

[NAME OF COUNTRY]
[NAME OF ORGANIZATION]

FORMATTING DATE: 01 Nov 2024
ENGLISH LANGUAGE: 09 Oct 2024

THE DHS PROGRAM SERVICE PROVISION ASSESSMENT OBSERVATION OF SICK CHILD CONSULTATION

FACILITY IDENTIFICATION

	QTYPE	O	S	C
FACILITY NUMBER				
PROVIDER SERIAL NUMBER [FROM STAFF LISTING FORM]				
CLIENT CODE [FROM CLIENT LISTING FORM]				

PROVIDER INFORMATION

<u>PROVIDER QUALIFICATION CATEGORY:</u> 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 <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> SEX OF PROVIDER <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td></tr></table> (1 = MALE; 2 = FEMALE)			

INFORMATION ABOUT OBSERVATION

DATE	DAY <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				
	MONTH <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				
	YEAR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px; text-align: center;">2</td><td style="width: 20px; height: 20px; text-align: center;">0</td><td style="width: 20px; height: 20px; text-align: center;">2</td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	2	
2	0	2			
INTERVIEWER'S NAME: _____	OBSERVER'S NUMBER ... <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				

LANGUAGE OF QUESTIONNAIRE**	01	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 <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NUMBER			TEAM SUPERVISOR _____ NAME <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NUMBER				

OBSERVATION OF SICK CHILD 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 APPROPRIATE, 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 services for sick children 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	<p><u>CLIENT CONSENT</u></p> <p>READ THE FOLLOWING CONSENT STATEMENT TO THE CLIENT</p> <p>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].</p> <p>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 sick child services are provided in this facility. The observation usually takes about 15-20 minutes.</p> <p>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.</p> <p>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.</p> <p>Please know that whether you decide to allow me to observe your visit is completely voluntary and that whether you agree to participate or not will not affect the services you receive. If at any point you would prefer I leave please feel free to tell me. There is no penalty for refusing to participate, however, we hope you won't mind our observing the consultation.</p> <p>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.</p> <p>Do you have any questions for me at this time?</p> <p>Do I have your permission to be present at this consultation?</p> <p style="text-align: center;">SIGNATURE OF INTERVIEWER _____</p> <p style="text-align: center;"> CLIENT AGREES TO BE OBSERVED .. 1 ↓ </p> <p style="text-align: center;"> CLIENT DOES NOT AGREE TO BE OBSERVED .. 2 → END </p>
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NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO								
102	RECORD THE TIME THE OBSERVATION STARTED	HOURS <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> MINUTES <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>									
103	IS THIS THE FIRST OBSERVATION FOR THIS PROVIDER FOR THIS SERVICE?	YES 1 NO 2									
104	RECORD SEX OF THE CHILD. CONFIRM SEX OF CHILD WITH THE PROVIDER	MALE 1 FEMALE 2									

PROVIDER INTERACTION WITH CARETAKER AND CHILD
FOR EACH OF THE GROUPS THAT FOLLOW, CIRCLE ANY ACTIONS TAKEN BY THE PROVIDER OR THE CLIENT. IF NO ACTION IN THE GROUP IS TAKEN, CIRCLE "Y" FOR EACH GROUP AT THE END OF THE OBSERVATION
CLIENT HISTORY

105	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED THAT THE CHILD HAD ANY OF THE FOLLOWING MAIN SYMPTOMS:	
01	FEVER A	
02	COUGH OR DIFFICULT BREATHING (E.G., FAST BREATHING OR CHEST IN-DRAWING) B	
03	DIARRHEA C	
04	NONE OF THE ABOVE Y	
106	RECORD WHETHER A PROVIDER ASKED ABOUT OR WHETHER THE CARETAKER MENTIONED ANY OF THE FOLLOWING GENERAL DANGER SIGNS:	
01	CHILD IS UNABLE TO DRINK OR BREASTFEED A	
02	CHILD VOMITS EVERYTHING B	
03	CHILD HAS HAD CONVULSIONS WITH THIS ILLNESS C	
04	CHILD HAS HAD LETHARGY. IF CHILD IS ASLEEP, TRIED TO ROUSE CHILD D	
05	NONE OF THE ABOVE Y	

PHYSICAL EXAMS			
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107	RECORD WHETHER A PROVIDER PERFORMED ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS ON THE SICK CHILD:	
01	TOOK CHILD'S TEMPERATURE BY THERMOMETER A	
02	FELT THE CHILD FOR FEVER OR BODY HOTNESS B	
03	COUNTED RESPIRATION (BREATHS) FOR 60 SECONDS C	
04	AUSCULTATED CHILD (LISTEN TO CHEST WITH STETHOSCOPE) OR COUNTED PULSE D	
05	CHECKED SPO2 USING PULSE OXIMETRY E	
06	CHECKED SKIN TURGOR FOR DEHYDRATION (E.G., PINCH ABDOMINAL SKIN) F	
07	CHECKED FOR PALLOR BY LOOKING AT PALMS G	
08	CHECKED FOR PALLOR BY LOOKING AT CONJUNCTIVA H	
09	CHECKED FOR PALLOR BY LOOKING AT NAILS I	
10	UNDRESSED CHILD FROM SHOULDER TO WAIST TO EXAMINI J	
11	PRESSED BOTH FEET TO CHECK FOR EDEMA K	
12	WEIGHED THE CHILD L	
13	MEASURED THE CHILD HEIGHT/LENGTH M	
14	PLOTTED WEIGHT ON GROWTH CHART N	
15	PLOTTED HEIGHT/LENGTH ON GROWTH CHART O	
16	CHECKED FOR ENLARGED LYMPH NODES P	
17	MEASURED MID-UPPER ARM CIRCUMFERENCE (OR MUAC) Q	
18	NONE OF THE ABOVE Y	

OTHER ASSESSMENTS			
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108	RECORD WHETHER A PROVIDER ASKED ABOUT OR PERFORMED OTHER ASSESSMENTS OF THE CHILD'S HEALTH BY DOING ANY OF THE FOLLOWING:	
01	OFFERED THE CHILD SOMETHING TO DRINK OR ASKED THE MOTHER TO PUT THE CHILD TO THE BREAST A	
02	MENTIONED THE CHILD'S WEIGHT OR GROWTH TO THE CARETAKER, OR DISCUSSED GROWTH CHART B	
03	ASKED IF CHILD RECEIVED VITAMIN A WITHIN THE PAST 6 MONTHS C	
04 (FN1)	ASKED IF CHILD RECEIVED MEBENDAZOLE OR ALBENDAZOLE WITHIN THE PAST 6 MON D	
05	NONE OF THE ABOVE Y	

COUNSELING OF CARETAKER			
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109	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING:	
01	PROVIDED GENERAL INFORMATION ABOUT FEEDING OR BREASTFEEDING THE CHILD EVEN WHEN NOT SICK A	
02	TOLD THE CARETAKER TO GIVE EXTRA FLUIDS TO THE CHILD DURING THIS ILLNE. B	
03	TOLD THE CARETAKER TO CONTINUE FEEDING SOLID FOOD TO THE CHILD DURING THIS ILLNESS C	
04	TOLD THE CARETAKER TO CONTINUE BREASTFEEDING THE CHILD DURING THIS ILLNESS D	
05	TOLD THE CARETAKER WHAT ILLNESS(ES) THE CHILD HAS E	
06	DESCRIBED SIGNS AND/OR SYMPTOMS IN THE CHILD FOR WHICH TO IMMEDIATELY BRING CHILD BACK F	
07	ASKED IF THE CARETAKER HAD ANY QUESTIONS AND ENCOURAGED QUESTIONS G	
08	ASKED PERMISSION BEFORE CARRYING OUT ANY EXAMS OR PROCEDURES H	
09	EXPLAINED TO CARETAKER WHY THEY WERE CARRYING OUT EXAMINATIONS OR PROCEDURES I	
10	EXPLAINED THE FINDINGS OF ANY EXAMS OR CONSULTATIONS J	
11	EXPLAINED WHY THEY WERE GIVING THE CHILD ANY MEDICINE K	
12	NONE OF THE ABOVE Y	

ADDITIONAL COUNSELING			
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110	RECORD WHETHER A PROVIDER DID ANY OF THE FOLLOWING. THIS REFERS ONLY TO COUNSELING TO BE APPLIED AFTER THE VISIT OR MEDICINES THAT THE CARETAKER WILL GIVE TO THE SICK CHILD AT HOME AND DOES NOT INCLUDE START DOSES OR ONE TIME MEDICINES GIVEN TO THE CHILD DURING THE VISIT (E.G., ORS OR PAIN MEDICINE) FOR URGENT TREATMENT OF SYMPTOMS.	
01	PRESCRIBED OR PROVIDED ORAL MEDICATIONS DURING OR AFTER CONSULTATION A	
02	EXPLAINED HOW TO ADMINISTER ORAL TREATMENT(S) B	
03	DISCUSS FOLLOW-UP VISIT FOR THE SICK CHILD C	
04	NONE OF THE ABOVE Y	

REFERRALS AND ADMISSIONS			
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111	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING:	
01	RECOMMEND THAT CHILD BE HOSPITALIZED URGENTLY (I.E., ADMITTED TO THE HOSPITAL OR REFERRED TO ANOTHER HOSPITAL) A	
02	REFERRED CHILD TO ANOTHER PROVIDER WITHIN FACILITY FOR OTHER C/ B	
03	REFERRED CHILD TO A NUTRITION CENTER C	
04	REFERRED CHILD FOR A LABORATORY TEST WITHIN FACILITY D	
05	REFERRED CHILD FOR A LABORATORY TEST OUTSIDE FACILITY E	
06	EXPLAINED THE REASON FOR (ANY) REFERRAL F	
07	GAVE REFERRAL SLIP TO CARETAKER G	
08	GAVE PRE-REFERRAL TREATMENT TO CHILD FOR DIAGNOSED CONDITION H	
09	EXPLAINED WHERE (OR TO WHOM) TO GO I	
10	EXPLAINED WHEN TO GO FOR REFERRAL J	
11	NONE OF THE ABOVE Y	

ADDITIONAL PROVIDER ACTIONS			
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112	RECORD WHETHER THE PROVIDER DID ANY OF THE FOLLOWING: (THIS IS THE POINT WHEN THE OBSERVATION IS CONCLUDED)	
01	LOOKED AT THE CHILD'S IMMUNIZATION CARD OR ASKED CARETAKER ABOUT CHILD VACCINATION HISTORY A	
02	LOOKED AT THE CHILD'S HEALTH CARD EITHER BEFORE BEGINNING THE CONSULTATION, OR WHILE COLLECTING INFORMATION FROM THE CARETAKER, OR WHILE EXAMINING THE CHILD THIS ITEM MAY BE EITHER THE VACCINATION CARD OR OTHER HEALTH CARD B	
03	WROTE ON THE CHILD'S HEALTH CARD C	
04	USED ANY VISUAL AIDS FOR HEALTH EDUCATION OR COUNSELING D	
05	WASHED HANDS BEFORE AND AFTER ANY PROCEDURE E	
06	NONE OF THE ABOVE Y	

<h2 style="margin:0;">QUESTIONS TO PROVIDER</h2> <p style="margin:0;">AFTER THE CONSULTATION, ASK THE PROVIDER THE FOLLOWING QUESTIONS:</p>

200	<p>Has (NAME) presented today or has the caretaker mentioned that the child had any of the following main symptoms or danger signs for any illness?</p> <p>READ EACH SYMPTOM AND SIGN OPTION AND CIRCLE CODE '1' IF YES, OR CODE '2' FOR NO.</p> <p>a) A Fever?</p> <p>b) Cough or difficult breathing that is fast, short, rapid breaths or chest indrawings?</p> <p>c) Diarrhea?</p> <p>d) Unable to drink or eat or breastfeed?</p> <p>e) Vomits everything?</p> <p>f) Convulsions?</p> <p>g) Being lethargic or unconscious?</p>	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;"></th> <th style="width:10%; text-align:center;">YES</th> <th style="width:10%; text-align:center;">NO</th> </tr> </thead> <tbody> <tr> <td>a) FEVER</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>b) COUGH OR DIFFICULT BREATHING</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>c) DIARRHEA</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>d) UNABLE TO DRINK OR EAT ..</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>e) VOMITS EVERYTHING ..</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>f) CONVULSIONS</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>g) LETHARGY</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> </tbody> </table>		YES	NO	a) FEVER	1	2	b) COUGH OR DIFFICULT BREATHING	1	2	c) DIARRHEA	1	2	d) UNABLE TO DRINK OR EAT ..	1	2	e) VOMITS EVERYTHING ..	1	2	f) CONVULSIONS	1	2	g) LETHARGY	1	2
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f) CONVULSIONS	1	2																								
g) LETHARGY	1	2																								

201	<p>What was the outcome of this consultation?</p> <p>READ EACH OUTCOME OPTION AND CIRCLE CODE '1' IF YES, OR CODE '2' FOR NO.</p> <p>a) Treated and sent home</p> <p>b) Child referred to provider, same facility</p> <p>c) Child admitted, same facility</p> <p>d) Child sent to lab for testing</p> <p>e) Child referred to other facility</p>	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;"></th> <th style="width:10%; text-align:center;">YES</th> <th style="width:10%; text-align:center;">NO</th> </tr> </thead> <tbody> <tr> <td>a) TREATED/SENT HOME</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>b) REFERRED TO PROVIDER SAME FACILITY</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>c) ADMITTED SAME FACILITY</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>d) SENT TO LAB FOR TESTING</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> <tr> <td>e) REFERRED TO OTHER FACILITY</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> </tr> </tbody> </table>		YES	NO	a) TREATED/SENT HOME	1	2	b) REFERRED TO PROVIDER SAME FACILITY	1	2	c) ADMITTED SAME FACILITY	1	2	d) SENT TO LAB FOR TESTING	1	2	e) REFERRED TO OTHER FACILITY	1	2
	YES	NO																		
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e) REFERRED TO OTHER FACILITY	1	2																		

<h2 style="margin:0;">DIAGNOSIS</h2>

<p>ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS FOR THE SICK CHILD. FOR ANY DIAGNOSIS, CIRCLE THE DIAGNOSIS MADE. IF NO DIAGNOSIS MADE, CIRCLE A "NONE OF THE ABOVE" RESPONSE CODE.</p>	
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<p>DIAGNOSIS (OR MAIN SYMPTOM, IF NO DIAGNOSIS)</p>	
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202	<p>DEHYDRATION CIRCLE CODE "3" FOR "NONE OF THE ABOVE" IF NO DEHYDRATION DIAGNOSIS MADE.</p>	<table style="width:100%; border-collapse: collapse;"> <tbody> <tr> <td>SEVERE DEHYDRATION</td> <td style="text-align:center;">1</td> </tr> <tr> <td>SOME DEHYDRATION</td> <td style="text-align:center;">2</td> </tr> <tr> <td>NONE OF THE ABOVE / NO DEHYDRATION</td> <td style="text-align:center;">3</td> </tr> </tbody> </table>	SEVERE DEHYDRATION	1	SOME DEHYDRATION	2	NONE OF THE ABOVE / NO DEHYDRATION	3
SEVERE DEHYDRATION	1							
SOME DEHYDRATION	2							
NONE OF THE ABOVE / NO DEHYDRATION	3							

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
203	RESPIRATORY SYSTEM CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO RESPIRATORY SYSTEM DIAGNOSIS MADE.	PNEUMONIA / BRONCHOPNEUMONIA A UPPER RESPIRATORY INFECTION (URI) / ACUTE RESPIRATORY ILLNESS (ARI) B OTHER COUGH AND RESPIRATORY ILLNESS C NONE OF THE ABOVE Y	
204	DIGESTIVE SYSTEM / INTESTINAL CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO DIGESTIVE SYSTEM / INTESTINAL SYSTEM DIAGNOSIS MADE.	DIARRHEA A DYSENTERY B OTHER GASTROINTESTINAL TRACT INFECTION C NONE OF THE ABOVE Y	
205	MALARIA CIRCLE CODE "3" FOR "NONE OF THE ABOVE" IF NO MALARIA DIAGNOSIS MADE.	MALARIA (UNCOMPLICATED) 1 MALARIA (SEVERE) 2 NONE OF THE ABOVE 3	
206	FEVER, MEASLES, AND OTHER INFECTIONS CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO FEVER, MEASLES AND OTHER INFECTIONS DIAGNOSIS MADE.	FEVER OF UNKNOWN ORIGIN A POSSIBLE SERIOUS BACTERIAL INFECTION (PSBI) B MEASLES C OTHER INFECTIONS D NONE OF THE ABOVE Y	
207	OTHER DIAGNOSIS CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO DEHYDRATION DIAGNOSIS MADE.	ABSCESS A EAR INFECTION B THROAT INFECTION C ANEMIA D MODERATE ACUTE MALNUTRITION (MAM) E SEVERE ACUTE MALNUTRITION (SAM) F OTHER DIAGNOSIS _____ X (SPECIFY) NO OTHER DIAGNOSIS Y	

<h2 style="margin: 0;">ADDITIONAL QUESTIONS ON PHYSICAL EXAMINATION AND TEST RESULTS</h2>

208	Is this (NAME)'s first visit to this facility for this illness, or is this a follow-up visit?	FIRST VISIT 1 FOLLOW-UP 2 DON'T KNOW 8	
209	Did (NAME) receive Vitamin A within the past 6 months?	YES 1 NO 2 DON'T KNOW 8	
210 (FN1)	Did (NAME) receive Mebendazole or Albendazole within the past 6 months?	YES 1 NO 2 DON'T KNOW 8	
211	You checked (NAME) palms for a pallor today. Did you find that (NAME) had a palmar pallor?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
212	Did you or other healthcare provider in this facility test/request a hemoglobin test for (NAME)?	YES 1 NO 2 DON'T KNOW 8	→ 215
213	Is (NAME)'s hemoglobin result available?	YES 1 NO 2 DON'T KNOW 8	→ 215
214	What is (NAME)'s hemoglobin concentration level? RECORD HEMOGLOBIN CONCENTRATION LEVEL IN BOXES IN G/DL in 00.0 FORMAT, ADD PRECEDING "0" IN THE FIRST BOX IF HB LEVEL IS LESS THAN 10.0 G/DL, FOR EXAMPLE 09.9 G/DL	G/DL <input type="text"/> <input type="text"/> . <input type="text"/> DECLINED TO ANSWER99.5 DON'T KNOW99.8	
215	CHECK 200(a) IF CHILD PRESENTED WITH A FEVER TODAY. YES HAS FEVER <input type="checkbox"/> NO FEVER <input type="checkbox"/>		→ 217
216	You said that (NAME) had a fever today. Has name had a fever with this illness [DIAGNOSIS IN 202, 203, 204, 205, 206, 207] or any time in the past two days?	YES 1 NO 2 DON'T KNOW 8	→ 218
217	You said that (NAME) did not have a fever today. Has (NAME) had a fever with this illness [DIAGNOSIS IN 202, 203, 204, 205, 206, 207] or any time in the past two days?	YES 1 NO 2 DON'T KNOW 8	
218	Have you or other healthcare provider in this facility measured (NAME)'s temperature today?	YES 1 NO 2 DON'T KNOW 8	→ 220
219	What is (NAME)'s body temperature? RECORD BODY TEMPERATURE IN BOXES IN THE UNIT DEGREES CELSIUS (°C) in 00.0 FORMAT.	DEGREES CELSIUS <input type="text"/> <input type="text"/> . <input type="text"/> DECLINED TO ANSWER99.5 DON'T KNOW99.8	
220	Did (NAME) have a malaria rapid diagnostic test (RDT) done anywhere in this facility before coming into this consultation room to see you today?	YES 1 NO 2 DON'T KNOW 8	→ 223
221	Did you see, or did the caretaker show you (NAME)'s malaria RDT result as part of this consultation?	YES 1 NO 2 DON'T KNOW 8	→ 223
222	What is (NAME)'s result of the malaria RDT test?	POSITIVE 1 NEGATIVE 2 DON'T KNOW 8	
223	CHECK 200, 205, 206, 211, 216, 217: IF CHILD HAD PRESENTED TODAY WITH A FEVER (CODE '1' IS CIRCLED IN 200(a), WAS DIAGNOSED WITH ANY MALARIA (CODE '1' OR CODE '2' IS CIRCLED IN 205) AND / OR WITH A FEVER (CODE 'A-D' IS CIRCLED IN 206) AND / OR FOUND WITH PALMAR PALLOR (CODE '1' IS CIRCLED IN 211), AND /OR HAD A FEVER WITH DIAGNOSED ILLNESS OR IN THE PAST TWO DAYS(CODE '1' IS CIRCLED IN 216 AND /OR 217) YES, DIAGNOSED WITH ANY MALARIA AND / OR ANY FEVER AND / OR PALMAR PALLOR <input type="checkbox"/> OTHER <input type="checkbox"/>		→ 230

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
224	(NAME) had fever and/or was diagnosed with (DIAGNOSIS FROM 205, 205, AND/OR 211), did you or other healthcare provider perform/request a mRDT test to confirm malaria?	YES 1 NO 2 DON'T KNOW 8	→ 227
225	Is (NAME)'s malaria rapid diagnostic test (mRDT) result available?	YES, AT THE PROVIDER SITE 1 YES, AT THE LABORATORY 2 NO 3 DON'T KNOW 8	→ 227
226	What is (NAME)'s result of the mRDT test?	POSITIVE 1 NEGATIVE 2 DON'T KNOW 8	
227	(NAME) had fever and/or was diagnosed with (DIAGNOSIS FROM 205, 206, AND/OR 211), did you or other healthcare provider perform/request a malaria microscopy to confirm malaria?	YES 1 NO 2 DON'T KNOW 8	→ 230
228	Is (NAME)'s malaria microscopy result available?	YES 1 NO 2 DON'T KNOW 8	→ 230
229	What is (NAME)'s result of the malaria microscopy?	POSITIVE 1 NEGATIVE 2 DON'T KNOW 8	
230	Did you vaccinate the child during this visit or refer the child for vaccination today other than for vitamin A supplementation? IF NO, ASK: Why not?	YES, VACCINATED CHILD 1 YES, REFERRED 2 NOT DUE FOR VACCINATION 3 VACCINE NOT AVAILABLE 4 CHILD TOO SICK 5 NOT DAY FOR VACCINATION 6 DID NOT CHECK FOR VACCINATION 7 VACCINATION COMPLETED 8	

TREATMENT

ASK ABOUT THE TREATMENT THAT WAS EITHER PRESCRIBED OR PROVIDED. PROMPT IF NECESSARY.		
231	Did you prescribe or provide any treatment today for this child? IF YES, CIRCLE ALL TREATMENTS THAT WERE PRESCRIBED OR PROVIDED TO CHILD IN THE FOLLOWING QUESTIONS	YES 1 NO 2 → 237

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO
232 (FN1)	<p>GENERAL TREATMENT</p> <p>CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO TREATMENT PRESCRIBED OR PROVIDED TODAY.</p>	<p>BENZYL PENICILLIN INJECTION .. A</p> <p>GENTAMYCINE INJECTION B</p> <p>CEFTRIAZONE INJECTION C</p> <p>AMPICILLINE INJECTION D</p> <p>OTHER ANTIBIOTIC INJECTION .. E</p> <p>OTHER INJECTION F</p> <p>CO-TRIMOXAZOLE</p> <p> TABLET/SYRUP G</p> <p>AMOXICILLIN SYRUP H</p> <p>AMOXICILLIN DISPERSIBLE</p> <p> TABLETS I</p> <p>CIPROFLOXACINE TABLETS J</p> <p>AZITHROMYCIN TABLETS/SYRUP ... K</p> <p>OTHER ANTIBIOTIC TABLET/ SYRUP L</p> <p>PARACETAMOL M</p> <p>OTHER FEVER REDUCING MEDICINE N</p> <p>ZINC O</p> <p>IRON P</p> <p>VITAMINS (OTHER THAN VITAMIN A) Q</p> <p>MEBENDAZOLE OR ALBENDAZOLE (IF NOT GIVEN FOR LAST 6 MONTHS) R</p> <p>COUGH SYRUPS/OTHER MEDICATION S</p> <p>NONE OF THE ABOVE Y</p>	
233	<p>MALARIA</p> <p>CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO MALARIA TREATMENT PRESCRIBED OR PROVIDED TODAY.</p>	<p>INJECTABLE QUININE A</p> <p>INJECTABLE ARTEMETHER B</p> <p>INJECTABLE ARTESUNATE C</p> <p>OTHER INJECTABLE ANTIMALARIAL (E.G., FANSIDAR) D</p> <p>SUPPOSITORY ARTESUNATE E</p> <p>ARTEMISININ COMBINATION THERAPY (ACT) (COUNTRY-SPECIFIC BRAND) FIRST LINE TREATMENT) F</p> <p>ORAL FANSIDAR (SP) G</p> <p>ORAL CHLOROQUINE H</p> <p>ORAL AMODIAQUINE I</p> <p>ORAL QUININE J</p> <p>OTHER ORAL ANTIMALARIAL K</p> <p>NONE OF THE ABOVE Y</p>	
234	<p>DEHYDRATION</p> <p>CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO TREATMENT FOR DEHYDRATION PRESCRIBED OR PROVIDED TODAY.</p>	<p>HOME ORT (PLAN A) A</p> <p>INITIAL ORT IN FACILITY (4 HOURS - PLAN B) B</p> <p>INTRAVENOUS FLUIDS (PLAN C) .. C</p> <p>HOME ORT (PLAN A) WITH ZINC .. D</p> <p>NONE OF THE ABOVE Y</p>	
235 (FN2)	<p>MALNUTRITION (PER COUNTRY-SPECIFIC GUIDELINES)</p> <p>CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO TREATMENT FOR MALNUTRITION PRESCRIBED OR PROVIDED TODAY.</p>	<p>READY-TO-USE THERAPEUTIC FOOD (RUTF) A</p> <p>READY-TO-USE SUPPLEMENTARY FOOD (RUSF) B</p> <p>F-75 FEEDING FORMULA C</p> <p>F-100 FEEDING FORMULA D</p> <p>ANY OTHER TREATMENT _____ X (SPECIFY)</p> <p>NONE OF THE ABOVE Y</p>	

NO.	QUESTION / OBSERVATIONS	CODING CATEGORIES	GO TO								
236	<p>OTHER TREATMENT & ADVICE</p> <p>CIRCLE CODE "Y" FOR "NONE OF THE ABOVE" IF NO OTHER TREATMENT & ADVICE PRESCRIBED OR PROVIDED TODAY.</p>	<p>VITAMIN A (MAY ALSO BE FOR IMMUNIZATION) A</p> <p>FEEDING SOLID FOODS B</p> <p>FEEDING EXTRA LIQUIDS C</p> <p>CONTINUED BREASTFEEDING D</p> <p>ANY OTHER TREATMENT _____ X (SPECIFY)</p> <p>NONE OF THE ABOVE Y</p>									
237	RECORD THE TIME THE OBSERVATION ENDED	<p>HOURS <table border="1" data-bbox="1187 386 1305 443"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table></p> <p>MINUTES <table border="1" data-bbox="1187 443 1305 499"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table></p>									
THANK THE SERVICE PROVIDER AND THE CLIENT AND MOVE TO THE NEXT DATA COLLECTION											
<p>Interviewer's comments:</p>											

OBSERVATION OF SICK CHILD CONSULTATION: FOOTNOTES

(FN1) Adapt using the country-specific medicines for deworming medication

(FN2) Adapt using the country specific names of a therapeutic food or supplemental food used or formulated for the country that could be in a form of a multiple micronutrient powder, ready to use therapeutic foods, and ready to use supplemental foods. Make sure the food is used as a therapeutic food to treat malnutrition in children under age 5.