[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FORMATTING DATE: 01 Nov 2024
ENGLISH LANGUAGE: 8 Aug 2024

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT

OBSERVATION OF ANTENATAL CARE CONSULTATION

FACILITY IDENTIFICATION

QTYPE [O][A][N]

FACILITY NUMBER . . . . . [ ][ ][ ][ ][ ]

PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM] . . . . . [ ][ ]

CLIENT CODE [FROM CLIENT LISTING FORM] . . . . . [ ][ ][ ]

PROVIDER INFORMATION

PROVIDER QUALIFICATION CATEGORY:

PROVIDER TYPE 1	01
PROVIDER TYPE 2	02
PROVIDER TYPE 3	03
PROVIDER TYPE 4	04
PROVIDER TYPE 5	05
PROVIDER TYPE 6	06
PROVIDER TYPE 7	07
PROVIDER TYPE 8	08
PROVIDER TYPE 9	09
OTHER TYPE	96

PROVIDER CATEGORY . . . . . [ ][ ]

SEX OF PROVIDER . . . . . [ ]
(1 = MALE; 2 = FEMALE)

INFORMATION ABOUT OBSERVATION

DATE . . . . . [ ][ ]

INTERVIEWER'S NAME: _____

DAY . . . . . [ ][ ]

MONTH . . . . . [ ][ ]

YEAR . . . . . [2][0][2][ ]

OBSERVER'S NUMBER . . . . . [ ][ ][ ][ ]

LANGUAGE OF QUESTIONNAIRE** [0][1]

LANGUAGE OF INTERVIEW** [ ][ ]

TRANSLATOR USED [ ]
(YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:

01 ENGLISH	03 LANGUAGE	05 LANGUAGE
02 LANGUAGE	04 LANGUAGE	06 LANGUAGE

TEAM NUMBER [ ][ ]

TEAM SUPERVISOR

NAME _____ NUMBER [ ][ ][ ][ ]

OBSERVATION OF ANTENATAL CARE CONSULTATION

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.

PC

INTRODUCTION AND PROVIDER CONSENT

READ THE FOLLOWING CONSENT STATEMENT TO THE PROVIDER. IF THIS IS NOT THE FIRST CLIENT YOU'RE OBSERVING FOR THIS PROVIDER, DON'T READ THE CONSENT AGAIN, BUT ASK THE PROVIDER IF YOU CAN STAY IN THE ROOM TO OBSERVE THE NEXT CLIENT'S CONSULTATION. RECORD THE ANSWER AS APROPRIATE, SIGN AND DATE. IF CONSENT IS GRANTED, MOVE TO THE CLIENT CONSENT.

Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY].

Your facility was selected to participate in this study. We will be observing your consultation with this client in order to understand how ANC services are provided in this facility. At the end of the consultation, we will ask you questions about the types of services that you provided. The observation usually takes about 15-20 minutes.

Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services.

Neither your name nor the names of your clients participating in this study will be included in the dataset or in any report; however, there is a small chance that the facility can be identified. Still, we are asking for your help to ensure that the information we collect is accurate.

Participation in the survey is voluntary. You may refuse to answer any question, or you can ask me to leave at any point, if you feel uncomfortable. There is no penalty for refusing to participate, however, we hope you won't mind our observing your consultation.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your facility manager.

Do you have any questions?

Do I have your permission to be present at this consultation?

SIGNATURE OF INTERVIEWER _____ DATE

DAY				
MONTH				
YEAR	2	0	2	

PROVIDER AGREES TO BE OBSERVED . . 1 ↓

PROVIDER DOES NOT AGREE TO BE OBSERVED . . . . 2 → END

101	CLIENT CONSENT READ THE FOLLOWING CONSENT STATEMENT TO THE CLIENT Good day! My name is _____. We are here on behalf of the [IMPLEMENTING AGENCY] conducting a survey of health facilities to assist the government in knowing more about health services in [COUNTRY]. This facility was selected to participate in the study. I would like to be present while you are receiving services today in order to understand how ANC services are provided in this facility. The observation usually takes about 15-20 minutes. We are not evaluating the [NURSE/DOCTOR/PROVIDER] or the facility. Information from this observation is confidential and will not be shared with anyone other than members of our survey team. The information acquired during this observation may be used by the [IMPLEMENTING AGENCY], other organizations or researchers, for planning service improvements or further studies of services. Neither your name nor the date of service will be provided in any shared data, so your identity and any information about you will remain completely confidential. Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. There is no penalty for refusing to participate, however, we hope you won't mind our observing the consultation. After the consultation, my colleague would like to talk with you about your experience here today. In case you need more information about the survey, you may contact the in-charge manager of this health facility. Do you have any questions for me at this time? Do I have your permission to be present at this consultation? SIGNATURE OF INTERVIEWER _____ CLIENT AGREES TO BE OBSERVED . . 1 ↓ CLIENT DOES NOT AGREE TO BE OBSERVED . . . . 2 → END		
102	RECORD THE TIME THE OBSERVATION STARTED USE 24 HOURS FORMAT	HOURS . . . . . MINUTES	
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES . . . . . 1 NO 2	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

FOR EACH OF THE GROUPS THAT FOLLOW, CIRCLE ANY ACTION TAKEN BY THE PROVIDER OR THE CLIENT. IF NO ACTION IN THE GROUP IS OBSERVED, CIRCLE "Y" FOR EACH GROUP AT THE END OF THE OBSERVATION.

CLIENT HISTORY

104	RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FACTS:		
01	CLIENT'S AGE	A	
02	MEDICATIONS THE CLIENT IS TAKING	B	
03	DATE CLIENT'S LAST MENSTRUAL PERIOD BEGAN	C	
04	NUMBER OF PRIOR PREGNANCIES CLIENT HAS HAD	D	
05 (FN1)	HIV STATUS	E	
06	NONE OF THE ABOVE	Y	

COMPLICATIONS OR ADVERSE OUTCOMES OF PRIOR PREGNANCIES

105	RECORD WHETHER THE PROVIDER OR THE CLIENT DISCUSSED ANY OF THE FOLLOWING ASPECTS OF THE CLIENT'S PRIOR PREGNANCIES:		
01	PRIOR STILLBIRTH(S)	A	
02	PRIOR PRETERM BIRTH(S)	B	
03	INFANT(S) WHO DIED IN THE FIRST WEEK OF LIFE	C	
04	HEAVY BLEEDING, DURING OR AFTER DELIVERY	D	
05	PREVIOUS INSTRUMENT ASSISTED DELIVERY (USE OF VENTOUSE/VACUUM, OR FORCEPS)	E	
06	PREVIOUS CAESAREAN SECTION	F	
07	PREVIOUS SPONTANEOUS ABORTIONS	G	
08	PREVIOUS MULTIPLE PREGNANCIES	H	
09	PREVIOUS PROLONGED LABOR	I	
10	PREVIOUS GESTATIONAL (ALSO KNOWN AS PREGNANCY-INDUCED) HYPERTENSION, CHRONIC HYPERTENSION, OR SYMPTOMS OF PREGNANCY-INDUCED HYPERTENSION (SEVERE HEADACHE AND BLURRED VISION)	J	
11	PREVIOUS CHRONIC OR GESTATIONAL DIABETES (HIGH BLOOD SUGAR)	K	
12	PREVIOUS PREGNANCY RELATED CONVULSIONS	L	
13	HIGH FEVER OR INFECTION DURING PRIOR PREGNANCY/PREGNANCIES OR SOON AFTER DELIVERY	M	
14	NONE OF THE ABOVE	Y	

POTENTIAL DANGER SIGNS OF CURRENT PREGNANCY

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES		GO TO
106	IN COLUMN A, RECORD WHETHER THE PROVIDER ASKED ABOUT OR THE CLIENT MENTIONED ANY OF THE FOLLOWING FOR CURRENT PREGNANCY. IN COLUMN B, RECORD WHETHER THE PROVIDER COUNSELLED ON THE DANGER SIGNS.	(A) PROVIDER ASKED ABOUT OR CLIENT MENTIONED	(B) PROVIDER COUNSELLED	
01	VAGINAL BLEEDING	A	A	
02	FEVER	B	B	
03	HEADACHE OR BLURRED VISION	C	C	
04	SWOLLEN FACE OR HANDS OR EXTREMITIES	D	D	
05	TIREDNESS OR BREATHLESSNESS	E	E	
06	FETAL MOVEMENT (LOSS OF, EXCESSIVE)	F	F	
07	PERSISTENT COUGH FOR 2 WEEKS OR LONGER	G	G	
08	FREQUENT AND PAINFUL URINATION	H	H	
09	FOUL SMELLING VAGINAL DISCHARGE	I	I	
10	ANY OTHER SYMPTOMS OR PROBLEMS THE CLIENT THINKS MIGHT BE RELATED TO THIS PREGNANCY	J	J	
11	NONE OF THE ABOVE	Y	Y	
107	RECORD WHETHER PROVIDER ADVISED ANY OF THESE COURSES OF ACTION IF CLIENT EXPERIENCED ANY OF THESE DANGER SIGNS	SEEK CARE AT A FACILITY . . . . . A REFERRAL TO SPECIALIST PROVIDER . . . . . B INITIATION OF MEDICATION . . . . . C REEVALUATION/FOLLOW-UP VISIT WITHIN SHORT TIME PERIOD . . . . D OTHER _____ X SPECIFY PROVIDER DID NOT ADVISE . . . . . Y		

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO

PHYSICAL EXAMINATION

108	RECORD WHETHER THE PROVIDER PERFORMED THE FOLLOWING PROCEDURES:		
01	TOOK THE CLIENT'S BLOOD PRESSURE , WITH ARM ABOVE OR BELOW HEART LEVEL . .	A	
02	TOOK THE CLIENT'S BLOOD PRESSURE WITH ARM AT HEART LEVEL	B	
03	WEIGHED THE CLIENT	C	
04	TOOK CLIENT'S HEIGHT	D	
05	AUSCULTATED THE CLIENT'S HEART	E	
06	AUSCULTATED THE CLIENT'S LUNGS	F	
07	CHECKED CONJUNCTIVA/PALMS/NAILS FOR ANEMIA	G	
08	EXAMINED LEGS/FEET/HANDS FOR EDEMA	H	
09	PALPATED THE CLIENT'S ABDOMEN FOR FETAL PRESENTATION	I	
10	AUSCULTATED THE CLIENT'S ABDOMEN FOR FETAL HEARTBEAT	J	
11	CONDUCTED AN ULTRASOUND/REFER CLIENT FOR ULTRASOUND/LOOK AT RECENT ULTRASOUND REPORT	K	
12	MEASURED FUNDAL HEIGHT USING TAPE MEASURE OR FINGER MET	L	
13	NONE OF THE ABOVE	Y	

ROUTINE TESTS

109 (FN2)	RECORD WHETHER THE PROVIDER A) ASKED ABOUT, B) PERFORMED OR, C) REFERRED THE CLIENT FOR THE FOLLOWING TESTS:	(A) PROVIDER ASKED	(B) PROVIDER PERFORMED	(C) PROVIDER REFERRED	(D) NO ACTION TAKEN	
01	HEMOGLOBIN TEST	A	B	C	Y	
02	BLOOD GROUPING	A	B	C	Y	
03	ANY URINE TEST	A	B	C	Y	
04	SYPHILIS TEST	A	B	C	Y	
05	BLOOD COUNT	A	B	C	Y	
06	ROUTINE HIV TEST	A	B	C	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
	MAINTAINING A HEALTHY PREGNANCY		
110	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING ADVICE OR COUNSEL ABOUT MAINTAINING A HEALTHY PREGNANCY		
01	DISCUSSED QUANTITY OF FOOD TO EAT DURING THE PREGNANCY	A	
02	DISCUSSED TYPES OF FOOD TO EAT DURING THE PREGNANCY	B	
03	DISCUSSED STAYING PHYSICALLY ACTIVE DURING THE PREGNANCY	C	
04	DISCUSSED THE AMOUNT OF WEIGHT TO GAIN DURING THE PREGNANCY	D	
05	INFORMED THE CLIENT ABOUT THE PROGRESS OF THE PREGNANCY	E	
06 (FN3)	DISCUSSED THE IMPORTANCE OF FREQUENT ANC VISITS	F	
07	NONE OF THE ABOVE	Y	
	IRON/ FOLATE SUPPLEMENTATION		
111	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	PRESCRIBED OR GAVE IRON PILLS AND FOLIC ACID	A	
02	EXPLAINED THE PURPOSE OF IRON AND FOLIC ACID	B	
03	EXPLAINED HOW TO TAKE IRON AND FOLIC ACID PILLS	C	
04	EXPLAINED SIDE EFFECTS OF IRON AND FOLIC ACID PILLS	D	
05	NONE OF THE ABOVE	Y	
	CALCIUM SUPPLEMENTS (FN4)		
112	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	PRESCRIBED OR GAVE CALCIUM SUPPLEMENTS	A	
02	EXPLAINED THE PURPOSE OF CALCIUM SUPPLEMENTS	B	
03	EXPLAINED HOW TO TAKE CALCIUM SUPPLEMENTS	C	
04	EXPLAINED SIDE EFFECTS OF CALCIUM SUPPLEMENTS	D	
05	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
MULTIPLE MICRONUTRIENT SUPPLEMENTS (FN4)			
113	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	PRESCRIBED OR GAVE MULTIPLE MICRONUTRIENT SUPPLEMENTS	A	
02	EXPLAINED THE PURPOSE OF MULTIPLE MICRONUTRIENT SUPPLEMENTS	B	
03	EXPLAINED HOW TO TAKE MULTIPLE MICRONUTRIENT SUPPLEMENTS	C	
04	EXPLAINED SIDE EFFECTS OF MULTIPLE MICRONUTRIENT SUPPLEMENTS	D	
05	NONE OF THE ABOVE	Y	
MALARIA			
114	RECORD WHETHER THE PROVIDER GAVE THE CLIENT ANY OF THE FOLLOWING TREATMENT AND COUNSELLING:		
01	GAVE/PRESCRIBED MALARIA PROPHYLAXIS MEDICINE (SP) TO CLIENT DURING THE CONSULTATION	A	
02	EXPLAINED THE PURPOSE OF THE PREVENTIVE TREATMENT WITH ANTI-MALARIA MEDICINE	B	
03	EXPLAINED HOW TO TAKE THE ANTI-MALARIA MEDICINE	C	
04	EXPLAINED POSSIBLE SIDE EFFECTS OF THE ANTI-MALARIA MEDICINE	D	
05	PROVIDED ITN TO CLIENT AS PART OF CONSULTATION OR INSTRUCTED CLIENT WHERE TO OBTAIN ITN	E	
06	EXPLICITLY EXPLAINED IMPORTANCE OF USING ITN TO CLIENT	F	
07	NONE OF THE ABOVE	Y	
PREPARATION FOR DELIVERY			
115	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT DELIVERY IN ANY OF THE FOLLOWING WAYS:		
01	ASKED THE CLIENT WHERE SHE WILL DELIVER	A	
02	ADVISED THE CLIENT TO PREPARE FOR DELIVERY (E.G. SET ASIDE MONEY, ARRANGE FOR EMERGENCY TRANSPORTATION)	B	
03	ADVISED THE CLIENT TO USE A SKILLED HEALTH WORKER FOR DELIVE	C	
04	ADVISED THE CLIENT WHAT ITEMS TO HAVE ON HAND IN CASE OF EMERGENCY AND THEIR IMPORTANCE (E.G., BLADE)	D	
05	ADVISED THE CLIENT TO DELIVER AT A HEALTH FACILITY	E	
06	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
	NEWBORN AND POSTPARTUM CARE		
116	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT NEWBORN OR POSTPARTUM CARE IN ANY OF THE FOLLOWING WAYS:		
01	DISCUSSED CARE FOR THE NEWBORN (I.E., WARMTH, HYGIENE, AND CORD CARE)	A	
02	DISCUSSED IMPORTANCE OF VACCINATION FOR THE NEWBORN	B	
03	DISCUSSED FAMILY PLANNING OPTIONS FOR AFTER DELIVERY	C	
04	DISCUSSED THE IMPORTANCE OF POSTNATAL CARE ATTENDANCE	D	
05	NONE OF THE ABOVE	Y	
	BREASTFEEDING		
117	RECORD WHETHER THE PROVIDER ADVISED OR COUNSELLED ABOUT BREASTFEEDING IN ANY OF THE FOLLOWING WAYS:		
01	DISCUSSED THE IMPORTANCE OF BREASTFEEDING	A	
02	DISCUSSED EARLY INITIATION OF BREASTFEEDING	B	
03	DISCUSSED EXCLUSIVE BREASTFEEDING UNTIL 6 MONTHS OF AGE	C	
04	DISCUSSED WHERE CLIENT COULD GET HELP FOR BREASTFEEDING	D	
05	NONE OF THE ABOVE	Y	
	ADDITIONAL PROVIDER ACTIONS		
118	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:		
01	LOOKED AT CLIENT'S HEALTH CARD AT ANY TIME BEFORE BEGINNING THE CONSULTATION, WHILE COLLECTING INFORMATION OR WHILE EXAMINING THE	A	
02	WROTE ON THE CLIENT'S HEALTH CARD	B	
03	ASKED IF THE CLIENT HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS	C	
04	ASKED PERMISSION BEFORE CARRYING OUT ANY EXAMS OR PROCEDURES	D	
05	EXPLAINED WHY THEY WERE CARRYING OUT ANY EXAMS OR PROCEDURES	E	
06	EXPLAINED THE FINDINGS OF ANY EXAMS OR CONSULTATIONS	F	
07	EXPLAINED WHY THEY WERE GIVING OUT ANY MEDICINE	G	
08	USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING	H	
09	WASHED HANDS BEFORE AND AFTER ANY PROCEDURE	I	
10	ADVISED THE CLIENT WHEN TO RETURN FOR HER NEXT ANC VISIT	J	
11	PRESCRIBED OR GAVE A TETANUS TOXOID (TT) VACCINATION	K	
12	NONE OF THE ABOVE	Y	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
	QUESTIONS TO PROVIDER		
	AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS:		
119	How many weeks pregnant is the client? PROBE TO GET THE INFORMATION. IF THE PROVIDER DOES NOT KNOW THE WEEKS OF PREGNANCY AFTER PROBING, ASK TO PROVIDE APPROXIMATE ESTIMATE. NO EMPTY BOXES ALLOWED FOR THIS QUESTION	WEEKS OF PREGNANCY ☐☐	
120	How many antenatal care visits has the client had at this facility for this pregnancy? PROBE TO GET THE INFORMATION. IF THE PROVIDER DOES NOT KNOW THE NUMBER OF ANC VISITS AFTER PROBING, ASK TO PROVIDE APPROXIMATE ESTIMATE. NO EMPTY BOXES ALLOWED FOR THIS QUESTION	NUMBER OF VISITS . . ☐☐	
121	Has the client visited other facilities for this pregnancy before coming to this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 124
122	How many antenatal care visits has the client had at other facilities for this pregnancy? PROBE TO GET THE INFORMATION. IF THE PROVIDER DOES NOT KNOW THE NUMBER OF ANC VISITS AFTER PROBING, ASK TO PROVIDE APPROXIMATE ESTIMATE. NO EMPTY BOXES ALLOWED FOR THIS QUESTION	NUMBER OF VISITS . . . . ☐☐	
123	Was the client referred from another facility for ANC care at this facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
124	Has the client had a previous pregnancy, regardless of the duration or outcome of that pregnancy, or is this the client's first pregnancy?	FIRST PREGNANCY . . . . . 1 NOT FIRST PREGNANCY . . . . . 2 DON'T KNOW 8	
125	Is this client's pregnancy high-risk?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
126	RECORD THE TIME THE OBSERVATION ENDED	HOURS . . . . . ☐☐ MINUTES . . . . . ☐☐	
	THANK THE SERVICE PROVIDER AND THE CLIENT AND MOVE TO THE NEXT DATA COLLECTION		

Interviewer's comments:

(FN1) Only include if this is included in country-specific guidelines

(FN2) Can be updated during the questionnaire adaptation according to country guidelines, but keep broader categories

(FN3) Can be adapted to a specific number according to country guidelines

(FN4) Include this section [MULTIPLE MICRONUTRIENT SUPPLEMENTS 113(01-05)] only if part of country guidelines