted)	57	354	17	8	408	844
Number of observed children ≥ 24 months old (weighted)	38	175	9	6	289	516
Number of observed children (weighted)	95	529	26	14	696	1,360

Table A-4.18 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Weight or nutritional status of the child	22	15	35	19	16	16
General feeding practices	18	15	29	25	16	16
Give food and liquid during the illness	8	7	24	13	9	9
Was told what the illness was	42	31	70	65	45	40
Number of interviewed caretakers (weighted)	95	529	26	14	696	1,360
Caretaker brought immunisation card to facility this visit	47	52	34	17	44	47
Caretaker reports child <24 month received immunisation	7	6	20	6	7	7
Number of caretakers of children < 24 months (weighted)	57	354	17	8	408	844

Table A-4.19 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Behavior/attitude of provider	3	5	0	1	3	4
Inability to discuss problem	4	2	3	2	2	2
Insufficient explanation about child's illness	5	10	3	2	5	7
Waiting time to see provider	31	20	4	20	19	20
Quality of examination and treatment	4	6	1	1	2	4
Availability of medicines	15	17	2	1	18	17
Days facility is open	4	6	0	1	6	6
Hours facility is open	8	7	0	2	10	8
Cleanliness of facility	4	3	0	1	1	2
Insufficient visual privacy	6	2	0	2	3	3
Insufficient auditory privacy	6	2	0	2	3	3
Number of interviewed caretakers (weighted)	95	529	26	14	696	1,360

Table A-4.20 Caretaker choice of facility

Among interviewed caretakers of observed children, percentage who reported this was not the closest health facility to their home, and among these, the main reasons they did not go to the nearest facility, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of interviewed caretakers who report this is not the closest facility to their home	Number of interviewed caretakers (weighted)	Percentage of caretakers mentioning the indicated item was a problem with the nearest facility								Number of interviewed caretakers for whom this was not the closest facility (weighted)
			Inconvenient operating hours	Bad reputation	Don't like personnel	No medi-cines	Prefer anony-mity	More expen-sive	Was referred to this facility	Don't know/ missing	
Type of facility											
Hospital	42	95	2	12	8	9	4	22	15	28	40
Health centre	23	529	2	7	5	9	8	32	0	35	124
Maternity	70	26	13	26	5	15	7	4	6	24	18
Clinic	49	14	3	17	17	6	6	28	0	23	7
Dispensary	22	696	0	14	9	15	3	26	2	30	153
Managing authority											
Government	20	967	0	7	10	16	6	28	1	32	190
NGO	19	49	0	18	1	2	3	55	0	20	9
Private (for-profit)	34	109	13	23	5	3	2	23	12	18	37
Faith-based organisation	45	236	1	17	5	9	5	24	4	35	106
Province											
Nairobi	55	186	1	16	3	0	0	29	4	47	102
Central	26	149	0	15	37	7	0	25	2	13	39
Coast	26	164	7	15	1	2	1	15	1	57	43
Eastern	24	271	0	7	9	47	7	28	1	2	66
North Eastern	13	15	0	0	5	51	0	15	0	29	2
Nyanza	16	172	7	14	3	7	18	10	3	37	28
Rift Valley	16	321	0	2	1	8	14	41	7	27	50
Western	14	82	0	21	11	2	2	33	2	29	12
Total	25	1,360	2	12	8	12	5	27	3	31	342

Table A-4.21 Educational characteristics of caretakers of observed sick children

Among interviewed caretakers of observed children, percentage indicating their education and literacy status as noted below, by type of facility, managing authority and province, Kenya 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	Secon-dary	Higher		Cannot read or write	Can read, cannot write	Can read and write	Missing	
Type of facility										
Hospital	10	49	24	18	95	19	5	73	3	55
Health centre	11	57	17	14	529	26	6	68	0	362
Maternity	3	42	30	25	26	10	0	90	0	12
Clinic	8	48	31	13	14	12	4	79	6	8
Dispensary	11	59	21	10	696	18	11	69	2	482
Managing authority										
Government	12	61	17	11	967	23	8	68	0	702
NGO	23	52	18	7	49	10	9	60	21	37
Private (for-profit)	7	40	23	30	109	16	15	68	1	51
Faith-based organisation	5	50	35	10	236	12	6	77	4	129
Province										
Nairobi	2	44	40	14	186	5	4	91	0	87
Central	5	61	17	17	149	8	5	87	0	98
Coast	25	51	17	7	164	38	3	59	0	125
Eastern	6	61	24	8	271	10	9	78	2	183
North Eastern	69	24	4	4	15	78	0	22	0	14
Nyanza	7	65	21	7	172	21	0	78	0	124
Rift Valley	13	60	10	17	321	27	19	50	4	234
Western	16	51	19	14	82	25	5	68	2	54
Total	11	57	20	12	1,360	21	8	69	2	919

Chapter 5

Table A-5.1 Offered methods of family planning

Percentage of facilities offering each of the indicated methods of family planning (FP), by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Methods offered	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Combined oral contraception	87	92	94	90	86	89
Progestin-only oral pill	58	63	69	56	31	46
Progestin-only injectable (two or three monthly)	93	90	92	95	87	89
Combined injectable (one monthly)	10	0	3	9	0	1
Male condom	88	90	86	82	83	86
Female condom	61	43	41	27	34	39
Intrauterine device	70	47	67	37	21	36
Implant	59	12	39	20	4	13
Spermicide	7	7	7	9	4	6
Diaphragm	7	2	3	2	4	3
Emergency contraceptive pill	31	14	25	19	4	11
Rhythm method	58	59	46	56	46	51
Female sterilisation	53	4	20	5	0	6
Male sterilisation	25	0	3	4	0	2
At least two of any temporary modern methods	92	96	94	98	89	92
Al least four of any temporary modern methods[1]	86	83	93	78	59	71
Number of facilities offering FP services (weighted)	24	107	18	5	169	322

[1] Among the following methods: contraceptive pills (combined or progestin-only), injections (combined or progestin-only), implants, intrauterine devices (IUD), condoms (male or female), spermicides, diaphragm, or emergency contraceptive. Permanent methods (sterilisation) and natural methods (rhythm) are not included.

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, Kenya SPA 2004

	Percentage by type of facility					
Methods	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Combined oral contraception	96	91	85	91	94	93
Progestin-only oral pill	82	72	46	51	78	73
Progestin-only injectable (two or three monthly)	96	88	91	91	90	90
Combined injectable (one monthly)	52	-	50	81	0	48
Male condom	94	99	93	89	90	93
Female condom	81	81	61	76	77	78
Intrauterine device	94	75	76	78	88	82
Implant	50	0	34	38	62	34
Spermicide	26	0	19	61	0	5
Diaphragm	15	0	0	100	0	3
Emergency contraceptive pill	57	71	71	68	0	54
Each method offered by a facility was available the day of the survey	45	53	39	51	67	58

Table A-5.3 Availability of offered methods of family planning by province

Among facilities offering the indicated method, percentage where the method was available on the day of the survey, by province, Kenya SPA 2004

	Percentage by province								
Methods	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total
Combined oral contraception	100	99	100	82	88	82	99	90	93
Progestin-only oral pill	78	75	99	71	91	47	69	77	73
Progestin-only injectable (two or three monthly)	100	100	68	91	88	91	90	94	90
Combined injectable (one monthly)	100	85	43	-	0	0	45	0	48
Male condom	99	91	98	91	98	96	90	94	93
Female condom	95	82	97	83	100	47	74	27	78
Intrauterine device	99	73	99	84	89	66	80	81	82
Implant	29	18	58	77	33	37	28	15	34
Spermicide	100	61	63	0	0	3	0	3	5
Diaphragm	0	61	32	-	0	0	0	0	3
Emergency contraceptive pill	29	76	92	91	41	22	35	27	54
Each method offered by a facility was available the day of the survey	43	67	67	50	61	57	62	57	58

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, Kenya SPA 2004

Item	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Items to support quality counseling						
Visual and auditory privacy	85	87	85	74	89	88
Visual privacy only	10	3	11	20	7	6
No privacy	3	6	1	0	1	3
Individual client health cards	76	72	53	60	63	67
Written FP guidelines	39	28	24	43	32	31
Written STI guidelines	40	55	41	45	70	61
Visual aids for health education on family planning	88	90	76	72	87	87
Visual aids for health education on sexually transmitted infections (STIs)	49	37	23	35	38	38
All items to support quality counseling[1]	30	21	16	28	23	22
All items to support quality counseling for FP and for STI services and client education[2]	12	12	8	8	13	12
Items for infection control						
Soap	82	65	58	82	75	72
Water	91	88	79	97	94	91
Clean latex gloves	91	91	81	93	100	95
Disinfecting solution	57	42	44	49	59	52
Sharps box	92	93	80	71	97	94
All items for infection control[3]	48	31	32	42	48	41
Waste receptacles[4]	46	28	37	30	29	31
All items plus waste receptacle for infection control	27	11	10	16	21	18
Items for pelvic examination						
Visual and auditory privacy	90	85	85	77	85	85
Visual privacy only	7	6	15	23	11	9
No privacy	2	6	0	0	4	4
Examination bed[5]	97	96	99	97	100	98
Examination light[6]	58	15	48	44	19	22
Vaginal speculum	51	36	37	29	17	27
All furnishings and equipment for pelvic examination	30	10	20	23	2	8
All items for both infection control and pelvic examination[7]	18	3	11	15	0	3
Number of facilities offering FP services (weighted)	24	107	18	5	169	322

[1] Either private room or visual barrier, individual client health cards, written guidelines for FP, and any visual aids for FP
[2] All items to support quality counseling, written STI guidelines and visual aids for health education on STIs.
[3] Soap, water, clean latex gloves, disinfecting solution, and sharps box.
[4] While important for infection control, this is not an item that has been commonly introduced so was not included in the aggregate for infection control.
[5] Any bed where a woman can lie down flat.
[6] Examination light, flashlight, or other spotlight source.
[7] Visual and auditory privacy, examination bed, 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, Kenya SPA 2004

Item	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Visual aids or teaching materials						
Samples of different methods	76	68	55	46	66	66
Posters for general promotion of FP	66	61	49	56	59	60
Visual aids about sexually transmitted infections	33	19	13	16	20	20
Visual aids about HIV/AIDS	28	18	17	21	26	23
Model for demonstrating how to use condom	54	48	45	29	52	50
Information for client to take home						
On family planning	47	47	35	38	26	35
On sexually transmitted infections	10	18	7	8	11	13
On HIV/AIDS	19	26	5	18	9	15
Service guidelines						
Any family planning guidelines	39	28	24	43	32	31
WHO guidelines for syndromic approach	40	52	41	45	70	60
Other guidelines for diagnosis and treatment of STIs	11	12	11	11	11	11
Number of facilities offering FP services (weighted)	24	107	18	5	169	322

Table A-5.6 Location in facility where equipment for family planning services is processed for reuse

Percentage of facilities where FP equipment is processed for reuse in the indicated location, by type of facility, Kenya SPA 2004

Type of facility	Percentage of facilities where FP service equipment is processed in indicated area[1]				Number of facilities offering FP services (weighted)
	FP service area	Main facility area	Delivery service area	Outside facility/ no processing FP equipment	
Hospital	14	73	1	4	24
Health centre	28	55	0	2	107
Maternity	18	77	1	4	18
Clinic	9	60	0	13	5
Dispensary	4	63	1	4	169
Total	17	78	1	4	322

[1] Main facility area and FP service area may be one location in small facility

Table A-5.7 Level of sterilisation/disinfecting capacity available in location where family planning equipment is processed

Highest level of processing for which the facility has all items to support quality sterilisation/high level disinfecting (HLD) processing, and the percentage with written guidelines at the site where FP equipment is processed for reuse, by type of facility, managing authority, and province, Kenya SPA 2004

Background characteristics	Percentage of facilities where the indicated procedure is the highest level for which all conditions for quality sterilisation/HLD of FP equipment was available			Percentage of facilities with written guidelines for sterilisation or HLD procedures at processing site	Number of facilities offering FP services (weighted)
	Dry heat or autoclave[1]	Boil/steam or chemical HLD[2]	No procedure		
Type of facility					
Hospital	46	1	53	33	24
Health centre	26	0	74	12	107
Maternity	26	0	74	17	18
Clinic	11	0	89	10	5
Dispensary	5	0	95	1	169
Managing authority					
Government	12	0	87	7	209
NGO	71	0	29	16	14
Private (for-profit)	25	0	75	20	36
Faith-based organisation	10	0	90	3	63
Province					
Nairobi	45	0	55	18	18
Central	14	0	85	5	42
Coast	23	0	77	32	35
Eastern	1	0	99	1	62
North Eastern	3	0	97	34	6
Nyanza	6	0	94	2	49
Rift Valley	24	0	76	2	89
Western	18	0	82	16	22
Total	16	0	84	8	322

[1] Equipment functions, and appropriate knowledge of temperature and time for method used, and an automatic timer are all present.
[2] Either equipment or knowledge was lacking or facility does not process FP equipment.

Table A-5.8 Storage conditions for sterilised or high-level disinfected FP equipment

Percentage of facilities with stored, sterilised/high-level disinfected (HLD) FP instruments present and storage conditions among facilities where sterilised/HLD items are present, by type of facility, managing authority, and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with stored sterilised/HLD FP items present	Number of facilities (weighted)	Percentage with: 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 sterilised items	Number of facilities with stored sterilised/ HLD FP items (weighted)
Type of facility							
Hospital	91	24	83	1	59	56	21
Health centre	85	107	49	10	10	7	90
Maternity	99	18	59	11	28	27	17
Clinic	79	5	54	14	15	15	4
Dispensary	72	169	48	11	6	6	121
Managing authority							
Government	79	209	50	12	11	11	166
NGO	98	14	74	1	17	16	14
Private (for-profit)	87	36	61	16	39	29	31
Faith-based organisation	69	63	46	0	4	4	43
Province							
Nairobi	98	18	66	24	32	32	18
Central	94	42	70	7	8	8	39
Coast	65	35	53	14	21	7	23
Eastern	66	62	38	20	4	4	41
North Eastern	76	6	24	13	11	11	4
Nyanza	98	49	43	2	15	14	48
Rift Valley	75	89	48	5	17	17	66
Western	68	22	81	16	4	4	15
Total	79	322	52	10	14	12	255

[1] Items are wrapped and sealed with time-steam-temperature (TST) tape or are in a sterile/HLD box that clasps shut and storage area is dry and clean.
[2] Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the steriliser of autoclave, or sitting in disinfecting solution, and storage area is dry and clean.

Table A-5.9 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, Kenya SPA 2004

	Percentage by type of facility					
Medicines	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
FP provides STI service	29	62	55	88	74	66
Metronidazole or tinidazole (trichomoniasis)	99	84	94	86	91	90
Ceftriaxone (gonorrhea)	46	27	22	11	3	15
Ciprofloxacin (gonorrhea)	37	14	42	34	6	13
Doxycycline (chlamydia, syphilis)	93	93	73	74	89	89
Tetracycline (chlamydia, syphilis)	34	16	58	48	11	18
Erythromycin (chlamydia, syphilis)	86	49	53	51	53	54
Any injectable or oral Penicillin (syphilis)	96	93	92	91	91	92
Nystatin or miconazole suppository (candidiasis)	27	24	19	32	9	16
At least one medication for gonorrhoea	54	34	50	34	9	23
At least one medication for chlamydia	97	96	81	79	90	92
At least one medication for syphilis	98	100	93	91	97	98
At least one medication for the four STIs assessed[1]	54	30	49	34	9	22
Number of facilities offering FP services (weighted)	24	107	18	5	169	322

[1] At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis.

Table A-5.10 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, Kenya SPA 2004

	Estrogen containing method			Injectables		IUD			Implants		
Type of facility	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	Number of facilities offering injectable method (weighted)	Percentage with basic items for IUD insertion[2]	Percentage with all items and conditions for quality IUD insertion[3]	Number of facilities offering IUD (weighted)	Percentage with items for implant insertion[4]	Percentage with all equipment, items for infection control, and infrastructure for implant insertion[5]	Number of facilities offering implants (weighted)
Hospital	88	95	21	96	22	55	35	17	24	19	14
Health centre	68	92	98	92	96	58	9	50	0	0	13
Maternity	94	89	17	91	16	28	15	12	21	21	7
Clinic	94	81	5	94	5	58	44	2	29	15	1
Dispensary	86	93	146	100	148	64	0	36	62	0	7
Total	80	92	286	96	287	56	11	117	22	10	41

[1] Stethoscope and sphygmomanometer.
[2] 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).
[3] Basic items 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, and IUD method.
[4] Forceps for grasping Implant, local anesthetic (Xylocaine), scalpel with blade, sterile needle and syringe, sterile gloves and antiseptic for cleaning skin, and implant method plus insertion devices.
[5] Equipment for Implant, all infection control items (soap, water, disinfecting solution, and sharps box) and visual privacy, examination bed, and examination light.

Table A-5.11 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, Kenya SPA 2004

	Percentage by type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Clean or sterile latex gloves	99	100	94	95	100	99
Antiseptic solution	73	68	51	88	64	66
Sponge holding forceps	72	79	62	78	71	73
Speculum	73	78	54	78	78	75
Tenacula	65	84	49	65	78	76
Uterine sound	69	78	51	65	78	73
All basic items	55	58	28	58	64	56
IUD method available	94	75	76	78	88	82
All basic items plus method	55	51	28	49	52	50
Number of facilities offering IUD (weighted)	17	50	12	2	36	117

Table A-5.12 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, Kenya SPA 2004

	Percentage by type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Sterile gloves	92	87	78	91	62	83
Antiseptic solution	71	13	50	91	62	49
Sponge holding forceps	71	57	49	74	62	62
Local anesthetic	82	75	64	100	62	74
Sterile syringe and needle	95	100	89	91	62	90
Scalpel with blade	54	49	55	65	62	54
Forceps for grasping implant	70	57	55	74	62	62
Implant method plus insertion devices	35	0	23	38	62	27
All items[1]	24	0	21	29	62	22
Number of facilities offering implants (weighted)	14	13	7	1	7	41

[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-5.13 Facility utilization statistics for family planning clients

Median number of family planning consultations per month, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Median number of family planning consultations[1]	Number of facilities providing consultation data (weighted)
Type of facility		
Hospital	117	21
Health centre	66	96
Maternity	27	14
Clinic	23	4
Dispensary	35	142
Managing authority		
Government	55	201
NGO	54	13
Private (for-profit)	42	26
Faith-based organisation	16	35
Province		
Nairobi	91	18
Central	57	35
Coast	44	32
Eastern	90	44
North Eastern	-	4
Nyanza	26	42
Rift Valley	33	79
Western	89	22
Total	50	276

[1] Median value for the average of the number of months out of the past 12 months, for which data were available.

Table A-5.14 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 , by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities charging for the indicated item:			Percentage of facilities charging for the indicated item among facilities offering the method:																Number of facilities offering FP services (weighted)
	Client chart or record	Consult fee	Any method	Pills	Number of facilities offering pills (weighted)	Male condom	Number of facilities offering male condom (weighted)	Female condom	Number of facilities offering female condom (weighted)	Injection	Number of facilities offering injection (weighted)	IUD	Number of facilities offering IUD (weighted)	Implant	Number of facilities offering implant (weighted)	Emergency contraception	Number of facilities offering emergency contraception (weighted)	No charges/ doesn't know	
Type of facility																				
Hospital	14	36	43	44	13	6	13	9	8	50	14	58	11	77	9	26	4	40	24
Health centre	20	19	22	44	47	19	41	0	16	45	43	46	28	69	10	29	10	56	107
Maternity	24	40	88	76	17	13	15	24	7	87	16	89	11	86	7	88	4	6	18
Clinic	24	46	82	81	5	19	4	41	1	84	5	90	2	82	1	59	1	7	5
Dispensary	25	13	15	31	83	6	72	13	31	31	83	23	18	0	7	-	0	51	169
Managing authority																				
Government	29	12	8	17	87	5	81	1	37	14	84	31	33	46	21	0	8	58	209
NGO	0	29	6	16	4	6	4	23	1	16	4	100	1	100	1	74	1	69	14
Private (for-profit)	24	47	91	76	33	23	29	19	12	89	34	90	21	87	10	76	10	5	36
Faith-based organisation	7	23	45	70	39	14	31	29	15	70	39	33	15	90	2	63	1	38	63
Province																				
Nairobi	24	47	24	26	13	1	12	2	8	35	13	39	11	47	6	45	3	28	18
Central	34	28	25	43	24	24	21	11	8	30	20	65	10	65	9	45	2	43	42
Coast	28	32	25	31	19	4	16	6	12	47	19	91	8	100	1	87	5	46	35
Eastern	41	8	18	29	36	27	31	23	18	29	36	15	10	15	5	0	4	42	62
North Eastern	0	2	11	100	1	0	1	-	0	100	1	100	0	100	0	-	0	89	6
Nyanza	12	5	44	72	27	1	19	0	2	75	28	72	8	57	3	46	2	43	49
Rift Valley	13	20	19	35	39	3	39	7	15	36	39	38	19	92	7	24	2	56	89
Western	8	18	20	67	6	1	6	10	2	71	6	50	3	100	1	46	2	72	22
Total	23	19	24	41	164	11	145	11	64	43	161	50	70	62	34	43	19	49	322

Table A-5.15 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 (KSH) paid on the day of the survey, by type of facility, managing authority and province, Kenya 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 (KSH) 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)
Type of facility				
Hospital	41	62	39	25
Health centre	69	255	25	176
Maternity	81	13	108	11
Clinic	85	3	70	3
Dispensary	66	196	21	130
Managing authority				
Government	64	400	24	256
NGO	33	38	26	12
Private (for-profit)	70	25	105	17
Faith-based organisation	87	67	29	58
Province				
Nairobi	70	52	28	36
Central	78	45	18	35
Coast	68	71	27	48
Eastern	74	133	24	99
North Eastern	0	1	-	0
Nyanza	79	33	24	26
Rift Valley	53	146	26	78
Western	44	49	23	21
Total	65	529	25	344

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

Table A-5.16 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 (KSH) paid on the day of the survey, by the main procedure received, Kenya SPA 2004

Procedure	Percentage of clients who paid out-of-pocket fee	Total number of cases receiving procedure	Median out-of-pocket fee paid by client receiving indicated procedure[1]	Number of cases who paid out-of-pocket fee
IUD insertion/removal[2]	69	3	59	2
Implant insertion/removal	80	3	606	3
Injection	70	367	25	255

[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

Table A-5.17 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage receiving indicated supportive management practices: Received in-service training during the 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 13-35 months preceding survey	Number of interviewed FP service providers (weighted)[2]
Type of facility					
Hospital	28	56	19	26	339
Health centre	19	68	16	18	299
Maternity	40	76	36	26	58
Clinic	29	74	24	17	6
Dispensary	24	84	23	28	151
Managing authority					
Government	25	65	19	25	583
NGO	23	70	20	47	23
Private (for-profit)	23	67	19	9	155
Faith-based organisation	30	75	25	30	92
Province					
Nairobi	37	72	30	26	110
Central	27	46	17	8	114
Coast	21	60	19	24	158
Eastern	18	73	13	22	117
North Eastern	26	58	14	17	7
Nyanza	22	72	17	36	91
Rift Valley	27	66	22	28	187
Western	20	89	18	19	69
Total	25	66	20	24	853

[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.

Table A-5.18 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 13-35 months preceding the survey, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of interviewed family planning providers who received in-service training[1] on specific items														
	Coun-selling on FP		Counselling on any contraceptive technology		Update on symptoms/ side effects of methods		Colposcopy		Symptom manage-ment for family planning methods		Syndromic approach to diagnosis and treatment of STIs		Other diagnosis and treatment of STIs (not HIV)		Number of interviewed FP service providers (weighted)[2]
Background characteristics	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility															
Hospital	13	18	14	16	11	15	4	3	12	15	15	15	10	13	339
Health centre	10	9	7	5	8	6	3	1	8	4	11	14	11	10	299
Maternity	13	40	20	32	18	30	10	3	22	33	16	20	24	19	58
Clinic	14	9	16	8	17	5	11	2	16	4	19	20	11	18	6
Dispensary	7	13	8	9	7	10	2	0	7	12	14	26	10	10	151
Managing authority															
Government	12	15	13	12	12	11	4	1	12	11	13	16	10	12	583
NGO	5	32	6	35	8	29	3	2	14	26	9	8	17	22	23
Private (for-profit)	10	12	5	10	4	12	2	3	6	10	12	10	10	9	155
Faith-based organisation	9	17	9	11	7	12	4	1	6	18	16	33	18	12	92
Province															
Nairobi	20	28	18	21	20	22	8	3	20	22	18	14	21	13	110
Central	16	5	14	4	16	4	8	2	16	4	10	10	10	4	114
Coast	9	13	8	7	6	7	0	1	9	6	8	18	7	11	158
Eastern	8	14	8	14	3	12	3	2	3	12	11	14	8	9	117
North Eastern	11	17	15	13	11	8	3	2	11	13	13	13	9	10	7
Nyanza	5	14	6	14	5	14	4	1	5	11	14	28	7	11	91
Rift Valley	9	19	10	14	7	15	1	1	8	18	18	18	15	18	187
Western	12	11	10	10	15	8	2	1	14	8	10	16	8	13	69
Total	11	15	11	12	10	12	3	2	10	12	13	17	11	12	853

[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.

Table A-5.19 Supportive supervision for family planning 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, managing authority and province, Kenya SPA 2004

Background characteristics	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]
	Deliver supplies	Checked records	Observed work	Provided feedback	Verbal praise	Written praises	Provided updates	Discussed problems	Other	
Type of facility										
Hospital	47	91	89	92	88	38	66	86	10	189
Health centre	51	99	90	74	65	39	73	89	10	202
Maternity	55	97	95	72	72	22	83	96	2	44
Clinic	42	92	86	85	81	63	71	80	3	5
Dispensary	75	96	94	89	84	60	78	95	10	127
Managing authority										
Government	59	95	89	87	83	42	66	88	12	379
NGO	55	97	95	96	95	78	65	97	14	16
Private (for-profit)	33	97	96	61	54	25	90	96	2	103
Faith-based organisation	69	95	94	91	78	57	88	90	6	69
Province										
Nairobi	49	94	92	83	81	27	73	93	6	79
Central	64	94	92	93	79	64	52	86	13	53
Coast	38	98	91	53	45	22	92	95	9	94
Eastern	67	99	91	96	90	56	76	98	7	86
North Eastern	70	92	75	87	87	49	60	93	14	4
Nyanza	56	87	92	85	82	36	76	85	22	66
Rift Valley	59	97	92	89	82	45	65	82	8	124
Western	58	97	88	90	88	53	70	89	3	62
Total	55	96	91	83	77	42	73	90	9	567

[1] Includes only providers of family planning services in facilities offering family planning services.

Table A-5.20 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 follow-up visit, and percentage who have no prior pregnancy, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of observed FP clients			Number of observed family planning clients (weighted)
	First visit	Follow-up visit	Never pregnant	
Type of facility				
Hospital	27	73	4	64
Health centre	35	65	5	259
Maternity	55	45	1	13
Clinic	29	71	7	3
Dispensary	19	81	6	199
Managing authority				
Government	31	69	5	407
NGO	20	80	0	38
Private (for-profit)	26	74	5	25
Faith-based organisation	22	78	10	68
Province				
Nairobi	47	53	6	52
Central	16	84	1	48
Coast	30	70	4	71
Eastern	19	81	3	138
North Eastern	29	71	0	1
Nyanza	18	82	21	33
Rift Valley	34	66	6	147
Western	38	62	0	49
Total	29	71	5	537

Table A-5.21 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, Kenya 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	70
Elective method change/discontinue family planning	3
Discuss problem with current method	1
Discuss non-FP health problem	0
Other/missing reason for user's visit	1
Non-user	
Used method in past	10
Never used method	15
Other not determined reason for visit	1
Number of observed family planning clients (weighted)	537

Table A-5.22 Method of choice for observed family planning clients

Among observed and interviewed 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage for whom indicated method was the main method either provided, prescribed, or continued being used								Number of observed and interviewed family planning clients (weighted)
	Combined oral contraceptive (COC)	Progestin-only pill or type unknown (POP)	Progestin injectable (2 or 3 monthly) (PIN)	Condom	IUD	Implant	Other[1]	No method	
Type of facility									
Hospital	5	7	79	1	5	2	9	1	62
Health centre	12	14	73	0	0	0	23	1	255
Maternity	13	2	58	0	6	8	6	0	13
Clinic	0	0	78	0	3	3	12	9	3
Dispensary	8	5	88	1	0	0	19	0	196
Managing authority									
Government	10	12	75	1	1	0	26	1	400
NGO	14	0	84	0	0	1	1	0	38
Private (for-profit)	3	2	92	0	0	2	3	1	25
Faith-based organisation	5	0	94	0	1	0	0	0	67
Province									
Nairobi	15	13	59	0	2	2	5	3	52
Central	28	0	70	0	1	0	0	0	45
Coast	13	31	54	0	0	0	26	0	71
Eastern	3	10	86	0	1	0	57	0	133
North Eastern	0	0	100	0	0	0	0	0	1
Nyanza	10	12	75	0	1	0	11	1	33
Rift Valley	7	0	92	0	0	0	0	0	146
Western	7	5	86	5	1	0	5	0	49
Total	10	9	79	1	1	0	20	0	529

[1] Other may include emergency contraception or rhythm or female sterilisation.

Table A-5.23 Conditions for counselling of observed family planning clients

Percentage of all observed family planning clients where the counselling portion was conducted under the indicated conditions, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Visual privacy assured	88	91	79	97	82	87
Auditory privacy assured	78	84	98	100	83	83
Client was assured of confidentiality	53	34	61	51	46	41
Client was asked about concerns of methods discussed or used	74	62	92	67	74	69
All counselling conditions met [1]	44	28	55	34	30	31
Individual client card reviewed during consultation	88	82	51	93	79	81
Individual client card written on after consultation	100	93	75	97	98	95
Visual aids were used during consultation	25	13	11	23	13	14
Return visit was discussed	96	92	86	87	92	92
Number of observed family planning clients (weighted)	64	259	13	3	199	537

[1] Visual and auditory privacy, confidentiality assured and client was asked about concerns of methods discussed or currently used.

Table A-5.24 General assessments, examinations, and interventions for observed first-visit family planning clients

Percentage of observed first-visit family planning clients where the indicated assessment or examination was a component of their consultation, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Client history						
Age	81	74	83	90	66	73
Any history of pregnancy	92	80	100	100	66	79
Current pregnancy status	45	41	11	70	12	33
Desired timing for next child or desire for another child	42	38	28	80	13	32
Breastfeeding status (if ever pregnancy)	52	50	37	51	14	41
Regularity of menstrual cycle	85	72	89	90	50	69
All elements of reproductive history[1]	20	18	0	46	0	13
Client medical history						
Asked about smoking	33	34	23	36	51	38
Asked about symptoms of sexuality transmitted infections (STIs)	43	21	34	36	51	32
Asked about any chronic illnesses	58	44	48	66	72	53
All risk-history[2]	27	15	23	36	51	26
Client examination						
Measure blood pressure	78	68	100	90	78	73
Measure weight	80	93	100	90	100	94
Number of first-visit FP clients who have had previous pregnancy	98	95	100	90	89	94
Number of first-visit FP clients (weighted)	17	91	7	1	38	154

[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-5.25 General assessments, examinations, and interventions for observed first-visit family planning clients

Percentage of observed first-visit family planning clients where the indicated assessment or examination was a component of their consultation, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Counselling topics covered						
Partner attitude toward family planning	28	40	46	36	12	32
Partner status[1]	19	13	0	10	12	13
Either partner question	33	43	46	36	12	35
Discussion related to STIs and condoms						
Use of condoms to prevent STIs	22	35	0	34	45	34
Use of condoms as dual method[2]	17	7	0	14	19	11
Any discussion related to STIs [3]	30	25	0	51	39	28
Individual client card reviewed during consultation	75	70	43	100	100	77
Individual client card written on after consultation	99	96	66	90	100	96
Visual aids were used during consultation	56	32	0	69	38	35
Client was assured of confidentiality	61	33	51	70	57	43
Number of first-visit FP clients (weighted)	17	91	7	1	38	154

[1] Asked about other partners for self or partner, absence of partner
[2] Both to prevent pregnancy and STIs
[3] Risk of STIs discussed or use of condoms to prevent STIs or as dual method discussed.

Table A-5.26 Observed assessments of client who received injections or oral contraceptives with estrogen

Percentage of observed family planning (FP) clients who received a contraceptive with estrogen, who had their blood pressured measured, and percentage who had their weight measured, by type of facility, Kenya SPA 2004

	Percentage by type of facility				
Components of consultation	Hospital	Health centre	Maternity	Dispen-sary	Total
Examination specific to estrogen-based contraceptive					
Blood pressure measured	82	68	100	72	71
Weight measured	82	82	75	100	87
Number of clients receiving estrogen-based contraception (weighted)	3	31	2	15	51

Table A-5.27 Observed and reported client counseling related to injectable or oral contraceptives

Percentage of observed and interviewed family planning 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Provider was observed to explain the item to the client						
Explained how to use method	87	83	94	68	84	84
Menstrual changes (side-effects)	66	42	79	48	32	41
Non-menstrual side effects	56	31	76	47	28	33
Any side effects	69	44	81	58	35	44
Explained what to do for problems	47	29	77	34	22	29
Mentioned follow-up visit	97	92	100	83	92	93
Client reported that the provider shared the indicated information						
Explained how to use the method	77	76	72	50	65	72
Explained about possible side effects	62	45	43	53	55	51
Explained what to do for problems	68	53	61	65	54	55
Mentioned follow-up visit	96	97	86	100	97	97
Among all pill and injection users:						
Percentage knowing correct response for question	99	98	93	100	99	98
Number of observed and interviewed FP pill/injection clients (weighted)	57	251	9	2	196	516

Table A-5.28 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 responses 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 follow-up, Kenya SPA 2004

Components of consultation	Percentage observed and interviewed clients
Condom user: client was observed being told	
Use one time	89
Can use a backup method	89
About dual protection	93
Interviewed client received condom and knows to use condom only once	89
Number of observed and interviewed clients receiving condom	3
Number of clients receiving IUD or prescription for IUD	4
Implant user: client was observed being told	
Implant is good for three/five years	89
Menstrual changes that might occur	71
Non-menstrual initial side effects that might occur	71
Interviewed client received implant and knows how long implant lasts	100
Number of clients receiving implants or prescription for implant	2
Summary of interviewed client responses	
Client knew the correct response for the survey question about their method	98
Client reported provider explained how to use the method	96
Client reported provider explained about possible side effects	81
Client reported provider explained what to do for problems	93
Client reported provider told about a follow-up visit	94
Number of other family planning clients (weighted)[1]	9

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-5.29 Client feedback on services

Percentage of observed and interviewed family planning (FP) clients who said that they considered specific items as major problems for them the day of the visit, by type of facility, Kenya SPA 2004

	Percentage by type of facility					
Client service issue	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Behavior/attitude of provider	3	3	0	0	1	2
Inability to discuss problem	2	1	0	0	1	1
Insufficient explanation about child's illness	3	2	6	0	2	2
Waiting time to see provider	23	24	0	6	15	20
Quality of examination and treatment	2	2	0	0	1	2
Availability of medicines	8	8	3	0	7	7
Days facility is open	2	4	0	0	0	2
Hours facility is open	4	6	3	6	2	4
Cleanliness of facility	2	3	0	0	0	1
Insufficient visual privacy	3	3	0	0	4	3
Insufficient auditory privacy	3	4	0	4	4	4
Number of interviewed FP clients (weighted)	62	255	13	3	196	529

Table A-5.30 Client choice of facility

Among interviewed family planning (FP) clients, percentage who reported this was not the closest health facility to their home, and among these, the main reasons they did not go to the nearest facility, by type of facility, managing authority and province, Kenya SPA 2004

			Percentage of family planning (FP) clients							
Background characteristics	Percentage of interviewed FP clients who report this is not the closest facility to their home	Number of interviewed FP clients (weighted)	Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	Number of interviewed FP clients for whom this was not the closest facility (weighted)
Type of facility										
Hospital	29	62	5	7	7	9	10	29	5	18
Health centre	22	255	0	0	3	9	3	29	6	56
Maternity	69	13	15	16	0	0	9	0	0	9
Clinic	39	3	7	7	7	0	12	0	0	1
Dispensary	9	196	0	0	0	45	0	14	0	18
Managing authority										
Government	19	400	0	1	3	13	4	26	5	78
NGO	5	38	44	17	0	0	0	0	0	2
Private (for-profit)	53	25	6	9	1	3	7	0	0	13
Faith-based organisation	15	67	3	5	4	43	0	33	2	10
Province										
Nairobi	49	52	3	3	7	0	10	21	13	25
Central	13	45	0	15	8	0	8	64	0	6
Coast	35	71	2	2	1	0	0	13	0	25
Eastern	18	133	0	0	1	53	1	21	1	24
North Eastern	43	1	0	0	33	0	0	33	0	0
Nyanza	7	33	33	0	0	7	15	22	4	2
Rift Valley	11	146	0	4	1	4	6	24	3	16
Western	9	49	5	0	0	30	0	46	3	4
Total	19	529	2	3	3	15	4	23	4	103

Table A-5.31 Educational characteristics of family planning clients

Among observed and interviewed family planning clients, percentage indicating their education and literacy status as noted below, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Among interviewed FP clients, percentage with: No education	Primary	Secondary	Higher	Number of interviewed FP clients (weighted)	Percentage of interviewed FP clients with primary or no education who: Cannot read or write	Can read, cannot write	Can read and write	Number of interviewed FP clients with primary or no education (weighted)
Type of facility									
Hospital	6	54	24	15	62	14	5	77	38
Health centre	10	64	15	10	255	9	8	78	191
Maternity	0	33	44	23	13	9	0	91	4
Clinic	6	46	37	11	3	8	6	86	2
Dispensary	1	67	25	6	196	8	6	85	134
Managing authority									
Government	7	62	19	12	400	10	5	81	277
NGO	0	94	3	2	38	0	9	86	35
Private (for-profit)	20	44	27	9	25	33	6	54	16
Faith-based organisation	0	60	37	3	67	1	17	82	40
Province									
Nairobi	3	48	34	14	52	0	0	88	27
Central	0	66	27	7	45	0	1	99	30
Coast	9	73	16	2	71	11	5	84	59
Eastern	3	73	20	4	133	1	12	87	101
North Eastern	43	29	14	14	1	60	0	40	0
Nyanza	11	46	29	15	33	59	1	40	18
Rift Valley	8	57	18	17	146	6	4	82	95
Western	10	68	11	11	49	28	16	57	38
Total	6	63	21	10	529	9	7	81	368

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/PNC) on the day of the survey, and offering ANC and tetanus toxoid vaccine (TT), ANC and family planning (FP), ANC and curative care for the sick child (SC), ANC and FP and SC services, and ANC and child immunisation (EPI), on the day of the survey, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of facilities offering the indicated services the day of the survey						Number of facilities offering ANC (weighted)
Background characteristics	ANC	ANC and TT vaccine	ANC and FP	ANC and SC	ANC and FP and SC services	ANC and EPI	
Type of facility							
Hospital	87	77	71	84	69	74	25
Health centre	86	78	79	85	77	71	111
Maternity	96	84	87	87	78	57	16
Clinic	95	79	82	89	76	52	4
Dispensary	75	58	58	75	58	54	191
Managing authority							
Government	87	74	85	86	83	73	202
NGO	100	98	99	100	99	44	14
Private (for-profit)	71	65	57	68	54	26	36
Faith-based organisation	68	49	29	68	29	51	95
Province							
Nairobi	77	76	60	67	50	54	25
Central	70	62	61	69	60	59	39
Coast	100	83	82	99	81	82	38
Eastern	93	92	72	93	72	67	66
North Eastern	73	73	72	73	72	72	7
Nyanza	82	63	66	82	66	69	51
Rift Valley	68	40	59	68	58	42	96
Western	86	83	80	85	79	76	25
Total	81	67	67	79	66	61	347

Table A-6.2 Availability of antenatal care and tetanus vaccine services

Percentage of facilities offering ANC and tetanus toxoid vaccine (TT) the indicated number of days per week and percentage of facilities where tetanus toxoid vaccine is reported offered every day ANC is offered, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of facilities with:								
	ANC services offered the indicated number of days per week[1]			TT services offered the indicated number of days per week				TT every day ANC is offered	Number of facilities offering ANC (weighted)
Background characteristics	1-2 days	3-4 days	5+ days	Not offered	1-2 days	3-4 days	5+ days		
Type of facility									
Hospital	10	4	86	1	8	4	87	99	25
Health centre	18	1	81	0	18	1	78	100	111
Maternity	3	5	93	6	3	5	87	92	16
Clinic	9	0	91	5	7	0	88	95	4
Dispensary	35	0	65	0	24	0	76	95	191
Managing authority									
Government	20	0	80	0	10	0	89	99	202
NGO	24	0	76	0	24	0	76	100	14
Private (for-profit)	26	4	70	3	5	4	88	97	36
Faith-based organisation	39	1	59	0	46	1	52	91	95
Province									
Nairobi	30	2	68	0	30	1	69	100	25
Central	13	1	86	0	7	1	92	93	39
Coast	9	0	91	0	8	0	84	100	38
Eastern	20	0	80	0	13	0	87	99	66
North Eastern	9	8	83	0	9	8	83	100	7
Nyanza	24	1	75	2	30	1	67	98	51
Rift Valley	47	0	53	0	28	0	72	92	96
Western	14	5	81	0	14	5	81	100	25
Total	26	1	73	0	20	1	78	97	347

[1] Some facilities offer the services less than one day per week.

Table A-6.3 Availability of items to support quality antenatal care services

Percentage of facilities where the indicated items are in the ANC/PNC service area or adjacent to the consultation or examination room and the indicated medications are in the facility, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage by type of facility					
Item	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Items to support quality counseling						
Individual client health cards	72	57	89	61	62	62
Written ANC guidelines	31	36	15	22	30	31
Visual aids for health education	49	31	38	20	26	30
All items to support quality counseling[1]	16	19	13	7	4	10
Items for infection control						
Soap	86	70	62	84	72	72
Water	90	84	78	100	94	90
Clean latex gloves	91	92	79	91	100	96
Disinfecting solution	51	43	53	46	50	48
Sharps box	92	88	84	81	98	93
All items for infection control[2]	42	30	40	36	41	37
Covered waste receptacle with plastic liner[3]	45	45	42	26	28	35
All items for infection control plus waste receptacle	24	16	16	17	21	19
Items for physical examination						
Visual and auditory privacy	88	86	94	84	88	88
Visual privacy only	10	3	5	16	8	7
No privacy	2	5	2	0	3	4
Examination bed[4]	99	97	100	97	100	99
Examination light[5]	49	14	57	44	20	22
All elements for physical examination[6]	72	22	75	61	23	29
All elements for physical examination and specific components for infection control present[7]	26	9	25	20	5	9
Essential supplies for basic ANC						
Blood pressure apparatus	91	69	92	97	88	83
Foetoscope (Pinard)	99	97	88	96	100	98
Iron tablets[8]	87	89	75	69	87	87
Folic acid tablets[8]	94	97	86	64	97	96
Tetanus toxoid vaccine	90	78	73	70	84	82
All basic ANC equipment and medicines[9]	70	50	56	43	59	57
Number of facilities offering ANC (weighted)	25	111	16	4	191	347

[1] Individual client health cards, written ANC 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 this is not an item that has been commonly introduced and thus was not included in the aggregate for infection control.
[4] May be any type of bed where woman can lie down flat.
[5] May be examination light, flashlight or other spotlight source
[6] Visual and auditory privacy, examination light, bed.
[7] Visual and auditory privacy, examination light, bed, and all infection control items, excluding sharps box.
[8] Iron and folic acid may be separate tablets, or one combined tablet.
[9] Blood pressure apparatus, foetoscope, iron and folic acid, tetanus toxoid vaccine.

Table A-6.4 Availability of specific medicines and guidelines for antenatal and postpartum 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 items for postnatal care, by type of facility Kenya SPA 2004

Item	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Medicines for managing common complications during pregnancy						
Antibiotic[1]	99	95	98	89	94	95
Mebendazole (antihelminth)	83	84	72	83	88	86
Albendazole (antihelminth)	44	36	44	60	29	33
Metronidazole or tinidazole (trichomoniasis)	99	88	100	85	92	92
Antimalarial	99	100	100	92	100	100
Medicines for STIs						
Ceftriaxone (gonorrhoea)	44	27	24	19	2	14
Ciprofloxacin (gonorrhoea)	35	18	41	29	11	17
Doxycycline (chlamydia, syphilis)	93	92	77	82	89	89
Tetracycline (chlamydia, syphilis)	32	16	60	42	20	22
Erythromycin (chlamydia, syphilis)	87	53	55	60	59	59
Any injectable or oral penicillin (syphilis)	96	93	98	89	91	92
At least one medication for gonorrhoea	53	36	50	36	14	26
At least one medication for chlamydia	97	99	85	82	90	93
At least one medication for syphilis	99	100	99	89	96	98
At least one medication for the four STIs assessed[2]	53	36	49	36	14	26
Nystatin or miconazole suppository (candidiasis)	25	21	21	37	13	17
All medicines for ANC complications[3]	15	8	14	20	0	4
Additional medicine: Methyldopa (aldomet)	70	17	53	51	15	22
ANC service components						
Preventive antimalarial	79	87	54	48	86	84
Treat STI by ANC providers (if needed)	46	68	80	90	82	75
Routine discussion about family planning	62	61	66	81	61	61
Equipment related to postnatal care						
Thermometer	58	51	84	82	70	64
Infant scale	77	68	81	84	82	77
Number of facilities offering ANC (weighted)	25	111	16	4	191	347

[1] Amoxicillin or cotrimoxazole
[2] At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis
[3] At least one broad-spectrum antibiotic, metronidazole, an antimalarial, at least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis, mebendazole, and nystatin (or miconazole) suppository all present

Table A-6.5 Facility capacity to provide anaemia screening with antenatal care

Percentage of facilities with the capacity to test for anaemia, percentage where the facility has a standard to routinely screen ANC/PNC clients for anaemia, and percentage where the facility routinely tests ANC clients for anaemia and testing capacity for anaemia exists, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities offering ANC (weighted)
	Facility offers ANC and has capacity to conduct anaemia test[1]	Facility has standard to routinely screen ANC clients for anaemia	Facility has standard to routinely screen ANC clients for anaemia and facility has capacity to conduct aanemia test	
Type of facility				
Hospital	86	89	77	25
Health centre	45	61	38	111
Maternity	80	92	73	16
Clinic	51	75	48	4
Dispensary	20	55	20	191
Managing authority				
Government	25	53	23	202
NGO	20	75	19	14
Private (for-profit)	88	84	75	36
Faith-based organisation	41	67	38	95
Province				
Nairobi	79	100	79	25
Central	24	40	24	39
Coast	50	52	42	38
Eastern	32	68	30	66
North Eastern	26	19	8	7
Nyanza	20	45	20	51
Rift Valley	34	65	29	96
Western	46	81	41	25
Total	36	61	33	347

[1] Any anaemia test. Specific tests assessed were use of hemoglobinometer or calorimeter, centrifuge and capillary tubes for hematocrit, or any of the blotting paper tests.

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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities offering ANC (weighted)
	Facility offers ANC and has capacity to conduct urine protein test[1]	Facility has standard to routinely screen ANC clients for urine protein	Facility has standard to routinely screen ANC clients for urine protein and facility has capacity to conduct urine protein test	
Type of facility				
Hospital	86	90	77	25
Health centre	36	67	27	111
Maternity	76	76	61	16
Clinic	62	69	54	4
Dispensary	29	52	29	191
Managing authority				
Government	20	50	17	202
NGO	21	99	20	14
Private (for-profit)	88	77	71	36
Faith-based organisation	58	72	57	95
Province				
Nairobi	73	99	72	25
Central	38	61	37	39
Coast	26	28	10	38
Eastern	38	68	30	66
North Eastern	16	27	13	7
Nyanza	12	42	10	51
Rift Valley	46	68	45	96
Western	45	73	43	25
Total	38	61	34	347

[1] Clinistix (Campus 3 or Campus 9 sticks) or flame, acetic acid and test tube for testing urine albumin.

Table A-6.7 Facility capacity to provide test for urine glucose with antenatal care

Percentage of facilities offering ANC and having the capacity to test urine for glucose, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering ANC and having capacity to conduct urine glucose test[1]	Number of facilities offering ANC (weighted)
Type of facility		
Hospital	83	25
Health centre	36	111
Maternity	72	16
Clinic	62	4
Dispensary	31	191
Managing authority		
Government	20	202
NGO	21	14
Private (for-profit)	86	36
Faith-based organisation	62	95
Province		
Nairobi	73	25
Central	38	39
Coast	25	38
Eastern	37	66
North Eastern	16	7
Nyanza	19	51
Rift Valley	46	96
Western	45	25
Total	39	347

[1] Dipstix (Campus 3 or Campus 9) or Benedict's solution with stove and test tube.

Table A-6.8 Facility capacity to test for syphilis

Percentage of facilities with the capacity to conduct test for syphilis, percentage where the facility has a standard to routinely screen ANC clients for syphilis, and percentage where the facility has the capacity for syphilis tests and routinely tests ANC clients for syphilis by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering ANC services			Number of facilities offering ANC (weighted)
	Facility had syphilis test[1]	Facility has standard to routinely screen ANC clients for syphilis	Facility has standard to routinely screen ANC clients for syphilis and facility has capacity to conduct syphilis test	
Type of facility				
Hospital	88	92	81	25
Health centre	45	72	44	111
Maternity	78	87	66	16
Clinic	66	84	66	4
Dispensary	35	57	31	191
Managing authority				
Government	25	56	23	202
NGO	44	99	44	14
Private (for-profit)	88	92	83	36
Faith-based organisation	68	72	63	95
Province				
Nairobi	79	100	79	25
Central	52	60	45	39
Coast	33	68	33	38
Eastern	38	68	37	66
North Eastern	20	30	20	7
Nyanza	31	37	21	51
Rift Valley	50	69	48	96
Western	41	86	37	25
Total	44	66	41	347

[1] Either VDRL with functioning microscope or RPR (rapid plasma reagin) test

Table A-6.9 Statistics on utilisation of antenatal care and postnatal care services for facilities in SPA

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, Kenya SPA 2004

Type of facility	Median monthly ANC visits	Number of facilities reporting ANC data (weighted)	Median monthly PNC visits	Number of facilities reporting PNC data (weighted)
Hospital	130	22	32	3
Health centre	78	94	-	12
Maternity	26	10	521	2
Clinic	14	3	-	0
Dispensary	36	180	41	6
Total	49	310	17	22

Table A-6.10 Information of user fees for antenatal care services

Percentage of facilities that have user fees for ANC/PNC, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities charging for the indicated item: Client card	Consul-tation by resident provider	Consultation by consultant	Any fees for tests	Blood test for anemia	Urine tests for protein	Iron tablets	Fixed fee for all ANC services	No charges/ Don't know	Number of facilities offering ANC (weighted)
Type of facility										
Hospital	28	20	23	52	50	45	14	44	20	25
Health centre	25	15	3	19	15	16	12	44	33	111
Maternity	45	42	25	51	51	48	18	52	0	16
Clinic	34	32	40	67	63	65	29	60	0	4
Dispensary	30	15	9	25	23	21	3	38	39	191
Managing authority										
Government	21	6	1	6	6	2	2	28	47	202
NGO	24	4	3	29	28	5	1	41	57	14
Private (for-profit)	34	26	25	52	52	50	33	28	24	36
Faith-based organisation	44	39	22	60	52	60	12	74	5	95
Province										
Nairobi	3	54	12	30	29	29	25	61	13	25
Central	39	33	11	33	23	32	11	30	23	39
Coast	19	5	10	24	24	23	11	56	33	38
Eastern	46	21	2	24	24	23	7	28	31	66
North Eastern	1	0	0	12	12	11	9	9	80	7
Nyanza	30	19	3	24	16	24	7	51	16	51
Rift Valley	22	2	17	31	30	19	1	41	48	96
Western	44	18	5	18	18	18	8	37	43	25
Total	29	17	9	27	24	23	8	41	33	347

Table A-6.11.1 Out-of-pocket payments for antenatal care services-first-visit clients

Among first-visit ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (KSH) paid on the day of the survey, by type of facility, Kenya SPA 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 (KSH) 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)
Hospital	70	37	110	26
Health centre	90	119	34	103
Maternity	89	15	76	13
Clinic	93	2	68	2
Dispensary	68	182	29	124
Total	77	356	46	269

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other.

Table A-6.11.2 Out-of-pocket payments for antenatal care services-follow-up clients

Among follow-up ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services median amount (KSH) paid on the day of the survey, by type of facility, Kenya SPA 2004

Type of facility	Percentage of interviewed follow-up visit ANC clients paying any out-of-pocket fees	Number of interviewed follow-up visit ANC clients (weighted)	Median out-of-pocket payment (KSH) by follow-up visit ANC clients who paid anything for ANC services day of survey[1]	Number of interviewed follow-up visit ANC clients providing valid responses for out-of-pocket payments (weighted)
Hospital	46	57	70	26
Health centre	71	230	26	164
Maternity	93	14	56	13
Clinic	92	3	60	3
Dispensary	42	241	28	102
Total	57	544	27	307

[1] Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

Table A-6.12 Supportive management for providers of ANC

Among interviewed antenatal care (ANC) service providers, percentage who received the indicated supportive management practices, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage receiving indicated supportive management practices: Received in-service training during the 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 13-35 months preceding survey	Number of interviewed ANC providers (weighted)[2]
Type of facility					
Hospital	48	52	31	18	428
Health centre	36	60	22	27	311
Maternity	45	80	34	10	112
Clinic	39	71	27	6	4
Dispensary	43	77	36	18	185
Managing authority					
Government	50	61	33	19	619
NGO	29	71	21	40	22
Private (for-profit)	32	63	22	9	172
Faith-based organisation	35	64	25	30	228
Province					
Nairobi	51	67	37	12	173
Central	57	47	22	10	122
Coast	33	41	29	26	111
Eastern	56	69	40	14	161
North Eastern	38	64	30	14	7
Nyanza	35	79	27	34	168
Rift Valley	34	51	23	22	219
Western	37	83	28	23	81
Total	43	62	29	20	1,041

[1] This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.
[2] Includes only providers of ANC services in facilities offering ANC services.

Table A-6.13.1 Supportive management: in-service training for antenatal care service providers: ANC and PNC

Among interviewed antenatal care (ANC) service providers, percentage who received in-service training[1] on specific ANC and PNC topics during the past 12 months or 13-35 months preceding the survey, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of interviewed ANC providers who received in-service training on specific topics																Number of interviewed ANC service providers (weighted)[3]
	ANC counseling		Focused ANC		Other ANC care		Anemia in pregnancy		Malaria in pregnancy		Any risk pregnancy		Symptom management for pregnancy		PNC[2]		
Background characteristics	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility																	
Hospital	11	10	11	7	9	9	11	11	14	11	15	11	11	10	10	10	428
Health centre	5	7	8	6	4	10	8	9	8	9	8	9	7	7	6	7	311
Maternity	11	12	13	6	10	7	15	12	15	8	16	12	15	8	10	12	112
Clinic	6	10	2	15	5	10	9	14	9	14	10	14	6	10	5	8	5
Dispensary	6	11	10	8	5	10	7	13	8	14	8	14	4	15	4	10	185
Managing authority																	
Government	8	8	11	7	7	8	10	9	12	9	12	10	9	7	8	8	619
NGO	2	3	10	3	5	7	5	3	10	3	10	3	3	6	3	2	22
Private (for-profit)	9	10	8	6	8	9	11	10	11	10	12	10	9	10	10	6	172
Faith-based organisation	10	14	10	8	8	13	9	16	10	16	11	17	8	18	7	17	228
Province																	
Nairobi	9	10	11	7	9	8	12	10	13	7	13	9	12	7	9	10	173
Central	6	6	8	6	6	6	6	6	5	6	6	7	6	6	2	7	122
Coast	7	6	7	9	4	11	8	13	7	13	8	13	7	6	7	6	111
Eastern	13	9	16	5	9	8	15	12	20	12	20	12	10	14	10	12	161
North Eastern	10	12	9	14	4	11	4	12	10	12	11	12	10	12	9	12	7
Nyanza	11	11	10	5	9	8	11	11	12	12	13	12	11	10	11	11	168
Rift Valley	4	11	8	6	4	10	7	11	9	11	9	11	5	11	5	8	219
Western	10	12	10	16	9	14	10	15	11	16	11	16	10	14	11	14	81
Total	8	9	10	7	7	9	10	11	11	11	12	11	9	10	8	10	1,041

[1] This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.
[2] Postnatal care (PNC)
[3] Includes only providers of ANC services in facilities offering ANC services

Table A-6.13.2 Supportive management: in-service training for antenatal care service providers: family planning, STIs, exclusive breastfeeding, and PMTCT

Among interviewed antenatal care (ANC) service providers, percentage who received in-service[1] training on specific topics (family planning, STIs, exclusive breastfeeding, amd PMTCT) during the past 12 months or 13-35 months preceding the survey, by type of facility, managing authority, and province, Kenya SPA 2004

	Percentage of interviewed ANC providers who received in-service training on specific topics								
	Family planning		Any prevention diagnosis, or treatment of STI		Exclusive breastfeeding		PMTCT[2]		Number of interviewed ANC service providers (weighted)[3]
Background characteristics	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	10	16	12	18	10	9	35	11	428
Health centre	7	10	9	25	5	9	25	16	311
Maternity	14	14	13	17	8	10	29	7	112
Clinic	16	4	12	18	5	3	25	0	5
Dispensary	8	9	26	16	5	6	22	4	185
Managing authority									
Government	11	13	12	17	7	6	35	9	619
NGO	16	30	17	23	4	7	14	1	22
Private (for-profit)	9	10	14	14	7	9	19	5	172
Faith-based organisation	5	12	18	29	8	14	22	21	228
Province									
Nairobi	11	14	11	16	10	8	39	11	173
Central	13	5	12	8	3	5	42	7	122
Coast	12	16	11	27	6	9	17	2	111
Eastern	7	16	15	15	8	10	40	11	161
North Eastern	12	15	12	17	5	12	11	6	7
Nyanza	5	12	12	33	11	8	21	27	168
Rift Valley	7	13	18	18	4	8	23	3	219
Western	14	10	13	21	9	15	19	13	81
Total	9	13	14	20	7	8	29	11	1,041

[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] Includes only providers of ANC services in facilities offering ANC services

Table A-6.14 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 managing authority and province, Kenya 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 ANC service providers who were supervised in past 6 months (weighted)[1]
		Deliver supplies	Checked records	Observed work	Provided feedback	Verbal praise	Written praises	Provided updates	Discussed problems	Other	
Type of facility											
Hospital	3	47	92	91	90	85	40	67	87	10	223
Health centre	3	49	99	91	90	83	42	58	94	7	186
Maternity	6	37	93	92	52	51	10	47	62	1	90
Clinic	2	34	95	86	85	83	68	82	88	4	4
Dispensary	5	70	94	91	94	88	68	75	94	9	144
Managing authority											
Government	4	58	94	89	87	83	42	64	92	10	377
NGO	6	52	97	95	95	93	75	65	97	13	16
Private (for-profit)	3	27	98	96	64	59	28	59	64	5	108
Faith-based organisation	3	52	93	92	97	88	51	64	89	5	146
Province											
Nairobi	12	49	90	88	88	85	21	65	93	5	117
Central	3	60	92	91	94	81	66	62	85	11	57
Coast	4	69	97	88	81	69	43	85	94	7	46
Eastern	4	58	99	91	93	87	54	67	91	9	111
North Eastern	4	68	91	88	86	81	48	52	86	7	5
Nyanza	3	31	93	95	69	67	27	46	68	11	133
Rift Valley	3	52	96	93	92	89	53	66	96	7	111
Western	4	60	95	88	87	84	52	73	89	3	67
Total	4	51	94	91	86	80	42	64	87	8	646

[1] Includes only providers of ANC services in facilities offering ANC services

Table A-6.15 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 follow-up 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 managing authority and province, Kenya SPA 2004

Background characteristics	Characteristics of observed ANC clients							Number of observed ANC clients (weighted)[1]
	First ANC visit for this pregnancy	Follow-up ANC visit	First pregnancy	Month of pregnancy				
				< 5m	≥ 5m	≥ 8m	Missing	
Type of facility								
Hospital	43	57	30	5	37	40	18	96
Health centre	35	65	32	3	40	50	6	356
Maternity	52	48	29	3	47	35	14	29
Clinic	34	66	19	2	25	59	14	5
Dispensary	45	55	28	4	47	48	1	427
Managing authority								
Government	41	59	33	5	45	46	4	589
NGO	33	67	25	0	25	63	11	28
Private (for-profit)	38	62	17	2	55	30	13	89
Faith-based organisation	43	57	26	2	35	57	6	207
Province								
Nairobi	47	53	46	4	43	44	9	90
Central	31	69	41	0	34	48	18	45
Coast	41	59	31	8	37	32	23	88
Eastern	36	64	28	6	49	45	0	165
North Eastern	44	56	14	0	62	38	0	5
Nyanza	61	39	26	3	43	52	1	162
Rift Valley	30	70	25	3	40	54	4	274
Western	50	50	30	3	54	41	2	85
Total	41	59	30	4	43	47	6	913

[1] Includes only providers of ANC services in facilities offering ANC services

Table A-6.16 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Prior history and client characteristics						
Client age	71	83	89	89	80	80
Date of last menstrual period	75	84	83	94	84	83
Any aspects related to prior pregnancy[1]	78	87	82	94	85	85
Any aspects of complications during prior pregnancy (if had prior pregnancy)	40	42	61	64	45	44
Medications client currently taking	39	22	31	45	33	30
All relevant elements for client history[2]	29	17	19	39	29	25
Laboratory tests and examinations						
Measure blood pressure	100	89	100	84	87	90
Weigh client	81	66	82	58	67	69
Urine test (protein)	96	86	95	100	59	74
Blood test (anemia)	96	83	100	100	68	77
Preventative interventions						
Give or prescribe iron tablets	49	66	37	86	75	68
Give or prescribe tetanus toxoid vaccine	78	76	77	75	69	73
Number of first-visit ANC clients (weighted)	41	123	15	2	194	375
Among women with prior pregnancies, specific prior complications discussed:						
Stillbirth	44	48	68	62	52	51
Infant mortality first one week after birth	40	40	65	35	32	37
Heavy bleeding during labor or postpartum	29	35	43	53	34	34
Assisted delivery	37	35	61	41	54	46
Number of observed first-visit ANC clients with prior pregnancy (weighted)	29	84	11	1	139	264

[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

Table A-6.17 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, Kenya SPA 2004

	Percentage by type of facility					
Components of consultation	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Client questioned regarding						
Vaginal bleeding	23	14	16	12	13	15
Fetal movement (at least 5m pregnant)	51	42	74	53	50	48
Any other problems	62	68	87	63	73	70
Basic physical examination						
Measured blood pressure	99	87	100	80	89	90
Urine test (protein)	96	75	95	95	68	74
Check fetal position (at least 8m pregnant)	99	100	98	100	100	100
Listened for fetal heart (at least 5m pregnant)	96	98	92	93	99	98
All questions and basic examination[1]	16	7	7	3	5	7
Other examinations						
Weigh client	84	62	82	58	71	69
Check uterine height	98	100	98	100	100	100
Blood test (anemia)	96	77	100	92	72	78
Preventative interventions						
Give or prescribe iron tablets	45	64	36	64	66	62
Give or prescribe tetanus toxoid vaccine	54	56	62	57	49	53
Number of observed ANC clients at least 5 months pregnant (weighted)	74	321	24	4	404	826
Number of observed ANC clients at least 8 months pregnant (weighted)	38	177	10	3	204	432
Number of observed ANC clients (weighted)	96	356	29	5	427	913

[1] Client was questioned regarding vaginal bleeding, fetal movement (if at least 5 months pregnant), blood pressure was measured, fetal position was palpated or ultrasound performed (if at least 8 months pregnant), and provider listened for fetal heart (if at least 5 months pregnant).

Table A-6.18 Observation of health education for preventive interventions

Among antenatal care (ANC) clients whose consultation was observed and who received the indicated item (or received a prescription for the item), percentage where the provider explained why the item was important, percentage where the provider explained how to take the medicine, by type of facility, managing authority and province Kenya SPA 2004

Background characteristics	Percentage among those receiving iron or folic acid			Number of ANC clients who received iron or folic acid (weighted)	Percentage receiving tetanus toxoid vaccine where provider explained purpose	Number of ANC clients who received tetanus toxoid vaccine (weighted)	Percentage among those receiving anti-malarial			Number of ANC clients who received antimalarial (weighted)
	Provider explained purpose	Provider explained how to take	Provider explained side effects				Provider explained purpose	Provider explained how to take	Provider explained side effects	
Type of facility										
Hospital	83	86	34	44	68	52	81	86	33	40
Health centre	78	91	23	227	59	199	66	94	23	158
Maternity	86	86	45	11	85	18	85	79	38	7
Clinic	94	81	42	3	66	3	80	100	7	1
Dispensary	76	71	16	282	67	209	75	75	29	186
Managing authority										
Government	79	85	19	407	69	329	70	85	19	316
NGO	70	99	39	11	4	17	15	100	15	4
Private (for-profit)	70	74	49	43	54	65	88	94	65	27
Faith-based organisation	77	64	14	106	68	70	83	70	60	45
Province										
Nairobi	99	67	28	47	68	43	95	95	45	4
Central	85	85	28	28	48	23	81	100	43	21
Coast	62	94	21	71	49	55	47	98	15	53
Eastern	89	71	20	91	67	69	78	67	34	79
North Eastern	68	37	37	1	42	3	66	66	0	1
Nyanza	72	86	13	92	74	82	66	80	15	70
Rift Valley	73	81	21	191	59	147	75	88	19	107
Western	82	75	25	46	82	59	86	84	50	58
Total	78	81	21	566	65	481	72	84	27	392

Table A-6.19 Observed content of ANC counselling for first and for follow-up clients

Percentage of first and follow-up visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, by type of facility, Kenya SPA, 2004

	Percentage by type of facility					
Counselling topic	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
First-visit ANC client						
Nutrition	58	56	73	66	56	57
Progress of pregnancy	69	65	77	39	69	68
Specific risk: vaginal bleeding	30	26	25	15	24	26
Specific risk: fever	22	22	8	22	18	19
Specific risk: short breath; excess tired	26	17	19	7	22	21
Specific risk: swelling hands or face	33	37	12	15	20	26
Specific risk: headache or blurred vision	30	28	8	0	13	19
Delivery plans	41	49	45	36	37	42
Exclusive breastfeeding	18	16	13	7	7	12
Family planning after birth	20	20	16	22	18	19
Provider used any visual aids	20	7	17	7	7	9
Number of first-visit ANC clients (weighted)	39	119	15	2	182	357
Follow-up visit ANC client						
Nutrition	55	36	84	49	62	50
Progress of pregnancy	76	74	89	68	72	74
Specific risk: vaginal bleeding	17	13	16	3	21	17
Specific risk: fever	10	10	17	6	20	14
Specific risk: short breath; excess tired	13	10	51	6	26	18
Specific risk: swelling hands or face	18	9	49	16	26	18
Specific risk: headache or blurred vision	12	11	25	9	17	14
Delivery plans	40	42	55	43	58	50
Exclusive breastfeeding	7	4	14	3	16	10
Family planning after birth	10	14	18	16	5	9
Provider used any visual aids	7	4	14	5	0	3
Number of follow-up visit ANC clients (weighted)	58	236	14	3	245	556

Table A-6.20 Observed content of ANC counselling for first and for follow-up clients

Percentage of first and follow-up visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, by province, Kenya SPA, 2004

	Percentage by type of facility					
Counselling topic	Hospital	Health centre	Maternity	Clinic	Dispensary	Total
First-visit ANC client						
Nutrition	58	56	73	66	56	57
Progress of pregnancy	69	65	77	39	69	68
Specific risk: vaginal bleeding	30	26	25	15	24	26
Specific risk: fever	22	22	8	22	18	19
Specific risk: short breath; excess tired	26	17	19	7	22	21
Specific risk: swelling hands or face	33	37	12	15	20	26
Specific risk: headache or blurred vision	30	28	8	0	13	19
Delivery plans	41	49	45	36	37	42
Exclusive breastfeeding	18	16	13	7	7	12
Family planning after birth	20	20	16	22	18	19
Provider used any visual aids	20	7	17	7	7	9
Number of first-visit ANC clients (weighted)	39	119	15	2	182	357
Follow-up visit ANC client						
Nutrition	55	36	84	49	62	50
Progress of pregnancy	76	74	89	68	72	74
Specific risk: vaginal bleeding	17	13	16	3	21	17
Specific risk: fever	10	10	17	6	20	14
Specific risk: short breath; excess tired	13	10	51	6	26	18
Specific risk: swelling hands or face	18	9	49	16	26	18
Specific risk: headache or blurred vision	12	11	25	9	17	14
Delivery plans	40	42	55	43	58	50
Exclusive breastfeeding	7	4	14	3	16	10
Family planning after birth	10	14	18	16	5	9
Provider used any visual aids	7	4	14	5	0	3
Number of follow-up visit ANC clients (weighted)	58	236	14	3	245	556

Table A-6.21 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, Kenya SPA, 2004

Issue discussed during current/previous visit	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Counselling on risk signs						
Client said provider mentioned any warning signs	39	32	48	32	37	36
Warning signs mentioned by client						
Bleeding	33	27	25	47	34	31
Fever	11	10	13	17	12	11
Swollen face or hands	11	10	14	10	5	8
Tiredness or breathlessness	9	8	5	8	13	10
Headache or blurred vision	13	8	26	13	13	11
Convulsions	8	9	10	5	14	11
Reduced fetal movement	7	8	20	6	4	6
What client was told to do if warning sign occurs						
Seek care at facility	50	47	51	47	56	52
Decrease activity	2	1	0	0	3	2
Change diet	1	1	3	3	0	1
Client reported provider discussed						
Exclusive breastfeeding	32	17	29	10	12	17
Exclusive breastfeeding for 6 months	15	10	11	0	5	8
Delivery plans	45	45	38	47	58	51
Supplies to prepare for delivery	33	35	25	30	40	37
Number of interviewed ANC clients (weighted)	94	349	29	5	423	900

Table A-6.22 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, and 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 province, Kenya SPA, 2004

Issue discussed during current/previous visit	Percentage by province								
	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Total
Warning signs mentioned by client									
Bleeding	37	33	52	33	0	27	27	16	31
Fever	3	4	16	23	10	18	4	5	11
Swollen face or hands	18	1	8	6	0	7	10	3	8
Tiredness or breathlessness	5	10	18	8	10	10	12	3	10
Headache or blurred vision	19	4	12	14	0	13	10	6	11
Convulsions	11	13	15	13	0	6	15	0	11
Reduced fetal movement	22	9	0	10	0	7	0	3	6
What client was told to do if warning sign occurs									
Seek care at facility	50	55	62	86	10	48	35	35	52
Decrease activity	4	0	0	0	0	0	5	0	2
Change diet	0	0	0	0	0	3	0	0	1
Client reported provider discussed									
Exclusive breastfeeding	25	17	6	17	12	9	20	22	17
Exclusive breastfeeding for 6 months	14	13	4	8	2	6	9	5	8
Delivery plans	48	21	57	48	26	46	57	57	51
Supplies to prepare for delivery	36	23	24	48	20	24	49	25	37
Number of interviewed ANC clients (weighted)	89	45	88	165	4	158	267	84	900

Table A-6.23 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, Kenya SPA, 2004

Background characteristics	Percentage of ANC clients who plan to deliver at: This facility	Other facility	Private home	Don't know	Number of interviewed ANC clients (weighted)
Type of facility					
Hospital	69	7	4	19	94
Health centre	33	32	8	27	349
Maternity	57	13	1	29	29
Clinic	28	45	12	15	5
Dispensary	5	71	6	17	423
Managing authority					
Government	22	48	8	21	582
NGO	50	2	12	36	28
Private (for-profit)	33	36	1	30	89
Faith-based organisation	24	57	3	16	201
Province					
Nairobi	32	51	0	17	89
Central	33	49	0	18	45
Coast	29	40	19	11	88
Eastern	14	63	8	16	165
North Eastern	27	30	18	25	4
Nyanza	28	44	0	28	158
Rift Valley	21	46	7	26	267
Western	34	33	11	22	84
Total	25	47	6	22	900

Table A-6.24 Use of individual client cards

Among first and follow-up 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, managing authority and province, Kenya SPA, 2004

Background characteristics	Percentage of ANC consultation where: Provider looked at client card during consultation: First visit	Provider looked at client card during consultation: Follow-up visit	Provider wrote on client card at end of visit: First visit	Provider wrote on client card at end of visit: Follow-up visit	Number of first-visit ANC clients (weighted)	Number of follow-up visit ANC clients (weighted)
Type of facility						
Hospital	93	94	99	99	39	58
Health centre	99	100	100	99	119	236
Maternity	98	93	95	98	15	14
Clinic	84	89	100	97	2	3
Dispensary	91	96	100	97	182	245
Managing authority						
Government	93	97	100	97	256	333
NGO	100	99	100	98	3	25
Private (for-profit)	96	97	97	100	34	56
Faith-based organisation	99	98	100	100	65	142
Province						
Nairobi	99	100	100	100	38	52
Central	100	90	100	91	16	29
Coast	93	99	100	99	46	42
Eastern	99	96	100	96	55	110
North Eastern	100	100	100	94	2	3
Nyanza	84	93	99	100	82	80
Rift Valley	98	99	100	98	87	187
Western	96	100	100	100	31	54
Total	94	97	100	98	357	556

Table A-6.25 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, managing authority and province, Kenya SPA, 2004

Background characteristics	Percentage of ANC consultations where: Client went home	Client referred, same facility	Client admitted to facility	Client referred elsewhere	Don't know	Number of observed ANC clients (weighted)
Type of facility						
Hospital	73	24	1	1	2	96
Health centre	80	18	0	2	0	356
Maternity	85	14	0	1	0	29
Clinic	90	6	0	2	3	5
Dispensary	86	10	0	5	0	427
Managing authority						
Government	78	18	0	4	0	589
NGO	93	7	0	0	0	28
Private (for-profit)	84	15	0	0	1	89
Faith-based organisation	92	6	0	2	0	207
Province						
Nairobi	92	3	0	4	0	90
Central	84	10	0	5	0	45
Coast	49	40	0	11	0	88
Eastern	92	8	0	0	0	165
North Eastern	62	29	0	10	0	5
Nyanza	98	2	0	0	0	162
Rift Valley	76	22	0	1	0	274
Western	77	13	0	10	0	85
Total	82	14	0	3	0	913

Table A-6.26 Client feedback on service

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, Kenya SPA, 2004

Client service issue	Percentage by type of facility: Hospital	Health centre	Maternity	Clinic	Dispensary	Total
Behavior/attitude of provider	2	5	3	0	1	3
Inability to discuss problem	3	5	1	0	1	3
Insufficient explanation about child's illness	4	7	1	2	4	5
Waiting time to see provider	23	21	4	19	22	21
Quality of examination and treatment	1	4	0	4	1	2
Availability of medicines	5	4	0	3	6	5
Days facility is open	2	5	0	0	4	4
Hours facility is open	3	7	0	0	4	5
Cleanliness of facility	1	6	0	0	0	2
Insufficient visual privacy	2	6	0	2	11	8
Insufficient auditory privacy	2	7	0	2	11	8
Number of interviewed ANC clients (weighted)	94	349	29	5	423	900

Table A-6.27 Client choice of facility

Among interviewed antenatal care (ANC) clients, percentage who reported this was not the closest health facility to their home, and among these, the main reasons they did not go to the nearest facility, by type of facility, managing authority and province Kenya SPA, 2004

Background characteristics	Percentage of interviewed ANC clients who report this is not the closest facility to their home	Number of interviewed caretakers (weighted)	Percentage of ANC clients mentioning the indicated item was a problem with the nearest facility							Number of interviewed ANC clients for whom this was not the closest facility (weighted)
			Inconvenient operating hours	Bad reputation	Don't like the personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	
Type of facility										
Hospital	44	94	4	17	4	6	6	9	10	42
Health centre	26	349	0	8	12	7	8	28	4	90
Maternity	63	29	4	14	8	0	11	7	32	18
Clinic	37	5	0	29	0	0	18	0	0	2
Dispensary	15	423	0	15	17	18	0	11	0	64
Managing authority										
Government	22	582	1	8	13	1	4	20	9	128
NGO	24	28	2	9	0	24	2	48	0	7
Private (for-profit)	22	89	5	27	9	0	11	2	3	20
Faith-based organisation	30	201	0	17	10	27	8	13	1	61
Province										
Nairobi	61	89	0	22	2	3	2	27	12	54
Central	43	45	1	30	35	0	4	24	2	19
Coast	30	88	0	4	0	1	0	35	1	26
Eastern	24	165	0	2	23	14	0	1	1	39
North Eastern	17	4	0	0	13	0	37	13	13	1
Nyanza	22	158	5	7	20	10	14	11	2	34
Rift Valley	11	267	0	8	0	29	1	13	17	28
Western	17	84	1	20	0	8	29	6	2	14
Total	24	900	1	12	11	9	5	17	6	216

Table A-6.28 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, managing authority and province Kenya 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)
	No education	Primary	Secondary	Higher		Cannot read or write	Can read, cannot write	Can read and write	
Type of facility									
Hospital	13	43	22	22	94	23	5	71	52
Health centre	8	71	14	7	349	14	4	76	275
Maternity	1	56	28	16	29	16	0	79	16
Clinic	9	38	32	20	5	16	0	80	2
Dispensary	7	78	8	7	423	8	7	82	358
Managing authority									
Government	8	74	11	7	582	12	6	78	479
NGO	0	73	26	1	28	24	0	76	20
Private (for-profit)	12	62	13	13	89	7	0	80	66
Faith-based organisation	7	63	16	14	201	13	8	79	140
Province									
Nairobi	0	50	37	13	89	7	4	89	45
Central	6	55	24	15	45	9	0	90	28
Coast	22	63	10	5	88	27	17	57	74
Eastern	3	82	12	3	165	7	3	90	140
North Eastern	75	8	12	4	4	66	0	10	4
Nyanza	3	78	13	6	158	9	4	83	128
Rift Valley	10	70	5	14	267	6	6	77	215
Western	8	75	9	8	84	30	4	66	70
Total	8	70	13	9	900	12	5	78	704

Table A-6.29 Emergency maternity transportation systems

Among facilities with systems to support emergency obstetric referrals, percentage with indicated system components and median transportation time (in minutes) by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Among facilities having emergency transportation, percentage in which means for transport is:			Number of facilities supporting emergency transportation (weighted)
	Ambulance or other facility based vehicle[1]	Other arrangement to support cost[2]	Facility is referral site	
Type of facility				
Hospital	75	16	5	26
Health centre	55	25	7	53
Maternity	53	35	2	12
Clinic	26	49	0	1
Dispensary	67	0	0	23
Managing authority				
Government	66	13	12	39
NGO	73	27	0	14
Private (for-profit)	55	36	1	23
Faith-based organisation	57	13	1	40
Province				
Nairobi	81	19	1	12
Central	46	29	24	16
Coast	42	55	4	13
Eastern	95	2	1	17
North Eastern	20	43	0	2
Nyanza	61	8	1	14
Rift Valley	50	16	2	26
Western	68	10	0	13
Total	62	19	5	115

[1] Ambulance or other vehicle that stays at the facility.
[2] This may include facility or community financial support or other system.

Table A-6.30 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, Kenya SPA 2004

Equipment and supplies for quality delivery services	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Infection control						
Soap	75	44	69	44	74	59
Water	95	83	73	86	100	88
Clean latex gloves	100	95	81	100	94	94
Disinfecting solution	74	56	68	76	43	57
Sharps box	89	85	77	84	80	84
All items for infection control[1]	54	35	45	36	37	40
Covered waste receptacle with plastic liner	46	36	39	22	26	35
All items for infection control plus waste receptacle	32	11	26	8	20	18
Infrastructure for delivery						
Visual privacy and auditory privacy	88	98	92	80	80	91
Visual privacy only	8	2	7	20	20	8
No privacy	4	0	1	0	0	1
Delivery bed[2]	99	96	98	100	100	98
Examination light[3]	69	22	58	67	11	31
All elements of infrastructure[4]	62	22	50	59	11	29
Other items to support quality services						
Blank partographs	79	40	44	24	6	39
Guidelines for normal /emergency obstetric care (Kenya)	23	7	6	12	12	11
Qualified delivery provider on site 24 hours[5]	92	70	61	29	26	62
Qualified delivery provider on call 24 hours [5]	1	0	0	0	11	3
All other items to support quality services[6]	21	7	1	0	0	7
Number of facilities offering delivery services (weighted)	27	80	18	1	38	164

[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] A duty schedule must be observed. Qualified delivery providers include nurses, midwives, clinical officers, and doctors
[6] Guidelines, partograph, and delivery staff available 24 hours per day with duty schedule observed.

Table A-6.31 Location 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, managing authority and province, Kenya SPA 2004

Background characteristics	Among facilities offering delivery services, percentage where: Equipment is processed in the indicated area[1,2]		Processed equipment is stored in the indicated area[1,2]		Number of facilities offering delivery services (weighted)
	Delivery service area	Main facility area	Delivery service area	Main facility area	
Type of facility					
Hospital	10	87	38	61	27
Health centre	6	92	25	75	80
Maternity	8	87	7	92	18
Clinic	8	79	8	79	1
Dispensary	28	72	48	52	38
Managing authority					
Government	11	86	40	59	86
NGO	0	100	2	98	14
Private (for-profit)	6	89	13	86	29
Faith-based organisation	24	76	33	67	35
Province					
Nairobi	15	69	17	83	11
Central	20	79	26	71	9
Coast	0	100	2	98	13
Eastern	17	83	38	61	26
North Eastern	0	100	3	75	3
Nyanza	29	67	32	68	26
Rift Valley	2	98	32	68	55
Western	16	84	44	56	20
Total	12	86	30	69	164

[1] Main facility area and delivery processing area may be the same location in small facilities
[2] One percent process equipment in FP service area, and one percent do not process delivery equipment.

Table A-6.32 Knowledge and systems for processing of delivery service equipment

Highest level of processing for which the facility has all items to support quality sterilisation/high level disinfecting (HLD) processing, and the percentage with written guidelines at the site where delivery equipment is processed for reuse, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities where the indicated procedure is the highest level for which all conditions for quality sterilisation/HLD of delivery equipment was available			Percentage of facilities with written guidelines for sterilisation or HLD procedures at processing site	Number of facilities offering delivery services (weighted)
	Dry heat or autoclave[1]	Boil/steam or chemical HLD[1]	Do not meet all criteria[2]		
Type of facility					
Hospital	53	2	44	30	27
Health centre	28	1	70	30	80
Maternity	21	0	79	16	18
Clinic	8	0	92	8	1
Dispensary	26	6	68	6	38
Managing authority					
Government	27	1	73	20	86
NGO	72	0	28	16	14
Private (for-profit)	36	0	63	35	29
Faith-based organisation	21	10	69	21	35
Province					
Nairobi	47	0	53	31	11
Central	21	1	77	13	9
Coast	86	1	13	84	13
Eastern	8	0	92	37	26
North Eastern	10	0	90	35	3
Nyanza	12	0	88	15	26
Rift Valley	33	0	67	2	55
Western	43	19	38	29	20
Total	31	3	66	23	164

[1] Equipment functions, and appropriate knowledge of temperature and time for method used, and an automatic timer are all present.
[2] Either equipment or knowledge was lacking or facility does not process delivery equipment.

Table A-6.33 Storage conditions for sterilised or high-level delivery equipment

Percentage of facilities with stored, sterilised/high-level disinfected (HLD) delivery instruments present and storage conditions among facilities where sterilised/HLD items are present, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with stored sterilised/HLD delivery items present	Number of facilities (weighted)	Percentage with: 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 sterilised items	Number of facilities with stored sterilised HLD delivery items (weighted)
Type of facility							
Hospital	99	27	85	2	63	60	27
Health centre	99	80	54	8	20	15	80
Maternity	99	18	71	15	37	36	17
Clinic	100	1	57	0	16	16	1
Dispensary	100	38	43	6	26	6	38
Managing authority							
Government	99	86	47	7	27	17	85
NGO	100	14	99	0	17	17	14
Private (for-profit)	99	29	70	19	57	47	29
Faith-based organisation	100	35	60	1	21	17	35
Province							
Nairobi	100	11	91	8	67	67	11
Central	98	9	95	0	43	42	9
Coast	100	13	52	23	41	17	13
Eastern	100	26	67	0	25	25	26
North Eastern	78	3	53	0	29	29	2
Nyanza	100	26	79	6	33	31	26
Rift Valley	100	55	31	6	22	9	55
Western	100	20	66	12	23	17	20
Total	100	164	58	7	30	23	163

[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 steriliser or autoclave, or sitting in disinfecting solution.

Table A-6.34 Delivery service providers

Percentage of facilities where a qualified trained delivery provider is available on site 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, managing authority and province, Kenya SPA 2004

	Percentage of facilities with:									
	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]					Number of facilities offering delivery services (weighted)
Background characteristics	On site	On call	On site	On call	Doctor	Clinical officer	Registered midwife	Enrolled midwife	Other[2]	
Type of facility										
Hospital	92	1	5	1	26	7	58	89	4	27
Health centre	70	0	25	4	0	4	32	90	20	80
Maternity	61	0	28	11	16	8	31	78	7	18
Clinic	29	0	24	13	0	8	21	54	21	1
Dispensary	26	11	0	11	0	20	0	48	11	38
Managing authority										
Government	63	5	17	0	5	2	25	78	15	86
NGO	74	0	25	0	0	56	28	97	1	14
Private (for-profit)	64	0	29	6	15	16	54	72	18	29
Faith-based organisation	55	0	1	22	5	2	17	77	13	35
Province										
Nairobi	82	0	15	1	19	0	26	88	1	11
Central	96	0	4	0	16	0	30	94	0	9
Coast	66	0	32	2	9	30	59	73	1	13
Eastern	67	16	15	2	4	1	59	82	64	26
North Eastern	35	0	25	3	13	31	41	41	6	3
Nyanza	53	0	15	31	9	4	13	92	15	26
Rift Valley	55	0	16	0	3	14	20	71	0	55
Western	62	0	12	2	1	0	13	73	8	20
Total	62	3	16	6	6	9	29	78	14	164

[1] May be more than one type of staff in a facility who routinely conducts night deliveries.
[2] Registered and enrolled nurses and other auxiliary staff

Table A-6.35 Availability of specific equipment and supplies for quality delivery services: basic and additional medicines and supplies

Percentage of facilities where indicated supplies are in the delivery room (DR) area or in the facility (DR or pharmacy), by type of facility, Kenya SPA 2004

Equipment and supplies for quality delivery services	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Basic medicines and supplies for delivery						
Scissor or blade	84	72	82	92	69	75
Cord clamp or tie	86	69	69	71	32	64
Suction apparatus (bulb or machine)	90	61	75	54	28	60
Suction bulb	58	21	51	32	17	29
Suction machine	82	50	64	45	22	50
Antibiotic eye ointment for newborn (delivery room)	70	50	67	87	54	56
Antibiotic eye ointment for newborn (pharmacy or delivery room)	91	73	93	100	80	80
Skin disinfectant for perineum	89	80	73	87	63	77
All basic supplies for delivery[1]	63	36	56	16	6	36
Additional medicines and supplies for managing common complications of delivery						
Syringes and needles in DR	97	88	84	100	74	86
Syringes and needles in facility	99	94	100	100	100	97
Intravenous solution[2] and perfusion set in DR	86	71	68	88	74	74
Intravenous solution[2] and perfusion set in facility	95	83	99	88	100	91
Oral antibiotic[3] in facility	99	93	85	100	100	95
Injectable oxytocic medication in DR	73	28	54	36	12	34
Injectable oxytocic medication in facility	96	83	87	92	80	85
Suture material in DR	94	65	80	100	43	67
Needle holder in DR	80	80	79	84	80	80
All basic treatment interventions[4]	59	22	36	16	6	26
Additional medicines and supplies for managing serious complications						
Injectable valium or magnesium sulfate in DR	25	7	10	0	20	13
Injectable valium or magnesium sulfate in facility	91	87	85	86	100	91
Broad spectrum injectable antibiotic in facility	97	51	90	100	63	66
Injectable amoxicillin or ampicillin in DR	35	13	20	22	0	15
Injectable procaine penicillin in DR	32	43	34	58	43	40
Injectable gentamycin in DR	68	40	52	74	37	45
All other medicines for complications[5]	25	7	10	0	20	13
Injectable hydralazine in DR	78	32	34	16	0	32
Injectable ergometrine/methergine in DR	95	88	69	87	74	84
Number of facilities offering delivery services (weighted)	27	80	18	1	38	164

[1] Scissor or blade, cord clamp, suction apparatus, antibiotic eye ointment for newborn, and skin disinfectant for perineum
[2] Accepted Intravenous solutions were Dextrose 5 percent and normal saline, 0.9 percent normal saline, or ringers lactate.
[3] Oral amoxicillin, ampicillin, or cotrimoxazole
[4] Needles and syringes, intravenous solution with infusion set, injectable oxytocic, and suture material and needle holder all located in delivery room area, oral antibiotic (cotrimoxazole or amoxicillin) located in pharmacy or delivery room area
[5] 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-6.36 Equipment and supplies for complications of labor and delivery

Percentage of facilities where indicated equipment is available, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of facilities offering delivery services with indicated capacity								Number of facilities offering delivery services (weighted)
	Assist labor		Remove retained products				Emergency support for newborn[1]		
Background characteristics	Forceps	Vacuum extractor	Vacuum aspirator	D&C kit	Blood transfusion services	Caesarean section	Newborn respiratory support	External heat source	
Type of facility									
Hospital	17	28	42	48	89	80	93	72	27
Health centre	5	4	8	4	1	5	59	14	80
Maternity	10	19	42	38	46	26	45	37	18
Clinic	0	0	16	0	8	8	58	21	1
Dispensary	31	20	0	0	0	0	31	0	38
Managing authority									
Government	3	3	14	7	11	10	65	22	86
NGO	2	3	4	5	6	5	18	5	14
Private (for-profit)	12	20	32	36	47	48	61	38	29
Faith-based organisation	45	38	9	16	23	20	48	19	35
Province									
Nairobi	15	21	31	20	32	25	84	39	11
Central	2	7	25	32	42	41	93	78	9
Coast	5	10	59	19	27	25	73	44	13
Eastern	0	6	5	10	17	27	65	16	26
North Eastern	31	13	13	13	48	16	63	3	3
Nyanza	34	19	12	21	23	13	56	13	26
Rift Valley	17	18	6	9	14	14	44	18	55
Western	1	1	19	10	11	8	37	12	20
Total	13	13	16	14	20	18	56	23	164

[1] Infant sized Ambu bag.

Table A-6.37 Capacity to conduct caesarean section

Among facilities that offer caesarean section, percentage where the indicated item was available by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities offering cesarean section, with indicated item					Number of facilities offering caesarean section (weighted)
	Basic item		Additional components		Provider for conducting caesarean section on duty 24-hours[2]	
	Operating table	Operating light	Anes-thetist[1]	Anesthesia-giving set		
Type of facility						
Hospital	90	89	76	88	87	21
Health centre	100	100	0	100	0	4
Maternity	95	95	48	95	75	5
Managing authority						
Government	92	91	82	91	88	8
NGO	87	87	67	67	100	1
Private (for-profit)	89	89	40	88	54	14
Faith-based organisation	97	97	79	97	93	7
Province						
Nairobi	94	94	82	94	94	3
Central	93	93	64	88	85	4
Coast	79	79	54	76	73	3
Eastern	100	99	41	100	41	7
North Eastern	80	80	80	80	80	0
Nyanza	100	100	74	96	82	3
Rift Valley	83	83	67	83	86	8
Western	100	100	65	100	76	2
Total	92	91	61	90	73	30

[1] Duty schedule observed.
[2] Duty schedule observed.

Table A-6.38 Newborn care practices

Percentage of facilities that report the indicated item is a routine component of newborn care, by type of facility, Kenya SPA 2004

Routine newborn care practices	Percentage by type of facility				
	Hospital	Health centre	Maternity	Dispensary	Total
Routine suction with catheter	46	38	53	42	42
Full immersion bath within 24-hours after birth	33	17	42	6	20
Weigh newborn	100	96	91	74	91
Infant scale available	95	84	77	54	78
Provide vitamin A to mother	50	52	26	69	53
Vitamin A in delivery area	39	48	25	74	50
Vitamin A in pharmacy or delivery area	67	85	52	94	80
Provide OPV to newborn	82	72	64	54	68
Provide BCG to newborn	80	69	61	54	66
Provide prelacteal liquids to newborn	21	16	16	0	13
Practices rooming in[1]	93	100	100	89	96
Number of facilities offering delivery services (weighted)[2]	27	80	18	38	164

[1] Newborn stays with mother
[2] Totals include data from one clinic.

Table A-6.39 Emergency obstetric practices

Percentage of facilities that report providing the indicated intervention during the past three months, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities providing the indicated intervention within the past three months							Number of facilities offering delivery services (weighted)
	Assisted delivery[1]	Removal of retained products[2]	Parental oxytocic drugs	Parental anti-convul-sants	Manual removal of placenta	Blood transfusion	Caesarian section	
Type of facility								
Hospital	24	48	81	61	69	63	76	27
Health centre	0	8	12	10	19	0	0	80
Maternity	10	29	33	26	41	14	22	18
Clinic	8	0	24	8	0	0	8	1
Dispensary	0	0	6	6	11	0	0	38
Managing authority								
Government	1	14	16	17	29	9	9	86
NGO	4	6	28	6	28	5	4	14
Private (for-profit)	16	25	38	25	36	18	31	29
Faith-based organisation	6	12	31	25	17	16	19	35
Province								
Nairobi	9	13	25	20	20	15	23	11
Central	3	25	45	29	42	30	41	9
Coast	6	63	53	42	41	17	20	13
Eastern	5	7	14	9	27	11	12	26
North Eastern	13	16	23	35	35	23	13	3
Nyanza	6	17	11	10	17	12	11	26
Rift Valley	5	5	19	10	28	8	14	55
Western	1	16	39	48	28	8	7	20
Total	5	15	24	19	27	12	15	164

[1] Forceps or ventouse (vacuum extractor)
[2] Manual vacuum aspiration or dilatation and curettage

Table A-6.40 Utilization of delivery services by facilities included in the KSPA

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, managing authority and province, Kenya SPA 2004

Background characteristics	Median monthly vaginal deliveries	Number of facilities reporting vaginal delivery data (weighted)[1]	Median monthly caesarean sections	Number of facilities reporting caesarean section data (weighted)
Type of facility				
Hospital	34	26	6	21
Health centre	5	80	-	0
Maternity	5	16	2	4
Dispensary	3	26	-	0
Managing authority				
Government	3	85	20	8
NGO	12	6	4	0
Private (for-profit)	5	28	2	9
Faith-based organisation	5	31	8	7
Province				
Nairobi	18	10	37	3
Central	40	9	5	4
Coast	7	13	5	3
Eastern	2	26	19	3
North Eastern	3	3	2	0
Nyanza	7	21	2	3
Rift Valley	4	48	4	7
Western	6	20	2	2
Total	5	149	5	25

[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.

Table A-6.41 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, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities charging for indicated item:					Number of facilities offering delivery services (weighted)	Number of facilities having any routine charges for delivery services (weighted)
	Normal delivery	Fixed fee for ANC plus delivery	Medicines	Tests	No charges/ don't know		
Type of facility							
Hospital	93	33	41	51	4	27	26
Health centre	76	20	40	24	24	80	61
Maternity	96	38	30	45	1	18	17
Clinic	100	45	63	63	0	1	1
Dispensary	43	0	17	0	57	38	16
Managing authority							
Government	60	16	31	14	39	86	52
NGO	42	4	30	41	58	14	6
Private (for-profit)	95	39	36	46	2	29	29
Faith-based organisation	99	18	43	31	1	35	35
Province							
Nairobi	68	19	32	32	29	11	8
Central	100	77	20	40	0	9	9
Coast	77	62	63	65	23	13	10
Eastern	67	9	10	16	32	26	18
North Eastern	26	6	13	16	74	3	1
Nyanza	86	25	49	42	13	26	23
Rift Valley	66	8	38	11	34	55	37
Western	81	4	28	20	17	20	17
Total	73	19	34	25	26	164	121

Table A-6.42 Supportive management for providers of delivery services

Among interviewed delivery service providers, percentage who received the indicated supportive management practices, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage receiving indicated supportive management practices: Received in-service training during the 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 13-35 months preceding survey	Number of interviewed delivery service providers (weighted)[2]
Type of facility					
Hospital	34	60	22	13	464
Health centre	25	67	10	23	248
Maternity	43	78	33	10	115
Clinic	32	69	14	25	1
Dispensary	12	80	12	2	52
Managing authority					
Government	38	61	22	13	484
NGO	15	66	6	3	21
Private (for-profit)	30	71	23	8	158
Faith-based organisation	18	70	12	23	218
Province					
Nairobi	49	74	39	12	145
Central	55	41	16	11	98
Coast	37	61	28	11	66
Eastern	28	72	18	15	122
North Eastern	24	49	11	5	7
Nyanza	22	81	17	29	152
Rift Valley	20	48	10	8	198
Western	18	85	13	14	93
Total	31	65	19	15	881

[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-6.43.1 Supportive management: in-service training for delivery service providers: delivery and newborn care

Among interviewed delivery service providers, percentage who received in-service training on specific topics (delivery and newborn care) during the past 12 months or 13-35 months preceding the survey, by type of facility, managing authority, and province, Kenya SPA 2004

Background characteristics	Percentage of interviewed service providers who received in-service training on specific topics																Number of interviewed delivery service providers (weighted)
	Labor/delivery care		Use of partograph		Life-saving skills		Post-abortion care		Maternal clinical audit		Exclusive breast-feeding		Care of normal newborn		Neonatal resusci-tation		
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility																	
Hospital	10	11	10	10	10	10	6	9	5	5	11	9	9	9	10	8	464
Health centre	3	9	2	9	2	9	1	9	1	6	5	11	4	13	3	10	248
Maternity	11	21	8	20	14	16	7	19	5	10	8	14	8	15	8	14	115
Clinic	15	27	13	29	11	29	15	24	8	21	3	21	5	24	5	28	1
Dispensary	4	2	4	2	4	2	2	2	2	2	4	0	2	0	4	0	52
Managing authority																	
Government	8	11	6	11	8	9	4	10	4	6	9	8	6	9	6	8	484
NGO	3	7	5	4	5	5	5	4	4	3	5	9	2	12	8	7	21
Private (for-profit)	10	14	13	12	10	13	8	12	6	5	10	14	9	15	12	13	158
Faith-based organisation	6	10	5	10	6	9	3	8	2	5	6	10	8	10	8	9	218
Province																	
Nairobi	13	17	11	17	16	14	8	16	8	10	10	14	9	13	12	12	145
Central	2	10	2	10	2	11	1	9	1	8	3	7	3	7	3	7	98
Coast	11	10	11	8	10	8	10	7	7	3	17	11	13	13	12	10	66
Eastern	7	10	7	9	6	9	3	7	2	3	8	9	8	9	9	9	122
North Eastern	13	6	13	6	13	6	4	5	3	4	12	6	12	6	13	6	7
Nyanza	7	12	7	10	6	5	4	6	4	2	10	8	8	11	7	9	152
Rift Valley	7	11	5	10	6	12	2	12	2	6	6	8	4	7	5	7	198
Western	9	10	8	10	10	9	7	8	4	7	8	13	7	13	8	12	93
Total	8	12	7	11	8	10	5	10	4	6	8	10	7	10	8	9	881

Table A-6.43.2 Supportive management: in-service training for delivery service providers: PMTCT and HIV/AIDS

Among interviewed delivery service providers, percentage who received in-service training on specific PMTCT and HIV/AIDS topics during the past 12 months or 13-35 months preceding the survey, by type of facility, managing authority and province, Kenya SPA 2004

	Percentage of interviewed service providers who received in-service training on specific topics						Number of interviewed delivery service providers (weighted)
	PMTCT[1]		Nutrition counselling for mothers with HIV/AIDS		Obstetric practices for HIV/AIDS		
Background characteristics	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility							
Hospital	26	11	25	10	22	10	464
Health centre	22	19	21	10	21	9	248
Maternity	30	7	24	7	20	7	115
Clinic	19	0	8	0	14	3	1
Dispensary	10	0	3	0	3	0	52
Managing authority							
Government	32	11	29	10	26	9	484
NGO	14	1	3	9	6	7	21
Private (for-profit)	21	7	17	5	18	5	158
Faith-based organisation	12	21	12	10	11	10	218
Province							
Nairobi	39	12	32	13	30	12	145
Central	53	8	53	4	49	6	98
Coast	24	5	24	3	19	3	66
Eastern	24	14	19	13	15	11	122
North Eastern	9	3	6	3	7	3	7
Nyanza	14	28	11	14	10	11	152
Rift Valley	16	5	16	4	14	4	198
Western	12	11	10	10	12	10	93
Total	25	12	22	9	20	8	881

[1] Prevention of mother-to-child transmission

Table A-6.44 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, managing authority and province, Kenya 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 delivery service providers who were supervised in past 6 months[1]
		Deliver supplies	Checked records	Observed work	Provided feedback	Verbal praise	Written praises	Provided updates	Discussed problems	Other	
Type of facility											
Hospital	8	48	91	91	90	84	33	59	88	19	277
Health centre	6	32	99	81	92	83	37	62	88	12	166
Maternity	2	39	93	93	52	52	15	48	64	1	90
Clinic	4	53	84	81	61	61	52	72	86	12	1
Dispensary	3	64	94	100	96	94	88	80	100	4	42
Managing authority											
Government	4	44	92	90	88	81	38	64	88	13	298
NGO	11	46	96	96	95	93	88	61	97	16	14
Private (for-profit)	2	30	97	93	63	58	27	56	65	5	112
Faith-based organisation	8	51	96	84	96	92	31	54	94	19	152
Province											
Nairobi	2	52	91	91	87	83	22	64	92	7	107
Central	3	43	89	87	94	85	62	55	80	11	41
Coast	11	33	94	89	85	71	35	80	93	22	40
Eastern	10	51	98	92	92	86	21	46	94	35	88
North Eastern	4	68	87	90	74	68	44	52	100	19	3
Nyanza	3	25	94	93	67	66	25	41	67	11	123
Rift Valley	2	47	95	93	92	81	56	66	84	8	95
Western	6	49	96	73	93	91	45	82	93	2	79
Total	5	43	94	89	85	80	35	59	85	13	576

[1] Includes only providers of delivery services in facilities where delivery services are offered

Chapter 7

Table A-7.1 Availability of system components, infrastructure, and resources to support quality services for sexually transmitted infections

Percentage of facilities where the indicated systems and items to support quality counselling and examination are present, by type of facility, Kenya SPA 2004

Systems and items to support quality services for STIs	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispensary	Total[8]
Items to support utilisation of STI services						
Active partner follow-up system	23	27	30	18	11	18
Passive partner follow-up system	69	64	41	68	71	67
No follow-up system for partners	8	9	28	14	18	15
Items to support quality counselling						
Visual and auditory privacy	95	88	81	79	87	87
Visual privacy only	4	4	15	18	12	9
No privacy	1	8	4	3	2	3
Any guidelines for STIs	77	89	64	56	71	76
Guidelines for syndromic diagnosis STIs	71	84	62	54	66	72
Any visual aids or educational materials for STIs	58	51	57	43	52	52
Educational materials specific for HIV/AIDS	47	25	38	33	32	31
Condoms at service delivery site	53	62	52	54	61	60
Condoms anywhere in facility	73	81	81	64	68	73
All items to support quality counselling[1]	33	35	26	21	30	31
Items for infection control						
Soap	86	71	73	80	72	73
Water	93	92	90	95	94	93
Clean latex gloves	89	86	88	92	100	94
Disinfecting solution for contaminated equipment	40	42	55	40	49	46
Sharps box	81	77	84	77	93	87
All items for control of infection[2]	30	31	48	32	32	32
Waste receptacle	50	38	57	30	26	33
All items for control of infection plus waste receptacle	17	17	27	12	10	14
Items for physical examination						
Visual and auditory privacy[3]	96	83	83	81	84	84
Visual privacy[4]	4	7	17	18	13	11
Examination bed[5]	95	101	100	99	100	100
Examination light[6]	53	18	45	45	19	23
All items for examination	51	17	39	38	14	19
All items for infection control and physical examination[7]	19	12	29	14	3	8
Number of facilities offering STI services (weighted)[8]	28	121	19	8	227	403

[1] Visual and auditory privacy (private room), any guidelines, any visual aids or educational materials, and condoms in 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.
[8] Totals include data from one stand-alone VCT centre (weighted).

Table A-7.2 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, Kenya SPA 2004

	Percentage by type of facility					
Items and medicines	Hospital	Health centre	Maternity	Clinic	Dispensary	Total[7]
Items for etiologic examination						
Vaginal speculum	53	56	70	52	57	57
Swab stick for specimen	39	30	36	20	11	20
Syphilis test capacity[1]	90	46	75	60	29	41
Gonorrhoea test capacity[2]	81	23	53	43	16	25
Chlamydia test capacity[3]	15	0	1	0	0	1
Wet mounting test capacity[4]	96	61	77	71	37	51
HIV/AIDS testing capacity[5]	88	14	41	26	11	19
All five laboratory tests	15	0	0	0	0	1
Medicines for treatment						
Metronidazole (trichomoniasis)	98	86	96	86	87	88
Ceftriaxone (gonorrhoea)	48	25	23	13	2	13
Ciprofloxacin (gonorrhoea)	38	16	38	38	12	17
Doxycycline (chlamydia, syphilis)	94	88	76	74	85	85
Tetracycline (chlamydia, syphilis)	34	15	60	40	22	23
Erythromycin (chlamydia, syphilis)	87	53	58	54	62	61
Penicillin, benzathine (syphilis)	96	94	96	89	79	86
Penicillin, procaine (syphilis)	50	68	66	69	79	73
All medicines for sexually transmitted infections[6]	55	30	46	41	13	24
Nystatin or miconazole suppository (candidiasis)	30	24	18	32	13	18
Number of facilities offering STI services (weighted)[7]	28	121	19	8	227	403

[1] Either VDRL test and functioning microscope, or RPR (rapid plasma reagin) test kit.
[2] Gram stain reagents and functioning microscope and glass slides or culture capacity.
[3] Giemsa stain for Chlamydia and functioning microscope and glass slides
[4] Functioning microscope and glass slides.
[5] ELISA, Western Blot, or Rapid test.
[6] At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis.
[7] Totals include data from one stand-alone VCT centre (weighted)

Table A-7.3 Information on user fees for services for sexually transmitted infections

Percentage of facilities with user fees for STI services and among those with user fees, percentage where each of the indicated fee systems is utilized, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities charging for the indicated item:					Number of facilities offering STI services (weighted)	Number of facilities having any user fees for STI services (weighted)
	Client chart or record	Consultation	Medicines	Tests	No charges or don't know		
Type of facility							
Hospital	31	38	46	55	33	28	19
Health centre	32	26	35	21	33	121	82
Maternity	18	61	70	64	14	19	16
Clinic	16	57	74	61	10	8	7
Dispensary	29	23	23	24	40	227	137
Managing authority							
Government	34	11	9	2	49	224	115
NGO	0	15	34	38	62	16	6
Private (for-profit)	14	53	61	50	21	59	46
Faith-based organisation	32	50	62	70	11	104	93
Province							
Nairobi	33	70	44	45	19	34	27
Central	47	13	20	20	33	45	30
Coast	15	50	26	26	22	48	38
Eastern	48	3	40	34	19	73	59
North Eastern	15	10	13	13	78	7	2
Nyanza	29	31	58	36	30	54	37
Rift Valley	17	25	18	20	52	115	55
Western	26	28	31	31	54	29	13
Total	29	27	31	28	35	403	260

[1] Totals include data from one stand-alone VCT centre (weighted)

Table A-7.4 Supportive management of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received the indicated supportive management practices, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage receiving indicated supportive management practices: Received in-service training during the past 12 months	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 13-35 months preceding survey	Number of interviewed providers of STI services (weighted)[1,2]
Type of facility					
Hospital	76	60	47	24	337
Health centre	60	64	33	40	321
Maternity	85	72	60	15	67
Clinic	71	65	44	29	8
Dispensary	63	72	48	37	221
Managing authority					
Government	70	64	45	30	605
NGO	75	79	60	25	29
Private (for-profit)	74	64	47	26	132
Faith-based organisation	58	68	36	42	192
Province					
Nairobi	71	66	46	29	159
Central	69	42	25	31	113
Coast	85	54	50	15	108
Eastern	71	66	44	29	154
North Eastern	63	60	40	37	12
Nyanza	67	82	50	33	120
Rift Valley	56	68	41	44	216
Western	71	78	54	29	76
Total[2]	68	65	44	32	957

[1] Includes only providers of STI services in facilities where STI services are offered in any assessed clinic
[2] Totals include data from three providers from stand-alone VCT centres (weighted)

Table A-7.5 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 13-35 months preceding the survey, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of interviewed providers who received in-service training on specific topics								Number of interviewed STI service providers (weighted)[2,3]
	Any diagnosis and treatment for STIs		Syndromic approach for diagnosing and treating STIs		Any course related to HIV/AIDS		Specific course related to PMTCT[1]		
	12m	13-35m	12m	13-35m	12m	13-35m	12m	13-35m	
Type of facility									
Hospital	18	25	16	23	64	36	32	10	337
Health centre	10	30	9	28	53	47	24	15	321
Maternity	26	24	19	24	81	19	34	12	67
Clinic	21	20	18	22	65	35	22	3	8
Dispensary	23	21	19	22	45	55	20	3	221
Managing authority									
Government	14	22	12	21	60	40	27	7	605
NGO	10	28	10	12	73	27	15	8	29
Private (for-profit)	28	18	23	19	68	32	28	7	132
Faith-based organisation	22	40	18	41	40	60	27	24	192
Province									
Nairobi	14	24	11	18	58	42	34	12	159
Central	11	5	7	9	62	38	35	5	113
Coast	17	32	15	29	73	27	22	4	108
Eastern	15	23	15	22	60	40	29	9	154
North Eastern	11	16	11	14	62	38	10	6	12
Nyanza	19	47	17	49	59	41	21	31	120
Rift Valley	22	23	19	22	44	56	24	3	216
Western	19	27	16	30	56	44	19	13	76
Total[3]	17	25	15	25	58	42	27	10	957

[1] Prevention of mother-to-child transmission (of HIV/AIDS).
[2] Includes only providers of STI services in facilities where STI services are offered in any assessed clinic
[3] Totals include data from three providers from stand-alone VCT centres (weighted)

Table A-7.6 Supportive supervision for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs) who were personally supervised in the 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, managing authority and province, Kenya 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 STI service providers who received supervision in past 6 months (weighted)[1,2]
		Deliver supplies	Checked records	Observed work	Provided feedback	Verbal praise	Written praises	Provided updates	Discussed problems	Other	
Type of facility											
Hospital	4	47	94	89	90	85	31	67	89	8	203
Health centre	3	50	98	88	90	78	36	60	89	8	204
Maternity	7	56	97	92	74	74	27	75	95	2	49
Clinic	2	31	91	82	79	70	42	68	77	7	5
Dispensary	3	63	94	92	89	82	59	72	91	11	159
Managing authority											
Government	4	57	96	88	87	80	38	65	91	10	384
NGO	3	35	98	96	80	77	54	48	97	10	23
Private (for-profit)	7	41	97	93	93	84	39	87	91	2	84
Faith-based organisation	3	51	92	92	92	82	44	61	85	6	131
Province											
Nairobi	7	46	92	90	90	87	29	73	94	1	105
Central	4	60	96	90	94	77	55	71	96	19	47
Coast	5	67	97	83	83	69	38	79	91	6	58
Eastern	4	55	100	91	94	83	45	68	91	10	101
North Eastern	5	63	93	88	84	84	44	65	85	11	7
Nyanza	3	44	93	91	88	85	30	56	91	13	98
Rift Valley	3	54	97	92	84	77	48	63	85	7	147
Western	3	52	93	86	88	85	35	63	88	5	59
Total[2]	4	53	96	90	88	81	40	66	90	8	622

[1] Includes only providers of STI services in facilities where STI services are offered in any assessed clinic
[2] Totals include data from two providers from stand-alone VCT centres (weighted)

Table A-7.7 Utilization of services for sexually transmitted infections and sources of data on sexually transmitted infections

Median average monthly number of clients for sexually transmitted infections (STIs) by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Median average number of STI clients per month[1]	Number of facilities reporting statistics (weighted)[2]
Type of facility		
Hospital	26	19
Health centre	16	95
Maternity	-	8
Clinic	-	4
Dispensary	-	167
Stand-alone VCT	-	0
Managing authority		
Government	12	192
NGO	16	14
Private (for-profit)	-	24
Faith-based organisation	-	64
Province		
Nairobi	27	17
Central	17	31
Coast	13	37
Eastern	-	62
North Eastern	34	3
Nyanza	12	25
Rift Valley	-	93
Western	14	26
Total	11	293

[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-7.8 Observed consultation for clients with symptoms of sexually transmitted infections

Among observed clients with symptoms of sexually transmitted infections (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, Kenya SPA 2004

	Percentage by type of facility			
Content of consultation	Hospital	Health centre	Dispensary	Total
Reassured about confidentiality	83	63	100	80
Client history elicited				
Client symptoms	99	100	100	100
How long symptoms have been present	93	88	81	86
History of recent sexual contact	80	75	84	78
Symptoms in partner	75	82	65	73
Partner status[1]	76	91	66	78
All elements of client history[2]	59	51	57	53
Types of laboratory tests				
Any laboratory test	45	25	53	39
Any blood test	26	9	45	25
HIV test	9	0	0	2
Microscopic examination of specimen	4	4	0	9
Examination				
Physical examination (male)	27	23	67	40
Number of observed male STI clients	5	19	12	38
Physical examination (female)	32	20	21	22
Number of observed female STI clients	12	32	30	78
Number of observed STI clients (weighted)[3]	18	52	43	116

[1] Monogamous, multiple partners, nonmonogamous partners, etc.
[2] Client symptoms, how long symptoms have been present, history of recent sexual contacts, symptoms in partner, and partner status.
[3] Totals include data from two maternity facilities (weighted) and two clinics (weighted)

Table A-7.9 Observed pelvic examination for female sexually transmitted infections clients

Among observed clients examined for sexually transmitted infections (STIs) who received pelvic examination, percentage for whom the indicated items were components of the examination, by type of facility, Kenya SPA 2004

Content of consultation and pelvic examination	Percentage by type of facility					
	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Provider treatment of client						
Visual privacy assured	100	100	100	100	100	100
Auditory privacy assured	95	100	100	38	100	98
Explained procedure before starting	86	100	100	100	100	97
Asked client to relax	60	50	100	0	100	71
Infection control procedure						
Provider washed hands with soap prior to examination	42	0	100	62	64	36
Provider wore clean gloves	95	100	100	100	100	99
Provider washed hands after removing gloves	72	100	100	62	100	93
General examination						
Inspect labia	80	100	100	38	100	94
Used speculum	50	25	0	100	0	22
Number of observed female STI client examinations (weighted)	4	6	0	0	6	18
Procedures for speculum examination						
Used sterilised or HLD instruments	61	0	-	0	-	32
Prepared all instruments before starting	44	0	-	0	-	23
Used items placed in decontaminating solutions	38	0	-	100	-	26
Contaminated surfaces wiped with disinfectant	46	0	-	0	-	24
Procedures utilised						
Explain speculum procedure	13	0	-	0	-	7
Inspect cervix	70	0	-	0	-	37
Performed bimanual examination	49	100	-	0	-	67
Number of observed clients with speculum examination (weighted)	2	2	0	0	0	4

Table A-7.10 Observed testing and counselling for clients assessed for sexually transmitted infections

Among clients whose consultation for sexually transmitted infections (STIs) was observed, percentage for whom the indicated items were components of counselling, by type of facility, Kenya SPA 2004

Components of counselling and health education	Percentage by type of facility			
	Hospital	Health centre	Dispensary	Total
Components of counselling				
Any mention of client diagnosis	90	82	81	82
Any mention of relationship between the infection and sexual activity	88	88	92	89
Client received prescription or medication	94	100	100	98
Client received prescription or medication for sexual partner	28	8	10	12
Client instructed about medications	85	89	100	91
Partner referral encouraged	83	90	82	84
Follow-up appointment discussed	89	76	95	85
Health education:risk of HIV/AIDS mentioned	65	57	56	57
Components of health education				
Discuss condoms for prevention	69	68	35	55
Instruct how to use condom	44	15	10	17
Offer condoms	28	38	0	21
Any discussion of condoms or HIV/AIDS	81	77	61	70
Wrote on client health card	97	100	100	99
Number of observed STI consultations (weighted)[1]	18	52	43	116

[1] Totals include data from two maternities (weighted) and two clinics (weighted)

Table A-7.11 Information from client exit interviews: reported knowledge and experience related to condom use

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percentage where the indicated information was reported by the client, Kenya SPA 2004

Information provided	Percentage of clients
Client and partner have used condom before	38
Client agrees indicated item may be a major contributing factor to lack of use of condoms	
Embarrassing to purchase	22
Problem with disposal	7
Embarrassing to discuss with partner	18
Reduces own sexual satisfaction	13
Reduces partner's sexual satisfaction	18
Client identified any of the above items as contributing to lack of use of condoms	47
Health workers talked about condoms today	7
Client received condoms today	13
Number of interviewed STI clients	114
Among clients who reported any items as contributing to lack of use of condoms, percentage who discussed the issue with provider	59
Number of interviewed STI clients who identified an item as contributing to lack of use of condoms (weighted)	54

Table A-7.12 Client feedback on services

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percentage who said that they considered specific items as large problems for them the day of the visit, by type of facility, Kenya SPA 2004

	Percentage by type of facility			
Reported (large) problems	Hospital	Health centre	Dispensary	Total[1]
Behavior/attitude of provider	2	11	0	5
Inability to discuss problem	1	0	5	2
Insufficient explanation about child's illness	2	3	5	4
Waiting time to see provider	25	23	32	26
Quality of examination and treatment	1	6	0	4
Availability of medicines	9	3	0	3
Days facility is open	6	6	8	7
Hours facility is open	8	19	8	13
Cleanliness of facility	3	0	0	1
Insufficient visual privacy	1	6	5	5
Insufficient auditory privacy	0	9	5	7
Number of interviewed ANC clients (weighted)[1]	17	52	43	114

[1] Totals include data from one client from maternity facility (weighted) and one client from clinic (weighted)

Table A-7.13 Client choice of facility

Among interviewed STI clients, percentage who reported this was not the closest health facility to their home, and among these, the main reasons they did not go to the nearest facility, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of interviewed STI clients who report this is not the closest facility to their home	Number of interviewed STI clients (weighted)	Percentage of STI clients mentioning the indicated item was a problem with the nearest facility							Number of interviewed STI clients for whom this was not the closest facility (weighted)[1]
			Inconvenient operating hours	Bad reputation	Don't like personnel	No medicines	Prefer anonymity	More expensive	Was referred to this facility	
Type of facility										
Hospital	57	17	7	4	2	11	14	23	8	10
Health centre	33	52	0	0	7	17	0	38	19	17
Dispensary	64	43	0	0	30	31	0	26	13	27
Managing authority										
Government	42	83	2	1	28	11	4	25	11	35
Faith-based organisation	75	26	0	0	0	43	0	36	18	19
Province										
Nairobi	63	28	0	0	0	0	0	59	39	18
Central	77	2	0	6	0	7	25	48	13	2
Coast	32	9	0	0	0	93	0	0	0	3
Eastern	98	9	0	1	96	2	0	0	1	9
Nyanza	53	22	4	7	0	77	0	4	0	12
Rift Valley	34	28	2	0	0	2	8	40	1	9
Western	21	16	0	4	35	3	7	20	11	3
Total[1]	48	114	1	2	17	22	2	29	14	55

[1] Totals include data from one client from maternity (weighted), one client from clinic (weighted), and one client from private (for-profit) facility (weighted)

Table A-7.14 Education status and literacy status of STI clients

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percent distribution by education status, and among STI clients with primary or no education, percent distribution by literacy status, according to type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Among interviewed STI clients, percentage with: No education	Primary	Pre-paratory	Secon-dary or higher	Number of interviewed STI clients (weighted)	Percentage of interviewed STI clients with primary or no education who: Cannot read or write	Can read, cannot write	Can read and write	Missing	Number of STI clients with primary or no education (weighted)[1]
Type of facility										
Hospital	5	47	27	21	17	8	1	83	8	9
Health centre	23	62	6	9	52	34	3	60	4	44
Dispensary	16	66	8	10	43	19	7	74	0	35
Managing authority										
Government	14	62	9	14	83	21	6	70	3	64
Faith-based organisation	19	66	14	0	26	27	0	72	1	22
Province										
Nairobi	18	56	25	1	28	17	0	75	8	21
Central	0	45	50	5	2	0	0	100	0	1
Coast	68	30	0	2	9	67	0	31	2	9
Eastern	1	51	0	48	9	2	0	98	0	5
Nyanza	0	83	12	5	22	1	0	99	0	18
Rift Valley	24	58	4	14	28	44	0	54	2	23
Western	11	69	5	14	16	18	31	50	0	13
Total[1]	18	61	11	11	114	25	4	68	3	90

[1] Totals include data from one client from maternity (weighted), one client from clinic (weighted), and four clients from private (for-profit) facility (weighted)

Table A-7.15 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, Kenya SPA 2004

	Percentage by type of facility					
Items and medicines to provide TB services	Hospital	Health centre	Maternity	Clinic	Dispen-sary	Total
Ability to conduct microscopic sputum exam[1]	97	66	80	100	44	63
Ability to stain sputum for TB diagnosis[2]	91	57	58	74	41	55
Availability of medicines						
Isoniazid (INH)	29	27	0	19	17	22
Pyrazinamide	24	21	0	29	12	17
Rifampin	33	30	8	29	28	29
Ethambutol	73	72	10	53	82	73
Rematazid (rifampin & INH)	66	43	12	32	55	49
Isoniazid+rifampin+pyrazinamide (RHZ,Rifater)	68	66	14	38	87	72
Streptomycin	73	28	39	38	21	32
Pre-packed DOTS TB drugs	29	35	15	30	34	33
All first-line treatment available[3]	84	70	21	53	79	73
All first and second-line treatment available [4]	70	23	21	38	14	26
Number of facilities providing TB services (weighted)	26	82	9	2	74	192
Facility has DOTS and all first-line treatment medicines in stock	87	86	49	100	94	89
Total number of facilities providing TB services and has DOTS	22	56	1	1	39	119
Facility does not have DOTS and has all first-line treatment medicines in stock	67	35	19	17	63	48
Total number of facilities providing TB services but does not have DOTS	4	25	8	1	35	73

[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

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Appendix D Survey Instruments

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Facility Inventory Questionnaire

1. Facility Identification

001	Name of the facility: _____	QTYPE	I N V
002	Location of the facility: _____	FACILITY CODE	
003	Province _____	PROVINCE NUMBER	
004	District _____	DISTRICT NUMBER	
005	Facility Number	FACILITY NUMBER	
006	Type of health facility: NATIONAL REFERRAL HOSPITAL 01; PROVINCIAL HOSPITAL 02; DISTRICT HOSPITAL 03; SUB-DISTRICT HOSPITAL 04; HOSPITAL 05; CLINIC 06; HEALTH CENTER 07; DISPENSARY 08; MATERNITY 09; STAND-ALONE VCT 10; OTHER _____ (SPECIFY) 96	FACILITY TYPE	
007	Managing authority: GOVERNMENT 01; NGO 02; PRIVATE (FOR-PROFIT) 03; MISSION 04; OTHER _____ (SPECIFY) 96	MANAGING AUTHORITY	

2. Information About Interview

008	Date: _____	DAY	
		MONTH	
		YEAR	
009	Name of the Interviewer: _____	INTERVIEWER CODE	
	Time interview started: _____	HOUR	
		MINUTES	

010	Number of questionnaires completed at facility:		Questionnaire Type		
	1	Sick Child Observations	CHILD OBSERVATION		
	2	Sick Child Caretaker Exit Interviews	SICK CHILD CARETAKER 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	Health Worker Interviews	HEALTH WORKER INTERVIEWS		
	10	Self-Administered Health Worker Interviews	SELF-ADMIN HEALTH WORKER . . .		
	11	Maternal Health Provider Knowledge	MATERNAL HEALTH KNOWLEDGE . .		
	12	Child Health Provider Knowledge	CHILD HEALTH KNOWLEDGE		
	13	Normal Delivery Record Review	NORMAL DELIVERY RECORD REV		
	14	Maternity Statistics/Complications	MATERNITY STATISTICS		

1 TURN GPS MACHINE ON AND WAIT UNTIL SATELLITE PAGE CHANGES TO “POSITION.”

2 WRITE ALTITUDE.

3 PRESS MARK.

4 HIGHLIGHT “AVERAGE” AND PRESS “ENTER.”

5 HIGHLIGHT “WAYPOINT NUMBER” AND PRESS “ENTER.”

6 ENTER FACILITY NUMBER (SIX DIGITS).

7 WAIT 5 MINUTES.

8 HIGHLIGHT “SAVE” AND PRESS “ENTER.”

9 PAGE TO MAIN MENU, HIGHLIGHT “WAYPOINT LIST,” AND PRESS “ENTER.”

10 HIGHLIGHT YOUR WAYPOINT.

11 COPY INFORMATION FROM WAYPOINT LIST PAGE—THIS IS THE AVERAGE OF ALL THE SATELLITE READINGS.

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

GPS INFORMATION

011	WAYPOINT NAME	NAME . . . . .
012	ALTITUDE	ALTITUDE . . . . .
013	LATITUDE	N/S . . . . . a ☐ DEGREES/DECIM. b ☐☐ c ☐☐☐☐☐
014	LONGITUDE	E/W . . . . . a ☐ DEGREES/DECIM. b ☐☐ c ☐☐☐☐☐

1. General Information

FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:

Hello. My name is _____. We are here on behalf of the NCPD and the MOH carrying out a survey of health facilities that provide services to women and children, with the goal of finding ways to improve the delivery of services. In addition, we want to ask about services for specific infectious diseases, such as tuberculosis, sexually transmitted infections, and HIV/AIDS. Your facility was randomly selected to participate in this study. In addition to asking about maternal and child health services, we will be asking you questions about the types of HIV/AIDS-related care and support services provided in this facility.

We will ask to see patient registers however no patient names from the registers will be reviewed, recorded, or shared.

You may decline to answer any question or choose to stop the interview at any time.

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

Please be assured that the information you give us will be completely confidential and will not be traced to you and will not be identified with the name of the facility.

Do you have any questions for me? May I continue?

_____ _____

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

Date

100	May I begin the interview?	YES . . . . . 1 NO 2	→ STOP

First I would like to ask you some general questions about how this facility is organized, and what infrastructure and resources are available. Then I will have some specific questions about HIV/AIDS services that may be provided from this facillity.

101	In addition to regular healthcare services, does the facility ever provide services for clients who are known or suspected to be HIV/AIDS infected or to have HIV/AIDS related illnesses?	YES . . . . . 1 NO 2	→ 103
102	Is there one person who is responsible overall for services specifically related to HIV/AIDS services? IF YES, ASK THE NAME AND ASK IF THAT PERSON CAN BE CALLED TO PARTICIPATE IN THE GENERAL DISCUSSION. IF THERE IS A DIFFERENT PERSON FOR INPATIENT AND FOR OUTPATIENT SERVICES RELATED TO HIV/AIDS ASK FOR THE PERSON MOST KNOWLEDGABLE ABOUT OUTPATIENT SERVICES RELATED TO CARE AND SUPPORT FOR HIV/AIDS CLIENTS WHO IS AVAILABLE TODAY. WHILE THE HIV/AIDS PERSON IS BEING CALLED, CONTINUE WITH Q103.	YES, _____ . . . 1 NAME OF HIV/AIDS SERVICE PERSON RESPONSIBLE NO ONE PERSON RESPONSIBLE FOR HIV/AIDS SERVICES 2	

2. Information About Services			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
103	How many days each week is the facility routinely open for outpatient curative services?	NUMBER OF DAYS . . . . . ☐ DON'T KNOW 8	
104	Is there a trained health provider assigned to and present at the facility at all times (24 hours a day) for emergencies? IF YES, ASK TO SEE DUTY SCHEDULE.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	→ 107
105	Is there a trained health provider available away from the facility but officially on call, at all times, after hours? IF YES, ASK TO SEE ON-CALL DUTY SCHEDULE.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . 2 NO 3	→ 107
106	Does a trained health provider live on the facility premises?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
107	Now I have some questions about staffing for this facility. Please tell me how many staff with this qualification this facility is authorized to have, that is staffing norms, and then tell me how many staff with this qualification are actually in post and the additional number required. We want to know the highest technical qualification that any staff may hold (such as nurse or doctor) regardless of the person's administrative position or specialist studies after qualification or the actual work that they do. For example, if a nurse provides counseling, then the highest qualification is nurse, not counselor.				
	QUALIFICATION	(a) STAFFING NORMS	(b) ACTUAL # IN POST	(c) ADDITIONAL REQUIRED	
01	Obstetrician/Gynecologist				
02	Physician Specialist				
03	Surgeon				
04	Pediatrician				
05	Medical Doctor/Officer (GP)				
06	Clinical Officer				
07	Registered Nurse				
08	Registered Midwife				
09	Enrolled Nurse				
10	Enrolled Midwife				
11	Anesthesiologist/Anesthetist				
12	Clinical Officer Anesthetist				
13	Nurse Anesthetist				
14	Pharmacist				
15	Pharmaceutical Technologist				
16	Laboratory Technologist				
17	Laboratory Technician				
18	Nutritionist/Nutrition Technician				
19	Health Education Officer				
20	Record Technician/Statistical Clerk . .				
21	Health Administrative Officer				
22	Social Worker				
23	HIV/AIDS Counselor				
24	Other Counselor				
25	All other staff				
26	SUM THE NUMBER OF STAFF REPORTED IN COLUMNS (a), (b), AND COLUMN (c)				
	You have told me that there are (TOTAL STAFF) who are employed by this facility. Is this correct? IF NOT CORRECT, PROBE AND CHANGE ITEM 107 (01-25) AS NECESSARY.				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108	In addition to the above mentioned staff, does this facility have any people who are not officially assigned to the facility but who work routinely (either full or part time part time) and who provide client services? This might include seconded staff from other organizations or volunteers.	YES . . . . . 1 NO 2	→ 112
109	Please tell me the qualification of the people who are **seconded** to the facility and indicate if they work specifically with HIV/AIDS related services or with other services.	SERVICES: HIV/AIDS, OTHER DOCTOR . . . . NURSE . . . . . COUNSELOR . . LAB TECH/ ASSISTANT . . COMMUNITY WORKER . . . OTHER . . . . (SPECIFY)	
110	SUM THE NUMBER OF OTHER PEOPLE IN Q109 WHO WORK WITH THE FACILITY.	TOTALS	
111	How many of the seconded staff that you have identified are foreigners?	NUMBER OF FOREIGN SECONDED STAFF . . . DON'T KNOW 98	
112	Do you have an estimate of the size of the catchment population that this facility serves, that is, the target, or total population living in the area served by this facility? IF YES: How many people is that?	CATCHMENT POPULATION NO CATCHMENT AREA . . . . . 9999995 DON'T KNOW SIZE OF CATCHMENT POPULATION 9999998	
113	Does this facility have any specific youth friendly services (YFS)?	YES, SEPARATE SERVICE AREA 1 YES, WITH OTHER CLINICS/UNITS 2 NO 3	→ 120 → 120
114	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED, COMPLETE . . . 1 YES, OBSERVED, NOT COMPLETE 2 YES, REPORTED NOT SEEN . . . . . 3 NO 4	
115	Do you have a staff member who has had specific training for providing youth friendly services? IF YES, ASK: Is the staff member present today?	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . . 2 NO 3	
116	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. What are the key components of the youth friendly services that are offered in this clinic/unit? ASK FOR EACH ITEM. CIRCLE ALL THAT APPLY.	SERVICES IN SEPARATE ROOM . . . . . A DISCOUNT FEES . . . . . B NO FEES . . . . . C OTHER _____ X (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
117	Please tell me if you have educational materials for any topic I mention, and if yes, which type of materials you have.	(a) FLIPCHART 1=YES 2=NO; (b) BROCHURES/ PAMPHLETS 1=YES 2=NO; (c) POSTERS 1=YES 2=NO; (d) VIDEO 1=YES 2=NO CONTRACEPTION . . . . . ☐ ☐ ☐ ☐ HIV/AIDS . . . . . ☐ ☐ ☐ ☐ STIs . . . . . ☐ ☐ ☐ ☐ NUTRITION . . . . . ☐ ☐ ☐ ☐ PREGNANCY . . . . . ☐ ☐ ☐ ☐ ABORTION . . . . . ☐ ☐ ☐ ☐ OTHER _____ (SPECIFY) ☐ ☐ ☐ ☐	
118	Are any of the materials for health education targeted to youth?	YES . . . . . 1 NO 2	→120
119	Which topic or topics are targeted toward youth? CIRCLE ALL THAT APPLY.	CONTRACEPTION . . . . . A HIV/AIDS . . . . . B STIs . . . . . C NUTRITION . . . . . D PREGNANCY . . . . . E ABORTION . . . . . F OTHER _____ (SPECIFY) X NONE OF THE ABOVE . . . . . Y	
120	Does this facility routinely admit inpatients for treatment?	YES . . . . . 1 NO 2	→122
121	Does this facility have beds for overnight observation?	YES . . . . . 1 NO 2	→123
122	How many overnight and/or inpatient beds does this facility have?	NUMBER OF BEDS . . . . ☐☐☐ DON'T KNOW 998	
123	Does this facility run routine outreach/mobile clinics from the facility? IF YES, ASK WHICH SERVICES ARE OFFERED, AND CIRCLE ALL THAT APPLY	ANTENATAL CARE . . . . . A FAMILY PLANNING . . . . . B IMMUNIZATIONS . . . . . C ADULT CURATIVE CARE . . . . . D CHILD CURATIVE CARE . . . . . E TETANUS TOXOID (TT) . . . . . F HIV/AIDS TESTING . . . . . G NO OUTREACH/MOBILE SERVICES . . . . . Y DON'T KNOW . . . . . Z	→126 →126
124	How many different outreach/mobile clinic sites do you serve?	# OF OUTREACH MOBILE CLINICS ☐☐☐	
125	How many times is the same site visited over a 12-month period? If visits vary, provide an estimate of the most common practice.	☐☐☐ IN 12 MONTHS DON'T KNOW 998	
126	Does this facility have routine meetings for reviewing managerial or administrative matters? By this I mean Facility Management Team Meetings.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→128a →128a
127	How often do meetings to discuss the facility managerial and administrative matters take place?	MONTHLY OR MORE OFTEN . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS THAN EVERY 6 MONTHS OR IRREGULARLY . . . . . 4 OTHER _____ (SPECIFY) 6	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
128	Is an official record of management meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES OR NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO RECORD MAINTAINED 3	
128a	Does this facility hold Facility Management Board Meetings to discuss facility managerial and administrative matters?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 →129 →129
128b	How often are Facility Management Board Meetings held?	MONTHLY OR MORE OFTEN . . . 1 EVERY 2-3 MONTHS . . . . . 2 EVERY 4-6 MONTHS . . . . . 3 LESS THAN EVERY 6 MONTHS OR IRREGULARLY . . . . . 4 OTHER _____ 6 (SPECIFY)	
128c	Is an official record of management board meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES OR NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . 2 NO RECORD MAINTAINED 3	
129	Are there any *routine* meetings about facility activities or management issues that include both facility staff and community members?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 →130 →130
129a	Does the facility give feedback of its key management decisions to the community during such *routine* meetings?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
130	Does this facility have any system for the ***community*** to provide feedback on quality of services provided by the facility? IF YES, CIRCLE ALL METHODS THAT ARE USED	SUGGESTION BOX . . . . . A QUALITY ASSURANCE SURVEYS . B REVIEW OF GENERAL COMPLAINTS . . . . . C INVOLVEMENT OF COMMUNITY REPRESENTATIVES IN MEETINGS . . . . . D COMMUNITY DIALOGUE . . . . . E OTHER _____ X (SPECIFY) NO COMMUNITY FEEDBACK . . . . . Y DON'T KNOW . . . . . Z	
131	Does this facility have any system for determining clients' opinions about the health facility or its services? IF YES, CIRCLE ALL METHODS THAT ARE USED FOR ELICITING CLIENTS' OPINIONS.	SUGGESTION BOX . . . . . A CLIENT SURVEY FORM . . . . . B CLIENT INTERVIEW FORM . . . . C OFFICIAL MEETING WITH COMMUNITY LEADERS . . . . . D INFORMAL DISCUSSIONS WITH CLIENT OR COMMUNITY . . . . . E OTHER _____ X (SPECIFY) NO CLIENT FEEDBACK . . . . . Y DON'T KNOW . . . . . Z	 →134 →134
132	Is there a procedure for reviewing or reporting on clients' opinions? IF YES, ASK TO SEE A REPORT OR FORM ON WHICH DATA ARE COMPILED OR DISCUSSION IS REPORTED.	YES, REPORT SEEN . . . . . 1 YES, REPORT NOT SEEN . . . . . 2 NO 3	
133	In the past 3 months, have any changes been made in the program as a result of client opinion? IF YES, INDICATE IF THE CHANGE(S) ARE RELATED TO ANY OF THE LISTED TOPICS.	YES, CHANGE IN SERVICES OR TIMES OFFERED OR WAY SERVICES ARE PROVIDED . . . A YES, CHANGE FOR CLIENT CONVENIENCE . . . . . B OTHER _____ X (SPECIFY) NO . . . . . Y DON'T KNOW . . . . . Z	
134	Does this facility monitor quality of care? (THIS REFERS TO A *ROUTINE* PROGRAM FOR QUALITY ASSURANCE).	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 →138 →138

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
135	Is this system implemented throughout the facility or only in specific services?	THROUGHOUT FACILITY . . . . . 1 ONLY SPECIFIC SERVICES 2	

136 Are any of the following methods for quality assurance used?

IF YES: ASCERTAIN FOR EACH TYPE OF ACTIVITY WHETHER IT IS IMPLEMENTED ANYWHERE IN THE FACILITY, AND IF YES, ASK TO SEE SOME FORM OF DOCUMENTATION (SUCH AS A REPORT OR MINUTES) FOR THE METHOD IMPLEMENTED.

		METHOD USED			
		DOCUMENT OBSERVED	DOCUMENT REPORTED, NOT SEEN	METHOD NOT USED	DON'T KNOW
01	Supervisory checklist of health system components (such as service-specific equipment, medications, and records)	1	2	3	8
02	Supervisory checklist of health service provision (such as an observation checklist)	1	2	3	8
03	Facility-wide review of mortality	1	2	3	8
04	Periodic audit of medical records or service registers	1	2	3	8
05	Other _____ (SPECIFY)	1	2	3	8

137 Who is responsible for reviewing findings and taking action regarding quality assurance? FOR EACH OF THE LISTED OPTIONS, INDICATE WHICH RESPONSE BEST DESCRIBES THE RELATIONSHIP WITH QUALITY ASSURANCE.

		INTERNAL TO FACILITY	EXTERNAL TO FACILITY	BOTH INTERNAL AND EXTERNAL	NOT ACTIVE WITH QUALITY ASSURANCE	DK
01	Individual staff members	1	2	3	4	8
02	Individual supervisors	1	2	3	4	8
03	Management committee (MAY BE DISTRICT OR PROVINCIAL MANAGEMENT TEAM)	1	2	3	4	8
04	Special quality assurance committee or team	1	2	3	4	8
05	Special quality assurance staff	1	2	3	4	8
06	Other _____ (SPECIFY)	1	2	3	4	8

				GO TO
138	Are there any routine fees assessed for any services or items related to curative services for adults?	YES . . . . . 1 NO 2		→141
139	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES / NO	(b) AMOUNT IN KSH	
01	FEE FOR HEALTH RECORD/CHART	1→01b 2→02		
02	FEE FOR CONSULTATION SERVICE	1→02b 2→140		
140	Are the official fees posted so that the client can see them?	YES, ALL FEES POSTED . . . . . 1 YES, SOME, NOT ALL FEES POSTED . . . . . 2 NO POSTED FEES 3		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
141	Does this facility receive any funding that helps to cover the cost of services provided to a client other than from the routine running budget or direct client fees? This may include accepting payment from insurance programs, receiving reimbursement for services provided when fees were exempted or discounted. IF YES, INDICATE WHICH PLANS APPLY.	CENTRAL GOVENRMENT THROUGH MOH . . . . . A LOCAL GOVERNMENT/ AUTHORITY . . . . . B NATIONAL HEALTH INSURANCE FUND (NHIF) . . . . . C NATIONAL SOCIAL HEALTH INSURANCE FUND . . . . . D PREPAYMENT SCHEME . . . . . E EQUITY (CHARITY) FUND FOR POOR . . . . . F REIMBURSED BY EMPLOYER OF CLIENT . . . . . G INSURANCE . . . . . H DONORS . . . . . I REVOLVING FUND (BAMAKO TYPE) . . . . . J OTHER _____ X (SPECIFY) NO . . . . . Y DON'T KNOW . . . . . Z	
142	When was the last time a supervisor from outside this facility came here to visit?	WITHIN THE PAST 6 MONTHS . . . . 1 MORE THAN 6 MONTHS AGO . . . . 2 NEVER SUPERVISED FROM OUTSIDE FACILITY 3	→ 145 → 145
143	The most recent time during the past 6 months that a supervisor from outside the facility visited, did he or she:	YES NO DON'T KNOW	
01	Check some registers or books	CHECKED REGISTERS 1 2 8	
02	Discuss problems and solutions	DISCUSSED PROBLEM/SOLUTION . 1 2 8	
03	Discuss policy or administrative matters	DISCUSSED POLICY 1 2 8	
04	Discuss technical protocols or issues in service delivery practices	DISCUSSED TECH. MATTERS 1 2 8	
05	Hold an official staff meeting	STAFF MEETING 1 2 8	
06	Observe individual staff providing services	SERVICE OBSERVED 1 2 8	
07	Do anything else _____ (SPECIFY)	OTHER 1 2 8	
144	Is there a report from the last external supervisory visit? IF YES, ASK TO SEE REPORT(S)	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . 2 NO . . . . . 3 DON'T KNOW 8	
145	When you refer a client **to another facility** for services, do you use a referral form? IF YES, ASK TO SEE THE DOCUMENT.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . 2 NO 3	→ 147 → 147
146	Do you use any method to provide client information to the referral site or to help the client receive services from the referral site? IF YES, ASK: What method do you use?	PATIENT SENT WITH MEDICAL RECORDS/FILE . . . . . 1 CALL TO GIVE CLIENT INFO. 2 OTHER _____ . 6 (SPECIFY) NO METHOD USED 7	→ 148 → 148 → 148 → 148
147	Does the referral form have a section requiring clients' information explaining the reason for the referral?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
148	Does this facility have a backup generator? IF YES, ASK TO SEE THE GENERATOR.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . 2 NO . . . . . 3 DON'T KNOW 8	→ 150 → 150
149	Is the generator functional and is there fuel today?	YES, FUNCTIONAL WITH FUEL . . 1 YES, FUNCTIONAL, NO FUEL . . . 2 NOT FUNCTIONAL . . . . . 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
150	Does this facility ever obtain electricity from a source other than a backup generator?	YES, CENTRAL SUPPLY . . . . . 1 YES, SOLAR OR OTHER SOURCE . . . . . 2 NO 8	→ 153
151	Is the electricity (not including any backup generator) always available during the times when the facility is providing services, or is it sometimes interrupted?	ALWAYS AVAILABLE . . . . . 1 SOMETIMES INTERRUPTED 2	→ 153
152	IF SOMETIMES INTERRUPTED, ASK: How many *days* during the past week was the electricity *not available for at least 2 hours?*	NUMBER OF DAYS *NOT AVAILABLE* PAST WEEK . . . . . ☐ NEVER INTERRUPTED 2 HOURS OR MORE 0	
153	What is the *most commonly used* source of water for the facility *at this time?*	PIPED FROM PROTECTED SOURCE OFFSITE . . . . . 01 PIPED FROM OFFSITE UNPROTECTED SOURCE . . . . . 02 PIPED FROM OFFSITE, SOURCE UNKNOWN . . . . . 03 PROTECTED WELL OR BOREHOLE . . . . . 04 UNPROTECTED WELL OR BOREHOLE . . . . . 05 RIVER OR LAKE OR POND . . . . . 06 OTHER _____ 96 (SPECIFY) NO WATER SOURCE 00	→ 157
154	Is water outlet from this source available onsite (that is, within 500m of the facility?) REPORTED RESPONSE IS ACCEPTABLE.	YES, ONSITE . . . . . 1 NO 2	
155	Does the availability of this source of water for the facility vary by season?	YES . . . . . 1 NO 2	
156	Is there routinely a time of year when the facility has a severe shortage or lack of water?	YES . . . . . 1 NO 2	
157	Now I would like to ask you a few questions about the waste disposal practices for hazardous waste such as used bandages. How does this facility/clinic/unit finally dispose of potentially contaminated waste and items which are not reused, such as bandages?	BURNED IN INCINERATOR . . . . . 01 BURNED AND BURIED . . . . . 02 BURNED AND REMOVED TO OFFSITE DUMP . . . . . 03 BURNED AND NOT BURIED . . . . 04 THROWN IN TRASH/OPEN PIT . . . 05 THROWN IN PIT LATRINE . . . . . 06 REMOVED OFFSITE . . . . . 07 OTHER _____ 96 (SPECIFY)	
158	ASK TO SEE PLACE USED FOR DISPOSAL OF CONTAMINATED WASTE OR WHERE WASTE IS KEPT PRIOR TO REMOVAL OFFSITE. INDICATE IF THE WASTE IS VISIBLE AND/OR PROTECTED	WASTE VISIBLE, PROTECTED . . 1 WASTE VISIBLE, UNPROTECTED . . . . . 2 NO WASTE VISIBLE . . . . . 3 WASTE SITE NOT INSPECTED . . 4	
159	How does the facility/clinic/unit finally dispose of needles and other sharps?	SAME AS OTHER WASTE (Q157) . . 01 BURNED IN INCINERATOR . . . 02 BURNED AND BURIED . . . . . 03 BURNED AND REMOVED TO OFFSITE DUMP . . . . . 04 BURNED AND NOT BURIED . . . 05 THROWN IN TRASH/OPEN PIT . . 06 THROWN IN PIT LATRINE . . . . 07 REMOVED OFFSITE . . . . . 08 OTHER _____ 96 (SPECIFY)	→ 161

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
160	ASK TO SEE WHERE SHARP ITEMS ARE DISPOSED OF OR KEPT PRIOR TO REMOVAL OFFSITE. INDICATE IF THE WASTE IS VISIBLE AND/OR PROTECTED.	WASTE VISIBLE, PROTECTED . . . . 1 WASTE VISIBLE, UNPROTECTED . . . . . 2 NO WASTE VISIBLE . . . . . 3 WASTE SITE NOT INSPECTED. . . . 4	
161	CHECK Q157 AND 159, IS ANY WASTE REMOVED OFFSITE FOR DISPOSAL?	YES . . . . . 1 NO 2	→ 163
162	How is the waste that is collected and removed offsite finally disposed?	INCINERATED . . . . . 1 TAKEN TO LOCAL DUMP AND BURNED . . . . . 2 TAKEN TO LOCAL DUMP AND NOT BURNED . . . . . 3 OTHER _____ . . . 6 (SPECIFY) DON'T KNOW 8	
163	Is there a waiting area for clients where they are protected from sun and rain?	YES . . . . . 1 NO 2	
164	Is there a toilet (latrine) in functioning condition that is available for client use?	YES . . . . . 1 NO 2	
165	ASSESS GENERAL CLEANLINESS OF FACILITY. A FACILITY IS CLEAN IF THE FLOORS ARE SWEPT AND COUNTERS AND TABLES ARE WIPED AND FREE OF OBVIOUS DIRT OR WASTE. A FACILITY IS NOT CLEAN IF OBVIOUS DIRT OR WASTE OR BROKEN OBJECTS ARE ON THE FLOORS OR COUNTERS.	FACILITY CLEAN . . . . . 1 FACILITY NOT CLEAN 2	
166	Does this facility have a working phone or shortwave radio to call outside, that is available at all times client services are offered?	YES . . . . . 1 NO 2	→ 168
167	Is there a phone or shortwave radio within 5 minutes' distance from the facility that staff can use in an emergency? IF YES, ASK: Is that phone or shorwave radio available at all times services are offered?	YES . . . . . 1 NO, NOT AVAILABLE ALL CLINIC HOURS . . . . . 2 NO, NONE WITHIN 5 MINUTES . . . 3	
168	Does the facility have a computer? (REPORTED RESPONSE IS ACCEPTABLE) IF YES, ASK: Is the computer functioning today?	YES, FUNCTIONING . . . . . 1 YES, NOT FUNCTIONING . . . . 2 NO 3	→ 170
169	Is there access to email/internet within the facility? (REPORTED RESPONSE IS ACCEPTABLE)	YES . . . . . 1 NO 2	
170	Does this facility have a program for routine maintenance and repair of ***infrastructure?*** IF YES: Who is responsible for the maintenance?	YES, ONSITE STAFF . . . . . 1 YES, OUTSIDE SUPPORT . . . . . 2 YES, BOTH ONSITE AND OUTSIDE STAFF . . . . . 3 NO ROUTINE MAINTENANCE . . . 4 DON'T KNOW 8	
171	Does this facility have a program for routine preventive maintenance for major equipment such as a generator, refrigerator, and sterilization equipment? This means the equipment is checked periodically even if there is no problem. IF YES: Who is responsible for the maintenance?	YES, ONSITE STAFF . . . . . 1 YES, OUTSIDE SUPPORT . . . . . 2 YES, BOTH ONSITE AND OUTSIDE STAFF . . . . . 3 NO ROUTINE MAINTENANCE . . . 4 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
172	What is the system used for repairing or replacing small equipment (such as blood pressure cuffs or stethoscopes)? CIRCLE ALL THAT APPLY.	ONSITE MAINTENANCE . . . . . A PETTY CASH FOR REPLACING . . . . . B SEND ELSEWHERE FOR REPAIR . . . . . C OTHER _____ X (SPECIFY) NO SYSTEM . . . . . Y DON'T KNOW . . . . . Z	
173	Please tell me the commonest means of transport used by patients who are referred from other facilities to this facility with emergencies?	PRIVATE VEHICLES . . . . . A MATATU/BUS . . . . . B HAND CART . . . . . C ANIMAL-DRIVEN CART . . . . . D AMBULANCE . . . . . E WHEELBARROW . . . . . F STRETCHER . . . . . G BICYCLE . . . . . H OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
174	Does this facility have a functional ambulance/ vehicle for emergency transportation for clients?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 176 → 176
175	Is fuel available today?	YES, OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 NO FUEL AVAILABLE . . . . . 3 DON'T KNOW 8	
176	Please tell me what arrangements for financing emergency referral this facility has in place	FUNDS SET ASIDE FOR EMERGENCY TRANSPORT . . . A VEHICLE AVAILABLE LOCALLY FOR HIRE . . . . . B COMMUNITY HEALTH INSURANCE SCHEME . . . . . C FUEL SET ASIDE FOR EMERGENCY TRANSPORT . . . D REVOLVING FUND SPECIFICALLY FOR PREGNANT WOMEN . . . . . E OTHER _____ X (SPECIFY) NONE . . . . . Y DON'T KNOW . . . . . Z	
177	Who makes transport arrangements for emergency evacuation of patients from this facility?	FACILITY STAFF . . . . . 1 RELATIVES . . . . . 2 BOTH FACILITY STAFF AND RELATIVES . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
178	Does the facility make a vehicle available to pick patients from their homes/villages?	YES . . . . . 1 NO 2	
179	AT THIS TIME CHECK Q101 TO SEE IF THE FACILITY OFFERS HIV/AIDS RELATED SERVICES.	YES . . . . . 1 NO 2	 → 180
	AT THIS TIME, EXPLAIN TO THE DIRECTOR THAT REMAINING QUESTIONS RELATE SPECIFICALLY TO HIV/AIDS. EXPLAIN THAT YOU NEED TO VISIT ALL SERVICE AREAS WHERE CLIENTS RECEIVE ANY SERVICES RELATED TO HIV/AIDS. IF THE PERSON MOST KNOWLEDGEABLE ABOUT HIV/AIDS SERVICES AND CARE WAS NOT PRESENT DISCUSS WITH THE DIRECTOR THE BEST PERSON TO RESPOND TO REMAINING QUESTIONS ABOUT FACILITY LEVEL HIV/AIDS POLICIES AND WHO IS THE BEST PERSON TO INTRODUCE YOU TO THE CLINICAL CARE AND/OR SUPPORT SERVICE AREAS FOR OUTPATIENT AND FOR INPATIENT SERVICES. MAKE SURE THE DIRECTOR KNOWS THAT HE/SHE DOES NOT NEED TO ACCOMPANY YOU IF THERE IS SOMEONE ELSE WHO CAN INTRODUCE YOU. REASSURE HIM/HER THAT WHEN YOUR WORK IS COMPLETED YOU WILL RETURN TO PROVIDE A BRIEFING ON YOUR EXPERIENCES IN THE FACILITY. AT THIS TIME, COMPLETE QRE A FROM THE HIV/AIDS MODULES		→ QRE A

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	ASK THE RESPONDENT TO TAKE YOU TO THE MAIN AREA WHERE EQUIPMENT IS CLEANED AND STERILIZED OR DISINFECTED AND ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE PROCESSES USED.		
180	What procedure is used for ***decontaminating*** and ***cleaning*** equipment before its final processing for reuse? PROBE, IF NECESSARY FOR APPROPRIATE RESPONSE	SOAKED IN DISINFECTANT SOLUTION AND BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 1 BRUSH SCRUBBED WITH SOAP AND WATER AND THEN SOAKED IN DISINFECTANT . . . . . 2 BRUSH SCRUBBED WITH SOAP AND WATER ONLY . . . . . 3 SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED . . . . . 4 OTHER _____ (SPECIFY) 6 NONE . . . . . 7 DON'T KNOW 8	
181	*After cleaning,* what is the ***final*** *processing* method most commonly used for sterilizing or disinfecting reusable syringes and needles? CIRCLE ALL THAT APPLY.	DRY-HEAT STERILIZATION . . . . . A AUTOCLAVING . . . . . B STEAM . . . . . C BOILING . . . . . D CHEMICAL METHOD . . . . . E PROCESS OUTSIDE FACILITY . . . F OTHER _____ (SPECIFY) X NONE . . . . . Y	
182	*After cleaning, what are the* ***final*** *processes most* commonly used for sterilizing or disinfecting medical equipment, such as surgical instruments, before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE ALL OF THE METHODS.	DRY-HEAT STERILIZATION . . . . . A AUTOCLAVING . . . . . B STEAM . . . . . C BOILING . . . . . D CHEMICAL METHOD . . . . . E PROCESS OUTSIDE FACILITY . . . F → 193 OTHER _____ (SPECIFY) X NONE . . . . . Y → 196	

GO TO WHERE EQUIPMENT IS PROCESSED AND ASSESS THE AVAILABILITY OF ITEMS AND THE PROCEDURES FOLLOWED AT THE FACILITY.

	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
183	Electric dry heat sterilizer	1→183b	2→183b	3 ┐ 184 ↵	8 ┐ 184 ↵	1	2	8
184	Electric autoclave (pressure and wet heat)	1→184b	2→184b	3 ┐ 185 ↵	8 ┐ 185 ↵	1	2	8
185	Non-electric autoclave	1→185b	2→185b	3 ┐ 186 ↵	8 ┐ 186 ↵	1	2	8
186	Pot with cover (for steaming or boiling)	1	2	3	8			
187	Other _____ (SPECIFY)	1	2	3	8			
188	Heat source (stove or cooker with fuel or power present) for steaming, boiling, or using a non-electric autoclave	1→188b	2→188b	3 ┐ 189 ↵	8 ┐ 189 ↵	1	2	8
189	Automatic timer (MAY BE ON MACHINE)	1→189b	2→189b	3 ┐ 190 ↵	8 ┐ 190 ↵	1	2	8
190	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
191	Written guidelines for disinfection and sterilization	1	2	3	8			

192	FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED						
		(1) Dry heat sterilization	**(2)** Autoclave	**(3)** Boil or steam (high level disinfectant, HLD)	**(4)** Chemical decontaminant	**(5)** Chemical High Level Disinfectant (HLD)	**(6)** OTHER
A	Method	USED . . . . . 1 NOT USED . . 2 → 01b	USED . . . . . 1 NOT USED . . 2 → 01c	USED . . . . . 1 NOT USED . . 2 → 01d	USED . . . . . 1 NOT USED . . 2 → 01e	USED . . . . . 1 NOT USED . . 2 → 01f	USED . . . . . 1 NOT USED . . 2 → 193
B	Temperature (centigrade)	TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW . . . 998	TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW . . . 998				TEMPERATURE ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW . . . 998
C	Pressure		PRESS-URE ☐☐☐ UNITS OF PRESSURE: POUNDS/SQ.IN . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4 AUTOMATIC . . . . 666 DON'T KNOW . . . 998				PRESS-URE ☐☐☐ UNITS OF PRESSURE: POUNDS/SQ.IN . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . . 3 MILLIMETER HG . . 4 AUTOMATIC . . . . 666 DON'T KNOW 998
D	Minutes-when equipment is not wrapped in cloth	MINUTES ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW . . . 998	MINUTES ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW 998
E	Minutes when equipment is wrapped		MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW . . . 998				MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW 998
F	Chemical solution				JIK (chlorine) 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8	JIK (chlorine) 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8	JIK (chlorine) 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8
G	Percent solution				PERCENT ☐☐ DON'T KNOW 98	PERCENT ☐☐ DON'T KNOW 98	
H	Mixture, parts solution and water				MIXTURE PARTS a) DISINFECTANT ☐ b) WATER ☐☐	MIXTURE PARTS a) DISINFECTANT ☐ b) WATER ☐☐	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
193	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.	OBSERVED PRESENT	REPORTED NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Wrapped in sterile cloth, sealed with TST tape	1	2	3	8
02	Stored in sterile container with lid that clasps shut	1	2	3	8
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8
04	On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8
05	In container with disinfectant or antiseptic	1	2	3	8
06	Other _____ (SPECIFY)	1	2	3	8
194	Date of sterilization written on packet or container with processed items	1	2	3	8
195	Storage location dry and clean	1	2	3	8
196	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐				

2a. Vaccine Logistical System

Code of facility: ☐☐ PROV ☐☐ DIST ☐☐ FAC Interviewer code: ☐☐ QRE TYPE INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
200	Now I would like to find out about immunization services provided to children or pregnant women either by or at your facility. Are any immunization services provided, either as outreach or at the facility itself? IF YES: ASK WHO RECEIVES IMMUNIZATIONS AND CIRCLE THE APPROPRIATE RESPONSE.	YES, CHILDREN ONLY . . . . . 1 YES, PREGNANT WOMEN ONLY . . . . . 2 BOTH CHILDREN AND PREGNANT WOMEN . . . . . 3 NO IMMUNIZATION SERVICES EVER PROVIDED 4	→ 250
	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF IMMUNIZATION SERVICES. IF THIS PERSON IS DIFFERENT FROM THE ONES YOU TALKED TO ALREADY AT THIS FACILITY, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 202. **READ TO RESPONDENT:** **(IF DIFFERENT FROM RESPONDENT FOR PREVIOUS SECTIONS)** Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that serve women and children, with the goal of finding ways to improve the delivery of services. We would be interested in talking to you about this facility and your experiences with the system for providing vaccination services. Please be assured that any information you share will be kept completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? May I continue? Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)		
201	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
202	Does this facility routinely store *any* vaccines, or are all its vaccines either picked up from another facility or delivered when services are being provided?	YES, STORES VACCINES . . 1 STORES NO VACCINES 2	→ 215
203	ASK TO GO WHERE VACCINES ARE STORED, AND EXPLAIN: I want to find out about your system for keeping vaccines. What type of equipment do you usually use to store your vaccines? CIRCLE ALL THAT APPLY	ELECTRIC REFRIGERATOR . A KEROSENE REFRIGERATOR . . B GAS REFRIGERATOR . . . . . C SOLAR REFRIGERATOR . . . . D COLD BOX . . . . . E	
204	INDICATE THE TEMPERATURE INSIDE THE REFRIGERATOR OR COLD BOX.	TEMPERATURE IN CENTIGRADE ☐☐ NOT OBSERVED . . . . . A THERMOMETER NOT FUNCTIONING . . . . . B NO THERMOMETER C	
205	INDICATE WHETHER TEMPERATURE INSIDE COOLING UNIT IS ABOVE OR BELOW 0 (ZERO) DEGREES CENTIGRADE. FOR 0 DEGREES, CIRCLE 1.	POSITIVE (+) . . . . . 1 NEGATIVE (-) 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
206	Do you have a cold-chain temperature-monitoring chart? IF YES: May I see it?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . 2 NO 3	 → 208 → 208
207	CHECK WHETHER THE TEMPERATURE RECORD WAS COMPLETED TWICE DAILY FOR EACH OF THE PAST 30 DAYS.	YES, COMPLETED . . . . . 1 NO, NOT COMPLETED 2	
208	INDICATE WHETHER THE REFRIGERATOR OR COLD BOX IS PROTECTED FROM DIRECT SUNLIGHT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
209	What is the plan or strategy for when the vaccine refrigerator is not functioning and you have vaccines? IF SPARE GAS OR KEROSENE IS KEPT, ASK TO SEE THE BACKUP SUPPLY. CIRCLE ALL THAT APPLY.	TRANSPORT VACCINES IN COLD BOX TO NEAREST FACILITY WITH VACCINE STORAGE . . . . . A KEEP SPARE GAS OR KEROSENE, OBSERVED . . . . . B KEEP SPARE GAS OR KEROSENE, REPORTED, NOT SEEN . . . . . C NEVER A PROBLEM . . . . . D OTHER _____ X (OTHER) NO PLAN . . . . . Y	
210	Is there a register or stock cards where the amount of each vaccine received, the amount issued, and the amount present today recorded? IF YES, ASK: May I see the records?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . 2 NO 3	 → 212
211	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN Q210.	REGISTER/STOCK CARDS NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES . 1 REGISTER/STOCK CARDS UPDATED DAILY . . . . . 2 OTHER _____ . . . . . 3 (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

ASK TO SEE THE VACCINES. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR NON-SHADED RESPONSES FOR (b) AND (c) CHECK ALL OF EACH VACCINE, TO VERIFY 1) IF THEY WERE ARRANGED BY EXPIRY DATE; 2) IF THERE ARE ANY EXPIRED UNITS PRESENT; AND 3) THAT THE INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY RECORD OR PRESCRIPTIONS AND SUBTRACT THESE FROM THE INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE.

212	VACCINE	(a) AVAILABILITY OF VACCINES WITH VALID EXPIRY DATE				(b) ALL VIALS OF THE VACCINE WERE VALID			(c) AMOUNT OF STOCK AND INVENTORY MATCH		
		AT LEAST ONE VALID	REPORTED NOT SEEN	NOT AVAIL-ABLE	NOT CHECKED	YES	NO	NOT CHECKED	YES	NO	NOT CHECKED
01	Tetanus toxoid	1→01b	2→02	3→02	8→02	1	2	8	1	2	8
02	BCG and dilutant	1	2	3	8						
03	Oral polio (OPV)	1	2	3	8						
04	DPT	1	2	3	8						
05	Measles and dilutant	1→05b	2→06	3→06	8→06	1	2	8	1	2	8
06	Hepatitis B	1→06b	2→07	3→07	8→07	1	2	8	1	2	8
07	Pentavalent	1→07b	2→08	3→08	8→08	1	2	8	1	2	8
08	Yellow fever	1→08b	2→213	3→213	8→213	1	2	8	1	2	8

213	Were the vaccines organized according to expiry date ("first expire, first out") in the fridge or cold box? (VERIFY WHEN COMPLETING 212.)	YES, VERIFIED . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
214	Have you experienced a stock-out of any of the vaccines we just asked about, during the past six months? IF YES, ASK: For which vaccines did you experience a stock-out? CIRCLE ALL THAT APPLY.	TETANUS TOXOID . . . . . A BCG . . . . . B ORAL POLIO . . . . . C DPT . . . . . D MEASLES . . . . . E HEPATITIS B . . . . . F PENTAVALENT . . . . . G YELLOW FEVER . . . . . H NO STOCK-OUT EXPERIENCED . . . . . Y	
215	When was the last time that you received a routine supply of vaccines?	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS . . . . 2 MORE THAN 12 WEEKS AGO . 3 DON'T KNOW 8	
216	Does this facility determine the quantity of vaccines required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 DON'T KNOW 8	→218 →221

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
217	Do you always receive a standard fixed supply or does the quantity you receive vary according to the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL . . . . . 1 STANDARD FIXED SUPPLY . 2 DON'T KNOW 8	→ 220 → 220 → 220
218	Routinely, when you order vaccines, which best describes the system you use to determine **how much** of each to order? Do you: Review the amount of each vaccine remaining, and order to bring the stock amount to a pre-determined (fixed) amount? Order exactly the same quantity each time, regardless of the existing stock? Review the amount of each vaccine used since the previous order, and plan based on prior utilization and expected future activity? Other _____ (SPECIFY)	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	→ 220 → 220 → 221
219	Which of the following best describes the routine system for deciding **when** to order vaccines? Do you: Place order whenever stock levels fall to a predetermined level? Have a fixed time that orders are submitted? IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. Place an order whenever there is believed to be a need, regardless of stock level? Other _____ (SPECIFY) Don't know	PREDETERMINED LEVEL . . . 1 FIXED TIME . . . . . 2 EVERY ☐☐ WEEKS ORDER WHEN NEEDED . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	
220	During the past 3 months, have you always, sometimes, or almost never received the amount of vaccines that you ordered (or that you are supposed to routinely receive)?	ALWAYS . . . . . 1 SOMETIMES . . . . . 2 ALMOST NEVER 3	
221	How many vaccine carriers do you have available?	ONE . . . . . 1 TWO OR MORE . . . . . 2 NONE 3	→ 223
222	Are there ice packs for the vaccine carriers (four or five per carrier)?	YES, ONE SET . . . . . 1 YES, TWO OR MORE SETS . . 2 NO, USE PURCHASED ICE . . . 3 NO 4	
223	What type of injection equipment is used during routine immunization sessions at this facility?	SINGLE-USE . . . . . A STERILIZABLE . . . . . B AUTO-DESTRUCT . . . . . C OTHER _____ X (SPECIFY)	

2b. Child Health Services

Code of facility: PROV DIST FAC Interviewer code: QRE TYPE INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
250	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis?	YES . . . . . 1 NO 2	→ 287 THEN 300
	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF CURATIVE HEALTH SERVICES FOR CHILDREN. IF THIS PERSON IS DIFFERENT FROM THE ONE YOU INTERVIEWED EARLIER, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME AS BEFORE, CONTINUE WITH 252.		
	READ TO RESPONDENT ON CHILDREN'S HEALTH SERVICES: **(IF DIFFERENT FROM RESPONDENT FOR PREVIOUS SECTIONS)** 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 a goal of finding ways to improve the delivery of services. We would like to talk to you about this facility and your experiences in providing health services. Please be assured that the information you share is completely confidential. You may choose to stop the interview at any time. Do you have any questions? May I continue? Interviewer's signature (Indicates respondent's willingness to participate) _____ Date _____		
251	May I begin the interview?	YES . . . . . 1 NO 2	→ 287 THEN 300
252	Now I would like to ask you specifically about child health services. For each of the following services, please tell me whether the service is offered by your facility, and if so, how many days per month the service is provided at the facility, and how many days per month outreach services are provided (if any).		

	CHILD HEALTH SERVICE (Use a 4-week month to calculate number of days for outreach)	(a) # of days per month service is provided at facility	(b) # of days per month service is provided through outreach (village level) activities
01	Consultation or curative services for a sick child	# OF DAYS 00=NO SERVICE	# OF DAYS 00=NO SERVICE
02	Growth monitoring or growth promotion (where a *healthy child* is routinely weighed, has his or her weight charted on a growth chart, and feeding advice is given.)	# OF DAYS 00=NO SERVICE	# OF DAYS 00=NO SERVICE
03	Routine series of immunizations for children (DPT or pentavalent, polio, measles)	# OF DAYS 00=NO SERVICE	# OF DAYS 00=NO SERVICE
04	BCG immunizations	# OF DAYS 00=NO SERVICE	# OF DAYS 00=NO SERVICE

253	CHECK 252a (03) AND INDICATE WHETHER ROUTINE CHILD IMMUNIZATIONS ARE EVER PROVIDED AT THE FACILITY.	YES . . . . . 1 NO 2	→ 266
254	Are routine immunizations for children available at the facility today?	YES . . . . . 1 NO 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
255	Are immunizations offered in the facility on every day that sick child consultations are provided? IF YES, ARE ALL VACCINES OFFERED?	YES, ALL VACCINES . . . . . 1 YES, SOME VACCINES, NOT ALL . . . . . 2 NO . . . . . 3 DON'T KNOW 4	
256	Are there any routine fees assessed for any services or items related to immunization? This includes fees for weighing children prior to immunization.	YES . . . . . 1 NO 2	→ 258
257	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES / NO; (b) AMOUNT IN KSH	
01	FEE FOR IMMUNIZATION CARD	1 → 01b; 2 → 02	
02	FEE FOR SYRINGE	1 → 02b; 2 → 03	
03	FEE FOR IMMUNIZATION SERVICE	1 → 03b; 2 → 04	
04	FEE FOR VACCINE	1 → 04b; 2 → 05	
05	FEE FOR WEIGHING CHILD	1 → 05b; 2 → 258	
	ASK TO SEE THE ROOM WHERE IMMUNIZATIONS ARE ADMINISTERED. FOR THE FOLLOWING ITEMS, CHECK WHETHER THE ITEM IS EITHER IN THE ROOM WHERE THE SERVICE IS BEING GIVEN OR IN AN ADJACENT ROOM.		
258	ITEMS REQUIRED FOR IMMUNIZATION SERVICES	OBSERVED / REPORTED, NOT SEEN / NOT AVAILABLE / DON'T KNOW	
01	Sharps box for disposable needles and syringes	1 / 2 / 3 / 8	
02	BCG syringes, at least five (with needles)	1 / 2 / 3 / 8	
03	At least five 2-ml or 3-ml syringes (with 21 gauge needles)	1 / 2 / 3 / 8	
04	At lease 5 auto-destruct syringes	1 / 2 / 3 / 8	
05	Waste receptacle with lid and plastic liner	1 / 2 / 3 / 8	
06	Hand-washing soap	1 / 2 / 3 / 8	
07	Single-use hand drying towels or functioning electric hand drier	1 / 2 / 3 / 8	
08	Water for washing hands	1 / 2 / 3 → 260 / 8 → 260	
259	How is water being made available for use in the immunization area ***today*** *?*	PIPED . . . . . 1 BUCKET WITH TAP . . . . . 2 BUCKET OR BASIN 3	
260	OTHER ITEMS REQUIRED FOR IMMUNIZATION SERVICES	OBSERVED / REPORTED, NOT SEEN / NOT AVAILABLE / DON'T KNOW	
01	Blank, individual child immunization cards	1 / 2 / 3 / 8	
02	Tally sheets	1 / 2 / 3 / 8	
03	Permanent register for recording immunizations	1 / 2 → 262 / 3 → 262 / 8 → 262	
261	ASK WHEN IMMUNIZATIONS WERE MOST RECENTLY PROVIDED IN THE FACILITY AND VERIFY THAT THE REGISTER IS UP-TO-DATE.	UP-TO-DATE . . . . . 1 NOT UP TO DATE 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
262	What is the current estimate for your DPT or pentavalent dropout rate?	DPT DROPOUT RATE (%) . . . . . ☐☐☐ DON'T KNOW 998	
263	Do you have an estimate of the target population for child immunizations in the facility catchment area? IF YES: How many children is that?	TARGET POPULATION ☐☐☐☐☐ NO CATCHMENT AREA . 99995 DON'T KNOW 99998	 → 265 → 265
264	What is the current estimate for your facility's measles coverage?	MEASLES COVERAGE (%) . . . ☐☐☐ DON'T KNOW 998	
265	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	
266	CHECK Q252a(01): DOES FACILITY PROVIDE SICK-CHILD CONSULTATIONS? YES ☐ NO ☐ → 287 THEN 300		
267	Are there any routine fees assessed for any services or items related to curative services for children?	YES . . . . . 1 NO 2	→ 269
268	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES NO / (b) AMOUNT IN KSH	
01	FEE FOR CHILD HEALTH RECORD/CHART	1 → 01b 2 → 02 / ☐☐☐☐	
02	FEE FOR RESIDENT PROVIDER CONSULTATION SERVICE	1 → 02b 2 → 03 / ☐☐☐☐	
03	FEE FOR "CONSULTANT" CONSULTATION SERVICE	1 → 03b 2 → 269 / ☐☐☐☐	
269	Does this facility have a system whereby certain measures and activities are routinely carried out on sick children before the consultation for the presenting illness? IF YES, ASK TO SEE THE PLACE WHERE SICK CHILDREN ARE SEEN BEFORE THE CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 271 → 271

270	Which of the following activities take place as part of routine services?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW
01	Weighing the child	1	2	3	8
02	Plotting child's weight on graph	1	2	3	8
03	Taking child's temperature	1	2	3	8
04	Assessing child's immunization status	1	2	3	8
05	Group health education	1	2	3	8
06	Other _____ (SPECIFY)	1	2	3	8

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
271	Is there a routine system for someone other than the health worker who examines the child to give him or her the first dose of prescribed oral medication? IF YES, ASK TO SEE WHERE THE FIRST DOSE IS PROVIDED.	YES, OBSERVED CHILD RECEIVING DOSE . . . . . 1 YES, REPORTED BUT NOT SEEN . . . . . 2 NO ROUTINE SYSTEM . . . . . 3 DON'T KNOW 8	 →273 →273 →273
272	OBSERVE WHETHER THE PERSON GIVING THE FIRST DOSE INSTRUCTS THE CARETAKER HOW TO GIVE THE MEDICINE AND IF THE CARETAKER IS ASKED TO REPEAT THE INSTRUCTIONS. CIRCLE EACH EVENT THAT IS OBSERVED OCCURRING ROUTINELY.	INSTRUCT HOW TO GIVE MEDICINE . . . . . A ASK CLIENT TO REPEAT INSTRUCTIONS . . . . . B NO INSTRUCTIONS . . . . . Y	
273	Does this facility provide blood tests to verify the diagnosis of malaria for children?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

ASK TO GO TO THE PLACE WHERE CONSULTATION IS PROVIDED TO SICK CHILDREN. FOR THE FOLLOWING ITEMS, CHECK WHETHER THE ITEM IS EITHER IN THE ROOM WHERE THE SERVICE IS GIVEN OR IN AN ADJACENT ROOM.

274	ITEMS FOR SICK CHILD CONSULTATIONS	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Infant scale	1→01b	2→01b	3 → 02	8 → 02	1	2	8
02	Child scale	1→02b	2→02b	3 → 03	8 → 03	1	2	8
03	Thermometer	1→03b	2→03b	3 → 04	8 → 04	1	2	8
04	Timer or watch with second hand	1→04b	2→04b	3 → 05	8 → 05	1	2	8
05	Butterfly or scalp vein 21-23g, or branula (intercath) 22-24g	1	2	3	8			
06	Intravenous fluid (D5NS, NS, ringers lactate (1/2 strength-darrows, or full strength Hartmans)	1	2	3	8			
07	D5W intravenous fluid	1	2	3	8			
08	Perfusion sets	1	2	3	8			
09	Jar or pitcher for oral rehydration solution (ORS)-1/2 or 1 liter	1	2	3	8			
10	Cup and spoon	1	2	3	8			
11	Waste receptacle with lid and plastic liner	1	2	3	8			
12	Hand-washing soap	1	2	3	8			
13	Single-use hand drying towels or functioning electric hand drier	1	2	3	8			
14	Water for washing hands	1	2	3 → 276	8 → 276			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
275	How is water being made available for use in the child consultation area *today?*	PIPED . . . . . 1 BUCKET WITH TAP . . . . . 2 BUCKET OR BASIN 3	

276	PROTOCOLS OR TEACHING MATERIALS	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Clinical Guidelines	1	2	3	8
02	Medical protocols for children's illnesses	1	2	3	8
03	IMCI chart booklet	1	2	3	8
04	IMCI counseling cards for provider to use	1	2	3	8
05	IMCI mother's cards (to give to caretaker)	1	2	3	8
06	Other visual aids for teaching caretakers	1	2	3	8

ASK TO SEE THE ROOM(S) WHERE THERAPEUTIC (TREATMENT) INJECTIONS ARE GIVEN TO SICK CHILDREN.

277	WAS ROOM ALREADY OBSERVED WHEN ASSESSING IMMUNIZATIONS?	YES, INFORMATION ASSESSED IN IMMUNIZATION ROOM (Q258) . . . . . 1 NO 2	→ 280

278 FOR THE FOLLOWING ITEMS, CHECK WHETHER EACH ITEM IS EITHER IN THE ROOM WHERE NON-VACCINATION INJECTIONS ARE BEING PROVIDED OR IN AN ADJACENT ROOM.

	ITEMS REQUIRED TO PROVIDE INJECTION SERVICES	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Sharps container	1	2	3	8
02	Five 2-ml syringes (with needles)	1	2	3	8
03	Five 5- or 10-ml syringes (with 21-gauge needles)	1	2	3	8
04	Waste receptacle with lid and plastic liner	1	2	3	8
05	Hand-washing soap	1	2	3	8
06	Single use hand drying towel or functioning electric hand drier	1	2	3	8
07	Water for washing hands	1	2	3 → 280	8 → 280

279	How is water being made available for use in the injection room area ***today*** *?*	PIPED . . . . . 1 BUCKET WITH TAP . . . . . 2 BUCKET OR BASIN 3	
280	Is there a patient register where information on each child consultation is written? IF YES, ASK TO SEE THE REGISTER AND INDICATE THE TYPE OF REGISTER OBSERVED. TO BE VALID, REGISTER MUST INDICATE CHILD'S AGE AND DIAGNOSIS OR MAJOR SYMPTOM.	OBSERVED, SEPARATE <5 REGISTER . . . . . 1 OBSERVED COMBINED ADULT AND <5 REGISTER . . . . . 2 YES, REPORTED, NOT SEEN 3 NO REGISTER 4	→ 282 → 282
281	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . . 2	
282	How many sick children (younger than 5 years of age) were attended during the previous 12 completed months?	NUMBER OF CHILDREN [ ][ ][ ][ ][ ] DON'T KNOW 99998	→ 284

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
283	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q282.	MONTHS OF DATA . . . . . ☐☐ DON'T KNOW 98	
284	Are individual health records maintained for sick children? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED . . . . 1 YES, REPORTED, NOT SEEN . 2 CARD SUPPLIED BY CLIENT . 3 NO 4	
285	Are curative child health services available at the facility today?	YES . . . . . 1 NO 2	
286	Are children with HIV/AIDS or suspected as having HIV/AIDS ever provided services related to HIV/AIDS in this clinic/unit?	YES . . . . . 1 NO 2	→ QRE B
287	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐		

3. Family Planning Services

Code of facility: PROV DIST FAC Interviewer code: QRE TYPE INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	Are sterilization procedures for men or women ever performed at this facility? IF YES, INDICATE WHICH PROCEDURES ARE CONDUCTED.	YES, MALE STERILIZATION . . A YES, FEMALE STERILIZATION . B NO STERILIZATION . . . . . Y	
301	Does this facility offer any other family planning services—including clinical methods or counseling on natural family planning?	YES . . . . . 1 NO 2	→ 400
	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF FAMILY PLANNING SERVICES. IF THIS PERSON IS DIFFERENT FROM RESPONDENTS IN THE FACILITY WHOM YOU OBTAINED INFORMATION FROM FOR EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 303. **READ TO NEW RESPONDENT:** Hello. I am representing the Ministry of Health. We are carrying out a survey of facilities that provide health services to women and children, with the goal of finding ways to improve the delivery of service. We would like to talk to you about this facility and your experiences providing health services. Any information you share will be completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? May I continue? Interviewer's signature (Indicates respondent's willingness to participate) ____ Date ____		
302	May I begin the interview now?	YES . . . . . 1 NO 2	→ 400
303	How many days of the week are family planning services provided at this facility?	NUMBER OF DAYS	
304	Are family planning services being provided at this facility today?	YES . . . . . 1 NO 2	
305	Are there any routine fees assessed for any services or items related to family planning services?	YES . . . . . 1 NO 2	→ 307

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
306	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES	NO	(b) AMOUNT IN KSH	
01	FEE FOR FP CLIENT RECORD/CHART	1→01b	2 → 02		
02	FEE FOR CONSULTATION SERVICE	1→02b	2 → 03		
	FEE FOR ANY METHOD SUPPLIED				
03	PILLS	1→03b	2 → 04		
04	MALE CONDOM	1→04b	2 → 05		
05	FEMALE CONDOM	1→05b	2 → 06		
06	INJECTION	1→06b	2 → 07		
07	IUD	1→07b	2 → 08		
08	IMPLANT	1→08b	2 → 09		
09	EMERGENCY CONTRACEPTIVE	1→09b	2 → 307		
307	Which of the following methods of contraception is provided, prescribed, or counseled at this facility?	YES	NO	DON'T KNOW	
01	Combined oral pill	1	2	8	
02	Progesterone-only pill	1	2	8	
03	IUD	1	2	8	
04	Progesterone injections (e.g., Depo)	1	2	8	
05	Combined injection (e.g., Norigynon)	1	2	8	
06	Implant	1	2	8	
07	Male condom	1	2	8	
08	Female condom	1	2	8	
09	Spermicides	1	2	8	
10	Diaphragm	1	2	8	
11	Emergency contraceptive pill	1	2	8	
12	Counseling on natural methods	1	2	8	
308	Does this facility have a system in which measurements of or activities for family planning are routinely carried out before the consultation takes place?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8			→ 310 → 310

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
309	ASK TO SEE THE PLACE WHERE FAMILY PLANNING CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.					
	Which of the following are activities performed as part of routine services?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW	
01	Weighing clients	1	2	3	8	
02	Taking blood pressure	1	2	3	8	
03	Conducting group health education sessions	1	2	3	8	
04	Other _____ (SPECIFY)	1	2	3	8	
310	ASK TO SEE WHERE COUNSELING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . 3 NO PRIVACY 4				
311	Are any of the following visual aids for teaching available in the counseling room or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Samples of various family planning methods	1	2	3	8	
02	Visual aids for teaching about STIs	1	2	3	8	
03	Visual aids for teaching about HIV/AIDS	1	2	3	8	
04	Model for demonstrating how to use condoms	1	2	3	8	
05	Posters about family planning	1	2	3	8	
312	Are any of the following types of information booklets or pamphlets for clients to take home available in the counseling or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Printed material about family planning	1	2	3	8	
02	Printed material about STIs	1	2	3	8	
03	Printed material about HIV/AIDS	1	2	3	8	
313	Are any of the following protocols for delivery of services available in the counseling room or the examination room?	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	RH/Family Planning Policy Guidelines for Service Providers	1→03	2	3	8	
02	Other family planning guidelines	1	2	3	8	
03	Guidelines for making a syndromic diagnosis of STIs and treating them	1	2	3	8	
04	Guidelines for making an etiological (laboratory) diagnosis of STI	1	2	3	8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
314	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE CHOSEN METHOD AND STATUS (NEW OR CONTINUING) FOR EACH CLIENT.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN. . . 2 NO 3	 → 316 → 316
315	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . . 2	
316	How many total clients (new and continuing) received family planning services during the previous 12 completed months?	TOTAL CLIENTS [ ][ ][ ][ ][ ] DON'T KNOW 99998	 → 318
317	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q316.	MONTHS OF DATA . . . . [ ][ ] DON'T KNOW 98	
318	Are individual records or charts maintained for family planning clients? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 CARD SUPPLIED BY CLIENT 3 NO 4	
319	Does the family planning provider routinely treat STIs, or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIs . . . 1 REFERS TO OTHER PROVIDER OR LOCATION . . . . . 2 NO TREATMENT PROVIDED . . 3	
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING ARE CONDUCTED.		
320	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 321-323, INDICATE WHICH SECTION THE ROOM WAS ASSESSED FOR.	ANTENATAL [Q430-Q432] . . . 1 DELIVERY [Q521-Q523] . . . . . 2 STI [Q623-Q625] . . . . . 3 NOT PREVIOUSLY SEEN . . . 4	→ 324 → 324 → 324
321	DESCRIBE THE SETTING OF THE EXAMINATION ROOM. IF THIS IS THE SAME ROOM AS THAT USED FOR COUNSELING (Q310), CIRCLE “5”.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . 3 NO PRIVACY . . . . . 4 CONSULT AND EXAM IN SAME ROOM 5	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

322 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

	ITEMS REQUIRED TO PROVIDE FAMILY PLANNING SERVICES	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight source (flash-light or examination light acceptable)	1 → 01b	2 → 01b	3 → 02	8 → 02	1	2	8
02	Table for gynecological exam	1	2	3	8			
03	Clean latex gloves	1 → 05	2	3	8			
04	Disposable non-latex gloves	1	2	3	8			
05	Sharps container	1	2	3	8			
06	At least five or more sterile syringes (with needles)	1	2	3	8			
07	Decontamination solution for clinical equipment	1	2	3	8			
08	Waste receptacle with lid and plastic liner	1	2	3	8			
09	Hand-washing soap	1	2	3	8			
10	Single-use hand drying towels or functioning electric hand dryer	1	2	3	8			
11	Water for handwashing	1	2	3 → 324	8 → 324			

323	How is water being made available for use in the family planning service area *today?*	PIPED . . . . . 1 BUCKET WITH TAP . . . . . 2 BUCKET OR BASIN 3	

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
324	NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASUREMENT IS TAKEN.							
		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Blood pressure apparatus	1→01b	2→01b	3 → 02	8 → 02	1	2	8
02	Stethoscope	1→02b	2→02b	3 → 03	8 → 03	1	2	8
03	Scale for weighing clients	1→03b	2→03b	3 → 325	8 → 325	1	2	8
325	CHECK Q307(03) and (06): DOES FACILITY OFFER IUD OR IMPLANT? YES ☐ NO ☐ → 331							
326	NOTE THE AVAILABILITY OF COMMON SUPPLIES FOR IUD OR IMPLANT SERVICES.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Sterile gloves	1	2	3	8			
02	Antiseptic solution (such as iodine)	1	2	3	8			
03	Sponge holding forceps	1	2	3	8			
04	Gauze pad or cotton wool	1	2	3	8			
327	CHECK Q307(03): DOES FACILITY OFFER IUD? YES ☐ NO ☐ → 329							
328	NOTE THE AVAILABILITY OF MATERIALS FOR THE INSERTIONS OF IUD	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Vaginal speculum (L)	1	2	3	8			
02	Vaginal speculum (M)	1	2	3	8			
03	Vaginal speculum (S)	1	2	3	8			
04	Tenacula	1	2	3	8			
05	Uterine sound	1	2	3	8			
329	CHECK Q307(06): DOES FACILITY OFFER IMPLANT? YES ☐ NO ☐ → 331							
330	NOTE THE AVAILABILITY OF THE FOLLOWING ITEMS:	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Local anesthetic (such as lidocaine)	1	2	3	8			
02	Sterile syringe and needle	1	2	3	8			
03	Cannula and trochar for inserting Implant	1	2	3	8			
04	Scalpel with blade	1	2	3	8			
05	Forceps for grasping implant (artery forceps or hemostat or tweezer or mosquito forceps)	1	2	3	8			
06	Dressing materials (gauze and tape)	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
331	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC/UNIT . . . . . 1 YES, OTHER LOCATION . . . . . 2 NO 3	 → 338 → 338
332	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED, COMPLETE. . 1 YES, OBSERVED, NOT COMPLETE . . . . . 2 YES, REPORTED NOT SEEN . 3 NO 4	
333	Do you have a staff member who has had specific training for providing youth friendly services? IF YES, ASK: Is the staff member present today?	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . 2 NO 3	
334	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. What are the key components of the youth friendly services that are offered in this clinic/unit? ASK FOR EACH ITEM. CIRCLE ALL THAT APPLY.	SERVICES IN SEPARATE ROOM . . . . . A DISCOUNT FEES . . . . . B NO FEES . . . . . C OTHER _____ . . X (SPECIFY)	
335	Please tell me if you have educational materials for any topic I mention, and if yes, which type of materials you have.	(a) FLIPCHART 1=YES 2=NO (b) BROCHURES/ PAMPHLETS 1=YES 2=NO (c) POSTERS 1=YES 2=NO (d) VIDEO 1=YES 2=NO	
01	CONTRACEPTION	☐ ☐ ☐ ☐	
02	HIV/AIDS	☐ ☐ ☐ ☐	
03	STIs	☐ ☐ ☐ ☐	
04	NUTRITION	☐ ☐ ☐ ☐	
05	PREGNANCY	☐ ☐ ☐ ☐	
06	ABORTION	☐ ☐ ☐ ☐	
07	OTHER _____ (SPECIFY)	☐ ☐ ☐ ☐	
336	Are any of the materials for health education targeted to youth?	YES . . . . . 1 NO 2	
337	Which topic or topics are targeted toward youth? CIRCLE ALL THAT APPLY.	CONTRACEPTION . . . . . A HIV/AIDS . . . . . B STIs . . . . . C NUTRITION . . . . . D PREGNANCY . . . . . E ABORTION . . . . . F OTHER _____ X (SPECIFY) NONE OF THE ABOVE . . . . . Y	
338	Are clients with HIV/AIDS or suspected HIV/AIDS ever provided services related to HIV/AIDS in this clinic/unit? This includes services related to prevention of mother to child transmission (PMTCT), counseling and testing (VCT), and treatment.	YES . . . . . 1 NO 2	→ QRE B

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
339	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. PROBE, IF NECESSARY, FOR CORRECT RESPONSE	SOAKED IN DISINFECTANT SOLUTION AND BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 01 BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT. . 02 BRUSH SCRUBBED WITH SOAP AND WATER ONLY. . . 03 SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED . . . 04 DO NOT USE ANY EQUIPMENTS IN UNIT . . . .05 OTHER_____ 96 (SPECIFY) NONE . . . . . .95 DON'T KNOW 98	→ 356
340	Where is this equipment then processed prior to reuse? IF THE SYSTEM AT THAT LOCATION HAS ALREADY BEEN SEEN, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "3 " AND CONTINUE.	SECTION 1 [Q182-192] . . . . . 1 DELIVERY [Q549-559] . . . . . 2 NOT PREVIOUSLY SEEN . . . 3 PROCESS OUTSIDE FACILITY 4	→ 352 → 352 → 352

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
341	*Besides decontaminating and cleaning,* what is the final process most commonly used for disinfecting or sterilizing medical equipment (such as surgical instruments) before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, CIRCLE ALL THAT APPLY.	DRY-HEAT STERILIZATION . A AUTOCLAVING . . . . . B STEAM . . . . . C BOILING . . . . . D CHEMICAL METHOD . . . . . E OTHER _____ X (SPECIFY) NONE . . . . . Y	→ 356

INDICATE THE RELEVANT INFORMATION FOR THE DECONTAMINATION AND CLEANING PROCEDURE FROM AMONG THOSE LISTED IN QUESTIONS 342-351.

GO TO WHERE EQUIPMENT IS PROCESSED AND ASSESS THE AVAILABILITY OF ITEMS AND THE PROCEDURES FOLLOWED AT THE FACILITY.

NO.	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
342	Electric dry heat sterilizer	1 → 342b	2 → 342b	3 → 343	8 → 343	1	2	8
343	Electric autoclave (pressure and wet heat)	1 → 343b	2 → 343b	3 → 344	8 → 344	1	2	8
344	Non-electric autoclave	1 → 344b	2 → 344b	3 → 345	8 → 345	1	2	8
345	Pot with cover (for steaming or boiling)	1	2	3	8			
346	Other _____ (SPECIFY)	1	2	3	8			
347	Heat source (stove or cooker with fuel or power present) for steaming, boiling, or using a non-electric autoclave	1 → 347b	2 → 347b	3 → 348	8 → 348	1	2	8
348	Automatic timer (MAY BE ON MACHINE)	1 → 348b	2 → 348b	3 → 349	8 → 349	1	2	8
349	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
350	Written guidelines for disinfection and sterilization	1	2	3	8			

351	FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED						
		(1) Dry heat sterilization	**(2)** Autoclave	**(3)** Boil or steam (high level disinfectant, HLD)	**(4)** Chemical decontaminant	**(5)** Chemical High Level Disinfectant (HLD)	**(6)** OTHER
A	Method	USED . . . . . 1 NOT USED . . 2 → 01b	USED . . . . . 1 NOT USED . . 2 → 01c	USED . . . . . 1 NOT USED . . 2 → 01d	USED . . . . . 1 NOT USED . . 2 → 01e	USED . . . . . 1 NOT USED . . 2 → 01f	USED . . . . . 1 NOT USED . . 2 → 352
B	Temperature (centigrade)	TEMPERATURE ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998	TEMPERATURE ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998				TEMPERATURE ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998
C	Pressure		PRESS-URE ☐☐☐ UNITS OF PRESSURE: POUNDS/SQ.IN . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4 AUTOMATIC . . . . 666 DON'T KNOW . . . 998				PRESS-URE ☐☐☐ UNITS OF PRESSURE: POUNDS/SQ.IN . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4 AUTOMATIC . . . . 666 DON'T KNOW . . . 998
D	Minutes-when equipment is not wrapped in cloth	MINUTES ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998	MINUTES ☐☐☐ AUTOMATIC . . . . 666 DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998
E	Minutes when equipment is wrapped		MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998				MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998
F	Chemical solution				JIK (chlorine) . . . . . 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8	JIK (chlorine) . . . . . 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8	JIK (chlorine) . . . . . 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8
G	Percent solution				PERCENT ☐☐ DON'T KNOW 98	PERCENT ☐☐ DON'T KNOW 98	
H	Mixture, parts solution and water				MIXTURE PARTS a) DISINFECTANT ☐ b) WATER ☐☐ DON'T KNOW 998	MIXTURE PARTS a) DISINFECTANT ☐ b) WATER ☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
352	INDICATE ALL STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (SUCH AS SPECULUM, FORCEPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "3" AND CONTINUE.	SECTION 1 [Q193-195] . . . . . 1 DELIVERY [Q560-563] . . . . . 2 NOT PREVIOUSLY SEEN 3				→ 400 → 400
353	INDICATE STORAGE CONDITIONS FOR PROCESSED EQUIPMENT USED FOR THIS SERVICE DELIVERY AREA.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile cloth, sealed with TST tape	1	2	3	8	
02	Stored in sterile container with lid that clasps shut	1	2	3	8	
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8	
04	On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other _____ (SPECIFY)	1	2	3	8	
354	Date of sterilization written on packet or container with processed items	1	2	3	8	
355	Storage location dry and clean	1	2	3	8	
356	RECORD THE TIME AT END OF INTERVIEW ☐☐.☐☐					

4. Antenatal and Postpartum Care

Code of facility: PROV DIST FAC Interviewer code: QRE TYPE INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
400	Does this facility offer antenatal services, postpartum services, or both? INDICATE THE SERVICES AVAILABLE.	YES, ANTENATAL . . . . . A YES, POSTPARTUM . . . . . B NO, NEITHER SERVICE . . . . Y	→ 441
	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF ANTENATAL CARE. IF THIS PERSON IS DIFFERENT FROM ANYONE WHOM YOU OBTAINED INFORMATION FROM FOR EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 402. **READ TO NEW RESPONDENT:** Hello. I am representing the Ministry of Health. We are carrying out a survey of facilities that provide health services to women and children, with the goal of finding ways to improve the delivery of services. We would like to talk to you about this facility and your experiences in providing health services. Any information you share will be completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? May I continue? Interviewer's signature (Indicates respondent's willingness to participate) ____ Date ____		
401	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
402	How many days of the week are antenatal-care services provided at the facility?	NUMBER OF DAYS	
403	Are antenatal-care services being provided at the facility today?	YES . . . . . 1 NO 2	
404	Are there any routine fees charged for any services or items related to ANC?	YES . . . . . 1 NO 2	→ 406
405	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE: YES / NO; (b) AMOUNT IN KSH	
01	FEE FOR ANC CLIENT CARD	1 → 01b; 2 → 02	
02	FEE FOR "RESIDENT" PROVIDER CONSULTATION SERVICE	1 → 02b; 2 → 03	
03	FEE FOR "CONSULTANT" CONSULTATION SERVICE	1 → 03b; 2 → 04	
04	FEE FOR BLOOD TEST FOR ANEMIA	1 → 04b; 2 → 05	
05	FEE FOR URINE TEST FOR PROTEIN	1 → 05b; 2 → 06	
06	FEE FOR IRON TABLETS	1 → 06b; 2 → 07	
07	FIXED FEE FOR ALL ANC SERVICES	1 → 07b; 2 → 406	
406	Does this facility have a system whereby measurements or procedures for ANC clients are routinely carried out before the consultation?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 408 → 408

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
407	ASK TO SEE THE PLACE WHERE ANTENATAL CLIENTS ARE SEEN BEFORE THEY HAVE THEIR MEDICAL CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.					
	Which of the following activities are performed as part of routine services?	OBSERVED ACTIVITY	ACTIVITY REPORTED, NOT SEEN	ACTIVITY NOT ROUTINELY CONDUCTED	DON'T KNOW	
01	Weighing clients	1	2	3	8	
02	Taking blood pressure	1	2	3	8	
03	Conducting group health education sessions	1	2	3	8	
04	Other _____ (SPECIFY)	1	2	3	8	
408	ASK ABOUT THE FOLLOWING TESTS AND SERVICES AS ROUTINE COMPONENTS OF ANTENATAL CARE.					
	Which of the following activities are performed as part of routine services?	YES	NO	DON'T KNOW		
01	Blood test for anemia	1	2	8		
02	Blood test for syphilis	1	2	8		
03	Urine test for protein	1	2	8		
409	Which of the following types of treatment and services are routinely offered to antenatal clients?					
01	Tetanus toxoid vaccination services **available all days antenatal care services are offered**	1	2	8		
02	Preventive antimalarial medication	1	2	8		
03	Counseling about family planning	1	2	8		
04	Voluntary counseling about HIV/AIDS	1	2	8		
05	Voluntary testing for HIV/AIDS	1	2	8		
410	How many days each week are tetanus toxoid vaccinations offered at this facility?	DAYS PER WEEK . . . . . [ ] NEVER OFFERED . . . . . 0 DON'T KNOW 8				
411	Do antenatal care providers here routinely treat STIs, or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIs . . . . 1 REFERS . . . . . 2 NO TREATMENT PROVIDED 3				
412	Is there a register where information on antenatal care clients' visits is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID IT MUST SHOW CLIENTS' STATUS (NEW OR CONTINUING).	YES, REGISTER SEEN . . . . . 1 YES, REGISTER NOT SEEN . . . 2 NO REGISTER KEPT 3				 →413a →413a
413	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . . 1 MORE THAN 7 DAYS OLD 2				
413a	CHECK Q408(02). DOES THIS FACILITY EVER PROVIDE OR PRESCRIBE SYPHILIS TESTS FOR ANC CLIENTS?	YES . . . . . 1 NO 2				 →417
414	Is there a register or record that shows if an ANC client was tested for syphilis? IF YES, ASK TO SEE THE REGISTER/RECORD	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . 2 NO 3				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
415	Is there a standard guideline or protocol for what to do when a pregnant woman is found to be positive for syphilis? IF YES, ASK TO SEE THE GUIDELINE/PROTOCOL	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . . . . . 2 NO 3	
416	What is the procedure for treatment when a pregnant woman is diagnosed with syphilis? RECORD THE MOST APPROPRIATE RESPONSE	TREATED WITH PENICILLIN BY PROVIDER IN ANC CLINIC . . . . . 1 REFERRED TO ANOTHER CLINIC FOR TREATMENT . . . . . 2 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
417	How many **new** antenatal visits took place during the previous 12 complete months?	# OF NEW ANC VISITS [ ][ ][ ][ ][ ] DON'T KNOW 99998	→ 418
417a	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q417.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
418	How many antenatal visits (both new and follow-up) took place during the previous 12 complete months?	NUMBER OF ANC VISITS [ ][ ][ ][ ][ ] DON'T KNOW 99998	→ 420
418a	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q418.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
419	Please tell me the percentage of women who had 4 or more ANC visits out of the total ANC visits in the last 12 months	% WOMEN WITH 4 OR MORE ANC VISITS [ ][ ][ ] DON'T KNOW 998	
420	Is there a register where client information from postpartum (PP) visits is recorded? IF YES, ASK TO SEE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW THE NUMBER OF DAYS POSTPARTUM AND INDICATE WHETHER OR NOT THERE ARE COMPLICATIONS.	YES, REGISTER SEEN . . . . . 1 YES, REGISTER NOT SEEN . . . . . 2 NO REGISTER KEPT . . . . . 3 NO PP SERVICES 5	→ 424 → 424 → 424
421	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . . . 1 MORE THAN 7 DAYS OLD 2	
422	How many postpartum visits took place during the previous 12 complete months?	NUMBER OF PP VISITS [ ][ ][ ][ ][ ] DON'T KNOW 99998	→ 424
423	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q422.	MONTHS OF DATA . . . . . [ ][ ] DON'T KNOW 98	
424	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment area?	NUMBER OF BIRTHS . . . [ ][ ][ ][ ][ ] NO CATCHMENT AREA . 99995 DON'T KNOW 99998	→ 427 → 427
425	What is the estimated annual rate of antenatal-care coverage for this facility?	ANC % COVERAGE . . . . . [ ][ ][ ] DON'T KNOW 998	→ 427
426	RECORD THE SOURCE OF INFORMATION FOR ESTIMATED PERCENT OF ANTENATAL CARE COVERAGE.	WRITTEN REPORT . . . . . A WALL GRAPH . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
427	Are individual client records or charts maintained for antenatal care clients? IF YES, ASK TO SEE A BLANK RECORD OR CHART.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . 2 CARD SUPPLIED BY CLIENT . . . 3 NO 4	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED.		
428	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 429-431, INDICATE WHICH SECTION THE ROOM WAS ASSESSED FOR.	FAM PLANNING [Q322-Q324] 1 DELIVERY [Q521-Q523] .... 2 STI [Q623-Q625] ..... 3 NOT PREVIOUSLY SEEN 4	→ 432 → 432 → 432
429	DESCRIBE THE SETTING OF THE EXAMINATION ROOM.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY ..... 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY ..... 2 VISUAL PRIVACY ONLY ..... 3 NO PRIVACY 4	

430 FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.

	EQUIPMENT REQUIRED FOR ANTENATAL CARE POSTPARTUM SERVICES	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight source flashlight or examination light acceptable)	1→01b	2→01b	3 → 02	8 → 02	1	2	8
02	Table for gynecological exam	1	2	3	8			
03	Clean latex gloves	1 → 05	2	3	8			
04	Disposable, non-latex gloves	1	2	3	8			
05	Sharps container	1	2	3	8			
06	At least five or more 2-ml or 3-ml syringes (with 21 gauge needles)	1	2	3	8			
07	Decontamination solution for clinical equipment	1	2	3	8			
08	Waste receptacle with lid and plastic liner	1	2	3	8			
09	Hand-washing soap	1	2	3	8			
10	Single-use towels or functional electric drier	1	2	3	8			
11	Water for handwashing	1	2	3 → 432	8 → 432			

431	How is water being made available for use in the antenatal care service area *today?*	PIPED ..... 1 BUCKET WITH TAP ..... 2 BUCKET OR BASIN 3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

432 NOTE THE AVAILABILITY AND CONDITION OF OTHER EQUIPMENT. EQUIPMENT MAY BE IN EXAMINATION ROOM, AN ADJACENT ROOM, OR ROOM WHERE MEASURE IS TAKEN.

		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Blood pressure apparatus	1 → 01b	2 → 01b	3 → 02	8 → 02	1	2	8
02	Stethoscope	1 → 02b	2 → 02b	3 → 03	8 → 03	1	2	8
03	Fetal stethoscope (Pinard)	1 → 03b	2 → 03b	3 → 04	8 → 04	1	2	8
04	Thermometer	1 → 04b	2 → 04b	3 → 05	8 → 05	1	2	8
05	Infant scale	1 → 05b	2 → 05b	3 → 06	8 → 06	1	2	8
06	Vaginal speculum (L)	1	2	3	8			
07	Vaginal speculum (M)	1	2	3	8			
08	Vaginal speculum (S)	1	2	3	8			
09	Adult weight scale	1	2	3	8			

433	NOTE THE AVAILABILITY OF PROTOCOLS AND TEACHING MATERIALS.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW
01	Guidelines or protocols for antenatal care	1	2	3	8
02	Guidelines for Syndromic Approach for STIs	1	2	3	8
03	Other guidelines or protocols for diagnosing or treating STIs	1	2	3	8
04	Teaching aids for antenatal care	1	2	3	8

434	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC UNIT . . . . . 1 YES, OTHER LOCATION . . . . . 2 NO 3	 → 441 → 441
435	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED, COMPLETE . . . 1 YES, OBSERVED, NOT COMPLETE . . . . . 2 YES, REPORTED NOT SEEN . . . . . 3 NO 4	
436	Do you have a staff member who has had specific training for providing youth friendly services? IF YES, ASK: Is the staff member present today?	YES, PRESENT TODAY . . . . . 1 YES, NOT PRESENT TODAY . . . . . 2 NO 3	
437	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. What are the key components of the youth friendly services that are offered in this clinic/unit? ASK FOR EACH ITEM. CIRCLE ALL THAT APPLY.	SERVICES IN SEPARATE ROOM . . . . . A DISCOUNT FEES . . . . . B NO FEES . . . . . C OTHER _____ X (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
438	Please tell me if you have educational materials for any topic I mention, and if yes, which type of materials you have.	(a) FLIPCHART 1=YES 2=NO; (b) BROCHURES/ PAMPHLETS 1=YES 2=NO; (c) POSTERS 1=YES 2=NO; (d) VIDEO 1=YES 2=NO	
01	CONTRACEPTION	☐ ☐ ☐ ☐	
02	HIV/AIDS	☐ ☐ ☐ ☐	
03	STIs	☐ ☐ ☐ ☐	
04	NUTRITION	☐ ☐ ☐ ☐	
05	PREGNANCY	☐ ☐ ☐ ☐	
06	ABORTION	☐ ☐ ☐ ☐	
07	OTHER _____ (SPECIFY)	☐ ☐ ☐ ☐	
439	Are any of the materials for health education targeted to youth?	YES . . . . . 1 NO 2	
440	Which topic or topics are targeted toward youth? CIRCLE ALL THAT APPLY.	CONTRACEPTION . . . . . A HIV/AIDS . . . . . B STIs . . . . . C NUTRITION . . . . . D PREGNANCY . . . . . E ABORTION . . . . . F OTHER _____ X (SPECIFY) NONE OF THE ABOVE . . . . . Z	
441	Does this facility have a formal relationship with traditional birth attendants (TBAs) in which they receive training or other types of support?	YES . . . . . 1 NO 2	→ 448
442	Is there any documentation on activities with TBAs (such as lists of affiliated TBAs or records of their training)?	YES, OBSERVED . . . . 1 YES, REPORTED, NOT SEEN . . . 2 NO 3	
443	Please tell me how many TBAs report to this facility? ENTER "00" FOR "NONE"	# OF TBAs REPORTING ☐☐ . . . . . . DON'T KNOW 98	
444	Does anyone from this facility supervise the activities of the TBAs?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
445	Do the TBAs refer women to this facility?	YES . . . . . 1 NO 2	→ 448
446	When the TBAs refer clients to this facility, do they **always** accompany them to the facility?	YES . . . . . 1 NO 2	→448
447	If the TBAs accompany referred clients, do they **always** stay with them in the facility during labor and delivery?	YES . . . . . 1 NO 2	
448	What is the **most common** means of transport used by women coming from their homes to this facility for help during obstetric emergencies? IF THERE IS MORE THAN ONE MOST COMMON MEANS, CIRCLE THE NUMBER FOR ALL THAT APPLY.	PRIVATE VEHICLES . . . . . A MATATU/BUS . . . . . B HAND CART . . . . . C ANIMAL-DRIVEN CART . . . . . D AMBULANCE . . . . . E WHEELBARROW . . . . . F STRETCHER . . . . . G BICYCLE . . . . . H NO DELIVERIES EVER COME TO FACILITY . . . . . I OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	→ 457 THEN 500

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
449	Does this facility have a procedure for transporting women or sick newborns to another facility if necessary in an obstetric/sick child emergency? IF THIS IS THE REFERRAL FACILITY, CIRCLE 3	YES . . . . . 1 NO . . . . . 2 REFERRAL FACILITY . . . . . 3 DON'T KNOW 8	→ 452 → 456 → 452
450	Does this facility have a functional ambulance or vehicle for emergency transportation for clients?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 452 → 452
451	Is fuel available today?	YES, OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . 2 NO FUEL AVAILABLE . . . . . 3 DON'T KNOW 8	
452	What is the **most common** means by which women or sick newborns are transported from this facility to the nearest referral facility to receive help during an obstetric/sick child emergency? CIRCLE ALL THAT APPLY.	PRIVATE VEHICLES . . . . . A MATATU/BUS . . . . . B HAND CART . . . . . C ANIMAL-DRIVEN CART . . . . . D AMBULANCE . . . . . E WHEELBARROW . . . . . F STRETCHER . . . . . G BICYCLE . . . . . H OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	→ 456
453	How long does it take, using this form of transportation, to get to the nearest referral facility? IF CALL ELSEWHERE MUST BE MADE TO OBTAIN A VEHICLE, RECORD AVERAGE TIME FROM THE CALL TO THE PATIENT'S ARRIVAL AT THE REFERRAL FACILITY.	MINUTES . . . . . ☐☐☐ DON'T KNOW 998	
454	Please tell me what arrangements for financing emergency referral this facility has in place	FUNDS SET ASIDE FOR EMERGENCY TRANSPORT . . . A VEHICLE AVAILABLE LOCALLY FOR HIRE . . . . . B COMMUNITY HEALTH INSURANCE SCHEME . . . . . C FUEL SET ASIDE FOR EMERGENCY TRANSPORT . . . . D REVOLVING FUND SPECIFICALLY FOR PREGNANT WOMEN . . . . . E OTHER _____ X (SPECIFY) NONE . . . . . Y DON'T KNOW . . . . . Z	
455	Who makes transport arrangements for emergency evacuation of patients from this facility?	FACILITY STAFF . . . . . 1 RELATIVES . . . . . 2 BOTH FACILITY STAFF AND RELATIVES . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
456	Are ANC clients with HIV/AIDS or suspected HIV/AIDS ever provided services related to HIV/AIDS in this clinic/unit? This includes services related to prevention of mother to child transmission (PMTCT).	YES . . . . . 1 NO 2	→ PMTCT QRE
457	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐		

5. Delivery and Newborn Care

Code of facility: PROV DIST FAC Interviewer code: QRE TYPE: INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
500	Does this facility offer services for normal deliveries?	YES . . . . . 1 INFRASTRUCTURE AVAILABLE BUT NO SERVICE PROVIDED . 2 NO 3	 →535 →535
	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 502. **READ TO NEW RESPONDENT:** 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. Do you have any questions for me? May I continue? Interviewer's signature (Indicates respondent's willingness to participate) Date		
501	May I begin the interview now?	YES . . . . . 1 NO 2	 → STOP
502	Please tell me the total number of beds in the maternity ward/unit in this facility	# OF BEDS IN MATERNITY DON'T KNOW 998	
503	Does the facility provide 24 hour coverage for delivery services?	YES . . . . . 1 NO 2	 → 506
504	Is a person skilled in conducting deliveries present at the facility or on call 24 hours a day, including weekends, to provide delivery care? IF YES, ASK TO SEE A SCHEDULE FOR 24-HR STAFF ASSIGNMENT.	YES, PRESENT, SCHEDULE OBSERVED . . . . . 1 YES, PRESENT, SCHEDULE REPORTED, NOT SEEN . . . 2 YES, ON-CALL SCHEDULE OBSERVED . . . . . 3 YES, ON-CALL, SCHEDULE REPORTED, NOT SEEN . . . 4 NO 5	
505	At night, what level of provider is most commonly on duty to conduct deliveries? IF DIFFERENT LEVELS ARE COMMONLY AVAILABLE, CIRCLE ALL RELEVANT LEVELS. IF NO NIGHT DUTY IS OFFERED, INDICATE THE QUALIFICATION OF THE PERSON WHO PERFORMS DELIVERIES DURING DAY.	OBSTETRICIAN/ GYNECOLOGIST . . . . . A MEDICAL DOCTOR . . . . . B CLINICAL OFFICER . . . . . C REGISTERED MIDWIFE . . . . D ENROLLED MIDWIFE . . . . . E OTHER _____ X (SPECIFY)	
506	During normal working hours, what level of provider is most commonly available to conduct complicated deliveries?	OBSTETRICIAN/ GYNECOLOGIST . . . . . A MEDICAL DOCTOR . . . . . B CLINICAL OFFICER . . . . . C REGISTERED MIDWIFE . . . . . D ENROLLED MIDWIFE . . . . . E OTHER _____ X (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
507	Are there any routine fees charged for assisting pregnant women with normal deliveries?	YES . . . . . 1 NO 2	→ 509
508	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE YES NO / (b) AMOUNT IN KSH	
01	FIXED FEE FOR ALL NORMAL DELIVERY COSTS	1 → 01b 2 → 02	
02	FIXED FEE FOR ANC PLUS NORMAL DELIVERY	1 → 02b 2 → 03	
03	FEE FOR TESTS	1 → 03b 2 → 04	
04	FEE FOR MEDICATIONS	1 → 04b 2 → 509	
509	Are women in labor expected to bring along supplies and medications? IF YES: what are they expected to bring along? PROBE IF NECESSARY	STERILE GLOVES . . . . . A CLOTHES FOR BABY . . . . . B SANITARY PADS . . . . . C NEEDLES AND SYRINGES . . . D DRUGS . . . . . E OTHER _____ . . . X (SPECIFY) NO . . . . . Z	
510	Is there a register where client information from attended births is recorded? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW BIRTH OUTCOME FOR MOTHER AND INFANT.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO 3	→ 512 → 512
511	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 30 DAYS . . . 1 MORE THAN 30 DAYS OLD . . . 2	
512	How many women delivered at this facility during the previous 12 completed months?	NUMBER OF DELIVERIES . . DON'T KNOW 9998	→ 516
513	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q512.	MONTHS OF DATA . . . . DON'T KNOW 98	
514	What percentage of deliveries in your catchment area are conducted by this facility (what is your estimated annual coverage rate?)	% COVERAGE . . . . NO CATCHMENT AREA . . . 995 DON'T KNOW 998	→ 516 → 516
515	RECORD THE SOURCE OF INFORMATION FOR THE ESTIMATED DELIVERY COVERAGE.	WRITTEN REPORT . . . . . A WALL GRAPH . . . . . B OTHER _____ X (SPECIFY) SOURCE NOT KNOWN . . . . . Z	
516	Do midwives routinely provide home deliveries or attend home delivery emergencies as a part of the facility's services?	YES, ROUTINELY . . . . . 1 YES, EMERGENCY ONLY . . . 2 NO 3	→ 519
517	Is there a home delivery bag or kit? IF YES, ASK TO SEE THE BAG/KIT.	YES, BAG SEEN . . . . . 1 YES, BAG NOT SEEN . . . . . 2 NO 3	→ 519 → 519

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
518	INDICATE WHETHER THE ITEMS LISTED ARE IN THE DELIVERY BAG OR NOT.	YES	NO	
01	Soap	1	2	
02	Scissor or blade	1	2	
03	Clamp or umbilical tie	1	2	
04	Ergometrine oral	1	2	
05	Ergometrine inj. with syringe and needle	1	2	
06	Decontaminant	1	2	
07	IV Fluid with infusion set	1	2	
08	Sutures	1	2	
09	Dissecting forcep	1	2	
10	Clean gloves	1	2	
11	Cotton wool	1	2	
	ASK TO SEE THE ROOM WHERE NORMAL DELIVERIES ARE CONDUCTED.			
519	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 520-522, INDICATE WHICH SECTION THE ROOM WAS ASSESSED FOR.	FAM PLANNING [Q322-Q324] . . 1 ANTENATAL [Q430-Q432] . . . . 2 STI [Q623-Q625] . . . . . 3 NOT PREVIOUSLY SEEN 4		→ 523 → 523 → 523
520	DESCRIBE THE SETTING OF THE DELIVERY ROOM.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . . . 3 NO PRIVACY 4		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

521 NOTE THE AVAILABILITY AND CONDITION OF SUPPLIES AND EQUIPMENT REQUIRED FOR DELIVERY SERVICES. EQUIPMENT MAY BE IN DELIVERY ROOM OR AN ADJACENT ROOM.

	EQUIPMENT REQUIRED FOR DELIVERY SERVICES	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight source flashlight or examination light acceptable)	1→01b	2→01b	3→02	8→02	1	2	8
02	Table for gynecological exam	1	2	3	8			
02a	Sterile gloves	1→05	2	3	8			
03	Clean latex gloves	1→05	2	3	8			
04	Disposable, non-latex gloves	1	2	3	8			
05	Sharps container	1	2	3	8			
06	At least five or more 2-ml or 3-ml syringes (with 21 gauge needles)	1	2	3	8			
07	Decontamination solution for clinical equipment	1	2	3	8			
08	Waste receptacle with lid and plastic liner	1	2	3	8			
09	Hand-washing soap	1	2	3	8			
10	Single-use towels or functional electric drier	1	2	3	8			
11	Water for hand washing	1	2	3→523	8→523			

522 How is water being made available for use in the delivery service area *today?*

PIPED 1
BUCKET WITH TAP 2
BUCKET OR BASIN 3

523 NOTE THE AVAILABILITY AND CONDITION OF OTHER SUPPLIES AND EQUIPMENT.

	OTHER SUPPLIES AND EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	24-hour functioning light source (lantern acceptable)	1→01b	2→01b	3→02	8→02	1	2	8
02	Skin antiseptic (such as Dettol or Savlon)	1	2	3	8			
03	Intravenous infusion set	1	2	3	8			
04	Syringes and needles	1	2	3	8			
05	Suture material with needle	1	2	3	8			
06	Sterile scissors or blade	1	2	3	8			
07	Needle holder	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
524	MEDICATIONS IN DELIVERY SERVICE AREA	(a) AVAILABILITY				(b) VALID EXPIRY DATE		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Intravenous solutions: either Ringers lactate, D5NS, or NS infusion	1→01b	2→02	3→02	8→02	1	2	8
02	Injectable ergometrine	1→02b	2→03	3→03	8→03	1	2	8
03	Injectable oxytocin	1→03b	2→04	3→04	8→04	1	2	8
04	Injectable diazepam	1→04b	2→05	3→05	8→05	1	2	8
05	Injectable magnesium sulfate	1→05b	2→06	3→06	8→06	1	2	8
06	Hydralazine or apresoline inj.	1→06b	2→07	3→07	8→07	1	2	8
07	Injectable amoxicillin or ampicillin	1→07b	2→08	3→08	8→08	1	2	8
08	Injectable gentamicin	1→08b	2→09	3→09	8→09	1	2	8
09	Antibiotic eye drops or ointment (not chloramphenicol)	1→09b	2→10	3→10	8→10	1	2	8
10	Vitamin A 200,000 IU (oral)	1→10b	2→11	3→11	8→11	1	2	8
11	Procaine penicillin injection	1→11b	2→525	3→525	8→525	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
525	EQUIPMENT AND SUPPLIES FOR NEWBORN CARE	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Bag and mask or tube e.g. Ambu bag) or tube and infant-sized mask for resuscitation	1 → 01b	2 → 02	3 → 02	8 → 02	1	2	8
02	Source of heat *(incubator)* for premature infants	1 → 02b	2 → 03	3 → 03	8 → 03	1	2	8
03	Source of heat *(light)* for premature infants	1 → 03b	2 → 04	3 → 04	8 → 04	1	2	8
04	Infant scale	1 → 04b	2 → 05	3 → 05	8 → 05	1	2	8
05	Suction bulb for mucus extraction	1 → 05b	2 → 06	3 → 06	8 → 06	1	2	8
06	Suction apparatus for use with catheter	1 → 06b	2 → 07	3 → 07	8 → 07	1	2	8
07	Resuscitation table for newborn	1	2 → 08	3 → 08	8 → 08			
08	Disposable cord ties or clamps	1	2 → 09	3 → 09	8 → 09			
09	Towel or blanket to wrap baby	1	2 → 526	3 → 526	8 → 526			
526	GUIDELINES/ PROTOCOLS							
01	Guidelines for delivery and emergency obstetric care	1	2	3	8			
02	Wall chart on resuscitation of newborn	1	2	3	8			
03	Blank partographs	1	2	3	8			

526a	CHECK Q525(02). IS AN INCUBATOR AVAILABLE IN UNIT?	YES, OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . . 2 NOT AVAILABLE . . . . . 3 DON'T KNOW 8	→ 527 → 527 → 527
526b	Is there someone in the unit who has received technical training to operate the incubator?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
527	Now I want to ask you about routine practices related to the newborn at this facility. I am using the word "routine" to indicate that the activity is conducted for essentially all newborns or their mothers.		
01	Is rooming-in the normal practice in this facility? That is, does the baby stay in the same room with the mother?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
02	Does this facility routinely provide vitamin A to mothers before their discharge?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
528	Does this facility routinely observe any of the following practices postpartum, or related to newborns?	YES NO DON'T KNOW	
01	Suction the newborn by means of catheter	1 2 8	
02	Weigh the newborn	1 2 8	
03	Give full bath (immerse newborn in water) within 24 hours of birth	1 2 8	
04	Give the newborn prelacteal liquids	1 2 8	
05	Give the newborn OPV prior to discharge	1 2 8	
06	Give the newborn BCG prior to discharge	1 2 8	
529	Does the facility participate in regular reviews of maternal or newborn deaths or "near-misses"?	YES, FOR MOTHERS . . . . . 1 YES, FOR NEWBORNS . . . . . 2 YES, FOR BOTH . . . . . 3 NO, DOES NOT PARTICIPATE 4	→ 531
530	How often are reviews/audits of maternal and/or infant deaths and/or near misses carried out?	EVERY WEEKS . . . . . ☐☐ WHEN CASE OCCURS . . . . . 53 NEVER . . . . . 95 DON'T KNOW 98	
531	Does this facility handle assisted deliveries—that is, use forceps or ventous (vacuum extractor)? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES . . . . . 1 NO 2	→ 533

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
532	CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.		

		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Forceps	1→01b	2 → 02	3 → 02	8 → 02	1	2	8
02	Ventous (vacuum extractor)	1→02b	2→02b	3 → 533	8 → 533	1	2	8

533	Is this facility able to extract retained products of conception when necessary? IF YES, ASK TO SEE THE EQUIPMENT USED.	YES . . . . . 1 NO 2	→ 535

534	CHECK WHETHER THE EQUIPMENT IS IN THE DELIVERY ROOM OR AN ADJACENT ROOM.							
		(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Manual vacuum aspirator	1→01b	2→01b	3 → 02	8 → 02	1	2	8
02	Dilatation and curettage (D&C) kit	1→02b	2→02b	3 → 03	8 → 03	1	2	8
03	Other _____ (SPECIFY)	1→03b	2→03b	3 → 534a	8 → 534a	1	2	8

534a	Is there someone in the unit capable of conducting manual removal of placenta?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
535	Does this facility perform blood transfusions? 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 TRANSFUSION . . . 3	
536	Does this facility ever perform caesarean sections?	YES . . . . . 1 NO 2	→ 543a
537	Is there a routine fee for caesarean sections? IF YES: Please indicate the amount of the fee.	(a) FEE: YES NO 1→01b 2 → 538 (b) AMOUNT IN KSH:	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO

538 ASK TO SEE THE ROOM WHERE CAESAREAN SECTIONS ARE PERFORMED. CHECK IF THE FOLLOWING EQUIPMENT AND SUPPLIES ARE AVAILABLE IN THE ROOM OR IN AN ADJACENT ROOM.

	EQUIPMENT AND SUPPLIES FOR CAESAREAN SECTION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Operating table	1→ 01b	2→ 01b	3 → 02	8 → 02	1	2	8
02	Operating light	1→ 02b	2→ 02b	3 → 03	8 → 03	1	2	8
03	Anesthesia giving set	1→ 03b	2→ 03b	3 → 04	8 → 04	1	2	8
04	Scrub area adjacent to or in the operating room	1	2	3	8			
05	Tray, drum, or package with sterilized instruments ready for use	1	2	3	8			

539	Does this facility have a health worker who can perform a caesarean section present in the facility or on call 24 hours a day (including weekends)?	YES, PRESENT . . . . . 1 YES, ON CALL, SCHEDULE SEEN . . . . . 2 YES, ON CALL, SCHEDULE NOT SEEN . . . . . 3 NO 4	
540	Does this facility have an anesthetist present in the facility or on call 24 hours a day (including weekends)?	YES, PRESENT . . . . . 1 YES, ON CALL, SCHEDULE SEEN . . . . . 2 YES, ON CALL, SCHEDULE NOT SEEN . . . . . 3 NO 4	
541	How many caesarean sections were conducted at this facility during the past 12 completed months?	NUMBER OF C-SECTION . . ☐☐☐☐ DON'T KNOW 9998	
542	RECORD THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q541.	MONTHS OF DATA . . . . ☐☐ DON'T KNOW 98	
543	What is the date of the last caesarean section? TAKE THE DATE FROM THE REGISTER OR REPORT FORM.	MONTH ☐☐ YEAR ☐☐☐☐ DON'T KNOW 9998	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
543a	Were any of the following services performed at least once in the last three months?	YES	NO	DON'T KNOW	
01	Parenteral antibiotics	1	2	8	
02	Parenteral oxytocics	1	2	8	
03	Parenteral anticonvulsants/sedatives	1	2	8	
04	Manual removal of placenta	1	2	8	
05	Manual removal of retained products (e.g. manual vacuum aspiration) . . .	1	2	8	
06	Assisted vaginal delivery (e.g. vacuum extraction)	1	2	8	
07	Blood transfusion	1	2	8	
08	Caesarian section	1	2	8	
544	Please tell me if there are guidelines or tools for supervision , e.g. checklists for use in the maternity unit? IF YES, ASK TO SEE A DOCUMENT	YES, OBSERVED . . . . . 1 REPORTED, NOT SEEN . . . . 2 NOT AVAILABLE . . . . . 3 DON'T KNOW 8			
545	When was the last time the maternity unit was visited by the District Health Management Team?	WITHIN LAST 2 MONTHS . . . . 1 3-6 MONTHS AGO . . . . . 2 6-12 MONTHS AGO . . . . . 3 OVER 12 MONTHS AGO . . . . 4 NEVER VISITED . . . . . 5 DON'T KNOW 8			
546	Are clients with HIV/AIDS or suspected HIV/AIDS ever provided services related to HIV/AIDS in this clinic/unit? This includes services related to prevention of mother to child transmission (PMTCT).	YES . . . . . 1 NO 2			→ PMTCT QRE
547	After completing a delivery, 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. **IF VAGINAL DELIVERIES ARE CONDUCTED IN A DIFFERENT ROOM THAN CAESAREAN SECTION DELIVERIES, ASSESS THE PROCESSING EQUIPMENT FOR VAGINAL DELIVERIES.** PROBE, IF NECESSARY, FOR CORRECT RESPONSE	SOAKED IN DISINFECTANT SOLUTION AND BRUSH SCRUBBED WITH SOAP AND WATER . . . . . 01 BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT . 02 BRUSH SCRUBBED WITH SOAP AND WATER ONLY 03 SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED . . . 04 OTHER _____ 96 (SPECIFY) NONE 95			
548	Where is this equipment then processed prior to reuse? IF THE SYSTEM AT THAT LOCATION HAS ALREADY BEEN SEEN, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "3 " AND CONTINUE.	SECTION 1 [Q182-192] . . . . . 1 FAM PLANNING [Q342-351] . . 2 NOT PREVIOUSLY SEEN . . . . . 3 PROCESS OUTSIDE FACILITY . 4			→ 560 → 560 → 560

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
549	*Besides decontaminating and cleaning,* what is the final process most commonly used for disinfecting or sterilizing medical equipment (such as surgical instruments) before they are reused? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, CIRCLE ALL THAT APPLY.	DRY-HEAT STERILIZATION . . . A AUTOCLAVING . . . . . B STEAM . . . . . C BOILING . . . . . D CHEMICAL METHOD . . . . . E OTHER_____ X (SPECIFY) NONE . . . . . Y	→ 564

INDICATE THE RELEVANT INFORMATION FOR THE DECONTAMINATION AND CLEANING PROCEDURE FROM AMONG THOSE LISTED IN QUESTIONS 549-557.

GO TO WHERE EQUIPMENT IS PROCESSED AND ASSESS THE AVAILABILITY OF ITEMS AND THE PROCEDURES FOLLOWED AT THE FACILITY.

	ITEM	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
550	Electric dry heat sterilizer	1→ 550b	2→ 550b	3 → 551	8 → 551	1	2	8
551	Electric autoclave (pressure and wet heat)	1→ 551b	2→ 551b	3 → 552	8 → 552	1	2	8
552	Non-electric autoclave	1→ 552b	2→ 552b	3 → 553	8 → 553	1	2	8
553	Pot with cover (for steaming or boiling)	1	2	3	8			
554	Other_____ (SPECIFY)	1	2	3	8			
555	Heat source (stove or cooker with fuel or power present) for steaming, boiling, or using a non-electric autoclave	1→ 555b	2→ 555b	3 → 556	8 → 556	1	2	8
556	Automatic timer (MAY BE ON MACHINE)	1→ 556b	2→ 556b	3 → 557	8 → 557	1	2	8
557	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
558	Written guildelines for disinfection and sterilization	1	2	3	8			

559	FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/ DISINFECTION USED IN THE FACILITY, INDICATE THE PROCESSING DETAILS INCLUDING TIME PROCESSED AFTER THE REQUIRED TEMPERATURE/ PRESSURE/ BOILING IS REACHED						
		(1) Dry heat sterilization	**(2)** Autoclave	**(3)** Boil or steam (high level disinfectant, HLD)	**(4)** Chemical decontaminant	**(5)** Chemical High Level Disinfectant (HLD)	**(6)** OTHER
A	Method	USED . . . . . 1 NOT USED . . 2 → 01b	USED . . . . . 1 NOT USED . . 2 → 01c	USED . . . . . 1 NOT USED . . 2 → 01d	USED . . . . . 1 NOT USED . . 2 → 01e	USED . . . . . 1 NOT USED . . 2 → 01f	USED . . . . . 1 NOT USED . . 2 → 560
B	Temperature (centigrade)	TEMPERATURE ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998	TEMPERATURE ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998				TEMPERATURE ☐☐☐ AUTOMATIC . . . . . 666 DON'T KNOW . . . 998
C	Pressure		PRESS-URE ☐☐☐ UNITS OF PRESSURE: POUNDS/SQ.IN . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4 AUTOMATIC . . . . 666 DON'T KNOW . . . 998				PRESS-URE ☐☐☐ UNITS OF PRESSURE: POUNDS/SQ.IN . . 1 ATM PRESSURE . . 2 KILOPASCAL . . . 3 MILLIMETER HG . . 4 AUTOMATIC . . . . 666 DON'T KNOW . . . 998
D	Minutes-when equipment is not wrapped in cloth	MINUTES ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998	MINUTES ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998	MINUTES ☐☐☐ DON'T KNOW . . . 998
E	Minutes when equipment is wrapped		MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998				MINUTES WRAPPED ☐☐☐ AUTOMATIC . . . 666 DON'T KNOW . . . 998
F	Chemical solution				JIK (chlorine) . . . . . 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8	JIK (chlorine) . . . . . 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8	JIK (chlorine) . . . . . 1 CIDEX . . . . . 2 BETADINE . . . . . 3 ALCOHOL . . . . . 4 OTHER . . . . . 6 DON'T KNOW 8
G	Percent solution				PERCENT ☐☐ DON'T KNOW 98	PERCENT ☐☐ DON'T KNOW 98	
H	Mixture, parts solution and water				MIXTURE PARTS a) DISINFECTANT ☐ b) WATER ☐☐ DON'T KNOW 998	MIXTURE PARTS a) DISINFECTANT ☐ b) WATER ☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
560	INDICATE ALL STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (SUCH AS SPECULUM , FORCEPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED, INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT PREVIOUSLY ASSESSED, CIRCLE “3” AND CONTINUE.	SECTION 1 [Q193-195] . . . . . 1 FAM PLANNING [Q352-355]. . . 2 NOT PREVIOUSLY SEEN 3				→ 564 → 564
561	INDICATE STORAGE CONDITIONS FOR PROCESSED EQUIPMENT USED FOR THIS SERVICE DELIVERY AREA.	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	Wrapped in sterile cloth, sealed with TST tape	1	2	3	8	
02	Stored in sterile container with lid that clasps shut	1	2	3	8	
03	Stored unwrapped inside an autoclave or dry-heat sterilizer	1	2	3	8	
04	On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8	
05	In container with disinfectant or antiseptic	1	2	3	8	
06	Other _____ (SPECIFY)	1	2	3	8	
562	Date of sterilization written on packet or container with processed items	1	2	3	8	
563	Storage location dry and clean	1	2	3	8	
564	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐					

6. STIs

Code of facility: PROV DIST FAC Interviewer code: QRE TYPE: INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
600	Does this facility offer any services related to diagnosis of or treatment for sexually transmitted infections (STIs?)	YES . . . . . 1 NO 2	→ STOP
	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF STI SERVICES. IF THIS PERSON IS DIFFERENT FROM RESPONDENTS IN THE FACILITY WHOM YOU OBTAINED INFORMATION FROM FOR EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 602. **READ TO NEW RESPONDENT:** Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services for infectious diseases such as 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. Do you have any questions for me? May I continue? Interviewer's signature (Indicates respondent's willingness to participate) _____ Date _____		
601	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
602	First, I want to ask specifically about services for clients with symptoms that may be STIs. Does this facility offer such services?	YES . . . . . 1 NO 2	→ 626
603	Are services for STI clients being offered at this facility today?	YES . . . . . 1 NO 2	
604	Are STI services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC . . . . . 1 GENERAL OUTPATIENT 2	
605	How many days per week are STI services available in either the special or the general clinic?	NUMBER OF DAYS	
606	Are there any routine fees charged for services or items related to STIs?	YES . . . . . 1 NO 2	→ 608
607	For each of the following items, indicate if there is any routine fee, and if yes, the amount of the fee	(a) FEE: YES / NO; (b) AMOUNT IN KSH	
01	FEE FOR HEALTH RECORD/CARD	1 → 01b 2 → 02	
02	FEE FOR CONSULTATION	1 → 02b 2 → 03	
03	FEE FOR LAB TESTS	1 → 03b 2 → 04	
04	FEE FOR MEDICATIONS	1 → 04b 2 → 608	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
608	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY.	SYNDROMIC APPROACH . . A ETIOLOGIC (LAB) . . . . . B CLINICAL JUDGMENT C	
609	Does this facility have a protocol regarding confidentiality for STI clients? IF YES, ASK TO SEE A COPY.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN 2 NO . . . . . 3 DON'T KNOW 8	
610	Does the facility normally perform partner notification or follow-up? IF YES: Is the follow-up ever active (where the facility makes contact with the partner) or is it only passive (where the facility asks the clients to inform or bring their partners)?	YES, SOMETIMES ACTIVE . . 1 YES, ONLY PASSIVE . . . . . 2 NO 3	 → 612 → 612
611	Do you have a form–a referral form or a register where records are kept about clients for active follow-up? IF YES, ASK TO SEE A COPY.	YES, FORM OBSERVED . . . . 1 YES, REGISTER OBSERVED . . 2 YES, FORM/REGISTER REPORTED, NOT SEEN . . 3 NO 4	
612	Is there a register where information is recorded on STI consultations? IF YES, ASK TO SEE THE REGISTER. FOR THE REGISTER TO BE VALID, IT MUST SHOW CLIENTS' NAME, AGE, SEX, AND DIAGNOSIS OR MAIN SYMPTOM.	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . 2 NO 3	 → 617 → 617
613	Does the register indicate a specific type of STI that was diagnosed?	YES . . . . . 1 NO 2	
614	HOW RECENT IS THE DATE OF THE MOST RECENT ENTRY?	WITHIN THE PAST 7 DAYS . . . 1 MORE THAN 7 DAYS OLD . . 2	
615	RECORD THE NUMBER OF CLIENTS WHO RECEIVED STI SERVICES DURING THE PAST 12 COMPLETED MONTHS.	NUMBER OF STI CLIENTS . . ☐☐☐☐ DON'T KNOW 9998	 → 617
616	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED IN Q615	MONTHS OF DATA . . . . ☐☐ DON'T KNOW 98	
617	Do you submit an official report externally to NASCOP (or a public-health agency responsible for communicable diseases) that specifically identifies numbers of cases of venereal diseases (syphilis, gonorrhea) or HIV/AIDS seen by the facility services? IF YES: Is the report generated from consultation records or from the laboratory?	YES, CONSULTATION . . . . . 1 YES, LABORATORY . . . . . 2 YES, BOTH . . . . . 3 NO 4	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
618	ASK TO SEE WHERE COUNSELING FOR CLIENTS WITH SYMPTOMS OF STIs IS PROVIDED. DESCRIBE THE SETTING.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . . . 3 NO PRIVACY 4				
	ASK TO SEE EACH OF THE FOLLOWING ITEMS, AND ASSESS IF THE ITEM IS IN THE ROOM (OR AN ADJACENT ROOM) WHERE COUNSELING OR EXAMINATION OF STI CLIENTS TAKES PLACE.					
619	VISUAL AIDS FOR TEACHING	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW	
01	About STIs	1	2	3	8	
02	About HIV/AIDS	1	2	3	8	
03	Model to demonstrate use of condom	1	2	3	8	
	INFORMATION FOR CLIENT TO TAKE HOME					
04	About STIs	1	2	3	8	
05	About HIV/AIDS	1	2	3	8	
06	Condoms that can be given to the client	1	2	3	8	
620	SERVICE DELIVERY STANDARDS/PROTOCOLS					
01	Etiologic (laboratory) diagnosis of STIs	1	2	3	8	
02	Treatment protocols for STIs	1	2	3	8	
03	Syndromic approach guidelines (treatment chart)	1	2	3	8	
04	Guidelines for diagnosing HIV/AIDS	1	2	3	8	
05	Clinical treatment guidelines for HIV/AIDS (antiretroviral therapy, or treatment of opportunistic infections)	1	2	3	8	
06	Individual client health records or charts	1	2	3	8	
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR STIs ARE CONDUCTED.					
621	IF THE *SAME EXAMINATION ROOM* HAS ALREADY BEEN OBSERVED FOR ITEMS IN 622-624, INDICATE WHICH SECTION THE ROOM WAS ASSESSED FOR.	FAM PLANNING [Q322-Q324] . . 1 ANTENATAL [Q430-Q432] . . . 2 DELIVERY [Q521-Q523] . . . . . 3 NOT PREVIOUSLY SEEN 4				→ 625 → 625 → 625
622	DESCRIBE THE SETTING OF THE EXAMINATION ROOM. IF THIS IS THE SAME ROOM WHERE CONSULTATIONS OCCUR (Q618), CIRCLE “5”.	PRIVATE ROOM WITH VISUAL AND AUDITORY PRIVACY . 1 NON-PRIVATE ROOM WITH AUDITORY AND VISUAL PRIVACY . . . . . 2 VISUAL PRIVACY ONLY . . 3 NO PRIVACY . . . . . 4 CONSULT AND EXAM IN SAME ROOM 5				

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
623	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM.							
	SUPPLIES AND EQUIPMENT REQUIRED FOR EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONING		
		OBSERVED PRESENT	REPORTED NOT SEEN	NOT AVAILABLE	DON'T KNOW	YES	NO	DON'T KNOW
01	Spotlight source flashlight or examination light acceptable)	1 → 01b	2 → 01b	3 → 02	8 → 02	1	2	8
02	Table for gynecological exam	1	2	3	8			
03	Clean latex gloves	1 → 05	2	3	8			
04	Disposable non-latex gloves	1	2	3	8			
05	Sharps container	1	2	3	8			
06	At least five or more 2-ml or 3-ml syringes (with 21 gauge needles)	1	2	3	8			
07	Decontamination solution for clinical equipment	1	2	3	8			
08	Waste receptacle with lid and plastic liner	1	2	3	8			
09	Hand-washing soap	1	2	3	8			
10	Single-use hand drying towels or functioning electric hand drier	1	2	3	8			
11	Water for handwashing	1	2	3 → 625	8 → 625			
624	How is water being made available for use in the service area *today?*	PIPED . . . . . 1 BUCKET WITH TAP . . . . . 2 BUCKET OR BASIN 3						
625	FOR EACH OF THE FOLLOWING ITEMS, CHECK TO SEE WHETHER ITEM IS EITHER IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN ADJACENT ROOM. OTHER EQUIPMENT REQUIRED FOR EXAMINATION	OBSERVED	REPORTED, NOT SEEN	NOT AVAILABLE	DON'T KNOW			
01	Vaginal speculum (L)	1	2	3	8			
02	Vaginal speculum (M)	1	2	3	8			
03	Vaginal speculum (S)	1	2	3	8			
04	Swab sticks	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
626	FOR EACH OF THE FOLLOWING LABORATORY TESTS, ASK: Is this test ever prescribed or provided for STI clients? IF YES, ASK: Is the test conducted in the facility? Or do you collect the specimen and send it elsewhere for the test, or does the client have to go somewhere else for the test?		

	FOR EACH TEST CONDUCTED AT FACILITY, ASSESS AVAILABILITY OF EQUIPMENT AND SUPPLIES (LAB MODULE IN HIV)	CONDUCT TEST	COLLECT SPECI-MEN	SEND CLIENT ELSEWHERE	TEST NOT UTILIZED	DON'T KNOW
01	Syphilis	1	2	3	4	8
02	Gonorrhea	1	2	3	4	8
03	TB sputum smear	1	2	3	4	8
04	HIV test	1	2	3	4	8

627	Does this clinic/unit have any specific youth friendly services (YFS)?	YES, IN CLINIC UNIT . . . . . 1 YES, OTHER LOCATION . . . . . 2 NO 3	→ 634 → 634
628	Are there any written policies or guidelines for the youth friendly services? IF YES, ASK TO SEE THE POLICY/GUIDELINE.	YES, OBSERVED, COMPLETE . 1 YES, OBSERVED, NOT COMPLETE . . . . . 2 YES, REPORTED NOT SEEN . 3 NO 4	
629	Do you have a staff member who has had specific training for providing youth friendly services? IF YES, ASK: Is the staff member present today?	YES, PRESENT TODAY . . . . 1 YES, NOT PRESENT TODAY . . 2 NO 3	
630	ASK TO SEE THE LOCATION WHERE YFS ARE PROVIDED. ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE ABOUT THE YOUTH FRIENDLY SERVICES. What are the key components of the youth friendly services that are offered in this clinic/unit? ASK FOR EACH ITEM. CIRCLE ALL THAT APPLY.	SERVICES IN SEPARATE ROOM . . . . . A DISCOUNT FEES . . . . . B NO FEES . . . . . C OTHER _____ X (SPECIFY)	

		(a) FLIPCHART 1=YES 2=NO	(b) BROCHURES/ PAMPHLETS 1=YES 2=NO	(c) POSTERS 1=YES 2=NO	(d) VIDEO 1=YES 2=NO
631	Please tell me if you have educational materials for any topic I mention, and if yes, which type of materials you have.				
01	CONTRACEPTION	☐	☐	☐	☐
02	HIV/AIDS	☐	☐	☐	☐
03	STI	☐	☐	☐	☐
04	NUTRITION	☐	☐	☐	☐
05	PREGNANCY	☐	☐	☐	☐
06	ABORTION	☐	☐	☐	☐
07	OTHER _____ (SPECIFY)	☐	☐	☐	☐

632	Are any of the materials for health education targeted to youth?	YES . . . . . 1 NO 2	→ 634

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
633	Which topic or topics are targeted toward youth? CIRCLE ALL THAT APPLY.	CONTRACEPTION . . . . . A HIV/AIDS . . . . . B STIs . . . . . C NUTRITION . . . . . D PREGNANCY . . . . . E ABORTION . . . . . F OTHER _____ X (SPECIFY) NONE OF THE ABOVE . . . . . Y	
634	Are clients with HIV/AIDS or suspected HIV/AIDS, or with tuberculosis ever provided services related to HIV/AIDS in this clinic/unit?	YES . . . . . 1 NO 2	→ 635 → QRE B
635	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐		

7. Availability of Contraceptive Supplies

Code of facility: ☐☐ PROV ☐☐ DIST ☐☐ FAC Interviewer code: ☐☐ QRE TYPE ☐ INV

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR CONTRACEPTIVE SUPPLIES AT THE FACILITY. IF THIS PERSON IS DIFFERENT FROM RESPONDENTS IN THE FACILITY WHOM YOU OBTAINED INFORMATION FROM FOR EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS NOT A NEW RESPONDENT, CONTINUE WITH 700. **READ TO NEW RESPONDENT:** Hello. I am representing the Ministry of Health. We are carrying out a survey of facilities that provide health services to women and children, with the goal of finding ways to improve the delivery of service. We would like to talk to you about this facility and your experiences providing health services. 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? May I continue? _____ Interviewer's signature (Indicates respondent's willingness to participate) _____ Date		
700	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
701	Are any contraceptive methods ever stored in this facility?	YES . . . . . 1 YES, AREA LOCKED, NO ACCESS . . . . . 2 NO 3	→ 717 → 717
702	Is there are register, or stock cards where the amount of contraceptive supplies received, the amount disbursed, and the amount present today is recorded? IF YES, ASK: May I see the record?	YES, OBSERVED . . . . . 1 YES, REPORTED NOT SEEN . 2 NO 3	→ 704
703	CIRCLE THE RESPONSE THAT BEST DESCRIBES THE SYSTEM IN Q702.	REGISTER/STOCK CARDS NOT UPDATED DAILY, BUT THERE IS DAILY RECORD OF DISTRIBUTED MEDICINES . . 1 REGISTER/STOCK CARDS UPDATED DAILY . . . . . 2 OTHER _____ SPECIFY 3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	ASK TO SEE WHERE CONTRACEPTIVE METHODS ARE STORED. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR NON-SHADED RESPONSES FOR (b) AND (c) CHECK ALL OF EACH METHOD, TO VERIFY: 1) IF THEY WERE ARRANGED BY EXPIRY DATE; 2) IF THERE ARE ANY EXPIRED UNITS PRESENT; AND 3) THAT THE INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY RECORD OR PRESCRIPTIONS AND SUBTRACT THESE FROM THE INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE.		

704	CONTRACEPTIVE METHOD	(a) AVAILABILITY OF METHOD WITH VALID EXPIRY DATE				(b) ALL CHECKED METHODS WERE VALID			(c) AMOUNT OF STOCK AND INVENTORY MATCH		
		AT LEAST ONE VALID	REPORTED, NOT SEEN	NOT AVAIL-ABLE	DON'T KNOW	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
01	Combined oral pill	1→01b	2→02	3→02	8→02	1	2	8	1	2	8
02	Progesterone-only pill	1	2	3	8						
03	Combined injection (e.g., Norigynon)	1	2	3	8						
04	Progesterone-only injection (e.g., Depo)	1→04b	2→05	3→05	8→05	1	2	8	1	2	8
05	Implant	1	2	3	8						
06	Male condoms	1→06b	2→07	3→07	8→07	1	2	8	1	2	8
07	Female condoms	1	2	3	8						
08	Intrauterine device (IUD)	1	2	3	8						
09	Emergency contraceptive pill	1	2	3	8						
10	Spermicide	1	2	3	8						
11	Diaphragm	1	2	3	8						

705	Were the methods organized according to expiry date ("first expire, first out")? (VERIFY WHEN COMPLETING Q704.)	YES, VERIFIED . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

706	Have you experienced a stockout of any of the methods we just discussed during the past 6 months? IF YES, which ones?	STOCKOUT IN LAST 6 MONTHS YES	NO	DON'T KNOW	
01	Combined oral pills	1	2	8	
02	Progesterone-only pills	1	2	8	
03	Combined injection (e.g., Norigynon)	1	2	8	
04	Progesterone-only injection (e.g., Depo)	1	2	8	
05	Implant	1	2	8	
06	Male condoms	1	2	8	
07	Female condoms	1	2	8	
08	IUD	1	2	8	
09	Emergency contraceptive pills	1	2	8	
10	Spermicides	1	2	8	
11	Diaphragm	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
707	Are contraceptive supplies stored in the same location as other medicines?	YES . . . . . 1 NO 2	→ 711
	OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE PRESENCE (OR ABSENCE) OR EACH OF THE FOLLOWING CONDITIONS.		
708	ARE THE METHODS OFF THE FLOOR AND PROTECTED FROM WATER?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
709	ARE THE METHODS PROTECTED FROM SUN?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
710	IS THE ROOM CLEAN OF EVIDENCE OF RODENTS (BATS, RATS) OR PESTS (COCKROACHES, ETC.).	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
711	When was the last time that you received a routine supply of contraceptive methods?	WITHIN PRIOR 4 FULL WEEKS 1 BETWEEN 4-12 WEEKS . . . . 2 MORE THAN 12 WEEKS AGO. . 3 DON'T KNOW 8	
712	Does this facility determine the quantity of each contraceptive method required and order that, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS . . . . . 1 NEED DETERMINED ELSEWHERE . . . . . 2 DON'T KNOW 8	→ 714 → 717
713	Do you always receive a standard fixed supply or does the quantity you receive vary according to the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL . . . . . 1 STANDARD FIXED SUPPLY . . 2 DON'T KNOW 8	→ 717 → 717 → 717
714	Routinely, when you order contraceptive methods, which best describes the system you use to determine **how much** of each to order? Do you: Review the amount of each method remaining, and order to bring the stock amount to a pre-determined (fixed) amount? Order exactly the same quantity each time, regardless of the existing stock? Review the amount of each method used since the previous order, and plan based on prior utilization and expected future activity? Other _____ (SPECIFY) DON'T KNOW	ORDER TO MAINTAIN FIXED STOCK . . . . . 1 ORDER SAME AMOUNT . . . . . 2 ORDER BASED ON UTILIZATION . . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	→ 716 → 716 → 717
715	Which of the following best describes the routine system for deciding **when** to order contraceptive methods? Do you: Place order whenever stock levels fall to a predetermined level? Have a fixed time that orders are submitted? IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. Place an order whenever there is believed to be a need, regardless of stock level? Other _____ (SPECIFY) Don't know	PREDETERMINED LEVEL . . . 1 FIXED TIME . . . . . 2 EVERY ☐☐ WEEKS ORDER WHEN NEEDED . . . . 3 OTHER . . . . . 6 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
716	During the past 3 months, have you always, sometimes, or almost never received the amount of contraceptive methods that you ordered (or that you are supposed to routinely receive)?	ALWAYS . . . . . 1 SOMETIMES . . . . . 2 ALMOST NEVER 3	
717	If there is a shortage of a specific method between routine orders, what is the most common procedure followed by this facility?		
	Submit special order to normal supplier	SPECIAL ORDER 1	
	Facility purchases from private market	FACILITY PURCHASE 2	
	Clients must purchase from outside the facility	CLIENT PURCHASE OUTSIDE 3	
718	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐		

MEASURE *DHS+* SERVICE PROVISION ASSESSMENT

Observation of Sick-Child Consultation

1. Facility Identification

QTYPE . . . . . O S C

Name of the facility: _____

Location of the facility: _____

Province _____ PROVINCE NUMBER . . . . . [ ][ ]

District _____ DISTRICT NUMBER . . . . . [ ][ ]

Number of the facility: _____ FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Provider Information

Provider category:

Consultant	01	Registered Midwife	05
Medical Doctor	02	Enrolled Nurse	06
Clinical Officer	03	Enrolled Midwife	07
Registered Nurse	04	Nurse Aid	08

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY . . . . . [ ][ ]

Sex of provider: (1=Female; 2=Male) SEX OF PROVIDER . . . . . [ ]

Code for provider should be the same as the one used for the provider interview. PROVIDER CODE . . . . . [ ][ ]

3. Information About Observation

DAY . . . . . [ ][ ]

Date: _____ MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the observer: _____ OBSERVER CODE . . . . . [ ][ ]

Time observation started: _____ TIME OBSERVATION STARTED [ ][ ] : [ ][ ]

Client code: _____ CLIENT CODE . . . . . [ ][ ]

4. Observation of Sick-Child Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CHILD'S CARETAKER. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. BE AS DISCREET AS POSSIBLE DURING THE ASSESSMENT. DO NOT TAKE PART IN THE INTERACTION BETWEEN THE PROVIDER AND THE CHILD'S CARETAKER. TRY TO SIT BEHIND THE CARETAKER AND CHILD BUT TO ONE SIDE, SO YOU WILL NOT BE SITTING DIRECTLY IN FRONT OF THE PROVIDER. FOR EACH OF THE ITEMS BELOW, CIRCLE THE ANSWER THAT BEST EXPRESSES YOUR ASSESSMENT OF WHAT HAPPENED DURING THE INTERACTION. **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 the delivery of services. I would like to observe your consultation with this caretaker and child in order to better understand how health care is provided in this facility. Any information you give me will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ STOP
	READ TO 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 this consultation in order to better understand how health care is provided. Any information you give will be kept completely confidential and will not affect the level of care you receive here, now or in the future. If, at any point, you would prefer I leave, please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
102	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CARETAKER.	YES . . . . . 1 NO 2	→ STOP
103	RECORD SEX OF THE CHILD.	MALE . . . . . 1 FEMALE 2	
104	RECORD THE VISIT TYPE (THIS REFERS TO THIS SICKNESS).	FIRST VISIT . . . . . 1 FOLLOW-UP . . . . . 2 DON'T KNOW 8	

5. Provider's Interaction With Caretaker and Child					
NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING **MAJOR SYMPTOMS**.	YES	NO	DK	
01	Cough or difficult breathing	1	2	8	
02	Diarrhea	1	2	8	
03	Fever or body hotness	1	2	8	
04	Ear problems	1	2	8	
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING.				
01	Whether the child is unable to drink or breastfeed at all	1	2	8	
02	Whether the child vomits everything	1	2	8	
03	Whether the child has had convulsions with this sickness	1	2	8	
107	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING **PHYSICAL EXAMINATIONS**.				
01	Take child's temperature by thermometer	1	2	8	
02	Feel the child for fever or body hotness	1	2	8	
03	Count respiration (breaths)	1	2	8	
04	Check skin turgor for dehydration (pinch abdominal skin)	1	2	8	
05	Check for pallor by looking at palms	1	2	8	
06	Check for pallor by looking at conjunctiva or mouth	1	2	8	
07	Look in child's ear	1	2	8	
08	Feel behind child's ear	1	2	8	
09	Undress child to examine	1	2	8	
10	Press both feet to check for edema	1	2	8	
11	Weigh the child IF YES:	1	2 → 108	8 → 108	
12	Plot weight on growth chart	1 → 108	2	8	
13	Compare child's weight to standard weight	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
108	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH **BY DOING ANY OF THE FOLLOWING.**	YES	NO	DK		
01	Offer the child something to drink or ask the mother to put the child to the breast (TO FIND OUT WHETHER THE CHILD CAN DRINK)	1	2	8		
02	Ask about normal feeding practices when the child is not ill	1	2	8		
03	Ask about normal breastfeeding practices when the child is not ill	1	2	8		
04	Ask about feeding or breastfeeding practices for the child during this illness	1	2	8		
05	Mention the child's weight or growth to the caretaker, or discuss the growth chart with the caretaker	1	2	8		
06	Look at the child's immunization card or ask the caretaker about child's vaccination history	1	2	8		
07	Ask if child received Vitamin A	1	2	8		
08	Look at the child's health card either before beginning the consultation, or while collecting information from the caretaker, or when examining the child (THIS ITEM MAY BE EITHER THE VACCINATION CARD OR ANOTHER HEALTH CARD).	1	2	8		
109	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING WHEN COUNSELING THE CARETAKER.	YES	NO	DK	NA	
01	Provide general information about feeding or breast-feeding the child even when not sick	1	2	8		
02	Tell the caretaker to give extra fluids to the child during this sickness	1	2	8		
03	Tell the caretaker to continue feeding the child during this sickness	1	2	8		
04	Tell the caretaker what illness(es) the child has	1	2	8		
05	Describe signs or symptoms in the child for which the caretaker should immediately bring the child back	1	2	8		
110	RECORD WHETHER THE CHILD WAS REFERRED TO ANOTHER PROVIDER OR FOR A LABORATORY TEST. IF YES:	1	2 → 111	8 → 111		
01	RECORD WHETHER THE PROVIDER EXPLAINED WHY THE REFERRAL WAS MADE.	1	2	8	5	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
111	RECORD WHETHER ORAL MEDICATIONS WERE PRESCRIBED OR PROVIDED DURING THE CONSULTATION. THIS REFERS TO MEDICINES THE CARETAKER WILL GIVE TO THE CHILD AT HOME, AND DOES NOT INCLUDE PARACETAMOL OR ORS PROVIDED FOR IMMEDIATE TREATMENT BUT NOT PRESCRIBED FOR HOME TREATMENT. IF YES: RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING.	YES 1	NO 2 → 112	DK 8 → 112	NA	
01	Explain how to administer oral treatment(s)	1	2	8	5	
02	Ask the caretaker to repeat the instructions for the medications	1	2	8	5	
03	Give the first dose of the oral treatment	1	2	8	5	
112	RECORD WHETHER A PROVIDER USED ANY VISUAL AIDS WHEN PROVIDING INDIVIDUAL HEALTH EDUCATION OR COUNSELING TO THE CARETAKER ABOUT THE CHILD.	1	2	8		
113	RECORD WHETHER THE MAIN PROVIDER WROTE ON THE CHILD'S HEALTH CARD/ BOOK.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD/BOOK USED . . . . . 3 DON'T KNOW 8				
114	RECORD THE OUTCOME OF THE CONSULTATION. (THIS IS THE POINT WHEN THE OBSERVATION CONCLUDED)	CHILD SENT HOME . . . . . 1 CHILD REFERRED TO PROVIDER AT SAME FACILITY . . . . . 2 CHILD ADMITTED TO SAME FACILITY . . . . . 3 CHILD SENT TO LAB . . . . . 4 CHILD REFERRED TO OTHER FACILITY 5				
115	RECORD THE TIME WHEN THE CONSULTATION ENDED.	☐☐ : ☐☐				

6. Diagnosis and Classification and Treatment

ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS. EXPLAIN THAT FOR ANY DIAGNOSIS OR SYMPTOM YOU WANT TO KNOW IF THE PROBLEM WAS SEVERE, MODERATE, OR MINOR. THEN ASK ABOUT THE TREATMENT PRESCRIBED OR PROVIDED.

	DIAGNOSIS OR MAIN SYMPTOMS (IF NO DIAGNOSIS)	201 1 SEVERE	2 MOD-ERATE	3 MINOR	4 NO	8 DON'T KNOW
RESPIRATORY SYSTEM	A) PNEUMONIA	1	2		4	8
	B) BRONCHO-PNEUMONIA	1	2		4	8
	C) BRONCHIAL SPASM/ASTHMA	1	2	3	4	8
	D) UPPER RESPIRATORY INFECTION (URI)	1	2	3	4	8
	E) RESPIRATORY ILLNESS, DIAGNOSIS UNCERTAIN	1	2	3	4	8
	F) COUGH, DIAGNOSIS UNCERTAIN	1	2	3	4	8
DIGESTIVE SYSTEM	G) PERSISTENT DIARRHEA	1	2	3	4	8
	H) DIARRHEA	1	2	3	4	8
	I) DYSENTERY	1	2	3	4	8
	J) AMEBIASIS	1	2	3	4	8
	K) OTHER DIARRHEA _____ (SPECIFY)	1	2	3	4	8
DEHY-DRA-TION	L) DEHYDRATION	1	2	3	4	8
MALARIA	M) MALARIA (CLINICAL DIAGNOSIS)	1	2	3	4	8
	N) MALARIA (BLOOD SMEAR)	1	2	3	4	8
	O) PROBABLE MALARIA (BY SYMPTOMS)	1	2	3	4	8
FEVER	P) FEVER	1	2	3	4	8
	Q) MEASLES	1	2	3	4	8
	R) MEASLES WITH COMPLICATIONS	1	2	3	4	8
EAR	S) MASTOIDITIS	1	2	3	4	8
	T) ACUTE EAR INFECTION	1	2	3	4	8
	U) CHRONIC EAR INFECTION	1	2	3	4	8
THROAT	V) STREPTOCOCCAL SORE THROAT	1	2	3	4	8
	W) NON-STREPTOCOCCAL SORE THROAT	1	2	3	4	8
	X) OTHER THROAT OR EAR DIAGNOSIS _____ (SPECIFY)	1	2	3	4	8
	Y) OTHER DIAGNOSIS _____ (SPECIFY)	1	2	3	4	8

202	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 NOT APPLICABLE . . . . . 5 NOT CERTAIN 8	

203	ASK ABOUT PRESCRIPTION, TREATMENT AND ACTIONS TAKEN FOR ILLNESS AND PROBE "ANYTHING ELSE?"	YES	NO	DK	
	01) TREATMENT	1	2	8	
TREATMENTS FOR VARIOUS ILLNESSES	02) BENZATHINE PENICILLIN INJECTION	1	2	8	
	03) OTHER ANTIBIOTIC INJECTION	1	2	8	
	04) OTHER INJECTION	1	2	8	
	05) CO-TRIMOXAZOLE/AMOXICILLIN	1	2	8	
	06) OTHER ANTIBIOTIC TABLET/SYRUP	1	2	8	
	07) PARACETAMOL	1	2	8	
	08) VITAMINS	1	2	8	
	09) COUGH SYRUPS/OTHER MEDICATION FOR SYMPTOMATIC TREATMENT	1	2	8	
RESPIRATORY	10) NEBULIZED OR INHALER	1	2	8	
	11) INJECTABLE BRONCHODILATOR (ADRENALINE)	1	2	8	
	12) ORAL BRONCHODILATOR	1	2	8	
	13) DRY EAR BY WICKING	1	2	8	
MALARIA	14) INJECTABLE QUININE, FANSIDAR OR ARTEMETHER	1	2	8	
	15) INJECTABLE CHLOROQUINE	1	2	8	
	16) OTHER INJECTABLE ANTIMALARIAL	1	2	8	
	17) ORAL ANTIMALARIAL	1	2	8	
DEHY-DRATION	18) HOME ORT	1	2	8	
	19) INITIAL ORT IN FACILITY (4 HOURS)	1	2	8	
	20) INTRAVENOUS FLUIDS	1	2	8	
MEASLES	21) VITAMIN A	1	2	8	
	22) FEEDING SOLID FOODS	1	2	8	
	23) FEEDING EXTRA LIQUIDS	1	2	8	
	24) FEEDING BREAST MILK	1	2	8	
	25) OTHER TREATMENT _____ (SPECIFY)	1	2	8	
204	Did you give or refer the child for an immunization? IF NO: Why not?	PROVIDER GAVE . . . . . 01 PROVIDER REFERRED . . . . 02 NOT DUE FOR IMMUNIZATION . . . . . 03 VACCINE NOT AVAILABLE . . 04 CHILD TOO SICK . . . . . 05 NOT DAY FOR IMMUNIZATION . . . . . 06 DID NOT CHECK FOR IMMUNIZATION . . . . . 08 OTHER _____ 96 (SPECIFY)			

205	RECORD THE TIME WHEN THE OBSERVATION ENDED.	☐☐ . ☐☐	
206	**Observer's comments:**		

MEASURE *DHS+* SERVICE PROVISION ASSESSMENT

Exit Interview for Caretaker of Sick Child

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____

District _____

Code of the facility: _____

QTYPE . . . . . X S C

PROVINCE NUMBER . . . . . [ ][ ]

DISTRICT CODE . . . . . [ ][ ]

FACILITY CODE . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Information About Interview

Date: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the interviewer: _____

INTERVIEWER CODE . . . . . [ ][ ]

Time interview started: _____

TIME INTERVIEW STARTED [ ][ ] : [ ][ ]

Client code: _____

CLIENT CODE: . . . . . [ ][ ]

Sex of caretaker
(1=Male; 2=Female)

SEX OF CARETAKER . . . . . [ ]

Name of provider: _____

PROVIDER CODE: . . . . . [ ][ ]

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Hello. In order to improve the services this facility offers, we would like to know about your experience here. All the information you give me will be kept strictly confidential, and the care that you receive at this facility in the future will not be affected by your participation or nonparticipation. You may refuse to answer any of the questions, and you may stop the interview anytime. Do you have any questions for me now? Do you agree to participate? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ STOP
101	What is the name of the sick child?	NAME _____	
102	What month and year was [NAME] born?	MONTH . . . . . ☐☐ DON'T KNOW MONTH . . . . . 98 YEAR . . . . . ☐☐☐☐ DON'T KNOW YEAR 9998	→ 103
103	IF CARETAKER DOES NOT KNOW [NAME]'S COMPLETE BIRTH DATE, PROBE: How old is [NAME] in completed months?	AGE IN MONTHS . . . . . ☐☐	
104	Did you bring [NAME] to the facility today because he or she had any of the following problems?	YES NO	
01	Cough or difficult breathing	COUGH/DIFF. BREATH. 1 2	
02	Diarrhea	DIARRHEA 1 2	
03	Fever/body hotness at home	FEVER/BODY HOTNESS 1 2	
105	For what other reason(s) did you bring [NAME] to this health facility today? CIRCLE ALL ITEMS THE RESPONDENT MENTIONS. PROBE: Anything else?	EYE PROBLEMS . . . . . A SKIN SORE . . . . . B INJURY . . . . . C OTHER _____ X (SPECIFY) NO OTHER REASON . . . . . Y	
106	Has [NAME] been brought to this facility before for this same sickness?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 108 → 108
107	IF YES: How long ago was that?	WITHIN THE PAST WEEK . . . . 1 WITHIN THE PAST 2-4 WEEKS 2 MORE THAN 4 WEEKS AGO . 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108	How many days ago did the illness for which you brought [NAME] here begin? IF LESS THAN 1 DAY, WRITE 00 IN THE BOXED CELLS.	DAYS AGO . . . . . ☐☐ DON'T KNOW 98	
109	Did the provider tell you what illness [NAME] has?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
110	What will you do if [NAME] does not get completely better or becomes worse?	RETURN TO FACILITY . . . . . 1 GO TO OTHER FACILITY . . . 2 GO TO OTHER HEALTH WORKER/PHARMACY . . . . 3 GO TO TRADITIONAL HEALER . . . . . 4 WAIT . . . . . 5 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
111	Did the provider tell you about any signs or symptoms you may see for which you must immediately bring the child back? IF NECESSARY, PROBE: Were there any serious symptoms or danger signs for which you were told to bring [NAME] back immediately? CIRCLE THE SYMPTOM LISTED IF THE CARETAKER UNDERSTANDS THAT THE CHILD SHOULD BE BROUGHT BACK IF THE SYMPTOM EITHER FAILS TO GO AWAY OR BECOMES WORSE.	FEVER . . . . . A BREATHING PROBLEMS . . . . B BECOMES SICKER . . . . . C BLOOD IN STOOL . . . . . D VOMITING . . . . . E POOR/NOT EATING . . . . . F POOR/NOT DRINKING . . . . . G OTHER _____ X (SPECIFY) NO, NONE . . . . . Y DON'T KNOW . . . . . Z	
112	Did the provider tell you anything about bringing [NAME] back to the health facility for follow-up or non-emergency reasons? IF YES: Why were you to return?	MORE MEDICINES . . . . . A IF SYMPTOMS INCREASE OR BECOME WORSE . . . . . B FOLLOW-UP APPOINTMENT C CHILD ADMITTED . . . . . D ROUTINE IMMUNIZATION . . . . E OTHER _____ X (SPECIFY) NO . . . . . Y DON'T KNOW . . . . . Z	
113	Did the provider give or prescribe any medicines for [NAME] to take at home?	YES, GAVE MEDS . . . . . 1 YES, GAVE PRESCRIPTION . . . 2 GAVE MEDS AND PRESCRIPTION . . . . . 3 NO 8	→ 118
114	ASK TO SEE ALL MEDICATIONS THAT THE CARETAKER RECEIVED AND ANY PRESCRIPTIONS THAT HAVE NOT BEEN FILLED CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS AND PRESCRIPTIONS YOU SEE.	HAS ALL MEDS . . . . . 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS . . 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY 3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
115	Did a provider at the facility explain to you how to give these medicines to [NAME] at home? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
116	Do you feel comfortable that you know how much of each medication to give [NAME] each day and how often to give it? IF "2" OR "8" SEND CLIENT BACK TO PROVIDER	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
117	Has [NAME] been given a dose of any of these medications here at the facility already?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
118	Was [NAME] given an injection for treating the sickness here at the facility today?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
119	Now I want to ask you some questions about [NAME]. When not sick, what types of food or fluid does [NAME] normally take?	ONLY BREASTMILK . . . . . 1 OTHER MILKS . . . . . 2 BREASTMILK AND LIQUIDS . . . 3 BREASTMILK AND OTHER FOODS AND LIQUIDS . . . . . 4 NO BREASTMILK, BUT FOODS . . . . . 5 DON'T KNOW 8	
120	Did any provider ask you today about the types of foods and amounts that you normally feed [NAME] when [NAME] is not sick?	YES . . . . . 1 NO . . . . . 2 CANNOT REMEMBER 8	
121	Did anyone at the health facility weigh [NAME] today?	YES . . . . . 1 NO 2	
122	Did anyone talk to you today about [NAME]'s weight and how [NAME] is growing?	YES . . . . . 1 NO 2	
123	Since becoming ill, has the way that [NAME] eats/drinks changed from normal? IF YES: CLARIFY WHETHER THE CHILD IS CONSUMING MORE OR LESS THAN NORMAL.	MORE THAN NORMAL . . . . . 1 SAME AS NORMAL . . . . . 2 LESS THAN NORMAL . . . . . 3 NOT EATING/DRINKING . . . . . 4 NOT CERTAIN 8	
124	What did the provider tell you about feeding solid foods to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . 3 GIVE NOTHING/DON'T FEED . . 4 DIDN'T DISCUSS . . . . . 6 NOT CERTAIN 8	
125	What did the provider tell you about giving fluids (or breast milk, if the child is breastfed) to [NAME] during this illness?	GIVE LESS THAN USUAL . . . . 1 GIVE SAME AS USUAL . . . . . 2 GIVE MORE THAN USUAL . . . . 3 GIVE NOTHING/DON'T FEED . . 4 DIDN'T DISCUSS . . . . . 6 DON'T KNOW 8	
126	CHECK THE ANSWERS TO QUESTIONS 102 AND 103: DOES FACILITY PROVIDE SICK-CHILD CONSULTATIONS? CHILD LESS THAN 24 MONTHS OLD ↓ CHILD 24 MONTHS OLD OR OLDER → 201		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
127	Was [NAME] given a vaccination today?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
128	Do you have [NAME]'s vaccination card with you?	YES . . . . . 1 NO 2	→ 201
129	ASK TO SEE THE CHILD'S VACCINATION CARD. INDICATE WHETHER THE RECORD SHOWS THAT THE CHILD WAS VACCINATED TODAY.	YES . . . . . 1 NO 2	

130 CHECK THE CHILD'S HEALTH CARD AND INDICATE IN COLUMN "A" WHETHER THE CHILD HAS EVER RECEIVED ANY OF THE FOLLOWING VACCINATIONS. ALSO CHECK THE DATE THAT EACH OF THE VACCINATIONS WAS GIVEN AND WRITE THE DATE IN COLUMN "B". IF NO DATE IS RECORDED ON THE CARD, ENTER 66 FOR THE DAY AND MONTH AND 6666 FOR THE YEAR.

		HAS CHILD **EVER** RECEIVED VACCINATION?	DATE DAY MONTH YEAR
		A	B
01	POLIO-0	YES . . . . . 1 NO OR NO RECORD . . . 2 → 02	
02	BCG	YES . . . . . 1 NO OR NO RECORD . . . 2 → 03	
03	POLIO-1	YES . . . . . 1 NO OR NO RECORD . . . 2 → 04	
04	POLIO-2	YES . . . . . 1 NO OR NO RECORD . . . 2 → 05	
05	POLIO-3	YES . . . . . 1 NO OR NO RECORD . . . 2 → 06	
06	DPT-1	YES . . . . . 1 NO OR NO RECORD . . . 2 → 07	
07	DPT-2	YES . . . . . 1 NO OR NO RECORD . . . 2 → 08	
08	DPT-3	YES . . . . . 1 NO OR NO RECORD . . . 2 → 09	
09	MEASLES	YES . . . . . 1 NO OR NO RECORD . . . 2 → 10	
10	PENTA-VALENT-1	YES . . . . . 1 NO OR NO RECORD . . . 2 → 11	
11	PENTA-VALENT-2	YES . . . . . 1 NO OR NO RECORD . . . 2 → 12	
12	PENTA-VALENT-3	YES . . . . . 1 NO OR NO RECORD . . . 2 → 201	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve child care services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were large or small problems for you.		

		LARGE	SMALL	NO PROB-LEM	DK
01	Time you waited	WAIT 1	2	3	8
02	Ability to discuss problems or concerns about your child's health with the provider	DISCUSS PROBLEMS 1	2	3	8
03	Amount of explanation you received about the problem or treatment	EXPLAIN PROB. OR TREATMENT . 1	2	3	8
04	Quality of the examination and treatment provided	QUALITY 1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY . . 1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY 1	2	3	8
07	Availability of medicines at this facility	MEDICINES 1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE 1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE 1	2	3	8
10	The cleanliness of the facility	CLEAN 1	2	3	8
11	How the staff treated you	HOW TREATED . . 1	2	3	8
12	Any problem you had today that I did not mention	_____ (SPECIFY) . 1	2	3	8

203	Are you a part of any prepayment plan (such as insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 207

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
205	What is the total amount you paid for all services or treatments you received at this facility today? Please include any money you paid for services, laboratory tests, or medicines. (IF NEEDED, ASSIST IN ADDING TO ACHIEVE THE TOTAL)	1) TOTAL AMOUNT ☐☐☐☐☐☐ PAID NO MONEY . . . 000000 DON'T KNOW . . . . . 999998 2) LAB ☐☐☐☐☐☐ 3) MEDI-CINE ☐☐☐☐☐☐ 4) CON-SULT ☐☐☐☐☐☐ 5) OTHER ☐☐☐☐☐☐	
206	How did you pay for the services that you received at the facility today?	CASH . . . . . 1 CREDIT . . . . . 2 INSURANCE . . . . . 3 IN KIND . . . . . 4 OTHER _____ 6 (SPECIFY)	→ 208 → 208 → 208 → 208 → 208
207	Why did you not pay for the services?	EMPLOYER PAYS . . . . . A WAIVED . . . . . B EXEMPT . . . . . C OTHER _____ X (SPECIFY)	
208	Would you encourage a friend/relative of yours to come to this facility for treatment of a sick child?	YES . . . . . 1 NO 2	
209	In which district and village/town do you live?* District _____ Village/Town _____	DISTRICT . . . . . ☐☐	
210	Is this the nearest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 212 → 212
211	What was the main reason you did not go to the nearest facility?	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . . 06 REFERRAL . . . . . 07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
212	How long did it take you to get here?	MINUTES . . . . . ☐☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
213	What was the main type of transport you used to get here?	WALKED . . . . . A TRACTOR . . . . . B BICYCLE . . . . . C MOTORCYCLE . . . . . D BUS/MATATU . . . . . E PRIVATE CAR . . . . . F HIRED CAR/TAXI . . . . . G WHEEL CART . . . . . H OTHER_____ X (SPECIFY)	
214	How much will it cost you to come to this facility today, including return transportation and food? This does not include fees for services received and medications	TOTAL COST [ ][ ][ ][ ][ ][ ] NO COST . . . . . 000000 DON'T KNOW 999998	
215	Did you lose wages from work or time from other important activities that contribute to your livelihood to come here today?	YES, LOST WAGES . . . . . 1 NO, LOST NO WAGES . . . . . 2 LOST TIME FROM NON-WAGE WORK 3	
216	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	

5. Personal Characteristics of Client			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
301	What is your relationship to [NAME]?	MOTHER . . . . . 1 FATHER . . . . . 2 SIBLING . . . . . 3 AUNT OR UNCLE . . . . . 4 OTHER _____ 6 (SPECIFY)	
302	How old were you at your last birthday?	AGE IN YEARS	
303	Have you ever attended school?	YES . . . . . 1 NO 2	→ 306
304	What is the highest level of school you attended? (IF POLYTECHNIC FROM PRIMARY CODE AS SECONDARY; IF POLYTECHNIC FROM COMPLETED SECONDARY CODE HIGHER)	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
305	What is the highest grade you completed at that level?	GRADE	
306	Do you know how to read or how to write?	YES, READ ONLY . . . . . 1 YES, READ AND WRITE . . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
307	RECORD THE TIME WHEN THE INTERVIEW ENDED.	. .	
307	**Interviewer's comments:**		

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Observation of Family Planning Consultation

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____ PROVINCE NUMBER

District _____ DISTRICT NUMBER

Number of the facility: _____ FACILITY NUMBER

QTYPE . . . . . O F P

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY

2. Provider Information

Provider category:

Consultant	01	Registered Midwife	05
Medical Doctor	02	Enrolled Nurse	06
Clinical Officer	03	Enrolled Midwife	07
Registered Nurse	04	Nurse Aid	08

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY

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

Code for provider should be the same as the one used for the provider interview. PROVIDER CODE

3. Information About Observation

Date: _____ DAY / MONTH / YEAR

Name of the observer: _____ OBSERVER CODE

Time observation started: _____ HOUR / MINUTES

Client code: _____ CLIENT CODE

4. Observation of Family Planning Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. BE AS DISCREET AS POSSIBLE DURING THE ASSESSMENT. DO NOT TAKE PART IN THE INTERACTION BETWEEN THE PROVIDER AND THE CLIENT. TRY TO SIT BEHIND THE CLIENT BUT TO ONE SIDE, SO YOU WILL NOT BE SITTING DIRECTLY IN FRONT OF THE PROVIDER. FOR EACH OF THE ITEMS BELOW, CIRCLE THE ANSWER THAT BEST EXPRESSES YOUR ASSESSMENT OF WHAT HAPPENED DURING THE INTERACTION. **READ TO PROVIDER:** Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities with the goal of finding ways to improve the delivery of services. I would like to observe your consultation with this client in order to better understand how health care is provided in this facility. Any information you give me will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ STOP
	READ TO CLIENT: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities. I would like to observe your consultation with this provider in order to better understand how health care is provided. Any information you give will be kept completely confidential and will not affect the level of care you receive here, now or in the future. If, at any point, you would prefer I leave, please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
102	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ STOP
103	RECORD THE SEX OF CLIENT.	MALE . . . . . 1 FEMALE 2	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
104	CLIENT STATUS. (OBSERVER TO COMPLETE)	YES	NO	DK	
01	INDICATE WHETHER THE CLIENT HAS HAD ANY PREVIOUS CONTACT WITH A PROVIDER AT THIS FAMILY PLANNING CLINIC.	1	2	8	
02	INDICATE WHETHER THE CLIENT HAS EVER BEEN PREGNANT.	1	2	8	
105	CLIENT'S PERSONAL INFORMATION AND REPRODUCTIVE HISTORY. INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT VOLUNTEERED INFORMATION ON THE FOLLOWING ITEMS:				
01	Age of client	1	2	8	
02	Number of living children	1	2	8	
03	Last delivery date or age of youngest child	1	2	8	
04	History of complications with pregnancy	1	2	8	
05	Current pregnancy status	1	2	8	
06	Desire for a child or more children	1	2	8	
07	Desired timing for birth of next child	1	2	8	
08	Breastfeeding status	1	2	8	
09	Regularity of menstrual cycle	1	2	8	
106	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS OR ASKED ANY OF THE FOLLOWING HEALTH QUESTIONS.				
01	Take the client's blood pressure	1	2	8	
02	Weigh the client	1	2	8	
03	Ask the client about smoking	1	2	8	
04	Ask the client about symptoms of STIs (e.g., abnormal discharge)	1	2	8	
05	Ask the client about chronic illnesses (heart disease, diabetes, hypertension, liver or jaundice problem, breast cancer)	1	2	8	
06	Look at the client's health card (either before beginning the consultation or while collecting information or examining the client)	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
107	RECORD WHETHER THE PROVIDER TOOK ANY OF THE FOLLOWING STEPS TO ASSURE THE CLIENT OF PRIVACY.	YES	NO	DK	
01	Ensure visual privacy	1	2	8	
02	Ensure auditory privacy	1	2	8	
03	Assure the client orally of confidentiality	1	2	8	
04	Ask the client about questions or concerns regarding methods currently used	1	2	8	
108	RECORD WHETHER THE PROVIDER DISCUSSED ANY OF THESE ISSUES RELATED TO SEXUAL PARTNERS AND CHOICE OF FAMILY PLANNING METHOD.				
01	Partner's attitude toward family planning	1	2	8	
02	Partner status (number of partners for client or for client's partner; partner's absence)	1	2	8	
03	Risk of STIs	1	2	8	
04	Use of condoms to prevent STIs	1	2	8	
05	Using condoms as well as or along with another method (dual method) to attempt to prevent STIs	1	2	8	
109	INDICATE WHICH METHOD(S) WERE PRESCRIBED DURING THIS VISIT. IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS. [IF CLIENT IS CONTINUING CLIENT WHO RECEIVED REFILLS FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUD DURING THIS VISIT, CIRCLE THE METHOD THAT WAS REPLENISHED]	ORAL PILL . . . . . A CONDOM . . . . . B IUD . . . . . C SPERMICIDE . . . . . D DIAPHRAGM . . . . . E INJECTABLE . . . . . F IMPLANT . . . . . G NATURAL METHODS (RHYTHM) . . . . . H BREASTFEEDING/LAM . . . . . I VASECTOMY . . . . . J FEMALE STERILIZATION . . . K EMERGENCY CONTRACEPTION . . . . . L OTHER _____ X (SPECIFY) NO METHOD . . . . . Y			→ 111

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
110	FOR THE METHOD(S) IN QUESTION 109, INDICATE WHETHER THE RELEVANT INFORMATION INDICATED WAS ASSESSED OR DISCUSSED.	YES	NO	DK	NA
	PILLS OR INJECTIONS				5 → 05
01	When to take (pill daily; injection either every month or every 3 months)	1	2	8	
02	Changes that may occur with menstruation (decreased flow, spotting)	1	2	8	
03	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
04	What to do if forget pill or do not get injection on time	1	2	8	
	IMPLANT				5 → 08
05	Good for 5 years	1	2	8	
06	Changes that may occur with menstruation (decreased flow, spotting)	1	2	8	
07	Initial side effects that may occur (such as nausea, weight gain, and breast tenderness)	1	2	8	
	EMERGENCY CONTRACEPTION				5 → 13
08	If vomit within 2 hours, need another dose	1	2	8	
09	If next period is unusually light or fails to occur within 4 weeks, return for pregnancy check	1	2	8	
10	First dose to be taken within 72 hours of contact	1	2	8	
11	Second dose should be taken 12 hours after first dose	1	2	8	
12	Regimen not to be repeated/taken more than three times in any one month	1	2	8	
	IUD				5 → 15
13	User should regularly check string after menstruation	1	2	8	
14	May cause heavy bleeding or spotting	1	2	8	
	STERILIZATION				5 → 18
15	Permanent: cannot impregnate or become pregnant again	1	2	8	
16	Slight discomfort at incision site may occur	1	2	8	
17	Male must use condom or some other method for the next 20 ejaculations or for 3 months	1	2	8	5

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	CONDOMS		5 → 23
18	Client cannot use if allergic to latex	1 2 8	
19	Can be used only one time	1 2 8	
20	Some lubricants may be used (male condom—water soluble only; female condom—any lubricant)	1 2 8	
21	Use as backup if client fears other method will fail	1 2 8	
22	Dual protection (from pregnancy and against STI)	1 2 8	
	SPERMICIDE/FOAM		5 → 25
23	May cause irritation	1 2 8	
24	Insert before each occurrence of intercourse	1 2 8	
	RHYTHM METHOD or PERIODIC ABSTINENCE		5 → 27
25	How to identify a woman's fertile period	1 2 8	
26	No intercourse during woman's fertile period without alternative method (condom/spermicide)	1 2 8	
	LAM		5 →111
27	Slight risk of pregnancy during the time shortly before menstruation resumes	1 2 8	
28	Most effective with exclusive breastfeeding without menstruation	1 2 8	
29	Not effective after menstruation begins again	1 2 8	
111	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD USED . . . 3 DON'T KNOW 8	
112	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING ABOUT FAMILY PLANNING METHODS.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
113	RECORD WHETHER THE PROVIDER DISCUSSED A RETURN VISIT.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
114	WAS THE CLIENT A TEENAGER, OR CONSIDERED A YOUTH?	YES . . . . . 1 NO . . . . . 2 → 201 DON'T KNOW . . . . . 8 → 201	
115	DID YOU OBSERVE ANY YOUTH FRIENDLY ACTIVITIES OCCURRING? IF YES, CIRCLE ALL PRACTICES OBSERVED.	YES, EXPLAINED PELVIC BUT DEFERRED UNTIL NEXT VISIT . . . . . A YES, EXPLAINED BLOOD TESTS BUT DEFERRED UNTIL NEXT VISIT . . . . . B YES, FOCUS WAS ON YOUTH ISSUES . . . . . C NO . . . . . Z	

5. Clinical Observation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	INDICATE WHETHER ANY CLINICAL PROCEDURE WAS CONDUCTED DURING THIS VISIT. CLINICAL PROCEDURES INCLUDE PELVIC EXAMINATIONS, OR PROVIDING THE IUD, INJECTABLE METHOD, OR IMPLANT.	YES . . . . . 1 NO 2	→ 301
202	INDICATE WHETHER CLINICAL PROVIDER IS PERSON WHO PROVIDED COUNSELING.	YES . . . . . 1 NO 2	→ 206
	READ TO PROVIDER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities, with the goal of finding ways to improve the delivery of services. I would like to observe the procedure you will conduct with this client. [Mrs. ___] has agreed that she has no objection to my presence. Observing all components of the services provided to [Mrs. ___] will help us to better understand how health services are provided. Any information relating to this procedure will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me. Do you have any questions for me? Do I have your permission to be present during this procedure? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
203	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ STOP
204	RECORD THE TYPE OF PROVIDER PERFORMING MOST OF THE CLINICAL EXAMINATION.	CONSULTANT . . . . . 01 MEDICAL DOCTOR . . . . . 02 CLINICAL OFFICER . . . . . 03 REGISTERED NURSE . . . . . 04 REGISTERED MIDWIFE . . . . 05 ENROLLED NURSE . . . . . 06 ENROLLED MIDWIFE . . . . . 07 NURSE AID . . . . . 08 OTHER_____ 96 (SPECIFY)	
205	RECORD THE SEX OF THE PROVIDER CONDUCTING THE CLINICAL EXAMINATION.	FEMALE . . . . . 1 MALE 2	
206	INDICATE CLINICAL PROCEDURE (S) CONDUCTED DURING THIS VISIT.	PELVIC EXAM . . . . . A IUD INSERTED/REMOVED/ INSPECTED . . . . . B INJECTABLE GIVEN . . . . . C IMPLANT INSERTED/ REMOVED . . . . . D	

6. Pelvic Examination

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
	CHECK Q206: WAS A PELVIC EXAMINATION CONDUCTED?	YES . . . . . 1 NO 2			→ 208
207	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:		YES	NO	NA
01	Ensure that the client had visual privacy	VISUAL PRIVACY	1	2	
02	Ensure that the client had auditory privacy	AUDITORY PRIVACY . .	1	2	
03	Explain the procedure before starting it	EXPLAIN PROCEDURE BEFOREHAND	1	2	
04	Prepare all instruments before the examination	PREPARED INSTRUMENTS	1	2	
05	Use sterilized or high-level disinfected instruments	STERILIZED/HLD INSTRUMENTS	1	2	
06	Wash his or her hands with soap, *before* the examination	WASHED HANDS	1	2	
07	Put on new or disinfected latex gloves *before* the examination	PUT ON GLOVES	1	2	
08	Ask the client to take slow, deep breaths and relax the muscles	ASK CLIENT TO RELAX MUSCLES	1	2	
09	Inspect the external genitalia	INSPECT GENITALIA . .	1	2	
10	(If used) Explain the speculum procedure	EXPLAIN SPECULUM . .	1	2	5
11	Inspect the cervix and vaginal mucosa (Aim light inside the inserted speculum)	INSPECT CERVIX	1	2	5
12	Perform a bimanual exam (one hand inside the vagina, the other palpating uterus through the abdomen)	BIMANUAL EXAM	1	2	
13	Wash hands after removing gloves	WASH HANDS AFTER .	1	2	
14	Wipe contaminated surfaces with disinfectant	DISINFECT AREA	1	2	
15	Place reusable gloves and instruments in a chlorine solution immediately after completing the procedure	DECONTAMINATE GLOVES OR INSTRUMENTS	1	2	
	CHECK 206: WAS ANY OTHER CLINICAL PROCEDURE CONDUCTED?	YES . . . . . 1 NO 2			→ 301

7. IUD Insertion and/or Removal

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	CHECK 206: WAS AN IUD EITHER INSERTED, REMOVED OR INSPECTED?	YES . . . . . 1 NO 2	→ 210
208	INDICATE PROCEDURE CONDUCTED.	IUD INSERTION . . . . . A IUD REMOVAL . . . . . B IUD INSPECTION C	
209	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:	YES NO NA	
01	Ensure that the client had visual privacy	VISUAL PRIVACY 1 2	
02	Ensure that the client had auditory privacy	AUDITORY PRIVACY . . 1 2	
03	Explain the procedure before starting it	EXPLAIN PROCEDURE BEFOREHAND 1 2	
04	(With a **new client**) Reconfirm the client's choice of method	RECONFIRM CHOICE 1 2	
05	(With a **new client**) Verify that client was not pregnant	CONFIRM CLIENT NOT PREGNANT 1 2	
06	Prepare all instruments before the procedure	PREPARED INSTRUMENTS 1 2	
07	Use sterilized or high-level disinfected instruments	STERILIZED/HLD INSTRUMENTS 1 2	
08	Wash his or her hands with soap, *before* the procedure	WASHED HANDS 1 2	
09	Put on new or disinfected latex gloves *before* the examination	PUT ON GLOVES 1 2	
10	Perform a speculum examination for reproductive-tract infections or STIs before conducting the bimanual examination	SPECULUM EXAM 1 2 5	
11	Perform a bimanual exam (one hand inside the vagina, the other palpating uterus through the abdomen)	BIMANUAL EXAM 1 2 5	
12	Visually inspect the cervix during cleaning (aim light inside the inserted speculum)	VISUALIZE CERVIX . . . 1 2 5	
13	Use a tenaculum	USE TENACULUM 1 2 5	
14	Sound the uterus *before* inserting the IUD	SOUND UTERUS 1 2 5	
15	Use the no-touch technique for inserting the IUD	NO-TOUCH TECHNIQUE 1 2 5	
16	Wash hands after removing gloves	WASH HANDS AFTER . . 1 2	
17	Ask client to wait and rest for 15 minutes after insertion of the IUD	ASK CLIENT TO WAIT . . 1 2	
18	Wipe contaminated surfaces with disinfectant	DISINFECT AREA 1 2	
19	Place reusable gloves and instruments in a chlorine solution immediately after completing the procedure	DECONTAMINATE GLOVES OR INSTRUMENTS 1 2	
	CHECK Q206: WAS ANY OTHER CLINICAL PROCEDURE CONDUCTED?	YES . . . . . 1 NO 2	→ 301

8. Injectable Contraceptive

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	CHECK Q206: WAS A CONTRACEPTIVE INJECTION GIVEN?	YES . . . . . 1 NO 2	→ 212
210	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:	YES NO NA	
01	(With a **new client**) Reconfirm the client's choice of method	RECONFIRM CHOICE 1 2 5	
02	(With a **new client**) Verify that client was not pregnant	CONFIRM CLIENT NOT PREGNANT 1 2 5	
03	(**Continuing client**) Check the client's card to ensure giving injection at correct time	ENSURE CORRECT TIMING 1 2 5	
04	Wash his or her hands with soap before giving the injection	WASHED HANDS 1 2	
05	(**If using reusables**) Use newly reprocessed needle and syringe	USE NEW/CLEAN NEEDLE 1 2 5	
06	Remove needle from multiple dose vial each time	REMOVE NEEDLE 1 2 5	
07	Stir or mix the bottle *before* drawing dose (DEPO)	STIR BOTTLE 1 2 5	
08	Clean and air-dry the injection site *before* injection	CLEAN AND AIR-DRY THE SITE 1 2	
09	Draw back plunger *before* giving injection	DRAW BACK PLUNGER 1 2	
10	Allow dose to self-disperse instead of massaging the site	NO MASSAGE 1 2	
11	Dispose of sharps in puncture-resistant containers	DISPOSE OF SHARPS . 1 2	
211	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY . . . . 1 PROVIDED BY CLIENT . . . . . 2 DON'T KNOW 8	
	CHECK Q206: WAS ANY OTHER CLINICAL PROCEDURE CONDUCTED?	YES . . . . . 1 NO 2	→ 301

9. Implant Insertion or Removal

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	CHECK 206: WERE IMPLANTS EITHER INSERTED OR REMOVED?	YES . . . . . 1 NO 2	→ 301
212	INDICATE PROCEDURE CONDUCTED.	INSERTION . . . . . A REMOVAL . . . . . B	
213	RECORD WHETHER THE PROVIDER DID THE FOLLOWING:	YES NO NA	
01	Reconfirm the client's choice of method	RECONFIRM CHOICE 1 2 5	
02	Verify that client was not pregnant	CONFIRM CLIENT NOT PREGNANT 1 2 5	
03	Ensure that the client had visual privacy	VISUAL PRIVACY 1 2	
04	Ensure that the client had auditory privacy	AUDITORY PRIVACY . . . 1 2	
05	Explain the procedure before starting it	EXPLAIN PROCEDURE BEFOREHAND 1 2	
06	Prepare all instruments before the procedure	PREPARED INSTRUMENTS 1 2	
07	Use sterilized or high-level disinfected instruments	STERILIZED/HLD INSTRUMENTS 1 2	
08	Wash his or her hands with soap, *before* the procedure	WASHED HANDS 1 2	
09	Put on sterile gloves and maintain sterility during insertion	GLOVES AND STERILITY 1 2	
10	Clean skin where incision will be made with antiseptic	USE ANTISEPTIC 1 2	
11	Use sterile towel to protect area	USE STERILE TOWEL . 1 2	
12	Use new or sterilized needle and syringe for local anesthetic	USE STERILE NEEDLE 1 2	
13	Allow time for local anesthetic to take effect prior to making incision	ALLOW TIME FOR ANESTHETIC TO WORK 1 2	
14	Dispose of sharps in puncture-resistant containers	DISPOSE OF SHARPS . 1 2	
15	Wipe contaminated surfaces with disinfectant	DISINFECT AREA 1 2	
16	Place reusable gloves and instruments in a chlorine solution immediately after completing the procedure	DECONTAMINATE GLOVES OR INSTRUMENTS 1 2	
17	Wash hands *after* removing gloves	WASH HANDS AFTER . 1 2	
18	Explain care of incision area and removal of the bandage	EXPLAIN INCISION CARE 1 2	
19	Discuss return visit to remove elastoplast	DISCUSS RETURN . . . 1 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
20	Provide woman with card stating date implant was inserted and date when 5 years of implant would be completed	PROVIDE CARD 1 2 5	
21	Reinforce expectations about side effects of implant	REINFORCE SIDE EFFECTS 1 2 5	
214	Did the provider show each implant stick removed to the client and reassure her that all were removed?	SHOW REMOVED IMPLANT 1 2 5	
215	INDICATE WHETHER THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT.	PROVIDED BY FACILITY . . . 1 PROVIDED BY CLIENT . . . . . 2 DON'T KNOW 8	

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

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
308	INDICATE WHETHER THE PROVIDER WROTE IN OR ON AN INDIVIDUAL CLIENT'S RECORD OR CARD AFTER THE CONSULTATION.	YES . . . . . 1 NO . . . . . 2 NO INDIVIDUAL CARD USED . . 3 DON'T KNOW 8	
309	RECORD THE TIME WHEN THE INTERVIEW ENDED.	☐☐ : ☐☐	
310	**Observer's comments:**		

MEASURE *DHS+* SERVICE PROVISION ASSESSMENT

Exit Interview for Family Planning Client

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____

District _____

Number of the facility: _____

QTYPE . . . . . X F P

PROVINCE NUMBER . . . . . [ ][ ]

DISTRICT NUMBER . . . . . [ ][ ]

FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Information About Interview

Date: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the interviewer: _____

INTERVIEWER CODE . . . . . [ ][ ]

Time interview started: _____

TIME INTERVIEW STARTED [ ][ ] : [ ][ ]

Client code: _____

CLIENT CODE: . . . . . [ ][ ]

Name of provider: _____

PROVIDER CODE: . . . . . [ ][ ]

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	INTRODUCE YOURSELF TO THE CLIENT. Hello. I am representing the Ministry of Health. We are carrying out a survey in order to improve the services offered by this facility. We would like to know about your experience here today. All the information you give me in this interview will be kept strictly confidential, and the care that you receive at this facility in the future will in no way be affected by your participation or nonparticipation. You may refuse to answer any question, and you may stop the interview at any time. Do you have any questions for me now? Do you agree to participate? _____ Interviewer's signature (Indicates respondent's willingness to participate) _____ Date		
100	May I begin the interview?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	→ STOP
101	Were you doing anything to prevent pregnancy before seeing the provider today?	YES . . . . . 1 NO 2	→ 103
102	Have you used a family planning method or taken any steps to prevent pregnancy at any time during the past 6 months?	YES . . . . . 1 NO 2	→ 109
103	What method were you (last) using? IF CONDOMS WERE PRESCRIBED FOR USE ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED PILL . . . . . A PROGESTIN-ONLY PILL . . . . . B PILL (TYPE UNSPECIFIED) . . . . C MALE CONDOM . . . . . D FEMALE CONDOM . . . . . E IUD . . . . . F SPERMICIDE . . . . . G DIAPHRAGM . . . . . H INJECTABLE DEPO-PROVERA I INJECTABLE NORIGYNON . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . . . . L BREASTFEEDING/LAM . . . . . M VASECTOMY . . . . . N FEMALE STERILIZATION . . . . . O EMERGENCY CONTRACEPTION . . . . . P OTHER _____ X (SPECIFY)	
104	Did the provider ask you today whether you were having (or had had) a problem with the method?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
105	Have you been having (did you have) a problem with the method?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 107 → 107

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
106	Did the provider suggest any action(s) you should take to resolve the problem?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
107	What was the outcome of this visit—did you decide to continue (restart) the same method or to switch methods?	CONTINUE WITH OR RESTART SAME METHOD . . 1 SWITCH METHOD . . . . . 2 STOP USING METHOD (DUE TO PROBLEMS) . . . . . 3 STOP USING METHOD (ELECTIVE-NO PROBLEMS) 4	→ 201
108	Had you thought about switching methods, and which method to switch to, before you came here today?	YES . . . . . 1 NO 2	→ 110 → 112
109	Had you thought about what family planning method you wanted to use before you came here today?	YES . . . . . 1 NO 2	→ 112
110	What method was that? IF CLIENT MENTIONS CONDOMS ALONG WITH ANOTHER METHOD, CIRCLE BOTH METHODS.	COMBINED PILL . . . . . A PROGESTIN-ONLY PILL . . . . . B PILL (TYPE UNSPECIFIED) . . . . C MALE CONDOM . . . . . D FEMALE CONDOM . . . . . E IUD . . . . . F SPERMICIDE . . . . . G DIAPHRAGM . . . . . H INJECTABLE DEPO-PROVERA I INJECTABLE NORIGYNON . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . . . . L BREASTFEEDING/LAM . . . . . M VASECTOMY . . . . . N FEMALE STERILIZATION . . . . . O EMERGENCY CONTRACEPTION . . . . . P OTHER _____ X (SPECIFY)	
111	Did the provider talk to you about any of the method(s) you just mentioned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
112	What (other) family planning methods did the provider talk with you about? CIRCLE ALL METHODS MENTIONED.	COMBINED PILL . . . . . A PROGESTIN-ONLY PILL . . . . . B PILL (TYPE UNSPECIFIED) . . . . C MALE CONDOM . . . . . D FEMALE CONDOM . . . . . E IUD . . . . . F SPERMICIDE . . . . . G DIAPHRAGM . . . . . H INJECTABLE DEPO-PROVERA I INJECTABLE NORIGYNON . . . . J IMPLANT . . . . . K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . . . . L BREASTFEEDING/LAM . . . . . M VASECTOMY . . . . . N FEMALE STERILIZATION . . . . . O EMERGENCY CONTRACEPTION . . . . . P OTHER _____ X (SPECIFY) NONE . . . . . Y	
113	What family planning method did you either receive or get a prescription or referral for? CIRCLE ALL METHODS THE CLIENT HAS RECEIVED (REC) OR HAS A PRESCRIPTION OR A REFERRAL (PRES) FOR. IF THE CLIENT IS CONTINUING USING A PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION, OR REFERRAL ON THIS VISIT, CIRCLE Y.	REC / PRES COMBINED PILL . . . . . A A PROGESTIN-ONLY PILL . . . . . B B PILL (TYPE UNSPECIFIED) . . . . C C MALE CONDOM . . . . . D D FEMALE CONDOM . . . . . E E IUD . . . . . F F SPERMICIDE . . . . . G G DIAPHRAGM . . . . . H H INJECTABLE DEPO-PROVERA I I INJECTABLE NORIGYNON . . . . J J IMPLANT . . . . . K K NATURAL METHODS (RHYTHM/ PERIODIC ABSTINENCE) . . . . L L BREASTFEEDING/LAM . . . . . M M VASECTOMY . . . . . N N FEMALE STERILIZATION . . . . . O O EMERGENCY CONTRACEPTION . . . . . P P CONTINUING WITH METHOD IN QUESTION 103 . . . . . Y Y OTHER _____ X X (SPECIFY) NO METHOD . . . . . Z Z → 201	
114	Does your method protect against Sexually Transmitted Infections (STIs) and HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

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

NO.	QUESTIONS		CODING CLASSIFICATION	GO TO
116	MARK BELOW THE METHOD THAT IS CIRCLED IN QUESTION 113. THEN, ASK THE CLIENT THE QUESTION RELATED TO THAT METHOD			
01	Pill	How often do you take the pill?	ONCE A DAY . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
02	IUD	What should you do to make sure that your IUD is in place?	CHECK STRING . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
03	Injectable (e.g., Depo-Provera)	How long does the Depo injection provide protection from pregnancy?	3 MONTHS . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
04	Injectable (Norigynon)	How long does the Norigynon injection provide protection from pregnancy?	1 MONTH . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
05	Implant	How long does your implant provide protection against pregnancy?	5 YEARS . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
06	Female sterilization	After you have been sterilized, could you ever become pregnant again?	NO . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
07	Male sterilization	After you have been sterilized (and after the first 3 months), can you make a woman pregnant again?	NO . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
08	Condom (both male and female)	How many times can you use a condom?	ONCE . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
09	Condom (female)	What type of lubricant can you use with the female condom?	ANY OIL OR LUBRICANT . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
10	Spermicide	Approximately how long before intercourse should you insert the vaginal tablet?	BETWEEN 15 MINUTES AND 1 HOUR . . . . . 1 OTHER . . . . . 2 DON'T KNOW 8	
11	Natural method (Periodic abstinence or rhythm)	How do you recognize the days on which you should not have sexual intercourse?	BODY TEMPERATURE RISES . . A MUCUS IN VAGINA . . . . . B DAYS 12–16 OF THE MENSTRUAL CYCLE . . . . . C OTHER . . . . . X DON'T KNOW . . . . . Z	
12	LAM (lactational amenorrhea method)	Can you use this method if your menstrual period has returned?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
13	Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	AT LEAST 6 HOURS (BUT NO LONGER THAN 24 HOURS) . . 1 OTHER . . . . . 2 DON'T KNOW 8	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help improve family planning services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were large or small problems for you.		

			LARGE	SMALL	NO PROB-LEM	DK
01	Time you waited	WAIT	1	2	3	8
02	Ability to discuss problems or concerns about your health with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about any problem or method of family planning	EXPLAIN PROB. OR TREATMENT	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines or methods at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Any problem you had today that I did not mention	_____ (SPECIFY)	1	2	3	8

203	Are you a part of any prepayment plan (such as insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 207

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
205	What is the total amount you paid for all services or treatments you received at this facility today? Please include any money you paid for services, laboratory tests, or medicines. (IF NEEDED, ASSIST IN ADDING TO ACHIEVE THE TOTAL)	1) TOTAL AMOUNT ☐☐☐☐☐☐ PAID NO MONEY . . . 000000 DON'T KNOW . . . . . 999998 2) LAB ☐☐☐☐☐☐ 3) MEDICINE ☐☐☐☐☐☐ 4) CONSULT ☐☐☐☐☐☐ 5) OTHER ☐☐☐☐☐☐	
206	How did you pay for the services that you received at the facility today?	CASH . . . . . 1 → 208 CREDIT . . . . . 2 → 208 INSURANCE . . . . . 3 → 208 IN KIND . . . . . 4 → 208 OTHER _____ 6 → 208 (SPECIFY)	
207	Why did you not pay for the services?	EMPLOYER PAYS . . . . . A WAIVED . . . . . B EXEMPT . . . . . C OTHER _____ X (SPECIFY)	
208	Would you encourage a friend/relative of yours to come to this facility for family planning services?	YES . . . . . 1 NO 2	
209	In which district and village/town do you live? District _____ Village/Town _____	DISTRICT . . . . . ☐☐	
210	Is this the nearest health facility to your home?	YES . . . . . 1 → 212 NO . . . . . 2 DON'T KNOW . . . . . 8 → 212	
211	What was the **main** reason you did not go to the nearest facility?	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . . 06 REFERRAL . . . . . 07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
212	How long did it take you to get here?	MINUTES . . . . . ☐☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
213	What was the main type of transport you used to get here?	WALKED . . . . . A TRACTOR . . . . . B BICYCLE . . . . . C MOTORCYCLE . . . . . D BUS/MATATU . . . . . E PRIVATE CAR . . . . . F HIRED CAR/TAXI . . . . . G WHEEL CART . . . . . H OTHER _____ X (SPECIFY)	
214	How much will it cost you to come to this facility today, including return transportation and food? This does not include fees for services received and medications.	TOTAL COST [ ][ ][ ][ ][ ][ ] NO COST . . . . . 000000 DON'T KNOW 999998	
215	Did you lose wages from work or time from other important activities that contribute to your livelihood to come here today?	YES, LOST WAGES . . . . . 1 NO, LOST NO WAGES . . . . . 2 LOST TIME FROM NON-WAGE WORK 3	
216	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	

5. Personal Characteristics of Client			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended? (IF POLYTECHNIC FROM PRIMARY CODE AS SECONDARY; IF POLYTECHNIC FROM COMPLETED SECONDARY CODE HIGHER)	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
304	What is the highest grade you completed at that level?	GRADE . . . . . ☐☐	
305	Do you know how to read or how to write?	YES, READ ONLY . . . . . 1 YES, READ AND WRITE . . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
306	RECORD THE TIME WHEN THE INTERVIEW ENDED.	☐☐ . ☐☐	
307	**Interviewer's comments:**		

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Observation of Antenatal-Care Consultation

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____ PROVINCE NUMBER

District _____ DISTRICT NUMBER

Number of the facility: _____ FACILITY NUMBER

QTYPE . . . . . O A N

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY

2. Provider Information

Provider category:

Consultant	01	Registered Midwife	05
Medical Doctor	02	Enrolled Nurse	06
Clinical Officer	03	Enrolled Midwife	07
Registered Nurse	04	Nurse Aid	08

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY

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

Code for provider should be the same as the one used for the provider interview. PROVIDER CODE

3. Information About Observation

Date: _____ DAY / MONTH / YEAR

Name of the observer: _____ OBSERVER CODE

Time observation started: _____ TIME OBSERVATION STARTED

Client code: _____ CLIENT CODE

4. Observation of Antenatal-Care Consultation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. BE AS DISCREET AS POSSIBLE DURING THE ASSESSMENT. DO NOT TAKE PART IN THE INTERACTION BETWEEN THE PROVIDER AND THE CLIENT. TRY TO SIT BEHIND THE CLIENT AND TO ONE SIDE, SO YOU WILL NOT BE SITTING DIRECTLY IN FRONT OF THE PROVIDER. FOR EACH OF THE ITEMS BELOW, CIRCLE THE ANSWER THAT BEST EXPRESSES YOUR ASSESSMENT OF WHAT HAPPENED DURING THE INTERACTION. **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 the delivery of services. I would like to observe your consultation with this client in order to better understand how health care is provided in this facility. Any information you give me will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ STOP
	READ TO CLIENT: Hello. I am representing the Ministry of Health. We are carrying out a survey of facilities that provide health 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. Any information you give will be kept completely confidential and will not affect the level of care you receive here, now or in the future. If, at any point, you would prefer I leave, please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
102	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ STOP

		YES	NO	DK	
103	CLIENT STATUS. (OBSERVER TO COMPLETE)				
01	RECORD WHETHER THIS IS CLIENT'S FIRST VISIT FOR ANTENATAL CARE **AT THIS FACILITY** FOR THIS PREGNANCY.	1	2	8	
02	RECORD WHETHER THIS IS THE CLIENT'S FIRST PREGNANCY.	1	2	8	
104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:				
01	Client's age	1	2	8	
02	Medications the client is taking	1	2	8	
03	Date client's last menstrual period began	1	2	8	
04	Number of prior pregnancies client has had	1	2	8	
05	Individual birth plan	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
105	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:				
01	Prior stillbirth(s)	1	2	8	
02	Infant(s) who died in the first week of life	1	2	8	
03	Heavy bleeding, during or after delivery	1	2	8	
04	Previous assisted delivery (caesarean section, ventouse, or forceps)	1	2	8	
106	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY:				
01	Bleeding	1	2	8	
02	Fever	1	2	8	
03	Headache or blurred vision	1	2	8	
04	Swollen face or hands	1	2	8	
05	Tiredness or breathlessness	1	2	8	
06	Whether the client has felt the baby move	1	2	8	
07	Whether there are any other symptoms or problems the client thinks might be related to this pregnancy	1	2	8	
107	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:	YES	NO	DK	
01	Take the client's blood pressure	1	2	8	
02	Palpate the client's abdomen for fetal presentation	1	2	8	
03	Palpate the client's abdomen for uterine height	1	2	8	
04	Listen to the client's abdomen for fetal heartbeat	1	2	8	
05	Perform or refer for anemia test	1	2	8	
06	Perform or refer for urine test	1	2	8	
07	Perform or refer the client for a syphilis test	1	2	8	
08	Perform or refer for HIV test	1	2	8	
09	Provide or refer for counseling related to HIV test	1	2	8	
10	Look at the client's health card (either before beginning the consultation or while collecting information or examining the client)	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
108	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENTS OR COUNSELING:	YES	NO	DK	NA	
01	Prescribe or give iron tablets or folic acid (IFA) or both	1	2	8		
02	Explain the purpose of iron or folic acid	1	2	8	5	
03	Explain how to take iron or folic-acid tablets	1	2	8	5	
04	Explain side effects of iron tablets	1	2	8	5	
05	Prescribe or give a tetanus toxoid (TT) injection	1	2	8		
06	Explain the purpose of the TT injection	1	2	8	5	
07	Prescribe or give anti-malarial prophylaxis	1	2	8	5	
08	Explain the purpose of the preventive treatment with malaria medications	1	2	8		
09	Explain how to take the anti-malarial medications	1	2	8	5	
10	Explain possible side effects of malaria tablets	1	2	8	5	
109	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT PREPARATIONS:	YES	NO	DK		
01	Discuss quantity or quality of food to eat during pregnancy	1	2	8		
02	Mention the following signs and symptoms as risk factors for which the woman should return to the facility:	YES	NO	DK		
	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		
03	Inform the client about the progress of the pregnancy	1	2	8		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
110	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:		
01	Ask the client where she will deliver	1 2 8	
02	Advise the client to use a skilled health worker during delivery	1 2 8	
03	Discuss with client what items to have on hand at home, for delivery at home, e.g., sterile blades	1 2 8	
04	Discussed importance of immunization for the newborn	1 2 8	
111	RECORD WHETHER THE PROVIDER ADVISED EXCLUSIVELY BREASTFEEDING THE INFANT FOR UP TO 6 MONTHS.	1 2 8	
112	RECORD WHETHER THE PROVIDER DISCUSSED FAMILY PLANNING (OR BIRTH CONTROL) FOR USE AFTER DELIVERY.	1 2 8	
113	RECORD WHETHER THE PROVIDER ASKED WHETHER THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS.	1 2 8	
114	RECORD WHETHER THE PROVIDER USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING DURING THE CONSULTATION.	1 2 8	
115	RECORD WHETHER THE PROVIDER WROTE ON THE CLIENT'S HEALTH CARD.	YES . . . . . 1 NO . . . . . 2 NO HEALTH CARD USED . . . 3 DON'T KNOW 8	
116	ASK THE PROVIDER HOW MANY WEEKS PREGNANT THE CLIENT IS.	WEEK OF PREGNANCY . . . . . ☐☐ DON'T KNOW 98	
117	RECORD THE OUTCOME OF THE CONSULTATION. [RECORD THE OUTCOME AT THE TIME THE OBSERVATION CONCLUDED]	CLIENT SENT HOME . . . . . 1 CLIENT REFERRED (TO LABORATORY OR OTHER PROVIDER) AT SAME FACILITY . . . . . 2 CLIENT ADMITTED TO SAME FACILITY . . . . . 3 CLIENT REFERRED TO OTHER FACILITY . . . . . 4 DON'T KNOW 8	
118	RECORD THE TIME WHEN THE INTERVIEW ENDED.	☐☐ : ☐☐	
119	**Observer's comments:**		

MEASURE *DHS+* SERVICE PROVISION ASSESSMENT

Exit Interview for Antenatal-Care Client

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____

District _____

Number of the facility: _____

QTYPE . . . . . X A N

PROVINCE NUMBER . . . . . [ ][ ]

DISTRICT NUMBER . . . . . [ ][ ]

FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Information About Interview

Date: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the interviewer: _____

INTERVIEWER CODE . . . . . [ ][ ]

Time interview started: _____

TIME INTERVIEW STARTED [ ][ ] : [ ][ ]

Client code: _____

CLIENT CODE . . . . . [ ][ ]

Name of provider: _____

PROVIDER CODE . . . . . [ ][ ]

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	INTRODUCE YOURSELF TO THE CLIENT. Hello. In order to improve the services this facility offers, we would like to know about your experience here today. All the information you give me will be kept strictly confidential, and the care that you receive at this facility in the future will not be affected by your participation or nonparticipation. You may refuse to answer any of the questions, and you may stop the interview anytime. Do you have any questions for me now? Do you agree to participate? Interviewer's signature _____ Date _____ (Indicates respondent's willingness to participate)		
100	May I begin the interview now?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	 → STOP
101	Do you have an antenatal-care card/book, or an immunization card with you today? IF YES: ASK TO SEE THE CARD/BOOK.	YES . . . . . 1 NO, CARD KEPT WITH FACILITY . . . . . 2 NO CARD/BOOK USED 3	 → 104 → 104
102	CHECK ANTENATAL-CARE CARD/BOOK, OR IMMUNIZATION CARD. INDICATE WHETHER THERE IS ANY NOTE OR RECORD OF THE CLIENT HAVING RECEIVED TETANUS TOXOID.	YES, 1 TIME . . . . . 1 YES, 2 OR MORE TIMES . . . . 2 NO . . . . . 3 DON'T KNOW 8	
103	HOW MANY WEEKS PREGNANT IS THE CLIENT, ACCORDING TO THE ANC CARD?	WEEKS . . . . . ☐☐	
104	Is this your first pregnancy?	YES . . . . . 1 NO 2	
105	Is this your first antenatal visit at this facility for this pregnancy?	YES . . . . . 1 NO 2	
106	During this visit, or previous visits, did the provider give you iron tablets, folic acid or iron with folic acid, or give you a prescription for them? SHOW THE CLIENT AN IRON TABLET, A FOLIC-ACID TABLET, OR A COMBINED TABLET.	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 108 → 111 → 111
107	ASK TO SEE THE CLIENT'S IRON/FOLIC ACID/IRON WITH FOLIC ACID TABLETS, OR THE PRESCRIPTION.	SAW TABLETS . . . . . 1 SAW PRESCRIPTION . . . . . 2 NO TABLETS OR PRESCRIPTION SEEN 3	
108	During this visit or previous visits, has a provider explained to you how to take the iron tablets?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
109	During this or previous visits, has a provider discussed with you the side effects of the iron tablet?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
110	Please tell me any side effects of the iron tablet that you know of.	NAUSEA . . . . . A BLACK STOOLS . . . . . B CONSTIPATION . . . . . C OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
111	During this or previous visits, has a provider given or prescribed any anti-malarial tablets for you? SHOW THE CLIENT CAPSULES OF CHLOROQUINE AND FANSIDAR.	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	→ 113 → 114 → 114
112	ASK TO SEE THE CLIENT'S ANTI-MALARIAL TABLETS.	SAW TABLETS . . . . . 1 SAW PRESCRIPTION . . . . . 2 NO TABLETS OR PRESCRIPTION SEEN 3	
113	During this or previous visits, did a provider explain to you how to take the anti-malarial tablets?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
114	During this visit or previous visits, has a provider asked you whether you had ever received a tetanus toxoid injection?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
115	Have you ever received a tetanus toxoid (TT) injection? IF YES: Including any injection you received today, how many times in total during your lifetime have you received a tetanus toxoid injection? (INJECTION MAY HAVE BEEN RECEIVED EITHER AT THIS FACILITY OR ELSEWHERE.)	NUMBER OF TETANUS INJECTIONS RECEIVED ☐☐ DON'T KNOW 98	
116	During this visit or previous visits, has a provider discussed things you should have in preparation for your delivery? This may include planning in case of emergency, things you should bring to a facility, or things you should prepare at home for home delivery.	YES . . . . . 1 NO 2	
117	Please tell me any things you know of that you should have in preparation for your delivery.	EMERGENCY TRANSPORT . . A MONEY . . . . . B DISINFECTANT . . . . . C STERILE BLADE/SCISSORS TO CUT CORD . . . . . D OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
118	Do you have money set aside for the delivery? IF YES, PROBE…enough?	YES, ENOUGH . . . . . 1 YES, BUT NOT ENOUGH . . . . 2 NO 3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
119	During this visit or previous visits, has a provider talked with you about any signs of complications (danger signs) that should warn you of problems with the pregnancy?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 122 → 122
120	Please tell me any signs of complications (danger signs) that you know of. CIRCLE ALL RESPONSES YOU MAY PROBE WITHOUT USING SPECIFIC ANSWERS GIVEN ON RIGHT	BLEEDING . . . . . A FEVER . . . . . B SWOLLEN FACE OR HAND . . . . . C TIREDNESS OR BREATHLESSNESS . . . . . D HEADACHE OR BLURRED VISION . . . . . E CONVULSIONS . . . . . F BABY STOPS MOVING OR REDUCED FETAL MOVEMENT . . . . . G OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
121	What did the provider advise you to do if you experienced any of the warning signs? CIRCLE LETTER FOR ALL COURSES OF ACTION THE CLIENT MENTIONS.	SEEK CARE AT A FACILITY . . . . . A DECREASE ACTIVITY . . . . . B CHANGE DIET . . . . . C OTHER _____ X (SPECIFY)	
122	Do you know any danger signs during/after delivery? IF YES: What danger signs do you know?	HEAVY BLEEDING . . . . . A FEVER . . . . . B GENITAL INJURIES . . . . . C OTHER _____ X (SPECIFY) NONE . . . . . Y	
123	During this visit or previous visits, has a provider talked to you about what you should eat during your pregnancy?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
124	During this visit or previous visits, has a provider given you advice on the importance of exclusively breastfeeding—that is, about giving your baby nothing apart from breast milk?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	 → 126 → 126
125	For how many months did the provider recommend that you exclusively breastfeed, that is, that you do not give your baby liquid or food in addition to your breast milk?	MONTHS . . . . . ☐☐ DON'T KNOW 98	
126	During this visit or previous visits, did the provider talk to you about where you plan to deliver your baby?	YES, THIS VISIT . . . . . A YES, PREVIOUS VISIT . . . . . B NO . . . . . Y DON'T KNOW . . . . . Z	
127	Have you decided where you will go for the delivery of your baby? IF YES: PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY AND WHICH TYPE, OR AT HOME.	AT THIS HEALTH FACILITY . . . . . 1 AT OTHER HEALTH FACILITY . . . . . 2 FACILITY TYPE . . . . . ☐☐ IN A PRIVATE HOME (e.g. TBAs) . . . . . 3 AT HOME . . . . . 4 DON'T KNOW/NOT DECIDED 8	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help us to improve services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were large or small problems for you.		

			LARGE	SMALL	NO PROB-LEM	DK
01	Time you waited	WAIT	1	2	3	8
02	Ability to discuss problems or concerns about your pregnancy with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about your pregnancy or any problems	EXPLAIN PROB. OR PREGNANCY	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Any problem you had today that I did not mention	_____ (SPECIFY)	1	2	3	8

203	Are you a part of any prepayment plan (such as insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 207

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
205	What is the total amount you paid for all services or treatments you received at this facility today? Please include any money you paid for services, laboratory tests, or medicines. (IF NEEDED, ASSIST IN ADDING TO ACHIEVE THE TOTAL)	1) TOTAL AMOUNT ☐☐☐☐☐☐ PAID NO MONEY . . . 000000 DON'T KNOW . . . . . 999998 2) LAB ☐☐☐☐☐☐ 3) MEDI-CINE ☐☐☐☐☐☐ 4) CON-SULT ☐☐☐☐☐☐ 5) OTHER ☐☐☐☐☐☐	
206	How did you pay for the services that you received at the facility today?	CASH . . . . . 1 CREDIT . . . . . 2 INSURANCE . . . . . 3 IN KIND . . . . . 4 OTHER _____ 6 (SPECIFY)	→ 208 → 208 → 208 → 208 → 208
207	Why did you not pay for the services?	EMPLOYER PAYS . . . . . A WAIVED . . . . . B EXEMPT . . . . . C OTHER _____ X (SPECIFY)	
208	Would you encourage a friend/relative of yours to come to this facility for antenatal care?	YES . . . . . 1 NO 2	
209	In which district and village/town do you live? District _____ Village/Town _____	DISTRICT . . . . . ☐☐	
210	Is this the nearest health facility to your home?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 212 → 212
211	What was the main reason you did not go to the nearest facility?	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE PERSONNEL . . . 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE 06 REFERRAL . . . . . 07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
212	How long did it take you to get here?	MINUTES . . . . . ☐☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
213	What was the main type of transport you used to get here?	WALKED . . . . . A TRACTOR . . . . . B BICYCLE . . . . . C MOTORCYCLE . . . . . D BUS/MATATU . . . . . E PRIVATE CAR . . . . . F HIRED CAR/TAXI . . . . . G WHEEL CART . . . . . H OTHER_____ X (SPECIFY)	
214	How much will it cost you to come to this facility today, including return transportation and food? This does not include fees for services received and medications	TOTAL COST [ ][ ][ ][ ][ ][ ] NO COST . . . . . 000000 DON'T KNOW 999998	
215	Did you lose wages from work or time from other important activities that contribute to your livelihood to come here today?	YES, LOST WAGES . . . . . 1 NO, LOST NO WAGES . . . . . 2 LOST TIME FROM NON-WAGE WORK 3	
216	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	

5. Personal Characteristics of Client			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended? (IF POLYTECHNIC FROM PRIMARY CODE AS SECONDARY; IF POLYTECHNIC FROM COMPLETED SECONDARY CODE HIGHER)	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
304	What is the highest grade you completed at that level?	GRADE . . . . . ☐☐	
305	Do you know how to read or how to write?	YES, READ ONLY . . . . . 1 YES, READ AND WRITE . . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
306	RECORD THE TIME WHEN THE INTERVIEW ENDED.	☐☐ . ☐☐	
307	**Interviewer's comments:**		

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Observation of STI Consultation

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____

District _____

Number of the facility: _____

QTYPE . . . . . O S I

PROVINCE NUMBER . . . . . [ ][ ]

DISTRICT NUMBER . . . . . [ ][ ]

FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Provider Information

Provider category:

Consultant	01	Registered Midwife	05
Medical Doctor	02	Enrolled Nurse	06
Clinical Officer	03	Enrolled Midwife	07
Registered Nurse	04	Nurse Aid	08

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY . . . . . [ ][ ]

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

SEX OF PROVIDER . . . . . [ ]

Code for provider should be the same as the one used for the provider interview.

PROVIDER CODE . . . . . [ ][ ]

3. Information About Observation

Date: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the observer: _____

OBSERVER CODE . . . . . [ ][ ]

Time observation started: _____

TIME OBSERVATION STARTED [ ][ ] : [ ][ ]

Client code: _____

CLIENT CODE . . . . . [ ][ ]

4. Observation of STI Client Consultation			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	BEFORE OBSERVING THE CONSULTATION, OBTAIN PERMISSION FROM BOTH THE SERVICE PROVIDER AND THE CLIENT. MAKE SURE THAT THE PROVIDER KNOWS THAT YOU ARE NOT THERE TO EVALUATE HIM OR HER, AND THAT YOU ARE NOT AN "EXPERT" TO BE CONSULTED DURING THE SESSION. BE AS DISCREET AS POSSIBLE DURING THE ASSESSMENT. DO NOT TAKE PART IN THE INTERACTION BETWEEN THE PROVIDER AND THE CLIENT. TRY TO SIT BEHIND THE CLIENT AND TO ONE SIDE, SO YOU WILL NOT BE SITTING DIRECTLY IN FRONT OF THE PROVIDER. FOR EACH OF THE ITEMS BELOW, CIRCLE THE ANSWER THAT BEST EXPRESSES YOUR ASSESSMENT OF WHAT HAPPENED DURING THE INTERACTION. **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 the delivery of services. I would like to observe your consultation with this client in order to better understand how health care is provided in this facility. Any information you give me will be completely confidential. If, at any point, you would prefer I leave, please feel free to tell me. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
101	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE PROVIDER.	YES . . . . . 1 NO 2	→ STOP
	READ TO CLIENT: Hello. I am representing the Ministry of Health. We are carrying out a survey of facilities that provide health services to women, children and men. I would like to observe your consultation with this provider in order to better understand how health care is provided. Any information you give will be kept completely confidential and will not affect the level of care you receive here, now or in the future. If, at any point, you would prefer I leave, please feel free to tell me. After the consultation, my colleague would like to talk with you about your experience here today. Do you have any questions for me? Do I have your permission to be present at this consultation? _____ _____ Interviewer's signature Date (Indicates respondent's willingness to participate)		
102	RECORD WHETHER PERMISSION WAS RECEIVED FROM THE CLIENT.	YES . . . . . 1 NO 2	→ STOP

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
		YES NO DK	
103	RECORD WHETHER THE PROVIDER ADVICED THE CLIENT THAT ANY INFORMATION SHARED DURING THE CONSULTATION IS CONFIDENTIAL	1 2 8	
104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR WHETHER THE CLIENT GAVE ANY OF THE FOLLOWING INFORMATION ABOUT MEDICAL SYMPTOMS AND TYPES OF RELATIONSHIPS:		
01	Symptoms the client is having	1 2 8	
02	How long the client has had the present symptoms	1 2 8	
03	The client's recent history of sexual contacts	1 2 8	
04	Symptoms in sexual partners	1 2 8	
05	The client's current sexual relationship status (monogamous; multiple partners; nonmonogamous partners)	1 2 8	
105	RECORD IF THE CLIENT IS MALE OR FEMALE	MALE . . . . . 1 FEMALE 2	
106	RECORD WHETHER THE PROVIDER EXAMINED THE CLIENT'S GENITALIA	YES, MALE CLIENT . . . . . 1 YES, FEMALE CLIENT . . . . . 2 NO . . . . . 3 DON'T KNOW 8	→108 →109 →109
107	RECORD WHETHER THE PROVIDER PERFORMED ANY OF THE FOLLOWING ACTIONS IN REGARD TO PRIVACY AND HYGIENE (FOR MALE CLIENTS)	YES NO	NA
01	Ensure the client's visual privacy	VISUAL PRIVACY 1 2	
02	Ensure the client's auditory privacy	AUDITORY PRIVACY 1 2	
03	Explain the procedure to the client before beginning	EXPLAIN PROCEDURE FIRST 1 2	
04	Wash hands before conducting the examination	WASH HANDS 1 2	
05	Wear clean latex gloves	WEAR GLOVES 1 2	
06	Make sure the client's genitalia were fully exposed	FULLY EXPOSED 1 2	
07	FOR MALE CLIENTS NOT CIRCUMCISED: Retract foreskin to inspect for lesions or discharge	RETRACT FORESKIN 1 2	5
08	Place reusable gloves and instruments in a disinfectant solution immediately after complete procedure	DECONTAMINATE GLOVES AND INSTRUMENTS 1 2 109 109	5 109

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

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

MEASURE *DHS+* SERVICE PROVISION ASSESSMENT

Exit Interview for STI Client

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____

District _____

Number of the facility: _____

QTYPE . . . . . [X] [S] [I]

PROVINCE NUMBER . . . . . [ ][ ]

DISTRICT NUMBER . . . . . [ ][ ]

FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Information About Interview

Date: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the interviewer: _____

INTERVIEWER CODE . . . . . [ ][ ]

Time interview started: _____

TIME INTERVIEW STARTED [ ][ ] : [ ][ ]

Client code: _____

CLIENT CODE: . . . . . [ ][ ]

Name of provider: _____

PROVIDER CODE: . . . . . [ ][ ]

3. Information About Visit

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	INTRODUCE YOURSELF TO THE CLIENT. Hello. In order to improve the services this facility offers, we would like to know about your experience here today. All the information you give me will be kept strictly confidential, and the care that you receive at this facility in the future will not be affected by your participation or nonparticipation. You may refuse to answer any of the questions, and you may stop the interview anytime. Do you have any questions for me now? Do you agree to participate? _____ Interviewer's signature (Indicates respondent's willingness to participate) _____ Date		
100	May I begin the interview now?	CLIENT AGREES . . . . . 1 CLIENT REFUSES 2	 → STOP
101	Did the health worker give you a diagnosis of your medical problem today - that is, did he or she tell you what is the reason/cause of your problem?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
102	Were you given a prescription or medications today? (PROBE WHICH)	YES, BOTH . . . . . 1 RECEIVED PRESCRIPTION ONLY . . . . . 2 RECEIVED INJECTION AND OTHER MEDICATIONS BUT NO PRESCRIPTIONS . . . . . 3 RECEIVED INJECTION BUT NO OTHER MEDICATIONS OR PRESCRIPTIONS . . . . . 4 NO 5	 → 105 → 105 → 105
103	ASK TO SEE ALL MEDICATIONS THAT THE CLIENT RECEIVED AND ANY PRESCRIPTIONS NOT YET FILLED CIRCLE THE RESPONSE THAT BEST DESCRIBES THE MEDICATIONS OR PRESCRIPTIONS SEEN	HAS ALL MEDS . . . . . 1 HAS SOME MEDS; SOME PRESCRIPTION NOT SUPPLIED 2 NO MEDS SEEN; HAS PRESCRIPTION ONLY 3	
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 a health worker talk to you about how to protect yourself against STIs or HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
106	What are some ways you can protect yourself from infections transmitted by sexual activity?	USE CONDOMS . . . . . A HAVE ONLY ONE SEXUAL PARTNER . . . . . B OTHER _____ X DON'T KNOW . . . . . Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	Did the health worker offer you an HIV/AIDS test or ask you to have one done?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
108	Have you ever used condoms?	YES . . . . . 1 NO 2	
109	I want to ask your opinion of some reasons people might not use a condom. As I mention each please tell me if you think that it might be, or has been, a reason you might not use condoms. Tell me if you think it has been or could be a large problem, a small problem, or not a problem for you to decide whether to use condoms.		
	How great a problem is each of the following about condoms	LARGE / SMALL / NO PROBLEM / DK	
01	Embarrassing to purchase or obtain condoms	EMBARRASSING TO OBTAIN 1 2 3 8	
02	Difficult to dispose of	PROBLEM WITH DISPOSAL 1 2 3 8	
03	Embarrassing to discuss with your sex partner	EMBARRASSING TO DISCUSS 1 2 3 8	
04	Reduces your own sexual satisfaction	REDUCES OWN 1 2 3 8	
05	Reduces your partner's sexual satisfaction	REDUCES PARTNER'S 1 2 3 8	
110	Did you discuss with the health worker any of the issues related to using condoms that we just referred to?	YES . . . . . 1 NO 2	→ 112
111	Did the health worker talk to you about condoms or mention condoms today?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
112	Were you given any condoms today?	YES . . . . . 1 NO 2	
113	Did you receive a blood test today or did the health worker take a specimen from you for a laboratory examination?	YES . . . . . 1 NO 2	→ 201
114	Did the health worker explain to you what the laboratory test was for? IF YES: What was the test for?	YES, INFECTION OR STI . . . . . A YES, HIV OR AIDS . . . . . B YES, OTHER . . . . . X NO . . . . . Y DON'T KNOW . . . . . Z	

4. Information About Client's Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services you received today. I would like to have your honest opinion about the things that we will talk about. This information will help us to improve services.		
201	How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation?	MINUTES . . . . . ☐☐☐ SAW PROVIDER IMMEDIATELY . . . . . 000 DON'T KNOW 998	
202	Now I am going to ask about some common problems clients have at health facilities. As I mention each one, please tell me whether any of these were problems for you today, and if so, whether they were large or small problems for you.		

			LARGE	SMALL	NO PROB-LEM	DK
01	Time you waited	WAIT	1	2	3	8
02	Ability to discuss problems or concerns about your problems with the provider	DISCUSS PROBLEMS	1	2	3	8
03	Amount of explanation you received about your problems	EXPLAIN PROBLEM	1	2	3	8
04	Quality of the examination and treatment provided	QUALITY	1	2	3	8
05	Privacy from having others see the examination	VISUAL PRIVACY	1	2	3	8
06	Privacy from having others hear your consultation discussion	AUDITORY PRIVACY	1	2	3	8
07	Availability of medicines at this facility	MEDICINES	1	2	3	8
08	The hours of service at this facility	HOURS OF SERVICE	1	2	3	8
09	The number of days services are available to you	DAYS OF SERVICE	1	2	3	8
10	The cleanliness of the facility	CLEAN	1	2	3	8
11	How the staff treated you	HOW TREATED	1	2	3	8
12	Any problem you had today that I did not mention	_____ (SPECIFY)	1	2	3	8

203	Are you a part of any prepayment plan (such as insurance or a similar program) or institutional arrangement that pays for some or all of the services you receive at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
204	Were you charged, or did you pay anything for any services provided today?	YES . . . . . 1 NO 2	→ 207

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
205	What is the total amount you paid for all services or treatments you received at this facility today? Please include any money you paid for services, laboratory tests, or medicines. (IF NEEDED, ASSIST IN ADDING TO ACHIEVE THE TOTAL)	1) TOTAL AMOUNT ☐☐☐☐☐☐ PAID NO MONEY . . . . . 000000 DON'T KNOW . . . . . 999998 2) LAB ☐☐☐☐☐☐ 3) MEDI-CINE ☐☐☐☐☐☐ 4) CON-SULT ☐☐☐☐☐☐ 5) OTHER ☐☐☐☐☐☐	
206	How did you pay for the services that you received at the facility today?	CASH . . . . . 1 → 208 CREDIT . . . . . 2 → 208 INSURANCE . . . . . 3 → 208 IN KIND 4 → 208 OTHER _____ 6 → 208	
207	Why did you not pay for the services?	EMPLOYER PAYS . . . . . A WAIVED . . . . . B EXEMPT . . . . . C OTHER _____ X (SPECIFY)	
208	Would you encourage a friend/relative of yours to come to this facility for STI services?	YES . . . . . 1 NO 2	
209	In which district and village/town do you live? District _____ Village/Town _____	DISTRICT . . . . . ☐☐	
210	Is this the nearest health facility to your home?	YES . . . . . 1 → 212 NO . . . . . 2 DON'T KNOW . . . . . 8 → 212	
211	What was the main reason you did not go to the nearest facility?	INCONVENIENT OPERATING HOURS . . . . . 01 BAD REPUTATION . . . . . 02 DON'T LIKE THE PERSONNEL 03 NO MEDICINE . . . . . 04 PREFERS TO REMAIN ANONYMOUS . . . . . 05 IT IS MORE EXPENSIVE . . . 06 REFERRAL . . . . . 07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
212	How long did it take you to get here?	MINUTES . . . . . ☐☐☐ DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
213	What was the main type of transport you used to get here?	WALKED . . . . . A TRACTOR . . . . . B BICYCLE . . . . . C MOTORCYCLE . . . . . D BUS/MATATU . . . . . E PRIVATE CAR . . . . . F HIRED CAR/TAXI . . . . . G WHEEL CART . . . . . H OTHER_____ X (SPECIFY)	
214	How much will it cost you to come to this facility today, including return transportation and food? This does not include fees that you paid or medicines you will buy.	TOTAL COST [ ][ ][ ][ ][ ][ ] NO COST . . . . . 000000 DON'T KNOW 999998	
215	Did you lose wages from work or time from other important activities that contribute to your livelihood to come here today?	YES, LOST WAGES . . . . . 1 NO, LOST NO WAGES . . . . . 2 LOST TIME FROM NON-WAGE WORK 3	
216	Have you ever visited this facility before (either as a patient or visiting or accompanying a patient)?	YES . . . . . 1 NO 2	

5. Personal Characteristics of Client			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about yourself. I would like to have your honest responses as this information will help us to improve services.		
301	How old were you at your last birthday?	AGE IN YEARS . . . . . ☐☐	
302	Have you ever attended school?	YES . . . . . 1 NO 2	→ 305
303	What is the highest level of school you attended? (IF POLYTECHNIC FROM PRIMARY CODE AS SECONDARY; IF POLYTECHNIC FROM COMPLETED SECONDARY CODE HIGHER)	PRIMARY . . . . . 1 SECONDARY . . . . . 2 HIGHER 3	
304	What is the highest grade you completed at that level?	GRADE . . . . . ☐☐	
305	Do you know how to read or how to write?	YES, READ ONLY . . . . . 1 YES, READ AND WRITE . . . . 2 NO 3	
	Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential. Have a good day!		
306	RECORD THE TIME WHEN THE INTERVIEW ENDED.	☐☐ . ☐☐	
307	**Interviewer's comments:**		

HEALTH WORKER INTERVIEW

Code of facility: ☐☐ PROV ☐☐ DISTRICT ☐☐ FACILITY

QRE TYPE ☐K

Interviewer Code: . . . . . ☐☐

Provider Code: . . . . . ☐☐

DATE: ☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR

Provider Sex: (1=MALE; 2=FEMALE) . . . . ☐

Provider Status: (1=Assigned; 2=Seconded) . . . . . ☐

Number of Observations Associated with Provider . . . . . ☐☐

Number of Exit Interviews Associated with Provide . . . . . ☐☐

CHECKED BY MONITOR/SUPERVISOR:

SIGNATURE _____ DATE ☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR

EXPLAIN TO THE HEALTH WORKER THAT HIS/HER NAME WAS PROVIDED AS A PERSON WHO PROVIDES CLIENT SERVICES INCLUDING SERVICES RELATED TO HIV/AIDS TESTING, COUNSELING, OR CARE AND SUPPORT SERVICES FOR HIV/AIDS-RELATED ILLNESSES. VALIDATE WITH THE HEALTH WORKER THAT HE/SHE DOES PROVIDE SOME SERVICES RELATED TO HIV/AIDS, AND THAT THESE SERVICES ARE A COMPONENT OF THEIR WORK FOR THIS FACILITY.

Now I will read a statement explaining the survey and asking your consent for responding to survey questions.

Hello. My name is _____. We are here on behalf of the NCPD and the MOH to assist the government in knowing more about the availability of maternal, child, and reproductive health services, as well as specific infectious diseases such as HIV/AIDS and tuberculosis. Your facility was randomly selected to participate in this study. We will be asking you several questions about the types of services that you personally provide, as well as questions about training you have received.
We would also like to ask you some questions about your training and experiences in HIV/AIDS-related care and support.
You may decline to answer any question and choose to stop the interview at any time.

Please be assured that the information you give us will be completely confidential and will not be traced to you and will not be identified with the name of the facility.

Do you have any questions for me at this time?

100	Do I have your agreement to participate? Thank you. Let's begin now.	YES . . . . . 1 NO 2	→ STOP
101	RECORD THE TIME AT BEGINNING OF INTERVIEW ☐☐ . ☐☐		

1. Education and Experience

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
102	May I begin the interview now?	YES . . . . . 1 NO 2	→ STOP
103	What year did you start working in this facility?	YEAR . . . . . ☐☐☐☐	
104	Now I would like to ask you some questions about your educational background. How many years of primary and secondary education did you complete in total?	YEARS . . . . . ☐☐	
105	What is your current technical qualification?	CONSULTANT . . . . . 01 MEDICAL DOCTOR . . . . . 02 CLINICAL OFFICER . . . . . 03 REGISTERED NURSE . . . . . 04 REGISTERED MIDWIFE . . . . . 05 ENROLLED NURSE . . . . . 06 ENROLLED MIDWIFE . . . . . 07 NURSE AIDE . . . . . 08 LAB TECHNICIAN/TECHNOLOGIS . . . . . 09 TRAINED COUNSELOR (FULL TIME) . . . . . 10 OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
106	What year did you graduate with this qualification?	YEAR	
107	How many years of study were required for this qualification (AFTER COMPLETING THE BASIC EDUCATION DESCRIBED IN Q104)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS FOR YEARS AND INDICATE THE NUMBER OF MONTHS.	YEARS . . . . . MONTHS	
108	In what year did you start working in your **current position** in this facility? IF YEAR IS NOT KNOWN, PROBE AND MAKE THE BEST ESTIMATE	YEAR	
109	What was your age at your last birthday?	AGE AT LAST BIRTHDAY (YRS)	
	SERVICES PROVIDED IN CURRENT POSITION IN THIS FACILITY		
110	Now I want to ask you about services you provide. In your **current** position, and as a part of your work for this facility, do you ever provide any client services other than laboratory tests?	YES . . . . . 1 NO 2	→ 621
111	Do you personally provide any of the following services?		
01	Diagnosis and treatment of STIs	YES . . . . . 1 NO 2	
02	Diagnosis and treatment of malaria	YES . . . . . 1 NO 2	
03	Manager for a clinical service	YES . . . . . 1 NO 2	
112	Do you provide any services that are designed to be Youth Friendly, that is that have a specific aim to encourage adolescent utilization?	YES . . . . . 1 NO 2	

113	Now I want to ask you about any pre-service or in-service training you have received during the past 3 years where any of the following topics were covered: ASK FOR EACH TOPIC	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	Universal precautions	1	2	3
02	Other infection prevention	1	2	3
03	Logistics management training	1	2	3
04	Decentralization or health sector reform	1	2	3
05	Management skills	1	2	3
06	Health Management Information Systems (HMIS) or reporting requirements for any service	1	2	3
07	Performance improvement approach	1	2	3
08	Client oriented service provision	1	2	3
09	Counseling and information sharing related to problems that affect adolescents	1	2	3
10	Diagnosis and treatment of problems that affect adolescents	1	2	3
11	Diagnosis and treatment of physical/sexual abuse in adolescents	1	2	3
12	Interaction and/or communication skills for working with adolescents	1	2	3
13	Confidentiality and rights to non-discrimination practices for People Living with HIV/AIDS	1	2	3
14	Syndromic approach to diagnosis and treatment of STIs	1	2	3
15	Other diagnosis and treatment of STIS (other than HIV/AIDS)	1	2	3
16	VIAA/VILI visual inspection of cervix	1	2	3
17	Diagnosis and treatment for malaria	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I want to ask about in-service or pre-service training related to specific health services		
	2. Child Health Services		
201	In your **current** position, and as a part of your work for this facility, do you ever personally provide any child health services?	YES . . . . . 1 NO 2	→ 203
202	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS	
203	During the past three years have you received any pre-service or in-service training on subjects related to child health or illness?	YES . . . . . 1 NO 2	→ 301

204	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	EPI/cold chain	1	2	3
02	ARI treatment	1	2	3
03	Diarrhea treatment	1	2	3
04	Malaria treatment for children	1	2	3
05	Nutrition/micronutrient deficiencies	1	2	3
06	Breast feeding (including exclusive breast-feeding)	1	2	3
07	Complementary feeding of infant	1	2	3
08	Integrated Management of Childhood Illness (IMCI)	1	2	3
09	Other: _____ (SPECIFY)	1	2	3

	3. Family Planning		
301	In your **current** position, and as a part of your work for this facility, do you ever personally provide any family planning services?	YES . . . . . 1 NO 2	→ 303
302	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS	
303	During the past three years have you received any pre-service or in-service training on subjects related to family planning?	YES . . . . . 1 NO 2	→ 401

304	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	Family planning counseling	1	2	3
02	Any contraceptive technology (CT) or clinical training skills	1	2	3
03	Symptom updates related to family planning methods	1	2	3
04	Colposcopy	1	2	3
05	Symptom management for family planning methods	1	2	3
06	Other: _____ (SPECIFY)	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	4. Maternal Health		
401	During the past three years have you received any pre-service or in-service training on subjects related to maternal or newborn health and HIV/AIDS?	YES . . . . . 1 NO 2	→ 403

402	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	Prevention of mother to child transmission for HIV/AIDS	1	2	3
02	Nutrition counseling for newborn of mother with HIV/AIDS	1	2	3
03	Optimal obstetric practices as relates to HIV	1	2	3

403	In your **current** position, and as a part of your work for this facility, do you ever personally provide any antenatal or postpartum care? IF YES, INDICATE WHICH SERVICE IS PROVIDED.	YES, ANTENATAL . . . . . 1 YES, POSTPARTUM . . . . . 2 YES, BOTH . . . . . 3 NO, NEITHER 4	→ 405
404	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS	
405	During the past three years have you received any pre-service or in-service training on subjects related to antenatal or postpartum care?	YES . . . . . 1 NO 2	→ 407

406	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	Focused antenatal care	1 → 02	2	3
02	Other antenatal care	1	2	3
03	Anemia in pregnancy	1	2	3
04	Malaria in pregnancy	1	2	3
05	Symptom management for pregnancy	1	2	3
06	Counseling/health education for maternity clients	1	2	3
07	Management of risk pregnancies	1	2	3
08	Postpartum care	1	2	3
09	OTHER _____ (SPECIFY)	1	2	3

407	In your **current** position, and as a part of your work for this facility, do you ever personally provide delivery services? By that I mean conducting the actual deliveries of newborns.	YES . . . . . 1 NO 2	→ 411
408	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS	
409	During the past 6 months, approximately how many deliveries have you done as the principal provider (include deliveries conducted for private practice and for facility)?	TOTAL DELIVERIES	
410	When was the last time you used a partograph?	NEVER . . . . . 0 IN PAST WEEK . . . . . 1 IN PAST MONTH . . . . . 2 IN PAST 6 MONTHS . . . . . 3 OVER 6 MONTHS AGO . . . . . 4 DON'T KNOW 8	
411	During the past three years have you received any pre-service or in-service training on subjects related to delivery care?	YES . . . . . 1 NO 2	→ 413

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
412	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING	
01	Care during labor or delivery	1	2	3	
02	Use of partograph	1	2	3	
03	Essential obstetric care/Life saving skills	1	2	3	
04	Lifesaving skills/emergency complications	1	2	3	
05	Post abortion care	1	2	3	
06	Maternal clinical audit	1	2	3	
07	OTHER _____ (SPECIFY)	1	2	3	
413	In your **current** position, and as a part of your work for this facility, do you ever personally provide care for the newborn?	YES . . . 1 NO . . . 2			→ 415
414	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS . . . [ ][ ]			
415	During the past three years have you received any pre-service or in-service training on subjects related to newborn care?	YES . . . 1 NO . . . 2			→ 501
416	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING	
01	Care of the normal newborn/neonatal care	1	2	3	
02	Neonatal resuscitation	1	2	3	
03	Exclusive breastfeeding	1	2	3	
04	Other: _____ (SPECIFY)	1	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	5. Tuberculosis		
501	In your **current** position, and as a part of your work for this facility, do you ever personally provide tuberculosis services? This includes diagnosis and laboratory testing.	YES, CLINICAL SERVICES . . . . . 1 NO 2	→ 601
502	How many years in total have you provided such services (Service may have been in another facility)? IF LESS THAN 1 YEAR, WRITE 00 IN THE BOXED CELLS.	YEARS	

503	Do you provide any of the following services?	PROVIDES SERVICE	
		YES	NO
01	Clinical diagnosis of tuberculosis	1	2
02	Sputum diagnosis for TB	1	2
03	Prescribe treatment for tuberculosis	1	2
04	Follow-up treatment for tuberculosis	1	2
05	Direct Observation Treatment Strategy (DOTS)	1	2

504	During the past three years have you received any pre-service or in-service training on subjects related to tuberculosis?	YES, CLINICAL SERVICES . . . . . 1 NO 2	→ 601

505	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	1 year Higher National Diploma for Chest and Skin (Medical Training College)	1	2	3
02	3 week Arusha training in TB Management and Control (International Union for TB and Lung Disease)	1	2	3
03	Other training for treatment of TB	1	2	3
04	Sputum diagnosis of TB	1	2	3
05	Other diagnosis of TB	1	2	3

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	6. HIV/AIDS		
601	In your **current** position, and as a part of your work for this facility, do you ever personally provide HIV/AIDS services? Services related to HIV/AIDS include counseling for prevention, counseling or testing, clinical care, care and support services such as social services, home care, or any other type of service for HIV/AIDS clients?	YES . . . . . 1 NO 2	
602	In your **current** position, and as a part of your work for this facility, do you ever personally provide any services related to HIV testing or counseling for HIV/AIDS patients?	YES . . . . . 1 NO 2	→ 604

603	Do you provide any of the following services? IF YES, FOR THE INDICATED SERVICES ASK: How long have you been providing this service? IF LESS THAN ONE YEAR WRITE '00'.	(a) PROVIDES SERVICE YES	(a) PROVIDES SERVICE NO	(b) LENGTH OF TIME PROVIDING SERVICE (YEARS)
01	HIV pre-test counseling	1 →01b	2 →02	
02	HIV post-test counseling	1 →02b	2 →03	
03	Follow-up counseling for HIV, after the initial post-test counseling or emotional support	1	2	
04	Ordering or prescribing HIV tests	1	2	
05	Counseling for prevention of mother to child transmission	1 →05b	2 →06	
06	Nutrition counseling for newborns of HIV infected women	1	2	
07	Adherence counseling for ART	1 →07b	2 →08	
08	Counseling **or** prescribing ARV for Post-exposure prophylaxis	1	2	
09	Education for patient and families on HIV care	1	2	
10	Nutrition counseling to HIV/AIDS infected clients	1	2	

604	In your **current** position, and as a part of your work for this facility, do you ever personally provide any clinical services for HIV/AIDS patients?	YES . . . . . 1 NO 2	→ 606

605	Do you provide any of the following services? IF YES, FOR THE INDICATED SERVICES ASK: How long have you been providing this service? IF LESS THAN ONE YEAR WRITE '00'.	(a) PROVIDES SERVICE YES	(a) PROVIDES SERVICE NO	(b) LENGTH OF TIME PROVIDING SERVICE (YEARS)
01	Clinical management of HIV/AID-related neurological disorders	1	2	
02	Diagnosis of opportunistic infections	1 → 02b	2 →03	
03	Management of opportunistic infections	1 →03b	2 →04	
04	Prescribing ART	1 →04b	2 →05	
05	Medical follow-up for ART clients	1 →05b	2 →06	
06	Ordering or prescribing Laboratory test for monitoring of ART	1	2	
07	Nutritional rehabilitation for HIV/AIDS patients	1 → 07b	2 →08	
08	Pediatric AIDS care	1 →08b	2 →606	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
606	In your **current** position, and as a part of your work for this facility, do you ever personally provide any preventive interventions for HIV/AIDS patients?	YES . . . . . 1 NO 2	→ 608

607	Do you provide any of the following services? IF YES, FOR THE INDICATED SERVICES ASK: How long have you been providing this service? IF LESS THAN ONE YEAR WRITE '00'.	(a) PROVIDES SERVICE YES	 NO	(b) LENGTH OF TIME PROVIDING SERVICE (YEARS)
01	Preventive treatment for TB (INH)	1	2	
02	Preventive treatment for other OIs , such as cotrimoxazole preventive therapy (CPT)	1	2	
03	ARV prophylaxis for prevention of mother to child transmission (PMTCT)	1 →03b	2 →04	
04	Ordering and/or prescribing ARVs for Post-exposure prophylaxis (PEP)	1	2	

608	In your **current** position, and as a part of your work for this facility, do you ever personally provide any services related to care and support for HIV/AIDS patients?	YES . . . . . 1 NO 2	→ 610

609	Do you provide any of the following services? IF YES, FOR THE INDICATED SERVICES ASK: How long have you been providing this service? IF LESS THAN ONE YEAR WRITE '00'.	(a) PROVIDES SERVICE YES	 NO	(b) LENGTH OF TIME PROVIDING SERVICE (YEARS)
01	Nursing care for HIV/AIDS patients	1	2	
02	Training caregivers and/or patients in HIV/AIDS care	1	2	
03	Palliative care for terminally ill AIDS patients, such as symptom or pain control, emotional and nursing care	1	2	
04	Home-based care services for people living with HIV/AIDS and their families	1 →04b	2 →610	
610	Do you provide any other service related to HIV/AIDS? IF YES, _____ SPECIFY	1	2	

611	During the past three years have you received any pre-service or in-service training related to any aspect of prevention, treatment, or providing care and support for HIV/AIDS, including laboratory testing?	YES . . . . . 1 NO 2	→ 627

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
612	Please tell me if you participated in any of the following courses, and if yes, if this was in the past 1 year, or the past 2 to 3 years.	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING	
01	Government 3 week course for VCT	1	2	3	
02	1 month course on counseling for HIV/AIDS	1	2	3	
03	1 week course on counseling drug users	1	2	3	
04	1 week course on counseling adolescents	1	2	3	
05	1 week course on couples counseling	1	2	3	
06	1 month course on counseling for HIV/AIDS	1	2	3	
07	Government 2 week course for PMTCT	1	2	3	
08	NASCOP 5 day training for ARVS	1	2	3	
613	Other than the specific government courses mentioned, during the past three years have you received any pre-service or in-service training related to HIV tests or counseling for care and support of HIV/AIDS clients?	YES . . . . . 1 NO 2			→ 615
614	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING	
01	HIV pre-test counseling	1	2	3	
02	HIV post-test counseling	1	2	3	
03	Follow-up counseling, after the initial post-test counseling or emotional support for HIV/AIDS clients	1	2	3	
04	Adherence counseling for ART	1	2	3	
05	Adherence counseling for TB preventive therapy	1	2	3	
06	Adherence counseling for cotrim preventive therapy	1			
07	Education for patient and families on HIV care	1	2	3	
08	Nutrition counseling to HIV/AIDS infected clients	1	2	3	
09	Primary prevention of HIV, such as behavior change education, partner counseling, condom promotion and distribution	1	2	3	
615	Other than the specific government courses mentioned, during the past three years have you received any pre-service or in-service training related to clinical services for HIV/AIDS clients?	YES . . . . . 1 NO 2			→ 617
616	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING	
01	Ordering or prescribing HIV tests	1	2	3	
02	Clinical management of HIV/AIDS-related neurological disorders	1	2	3	
03	Diagnosis of opportunistic infections	1	2	3	
04	Management of opportunistic infections	1	2	3	
05	Prescribing antiretroviral therapy (ART)	1	2	3	
06	Ordering or prescribing laboratory tests for monitoring of ART	1	2	3	
07	Nutritional rehabilitation for HIV/AIDS patients	1	2	3	
08	Pediatric AIDS care	1	2	3	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
617	Other than the specific government courses mentioned, during the past three years have you received any pre-service or in-service training related to preventive services or preventive treatment for HIV/AIDS clients?	YES . . . . . 1 NO 2	→ 619

618	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	Preventive treatment for TB (INH)	1	2	3
02	Preventive treatment for other OIs, such as cotrimoxazole preventive therapy (CPT))	1	2	3
03	ARV prophylaxis for prevention of mother to child transmission (PMTCT)	1	2	3
04	Ordering or prescribing Post-exposure prophylaxis (PEP)	1	2	3

619	Other than the specific government courses mentioned, during the past three years have you received any related to providing home care or other supportive care for HIV/AIDS clients?	YES . . . . . 1 NO 2	→ 621

620	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING
01	Nursing care for HIV/AIDS patients	1	2	3
02	Training caregivers and/or patients in HIV/AIDS care	1	2	3
03	Palliative care for terminally ill AIDS patients, such as symptom or pain control, emotional and nursing care	1	2	3
04	Home-based care services for people living with HIV/AIDS and their families	1	2	3

621	In your **current** position, and as a part of your work for this facility, do you ever personally provide any laboratory services or tests for HIV?	YES . . . . . 1 NO 2	→ 623

622	Do you provide any of the following services?	PROVIDES SERVICE	
		YES	NO
01	Sputum diagnosis of TB	1	2
02	Conduct HIV test	1	2
03	Drawing blood for HIV test	1	2
04	Laboratory tests for monitoring of ART	1	2

623	During the past three years have you received any pre-service or in-service training related to laboratory tests for TB or HIV/AIDS clients, or blood transfusion?	YES . . . . . 1 NO 2	→ 625

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
624	Did you receive the training in any topic related to (READ SPECIFIC TOPIC)? IF YES, when was the most recent training?	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS	NO PRE OR IN-SERVICE TRAINING	
01	Universal precautions	1	2	3	
02	Other infection control	1	2	3	
03	Prevention of work-related injuries	1	2	3	
04	How to carry out sputum test for TB	1	2	3	
05	HIV testing	1	2	3	
06	CD4 testing	1	2	3	
07	Blood screening	1	2	3	
08	Appropriate use of blood	1	2	3	
09	Blood donor procurement	1	2	3	
10	Test kits evaluation	1	2	3	
11	Tests for monitoring ART	1	2	3	
12	Sentinel surveillance compliance	1	2	3	
13	Other _____ (SPECIFY)	1	2	3	
625	Have you received any other in-service or pre-service training related to HIV/AIDS clinical care and/or support services?	YES . . . . . 1 NO 2			→ 627
626	IF YES, SPECIFY THE SUBJECTS OF OTHER IN-SERVICE OR PRE-SERVICE TRAINING	YES, IN PAST 1 YEAR	YES, IN PAST 2-3 YEARS		
01	_____	1	2		
02	_____	1	2		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
627	Now I want to ask you a few more questions about your work in this facility. In an average week, how many hours do you work in this facility? IF WEEKS ARE NOT CONSISTENT, ASK THE RESPONDENT TO AVERAGE OUT HOW MANY HOURS PER MONTH AND THEN DIVIDE THIS BY 4.	AVERAGE HOURS PER WEEK WORKING IN THIS FACILITY . . . . . [ ][ ]	
628	I want to know if you can estimate how much of your time each week is spent providing services or performing tasks related to HIV/AIDS. This includes such services as counseling, testing, providing clinical care and support, providing social support services, as well as record keeping and documentation related to HIV/AIDS. When you add up all the time you spend, on average, during a normal week either providing services or performing tasks related to HIV/AIDS, what percentage of your time do you estimate this is? IF NO HIV/AIDS-RELATED SERVICES CODE "000"	AVERAGE WEEKLY PERCENTAGE OF WORK TIME . . . . . [ ][ ][ ]	
629	During the past 12 months, if you add together all of the formal training you have received related to HIV/AIDS, how many days is this? By formal training I mean training where there was a structured class. This may have been conducted by this facility or external to the facility. I am interested in actual days of training. For example, a one week training usually entails 5 actual days of training, a four week training usually entails 20 days of training. IF THE TRAINING WAS LESS THAN ONE FULL DAY, ENTER 001. PROBE IF NECESSARY.	NUMBER OF DAYS OF HIV/AIDS RELATED TRAINING . . . . . [ ][ ][ ]	
630	Now I would like to ask you some questions about supervision you have personally received. This supervision may have been from a supervisor either in this facility , or from outside the facility. Do you receive technical support or supervision in your work? IF YES, ASK: When was the most recent time?	YES, IN THE PAST 3 MONTHS . . . . . 1 YES, IN THE PAST 4-6 MONTHS . . . . . 2 YES, IN THE PAST 7-12 MONTHS . . . . . 3 → 632 YES, MORE THAN 12 MONTHS AGO . . . . 4 → 632 NO . . . . . 5 → 633	
631	How many times in the past six months has your work been supervised?	NUMBER OF TIMES [ ][ ]	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
632	The last time you were personally supervised, did your supervisor do any of the following:		YES	NO	DK	
01	Deliver supplies	DELIVERED SUPPLIES	1	2	8	
02	Check your records or reports	CHECKED RECORD	1	2	8	
03	Observe your work	OBSERVED	1	2	8	
04	Provide any feedback (either positive or negative) on your performance	FEEDBACK	1	2 → 07	8 → 07	
05	Give you verbal feedback that you were doing your work well	VERBAL PRAISE	1	2	8	
06	Provide any written comment that you were doing your work well	WRITTEN PRAISE	1	2	8	
07	Provide updates on administrative or technical issues related to your work	UPDATES	1	2	8	
08	Discuss problems you have encountered	DISCUSS	1	2	8	
09	Anything else?	OTHER _____ (SPECIFY)	1	2		
633	Do you have a written job description of your current job or position in this facility? IF YES, ASK: May I see it?	YES, OBSERVED . . . . . 1 YES, REPORTED, NOT SEEN . . . . . 2 NO 3				
634	Are there any opportunities for promotion in your current job?	YES . . . . . 1 UNCERTAIN . . . . . 2 NO 3				
635	Do you personally receive any salary supplement, that is, money outside of your routine salary, that is related to your work in this facility?	YES . . . . . 1 NO 2				→ 637
636	Which type of salary supplement do you receive?	MONTHLY OR DAILY SALARY SUPPLEMENT . . . . . A PER DIEM WHEN ATTENDING TRAINING . . B OTHER _____ (SPECIFY) X				
637	In your current position, have you ever received any non-monetary incentives for the work you do? This might include such things as discounts for medicines or other items, uniforms or other clothing, food, training, or other things like this.	YES . . . . . 1 NO 2				→ 639
638	Describe any incentives that you have received. CIRCLE ALL THAT APPLY.	UNIFORMS, BACKPACKS, CAPS ETC. . . . . A DISCOUNT MEDICINES, VOUCHERS, FREE TICKETS FOR CARE . . . . . B TRAINING . . . . . C FOOD RATION . . . . . D OTHER _____ (SPECIFY) X				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
639	Among the various things related to your working situation that you would like to see improved, can you tell me the three that you think would most improve your ability to provide care and support services for HIV/AIDS? CIRCLE ONLY THREE ITEMS. IF THE PROVIDER MENTIONS MORE THAN THREE ITEMS, ASK THE PROVIDER TO PRIORITIZE TO ONLY THREE. IF THE PROVIDER DOES NOT MENTION THREE ITEMS, PROBE FOR ANY OTHERS IN AN ATTEMPT TO HAVE THREE ANSWERS.	MORE SUPPORT FROM SUPERVISOR . . A MORE KNOWLEDGE/TRAINING . . . . . B MORE SUPPLIES/STOCK . . . . . C BETTER QUALITY EQUIPMENT/ SUPPLIES . . . . . D LESS WORKLOAD (i.e. MORE STAFF) . . . . E BETTER WORKING HOURS . . . . . F MORE INCENTIVES (SALARY, PROMOTION, HOLIDAYS) . . G TRANSPORTATION FOR PATIENTS WHO ARE REFERRED . . . . . H PROVIDING ART . . . . . I INCREASED SECURITY . . . . . J BETTER FACILITY INFRASTRUCTURE . . . . K MORE AUTONOMY/INDEPENDENCE . . . . L EMOTIONAL SUPPORT FOR STAFF (COUNSELING/GROUP SOCIAL ACTIVITIES) . . . . . M OTHER _____ W (SPECIFY) OTHER _____ X (SPECIFY)	
	Finally, I would like to ask you a few additional questions about HIV/AIDS and working with clients who may have HIV/AIDS		
640	What should you do if you got a needle stick injury? PROBE: ANYTHING ELSE? CIRCLE ALL THAT ARE MENTIONED.	SQUEEZE FINGER AND PUT IT IN ALCOHOL/IODINE . . . . . A SQUEEZE FINGER AND WASH WITH BLEACH/OTHER DISINFECTANT . . . . . B REPORT TO MANAGER . . . . . C GET AN HIV TEST IMMEDIATELY . . . . . D GET ANTIRETROVIRAL OR REFERRAL FOR ARVs . . . . . E OTHER _____ X (SPECIFY) NOTHING . . . . . Y DON'T KNOW . . . . . Z	
641	If you had a choice, would you work with AIDS patients?	YES . . . . . 1 DEPENDS . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
642	Do you think that a health care worker who has HIV but is not sick, should be allowed to continue to work?	YES . . . . . 1 DEPENDS . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
643	If a member of your family became ill with HIV, would you want it to remain secret?	YES . . . . . 1 DEPENDS . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
644	There are some people who think that HIV/AIDS patients deserve the illness that they have. Do you agree with this point of view? IF YES, ASK: Do you completely agree or agree somewhat?	YES, COMPLETELY . . . . . 1 YES, SOMEWHAT . . . . . 2 NO . . . . . 3 DON'T KNOW 8	
645	I don't want to know the result, but have you ever had an HIV test?	YES . . . . . 1 NO 2	→ 647
646	The last time you had an HIV test, did you yourself ask for the test, was it offered to you and you accepted, or was it required?	ASK SELF . . . . . 1 WAS OFFERED . . . . . 2 WAS REQUIRED 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
647	Finally, please tell me: In your opinion, how effective are condoms in preventing HIV infections when used correctly? Use a scale of 0 to 10 with zero being least, and 10 being maximum	CONDOM EFFECTIVENESS IN PREVENTING HIV INFECTION ☐☐ DON'T KNOW 98	
648	RECORD THE TIME AT END OF INTERVIEW ☐☐ : ☐☐		
	Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential.		

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Child Health Provider Knowledge Interview

1. Facility Identification

Name of the facility: _____

Location of the facility: _____

Province _____

District _____

Number of the facility: _____

QTYPE . . . . . C H K

PROVINCE NUMBER . . . . . [ ][ ]

DISTRICT NUMBER . . . . . [ ][ ]

FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Provider Information

Provider category:

Consultant	01	Registered Midwife	05
Medical Doctor	02	Enrolled Nurse	06
Clinical Officer	03	Enrolled Midwife	07
Registered Nurse	04	Nurse Aid	08

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY . . . . . [ ][ ]

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

SEX OF PROVIDER . . . . . [ ]

Code for provider should be the same as the one used for all other provider interviews/observations.

PROVIDER CODE . . . . . [ ][ ]

3. Information About Interview

Date: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the Interviewer: _____

INTERVIEWER CODE . . . . . [ ][ ]

Time Interview started: _____

TIME INTERVIEW STARTED [ ][ ] : [ ][ ]

CHILD HEALTH PROVIDER KNOWLEDGE QUESTIONNAIRE

EXPLAIN TO THE HEALTH WORKER THAT HIS/HER NAME WAS PROVIDED AS THE MOST KNOWLEDGEABLE CHILD HEALTH PROVIDER AVAILABLE ON THAT DAY. VALIDATE WITH THE HEALTH WORKER THAT HE/SHE DOES PROVIDE SOME CHILD HEALTH SERVICES AND THAT THESE SERVICES ARE A COMPONENT OF THEIR WORK AT THIS FACILITY

Now I will read a statement explaining the survey and asking your consent for responding to survey questions

Hello. My name is _____ I am here on behalf of the Ministry of Health and the NCPD to assist the government in knowing more about the availability of maternal, child, and reproductive health services as well as specific infectious diseases such as HIV/AIDS and tuberculosis. Your facility was randomly selected participate in this study. I will be asking you specific questions about what you look for when assessing children who present with certain illnesses and the common interventions for those illnesses.

You may decline to answer any question and may choose to stop the interview at any time.
Please be assured that the information you give us will be completely confidential and will not be traced to you and will not be identified with the name of the facility.

Do you have any questions for me at this time?

100	Do I have your agreement to participate? Thank you. Let us begin now.	YES . . . . . 1 NO 2	► STOP
101	RECORD THE TIME AT BEGINNING OF INTERVIEW ☐☐ . ☐☐		

PROVIDER KNOWLEDGE

NO.	QUESTIONS	CODING CATEGORIES	GO TO
102	May I begin the interview now?	YES . . . . . 1 NO 2	→►STOP
103	Please tell me, what signs and symptoms you would look for if a child presented with fever and convulsions? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER SIGNS OR SYMPTOMS	NECK STIFFNESS . . . . . A GENERALIZED RASH . . . . . B RHINORRHEA (RUNNING NOSE) . . . C BULGING FONTANELS . . . . . D RED EYES . . . . . E OTHER _____ . . . X (SPECIFY)	
104	What actions, diagnostic tests or interventions/ treatment are appropriate for a child with fever and febrile convulsions? Mention all actions, tests, and interventions think should take place. WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS, TESTS OR INTERVENTIONS.	ADMIT TO INPATIENT UNIT . . . . . A REFER TO DOCTOR OR HOSPITAL . . . . B DO BLOOD SLIDE FOR MALARIA PARASITES . . . . . C DO LUMBAR PUNCTURE . . . . . D DO BLOOD SUGAR . . . . . E GIVE IM CHLORAMPHENICOL . . . . . F GIVE IM/IV QUININE . . . . . G GIVE VITAMIN A . . . . . H GIVE PARACETAMOL . . . . . I GIVE DIAZEPAM . . . . . J DO WHITE CELLS COUNT . . . . . K OTHER: _____ . . X	
105	Please tell me, what signs and symptoms would you look for in a child with diarrhea to make a diagnosis of severe dehydration? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER SIGNS OR SYMPTOMS	SUNKEN EYES WITH NO TEARS . . . . . A DRY MOUTH AND TONGUE . . . . . B LETHARGY/UNCONSCIOUSNESS . . . . . C SUNKEN FONTANEL . . . . . D RAPID AND WEAK PULSE . . . . . E COLD HANDS AND FEET . . . . . F RAPID BREATHING . . . . . G INABILITY TO DRINK/DRINKS POORLY . . H OTHER: _____ . . X SPECIFY	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
106	What actions, diagnostic tests or interventions/ treatment are appropriate for a child with diarrhea and severe dehydration? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS, TESTS OR INTERVENTIONS.	REFER TO DOCTOR OR HOSPITAL . . . . A GIVE ORS . . . . . B GIVE IV FLUIDS . . . . . C GIVE FLUIDS BY NASOGRASTRIC TUBE . . . . . D GIVE VITAMIN A . . . . . E OTHER: _____ . . X (SPECIFY)	
107	What signs or symptoms exist in a child with severe malnutrition? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER SIGNS OR SYMPTOMS	EDEMA . . . . . A SEVERE PALLOR . . . . . B ENLARGED/TENDER LIVER . . . . . C JAUNDICE . . . . . D ABDOMINAL DISTENSION . . . . . E THIRST . . . . . F HYPOTHERMIA OR FEVER . . . . . G CORNEAL LESIONS INDICATIVE OF VITAMIN A DEFICIENCY . . . . . H EVIDENCE OF INFECTION IN MOUTH, THROAT, EARS AND ON SKIN . . . . . I COLD HANDS AND FEET . . . . . J OTHER _____ X (SPECIFY)	
108	What actions, diagnostic tests or interventions/ treatment are appropriate for a child with severe malnutrition? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS, TESTS OR INTERVENTIONS.	REFER TO DOCTOR OR HOSPITAL . . . A TREAT AND PREVENT LOW BLOOD SUGAR (GIVE DEXTROSE 10%) . . . . . B KEEP CHILD WARM . . . . . C GIVE ORS OR START IV FLUIDS . . . . . D MANAGE ELECTROLYTE IMBALANCE . . . . . E GIVE ANTIBIOTICS . . . . . F GIVE VITAMIN A, IRON TABLETS . . . . . G OTHER: _____ X SPECIFY	
109	Please tell me, what signs and symptoms you would look for in a child to make a diagnosis of Severe Respiratory Distress (SRD)? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER SIGNS OR SYMPTOMS	HEAD NODDING . . . . . A LABORED BREATHING . . . . . B INABILITY TO DRINK OR DRINKING POORLY . . . . . C INABILITY TO EAT OR EATING POORLY . . . . . D LETHARGY OR RESTLESSNESS . . . E OTHER _____ X SPECIFY	
110	What actions, diagnostic tests or interventions/ treatment are appropriate for a child with severe respiratory distress? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS, TESTS OR INTERVENTIONS.	REFER TO DOCTOR OR HOSPITAL . . . A GIVE ANTIBIOTICS . . . . . B GIVE OXYGEN . . . . . C CLEAR THE AIRWAYS . . . . . D TREAT FEVER IF PRESENT . . . . . E START IV FLUIDS . . . . . F OTHER: _____ X SPECIFY	
111	Please tell me, have you ever attended a child who has been physically abused or battered?	YES . . . . . 1 NO 2	→ 113
112	When did you last see a physically abused or battered child?	WITHIN PAST 7 DAYS . . . . . 1 WITHIN PAST MONTH . . . . . 2 WITHIN PAST 6 MONTHS . . . . . 3 OVER 6 MONTHS AGO 4	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
113	What actions, diagnostic tests or interventions are appropriate for a child who has been abused/ assaulted? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS, TESTS OR INTERVENTIONS.	EXAMINE AND TREAT . . . . . A TAKE DETAILED HISTORY . . . . . B REFER FOR SOCIAL SERVICES . . . C REPORT TO CHILDREN'S OFFICER OR TO THE POLICE D REFER TO MENTAL HEALTH SERVICES E OTHER: _____ . X SPECIFY	
114	RECORD THE TIME AT THE END OF THE INTERVIEW	☐☐ : ☐☐	
	Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential		

MEASURE *DHS*+ SERVICE PROVISION ASSESSMENT

Maternal Health Provider Knowledge Interview

1. Facility Identification

Name of the facility: _____ QTYPE . . . . . M H K

Location of the facility: _____

Province _____ PROVINCE NUMBER . . . . . [ ][ ]

District _____ DISTRICT NUMBER . . . . . [ ][ ]

Number of the facility: _____ FACILITY NUMBER . . . . . [ ][ ]

Type of health facility:

National Referral Hospital	01	Private Clinic	06
Provincial Hospital	02	Health Center	07
District Hospital	03	Dispensary	08
Sub-district Hospital	04	Maternity	09
Private Hospital	05	Stand-alone VCT	10

Other _____ 96
(SPECIFY)

FACILITY TYPE . . . . . [ ][ ]

Managing authority:

Government	01	Private for-profit	03
NGO	02	Mission	04

Other _____ 96
(SPECIFY)

MANAGING AUTHORITY . . . . . [ ][ ]

2. Provider Information

Provider category:

Consultant	01	Registered Midwife	05
Medical Doctor	02	Enrolled Nurse	06
Clinical Officer	03	Enrolled Midwife	07
Registered Nurse	04	Nurse Aid	08

Other _____ 96
(SPECIFY)

PROVIDER CATEGORY . . . . . [ ][ ]

Sex of provider: (1=Female; 2=Male) SEX OF PROVIDER . . . . . [ ]

Code for provider should be the same as the one used for all other provider interviews/observations. PROVIDER CODE . . . . . [ ][ ]

3. Information About Interview

Date: _____ DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [ ][ ][ ][ ]

Name of the interviewer: _____ INTERVIEWER CODE . . . . . [ ][ ]

Time Interview started: _____ TIME INTERVIEW STARTED [ ][ ] : [ ][ ]

MATERNAL HEALTH PROVIDER KNOWLEDGE QUESTIONNAIRE

EXPLAIN TO THE HEALTH WORKER THAT HIS/HER NAME WAS PROVIDED AS THE MOST KNOWLEDGEABLE MATERNAL HEALTH PROVIDER AVAILABLE ON THAT DAY. VALIDATE WITH THE HEALTH WORKER THAT HE/SHE DOES PROVIDE SOME MATERNAL HEALTH SERVICES AND THAT THESE SERVICES ARE A COMPONENT OF THEIR WORK AT THIS FACILITY

Now I will read a statement explaining the survey and asking your consent for responding to survey questions

Hello. My name is _____ I am here on behalf of the Ministry of Health and the NCPD to assist the government in knowing more about the availability of maternal, child, and reproductive health services as well as specific infectious diseases such as HIV/AIDS and tuberculosis. Your facility was randomly selected to participate in this study. I will be asking you specific questions about your experiences with delivery services and then will ask about various situations related to labor, delivery, and the postpartum period.

You may decline to answer any question and may choose to stop the interview at any time. Please be assured that the information you give us will be completely confidential and will not be traced to you and will not be identified with the name of the facility.

Do you have any questions for me at this time?

100	Do I have your agreement to participate? Thank you. Let us begin now.	YES . . . . . 1 NO 2	→STOP
101	RECORD THE TIME AT BEGINNING OF INTERVIEW ☐☐ : ☐☐		

PROVIDER KNOWLEDGE

NO.	QUESTIONS	CODING CATEGORIES				GO TO
	Please answer the following questions to the best of your knowledge. Most of the questions I will be asking you will require multiple responses from you. Please provide all responses that come to mind. I will probe sometimes to help you remember some more information.					
	DELIVERY AND NEWBORN CARE					
102	Do you personally provide delivery care? By that I mean conducting the actual deliveries of newborns.	YES . . . . . 1 NO 2				→105
103	Of the list of procedures I am going to read you, please tell me which procedures are carried out routinely during labor and delivery		YES	NO	DK	
01	Artificial Rupture of Membranes	ARTIFICIAL RUPTURE	1	2	8	
02	Episiotomies	EPISIOTOMIES	1	2	8	
03	Shavings	SHAVING	1	2	8	
04	Suctioning of Nose and Nasopharynx of Newborn	SUCTIONING	1	2	8	
05	Other Procedures _____ (SPECIFY)	OTHER	1	2	8	
104	What actions would you take in an HIV+ woman to prevent mother-to-child transmission of the virus during labor and delivery? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS.	PMTCT COUNSELING . . . . . A PROVIDE NVP IN EARLY LABOR . . . . . B WIPE NOSE, MOUTH, EYES OF NEWBORN WITH GAUZE . . . . . C PROVIDE NVP TO INFANT . . . . . D OTHER _____ (SPECIFY) X				

NO.	QUESTIONS	CODING CATEGORIES	GO TO
105	Do you personally provide newborn care?	YES . . . . . 1 NO 2	→108
106	Please tell me, the last time you provided newborn care, what was the care you gave the newborn during the first one hour after birth. WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER CARE PROVIDED OR ACTIONS TAKEN DURING THE FIRST ONE HOUR AFTER BIRTH.	WIPED FACE AFTER BIRTH OF HEAD . A CORD CARE (STERILE-CUT 4-6 CM FROM UMBILICUS) . . . . . B ENSURED BABY WAS BREATHING . . . C PROVIDED THERMAL PROTECTION . . . D INITIATED BREAST FEEDING WITHIN 1 HOUR . . . . . E ASSESSED/EXAMINED NEWBORN WITHIN 1 HOUR . . . . . F WEIGHED NEWBORN . . . . . G PROVIDED EYE PROPHYLAXIS . . . . . H OTHER _____ X (SPECIFY)	
107	Please tell me what actions you would take if a newborn fails to breath at birth WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS.	CLEAR/SUCTION AIRWAYS . . . . . A DRY AND WRAP NEWBORN IN CLEAN CLOTH . . . . . B PLACE NEWBORN UNDER RADIANT HEAT WARMER . . . . . C ASSIST BREATHING WITH AMBU BAG . . D DO CARDIAC MASSAGE . . . . . E OTHER _____ X (SPECIFY)	
108	Now I will ask you a few questions on postpartum hemorrhage and retained products of conception		
	Please tell me, when a woman presents with or develops heavy bleeding postpartum what signs do you look for to assess the level of risk to the woman? WAIT FOR SPONTANEOUS RESPONSES THEN PROBE FOR ANY OTHER SIGNS OR SYMPTOMS.	UNCONTRACTED UTERUS . . . . . A RAPID PULSE . . . . . B FAINT/WEAK PULSE . . . . . C AMOUNT OF EXTERNAL BLEEDING . . . D RETAINED PRODUCTS/PLACENTA . . . E GENITAL TRACT INJURIES . . . . . F PALLOR . . . . . G CHECK IF BLADDER IS FULL . . . . . H OTHER _____ X (SPECIFY)	
109	What actions, diagnostic test or interventions are appropriate for a woman who presents with, or develops heavy bleeding postpartum from atonic/ uncontracted uterus? WAIT FOR SPONTANEOUS RESPONSES THEN PROBE FOR ANY OTHER RESPONSES.	MASSAGE THE FUNDUS . . . . . A EMPTY URINARY BLADDER . . . . . B GIVE OXYTOCICS IM OR IV . . . . . C START IV FLUIDS . . . . . D TAKE BLOOD FOR Hb, GROUPING AND X-MATCHING . . . . . E REFER TO DOCTOR OR HOSPITAL . . . . F RAISE FOOT OF BED . . . . . G OTHER _____ X (SPECIFY)	
110	What actions, diagnostic tests or interventions are appropriate for a woman with retained placenta/ products of conception after delivery? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER ACTIONS, DIAGNOSTIC TESTS, OR INTERVENTIONS.	EMPTY URINARY BLADDER . . . . . A REPEAT OXYTOCICS . . . . . B MANUALLY REMOVE PLACENTA/ PRODUCTS . . . . . C GIVE IV FLUIDS . . . . . D MONITOR VITAL SIGNS FOR SHOCK . . . E CHECK CONTRACTION OF UTERUS . . . . F TAKE BLOOD FOR GROUPING & X-MATCHING . . . . . G PREPARE FOR THEATER IF BLEEDING DOES NOT STOP . . . . . H REFER TO DOCTOR OR HOSPITAL . . . I OTHER _____ X (SPECIFY)	

NO.	QUESTIONS	CODING CATEGORIES	GO TO
111	Now I am going to ask you a few questions on post abortion care.		
	Can you please tell me what the immediate complications of unsafe abortion are? WAIT FOR SPONTANEOUS RESPONSES THEN PROBE FOR ANY OTHER COMPLICATIONS.	SEPSIS . . . . . A BLEEDING . . . . . B GENITAL TRACT INJURIES C SHOCK . . . . . D OTHER _____ X (SPECIFY)	
112	What actions, diagnostic tests or interventions are appropriate for a woman with complications resulting from an incomplete or unsafe abortion? WAIT FOR SPONTANEOUS RESPONSES THEN PROBE FOR ANY OTHER ACTIONS, TESTS, OR INTERVENTIONS.	ASSESS VAGINAL BLEEDING . . . . . A ASSESS VITAL SIGNS . . . . . B START ON IV FLUIDS . . . . . C START ON ANTIBIOTICS . . . . . D PERFORM MANUAL VACUUM ASPIRATION . . . . . E DO CONVENTIONAL EVACUATION (D&C) F PROVIDE COUNSELING . . . . . G DO BIMANUAL PELVIC EXAMINATION . . H OTHER _____ . X (SPECIFY)	
113	Finally, please tell me, what information do you give to patients who present with complications resulting from an incomplete or unsafe abortion? WAIT FOR SPONTANEOUS RESPONSES, THEN PROBE FOR ANY OTHER INFORMATION.	STI/HIV-AIDS . . . . . A PAP SMEAR/VIAA/VILI . . . . . B FAMILY PLANNING . . . . . C INFERTILITY . . . . . D PERSONAL CARE . . . . . E RISKS OF ABORTION . . . . . F OTHER _____ X (SPECIFY)	
114	RECORD TIME THE INTERVIEW ENDED ☐☐ : ☐☐		
	Thank you for taking the time to talk with me and to answer these questions. As I mentioned at the beginning, all of your responses will remain confidential		

MATERNITY STATISTICS

Code of facility: ☐☐ PROV ☐☐☐ DISTRICT ☐☐ FACILITY

QRE TYPE M A T

Interviewer: Code ☐☐

NO.	QUESTIONS	CODING CATEGORIES	GO TO
101	Were there any obstetric admissions/deliveries in this facility during January-June 2004?	YES . . . . . 1 NO 2	→ END MATERNAL RECORD REVIEW

ASK TO SEE RECORDS TO SUPPLY THE INFORMATION REQUESTED BELOW, AND COMPLETE THE STATISTICS AS INDICATED. IF THE INFORMATION IS NOT AVAILABLE, RECORD '9998'. IN THE CASE OF MATERNAL COMPLICATIONS, IF MORE THAN ONE CAUSE, SELECT THE MOST SERIOUS (e.g. HEMORRHAGE AND ANEMIA=HEMORRHAGE)

	SUMMARY OF MATERNITY CASES	JAN	FEB	MARCH	APRIL	MAY	JUNE
102	TOTAL OBSTETRIC ADMISSIONS (103 + 107.08 + 108)	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
103	TOTAL DELIVERIES (including C-sections)	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
104	TOTAL CAESAREAN SECTIONS	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
105	TOTAL LIVE BIRTHS	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
106 01	TOTAL STILLBIRTHS (106.02 + 106.03)	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
02	NUMBER OF FRESH STILLBIRTHS	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
03	NUMBER OF MACERATED STILLBIRTHS	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐

Code of facility: PROV DISTRICT FACILITY

Interviewer: Code

QRE TYPE M A T

NO.	QUESTIONS	CODING CATEGORIES	GO TO

	SUMMARY OF MATERNITY CASES	JAN	FEB	MARCH	APRIL	MAY	JUNE
107	DIRECT OBSTETRIC COMPLICATIONS						
01	HEMORRHAGE CASES (TREATED)						
02	OBSTRUCTED/PROLONGED DELIVERIES ATTENDED						
03	RUPTURED UTERUS (TREATED)						
04	POSTPARTUM SEPSIS (TREATED)						
05	PRE-ECLAMPSIA/ECLAMPSIA (TREATED)						
06	ECTOPIC PREGNANCIES (TREATED)						
07	COMPLICATIONS OF ABORTION (TREATED)						
08	TOTAL DIRECT OBSTETRIC COMPLICATIONS TREATED (Sum 107.01.....107.07)						
108	TOTAL MATERNAL TRANSFERS						
109	WERE THERE ANY MATERNAL DEATHS DURING JAN-JUN 2004?	YES ..... 1 NO ..... 2 → END					
110	TOTAL MATERNAL DEATHS						

Code of facility: ☐☐ PROV ☐☐ DISTRICT ☐☐ FACILITY

QRE TYPE N D L

Interviewer: Code ☐☐

NO.	QUESTIONS	CODING CATEGORIES	GO TO
201a	IS THERE ANY RECORD THAT THE WOMAN WAS IN ACTIVE LABOR UPON ADMISSION?	YES . . . . . 1 NO 2	→ 201c
201b	HOW LONG HAD SHE BEEN IN LABOR PRIOR TO ADMISSION?	NUMBER OF HOURS ☐☐ INFORMATION NOT AVAILABLE 98	
201c	HOW MANY HOURS IS PASSED, FROM THE TIME THAT ACTIVE LABOR IS DOCUMENTED (AT LEAST 3 CM DILATED OR CONTRACTIONS EVERY 2-3 MINUTES) TO THE TIME OF DELIVERY?	NUMBER OF HOURS ☐☐ INFORMATION NOT AVAILABLE 98	
202	WHAT IS THE FREQUENCY WITH WHICH FETAL HEART RATE IS RECORDED?	AT LEAST EVERY 30 MINUTES . . . . . 1 EVERY 31-60 MINUTES . . . . . 2 MORE THAN HOURLY 3 INFORMATION NOT AVAILABLE 8	→ 204
203	WAS THE FETAL HEART RATE RECORDED ON A PARTOGRAPH?	YES . . . . . 1 NO 2	
204	WHAT IS THE FREQUENCY WITH WHICH MATERNAL BLOOD PRESSURE IS RECORDED?	AT LEAST EVERY FOUR HOURS . . . . . 1 BETWEEN >4-8 HOURLY . . . . . 2 MORE THAN 8 HOURLY . . . . . 3 INFORMATION NOT AVAILABLE 8	→ 206
205	WAS THE MATERNAL BLOOD PRESSURE RECORDED ON A PARTOGRAPH?	YES . . . . . 1 NO 2	
206	WHAT IS THE FREQUENCY WITH WHICH MATERNAL PULSE RATE IS RECORDED?	AT LEAST EVERY 30 MINUTES . . . . . 1 EVERY 31-60 MINUTES . . . . . 2 MORE THAN HOURLY 3 INFORMATION NOT AVAILABLE 8	→ 208
207	WAS THE MATERNAL PULSE RATE RECORDED ON A PARTOGRAPH?	YES . . . . . 1 NO 2	
208	HOW MANY VAGINAL EXAMINATIONS ARE RECORDED?	NUMBER OF VAGINAL EXAMINATIONS ☐☐ INFORMATION NOT AVAILABLE 98	→ 211
209	WERE THE VAGINAL EXAMINATIONS RECORDED ON A PARTOGRAPH?	YES . . . . . 1 NO 2	
210	WAS DEGREE OF CERVICAL DILATION RECORDED WITH MOST VAGINAL EXAMINATIONS?	YES . . . . . 1 NO 2	
211	WHAT IS THE FREQUENCY WITH WHICH UTERINE CONTRACTIONS ARE RECORDED?	AT LEAST EVERY 30 MINUTES . . . . . 1 EVERY 31-60 MINUTES . . . . . 2 MORE THAN HOURLY 3 INFORMATION NOT AVAILABLE 8	
212	IS AMOUNT OF BLOOD LOSS ESTIMATED AND RECORDED IN ML?	YES . . . . . 1 NO 2	
213	WAS THE NEWBORN APGAR SCORE RECORDED?	YES . . . . . 1 NO 2	
214	IS THE BIRTH WEIGHT OF THE NEWBORN RECORDED ON THE DELIVERY RECORD?	YES . . . . . 1 NO 2	
215	IS A MATERNAL BLOOD PRESSURE RECORDED WITHIN FOUR HOURS POSTPARTUM?	YES . . . . . 1 NO 2	

STAFF LISTING FORM

INTERVIEWER CODE ☐☐

FACILITY CODE ☐☐☐☐☐☐ (PROV DIST FAC)

CLINIC/ UNIT NUMBER **	PROVIDER CODE AND NAME: CIRCLE PROVIDER CODE FOR THOSE SELECTED FOR INTERVIEW — CODE	NAME	QUALI-FICATION * (ENTER NUMBER)	SERVICE RELATED TO HIV/AIDS: COUNSEL	TEST	PMTCT	ART	SOC. SERV.	CLINICAL CARE HIV	LAB	TB	OTHER CURATIVE (MALARIA) (STI) (CHILD)	MATE-RNITY	ANC	FP	OTHER (SPECIFY)	CHECK IF INTERVIEW COMPLETED OR IF SELF-ADMINISTERED QRE HAS BEEN RETURNED: INTERVIEW COMPLETE YES	INTERVIEW COMPLETE NO	SELF-ADMIN QRE COMPLETE YES	SELF-ADMIN QRE COMPLETE NO
	01																			
	02																			
	03																			
	04																			
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	14																			
	15																			

*Provider Qualification Code: **01**=Consultant **02**=Medical Doctor **03**=Clinical Officer **04**=Nurse(R) **05**=Midwife (R) **06**=Nurse (E) **07**=Midwife (E) **08**=Nurse Aide **09**=Lab. Technicial/Technologist **10**=Counselor **96**=Other (Write in)

**OPD Clinic/Unit Number: 01=General Outpatient 02=Pediatric Outpatient 03=Antenatal Care (ANC) 04=Fam Planning (FP) 05=Delivery 06=Tuberculosis (TB) 07=VCT OR CT Only 08=PMTCT Only 09=HIV/AIDS Only
10=Clinic/Unit Combines Special Diagnoses 11=STI Only 12=Gynecology 13=Urology 14=Dermatology 15=Emergency (ER) 16=Other (write in) 17= Other (write in)
18=HMIS (OPD or OPD & IPD) 19=LAB (OPD or OPD & IPD) 20=Pharmacy (OPD or OPD & IPD)

**IPD Clinic/Unit Number: 21=General Medical Inpatient (Male & Female) 22=Male Medical Inpatient 23=Female Medical Inpatnet 24=Pediatric Inpatient 25=HIV/AIDS Inpatient 26=Delivery Inpatient 27=TB Inpatient 28=Combines Special Diagnoses
29=Surgery Inpatient (Male & Female) 30=Male Surgical 31 =Female Surgical 32=Other IPD (write in) 33=Inpatient Only HMIS 34=Inpatient Only Lab
35=Inpatient Only Pharmacy

STAFF LISTING FORM

INTERVIEWER CODE ☐☐

FACILITY CODE ☐☐☐☐☐☐ (PROV DIST FAC)

CLINIC/ UNIT NUMBER	PROVIDER CODE AND NAME: CIRCLE PROVIDER CODE FOR THOSE SELECTED FOR INTERVIEW — CODE	NAME	QUALI-FICATION * (ENTER NUMBER)	SERVICE RELATED TO HIV/AIDS: COUNSEL	TEST	PMTCT	ART	SOC. SERV.	CLINICAL CARE HIV	LAB	TB	OTHER CURATIVE (MALARIA) (STI) (CHILD)	MATE-RNITY	ANC	FP	OTHER (SPECIFY)	CHECK IF INTERVIEW COMPLETED OR IF SELF-ADMINISTERED QRE HAS BEEN RETURNED: INTERVIEW COMPLETE YES	NO	SELF ADMIN QRE COMPLETE YES	NO
	16																			
	17																			
	18																			
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	30																			

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**IPD Clinic/Unit Number: 21=General Medical Inpatient (Male & Female) 22=Male Medical Inpatient 23=Female Medical Inpatnet 24=Pediatric Inpatient 25=HIV/AIDS Inpatient 26=Delivery Inpatient 27=TB Inpatient 28=Combines Special Diagnoses 29=Surgery Inpatient (Male & Female) 30=Male Surgical 31 =Female Surgical 32=Other IPD (Write in) 33=Inpatient Only HMIS 34=Inpatient Only Lab 35=Inpatient Only Pharmacy

STAFF LISTING FORM

INTERVIEWER CODE ☐☐

FACILITY CODE ☐☐☐☐☐☐ (PROV DIST FAC)

CLINIC/ UNIT NUMBER	PROVIDER CODE AND NAME: CIRCLE PROVIDER CODE FOR THOSE SELECTED FOR INTERVIEW — CODE	NAME	QUALI-FICATION * (ENTER NUMBER)	SERVICE RELATED TO HIV/AIDS: COUNSEL	TEST	PMTCT	ART	SOC. SERV.	CLINICAL CARE HIV	LAB	TB	OTHER CURATIVE (MALARIA) (STI) (CHILD)	MATE-RNITY	ANC	FP	OTHER (SPECIFY)	CHECK IF INTERVIEW COMPLETED OR IF SELF-ADMINISTERED QRE HAS BEEN RETURNED: INTERVIEW COMPLETE YES	NO	SELF ADMIN QRE COMPLETE YES	NO
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	32																			
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*Provider Qualification Code: **01**=Consultant **02**=Medical Doctor **03**=Clinical Officer **04**=Nurse(R) **05**=Midwife (R) **06**=Nurse (E) **07**=Midwife (E) **08**=Nurse Aide **09=**Lab. Technicial/Technologist **10**=Counselor **96**=Other (Write in)

**OPD Clinic/Unit Number: 01=General Outpatient 02=Pediatric Outpatient 03=Antenatal Care (ANC) 04=Fam Planning (FP) 05=Delivery 06=Tuberculosis (TB) 07=VCT OR CT Only 08=PMTCT Only 09=HIV/AIDS Only 10=Clinic/Unit Combines Special Diagnoses 11=STI Only 12=Gynecology 13=Urology 14=Dermatology 15=Emergency (ER) 16=Other (write in) 17= Other (write in) 18=HMIS (OPD or OPD & IPD) 19=LAB (OPD or OPD & IPD) 20=Pharmacy (OPD or OPD & IPD)

**IPD Clinic/Unit Number: 21=General Medical Inpatient (Male & Female) 22=Male Medical Inpatient 23=Female Medical Inpatnet 24=Pediatric Inpatient 25=HIV/AIDS Inpatient 26=Delivery Inpatient 27=TB Inpatient 28=Combines Special Diagnoses 29=Surgery Inpatient (Male & Female) 30=Male Surgical 31 =Female Surgical 32=Other IPD (write in) 33=Inpatient Only HMIS 34=Inpatient Only Lab 35=Inpatient Only Pharmacy

STAFF LISTING FORM

INTERVIEWER CODE ☐☐

FACILITY CODE ☐☐☐☐☐☐ (PROV DIST FAC)

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