

Egypt



**Service Provision Assessment
Survey 2002**

Egypt

Service Provision Assessment Survey

2002

Ministry of Health and Population
Cairo, Egypt

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Cairo, Egypt

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

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Preface

The 2002 Egypt Service Provision Assessment Survey (ESPA) was designed to collect information on the provision of reproductive health and child health services in Egypt in order to complement the information obtained through the 2000 Egypt Demographic and Health Survey.

The ESPA collected information on the preparedness of health facilities in Egypt to provide high-quality care to clients seeking services for family planning, maternal health, child health, and sexually transmitted infections. A representative sample of 650 clinics of all types of facilities, in both government and non-governmental organization facilities, was assessed.

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

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

The Ministry of Health and Population will ensure that implementation of activities in the proposed areas of intervention is followed through.

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

Finally, I would like to take this opportunity to thank the U.S. Agency for International Development for its financial support for the 2002 ESPA.

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

Acknowledgments

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

The 2002 ESPA was accomplished through the collaborative efforts of many individuals and institutions. The Ministry of Health and Population (MOHP), under the leadership of Dr. Awad Tag El-Din, contributed to the success of the survey implementation. I would like to acknowledge the contributions of various technical committees at the MOHP, the staff of the Management Information System Unit of the MOHP/Family Planning sector, and of other professionals who individually and collectively gave comments and advice during the design and development of questionnaires as well as report writing.

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

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

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

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

Fatma El-Zanaty
Technical Director

Key Findings and Recommendations

The 2002 Egypt Service Provision Assessment (ESPA) was conducted in a representative sample of 650 health facilities throughout Egypt. The survey covered general, district, and integrated hospitals (referred to in the report as “general service hospitals”), fever hospitals, maternal and child health centers and urban health units (MCH/urban HUs), rural health units (rural HUs), mobile units, health offices, and nongovernmental organization (NGO) facilities. The ESPA used interviews with health service providers and clients, as well as observations of provider-client consultations, to obtain information on the capacity of facilities to provide quality services and the existence of functioning systems to support quality services. The areas addressed were the overall facility infrastructure and resources; specific child health, family planning, and maternal health services; and services for specific infectious illnesses—sexually transmitted infections (STIs) including HIV/AIDS, and tuberculosis. The objective was to assess the strengths and weaknesses of the infrastructure and systems supporting these services, as well as to assess the adherence to standards in the delivery of curative care for children, family planning, antenatal care (ANC), and consultations for STIs.

The ESPA was undertaken jointly by the Egyptian Ministry of Health and Population (MOHP) and El-Zanaty Associates, with technical assistance provided through ORC Macro under the MEASURE *DHS+* project. The U.S. Agency for International Development provided financial support for the survey.

Facility Infrastructure and Infection Control

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

Year-round, onsite water was available at 86 percent of facilities, with almost all (96 percent) indicating that their water was normally supplied through a piped system. Large facilities have multiple locations for providing client consultations and examinations, and small facilities often have only one location. Items for infection control were assessed for each service delivery area included in the ESPA. Although water was present in each service area in most facilities (62 percent), soap for hand-washing was rarely present in each assessed service delivery area in a facility (15 percent).

When assessing procedures used in the principal location in a facility where equipment to be reused is sterilized or high-level disinfected for reuse, 78 percent of facilities (96 percent of general service hospitals, but only 33 percent of fever hospitals) had functioning equipment for either high-level disinfection (HLD) or sterilization of reusable equipment. Only 45 percent (75 percent of general service hospitals) had the equipment, staff present who knew the correct processing time and temperature (when relevant), and equipment with an automatic timing device. Equipment may be processed in different locations within the same facility, depending on the size and organization of a facility. The area where equipment for specific services is processed was assessed (whether it was the main facility processing area or another location) for family planning, delivery, and STI services. The equipment and knowledge for processing family planning and delivery equipment were somewhat better, with 78 percent of family planning equipment processed in an area with functioning equipment and staff who knew the correct processing time and temperature. This was true for 77 percent of delivery service equipment. Sixty percent of delivery equipment was processed in areas with sterilization equipment and staff with knowledge of the processing time and temperature for sterilization. An additional 17 percent used HLD procedures. HLD does not kill the tetanus spore.

Service Availability

The MOHP does not expect all facilities to offer all basic health services. For example, district and general hospitals do not routinely offer child immunization services, but integrated hospitals do; mobile units rarely offer immunization, but they offer family planning, ANC, and curative care; and health offices primarily offer child immunization and family planning. Health offices are often located adjacent to hospitals, so services may be conveniently accessed, even if they are not in the same building or under the same manager. In total, 35 percent of facilities offer some level of each of the assessed basic child, maternal, and reproductive health services. As expected, MCH/urban HUs and rural HUs are more likely to offer the package of assessed services (39 percent and 51 percent, respectively). NGO facilities rarely offer child immunization or growth-monitoring services.

Essentially all facilities had at least one physician assigned.

Sixty-three percent of general service hospitals (69 percent of fever hospitals) and few other facilities had all items available that were assessed for supporting high-quality, 24-hour emergency services (overnight or inpatient beds; at least two secondary-level qualified staff; 24-hour onsite or on-call staffing, with a duty schedule present; access to 24-hour emergency communication; a client latrine; and an onsite water source). All elements, plus a year-round onsite water supply and a 24-hour regular supply of electricity (or a generator), were available at 53 percent of general service hospitals (66 percent of fever hospitals).

Facility Management

Fifty-one percent of facilities reported that they had management meetings at least every six months, with half reporting monthly or more frequent meetings. Only 13 percent, however, had any documentation of the meetings. General service hospitals (34 percent), fever hospitals (31 percent), and MCH/urban HUs (22 percent) were more likely to have documentation (such as minutes from meetings) available.

Fifteen percent of all facilities (21 percent of general service hospitals and 18 percent of rural HUs) had documentation of functioning quality assurance activities for any service area.

Structured in-service training on topics related to the services provided had not been consistently experienced by interviewed providers. At least half of the interviewed health service providers from a facility had received in-service training related to their work during the past 12 months in 28 percent of facilities, with 30 percent of all providers having received in-service training. An additional 43 percent had received related in-service training within the past five years. Providers of family planning and antenatal services were more likely than others to have received related in-service training during the past five years.

Supervision was particularly strong across all government facilities and services, but less so for NGO facilities. Ninety-six percent of facilities had experienced a supervisory visit from officials external to the facility (70 percent of NGO facilities) during the past six months.

At least half of the interviewed health service providers within a facility had been individually supervised during the past six months at 94 percent of the facilities. These were 90 percent of all interviewed health service providers. Supervision patterns were similar for providers of the various services assessed, with most reporting being personally supervised at least once per month.

Management of Vaccines, Contraceptives, and Medicine Supplies

Seventy-six percent of facilities that stored vaccines had all of the components for maintaining and monitoring the cold chain. The temperature was not within the accepted range (0° to 8°C) for 17 percent

of facilities. Health offices had the strongest systems (94 percent) and integrated hospitals the weakest (71 percent) for monitoring and maintaining the cold chain. NGO facilities had no systematic means for monitoring the cold chain.

Storage conditions for contraceptives were adequate at 86 percent of facilities, but storage conditions for medicines were adequate for only 68 percent of facilities. Medicine storage areas for 22 percent of facilities had evidence of rodents or pests, and 21 percent did not have the medicines off the ground and protected from water.

Among the selected medicines or contraceptives checked, expired items were rarely found (4 percent of facilities).

Up-to-date inventories (or daily registers that easily reconciled the stock with the inventory) were present in 69 percent of the facilities storing vaccines, 79 percent of facilities with contraceptive methods, and 72 percent of facilities with medicines.

Service-Specific Findings

Use of individual client cards, important for providing a record of findings and treatments and for continuity of care, varies by service and type of facility. An individual card or other means for supporting continuity of care for sick children was available in 40 percent of facilities offering sick child services. Individual records for family planning clients were more widely available (87 percent), with NGO facilities the least likely to have them (63 percent), although use during consultation (the provider referred to information on the card or wrote on the card) was observed for less than half of the clients. Individual records for ANC were widely available in MCH/urban HUs and rural HUs (83 percent and 81 percent, respectively) but were available in less than half of the general service hospitals and in less than one in four NGO facilities. Use of ANC client cards during observations was similar to the findings for availability of the cards. Client cards were used for only one in three observations for clients assessed for STIs.

Most services are provided under conditions where the clients have visual and auditory privacy. This was available in 78 percent of the STI client counseling areas (and 82 percent of the client examination areas) and 76 percent of family planning client counseling areas (and 81 percent of the client examination areas). These are two services where privacy is critical to ensure client confidentiality and to encourage sharing of necessary information.

Any guidelines or protocols that can be used as references by providers for the delivery of specific services—and/or management of health issues related to that service—are not available in the service delivery area for most facilities and for most services assessed. Family planning services were the most likely to have service guidelines or protocols (46 percent), followed by sick child services (24 percent). Only 12 percent of facilities had protocols or guidelines for ANC in the service area, 9 percent had protocols for delivery, and 19 percent had guidelines or protocols for STI diagnosis and treatment in the service area.

Visual aids for client education were available in most family planning service areas (93 percent) and in many STI service areas (41 percent), but they were available in only one of four sick child or ANC service areas. Overall, visual aids were rarely used (3 percent of observed sick child consultations, 9 percent of observed family planning consultations, 2 percent of ANC clients, and less than 1 percent of STI clients).

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

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

Child Health Services

All basic child health services (curative care, growth monitoring, and immunization) are available at 81 percent of rural HUs and 65 percent of MCH/urban HUs. Although 88 percent of facilities provide consultation services for sick children, fewer provide preventive services such as growth monitoring (60 percent) and immunization (71 percent). Immunization and growth monitoring are most often offered one or two days per week, whereas sick child services are offered at least five days per week in 92 percent of facilities offering any child health services.

Sixty-five percent of facilities that stored child vaccines had all basic vaccines (BCG, polio, DPT, and measles) and 61 percent had all basic vaccines as well as hepatitis and measles, mumps, and rubella (MMR) vaccines. All types of vaccines were missing in equal proportion, with each type of vaccine missing in at least 10 percent of facilities.

Disposable syringes are universally used for immunization.

Although immunization services are not integrated to allow sick children who are not fully immunized to be immunized at the time they are seeking curative care, it is important to note that the national immunization coverage is very high (92 percent), so this may not be a program priority.

Seventy-two percent of facilities offering immunization had records showing they monitor community coverage levels. This was true for 91 percent of health offices and 37 percent of MCH/urban HUs.

The MOHP standards specify that most seriously ill children (specifically including those requiring intravenous rehydration) be referred to hospitals. This necessitates that seriously ill children be referred (and the caretaker follow up on the referral) for quality care. Only slightly more than half of general service hospitals and fever hospitals had medicines for all prereferral treatments in accordance with guidelines recommended by the Integrated Management of Childhood Illness (IMCI) programs.

Assessments of sick children rarely adhere to IMCI guidelines, with a notable lack of a thorough history and physical examination. In spite of this, the assessment, reported diagnosis, and prescribed treatments for observed sick children indicated that providers reasonably fit their evaluations to the illness and their perception of its severity.

Provision of essential information to the caretaker about continuing to provide (or providing more) food and fluid to sick children was noted during fewer than one in five observed consultations. Information on symptoms for which the child should immediately be brought to a facility was provided during 10 percent of observed consultations for sick children.

While 42 percent of the observed ill children were weighed, only 20 percent were weighed and the weight plotted against a standard. Assessment of immunization status was not a common component of the evaluation.

Forty-nine percent of children diagnosed with a nonsevere respiratory illness (primarily cough or cold) received or were prescribed antibiotics, and 58 percent of all observed children received an antibiotic. The appropriateness of current use of antibiotics should be assessed and standards for use developed. The proportion of injectable antibiotics compared with oral antibiotics did not appear excessively high (11 percent of injectables).

Family Planning Services

The intrauterine device (IUD), injectable progesterone, combined oral pill, and male condoms are the four most commonly offered contraceptive methods (all four offered at 84 percent of facilities that offer modern temporary methods of family planning). Almost all (90 percent) of the facilities offering these methods had all four methods available on the day of the survey.

Among the visual aids available, 87 percent of facilities had trays with samples of methods, 79 percent had teaching aids about specific types of family planning, and 84 percent had information pamphlets for clients to take home. Visual aids related to STIs were available in the family planning service area in 17 percent of the facilities, and information pamphlets on STIs that clients can take home were available in 32 percent of facilities.

All items for infection control were available in the client examination area in 20 percent of facilities. All items were most commonly found in MCH/urban HUs (31 percent) and least commonly found in mobile units (9 percent). Latex examination gloves and hand-washing soap are the items most commonly lacking (in half of all family planning service areas).

Diagnosis of and treatment for sexually transmitted infections are provided by family planning service providers in 82 percent of facilities offering family planning. All infrastructure and equipment assessed for conducting a pelvic examination under quality conditions were available in 71 percent of facilities, with an examination light being the item most often lacking.

Among facilities offering a method with estrogen, 11 percent (primarily rural HUs) had no blood pressure apparatus.

Although 87 percent of facilities had individual client cards available for family planning clients, cards were reviewed by the provider either prior to or during the family planning consultation for only 46 percent of observed family planning clients. Providers wrote information on the cards either during or after the consultations for 65 percent of observed family planning clients.

A followup visit was mentioned for 74 percent of observed family planning consultations.

Thirty-seven percent of first-visit consultation clients were assessed for symptoms of STIs, and 40 percent were asked about chronic illness.

Among all first-visit clients, 66 percent had their blood pressure measured. Among clients receiving a method including estrogen, 71 percent had their blood pressure measured.

Breast examinations were conducted on 4 percent of the observed family planning clients, although 13 percent indicated that they had been taught self breast examination either during this visit or a previous visit.

Fourteen percent of women who received either contraceptive pills or injections were observed being given information on how to use the method, side effects, and what to do for problems, as well as information on a followup visit. Among these same women, the proportion was higher when they were asked if they had received these four items of information (43 percent). The women may have been reporting on knowledge or information received previously, rather than information from this specific visit.

Maternal Health Services

ANC is offered by 88 percent of eligible facilities, with about half (57 percent) offering the service five days per week.

Tetanus toxoid (TT) immunization services are not always available at the same time as ANC. Although 56 percent of facilities indicated they offer TT immunization whenever ANC is offered, on the day of the survey, 71 percent of facilities were offering ANC, but only 33 percent were offering both ANC and TT immunization.

All equipment and medicines for basic ANC assessment (blood pressure apparatus, fetoscope, iron tablets, folic acid tablets, and TT vaccine) were all available at only 22 percent of facilities. Folic acid, TT vaccine, and a fetoscope were each missing from about half of the facilities.

Medicines for management of common complications of ANC or for postpartum infections were not routinely available. Methyldopa (for hypertension) was available in only 10 percent of general service hospitals.

Diagnosis of and treatment for sexually transmitted infections are provided by ANC service providers in 87 percent of facilities offering ANC. Testing for syphilis or for HIV/AIDS is not a routine component of ANC in Egypt. Population rates for these illnesses are low.

Twenty-five percent of facilities had a functioning ultrasound machine with a trained health service provider to use it. Blood typing and testing for Rh factor capacity were described as routine components of ANC in 44 percent of facilities, and 25 percent had the capacity to provide these services; however, only 22 percent had the capacity on the day of the survey and said that testing the blood was a routine component for ANC. Testing urine for glucose and testing urine for protein were described as routine components of ANC in 83 percent and 82 percent of facilities, respectively, with the capacity to conduct the tests available in 45 percent and 69 percent of facilities, respectively, on the day of the survey. Glucose testing and protein testing were both routine for ANC and available in 41 percent and 64 percent of facilities, respectively.

Among first-visit ANC clients whose consultation was observed, only 29 percent were asked about any medicines they were taking. Forty-two percent were given or prescribed TT immunization, 60 percent had their urine tested (or a test was prescribed), and 47 percent were given (or prescribed) iron tablets.

Among all observed clients, the assessment of current health status was not routinely complete. Seven percent were asked about vaginal bleeding, and 3 percent were counseled on vaginal bleeding being a risk sign: Forty-six percent of women at least five months pregnant were asked about fetal movement, and 75 percent of women at least eight months pregnant had the fetal position assessed (either through palpation or ultrasound); 92 percent had their blood pressure measured.

About one in four first-visit and followup-visit ANC clients received education about nutritional needs during pregnancy. Less than 10 percent of observed first-visit or followup-visit clients were advised on specific risk symptoms for which they should seek help. During the exit interview, one in five of the interviewed clients reported that they had been told about risk factors either during this or a prior visit. Advice on exclusive breastfeeding is not commonly provided. It was observed being provided during 1 percent of ANC consultations and reported by 10 percent of interviewed clients to have been discussed during this or a prior visit.

Partographs are not commonly used (available in 6 percent of facilities offering delivery services). All assessed basic supplies (a cord-cutting item, cord clamp, any suction apparatus, antibiotic eye ointment

for newborn, and skin disinfectant for perineum) were all only available in 21 percent of facilities (44 percent of MCH/urban HUs and 31 percent of general service hospitals).

Although, in Egypt, management of complications during pregnancy or labor and delivery is not routinely expected to be provided below the hospital level, facility-supported emergency transportation for referrals is available at only 13 percent of facilities, and caesarean sections are offered at only about half of the general service hospitals.

Emergency medicines for severe preeclampsia or eclampsia, as well as injectable antibiotics for sepsis, were available in only half of the general service hospitals providing delivery services, with four in ten having both. Equipment to support insufficient labor (forceps or vacuum extractor) is available in only half of the general service hospitals, and blood transfusion services are available in 60 percent.

Sexually Transmitted Infections and HIV/AIDS

STI services are offered at 62 percent of facilities; however, services are available through family planning and ANC services even when facilities do not offer STI services as a walk-in service. STI services are provided by ANC and family planning providers in about two of three facilities that reported they provide no routine services for STIs.

Medicines for treating gonorrhea are available at less than one in five facilities offering STI services. Medicines to treat other STIs were more widely available, with 63 percent having metronidazole for trichomoniasis and about half having a medicine for chlamydia and for syphilis. Almost all facilities (87 percent) had condoms available, with 58 percent having condoms in the STI service delivery area.

All assessed infrastructure for high-quality pelvic examinations was available in 74 percent of the service areas where STI clients are normally examined. All items for infection control were available in only 23 percent of these areas, with hand-washing soap the item most often missing (about half of the examination areas). Capacity to provide laboratory confirmation of specific STIs is lacking, with 16 percent of general service hospitals having testing capacity for syphilis and 9 percent (29 percent of fever hospitals) having testing capacity for gonorrhea. Microscopic examination using wet-mount testing was available in 30 percent of general service hospitals and 35 percent of fever hospitals.

HIV/AIDS diagnostic and care and support services are newly developed. Voluntary counseling and testing (VCT) and anti-retroviral treatment (ART) services are not yet available. HIV-testing capacity exists in 23 percent of general service hospitals and fever hospitals that offer STI services.

Abbreviations

AFB	Acid-fast bacillus
AIDS	Acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Anti-retroviral treatment
BEOC	Basic essential obstetric care
BCG	Bacille de Calmette et Guérin
CDC	Centers for Disease Control and Prevention
CEOC	Comprehensive essential obstetric care
CAOA	Central Agency for Organization and Administration
CCO	Curative Care Organization
CDD	Control of Diarrheal Diseases
CSI	Clinical Service Improvement
D&C	Dilatation and curettage
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DPT	Diphtheria, pertussis, and tetanus
DR	Delivery room
EDHS	Egypt Demographic Health Survey
EFPA	Egyptian Family Planning Association
EmOC	Emergency obstetric care
EPI	Expanded Program on Immunization
ESPA	Egypt Service Provision Assessment
FHT	Fetal heart tone
FP	Family planning
GM	Growth monitoring
GS	General service
HIO	Health Insurance Organization
HIV	Human immunodeficiency virus
HLD	High-level disinfection
HM/HC	Healthy Mother/Healthy Child
HSRP	Health Sector Reform Project
HU	Health unit
IEC	Information, Education, Communication
INH	Isonicotinic acid hydrazide (isoniazid)
IMCI	Integrated Management of Childhood Illness
IUD	Intrauterine device
KOH	Potassium hydroxide
MCH	Maternal and child health
MMWR	Morbidity and Mortality Weekly Report
MNH	Maternal and Neonatal Health Project
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
MOSA	Ministry of Social Affairs
NACP	National AIDS Control Program
NAMRU	Naval Medical Research Unit

NEDSS	National Electronic Diseases Surveillance System (NEDSS)
NGO	Nongovernmental organization
NMMS	National Maternal Mortality Study
NPC	National Population Council
OPD	Outpatient department
OPV	Oral polio vaccine
ORC	Opinion Research Corporation
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
OVC	Orphans and vulnerable children
PHIF	Public and Health Insurance Fund
PIO	Pensioners Insurance Organization
PLHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PVO	Private voluntary organization
QA	Quality assurance
QIP	Quality Improvement Program
RPR	Reactive protein reagent test
RTI	Reproductive tract infection
SC	Curative care for sick children
SHIP	Student Health Insurance Plan
SIO	Social Insurance Organization
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
THO	Teaching Hospital and Institutes Organization
TPHA	Treponema pallidum hemagglutination assay
TST	Time-steam-temperature-sensitive (tape)
TT	Tetanus toxoid
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VDRL	Venereal disease research laboratory
WHO	World Health Organization

1.1 Overview

The Egypt Service Provision Assessment (ESPA) is a survey 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 (sexually transmitted infections (STIs), HIV/AIDS, and tuberculosis). Through a representative sample of nongovernmental and public facilities, information was collected to provide a picture of the strengths and weaknesses of the service delivery environment for each assessed service. The information that the ESPA elicited on health services and health service providers may help policymakers and program administrators develop effective strategies for improving the utilization and coverage of services and for prioritizing resources in ways that will ensure better health outcomes.

The ESPA provides regional- and national-level representative information for both government and specific nongovernment facilities. Findings can supplement household-based health information from the Egypt Demographic and Health Survey (EDHS) conducted in 2000, which provides information on the health status and utilization of services by the overall population.

1.2 Institutional Framework and Objectives of the ESPA

The ESPA was undertaken jointly by the Ministry of Health and Population (MOHP) and El-Zanaty Associates, with technical assistance from ORC Macro under the MEASURE *DHS+* Project. The study was funded by the U.S. Agency for International Development (USAID).

The primary objectives of ESPA are the following:

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

1.3 ESPA Content and Methods for Data Collection

1.3.1 Content of the ESPA

The ESPA focused on basic-level health services that have been developed to achieve improvements in people's health status, particularly that of women and children. Four high-priority health services, all interrelated to various degrees, were assessed: 1) child health, 2) family planning, 3) maternal health, and 4) specific infectious diseases (STIs, HIV/AIDS, and tuberculosis).

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

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

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

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

The infectious disease component for sexually transmitted infections assessed the availability of services for diagnosing and treating STIs, with a focus on the process used in assessing and counseling the STI client. Although HIV/AIDS services are newly introduced into Egypt, the ESPA included them to provide baseline information. The infectious diseases module also addressed the general availability of tuberculosis diagnostic and treatment programs.

1.3.2 Methods for Data Collection

Four types of data collection tools were used.

The first was a *Facility Resources Questionnaire* of resources and support services, which was designed to obtain information on the facility's preparedness to provide each of the priority services. The questionnaire was used to collect information on the availability of specific items (such as their location and functional status), components of support systems (such as logistics, maintenance, and management), and facility infrastructure, including the environment in which the services are delivered. The resources assessed were those necessary to provide a level of service that meets generally accepted standards. The support services are those that are commonly acknowledged as essential management tools for maintaining health services.

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

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

The fourth was an *Exit Interview* with the client who was observed receiving a service. The exit interview assessed the client's understanding of the consultation or examination, as well as his or her recollection of the instructions that he or she received about treatment or preventive behavior. The ability to recall key messages increases the likelihood that clients will be able to successfully follow treatment or perform the preventive behaviors that optimize health outcomes. The client's perception of the service delivery environment was also elicited.

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

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

For each of the high-priority services, the Facility Resources Questionnaire and provider interviews gathered information on whether the 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 items that are assessed for quality of services include training and supervision of staff; availability of service delivery protocols and of materials for client education; availability and utilization of health information records; the service delivery environment; and facility systems for maintaining equipment, supplies, infection control, and quality assurance.

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

The ESPA assesses whether the process followed in service delivery meets the standards for acceptable content and quality. This assessment was made by observing consultations between clients and providers. The core services that were observed are consultations for sick children, for STIs, for family planning, and for antenatal care services. The observation focused on the information shared between the client and provider and the process the provider followed when assessing the client, conducting procedures, and providing treatments.

With the exit interview, the ESPA also collected information to obtain the client's perspective on information shared and received. This information provides further data on the quality of the client-provider interaction.

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

The Facility Resources Questionnaire collected information on whether there are specific support services for a health system, as well as evidence that they are functioning. The systems that were assessed were those related to general management, quality assurance, logistics for medicines, equipment maintenance, infection control, and various systems for monitoring activities (such as following service coverage rates and referrals).

The ESPA also collected data on the basic infrastructure of each facility, which may contribute to a better standard of services or increase clients' utilization. Data items obtained to assess this component included the presence of electricity and water, as well as the availability of amenities and service (types and days of services and staffing levels).

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

Client and provider interviews were used to collect information on issues related to clients' and providers' satisfaction.

1.4 Sample

A representative sample of facilities; a sample of health service providers at each facility; a sample of sick child, family planning, antenatal, and STI clients; and a sample of children receiving injections were selected.

1.4.1 Sample of Facilities

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

Among public sector facilities, the sample covered hospitals, maternal and child health and urban health units (MCH/urban HUs), rural health units (rural HUs), mobile units, and health offices. General/district and integrated hospitals were selected to represent general service hospitals. In addition, fever hospitals were also sampled. Although they do not provide the range of services covered by the ESPA, fever hospitals provide health services for sick children and some services for infectious diseases that were of interest to the ESPA and policymakers. Health sector reform facilities, primarily rural HUs, were specifically oversampled (all facilities where reform activities have been introduced were included) to provide data for the program. NGO facilities included facilities operated by the Egyptian Family Planning Association (EFPA), Clinical Service Improvement (CSI) facilities, and other (often religious affiliated) NGO facilities.

The total sample size was determined on the basis of funding and logistic considerations, as well as the minimum sample size required to allow the levels of analysis desired. Using a list of facilities supplied by the MOHP, all facilities of interest were listed by facility type and region—stratifying by governorate—and then systematically selected. The assigned number of facilities to be selected for each region was determined to ensure adequate regional representation of facilities. The sampling universe thus established contained 650 health facilities. During data collection, four facilities were discovered to be of different classifications from that indicated on the sample frame. During data analysis, two facilities originally classified as health offices were reclassified to urban HUs, and two facilities originally classified as rural HUs were reclassified as integrated hospitals.

As described above, to ensure that the sample included an appropriate number of facilities to permit analysis according to the type of facility and region, certain types of facilities were oversampled. As a result, the distribution of the sample of health facilities selected for the ESPA was not directly proportional to the distribution of the total universe of facilities by type and region. Data were weighted during analysis to account for the differentials caused by oversampling. Table 1.1 provides information

on the weighted percent distribution of facilities included in the sample, as well as the weighted and unweighted number of facilities. Table 1.2 provides this information for the facilities offering each assessed service.

Table 1.1 Distribution of facilities by type of facility and region			
Percent distribution of facilities (weighted) and weighted and unweighted number of facilities, by type of facility and region, Egypt SPA 2002			
Background characteristics	Percent distribution of facilities (weighted)	Number of facilities	
		Weighted	Unweighted
Type of facility			
GS hospital	10	64	107
Fever hospital	2	13	33
MCH/urban health unit	10	65	105
Rural health unit	57	367	191
Mobile unit	6	38	56
Health office	5	32	52
NGO facility	11	71	106
Region			
Urban Governorates	10	65	105
Lower Egypt	48	315	296
Upper Egypt	42	270	249
Total	100	650	650

Table 1.2 Percentage of facilities providing specific services			
Percentage of facilities providing specific services (weighted) and weighted and unweighted number of facilities providing services, by service provided, Egypt SPA 2002			
Service provided	Percentage of facilities providing services (weighted)	Number of facilities providing services	
		Weighted	Unweighted
Immunization	71	465	365
Consultation for sick children	88	570	528
Family planning	96	624	596
Antenatal care	86	559	497
Delivery	34	221	216
Services for sexually transmitted infections ¹	62	405	404
Services for HIV/AIDS ¹	3	22	28
Total	100	650	650

¹ The facility indicated that it offered at least one service related to STIs or HIV/AIDS. This may include only laboratory examinations, only preventive measures, or client care.

Appendix Table A-1.1 provides additional details on the distribution of the sample by type of facility and geographic location. Appendix Table A-1.2 provides additional details on the weighted and unweighted numbers of facilities in the sample, by type of facility before grouping for analysis.

1.4.2 Sample of Health Service Providers

The sample of health service providers was selected from providers who were present in the facility on the day of the survey and who provided services that were assessed by the ESPA. In facilities with fewer than eight health providers, all of the providers present on the day of the visit to the unit were interviewed. In those facilities where there were more than eight providers, all providers whose work was

observed were interviewed, and a random selection of the providers not included in the observation component were interviewed to compile a minimum of eight provider interviews. The selection was carried out to ensure that, if available, at least one provider from each service was interviewed, even if no observations were conducted for that service. A maximum of three providers for any given service were interviewed. A provider was defined as a physician or a nurse who actually provided client services of some type (counseling, health education, or consultation services). Thus, for example, a nurse who only completed registers and who never provided any type of professional client services was not included in a group identified as eligible for the ESPA interviewer. In total, 66 percent of the eligible doctors, half of eligible nurses, and half of other or auxiliary staff were interviewed.

To ensure that the relevant providers were interviewed in each facility, providers were selected without consideration of their representativeness of the qualification and number of staff who were assigned to the facility. Thus, the results of the ESPA provider interviewers are potentially biased because the staff who were present the day of the survey may not be representative of the staff who normally provide the services of interest in the facility. Therefore, data were weighted during analysis to account for the differentials caused by oversampling or undersampling of a particular qualification of provider in a facility type and region.

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

Table 1.3 Distribution of interviewed providers			
Percent distribution of interviewed providers (weighted) and weighted and unweighted number of interviewed providers, by type of facility, region, and qualification of provider, Egypt SPA 2002			
Background characteristic	Percent distribution of interviewed providers (weighted)	Number of interviewed providers	
		Weighted	Unweighted
Type of facility			
GS hospital	21	585	655
Fever hospital	2	47	110
MCH/Urban health unit	16	427	608
Rural health unit	49	1,344	762
Mobile unit	2	62	129
Health office	5	140	224
NGO facility	5	132	248
Region			
Urban Governorates	9	233	467
Lower Egypt	54	1,481	1,236
Upper Egypt	37	1,022	1,033
Qualification of provider			
Doctor, specialist	14	375	634
Doctor, generalist	15	423	532
Nurse with midwifery	3	72	89
Nurse	58	1,600	1,261
Midwife	1	30	23
Nurse assistant	4	107	121
Raida Refia	1	25	37
Other	4	104	39
Total	100	2,736	2,736

1.4.3 Sample for Observations

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

In addition to the above, observers were instructed to complete an observation checklist for five injections¹ (either therapeutic or vaccine) in all facilities where curative care for children was being provided. They were to attempt to observe therapeutic injections for children, but if clients receiving injections were not readily available, injections for vaccinations as well as injections for adults were accepted.

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

At the end of the day, data collectors collected data on the total number of eligible clients who attended the facility that day. This allows calculation of the proportion of all consultations during the day that they were observed. In total, among all eligible clients who received services the day of the survey, 37 percent of the sick children were observed, 62 percent of the family planning clients were observed, 50 percent of the ANC clients were observed, and 82 percent of the STI clients were observed (Appendix Table A-1.4). Information on injections that were observed was not collected. Details on characteristics of the observed clients are presented in the relevant chapters.

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

Table 1.4 provides information on the weighted proportion of the observations of service consultations for each service, as a percentage of the total number of observations by facility type, the weighted number of observations utilized during analysis, and the actual number of observations. Table 1.5 shows similar information for injections.

Descriptive information on facilities included in the ESPA is presented in Appendix Tables A-1.5 through A-1.7. The data include the size of catchment populations (Appendix Table A-1.5), median numbers of staff assigned to facilities by provider and facility type (Appendix Table A-1.6), and the median number of years of basic and technical training received by interviewed providers by type of provider (Appendix Table A-1.7).

¹ Injections for contraceptive purposes were assessed with the family planning services.

Table 1.4 Distribution of observed consultations			
Percent distribution of observed consultations (weighted) and weighted and unweighted number of observed consultations for curative care for sick children, family planning, antenatal care, and sexually transmitted infections, by type of facility, Egypt SPA 2002			
Background characteristics	Percent distribution of observed consultations (weighted)	Number of observed consultations	
		Weighted	Unweighted
Outpatient care for sick children			
GS hospital	18	365	595
Fever hospital ¹	4	71	177
MCH/urban health unit	15	307	489
Rural health unit	58	1,173	606
Mobile unit	1	18	27
Health office	1	12	20
NGO facility	3	66	99
Total	100	2,012	2,013
Family planning			
GS hospital	19	314	428
Fever hospital ¹	NA	NA	NA
MCH/urban health unit	19	323	432
Rural health unit	36	608	269
Mobile unit	11	188	231
Health office	5	85	118
NGO facility	10	169	210
Total	100	1,688	1,688
Antenatal care			
GS hospital	14	136	223
Fever hospital	NA	NA	NA
MCH/urban health unit	20	191	300
Rural health unit	53	517	260
Mobile unit	5	47	67
Health office	0	3	5
NGO facility	8	83	122
Total	100	977	977
Sexually transmitted infections			
GS hospital	20	90	115
Fever hospital	0	0	0
MCH/urban health unit	19	85	106
Rural health unit	27	120	51
Mobile unit	13	56	63
Health office	3	15	19
NGO facility	18	78	90
Total	100	444	444
NA = Not applicable			
¹ Fever hospitals do not provide family planning or ANC services and, while providing STI services, no clients were identified the day of the survey.			

Table 1.5 Distribution of observed therapeutic (or vaccine) injections			
Percent distribution of observed injections (weighted), and weighted and unweighted number of observed injections, by type of facility, Egypt SPA 2002			
Type of facility	Percent distribution of observed injections (weighted)	Number of observed injections	
		Weighted	Unweighted
GS hospital	13	115	194
Fever hospital	1	6	16
MCH/urban health unit	16	138	228
Rural health unit	59	511	270
Mobile unit	1	5	7
Health office	8	66	111
NGO facility	3	26	41
Total	100	867	867

1.5 Study Implementation

1.5.1 Data Collection Instruments

Data were collected using structured printed instruments. These instruments were based on generic questionnaires developed in the MEASURE *DHS+* project and were adapted after consulting with technical specialists from the MOHP, USAID, and NGOs knowledgeable about the health services and service program priorities covered by the ESPA.

Operational definitions were developed for the health system components that were measured. These were revised for the ESPA after discussions in Egypt and after the pretest. A training manual was developed and distributed to all data collectors to support standardized data collection.

Researchers from El-Zanaty Associates and the physician technical advisors recruited for the project trained nine physicians to pretest the survey instruments. The instruments were pretested in eight facilities.

1.5.2 Training and Supervision of Data Collectors

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

1.5.3 Methods for Data Collection

A total of 16 teams of three people each participated in the data collection. Each team was composed of at least two females and at least two physicians.

Each team received a list of facilities to be visited. Data collection took one day in most facilities, with two days being allotted to hospitals, if required. In addition, if one of the observed services was not being offered the day of the survey, the teams returned on a day when the service was offered. If the service was offered, the clients for that day were observed. If the service was offered but no clients came (as occurred occasionally for consultations of sick children and, more often, STI clients), teams did not revisit the facility.

The team leader was instructed to ensure that the informant for each component of the facility survey was the most knowledgeable person for the particular health service or system component being addressed. Where relevant, the data collector indicated whether a specific item being assessed was observed, 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 required to be in the relevant service delivery area or in an immediately adjacent room to be accepted as available. Informed consent was taken from the facility director and all respondents for the Facility Resources Questionnaire, from observed and interviewed providers, and from clients for observations and exit interviews.

Data collection teams were supervised throughout the field activities, and reinterviews were implemented for selected sections of the questionnaires for quality control.

1.5.4 Process for Data Management and Report Writing

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

- Management of questionnaires. Completed and verified questionnaires were collected by supervisors and sent to the El-Zanaty Associates office for editing. Two physician supervisors reviewed all “other” responses and recoded responses into categories relevant for data analysis.
- Data entry. Data entry was conducted by El-Zanaty Associates staff. CSPro software developed by ORC Macro and the U.S. Census Bureau was used for data entry. Double entry of all questionnaires was carried out to catch errors. This operation took place from September through November 2002.
- Data analysis. The design of the tabulation plan and the preparation of the programs for the production of statistical tables were carried out from October through December 2002. Data analysis and clarification of questionable results were carried out during January through March 2003. During the data analysis, revisions were made to the analysis plan on the basis of feedback from the MOHP and the ESPA technical advisors to ensure that the analysis is appropriate for the Egyptian health system.
- Development of final report. The final report was written with input from ORC Macro technical staff, El-Zanaty Associates, and MOHP officials responsible for the programs included in the survey.

After the draft report was finalized, a workshop was held with the technical staff of the MOHP to present findings and make any corrections, changes, or additional explanations that were required before final publication. This took place during June 2003.

1.5.5 Data Analysis

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

- Assessing the availability of items. Unless specifically indicated, the ESPA considered observed items as available.
- Observations. In looking at the observation data, it should be noted that many facilities provide routine services for clients separately from the actual consultation (taking blood pressures and temperatures). There is often a period between these events and the point at which the primary provider assesses the client. Although ESPA observers were instructed to

follow a client through the entire system, this was not always possible logistically. Thus, when services were being provided outside the observed consultation on the day of the survey, the observed client was assumed to have received these services. Where this type of system applies, multiple providers contribute the services received by each client. The provider who ultimately diagnosed and prescribed was defined as the primary provider.

- Observation data were collected on the basis of whether a practice occurred or a piece of information was shared (process). No attempt was made to verify whether the practice was correct or if the information shared was correct or complete.
- Provider information. Not infrequently, providers indicated that they “personally provided” a service that the facility did not offer. It may be that providers indicated services they provided outside the facility. For the ESPA, only providers from facilities that offered the service in question were included in the analysis.
- Development of aggregate variables. Aggregating the data into subsets makes it possible to analyze many pieces of information and to see how they relate to the overall capacity to provide services. It also enables monitoring changes in capacity to provide services and changes in adherence to standards, since there may be improvements in some items but not in others. There are not yet generally accepted aggregates of the health information collected in the ESPA. The aggregate variables presented in this report, however, are an initial phase in the process of defining useful health information aggregates. They will be refined as users provide feedback on the aggregate variables found useful (or not useful) to policymakers and program implementers.

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

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

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

Information is presented with respect to

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

2.1 General Organization of the Health System

Egypt has a highly pluralistic health care system, with many different public and private providers and financing agents. Health services in Egypt are currently managed, financed, and provided by agencies in all three sectors of the economy—government, parastatal, and private.

The government sector represents activities of ministries that receive funding from the Ministry of Finance (MOF). As in many lower- and middle-income countries, the government health services in Egypt are organized as an integrated delivery system in which the financing and provider functions are included under the same organizational structure. This means that government providers receiving budgetary support from the government general revenues (MOF) are also subject to the administrative rules and regulations that govern all civil service organizations. For example, staff are subject to the Civil Service Employment Law, and remuneration is based on the civil service salary scale determined by the Central Agency for Organization and Administration (CAOA).

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

The parastatal sector is composed of quasi-governmental organizations in which government ministries have a controlling share of decisionmaking, including the Health Insurance Organization (HIO), the Curative Care Organization (CCO), and the Teaching Hospitals and Institutes Organization (THO). Although the distinction between the government sector and the parastatal or quasi-governmental sector is usually made when describing the Egyptian health sector, both sectors are run by the state. From an operational and a financial perspective, the parastatal sector is governed by its own set of rules and regulations, has separate budgets, and exercises more autonomy in daily operations. However, from a

political perspective, the Ministry of Health and Population (MOHP) has a controlling share of decision-making in parastatal organizations.

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

2.2 Organization of the Ministry of Health and Population

The organizational structure of the MOHP consists of two functional structures: the administrative structure and the service delivery structure.

2.2.1 Administrative Structure

The administrative organization of the MOHP comprises the central headquarters and the governorate-level health directorates. The main functions of the central headquarters include planning, supervision, and program management. The population portfolio, which was previously an independent Ministry, was merged into the Ministry of Health in 1995.

All functions of the central headquarters are divided into five broad sector divisions: 1) central administration for the minister's office, 2) curative health services, 3) population and family planning, 4) basic and preventive health services, and 5) administration and finance.

There are 13 headquarter undersecretaries in charge of various functions reporting to the minister. The responsibilities of these undersecretaries include preventive care, laboratories, primary health care, endemic diseases, curative care, research and development, pharmaceuticals, dentistry, family planning, and nursing. On average, about 30 to 35 functional areas and specialized units, headed by the general directors and directors, are grouped under each sector area headed by an undersecretary.

The sector-level model is replicated at each governorate level. The governorate-level health directorates report to the MOHP on technical matters, but they report to the governorate administration headed by the governor on administrative and day-to-day activities. Each governorate health directorate is headed by an undersecretary or a general director who reports to the minister, who in turn supervises the health district directors.

Reporting to the governorate health directorates are 230 health districts. Each district has a director, who is sometimes the district hospital director.

2.2.2 Service Delivery Structure

The MOHP is currently the major provider of primary, preventive, and curative care in Egypt, with around 5,000 health facilities and more than 80,000 beds spread nationwide. There are no formal referral systems in the MOHP delivery system. The MOHP service delivery units are organized along a number of different dimensions. These include geographic (rural and urban), structural (health units, health centers, and hospitals), functional (maternal child health centers), or programmatic (immunization, and diarrhoeal disease control).

Specifically, with respect to inpatient services, the MOHP is the largest institutional provider of inpatient health care services in Egypt. It has about 1,048 inpatient facilities, accounting for more than 80,000 beds. Hospital services are provided through the following types of facilities.

Integrated hospitals are small, 20- to 60-bed hospitals providing primary health care and specialized medical services in the rural areas. Integrated hospitals contain well-equipped surgical theatres, X-ray equipment, and laboratories and are responsible for serving a catchment population of between 10,000 and 25,000 people.

District hospitals are 100- to 200-bed hospitals that provide more specialized medical services and are available in every district. District hospitals are responsible for serving a catchment population of between 50,000 to 100,000 people in the urban district area.

General hospitals contain more than 200 beds and contain all medical specialties. General hospitals are available in every capital of a governorate.

Integrated, district, and general hospitals were included in the ESPA and were categorized as general service hospitals for this report.

Specialty hospitals are located in urban areas and include specialties such as eye, psychiatric, chest (34), fever (88), heart ophthalmology (31), tumors, and gynecology and obstetrics. Specialty hospitals are available in all governorates. Fever hospitals were the only type of specialty hospital included in the ESPA.

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

2.3 MOHP Public Health Programs

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

2.3.1 Population, Reproductive Health, and Family Planning Program

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

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

2.3.2 Control of Diarrhoeal Diseases and Acute Respiratory Infections Programs

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

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

The CDD program has been effective in reducing infant mortality caused by diarrhoeal diseases; they are now in second place as a cause of infant deaths.

2.3.3 Expanded Program on Immunization

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

2.3.4 Maternal Health

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

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

At the national level, the MCH directorate has defined a package of MCH services, which includes basic and comprehensive essential obstetric care for normal delivery and management of obstetric complications. Clinical protocols and service standards for essential obstetric care (EOC) and competency-based training curricula and materials have been developed and officially approved for national use. Quality of care has also been addressed through a series of administrative decrees covering issues such as the presence of senior obstetricians during deliveries, midwife training and licensing, improvement in blood services, and use of facility-generated revenues for local service improvement. More than 170 maternity centers have been upgraded in the underserved urban and rural areas to provide safe and clean normal delivery services and to be able to refer pregnant women with complications. Seventy-five rural and postnatal care (PNC) units have also been upgraded to offer normal delivery care and to improve linkages with referral centers.

2.4 Health Sector Reform Strategy

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

Major components of the strategy include

- Expanding the social health insurance coverage from 47 percent (in 2003) of the population to universal coverage based on the “family” as the basic unit. An affordable and cost-effective package of basic health services based on the priority health needs of the population will be provided.
- Reorganizing services so that they are provided through a holistic family health approach. Provision of the basic package will be based on competition and choice among the different public and private service providers, under a single Public and Health Insurance Fund (PHIF) using incentive-based and other provider payment mechanisms. The MOHP service provision management will be decentralized to the district level (the district management approach), in the transition period until the MOHP phases out its service delivery function.
- Strengthening management systems and developing a regulatory framework and institutional relationships to ensure quality of care and to support the reform of the health sector.
- Developing the domestic pharmaceutical industry and reducing government involvement in the production of pharmaceuticals while strengthening its role as a financier.

The health sector reform strategies are assisted through the Health Sector Reform Program (HSRP).

2.5 Other Government and Public Sector Agencies

Many other ministries operate their own health facilities that cater to their employees. The most important is the Ministry of Interior, which operates health facilities for police and the prison population; the Transport Ministry, which operates at least two hospitals for railway employees; the Ministry of Agriculture; the Ministry of Religious Affairs; and the Defense Ministry, which is responsible for health facilities run by the Armed Forces.

Egypt has 14 medical schools (Faculties of Medicine), affiliated with the major universities and 36 university hospitals. University hospitals are regarded as secondary and tertiary care facilities and tend to be much more advanced in terms of technology and medical expertise in comparison with MOHP facilities. Cairo University, with a new modern hospital, is considered the largest and most sophisticated hospital in this group. These university hospitals are operated under the authority of Ministry of Higher Education.

2.6 Parastatal Sector

The parastatal organizations are governmental establishments operated through the MOHP or other ministries. They include the Teaching Hospitals and Institutes Organization (THO), the Health Insurance Organization (HIO), and the Curative Care Organization (CCO).

2.6.1 General Organization of Teaching Hospitals and Institutes

THO includes nine institutes and nine hospitals distributed over Egypt. The nine THO hospitals are distributed as follows: four hospitals in Cairo, two hospitals in Upper Egypt governorates, and three hospitals in Lower Egypt governorates.

2.6.2 Health Insurance Organization

The Egyptian Health Insurance Organization was created in 1964. It is a parastatal government-owned entity under the Minister of Health and Population. There are four broad classes of HIO beneficiaries: all employees working in the government sector, some public and private sector employees, pensioners, and

widows. In February 1993, the Student Health Insurance Program (SHIP) was introduced to cover 15 million students and school age children, thus increasing the total beneficiary population from 5 million in 1992 to 20 million in 1995 (Rannan-Eliya et al., 1997). The 1997 Ministerial Decree 380 extended coverage to newborns (under one) and, by 2002, had increased the eligible beneficiary population to more than 30 million.

The HIO revenues come from four primary sources. The Social Insurance Organization (SIO) and the Pensioners Insurance Organization (PIO) receive contributions as a proportion of employees' salaries, SHIP receives contributions through a fixed amount from school registration fees and from government subsidy. HIO also receives some revenues in the form of copayments, primarily from government employees.

As a provider of health care, the HIO manages 39 hospitals, general practitioner clinics inside and outside factories, as well as the following:

- 7,141 school health clinics
- 1,040 specialist clinics or polyclinics
- 51 owned and 49 contracted pharmacies

2.6.3 The Curative Care Organizations

The Curative Care Organization (CCO) is a nonprofit system established in 1964 under the ultimate authority of the MOHP. CCOs operate 11 hospitals, which together account for about 1.5 percent of Egypt's total hospital beds. Each CCO is run independently on a nonprofit basis, with surplus revenue being invested into service improvement. In general, the 11 hospitals are high-quality "middle- and top-of-the-market" institutions, providing a full range of quality curative care services and programs. In 2002, the CCOs operated facilities with 2,127 beds.

2.7 Private and Nongovernmental Sector

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

2.7.1 Private Practices

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

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

The MOHP employs 53 percent of physicians with multiple jobs, followed by universities with 14 percent, and HIO with 11 percent. The remaining physicians include well-established and qualified senior

physicians who are usually faculty members in the major medical schools or shareholders in modern private hospitals. These physicians have the technology, the resources, and the visibility required to run very successful and profitable private practices.

2.7.2 Private Facilities

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

2.7.3 Private Voluntary Organizations

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

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

2.7.4 Nongovernmental Organizations

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

According to the 2000 Egypt Demographic and Health Survey, the public sector is providing 49 percent of family planning services in Egypt, and the private sector is providing 44 percent. PVOs/NGOs were found to be providing 7 percent of family planning services.

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

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

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

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

- A range of preventive and curative maternal, child, and reproductive health services, and at least one staff member qualified to provide curative services
- Facility infrastructure supportive of client utilization and quality services
- Facility infrastructure supportive of quality, 24-hour emergency services.

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

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

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

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

3.1 Basic Infrastructure and Resources Supportive of Utilization of Services

3.1.1 Availability of a Range of Services and Qualified Staff

The availability of a range of maternal, child, and reproductive health services and the frequency with which the services are offered are key elements influencing client utilization. Clients are more likely to seek services at a facility if they are certain the needed service will be available; indeed, they may be more likely to use a facility that provides a full range of services meeting most of their (and their family's) health needs. In addition, there should be qualified staff to provide the services, including at least one provider qualified to provide curative care who can be a resource to other, less qualified staff. In Egypt, the physician is the only provider classified as qualified to provide curative health services.

The following were defined by the Egypt Service Provision Assessment (ESPA) as the range of services, minimum availability, and minimum qualifications of staffing desirable at a facility to encourage utilization of facility services:

- A range of services offered a minimum number of days per week
 - Outpatient care for sick children (SC) at least 5 days per week
 - Services for sexually transmitted infections (STIs) at least one day per week¹
 - Preventive services (child immunization [Expanded Program on Immunization], routine growth monitoring, and antenatal care [ANC]) at least one day per week and
 - Temporary method of family planning at least one day per week.
- Availability of facility-based normal-delivery services and
- At least one physician assigned to the facility.

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

Table 3.1 Availability of services and qualified staff to meet basic client needs					
Percentage of facilities that provide basic maternal, child, and reproductive health services at appropriate frequencies, offer delivery care, and have available staff with appropriate qualifications to serve basic client needs, by type of facility and region, Egypt SPA 2002					
Background characteristics	Percentage of facilities with:				Number of facilities (weighted)
	All basic maternal, child, and reproductive health services ¹	All basic maternal, child, and reproductive health services provided at defined minimum frequencies ²	All basic services at defined minimum frequencies and facility-based 24-hour delivery services	All services provided at minimum defined frequencies, facility-based 24-hour delivery services, and at least one physician ³	
Type of facility					
GS hospital ⁴	23	23	13	13	64
Fever hospital	0	0	0	0	13
MCH/urban HU	39	39	21	21	65
Rural HU	51	43	15	15	367
Mobile unit	0	0	0	0	38
Health office	0	0	0	0	32
NGO facility	1	1	0	0	71
Region					
Urban Governorates	13	13	12	12	65
Lower Egypt	37	30	9	9	315
Upper Egypt	39	35	16	16	270
Total	35	31	12	12	650

¹ The range of services offered: The range of services assessed were curative care for children and for sexually transmitted infections, temporary methods of family planning, antenatal care, immunization, and child growth monitoring.

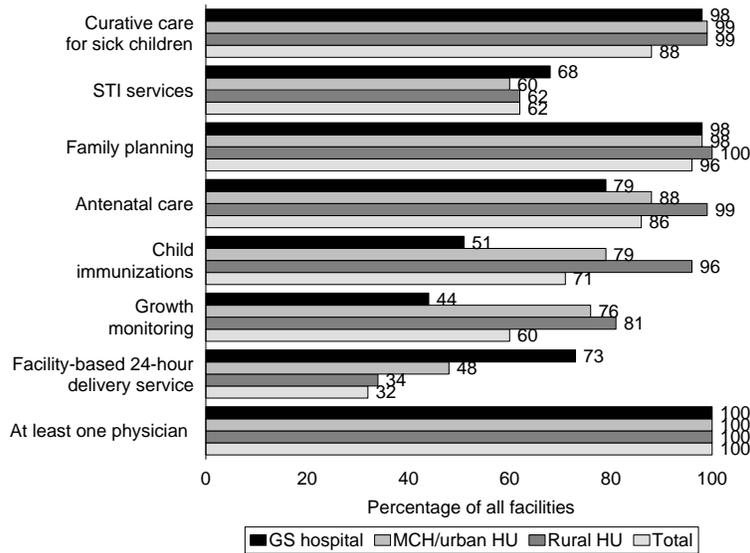
² The defined range of all services available, with each offered at a defined minimum frequency: curative care for children offered at least five days per week, STI services at least one day per week, and preventive or elective services (any temporary methods of family planning, antenatal care, immunization,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

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

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

¹ Among the 62 percent of facilities offering STI services, almost all (89 percent) reported STI treatment was available through adult curative outpatient services at least five days per week.

Figure 3.1 Availability of services and staff to meet basic client needs (N=650)



Egypt SPA 2002

There were notable differences in the types of services provided by different types of facilities. Under the Egyptian health system, facilities are often meant to provide only a select group of services. For example, fever hospitals specialize in curative care and do not provide routine preventive services. Health offices primarily provide immunization and family planning services; delivery services are most frequently available in general service hospitals. Among the general service hospitals, immunization services are provided in integrated hospitals but not in general or district hospitals.

The facilities where the full range of services is expected to be offered are the integrated hospitals, rural health units (rural HUs), and maternal and child health/urban health units (MCH/urban HUs). Thus, when the data are presented for “percentage of facilities having all services,” it should not be assumed that facilities without certain services are not working to standard. This does mean, however, that clients may have to seek out several different facilities to meet all of the basic health needs of their family.

Thirty-five percent of facilities offered the full range of basic services (curative care for children, STI services, and preventive and elective services [child immunization, growth monitoring, antenatal care, and family planning]) with almost all of these (31 percent) providing the services with the defined minimum frequency (Table 3.1). Rural HUs and MCH/urban HUs were more likely to offer the full range of basic service with the defined minimum frequencies (43 percent and 39 percent, respectively) than were general service hospitals (23 percent). When types of general service hospitals were reviewed separately, it was found that 42 percent of integrated hospitals provided the package, compared with less than 3 percent of other general and district hospitals (data not shown).

The Urban Governorates were the least likely to have facilities that provided the range of services in one facility with the minimum defined frequency (only 13 percent of facilities) compared with governorates in Lower Egypt (30 percent) and Upper Egypt (35 percent). One reason for this is the way in which health services are organized. MCH centers and general service hospitals are frequently located adjacent to health offices. In these cases, health offices most commonly provide the child immunization services for both facilities, rather than duplicate the resource necessary for this service.

Only 12 percent of all facilities were found to offer all of the basic services at the minimum frequency, plus 24-hour delivery services, with a larger proportion of MCH/urban HUs offering the full package (21 percent) (Table 3.1). All facilities had at least one physician assigned, with the rare exception of a small percentage (2 percent each) of the health offices and nongovernmental organization (NGO) facilities (Appendix Table A-3.1).

Among the different services that were assessed, FP, outpatient care for sick children, and ANC were the most widely available (96 percent, 88 percent, and 86 percent of all facilities, respectively) (Figure 3.1). The least widely available of the basic services were services for STIs (62 percent), child immunizations (71 percent), and routine growth monitoring (60 percent) (Figure 3.1). Egypt is considered to have relatively low rates of STIs, and therefore, STIs are not considered a priority health problem. While a facility may say it does not offer STI services, this does not mean that if a client who comes for another issue has STI symptoms, he or she will not be treated. It was observed during the survey that facilities claiming not to offer STI services did assess and treat ANC and FP clients who had symptoms of STIs (Appendix Table A-7.1). Among the assessed services, fever hospitals essentially offered only outpatient care for the sick child (97 percent) and services for STIs (53 percent) (Appendix Table A-3.1).

General service hospitals (general/district, or integrated hospitals) were the facilities where 24-hour delivery services were most often available (73 percent, compared with 48 percent of MCH/urban HUs and 34 percent of rural HUs) (Figure 3.1).

Key Findings

A full package of maternal, child, and reproductive health services is available at a minimum frequency in 31 percent of all health facilities. This package is most commonly found in MCH/urban HUs and rural HUs (39 and 43 percent, respectively).

A full package of maternal, child, and reproductive health services, available at a minimum frequency, and 24-hour facility-based delivery services are found in 12 percent of all facilities, including 21 percent of MCH/urban HUs, 15 percent of rural HUs, and 13 percent of general service hospitals.

Virtually all facilities have at least one assigned physician.

3.1.2 Facility Infrastructure Supportive of Client Utilization and Quality Services

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

The availability of the following key amenities and infrastructure components was assessed:

- A functioning client latrine, a waiting area that protects clients from sun and rain, and a basic level of cleanliness² (basic client comfort amenities)
- An on-site (either inside or within 500 meters of the facility) water source, available year-round (regular water supply)

² The standard for "clean" was that there was no obvious waste or dirt on the floor or furnishings.

- Electricity available 24 hours a day, with minimal or no disruption, during the period client services are normally provided, or a functioning generator with fuel (regular electric supply).

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

Sixty-two percent of facilities had all basic client comfort amenities (Table 3.2). Approximately 20 percent of facilities did not have at least one of the client comfort item assessed (a functioning client latrine, a protected waiting area, or a clean environment) (Appendix Table A-3.3). An additional 4 percent of facilities reported that they had a functioning client latrine, but it was not observed (data not shown). NGO facilities and MCH/urban HUs were the most likely to have all amenities (88 and 80 percent, respectively). Mobile units were not equipped with amenities and rarely had client latrines (23 percent) or protected waiting areas (13 percent). While they may not have client amenities, the mobile units do ensure that services reach locations where there is no fixed site facility.

Table 3.2 Service and facility infrastructure to support quality 24-hour emergency services							
Percentage of facilities with client amenities, on-site water, on-site and year-round water, regular supply of electricity or generator with fuel, and both regular water and regular electricity, by type of facility and region, Egypt SPA 2002							
Background characteristics	Percentage of facilities with:						Number of facilities (weighted)
	All basic client amenities ¹	On-site water source ²	Regular water supply available ³	Regular electric supply/backup generator available ⁴	Regular electric and water supply available ⁵	All basic client amenities, regular electric and water supply	
Type of facility							
GS hospital	69	98	90	92	83	55	64
Fever hospital	60	100	94	100	94	53	13
MCH/urban HU	80	99	86	93	81	66	65
Rural HU	59	95	87	85	75	44	367
Mobile unit	5	70	52	84	48	4	38
Health office	54	98	92	100	92	52	32
NGO facility	88	100	91	95	87	76	71
Region							
Urban Governorates	78	99	77	96	75	61	65
Lower Egypt	65	93	85	83	73	51	315
Upper Egypt	55	96	89	94	83	44	270
Total	62	95	86	89	77	49	650
¹ Functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness ² Water supplied in facility by tap or available within 500 meters of facility, may not be available year-round ³ Year-round water supplied in facility by tap or available within 500 meters of facility ⁴ Twenty-four-hour regular electricity or a backup generator with fuel ⁵ Twenty-four hour regular electricity or a backup generator with fuel and year-round water supplied in facility by tap or available within 500 meters of facility							

A regular supply of water is obviously crucial in the delivery of quality services. When asked about their most commonly available source of water at the time of the survey, almost all facilities (96 percent) reported that they had piped water (data not shown). Mobile units use the local water source from their mobile site on the day of service and were least likely to have piped water (72 percent), with 25 percent reporting that they had no routine water source. Two percent of rural HUs also indicated that they had no routine water source. Facilities without routine water sources were found primarily in Lower and Upper Egypt (3 and 2 percent, respectively). There is not a large variation in availability of on-site water by season (data not shown).

A regular supply of electricity contributes to the capacity of a facility to utilize equipment that contributes to quality of care and provides a reliable source of lighting when patient care is provided at night. Although quality care is possible without electricity, ensuring consistently available adequate lighting for patient care and fuel for a vaccine refrigerator and for sterilizing or disinfecting equipment for reuse is difficult without electricity. Eighty-six percent of facilities had a regular supply of water, and 89 percent had a regular supply of electricity or a backup generator with fuel. Seventy-seven percent of all facilities (83 percent of general service hospitals) had both a regular supply of electricity (or backup generator) and water (Appendix Table A-3.3).

Among all facilities, only 49 percent had all client amenities and a regular supply of water and electricity. Availability of all of these basic elements to support services and utilization ranged from 76 percent of the NGO facilities to only 4 percent of the mobile units. Only 55 percent of general service hospitals and 53 percent of fever hospitals had all of these items. The items most commonly lacking varied by type of facility (Appendix Table A-3.3). All client amenities and regular water and electricity were more often found in facilities in Urban Governorates (61 percent) than those in Lower or Upper Egypt (51 percent and 44 percent, respectively) (Table 3.2).

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

It is not expected that all levels of health facilities will provide 24-hour emergency services, but because 24-hour care is essential for managing serious illness and potentially decreasing mortality, it is important to know about the availability of emergency services. For the ESPA, 24-hour emergency services refers to a facility offering 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. Mobile units and health offices are not eligible to provide 24-hour services and are excluded from this analysis.

Although emergency services (such as first aid for injuries) can be provided under minimal conditions, the ESPA defined components believed to contribute to a service delivery environment that supports routine availability of 24-hour emergency services and a reasonable quality of service if a seriously ill client must remain overnight. The components assessed were as follows:

- Functioning client latrines
- An on-site source of water, at a minimum within 500 meters of the facility (seasonal shortages were defined as acceptable)
- A minimum of two qualified providers for curative care (physicians) assigned to the facility³
- Twenty-four hour duty staff (either on-site or on call)⁴
- Twenty-four hour access to emergency communication (on-site, or within five minutes distance)
- Inpatient or overnight beds for caring for clients, at minimum, until they are stable enough to be transferred to a higher-level facility if needed.

³ At least two physicians are necessary to provide 24-hour coverage for the facility.

⁴ The ESPA defined duty staff as available if there was documentation of a duty schedule or other documentation of 24-hour official responsibility of staff to be available and within close proximity in case an emergency arises.

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

Table 3.3 Service and facility infrastructure to support quality 24-hour emergency services			
Percentage of facilities with basic components to support quality 24-hour emergency services, and basic components to support quality 24-hour emergency services plus regular water and electricity, by type of facility and region, Egypt SPA 2002			
Background characteristics	Percentage of facilities with:		Number of facilities (weighted)
	Basic components to support quality 24-hour emergency services ¹	Basic components to support 24-hour emergency services and regular water and electricity ²	
Type of facility³			
GS hospital	63	53	64
Fever hospital	69	66	13
MCH/urban HU	13	10	65
Rural HU	2	2	367
NGO facility	10	8	71
Region			
Urban Governorates	23	18	50
Lower Egypt	11	9	286
Upper Egypt	12	11	244
Total	12	11	580

¹ At least two qualified physicians assigned to facility, duty schedule was observed indicating staff are on site or on call 24 hours a day, availability of overnight beds, a patient latrine, 24-hour emergency communication, and an on-site water source at least sometime during year.

² Availability of all basic components to support quality 24-hour emergency services, as well as a year-round on-site water source and a regular source of electricity or backup generator

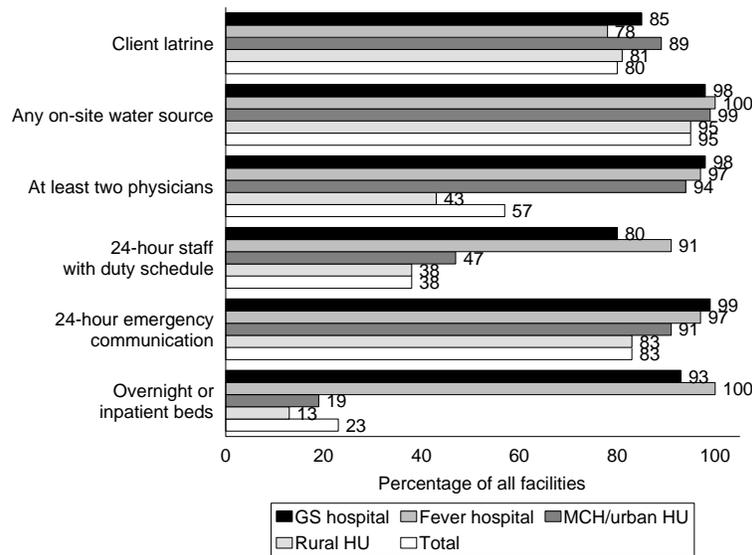
³ Mobile units (weighted N=38) and health offices (weighted N=32) are not eligible for 24-hour services, and so are excluded from the analysis.

Sixty-three percent of general service hospitals, 69 percent of the fever hospitals, and almost no MCH/urban HUs, rural HUs or NGO facilities (13 percent, 2 percent, and 10 percent, respectively) had all of the defined infrastructure components (client latrines, any on-site water source, at least two assigned physicians, 24-hour duty staff with schedule, 24-hour emergency communication, and overnight beds) to support quality 24-hour emergency services (Table 3.3).

A nonseasonal on-site source of water and a regular supply of electricity (24-hour electricity with minimum interruption, or a generator with fuel available) were not considered essential but were preferable for providing 24-hour emergency services. Slightly lower percentages (10 percent of all facilities, 53 percent of general service hospitals, and 66 percent of fever hospitals) had a regular water and electric supply in addition to all components to support quality 24-hour emergency services (Table 3.3).

Availability of a written duty schedule for 24 hours was the major weakness for the general service and fever hospitals. The ESPA 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. Eighty percent of general service hospitals, and 91 percent of fever hospitals had such a schedule (Appendix Table A-3.3 and Figure 3.2). An additional 27 percent of facilities (14 percent of general service hospitals, 9 percent

Figure 3.2 Availability of items to support quality 24-hour emergency services (N=650)



Egypt SPA 2002

of fever hospitals, 10 percent of MCH/urban HUs, and 41 percent of rural HUs) reported that they had 24-hour duty coverage but could not show a schedule indicating that staff had an official obligation to remain available for duty. Among rural HUs, where only one physician is commonly assigned but availability of 24-hour emergency services is reported, the physician may live on the premises and may make arrangements with district officials for another physician to be assigned only if there is a plan to be away for an extended period. Without a duty schedule, however, it is uncertain whether arrangements are routinely made for emergency staff availability if the physician is out of the area for a day or an evening.

More than 90 percent of the general service hospitals, fever hospitals, and MCH/urban HUs had at least two physicians assigned (Figure 3.2 and Appendix Table A-3.3). A review of the availability of overnight beds, however, shows that essentially only the general service and fever hospitals are equipped to provide overnight emergency care (Appendix Table A-3.3). Almost all facilities had 24-hour emergency communication, including 99 percent of general service hospitals, 97 percent of fever hospitals, 91 percent of MCH/urban HUs, and 83 percent of rural HUs.

There were notable regional differences in the availability of staff and furnishings, with facilities in Urban Governorates consistently having greater availability of resources for supporting 24-hour emergency services (23 percent), compared with facilities located in Lower or Upper Egypt (11 percent and 12 percent, respectively) (Table 3.3 and Appendix Table A-3.4). This may reflect a lower proportion of hospitals among the nonurban governorate facilities rather than a difference in quality among facilities. It does, however, indicate less access by the population to 24-hour emergency services.

Key Findings

Infrastructure support (client comfort amenities, water, and electricity) are regularly available for almost half of all facilities (49 percent), including 55 percent of general service hospitals, 66 percent of MCH/urban HUs, and 76 percent of NGO facilities.

Almost all facilities have an on-site water source (95 percent), with 86 percent indicating the water is available year-round.

Almost all facilities (89 percent) have a regular supply of electricity, and more than 30 percent of the General Service and fever hospitals have a backup generator as well.

Hospitals are the primary site where 24-hour emergency service infrastructure support is available, with 63 percent of general service hospitals and 69 percent of fever hospitals having all assessed components.

Nationally, a larger proportion of facilities located in Urban Governorates (23 percent) have all of the components to support 24-hour emergency services than facilities located in Lower or Upper Egypt (11 percent and 12 percent, respectively).

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

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

3.2.1 Management, Quality Assurance, and Referral Systems

The components assessed for supporting consistent provision of services at an acceptable level of quality were as follows:

- Functioning management committees
- Routine quality assurance (QA) activities
- Referral systems.

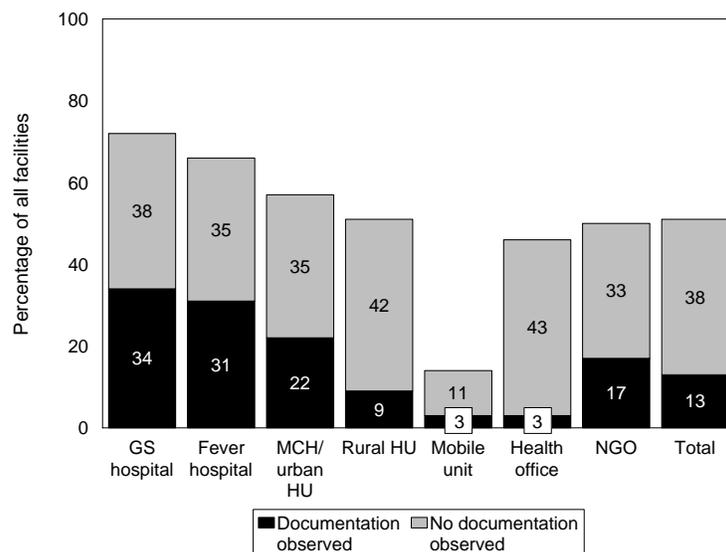
Information on the availability of functioning systems for each of the assessed components is shown in Table 3.4. Further information on the components is shown in Figures 3.3 through 3.6, and Appendix Tables A-3.5 and A-3.6.

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

Percentage of facilities with:					
Background characteristics	Management committee meetings at least every 6 months and observed			Referral form observed ¹	Number of facilities (weighted)
	documentation of a recent meeting	Facility reports QA activities documentation observed			
Type of facility					
GS hospital	34	21	55	64	
Fever hospital	31	10	56	13	
MCH/urban HU	22	9	50	65	
Rural HU	9	18	28	367	
Mobile unit	3	5	0	38	
Health office	3	11	15	32	
NGO facility	17	7	8	71	
Region					
Urban Governorates	35	11	39	65	
Lower Egypt	14	22	37	315	
Upper Egypt	7	9	18	270	
Total	13	15	29	650	

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

Figure 3.3 Facilities reporting routine management committee meetings (N=650)



Egypt SPA 2002

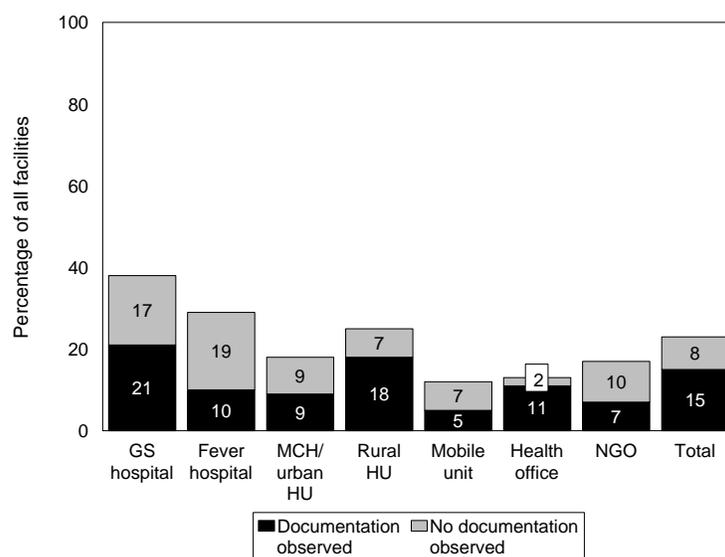
When asked about the frequency of management committee meetings, 51 percent of facilities reported having a committee that met at least every six months (Figure 3.3), with half of the facilities reporting that they met monthly or more often (Appendix Table A-3.5). A record of meetings, where decisions are documented and followup on issues that are discussed can be monitored, is considered an indicator of a functioning committee. Only 13 percent of facilities both met at least every six months and had any minutes or other documentation of meetings available for observation (Figure 3.3 and Table 3.4). An additional 6 percent of facilities reported that meetings were held at least every six months and records were maintained, but they could not show any records of recent meetings on the day of the survey (data not shown). General service hospitals, fever hospitals, and MCH/urban HUs were most likely to have documentation of meetings.

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

Although 23 percent of facilities indicated that they carried out QA activities, only 15 percent of facilities had any documentation of the QA tools that were used (Figure 3.4). QA with documentation was most often found in general service hospitals and rural HUs. Documentation of QA activities was also more frequently found in facilities in Lower Egypt (Table 3.4).

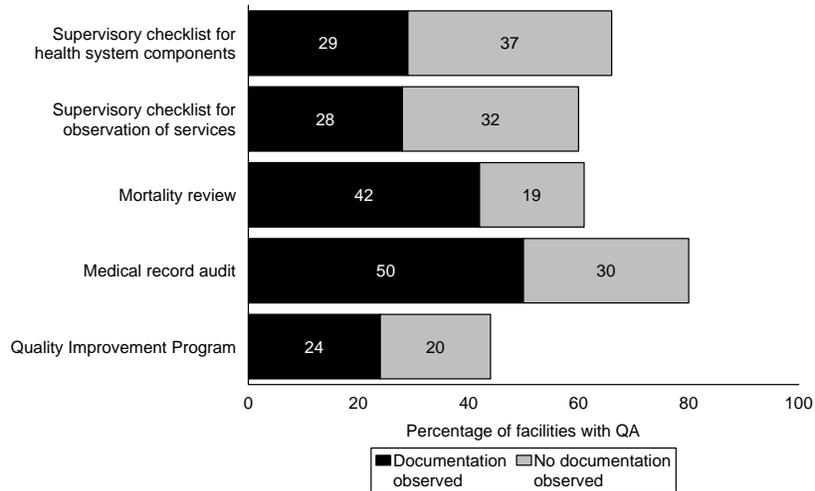
Among the facilities reporting QA activities, 82 percent reported that the QA system was facility-wide, and 18 percent indicated that it was implemented for specific services only (data not shown). When asked about their QA activities, 66 percent of facilities indicated that they used some type of supervisory checklists for assessing health system components, 60 percent reported using some type of supervisory checklists for observing service provision, and 61 percent indicated that they conducted some type of mortality review (Figure 3.5). Many facilities did not have documentation available for the QA tool they reported using.

Figure 3.4 Facilities reporting quality assurance activities (N=650)



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Figure 3.5 Reported quality assurance activities (N=152)



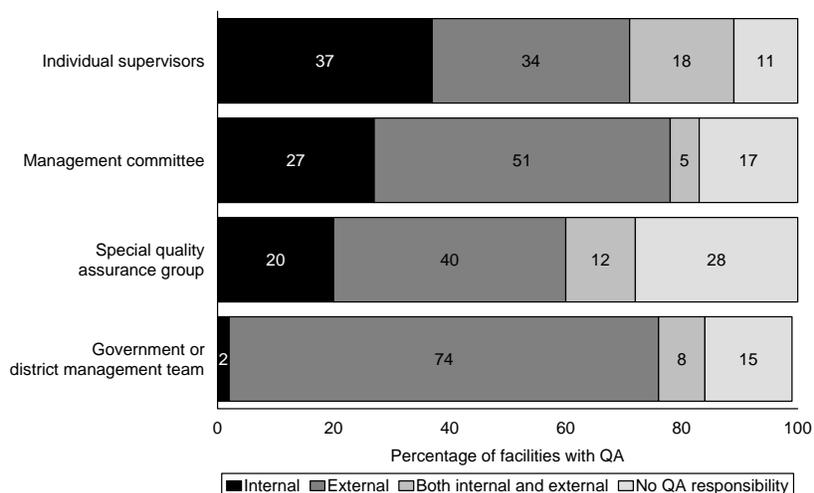
Egypt SPA 2002

Only 29 percent reported using and had available a supervisory checklist for the health system components, 28 percent used and had available an observation checklist, and 42 percent used and had available a document related to mortality review. Eighty percent of facilities reporting they implemented QA activities reported they conducted some type of medical record audits, with 50 percent reporting they conducted audits having documentation available. Finally, 44 percent of facilities reported that they implemented the Quality Improvement Program (QIP), a system program in Egypt. Twenty-four percent of facilities indicated that they used QIP and had documentation available.

Among the facilities with QA activities, the people reported as responsible for the QA included those based inside as well as outside the facility (Figure 3.6). Externally based management teams (74 percent), management committees (51 percent), or groups specific for QA (40 percent) were the most commonly reported implementers for QA activities. Thirty-seven percent of the facilities indicated that supervisors from the facility were responsible for QA, 27 percent indicated that an internal management committee was responsible, and 20 percent indicated that the facility had a special QA group.

Clients who are referred to other facilities without any formal documentation risk being refused services or having services delayed if the referral facility must assess them as totally new clients. Thus, systematic means to support clients needing services from a higher-level facility in receiving these services is an important aspect of quality of care. If clients are confident that, if needed, they will be assisted in gaining access to higher-level facilities, they may be less likely to bypass lower-level facilities for their health needs. The ESPA collected information on whether any official, printed form, which at minimum documents the reason for referral and any treatment already provided, is used for referrals. Twenty-nine percent of facilities either had an observed referral form or were the referral facility (Table 3.4). These included about half of the general service and fever hospitals and MCH/urban HUs. Referral facilities or referral forms were more often found in facilities in Urban Governorates (39 percent) and Lower Egypt (37 percent) than in Upper Egypt (18 percent). An additional 4 percent of facilities indicated that they used a printed referral form but were unable to show the form on the day of the survey (data not shown).

Figure 3.6 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=152)



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3.2.2 Supportive Management for Providers

The ESPA collects information to assess the extent to which facilities have supervisory and staff development activities important for supporting quality care. Supportive management activities that were assessed include the following:

- Supervision by external staff
- Personal supervision of service delivery providers
- Structured in-service training related to the services of health service providers.

Summary information on supportive management practices at the facility level is provided in Table 3.5, with further details in Appendix Table A-3.7. Details on supervision and in-service training from the perspective of the health service provider are provided in Appendix Table A-3.8.⁵

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 “organizational 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. A facility reporting at least one visit by external supervisors during the past six months was defined as having routine external supervision. Overall, 96 percent of facilities reported that they had received a supervisory visit from authorities external to the facility during the past six months (Table 3.5). Among facilities having received external supervision, 97 percent said that during the supervisory visit official registers or records were checked, 85 percent said that they had discussed problems, and more than 70 percent said that policy issues and/or

⁵ Information on in-service topics and staff supervision related to a particular service is presented in the report section for each specific service assessed.

technical matters had been discussed. Forty percent said a staff meeting was held, and 77 percent indicated that the supervisor had written in the supervision book (data not shown).⁶ Eighty-one percent of the facilities said that an external supervisor had observed services being provided, an important means of supporting quality of care.

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 facility was defined as providing routine staff supervision. At least half of the interviewed health service providers had been personally supervised during the past six months in 94 percent of facilities (Table 3.5). Facility-level practices related to supervision of individual health service providers varied by type of facility and by geographic region. None of the interviewed health service providers reported being personally supervised in 3 percent of facilities (29 percent of NGO facilities) (Appendix Table A-3.7), although all of the interviewed health service providers reported having been personally supervised during the past six months in 66 percent of facilities. Facility-level supervision was weaker for facilities in the Urban Governorates than for those in Lower and Upper Egypt. This may be due to a different mix of facilities: Urban areas have a higher proportion of hospitals and, subsequently, a larger number of staff requiring supervision, and urban areas have a higher proportion of NGO facilities. Among all interviewed health service providers, 90 percent had been personally supervised during the past six months, with providers from NGO facilities least likely to be supervised (56 percent) (Appendix Table A-3.8).

To maintain levels of knowledge and technical competence achieved during basic training, it is essential that health service providers be provided continuous exposure to current and new information. This not only refreshes knowledge but also serves to update practices as new policies and protocols are introduced. This is most often achieved through in-service training. It is recognized that health service providers may receive new information and individual instruction related to their work during routine supervisory visits. The ESPA, however, assessed specifically whether the health service provider had received any formal in-service training on topics related to the service offered.

Similar to the findings for supervision, there were differences in routine practices for in-service training by type of facility and geographic region. None of the interviewed health service providers in 27 percent of facilities had received in-service training during the past 12 months (Appendix Table A-3.7), with 61 percent of the fever hospitals and almost half (49 percent) of the NGO facilities having no interviewed health service providers report in-service training during the past 12 months. All of the interviewed providers had received in-service training during the past 12 months in only 7 percent of facilities. Facilities in Upper Egypt were more likely to have all staff report having received in-service training (12 percent) than those in the Urban Governorates (5 percent) and Lower Egypt (3 percent). Among all interviewed health service providers, 30 percent had received in-service training related to their service during the past 12 months (Appendix Table A-3.8), and an additional 43 percent reported that their most recent in-service training was within the past 13 to 59 months.

If at least half of the interviewed health service providers at a facility had received any in-service training relevant to their service during the past 12 months, the facility was defined as having routine staff development activities. Unlike the almost universal experience of supervision, at least half of the interviewed providers had received in-service training related to their service during the past 12 months in only 28 percent of facilities, with fever hospitals having the lowest level of routine in-service training (4 percent) (Table 3.5).

⁶ A facility could provide multiple responses.

Table 3.5 Supportive management practices at the facility level						
Percentage of facilities that had an external supervisory visit during the past 6 months; percentage where at least half of the interviewed health service providers received in-service training related to maternal, child, or reproductive health services during the past 12 months; percentage where at least half of the interviewed providers were personally supervised during the past 6 months; percentage where at least half of the interviewed providers were both supervised in the past 6 months and received related in-service training during the past 12 months; and percentage of facilities that had external supervision to the facility during the past 6 months and at least half of the interviewed providers were both supervised during the past 6 months and received in-service training during the past 12 months, by type of facility and region, Egypt SPA 2002						
Background characteristics	Percentage of facilities where at least half of the interviewed service providers:					
	Percentage of facilities with external supervisory visit during the past 6 months	Received in-service training during past 12 months ¹	Were personally supervised during past 6 months	Were both personally supervised past 6 months and received in-service training past 12 months	Percentage of facilities with all supportive management practices ²	Number of facilities with at least one eligible health service provider ³ (weighted)
Type of facility						
GS hospital	98	13	92	9	9	64
Fever hospital	97	4	91	4	4	13
MCH/urban HU	100	23	99	20	20	65
Rural HU	100	33	99	32	32	367
Mobile unit	96	25	100	25	23	38
Health office	100	17	96	17	17	31
NGO facility	70	28	58	17	16	70
Region						
Urban Governorates	91	29	89	26	25	65
Lower Egypt	98	18	95	17	17	314
Upper Egypt	95	38	93	34	34	270
Total	96	28	94	25	25	649
¹ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.						
² Facility received external supervision within the past 6 months; at least half of all interviewed health service providers both received in-service training relevant to the services they provided during the past 12 months and were personally supervised during the past 6 months.						
³ Interviewed providers who did not personally provide one of the services assessed by the ESPA (i.e., administrators who might have been interviewed) are excluded.						

In all, 25 percent of all facilities had all elements defined as routine supportive management practices (the facility had received external supervision during the past 6 months, and at least half of the interviewed providers had been both individually supervised during the past 6 months and had received in-service training related to their service during the past 12 months). Findings of all elements of routine supportive management varied from 32 percent of rural HUs to 4 percent of fever hospitals (Table 3.5).

3.2.3 Management Practices Supporting Community Involvement

It is generally accepted that encouraging community input into aspects of facility functions increases the accountability of the facility to the community it serves and its understanding of the needs of the community, with the expected result being increased appropriate utilization of the facility and subsequent improved health within the population. Two of the most common mechanisms promoted under health sector development programs include the following:

- Community representation at facility meetings
- Mechanisms to elicit client feedback regarding the facility and services.

Community involvement through participation in meetings or activities is routine in about 4 of 10 facilities (Table 3.6). Surprisingly, general service hospitals and fever hospitals report this practice more often (63 percent and 53 percent, respectively) than MCH/urban HUs (49 percent) or rural HUs (41 percent). It was expected that the MCH/urban HUs and rural HUs would be more likely to have implemented activities to promote community participation since they provide outpatient and preventive services more often and thus may have closer day-to-day contact with the community. Facilities in Upper Egypt reported community participation less often (31 percent) than those in Lower Egypt and the Urban Governorates (both 44 percent).

Table 3.6 Management practices supporting community feedback and access to facility				
Percentage of facilities that have routine community participation in management meetings, percentage having a system of acquiring client opinion and feedback, and percentage with either mechanism for obtaining community input, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities:			Number of facilities (weighted)
	Where community participation in some management meetings is routine	Where client opinion is elicited and a system for review is implemented ¹	That have any mechanism for obtaining community input for services ²	
Type of facility				
GS hospital	63	3	64	64
Fever hospital	53	3	53	13
MCH/urban HU	49	2	50	65
Rural HU	41	4	41	367
Mobile unit	4	0	4	38
Health office	20	0	20	32
NGO facility	16	4	18	71
Region				
Urban Governorates	44	3	44	65
Lower Egypt	44	4	44	315
Upper Egypt	31	2	32	270
Total	39	3	39	650

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.

Systems to elicit client opinion, where there is any documentation that the responses from clients are reviewed, are rare. Although 28 percent of facilities reported that they had systems to elicit client feedback (data not shown), only 3 percent of facilities both reported eliciting client opinion and had any documentation to indicate that the client responses were reviewed (Table 3.6). Among the facilities reporting a system for eliciting client opinion, 23 percent used suggestion boxes, 11 percent used client survey forms, and 79 percent conducted client interviews (data not shown). It was uncertain if the client interviews were structured or were based on informal conversation. Only 5 percent of the facilities reporting they elicited client feedback could mention any changes they had made during the past three months, based on client opinion.

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

User fees may have a positive effect on utilization of health facilities (augmenting funds to improve services) or a negative effect (detering poor clients from using services). User fees with exemption schemes for vulnerable people often help to augment inadequate facility budgets and, when used to supplement provider salaries, may decrease under-the-table payments that may be expected when health service providers are not paid adequately. However, providing exemptions or discounts for poor clients can result in budget shortages if there is no system for reimbursing these exempted or discounted costs. Other methods that encourage appropriate utilization by poor clients but that also reimburse facilities for

client services include insurance plans, credit plans (delayed payment for services received 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 utilization.

The ESPA obtained information on various aspects of funding of health services at the facility level including the following:

- Practices related to user fees
- Other reimbursement mechanisms.

Facility practices regarding user fees and discounting fees are summarized in Table 3.7. Details on types of fee systems utilized are given in Appendix Table A-3.9; items for which user fees are charged in the economic and free sections of facilities are shown in Appendix Table A-3.10; and reported sources of reimbursement for clients with discounted or exempted user fees are available in Appendix Table A-3.11.⁷

Table 3.7 Funding mechanisms utilized in the facilities				
Percentage of facilities with a routine user fee for curative care for adults, for curative care for children, and with both a routine user fee as well as some external source of reimbursement for clients in lieu of direct charges, by type of facility and region, Egypt SPA 2002				
Background characteristic	Percentage of facilities with any routine user fee for curative care for:		Percentage of facilities that have both user fees and some external source of reimbursement of costs for clients, in lieu of out-of-pocket payments by clients ¹	Number of facilities (weighted)
	Adults	Children		
Type of facility				
GS hospital	98	91	59	64
Fever hospital	94	94	50	13
MCH/urban HU	95	92	36	65
Rural HU	99	94	57	367
Mobile unit	44	65	3	38
Health office	44	75	10	32
NGO facility	95	97	18	71
Region				
Urban Governorates	85	95	19	65
Lower Egypt	94	91	51	315
Upper Egypt	92	95	45	270
Total	92	93	45	650
¹ This may be from insurance systems, reimbursement from external charities, or other sources of funds (e.g. charities, NGOs) for poor clients.				

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

⁷ Additional information is presented on clients’ out-of-pocket payment for services received and clients’ participation in any health insurance program that might decrease or defer out-of-pocket expenses at the time of service in the report section for each specific service assessed.

costs for services, medicines, or laboratory tests (if they are available at the facility). Access to the “free” section services depends on the economic status of the client.

User fees for adult curative services are implemented almost universally (92 percent of facilities), with the exception of health offices and mobile units, where only 44 percent of either type of facility has user fees for adult curative care and around 70 percent have user fees for curative child care (Table 3.7).

Forty-five percent of facilities reported that they had user fees but also received reimbursements for client fees, in lieu of out-of-pocket payments by clients. Systems for reimbursement for client fees were reported more often from facilities in Upper and Lower Egypt (45 percent and 51 percent, respectively) than from facilities in Urban Governorates (Table 3.7), with the most frequently cited source being Health Insurance Organization/Student Health Insurance Program (Appendix Table A-3.11).

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

Among facilities reporting that they had user fees, 49 percent used a two-tiered system, discounts or exemptions, or a mixture of these systems, for decreasing out-of-pocket costs for poor clients (Appendix Table A-3.9). Hospitals were most likely to have the economic and free system (62 percent of general service hospitals and 80 percent of fever hospitals) followed by MCH/urban HUs (56 percent) and rural HUs (45 percent). Facilities in Lower Egypt were least likely to implement the two-tiered system (36 percent compared with more than 50 percent for facilities in Urban Governorates and Upper Egypt).

Among the facilities having user fees, 22 percent reported that they practiced systems different from the two-tiered system, to allow discounts or exemptions for clients. Only 3 percent, however, had any record showing that exemptions had been provided during the prior seven days (Appendix Table A-3.9). When asked who authorized exemptions, almost all facilities (82 percent) indicated that it was the person in charge of the facility, and that 27 percent indicated there was a social worker who also authorized exemptions (data not shown).

Public posting of user fees helps to reinforce to the public and to the staff the officially sanctioned fee structure. Among facilities having user fees, few (22 percent) had a schedule for all fees posted where clients could see them, although an additional 9 percent had some, although not all of their fees, posted (Appendix Table A-3.9).

Key Findings

More than half of facilities (51 percent) hold routine management meetings; however, only 13 percent both hold routine meetings and have documentation of recent meetings.

QA activities have been introduced into 23 percent of facilities, with general service hospitals and rural HUs having the highest percentage of facilities (21 percent and 18 percent, respectively) with documentation of tools used for QA activities available.

Supervision is strong; more than half of all interviewed service providers in 94 percent of facilities indicated that they had been personally supervised during the prior six months. A notable weakness was seen in NGO facilities, where the percent having routine supervision was only 59 percent. In addition, almost all facilities (96 percent) received supervision from authorities external to the facility during the prior six months.

Formal in-service training related to the service of the provider is less routinely provided, with at least half of all interviewed providers in 28 percent of facilities having received related in-service training during the prior 12 months. Fever hospitals showed the lowest level of in-service provision, with routine in-service training noted at only 4 percent.

Systems for eliciting community input for facility activities are not widespread. While 39 percent of facilities have routine community participation on some management committee, only 3 percent indicated that they have any formal means for seeking client feedback.

Client user fees are universal, and almost half (49 percent) of facilities that have user fees also report a system to decrease client out-of-pocket costs. Facilities with user fees report using a two-tiered system (44 percent) where clients can select either to pay more for convenience (“economic section”) or can receive services for minor fees but possibly less convenience (“free section”). Discounts or exemptions for fees are reported by 22 percent of facilities with user fees.

Forty-five percent of all facilities participate in some system whereby they receive external reimbursement for deferred client charges.

3.2.5 Maintenance and Repair of Equipment

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

- Major equipment
- Minor equipment
- Buildings and infrastructure.

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

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

Thirty-two percent of facilities reported that they have preventive maintenance programs for major equipment, such as generators or sterilizers (Table 3.8). These were most commonly reported in general service hospitals (60 percent) and mobile units (64 percent). Among facilities with preventive maintenance programs, three in four used external technicians for the preventive maintenance activities, 17 percent reported having on-site staff (including 40 percent of general service hospitals), and 6 percent reported having both on-site staff and using external technicians for preventive maintenance (Appendix Table A-3.12). Almost all facilities (91 percent) reported a system for maintenance and repair of small equipment (such as stethoscopes or sphygmomanometers), with most (74 percent) indicating that the equipment is sent elsewhere (often to the health directorate office) and 10 percent that they had funds in the facility for repair or replacement of the small equipment (Appendix Table A-3.12).

Table 3.8 Facility systems for maintenance and repair of equipment and infrastructure				
Percentage of facilities that have a preventive maintenance program for major equipment, percentage that have a system for repairing or replacing small equipment, and percentage that have a system for maintenance and repair of the building or infrastructure, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities with:			Number of facilities (weighted)
	Preventive maintenance program for major equipment ¹	System for repair or replacement of small equipment ²	System for maintenance and repair of building or structure	
Type of facility				
GS hospital	60	96	77	64
Fever hospital	30	88	71	14
MCH/urban HU	23	94	71	65
Rural HU	28	89	59	367
Mobile unit	64	98	68	38
Health office	16	86	63	32
NGO facility	23	90	74	71
Region				
Urban Governorates	21	92	78	65
Lower Egypt	36	95	67	315
Upper Egypt	29	86	58	270
Total	32	91	64	650
¹ This refers to equipment such as a generator or sterilizer.				
² This refers to equipment such as stethoscopes or sphygmomanometers.				

Forty-six percent of all facilities reported that they had no source of funding for equipment maintenance and repair (Appendix Table A-3.13). Fourteen percent of facilities reported that their source of funding for equipment maintenance was a budget line item, 45 percent reported funds from the service improvement box,⁸ and 5 percent reported having funds both from a budget line item and the service improvement box. Among the facilities with one of these sources of funding for equipment repairs, two-thirds reported that the funds available were sufficient (Appendix Table A-3.13).

Sixty-four percent of facilities indicated that they had a system for building maintenance and repair (Table 3.8), with 73 percent reporting that individuals in charge of the facility could authorize repairs, 5 percent reporting that individuals in charge of service units within the facility could authorize repairs, and 28 percent reporting that other people (primarily higher level authorities external to the facility) were

⁸ Service improvement box funds are from user fees.

responsible for authorizing repairs. Several facilities reported that more than one individual was responsible for authorizing repairs. Ten percent of facilities with a system for building maintenance reported that they had on-site staff, 82 percent reported using external staff, and 7 percent reported using both on-site staff and hiring external staff for building maintenance (Appendix Table A-3.14). The source of funding for building repairs would be the same as that for small equipment and supplies.

Key Findings

Thirty-two percent of facilities have preventive maintenance programs for major equipment. Over 60 percent of both general service hospitals and mobile units reported preventive maintenance programs for major equipment.

Among facilities with sources of funding for repair and maintenance of small equipment (54 percent), two-thirds reported that the funds available were sufficient to meet their needs.

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

To ensure that necessary pharmaceutical commodities are available for daily use, the commodities must be stored under conditions that protect them from damage, monitoring systems must minimize wastage resulting from commodity expiration, and systems must exist to monitor stockage and to ensure timely ordering and resupply of the needed amount of commodities. Specific components that were assessed to determine if logistic systems were sufficient for maintaining the quality and quantity of pharmaceutical commodities include the following:

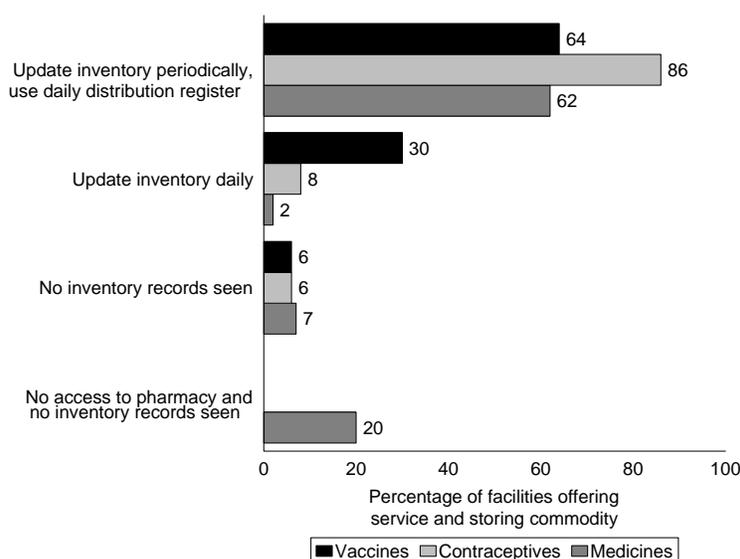
- Storage conditions
- Stock monitoring systems
 - Storage of commodities by expiration date⁹
 - Absence of expired commodities
 - Up-to-date inventory records
- Ordering practices for commodities
- Reliability of supply of ordered commodities.

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

⁹ Often the utilization and supply patterns for vaccines and medications result in all the current supplies having the same expiration date. In that case, it cannot be ascertained if the facility monitors and disburses according to expiration date. For the purposes of the ESPA, if the supply was seen but there was no variation in date for the supplies assessed, the facility was assumed to appropriately store and monitor by expiration date.

When assessing the presence of an up-to-date inventory, it was noted that 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 was not up to date, but there was a register where the current inventory could be quickly calculated (and this tallied with the actual commodity stock), the facility was defined as having an up-to-date inventory. Over two-thirds of facilities used daily distribution records for vaccines, contraceptives, and medicines and only periodically updated inventory records.

Figure 3.7 Inventory system used for stored commodities: vaccines (N=395), contraceptives (N=622), medicines (N=650)



Egypt SPA 2002

Information on storage conditions and stock monitoring for vaccines is presented in Table 3.9, and information for contraceptive methods and medicines is shown in Table 3.10. Details for each element assessed for monitoring the cold chain for vaccine storage are shown in Figure 3.8, and details for the vaccine stock monitoring systems are shown in Figure 3.9. Similar information on storage conditions and stock monitoring systems for contraceptive methods and 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 Figures 3.12 and 3.13, as well as 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 and region, Egypt SPA 2002			
Background characteristic	Percentage of facilities with:		
	Adequate system for monitoring storage temperature ¹	Adequate system for monitoring stock ²	Number of facilities with vaccines (weighted)
Type of facility			
GS hospital	71	30	27
MCH/urban HU	83	61	53
Rural HU	76	31	273
Health office	94	52	29
NGO facility	0	77	6
Region			
Urban Governorates	94	71	35
Lower Egypt	76	41	178
Upper Egypt	74	26	173
Total	76	37	395
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			

3.3.1 Storage and Stock Monitoring Systems for Vaccines

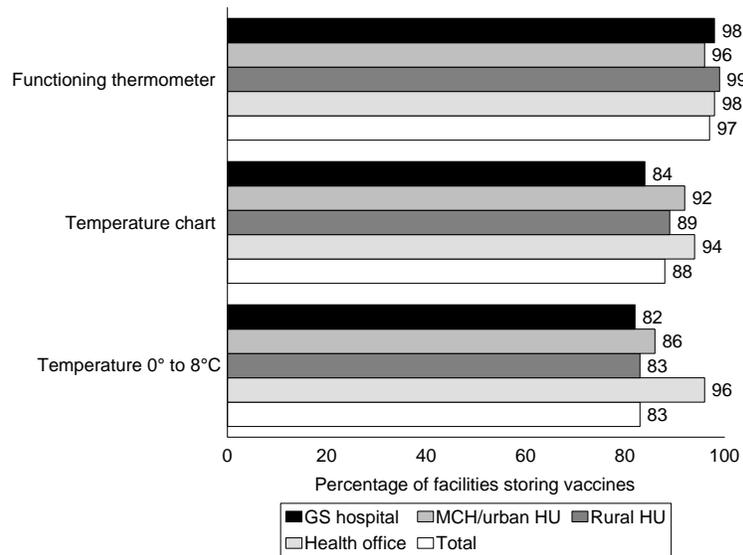
Vaccines must be stored at an appropriate temperature to maintain potency. WHO and UNICEF policy is to monitor the temperature of a refrigerator (or cold box) at a minimum of twice daily and to record the temperature on a graph as proof of monitoring (WHO, 1998). For evidence of adequate storage conditions, facilities were assessed for (1) presence of a functioning thermometer in the refrigerator, (2) a temperature of 0° to 8°C¹⁰ at the time of the survey, and (3) a completed temperature graph (completed twice a day) for the prior 30 days.

Among facilities that store vaccines,¹¹ 76 percent had all components for adequate monitoring of the storage temperature (Table 3.9). NGO facilities had the weakest systems, with none of the six reporting that they stored vaccines having any of the items for monitoring the storage temperature (Appendix Table A-3.15). Details for each element for monitoring the storage temperature are shown in Figure 3.8. Almost all facilities (96 percent) ensured that the vaccine refrigerator was protected from sunlight (Appendix Table A-3.15).

¹⁰ This is the UNICEF recommendation for vaccine storage at the health center level.

¹¹ No fever hospitals or mobile units store vaccines.

Figure 3.8 Elements for monitoring vaccine storage conditions (N=395)

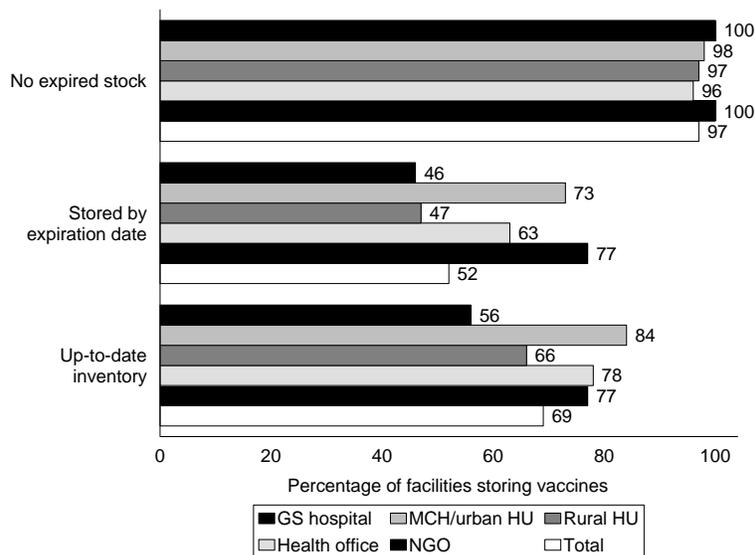


Note: Six NGO facilities had none of the items.

Egypt SPA 2002

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. Expired vaccines were observed in 3 percent of facilities (Figure 3.9) with no expired stock noted in general service hospitals or NGO facilities. The practices of storing vaccines by expiration date and maintaining an up-to-date inventory were not systematically utilized across facilities, with 52 percent of facilities storing by expiration date and 69 percent having an up-to-date inventory.

Figure 3.9 Elements for monitoring vaccine stock (N=395)



Note: Nine facilities had no vaccines present.

Egypt SPA 2002

Overall, 37 percent of facilities that stored vaccines had all conditions for quality monitoring of vaccine stock. The MCH/urban HUs, and health offices were more consistent in maintaining the vaccine management systems (Table 3.9). Three-quarters of the NGO facilities storing vaccines also had all elements for quality monitoring of vaccine stock, although they did not monitor the storage temperature for safe vaccine storage conditions. Stock monitoring systems were weakest in Upper Egypt and strongest for facilities in Urban Governorates (Appendix Table A-3.15).

3.3.2 Storage and Stock Monitoring Systems for Contraceptive Methods and Medicines¹²

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

In general, storage conditions for contraceptives were inadequate in 14 percent of facilities (Figure 3.10) and for medicines in 32 percent of facilities (Table 3.10 and Figure 3.11). The most common weakness was in protecting commodities from pests and rodents (Appendix Table A-3.16). Twelve percent of the facilities with observed contraceptives and 22 percent of the facilities with observed medicines had evidence of pests or rodents in the storage area. Twenty-one percent of the facilities also did not ensure that medicines were off the floor and protected from water. It is not unusual to find contraceptives stored separately from medicines. Among the facilities with observed contraceptive methods, 83 percent had different storage sites for contraceptive supplies and medicines. Those contraceptives stored separately were stored under somewhat better conditions than those stored with medicines, with only 9 percent having evidence of pests or rodents (compared with 34 percent of those stored with medicines) and only 2 percent not protected from the ground or water (compared with 22 percent of those stored with medicines) (data not shown).

Contraceptive methods for which stock maintenance practices were assessed were the combined oral pill, the injectable (three monthly), and the condom. Medicines assessed for stock maintenance practices were antibiotics and Ringers Lactate intravenous solution. Four percent of facilities had expired contraceptive methods (Figure 3.10), and 4 percent had expired medicines (Figure 3.11). More than half (55 percent) of the facilities stored their medicines by expiration date, with less than half (42 percent) storing contraceptive methods by expiration date. Up-to-date inventories were maintained for contraceptive methods in 79 percent of facilities and for medicines in 72 percent of facilities.

Overall, 36 percent and 41 percent of facilities had evidence of quality stock monitoring systems for contraceptive methods and for medicines, respectively (Table 3.10). Facilities were consistently weak in Upper Egypt and strong in the Urban Governorates for all items assessed.

¹² Twenty percent of facilities either stored no medicines or access to the storage area was not possible on the day of the survey. This situation was found primarily at mobile units, health offices, and NGO facilities. In addition, there was no access to the medicine storage area at 1 percent of general service hospitals, 2 percent of MCH/urban HUs, and 4 percent of rural HUs.

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

Among facilities storing medicines and clinical methods of contraception, percentage in which good storage conditions were observed and stock monitoring systems were in place, by type of facility and region, Egypt SPA 2002

Background characteristic	Contraceptive methods				Medicines			
	Percentage with all assessed items for system for storing methods ¹	Number of facilities storing contraceptive methods	Percentage with all assessed items for system for monitoring stock ²	Number of facilities with observed stored contraceptive methods ³ (weighed)	Percentage with all assessed items for system for storing medicines ¹	Number of facilities storing medicines	Percentage with all assessed items for system for monitoring stock ²	Number of facilities with observed stored medicines ⁴ (weighted)
Type of facility								
GS hospital	86	63	34	62	66	63	37	61
Fever hospital ³	NA	NA	NA	NA	65	13	35	13
MCH/urban HU	91	64	53	64	74	65	46	62
Rural HU	83	357	34	355	66	352	42	334
Mobile unit	96	38	34	38	92	17	11	6
Health office	93	27	50	27	90	6	50	2
NGO facility	86	63	34	58	100	5	72	5
Region								
Urban Governorates	91	62	50	61	88	41	65	36
Lower Egypt	89	300	42	299	76	261	49	240
Upper Egypt	81	251	26	244	56	218	29	206
Total	86	612	36	604	68	519	41	482

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

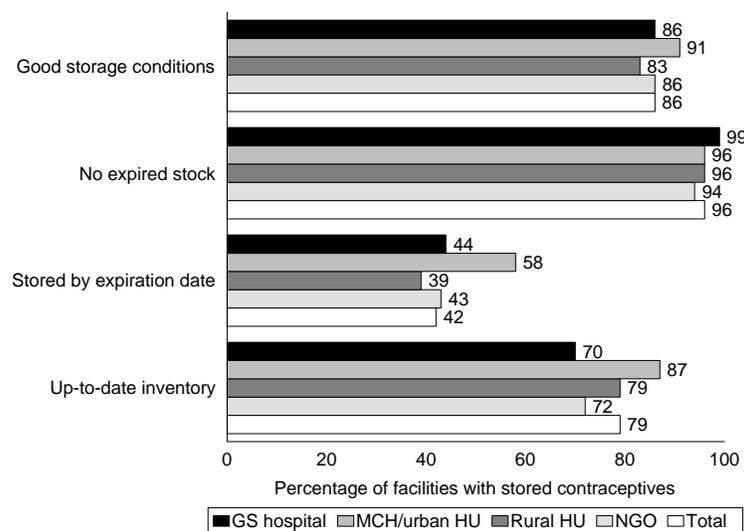
² No expired items present, items stored by expiration date and up-to-date inventory available.

³ Fever hospitals do not provide family planning services so they were excluded from analysis. Data were missing for 17 facilities providing clinical methods of family planning.

⁴ Access was not available for 129 facilities (20 percent), and 39 facilities had no storage of medicines.

NA = Not applicable

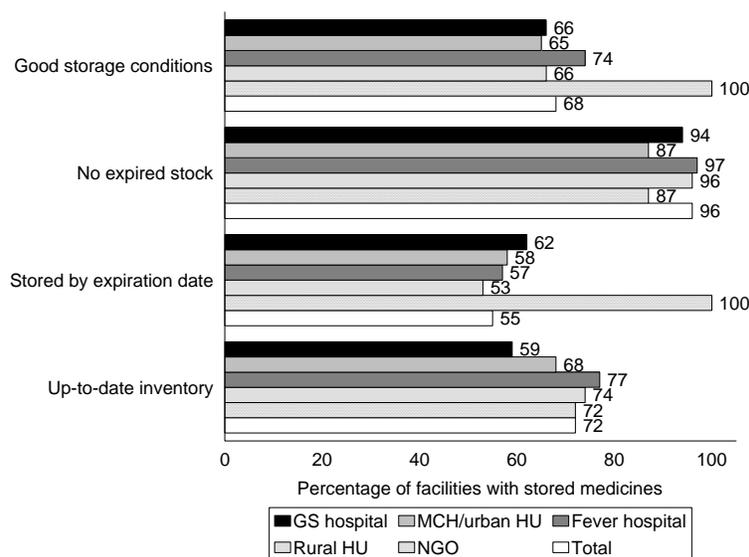
Figure 3.10 Elements for storing and monitoring stock for contraceptives (N=604)



Note: Twenty facilities had no observed contraceptives.

Egypt SPA 2002

Figure 3.11 Elements for storing and monitoring stock for medicines (N=482)



Note: No access or no stored medicines at 129 facilities; assessed medicines not available at 39 facilities.

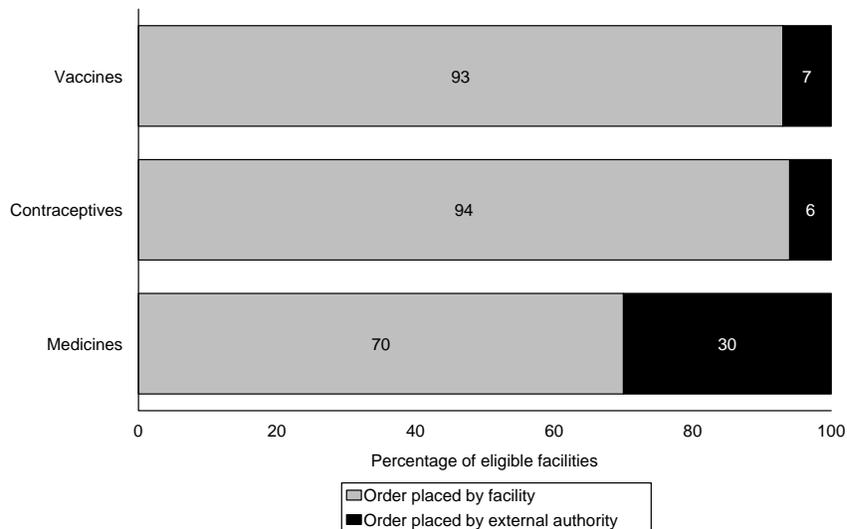
Egypt SPA 2002

3.3.3 Ordering Systems and Timely Receipt of Commodities

To maintain an adequate supply of medical commodities and to prevent wastage due to excess stock, facilities must place orders in sufficient time to allow delivery before experiencing a stock outage. For ensuring this, orders are frequently adjusted, depending on prior utilization, current stock, and anticipated utilization. Common systems for determining how much of a commodity to order and when to order range from the most basic (a fixed amount of specific commodities is supplied at a given time interval) to ideal (individual facilities order or purchase the amounts required when needed, based on utilization patterns, and receive their full order). The type of ordering system and the responsiveness of the health system to the facility needs frequently depend on management capacity, available sources of medicines, funding, and logistic considerations.

Most facilities indicated that they placed their own order for vaccines (93 percent) and contraceptive methods (94 percent), with most of these (85 percent or more) reporting that they reliably received the vaccines or contraceptives as ordered (Figure 3.12 and Appendix Table A-3.17). Ninety-five percent of facilities indicated that they had received their most recent supply of vaccines, and 89 percent received their most recent supply of contraceptives within the prior four weeks (Appendix Table A-3.17). Only 2 percent of facilities indicated that they had not received a supply of vaccines or contraceptives within the past 12 weeks (data not shown). NGO facilities were less likely to have received a recent supply of either vaccines or contraceptive methods, with 55 percent reporting they had received their most recent order of vaccines during the past four weeks and 72 percent indicating this for contraceptive methods. Almost all facilities that placed their own vaccine or contraceptive method order reported that they place an order at least once a month (Appendix Tables A-3.19 and A-3.20). Among facilities reporting that external authorities order their commodities, the reports on reliability of the order were similar, with 83 percent indicating that their vaccine supplies were reliable and 82 percent indicating that their contraceptive supplies were reliable (Appendix Table A-3.18).

Figure 3.12 Who places commodity orders for facilities



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The ordering and supply systems for medicines were less flexible and were reported as less reliable. Only 70 percent of facilities indicated that they placed their own order for medicines (Figure 3.12), and only 4 in 10 facilities reported that they almost always received their expected order (Appendix Table A-3.17). The reported reliability of the supply of medicines was similar for the facilities where the order for medicines was placed by authorities external to the facility, with 35 percent reporting that their order was reliably received (Appendix Table A-3.18).

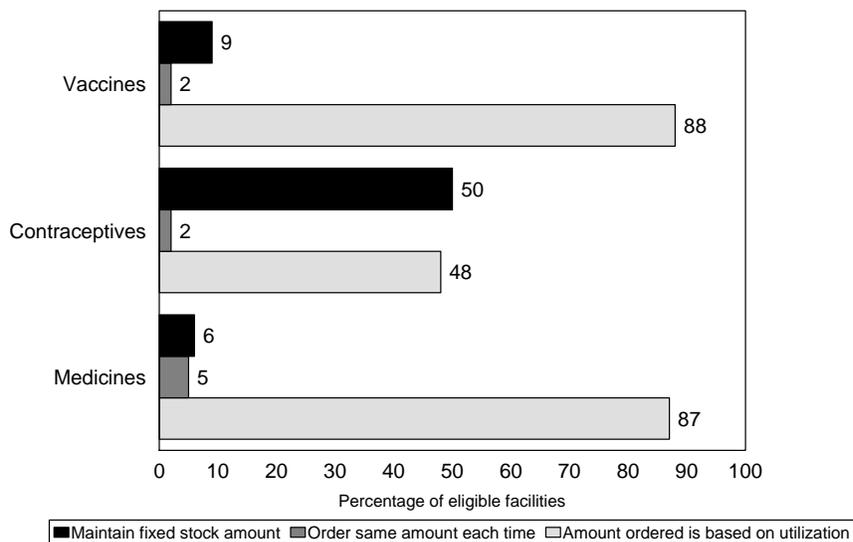
Eighteen percent of facilities indicated that they place their order for medicines less often than once a month (Table A-3.20), and 76 percent of facilities indicated that they had received a supply of medicines during the past 4 weeks (Table A-3.17), with 3 percent indicating that they had not received an order during the past 12 weeks (data not shown).

Ensuring the variety and amounts of medicines that are supplied to different levels of facilities is a more complex endeavor than ensuring the supply of vaccines or contraceptive methods, since the variety in type and need for the latter commodities is more limited. Stored medicines were observed in only small percentages of mobile units, health offices, and NGO facilities. A lack of availability of essential medicines was noted in all service areas assessed. Availability of essential medicines is discussed in the report section for each specific service assessed.

Among facilities placing their own commodity order for vaccines, 88 percent reported using activity levels and anticipated utilization to determine how much to order. Utilization was also the basis for the order for 87 percent of facilities that place their own order for medicines (Figure 3.13 and Appendix Tables A-3.19 and A-3.20). The practice for ordering contraceptive methods, however, was different, with 50 percent of facilities reporting that they order to maintain a fixed stock amount and only 48 percent reporting that they base the amount ordered on utilization (Figure 3.13 and Appendix Table A-3.20). Among facilities where authorities external to the facility determine the commodity order, the proportions that base their order on activity are similar to those found when facilities order their own stock for each

commodity. A higher proportion of facilities where the order was placed by external authorities ordered a fixed amount for each commodity, as compared with those facilities that placed their own order (Appendix Tables A-3.19 through A-3.21).

Figure 3.13 Method for determining amount of vaccine, contraceptive methods, and medicines to order, for facilities reporting that they place their own order



Egypt SPA 2002

Key Findings

Problems in monitoring and maintaining a safe temperature for storing vaccines were noted with all types of facilities. NGO facilities that stored vaccines were notable, however, in their lack of functioning thermometers in vaccine refrigerators.

Management of stock for all commodities was notably weak, with storage by expiration date and maintenance of an up-to-date inventory lacking for more than half of the facilities for all three commodity categories.

Most facilities (over 90 percent) have flexible ordering systems for vaccines and contraceptives and perceive the systems as reliable.

The systems for ordering and the reliability of receiving the amount ordered were less flexible for medicines than for other commodities, with only 70 percent of facilities placing their own orders and only 40 percent of these reporting that they consistently received their full order.

3.4 Systems for Infection Control

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

The components of general infection control and universal precautions assessed by the ESPA were as follows:

- Facility-level capacity to adhere to standards for quality sterilization or high-level disinfection (HLD) of equipment for reuse
- Storage practices that maintain appropriate levels of cleanliness of equipment
- Infection-control items in relevant service delivery areas. These included 1) soap and water for hand washing; 2) chlorine-based decontaminating solution for immediate immersion of contaminated equipment that will be reused; 3) puncture-proof, covered containers (sharps containers) for disposing of needles, blades, or other sharp items to prevent accidental injury and possible subsequent infection with HIV or hepatitis; and 4) clean latex gloves
- Safe disposal of contaminated (biohazardous) materials
- Conditions and practices for safe injections.

Summary information on capacity for processing equipment is presented in Table 3.11, and aggregate information on capacity for processing equipment and infection control measures available in service delivery areas is presented in Table 3.12. Details on elements assessed for capacity to process equipment and items for infection control are presented in Figures 3.14 through 3.17. Further details are presented in Appendix Tables A-3.22 through A-3.25.

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

Percentage of facilities that have functioning equipment (equipment and power source, if required), knowledge of minimum processing time and temperature, and an automatic timing device for at least one sterilization or high-level disinfection process; percentage with an automatic timing device; percentage with time-steam-temperature-sensitive (TST) tape; and percentage with written guidelines or protocols for processing equipment, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:						Number of facilities (weighted)
	Capacity for proper sterilization/HLD process ¹						
	Equipment	Equipment and knowledge of process time	Functioning automatic timing device	Equipment, knowledge of process time, and automatic timer	TST tape	Written guidelines or protocols for sterilization or HLD present	
Type of facility							
GS hospital	96	81	75	75	8	17	64
Fever hospital	33	20	10	10	0	0	13
MCH/urban HU	87	71	44	44	2	36	65
Rural HU	76	56	44	44	1	24	367
Mobile unit	93	79	55	55	0	11	38
Health office	50	34	21	21	0	33	32
NGO facility	78	44	44	43	12	15	71
Region							
Urban Governorates	90	72	41	41	6	44	65
Lower Egypt	72	56	46	46	3	22	315
Upper Egypt	82	57	47	46	2	18	270
Total	78	58	46	45	3	23	650

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

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

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

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

For syringes and most examination equipment, either sterilization or HLD procedures are sufficient to prevent the spread of infection. For killing the spores that cause illnesses such as tetanus, however, either the dry sterilization or autoclave system (or, less frequently used, chemical sterilization¹³) is required. These systems are necessary for processing gloves or surgical equipment that will be reused, including blades and scissors used to cut an umbilical cord.

To properly process equipment, the used equipment should first be decontaminated (soaked in a 0.5 percent chlorine solution for at least 10 minutes) and then brush-scrubbed with soap and water. The equipment must then be processed at the proper temperature for the proper time, and it must be stored under sterile or HLD conditions (dry, stored in sterile wrapping or a sterile or HLD box that closes with a clasp). The date of sterilization should be indicated because sterility cannot be ensured after one week unless the item is also sealed in plastic.

¹³ Formaldehyde or glutaraldehyde (Cydex).

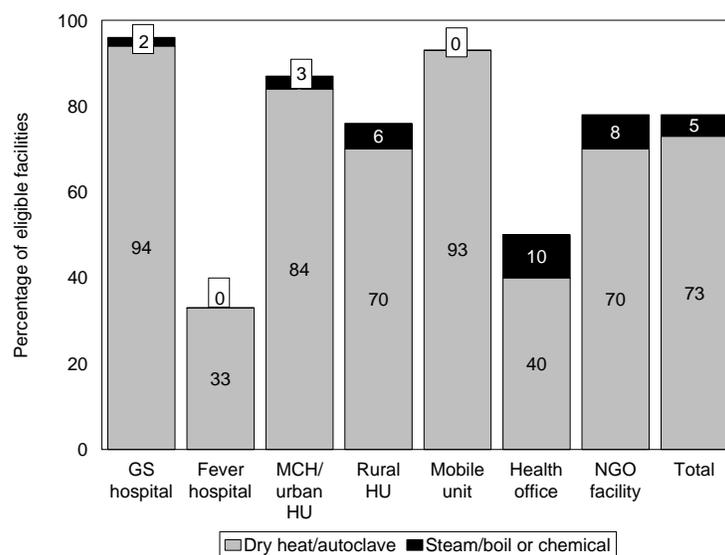
Table 3.12 Infection control and hazardous waste control					
Percentage of facilities that store sterile or HLD processed items under adequate conditions, percentage that have all items for infection control in service delivery areas assessed by the ESPA, percentage with an adequate disposal system for hazardous waste and no unprotected waste was noted, by type of facility and region, Egypt SPA 2002					
Background characteristics	Percentage with sterile storage conditions and processing dates on sterilized items ¹	Weighted number of facilities with stored processed items	Percentage with all items for infection control in service delivery areas ²	Percentage with adequate waste disposal system ³	Number of facilities (weighted)
Type of facility					
GS hospital	23	60	1	32	64
Fever hospital	38	3	0	21	13
MCH/urban HU	15	57	4	31	65
Rural HU	6	313	3	30	367
Mobile unit	0	36	9	25	38
Health office	5	25	11	32	32
NGO facility	14	61	13	29	71
Region					
Urban Governorates	20	63	22	45	65
Lower Egypt	12	256	3	25	315
Upper Egypt	5	236	3	32	270
Total	10	555	5	30	650
¹ Items are wrapped and sealed with TST (time-steam-temperature-sensitive) tape, or items are in sterile or HLD-processed container that clasps shut, and processing time is written.					
² Soap and water in all areas, sharps box in all areas (except consultation for sick child), disinfecting solution and latex gloves in family planning, antenatal care, delivery, and STI service delivery areas					
³ Final disposal of contaminated waste is to incinerate, bury, or remove off site, and waste is not visible or is kept under protected conditions on day of survey.					

The elements assessed for supporting consistent quality sterilization or HLD processing were 1) functioning equipment, 2) a power source for heat, 3) an automatic timer that indicates when the required amount of time has elapsed, and 4) a staff member who knows the proper processing time¹⁴ (and temperature, if relevant). The availability of other means for evaluating the quality of the procedure (such as temperature indicator tape) and written guidelines or procedures were also assessed. Often, facilities process equipment differently depending on the size of the facility and the functional status of the equipment. Thus, the ESPA assessed the highest-level capacity for a facility, rather than its stated “most common method.” Also, depending on the size of a facility, equipment may be processed with different methods or in more than one site in the facility. Information presented in this chapter refers to the primary site in the facility where equipment is processed. Information on the processing of equipment used in the family planning, STI, and delivery service areas is discussed in sections of the report where these services are assessed.

Three in four facilities had functioning equipment for sterilizing (either a dry heat sterilizer or an autoclave) (Figure 3.14); an additional 5 percent had equipment for either steaming or boiling or had an appropriate chemical for chemically disinfecting equipment. Ninety-four percent of general service hospitals, but only 33 percent of fever hospitals, had functioning equipment for sterilizing equipment.

¹⁴ Equipment that automatically sets the temperature or time was acceptable even if the staff could not tell how long the processing took or the temperature for processing. The ESPA also accepted reports of processing times (and other procedures) given after looking in a manual for facilities where interviewed providers checked a manual.

Figure 3.14 Highest level of sterilization or HLD for which there is functioning equipment in each type of facility (N=650)



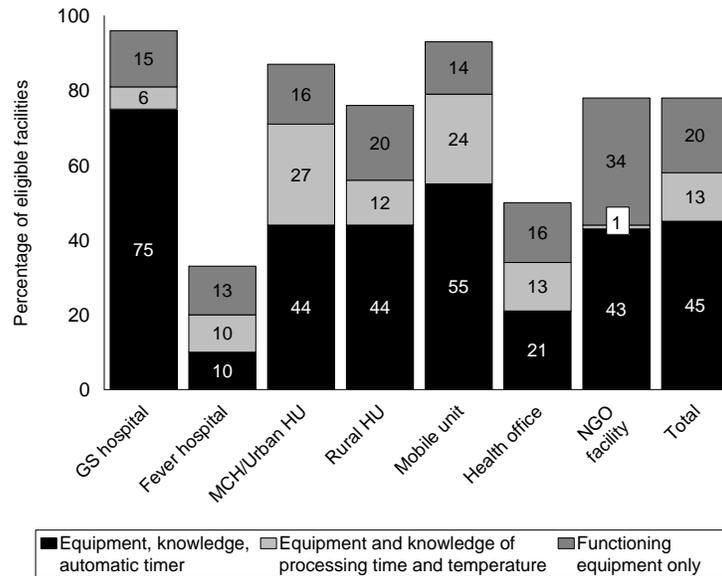
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An automatic timer (one that can be set to indicate when the correct processing time has passed—including automatic timers on machinery) was only available in 46 percent of facilities (Table 3.11).

Although almost all facilities (78 percent) had the equipment or chemicals for sterilization or HLD processing of equipment only 58 percent had the equipment and knew the appropriate processing time (and temperature, for dry heat sterilization) for the method. Even fewer (45 percent) had the equipment, knowledge of processing time, and an automatic timer (Figure 3.15 and Table 3.11). Availability of equipment with knowledge of correct processing time and temperature and an automatic timer varied from 75 percent of general service hospitals to 10 percent of fever hospitals. An additional 2 percent of general service hospitals had equipment for HLD processing.

Three percent of facilities had time-steam-temperature-sensitive (TST) tape that is used to seal wrapped equipment and that indicates equipment has been autoclaved at the correct temperature for a sufficient amount of time. This was found primarily in general service hospitals (8 percent) and NGO facilities (12 percent). Twenty-three percent of facilities had a written guideline for processing equipment in the area where the equipment was processed (Table 3.11). An additional 2 percent of facilities reported that they had protocols, but they were unable to show them (data not shown). The availability of guidelines varied by region with 44 percent of facilities in Urban Governorates having written guidelines, compared with 22 percent of those in Lower Egypt and 18 percent in Upper Egypt.

Figure 3.15 Capacity to sterilize or HLD process equipment (any process) (N=650)



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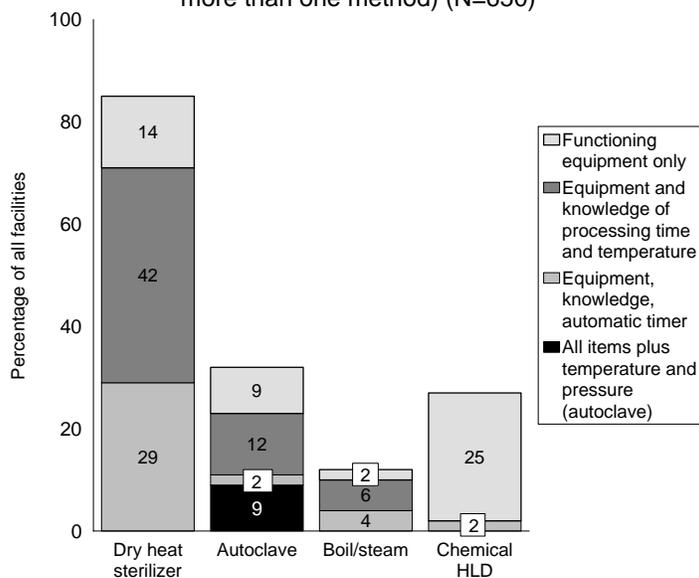
Findings that staff lack knowledge of appropriate processing times and/or that there are no automatic timing devices do not necessarily mean that facilities do not follow proper procedures. It is possible that the staff who process equipment were not available for interview the day of the survey or that careful staff may use a watch to time processing in place of an automatic timing device. However, for assurance that procedures will be systematically followed, it is important that there are both a means for ensuring that proper procedures are known by at least one staff on duty (e.g., written procedures that are easily accessed) and a method for ensuring that no mistake is made with the processing time (a timer that can be set to indicate when the necessary time has elapsed).

Among the various methods for processing equipment, dry heat sterilization was the one for which functioning equipment, knowledge of correct processing temperature and time, and an automatic timer were most often found (29 percent of facilities); an additional 42 percent of facilities had the equipment and knowledge of processing time but lacked the timer (Figure 3.16).

The next most commonly found capacity was for autoclave processing, with 9 percent of facilities having a functioning autoclave with staff who could report the correct processing time, temperature, and pressure for correct utilization and an additional 14 percent of facilities with staff who had knowledge of correct processing time. Although knowledge of temperature and pressure utilized for autoclaves was assessed and was included in the analysis when determining the capacity to carry out autoclave procedures, responses for pressure and temperature should be interpreted cautiously. The respondent in more than half of facilities having autoclaves reported that they did not know the pressure and/or the temperature required and did not have an automatic machine (Appendix Table A-3.22). Among the other half of facilities, many responses were so far beyond the normal temperatures or pressures that it was likely that either the question was not understood or the respondents were guessing. Among those with an answer that appeared relevant to the question, 41 percent of facilities indicated a reasonably correct temperature and 15 percent indicated a reasonably correct pressure for autoclaving materials. Followup to determine whether the correct temperatures and pressures for autoclaving are known and being used is indicated.

Few facilities had the equipment and power source for heating water to boil or steam (12 percent). Among these, however, essentially all (10 percent) knew the correct processing time. Chemical processing is rarely used: only 1 percent of facilities indicated that they used it, although 25 percent did have a chlorine-based chemical for decontaminating equipment and 2 percent knew the time and had an automatic timer (Figure 3.16).

Figure 3.16 Facilities with indicated elements for processing equipment using indicated method (facility may have more than one method) (N=650)



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3.4.2 Appropriate Storage Conditions for Processed Items

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

Among the 85 percent of facilities where there were any sterile or HLD items present (Appendix Table A-3.23), 1 in 4 were storing the items under conditions that were adequate for maintaining HLD or higher level of cleanliness, but only 1 of 10 had any written date of when the equipment was processed (Table 3.12). General service hospitals, fever hospitals, MCH/urban HUs, and NGO facilities were more likely to store and date processed items under conditions to maintain sterility/HLD status. Documenting processing date, while important for maintaining quality, may have less practical importance in small facilities where items are routinely processed and used either the same day or within a few days. An additional 67 percent of facilities stored items under clean conditions (Appendix Table A-3.23). Storage conditions considered “clean” were processed items stored 1) on a tray under a towel, 2) unwrapped in a sterilizer or autoclave; 3) in a disinfecting solution; or 4) wrapped but not sealed.

3.4.3 Infection Control and Hazardous Waste Control in Service Delivery Area

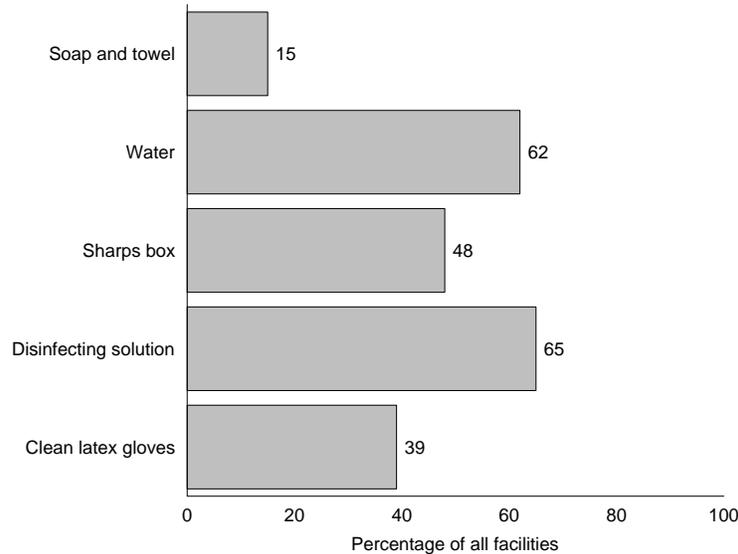
Nosocomial infections (infections that are contracted from the health facility) are always possible and complicate caregiving for any health system. Control measures and constant vigilance are needed to prevent infections. Items that were assessed for infection control were the following:

- Soap and water for hand washing
- Sharps box
- Disinfecting solution (in areas where reusable equipment might be contaminated by blood or body fluids)
- Clean, latex gloves.

So that providers can wash their hands before and after seeing each client, soap and water must be in the immediate vicinity of the area where patients are being seen. Knowing that a facility has water does not provide any indication as to whether it is in a location convenient to service providers. For example, it is unlikely that providers will go to a water pump or tap outside of the building between seeing each client. Because of the frequency with which even inside piped water systems malfunction because of maintenance problems, the presence of soap and water in each service area must be ensured. In addition, where relevant, service delivery areas must have a sharps box (to decrease injury and inadvertent exposure to hepatitis or HIV if staff are stuck or cut); mixed, chlorine-based disinfecting solution (for immersing reusable contaminated equipment such as speculums and minor surgical equipment); and clean latex gloves.

All relevant infection control items were available in all assessed service delivery areas in only 5 percent of all facilities (Table 3.12). Lack of soap for hand washing was the item most often missing (Figure 3.17). Mobile units, NGO facilities, and facilities in Urban Governorates were more likely to have soap (48 percent, 51 percent, and 35 percent, respectively) in all service areas (Appendix Table A-3.24). It should be noted that the examination gloves required, by definition, were latex (either clean or sterile). Thin, nonlatex examination gloves were almost universally available in all service areas where pelvic examinations were conducted. However, these gloves frequently tear during procedures, according to physicians, and they were not accepted by the ESPA for infection control. Information specific to each service delivery site is presented in subsequent chapters.

Figure 3.17 Availability of specific infection control items in all assessed and relevant service delivery areas in a facility (N=650)



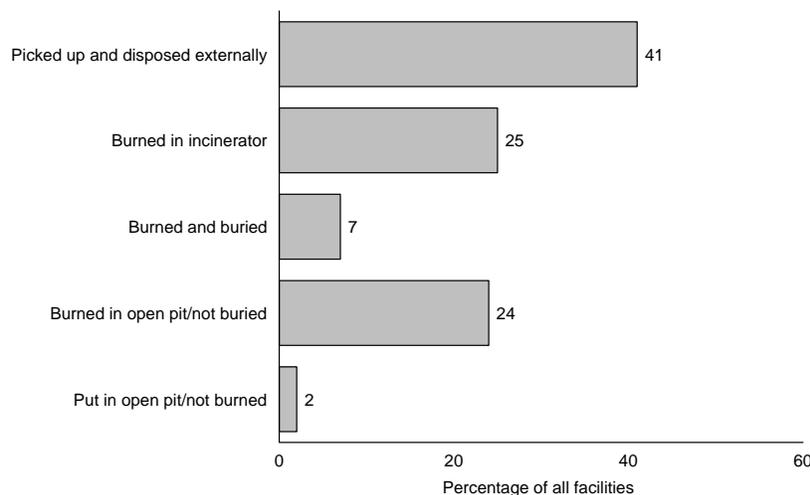
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3.4.4 Adequate Disposal of Hazardous Waste

Contaminated waste includes items (e.g., bandages, used cotton balls, needles, syringes) that may be contaminated by blood or other biological waste and may be infectious if touched. 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. The most important issue is verifying that there is 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, chances are increased that people can inadvertently come in contact with it and risk subsequent infection.

The systems most commonly found during the ESPA that are considered adequate disposal measures were collection and disposal of waste by an external party (41 percent), burning in an incinerator (25 percent), and burning and burying (7 percent) (Figure 3.18 and Appendix Table A-3.25). Data collectors were asked to determine the system utilized by the facility and then to go to the location where waste was stored until disposal or to the disposal site to assess if there was nonprocessed waste that was not protected. Despite more than two-thirds of facilities having an adequate final waste disposal system (data not shown), only 30 percent of the facilities both reported an adequate system and had no unprotected contaminated waste present on the day of the survey (Table 3.12). Effective disposal conditions were found in similar proportions for all types of facilities. They were found more often in facilities in Urban Governorates (45 percent) than in those in Upper Egypt (32 percent) or Lower Egypt (25 percent).

Figure 3.18 Waste disposal methods for hazardous materials (N=650)



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Key Findings

Six percent of general service hospitals did not have functioning equipment for sterilization; 18 percent of all facilities had no functioning equipment for either high-level disinfection (HLD) or sterilization.

Support for consistent adherence to quality sterilization or HLD procedures (equipment, an automatic timer, knowledge or a written reference for the time required for processing) were lacking in more than half of facilities (and in 25 percent of general service hospitals).

Among the facilities with stored, sterile, or HLD-processed items, most (90 percent) ensured that the items were kept clean. Only 23 percent, however, stored the items under conditions appropriate for maintaining sterile or HLD status, and only 10 percent wrote the date of processing on items that were stored adequately.

Capacity to adhere to infection control measures at all relevant service delivery areas was weak, with hand-washing soap the item most consistently missing. Only 5 percent of all facilities had all items for infection control in all assessed service delivery areas.

Although three in four facilities used appropriate systems for disposal of contaminated waste, only 30 percent also ensured that nondisposed of contaminated waste was kept in a protected environment.

3.5 Conditions and Practices for Safe Injections

The ESPA assessed infection control measures in facilities offering curative care for sick children, in service areas where injections are provided, and observed the procedures used when administering injections. Observers were asked to observe at least five injections being provided in the facility, with the priority for therapeutic rather than vaccination injections and for children rather than adults. Injections for family planning are assessed in the section of the report where family planning services are assessed.

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

In total, 867 injections were observed from 290 different facilities out of the 570 facilities offering curative care for sick children. Among the facilities in which there were no observed injections, the principal reason was that no eligible clients for observation were present at the facility on the day of the survey. Among the observed clients, 51 percent were younger than five years of age, and 65 percent received immunizations (data not shown).

Table 3.13 Observed injection practices					
Among facilities providing therapeutic or immunization injections where injection procedures were observed, percentage where a new needle and syringe was used, percentage where the provider was observed opening a new syringe/needle packet, percentage where the facility supplied the needle and syringe, and percentage where a sharps box was used after the injection, by age category of client and type of injection, Egypt SPA 2002					
Client age/type of injection	Percentage of observations				Number of observed injections (weighted)
	New syringe and needle used	Provider observed opening new syringe/needle packet	Facility provided new needle and syringe	Provider disposed of used needle in sharps box	
Client < 5 years	98	91	89	80	440
Therapeutic injection	95	94	41	45	84
Vaccination	98	90	100	88	357
Client 5+ years	99	99	83	66	427
Therapeutic injection	98	98	68	53	218
Vaccination	100	100	99	78	209
Total	98	95	86	73	867

Forty-seven percent of facilities provided immunizations and therapeutic injections for children in the same location, 33 percent had a different injection room for therapeutic injections, and 20 percent indicated that they either did not provide therapeutic injections or did not have a specific location for therapeutic injections (Appendix Table A-3.26). Facilities that did not provide therapeutic injections were most commonly the mobile units (77 percent) and NGO facilities (47 percent). When there were two separate locations for immunizations and for therapeutic injections, the separate injection room was more likely to have soap (23 percent, compared with 17 percent) and less likely to have a sharps box (55 percent, compared with 84 percent) than were service areas that provide both immunizations and therapeutic injections (Appendix Table A-3.27).

Although almost all (98 percent) injections were with new needle and syringes, only 86 percent of the injections used syringes provided by the facility. The disparity was greatest for fever hospitals (100 percent used new needles and syringes, but only 57 percent of the needles and syringes were provided by the facility and NGO facilities (100 percent used new needles and syringes, but only 47 percent were provided by the facility) (Table 3.13 and Appendix Table A-3.28). The provider was actually observed opening the new needle and syringe packet for 95 percent of observed injections. Disposal of used needles in sharps boxes was not universal. Health offices were the most likely to use the sharps boxes (92 percent of observations), and NGO facilities were least likely (26 percent of observations). Sharps boxes were found more often in the room where immunizations were given (84 percent) than in the room where therapeutic injections were provided (55 percent) (Appendix Table A-3.27), and providers of child immunizations were twice as likely to dispose of the needle in a sharps box (88 percent) than were

providers of therapeutic injections (45 percent) (Table 3.13). Findings on the use of the sharps box were similar for injections received by clients over five years of age.

Key Findings

Use of new syringes and needles for injections is universal (98 percent).

Although almost all (98 percent) injections were with new needles and syringes, only 86 percent of the injections used syringes provided by the facility. The disparity was greatest for fever hospitals (100 percent used new needles and syringes, but only 57 percent of the needles and syringes were provided by the facility) and NGO facilities (100 percent used new needles and syringes, but only 47 percent were provided by the facility).

Facility-provided syringes and needles are universal for immunizations.

Sharps boxes are more widely used by providers of immunizations (about 80 percent of observed immunization injections) than by providers of therapeutic injections (about half of observed therapeutic injections). This reflects the availability of sharps boxes in the injection areas.

Hand-washing soap is lacking in almost all injection areas.

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

According to the World Health Organization (WHO), many sick children who are brought to the attention of health providers do not receive adequate assessment and treatment (WHO, 1999b). It is not uncommon for a provider to treat the symptom that is most evident, without conducting a full assessment of the health status of the child. One result of this practice is that often the underlying cause of an illness or other existing health problems is overlooked. For this reason, WHO and other agencies developed the strategy of integrated management of childhood illnesses (IMCI). The strategy promotes using every visit to a health care provider as an opportunity not only to conduct a full assessment of the child's current health and possible underlying problems, but also to provide preventive interventions such as immunization and growth monitoring (for early detection of faltering growth) to prevent or minimize progression to illness.

The ESPA uses the IMCI guidelines as the basis for assessing child health services and uses the national Expanded Program on Immunizations (EPI) policy as the basis for assessing childhood immunization services. The Egypt Ministry of Health and Population has adopted the IMCI program. It is, however, in an expansion phase with only 28 percent of primary health care facilities included under IMCI at the time of the survey.

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

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

4.1.2 Health Situation of Children in Egypt**Vaccine coverage**

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

Community coverage figures indicate that the EPI program has been very successful. According to the Egypt Demographic and Health Survey conducted in 2000 (El-Zanaty and Way, 2001), 92 percent of

children 12-23 months of age had been fully immunized with the 6 basic antigens (BCG, measles, OPV, and DPT). Ninety-three percent had also been immunized against hepatitis B by 2000.

Childhood mortality and morbidity

The 2000 EDHS provides household-based child mortality data as well as information on illnesses experienced and health service utilization during the two weeks preceding the household visit for the survey. Key findings include the following:

- The infant mortality rate was estimated at 44 deaths per 1,000 live births among children under 12 months of age in the five years preceding the survey.
- The under-five mortality rate was estimated at 54 deaths per 1,000 live births among children under five years of age.
- Sixty-six percent of children with reported acute respiratory infections (ARI) during the two weeks prior to the survey were reported by their caretaker to have been seen by a health professional.
- Antibiotics were reported to have been given to 75 percent of children whose caretaker said they had symptoms of cough and short, rapid breathing during the two weeks prior to the survey.
- Nineteen percent of children under five years were stunted (low height-for-age) and 3 percent wasted (low weight-for-height).
- Seven percent of children under five years were reported by their caretaker to have had diarrhea in the two weeks preceding the survey.
- Asked about feeding during the child's diarrheal illness, 10 percent of caretakers reported they stopping feeding the child, 13 percent reported giving much less food, and 36 percent reported giving somewhat less food. Only 4 percent said they gave more food.
- Asked about providing fluids during the child's diarrheal illness, 10 percent of caretakers reported giving much less, 33 percent reported giving somewhat less, and only 17 percent said they gave more.
- Almost all (98 percent) caretakers interviewed for the 2000 EDHS reported knowledge of oral rehydration therapy (ORT).
- Thirty-three percent of the children with diarrhea were reported to have received ORT and 24 percent to have received antibiotics. A significant proportion of children with diarrhea were reported to have been treated with medicines bought directly from the pharmacy or with home remedies.

4.2 Availability of Child Health Services

Among essential preventive and curative child health services, outpatient care for sick children, routine childhood immunization services (EPI), and routine growth monitoring services were assessed by the ESPA. Table 4.1 provides information on the availability of these child health services. Appendix Table

A-4.1 provides details on the availability of these services at facilities, and Appendix Table A-4.2 provides details on the availability of these services through community outreach.¹

The three assessed child health services (outpatient care for sick children, routine childhood immunizations, and growth monitoring) are offered mainly at the MCH/urban health units (HUs) and rural HUs (65 percent and 81 percent, respectively) (Table 4.1). Almost all fever hospitals (97 percent) offer outpatient care for sick children, but none offers EPI services, and only a few (9 percent) offer growth monitoring services. Among the 51 percent of general service hospitals offering EPI services, all were integrated hospitals; none of the general or district hospitals provided this service (data not shown). Almost all (83 percent) health offices provide immunization services, but only a few (15 percent) provide sick child services. As mentioned previously, it is common under the government health system in Egypt for hospitals to offer curative services but not routine preventive services, but to be located adjacent to a HU or health office that provides preventive services.

Background characteristics	Percentage of facilities that provide:				Number of facilities (weighted)
	Outpatient care for sick children	Growth monitoring	Childhood immunization	All basic child health services	
Type of facility					
GS hospital	98	44	51	34	64
Fever hospital	97	9	0	0	13
MCH/urban HU	99	76	79	65	65
Rural HU	99	81	96	81	367
Mobile unit	46	5	2	0	38
Health office	15	23	83	8	32
NGO facility	60	5	2	1	71
Region					
Urban Governorates	68	40	54	31	65
Lower Egypt	90	59	73	56	315
Upper Egypt	90	65	74	62	270
Total	88	60	71	56	650

Health facilities in Urban Governorates (where there are a larger proportion of hospitals) are more specialized, with only 31 percent providing all three child health services, while those in Lower and Upper Egypt are more integrated, with more than 50 percent of facilities in each region providing the three services from a single facility.

Almost all (92 percent) facilities offering sick child services said the service is available at least 5 days per week (Appendix Table A-4.1). Routine EPI and growth monitoring services are available less frequently. For example, 81 percent of the facilities offering EPI services reported that the services are offered 1 or 2 days per week; only 5 percent reported offering EPI services at least 5 days per week. In Egypt, BCG is sometimes offered as a newborn child health service, separate from EPI services. A small number of facilities that offer EPI services (5 percent) do not offer BCG as one of the vaccines (data not shown). Among the facilities that offer BCG, all except two facilities (less than 1 percent) offer all other immunizations.

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

While growth monitoring services are less available (60 percent of facilities) than other child health services, where growth monitoring is offered, 33 percent of the facilities report the service is available 5 or more days per week. According to the EDHS 2000, 19 percent of children under five years were stunted and 3 percent wasted. In view of this, increased availability of growth monitoring services might be considered as one means for addressing this problem.

One means of increasing availability and coverage for health services is to take services to the population, through outreach services at the village level. This is a common approach internationally for EPI services. Egypt has a high immunization coverage rate (92 percent full immunization, 2000 EDHS) and, as such, village outreach may not be a priority activity. Eleven percent of all facilities, primarily rural HUs (15 percent) and health offices (16 percent), report offering immunization services through village outreach (Appendix Table A-4.2). Only 6 percent of facilities include BCG vaccine among the vaccines provided through outreach. Sick child services and growth monitoring services through outreach are reported less often, with 4 percent of facilities offering these services through outreach (primarily facilities in Lower Egypt, where 5 percent reported offering sick child services and 8 percent reported offering growth monitoring services through outreach). Whether sick child and growth monitoring services are routine components of outreach services or whether they are provided as needed (e.g., if a sick child is brought to an immunization session, the service provider may diagnose and treat the illness) was not clarified.

Key Findings

One in two facilities offers the three assessed child health services (outpatient care for sick children, EPI, and growth monitoring). All three services are found most often at MCH/urban HUs (65 percent) and rural HUs (81 percent).

Outpatient care for sick children is the most commonly offered child health service (88 percent of facilities) and growth monitoring the least offered (60 percent). Given documented levels of malnutrition, increasing availability of growth monitoring services might be desired.

Only 5 percent of facilities offer EPI services 5 days per week.

4.3 Capacity to Provide Quality Immunization Services

The following section addresses elements that are important for quality immunization services. They include the following:

- Capacity to maintain the quality of vaccines
- Availability of all vaccines
- Availability of equipment and supplies for vaccination session
- Availability of administrative components for monitoring immunization activities.

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 may 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,

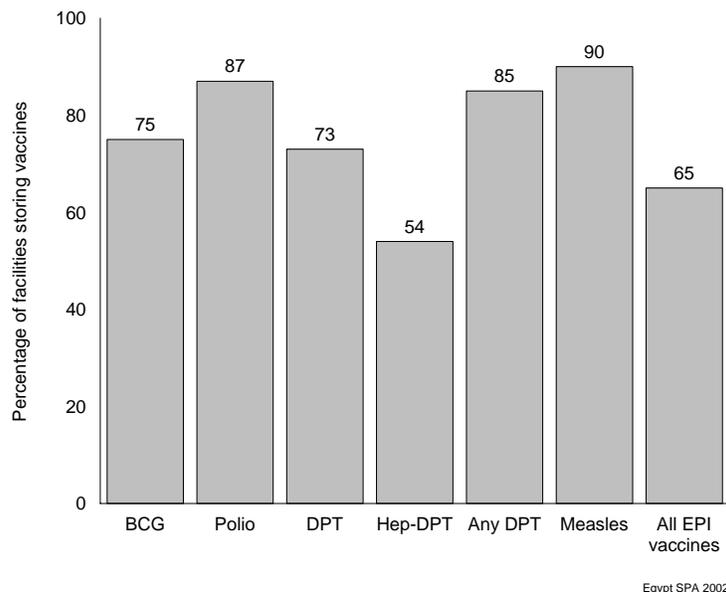
with details on elements assessed provided in Table 3.9 and Appendix Table A-3.14. As shown in Table 3.9, 76 percent of facilities storing vaccines had all elements for monitoring and storing vaccines under quality conditions. Only 37 percent, however, had all elements for adequately monitoring the stock.

4.3.2 Availability of Vaccines

The ESPA obtained information on the availability of child vaccines at facilities reporting child immunization services. These results are summarized in Figures 4.1 and 4.2. Additional detail on vaccine availability is found in Appendix Table A-4.3.

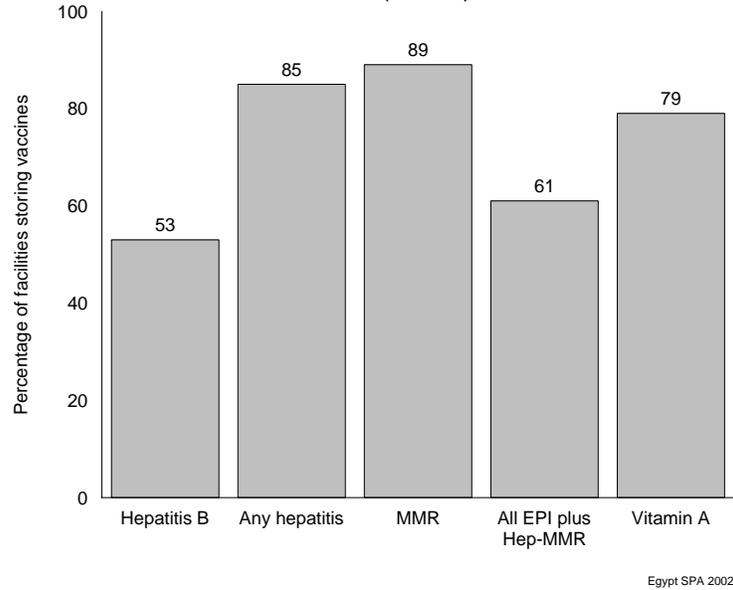
Within facilities that both offer child immunization services and store vaccines, all basic vaccines for the six major childhood diseases were available in 65 percent of facilities (Figure 4.1). All basic vaccines were found in 88 percent of the health offices, 80 percent of MCH/urban HUs, and 70 percent of the general service hospitals (Appendix Table A-4.3). DPT was missing at 15 percent of facilities (DPT was available either alone or combined with hepatitis vaccine), BCG at 25 percent of facilities, and polio at 13 percent of facilities. The combined vaccines against measles-mumps-rubella (MMR) and hepatitis B (HB), which have recently been added as routine child vaccines, were available in 89 percent and 85 percent of facilities, respectively (hepatitis was available either alone or combined with DPT). All basic vaccines as well as MMR and HB were available in 61 percent of facilities storing vaccines (Figure 4.2), with all most often available at health offices (85 percent) (Appendix Table A-4.3).

Figure 4.1 Availability of vaccines among facilities offering child vaccination services and storing vaccines (N=373)



It is a recommended WHO policy to routinely distribute high-dose vitamin A capsules to children, to provide protection from respiratory infections that are more common when children are vitamin-A-depleted. This activity has been added to the EPI program components in many countries. In Egypt, the policy is to provide the high-dose vitamin A at 9 months and at 18 months of age. Seventy-nine percent of facilities that store vaccines also had vitamin A available on the day of the survey (Figure 4.2).

Figure 4.2 Availability of additional child vaccines and vitamin A among facilities offering child vaccination services and storing vaccines (N=373)



4.3.3 Availability of Equipment and Supplies for Vaccination Sessions

Items assessed for quality EPI services were the following:

- Individual child immunization records
- Vaccine syringes
- Cold boxes and ice packs
- Items for infection control.

A summary of the availability of components assessed for quality immunization services is provided in Table 4.2, with Figure 4.3 and Appendix Table A-4.4 providing details on these items.

Individual child immunization records (cards or child health booklets where immunizations are recorded) are an integral part of immunization services and should be available wherever child immunizations are provided. Since mothers often keep their children's health records, the ESPA checked for the availability of blank records. Individual child immunization records were available in 95 percent of health offices (Appendix Table A-4.4), although they were available in only 77 percent of all facilities offering child immunizations (Figure 4.3). An additional 6 percent of facilities that were not offering EPI services the day of the survey reported they had child EPI cards but were unable to show them (data not shown).

Table 4.2 Health system components required for childhood immunization services

Percentage of facilities offering child immunization services at the facility that have all equipment, items for preventing infection, and records indicating good administrative practices, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering child immunization with:				Number of facilities offering child immunization services ⁴ (weighted)	Percentage of facilities offering child immunization services and storing vaccines with:		Number of facilities offering child immunization services and storing vaccines (weighted)
	All equipment ¹	All items for infection control ²	Administrative components ³	All equipment, items for infection controls, and administrative components		All basic child vaccines ^{5, 6}	All components for providing quality child immunization services (including vaccines) present	
Type of facility								
GS hospital	55	17	85	11	33	70	15	25
MCH/urban HU	48	31	36	5	52	80	5	48
Rural HU	59	12	72	7	352	59	6	274
Health office	70	11	88	7	26	88	7	26
Region								
Urban Governorates	49	60	63	20	35	91	22	33
Lower Egypt	49	11	67	6	228	54	5	174
Upper Egypt	69	10	74	6	201	71	5	166
Total	58	14	70	7	465	65	6	373

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

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

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

⁴ All facilities offered immunizations at the facility, in addition to some facilities offering the service through village outreach activities.

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

⁶ In addition, all vaccines were found at one mobile unit and one NGO facility that provide child immunization services but do not store vaccines.

Egypt uses disposable syringes and needles universally. On the day of the survey, at least five of each size syringe and needles for BCG (1 or 0.5 ml) and for other vaccines (2 or 3 ml)² were available at 72 percent of the facilities offering child immunization services (Figure 4.3). An additional 10 percent of facilities that were not offering EPI services the day of the survey indicated they had the syringes but were unable to show them (data not shown).

During vaccination sessions, vaccines are frequently stored in portable cold boxes to maintain the temperature of vaccines that are being used and to avoid the need for frequent opening of freezers and refrigerators. Almost all of the facilities offering child immunization services (99 percent) had cold boxes and ice packs for transporting vaccines and for maintaining the cold chain during vaccination sessions (Figure 4.3).

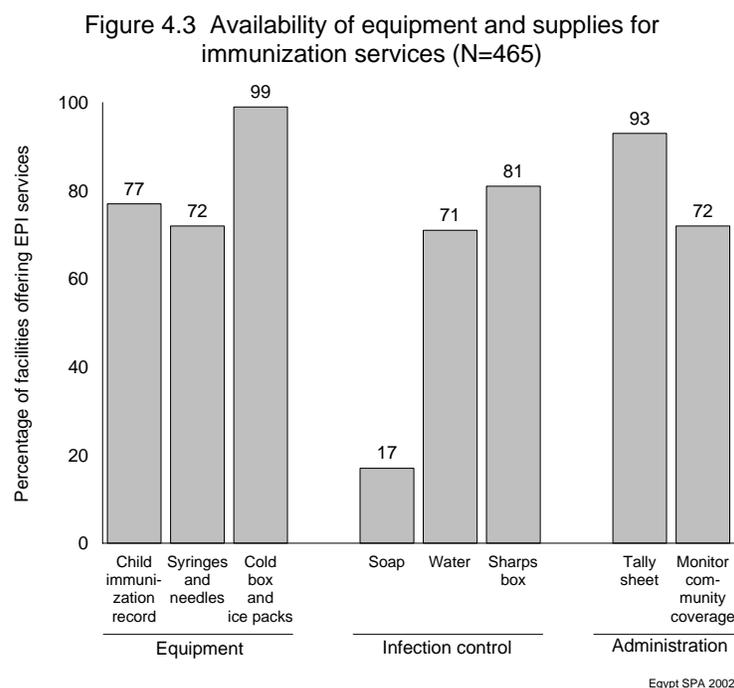
All equipment for quality immunization services was available in 58 percent of facilities, with all items more often available in health offices (70 percent) than in other types of facilities, and more often in facilities in Upper Egypt (69 percent) than in Lower Egypt and Urban Governorates (49 percent, each) (Table 4.2).

A provider must be able to wash hands between clients for infection control. While water was available in the immunization service area in 71 percent of facilities, soap was only available in 17 percent of facilities (Figure 4.3). Water availability was similar between types of facilities (Appendix Table A-4.4); although there was a large difference between regions (94 percent of facilities in Urban Governorates had water, while only 66 percent of those in Lower Egypt had water in the immunization service area the day of the survey). Most facilities had piped water (72 percent), with 1 percent providing the water for the immunization area in a bucket or basin (data not shown). Soap was more often available in MCH/urban HUs (33 percent) than in other facilities, and similar to findings for water, soap was more available in

² This was defined for the ESPA as the minimum supply required for “availability of syringes and needles.”

facilities in Urban Governorates (60 percent had soap) than those in Upper and Lower Egypt (12 and 13 percent, respectively) (Appendix Table A-4.4).

Sharps boxes for safely disposing of needles and syringe were available in 81 percent of the immunization service delivery areas, with health offices and MCH/urban HUs (91 and 88 percent, respectively) more likely to have sharps boxes in the immunization area than other types of facilities (83 percent of general service hospitals and 80 percent of rural HUs) (Appendix Table A-4.4).



All items for infection control were available in only 14 percent of all the facilities providing immunization services. These included 60 percent of facilities in Urban Governorates, but only about 10 percent of facilities located in other regions (Table 4.2).

Actual injection practices were verified in facilities offering sick child services (see section 3.5). Among immunizations observed being provided in these facilities (N=357 children below 5 years of age), almost all provided new needles and syringes, although among the observed injections a small proportion (2 percent) used a needle and syringe that was not observed in a sterile packet (multiple syringes may have been removed from their packet prior to an immunization session to speed up the injection process), so the status could not be verified (Table 3.13). It was noteworthy that used needles were disposed of in sharps boxes for 88 percent of observed child immunizations.

4.3.4 Availability of Administrative Components for Monitoring Immunization Activities

The ESPA looked for evidence of record keeping that provides information for monitoring immunization activities. Specific items assessed were as follows:

- Documentation for immunizations provided and
- Evidence of monitoring immunization coverage.

Nine in ten facilities (93 percent) had an up-to-date register (or tally sheets) for documenting immunizations provided (Figure 4.3), with little difference by type of facility (Appendix Table A-4.4).

Measures often used for monitoring immunization coverage include the DPT dropout rate (the difference between the number of children who receive the first dose of DPT and the number among those who completed the three doses of DPT), and vaccine coverage rates (the percentage of eligible children who have been fully immunized with a specific vaccine or with all vaccines). Measures of immunization coverage require an estimate of a target population. The ESPA specifically assessed whether the DPT dropout rate or measles coverage information was available. Seventy-two percent of facilities had documentation that they monitored either DPT dropout or measles coverage (Figure 4.3), with about 90 percent of health offices and general service hospitals having documentation (Appendix Table A-4.4). Only 37 percent of MCH/urban HUs had any records indicating they monitor immunization coverage information.

In total, 58 percent of facilities offering child immunization services had all of the essential equipment, 14 percent had all infection control items, and 70 percent had both administrative components (Table 4.2). Only 7 percent of facilities (ranging from 20 percent of facilities in Urban Governorates to 6 percent in other regions), however, had all essential equipment, infection control items, and administrative components assessed for quality immunization services. Among the facilities storing vaccines and offering child immunization services, 6 percent had all equipment, infection control, and administrative components as well as all vaccines. The main weakness in all cases was the availability of soap for washing hands (Appendix Table A-4.4).

Key Findings

Eight in ten facilities that offer child immunization services also store vaccines.

Sixty-five percent of the facilities storing vaccines had all basic vaccines for child immunizations available the day of the survey. BCG, DPT, and polio vaccines were missing in 25 percent, 15 percent, 14 percent of facilities, respectively.

All basic vaccines for children, plus MMR and hepatitis B, were available at 61 percent of facilities storing vaccines.

Use of disposable syringes and needles for immunization is universal in Egypt, but only 72 percent of facilities had at least five BCG (0.5 or 1 ml) syringes and five 2 or 3 ml syringes available in the EPI service area the day of the survey.

Nineteen percent of facilities did not have a sharps box in the immunization area.

Observation of immunization injections, in facilities providing sick child services, verified that new, sterile needles and syringes are used universally, and that sharps boxes are used for disposing of needles in most (88 percent of the observed immunizations) cases.

All items for infection control were available in the immunization service delivery area in only 14 percent of facilities. Soap for hand washing was the item most often lacking.

4.4 Capacity to Provide Quality Outpatient Care for Sick Children

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

- Assessing immunization status and providing vaccines that are due

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

The ESPA 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). Elements that were assessed were as follows:

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

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

Items for supporting quality assessment and counseling for the sick child include the following:

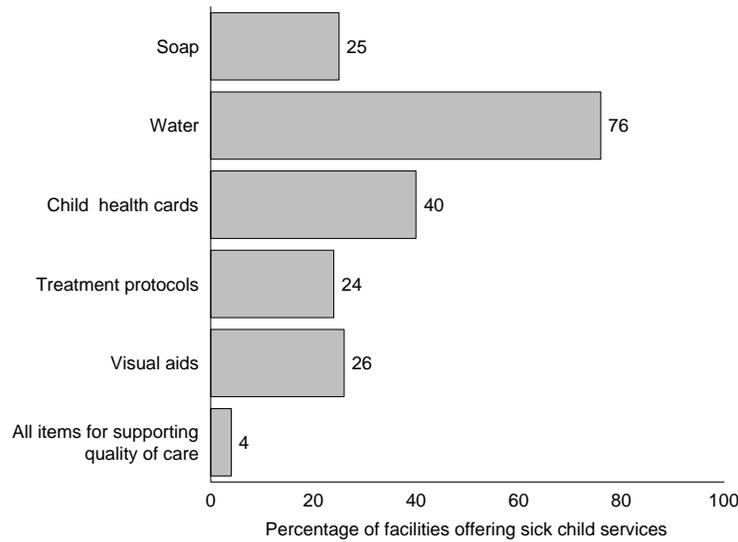
- Items for infection control
- Individual child health cards
- Treatment protocols
- Visual aids.

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

Among facilities offering sick child services, 25 percent had soap and 76 percent had water in the area where sick child services are provided (Figure 4.4). Water was provided primarily through piped systems (74 percent), except for mobile units, where more than half (58 percent) had water provided in a bucket with a tap and 27 percent had used a bucket or basin without a tap on the day of the survey (data not shown).

Use of individual child health records is important for continuity of care, providing a means for maintaining a record of prior illnesses and treatments. Because many facilities do not keep child health records but give them to the caretaker to maintain, the ESPA assessed whether blank cards (for use with new clients) were available. New individual child health cards were available at 40 percent of facilities (Figure 4.4) (with nearly half of rural HUs having cards, but only 14 percent of fever hospitals having cards) (Appendix Table A-4.5).

Figure 4.4 Availability of items to support quality of care for sick children (N=570)



Egypt SPA 2002

One in four facilities had treatment protocols or guidelines in the delivery area for use during consultations (Figure 4.4). These were most commonly found at rural HUs (30 percent) (Appendix Table A-4.5). The IMCI program has been introduced in a limited number of facilities in Egypt (28 percent of the primary health care facilities), and the IMCI chart booklet or wallchart (with guidelines for treatment) was available in 17 percent of facilities, primarily in rural HUs (21 percent) (Appendix Table A-4.6).

Visual aids and other materials for providing health education were not frequently found. Only 26 percent of facilities had any visual aids or other materials to support provision of health education to caretakers of sick children receiving care. These materials were more often available in MCH/urban HUs and rural HUs (both approximately 30 percent) (Appendix Table A-4.5). IMCI counseling cards and mother cards, for health education, were available in 14 percent and 16 percent of facilities, respectively (Appendix Table A-4.6).

Four percent of facilities had all items (soap and water, child health cards, treatment protocols, and visual aids) for supporting quality of care for sick child services (Figure 4.4). Soap, treatment protocols, and visual aids were lacking in equal proportions.

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

As mentioned previously, it is common that curative care is provided in hospitals and preventive services in health offices or MCH/urban HUs (frequently located adjacent to hospitals). The result of this system is that all services needed to follow IMCI guidelines are often, by design, not available in the same facility. Where this service arrangement is found, close coordination between the managers of the two adjacent facilities is needed for any assurance that a sick child will be able to receive all services required for adherence to IMCI guidelines.

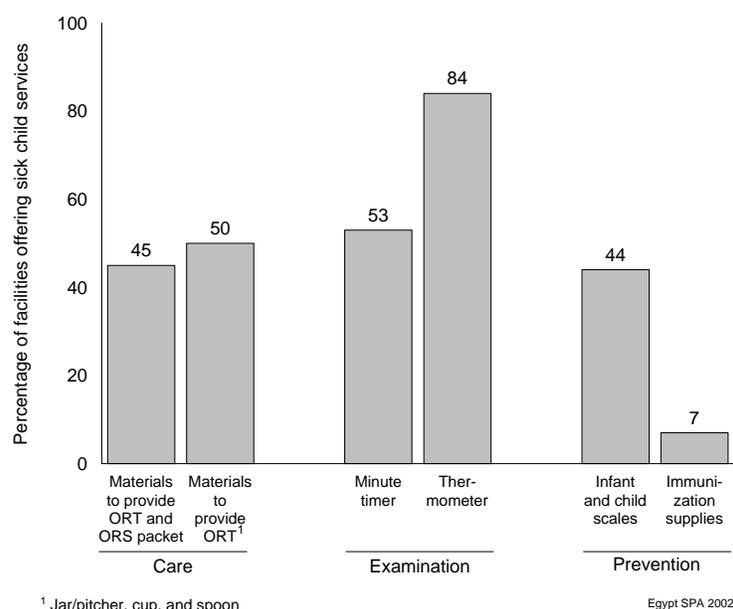
When assessing capacity to adhere to IMCI guidelines, the ESPA did not look at adjacent facilities to determine service availability. The ESPA looked at facilities that provide sick child services and assessed the availability of the equipment and supplies necessary for assessing the status of sick children and for

providing preventive interventions for adherence to IMCI guidelines. Items assessed included the following:

- Equipment and supplies for providing immunization
- Equipment for growth monitoring
- Equipment for assessing the severity of illness.

Figure 4.5 summarizes information on these items. Table 4.3 provides aggregate information for all assessed items. Appendix Table A-4.5 provides details on these items, by type of facility. Appendix Table A-4.7 provides information on the availability of sick child and EPI services on the same day in the same facility.

Figure 4.5 Availability of equipment and supplies for assessing health status of the sick child (N=570)



Among the facilities offering sick child services, 7 percent had all components (basic vaccines, syringes, cold boxes, items for infection control in the EPI service area, and child immunization cards) for quality immunization services the day of the survey (Figure 4.5). Thus, most facilities that offer sick child services have neither the service delivery pattern or the capacity to adhere to the IMCI guidelines for using every contact with the facility to provide needed immunizations.

Only 9 percent of facilities, primarily MCH/urban HUs (30 percent) indicated that immunization services are offered every day that sick child services are offered. Both immunization and sick child services were being offered, on the day of the survey, at 19 percent of facilities (36 percent of MCH/urban HUs and 20 percent of rural HUs) (Appendix Table A-4.7).

Findings were similar for the capacity of facilities offering sick child services to adhere to the IMCI guidelines for assessing the nutritional status of all sick children. Weighing scales are necessary for assessing a child's nutritional status. While 60 percent of facilities offering sick child services had a scale

appropriate for weighing an infant (100 gram increments) and 60 percent had a scale appropriate for measuring a child (maximum 250 gram increments), only 44 percent had scales for both infants and children (Figure 4.5 and Appendix Table A-4.5). The availability of this equipment did not vary greatly between types of facilities, except for mobile units, where no scales were found. Height boards (for weight-for-height assessments) were available in 61 percent of facilities (Appendix Table A-4.5).

Evaluating fever by touch is sufficient to meet the IMCI guidelines, but a thermometer provides a more objective assessment. Thermometers were available in most facilities (84 percent). For assessing the severity of respiratory illness, a clock or other means for measuring one minute is necessary to count the respiratory rate. Although a wristwatch with a second hand is sufficient, the ESPA looked for a facility supplied device (such as a wall clock with a second hand). Slightly more than half (53 percent) of facilities had a facility-based minute timer in the sick child service delivery area (Figure 4.5 and Appendix Table A-4.5). In practice, almost all staff had a wristwatch with a second hand, which would enable them to count respirations if necessary.

Other equipment assessed for evaluating illness included a wooden tongue depressor for examining the throat of a child, and a light to see the back of the throat. While 60 percent of facilities had wooden tongue depressors, only 31 percent had a light that could be used to see the back of the throat (Appendix Table A-4.5).

IMCI guidelines indicate that oral rehydration therapy (ORT) should be provided on-site for children with specified degrees of dehydration. Materials (jar/pitcher, cup, and spoon) for mixing and administering ORT were available in half of the facilities offering sick child services. They were most commonly found at MCH/urban HUs (62 percent) and rural HUs (56 percent) (Appendix Table A-4.5). A majority (75 percent) of the facilities offering sick child services had packets of oral rehydration salts for making ORS solution (Appendix Table A-4.8), and 45 percent had both the administration materials and the ORS packets (Figure 4.5).

Only 19 percent of facilities had all items for assessing the sick child (child weighing scales, thermometer, facility minute timer) and had materials for administering ORT (Table 4.3). All items were most often found in facilities in Urban Governorates (30 percent) and MCH/urban HUs (27 percent).

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

Percentage of facilities offering outpatient care for sick children (SC) that have all items for assessments and preventive interventions, all first-line and pre-referral medicines, oxygen with a regulator, and a nebulizer, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:					Number of facilities offering SC services ⁵ (weighted)
	All essential equipment and supplies ¹	All essential medications ⁴		Oxygen and regulator	Nebulizer	
		First line ²	Prereferral ³			
Type of facility						
GS hospital	8	59	53	27	29	63
Fever hospital	0	79	51	36	24	13
MCH/urban HU	27	73	9	22	17	65
Rural HU	22	70	26	19	20	365
Mobile unit	0	11	0	0	0	17
NGO facility	8	5	3	14	14	42
Region						
Urban Governorates	30	61	31	34	27	44
Lower Egypt	18	63	28	19	21	282
Upper Egypt	18	62	20	18	19	244
Total⁵	19	62	25	19	19	570

¹ Equipment: infant and child weighing scale, facility equipment for measuring one minute, supplies for on-site administration of ORT (jar/pitcher, cup, and spoon), and a thermometer. (The items needed to provide quality immunizations are not included because providing immunizations with sick child services is not an implemented policy in Egypt.)

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

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

⁴ Eleven percent of facilities either did not have medicine stocks or the ESPA did not gain access to the pharmacy. For these facilities, if the medicine was not observed in another area, such as a distribution pharmacy, it is classified as not available.

⁵ Includes data for five health offices providing sick child services.

4.4.3 Essential Medicines for Treating Sick Children

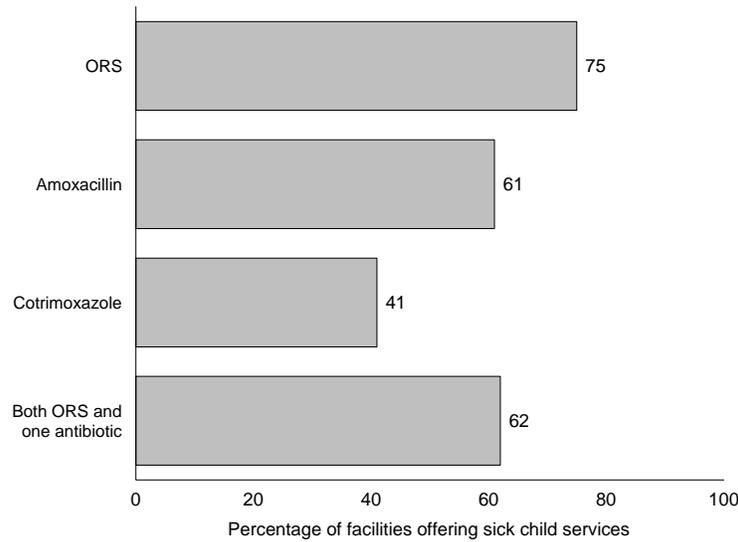
The ESPA assessed the availability of essential medicines for sick child services as defined in IMCI guidelines. Summary information on the availability of medicines for sick child services is provided in Figures 4.6 through 4.8, with Appendix Table A-4.8 providing details on these items, by type of facility. In addition, information was collected on specific items for treating respiratory illness. Table 4.3 provides aggregate information on the items.

According to IMCI guidelines, essential medicines for treating a sick child include first-line, pre-referral, and other important medications. First-line medicines include ORS (solution prepared from packets of oral rehydration salts) and oral antibiotics such as amoxicillin or co-trimoxazole for respiratory infections.

Eleven percent of the facilities offering sick child services either stocked no medicines or were unable to provide access to the pharmacy. These were primarily NGO facilities (88 percent of those offering sick child services), nearly 40 percent of mobile clinics and health offices, as well as 4 percent of rural HUs and 2 percent of general service hospitals (data not shown). Since sick child services were being provided during the survey visit, if the assessed medicines were not observed—even if they were locked away somewhere—they were classified as not available for clients.

Seventy-five percent of facilities had ORS packets, 62 percent had at least one of the oral antibiotics, and 62 percent had all of the essential first-line oral medicines for sick children (Figure 4.6), with more than 70 percent of the fever hospitals, MCH/urban HUs, and rural HUs having these items (Appendix Table A-4.8).

Figure 4.6 Availability of first-line medicines for treating sick children (N=570)

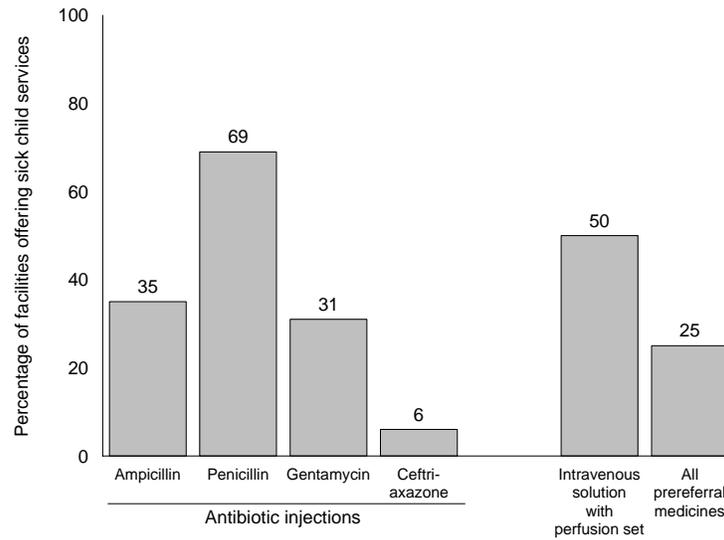


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Pre-referral medicines include injectable medications for providing urgent treatment before transferring to another facility or admission to the current facility, if necessary. IMCI guidelines define basic prereferral medications as injectable antibiotics for serious infections (ampicillin or penicillin, and ceftriaxone or gentamicin are recommended), and intravenous solution (either normal saline, dextrose and normal saline, or Ringers lactate) with perfusion sets for treating severe dehydration. According to the MOHP policies at present, however, only hospitals are authorized to provide rapid rehydration for severely dehydrated children using intravenous solutions. Among all facilities offering curative care for sick children, one in four had all prereferral medicines to adhere to IMCI prereferral treatment guidelines (Figure 4.7). Among the general service and fever hospitals offering sick child services, more than half had all prereferral medications (Table 4.3 and Appendix Table A-4.8). One in four rural HUs also had all prereferral medicines; although this level facility is expected to refer severely dehydrated children rather than to rehydrate them at the facility. Intravenous supplies are multipurpose, so most likely they were available at the nonhospital-level facilities for other treatments. Availability of all prereferral medicines was more common for facilities located in Urban Governorates and Lower Egypt (31 percent and 28 percent, respectively) than in Upper Egypt (20 percent) (Table 4.3).

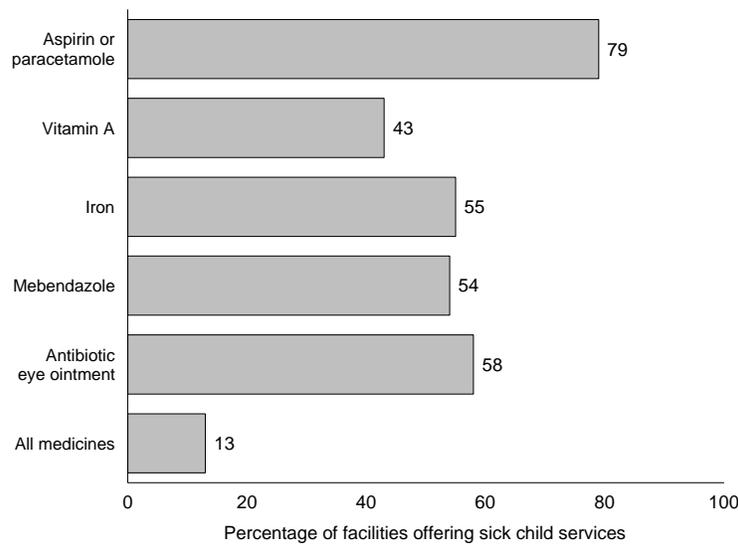
Other essential medicines are those that may be less critical for treating serious illness but are important for treating common symptoms and illnesses of sick children. These include an antipyretic (aspirin or paracetamol), vitamin A and iron supplements, a deworming medication (anthelmintic), and antibiotic eye ointment. With the exception of aspirin or paracetamol, only around half of the facilities had any of each of the other essential medicines, and only 13 percent had all of these items (Figure 4.8). There were variations by facility type in the availability of the different medicines, with mobile units and NGO facilities being least likely to have each of the individual items (Appendix Table A-4.8).

Figure 4.7 Availability of prereferral medicines (injectables) (N=570)



Egypt SPA 2002

Figure 4.8 Availability of other essential medicines (N=570)



Egypt SPA 2002

In addition to the items mentioned above, availability of specific items for managing respiratory illness were assessed. Overall, 19 percent of facilities had an oxygen cylinder with oxygen and a regulator and 19 percent had a nebulizer (Table 4.3). Not unexpectedly, the availability of these items was more common in the sick child service areas at hospitals than at other types of facilities. Oxygen was available for outpatient care of the sick child at 27 percent of general service hospitals and at 36 percent of the fever hospitals; nebulizers were available for outpatient care of the sick child at 29 percent of general service hospitals and at 24 percent of fever hospitals. Oxygen was available at 34 percent of facilities located in

the Urban Governorates (compared with 19 percent and 18 percent in Lower Egypt and Upper Egypt, respectively) and a nebulizer was available at 27 percent of facilities in the Urban Governorates (compared with 21 percent and 19 percent in Lower Egypt and Upper Egypt, respectively).

Key Findings

The IMCI program is in its early phase in Egypt, having been introduced in around one in four primary health care facilities. IMCI guidelines or counseling materials were available at 17 percent of facilities.

Child immunization services are not routinely offered and supplies are not available at facilities on the same days services for sick children are offered.

Items to support quality of care for sick children (soap and water for infection control, individual child health cards, treatment protocols, and visual aids) were not commonly available, with soap, treatment protocols, and visual aids each missing from three in four facilities.

Medicines are lacking at the facilities for all levels (first-line, prereferral, and additional treatments) of services for sick children.

With regard to prereferral treatments, MOHP standards limit the scope for facilities other than hospitals to provide prereferral intravenous rehydration. Nearly three-quarters of general service and fever hospitals had the capacity to provide intravenous rehydration but only around half among both categories of hospitals had all prereferral medicines.

4.5 Management Practices Supportive of Quality Sick Child Services

Management practices that were assessed for supporting quality curative care for sick children include the following:

- Facility documentation and records
- Practices related to user fees
- Supervision and staff development.

Summary information on the availability of these items is presented in Table 4.4. Appendix Table A-4.9 provides sick child client utilization statistics for facilities in the ESPA. Appendix Table A-4.10 provides information on routine charging practices for sick child services. Data collected from caretakers of sick children provide additional information on financing systems clients belonging to that may defer or decrease out-of-pocket costs paid for sick child services the day of the survey. Results from these interviews are presented in Appendix Tables A-4.11 and A-4.12. Figure 4.9 provides summary information on in-service training experiences of child health service providers. Appendix Tables A-4.13–A-4.15 provide details on in-service training and supervision from the perspective of the child health service provider.

Table 4.4 Management practices supportive of quality child health services						
Percentage of facilities providing outpatient care for sick children (SC) that had an up-to-date patient register for sick-child services, percentage where there are some charges for consultation services for the sick child, percentage where at least half of the interviewed providers of child health services received in-service training related to child health services during the past 12 months, and percentage where at least half of the interviewed providers of child health services were personally supervised during the past 6 months, by type of facility and region, Egypt SPA 2002						
Background characteristics	Facilities with outpatient care for sick children		Number of facilities offering SC services (weighted)	Percentage of facilities where at least half of the interviewed child health service providers:		Number of facilities with interviewed child health service providers (weighted)
	Percentage with observed up-to-date patient register ¹	Percentage with charges for SC services		Received in-service training during past 12 months ²	Were personally supervised during past 6 months	
Type of facility						
GS hospital	49	91	63	12	84	63
Fever hospital	46	94	13	5	90	13
MCH/urban HU	58	92	65	18	97	65
Rural HU	38	94	365	21	98	365
Mobile unit	28	65	17	15	96	17
Health office	50	75	5	18	95	23
NGO facility	7	97	42	11	48	40
Region						
Urban Governorates	72	95	44	30	85	51
Lower Egypt	43	91	282	15	95	286
Upper Egypt	28	95	244	20	91	250
Total	40	93	570	18	93	587

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.

4.5.1 Facility Documentation and Records

Although 47 percent of facilities were able to show a register where information on sick child clients was recorded (data not shown), only 40 percent were able to produce an up-to-date register, where there was an entry within the prior 7 days with documentation of the child's age and diagnosis (Table 4.4). The discrepancy between observed and up-to-date registers was found primarily in facilities in Upper Egypt, where 41 percent of facilities were able to show a register (data not shown), but only 28 percent met all of the conditions for being up-to-date.

The median monthly numbers of outpatient sick child consultations for each facility, (from monthly statistics provided by ESPA facilities the day of the survey), ranged from 3 for NGO facilities to 336 for general service hospitals (Appendix Table A-4.9). Facilities in Urban Governorates documented more sick child consultations each month (median 386 per month) than those facilities in Lower and Upper Egypt (median 83 and 68 children per month, respectively).

4.5.2 Practices Related to User Fees

User fees may have a positive effect on utilization of health facilities (augmenting funds to improve services) or a negative effect (detering poor clients from using services). Public posting of fees for services helps ensure transparency in the fee structure. Charges for sick child consultation services were almost universal (93 percent) (Table 4.4), with most facilities (92 percent) charging a fixed fee for the consultation (Appendix Table A-4.10) with few other out-of-pocket charges. Only 4 percent (26 percent of NGO facilities) indicated that they charged for medicines supplied by the facility. One in five facilities collect a fixed fee for the child health card. One in five facilities had the fee schedule for sick child services posted publicly (Appendix Table A-4.10).

Approximately half (47 percent) of interviewed caretakers for observed sick children reported that the children were covered under some program that decreased out-of-pocket costs. Almost all of these were covered under the government student health insurance program (SHIP) (Appendix Table A-4.11). It was notable that fewer clients attending facilities in Upper Egypt belonged to any program for deferring health care costs than those attending facilities in Lower Egypt or Urban Governorates (32 percent compared with 45 percent and 61 percent, respectively) (Appendix Table A-4.11).

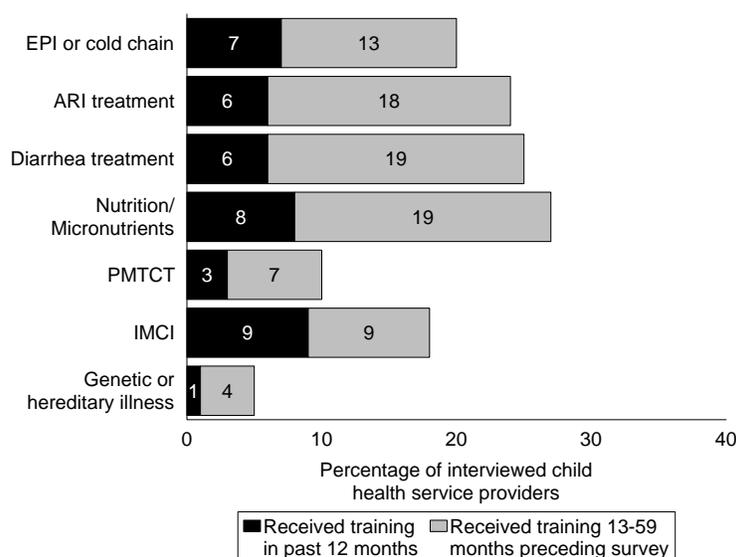
Almost all of the caretakers reported paying the same amount (most likely a registration fee) for the consultation (a median of 100 piasters) (Appendix Table A-4.12) and reported that charges for medicines were not applicable (data not shown). There was no difference between the fee paid by those belonging and not belonging to a program. This information does not capture differences that might result if some clients receive free medicines from the facility and others must purchase medicines from outside the facility.

4.5.3 Supervision and Staff Development

Child health service providers were interviewed from facilities offering any child health services, whether preventive or curative. If at least half of the interviewed child health service providers at a facility had received any structured in-service training (excluding on-the-job training that may be received during discussions with supervisors) relevant to child health during the past 12 months, the facility was defined as providing routine staff development activities. At least half of the interviewed providers had received in-service training related to their service during the past 12 months in only 18 percent of facilities (Table 4.4). Routine provision of in-service training was found least often among providers at fever hospitals (5 percent), and most often among providers at rural HUs (21 percent). Facilities in Urban Governorates were also more likely to routinely ensure in-service training for their providers (30 percent of facilities) compared with those in Lower Egypt (15 percent) and Upper Egypt (20 percent). From the individual provider's perspective, among all interviewed child health service providers, 21 percent reported some structured in-service training related to child health in the past 12 months (Appendix Table A-4.13), with an additional 32 percent reporting in-service training related to child health services 13-59 months preceding the survey.

During the past 12 months, in-service training related to IMCI was received by 9 percent of providers with an additional 9 percent having received in-service training on IMCI 13-59 months preceding the survey (Figure 4.9). Around 6 percent of providers had received in-service training during the past 12 months that was related to acute respiratory infection (ARI), diarrhea, and micronutrients, with nearly 20 percent additionally having received in-service training on the same topics 13-59 months preceding the survey (Figure 4.9, Appendix Table A-4.14).

Figure 4.9 In-service training received by interviewed child health service providers, by topic and timing of most recent education (N=1731)



Egypt SPA 2002

If at least half of the interviewed child health service providers at a facility had been personally supervised during the past six months, the facility was defined as providing routine staff supervision. At least half of the interviewed providers had been personally supervised in the past six months at 93 percent of facilities (Table 4.4). Routine supervision was weakest in NGO facilities (48 percent) and in facilities located in Urban Governorates (85 percent).

From the individual provider's perspective, 90 percent of all interviewed child health providers reported having been personally supervised in the past six months (Appendix Table A-4.13). Among interviewed providers who had been supervised, the median number of times they remembered being supervised was nine times during the past six months (Appendix Table A-4.15). When asked what the supervisor did, more than 90 percent of the interviewed providers indicated that their supervisor checked records, observed their work, and/or provided feedback. Eighty percent indicated they had received information updates, and 82 percent indicated that the supervisor discussed problems. Eighty-five percent of the providers reported that the supervisor wrote in the unit record (Appendix Table A-4.15).

Key Findings

Maintenance of registers for service statistics was noted in less than half of facilities, with facilities in Urban Governorates more likely to have an up-to-date register in the facility (72 percent), than those in Upper Egypt (28 percent) or Lower Egypt (43 percent).

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

In-service topics most commonly received by interviewed providers during the past five years were related to management of ARI (24 percent), diarrhea (25 percent), and nutrition (27 percent).

Eighteen percent of providers had received in-service training related to IMCI during the past five years.

Supervision for child health services is strong across all types of government facilities, with at least half of all interviewed child health providers having been personally supervised during the past six months in 93 percent of facilities. The median number of times staff reported being supervised during the past six months was nine.

The activities of supervisors indicate that supportive supervision activities aimed at improving quality are routine.

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

4.6 Adherence to Guidelines for Sick-Child Service Provision

The observations of sick-child consultations conducted in the ESPA provide the basis for assessing whether providers are adhering to standards for providing quality service. The observation checklists were based on IMCI guidelines and collected information on whether the consultation process included the following:

- Full assessment of the child's illness, including a physical examination, following IMCI guidelines
- Assessment of immunization and nutritional status
- Instruction about preventive measures and how to provide any prescribed treatment
- Adherence to practices to support continuity of care.

Observers watched the process used when sick children were seen at the facility, noting information shared and procedures or examinations conducted. The objective was to note whether information on a topic was shared (process information). An assessment of whether the information was correct or whether findings were appropriately interpreted was not a component of the observation.

A total of 2,013 consultations were observed at 466 facilities. Among the 2,013 observations, 12 caretakers either refused or were not located for the exit interview.

Table 4.5 provides summary information on the assessments and examinations observed and subsequent treatments by the provider, by classification of diagnosis or major symptoms. Figures 4.10 through 4.14 provide information on practices observed during consultations for sick children.

Appendix Tables A-4.16 through A-4.20 provide details on observed practices and information reported from interviewed caretakers of observed sick children.

Table 4.5 Assessments, examinations, and treatment for children, classified by diagnosis or major symptom										
Percentage of observed children who were diagnosed by the provider with the indicated illness or symptom for whom the indicated assessment, examination, and/or treatment was provided, Egypt SPA 2002										
Item	Among children with indicated diagnosis, percentage for whom indicated assessment, examination, and/or treatment was observed									
	Respiratory illness			Febrile illness			Intestinal illness			
	Pneumonia or other severe respiratory illness ¹	Bronchitis moderate or mild	Cough or other non-severe respiratory illness without another severe diagnosis	Severe fever	Fever without other severe diagnosis or cough	Strep throat	Severe or persistent diarrhea or dysentery or any dehydration with diarrhea	Other diarrhea without other severe diagnosis	Other	All other diagnoses
IMCI assessment										
3 major symptoms	36	32	34	41	31	31	29	33	17	28
3 major danger signs	6	1	8	2	6	2	5	7	2	4
Current eating/ drinking	19	11	20	16	23	15	29	23	12	18
Advise continue feeding/ increase food or drink	14	9	13	12	8	11	18	13	3	10
Physical exam										
Temperature	82	68	75	84	69	79	73	65	52	68
Respiratory rate	36	10	25	13	6	10	12	14	5	14
Dehydration	7	9	13	13	21	13	68	37	9	18
Anemia	16	4	16	12	11	10	14	15	10	11
Throat	52	53	57	63	42	81	45	42	29	51
Ear	10	6	10	17	13	13	4	9	10	10
Body muscle	5	1	4	5	0	1	4	5	2	2
Edema	9	1	12	6	3	5	13	10	6	7
Treatment										
Refer/admit	6	1	1	7	3	1	9	1	4	2
Any antibiotic	79	86	49	75	48	90	44	34	34	58
Injectable antibiotic	13	17	5	23	11	22	15	5	5	11
Oral antibiotic	70	75	46	61	38	75	31	31	31	50
Oral bronchodilator	34	31	5	12	2	10	5	1	4	10
Oral medicine for symptomatic treatment ²	79	91	91	94	78	95	78	84	48	81
Oral rehydration (ORS)	3	8	8	10	36	8	72	50	1	17
Intravenous fluid	0	0	0	1	1	0	2	1	0	0
Discussed return visit	33	19	23	35	23	19	21	21	26	23
Percentage of observed children with diagnosis ³	7	19	23	4	17	8	6	19	12	100
Number of children (weighted)	128	345	459	61	180	319	119	405	284	2,013

¹ Pneumonia, bronchopneumonia, or severe bronchitis

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

³ Child may be classified with more than one diagnosis.

4.6.1 Full Assessment of Illness

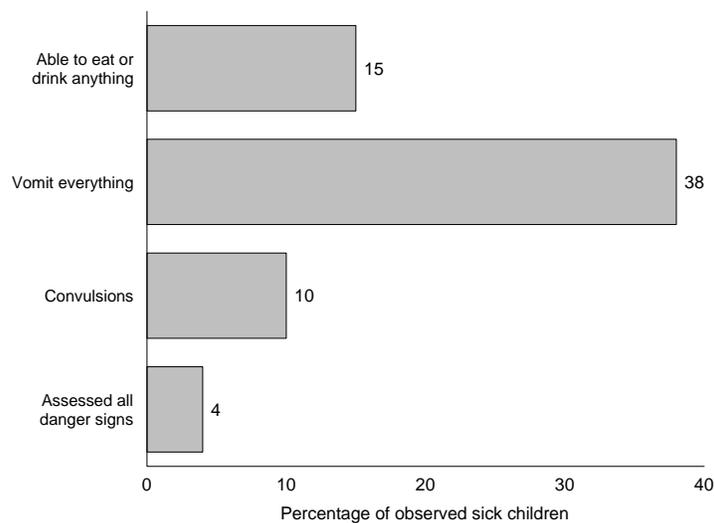
Where there are not sufficient numbers of qualified providers of curative care to provide all child health services, lesser qualified persons can be trained to provide EPI and growth monitoring services, as well as

initial consultation services for sick children. For curative care, however, this assumes that seriously ill children, with illnesses beyond the training of the staff, will be appropriately identified and referred to a better-qualified provider. When reviewing factors that influence quality of care, it is important to know how many facilities depend on referral for the management of severe illnesses. As noted in Chapter 3 (Figure 3.1), almost all of the facilities in Egypt have a physician assigned, and on the day of the survey, almost all (over 99 percent) of the observed sick child consultations were conducted by physicians (Appendix Table A-4.16).

The observation checklist covered all critical IMCI components for assessing an ill child. As noted earlier, IMCI is being expanded and now covers approximately 28 percent of primary health care facilities. The IMCI components for assessing an ill child are not unique to IMCI, however, so they remain a valid guideline when observing the service delivery process. In interpreting the findings, it is recognized that, even following the IMCI guidelines, a provider will use judgment based on the child signs and symptoms. For example, a provider seeing a child who appears to have a common cough or cold and who is clearly alert would not be expected to ask about convulsions or whether the child is vomiting everything or not drinking anything. Thus, findings of low percentages for some categories of assessment do not necessarily indicate poor practices.

According to IMCI guidelines, the major danger signs a provider must assess include whether the child is able to breastfeed or drink anything, whether the child vomits everything, whether the child has had convulsions at home or in the facility, and whether the child is lethargic or unconscious. If there is any doubt about the child's ability to take fluids, the provider should attempt to give the child something orally. Assessments for all danger signs defined by IMCI guidelines were rarely carried out (4 percent of observed consultations) (Figure 4.10). Fifteen percent of the children were assessed for whether they drank anything, including breast milk, 38 percent for whether they vomited all food and drink, and 10 percent for whether they had convulsions.

Figure 4.10 Major danger signs assessed during observed sick child consultations (N=2013)

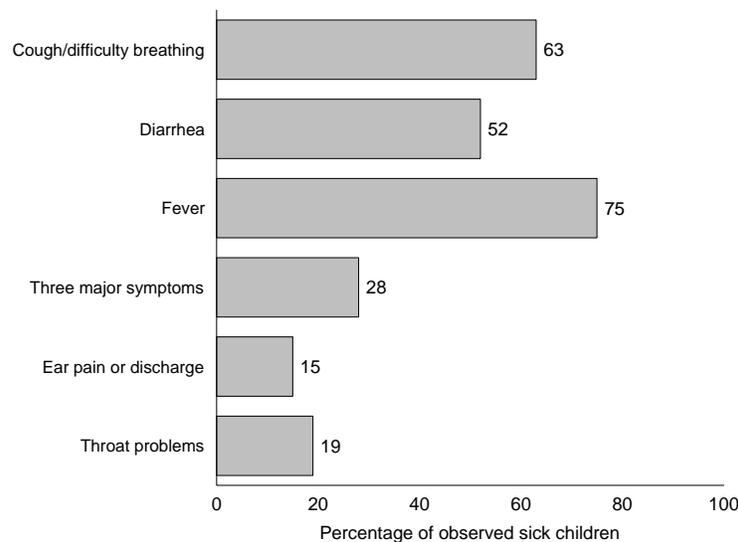


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Regardless of the reason for the consultation, IMCI guidelines call for each child to be evaluated for the major symptoms of cough, respiratory difficulty, diarrhea, and fever. Information may be shared either when the caretaker of the sick child discusses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

Overall, during the course of the consultation, an assessment of the three major signs and symptoms of respiratory problems, diarrhea, and fever were conducted for one in four (28 percent) of the sick children (Figure 4.11). Fever was the symptom most commonly assessed (75 percent), followed by respiratory symptoms (63 percent) and diarrhea (52 percent). Assessment of other symptoms related to common child illnesses, such as ear and throat problems, were less often observed (15 percent and 19 percent, respectively).

Figure 4.11 Major symptoms assessed during observed sick child consultations (N=2013)

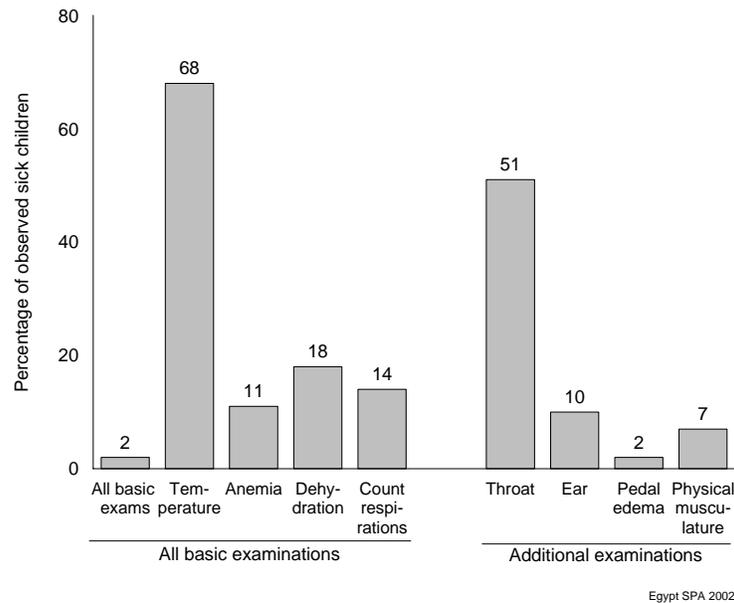


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After information is obtained on the various signs and symptoms of illness, the provider should conduct a physical examination. This should include a hands-on evaluation of the child to verify the presence of fever (by touch or by taking the temperature),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

The most commonly observed examination procedure was taking the child's temperature (68 percent) (Figure 4.12), using a thermometer (56 percent) or by touch only (12 percent) (Appendix Table A-4.16). One in ten children was assessed for the presence of anemia (7 percent checked the palms, 9 percent checked the conjunctiva or mucosa of mouth, and 5 percent checked both) (Appendix Table A-4.16). Dehydration status was assessed for 18 percent of the children, and the respiratory rate was counted for 14 percent of the children. In total, only 2 percent of the children had all of these items assessed. Additional physical examinations observed were whether the throat was checked using a tongue depressor (51 percent, with only 9 percent using any artificial light to observe the throat), 10 percent looked inside and felt behind the ear, 2 percent checked for pedal edema, and 7 percent removed the child's clothing to check the muscular and general physical status. None of the observations included all of these elements of physical examination (Appendix Table A-4.16).

Figure 4.12 Elements of physical examination conducted during observed sick child consultations (N=2013)



There were not consistent differences in the elements of the assessment and physical examination of the child between different types of facilities (Appendix Table A-4.16).

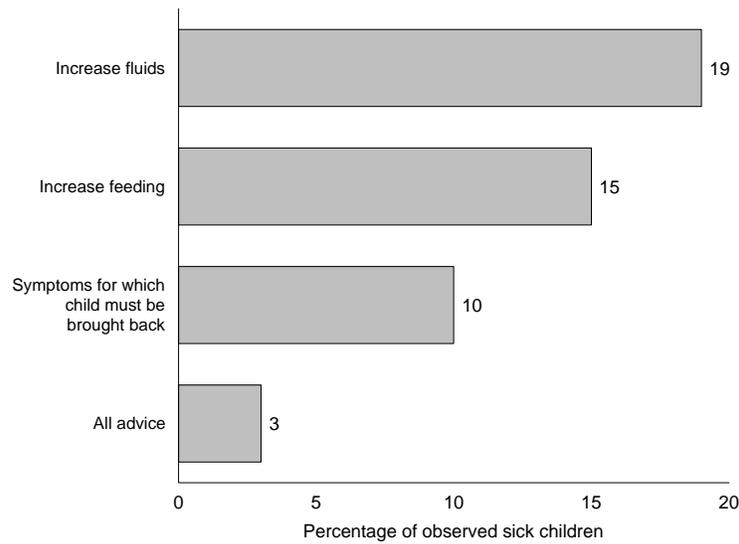
There is a direct relationship between nutritional status and health. It is not uncommon for a child to be caught in a cycle of malnutrition and illness, where malnutrition makes a child more susceptible to illness and illness contributes to malnutrition. Aggravating this cycle is the tendency for sick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

Among children younger than 24 months of age, 18 percent were evaluated for breastfeeding practices during the illness, with this more commonly conducted in health offices (although this represented only 12 children in 5 facilities) and NGO facilities, and 3 percent were specifically assessed for whether they could drink or breastfeed at the time of the consultation (Appendix Table A-4.16).

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

Advice to increase the quantity of liquids was given in 19 percent of the cases; advice to give the same or increased amount of food or breast milk was given to 15 percent of caretakers; and for 10 percent of the cases, the provider discussed signs and symptoms for which the child should be immediately returned to the facility (Figure 4.13). All three items of advice were provided to only 3 percent of clients (Appendix Table A-4.16).

Figure 4.13 Essential advice provided to caretakers of observed sick children (N=2013)



Egypt SPA 2002

After concluding the consultation for the sick child, the observed providers were asked about the diagnosis and major symptoms on which the prescribed treatment was based. This information provided a measure 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, several points should be noted. For severe respiratory illnesses such as pneumonia, bronchopneumonia, or bronchitis, the assessment should include counting the respiratory rate.

This specific assessment occurred for 36 percent of children diagnosed with a severe respiratory illness (Table 4.5). In most of these cases, recourse to antibiotics is warranted, and practically all of the children (79 percent) were given or prescribed antibiotics: 13 percent by injection, 70 percent orally, and some children received both forms. Egypt has implemented a project focusing on physician education to decrease unnecessary injections (Rational Choice). Some success in this campaign is evident when the proportion of injectable antibiotics is compared with the proportion of oral antibiotics prescribed.

Children with severe respiratory illnesses should be examined by a physician and often require hospitalization. Overall, 6 percent of children diagnosed with severe respiratory illness were referred or admitted (Table 4.5). It is interesting to note, however, that among the 22 percent of all cases diagnosed as severe respiratory illness that were observed in general service or fever hospitals, 18 percent were admitted to the facilities (data not shown), and among the 75 percent of cases observed in rural HUs or MCH/urban HUs, only 4 percent were referred (data not shown). This may mean that sick children taken to hospitals were either more seriously ill than those who were taken to rural HUs or MCH/urban HUs, or that severe cases at the health units were less frequently diagnosed or referred. There are many barriers to clients receiving and/or accepting referrals or admission to facilities that may influence the provider's decisions to refer or not refer. One should, therefore, use this information only as an indicator of a need to

conduct a more detailed assessment to determine the quality of care for children with severe respiratory illness.

Among children with non-severe bronchitis, 1 percent were referred or admitted to a facility. Twenty-nine percent of these cases were observed in general service or fever hospitals, where 4 percent were admitted or referred, and 65 percent were observed in rural HUs and MCH/urban HUs, where none were referred or admitted (data not shown). Prescriptions of antibiotics for the bronchitis cases were slightly higher than the proportions seen for severe respiratory illness (86 percent, compared with 79 percent). Among children diagnosed as having a non-severe cough, cold, or other respiratory diagnosis, 22 percent were observed in general service or fever hospitals and 73 percent in rural HUs or MCH/urban HUs with only 1 percent of clients (2 percent of hospital clients and 1 percent of MCH/urban HU clients) referred or admitted (data not shown). Among the clients diagnosed with non-severe coughs and colds, 49 percent were prescribed antibiotics (Table 4.5).

Severe respiratory (pneumonia or bronchopneumonia) or bronchitis cases for whom the provider noted wheezing were prescribed bronchodilator medications twice as often (around 40 percent of cases) as those without (about 20 percent of cases) (Appendix Table A-4.17). Other respiratory illnesses where wheezing was noted also received a higher proportion of bronchodilators (15 percent) than those without (4 percent).

Among children diagnosed as having severe diarrhea or diagnosed with any dehydration linked to diarrhea, 68 percent were physically assessed for dehydration using the skin-pinch test. Using antibiotics inappropriately can prolong the diarrhea. Forty-four percent of the children were given antibiotics, although only 6 percent were classified as having dysentery (data not shown). Among children diagnosed as having severe dehydration, 72 percent received or were prescribed ORS and 2 percent received intravenous fluids (Table 4.5). Referrals were similar for children assessed at hospitals and health centers (data not shown).

For children with severe febrile illness, IMCI guidelines recommend the use of antipyretics followed by referral. Among these children, 7 percent were referred or admitted (Table 4.5). Thirty-three percent were observed at general service or fever hospitals, with 20 percent of these admitted, and 65 percent were observed at rural HUs and MCH/urban HUs, with 3 percent referred or admitted (data not shown). Seventy-five percent of the severe febrile illness cases received antibiotics, with 23 percent of these receiving injectable antibiotics.

Finally, among children diagnosed with strep throat, the throat was examined in 81 percent of the cases and antibiotics were prescribed for 90 percent (with 22 percent receiving an injectable antibiotic). This appears to be appropriate for the diagnosis.

From this brief review it appears that the type of physical examination conducted and treatment provided, including referrals, tended to vary appropriately according to the assessed severity and type of illness. Assessments of symptoms, danger signs, and advice regarding eating and drinking during illness, however, did not consistently vary by severity of illness (Table 4.5). It was interesting that the median time from starting to completing the assessment of the sick children was five minutes (data not shown). It would be difficult to take a full history of signs and symptoms and to physically assess a child in this time.

IMCI guidelines recommend that the first dose of a medicine (particularly an antibiotic) should be provided at the facility so that treatment can begin immediately. This practice also provides an opportunity to reinforce the dosage to the caretaker and to ensure that the child is able to take the medicine. Among children who received any prescription, 3 percent of caretakers reported that their child received the first dose of the prescribed oral medicine at the facility and 4 percent indicated the child

received an injection (Appendix Table A-4.18). This was supported by observers who noted medicines being administered to 1 percent of the children. It was noted that upon departure, 31 percent of the caretakers had all prescribed medicines with them, 22 percent had some medicines and some prescriptions, and 47 percent had only prescriptions (with 16 percent having prescriptions for injections) to be filled outside the facility. This supports the earlier information about the lack of essential medicines at the facilities. More than half of the caretakers were observed being told how to give the medicines; although, only 3 percent were asked to repeat the instructions to verify that they understood. Among the interviewed caretakers, 72 percent indicated that they had been told how to give the medicine, with 73 percent indicating that they felt comfortable with their knowledge of how to give the medicine.

The ESPA observed therapeutic injections provided to children in facilities offering sick child services (the observed children were not necessarily those whose consultation was observed) for infection prevention practices (see section 3.5). Few therapeutic injections were observed (N=84 for children under five years of age) (Table 3.13). Among these, however, new needles and syringes were observed used for almost all (95 percent) injections. The needles were disposed of in sharps boxes, however, for only 45 percent of these observed therapeutic injections.

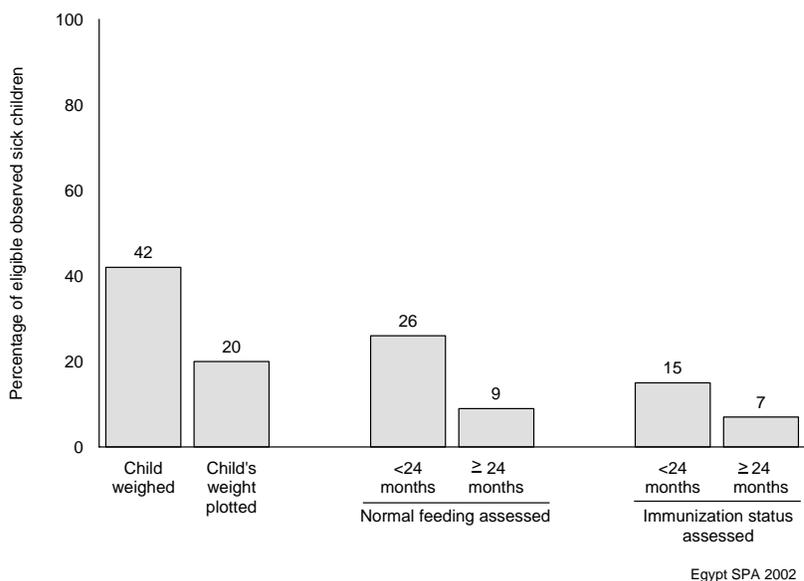
Key Findings
<p>Almost all of the observed sick children were assessed by physicians.</p> <p>Comparison between the observed assessment, prescribed treatment, and final diagnosis by the provider shows that the providers reasonably adapted their evaluation to their assessment of the type of illness and its severity. Complete evaluations, however, including questioning about signs and symptoms and physical examinations for children diagnosed as having a serious illness were rarely observed.</p> <p>Antibiotic use appears high for the non-severe cases for all diagnoses. Guidelines with indications for antibiotic use may be warranted.</p> <p>Essential information on continuing to provide food and fluid and symptoms for immediate return were provided to only 3 percent of the observed sick children.</p> <p>Provision of the first dose of oral medication at the facility is not a common practice.</p> <p>Most prescribed medicines (for 68 percent of the observed clients) must be purchased from outside the facility.</p> <p>Safe disposal practices for used needles after therapeutic injections is lacking.</p>

4.6.2 Reducing Missed Opportunities for Promoting Child Health Care

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

Activities for nutritional assessment or discussion of nutritional status or feeding practices were observed (or reported by the caretaker) for only about one in five observed children (Appendix Tables A-4.19 and A-4.20). Forty-two percent of the sick children were weighed, but only 20 percent of these children had their weight plotted for comparison against a standard (Figure 4.14 and Appendix Table A-4.19), and only 18 percent of caretakers reported that a health care provider discussed their child’s weight or nutritional status (Appendix Table A-4.20). Observers noted 19 percent of providers discussing normal feeding practices with the provider. This was observed more frequently with caretakers of children less than 24 months of age (26 percent) (Figure 4.14 and Appendix Table A-4.19). Interviewed caretakers similarly reported (15 percent) that the provider had discussed general feeding practices (Appendix Table A-4.20). In addition, 19 percent of the caretakers were observed being instructed to continue to provide or to increase food and/or fluid for the child, and 18 percent of caretakers, when interviewed, indicated they were told to continue or increase food and fluid.

Figure 4.14 Observed preventive assessments (N=2013)
(<24 months N=1154)



In Egypt, a child’s immunization record is frequently included in his or her health record. Only 16 percent of the interviewed caretakers had this record with them (Appendix Table A-4.20). While the immunization status can be assessed using a history, if the card is not available, only 15 percent of children under 24 months of age and 7 percent of children 2 years and older were observed having their immunization status assessed by a provider (Figure 4.14). Five percent of caretakers reported their child younger than 24 months of age received an immunization (Appendix Table A-4.20). This was primarily noted at health offices (reported by 22 percent of the caretakers).

Key Findings

Observations during the ESPA support the results of the facility findings that opportunities to promote preventive health interventions each time a child is brought to a facility for a consultation are being missed despite existing capability. These preventive practices are not routine policy throughout the health facilities. The IMCI approach is expanding, but at present only covers one in four primary health care facilities.

Providers are not assessing whether sick children are due immunizations and are not assessing nutritional status using an objective method. While 42 percent of the children were weighed, the weight was rarely compared with any standard to provide a frame of reference to determine the weight was appropriate for the child.

Although the immunization coverage in Egypt is high, there remains a need to ensure that the children who are not immunized are not missed when they do come to a health facility.

There is a need for more attention to nutritional assessment and interventions to improve the overall child nutritional status. Sick children are at higher risk than most for increased or continued problems related to nutrition.

4.6.3 Counseling on Child Health Issues and Supporting Continuity of Care

The use of visual aids during the consultation with the caretaker was almost nonexistent (3 percent) (Table 4.6). It should be recalled that only 26 percent of facilities had any visual aids available for use for child health services (see Figure 4.4). Other instructions related to the illness and preventive health messages that were shared are discussed under the relevant sections of this chapter.

Supporting continuity of care

Frequently, health services are organized in such a way that measurements of temperatures, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client record. Twenty-two percent of facilities were observed to routinely weigh children and 16 percent to plot the weight prior to the consultation (data not shown). In addition, 23 percent measured the temperature prior to the consultation (data not shown). In only 11 percent of the observations did providers refer to the health card during the examination (Table 4.6); thus, they might not have used information from measurements taken by others in their assessment of the child. Only 16 percent of the providers wrote any note on a child health card at the end of the consultation (Table 4.6), thereby leaving no written record for reference during subsequent illnesses or followup visits. A return visit was discussed for only about 30 percent of the children diagnosed as having severe respiratory infections or severe febrile illness and with only 21 percent of children diagnosed with a severe diarrheal illness or dehydration (Table 4.5).

Table 4.6 Provider practices related to health education and continuity of care				
Percentage of observations where visual aids were used when providing health education to the caretaker of observed sick children, percentage of observations where the provider referred to the child health card, percentage of observations where the provider wrote on the child health card, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of observations where visual aids were used for health education	Use of individual child health card		Number of observed sick children (weighted)
		Percentage of observations where provider referred to card during consultation	Percentage of observations where provider wrote on card after consultation	
Type of facility				
GS hospital	3	5	9	365
Fever hospital	1	1	1	71
MCH/urban HU	3	19	30	307
Rural HU	3	11	15	1,173
Mobile unit	0	4	4	18
Health office	33	69	74	12
NGO facility	0	2	6	66
Region				
Urban Governorates	3	23	29	196
Lower Egypt	3	14	17	998
Upper Egypt	3	4	10	819
Total	3	11	16	2,013

Key Findings

Providers rarely use visual aids during consultation with caretakers. Although visual aids for caretaker education were present in 26 percent of facilities, only 2 percent used them.

Individual child health cards were not actively used during most consultations. This limits the ability for the provider during this visit, or during subsequent visits, to have all relevant information for provision of continuity of care.

Followup care is not promoted.

4.7 Caretaker Opinion from Exit Interviews

Prior to leaving the facility, observed caretakers of sick children were interviewed for their opinions on the processes of the consultation, the quality of the providers' services, and the principal problems encountered on the day of the visit. The caretaker was read a list of specific issues commonly related to client satisfaction and was asked to rate the issue as a big, small, or as no problem. The main complaint was lack of availability of medicines (19 percent), followed by the long waiting time and an insufficient explanation about the child's illness (both 13 percent) (Appendix Table A-4.21). When asked why they used this particular facility, 59 percent of caretakers stated it was nearby and 28 percent indicated that the physician was efficient (Appendix Table A-4.22). Appendix Tables A-4.23 and A-4.24 provide information on the personal characteristics of interviewed caretakers.

Key Findings

Lack of availability of medicines and supplies was a primary complaint of the caretakers.

An overly long waiting time and insufficient explanation about their child's illness were also considered big problems.

The efficiency of the physician and the nearness of the facility were two of the main reasons for using the facility for the child's health services.

5.1 Background**5.1.1 ESPA Approach to Collection of Family Planning Service Information**

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

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

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

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

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

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

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

5.1.2 Family Planning Services in Egypt

The Ministry of Health and Population (MOHP) Reproductive Health and Family Planning (RH/FP) clinics constitute the majority of all family planning clinics in Egypt. According to the National Population Council (NPC) Annual Statistical Report 2000, there are 4,470 family planning clinics run by the MOHP. The MOHP family planning clinics include rural health units (rural HUs), maternal and child health/urban health units (MCH/urban HUs), clinics at general service hospitals (these include general, district, and integrated hospitals), and mobile units.

Use of reproductive health services has been increasing over the years, with contraceptive use increasing between 1980 and 2000 from 24 percent to 56 percent of married women 15-49. Most of the increase took place in the late 1980s, with virtually no change in the overall rate of use between 1991 and 1995, followed by another increase between 1995 and 1997 (El-Zanaty and Way, 2001). The Egypt Demographic and Health Survey 2000 (EDHS-2000) documented 54 percent of women of reproductive age using modern methods of contraception. The intrauterine device (IUD) is the most widely used method, followed by the oral contraceptive pill (36 percent and 10 percent, respectively). The majority of the pill users (82 percent) obtain their methods from a private pharmacy. Slightly more than half (54 percent) of all IUD users use public sector facilities.

The Population and Family Planning Program has been relatively effective over time. Total fertility has decreased from 5.3 children per woman (15-49 years) in 1979-1980 to 3.5 in 2000. Success has been uneven across the country, with fertility rates higher in rural (3.9) than in urban areas (3.1), and higher in Upper (4.2) than in Lower Egypt (3.2) and in the Urban Governorates (2.4) (El-Zanaty and Way, 2001).

5.2 Availability of Family Planning Services

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

Summary information on the availability of family planning services is provided in Table 5.1, and information on frequency with which family planning services are offered is provided in Table 5.2. Figure 5.1 provides details on the availability of different methods of contraception, and Appendix Tables A-5.1 through A-5.3 provide further details on method availability by type of facility and region. Fever hospitals are not eligible to offer family planning services and are excluded from the analysis of availability of family planning services.

The modern methods most commonly used in Egypt (El-Zanaty and Way, 2001) are:

- Intrauterine devices
- Contraceptive pills
- Contraceptive injections
- Male condoms (female condoms are not available).

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

Table 5.1 Availability of family planning services					
Percentage of all eligible facilities offering any temporary modern methods of contraception, ¹ among facilities offering any temporary modern method of family planning, percentage offering all four most commonly used methods, and percentage offering counseling on the rhythm method, by type of facility and region, Egypt SPA 2002					
Background characteristics	Facilities eligible for offering family planning services		Among facilities offering any modern method of family planning		Number of facilities (weighted)
	Percentage offering any modern method of FP ¹	Weighted number of facilities	Percentage offering all four of the most common methods ³	Percentage offering counseling on rhythm method	
Type of facility⁴					
Hospital	98	64	92	86	63
MCH/urban HU	98	65	88	81	64
Rural HU	100	367	86	77	367
Mobile unit	100	38	87	80	38
Health office ²	88	32	89	71	28
NGO facility	91	71	50	57	64
Region					
Urban Governorates	95	65	80	89	61
Lower Egypt	99	308	89	85	306
Upper Egypt	98	264	79	67	257
Total	98	637	84	78	624

¹ Any of the following: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), implants, intrauterine devices (IUDs), male condoms, spermicides, diaphragm, or emergency contraceptive. Permanent methods (sterilization) are not included.

² Often health offices are located in a hospital or MCH unit. In these cases, family planning services may be offered by the hospital or MCH unit, rather than through the health office.

³ The four most common methods used in Egypt are the combined oral pill, the progesterone injection, the male condom, and the IUD.

⁴ Fewer hospitals are not eligible to provide family planning services, so they are excluded from analysis of availability of family planning services.

The ESPA first looked at the availability of family planning services in all eligible services. Fewer hospitals are not eligible to provide family planning services, so they are excluded from the analysis.

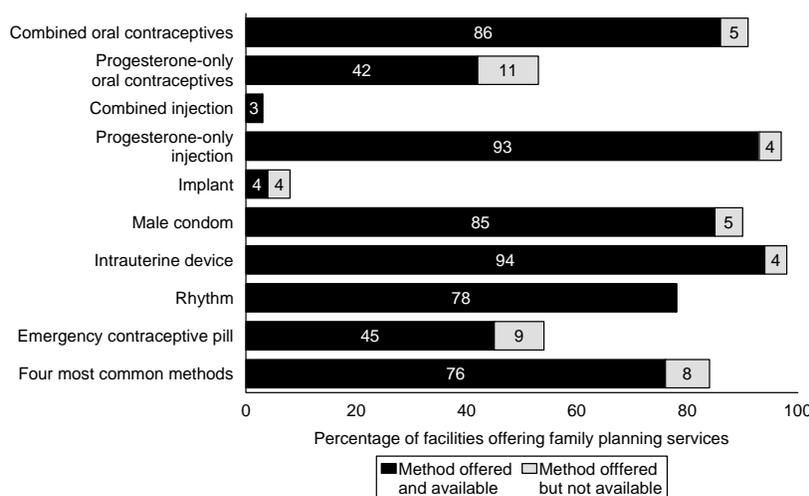
A facility that offers all methods of family planning is best able to meet the needs of clients. However, some variation in the availability of methods at facilities is expected because of differences in the qualifications and training required for service providers and in the infrastructure required to provide the methods safely. Commonly used methods that require minimal training to provide safely are pills, injections, and condoms. Implants and IUDs require a higher level of skill and a more developed infrastructure to administer safely.

Almost all facilities (98 percent) assessed by the ESPA (excluding fewer hospitals) offer modern methods of family planning. Among the facilities that offer any temporary modern method of family planning, 84 percent offer all of the four most commonly used methods (Table 5.1) and 78 percent offer counseling on the rhythm method of contraception. Facilities in Lower Egypt offered the four most commonly used methods more often (89 percent) than facilities in Urban Governorates (80 percent) or in Upper Egypt (79 percent). NGO facilities offer less variety in methods, with only 50 percent offering the four most commonly used methods. When asked, 3 percent of facilities (15 percent of the general service hospitals) indicated that they offer female sterilization as a method of birth control (data not shown). The percentage of facilities that provide tubal procedures may be higher than this because, in Egypt, tubal ligation is more often provided for medical reasons other than for family planning purposes.

The combined injectable is a new method, offered primarily by NGO facilities (Appendix Table A-5.1). Although it is not a part of the MOHP family planning program, three government facilities (one hospital, one MCH/urban HU and one mobile unit) reported they did offer the method, with two of these facilities having the method available on the day of the survey (Appendix Tables A-5.1 and A-5.2).

The percentage of eligible facilities that offer specific methods of family planning and whether the offered method was available the day of the survey are presented in Figure 5.1.

Figure 5.1 Method of contraception offered and availability of method on the day of the survey (N=624)



Egypt SPA 2002

Among the 84 percent of facilities offering the four most commonly used methods, 90 percent had all four methods available the day of the survey (Appendix Table A-5.2), with rural HUs, NGO facilities, and facilities in Upper Egypt the most likely to be missing at least one of the methods the day of the survey (Appendix Tables A-5.2 and A-5.3).

Implants are not widely used and are offered at only 8 percent of facilities (mostly general service hospitals), although implants were actually available at only half of these facilities the day of the survey (Figure 5.1). Spermicides and diaphragms are rarely offered (each at only 1 percent of facilities), and none had the methods available the day of the survey. Emergency contraceptive pills and progesterone-only pills are both offered at half of the facilities, with four of five facilities that offer each method having it available the day of the survey. Thirty-one percent of facilities indicated that they had both the emergency contraceptive pill and the progesterone-only pill (data not shown). The progesterone-only pill can be used for emergency contraception in higher than normal doses, so it is possible that for some facilities, the progesterone-only pill is available, when needed, for dual purpose.

The diaphragm is not widely used in Egypt and is not a part of the MOHP family planning program. It was reported as offered by some government and NGO facilities in the Urban Governorates, although it was not commonly available (Appendix Tables A-5.1 through A-5.3). It is possible that providers prescribe the method for purchase outside the facility.

In addition to providing a range of methods, it is important that family planning services be offered regularly so that clients can depend on services being available when needed and providers being available to answer questions and respond to concerns. Family planning services are offered five days per week by almost all facilities (94 percent) that provide family planning services (Table 5.2).

Table 5.2 Frequency of availability of family planning services				
Percentage of facilities where temporary methods of family planning (FP) ¹ are offered 1 to 2 days per week, 3 to 4 days per week, and 5 or more days per week, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities where family planning services are offered			Number of facilities offering FP services (weighted)
	1-2 days per week	3-4 days per week	5 or more days per week	
Type of facility				
GS hospital	1	3	96	63
MCH/urban HU	1	1	98	64
Rural HU	3	2	95	367
Mobile unit	0	0	100	38
Health office	2	2	96	28
NGO facility	14	11	75	64
Region				
Urban Governorates	4	6	90	61
Lower Egypt	4	3	93	306
Upper Egypt	3	2	95	257
Total	4	2	94	624
¹ Any of the following methods: oral contraceptives (combined or progesterone-only), injections (combined or progesterone only), implants, intrauterine devices (IUDs), condoms (male–female condom is not available), spermicides, diaphragm, or emergency contraceptive.				

Key Findings

Modern, temporary methods of contraception are available in 98 percent of all facilities (excluding fever hospitals).

A variety of methods are available in most facilities, with 82 percent of facilities offering the four most commonly used methods. The IUD is the most widely available method, offered by 96 percent of all facilities.

NGO facilities offer the least variety in methods, with only 46 percent offering the four most commonly used methods.

The supply for the four most commonly used methods is reliable, with 90 percent of facilities offering the four methods (combined oral contraceptives, progesterone injection, male condom, and IUD) having all four methods available.

The supply for less used methods is less reliable. Only half of the few (8 percent) facilities offering implant had it available.

Family planning services are frequently offered, with 94 percent of facilities offering them at least five days per week.

5.3 Components Supporting Quality Family Planning Services

Components that were assessed for quality family planning services were as follows:

- Infrastructure and resources to support quality assessment and counseling
- Infrastructure and resources for examinations
- Provision of STI treatment with family planning
- Availability of equipment and supplies for specific methods.

Aggregated information on the availability of items for each of the above components is provided in Table 5.3. Summary information on each specific item for counseling, pelvic examinations and control of infection, STI services, and providing specific methods of contraception is provided in Figures 5.2 through 5.4. Details on the items assessed for each of the components for counseling and examinations are provided in Appendix Table A-5.4, and details on the topics for which visual aids and guidelines or protocols were available, by type of facility, are provided in Appendix Table A-5.5. Details on sterilizing and high-level disinfecting (HLD) procedures used when processing family planning equipment for reuse are provided in Appendix Tables A-5.6 through A-5.9. Details on items related to STI treatment by family planning service providers are provided in Appendix Table A-5.10. Finally, details on availability of specific equipment necessary for safely providing various contraceptive methods are provided in Appendix Tables A-5.11 through A-5.13.

5.3.1 Infrastructure and Resources to Support Quality Assessment and Counseling of Family Planning Clients¹

Items for supporting quality assessment and counseling for family planning include the following:

- Some level of auditory or visual privacy for counseling
- Individual client health cards or records
- Written guidelines or protocols
- Visual aids or written information for client education.

Family planning is often a sensitive issue for discussion. Assuring clients that conversations between client and provider cannot be overheard (either by using a private room or placing a visual barrier between the client consultation area and other people) improves communication and ultimately the likelihood that the method provided is suitable for the client. It is not uncommon to find that family planning clients are counseled in a room where other clients are waiting, but that examination and procedures requiring them to lie down or be exposed take place in a small adjacent room. Almost all facilities (83 percent) (Figure 5.2) counseled family planning clients in either a private room (76 percent) or a room where there was a visual screen that could be drawn (7 percent) (Appendix Table A-5.4). Both of these situations were defined as providing an adequate level of privacy for counseling.

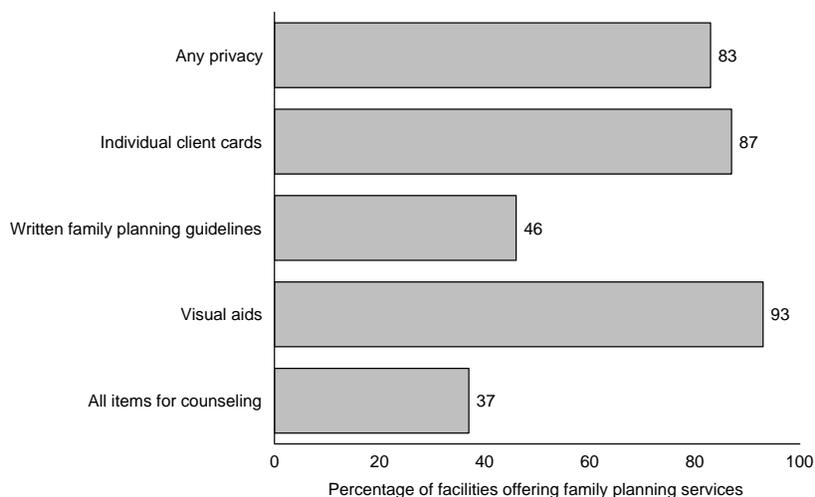
¹ Counseling about family planning often takes place in a location different from where procedures (e.g., pelvic examinations, IUD insertions) are conducted, thus the conditions for counseling are assessed separately from those for procedures.

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 ESPA assessed the availability of blank cards for new family planning clients. Individual client cards were found at 87 percent of facilities (Figure 5.2), with NGO facilities the least likely (63 percent) to have these available (Appendix Table A-5.4).

Written guidelines or protocols for family planning that include information on screening for eligibility for different methods had to be available in the family planning service delivery area or in an immediately adjacent area to be considered available for use. Guidelines or protocols were available in the service delivery area for 46 percent of facilities (Figure 5.2). Respondents from an additional 4 percent of the facilities reported that these guidelines were available but were unable to show them or they were not in the service delivery area (data not shown). Written guidelines or protocols were more often available at public (half of general service hospitals, MCH/urban HUs, rural HUs, and health offices) than NGO facilities (13 percent) (Appendix Table A-5.4).

Visual aids related to family planning were available in the service delivery area in 93 percent of facilities (Figure 5.2) and in over 96 percent of each type of government-managed facility assessed (Appendix Table A-5.4). NGO facilities were less likely to have visual aids (57 percent). Most facilities had both printed materials on the different methods of family planning (79 percent) and samples of the different methods (87 percent) to use during counseling (Appendix Table A-5.5).

Figure 5.2 Items to support quality counseling for family planning (N=624)



Egypt SPA 2002

All conditions for quality counseling were available in 37 percent of all facilities, with the proportion varying by type of facility, ranging from 48 percent for health offices to 11 percent for NGO facilities (Table 5.3). Written protocols or guidelines for family planning were the items most often missing (Figure 5.2).

Key Findings

Privacy for family planning counseling services and availability of individual family planning client cards was widespread.

Visual aids were widely available (93 percent of facilities).

Guidelines and protocols were available in less than half of the facilities (46 percent).

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

Percentage of facilities with all items for quality counseling, percentage with functioning equipment and knowledge of minimum processing time for either sterilizing or high-level disinfecting (HLD) equipment, percentage with all items for infection control, percentage with all conditions for quality pelvic examinations, and percentage where treatment for sexually transmitted infections (STIs) is provided by family planning (FP) service providers, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:					Number of facilities offering FP (weighted)
	All items to support quality counseling ¹	All items for infection control ²	Equipment and knowledge for sterilizing/HLD processing ³	Conditions for quality pelvic examination ⁴	STI treatment provided by FP providers	
Type of facility						
GS hospital	38	29	89	73	88	63
MCH/urban HU	37	31	84	68	87	64
Rural HU	41	18	79	72	80	367
Mobile unit	20	9	82	56	80	38
Health office	48	26	64	58	80	28
NGO facility	11	17	58	80	85	64
Region						
Urban Governorates	31	44	77	80	94	61
Lower Egypt	45	20	82	66	78	306
Upper Egypt	29	14	73	75	84	257
Total	37	20	78	71	82	624

¹ Visual privacy, individual client cards, written protocols or 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 sterilizing or HLD processing were available.

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

5.3.2 Infrastructure and Resources for Examinations

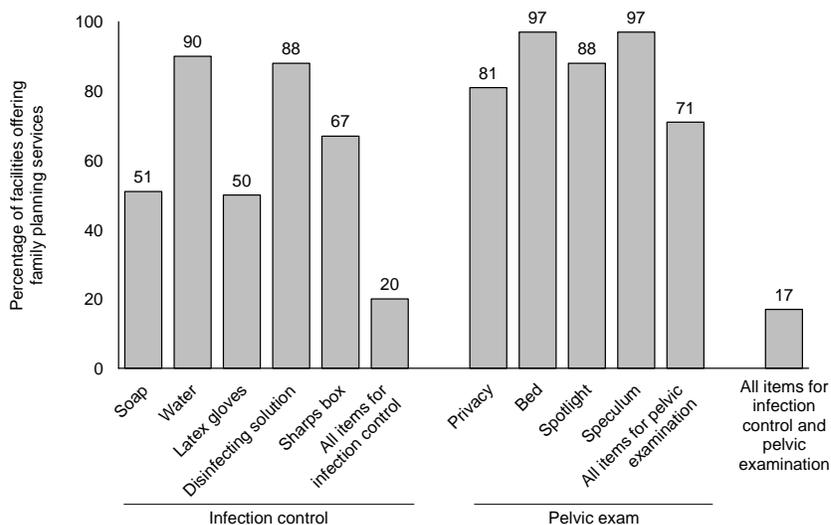
Frequently, a physical examination, often including a pelvic examination, is necessary to determine the suitability of a method, to insert a method, or to evaluate problems with a method. The following items were assessed for quality conditions for examination of family planning clients:

- Items for infection control
- Visual privacy
- Bed for examination
- Spotlight source for visualizing procedures
- Vaginal speculum.

The ESPA assessed the presence of items for the control of infections in the area where family planning examinations (such as pelvic examinations) and provision of methods (the implant, IUD, and injection)

most often took place. All items for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) were available in one of five facilities (Table 5.3), with approximately one in three general service hospitals and MCH/urban HUs having all items (Appendix Table A-5.4). The items most often lacking were hand-washing soap and latex gloves (each missing in about 50 percent of facilities) (Figure 5.3). As mentioned earlier, thin nonlatex disposable gloves were universally available, but these were not accepted for infection control. Water was primarily supplied through piped sources (data not shown), with 6 percent of facilities (primarily the mobile units) having water provided in a bucket (either with or without a tap) on the day of the survey. Ten percent of facilities had no water in the family planning service delivery area on the day of the survey (Figure 5.3).

Figure 5.3 Conditions for quality examination of family planning clients (N=624)



Egypt SPA 2002

The procedures used for sterilizing or high-level disinfecting (HLD) family planning equipment were also assessed.² Among the facilities providing family planning services, about half processed equipment in the family planning service area; the other half processed equipment in a central location in the facility (Appendix Table A-5.6). In small facilities (rural HUs, mobile units and health offices) the family planning service area might also be the main equipment processing area. Overall, when assessing conditions at the location where family planning equipment is processed, 60 percent of the facilities had the equipment and knowledge of minimum processing time (and temperature for dry heat sterilization) for sterilizing (either dry heat or autoclave method), 18 percent for HLD processing (boiling, steaming, or chemical processing),³ and 22 percent were lacking either equipment or knowledge. Thirty-two percent had written guidelines for sterilizing or HLD processing (Appendix Table A-5.7). Facilities that processed family planning equipment in the family planning service area were somewhat better prepared for quality processing, with only 11 percent lacking equipment or knowledge of appropriate processing time and temperatures (Appendix Table A-5.8).

² Chapter 3, section 3.4.1 and 3.4.2 provide details on the definitions for adequate sterilization or HLD procedures and storage practices.

³ Only one facility used chemical HLD procedures.

In facilities where processed equipment was stored in the family planning area, equipment was most often stored under conditions that maintained cleanliness (78 percent) rather than under conditions that maintained the sterile/HLD status (10 percent) (Appendix Table A-5.9). Only 2 percent of the facilities stored the equipment to maintain sterile/HLD status and wrote the processing date. Writing the processing date may not be an important issue where equipment is routinely used and processed daily.

Family planning clients frequently require a pelvic examination. Seventy-one percent of facilities had all the items defined as important for a pelvic examination, with a spotlight source (for visualizing the cervix or procedure site) most often missing (12 percent of facilities) (Figure 5.3). Mobile units and health offices were least likely to have all the equipment and furnishings for a pelvic examination (56 percent and 58 percent, respectively) (Appendix Table A-5.4).

Key Findings
<p>All assessed items for infection control were available in 20 percent of facilities. Hand-washing soap and latex gloves were the most commonly missing items (each available in only half of the facilities). Sharps boxes were missing from 33 percent of facilities.</p> <p>Sixty percent of facilities had equipment and knowledge of processing time and temperature for sterilizing family planning equipment, and an additional 18 percent had equipment and knowledge of processing time for boiling or steaming. Thirty-two percent had written guidelines present.</p> <p>When equipment was processed in the family planning service area, the processing capacity was slightly better, with 62 percent having knowledge and equipment for sterilizing and an additional 27 percent for HLD processing (either boiling, steaming, or chemical disinfection).</p> <p>All furnishings and equipment for pelvic examinations were available in 71 percent of facilities, with each item available in approximately 90 percent of facilities.</p>

5.3.3 Provision of STI Treatment for Family Planning Clients

Because they are sexually active, family planning clients are at increased risk for contracting STIs. Consequently, counseling for prevention as well as diagnosis and treatment constitute 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, the modern method most commonly used in Egypt. If these services are available at the same time and place as family planning services, it is more likely that clients will have the necessary exams and will receive the appropriate treatment for an STI if needed. Tables 5.3 and 5.4 and Figure 5.4 provide information on the provision of STI treatment for family planning clients. Appendix Table A-5.10 provides additional detail on the availability of medicines.

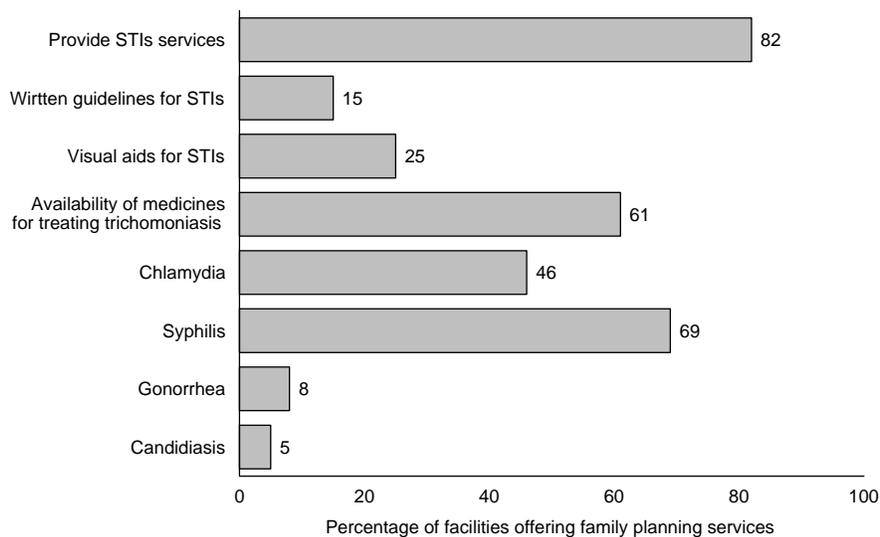
Eighty-two percent of facilities offering family planning services indicated that the family planning service providers diagnose and treat STIs for family planning clients when necessary (Table 5.3 and Figure 5.4). Validation of the provider-reported activity in screening for STIs (and vaginal infections) was found when it was noted that among the 444 clients observed for STI services, 158 (36 percent) were identified during observations of family planning clients (where their consultation was observed both for components of quality family planning and STI services) (Table 7.4). Chapter 7 discusses the findings for the STI component of the observation of these clients.

Protocols for diagnosis and treatment of STIs were available in 15 percent of facilities (Figure 5.4), most often in MCH/urban HUs, rural HUs, and health offices (Appendix Table A-5.4); visual aids for client education related to STIs were available in 25 percent of facilities. The World Health Organization

syndromic approach guidelines were available in 7 percent of facilities (11 percent of MCH/urban HUs) (Appendix Table A-5.5).

Among facilities providing family planning services, only 5 percent had at least one WHO-recommended medicine for treating the four STIs—chlamydia, syphilis, trichomoniasis, and gonorrhea (Appendix Table A-5.10). Treatment for the most common STIs and vaginal infections, however, were more available, with medicine for trichomoniasis available in 61 percent of facilities (Figure 5.4). Medicine for treating candidiasis, a common vaginal infection, was only available in 5 percent of facilities (Figure 5.4).

Figure 5.4 Conditions to support quality STI services for family planning clients (N=624)



Egypt SPA 2002

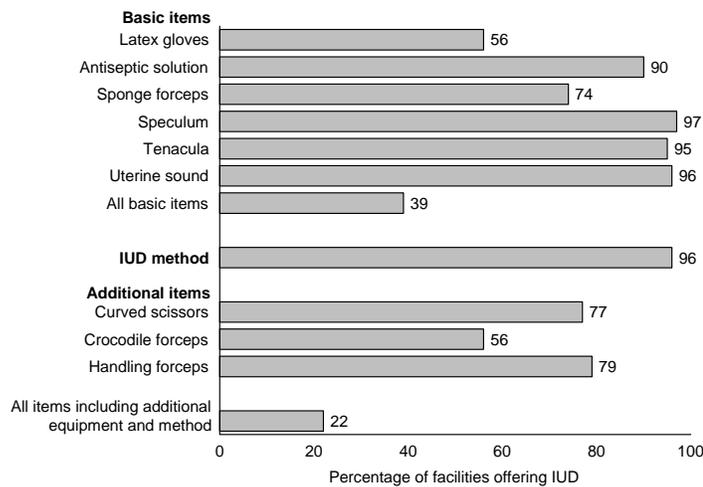
5.3.4 Availability of Equipment and Supplies for Specific Methods

Different contraceptive methods require different equipment to provide the method safely and to monitor the client. This equipment includes blood pressure apparatus (with some standards including monitoring weight) for clients being assessed and followed-up for estrogen-based contraceptives and specific equipment for insertion and removal of IUDs and implants. Methods such as the IUD and implant also require an appropriate infrastructure to provide quality service in the delivery of family planning methods. Figure 5.5 provides information to assess the availability of items basic to the provision of the IUD. Appendix Tables A-5.11 through 5.13 provide additional detail on the availability of equipment and supplies for specific methods.

Among facilities providing methods containing estrogen, 89 percent had blood pressure apparatus and 76 percent had an adult weighing scale (Appendix Table A-5.11). Among those providing injectable contraceptives, 89 percent had sterile needles and syringes (Appendix Table A-5.11). It should be noted that in Egypt, each progesterone injection vial is supplied with a syringe; so it is possible that 4 percent of the facilities without sterile needles and syringes were those facilities without progesterone injection available the day of the survey (Figure 5.1) or that syringes had been used elsewhere.

Equipment assessed for the IUD and implant methods included not only the specific items for insertion, but also the relevant forceps and disinfectant for cleaning prior to insertion and for removal. Among those offering IUDs, 39 percent had the basic equipment necessary for insertion and 13 percent had the basic equipment plus all conditions for quality pelvic examinations, including items for infection control (Appendix Tables A-5.11). The ESPA specifically defined latex gloves as required for infection control for IUD insertion. While latex gloves were frequently lacking (available in 56 percent of facilities) (Appendix Table A-5.12), disposable gloves (a thin type that physicians explain tears easily) were available universally (data not shown). Other than gloves, basic equipment for IUD insertion (antiseptic for cleaning the cervix, speculum, tenacula, uterine sound) were each available in about 90 percent of facilities offering the IUD, and sponge holding forceps (for cleaning the cervix prior to insertion) were available in 74 percent of facilities (Figure 5.5 and Appendix Table A-5.12). Availability of additional equipment for removal (curved scissors, crocodile forceps) and for maintaining equipment sterility (handling forceps) as well as the IUD method were also assessed. In total, 22 percent of the facilities offering the IUD method had all of the basic and additional items that were assessed for quality insertion and removal of the IUD (Figure 5.5 and Appendix Table A-5.12).

Figure 5.5 Equipment for IUD insertion and removal (N=612)



Egypt SPA 2002

Among facilities offering the implant method (N=50), 24 percent had the equipment and 14 percent had both the equipment and the infrastructure for insertion and removal, including infection control items (Appendix Table A-5.11). Sterile latex gloves were the items most often lacking (missing in 62 percent of facilities) (Appendix Table A-5.13). Only 74 percent of these facilities had the canula and trochar for inserting the implant; other items required were each available in less than 70 percent of facilities, with the exception of antiseptic solution (available in 95 percent of facilities offering the implant).

Key Findings

STI treatment is integrated with family planning services in 82 percent of facilities.

Medicines for treatment of STIs and other vaginal infections are not widely available. Treatment for trichomoniasis is available in 61 percent of facilities; however, treatment for candidiasis is only available in 5 percent of facilities.

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

Clean latex gloves were available in 56 percent of facilities offering IUDs. Nonlatex gloves, however, were universally available and used. Other basic equipment was available in about 90 percent of facilities, with the exception of forceps for holding gauze to clean the cervix (74 percent).

Only 38 percent of facilities offering implant methods had sterile gloves in the service delivery area.

5.4 Management Practices Supportive of Quality Family Planning Services

Management practices that were assessed for supporting quality family planning services include the following:

- Facility documentation and records
- Practices related to user fees
- Supervision and staff development.

Summary information on each of these items is provided in Table 5.4. Utilization statistics provided by ESPA facilities for family planning services are provided in Appendix Table A-5.14. Details on charging practices for family planning services are provided in Appendix Tables A-5.15 through A-5.17. Details on in-service and supervisory activities from the provider's perspective are provided in Appendix Tables A-5.18–A-5.20. Finally, information on topics for in-service training and when training was received is provided in Figure 5.6.

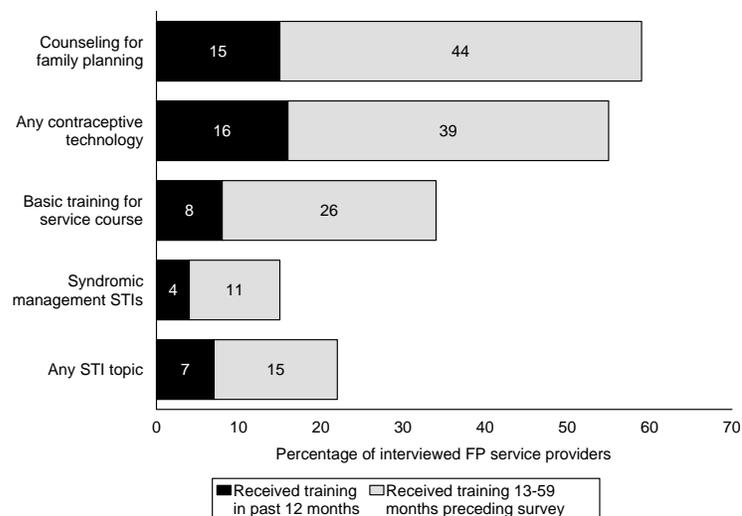
5.4.1 Facility Documentation and Records

The ESPA assessed the availability of up-to-date registers with information on family planning services provided. This is most often the source of health information system data. A register was defined as up to date if there was an entry within the past seven days, and the entry, at minimum, reported the method or service provided and the client's status (first visit or followup visit). Almost all (90 percent) facilities had an up-to-date register (Table 5.4), with the exception of NGO facilities, where only 56 percent had an up-to-date family planning register. General service hospitals, MCH/urban HUs and mobile units reported the highest median monthly number of family planning clients (Appendix Table A-5.14), with at least half of the facilities seeing more than 125 family planning clients per month. Facilities in Urban Governorates also saw more family planning clients, with over half seeing 132 clients per month, compared with facilities in Lower Egypt and Upper Egypt, where the median monthly number of clients was 65 percent and 55 percent, respectively.

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 where at least half of the interviewed family planning service providers received in-service training related to family planning during the past 12 months, and percentage where at least half of the interviewed family planning providers were personally supervised during the past 6 months, by type of facility and region, Egypt SPA 2002						
Background characteristics	Facilities that offer family planning services		Number of facilities offering FP (weighted)	Percentage of facilities where at least half of the interviewed FP service providers		Number of facilities with interviewed FP service providers (weighted)
	Percentage with observed up-to-date patient register ¹	Percentage with user fees for FP services		Received in-service training during past 12 months ²	Were personally supervised during past 6 months	
Type of facility						
GS hospital	95	90	63	13	97	62
MCH/urban HU	93	91	64	22	98	63
Rural HU	94	94	367	19	99	365
Mobile unit	98	23	38	18	100	38
Health office	93	89	28	19	98	27
NGO facility	56	97	64	21	62	63
Region						
Urban Governorates	87	85	61	24	89	61
Lower Egypt	92	87	306	11	97	303
Upper Egypt	89	92	257	28	95	255
Total	90	89	624	19	95	618

¹ Register has entry within past seven days and indicates visit status (first or followup) and service provided.
² This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

Figure 5.6 In-service training received by interviewed family planning service providers, by topic and timing of most recent training (N=1603)



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5.4.2 Practices Related to User Fees

Health insurance is not applicable for family planning clients in public sector facilities. Most facilities (89 percent) had some type of user fees for family planning services (Table 5.4). Among facilities with user fees, 14 percent indicated that they have a fixed fee for the consultation and examination, and most facilities (85 percent) reported that fees vary according to method provided or whether laboratory tests or medicines are provided (Appendix Table A-5.15). User fees for family planning services were posted where clients could see them in 67 percent of facilities. Among observed and interviewed family

planning clients who had paid anything out of pocket for their family planning services (74 percent of interviewed clients), the median out-of-pocket payment was 101 piasters (Appendix Table A 5.16); it is likely this was a registration fee. Clients who reported this amount had received a variety of services including pelvic examinations, injections, and IUD removal. Clients who had IUD insertions reported a median fee of 200 piasters (Appendix Table A 5.17).

5.4.3 Supervision and Staff Development

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

If at least half of the interviewed family planning service providers at a facility had received any structured in-service training (excluding on-the-job training that may be received during discussions with supervisors) relevant to family planning during the past 12 months, the facility was defined as providing routine staff development activities. During the past 12 months, at least half of the interviewed family planning providers had received in-service training related to family planning in only 19 percent of facilities (Table 5.4). Among all interviewed providers of family planning services, 23 percent had received related in-service during the past 12 months, and an additional 49 percent during the past 13-59 months (Appendix Table A-5.18). Counseling for family planning and contraceptive technology topics were the in-service training topics most often reported, with about 15 percent of the providers having received training in either of these subjects during the past 12 months and an additional 40 percent during the past 13-59 months (Figure 5.6, Appendix Table A-5.19). Four percent of the interviewed family planning providers had received in-service training on syndromic management of STIs, and 7 percent had received training on a topic related to STIs during the past 12 months, with an additional 15 percent having received in-service training on a topic related to STIs during the past 13-59 months.

Supervision of individual staff helps promote adherence to standards and identify problems that contribute to poor-quality services. The ESPA collected information both on the frequency of supervision and on the activities of the supervisor. If at least half of the interviewed FP service providers in a facility had been personally supervised in the past six months, the facility was defined as providing routine staff supervision. Similar to findings in other services, supervision of FP providers is common, with at least half of the interviewed FP providers having been supervised during the past six months in 95 percent of facilities. Interviewed providers indicated they had received supervision a median of seven times during the past 6 months, with over 90 percent of the providers reporting that their supervisor checked their records, observed their work, and provided feedback (Appendix Table A-5.20). Eighty percent reported that the supervisor provided updates on FP topics.

Key Findings

Up-to-date registers were found almost universally (90 percent of facilities), except in NGO facilities, where 56 percent of facilities had up-to-date registers.

Formal in-service training is not routinely provided, with at least half of the interviewed family planning service providers having received any related in-service training during the past 12 months in only 19 percent of facilities. The topics most frequently reported for the past five years were related to counseling on family planning (69 percent) and issues related to contraceptive technology (55 percent).

Supervision of family planning service providers is widespread, with over half of the interviewed providers having been personally supervised during the past 6 months in 95 percent of facilities. At least half of the interviewed providers each indicated they were supervised approximately seven times during the 6 months.

5.5 Adherence to Standards for Quality Service Provision

Observations of family planning consultations included in the 2002 ESPA provide the basis for assessing whether providers are adhering to standards for providing quality service. The observation checklist was based on commonly accepted guidelines for screening and counseling of family planning clients and collected information on whether the consultation process answered the following questions:

- Were essential items relevant to determining appropriateness of various methods discussed and were essential physical examinations for screening a client for method appropriateness conducted?
- Did the conditions and procedures followed for provision of specific methods meet the criteria defined for quality?

Observers watched the process utilized when family planning clients were seen at the facility, noting information shared and procedures or examinations conducted. The objective was to note whether information on a topic was shared (process information). An assessment of whether the information was correct or whether findings were appropriately interpreted was not a component of the observation.

A total of 1,688 clients were observed at 453 facilities. Among the 1,688 observations (593 new and 1,095 followup clients), 4 clients either refused or were not located for the exit interview.

This was the first visit for 35 percent of the women, and 1 percent had no prior pregnancy (Appendix Table A-5.21). All clients were female. Further details on the observed client status and principal reason for the clinic visit on the day of the survey are provided in Appendix Table A-5.22. Details on the primary method provided, prescribed, or discussed during this visit are provided in Appendix Tables A-5.23.

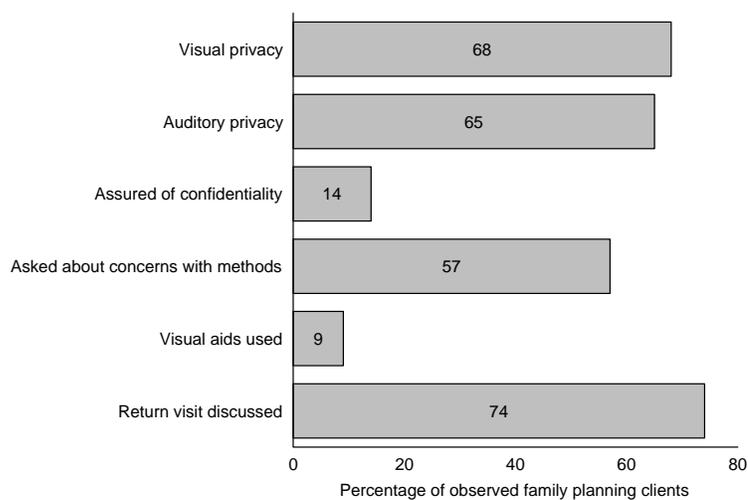
5.5.1 Assessment of Relevant History, Examination, and Counseling

Information essential for the provider to provide quality counseling and advice regarding contraception, depends on whether the client is a prior user or a nonuser upon arrival, and whether this is the first or a followup visit at the particular facility. During the observation the ESPA noted the following:

- Were relevant items for reproductive history shared? For new family planning users in particular, factors such as age, parity, pregnancy status, breastfeeding status, and the regularity of the menstrual cycle are relevant for providing advice on a choice of method.
- Was there any discussion that specifically addressed STIs or use of condoms?
- Were basic physical assessments conducted and information relevant to the client's general health shared? For new family planning clients, information related to their general health, including information on current health status and use of tobacco, any history of chronic illnesses, and symptoms of STIs are important when offering advice on methods of contraception. Basic physical assessment (blood pressure and weight measurement) should be a standard component of a consultation with a new family planning client.
- Did the counseling occur under conditions of assured confidentiality and under conditions where privacy was provided?
- Was an individual client card/record used?
- Did clients leave the counseling session with an understanding of how to use the method they were provided and the side effects of the method?

Figure 5.7 provides summary information for observed counseling conditions, Figure 5.8 provides summary information for the client history assessed for first-visit family planning clients, and Figures 5.9 through 5.12 provide summary information on observations during consultations and examinations for specific methods or procedures. Details on the conditions and information shared during the consultation for first-visit clients are provided in Appendix Tables A-5.24 through A-5.26. Information from observations related to specific methods or examinations is provided in Appendix Tables A-5.27 through A-5.30.

Figure 5.7 Observed conditions and content for family planning counseling (N=1688)



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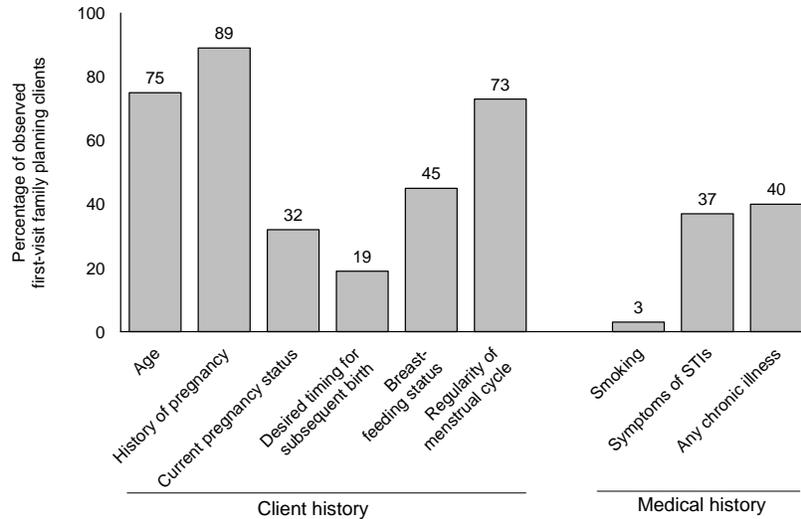
5.5.2 Counseling and Client Assessment

Counseling was conducted under conditions of some privacy (visual privacy using either a private room or a screen to separate the client from others) for 68 percent of the observations, and full privacy (a private room where both visual and auditory privacy were assured) for 65 percent of the observations (Figure 5.7). Clients were rarely explicitly assured of the confidentiality of the consultation (14 percent). More than half of the clients, however, were explicitly asked about concerns about the methods discussed and 74 percent were advised about a return visit. Visual aids were rarely used (9 percent) during the consultation. No consistent differences in conditions for counseling were noted between types of facilities (Appendix Table A-5.24).

Individual client cards are necessary to monitor a family planning client over time and to document relevant history so that it does not need to be collected multiple times. Frequently, health services are organized in such a way that measurements of blood pressure, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client record. Eleven percent of facilities were observed to routinely measure blood pressure and collect routine information for family planning clients before they were seen by the primary provider (data not shown). If an individual client card is not reviewed, this information, as well as information from prior visits, may not be available to the provider when assessing the client. Similarly, if the provider does not write pertinent information from this visit, important information for followup and continuity of care may be lost. Among the observed consultations, the provider reviewed the client card for 48 percent of clients and wrote on the card after the consultation for 65 percent of clients (Appendix Table A-5.24).

Among first-visit family planning clients, the provider should elicit relevant personal and health history that provides the information necessary to make an informed recommendation on contraceptive methods and to screen clients for safety of specific methods. Client age was assessed in 75 percent of cases and prior pregnancy history for 89 percent of cases (Figure 5.8). Current pregnancy status (either ascertained through information sharing or through laboratory testing) and desired timing for pregnancy were the least frequently elicited items of client history (32 percent and 19 percent, respectively). Since most women in Egypt who begin using family planning have already had a pregnancy (99 percent of the observations) (Appendix Table A-5.21), breastfeeding status is important when counseling on suitable methods of contraception. Breastfeeding status was ascertained for slightly less than half of the first-visit clients. Information on the regularity of menstrual cycle was shared for 73 percent of the first-visit family planning clients (Figure 5.8). Regarding medical history, almost none of the observed clients (3 percent) were asked about smoking, 37 percent were asked about symptoms of STIs, and 40 percent were asked about chronic illnesses. Mobile units and health offices were more thorough in asking about all items assessed for client history, and NGO facilities were the least thorough (Appendix Table A-5.25).

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



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An assessment of whether the husband's attitude toward family planning or whether factors related to the husband might affect the risk for STIs or method choice were components of only 14 percent of the observations for first-visit clients (Appendix Table A-5.26). Condoms were rarely discussed (1 percent). Use of visual aids was slightly higher for first-visit clients (13 percent, compared with 9 percent for all clients), and utilization of individual cards to record findings was about the same for first and follow-up visit clients (Appendix Tables A-5.24 and A-5.26).

Key Findings

Counseling for family planning clients is conducted under conditions that provide both visual and auditory privacy in 65 percent of facilities.

Current pregnancy status was assessed (either by history or laboratory) for 32 percent of first-visit clients, and breastfeeding status was assessed for less than half of all first-visit clients.

Assessments of chronic illnesses or symptoms of STIs were not routine components of first-visit consultations (about 40 percent each).

Factors related to the husband that might influence counseling on the suitability of different methods of contraception were rarely assessed.

Visual aids were used for counseling for only 9 percent of all clients (13 percent of first-visit clients).

Individual client cards to enable individual followup were used for only 65 percent of consultations.

5.5.3 Method-Specific Assessments and Examinations

First-visit clients usually receive a more complete examination than continuing clients, since examination findings help determine the appropriateness of a method. Among all first-visit clients, 66 percent had

their blood pressure measured, 42 percent had their weight measured, 7 percent had their urine checked, and 3 percent had a blood specimen taken (Appendix Table A-5.25).

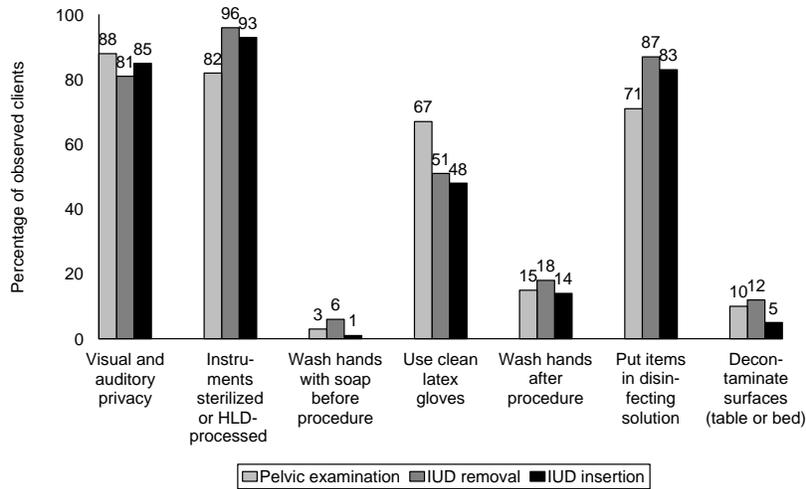
Among all clients receiving methods with estrogen, where monitoring for hypertension should be a component of care, 71 percent had their blood pressure measured and 49 percent had their weight measured (gaining weight may be an indicator of fluid retention and hypertension) (Appendix Table A-5.27).

The MOHP is promoting breast examinations as an early detection and prevention measure. Among all observed and subsequently interviewed clients, 4 percent were observed receiving a breast examination and 3 percent were observed being taught how to conduct a breast self-examination. Thirteen percent of interviewed clients, however, reported they had been taught how to conduct a breast self-examination. The difference may be caused by women reporting having been taught self-examination elsewhere or during previous visits. (Appendix Table A-5.28). Providers in health offices were both observed and reported by clients to teach breast self-examination and to conduct more breast examinations than providers in other facilities.

In the observations of family planning consultations, particular effort was placed on determining specific procedures, whether critical information was shared, whether the procedure followed defined steps for quality, and whether infection control practices were followed.

Among the women who received pelvic examinations or IUD procedures, almost all (more than 80 percent) were conducted under conditions where both visual and auditory privacy were protected (Figure 5.9). Sterilized or HLD-processed instruments were almost always used (82 percent for pelvic examinations and 96 percent for IUD insertion). Hand washing, either before or after the procedure, was not commonly practiced (6 percent or less before the procedure and less than 20 percent after the procedure). Latex gloves were more commonly used for pelvic examinations (67 percent) than for IUD insertions (51 percent). As mentioned previously, use of disposable gloves was universal, but these disposable gloves were nonlatex, thin, and easily torn, and were not defined by the ESPA as sufficient for infection control. Immediately placing items in disinfecting solution was a common practice (71 percent of pelvic examination equipment and 89 percent of IUD insertion equipment), however, decontaminating the table or bed after the procedure was rare (about 10 percent).

Figure 5.9 Key components for pelvic examination (N=400), and IUD insertion (N=352), and IUD removal without reinsertion (N=156)

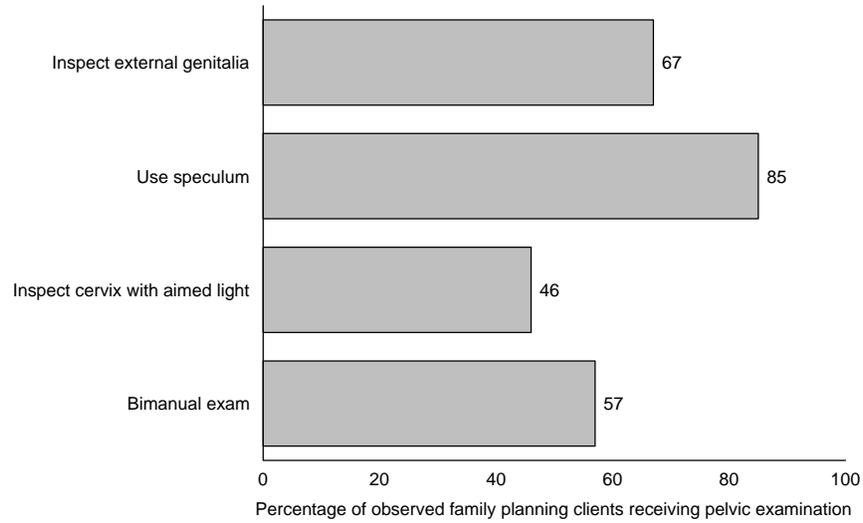


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While only five implant insertions were observed (unweighted data), the provider was noted to wash his or her hands before starting for four of the five cases, and sterile gloves were utilized in all five implant insertion and removal cases (data not shown).

In general, providers did not explain procedures to the clients before starting procedures (3 percent of pelvic examinations and 7 percent of IUD insertions) (Figures 5.10 and 5.11) or during procedures, and among those pelvic examinations where a speculum was used (85 percent), only 2 percent of providers explained the procedure (data not shown). For only 46 percent of the pelvic examinations was an inspection of the cervix (using a speculum and an aimed spotlight) observed (Figure 5.10). The provider inspected the cervix (using a speculum and an aimed spotlight) for 94 percent of women having an IUD insertion. Bimanual examinations were conducted in about half of the examinations (57 percent for pelvic examinations and 43 percent for IUD insertions). Among the observed IUD procedures, 86 percent sounded the uterus prior to insertion, 89 percent used a tenaculum, and 89 percent used the no-touch technique for handling the IUD (Figure 5.11).

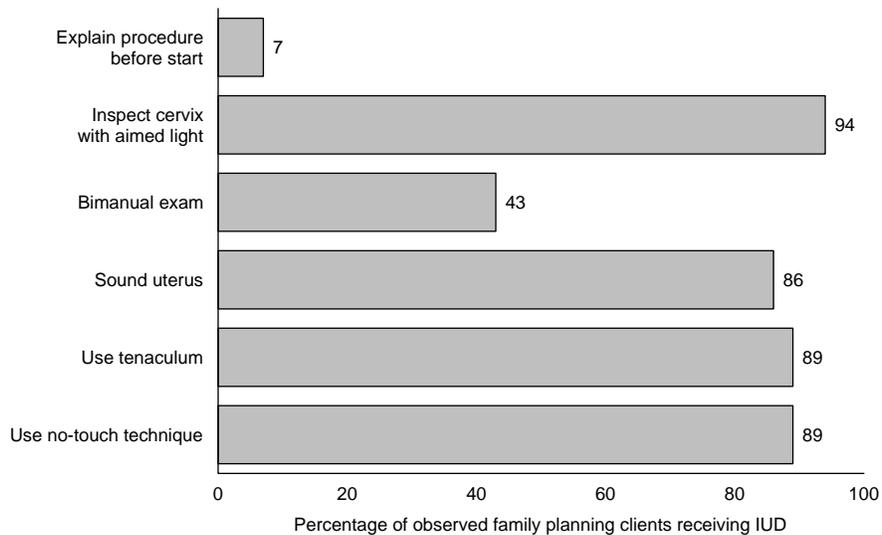
Figure 5.10 Selected pelvic examination procedures observed (N=400)



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Among clients observed receiving an injectable contraceptive (36 percent of observed clients), all (100 percent) providers were observed opening new needle and syringe packets, with 99 percent of the needles and syringes provided by the facility. Sharps containers were observed being used for only 70 percent of the cases (data not shown).

Figure 5.11 Selected IUD insertion procedures observed (N=352)



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Key Findings

Blood pressure was measured for 71 percent of clients receiving estrogen-containing contraceptives.

Hand washing was rarely done before conducting a procedure.

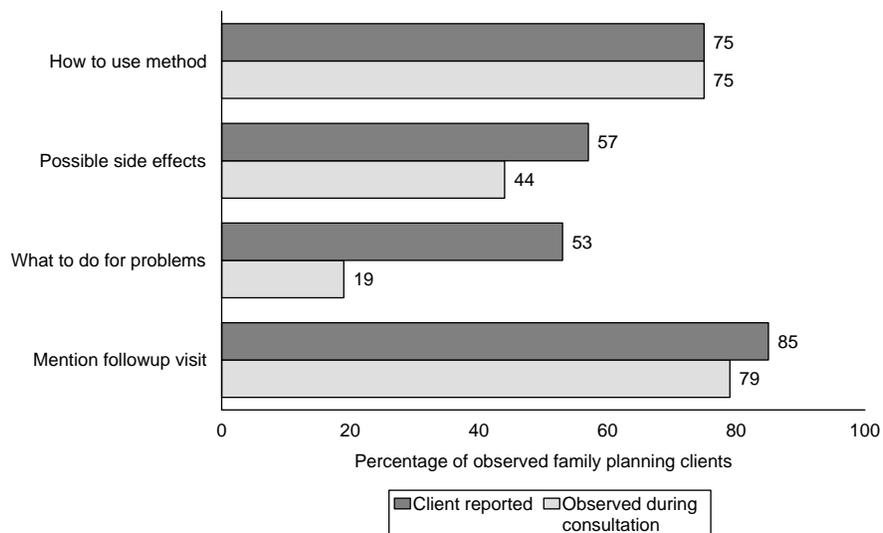
New needles and syringes were used universally when providing an injectable contraceptive.

Adherence to all quality procedures for the pelvic examination and IUD insertion is not consistent, with explanations to the client particularly lacking.

5.5.4 Counseling of Clients

Whether they are new contraceptive users or continuing users, certain information should be reviewed with clients during consultations. The ESPA specifically assessed whether the provider explained how to use the method, its possible side effects, what to do for problems, and whether the provider instructed the client about a followup visit. There was general consistency between what was observed during the consultation and what the client reported being told about the pill or injectable hormonal methods when interviewed after the consultation (Figure 5.12 and Appendix Table A-5.29). The differences in the percentages may reflect the client's prior knowledge about the method and the provider's explanations during previous visits.

Figure 5.12 Information provided to hormonal method users, by client report and by observation (N=828)



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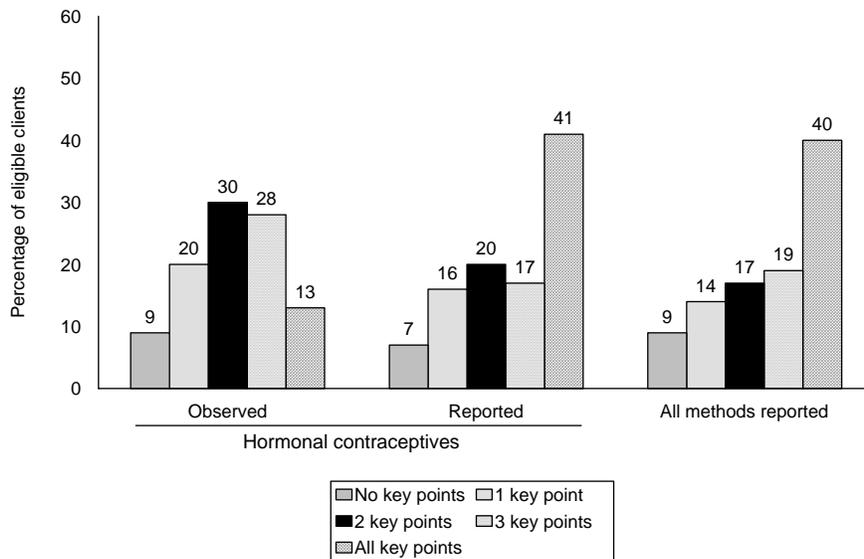
Findings from observation and client reports about counseling on the side effects and use of the method were less consistent for users of other contraceptive methods than for users of the hormonal pill or injection. Among the 663 women who received an IUD, only 31 percent were observed being instructed to check the string and 39 percent were observed being advised about possible heavy bleeding (Appendix Table A-5.30). Three in four IUD users, however, reported that they knew how to check the string, indicating that many continuing clients had previously received this information. This finding was similar

for implant clients who were only observed being told information in one of three consultations; yet, three in four clients knew the critical information asked.

For 13 percent of observed consultations for hormonal contraceptive (pills or injection) users the provider was noted to provide advice on four key points for their method (how to use, possible side effects, what to do for problems, time for followup visit), 31 percent were noted advising on three of the points, 50 percent on one or two key points (Figure 5.13), and 4 percent were noted to include no information on any of the key points. When interviewed after the consultation, client reports were similar to those of the observers, with 43 percent of the hormonal contraceptive users reporting that they were advised on all four key points,⁴ 16 percent reporting three of the key points, 36 percent one or two key points, and 5 percent reporting none of the key points were discussed.

When asked during the exit interview how often to take the pill or how often the injection should be received, almost all pill and injection users (98 percent) knew the correct response (Appendix Table A-5.29).

Figure 5.13 Number of key informational points discussed during consultations, by observation and by client report for oral and injectable hormonal contraceptive users (N=828), and by client report for all contraceptive method users (N=1558)



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During exit interviews, reports from client on whether key information points had been discussed were similar regardless of method of contraception, with 40 percent of all women reporting they had received information on all four key points and 9 percent reporting that they had received no information on the key points relevant to their method (Figure 5.13)

⁴ In exit interviews women were asked if they were told what to do for problems. The observers were instructed to note specifically if women were told what to do if they missed or were late with their method.

Key Findings

Observed sharing of key information on how to use contraceptive methods, what the side effects are, and how to manage associated problems varied by type of method. Client knowledge on these key points was good for most methods, indicating that although counseling on use, side effects, and problem management may not have occurred on the day of the survey, it most likely occurred during prior visits.

5.6 Client Opinion from Exit Interviews

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

Few issues were considered big problems. The areas identified as problems were a long waiting time to see the provider (8 percent) and the lack of medicines or supplies (6 percent) (Appendix Table A 5.31).

Half of the interviewed clients (50 percent) indicated that the proximity of the facility was a factor in selecting the facility, and 24 percent said that they selected the facility because the service they needed was available (Appendix Table A-5.32). Clients agreed that other important considerations for choosing the facility were that they were treated well (30 percent), the efficiency of the physician (26 percent), the good reputation of the facility (23 percent), and the presence of a female physician (20 percent).

Appendix Tables A-5.33 and A-5.34 provide information on the employment and educational backgrounds of the observed clients.

6.1 Background

6.1.1 ESPA Approach to Collection of Maternal Health Information

Maternal health is an issue for women, but it also has a direct bearing on the health of the newborn. About 15 percent of all pregnant women experience life-threatening complications as a result of their pregnancy (MNH, 2001a). Many complications and subsequent poor outcomes for women and infants can be prevented or minimized with early recognition of problems and appropriate interventions.

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

- **Antenatal care (ANC):** Because all pregnant women are at risk of developing complications and because many of these complications are unpredictable, it is important to ensure that all pregnant women have access to preventive interventions, early diagnosis and treatment for problems, and emergency care when needed. It is now emphasized that ANC should focus on early detection and skilled and timely interventions for factors having proven impacts on maternal and infant outcome (MNH, 2001a).
- **Delivery care:** Because every pregnancy may have complications, the emphasis is to promote use of skilled and trained delivery care providers and to ensure that all women have access to life-saving emergency interventions at the time of labor and delivery. In many countries, deliveries occur at home attended by traditional birth attendants (TBAs). Previously, there were extensive efforts and funds expended toward upgrading the skills of TBAs, but safe motherhood program initiatives have concluded that, in almost all cases, “the level of skill among ‘skilled birth attendants’ is lower than is ‘safe’ for safe motherhood. In-service training cannot improve the skill level of trained providers to the level of competency desired in all skills” (MNH, 2001b). With this conclusion has come a shift in the definition of qualified delivery providers to “persons with midwifery skills who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose and manage or refer complicated cases” (MotherCare Policy Brief #3) (Koblinsky, 2000).
- **Postnatal care (PNC):** There is increasing emphasis placed on ensuring that women receive PNC within a few days of birth for early diagnosis of postpartum complications. PNC also provides an opportunity to counsel the new mother on family planning and on caring for herself and her newborn, as well as to assess the newborn for any problems.
- **Newborn care:** More attention has also been given recently to newborn care, with the increased awareness of common practices that are detrimental to newborn health and a focus on those good practices that should be promoted.

Internationally accepted guidelines define the maternal health services necessary for safe delivery and improved maternal and newborn outcomes as follows (MotherCare Policy Brief #1) (Koblinsky, 1999):

- **Basic essential obstetric care (BEOC):** BEOC includes preventive services as well as medical interventions and procedures that can be provided by well-trained primary care physicians and nonphysician providers. This includes ANC, with preventive interventions,

early detection and treatment of common problems of pregnancy, and the ability to manage simple problems of pregnancy and to provide first aid for complications of pregnancy and labor to minimize the need for emergency interventions.

- **Emergency obstetric care (EmOC):** EmOC specifically covers life-saving interventions of blood transfusion and surgery.

Together basic essential and emergency obstetric care form the basis of what is considered comprehensive essential obstetric care (CEOC). CEOC has been adopted by the MOHP and forms the strategy of programs to improve maternal health.

Maternal and newborn health services represent a wide range of interventions, depending on whether the mother and newborn are healthy or experiencing problems. The ESPA drew on the findings and recommendations of Safe Motherhood initiatives such as the Maternal and Neonatal Health Project (MNH) and MotherCare, promoted by the World Health Organization (WHO) and other international organizations to determine which aspects of maternal health to assess.

This chapter uses information obtained in the ESPA to address six central questions regarding maternal health services:

- What is the availability of ANC?
- To what extent do facilities have the capacity to support quality ANC services?
- To what extent is there evidence that health service providers adhere to standards for provision of quality ANC services?
- To what extent is PNC¹ available where ANC is offered, and do facilities have the capacity to support quality PNC services?
- What is the availability of delivery services, and to what extent do facilities have the capacity to support quality delivery services?
- What are the common newborn care practices in facilities providing delivery services?

6.1.2 Maternal Health and the Utilization of Services in Egypt

The Ministry of Health and Population (MOHP) has identified maternal health as a priority health issue and has developed a strategy based on CEOC to reduce maternal morbidity and mortality. The U.S. Agency for International Development (USAID) is assisting the MOHP, through the Healthy Mother/Healthy Child (HM/HC) program, to implement the strategy.

The national maternal mortality study carried out in 2000 (MOHP, 2001) came to the following conclusions:

- Lack of ANC contributed to 19 percent of maternal deaths, and the poor quality of ANC contributed to 15 percent of maternal deaths.

¹ For the ESPA, any report of offering routine outpatient postnatal examination and services was accepted as PNC. Details on the content of PNC were not collected. Capacity was assessed by whether the facility could identify and manage postpartum infections and whether the newborn weight could be measured.

- Twenty-six percent of maternal deaths in Egypt occurred during delivery or the first 24 hours after delivery.
- Thirty-four percent of direct causes of maternal deaths in Egypt were due to postpartum hemorrhage. In total, 26 percent of deaths occurred postpartum.
- Cardiac diseases were the leading indirect cause of maternal deaths (13 percent), and the most common cardiac problem was rheumatic fever.
- Most (62 percent) maternal deaths occurred in health facilities, 29 percent occurred at home, and 9 percent occurred during transportation, with 93 percent of the women who died having sought medical help for their problems. Of those who delivered in a health facility, a disproportionate number of postpartum hemorrhage and caesarean section deaths occurred in private facilities (37 percent and 47 percent, respectively), possibly because of lack of blood, poor backup, or delays in transferring patients to hospital.
- Substandard care (poor diagnosis and management) by health providers, in particular obstetricians and general practitioners, remains the most important avoidable factor, contributing to 54 percent of maternal deaths. Substandard care in the private sector is of particular concern, since deliveries in the private sector have overtaken deliveries in the public sector (26 percent and 22 percent, respectively) (El-Zanaty and Way, 2001).
- Failure of the woman or her family to recognize danger signs, resulting in a delay in seeking care, was the second most important avoidable factor, contributing to 30 percent of all maternal deaths. Shortage of blood was the most frequently avoidable health facility factor, contributing to 16 percent of maternal deaths.

Through the HM/HC program, the MOHP has developed interventions to decrease 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 MOHP has also been expanding the midwifery training of nurses. The objective is to increase the skills of primary care physicians and nurses trained in midwifery so that they acquire proficiency in the skills necessary to manage normal deliveries and to diagnose and manage or refer complicated cases.

Improvement in maternal health is being achieved. According to the 2000 Maternal Mortality Study (MOHP, 2001):

- Nationally, maternal mortality has decreased from 174 deaths per 100,000 live births in 1992 and 1993 to 84 deaths per 100,000 live births in 2000.
- There were significant regional differences in maternal mortality. Comparing 1992 and 1993 results with the 2000 results, Metropolitan Egypt had the largest percentage decrease in maternal mortality (79 percent) followed by Upper Egypt (59 percent) and Lower Egypt (29 percent).

The current goal for 2007 is to reduce maternal mortality to 50 or less maternal deaths per 100,000 live births.

Finally, the EDHS 2000 provides information on levels of utilization of health services during pregnancy. Findings from the EDHS 2000 include the following (El-Zanaty and Way, 2001):

- Fifty-three percent of women who had been pregnant during the five-year period preceding the survey had received some type of ANC.
- Four ANC visits with services provided by a trained provider (the MOHP definition for ANC) were received by an average of 37 percent of pregnant women, during the five-year period preceding the survey.
- Almost two-thirds of women receiving ANC received their ANC from private service providers, and one-third received ANC from public service providers.
- Utilization of ANC in urban regions was more than twice that for rural regions.
- Slightly less than 50 percent of births were in a medical facility, although 61 percent gave birth with the assistance of a trained provider.

6.2 Antenatal Care

6.2.1 Availability of ANC and PNC Services

To support appropriate utilization of ANC, services should be available with sufficient frequency to meet the needs of most pregnant women. Preventive services, such as ANC, are commonly offered only one or two days per week. Although this strategy may facilitate the management of services and personnel, particularly where limited space and equipment are problems, this can create “missed opportunities” for providing ANC. A pregnant woman may be at the facility for another purpose (e.g., for a sick child or a child receiving immunization or other well-child services, or even for herself if she is sick), and if she cannot receive the ANC services at the same time, she might be disinclined to return another day specifically for ANC (because of time, financial constraints, or other factors).

Information on the availability of ANC, PNC, and tetanus toxoid (TT) vaccine is provided in Table 6.1. Information on the availability of various family health services at a facility on the same day as ANC is provided in Appendix Table A-6.1, and more detail on the availability of ANC and TT vaccines is

Background characteristic	Percentage of facilities offering the indicated services			Number of facilities (weighted)
	ANC	PNC	TT vaccine	
Type of facility¹				
GS hospital	79	51	53	64
MCH/urban HU	88	70	88	65
Rural HU	99	78	93	367
Mobile unit	73	5	2	38
Health office	4	4	6	32
NGO facilities	82	25	11	71
Region				
Urban Governorates	77	51	42	65
Lower Egypt	87	58	72	308
Upper Egypt	91	66	74	264
Total	88	61	70	637

provided in Appendix Table A-6.2. Fever hospitals are excluded from the analyses because they are not eligible to provide ANC.

Most facilities (88 percent) offer ANC, with fewer (61 percent) offering PNC and TT vaccine (70 percent) (Table 6.1). Fifty-three percent of facilities offer all three services. Facilities in Upper Egypt are more likely to offer each of the services (ANC, 91 percent; PNC, 66 percent; TT, 74 percent) than those in the Urban Governorates (ANC, 77 percent; PNC, 51 percent; TT, 42 percent). Among facilities that offer ANC, 71 percent were offering ANC on the day of the survey, but both ANC and TT were offered at only 33 percent of facilities on the day of the survey (Appendix Table A-6.1). MCH/urban HUs offered both ANC and TT on the day of the survey more frequently than other facilities (63 percent, compared with about 31 percent of general service hospitals,² 34 percent of rural HUs, 12 percent of NGO facilities, and none of the mobile units) (Appendix Table A-6.1).

Both family planning services and ANC were offered at 69 percent of the ESPA facilities on the day of the survey, and both ANC and curative care for sick children were offered at 59 percent of the facilities (Appendix Table A-6.1). ANC, family planning, and sick child services were all offered on the day of the survey in 56 percent of the facilities. These three family health services were more likely to be offered on the same day in facilities located in Urban Governorates (71 percent) than in those located in Upper Egypt (47 percent); these services were also more likely to be offered on the same day in general service hospitals and MCH/urban HUs (about 80 percent, compared with about half in other types of facilities). As mentioned in Chapter 4, it is not MOHP practice to offer child immunization services (EPI) daily, and this was evident, as only 9 percent of facilities were offering both ANC and EPI at the same facility the day of the survey.

Facility respondents were asked the number of days per week that ANC and TT are routinely offered. Rural HUs tend to offer ANC less frequently than other facilities (52 percent offer the service one or two days per week) (Appendix Table A-6.2). Although 56 percent of facilities reported offering TT every day that ANC is offered and 57 percent indicated that ANC is offered five days per week, only 21 percent indicated that they offer TT five days per week. It is possible that facilities considered advising women to return or making referrals as offering the service. TT vaccine in Egypt is routinely provided through normal services. Village outreach and campaign activities for providing TT are usually only carried out in areas where the incidence of tetanus is more than 1 per 1,000 live births.

Key Findings

ANC is offered in most (88 percent) facilities (excluding fever hospitals) and, among these, is offered five days per week in 57 percent of facilities. Rural HUs are least likely to offer the service five days per week (46 percent).

PNC is less available, being offered in only 61 percent of facilities. PNC is most often available in rural HUs (78 percent) and MCH/urban HUs (70 percent).

ANC, PNC, and TT vaccine are all offered at 53 percent of facilities, with MCH/urban HUs and rural HUs offering all three services more frequently than other facilities.

On the day of the survey, family planning and sick child services were being offered in the same facilities with ANC in more than half of the facilities (56 percent).

TT and ANC services were both being offered on the day of the survey in around one-third of the facilities. Nineteen percent of facilities offering ANC do not themselves offer TT services.

² These include general/district and integrated hospitals.

6.3 Capacity to Provide Quality ANC

ANC aims to promote healthy behaviors in pregnant women and to provide early detection for and treatment of complications. Specific items that were assessed include the following:

- Infrastructure and resources to support quality assessment and counseling
- Infrastructure and resources for examinations
- Essential supplies for basic ANC services
- Additional equipment and supplies for ANC (and PNC) services.

6.3.1 Infrastructure and Resources to Support Quality Assessment and Counseling of ANC Clients

The following items were assessed for supporting quality ANC services:

- Individual client cards
- Guidelines or protocols for ANC
- Visual aids for client education.

Aggregate information on the availability of all items for quality counseling is provided in Table 6.2 by type of facility and region. Summary information on the availability of each of these items is provided in Figure 6.1, with details, by facility type, provided in Appendix Table A-6.3.

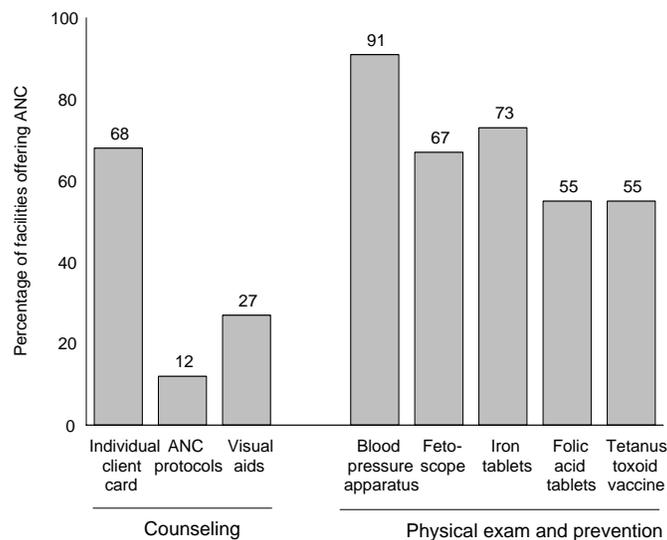
Background characteristics	Percentage of facilities offering ANC services with:				Number of facilities offering ANC (weighted)
	All items to support quality counseling ¹	All items for infection control ²	All items for physical examination ³	All essential supplies for basic ANC ⁴	
Type of facility					
GS hospital	6	15	52	17	51
MCH/urban HU	18	17	39	34	57
Rural HU	10	12	52	26	364
Mobile unit	0	12	61	0	28
NGO facilities	2	18	81	0	58
Region					
Urban Governorates	13	43	69	31	50
Lower Egypt	8	16	54	21	268
Upper Egypt	10	10	52	21	240
Total ⁵	9	14	54	22	559

Individual client cards, important for recording information to allow followup of a woman's pregnancy and health status over time, were available in 68 percent of facilities (Figure 6.1) and were available more often in MCH/urban HUs (83 percent) and rural HUs (81 percent) than in other types of facilities

(Appendix Table A-6.3). Written ANC guidelines or protocols that include management of common problems during pregnancy were available in the ANC service delivery area in only 12 percent of facilities. An additional 4 percent of facilities that were not offering ANC the day of the survey indicated they had protocols but were unable to show them (data not shown). Visual aids for ANC client counseling were available in 27 percent of facilities. With the exception of mobile units, where these items to support quality were unavailable, each of the items assessed were available more often in government facilities than in NGO facilities. In total, 9 percent of facilities had all items assessed for supporting quality ANC services (Table 6.2).

Health education sessions providing information on maternal and child health are important for promoting good health practices, early detection of problems, and the appropriate use of health services. While 64 percent of facilities reported that they provide group education for ANC clients (data not shown), only 10 percent were observed providing this service on the day of the survey (Appendix Table A-6.3). MCH/urban HUs were more likely to be observed providing group education to ANC clients (22 percent of facilities) than other facilities.

Figure 6.1 Availability of items to support quality ANC services (N=559)



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6.3.2 Infrastructure and Resources for Examinations

Items for basic physical examinations (most of which are necessary for PNC as well) were as follows:

- Items for infection control
- Conditions for examinations.

Aggregate information on these elements is provided in Table 6.2, and summary information on specific equipment and supplies is given in Figure 6.1. Appendix Table A-6.3 provides details on each of the items assessed, by facility type.

Items for infection control were assessed in the area where ANC examinations, such as abdominal examinations or pelvic examinations, took place. Because some ANC services also provide injections and

check blood anemia, a box for disposal of sharp items was included as an item for infection control. All items (soap and water for hand washing, clean latex gloves, disinfecting solution, and a sharps box) were available in only 14 percent of the ANC service delivery areas (Table 6.2). Similar to findings for other services, availability of soap was the weakest component and was available in the ANC service area in only 39 percent of facilities. (Appendix Table A-6.3). Water was available in 85 percent of facilities (Appendix Table A-6.3), mostly through a piped system (81 percent) (data not shown). An additional 2 percent of facilities had supplied water to the service area using a bucket with a tap, and 3 percent used a bucket without a tap, on the day of the survey. Water in buckets was most commonly found in mobile units (data not shown). Clean latex gloves for pelvic examinations were available in only 44 percent of facilities, although, as mentioned in other sections, disposable gloves that were thin and easily torn (and not defined as acceptable for infection control by the ESPA) were available uniformly. Sharps boxes were available in 66 percent of facilities. NGO facilities and mobile units were least likely to have sharps boxes (35 percent and 42 percent, respectively). Facilities in Urban Governorates were far more likely to have all items for infection control (43 percent) than those in Lower Egypt (16 percent) and Upper Egypt (10 percent) (Table 6.2).

The common physical examinations for ANC include palpating the abdomen, a breast examination, and, when necessary, a pelvic examination. Pelvic examinations are not routine practices for ANC in Egypt. The basic components assessed for examination of the ANC client were visual and auditory privacy (78 percent), a bed or examination table (89 percent), and an examination light (68 percent) (Appendix Table A-6.3). All three items were found in 54 percent of facilities and were most frequently found in NGO facilities (81 percent) and facilities in Urban Governorates (69 percent) (Table 6.2). The item most often missing was an examination light.

6.3.3 Essential Supplies for Basic ANC

Essential supplies for basic ANC were defined as a functioning blood pressure apparatus (found in the ANC service area in 91 percent of facilities), a fetoscope (67 percent), iron tablets (73 percent), folic acid tablets (55 percent) (in either separate tablets or one combined tablet),³ and TT vaccine (55 percent of facilities) (Figure 6.1). All of these items, defined as essential for basic ANC care, were found in only 22 percent of facilities (Table 6.2). The lack of availability of folic acid and iron tablets (assessed in the facility pharmacy) is of importance. These were most often lacking in mobile units and NGO facilities (Appendix Table A-6.3).

Facilities in Urban Governorates were more likely to have all of the items assessed for quality assessment and counseling (13 percent), infection control (43 percent), physical examinations (69 percent), and essential supplies for basic ANC (31 percent) than facilities in other regions (Table 6.2).

³ More than half (52 percent) of the facilities had the combined iron and folic acid tablets.

Key Findings

Individual client ANC cards were available in 68 percent of facilities (83 percent of MCH/urban HUs and 81 percent of rural HUs).

ANC protocols and visual aids were available in 12 percent and 27 percent of facilities, respectively.

Although water was available in most (85 percent) ANC service delivery areas, hand-washing soap and clean latex gloves were available in only 39 percent and 44 percent of the ANC service examination areas, respectively.

Functioning blood pressure apparatus was available in 91 percent of the ANC service areas.

Folic acid was not available in 45 percent of facilities, and iron tablets were not available in 27 percent of facilities.

Facilities in Urban Governorates were notably better equipped and supplied to provide quality ANC than those in Upper and Lower Egypt.

6.3.4 Additional Equipment and Supplies for Quality ANC and PNC Services

Additional equipment and resources that were assessed included the following:

- Medicines
- Routine ANC diagnostic interventions and service components
- Equipment for basic PNC.

Summary information on each component is provided in Figures 6.2 and 6.3, and aggregated information is given in Table 6.3. Appendix Tables A-6.4 through A-6.9 provide details on each item assessed, by type of facility.

Hypertensive disorder of pregnancy (preeclampsia), anemia, sexually transmitted infections (STIs), and vaginal infections are conditions that can directly affect both maternal and newborn health. BEOC requires that a facility provide early treatment for the common problems and complications of pregnancy to prevent progression to more serious problems.

Medicines to manage common conditions that may affect pregnancy and birth outcome are not specific to ANC, and they are commonly used for other routine adult health problems. Their use at different types of facilities for complications of ANC depends on the policies of the facility or ministry.

Treatment of STIs by ANC providers, where ANC providers can diagnose and prescribe treatment for clients with symptoms without referring the client elsewhere, was a routine component of ANC in 87 percent of facilities (Table 6.3). Eight percent of the observed STI clients⁴ (N=36) were identified during observations for ANC, providing supporting evidence that ANC providers do provide STI services. These clients were observed in higher proportions in rural HUs and mobile units and in facilities in Upper Egypt (data not shown). This finding is not surprising. Rural HUs and mobile units may by necessity provide integrated services because they have only a few providers who see all clients. This differs from

⁴ The STI observations are discussed in Chapter 7.

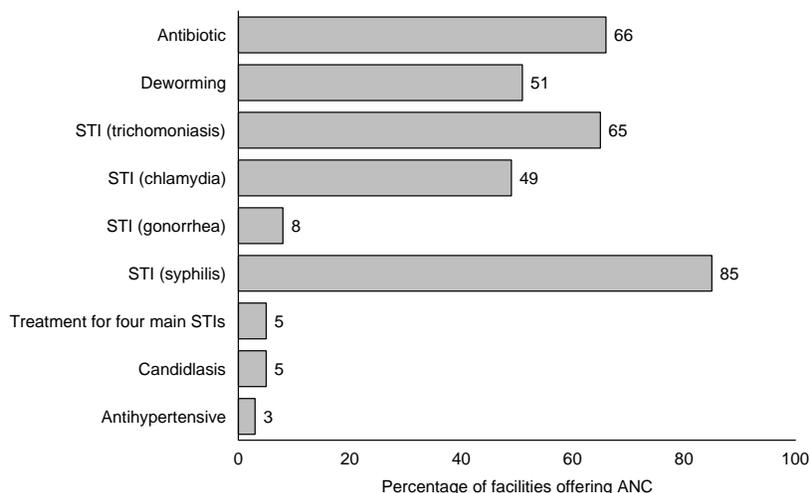
general service hospitals and larger MCH/urban HUs, where there may be specialized service areas with staff who provide only specific services.

Sixty-six percent of facilities had an antibiotic for managing urinary tract infections or postpartum infections (either amoxicillin or cotrimoxazole), 51 percent had mebendazole for treating worms, and 5 percent had at least one medicine to manage each of the four major STIs (trichomoniasis, chlamydia, syphilis, and gonorrhea), with a medicine for gonorrhea most often lacking (Figure 6.2 and Appendix Table A-6.4). Only 5 percent of facilities had a medicine for candidiasis, a common vaginal or sexually transmitted infection, and only 3 percent of all facilities (9 percent of general service hospitals) had methyldopa for managing hypertension during pregnancy⁵ (Appendix Table A-6.4). Almost no facilities had all medicines assessed for management of basic infections or health problems during pregnancy (Table 6.3).

Table 6.3 Facility practices and resources for diagnosis and management of common complications of pregnancy								
Percentage of facilities where ANC service providers can diagnose and treat STIs for ANC clients, percentage with all medicines to manage common complications of pregnancy, percentage with testing capacity for anemia, urine protein, urine glucose, blood grouping, and for ultrasound, by type of facility and region, Egypt SPA 2002								
Background characteristics	Percentage where STI treatment is provided by ANC providers	Percentage with all medicines for treating ANC complications ¹	Percentage with capacity for conducting the indicated diagnostic test:				Number of facilities offering ANC (weighted)	
			Anemia ²	Urine protein ³	Urine glucose ⁴	Blood grouping ⁵		Ultrasound ⁶
Type of facility								
GS hospital	90	0	84	79	47	60	41	51
MCH/urban HU	89	1	88	86	67	54	46	57
Rural HU	87	0	85	71	41	15	13	364
Mobile unit	81	0	10	10	10	0	76	28
NGO facility	92	0	63	63	59	43	39	58
Region								
Urban Governorates	95	0	78	79	75	76	59	50
Lower Egypt	83	0	80	76	47	18	19	268
Upper Egypt	90	0	78	60	36	22	24	240
Total ⁷	87	0	79	69	45	25	25	559
¹ At least one broad-spectrum antibiotic; at least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis; mebendazole; and nystatin suppository all present. ² Includes any test (hemoglobinometer 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 Anti-A, Anti-B, Anti-D, and glass slides. ⁶ Functioning ultrasound machine and provider trained in obstetric ultrasound. ⁷ Includes data from one health office offering ANC.								

⁵ In Egypt, methyldopa, for managing hypertension, is to be used for ANC clients only by specialists, and facilities without specialists are expected to refer these cases.

Figure 6.2 Medicines for managing common complications during ANC (N=559)

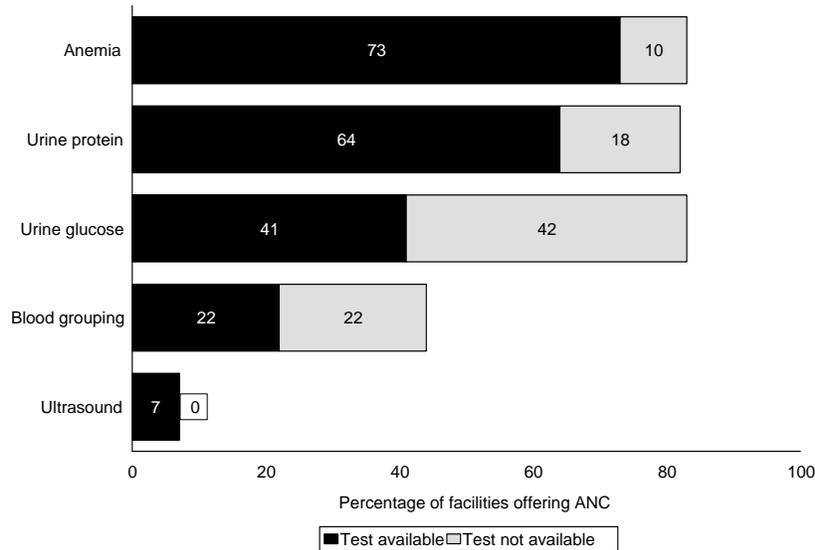


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Some health issues are exacerbated during pregnancy or can affect newborn health. Laboratory tests for anemia, urine protein (for preeclampsia), and urine glucose (for diabetes) can either identify or facilitate early detection of these conditions. It is helpful to know the proportion of facilities that routinely offer or actually provide these tests during pregnancy, as well as the proportion of those that have the laboratory capacity (all equipment and, where applicable, reagents) to conduct the test in-house. Syphilis testing is not a routine practice for ANC services in Egypt; therefore, information on syphilis testing for ANC was not collected.

Around 80 percent of facilities indicated that laboratory testing for anemia, urine protein, and urine sugar was a routine component of ANC. Almost half reported that they routinely tested for blood group and Rh factor. Seven percent of facilities, primarily MCH/urban HUs (18 percent), indicated that ultrasound was a routine component for ANC (Appendix Table A-6.4). Among facilities that reported routine anemia testing as a component of ANC, seven in eight had the test available the day of the survey, and among those reporting routine urine testing for protein, three in four facilities had the test available (Figure 6.3). All facilities that reported routine ultrasound with ANC (7 percent) had functioning ultrasound equipment available on the day of the survey. This was not the case however for facilities reporting that urine glucose testing, blood grouping, and Rh factor analysis were routine components of ANC. Clinistix for testing urine glucose, as well as equipment and reagents for blood grouping and Rh factor analysis, were available in only half of the facilities that indicated the test was a routine component of ANC (Figure 6.3). In general, blood grouping and urine glucose testing capacity (for either routine or selective use during ANC) were primarily available at facilities in Urban Governorates (over 70 percent each), as was ultrasound capacity (59 percent) (Table 6.3 and Appendix Tables A-6.7 and A-6.8).

Figure 6.3 Availability of ANC tests in facilities where tests are reported to be routine components of ANC (N=559)



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Although only 7 percent of facilities reported that ultrasound was a routine component of ANC, 29 percent of facilities had an ultrasound machine, with almost all of these having a trained provider in ultrasound. Twenty-five percent of facilities had both the machine and a trained provider (Appendix Table A-6.9).

Half (49 percent) of facilities indicated that discussion about family planning was a routine component of ANC during the last trimester of pregnancy, with MCH/urban HUs being more likely than other facility types to include FP as a routine component of ANC (63 percent, compared with around 49 percent of all facilities) (Appendix Table A-6.4).

In Egypt, PNC is often provided through outreach services, with a provider from the facility making home visits for newborns and their mothers. In many facilities, when a woman comes for routine PNC, she is seen by the same provider and in the same service area as ANC clients. Thus, the information on infrastructure and resources for counseling, physical examination, and management of common complications during pregnancy are all relevant to the capacity for providing quality routine PNC. In addition, there should be an assessment of postpartum infection. A thermometer was available in the ANC service delivery area in 75 percent of facilities and a functioning infant scale was available in 61 percent (Appendix Table A-6.4). General service hospitals, NGO facilities, and mobile units were least likely to have an infant scale in the ANC area (45 percent, 22 percent, and none, respectively).

Key Findings

The lack of medicines for managing common complications of ANC was notable in all facilities, including general service hospitals. Commonly recommended antibiotics were available in 66 percent of the facilities.

Eighty-seven percent of facilities diagnose and prescribe treatment for STIs in the ANC service area; however, only 5 percent of these facilities had a medicine to treat each of the four main STIs (syphilis, gonorrhea, chlamydia, and trichomoniasis). The recommended treatment for gonorrhea is most often lacking (available in only 8 percent of facilities).

Around 80 percent of facilities routinely check urine protein and blood for anemia during ANC, with most having the test capacity available on the day of the survey.

Only half of the facilities where blood grouping and urine glucose testing are routine components of ANC had the capacity to conduct the test on the day of the survey. Blood grouping and urine glucose test capacity were available more frequently in facilities located in Urban Governorates (around 75 percent) than in facilities in other areas.

Half of all facilities indicated that counseling about family planning is a routine component of ANC during the third trimester.

6.4 Management Practices Supportive of Quality ANC and PNC Services

Management practices that were assessed include the following:

- Facility documentation and records
- Charging practices for ANC
- Supervision and staff development.

Table 6.4 provides information on management practices, by type of facility and region, and Figure 6.4 provides summary information on in-service training topics related to ANC that were received during the past five years. Appendix Tables A-6.10 through A-6.15 provide details on utilization of ANC services at facilities included in the ESPA, information on charging practices and out-of-pocket payments, supervision and in-service training from the perspective of the provider, and details on the content of in-service training and supervision for ANC providers.

6.4.1 Facility Documentation and Records

Up-to-date registers for ANC that included an entry in the past seven days and indicated, at minimum, if the visit was a first or followup visit were available in 74 percent of facilities (Table 6.4). A register for PNC clients was observed in 54 percent of facilities offering ANC. The PNC register could include outreach services (home visits) or facility-based services. The median number of ANC clients per month (either first or followup visits) for facilities with data available on the day of the survey ranged from 164 for MCH/urban HUs, to 41 for mobile units, to less than 10 for health offices (only one provides ANC) and NGO facilities (Appendix Table A-6.10). The median numbers were similar for PNC, for facilities providing data.

Table 6.4 Management practices supportive of quality maternal health services

Among facilities providing antenatal care (ANC), percentage with an up-to-date ANC register, with an up-to-date postnatal care (PNC) register, percentage with documentation that they monitor ANC coverage, percentage where there are some user fees for ANC, percentage where at least half of the interviewed ANC service providers received in-service training related to ANC during the past 12 months, and percentage where at least half of the interviewed ANC providers were personally supervised during the past 6 months, by type of facility and region, Egypt SPA 2002

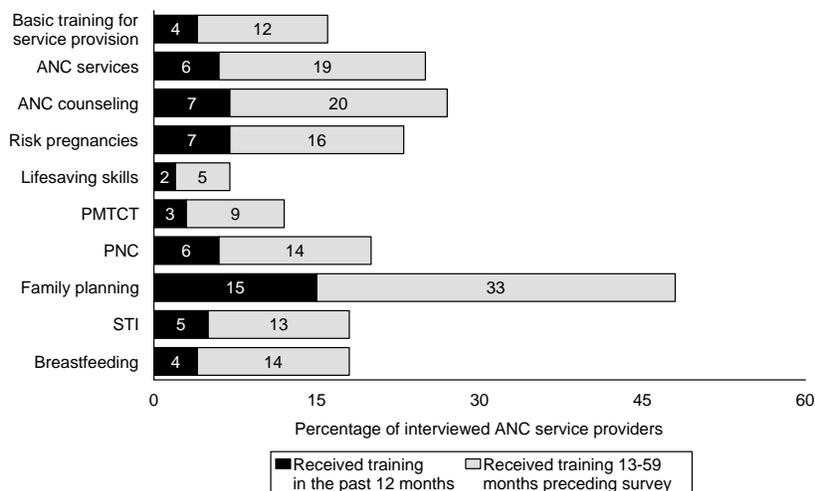
Background characteristic	Percentage of facilities offering ANC that have:				Number of facilities offering ANC ² (weighted)	Percentage of facilities where at least half of the interviewed ANC service providers		
	Observed up-to-date patient register ¹		Documentation of monitoring ANC coverage	User fees for ANC		Received in-service training during past 12 months ³	Were personally supervised during past 6 months	Number of facilities with interviewed ANC providers (weighted)
	ANC	PNC						
Type of facility								
GS hospital	65	45	26	56	51	16	93	49
MCH/urban HU	97	79	30	40	57	23	97	57
Rural HU	85	63	43	29	364	25	98	360
Mobile unit	15	3	0	56	28	20	98	28
NGO facility	15	1	0	96	58	32	59	57
Region								
Urban Governorates	64	34	18	73	50	24	84	49
Lower Egypt	77	62	42	41	268	16	95	264
Upper Egypt	72	48	28	34	240	34	94	238
Total ³	74	54	34	41	559	24	94	551

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 Includes data from one health office offering ANC.

³ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

Figure 6.4 In-service training received by interviewed ANC service providers, by topic and timing of most recent training (N=1465)



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The ESPA assessed whether the facility monitors the proportion of eligible women who are in its catchment areas and who receive ANC services, either at the facility or from facility staff through outreach; documentation of monitoring was also assessed. Thirty-four percent of facilities had documentation indicating that they monitor their ANC coverage, and rural HUs are more likely to monitor this (43 percent) than other types of facilities (Table 6.4). Mobile units and NGO facilities indicated that this is not one of their ANC program components. When asked the definition for ANC that was used to calculate ANC coverage, 34 percent of facilities indicated that a woman must have at least 4 visits (the MOHP standard definition) (data not shown). Three percent indicated that one visit was accepted for ANC coverage, and the rest indicated that two or three visits were accepted.

6.4.2 Practices Related to User Fees

Health insurance does not apply for ANC clients in public sector facilities. Forty-one percent of facilities indicated that they have some user fee for ANC (Table 6.4). Among these, 29 percent indicated that they collect a routine fee for the consultation, 11 percent indicated that they have user fees for medicines or tests, and 3 percent indicated that they had one fixed fee that covered all ANC visits (Appendix Table A-6.11). NGO facilities were far more likely to have user fees (96 percent) than government facilities (ranging from 29 percent to 56 percent). Few facilities (27 percent) publicly posted the fee schedule for ANC services where it could be seen by clients. Among the observed, and subsequently interviewed, ANC clients who paid anything out of pocket the day of the survey (57 percent of first-visit and 48 percent of followup-visit clients), the median out-of-pocket payment was about the same (around 100 piasters), whether for a first or followup visit. (Appendix Tables A-6.12-1 and A-6.12-2). The exception was mobile units and NGO facilities, where the median out-of-pocket payment was 500 piasters for both first and followup ANC clients. Most clients indicated that the fee was for the consultation (most likely a registration fee) (data not shown) rather than for medicines or for laboratory tests. The out-of-pocket payments do not include any costs for purchasing medicines or laboratory tests that were not provided at the facility.

6.4.3 Supervision and Staff Development

If at least half of the interviewed ANC providers at a facility had received any structured in-service training relevant to ANC during the past 12 months (excluding on-the-job training that may be received during discussions with supervisors), the facility was defined as providing routine staff development activities. During the past 12 months, at least half of the interviewed ANC providers had received in-service training related to ANC in only 24 percent of facilities (Table 6.4). Among all interviewed providers of ANC services, 25 percent had received related in-service training during the past 12 months, and 43 percent received training in the period 13 to 59 months preceding the survey (Appendix Table A-6.13). The most frequently reported topics of in-service training during the past 12 months were related to family planning (15 percent), with around 6 percent reporting in-service training on other topics specific to ANC, PNC, or STIs (Figure 6.4). An additional one in four providers reported in-service training on topics specific to ANC or PNC during the 13 to 59 months preceding the survey. Specific topics and the timing of providers' most recent in-service training are described in detail in Appendix Tables A-6.14-1 and A-6.14-2.

Supervision of individual staff helps to promote adherence to standards and to identify problems that contribute to poor-quality services. The ESPA collected information on both the frequency of supervision and the activities of the supervisor. Similar to findings in other services, supervision of ANC providers is common, with at least half of the interviewed ANC providers having been personally supervised during the past six months in 94 percent of facilities (Table 6.4). Routine supervision practices for ANC providers were found least often in facilities in Urban Governorates (84 percent). Interviewed providers indicated that they had received supervision a median of nine times during the past six months, with over

90 percent of the providers reporting that their supervisor checked their records, observed their work, and provided feedback (Appendix Table A-6.15). Eighty percent reported that the supervisor provided updates on ANC topics.

Key Findings
Up-to-date registers for ANC were available in 74 percent of facilities that offer ANC; up-to-date registers for PNC were available in 54 percent of facilities offering ANC.
Monitoring ANC coverage is routine in 34 percent of facilities.
Routine provision of in-service training for ANC service providers during the past 12 months was found in 24 percent of facilities; routine provision of in-service training was least often found in facilities in Lower Egypt (16 percent).
Within the past five years, however, 68 percent of the interviewed ANC providers had received some related in-service training.
Routine supervision of ANC service providers during the past six months, where supportive activities were a part of the supervision, was common across all facilities (94 percent), with the notable exception being NGO facilities (59 percent); routine supervision was least often found in facilities in the Urban Governorates (84 percent).

6.5 Adherence to Standards for Quality ANC Service Provision

Observers watched the process utilized when ANC clients were seen at the facility, noting information shared and procedures or examinations conducted. Checklists based on elements of focused ANC and additional elements that are components of ANC in Egypt were used to collect information on whether the consultation process during ANC included the following:

- Appropriate assessment and examination for the visit number and gestational age
- Health education provided under conditions and with appropriate content to promote healthy behaviors
- Adherence to practices to support continuity of care.

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

Because ANC services are not provided every day, the survey team made a special effort to schedule the visit on the day when ANC services were offered. If ANC services were not provided on the day of the survey, when possible, the team returned another day specifically for observation of ANC clients. A total of 977 women were observed in 169 facilities. Overall, this represents half of all ANC clients registered in facilities the day of the survey (data not shown). Details on characteristics of observed ANC clients are provided in Appendix Table A-6.16. Among the observed ANC clients, this was the first visit for 46 percent of the women. Twenty-four percent of the observed clients were estimated to be less than five

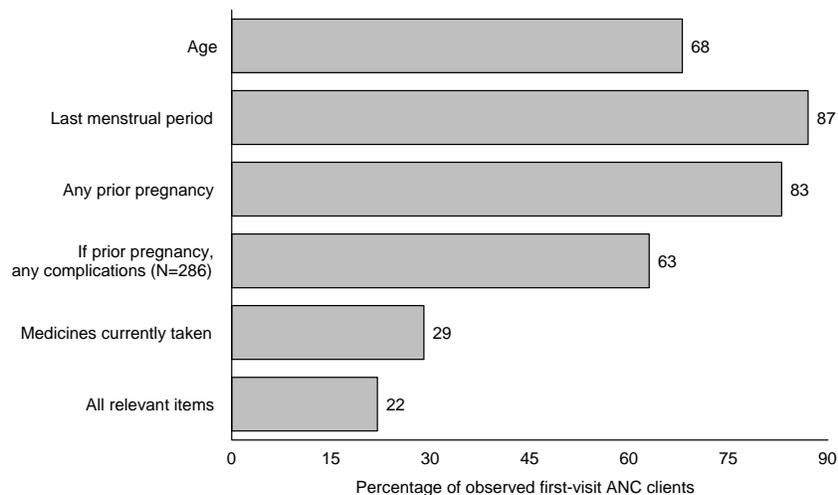
months pregnant, and 24 percent were at least eight months pregnant.⁶ This was the first pregnancy for 37 percent of the clients. Three observed clients either refused or were not located for the exit interview (data not shown).

Summary information on observed and reported components of ANC, as well as client knowledge, is provided in Figures 6.5 through 6.9. Appendix Tables A-6.17 through A-6.25 provide details on observed and reported components of ANC. Appendix Table A-6.26 provides information on where interviewed clients planned to deliver. Appendix Tables A-6.27 and A-6.28 provide information on use of individual client health cards and whether observed ANC clients were referred or sent home after the consultation.

6.5.1 Appropriate Assessment and Examination for the Visit Number and Gestational Age

The first ANC visit should include a basic history to assess preexisting risk factors. Among the first-visit clients, age was elicited for 68 percent of them, and information about the date of last menstrual period and any prior pregnancy was elicited for over 80 percent of clients (Figure 6.5). Information about any complications during prior pregnancies was sought for 63 percent of the women who had previously been pregnant. Twenty-nine percent were asked about medicines being taken, and all relevant items were assessed for 22 percent of the first-visit clients. More complete histories were noted for clients observed at rural HUs (all items observed for 26 percent of observations) and at NGO facilities (all items observed for 24 percent of observations) than for clients observed elsewhere (18 percent or less) (Appendix Table A-6.17).

Figure 6.5 Content of client history assessed for first-visit ANC clients (N=446)



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Two of three first-visit clients who had had prior pregnancies were asked about any specific complications during a prior pregnancy. Among these, whether the client had had a stillbirth was

⁶ Month of pregnancy was noted if information was shared during the observation. The client was also asked during the exit interview. Where there were discrepancies, the observation information was utilized, since the provider assessment of pregnancy status influences the ANC activities.

assessed for 33 percent, whether she had had an infant die in the first week after birth was assessed for 21 percent, any history of severe bleeding during a previous labor and delivery (or postpartum period) was assessed for 8 percent, any prior assisted delivery (either caesarean section, use of forceps, or other intervention) was assessed for 44 percent, and any previous abortion was assessed for 58 percent (Appendix Table A-6.17). Any history of complications from prior pregnancies was assessed most often for clients at rural HUs (72 percent) and least often for clients at MCH/urban HUs, mobile units, and NGO facilities (assessed for less than 50 percent of clients who had had prior pregnancies).

All ANC clients should receive certain assessments to monitor the progress of their pregnancy and to identify risk factors. Observers noted whether providers 1) assessed whether the client had any vaginal bleeding, 2) assessed if fetal movement had been noticed (at least five months pregnant), 3) measured blood pressure, 4) assessed the fetal position (for women at least eight months pregnant), and 5) listened to the fetal heart (at least five months pregnant).

Laboratory facilities and cold chain maintenance capability are required for some screening and preventive interventions. If a facility does not have the capacity to provide the service itself, it should have a referral site that will provide the service to the ANC client. Some interventions, however, such as provision of iron tablets, require minimal support and are most often components of ANC at all levels of service.

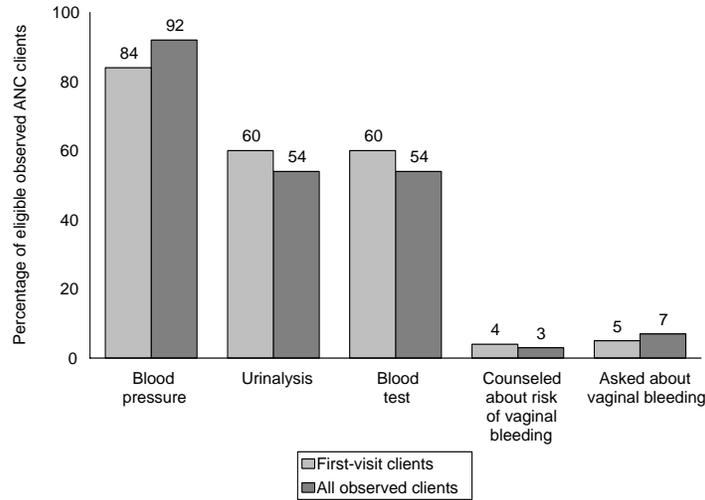
Vaginal bleeding was assessed for 7 percent of the ANC clients, and 46 percent of women at least five months pregnant were asked about fetal movement (Appendix Table A-6.18). Blood pressure was measured for 92 percent of women, the fetal heart was listened for in only 19 percent of those at least five months pregnant, and the abdomen was palpated or an ultrasound was performed (both of which allow the provider to assess fetal position) for 75 percent of women at least eight months pregnant. Few of the women (3 percent) had all relevant components for their month of pregnancy (Appendix Table A-6.18). There was no consistent difference by facility type in whether or not assessments were conducted.

In addition to the basic examinations, weight was measured for 78 percent of women, and activities to allow assessment of gestational age (either palpation or measuring of fundal height or conducting an ultrasound) were conducted for 63 percent of women. In total, an ultrasound was conducted on 17 percent of the women, with the mobile units using the ultrasound the most frequently (52 percent of ANC clients), followed by NGO facilities (31 percent) (Appendix Table A-6.18).

Around half of all clients received (or were prescribed) a urine test and/or a blood test, and 44 percent received iron tablets (Appendix Table A-6.18). First-visit clients were somewhat more likely to have the urine and blood tests prescribed or provided (60 percent each) (Appendix Table A-6.17). In addition, 42 percent of first-visit clients (one in three of all clients) received or were prescribed TT vaccine. These items were components of ANC at MCH/urban HUs and rural HUs more often than they were at other facilities. TT vaccine was least often offered to clients at NGO facilities and mobile units (both less than 10 percent).

To meet defined minimum standards for ANC that are promoted in Egypt, each ANC visit should include the following components: 1) counseling on vaginal bleeding as a risk sign for which help should be sought, 2) measuring blood pressure, and 3) a urinalysis (checking for urine protein and glucose). In addition, first-visit clients should have their blood checked (for anemia). Almost no clients (3 percent) were counseled about vaginal bleeding as a risk sign, and only 7 percent were assessed for whether they had experienced any vaginal bleeding (Figure 6.6). Figure 6.6 provides information comparing the content of observed ANC for these items for first-visit and all ANC clients.

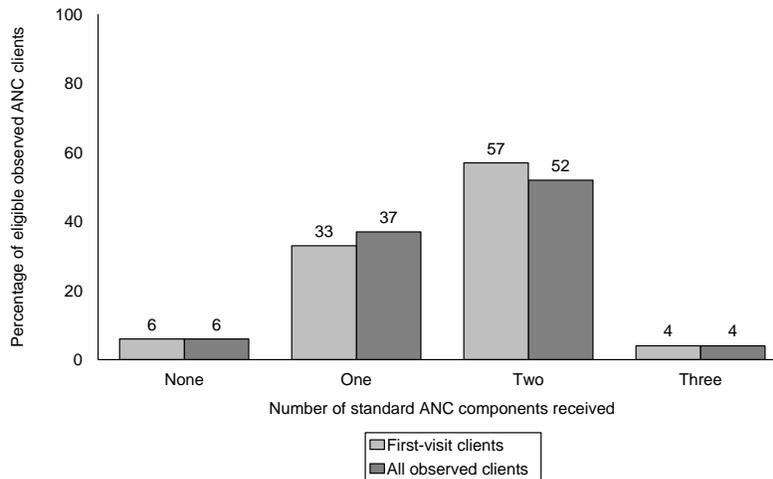
Figure 6.6 ANC content for first-visit ANC clients (N=446) and all observed ANC clients (N=977)



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One in three observed ANC clients received one of the standard components during their ANC visit, over half received two of the three standards components of ANC, and 4 percent received all three standard components (Figure 6.7), with findings similar for first-visit and all ANC clients. General service hospitals and mobile units most frequently provided ANC services that did not include any of these components of ANC (Appendix Tables A-6.19 and A-6.20). Facilities in Urban Governorates were somewhat better than those in other regions were in providing these standard components of ANC, although percentages for all items were low (7 percent of first-visit clients in facilities in Urban Governorates).

Figure 6.7 Percentage of first-visit ANC clients (N=446) and all observed ANC clients (N=977) who received the indicated number of standard ANC components during the observed visit



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Key Findings

Assessments of first-visit ANC clients do not consistently include important items for assessing preexisting risk. Complications of prior pregnancies (63 percent) and medicines being taken (29 percent) were the information items least assessed among observed components of histories.

Basic components for routine ANC care were also not consistently provided. Assessing the presence of vaginal bleeding (7 percent), assessing fetal movement after five months of pregnancy (46 percent), and listening for the fetal heart (19 percent) were the weakest components.

Blood pressure was measured for over 90 percent of the observed ANC clients.

Laboratory tests to support screening for risk symptoms were utilized for around half of both first- and followup-visit ANC clients.

The three components identified for standard ANC (check blood pressure, urine protein, and vaginal bleeding) were almost never provided during an ANC visit (4 percent of all clients).

6.5.2 Counseling to Promote Healthy Outcome

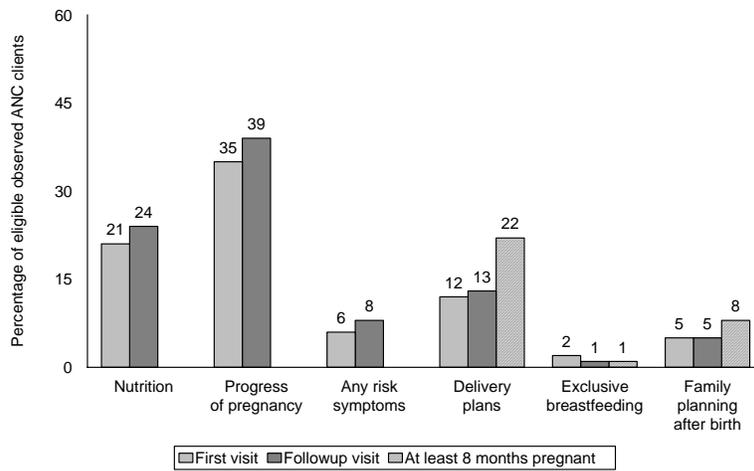
The common preventive interventions for ANC are iron (and folic acid) tablets and TT vaccine. To improve the chances that a client will accept preventive medicines and take them as required, providers should explain why the medicine is important and how to take it properly. Among the women who received (or were prescribed) iron or folic acid tablets, 26 percent were observed receiving an explanation of why they were necessary, and 55 percent were observed receiving information on how to take the tablets (Appendix Table A-6.21). Among those who received or were prescribed TT vaccine, 11 percent were observed being told why it was necessary. Explanations of why either intervention was important were weakest for clients at general service hospitals (19 percent were told why iron was needed, and 3 percent were told why TT was needed) and in facilities in Upper Egypt (6 percent were told the purpose for iron tablets, and 6 percent were told the purpose for TT vaccine).

Informing a pregnant women about special nutritional needs during pregnancy and signs and symptoms that may indicate a problem should be a routine component of ANC counseling. It is of interest to know not only what was shared during the consultation, but also what the ANC client understood and remembered after the consultation. Thus, the ESPA collected information both through observing the consultation and through interviewing the observed client after she had completed her visit. In reviewing the observation and exit interview, it should be remembered that it is not uncommon for there to be differences between what is observed and what is reported by the client. This may be because a client forgets or does not understand elements of counseling, a client recalls information shared during a prior visit or received elsewhere as information from the current visit, or an observer did not hear some elements of counseling.

It is not unreasonable to assume that all components of counseling are not discussed during each visit, when a woman makes multiple ANC visits. Thus, the content of counseling for first and followup visits was assessed separately.

Nutritional issues were discussed during the observed consultation with around a quarter of the ANC clients, both for the first-visit and followup clients (Figure 6.8). Discussions on the progress of the pregnancy were observed for over one-third of the ANC clients. Nutritional issues were discussed more often with clients observed in NGO facilities (Appendix Table A-6.22) and facilities in the Urban Governorates (42 percent) than facilities in Lower Egypt (27 percent) and Upper Egypt (11 percent) (Appendix Table A-6.23).

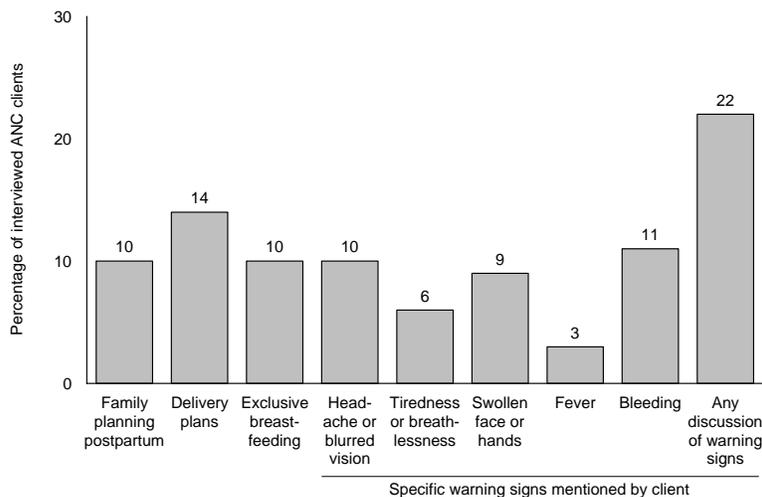
Figure 6.8 Counseling topics discussed during observed first visit (N=466) and followup visit (N=551) and with ANC clients at least 8 months pregnant (N=235), when relevant



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Risk symptoms, for which a woman should seek help, were rarely discussed (less than 10 percent for either first or followup visits) (Figure 6.8). Observers noted discussions about risk symptoms more often with clients at NGO facilities (16 percent for both first and followup visits) (Appendix Table A-6.22), and this was also more commonly reported by clients at NGO facilities (40 percent compared with 22 percent for all facilities) (Appendix Table A-6.24). While 22 percent of the interviewed clients said they had been told about warning signs (during the current visit or a past visit), only 11 percent mentioned vaginal bleeding as a risk sign when asked to name any risk symptoms (without prompted responses) (Figure 6.9). Nine percent of the women mentioned swollen face or hands, 6 percent mentioned breathlessness or tiredness, and 10 percent mentioned headache or blurred vision as risk symptoms. When asked what they

Figure 6.9 Topics reported by interviewed clients as having been discussed either during this or a previous ANC visit (N=974)



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were told to do if the symptom occurred, only 20 percent mentioned seeking care at the facility (Appendix Table A-6.24). While, overall, the observed discussion of any particular risk symptom was low (7 percent), discussion was more often observed in facilities located in Urban Governorates and Lower Egypt, with 10 percent of clients in each location observed receiving information on at least one of the assessed risk symptoms (compared with 4 percent in Upper Egypt) (Appendix Table A-6.23).

Discussions about plans for delivery were observed with around 12 percent of ANC clients. Plans were most more commonly discussed with clients at facilities in Upper Egypt (16 percent) (Appendix Table A-6.23) and during consultations with clients who were at least eight months pregnant (22 percent) (Figure 6.8). When asked during the exit interview where they planned to deliver, 37 percent of clients indicated that they would deliver at a health facility, either at the facility where they were receiving ANC (8 percent) or at another facility (29 percent), with 25 percent indicating that they would deliver at home and 39 percent being uncertain (Appendix Table A-6.26). These findings are similar to the actual reported patterns for delivery noted in the EDHS 2000, where slightly less than half of the women indicated that they gave birth in facilities. There were regional differences in the planned place for birth, with 38 percent of women in facilities in Upper Egypt reporting that they planned to deliver in their home (compared with 17 percent in Lower Egypt and 8 percent in facilities in Urban Governorates).

Counseling on exclusive breastfeeding was essentially nonexistent, observed during only 1 to 2 percent of the consultations. The finding from the observation was supported by reports during exit interviews. When ANC clients were asked if they had ever been instructed about exclusive breastfeeding, only 10 percent said that they had (Figure 6.9), and 1 percent said that they had been told to exclusive breastfeed for 6 months (Appendix Table A-6.24). Among the women who said that they had been told about exclusive breastfeeding (N=65), one-quarter said that they were advised to exclusively breastfeed for 6 months, another 22 percent for 4 to 5 months, and 40 percent for 24 months (data not shown). It is assumed that these women were responding with how long they would breastfeed, rather than how long they should exclusively breastfeed. Whether exclusive breastfeeding or breastfeeding in general is being discussed during ANC consultations should be investigated.

Discussion about use of family planning after delivery was also not common among all ANC clients (5 percent), and it was only slightly more common for women who were at least eight months pregnant (8 percent) (Figure 6.8). During the exit interview, 10 percent of the interviewed clients mentioned that they had been advised about using family planning postpartum (Figure 6.9).

Overall, NGO facilities provided counseling, and information from interviewed clients at NGO facilities confirmed that they had received health education more often than clients at for other types of facilities (Appendix Tables A-6.22 through A-6.24).

Key Findings
Counseling related to nutrition during pregnancy is commonly provided (21 percent of first-visit clients and 24 percent of followup-visit clients).
Advice on risk symptoms is not a routine component of ANC consultations (less than 10 percent of observed clients and 22 percent of interviewed clients).
Counseling on exclusive breastfeeding is rarely provided (1 percent of observed clients, and 10 percent of interviewed clients). Only 1 percent of interviewed women reported that they were told that exclusive breastfeeding should be provided to the infant for 6 months.
In general, health education topics were addressed more often in NGO facilities than in other facilities.

6.5.3 Supporting Continuity of Care

For quality ANC, continuity of care, which includes monitoring changes between visits, is important. One of the more reliable means for achieving this is to maintain a record of relevant history and findings, as well as interventions or treatments provided. Frequently, health services are organized in such a way that measurements of blood pressure, weight, and other components of a consultation take place prior to the client being seen by the ANC provider responsible for the consultation, and the information is recorded on a client record. Forty-five percent of facilities were observed to weigh ANC clients and 48 percent to measure blood pressure before the consultation (data not shown). Thus, for this information to be available to the provider for use during the assessment, an individual client card must be used.

Individual client cards were used (the provider was noted to look at the card prior to or during the consultation and/or to write on the card after the consultation) during two-thirds of the observed ANC consultations (Appendix Table A-6.27). Thus, the ability to provide continuity of care and to assess changes in health status over time was limited for one-third of the ANC clients. Individual client cards were more often used in the MCH/urban HUs and rural HUs than in other facilities. Information on the use of cards is presented in Appendix Table A-6.27.

Among the observed ANC clients, 92 percent went home after their consultation, 6 percent were referred within the facility for additional consultation or treatment, 1 percent were referred outside the facility, and 1 percent were admitted to the facility (Appendix Table A-6.28). For client referrals there were notable differences between regions, with 25 percent of clients in the Urban Governorates being referred within the same facility. This may be a reflection of more complex facilities, with more specialist physicians in Urban Governorates and different service delivery patterns, rather than a reflection of client differences. The proportion of ANC clients in Lower and Upper Egypt who have need of higher-level services is not known.

6.6 Client Opinion from Exit Interviews

Before they left the facility, observed ANC clients were interviewed for their opinions on the services they received and any problems they encountered on the day of the visit. Similar to findings from other services, there was not much dissatisfaction. The issues of greatest concern were a long waiting time (11 percent) and a lack of medicines or supplies (10 percent) (Appendix Table A-6.29). Over 5 percent of the women also identified different issues related to the perceived quality of the examination and explanations as problems.

When asked if specific factors were important in determining why they chose the facility for ANC, 52 percent responded that the proximity of the facility was a major factor (Appendix Table A-6.30). In addition, around one in four clients reported that the efficiency of the physician, the availability of the needed service, the good reputation of the facility (or provider) and how they were treated were also important factors. Only 9 percent indicated that the presence of a female physician was an issue.

Appendix Tables A-6.31 and A-6.32 provide additional details on client employment and educational backgrounds.

6.7 Availability of Delivery Services and Capacity to Provide Quality Delivery Care

The availability of emergency obstetric care services and the presence of standards, equipment and supplies, and health system components to support quality delivery services were assessed. Specific items that were assessed include the following:

- Components of comprehensive essential obstetric care services (CEOC)

- Support for safe home deliveries
- Infrastructure and resources to support quality delivery services.

Because of resource and logistic constraints, it is not uncommon to find that a single facility cannot provide all services required to meet the standards for CEOC. When facilities cannot provide all necessary services, they should have systems in place to assist women in receiving the help required. For example, a facility that does not provide emergency obstetric care should have an emergency transportation plan that supports appropriate referrals to ensure access to life-saving interventions.

6.7.1 Availability of Components of CEOC Services

Table 6.5 provides information on the availability of CEOC services that were assessed by the ESPA, by facility type and region, and Appendix Table A-6.33 provides details on the systems for emergency transportation for obstetric cases that were reported.

Almost all facilities offer some maternal health service, with 88 percent offering ANC but only 35 percent offering delivery services (Table 6.5). Only 33 percent of all facilities provided both ANC and delivery services. This is primarily because of the organization of the health system: Inpatient services, such as deliveries, are offered primarily at general service hospitals (77 percent) or at MCH/urban HUs (53 percent). Among rural HUs, 35 percent offered delivery services. In addition, three of the rural HUs surveyed (1 percent) had a delivery room and equipment but lacked qualified delivery providers and so were not offering delivery services at the time of the survey (data not shown). Caesarean sections were offered at 55 percent of general service hospitals and at 7 percent of NGO facilities. The difference in availability of delivery services and caesarean sections was evident between regions, with only 26 percent of facilities in Lower Egypt offering delivery services (compared with around 40 percent for Upper Egypt and facilities in Urban Governorates). While 10 percent of facilities in Urban Governorates offered caesarean sections, only 5 percent of those in Upper Egypt and 6 percent in Lower Egypt offered this service.

The EDHS 2000 findings indicate that slightly less than half of deliveries take place in a medical facility, and the 2000 national Maternal Mortality Study (MOHP, 2001) indicates that 29 percent of maternal deaths occur at home. The ESPA found that only about one-third of rural HUs and half of MCH/urban HUs provide delivery services, and that only general service hospitals (55 percent) provide caesarean section. Where facilities do not provide delivery services but do provide ANC, it is probable that, for many home deliveries, the facility where a woman received ANC may be the nearest formal health sector site from which help can be sought. Where facilities do offer delivery services but do not provide caesarean sections, it is even more essential to ensure that, when necessary, women have access to emergency obstetric surgery. One means of increasing the probability that women have access to emergency obstetric care when needed is to offer a means for rapid transfer to a site where the needed service is available. Without a facility-supported emergency transportation system, the woman and family are left to their own devices to arrange for transportation for help during an emergency. Only 13 percent of facilities reported that they had some system for supporting transportation to another facility for obstetric emergencies (Table 6.5). General service hospitals were more likely to have a system for emergency transportation⁷ (58 percent) than MCH/urban HUs (33 percent) or other types of health facilities (ranging from 0 to 6 percent). Among facilities that offer facility-based delivery services the findings were more supportive of ensuring access to emergency obstetric care, with 35 percent of

⁷ Hospitals that were referral centers were counted as having an emergency transportation system, since they could provide all relevant services.

facilities that offer delivery services reporting that they have an emergency transportation system (data not shown). This included 74 percent of the general service hospitals, 64 percent of MCH/urban HUs, 35 percent of rural HUs, and 38 percent of NGO facilities that offer delivery services (data not shown).

Among the facilities that did have some arrangement for emergency transportation, the arrangements were described as a dedicated emergency vehicle located at the facility (68 percent), an official arrangement where the vehicle was based elsewhere (usually at a general service hospital) and the referring facility (most often a rural HU or MCH/urban HU) called for the vehicle when needed (59 percent), a multipurpose vehicle based at the facility (33 percent), or other means (e.g., funds to pay for a hired vehicle) (34 percent). It can be seen from the responses that some facilities use several systems, most likely having a backup system for when the facility-based vehicle is not available (Appendix Table A-6.33).

Table 6.5 Availability of maternal health services

Percentage of facilities that provide antenatal care, delivery services, or caesarean sections; percentage providing both ANC and delivery services; percentage providing ANC, delivery services, and caesarean section; percentage having a system for emergency transportation; percentage providing any home delivery services; and percentage with documentation of activities with traditional birth attendants (TBAs), by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities providing indicated services								Number of facilities (weighted)
	Facility-based maternity services					Emergency transportation support for maternity emergencies ²	Services supporting safe home delivery		
	Antenatal care	Normal delivery services ¹	Caesarean section	ANC and normal delivery services	ANC, normal delivery, and caesarean section		Any home delivery services ³	Documented official program supportive of TBAs ⁴	
Type of facility⁵									
GS hospital	79	77	55	58	38	58	31	11	64
MCH/urban HU	88	53	0	51	0	33	57	16	65
Rural HU	99	35	0	35	0	6	46	12	367
Mobile unit	73	0	0	0	0	0	0	0	38
Health office	4	0	0	0	0	0	0	2	32
NGO facility	82	11	7	10	6	4	0	0	71
Region									
Urban Governorates	77	39	10	38	8	27	25	8	65
Lower Egypt	87	26	6	23	4	11	29	10	308
Upper Egypt	91	44	5	42	4	13	45	10	264
Total	88	35	6	33	5	13	36	10	637

¹ One GS hospital and three rural health units have delivery rooms but no staff for providing delivery services. These facilities are not classified as providing normal delivery services.
² Any system where the facility provides some support for emergency transportation to referral site, or the facility is the referral site.
³ This may be either a routine service or service only for emergency cases.
⁴ Any official activity with TBAs for which the facility has any documentation.
⁵ Fever hospitals are not eligible for maternity services, and so are not included.

The median reported time it took a referred client to reach the referral facility—starting from when the vehicle was called for, if the vehicle was based at another facility—was 16 minutes, with MCH/urban HUs reporting 11 minutes and general service hospitals and rural HUs reporting about 20 minutes. There are no seasonal variations in travel time in Egypt.

6.7.2 Support for Safe Home Deliveries

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 facility may increase the chances of having a safe delivery. The common support systems are for facility staff to attend home births, either routinely or for emergencies only. Facilities are often encouraged to develop formal systems for working with TBAs. There is some evidence that TBAs who have some linkage with the formal health sector are more likely to

refer women appropriately and to adopt safer delivery practices (MNH, 2002a). The Egypt MOHP encourages facilities to develop programs to link with TBAs and to upgrade the skills of the TBAs.

In assessing TBA support programs, the ESPA looked for documentation of some official relationship between the TBA and the facility (e.g., minutes or an attendance list from a meeting) for some assurance that the relationship was more structured than simply accepting TBA referrals or letting TBAs know they could call for help.

Ten percent of facilities (11 percent of general service hospitals, 16 percent of MCH/urban HUs, and 12 percent of rural HUs) indicated that they had programs with TBAs and had documentation to indicate that the program was active (Table 6.5). An additional 4 percent of facilities (5 percent of general service hospitals, 4 percent of MCH/urban HUs, and 8 percent of rural HUs) reported that they had activities with TBAs but had no documentation to support this (data not shown).

Thirty-six percent of the facilities indicated that they did provide home delivery services (Table 6.5), with 27 percent saying that they routinely conducted home deliveries and 9 percent indicating that this was offered as an emergency service only (data not shown). Facilities in Upper Egypt were more likely to provide some home delivery service (45 percent), with 30 percent of the facilities in Upper Egypt indicating that this was a routine service and 15 percent indicating that it was an emergency service only (data not shown).

Key Findings

Delivery services are offered in 35 percent of facilities, while ANC is offered in 88 percent.

Caesarean section services are offered in 6 percent of facilities (55 percent of general service hospitals and 7 percent of NGO facilities).

All three maternity services are offered in 5 percent of all facilities; however, this includes 38 percent of general service hospitals.

Delivery services are more available in facilities in Upper Egypt (44 percent offer delivery, and 5 percent offer caesarean section) and the Urban Governorates (39 percent offer delivery and 10 percent offer caesarean section) than in facilities in Lower Egypt (26 percent offer delivery services, and 6 percent offer caesarean section).

Support for emergency transportation of maternity emergencies to referral facilities is weak (13 percent of facilities). Where transportation is supported, median travel times are short (less than 20 minutes).

Forty-five percent of facilities in Upper Egypt provide home delivery services, with 30 percent indicating that the service is a routine one, not only for emergencies.

6.7.3 Infrastructure and Resources to Support Quality Delivery Services

Items assessed for quality delivery services include the following:

- Items for infection control
- Infrastructure, equipment and supplies for basic delivery services
- Equipment and supplies for emergency obstetric care.

Aggregate information on infrastructure, as well as equipment and supplies for basic delivery services, including emergency medicines, is provided in Table 6.6. Figures 6.10 through 6.12 provide summary information on individual items, and Appendix Tables A-6.34 through A-6.40 provide details, with Tables A-6.35 through A-6.38 providing details on sterilization/high-level disinfecting (HLD) procedures for delivery equipment. Further detail on delivery room infrastructure is provided in Appendix Table A-6.41. Figure 6.13 provides information on equipment for emergency obstetric care, with further details provided in Appendix Tables A-6.42 and A-6.43.

Background characteristics	Percentage of facilities offering delivery services with:				Among facilities offering delivery services, percentage with additional medicines and supplies for managing complications of delivery		Number of facilities offering delivery services (weighted)
	All items for infection control ¹	All delivery room infrastructure and furnishings ²	All other items to support quality ³	All essential supplies for delivery ⁴	Common complications ⁵	Serious complications ⁶	
Type of facility							
GS hospital	26	78	2	31	49	39	49
MCH/urban HU	39	64	4	44	33	0	35
Rural HU	20	80	0	12	5	2	129
NGO facility	32	91	0	8	16	16	8
Region							
Urban Governorates	58	72	2	64	57	18	25
Lower Egypt	33	79	0	27	23	12	81
Upper Egypt	12	78	2	8	10	7	115
Total	25	77	1	21	20	10	221

Infection is one of the most common causes of maternal and neonatal morbidity and mortality. Thus, infection control practices are essential for quality delivery care. All items assessed for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) were present in the delivery service area in one of four facilities (Table 6.6). The item most often lacking was hand-washing soap (available in only 41 percent of facilities) (Appendix Table A-6.34). Latex gloves and a sharps box were also lacking, available in only 61 percent and 67 percent of facilities, respectively. Water was primarily supplied through piped sources (88 percent), with 13 percent of facilities (including 11 percent of general service hospitals and 17 percent of rural HUs) having no water in the delivery service area on the day of the survey (data not shown).

The procedures used for sterilizing or HLD processing of equipment used for deliveries were also assessed.⁸ Among the facilities providing delivery services, 31 percent processed equipment in the delivery service area, 26 percent in the family planning service delivery area, and 43 percent in the main facility area for processing equipment (Appendix Table A-6.35). In small facilities (some MCH/urban HUs and rural HUs), delivery, family planning, and main facility equipment may be processed in one

⁸ Chapter 3, sections 3.4.1 and 3.4.2 provide details on the definitions for adequate sterilization or HLD procedures and storage practices.

location. Overall, when assessing processing conditions that exist where delivery equipment is processed, 60 percent of facilities had the equipment and knowledge of minimum processing time (and temperature, for dry heat sterilization) for sterilizing (either dry heat or autoclave method), 17 percent did not have equipment and/or knowledge for sterilizing but did have equipment and/or knowledge for HLD processing (boiling, steaming, or chemical disinfecting⁹), and 24 percent were lacking either equipment or knowledge for adequate processing procedures (Appendix Table A-6.36). HLD processing does not kill the tetanus spore and thus does not provide a sufficient level of cleanliness for most equipment used for deliveries. Although facilities in Urban Governorates were more likely than those in other locations to have the equipment and knowledge for sterilizing (68 percent), they were less likely to have HLD capacity where there was no capacity to sterilize. Facilities in Lower and Upper Egypt, while having high capacity to sterilize (64 percent and 55 percent, respectively), also had the capacity to use HLD if the knowledge or equipment for sterilizing was lacking. It is possible that facilities in Urban Governorates are more dependent on high-technology sterilization and therefore no longer have the systems (or knowledge) for HLD processing (should their sterilizing system be broken or the knowledgeable person be absent).

Facilities that processed their equipment in the delivery service area were slightly less likely to have the capacity for adequate processing (47 percent had the equipment and knowledge of correct time and temperature for sterilizing, compared with 60 percent of all facilities) (Appendix Table A-6.37). Processing in the delivery area was reported more often in facilities in Urban Governorates (61 percent) than in those in Lower Egypt (34 percent) and Upper Egypt (22 percent) (Appendix Table A-6.35). This may reflect a greater proportion of large, complex facilities in the Urban Governorates (where a facility may process equipment in multiple sites) than found in Upper and Lower Egypt.

Written guidelines for sterilization or HLD processing were observed in the processing area at 29 percent of facilities. An additional 3 percent of facilities indicated that they had written guidelines but were unable to show them (data not shown). Guidelines were found more often in MCH/urban HUs (34 percent), rural HUs (32 percent), and NGO facilities (29 percent) than in general service hospitals (14 percent). They were also more often found in facilities in Urban Governorates (58 percent) than in those in Lower Egypt (30 percent) or Upper Egypt (23 percent) (Appendix Table A-6.36).

One in four facilities had processed equipment stored in the delivery service area on the day of the survey. Among these, 86 percent had stored the equipment under conditions that maintain sterility or cleanliness¹⁰ (Appendix Table A-6.38), and 17 percent had stored equipment under conditions sufficient to maintain sterile or HLD status.

The basic infrastructure and furnishings for the delivery room (visual and auditory privacy, a bed or delivery table, and an examination light) were assessed. The delivery area in most facilities (93 percent) provided visual privacy (either a private room or a room with a temporary divider), and 89 percent provided both visual and auditory privacy (a private room). Almost all facilities had a bed for delivery (98 percent), and 84 percent had an examination light that could be aimed to view the perineum. Overall, 77 percent of facilities offering delivery services had all of the basic infrastructure and furnishings (Table 6.6), with NGO facilities being the best equipped (91 percent having all items) and MCH/urban HUs being the least well equipped (64 percent having all items), because of the lack of an examination light (Appendix Table A-6.34).

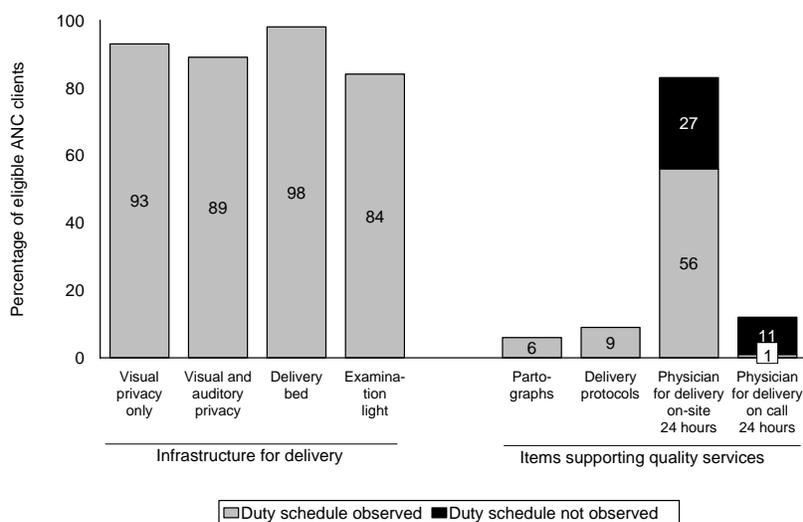
The partograph—a document used to monitor an individual woman’s labor—is promoted internationally as a means for improving quality of care. It provides guidelines for monitoring and for early identification

⁹ Chemical disinfecting was the only means of processing for one facility only.

¹⁰ This might include items that were wrapped but not sealed, items stored under a cloth or in an autoclave on a tray, or items sitting in disinfecting solution.

of complications (MNH, 2002b). Partographs were rarely available in any type of facility (6 percent) (Figure 6.10), although, when found, they were most often in general service hospitals (10 percent) or MCH/urban HUs (11 percent) (Appendix Table A-6.34). Protocols or guidelines for deliveries and managing complications of deliveries were also not commonly found, with only 9 percent of all facilities having them in the delivery service area. An additional 6 percent of facilities indicated that they had protocols but were unable to show them (data not shown).

Figure 6.10 Items to support quality delivery services (N=221)



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In Egypt, physicians are the principal delivery service providers in facilities. Although 94 percent of facilities indicated that there was a physician available 24 hours to conduct deliveries, either on-site (83 percent) or on call (12 percent), a 24-hour duty schedule was observed at only 56 percent of the facilities reporting site providers and at only 1 percent of facilities with on-call staff available 24 hours (Figure 6.10). Without an official schedule assigning duty during nights and holidays, the consistency with which a provider will routinely be found is uncertain. An on-site physician with an observed duty schedule was the pattern for almost all (81 percent) facilities in Urban Governorates, compared with about half of facilities in Lower and Upper Egypt (Appendix Table A-6.39). An additional four in ten facilities in Lower and Upper Egypt reported that they did have 24-hour staff but did not have a duty schedule. In many rural HUs, there is one physician assigned who lives at the facility. In this situation there might reasonably be no duty schedule observed; however, staff coverage for when the physician is out of the immediate area for more than a few hours (e.g., visiting another town) is uncertain. Among all facilities offering delivery services, 5 percent indicated that in addition to physicians, nurses trained in midwifery sometimes conduct deliveries at night, and 7 percent indicated that graduate nurses sometimes conduct deliveries at night. Nurses conducting deliveries were most often reported for MCH/urban HUs. Graduate nurses were reported as delivery providers most often in Lower Egypt (12 percent), compared with 4 percent for facilities in Urban Governorates and Upper Egypt.

Key Findings

Hand-washing soap was available in 41 percent of delivery service areas, and latex gloves were available in 61 percent.

Equipment and knowledge of processing details for sterilizing delivery equipment were available in 60 percent of facilities; equipment and knowledge of HLD processing were available in 17 percent of facilities.

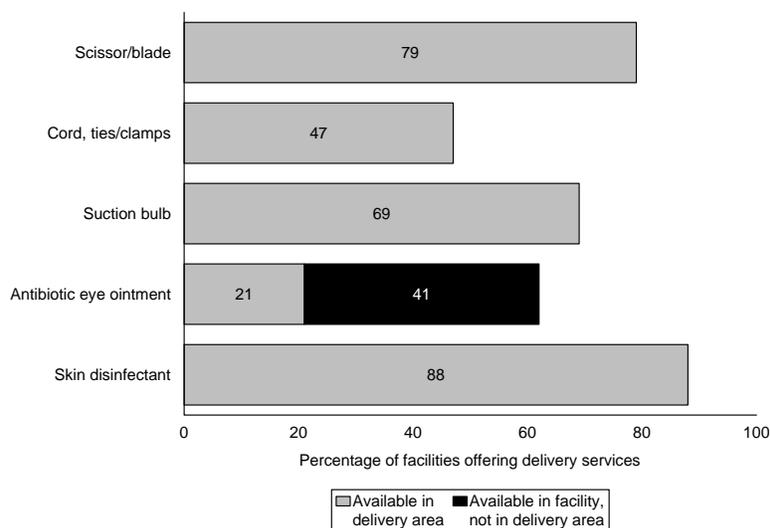
The basic infrastructure for delivery services was strong, with the delivery service area providing visual and auditory privacy in 89 percent of facilities. An examination light was the infrastructure item least often found (available in 84 percent of facilities).

Partographs and protocols to support a routine standard of delivery service are rarely available (6 percent and 9 percent of facilities, respectively).

Delivery service providers are reported available 24 hours in 95 percent of facilities; however, a duty schedule for night duty was observed in 57 percent of facilities.

The availability of essential items for deliveries was assessed. Scissors or a blade for cutting the umbilical cord and, if necessary, conducting an episiotomy were available in 79 percent of facilities; materials for clamping or tying the umbilical cord were available in 47 percent; a suction bulb or other means for suction of the newborn was available in 69 percent;¹¹ an antibiotic ointment for the eyes of the newborn was available in 65 percent; and a disinfectant for cleaning the perineal area was available in 88 percent (Figure 6.11). All basic supplies were available in 21 percent of the facilities, with MCH/urban HUs being the best supplied (44 percent) (Table 6.6). Facilities located in Urban Governorates were better

Figure 6.11 Essential supplies for delivery (N=221)



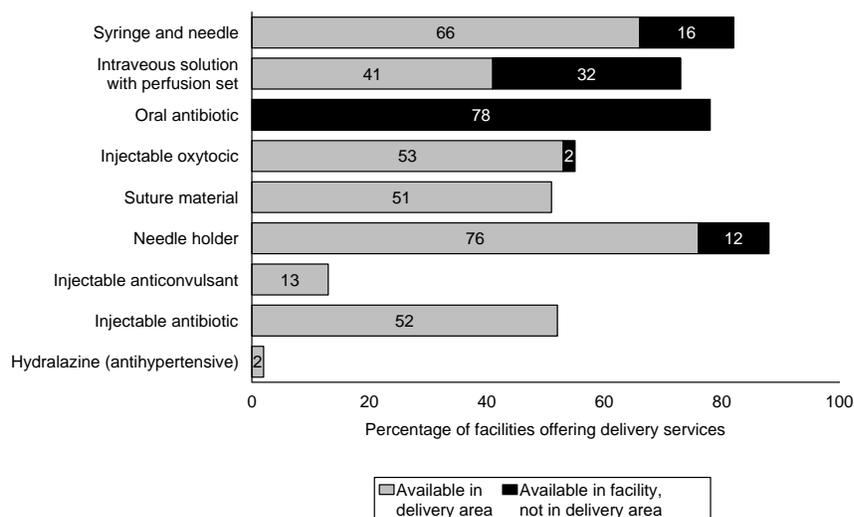
Egypt SPA 2002

¹¹ Thirty-eight percent of facilities had a suction bulb and 50 percent had a suction machine (Appendix Table A-6.40).

equipped (64 percent had all basic supplies) than facilities in Lower Egypt (27 percent) or Upper Egypt (8 percent). Cord ties or clamps and a suction apparatus were the items with the greatest regional disparity in availability (data not shown). Cord ties or clamps were available in 85 percent of facilities in Urban Governorates but only in 50 percent of those in Lower Egypt and 37 percent of those in Upper Egypt. A suction apparatus was available in 89 percent of facilities in Urban Governorates but only in 66 percent of those in Upper Egypt and 57 percent of those in Lower Egypt (data not shown).

Medicines and supplies to manage complications and emergencies of labor and delivery were assessed for all facilities offering delivery services, although in Egypt it is expected that complications will be referred to a general service hospital if there is not a specialist assigned to the facility. Specific items for managing common complications (needles and syringes, intravenous solution and infusion sets, injectable oxytocic medicines, and suture supplies) were classified as available if they were in the delivery room or an immediately adjacent area; during an emergency, the items must be available immediately, and if they are stored in a pharmacy or other location in the facility, they might be locked away and, hence, not available at night. Figure 6.12 provides information on the availability of these items in the delivery area, as well as the additional availability of select items that were not in the delivery area but were in the facility (most often either in the pharmacy or stock room). Syringes and needles were available in the delivery area in 66 percent of facilities (and 82 percent of facilities). Intravenous solution (dextrose and normal saline, normal saline, or Ringers lactate) with perfusion sets were available in 41 percent of the delivery service areas (and in 73 percent of facilities) (Figure 6.12). Intravenous solutions were primarily available in general service hospitals and NGO facilities (around 75 percent for both) (Appendix Table A-6.40). An injectable oxytocic medicine was available in the delivery area in 53 percent of facilities (with an additional 2 percent having the medicine in the pharmacy). Oral antibiotics (amoxicillin or cotrimoxazole) were available in 78 percent of facilities (mainly in the pharmacy). Suture materials with a needle holder for the suture procedure were available in 51 percent of delivery service areas. All of these items, with any one of the antibiotics acceptable, were available in 20 percent of facilities (Table 6.6). All items, however, were primarily available in general service hospitals (49 percent) and MCH/urban HUs (33 percent) and in facilities in Urban Governorates (57 percent).

Figure 6.12 Additional medicines and supplies for managing complications of delivery (N=221)



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The availability of selected additional medicines for managing complications was assessed. Injectable valium or magnesium sulfate (anticonvulsants for severe preeclampsia and eclampsia) was available in 13 percent of the delivery service areas (and 15 percent of facilities) (Figure 6.12 and Appendix Table A-6.40). Anticonvulsants were most often available in general service hospitals (in 43 percent of delivery areas and 53 percent of facilities) and NGO facilities (in 48 percent of delivery areas and facilities) (Appendix Table A-6.40). Injectable antibiotics for sepsis (either gentamycin or both ampicillin and penicillin) were available in 52 percent of facilities. Both an anticonvulsant and an injectable broad-spectrum antibiotic were available in 10 percent of facilities (Table 6.6). Hydralazine, commonly used to manage hypertension during labor, was available in only 2 percent of facilities (25 percent of NGO facilities) (Figure 6.12 and Appendix Table A-6.40).

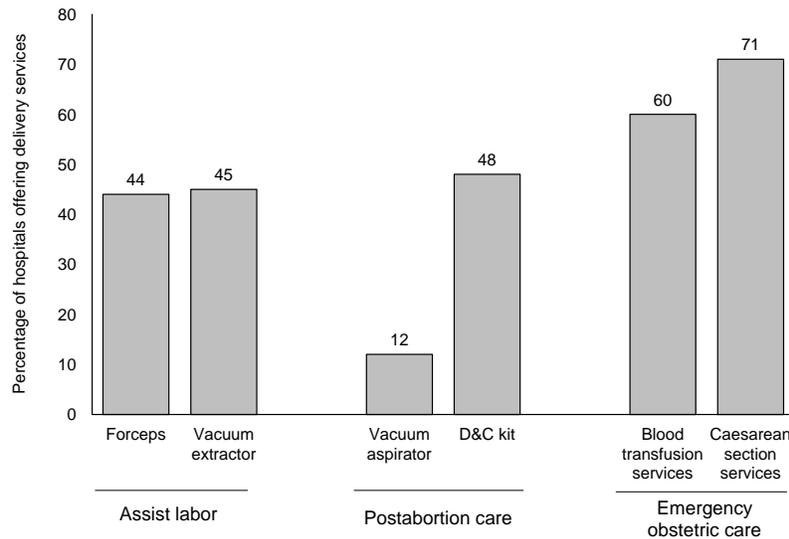
Information on the availability of other desirable equipment and conditions that improve the hygiene and monitoring capacity for labor and delivery is provided in Appendix Table A-6.41.

Key Findings
<p>Basic equipment and supplies that should be available for any delivery services (item to cut cord, item to clamp cord, suction apparatus, antibiotic eye ointment, and perineal disinfectant) were available in 21 percent of facilities. All items were most often found in facilities located in Urban Governorates (64 percent) and were least available in facilities in Upper Egypt (8 percent).</p> <p>Capacity to manage complications is expected primarily in general service hospitals. Forty-nine percent of general service hospitals had all the basic medicines and supplies for managing common complications of labor and delivery.</p> <p>An injectable oxytocic medicine was available in 55 percent of facilities (in the delivery area for 53 percent) and in about 75 percent of both general service hospitals and MCH/urban HUs.</p> <p>Facilities in Urban Governorates are consistently better equipped to provide normal delivery services and to manage common and serious complications of labor and delivery than facilities in Lower and Upper Egypt.</p>

In addition to the previously mentioned equipment and supplies, a facility that is expected to manage complicated deliveries should have the capacity to mechanically assist the delivery when contractions are ineffective (using either forceps or a vacuum extractor) and should be able to provide postabortion care by removing retained materials from the uterus that contribute to hemorrhage and infection (dilatation and curettage [D&C] equipment or a vacuum aspirator). In cases where life-saving emergency obstetric care is required, the capacity to provide a caesarean section and to transfuse blood is essential. Finally, there is sometimes a need for special equipment to support the newborn. The equipment assessed was a means for providing emergency respiratory support (a resuscitator or ambu bag) and an external heat source to maintain the body heat in a premature newborn (incubator, heat lamp, or other device).

In Egypt, this level of support for complicated deliveries in government facilities is authorized primarily in general service hospitals, and other facilities that do not have a specialist are expected to refer the clients. Among the general service hospitals offering delivery services, 44 percent had forceps, 45 percent had a vacuum extractor, 12 percent had a vacuum aspirator, and 48 percent had a D&C kit (Figure 6.13). In addition, 44 percent had a resuscitator for the newborn, and 56 percent had an incubator or other external heat source for premature infants. Around one-third to one-half of NGO facilities also had different items of equipment to support complicated deliveries (Appendix Table A-6.42). Each of these items for emergency support to the mother and newborn was most often found in facilities in Urban Governorates, followed by those in Lower Egypt, and least often found in facilities in Upper Egypt.

Figure 6.13 Emergency equipment and services available in general service hospitals (N=49)



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Sixty percent of general service hospitals offer blood transfusion services (Appendix Table A-6.42), with 49 percent having a blood bank and 11 percent providing transfusion services only (data not shown).

Among the general service hospitals offering delivery services, 71 percent offer caesarean section and more than half of NGO facilities that offer delivery services also offer caesarean sections (Appendix Table A-6.42). Among the government general service hospitals offering caesarean section, 82 percent had all basic equipment and furnishings for caesarean sections observed and functioning on the day of the survey (Appendix Table A-6.43). In addition, 95 percent had a set for providing anesthesia, and 68 percent reported that they had an anesthetist available and observed a duty schedule. An additional 23 percent indicated that they had an anesthetist but had no duty schedule. Seventy-six percent had a provider available 24 hours to conduct caesarean sections, with a duty schedule indicating 24-hour coverage. Findings for equipment were similar in the five NGO facilities that conduct caesarean sections. Findings for staffing were different, with all NGO facilities having an anesthetist (with an observed duty schedule); however, only 25 percent had a duty schedule for 24-hour coverage for a provider to conduct a caesarean section.

Key Findings

Equipment for assisting complicated deliveries is available primarily in general service hospitals. Thus, referrals for most complications are required.

Among general service hospitals offering delivery services, less than half had equipment to support inefficient labor or to provide postabortion D&C.

The vacuum extractor is not available in MCH/urban HUs or in most rural HUs. The benefits of introducing this method of supporting inefficient labor outside of general service hospitals should be assessed by the MOHP.

While 71 percent of general service hospitals offered caesarean section, only 60 percent offered blood transfusion services.

6.8 Newborn Care Practices

Delivery service providers were questioned about routine newborn care practices at the facility. Information on these practices is provided in Appendix Table A-6.44.

Using catheter suction to stimulate respirations in newborns who are not breathing is not an uncommon practice; however, this should not be a routine practice as it may cause injury to the newborn. Seventy-two percent of facilities (91 percent of general service hospitals) indicated that they routinely suction the mouth and nose of the newborn with a catheter (Appendix Table A-6.44). Only 38 percent of facilities had a suction bulb for clearing the respiratory path of the newborn (Appendix Table A-6.40).

Hypothermia is a contributing factor to increased morbidity and death for newborns. It can be prevented by avoiding full-immersion bathing the first few hours after birth and, instead, drying the newborn and either immediately giving the infant to the mother for skin-to-skin contact or wrapping the newborn in a warm blanket. Full-immersion bathing is not common, with only 23 percent of facilities indicating that this practice is routine. MCH/urban HUs reported full-immersion bathing more often than other facilities (45 percent, compared with 25 percent or less for other facilities).

Weighing the newborn provides health information for monitoring postnatal care. Birth weight is also an indicator for risk of infant death. While 82 percent of facilities indicated that they routinely weigh the newborn, 68 percent had a functioning infant scale in the delivery service area on the day of the survey (Appendix Table A-6.44).

Vitamin A supplementation in depleted children has been shown to decrease risk of infection and death. Newborns can receive a healthy amount of vitamin A through breast milk; however, pregnant women are also at risk of developing vitamin A deficiency. When vitamin A deficiency is a problem, providing vitamin A to the mother immediately postpartum not only replaces depleted vitamin A in the mother but also increases the vitamin A available to the newborn through breast milk. Seventy-one percent of facilities indicated that they routinely provide vitamin A to the new mother, with 61 percent of facilities having vitamin A available in the delivery service area and 76 percent having it available either in the delivery room or in the pharmacy.

When assessing policies and practices for providing oral polio vaccine (OPV) and BCG vaccine to the newborn, it should be remembered that the full immunization coverage for children in Egypt is more than 90 percent. The MOHP has recently adopted recommendations from a technical advisory group of international polio experts¹² to provide a dose of oral polio vaccine (considered dose 0) after birth to provide extra protection for the infant. This is a new policy for the MOHP. At the time of the survey, OPV was reported as being provided to newborns prior to discharge in 19 percent of facilities. It is current MOHP policy to provide BCG vaccine to the newborn within 42 days of birth. When asked, 10 percent of facilities indicated that they provide BCG to the newborn prior to discharge.

The MOHP promotes providing vitamin K to the newborn. Twenty percent of facilities indicated that they routinely provide vitamin K to newborns (Appendix Table A-6.44). Forty-five percent of facilities had vitamin K available; this suggests that, should it be desirable, this practice could easily be expanded.

Internationally, exclusive breastfeeding is promoted for the first six months of age, with provision of prelacteal liquids discouraged. As noted in the section on ANC, however, pregnant women are not routinely counseled on exclusive breastfeeding. Prelacteal liquids are not routinely provided (only 12

¹² The Technical Advisory Committee was formed of international polio experts from WHO, UNICEF, USAID, CDC, and Rotary International.

percent of the facilities), although general service hospitals reported this as a routine practice more often (31 percent) than other facilities.

“Rooming in,” where the infant routinely stays with the mother (a practice to support exclusive breastfeeding and mother-child bonding), is routinely practiced in most (88 percent) facilities.

When asked about care of the umbilical cord, 85 percent of facilities indicated that they apply 70 percent alcohol, 22 percent apply Betadine, and 25 percent use dry dressings only. It is evident that facilities sometimes have more than one umbilical cord-care practice.

Key Findings
Weighing the infant, providing vitamin A to the mother, and rooming in are practices that are common in Egyptian facilities and are considered supportive of newborn health.
Routine suctioning with a catheter (72 percent of facilities) is a practice that should be assessed and potentially discouraged.
One-third of general service hospitals report routinely providing prelacteal feeds to newborns. This practice should be assessed and potentially discouraged. Other facilities do not report this as a routine practice.

6.9 Management Practices Supportive of Quality Delivery Services

Management practices that were assessed for supporting quality delivery services include the following:

- Facility documentation and records
- Systems for quality assurance
- Practices related to user fees
- Supervision and staff development.

Table 6.7 provides information on these items. Appendix Table A-6.45 provides information on user statistics, Appendix Table A-6.46 provides information on user fee practices, and Appendix Tables A-6.47 through A-6.49 provide information on supervision and staff development from the perspective of the provider.

6.9.1 Facility Documentation and Records

A delivery register was defined as being up to date if there was 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, provided the birth outcome. Forty-seven percent of facilities had an up-to-date delivery register available (Table 6.7). Among the facilities that provide routine home delivery services, 84 percent had a register where home delivery information was recorded and among those that provide home delivery services for emergencies only, 36 percent had a register for recording these services (data not shown).

Table 6.7 Facility-based supportive management practices

Among facilities providing delivery services, percentage with an up-to-date delivery register, percentage with documentation that they monitor delivery coverage, percentage that monitors deaths or near misses, percentage of facilities having any user fee for normal deliveries, percentage where at least half of the interviewed delivery service providers received in-service training related to deliveries during the past 12 months, and percentage where at least half of the interviewed delivery service providers were personally supervised during the past 6 months, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering 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)
	Observed up-to-date patient register ¹	Documentation of monitoring delivery coverage	Facility reviews maternal/newborn deaths or near misses	User fee for delivery		Received in-service training during past 12 months ²	Were personally supervised during past 6 months	
Type of facility								
GS hospital	68	2	48	17	49	8	84	46
MCH/urban HU	70	14	24	56	35	12	94	31
Rural HU	34	14	58	37	129	25	95	120
NGO facility	33	9	9	100	8	24	44	6
Region								
Urban Governorates	73	7	7	51	25	13	87	22
Lower Egypt	49	12	63	25	81	14	90	71
Upper Egypt	40	12	48	44	115	23	93	109
Total	47	11	49	38	221	19	91	202

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.

Facilities were asked for their monthly service statistics. Among the 172 facilities having data for facility-based vaginal deliveries, the median monthly number of deliveries was 30 for general service hospitals and less than 10 for other facility types (Appendix Table A-6.45). The median monthly number of home deliveries (from 117 facilities) was 9; the median number of caesarean sections was 10 for general service hospitals and 4 for NGO facilities.

Facilities frequently have catchment populations for whom they provide services. The ESPA assessed whether the facility had any documentation indicating that it monitored the proportion of deliveries that occurred in its catchment area and were attended by facility staff (or, for some program strategies, deliveries that are attended by skilled providers affiliated with the facility). This is a facility's delivery coverage for its catchment population. The facilities did not routinely monitor delivery coverage, with only 11 percent (primarily MCH/urban HUs and rural HUs) having any documentation of calculations of coverage (Table 6.7).

6.9.2 Systems for Quality Assurance

One quality assurance measure is to systematically review all maternal and newborn deaths or near deaths to develop interventions to decrease or prevent these events. The ESPA does not assess the quality of these review programs, but it does assess whether facilities have implemented the process. Forty-nine percent of facilities indicated that they conduct reviews of maternal or newborn deaths or near deaths. These were primarily facilities in Lower Egypt (63 percent) and Upper Egypt (48 percent) (Table 6.7).

It was previously noted that blank partographs were available in only 6 percent of facilities (Appendix Table A-6.34). Among interviewed delivery service providers, 76 percent indicated that they have never used a partograph (data not shown).

Referral forms, a means for improving effective referrals of obstetric emergencies, were found in 25 percent of facilities (primarily in MCH/urban HUs, 43 percent) (Appendix Table A-6.41).

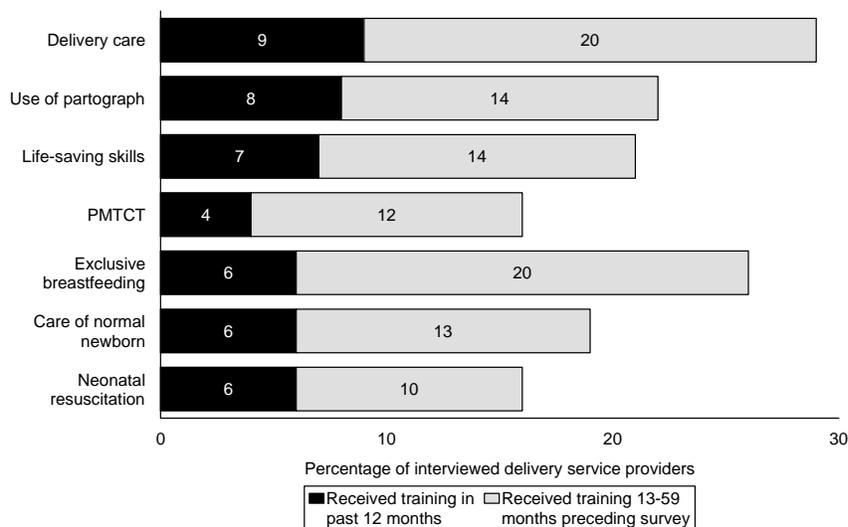
6.9.3 Practices Related to User Fees

The ESPA documents the percentage of facilities where user fees are collected for delivery services. Thirty-eight percent of facilities (51 percent in Urban Governorates, 44 percent in Upper Egypt, and 25 percent in Lower Egypt) indicated that they have user fees for some aspects of deliveries (Table 6.7). Thirty-two percent of facilities indicated that they had a fixed fee for all delivery costs; 1 percent indicated that they have a fixed fee that includes ANC; 1 percent indicated that they charge for medicines and tests provided by the facility (Appendix Table A-6.46); and 3 percent indicated that fees were not fixed but varied, depending on the case (data not shown).

6.9.4 Supervision and Staff Development

If at least half of the interviewed delivery service providers at a facility had received any structured in-service training (excluding on-the-job training that may have been received during discussions with supervisors) relevant to delivery services during the past 12 months, the facility was defined as providing routine staff development activities. More than half of the interviewed delivery service providers from 19 percent of facilities indicated that they had received formal in-service training during the past 12 months (Table 6.7). Among all interviewed delivery service providers, 18 percent received in-service training during the past 12 months (Appendix Table A-6.47). An additional 34 percent of providers indicated that they had not had formal in-service training during the past 12 months but had received in-service training during the past five years. The percentage of providers who had received in-service training on the various topics related to delivery services was similar for each topic. Specific topics and when providers attended are provided in Figure 6.14 and, by facility type and region, in Appendix Table A-6.48.

Figure 6.14 In-service training received by interviewed delivery service providers, by topic and timing of most recent training (N=221)



PMTCT = Prevention of mother-to-child transmission.

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If at least half of the interviewed delivery service providers in a facility had been personally supervised in the past 6 months, the facility was defined as providing routine staff supervision. More than half of the interviewed delivery service providers in 91 percent of the facilities had been personally supervised during the past 6 months (Table 6.7). At the individual-provider level, 87 percent of all interviewed delivery service providers had been personally supervised, and among the delivery service providers who had been personally supervised, at least half of them indicated that they had been supervised at least nine times during the past 6 months (Appendix Table A-6.49). Although the percentage of staff receiving supervision was similar between regions, the frequency of supervision was much higher for providers working in facilities in Urban Governorates (median number of 15 times during the past 6 months) than for providers in facilities in Lower Egypt (a median of three times) and Upper Egypt (a median of four times). When asked what their supervisor had done providers said that they checked their records (96 percent), observed their work (93 percent), provided feedback (91 percent), provided information updates (74 percent), and discussed problems (81 percent).

Supervision activities were similar between regions. Appendix Table A-6.49 provides details on supervision activities by facility type and region.

Key Findings
Facility-level documentation of delivery services is available in only 47 percent of facilities offering delivery services.
Community coverage of delivery services is rarely monitored (11 percent of facilities).
Routine supervision of delivery service providers is almost universal (91 percent of facilities).
In-service training was not routinely provided for delivery service providers (19 percent of facilities).

7.1 Background**7.1.1 ESPA Approach to Collection of Information on STI and HIV/AIDS Services**

Sexually transmitted infections (STIs) are a major public health problem throughout the world. These illnesses affect millions of men, women, and children and can cause infertility, serious illness, and even death. STIs have also been shown to increase the risk of transmission of the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS) (AIDSCAP/FHI, 1996). Most people infected with STIs do not have symptoms, but they can still transmit the disease to their sexual partners. Pregnant women with STIs are more likely to have low-birth-weight babies, premature babies, and stillbirths (Cotch et al., 1997; AIDSCAP/FHI, 1996).

As of December 2002, more than 40 million people worldwide have been infected with the AIDS virus (UNAIDS/WHO, 2002). In sub-Saharan Africa, an estimated 29 million people are infected with HIV/AIDS, which has become a leading cause of adult mortality in this region. A majority of people infected with HIV do not know that they are infected and, as a result, may unknowingly infect others. These people will die from AIDS if they do not receive appropriate treatment and care. However, with the development of powerful antiretroviral drugs, many people who are HIV-positive are living longer, and many infected mothers are giving birth to infection-free babies. Consequently, the role of health systems in addressing the HIV/AIDS epidemic has expanded to include a range of care and support services for people living with HIV/AIDS. Although the prevalence of HIV/AIDS in Egypt is one of the lowest in the region, estimated at .03 percent among the general population (MOHP, 2003), the pandemic status of this illness necessitates that vigilance for monitoring and early detection continue to be public health priorities for all countries.

Although sexual contact is not the only means of transmission of HIV/AIDS, it is the most common (UNAIDS/WHO, 2000); thus, preventive measures for STIs are equally relevant to HIV/AIDS. However, the initial symptoms of a person with AIDS differ from those of clients with other STIs. Diagnosis and management of clients with HIV/AIDS requires additional resources that may not yet be incorporated as a part of routine STI services. As services for management and treatment of HIV/AIDS develop, they may be offered by different personnel and at sites other than those offering services for other STIs. For this reason, the ESPA presents information on services specific to HIV/AIDS and the providers of those services separate from general STI service information.

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

- What is the availability of STI services?
- To what extent do the facilities offering STI services have the capacity to support quality STI services?
- What is the availability of specific HIV/AIDS services?
- To what extent do the facilities offering HIV/AIDS services have the capacity to support quality HIV/AIDS services?

7.1.2 Health Situation Related to STIs and HIV/AIDS in Egypt

The prevalence of STIs is not believed to be high in Egypt, and as a result health services related to STIs have not been a priority area of development. Surveillance for and statistics on the prevalence of STIs is 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 MOHP has developed a new curriculum, in 2002, to strengthen the STI and HIV/AIDS component of preservice training for health service providers. In addition, health service providers are encouraged to include screening for STIs as a component of health services for clients who are at risk.

The first AIDS case in Egypt was diagnosed in 1986. Subsequently, a National AIDS program and a National AIDS Committee were established. Since 1986, HIV/AIDS has been classified as a notifiable disease. Blood for transfusion has been screened for HIV/AIDS since 1987. The current prevalence of HIV/AIDS is estimated at .03 percent among the general population, and from .05 to 0.5 percent among high-risk populations. During 2002, development of services related to HIV have been expanded. The National AIDS Control Programme (NACP) has developed a strategy with the following priorities (MOHP, 2003):

- Epidemiological surveillance to identify trends and the extent of the problem
- Information-Education-Communications (IEC) activities for the public
- IEC for prevention of sexual transmission of HIV through decreasing risk behaviors, and early and effective management of STIs
- Screening all blood donations to prevent transmission of HIV through blood
- Prevention of prenatal transmission
- Reducing the impact of HIV infection through supportive care for AIDS patients.

7.2 Availability of STI Services

The integration of STI diagnosis and treatment into relevant health services increases opportunities for case detection and followup on treatment. The ESPA assessed STI service availability in the facility. Most commonly, clients seeking health care specifically for symptoms of STIs are seen in a general outpatient department (OPD). Less commonly, there is a specific STI service area. Both ANC and family planning services are commonly used by sexually active women and, as such, are also relevant services through which STI diagnosis and treatment might be offered. Including STI screening and treatment as a component of these services may 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 service, there is a greater chance that she may decide not to seek followup care.

Table 7.1 provides information on the availability of STI services of any type and availability depending on which service the client is using in the facility. Appendix Table A-7.1 provides information on availability of STI services in facilities that reported they do not offer STI services, but service providers for family planning and ANC reported they do offer the service to their clients.

Facility respondents were asked if they offer any STI services, without a specific definition. The service could have been only counseling, only testing, or diagnosis and treatment. STI services were reported by

62 percent of all facilities, with few differences in availability of the service by geographic region (Table 7.1). A point of note is that only 53 percent of fever hospitals offer STI services, yet fever hospitals are a priority for training providers in diagnosing and managing HIV/AIDS (MOHP, 2003). Among facilities reporting STI services, most (89 percent) offer these services as a part of the general outpatient curative services, with essentially all offering the service at least five days per week (Table 7.1). Integration of STI services with family planning and ANC services is high, with 86 percent of the facilities offering any STI services, indicating that they offer STI services to family planning clients when they come for family planning services, and 83 percent to ANC clients when they come for ANC services. Among the facilities that offer STI services, 76 percent reported that the service was available to clients in all three relevant service areas (general outpatient, family planning, and ANC). In small facilities such as mobile units and rural HUs, there may be one provider who sees all sick adults (routine outpatient services), ANC and family planning clients, and who provides the STI services to any of these clients who need the service.

It was noted that among facilities reporting they do not offer STI services, providers of ANC and family planning services reported they did offer the services for their clients. Among the 245 facilities that did not offer routine STI services, 69 percent indicated the services were available for family planning clients and 63 percent for ANC clients (Appendix Table A-7.1). Anecdotal information indicates that the likely explanation is that facilities that do not normally have clients who come to the outpatient department for STI symptoms reported they do not provide the service, while family planning and ANC providers see clients with symptoms of STIs, so they report providing the service. For the ESPA, information specifically related to STI services was only collected from the facilities indicating the service was a routine service (either in the outpatient department or a special clinic). Information on STI services offered through family planning and ANC services is discussed in the chapters related to those services.

Table 7.1 Availability of services for sexually transmitted infections

Percentage of facilities offering services for sexually transmitted infections (STIs), percentage offering services for HIV/AIDS, percentage offering services for STIs including HIV/AIDS and, among facilities offering services for STIs, percentage where STI services are provided in the general outpatient department (OPD), a special clinic, by family planning (FP) service providers, and by antenatal care (ANC) service providers, percentage where STI services are offered in the OPD, FP and ANC service areas, and percentage where STI services are offered five or more days per week, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering:			Number of facilities ¹ (weighted)	Percentage of facilities where STI services are available in the indicated service area ¹					Percentage facilities where services for STIs are available at least 5 days per week	Number of facilities offering STI services (weighted)
	Any STI services	Any HIV/AIDS services	Both STI and HIV/AIDS services		General outpatient	Special clinic ²	FP	ANC	OPD, FP, and ANC service areas		
Type of facility											
GS hospital	68	7	7	64	94	6	90	76	72	96	44
Fever hospital	53	31	31	13	82	18	0	0	0	94	7
MCH/urbanHU	60	2	2	65	93	7	87	88	81	92	39
Rural HU	62	3	3	367	91	9	88	95	86	90	226
Mobile unit	68	0	0	38	82	18	82	56	56	100	26
Health office	44	0	0	32	87	13	82	0	0	95	14
NGO facility	70	1	1	71	75	25	86	78	74	75	49
Region											
Urban Governorates	61	3	3	65	89	11	99	82	81	83	40
Lower Egypt	65	5	5	315	93	7	82	80	73	87	204
Upper Egypt	60	1	1	270	83	17	87	86	79	95	161
Total	62	3	3	650	89	11	86	83	76	90	405

¹ Services may be available at multiple sites in the same facility if they are integrated. In small facilities, one service site and one provider may provide services for general outpatients, ANC, and family planning clients.

² STI services at the public and NGO facilities are utilized primarily by females, so in almost all cases the special clinic is the gynecologic clinic. Males might receive STI services in urology clinic.

Key Findings

STI services are offered by 62 percent of all facilities.

Within facilities reporting STI services, the services are integrated, with 76 percent of facilities indicating STI services are available through general outpatient services as well as through ANC and family planning services.

Within facilities that report they do not offer STI services, family planning and ANC providers do offer the service to their clients (69 percent and 63 percent of the non-STI service facilities, respectively) if needed.

7.3 Capacity to Provide Quality STI Services

Equipment, supplies, and health system components defined as important for supporting quality STI services were assessed. These included the following:

- System components to support utilization of services
- Infrastructure and resources to support quality assessment and counseling
- Infrastructure and resources for examinations
- Essential supplies for basic STI services
- Additional equipment and supplies for STI services.

Table 7.2 provides information on system components and resources for STI services. Figures 7.1 to 7.4 provide summary information on items assessed for counseling, diagnosis, and treatment for STIs. Appendix Tables A-7.2 and A-7.3 provide details on items assessed for counseling, physical examinations, and infection control for STIs. Appendix Table A-7.4 provides details on availability of components for laboratory tests and treatment of STIs.

7.3.1 System Components to Support Utilization of Services

Special efforts should be made to encourage clients with STIs to seek modern medical help, because of the stigma that is frequently associated with having an STI, and because many people with STIs have no symptoms and do not recognize that they need treatment. The ESPA assessed the presence of program strategies and service delivery components that contribute to the availability and improved utilization of STI services.

One essential condition for encouraging the use of services is to ensure client confidentiality. Adherence to confidentiality standards is supported when a facility has an official written confidentiality policy that is shared with all staff. For the ESPA, any document or notice that specified that information related to the client will remain confidential between the provider and the client was accepted as proof of a confidentiality policy. Only 1 percent of facilities had a written confidentiality policy for STI services (Appendix Table A-7.2), with an additional 1 percent reporting they had this, but were unable to show any documentation (data not shown). No facilities had any document for informed consent for STI laboratory examinations, although one percent reported they had such a policy (data not shown). The ESPA accepted any written notice that provided an indication that confidentiality was a policy. Since confidentiality policies have not yet been introduced through the MOHP, it is possible that the

MCH/urban HU and rural HU where these were found might have developed their own internal directive on this issue to remind providers or to reassure clients of the importance of confidentiality of information shared.

For effective interruption of STI transmission, the husband or wife of clients with STIs must also be tested and, if they are found to be infected, they also need to be treated. The client with an STI (all cases observed in the ESPA were women) should be asked to notify her husband and to ask him to be examined. This is classified as passive followup. If the client feels uncomfortable or ashamed informing her husband that he may be infected, the client may allow local health authorities to contact the husband to inform him of the risk of infection and to advise him to seek care. This is called active followup.

Table 7.2 Availability of infrastructure and resources to support quality counseling and examinations for sexually transmitted infections

Among facilities offering services for sexually transmitted infections (STIs), percentage with all conditions to support quality STI services, percentage with all infection control and furnishings for physical examination, percentage that use etiologic methods for diagnosis, percentage using syndromic methods for diagnosis, percentage with laboratory capacity to conduct a test for syphilis, gonorrhea, wet mount examination, and HIV/AIDS tests, and percentage with medicine to treat four major STIs, by type of facility and region, Egypt SPA 2002

Background characteristics	All items to support quality counseling ¹	All conditions to provide quality physical examination ²	Method for diagnosing STIs		Testing capacity for: ⁴				Medicines to treat four major STIs ⁹	Number of facilities offering STI services (weighted)
			Etiologic	Syndromic ³	Syphilis ⁵	Gonorrhea ⁶	Wet mount ⁷	HIV/AIDS ⁸		
Type of facility										
GS hospital	11	18	24	100	16	9	30	23	18	44
Fever hospital	0	0	47	100	0	29	35	23	35	7
MCH/urban HU	16	36	18	98	12	2	17	2	2	39
Rural HU	10	19	1	100	1	0	2	0	3	226
Mobile unit	11	8	0	100	0	0	0	0	0	26
Health office	5	30	4	96	0	0	0	0	0	14
NGO facility	5	20	23	99	11	7	16	9	0	49
Region										
Urban Governorates	11	52	16	100	9	4	18	3	5	40
Lower Egypt	12	22	9	99	2	1	5	3	3	204
Upper Egypt	7	11	7	100	6	3	10	6	6	161
Total	10	20	9	100	5	2	8	4	4	405

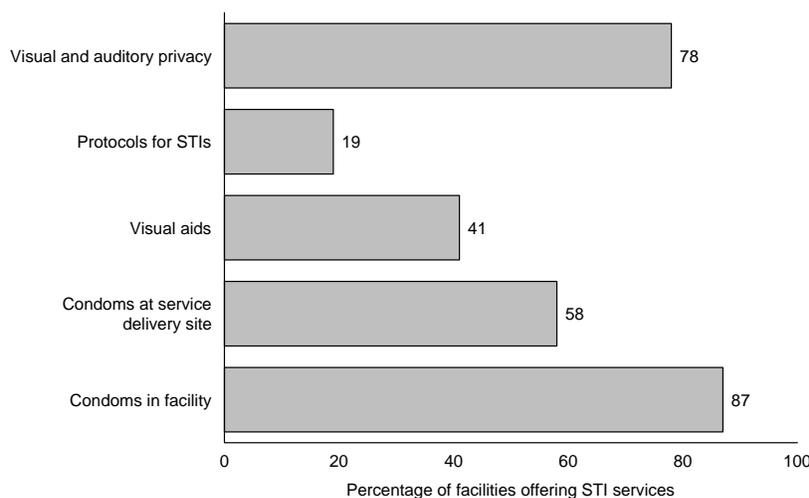
¹ Visual and auditory privacy, any guidelines or protocols and any visual aids or educational materials
² All infection control items (soap, water, latex gloves, disinfecting solution, and sharps box), visual privacy, examination bed, and examination light
³ This may include diagnosing by symptoms where the syndromic approach algorithms were not followed.
⁴ Capacity to conduct a test does not mean the facility routinely utilizes the test
⁵ Either venereal disease research laboratory (VDRL) test and functioning microscope, or reactive protein reagent (RPR) test kit
⁶ Gram stain reagents and functioning microscope or culture capacity
⁷ Functioning microscope and slides
⁸ ELISA, Western Blot, or Rapid test
⁹ At least one medicine to treat syphilis, gonorrhea, trichomoniasis, and chlamydia

Thirty-six percent of facilities indicated they do ask clients to bring their husbands for checkup. This practice was most commonly reported by general service hospitals (general, district, or integrated hospitals)—at 42 percent, and least commonly reported by health offices and NGO facilities (26 and 28 percent, respectively). While 3 percent of facilities indicated they would conduct active followup of the husband, if necessary (6 percent of fever hospitals and 5 percent of MCH/urban HUs), it is possible that the question was not understood, since active followup is not MOHP policy. When asked for any documentation indicating there is followup on contacts (active followup), a small proportion of fever hospitals (6 percent) and general service hospitals (1 percent) were able to show a register or form used for monitoring case followup (data not shown). It was not clarified if the followup system was for all STIs or specifically for HIV/AIDS.

7.3.2 Infrastructure and Resources to Support Quality Assessment and Counseling

Conditions to support quality counseling for STIs require complete privacy to facilitate open communication between the provider and the client. Because counseling for diagnosis and prevention of STIs often takes place in a different location than the physical examination, the conditions for counseling are assessed separately from those for physical examinations. Complete privacy is necessary when taking the client history because of the discomfort many clients feel when talking about issues related to their sexual practices. Ensuring auditory and visual privacy is expected to encourage the use of services by the client and adherence to protocols and standards by the provider. Without these conditions, the provider may not ask the appropriate questions or make the appropriate examinations. Seventy-eight percent of facilities offered counseling for STI clients under conditions that allowed both visual and auditory privacy (Figure 7.1). Another 6 percent had conditions for visual privacy but auditory privacy was not assured (Appendix Table A-7.2).

Figure 7.1 Items to support quality STI services (N=405)



Egypt SPA 2002

Only 19 percent had guidelines or protocols for diagnosis and treatment of STIs in the service delivery area, with 4 percent specifically having guidelines or protocols that included the syndromic approach guidelines. The syndromic approach is a systematic method for assessing symptoms in a client, and then, based on the symptoms, a specific protocol for which medicines should be prescribed (WHO, 2001). The syndromic approach has not been widely introduced in Egypt; however, the guidelines can be found in a variety of general materials and may have been part of other general guidelines for reproductive health in the facilities where they were found.

Forty-one percent of facilities had visual aids for client education related to STIs and 58 percent had condoms in the service delivery area, with 87 percent having condoms anywhere in the facility. The availability of condoms at the service delivery site allows the provider to demonstrate how to use them and to ensure that the client leaves with them.

All conditions (visual and auditory privacy, treatment guidelines, visual aids, and condoms in the STI service area) were available in 10 percent of facilities, (16 percent of MCH/urban HUs and none of the fever hospitals) (Table 7.2).

Key Findings
Practices to increase case detection (confidentiality policies and partner followup procedures) are not yet policy within the health system.
Guidelines for STI diagnosis and treatment are available in 19 percent of facilities.
Visual aids for client education are available in 41 percent of facilities and condoms in 87 percent, although only 58 percent of facilities had condoms in the STI service area.

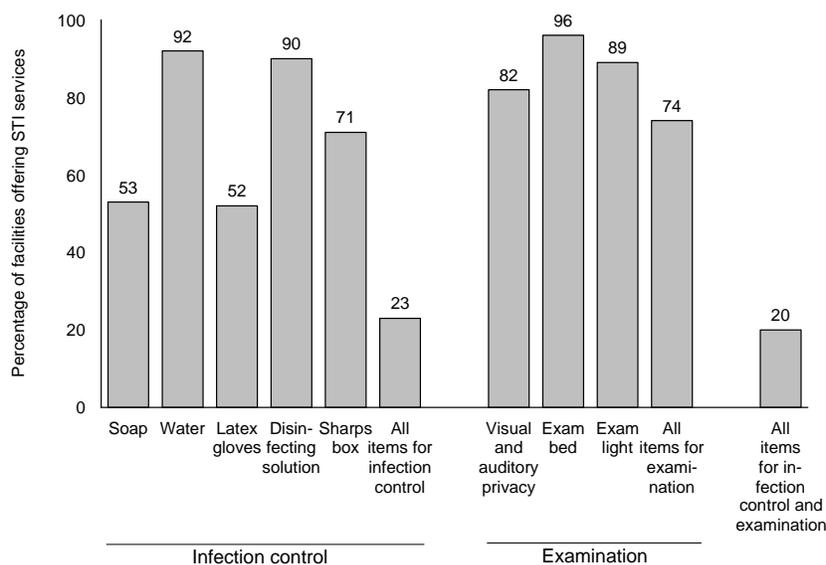
7.3.3 Infrastructure and Resources for Examinations

Items assessed included the following:

- Infrastructure (furnishings and infection control measures) for physical examination
- STI diagnostic methods used, and laboratory capacity for STI testing
- Medicines for treating STIs.

Quality physical examination requires the presence of measures for infection control, a bed and an examination light for pelvic examinations, and visual privacy. Hand-washing soap was available in the STI service area at 53 percent of facilities and water in 92 percent (Figure 7.2). On the day of the survey there was no water available in the service area for 8 percent of facilities. This included more than half of fever hospitals (data not shown). Eighty-four percent of the facilities provided the water in the STI service area through a piped system, 3 percent in a bucket with a tap, and 5 percent in a bucket or basin.

Figure 7.2 Items to support quality examination for STIs (N=405)



Egypt SPA 2002

The nonpiped water was primarily in mobile units (data not shown). Latex examination gloves were available in the STI service area in 52 percent of facilities (61 percent of general service hospitals) (Appendix Table A-7.2). Disinfecting solution for decontaminating used equipment was available in almost all (90 percent) STI service areas, and a sharps box in 71 percent. All items for preventing infection were available in 23 percent of facilities, with MCH/urban HUs and health offices being the best equipped, with 41 percent and 38 percent, respectively, having all items. Fever hospitals were the least well equipped, with none of the fever hospitals offering STI services having all items for infection control in the STI service delivery area.

When asked where equipment utilized for STI examinations was processed for reuse, 41 percent of facilities indicated their equipment was processed in the main equipment processing area for the facility and 54 percent in the family planning service area. Only two percent indicated they processed the equipment in the area where STI services were offered (data not shown). The availability of equipment, fuel for heating (if applicable), and knowledge of the minimum processing time (and temperature, for dry heat sterilizing) was assessed for the location where STI equipment was processed for reuse.¹ Sixty-two percent of facilities had all items (equipment, fuel, and knowledge of processing time) for either dry heat sterilization or autoclaving, and an additional 16 percent had the equipment and knowledge for high-level disinfecting (HLD) procedures (either boiling, steaming, or chemical) (Appendix Table A-7.3). Twenty-eight percent had written guidelines for the processing procedure in the area where the equipment was processed. MCH/urban HUs were more likely to have the guidelines available (41 percent) than other facilities. It was notable that 74 percent of fever hospitals indicated they had no system for processing equipment. Only 12 facilities had processed items stored in the STI service area (data not shown). Of these, 5 percent were stored to maintain sterility or HLD status, and 64 percent were stored under clean conditions, but where sterility or HLD status was not guaranteed.

A private room (to ensure visual and auditory privacy) was available in 82 percent of the STI examination areas, and an examination bed and an examination light were each available in about 90 percent of facilities (Figure 7.2), with all furnishings for an examination available in 74 percent of facilities. NGO facilities were more likely to have all furnishings for examinations (81 percent) and fever hospitals the least likely (3 percent, with an examination light being the least available item) (Appendix Table A-7.2). All conditions for quality physical examination, including items for infection control and infrastructure for examination, were available in 20 percent of facilities (Table 7.2) (36 percent of MCH/urban HUs, and 30 percent of health offices) (Appendix Table A-7.2).

Key Findings

Items for infection control are more available in MCH/urban HUs (41 percent) and health offices (38 percent) than in other types of facilities.

Fever hospitals were noticeably lacking supplies for infection control and supplies and knowledge for sterilizing or HLD processing equipment for reuse.

MCH/urban HUs and health offices were best equipped for infection control and for client examination, with 36 percent of MCH/urban HUs and 30 percent of health offices having all assessed items for infection control and infrastructure for physical examination.

¹ Chapter 3, sections 3.4.1 and 3.4.2, provides details on the definitions for adequate sterilization or HLD procedures and storage practices.

The World Health Organization (WHO) recommends the use of two approaches in providing STI services at primary care facilities: etiologic and syndromic approaches (WHO, 2001). The etiologic approach uses laboratory tests for diagnosing STIs. This method is more accurate than syndromic diagnosis; however, laboratory facilities are often not available. The syndromic approach is recommended for facilities with no laboratory. The syndromic approach assesses the presence of specific symptoms and then uses an algorithm to determine treatments to be provided. When neither an etiologic nor a syndromic approach is used, providers often diagnose and prescribe medication 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, mistreatment is common (Lande, 1993).

Many physician respondents were not familiar with the syndromic approach algorithms and indicated that they used syndromic diagnosis and treatment when they actually practice clinical diagnosis and treatment, not necessarily following the syndromic approach algorithms. Thus, while almost all facilities indicated they used syndromic methods for diagnosing (Table 7.2), it was clarified that most were referring to clinical diagnosis. Nine percent of facilities (24 percent of general service hospitals and 47 percent of fever hospitals) indicated they used etiologic diagnostic methods.

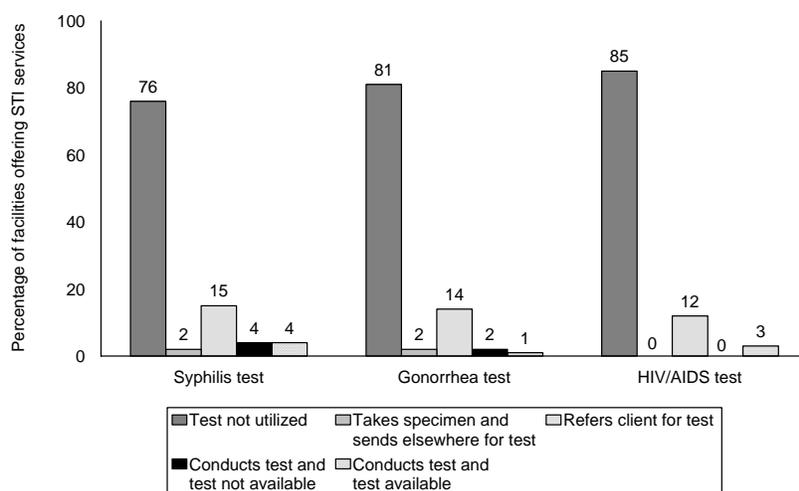
The most reliable means for ensuring that clients receive a desired laboratory test is for the facility to conduct the test in house. Another alternative is to take the specimen and send it to another facility for testing. The least reliable means is to refer the client to another facility to receive the laboratory test, because there is a likelihood that the client may decide not to take the test at all.

Five percent of facilities had the laboratory capacity to conduct a venereal disease research laboratory (VDRL) or reactive protein reagent (RPR) test for syphilis (Table 7.2); 2 percent had the laboratory capacity to conduct a gram stain or culture for gonorrhea; 8 percent had a microscopic for a wet-mount examination of a specimen; and 4 percent had laboratory test capacity for HIV/AIDS (either ELISA, Western Blot, or Rapid Test). The laboratory tests were primarily available in general service or fever hospitals, or in NGO facilities. Among general service hospitals, 16 percent had the capacity to test for syphilis the day of the survey, 9 percent to test for gonorrhea, 30 percent to conduct a wet-mount examination, and 23 percent to test for HIV/AIDS (Appendix Table A-7.4). Among fever hospitals, however, none had the capacity to test for syphilis, but 29 percent did have capacity to test for gonorrhea, 35 percent to conduct a wet-mount examination, and 23 percent to conduct an HIV test. Almost all facilities (92 percent) had vaginal speculums but few (2 percent) had swab sticks for taking a specimen (Appendix Table A-7.4).

Among the facilities offering STI services, 76 percent reported they did not use syphilis tests, 15 percent indicated they refer clients elsewhere for syphilis tests, 2 percent indicated they send a specimen elsewhere for the syphilis test when needed, and 8 percent indicated they actually conduct the test, with 4 percent having the capacity to conduct the test the day of the survey² (Figure 7.3). Eighty-one percent of facilities reported they did not use laboratory tests for gonorrhea, 14 percent indicated they refer clients elsewhere if they need to be tested for gonorrhea, and although 3 percent of facilities indicated they conduct laboratory tests for gonorrhea, only 1 percent had the capacity to conduct the test the day of the survey. Eighty-eight percent of facilities indicated they did not utilize the wet-mount laboratory test (for trichomoniasis, candidiasis, and other vaginal infections), and the 12 percent who did use the test reported they referred clients elsewhere (data not shown). Eighty-five percent of facilities reported they did not use

² Three percent of facilities had VDRL and 3 percent RPR testing capacity; treponema pallidum hemagglutination assay (TPHA) was not assessed.

Figure 7.3 Utilization and availability of diagnostic tests for STIs (N=405)



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HIV/AIDS tests, 12 percent indicated they referred clients elsewhere for the test, 3 percent of facilities indicated they conducted HIV tests, and all of these facilities had the capacity to provide the test³ the day of the survey.

Key Findings

Etiologic diagnostic methods for STIs are not widely used (9 percent of facilities), although they are more commonly reported for general service hospitals (24 percent), fever hospitals (47 percent), NGO facilities (23 percent), and MCH/urban HUs (18 percent).

Among general service hospitals, 16 percent had the capacity to test for syphilis the day of the survey, 9 percent to test for gonorrhea, 30 percent to conduct a wet-mount examination, and 23 percent to test for HIV/AIDS.

Among fever hospitals, none had the capacity to test for syphilis, but 29 percent did have capacity to test for gonorrhea, 35 percent to conduct a wet-mount examination, and 23 percent to conduct an HIV test.

The presence of at least one of the following medicines for treating STI was considered essential to be able to provide quality STI treatment:

Trichomoniasis: Metronidazole

Gonorrhea: Ceftriaxone, ciprofloxacin

³ Three percent had ELISA and 4 percent the rapid test.

Chlamydia: Doxycycline, tetracycline, or erythromycin

Syphilis: Doxycycline, tetracycline, erythromycin, benzathine penicillin, or procaine penicillin

A medicine to treat all of the above infections was available in only 4 percent of facilities, with metronidazole the most commonly available (63 percent) and a treatment for gonorrhea (either ceftriaxone or ciprofloxacin) least available (4 percent) (Appendix Table A-7.4). General service and fever hospitals were more likely than other facilities to have medicines available; however, only 18 percent and 35 percent, respectively, had the capacity to treat all of the four above infections (Table 7.2). There were no major regional differences in the availability of medicines for STIs.

In addition to the above, only 6 percent of facilities had nystatin suppositories for treating candidiasis, a yeast infection that may be sexually transmitted (Appendix Table A-7.4).

There were no differences in the availability of STI treatment protocols and the availability of STI medicines. Treatment protocols for STIs were found at 19 percent of all facilities where STI services were available (Appendix Table A-7.2), this included 19 percent of facilities where medicines to treat the four STIs were not available, and 17 percent of those where medicines for treating the four STIs were available the day of the survey (data not shown).

Key Findings

Few facilities (4 percent) had medicines available to treat all of the STIs—trichomoniasis, gonorrhea, chlamydia, and syphilis.

Eighteen percent of general service hospitals and 35 percent of fever hospitals had a medicine available to treat each of these infections.

7.4 Management Practices Supportive of Quality Services

Management practices that were assessed include the following:

- Facility documentation and records
- Charging practices for STI services
- Supervision and staff development.

Summary information on management practices supportive of quality STI services is provided in Table 7.3. Summary information on topics of in-service training received by providers of STI services is provided in Figure 7.5. Appendix Tables A-7.5 through A-7.9 provide details on service statistics, charging practices for STI services, supervision, and provider in-service training.

Table 7.3 Management practices supportive of quality services for sexually transmitted infections

Among facilities providing services for clients with sexually transmitted infections (STIs), percentage with an up-to-date register including clients with symptoms or diagnoses of STIs, percentage that submit reports for specific STIs, percentage that have any user fees for STI services, percentage where at least half of the interviewed providers of STI services received in-service training related to STIs during the past 12 months, and percentage where at least half of the interviewed providers of STI services were personally supervised during the past 6 months, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering STI services:			Number of facilities offering STI services (weighted)	Percentage of facilities where at least half of the interviewed ANC service providers:		Number of facilities with interviewed providers of STI services (weighted)
	With observed, up-to-date patient register ¹	That report specific STIs ²	That have user fees for STI services		Received in-service training during past 12 months ³	Were personally supervised during past 6 months	
Type of facility							
GS hospital	7	5	81	44	3	91	41
Fever hospital	0	38	80	7	18	85	6
MCH/urban HU	6	3	71	39	11	93	38
Rural HU	8	1	67	226	10	97	204
Mobile unit	11	3	29	26	6	97	24
Health office	0	0	22	14	11	100	11
NGO facility	3	4	88	49	10	60	44
Region							
Urban Governorates	0	5	70	40	14	85	38
Lower Egypt	8	3	69	204	8	94	193
Upper Egypt	6	1	65	161	10	90	138
Total	7	3	68	405	9	92	369

¹ Register has entry within past seven days and symptom or diagnosis indicates probable STI.
² Facility indicates it submits reports for specific STI diagnoses to the government.
³ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

7.4.1 Facility Documentation and Records

WHO considers record keeping and reporting of STIs and STI service utilization to be key elements in STI surveillance and necessary for improving STI program management (WHO, 1999a). The ESPA assessed the availability of an up-to-date register where STI service statistics were maintained. An STI register was considered up to date if there was an entry in the past seven days and if symptoms or a diagnosis consistent with STI were written. Because most STI services were provided in outpatient departments, these records were checked for entries on clients with STI symptoms or diagnoses. Only 7 percent of facilities had a register with an entry indicating an STI diagnosis in the past seven days (Table 7.3). An additional 2 percent of facilities had a register that was observed without an entry in the past seven days, and an additional 4 percent reported they had a register but were unable to show the register the day of the survey (data not shown).

Specific STIs are classified notifiable diseases in many countries where the public health system monitors illnesses of public health significance. Statistics on newly diagnosed cases and service utilization provide information for assessing changes in disease patterns. The most common notifiable STIs are syphilis, gonorrhea, and HIV/AIDS.

USAID/Egypt in collaboration with United States Naval Medical Research Unit (NAMRU)-3 and the Epidemiology and Surveillance Unit (ESU)/MOHP launched the Communicable Diseases Surveillance program for Egypt in early 2001 by developing guidelines for infectious disease surveillance and reporting forms. The system currently collects data on 27 priority infectious diseases (26 identified priority diseases with one additional line of “other” unanticipated emerging diseases) (USAID, 2003). This National Electronic Diseases Surveillance System (NEDSS) currently tracks the incidence of the

listed notifiable infectious diseases in 13 governorates and is planned to extend to the remaining 14 governorates.

Three percent of facilities, primarily fever hospitals (38 percent), indicated they submit reports on specific STIs and/or HIV/AIDS (Table 7.3). Among the few facilities that do submit reports on notifiable diseases, 61 percent said their source of information for cases data was the client register, 7 percent use laboratory records, and 33 percent reported using both the client register and laboratory records (data not shown).

7.4.2 Practices Related to User Fees

The effect of a fee for services can be negative (the cost is deemed too high) or positive (free items are often perceived not as good as items that are paid for). Sixty-eight percent of facilities indicated they charged any routine fee for STI services (Table 7.3) with almost all indicating this was a fixed fee for the consultation (Appendix Table A-7.5), and only 3 percent reporting they charge for medicines and tests provided by the facility. Among facilities having any user fees 21 percent had publicly posted at least some of the fee schedule.

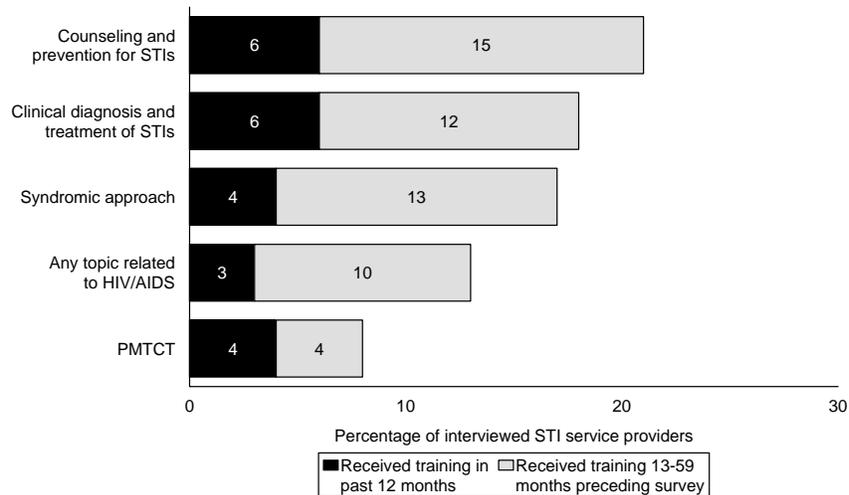
Sixty-four percent of the observed and interviewed clients who received STI services the day of the survey reported they paid something out of pocket the day of the survey (data not shown). Almost all reported that they payment was for the consultation, with 10 percent indicating they paid for medicines. The median payment for all services, tests, or medicines (for those who paid anything) was 105 piasters (data not shown), and was most likely a registration fee. These out-of-pocket payments do not include the costs of medicines or tests not provided at the facility.

7.4.3 Supervision and Staff Development

If at least half of the interviewed STI providers in a facility had received in-service training related to STI services in the past 12 months the facility was defined as providing routine staff development. At least half of the interviewed STI service providers in 9 percent of facilities had received formal in-service training related to STIs during the past 12 months (Table 7.3). Overall, 10 percent of all interviewed STI service providers had received recent in-service training in the past 12 months (Appendix Table A-7.6). An additional 21 percent of interviewed STI service providers had received in-service training related to STIs during the past five years. The percentage of providers receiving in-service training on any particular topic was similar for the past 12 months, and for the past five years (Figure 7.4). Appendix Table A-7.7 provides details on in-service training by facility type and region.

If at least half of the STI service providers in a facility had been personally supervised during the past six months the facility was defined as providing routine supervision. At least half of the interviewed STI service providers in 92 percent of facilities indicated they had been personally supervised during the past six months (Table 7.3). Ninety-one percent of all interviewed STI providers had been personally supervised during the past six months (Appendix Table A-7.8). Among those who had been supervised, the median number of times they remembered being supervised during the past six months was seven times, with providers in Urban Governorate facilities indicating more frequent supervision (a median of 13 times during the past six months). Staff indicated that supervisory activities were those that support quality services, with 94 percent indicating their work had been observed and 93 percent indicating the supervisor had provided feedback on their work. Details on supervisory activities are provided in Appendix Table A-7.8.

Figure 7.4 In-service training received by interviewed STI service providers, by topic and timing of most recent training (N=697)



PMTCT = Prevention of mother-to-child transmission

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Appendix Table A-7.9 provides service statistics for STI clients for the ESPA facilities for which data was available at the facility. It is notable that few clients (for half of the facilities, the monthly average is five STI clients) are documented as seeking services for STIs. Service statistics for STIs are often difficult to assess when there is not an etiologic basis for diagnosis. It is not certain if clients who are treated in family planning and ANC clinics for reproductive tract infections (RTIs), that may or may not be STIs, are reported in monthly statistics. It is most likely that the service statistic numbers reflect clients for whom a RTI or related symptom was the principle reason for visiting the facility. These clients may be more often seen in the general outpatient or gynecology clinic.

Key Findings

Routine provision of in-service training for STI service providers was not common (9 percent of facilities). Only 31 percent of interviewed providers indicated they had received any related in-service training during the past five years.

Routine supervision of STI service providers within facilities was common (92 percent of facilities).

The system for recording service statistics for clients receiving treatments for RTIs or STIs appears weak.

7.5 Adherence to Standards for Quality Service Provision

Observers watched the process utilized when clients were assessed for possible STIs (STI clients), noting information shared and procedures or examinations conducted. The objective was to note if information on a topic was shared (process information). An assessment of whether the information was correct, or findings were appropriately interpreted was not a component of the observation. Checklists based on

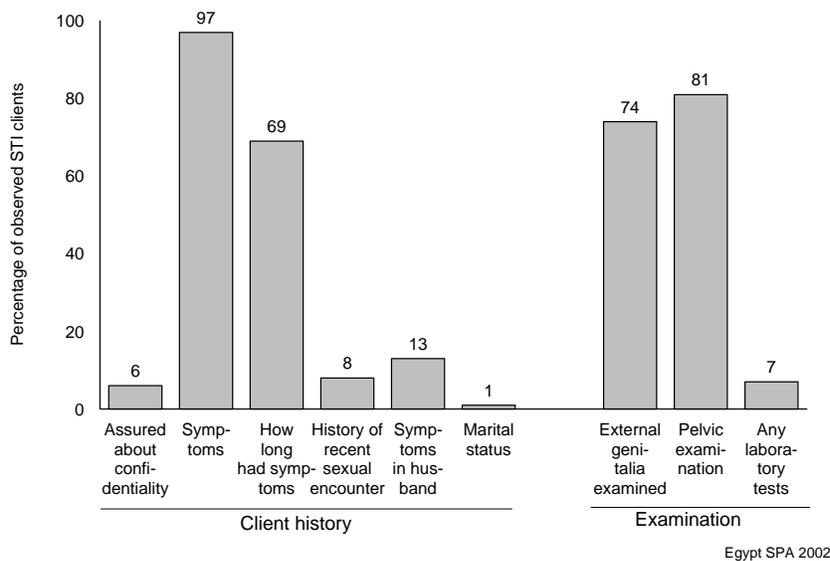
elements of care that are generally accepted in literature (WHO, 2001; AIDSCAP/FHI, 1996) were used to collect information on whether the consultation process included the following:

- Was information related to the clients history and relevant social information shared?
- Were appropriate physical examinations and laboratory tests carried out?
- Did client counseling address relevant topics to support client curative and preventive practices?

All of the observed STI clients (those who were assessed for symptoms that might be STIs) were female. A total of 444 STI clients were observed in 152 different facilities. Among these women, 36 percent were family planning service clients, 8 percent were ANC service clients, and 56 percent came to the facility primarily for the STI or RTI problem (Appendix Table A-7.10). It is not certain where in the facility (general outpatient, gynecology, family planning or ANC clinics) the clients whose primary reason for visiting the facility was symptoms for STI were observed. Overall, this represents 82 percent of the identified RTI/STI clients on the day of the survey (data not shown). Twelve of the observed clients either refused or were not located for the exit interview.

A summary of information shared during the consultation and the types of examinations conducted is provided in Figure 7.5. Appendix Tables A-7.11 through A-7.15 provide details on the content of the observed assessment, physical examinations, and counseling.

Figure 7.5 Components of the assessment of women with symptoms of STIs (N=444)



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 risk of contracting an STI. Only 6 percent of the clients were explicitly assured about the confidentiality of the information shared between herself and the provider (Figure 7.5).

While client symptoms were elicited in almost all observed consultations (97 percent) (Figure 7.5), more detail on how long the symptoms had been present were less often asked (69 percent). Information on items that might indicate whether the infection is likely to be sexually transmitted or not, or that might indicate that the woman is at higher risk for STIs (such as cases where a husband has another wife, or cases where the woman suspects her husband has symptoms of an STI), help to determine the diagnosis. Among the observed clients, only 8 percent were asked about recent sexual contact, 13 percent were asked about symptoms in their husband, and 1 percent were asked about other items related to the husband that might increase risk. Elements of the client assessment were similar regardless of the type of facility where the client was observed (Appendix Table A-7.11).

Table 7.4 Service area where client was observed for sexually transmitted infection				
Among clients observed for consultation on sexually transmitted infections (STIs), percentage who were antenatal care (ANC) clients and who were observed in the ANC service area, percentage who were family planning (FP) clients and who were observed in the FP service area, and percentage who's primary reason for visiting the facility was their symptom related to STIs, by type of facility and region, Egypt SPA 2002				
Background characteristic	Percentage of observed STI clients whose primary service was:			Number of observed STI clients
	FP	ANC	STI	
Type of facility				
GS hospital	24	6	70	115
Fever hospital	No observed STI clients			0
MCH/urban HU	42	6	52	105
Rural HU	45	18	37	51
Mobile unit	32	10	59	63
Health office	65	0	35	20
NGO facility	34	9	57	90
Region				
Urban				
Governorates	36	6	59	128
Lower Egypt	37	4	59	143
Upper Egypt	34	13	53	173
Total	36	8	56	444

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 on the symptoms, which contributes to a proper diagnosis. Eighty-eight percent of the women had some level of physical examination, with 81 percent receiving a pelvic examination, and 74 percent having their genitalia examined (either with or without a pelvic examination) (Appendix Table A-7.11). Findings are presented separately for all clients receiving any physical examination and for clients receiving a pelvic examination although the pelvic examination women are a subgroup of the physical examination.

The observer noted if the physical examination took place under conditions where visual privacy was assured (91 percent) or where both visual and auditory privacy were assured (88 percent) (Appendix Table A-7.12). Findings were similar when the subgroup of women receiving pelvic examinations were assessed (Appendix Table A-7.13). During the observation, if people entered and left from the room, or if curtains were not secure so that persons passing by might glance into the examination area, visual privacy was not assured.

Infection control procedures varied. Almost no providers washed their hands prior to the examination (3 percent), although 17 percent washed their hands after the examination, and 70 percent wore clean latex

gloves (Appendix Tables A-7.12 and A-7.13). Thin, disposable gloves were universally available, but these tear easily and were not accepted for infection-control purposes.

Among all women having a physical examination, the external genitalia were examined for 80 percent (Appendix Table A-7.12). During observations it was noted that not all providers who conducted pelvic examinations examined the external genitalia. Some simply did a rapid examination using a speculum or a manual examination for discharge.

Utilization of sterilized or high-level disinfected (HLD) equipment for the pelvic examination was verified for 85 percent of the examinations (with most other equipment of uncertain status because equipment was already prepared before the observer was in the room), and used equipment was placed in decontaminating solution for 78 percent of the pelvic examinations (Appendix Table A-7.13).

Although a speculum was used during 92 percent of the pelvic examinations (Appendix Table A-7.13), the observer noted that the provider carried out actions necessary to inspect the cervix for only 78 percent of women. Anecdotal evidence was that the provider frequently did a quick examination using a speculum, but did not aim the light or did not take any time to visualize the condition of the cervix. Forty-four percent of the examinations included a bimanual examination. There were almost no explanations of the pelvic examination procedure prior to beginning (3 percent).

Although there were no consistent differences in examination practices by type of facility, rural HUs tended to carry out each assessed item more frequently than other facility types.

Only 7 percent of the clients received or were referred for laboratory examination, with 6 percent receiving a urine test and 2 percent receiving a blood test (Appendix Table A-7.11).

Key Findings
Components of a client history and marital status that might indicate risk for STIs are not routinely elicited.
Physical examinations for STIs are common, with 88 percent of observed clients receiving a physical examination (74 percent had the external genitalia examined, and 81 percent had a pelvic examination).
Infection control practices during pelvic examinations vary with 70 percent of providers using latex gloves and 78 percent using decontaminating solution for used equipment, but only 3 percent washing their hands prior to, and 16 percent after, a procedure. Verification that equipment was sterile or high-level disinfected was noted for 84 percent of the examinations.
Almost all examinations include a speculum exam (92 percent), with 78 percent using the speculum and visualizing the cervix. Bimanual examinations are not common (44 percent of pelvic examinations).
Laboratory examination for the diagnosis is not common (7 percent); however, the most common test is a urine test (6 percent).

7.5.3 Client Counseling and Knowledge

During 87 percent of the observations, the provider mentioned some diagnosis, with only 18 percent indicating specifically the relationship between the infection and sexual activity. It was uncertain from the data whether the client actually had an STI or whether the diagnosis was a nonsexually transmitted

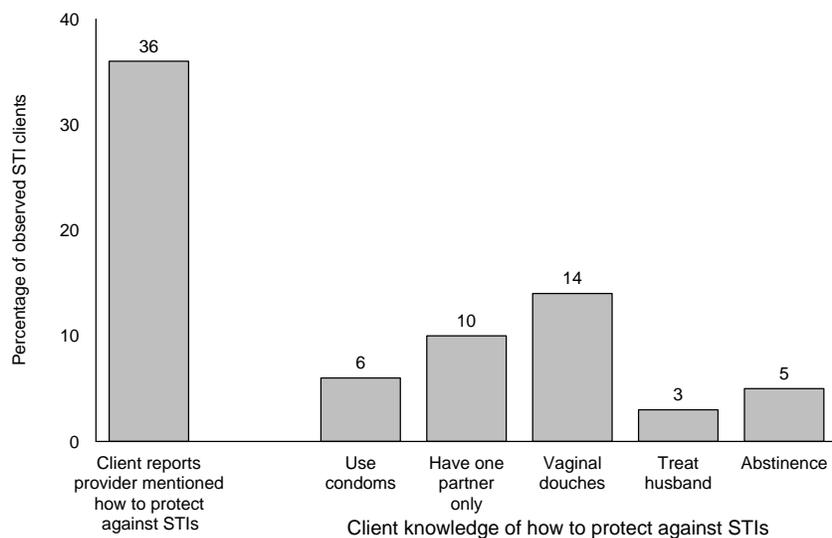
vaginal infection. However, 98 percent of the women were prescribed (or received) antibiotics for their infection, and 12 percent also received medicine for their husband (Appendix Table A-7.14). Fifty-nine percent were observed being told how to take the medicine, and for 55 percent of the clients a followup appointment was mentioned.

Condoms as a means for prevention or to use until treatment was completed were almost never discussed or offered during the observed consultations. During only 5 percent of the observations were condoms or HIV/AIDS noted to be mentioned at all (Appendix Table A-7.14). Visual aids as resources during client counseling were essentially never used. During exit interviews clients supported these findings, with 6 percent reporting the provider had talked about condoms during the visit, and 4 percent indicating they had received condoms (Appendix Table A-7.15). Finally, an individual client health card is important for ensuring that information necessary for followup and for continuity of care is available. Twenty-nine percent of the clients had an individual client card where the provider wrote information (Appendix Table A-7.14). An additional 38 percent had a client card present, but the provider did not write on it (data not shown).

After the observed consultation the client was asked to participate in an exit interview. Thirty-six percent reported that the provider had provided information on how to protect themselves against reproductive tract infections or HIV/AIDS. (Figure 7.6). Clients were then asked (without prompting) to mention ways that they can protect themselves in the future from infections transmitted through sexual activity. Among all interviewed clients, 6 percent indicated that using condoms was a way to protect against STIs or HIV/AIDS, 10 percent indicated having only one partner was a means. In addition, 14 percent thought that vaginal douches would protect against STIs or HIV/AIDS. Finally, 3 percent said the husband must be treated and 5 percent mentioned abstinence.

Nineteen percent of the interviewed clients reported that they had used condoms with their husband previously (Appendix Table A-7.15). Appendix Table A-7.15 provides detailed information on client experience and attitude toward use of condoms.

Figure 7.6 Client reports that provider mentioned how to protect against STIs; client knowledge of how to protect against STIs (N=440)



Egypt SPA 2002

Key Findings

Although 98 percent of the observed clients were prescribed antibiotics, only 12 percent were provided medicines for their husbands and only 4 percent were encouraged to refer the husband. A more thorough study to assess whether cases such as these are STIs or whether the use of antibiotics for non-STI vaginal infections is appropriate, may be warranted.

Individual client health cards, necessary for followup information and continuity of care, were used in one in three STI consultations.

Education about using condoms for prevention of STIs is almost never provided.

Client reported knowledge on how to protect against STIs is weak and, in some cases (14 percent mentioned vaginal douches), faulty.

7.6 Client Opinion from Exit Interviews

During the exit interview, clients were asked their opinion on issues commonly related to client satisfaction. The client was first asked to identify issues without prompting, and then specific issues were probed, with the client asked to comment if these were big, small, or not a problem for them. Few items were identified as major problems. Among identified problems, 9 percent felt the waiting time was too long, and lack of availability of medicines or supplies was a big problem (13 percent) (Appendix Table A-7.16). Lack of supplies was identified in all types of facilities, although clients observed in NGO facilities were least likely to identify this as a big problem (6 percent). Waiting time was most often identified as a problem in general service hospitals and rural HUs.

When asked why they chose the facility for services, 45 percent reported it was the proximity of the facility. However, 31 percent reported it was the efficiency of the physician, 27 percent indicated that the presence of a female physician was important, and 22 percent cited the reputation of the facility (or provider). These findings are similar to those mentioned by clients from other observed services. Appendix Table A-7.17 provides details on why the facility was selected.

Appendix Tables A-7.18 and A-7.19 provide additional details on client employment and educational background.

7.7 Availability of Services Related to HIV/AIDS

7.7.1 ESPA Approach to Collection of Information on HIV/AIDS Services

During the past decade, the emphasis of HIV-related activities has been on awareness and prevention. With the development of new methods of detection and antiretroviral therapies, and better knowledge of HIV transmission and prevention, comprehensive HIV services that include treatment, prevention, and support are being advocated (Lampthey and Gayle, 2001).

The package of services for comprehensive HIV services generally includes the following:

- Programs and strategies for prevention and early detection
 - Voluntary counseling and testing (VCT) services
 - Prevention of mother-to-child transmission (PMTCT).

- Improving the quality of life for HIV-infected clients by providing preventive and curative medical interventions. These interventions include the following:
 - Antiretroviral therapy (ART)
 - Preventive or curative antibiotics for opportunistic infections
 - Palliative care for the end-stage AIDS patient (either in a facility or through home care).
- Improving the quality of life for HIV-infected clients through social and psychological support, for them as well as for their family and eventually their surviving children. Specific target groups for support and assistance include the following:
 - Infected persons living with HIV/AIDS (PLHA)
 - Orphans and vulnerable children (OVC).

Because of the high cost of highly active antiretroviral therapies (HAART) and laboratory supplies and the lack of an effective structure or funds needed to provide the social care and support activities required by persons living with HIV/AIDS, all components of this care and support package are not yet available in many countries. The low prevalence of HIV/AIDS in Egypt, combined with these factors, has not made development of HIV/AIDS services a priority. It is important, however, as HIV/AIDS services are introduced, to periodically monitor and evaluate the extent to which the package is becoming available.

7.7.2 Capacity to Provide Quality Services for HIV/AIDS Clients

Egypt has recently begun developing services for HIV/AIDS, recognizing that prevention and early detection are critical measures for maintaining a low prevalence of HIV/AIDS (MOHP, 2003).

Where HIV/AIDS services are not well developed, providers may still see clients who they suspect of being infected with HIV/AIDS. Although officially they should refer such clients for testing, this may not always occur. The ESPA defined services for HIV/AIDS as any care for someone suspected of being infected with HIV. The respondent at a facility (most often either the in-charge or the head of the outpatient department) was asked if the facility offered any services related to HIV/AIDS including diagnosis, treatment, or counseling. Three percent of facilities (primarily fever hospitals) indicated that they did provide some services related to HIV/AIDS. This was a total of 28 facilities (unweighted number). Information on numbers of facilities reporting different components of HIV/AIDS services are provided in Appendix Table A-7.20.

It is important to understand what services providers report as being offered, so that program strategies can be developed to address problem areas to ensure that services are provided with adequate quality. Eleven of the facilities reporting that they provide some HIV/AIDS service reported that they provide voluntary counseling and testing (VCT) (Appendix Table A-7.20). The MOHP indicates that at the time of the survey there were no VCT programs in Egypt, thus, this most likely represents referral of ill clients for testing, or testing conducted at the request of a client for employment purposes, and not the accepted definition of VCT services. None of the facilities had an observed register with VCT client data (data not shown). Two facilities reported they had a register but could not produce it. They may have been referring to a laboratory test result register.

Eight facilities reported that they provide services for HIV/AIDS patients in addition to testing (Appendix Table A-7.20), with five of these facilities reporting that the additional services were counseling and medical followup (data not shown).

Among the 28 facilities that reported any services for HIV/AIDS, 51 interviewed providers (unweighted number) reported they provide some services for HIV positive clients (Appendix Table A-7.21). All of these providers were also STI service providers (data not shown). When providers were asked what HIV/AIDS services they provided, 69 percent reported that they diagnose HIV/AIDS, 41 percent reported they provide medical treatment for AIDS patients, and 67 percent indicated they provide counseling and support (data not shown). After discussion with the MOHP National AIDS Control Programme, it appears that these reports are for services the staff have received some training in, or that they may feel they can provide, but are not services that are routinely offered by facilities. Antiretroviral therapy (ART) is not currently available in Egypt except in one facility. It was interesting to note that nine of the interviewed HIV/AIDS service providers (two from general service hospitals and seven from fever hospitals) indicated they did provide ART services. It is assumed that their intention was to indicate they could provide this service, not that they did, at present, provide the service.

All of these providers indicated they had received in-service training related to STIs, and specifically for syndromic approach, during the prior 12 months. Appendix Table A-7.21 provides details on the in-service training related to HIV/AIDS.

Key Findings
HIV/AIDS services are new in Egypt, and consist primarily of testing and providing medical or symptomatic treatment for clients who appear at the facility.
Providers of STI services are beginning to receive in-service training on aspects of HIV/AIDS services.
Protocols and standards for HIV/AIDS services are not yet implemented. Thus, services that are currently provided depend on the training and awareness of the individual provider.

7.7.3 Facility-level Implementation of Universal Precautions

Because many HIV infected persons are not aware of their status, the risk of transmission of HIV/AIDS is possible wherever someone might come into contact with infected blood or body secretions, regardless of whether services related to HIV/AIDS are being provided or not. In a high-risk environment such as a health facility, ensuring that no one can become infected inadvertently is critical. An essential step in preventing transmission of HIV/AIDS (as well as hepatitis B or C) is to ensure that any potentially contaminated items are appropriately disinfected, eliminating this avenue for transmission. For this reason, it is recommended that universal precautions should be applied throughout all service delivery areas in all health facilities. Use of sharps containers and procedures for immediately disinfecting used equipment are two of the most critical components for preventing inadvertent transmission.

Although asepsis (absence of infection-causing microorganisms) is a basic concept in medical and paramedical schools, experience indicates that providers who do not work in an environment that actively promotes universal precautions are frequently lax in implementation (Pittet et al., 1999; Williams et al., 1994). Thus, a facility-level strategy to promote adherence to universal precautions is an important factor in improving infection control.

Throughout the service assessment, a lack of soap for hand-washing was evident. Soap was present in all assessed service delivery areas in only 15 percent of facilities (Appendix Table A-3.24). Capacity to adequately process equipment for reuse (functioning equipment and knowledge of processing time and temperature) was evident in 65 to 76 percent of all assessed service delivery areas (data in relevant chapters).

Key Findings

Quality of sterilization and HLD processing of equipment is consistent when processed in different areas of facilities. Between 65 and 75 percent of facilities had functioning equipment and knowledge for appropriate processing methods.

Fever hospitals are particularly weak in availability of systems and equipment to support routine implementation of infection control measures.

Hand-washing soap is a simple intervention that is consistently lacking.

7.8 Resources for Diagnosis and Management of Tuberculosis

Tuberculosis (TB) is one of the most common opportunistic infections for AIDS patients, as well as a communicable disease of public health significance. The ESPA looked at TB services provided at all facilities. For facilities that provide TB services, the ability to conduct a sputum examination and the availability of medications for short course and standard treatment, and prophylactic treatment were assessed.

Nineteen percent of facilities indicated that they provide services for TB, with 13 percent stating they use the Directly Observed Treatment Short-course (DOTS) approach, and 6 percent indicating they did not use the DOTS approach (Table 7.5). Medicines for TB treatment were not available in pharmacies. Only 5 percent of facilities using the DOTS approach had all medicines for first-line treatment, and 2 percent of facilities not using the DOTS approach had all medicines (Appendix Table A-7.22). Facilities using the DOTS approach receive their medicines weekly, in an individual client packet, and frequently do not store these medicines in the pharmacy. The availability of the individual packets of medicines was not assessed.

Six percent of facilities that offer TB services, mostly hospitals, also had a functioning microscope for testing sputum.

Background characteristics	Percentage of facilities providing:			Number of facilities (weighted)
	Any services for TB	TB services through DOTS	TB services not through DOTS	
Type of facility				
GS hospital	23	16	8	64
Fever hospital	11	3	8	13
MCH/urban HU	7	5	2	65
Rural HU	27	18	9	367
Mobile unit	0	0	0	38
Health office	2	2	0	32
NGO facility	1	0	1	71
Region				
Urban Governorates	2	1	0	65
Lower Egypt	21	12	9	315
Upper Egypt	20	15	5	270
Total	19	13	6	650

Key Findings

TB services are available in one out of five facilities, with most using the DOTS approach.

Stock TB medicines are not commonly found (less than 5 percent of facilities providing TB services). This means that backup supplies of medicines are not available if individual client medicines are ruined or late are not readily available. Whether this is a factor that affects continuity of treatment should be considered.

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Chapter 1

Facilities included in the facility type category	Number of facilities								Percentage of total for facility type included in ESPA sample
	Urban Governorates		Lower Egypt		Upper Egypt		Total		
	Sample frame	ESPA sample	Sample frame	ESPA sample	Sample frame	ESPA sample	Sample frame	ESPA sample	
Hospital									
General or district hospital	37	8	113	24	85	18	235	50	21
Integrated hospital	2	0	167	34	86	18	255	52	20
Fever hospital	5	2	48	15	49	16	102	33	32
MCH/urban HU									
Maternal child health unit	39	9	93	21	82	18	214	48	22
Urban health unit	99	19	99	19	88	17	286	55	19
Rural HU									
Rural health unit	59	4	1,456	90	1,275	79	2,790	173	6
Health Sector Reform Project unit	12	12	10	10	4	4	26	26	100
Mobile unit	48	9	121	24	120	23	289	56	19
Health office	71	15	100	21	73	15	244	51	21
NGO facility									
Egyptian Family Planning Association	62	10	170	29	141	24	373	63	17
Clinical Service Improvement	65	17	36	9	68	17	169	43	25
Other NGO	65	17	36	9	68	17	169	43	25
Number of facilities	487	105	2,403	296	2,067	249	4,957	650	13

Percentage of each type of facility in the total sample (weighted), and weighted and unweighted number of facilities, by type of facility, Egypt SPA 2002			
Type of facility	Percentage of total sample (weighted)	Number of facilities (weighted)	Number of facilities (unweighted)
General or district hospital	5	31	51
Integrated hospital	5	34	56
Fever hospital	2	13	33
MCH unit	4	28	48
Urban HU	6	37	57
Rural HU	57	367	191
Mobile unit	6	38	56
Health office	5	32	52
EFPA, CSI (NGO facility)	7	44	65
Other NGO facility	4	27	41
Total	100	650	650

Number of interviewed health care providers (weighted and unweighted), by type of provider and type of facility, Egypt SPA 2002		
Type of facility	Number of interviewed providers (weighted)	Number of interviewed providers (unweighted)
PHYSICIANS		
GS hospital	231	348
Fever hospital	24	66
MCH/urban HU	143	291
Rural HU	282	216
Health office	26	57
Mobile unit	31	65
NGO facility	62	123
Total	798	1,166
NURSES		
GS hospital	340	285
Fever hospital	22	44
MCH/urban HU	249	270
Rural HU	900	491
Health office	30	61
Mobile unit	99	136
NGO facility	32	63
Total	1,672	1,350
AUXILIARY AND OTHER STAFF¹		
GS hospital	14	22
Fever hospital	0	0
MCH/urban HU	35	47
Rural HU	163	55
Health office	5	11
Mobile unit	10	23
NGO facility	37	62
Total	266	220
Total interviewed staff	2,736	2,736
¹ Includes social workers.		

Table A-1.4 Sample of observed and interviewed clients			
Number of children/women attending facility on the day of the survey (eligible), number whose consultation was observed, and percentage of eligible clients who were observed, by type of care and type of facility, Egypt SPA 2002			
Background characteristics	Number of clients present on the day of the survey (eligible for observation)	Actual number of clients observed	Percentage of eligible clients who were observed
CURATIVE CARE FOR SICK CHILDREN			
GS hospital	2,038	595	29
Fever hospital ¹	519	177	34
MCH/urban HU	1597	489	31
Rural HU	1,021	606	59
Health office	28	27	96
Mobile unit	93	20	22
NGO facility	143	99	69
Total	5,439	2,013	37
FAMILY PLANNING			
GS hospital	634	428	68
Fever hospital ¹	0	0	N/A
MCH/urban HU	785	432	55
Rural HU	406	269	66
Health office	361	231	64
Mobile unit	234	118	50
NGO facility	302	210	70
Total	2,722	1,688	62
ANTENATAL CARE			
GS hospital	363	223	61
Fever hospital ¹	0	0	NA
MCH/urban HU	838	300	36
Rural HU	494	260	53
Health office	88	67	76
Mobile unit	12	5	42
NGO facility	171	122	71
Total	1,966	977	50
STI			
GS hospital	168	115	68
Fever hospital ¹	0	0	NA
MCH/urban HU	126	106	84
Rural HU	61	51	84
Health office	63	63	100
Mobile unit	29	19	66
NGO facility	96	90	94
Total	543	444	82
¹ Fever hospitals do not provide family planning or ANC services and, while providing STI services, no clients were identified on the day of the survey.			

Median population of assigned catchment areas for facilities providing data on a known catchment population, by type of facility and region, Egypt SPA 2002		
Background characteristics	Median population in catchment area	Number of facilities (weighted)
Type of facility		
General or district hospital	180,249	16
Integrated hospital	20,679	31
Fever hospital	322,296	3
MCH unit	60,453	16
Urban HU	47,684	31
Rural HU	11,117	350
Mobile unit	26,529	3
Health office	60,745	28
EFPA, CSI (NGO facility)	128,404	10
Other NGO facility	15,700	5
Region		
Urban Governorates	71,943	37
Lower Egypt	12,961	252
Upper Egypt	11,892	204
Total	13,109	494

Median number of health care providers assigned to outpatient services, by staff qualification and type of facility, Egypt SPA 2002						
Type of facility	Median number of providers assigned to each facility ¹					Number of facilities (weighted) ²
	Total staff	Physicians	Qualified nurses	Auxiliary	Other	
General or district hospital	117	54	58	4	22	31
Integrated hospital	26	9	14	2	8	34
Fever hospital	21	7	14	2	7	13
MCH unit	24	7	13	4	7	28
Urban HU	29	7	16	3	8	37
Rural HU	9	2	6	2	5	367
Mobile unit	3	2	2	2	2	38
Health office	14	3	10	3	9	32
EFPA, CSI (NGO facility)	3	2	2	3	3	44
Other NGO facility	8	7	2	2	3	27
Total	10	2	7	2	5	650

¹ Numbers were provided by facility administrators. Staff who routinely rotate between inpatient and outpatient services are included.

² See Table 1.1 for actual number of facilities included in analysis.

Table A-1.7 Educational levels of interviewed health service providers

Median number of years of basic schooling, and median number of years for technical qualification, reported by interviewed health service providers, by qualification, Egypt SPA 2002

Qualification	Median number of years of basic education prior to technical training	Median number of years of technical training for qualification	Number of interviewed providers
Doctor, specialist	13	8	375
Doctor, generalist	13	7	423
Nurse with midwifery	10	4	72
Nurse	9	4	1,600
Midwife	9	2	30
Nurse assistant	10	3	107
Raida Refia	12	4	25
Total	10	4	2,736

Chapter 3

Table A-3.1 Availability of basic services by type of facility

Percentage of facilities offering basic outpatient services (curative care for children, any services for sexually transmitted infections (STI), temporary methods for family planning, antenatal care, child immunization, routine growth monitoring at any frequency), facility-based 24-hour delivery services, with at least one physician;¹ and percentage offering all basic services with the minimum defined frequencies and facility-based 24-hour delivery services and at least one qualified provider for curative care, by type of facility, Egypt SPA 2002

Basic services	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Curative care for children	98	97	99	99	46	15	60	88
Any services for sexually transmitted infections	68	53	60	62	68	44	70	62
Temporary methods of family planning	98	0	98	100	100	88	91	96
Antenatal care	79	0	88	99	73	4	82	86
Child immunization	51	0	79	96	2	83	2	71
Growth monitoring	44	9	76	81	5	23	5	60
All basic services ² at any frequency	23	0	39	51	0	0	1	35
Facility-based 24-hour delivery services	73	0	48	34	0	0	10	32
At least one qualified provider for curative care ¹ (physician)	100	100	100	100	100	98	98	100
All services minimum frequency ³	23	0	39	43	0	0	1	31
All services, minimum frequency, and 24-hour delivery services	13	0	21	15	0	0	0	12
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	13	0	21	15	0	0	0	12

¹ In Egypt, a physician is the level of staff qualified for provision of curative care and caring for complicated cases seen by lower-level providers.

² 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, immunization, and child growth monitoring

³ Curative services for children provided 5 days per week, STI services offered at least 1 day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least 1 day per week

Table A-3.2 Availability of basic services by region

Percentage of facilities offering basic outpatient services (curative care for children, any services for sexually transmitted infections (STI), temporary methods for family planning, antenatal care, child immunization, routine growth monitoring at any frequency), facility-based 24-hour delivery services, with at least one physician;¹ and percentage offering all basic services with the defined minimum frequencies, facility-based 24-hour delivery services, and at least one physician, by region, Egypt SPA 2002

Basic services	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Curative care for children	68	90	90	88
Any services for sexually transmitted infections	61	65	60	62
Temporary methods of family planning	94	97	95	96
Antenatal care	77	85	89	86
Child immunization	54	73	74	71
Growth monitoring	40	60	65	60
All basic services at any frequency ²	13	37	39	35
Facility-based 24-hour delivery services	38	23	42	32
At least one qualified staff ¹	100	100	100	100
All services minimum frequency ³	13	30	35	31
All services, minimum frequency, and 24-hour delivery services	12	9	16	12
All services, minimum frequency, 24-hour delivery services, and at least one qualified staff	12	9	16	12
Number of facilities (weighted)	65	315	270	650

¹ In Egypt, a physician is the level of staff qualified for provision of curative care and caring for complicated cases seen by lower-level providers.

² 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, immunization, and child growth monitoring

³ Curative services for children provided 5 days per week, STI services offered at least 1 day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least 1 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, Egypt SPA 2002

Items	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Client comfort amenities								
Client latrine	85	78	89	81	23	71	93	80
Protected waiting area	91	72	95	80	13	90	97	81
Clean facility	79	91	88	77	98	75	93	82
All client comfort items ¹	69	60	80	59	5	54	88	62
Facility infrastructure								
No electricity or generator	0	0	0	0	14	0	1	1
Generator observed with fuel	36	31	1	1	38	0	9	8
Regular electricity or generator	92	100	93	85	84	100	95	89
Onsite water	98	100	99	95	70	98	100	95
Regular water supply (onsite and year-round)	90	94	86	87	52	92	91	86
Regular water and electricity ²	83	94	81	75	48	92	87	77
All client amenities, regular water, and electricity	55	53	66	44	4	52	76	49
Staff and furnishings								
At least two physicians ³	98	97	94	43	41	69	55	57
Duty staff onsite 24 hours ⁴	80	85	40	37	0	4	10	36
Duty staff on-call 24 hours ⁴	0	6	7	1	0	6	2	2
Emergency communication ⁵	99	97	91	83	23	93	88	83
Overnight patient beds ⁶	93	100	19	13	0	2	17	23
Basic components supporting 24 hours ⁷	63	69	13	2	0	0	10	11
Basic plus regular water and electric ⁸	53	66	10	2	0	0	8	10
Number of facilities (weighted)	64	13	65	367	38	32	71	650

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

² Year-round, onsite water, and electricity available 24 hours a day or a generator with fuel

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

⁴ A duty schedule or other documentation of official duty status was observed.

⁵ Communication device either in facility or within a 5-minute walk and available 24 hours a day

⁶ Either routine inpatient services or beds for overnight care for emergencies

⁷ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and any onsite water source

⁸ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and regular water and electricity

Table A-3.4 Facility infrastructure supportive of client utilization and quality services by region				
Percentage of facilities with client amenities, regular electricity and water supply, items to support quality 24-hour emergency services, by type of facility, Egypt SPA 2002				
Items	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Client comfort amenities				
Client latrine	86	79	79	80
Protected waiting area	90	87	71	81
Clean facility	96	82	78	82
All client comfort items ¹	78	65	55	62
Facility infrastructure				
No electricity or generator	0	1	1	8
Generator observed with fuel	17	8	6	89
Regular electricity or generator	96	83	94	
Onsite water	99	93	96	95
Regular water supply (onsite and year-round)	77	85	89	86
Regular water and electricity ²	75	73	83	77
All client amenities, regular water, and electricity	61	51	44	49
Staff and furnishings				
At least two physicians ³	87	60	46	57
Duty staff onsite 24 hours ⁴	41	30	42	36
Duty staff on-call 24 hours ⁴	2	1	3	2
Emergency communication ⁵	81	83	83	83
Overnight patient beds ⁶	21	26	19	23
Basic components supporting 24 hours ⁷	18	10	11	11
Basic plus regular water and electric ⁸	14	8	10	10
Number of facilities (weighted)	65	315	270	650
¹ Clean, functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness				
² Year-round, onsite water, and electricity available 24 hours a day or a generator with fuel				
³ In Egypt, only physicians were defined as qualified for providing curative care.				
⁴ A duty schedule or other documentation of official duty status was observed.				
⁵ Communication device either in facility or within a 5-minute walk and available 24 hours a day				
⁶ Either routine inpatient services or beds for overnight care for emergencies				
⁷ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and any onsite water source				
⁸ At least two physicians assigned to facility, duty staff on site or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and regular water and electricity				

Table A-3.5 Routine management meetings					
Percentage of facilities reporting they have routine management meetings every 1 to 2 weeks, monthly, quarterly, or every 6 months (documentation of meetings may or may not have been observed), by type of facility and region, Egypt SPA 2002					
Background characteristics	Percentage				Number of facilities (weighted)
	Every 1-2 weeks	Monthly	Quarterly	Every 6 months	
Type of facility					
GS hospital	9	60	3	0	64
Fever hospital	8	58	0	0	13
MCH/urban HU	8	47	2	0	65
Rural HU	10	40	0	1	367
Mobile unit	0	11	3	0	38
Health office	9	37	3	0	32
NGO facility	3	47	0	0	71
Region					
Urban Governorates	3	51	0	0	65
Lower Egypt	8	51	1	1	315
Upper Egypt	10	29	0	0	270
Total	8	42	1	0	650

Table A-3.6 Quality assurance activities with documentation observed

Among facilities having quality assurance (QA) activities, percentage that both reported that the indicated method for QA is used and had some documentation for the method, by type of facility, Egypt SPA 2002

Type of facility	Percentage						Number of facilities reporting quality assurance activities (weighted)
	Supervisory checklist for health system components	Supervisory checklist for observation of services	Mortality review	Auditing of medical records or registers	Quality assurance committee	Quality improvement program	
GS hospital	17	25	43	43	10	10	24
Fever hospital	33	33	22	33	11	11	4
MCH/urban HU	36	36	5	32	21	21	12
Rural HU	31	29	54	59	34	29	91
Mobile unit	29	29	0	29	29	15	5
Health office	57	28	57	57	28	43	4
NGO facility	12	11	0	28	17	22	12
Total	29	28	42	50	27	24	152

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 in-service training relevant to maternal, child, or reproductive health services or specific infectious diseases during the past 12 months, and percentage where none, at least half, or all of the providers were personally supervised during the past 6 months, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities where the indicated percentage of interviewed providers:						Number of facilities with interviewed providers (weighted)
	Received related in-service training during the past 12 months: ¹			Were personally supervised during the past 6 months:			
	None	At least 50 percent	All	None	At least 50 percent	All	
Type of facility							
GS hospital	26	13	0	0	92	47	64
Fever hospital	61	4	3	3	91	51	13
MCH/urban HU	16	23	1	0	99	59	65
Rural HU	22	33	9	0	99	76	367
Mobile unit	39	25	4	0	100	52	38
Health office	36	17	0	0	96	63	31
NGO facility	49	28	13	29	58	44	70
Region							
Urban Governorates	25	29	5	7	89	55	65
Lower Egypt	32	18	3	2	95	71	314
Upper Egypt	21	38	12	4	93	62	270
Total	27	28	7	3	94	66	649

¹ This refers to structured in-service sessions and 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 of who received in-service training (related to maternal, child, or reproductive health) during the past 12 months, percentage who were personally supervised in the past 6 months, percentage who received both in-service training in the past 12 months and personal supervision in the past 6 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage				Number of interviewed health service providers (weighted) ²
	Received in-service training during past 12 months ¹	Personally supervised in past 6 months	Personally supervised during past 6 months and received in-service training during the past 12 months	Most recent in-service training was 13-59 months preceding the survey	
Type of facility					
GS hospital	24	85	20	48	569
Fever hospital	16	79	12	44	46
MCH/urban HU	28	94	27	44	425
Rural HU	35	95	35	40	1,321
Mobile unit	32	96	32	53	62
Health office	24	94	24	43	139
NGO facility	29	56	19	37	131
Region					
Urban Governorates	35	87	33	42	232
Lower Egypt	23	92	22	45	1,443
Upper Egypt	40	89	36	40	1,019
Total	30	90	28	43	2,694

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.
² Interviewed providers who do not personally provide any of the assessed services (i.e., managers who might have been interviewed) are excluded.

Table A-3.9 Types of funding options utilized

Among facilities having user fees, percentage where the indicated financing mechanism is utilized, percentage where all fees are publicly posted, and percentage where some fees are publicly posted, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities having indicated system								Number of facilities having any user fees (weighted)
	System for decreasing client out-of-pocket cost				Fee system				
	Economic and free sections	Facility has discount/exemption for some clients	Record available that indicates discount/exemption was provided during prior 7 days	Facility has any system to decrease out-of-pocket costs to client ¹	Fixed fee, varies by type of client	Prepay for multiple visits one service	All fees are posted publicly	Some fees are posted publicly	
Type of facility									
GS hospital	62	50	10	73	43	0	28	9	63
Fever hospital	80	23	0	75	33	0	20	3	12
MCH/urban HU	56	37	5	60	46	2	30	9	62
Rural HU	45	8	1	41	55	0	14	11	365
Mobile unit	20	28	0	44	68	0	16	0	17
Health office	13	13	0	21	87	0	40	9	14
NGO facility	15	59	5	61	85	5	49	5	67
Region									
Urban Governorates	56	61	9	78	48	6	43	14	55
Lower Egypt	36	17	2	43	67	0	25	13	297
Upper Egypt	51	19	2	50	47	0	14	3	249
Total	44	22	3	49	57	1	22	9	600

¹ Facility has either economic/free section, discount/exemption system, or both systems.

Table A-3.10 Components for which fees are charged under the economic and free service system

Among facilities with user fees, percentage charging for the indicated item under the "economic" and under the "free" service delivery system, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage								Number of facilities with client fees (weighted)
	Fixed fee for ticket or consultation		Fixed fee for health card		Charges for medicine		Charges for tests		
	Economic	Free	Economic	Free	Economic ¹	Free ²	Economic ¹	Free ²	
Type of facility									
GS hospital	61	96	4	22	15	12	49	35	63
Fever hospital	77	100	0	7	13	5	57	25	12
MCH/urban HU	55	95	3	28	10	17	39	33	62
Rural HU	34	99	2	26	0	7	5	17	365
Mobile unit	8	68	0	0	0	8	8	12	17
Health office	4	43	0	9	0	9	4	0	14
NGO facility	83	17	3	0	13	4	61	11	67
Region									
Urban									
Governorates	75	71	4	16	24	20	66	40	55
Lower Egypt	36	91	1	31	3	2	17	14	297
Upper Egypt	47	87	3	11	2	13	15	21	249
Total	44	87	2	21	4	8	21	19	600

¹ It is not uncommon for facilities to provide prescriptions to "economic" clients for medicine or test from outside the facility. If the facility does not provide the medicine or test to the economic section client, it would indicate no charge, even if the client must purchase from outside the facility.

² According to government policy there is no official charge for medicines or tests in the "free" sector. The response that there are charges might indicate that clients must pay for medicines or tests not available in the facility, or the question might not have been fully understood. It is unlikely someone would report that they routinely implement a charging policy that is not sanctioned.

Table A-3.11 Sources of funding for reimbursement for clients receiving services with discount or exemption of fees

Percentage of facilities that receive reimbursements for services to clients, from the indicated reimbursement mechanisms, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities indicating source of reimbursement				Percentage where most recent exemption was within 7 days	Number of facilities (weighted)
	Charity fund	HIO/SHIP ¹	Ministry of Health and Population	Other		
Type of facility						
GS hospital	17	48	22	4	41	64
Fever hospital	6	44	16	0	50	13
MCH/urban HU	5	28	0	2	64	65
Rural HU	0	57	3	1	43	367
Mobile unit	3	0	0	0	97	38
Health office	0	6	2	2	90	32
NGO facility	13	2	0	3	82	71
Region						
Urban Governorates	8	9	2	2	81	65
Lower Egypt	4	47	7	1	49	315
Upper Egypt	3	42	1	2	55	270
Total	4	41	4	1	55	650

¹ Health Insurance Organization or Student Health Insurance Program

Table A-3.12 Facility systems for maintenance and repair of equipment

Percentage of facilities that report having a preventive maintenance program for major equipment and percentage that report having a system for repairing or replacing small equipment; among facilities with preventive maintenance programs for large equipment, percentage that report having on-site staff, external technicians, or both for conducting the repair work; and among facilities with systems for repairing small equipment, percentage that repair equipment on site, using an outside facility or technician, and percentage that have a petty cash fund for repairs, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage with persons responsible for preventive maintenance for major equipment: ¹			Number of facilities with preventative maintenance for large equipment (weighted)	Percentage reporting method used for maintenance or replacing small equipment: ²			Number of facilities with system for small equipment repair	Number of facilities (weighted)
	On-site staff	External technicians	Both on-site and external technicians		On-site repair	Send outside for repair or replace	Purchase or pay for from funds on hand		
Type of facility									
GS hospital	40	52	8	38	44	62	8	62	64
Fever hospital	30	70	0	4	32	68	12	11	13
MCH/urban HU	13	83	4	15	11	71	16	61	65
Rural HU	11	85	4	103	11	75	9	327	367
Mobile unit	8	86	6	24	5	85	2	37	38
Health office	12	75	12	5	11	73	7	27	32
NGO facility	24	63	13	16	14	77	14	63	71
Region									
Urban									
Governorates	44	56	0	14	16	70	26	60	65
Lower Egypt	15	80	5	113	16	72	9	298	315
Upper Egypt	17	75	8	79	14	77	6	231	270
Total	17	77	6	206	15	74	10	590	650

¹ Major equipment refers to generators, sterilizers, other large equipment where routine maintenance is recommended to extend the life of the machine.

² Minor equipment refers to stethoscopes, sphygmomanometers, other small equipment where either minor repairs or replacement are common when broken.

Table A-3.13 Source of funding for maintenance and repair of equipment

Among all facilities, percentage with a source of funding for equipment maintenance and repair from a budget line item, from the service improvement box,¹ from both a budget line item and service; improvement box funds, or where there is no established source of funding for equipment maintenance and repair; and, among those facilities with a system and funding for equipment maintenance and repair, percentage who assess that the available funding is sufficient, who are uncertain whether the funding is sufficient or not, or who assess that the funding available is not sufficient, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage where source of funding for maintenance and repairs for equipment was:				Number of facilities (weighted)	Percentage where amount available for equipment maintenance and repair was:			Number of facilities with source of funding (weighted)
	Budget line item	Service improvement box	Both sources of funding	None		Sufficient	Not sure if sufficient	Not sufficient	
Type of facility									
GS hospital	33	66	20	21	64	63	12	24	51
Fever hospital	31	70	29	28	13	61	4	30	9
MCH/urban HU	12	70	8	26	65	65	7	26	48
Rural HU	8	47	3	48	367	67	6	25	192
Mobile unit	16	7	0	77	38	69	8	23	9
Health office	10	14	5	81	32	60	0	40	6
NGO facility	29	20	1	52	71	86	6	8	34
Region									
Urban									
Governorates	18	49	5	38	65	59	13	28	40
Lower Egypt	16	43	6	47	315	75	6	18	167
Upper Egypt	10	45	4	47	270	62	6	29	143
Total	14	45	5	46	650	68	7	24	349

¹ Money collected from user fees

Background characteristics	Percentage where person responsible for authorizing repair is the ² :			Percentage where repairs on building or infrastructure are made by:			Number of facilities with system for maintenance and repair (weighted)
	In-charge of facility	In-charge of unit	Other ¹	On-site staff	Persons hired from outside	Both on-site staff and externally hired	
Type of facility							
GS hospital	80	15	15	36	38	26	49
Fever hospital	65	9	37	27	51	22	9
MCH/urban HU	66	5	31	5	90	4	46
Rural HU	76	0	30	6	89	5	215
Mobile unit	34	13	53	0	90	5	25
Health office	84	6	16	6	91	3	20
NGO facility	75	9	18	12	85	3	52
Region							
Urban							
Governorates	94	8	5	9	83	9	51
Lower Egypt	76	6	23	8	82	10	211
Upper Egypt	62	2	42	14	82	4	156
Total	73	5	28	10	82	7	418

Background characteristics	Percentage of facilities routinely storing vaccines with:					Number of facilities storing vaccines (weighted)	Percentage of facilities where vaccines observed with:			Number of facilities storing vaccines where vaccines were observed (weighted)
	Functioning thermometer in refrigerator	Temperature chart up-to-date	Temperature 0-8°C at time of survey	Adequate cold chain monitoring system	Refrigerator protected from sun		No expired vaccines present	Vaccines stored by expiration date	Inventory up-to-date	
Type of facility¹										
GS hospital	98	84	82	71	93	27	100	46	56	27
MCH/urban HU	96	92	86	83	96	53	98	73	84	53
Rural HU	99	89	83	76	97	278	97	47	66	273
Health office	98	94	96	94	94	29	96	63	78	29
NGO facility	0	0	0	0	90	6	100	77	77	6
Region										
Urban Governorates	97	98	94	94	95	35	100	71	98	35
Lower Egypt	94	88	80	76	98	184	97	59	68	178
Upper Egypt	99	86	83	74	94	175	97	41	63	173
Total	97	88	83	76	96	395	97	52	69	386

Table A-3.16 Storage conditions and stock monitoring systems for contraceptive methods and for medicines

Among facilities that store clinical methods of contraception and facilities that store medicines, percentage in which good storage conditions were observed, percentage in which no expired items were observed, percentage in which items were stored by expiration date, and percentage with up-to-date inventory, by type of facility and region, Egypt SPA 2002

Background characteristics	Among facilities that store commodities, percentage with:							
	Proper storage condition			Number of facilities where storage area was observed (weighted)	Proper stock monitoring systems ¹			Number of facilities with observed commodities (weighted)
	Off the ground and protected from water	Protected from sun	No evidence of pests or rodents		No expired items present	Stored by expiration date	Inventory up to date	
CONTRACEPTIVE METHODS (CLINICAL)²								
Type of facility³								
GS hospital	93	99	90	63	99	44	70	62
MCH/urban HU	96	100	95	64	96	58	87	64
Rural HU	95	98	84	357	96	39	79	355
Mobile unit	98	100	98	38	100	37	82	38
Health office	100	100	93	27	95	54	86	27
NGO facility	94	96	90	63	94	43	72	58
Region								
Urban Governorates	93	97	95	61	98	51	96	61
Lower Egypt	94	99	91	300	97	51	76	299
Upper Egypt	97	98	82	251	95	30	78	244
Total	95	99	88	612	96	42	79	604
MEDICINES⁴								
Type of facility								
GS hospital	75	90	85	63	94	62	59	61
Fever hospital	71	94	81	13	87	58	68	13
MCH/urban HU	85	95	88	64	97	57	77	62
Rural HU	77	93	73	353	96	53	74	334
Mobile unit	96	100	96	16	100	33	45	6
Health office	90	100	90	7	100	50	100	2
NGO facility	100	100	100	5	87	100	72	5
Region								
Urban Governorates	92	100	96	41	95	75	90	36
Lower Egypt	81	96	86	263	93	67	74	240
Upper Egypt	74	88	64	218	98	38	68	206
Total	79	93	78	522	96	55	72	482
<p>¹ Only selected items were evaluated for the stock maintenance system. Contraceptives items assessed were oral pills, injectable progesterone, and condoms. Medicines assessed were antibiotics and Ringers lactate intravenous solution. Eight facilities did not have any of the contraceptive items, and 40 facilities did not have any of the medicines that were evaluated for the stock maintenance system.</p> <p>² The storage area for contraceptive methods was not observed for eleven facilities that store contraceptives. One facility that offers clinical methods of family planning does not store contraceptive methods.</p> <p>³ Fever hospitals do not provide family planning services.</p> <p>⁴ Twenty percent of facilities (weighted N=128) either stored no medicines or access to the storage area was not possible the day of the survey. This situation was found primarily at mobile units (57 percent), health offices (79 percent), and NGO facilities (93 percent). In addition, there was no access to the medicine storage area at 1 percent of general service hospitals, 2 percent of MCH/urban HUs and 4 percent of rural HUs.</p>								

Table A-3.17 Reported reliability of ordering system for commodities where order is placed by facility

Among facilities that provide vaccinations, contraceptive methods, or medicines, percentage in which decisions on when to order the commodity are made by facility staff, percentage of facilities reporting that their supplies were very reliable, sometimes reliable, or rarely reliable during the prior 3 months, and percentage that received their most recent supply during the past 4 weeks, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities providing commodity in which:					Number of facilities that determine commodity order (weighted)	Number of eligible facilities (weighted)
	Commodity order determined by facility	Receipt of ordered commodity considered:			Most recent order received during past 4 weeks		
		Very reliable	Sometimes reliable	Rarely reliable			
VACCINES							
Type of facility¹							
GS hospital	93	85	15	0	100	32	33
MCH/urban HU	95	95	5	0	90	57	52
Rural HU	92	89	11	0	98	334	349
Health office	98	94	6	0	96	31	32
NGO facility	78				55	8	10
Region							
Urban Governorates	98	98	2	0	97	37	38
Lower Egypt	95	93	7	0	94	236	250
Upper Egypt	90	83	17	0	95	188	210
Total	93	89	11	0	95	462	498
CONTRACEPTIVE METHODS²							
Type of facility¹							
GS hospital	97	84	16	0	92	61	63
MCH/urban HU	98	80	19	0	92	63	64
Rural HU	94	86	14	0	90	34	367
Mobile unit	96	83	17	0	92	36	38
Health office	91	85	15	0	92	26	28
NGO facility	88	85	12	1	72	57	63
Region							
Urban Governorates	99	79	19	1	90	61	61
Lower Egypt	93	91	9	0	91	284	306
Upper Egypt	94	79	21	0	86	241	256
Total⁴	94	85	15	0	89	587	623
MEDICINES³							
Type of facility							
GS hospital	75	46	52	2	85	47	63
Fever hospital	85	36	64	0	100	11	13
MCH/urban HU	72	43	53	4	79	47	64
Rural HU	70	37	60	2	74	245	353
Mobile unit	47	51	38	13	75	9	16
Health office	33	0	67	0	50	4	7
NGO facility	83	80	20	0	60	5	5
Region							
Urban Governorates	85	40	57	3	80	35	41
Lower Egypt	67	58	36	4	79	177	263
Upper Egypt	71	19	81	0	73	154	218
Total⁴	70	40	57	2	76	366	522

¹ Fever hospitals do not provide child immunizations and do not provide family planning services.

² One NGO facility does not have own stock of contraceptive methods.

³ Twenty percent of facilities (weighted N=128) either stored no medicines or access to the storage area was not possible the day of the survey. This situation was found primarily at mobile units (57 percent), health offices (79 percent) and NGO facilities (93 percent), as well as at small percentages of general service hospitals (1 percent), MCH/urban HUs (2 percent), and rural HUs (4 percent).

⁴ The respondents at one percent of facilities did not know about the reliability of the contraceptive supply and at 1 percent did not know about the reliability of the medicine supply.

Table A-3.18 Perceived reliability of ordering system for commodities where order is placed by authority external to facility

Among facilities that provide vaccinations, contraceptive methods, or medicines, percentages in which decisions on when to order the commodity are made external to the facility, and percentage of facilities reporting that the externally ordered supply is very reliable, sometimes reliable, or rarely reliable, by type of facility and region, Egypt SPA 2002

Region	Percentage of facilities providing commodity			Number of facilities where commodity order is determined external to facility (weighted)	Number of eligible facilities (weighted)	
	With order determined external to facility	Reporting reliability of receiving ordered stock during the 3 months preceding the ESPA as				
		Very reliable	Sometimes reliable			Rarely reliable
VACCINES						
Urban Governorates	2	100	0	1	38	
Lower Egypt	5	71	17	12	250	
Upper Egypt	10	88	12	0	210	
Total	7	83	13	4	498	
CONTRACEPTIVES						
Urban Governorates	24	76	0	1	61	
Lower Egypt	90	10	0	20	306	
Upper Egypt	74	22	0	15	256	
Total	82	16	0	36	623	
MEDICINES¹						
Urban Governorates	15	0	67	17	41	
Lower Egypt	33	39	44	10	263	
Upper Egypt	29	32	57	5	218	
Total	30	35	50	8	522	

Note: Numbers were too small to present percentages by type of facility. Respondents at 3 percent of facilities did not know about the reliability of contraceptive supplies and at 7 percent of facilities did not know about the reliability of medicine supplies.

¹ Twenty percent of facilities (weighted N=128) either stored no medicines or access to the storage area was not possible the day of the survey. This situation was found primarily at mobile units (57 percent), health offices (79 percent) and NGO facilities (93 percent), as well as at small percentages of general service hospitals (1 percent), MCH/urban HUs (2 percent), and rural HUs (4 percent).

Table A-3.19 System for ordering vaccines for facilities placing their own order

Among facilities that provide vaccinations and that order their own supply, percentage in which the basis for determining how much to order is to maintain a fixed stock, a fixed amount is ordered each time, the amount needed is calculated based on utilization, the amount needed is estimated, based on utilization, or the basis is not known, and percentages in which orders are allowed to be placed when stock falls to a predetermined level, orders are routinely placed more often than once monthly, every 4 weeks, less often than once a month, whenever needed, or is not known, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities providing vaccinations and ordering own supplies in which:											Number of facilities (weighted)
	Amount ordered based on: ¹					Stock orders placed: ¹						
	Maintaining a fixed stock	Ordering same amount each time	Mathematical formula based on utilization	Judgment based on utilization	Don't know	When stock falls to a predetermined level	Routinely order:			When- ever needed	Don't know	
Type of facility²												
GS hospital	15	0	36	46	2	2	54	19	0	23	2	32
MCH/urban HU	14	3	42	40	1	10	24	32	0	33	2	57
Rural HU	6	1	47	44	2	4	45	30	1	19	1	334
Health office	14	4	40	41	2	10	24	39	0	24	4	31
NGO facility	19	9	18	54	0	0	0	28	19	53	0	8
Region												
Urban												
Governorates	23	2	28	47	0	5	18	45	0	32	0	37
Lower Egypt	9	2	53	33	2	5	52	30	1	11	2	236
Upper Egypt	5	1	37	55	1	4	31	27	2	34	1	188
Total	9	2	45	43	1	5	41	30	1	22	1	462

¹ Multiple responses might apply.

² Fever hospitals do not provide child immunization services.

Table A-3.20 System for ordering contraceptive methods and medicines for facilities placing their own orders

Among facilities that provide contraceptive methods, and among facilities that store medicines, that order their own supply, percentage in which the basis for deciding how much to order and the basis for deciding when to place an order, is that indicated in the table, or is not known, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities providing vaccinations and ordering own supplies in which:												Number of facilities (weighted)
	Amount ordered based on: ¹						Stock orders placed: ¹						
	Maintaining a fixed stock	Calculate			Determine amount using judgment based on utilization	Don't know	Routinely order:				When-ever needed	Don't know	
		Ordering same amount each time	mathematical formula based on	amount using			More often than once monthly	Every 4 weeks	Less often than once monthly				
CONTRACEPTIVES													
Type of facility²													
GS hospital	51	2	35	11	2	13	0	57	2	26	1	61	
MCH/urban HU	49	0	40	10	2	12	5	54	3	24	2	63	
Rural HU	53	1	33	13	0	15	1	47	4	32	0	34	
Mobile unit	44	0	43	11	3	9	0	61	4	24	2	36	
Health office	58	4	15	19	4	10	3	52	0	35	0	26	
NGO facility	28	5	18	44	4	12	4	41	5	39	0	57	
Region													
Urban													
Governorates	41	2	18	38	2	9	3	50	6	33	0	61	
Lower Egypt	62	0	27	11	0	15	1	59	3	22	0	284	
Upper Egypt	38	3	42	16	1	13	2	38	4	42	1	241	
Total	50	2	32	16	1	14	2	50	4	31	0	587	
MEDICINES													
Type of facility													
GS hospital	11	6	21	57	4	8	26	36	8	22	1	47	
Fever hospital	9	11	11	70	4	13	23	23	4	30	8	11	
MCH/urban HU	11	4	32	51	0	8	6	39	17	29	0	47	
Rural HU	4	5	22	67	2	3	0	52	22	21	2	245	
Mobile unit	0	0	38	63	2	17	0	50	34	0	0	9	
Health office	33	0	33	33	0	0	0	0	0	100	0	4	
NGO facility	25	0	50	25	0	15	0	13	0	71	0	5	
Region													
Urban													
Governorates	8	3	33	50	6	2	5	30	7	51	5	35	
Lower Egypt	6	7	35	49	2	6	4	60	9	19	1	177	
Upper Egypt	5	3	9	82	1	3	6	35	32	22	1	154	
Total	6	5	24	63	2	5	5	47	18	23	2	366	

¹ Multiple responses might apply.

² Fever hospitals do not provide family planning services.

Table A-3.21 System for ordering commodities where order is placed by authorities external to facility				
Among facilities providing commodities where stock orders are placed by authorities external to the facility, percentage in which the basis for determining the amount ordered is activity level, a fixed supply is provided, or the basis for deciding how much to order is not known, by type of facility and region, Egypt SPA 2002				
Region	Percentage of facilities in which amount provided based on:			Number of facilities where decision for how much to order is made external to facility (weighted) ¹
	Activity level	Fixed supply	Don't know	
VACCINES				
Urban Governorates	100	0	0	1
Lower Egypt	83	11	6	12
Upper Egypt	78	22	0	22
Total	80	18	2	34
CONTRACEPTIVES				
Urban Governorates	100	0	0	1
Lower Egypt	86	7	7	20
Upper Egypt	91	4	4	15
Total	89	6	6	36
MEDICINES				
Urban Governorates	20	0	80	6
Lower Egypt	48	33	18	86
Upper Egypt	42	16	42	64
Total	45	25	30	156

¹ Fever hospitals do not provide child immunizations and do not provide family planning services.

Table A-3.22 Knowledge and capacity for autoclave processing of equipment		
Among facilities with a functioning autoclave machine, percentage where the informant provided the indicated answer concerning processing temperature and pressure used for autoclaving, Egypt SPA 2002		
Items	Percentage of facilities providing indicated response	Number of facilities with functioning autoclave equipment (weighted)
Temperature		
Reasonable ¹	41	87
High ²	13	27
Don't know/invalid	46	96
Pressure		
Reasonable ³	15	32
High ⁴	35	73
Don't know/invalid	50	106
Temperature and Pressure		
Both reasonable	8	16
Both valid, but one value high	33	70
Don't know/invalid response for temperature or pressure	59	124
Total	100	210

¹ Autoclave had automatic temperature control, or response was 120 to 130°C.
² Response was more than 130°C but was less than 361°C (high cutoff point was selected to include any response that appeared valid).
³ Either automatic machine (one facility) or response was PPI of 15 or ATM of 1 or 2.
⁴ Response was PPI more than 15 and less than 61, or ATM more than 2 and less than 8 (high cutoff points were selected to include any response that appeared valid).

Table A-3.23 Storage conditions for sterilized or high-level disinfected items

Percentage of facilities with sterilized or disinfected instruments present and, among facilities where sterilized items are present, percentage with specific storage conditions for processed items, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with sterilized or disinfected items present	Number of facilities (weighted)	Among facilities with sterilized items present, percentage in which items stored in indicated manner:				Number of facilities with stored processed items (weighted)
			Sterile/HL D status storage conditions ¹	Clean, but not sterile, storage conditions ²	Processing dates observed on processed and stored items	Sterile/HLD status storage conditions and processing dates on sterilized items	
Type of facility							
GS hospital	94	64	50	71	23	21	60
Fever hospital	20	13	31	61	38	31	3
MCH/urban HU	88	65	30	84	15	11	57
Rural HU	85	367	17	66	6	3	313
Mobile unit	95	38	4	89	0	0	36
Health office	79	32	7	61	5	2	25
NGO facility	86	71	41	45	14	14	61
Region							
Urban Governorates	96	65	31	78	20	16	63
Lower Egypt	81	315	30	61	12	8	256
Upper Egypt	87	270	14	71	5	4	236
Total	85	650	23	67	10	7	555

¹ Items are wrapped and sealed with time-steam-temperature (TST) or are in a sterile/HLD box that clasps shut.
² Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer or autoclave, or sitting in disinfecting solution.

Table A-3.24 Specific items for infection control that were available in all relevant service areas¹

Percentage of facilities where the indicated infection control items were either observed or reported available when the service being assessed was not being offered at the time of the survey in each of the service delivery areas assessed for that facility, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:						Number of facilities (weighted)
	Soap and towel	Water	Sharps box	Disinfectant	Clean latex or sterile gloves	Waste receptacle ²	
Type of facility							
GS hospital	6	53	26	57	45	5	64
Fever hospital	8	47	28	11	8	8	13
MCH/urban HU	10	49	51	59	34	16	65
Rural HU	7	62	55	63	38	6	367
Mobile unit	48	77	47	93	48	23	38
Health office	17	65	71	78	48	17	32
NGO facility	51	77	29	72	46	31	71
Region							
Urban Governorates	35	82	63	79	55	41	65
Lower Egypt	13	58	45	67	46	9	315
Upper Egypt	13	61	48	58	28	7	270
Total	15	62	48	65	39	11	650

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. For antenatal care services this added 5 percent for soap. Relevant services and items were: Immunization area—soap, water, sharps box; Injection room: soap, water, sharps box; consultation area for sick children: soap, water; and consultation/examination area for 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 the MoH maternity standards, this is not an item that has been commonly introduced.

Table A-3.25 Waste disposal methods for hazardous materials

Percentage of facilities that dispose of hazardous materials through specific methods, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities in which hazardous materials:							Number of facilities (weighted)
	Collected and disposed of by external party	Burned in incinerator	Burned and buried	Burned in open pit	Burned but not buried	Thrown in open pit	Thrown in pit latrine	
Type of facility								
GS hospital	39	43	7	7	4	1	0	64
Fever hospital	50	29	0	12	9	0	0	13
MCH/urban HU	62	18	6	6	5	2	0	65
Rural HU	24	29	9	20	15	2	1	367
Mobile unit	75	2	5	7	3	7	0	38
Health office	65	18	8	8	2	0	0	32
NGO facility	81	6	4	1	5	2	0	71
Region								
Urban Governorates	91	3	3	2	2	0	0	65
Lower Egypt	32	27	9	12	16	2	0	315
Upper Egypt	39	27	6	19	6	1	1	270
Total	41	25	7	14	10	2	0	650

Table A-3.26 Infrastructure and infection control for the therapeutic injection by type of facility and region

Among facilities providing curative care for sick children, percentage where therapeutic injections are provided in the same service area as immunizations, in a different location from immunizations, and percentage that either do not provide therapeutic injections, or have no specific location where these are provided, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering sick-child care where therapeutic injection service in site:			Number of facilities assessed for therapeutic injection (weighted)
	With immunization	Not with immunization	No area for therapeutic injections	
Type of facility				
GS hospital	24	51	25	63
Fever hospital	NA	50	50	13
MCH/urban HU	41	38	22	65
Rural HU	61	27	13	365
Mobile unit	6	18	77	17
Health office	80	0	20	5
NGO facility	2	51	47	42
Region				
Urban Governorates	36	24	40	44
Lower Egypt	49	19	32	282
Upper Egypt	46	22	32	244
Total	47	33	20	570

NA = Not applicable

Table A-3.27 Infrastructure and infection control for the therapeutic injection service area by items of infection control

Among facilities offering therapeutic injections, percentage with soap, water, sharps box, and sterile syringes in the service area where the injections are provided, by whether therapeutic injections are provided in the same, or a different service site than immunization services, Egypt SPA 2002

Items	Percentage of facilities offering therapeutic injections:		Total percentage
	With immunization	Not with immunization	
Soap	17	23	20
Water	73	73	73
Sharps box	84	55	72
Syringes 0.5-1 ml	77	20	54
Syringes 2-3 ml	81	45	66
Number of facilities with injection area (weighted)	267	186	453

Table A-3.28 Observed injection practices

Among facilities providing therapeutic or immunization injections, percentage where a new needle and syringe was used, percentage where the providers was observed opening a new syringe/needle packet, percentage where the facility supplied the needle and syringe, and percentage where a sharps box was used after the injection, by type of facility, Egypt SPA 2002

Items	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
New syringe and needle used	97	100	100	98	100	99	100	98
Provider observed opening new syringe/needle packet	99	100	94	94	100	94	100	95
Facility provided new needle and syringe	89	57	95	83	100	100	47	86
Provider disposed of used needle in sharps box	60	71	78	75	86	92	21	73
Number of observed injections (weighted)	115	6	138	511	5	66	26	867

Chapter 4

Table A-4.1 Availability of child health services at the facility

Among facilities offering outpatient care for sick children, routine growth monitoring services, or routine child immunization services, percentage providing the service at the facility, 1 to 2 days per week, 3 to 4 days per week, or 5 or more days per week, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering the service															
	Outpatient care for sick children				Growth monitoring				Child immunization ²				BCG immunization ³			
	Days per week		Number of facilities (weighted) ¹		Days per week		Number of facilities (weighted) ¹		Days per week		Number of facilities (weighted) ¹		Days per week		Number of facilities (weighted) ¹	
	1-2	3-4			5 or more	1-2			3-4	5 or more			1-2	3-4		
Type of facility																
GS hospital	1	0	99	63	59	3	38	28	89	11	0	33	94	4	2	32
Fever hospital	0	0	100	13	0	0	100	1	NA	NA	NA	0	NA	NA	NA	0
MCH/urban HU	0	2	98	65	31	8	61	49	60	14	26	52	92	8	0	46
Rural HU	3	7	90	365	68	6	26	297	87	12	1	352	82	18	0	336
Mobile unit	0	0	100	17	0	0	100	2	100	0	0	1	100	0	0	1
Health office	0	0	100	5	34	9	57	7	38	30	32	26	93	2	5	26
NGO facility	9	11	80	42	0	21	79	3	52	0	48	1	52	0	48	1
Region																
Urban																
Governorates	1	3	96	44	4	6	90	26	14	30	56	35	88	10	2	33
Lower Egypt	4	4	92	282	56	9	35	187	84	14	2	228	83	16	1	213
Upper Egypt	1	7	92	244	76	2	22	176	90	9	1	201	86	14	0	195
Total	2	6	92	570	61	6	33	389	81	14	5	465	84	15	1	441

NA = Not applicable

¹ Number of facilities that provide the service.

² Twenty-four (5 percent) of these facilities do not provide BCG vaccine, but offer all other child immunizations.

³ All but two (<1 percent) facilities provide all immunizations, including BCG.

Table A-4.2 Availability of child health services through village outreach activities

Among all facilities, percentage offering curative care for sick children, percentage offering growth monitoring, and percentage offering child immunization (EPI) services that may or may not include BCG vaccine, and percentage offering EPI services that include BCG vaccine, at least 1 day monthly, through outreach services to villages, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of all facilities offering indicated services through outreach				Number of facilities (weighted)
	Sick child services	Growth monitoring ¹	Child immunization excluding BCG ²	All child immunization including BCG ^{1,3}	
Type of facility					
GS hospital	5	5	11	8	64
Fever hospital	0	0	0	0	13
MCH/urban HU	3	2	9	5	65
Rural HU	4	5	15	8	367
Mobile unit	3	3	0	0	38
Health office	3	3	16	6	32
NGO facility	3	0	0	0	71
Region					
Urban					
Governorates	2	0	5	2	65
Lower Egypt	5	8	11	10	315
Upper Egypt	2	0	12	3	270
Total	4	4	11	6	650

¹ One percent of rural HUs did not offer growth monitoring and BCG vaccine at the facility, but offered them only through outreach services.

² Oral polio vaccine (OPV), diphtheria-pertussis-tetanus (DPT), and measles.

³ OPV, DPT, measles, and BCG vaccines offered.

Table A-4.3 Availability of child vaccines											
Among facilities offering child immunization services and routinely storing vaccines, percentage with the indicated child vaccine observed on the day of the survey, by type of facility and region, Egypt SPA 2002											
Background characteristics	Percentage of facilities offering immunization services and storing vaccines with vaccine observed									Number of facilities offering child immunization services and storing vaccines (weighted)	
	BCG	Polio	DPT	Hep-DPT	Measles	Hepatitis B	MMR	Vitamin A	All basic child vaccines available ¹	All child vaccines plus available ²	
Type of facility³											
GS hospital	83	93	83	63	90	58	85	80	70	65	25
MCH/urban HU	83	96	90	74	97	50	96	87	80	77	48
Rural HU	71	84	68	48	89	54	87	76	59	56	274
Health office	93	93	88	73	95	43	98	93	88	85	26
Region											
Urban											
Governorates	91	100	93	100	100	27	100	95	91	91	33
Lower Egypt	63	80	67	53	86	46	80	71	54	48	174
Upper Egypt	84	90	76	47	93	66	96	84	71	69	166
Total	75	87	73	54	90	53	89	79	65	61	373
¹ BCG, polio, DPT or Hep-DPT, and measles.											
² All basic child vaccines plus Hepatitis B (or Hep-DPT) and measles, mumps, rubella (MMR).											
³ None of the NGO facilities that store vaccines also provide child EPI services themselves.											

Table A-4.4 Specific equipment and supplies for child immunization services										
Among facilities offering childhood immunization services, percentage with specific equipment and supplies, items for infection control, and recordkeeping system components, by type of facility and region, Egypt SPA 2002										
Background characteristics	Percentage of facilities offering child immunization services with:									Number of facilities offering child immunization services (weighted)
	Equipment and supplies			Items for infection control			Administrative practices			
	Blank immunization cards	Adequate supplies of syringes and needles ¹	Cold box with ice pack ²	Soap	Water	Sharps box	Register or tally sheet ³	Monitoring of community coverage ⁴		
Type of facility										
GS hospital	66	72	100	18	73	83	96	87	33	
MCH/urban HU	57	78	100	33	71	88	92	37	52	
Rural HU	80	71	99	14	71	80	93	75	352	
Health office	95	75	100	12	73	91	98	91	26	
Region										
Urban										
Governorates	71	71	98	60	94	94	98	63	35	
Lower Egypt	71	68	98	13	66	80	90	69	228	
Upper Egypt	85	78	100	12	73	80	95	77	201	
Total⁵	77	72	99	17	71	81	93	72	465	
¹ Disposable syringes and needles are universally utilized in Egypt.										
² If a facility reported it purchased ice, this was accepted in place of the ice pack.										
³ Either a register or tally sheet for recording immunizations provided was observed.										
⁴ Either DPT dropout rate or measles coverage were documented.										
⁵ Total percentages include data from one Mobile unit and one NGO facility that provide immunization services.										

Table A-4.5 Availability of specific equipment and supplies for quality assessments of the sick child

Among facilities that provide outpatient care for sick children, percentage with indicated items to support quality of services, to provide preventive services, and to assess the sick child in the service delivery room, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage ³
	GS hospital	Fever Hospital	MCH/urban HU	Rural HU	Mobile Unit	NGO facility	
Items to support quality							
Soap	11	15	26	24	71	48	25
Water	67	54	63	79	88	79	76
Child health cards	34	14	39	48	0	4	40
Treatment protocols/standards (any)	14	8	21	30	0	3	24
Visual aids for health education	18	11	31	32	0	2	26
All items to support quality of care	1	0	4	5	0	0	4
Preventive measures							
Capacity to provide vaccinations ¹	6	0	9	9	0	0	7
Infant weighing scale	65	23	61	65	0	45	60
Child weighing scale	53	16	68	66	0	43	60
Both infant and child weighing scale	37	3	49	50	0	26	44
All preventive measures	3	0	5	7	0	0	6
Equipment for assessment							
Thermometer	77	87	88	87	35	90	84
Minute timer ²	43	40	67	54	38	43	53
Oral rehydration therapy (ORT) administration materials	43	26	62	56	8	17	50
All equipment for assessment	20	8	43	35	4	11	31
All equipment and supplies for preventive measures and for assessment	1	0	1	1	0	0	1
Additional equipment							
Wooden tongue depressor	65	75	74	56	35	81	60
Light for checking throat	18	8	27	31	53	57	31
Height measuring board	46	0	62	71	6	24	61
Number of facilities offering sick child services (weighted) ³	63	13	65	365	17	42	570

¹ Vaccines, equipment, immunization cards, and infection control items all available. Register and monitoring of coverage were not considered essential for providing vaccines for sick children on the day of survey.

² This represents a minute timer that is facility equipment. In addition to these, many staff had personal watches with second hands that could be used to time for 1 minute.

³ Totals include data from five health offices offering sick child services.

Table A-4.6 Availability of IMCI protocols and client educational materials

Among facilities providing outpatient care for sick children, percentage where indicated protocol or client educational aid was available, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering sick child services with:			Number of facilities offering sick child services (weighted)
	IMCI chart booklet	IMCI counseling cards for provider	IMCI mother cards	
Type of facility				
GS hospital	11	12	12	63
Fever hospital	8	8	8	13
MCH/urban HU	15	14	15	65
Rural HU	21	16	19	365
Mobile unit	0	0	0	17
NGO facility	2	2	2	42
Region				
Urban Governorates	18	20	22	44
Lower Egypt	17	14	18	282
Upper Egypt	17	12	12	244
Total ¹	17	14	16	570

¹ Totals include data from five health offices offering sick child services.

Table A-4.7 Availability of services for immunization and outpatient care for sick children on the same day			
Among all facilities offering outpatient care for sick children, percentage offering child immunization (EPI) every day sick child services are offered, and percentage where both sick child and EPI services were both being offered the day of the survey, by type of facility and region, Egypt SPA 2002			
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			
GS hospital ¹	6	13	63
Fever hospital ¹	0	0	13
MCH/urban HU	30	36	65
Rural HU	8	20	365
Mobile unit	0	0	17
NGO facility	1	1	42
Region			
Urban Governorates	36	37	44
Lower Egypt	12	19	282
Upper Egypt	1	15	244
Total ²	9	19	570
¹ Most hospitals do not offer immunization services but may be adjacent to health offices that provide preventive services. Availability of service in adjacent facilities that could be used by sick children seen in hospitals was not assessed.			
² Totals include data from five health offices offering sick child services.			

Table A-4.8 Availability of specific medicines for treatment of the sick child							
Among facilities that provide outpatient care for sick children, percentage where first-line, prereferral, and other essential medications are available, by type of facility, Egypt SPA 2002							
Item	Percentage by type of facility						Total percentage ³
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
First-line oral medicines							
Oral rehydration solution (ORS)	77	82	87	83	15	5	75
Antibiotic: amoxicillin	59	87	72	67	11	6	61
Antibiotic: cotrimoxazole	50	52	40	45	8	3	41
Either antibiotic	75	92	79	77	8	4	62
All first-line oral medicines ¹	59	79	73	70	11	5	62
Pre-referral injectable medicines							
Antibiotic: ampicillin	50	55	27	39	8	3	35
Antibiotic: penicillin	83	81	65	78	11	5	69
Antibiotic: gentamycin	56	55	24	31	4	4	31
Antibiotic: ceftriaxone	22	19	5	3	0	3	6
Intravenous solution with perfusion set	76	77	42	55	0	8	50
All pre-referral medicines ²	53	51	9	26	0	3	25
Other essential medicines							
Aspirin or paracetamol (antipyretic)	83	90	92	88	23	6	79
Vitamin A (any dose)	40	13	51	50	4	3	43
Iron tablet	67	54	52	61	27	3	55
Mebendazole (for deworming)	61	46	53	61	4	3	54
Antibiotic eye ointment	73	34	74	62	11	6	58
All other essential medicines	15	3	12	15	4	0	13
Number of facilities offering sick child services (weighted) ³	63	13	65	365	17	42	570
¹ ORS and at least one antibiotic.							
² At least one first-line injectable antibiotic (ampicillin or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamycin) and intravenous solution (normal saline, Ringers lactate, or dextrose and saline 0.9%) with perfusion set.							
³ Totals include data from five health offices offering sick child services.							

Table A-4.9 Facility utilization statistics for outpatient care for sick children		
Among facilities providing outpatient care for sick children, the median number of sick-child consultations per month, by type of facility and region, Egypt SPA 2002		
Background characteristics	Median monthly number of sick-child consultations ¹	Number of facilities providing consultation data (weighted)
Type of facility		
GS hospital	336	44
Fever hospital	181	9
MCH/urban HU	312	49
Rural HU	67	277
Mobile unit	24	9
Health office	148	3
NGO facility	3	8
Region		
Urban		
Governorates	386	31
Lower Egypt	83	203
Upper Egypt	68	165
Total	81	399
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 the indicated practice for user fees is reported and percentage where the indicated practices exists for publicly posting of fees, by type of facility and region, Egypt SPA 2002									
Background characteristics	Percentage charging for the indicated item				Number of facilities offering sick child services (weighted)	Percentage where fees are posted in public view			Number of facilities having any user fees for sick child services (weighted)
	Fixed fee for health card	Fixed fee for each consult	Charge for medicines and tests	No charges or don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility									
GS hospital	21	91	5	9	63	22	8	70	57
Fever hospital	0	94	3	6	13	10	4	86	12
MCH/urban HU	20	90	4	8	65	27	4	69	59
Rural HU	25	94	1	6	365	16	4	80	344
Mobile unit	0	61	4	35	17	18	0	82	11
NGO facility	0	95	26	3	42	38	3	58	41
Region									
Urban									
Governorates	17	94	17	5	44	53	5	42	41
Lower Egypt	30	90	2	9	282	25	6	69	256
Upper Egypt	11	94	3	5	244	9	2	89	231
Total ¹	21	92	4	7	570	20	4	76	528
¹ Totals include data from five health offices offering sick child services.									

Table A-4.11 Health finance programs in which observed sick children participate

Among observed sick children, the percentage of caretakers reporting participation in health finance programs, and the types of prepay or other finance plans (program) in which the caretaker reported they participate, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage belonging to any program	Number of interviewed caretakers (weighted)	Percentage belonging to indicated health finance program			Number of interviewed caretakers of sick children belonging to program (weighted)
			HIO or SHIP ¹	Prepay at facility for package of services	Discount or exemption status	
Type of facility						
GS hospital	45	360	90	9	0	162
Fever hospital	28	71	77	23	0	20
MCH/Urban	58	305	96	4	0	176
Rural Health	48	1,169	72	27	1	561
Mobile unit	61	18	100	0	0	11
Health office	58	12	100	0	0	7
NGO facility	17	66	100	0	0	11
Region						
Urban Governorates	45	194	100	0	0	87
Lower Egypt	61	989	70	29	1	602
Upper Egypt	32	818	100	0	0	259
Total	47	2,001	81	18	1	948

¹ Health insurance organization or the School Health Insurance Program.

Table A-4.12 Out-of-pocket payments for sick-child consultations

Among interviewed caretakers of sick children, percentage who reported that they are part of a program for prepayment or deferring child health costs (program), and percentage who reported paying any out-of-pocket fees for services for the sick child on the day of the survey and, among the caretakers who paid any fees for services for the sick child, median amount (piasters) paid on the day of the survey, by whether the child belongs to a program or not, by type of facility, Egypt SPA 2002

Type of facility	Percentage of interviewed caretakers of sick children reporting:			Number of interviewed caretakers (weighted)	Median out-of-pocket fee (piasters) paid by caretakers who paid anything for child health services on the day of survey		Number of interviewed caretakers providing valid responses for out-of-pocket payments (weighted)	
	Child belongs to program	Paying out-of-pocket fees for this visit ¹			Belongs to program	Does not belong to program	Belongs to program	Does not belong to program
		Belongs to program	Does not belong to program					
Type of facility								
GS hospital	45	99	100	360	100	100	162	198
Fever hospital	28	100	98	71	104	100	20	51
MCH/urban HU	58	99	99	305	59	100	176	129
Rural HU	48	96	96	1,169	100	100	561	608
Mobile unit	61	82	77	18	100	0	11	7
Health office	58	95	100	12	50	0	7	5
NGO facility	17	99	88	66	100	350	11	55
Total	53	97	97	2,001	100	100	948²	1,054²

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other.

² Numbers do not add to 2,001 due to rounding, when weighted by program status.

Table A-4.13 Supportive management for providers of child health services

Among interviewed child health service providers, percentage who received in-service training related to child health in the past 12 months, percentage of providers who were personally supervised in the past 6 months, percentage who received both in-service training in the past 12 months and personal supervision in the past 6 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed child health service providers who:				Number of interviewed child health service providers (weighted) ²
	Received in-service training during the past 12 months ¹	Were personally supervised in past 6 months	Both received in-service training during the past 12 months and was personally supervised during the past 6 months	Most recent in-service training was 13-59 months preceding survey	
Type of facility					
GS hospital	16	84	14	37	293
Fever hospital	15	78	12	44	44
MCH/urban HU	21	93	19	39	252
Rural HU	25	94	24	29	990
Mobile unit	11	96	11	23	24
Health office	19	92	19	31	68
NGO facility	10	46	6	30	60
Region					
Urban Governorates	27	86	26	38	119
Lower Egypt	17	90	17	32	908
Upper Egypt	26	90	24	32	704
Total	21	90	20	32	1,731

¹ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
² Includes providers from facilities offering immunization or growth monitoring or curative care for sick children.

Table A-4.14 In-service training for child health service providers

Among interviewed child health service providers, percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of child health service providers who received in-service training on specific topics														Number of interviewed child health service providers (weighted)
	EPI/Cold chain		ARI ¹ treatment		Diarrhea treatment		Nutrition/micronutrient deficiencies		PMTCT ²		IMCI ³		Genetic/hereditary illnesses		
	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	
Type of facility															
GS hospital	3	9	4	27	4	22	7	20	1	4	8	6	0	3	293
Fever hospital	3	7	4	24	3	23	3	10	7	14	6	10	2	1	44
MCH/urban HU	6	15	5	23	5	22	7	26	3	7	7	9	3	5	252
Rural HU	8	15	7	15	7	18	10	18	3	8	11	10	1	4	990
Mobile unit	8	4	2	14	2	21	4	17	4	9	0	8	0	7	24
Health office	9	13	2	9	2	18	7	15	1	9	3	11	3	2	68
NGO facility	0	14	2	18	5	16	5	23	4	9	3	9	2	4	60
Region															
Urban															
Governorates	8	12	7	25	9	22	11	27	5	16	8	11	5	7	119
Lower Egypt	5	14	4	15	5	19	7	16	2	7	6	11	1	4	908
Upper Egypt	8	13	8	21	6	20	9	22	3	6	13	7	1	3	704
Total	7	13	6	18	6	19	8	19	3	7	9	9	1	4	1,731

¹ Acute respiratory infection.

² Prevention of mother-to-child transmission (of HIV/AIDs).

³ Integrated management of childhood illness.

Table A-4.15 Supportive supervision for child health service providers

Among interviewed child health service providers, percentage who were personally supervised in the past 6 months, and among those who received such a supervisory visit, median number of times staff were supervised, and percentage who reported specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2002

Background characteristics	Median number of times staff were supervised in past 6 months	Number of interviewed child health service providers (weighted)	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)
			Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Wrote note on unit record	
Type of facility									
GS hospital	8	293	95	93	92	82	79	83	245
Fever hospital	6	44	82	85	77	57	55	67	35
MCH/urban HU	10	252	98	96	89	74	77	88	235
Rural HU	8	990	98	98	96	82	85	86	928
Mobile unit	5	24	100	96	93	81	83	94	23
Health office	17	68	100	99	97	80	79	87	63
NGO facility	3	60	84	82	84	57	73	65	27
Region									
Urban									
Governorates	17	119	95	94	90	71	70	93	103
Lower Egypt	9	908	98	96	94	82	84	94	818
Upper Egypt	8	704	96	96	93	78	81	73	635
Total	9	1,731	97	96	93	80	82	85	1,557

Table A-4.16 Observed assessments, examinations, and treatments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2002

Consultation components	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Consultations conducted by physicians	99	98	100	100	100	100	100	100
History: assessment of danger signs								
Inability to eat or drink anything	12	8	14	16	15	30	27	15
Vomiting everything	38	48	32	39	15	20	40	38
Convulsions	5	6	5	14	0	14	5	10
All danger signs	2	0	1	6	0	5	2	4
History: assessment of symptoms								
Cough or difficult breathing	64	63	66	62	48	55	64	63
Diarrhea	51	63	41	55	37	40	55	52
Fever	76	88	74	76	59	65	67	75
All three key symptoms ¹	23	31	23	32	11	15	30	28
Ear pain or discharge	6	7	11	20	0	5	10	15
Throat problems	13	17	19	21	15	30	17	19
All major symptoms ²	1	1	2	5	0	0	2	4
Physical examination								
Felt temperature	25	32	26	31	33	61	34	29
Measured temperature (observed or system)	44	57	60	60	11	84	57	56
Any temperature	57	71	70	71	40	90	73	68
Assessed anemia: Looked at palms	3	4	5	9	4	9	4	7
Assessed anemia: Looked at eye conjunctiva or mucosa of mouth	3	6	5	11	4	30	6	9
Any assessment of anemia	5	8	7	15	4	30	6	11
Assessed dehydration	14	18	12	20	22	40	18	18
Counted respiratory rate per minute	7	12	12	17	0	38	8	14
All key physical checks ³	0	1	1	2	0	0	3	2
Checked throat (tongue depressor no light)	52	67	50	36	15	64	41	42
Checked throat (tongue depressor and light)	1	1	3	13	8	5	17	9
Any check of throat with tongue depressor	53	69	53	48	22	69	58	51
Looked in ear and feel behind ear	8	8	10	10	4	20	7	10
Checked for pedal edema (press both feet)	1	1	1	4	4	5	0	2
Remove clothing and observe musculature	4	7	7	8	4	15	3	7
All physical checks ⁴	0	0	0	0	0	0	0	0
Drinking/feeding practices during illness for children <24 months (N=892)								
Breastfeeding practices	14	14	18	18	7	49	34	18
Observed if child can drink or suck	2	3	1	4	0	0	0	3
Both assessments of drinking/feeding status	1	1	1	2	0	0	0	1
Essential advice								
Increase fluids	14	15	21	19	26	43	23	19
Continue/increase feeding	13	11	17	14	19	43	28	15
Symptoms for immediate return	5	5	5	12	8	33	11	10
All three essential messages	2	1	2	4	0	33	6	3
Number of observed children <24 months old (weighted)	205	37	191	665	11	9	37	1,154
Number of observed children (weighted)	365	71	307	1,173	18	12	66	2,013

¹ Assessed cough, diarrhea, fever.

² Assessed cough, diarrhea, fever, ear symptoms and throat symptoms.

³ Counted respiratory rate, assessed presence of fever (either measured or by touch), and assessed presence of anemia (either palms or mucosa).

⁴ Counted respiratory rate, assessed presence of fever (either measured or by touch), assessed presence of anemia (either palms or mucosa), checked throat (either with or without light), checked ear, checked feet (pedal edema), and checked musculature.

Status	Pneumonia or other severe respiratory illness		Bronchitis		Other respiratory illness	
	Percentage receiving bronchodilator	Number with diagnosis (weighted)	Percentage receiving bronchodilator	Number with diagnosis (weighted)	Percentage receiving bronchodilator	Number with diagnosis (weighted)
Wheezing	47	63	39	180	15	31
No wheezing	21	65	21	165	4	428
Total	34	128	31	345	5	459

Topic discussed	Percentage by type of facility							
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	Total percentage
Observed during consultation								
Caretaker was told about medicines	55	54	66	63	67	83	85	63
Caretaker was asked to repeat instructions	2	2	3	4	0	9	3	3
Child received first dose of any medicine at facility	1	0	1	1	0	0	0	1
Antibiotic was prescribed	53	64	47	50	53	27	54	51
Number of observed sick children who received medicines (weighted)	350	65	293	1,046	16	11	63	1,845
Observed during exit interview								
Caretaker has all medicines	16	36	20	41	12	17	0	31
Caretaker has some medicines and some prescriptions	25	41	24	20	12	11	10	22
Caretaker has only prescriptions	58	23	56	39	76	72	90	47
Child was prescribed an injectable medicine	20	22	10	15	8	6	15	16
Reported by caretaker								
Was told how to give the medicine at home	58	67	70	76	80	72	88	72
Feels comfortable in knowledge of how to provide medicine at home	59	65	74	77	76	77	90	73
Child was provided a dose of the medicine at the facility	2	4	3	3	0	0	1	3
Child received injection at the facility	4	7	2	5	4	0	0	4
Number of interviewed caretakers of sick children who received prescription, medicine, or both (weighted)	349	67	298	1,098	17	11	63	1,904

Table A-4.19 Observed preventive assessments for sick children								
Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2002.								
Items	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Preventive measures								
Child weighed	41	15	54	42	8	54	35	42
Weight plotted	8	10	31	22	8	41	7	20
Normal feeding assessed (<24 months)	22	11	26	27	25	49	44	26
Normal feeding assessed (≥24 months)	8	4	9	10	9	19	11	9
Any age normal feeding practices assessed	16	7	20	20	18	43	30	19
Immunization status assessed (<24 months)	7	8	16	17	7	70	2	15
Immunization status assessed (≥24 months)	3	1	3	10	0	19	0	7
Any age immunization status assessed	10	9	34	27	8	69	6	24
Number of observed children <24 months old (weighted)	205	37	191	665	11	9	37	1,154
Number of observed children ≥24 months old (weighted)	154	34	112	496	7	3	29	836
Number of observed children (weighted)	365	71	307	1,173	18	12	66	2,013

Table A-4.20 Reported information from interview of caretaker of observed child								
Percentage of interviewed caretakers of observed children who, when asked, reported that a provider discussed the indicated items, by type of facility, Egypt SPA 2002								
Items	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Weight or nutritional status of the child	14	4	19	20	4	36	18	18
General feeding practices	11	10	12	16	7	30	22	15
Give food and liquid during the illness	13	17	19	17	15	41	40	17
Was told what the illness was	58	54	64	58	70	42	86	60
Caretaker brought immunization card to facility this visit	10	0	27	16	4	62	4	16
Caretaker reports child < 24 months received immunization	5	2	5	6	0	22	0	5
Caretaker reports child ≥ 24 months received immunization	0	0	0	0	0	0	0	0
Number of caretakers of children < 24 months (weighted)	205	37	191	665	11	9	37	1,154
Number of caretakers of children ≥ 24 months (weighted)	155	34	114	503	7	3	29	847
Number of interviewed caretakers (weighted)	360	71	305	1,169	18	12	66	2,001

Table A-4.21 Client feedback during exit interview

Percentage of interviewed caretakers of observed children who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2002

Client service issue	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Behavior/attitude of provider	4	5	4	2	4	11	3	3
Insufficient explanation about child's illness	16	20	14	12	22	16	3	13
Waiting time to see provider	17	17	20	11	4	16	9	13
Quality of examination or treatment	9	8	8	7	15	16	0	7
Availability of medicines or supplies	25	17	23	16	26	22	12	19
Hours facility is open	2	1	4	4	4	0	7	4
Cleanliness of facility	2	1	3	2	0	11	2	2
Cost of services	2	3	1	1	0	0	1	1
Insufficient visual privacy	3	4	7	2	4	5	1	3
Insufficient auditory privacy	3	4	7	2	4	5	1	3
Time required to complete all steps in the consultation	6	9	7	4	0	16	1	5
Time it took to receive laboratory results	2	0	0	0	0	0	0	0
Number of interviewed caretakers (weighted)	360	71	305	1,169	18	12	66	2,001

Table A-4.22 Reasons caretakers of observed sick child consultations chose this facility for services

Among interviewed caretakers of observed sick children, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of caretakers of observed sick children agreeing item was a factor in choosing facility							Number of interviewed caretakers (weighted)
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well treated	Facility is nearby	Facility has good reputation	
Type of facility								
GS hospital	0	25	6	20	11	55	14	360
Fever hospital	1	32	3	37	21	36	22	71
MCH/urban HU	1	29	6	18	17	51	15	305
Rural HU	2	28	1	17	28	65	21	1,169
Mobile unit	22	34	0	11	41	56	27	18
Health office	0	26	0	30	22	47	5	12
NGO facility	5	48	4	12	26	47	16	66
Region								
Urban Governorates	2	31	5	23	11	63	14	194
Lower Egypt	2	31	3	17	23	56	23	989
Upper Egypt	2	24	2	18	26	62	15	818
Total	2	28	3	18	23	59	19	2,001

A-4.23 Personal characteristics of caretakers of observed sick children by employment status

Among caretakers of sick children whose consultation was observed and who were interviewed, percent distribution by employment status, and among employed caretakers of sick children, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2002

Background characteristics	Among employed caretakers of sick children, percentage who:										Number of interviewed caretakers who are employed (weighted)
	Among all caretakers of sick children, percentage who are:		Number of inter-viewed caretakers (weighted)	Work for:			Receive:				
	Employed	Not employed		Family member	Some-one else	Self	Salary in cash	Salary in kind	Salary both in cash and in kind	No salary	
Type of facility											
GS hospital	13	87	360	7	65	28	93	0	1	6	46
Fever hospital	19	81	71	6	69	25	88	0	6	6	13
MCH/urban HU	14	86	305	7	71	23	93	0	0	7	41
Rural HU	16	84	1,169	19	57	25	66	1	14	19	186
Mobile unit	11	89	18	32	68	0	68	0	0	32	2
Health office	16	84	12	0	67	33	100	0	0	0	2
NGO facility	15	85	66	0	100	0	100	0	0	0	10
Region											
Urban Governorates	14	86	194	4	73	23	96	0	0	4	27
Lower Egypt	19	81	989	13	63	24	77	1	8	14	187
Upper Egypt	10	90	818	19	57	24	69	0	15	16	86
Total	15	85	2,001	14	62	24	76	1	9	14	300

A-4.24 Personal characteristics of caretakers of observed sick children by education

Among interviewed caretakers of observed sick children, percentage indicating their education and literacy status as noted below, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed caretakers who:				Number of interviewed caretakers (weighted)	Percentage of interviewed caretakers with primary or no education who:			Number of interviewed caretakers with no education (weighted)	
	Have no education	Cannot read or write	Can read, cannot write	Can read and write		Cannot read or write	Can read, cannot write			Can read and write
							Can read	Cannot write		
Type of facility										
GS hospital	52	6	9	33	360	77	2	21	210	
Fever hospital	52	7	9	31	71	83	2	15	43	
MCH/urban HU	38	9	9	44	305	72	3	26	142	
Rural HU	55	9	7	29	1,169	76	3	21	753	
Mobile unit	48	19	15	19	18	66	6	28	12	
Health office	26	15	26	32	12	26	0	74	5	
NGO facility	27	7	10	56	66	73	3	24	23	
Region										
Urban Governorates	30	8	12	51	194	59	3	38	73	
Lower Egypt	45	7	6	42	989	76	1	22	513	
Upper Egypt	62	11	9	18	818	78	4	19	601	
Total	51	9	8	33	2,001	76	3	21	1,188	

Chapter 5

Table A-5.1 Offered methods of family planning

Among facilities offering family planning, percentage offering each of the indicated methods of family planning, and percentage offering at least two temporary modern methods of contraception, at least four temporary modern methods of contraception, and offering the four main methods for Egypt, by type of facility, Egypt SPA 2002

Methods offered	Percentage by type of facility						Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Combined oral contraceptives	97	94	93	87	93	75	91
Progesterone-only oral pill	60	56	57	34	57	31	53
Progesterone-only injectable (two or three monthly)	98	97	99	100	100	86	97
Combined injectable (one monthly)	2	2	0	3	0	28	3
Implant	40	16	3	8	7	2	8
Intrauterine device	98	99	98	100	96	95	98
Male condom	97	95	92	97	96	61	90
Spermicide	0	2	0	2	4	2	1
Diaphragm	2	3	1	0	0	2	1
Rhythm method	87	83	78	81	79	64	78
Female sterilization	15	2	1	2	0	5	3
Emergency contraceptive pill	67	60	58	58	62	6	54
At least two of any temporary modern methods ¹	100	100	98	100	100	77	97
At least four of any temporary modern methods ¹	97	95	92	97	96	59	90
All four most common methods offered ²	92	88	86	87	89	50	84
Number of facilities (weighted)	63	64	367	38	28	64	624

¹ Among the following methods: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), implants, intrauterine devices (IUD), condoms (male-female condom is not available), spermicides, diaphragm, or emergency contraceptive. Permanent methods (sterilization) are not included.

² Combined oral contraceptive (COC) pill, progesterone-only injection (PIN), intrauterine device (IUD), and male condom.

Table A-5.2 Availability of offered methods of family planning by type of facility

Among facilities offering the indicated method, percentage where the method was available on the day of the survey, by type of facility, Egypt SPA 2002

Methods	Percentage by type of facility						Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Combined oral contraceptives	96	96	96	95	93	91	95
Progesterone only oral pill	83	73	81	94	65	82	80
Progesterone only injectable (two or three monthly)	98	98	96	98	95	96	96
Combined injectable (one monthly)	100	100	na	na	na	88	100
Implant	64	67	50	57	29	50	50
Intrauterine device	98	98	94	100	98	99	96
Male condom	97	98	92	98	93	93	94
Spermicide	na	50	na	100	50	50	0
Diaphragm	0	33	0	na	na	100	0
Emergency contraceptive pill	83	85	81	95	82	80	83
Each method offered by a facility was available the day of the survey	72	73	71	86	69	85	74
Four most common methods offered and available	93	93	88	91	92	84	90
Number of facilities offering FP (weighted)	63	64	367	38	28	64	624

na = Not applicable

Table A-5.3 Availability of offered methods of family planning by region

Among facilities offering each of the indicated methods of family planning, percentage where the method was available on the day of the survey, by region, Egypt SPA 2002

Methods	Percentage by region		
	Urban Governorates	Lower Egypt	Upper Egypt
Combined oral contraceptives	94	97	94
Progesterone-only oral pill	69	83	81
Progesterone-only injectable (two or three monthly)	98	98	94
Combined injectable (one monthly)	67	92	80
Implant	42	53	65
Intrauterine device	98	97	93
Male condom	98	97	89
Spermicide	50	50	50
Diaphragm	50	0	0
Emergency contraceptive pill	86	82	82
Each method offered by a facility was available the day of the survey	70	75	72
Four most common methods offered and available	89	94	83
Number of facilities offering FP (weighted)	61	306	257

Table A-5.4 Availability of infrastructure, resources, and systems for quality family planning services

Percentage of facilities that offer temporary methods of family planning (FP) where there are items to support quality counseling and items for quality physical examination, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Items to support quality counseling							
Private room (complete privacy)	79	69	78	79	60	78	76
Either private room or screen (visual privacy)	83	82	83	88	82	83	83
No privacy	17	18	17	12	18	16	16
Individual client health cards	87	92	89	89	96	63	87
Written FP protocols or guidelines	52	49	52	25	57	13	46
Written STI protocols or guidelines	12	18	15	9	19	10	15
Visual aids for health education on family planning	98	99	96	96	100	57	93
Visual aids for health education on sexually transmitted infections (STIs)	27	25	28	12	31	11	25
All items to support quality counseling ¹	38	37	41	20	48	11	37
All items to support quality counseling for FP and for STI services and education ²	4	4	8	5	7	3	6
Items for infection control							
Soap	54	66	45	52	45	68	51
Water	96	92	90	78	82	93	90
Clean latex gloves	61	51	48	48	54	49	50
Disinfecting solution	93	93	88	93	89	77	88
Sharps box	68	78	73	48	73	33	67
All items for infection control ³	29	31	18	9	26	17	20
Waste receptacle ⁴	29	37	29	23	32	35	31
All items plus waste receptacle for infection control	10	15	8	4	13	15	10
Items for pelvic examination							
Private room (complete privacy)	83	72	83	84	63	86	81
Either private room or screen (visual privacy)	91	92	90	91	89	91	91
No privacy	9	8	10	9	11	9	9
Examination bed ⁵	100	99	96	100	98	97	97
Examination light ⁶	90	98	86	70	91	95	88
Vaginal speculum	98	97	96	98	100	98	97
All furnishings and equipment for pelvic examination ⁷	73	68	72	56	58	80	71
All items for both infection control and pelvic examination	23	26	15	7	19	15	17
Number of facilities offering FP (weighted)	63	64	367	38	28	64	624
¹ Either private room or visual barrier, individual client health cards, written protocols for FP, and any visual aids for FP.							
² All items to support quality counseling, written STI protocols or 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, and listed in the MoH maternity standards, this is not an item that has been commonly introduced so was not included in the aggregate for infection control.							
⁵ Any bed where a woman can lie down flat.							
⁶ Examination light, flashlight, or other spotlight source.							
⁷ Visual and auditory privacy (private room), examination bed, examination light, and vaginal speculum.							

Table A-5.5 Availability of specific teaching and visual aids

Percentage of facilities that offer temporary methods of family planning (FP) where the indicated teaching tool or visual aid was available, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Visual aids or teaching materials							
About specific methods of family planning	88	87	84	77	85	37	79
About sexually transmitted infections	19	16	20	7	20	4	17
About HIV/AIDS	9	8	6	5	7	5	6
Posters on family planning	73	85	80	52	74	40	74
Poster about hepatitis	0	4	2	2	0	1	2
Samples of different methods	92	91	92	91	94	46	87
Information for client to take home							
On family planning	91	89	89	89	87	35	84
On sexually transmitted infections	37	32	35	30	33	5	32
On HIV/AIDS	25	16	20	18	22	7	19
On hepatitis	1	3	3	2	2	0	2
Service protocols or guidelines							
Any reproductive health guidelines or protocols	52	49	52	25	57	13	46
WHO guidelines for syndromic approach	5	11	7	2	4	4	7
Number of facilities offering FP (weighted)	63	64	367	38	28	64	624

Table A-5.6 Location in facility where equipment for family planning services is processed for reuse

Among facilities offering family planning (FP) services, percentage that process equipment for reuse in the FP service area, in the main facility sterilization area, or another service area, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities where FP service equipment is processed in indicated area ¹		
	FP service area	Main facility area	Other service area ²
Type of facility			
GS hospital	84	15	1
MCH/urban HU	62	38	0
Rural HU	52	47	0
Mobile Health unit	25	75	0
Health office	43	57	0
NGO facility	34	66	0
Region			
Urban Governorates	71	29	0
Lower Egypt	65	34	0
Upper Egypt	33	67	0
Total	53	47	0

¹ Main facility area and FP service area may be one location in small facilities.

² Equipment was reported to be processed in the maternity service area.

Table A-5.7 Level of sterilization/disinfecting capacity available in location where family planning equipment is processed for reuse

Among facilities offering family planning (FP) services, percent distribution by level of processing (sterilization or high-level disinfecting [HLD]) for which the functioning equipment is available and the correct processing procedure (time and temperature) is known for processing FP equipment, and percentage with written guidelines available by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:				Number of facilities offering FP (weighted)
	All conditions for either dry sterilization or autoclave ¹	All conditions for boil, steam, or chemical HLD ²	No equipment or no knowledge of processing time	Written guidelines for sterilization or HLD procedures observed	
Type of facility					
GS hospital	74	16	11	33	63
MCH/urban HU	73	11	16	41	64
Rural HU	57	22	21	34	367
Mobile unit	79	3	18	14	38
Health office	40	25	36	32	28
NGO facility	47	11	42	19	64
Region					
Urban Governorates	73	5	23	45	61
Lower Egypt	58	23	18	35	306
Upper Egypt	58	15	27	24	257
Total	60	18	22	32	624

¹ Dry heat: temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 120 minutes, or automatic; autoclave: Process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.
² Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes.

Table A-5.8 Highest level of sterilization/disinfecting capacity available in family planning service area, for facilities that process equipment for reuse in the FP service area

Among facilities offering family planning (FP) services and processing FP equipment for reuse in the FP service area, percent distribution by the level of processing for which the functioning equipment is available and the correct processing procedure is known, the percentage with written guidelines available, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities processing family planning equipment in FP service area			Percentage of facilities with written guidelines for sterilization or HLD procedures observed	Number of facilities offering FP, with processing equipment in FP service area (weighted)
	Dry heat or autoclave ¹	Boil/steam or chemical ²	None: equipment or knowledge missing		
Type of facility					
GS hospital	71	18	11	35	53
MCH/urban HU	70	13	17	42	39
Rural HU	56	33	11	39	192
Mobile units	78	11	11	14	9
Health office	50	42	8	49	12
NGO facility	55	27	18	19	22
Region					
Urban Governorates	80	7	13	50	43
Lower Egypt	58	34	8	38	200
Upper Egypt	62	21	17	28	85
Total	62	27	11	37	328

¹ Dry heat: temperature at least 170° C and process at least 60 minutes or temperature 160-169° C and process at least 120 minutes, or automatic; autoclave: Process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.
² Boil or steam at least 20 minutes. Includes one facility using chemical processing: chlorine based or glutaraldehyde with soaking at least 20 minutes.

Table A-5.9 Details for storing processed equipment in family planning service area					
Among facilities offering family planning (FP) services and having sterile/high-level disinfected (HLD) equipment stored in the FP service area, percentage where the indicated conditions were observed, by type of facility and region, Egypt SPA 2002					
Background characteristics	Percentage of facilities with:				Number of facilities offering FP services with sterile/HLD items in FP service area ³ (weighted)
	Sterile storage conditions ¹	Clean storage conditions ²	Processing date indicated on stored items	Sterile storage and processing date	
Type of facility					
GS hospital	12	82	7	6	53
MCH/urban HU	11	91	8	2	39
Rural HU	7	75	5	0	186
Mobile	8	77	0	0	9
Health office	6	75	0	0	10
NGO facility	34	65	15	15	18
Region					
Urban Governorates	15	92	20	8	37
Lower Egypt	10	71	4	1	194
Upper Egypt	7	87	5	2	84
Total	10	78	6	2	314
¹ Items are wrapped and sealed with time-steam-temperature (TST) sensitive tape, or are in a sterile/HLD box that clasps shut.					
² Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer or autoclave, or sitting in disinfecting solution.					
³ Most facilities had no equipment stored in the FP service area.					

Table A-5.10 Availability of medicines for treating sexually transmitted infections							
Among facilities offering family planning (FP), percentage where the indicated medicine is available, and percentage with at least one treatment for each of the four sexually transmitted infections (STIs), by type of facility, Egypt SPA 2002							
Medicine (illness treated)	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Metronidazole (trichomoniasis)	72	77	73	30	17	5	61
Ceftriaxone (gonorrhea)	22	5	3	0	2	2	5
Ciprofloxacin (gonorrhea)	8	2	4	7	2	2	4
Doxycycline (chlamydia, syphilis)	4	4	11	2	4	2	8
Tetracycline (chlamydia, syphilis)	57	39	52	5	2	1	41
Erythromycin (chlamydia, syphilis)	14	18	15	2	4	3	13
Benzathine or Procaine Penicillin (syphilis)	83	64	78	5	4	3	62
At least one medicines for each indicated STI ¹	19	3	4	0	2	2	5
Nystatin suppository (candidiasis)	8	8	5	2	2	0	5
Number of facilities offering FP (weighted)	63	64	367	38	28	64	624
¹ At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis.							

Table A-5.11 Availability of equipment and infrastructure for providing specific methods of contraception

Among facilities offering contraceptive methods containing estrogen, injectable methods, intrauterine devices (IUDs), or implants, percentage having the required equipment and infrastructure to provide the method safely, by type of facility, Egypt SPA 2002

Type of facility	Estrogen containing method		Number of facilities offering method with estrogen (weighted)	Injectables Percentage with sterile needle and syringe ²	Number of facilities offering injectable method (weighted)	IUD		Implants				
	Percentage with blood pressure apparatus ¹	Percentage with adult weight scale				Percentage with items for IUD insertion ³	Percentage with all items for IUD and all quality conditions for pelvic examination ⁴	Number of facilities offering IUD (weighted)	Percentage with items for implant insertion ⁵	Percentage with items for implant insertion plus ⁶	Percentage with all equipment, items for infection control, and infrastructure for implant insertion ⁷	Number of facilities offering implants (weighted)
GS hospital	93	76	61	91	62	57	20	63	38	38	24	25
MCH/urban HU	96	88	62	93	62	50	21	64	19	12	7	10
Rural HU	84	79	349	88	363	35	10	360	0	0	0	9
Mobile unit	98	35	36	95	38	32	6	38	0	0	0	3
Health office	95	68	27	93	28	46	17	27	0	0	0	2
NGO facility	97	78	48	86	55	35	14	62	50	50	50	1
Total	89	76	584	89	608	39	13	612	24	23	14	50

¹ Stethoscope and sphygmomanometer.

² Progesterone injectable supplied through the MoHP comes with an individual needle and syringe so this may reflect facilities where a stock of the injectable method was not available the day of the survey (4 percent of facilities). It is uncertain why the remaining 4 percent of facilities were reported as not having needles and syringes. This may be an error in data collection or may be that needles and syringes are occasionally borrowed from the progesterone injectable packet.

³ Clean latex gloves, iodine antiseptic, speculum, forceps for holding gauze to clean cervix, tenacula and uterine sound (or IUD kit that includes a tenacula and uterine sound).

⁴ Equipment for IUD insertion, all infection control items (soap, water, clean latex gloves, disinfecting solution, and sharps box) and visual privacy, an examination bed and an examination light.

⁵ Forceps for grasping Norplant, local anesthetic (Xylocaine), scalpel with blade, sterile needle and syringe, sterile gloves and antiseptic for cleaning skin.

⁶ Equipment for implant, including at least two mosquito forceps.

⁷ Equipment for implant, all infection control items (soap, water, disinfecting solution, and sharps box) and visual privacy, examination bed, and examination light.

Table A-5.12 Availability of specific items for intrauterine device

Among facilities that offer the intrauterine device (IUD) percentage that have each of the indicated supplies and pieces of equipment to support insertion and removal of IUD, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	Total percentage
Clean or sterile latex gloves	70	64	52	53	60	53	56
Antiseptic solution	96	93	88	97	84	92	90
Sponge holding forceps	80	76	73	70	66	77	74
Speculum	98	98	96	98	100	99	97
Tenacula	97	97	95	95	98	97	95
Uterine sound	98	98	96	98	100	94	96
Curved scissors	79	80	75	75	89	78	77
Crocodile forceps	65	65	53	48	57	59	56
Handling forceps	88	87	77	70	70	84	79
IUD method available	98	98	94	100	98	99	96
All items for insertion and removal plus method available	37	35	17	13	26	21	22
Number of facilities offering IUD (weighted)	63	64	360	38	27	62	612

Table A-5.13 Availability of specific items for implant	
Among facilities that offer the implant method, percentage that have each of the indicated supplies and pieces of equipment by type of facility, Egypt SPA 2002	
Item	Percentage with item available
Sterile gloves	38
Antiseptic solution	95
Sponge holding forceps	66
Local anesthetic	68
Sterile syringe and needle	69
Canula and trochar for inserting Implant	74
Scalpel with blade	55
Two mosquito forceps	58
Implant method	55
Any forceps	68
Number of facilities offering implants (weighted)	50

Table A-5.14 Facility utilization statistics for family planning clients		
Among facilities providing temporary methods of family planning, the median number of FP consultations per month, by type of facility and region, Egypt SPA 2002		
Background characteristics	Median monthly number of family planning consultations ¹	Number of facilities providing consultation data (weighted)
Type of facility		
GS hospital	126	63
MCH/urban HU	147	63
Rural HU	50	364
Mobile unit	139	36
Health office	91	28
NGO facility	45	50
Region		
Urban Governorates	132	57
Lower Egypt	65	298
Upper Egypt	50	248
Total	61	603
¹ Median value for the average of the number of months out of the past 12 months, for which data were available.		

Table A-5.15 Information on user fees for family planning services

Among facilities offering family planning services (FP), percentage where the indicated practice for user fees is reported, and percentage where the indicated practices exists for publicly posting fees, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage charging for the indicated item				Number of facilities offering FP (weighted)	Percentage where fees are posted in public view			Number of facilities having any user fees for FP (weighted)
	Fixed fee for FP card	Fixed fee for each consultation and examination ¹	Fee varies depending on method, laboratory tests, and medicines provided	No charges/ don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility									
GS hospital	0	9	89	10	63	73	3	24	56
MCH/urban HU	0	12	89	9	64	79	3	18	58
Rural HU	0	9	89	6	367	68	3	29	345
Mobile unit	0	10	19	77	38	34	0	66	8
Health office	0	0	89	11	28	73	0	27	25
NGO facility	2	63	95	3	64	45	5	50	62
Region									
Urban									
Governorates	0	25	83	15	61	71	4	24	52
Lower Egypt	0	14	81	13	306	70	2	27	266
Upper Egypt	0	12	91	8	257	62	4	34	236
Total	0	14	85	11	624	67	3	30	555

¹ More than one fee system may apply.

Table A-5.16 Out-of-pocket payments for family planning services

Among observed and interviewed FP clients, percentage who reported paying any out-of-pocket fees for FP services on the day of the survey and, among the clients who paid any fees for services, median amount (piasters) paid on the day of the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed FP clients paying any out-of-pocket fees	Number of interviewed FP clients (weighted)	Median out-of-pocket payment (piasters) by FP clients who paid anything for FP services day of survey ¹	Number of interviewed FP clients providing valid responses for out-of-pocket payments (weighted)
Type of facility				
GS hospital	81	314	101	254
MCH/urban HU	81	320	101	260
Rural HU	81	608	101	494
Mobile unit	12	188	101	22
Health office	74	85	101	63
NGO facility	86	169	501	145
Region				
Urban				
Governorates	67	272	200	181
Lower Egypt	79	802	101	635
Upper Egypt	69	610	101	422
Total	74	1,684	101	1,238

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

Table A-5.17 Out-of-pocket payments for clients who received specific family planning procedures

Among observed and interviewed FP clients who received IUD insertion, IUD removal, injectable contraceptive, or a pelvic exam without another procedure, percentage who paid any out-of-pocket fees, and median amount (piasters) paid on the day of the survey, by the main procedure received, Egypt SPA 2002

Procedure	Percentage of clients who paid out-of-pocket fee	Median out-of-pocket fee paid by client receiving indicated procedure ¹	Number of cases who paid out-of-pocket fee	Total number of cases receiving procedure
IUD insertion ²	89	200	321	368
IUD removal	72	113	125	174
Injection	89	100	329	379
Pelvic exam ³	59	105	225	387

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other
² May or may not include IUD removal as well
³ Clients who received a pelvic exam but did not also receive IUD procedure, injection, or implant or classified here.

Table A-5.18 Supportive management for providers of family planning services

Among interviewed family planning (FP) service providers, percentage who received in-service training related to FP in the past 12 months, percentage who were personally supervised in the past 6 months, percentage who received both in-service training in the past 12 months and personal supervision in the past 6 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed FP service providers who:				Number of interviewed FP service providers (weighted)
	Received in-service training during the past 12 months ¹	Were personally supervised in the past 6 months	Both received in-service training during the past 12 months and was personally supervised during the past 6 months	Most recent in-service training was 13-59 months preceding the survey	
Type of facility					
GS hospital	21	92	19	55	268
MCH/urban HU	23	95	22	49	234
Rural HU	24	97	23	47	851
Mobile unit	24	96	23	54	62
Health office	22	97	22	50	83
NGO facility	26	64	17	44	105
Region					
Urban Governorates	28	90	26	52	145
Lower Egypt	17	95	17	52	837
Upper Egypt	30	93	28	44	621
Total	23	94	22	49	1,603

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

Table A-5.19 In-service training for family planning service providers

Among interviewed family planning (FP) service providers, percentage who received in-service training¹ on specific topics during the past 12 months or 13-59 months preceding survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed family planning providers who received in-service training on specific topics										Number of interviewed FP service providers (weighted)
	Counseling on FP		Any contraceptive technology		Basic training for service provision course		Syndromic management of STIs		Any counseling or treatment topics for STIs		
	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	
Type of facility											
GS hospital	14	43	13	35	8	27	4	12	5	16	268
MCH/urban HU	16	43	14	42	8	21	5	11	8	15	234
Rural HU	15	44	17	39	7	27	3	9	7	13	851
Mobile unit	16	46	15	44	8	33	5	12	7	17	62
Health office	11	47	13	37	5	26	6	17	8	20	83
NGO facility	18	42	19	43	10	20	7	16	8	20	105
Region											
Urban Governorates	15	48	17	50	6	24	8	15	13	24	145
Lower Egypt	10	47	12	40	7	21	3	12	4	16	837
Upper Egypt	21	39	20	36	9	32	5	8	8	11	621
Total	15	44	16	39	8	26	4	11	7	15	1,603

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

Table A-5.20 Supportive supervision for family planning service providers

Among interviewed family planning (FP) service providers, percentage who were personally supervised in the past 6 months, and among those who received such a supervisory visit, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2002

Background characteristics	Median number of times staff were supervised in past 6 months	Number of interviewed FP service providers (weighted)	Percentage of providers reporting indicated activities of the supervisor during the last supervisory visit					Dis-cussed problems	Wrote note on unit record	Number of FP service providers who were supervised in the past 6 months (weighted)
			Checked records	Observed work	Provided feedback	Provided updates				
Type of facility										
GS hospital	7	268	97	96	91	76	84	88	248	
MCH/urban HU	7	234	99	97	93	79	84	89	222	
Rural HU	8	851	99	98	96	83	89	88	829	
Mobile unit	6	62	100	96	94	78	85	88	59	
Health office	12	83	100	98	96	85	92	95	81	
NGO facility	6	105	90	89	88	71	83	81	67	
Region										
Urban Governorates	12	145	97	95	92	78	82	96	131	
Lower Egypt	7	837	99	97	95	82	89	94	799	
Upper Egypt	8	621	98	97	94	79	86	77	576	
Total	7	1,603	98	97	94	80	87	88	1,506	

Table A-5.21 Description of observed family planning clients

Among observed family planning (FP) clients, percentage for whom this was the first visit for family planning at this facility, percentage for whom this was a followup visit, and percentage who have no prior pregnancy by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of observed FP clients			Number of observed family planning clients (weighted)
	First visit	Followup visit	No prior pregnancy ¹	
Type of facility				
GS hospital	36	64	1	314
MCH/urban HU	33	67	1	323
Rural HU	35	65	1	608
Mobile unit	46	54	0	188
Health office	34	66	2	85
NGO facility	25	75	2	169
Region				
Urban Governorates	34	66	1	274
Lower Egypt	34	66	1	804
Upper Egypt	36	64	1	610
Total	35	66	1	1,688

¹ Forty-five women for whom observer could not ascertain status during consultation and for whom the provider asked no questions about prior pregnancies were considered to have had a prior pregnancy.

Table A-5.22 Description of observed clients

Among all interviewed family planning (FP) clients, percentage who continued their current method, percentage who received a method, and percentage who received a prescription for a method, Egypt SPA 2002

Principal reason for visit	Percentage of observed clients with indicated status
Current user at clinic for:	
Resupply current method/routine visit	33
Elective method change	5
Discuss problem with current method	22
Discuss non-FP health problem	1
Elective discontinue FP	5
Nonuser	
Used method in past	20
Never used method	13
Number of observed FP clients (weighted)	1,688

Table A-5.23 Description of observed family planning clients

Among observed family planning (FP) clients, percentage for whom each of the indicated methods was provided, prescribed, or continued being used at the end of the visit, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage for whom indicated method was the main method either provided, prescribed, or discussed								Number of observed and interviewed family planning clients (weighted)
	Oral contraceptive (OC)	Injectable (3 monthly) (PIN)	Injectable (once monthly) (CIN)	Male condom	Spermicide	IUD	Implant	Other ²	
Type of facility									
GS hospital	14	34	0	3	0	39	3	0	314
MCH/urban HU	12	25	0	4	0	51	1	0	320
Rural HU	13	48	0	2	0	30	0	1	608
Mobile unit	19	27	0	6	0	41	0	1	188
Health office	16	32	1	3	0	42	1 ¹	1	85
NGO facility	12	16	4	2	0	50	2	0	169
Region									
Urban									
Governorates	10	28	1	4	0	50	0	1	272
Lower Egypt	15	34	0	2	0	40	1	1	802
Upper Egypt	13	39	1	3	0	34	1	1	610
Total	14	35	1	3	0	39	1	1	1,684

¹ Health offices do not normally provide implant. Investigation indicated that this was one client who received a pelvic exam through the FP clinic, who was a continuing user of the implant method.

² Other includes: 8 emergency contraception (2 with condoms); 1 rhythm; no LAM, 1 prescribed spermicide, no female sterilization.

Table A-5.24 Conditions for counseling of observed family planning clients

Percentage of all observed family planning clients where the counseling portion was conducted under the indicated conditions, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Visual privacy assured	62	67	64	75	72	85	68
Auditory privacy assured	60	62	61	74	69	82	65
Client was assured of confidentiality	10	14	16	19	12	12	14
Client was asked about concern with methods discussed or currently used	50	57	56	61	69	68	57
All counseling conditions met ¹	6	8	11	15	6	9	10
Individual client card reviewed during consultation	43	52	52	38	58	38	48
Individual client card written on after consultation	59	66	73	58	80	43	65
Visual aids were used during consultation	8	7	10	8	19	7	9
Return visit was discussed	68	69	81	68	80	71	74
Number of observed FP clients (weighted)	427	427	270	231	123	210	1,688

¹ Visual and auditory privacy, confidentiality assured and client was asked about concerns of methods discussed or currently used.

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, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Client history							
Age	63	69	80	78	95	69	75
Any history of pregnancy	86	89	91	86	95	92	89
Current pregnancy status	30	33	25	34	65	45	32
Desired timing for next child or desire for another child	16	20	16	30	29	15	19
Breastfeeding status	36	46	46	45	50	55	45
Regularity of menstrual cycle	74	68	72	74	95	72	73
All elements of reproductive history ¹	6	9	7	17	24	4	9
Client medical history							
Asked about smoking	2	2	2	1	12	4	3
Asked about symptoms of sexually transmitted infections (STIs)	29	28	37	49	65	36	37
Asked about any chronic illnesses	32	35	41	44	75	42	40
All risk-history ²	0	1	1	0	5	2	1
Client examination							
Measure blood pressure	58	57	71	62	82	77	66
Measure weight	29	42	54	26	44	51	42
Take urine specimen	5	10	5	2	0	21	7
Take blood specimen	1	1	4	0	0	19	3
Number of first-visit FP clients (weighted)	113	108	214	86	29	42	593

¹ Age, any history of pregnancy, current pregnancy status, desired timing for next child or desire for another child and regularity of menstrual cycle.

² Asked about smoking, symptoms of STIs and any chronic illness.

Table A-5.26 General assessments, examination, 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, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Counseling topics covered							
Husband attitude toward family planning	8	7	12	10	16	6	10
Husband status ¹	4	5	10	2	3	4	6
Either husband question	10	12	19	12	16	10	14
Discussions related to STIs and condoms							
Use of condoms to prevent STIs discussed	0	2	1	0	0	0	1
Use of condoms as dual method	0	2	0	1	0	0	1
Any discussion related to STIs ²	0	2	1	1	0	0	1
Individual client card reviewed during consultation	26	32	36	27	36	25	31
Individual client card reviewed after consultation	60	61	70	54	77	48	63
Visual aids were used during consultation	11	11	13	13	32	12	13
Client was assured of confidentiality	7	13	23	20	15	9	16
Number of first-visit FP clients (weighted)	113	108	214	56	29	43	593

¹ Asked if husband has other wife or about husband's absence.

² Risk of STIs discussed or use of condoms to prevent STIs or as dual method discussed.

Table A-5.27 Observed assessments of client who received injections or oral contraceptives with estrogen

Percentage of observed and interviewed family planning (FP) clients who received a contraceptive with estrogen and who had their blood pressure measured, percentage who had their weight measured, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Examination specific to estrogen based contraceptive							
Blood pressure measured	68	65	79	64	73	72	71
Weight measured	48	63	63	22	46	45	49
Number of clients receiving estrogen-based contraceptive (weighted)	28	22	45	29	8	18	150

Table A-5.28 Breast examination

Percentage of observed family planning (FP) clients who received a breast examination, percentage who were taught how to conduct a self breast exam, and percentage who report they were taught how to self breast-exam, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of observed FP clients				Number of observed and interviewed FP clients (weighted)
	Provider conducted breast examination	Provider taught client how to do breast self-examination	Client reported provider taught how to do breast self-examination		
Type of facility					
GS hospital	3	0	14		314
MCH/urban HU	3	2	11		320
Rural HU	3	2	17		608
Mobile unit	3	3	6		188
Health office	22	17	23		85
NGO facility	4	2	15		169
Region					
Urban Governorates	8	4	6		272
Lower Egypt	4	3	19		802
Upper Egypt	3	2	11		610
Total	4	3	13		1,684

Table A-5.29 Observed and reported client education related to injectable or oral contraceptives

Percentage of observed and interviewed family planning (FP) clients who received a hormonal contraceptive pill or injection where the indicated counseling item was observed being shared by the provider, or was reported by the client that they were told the information, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/ urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Provider was observed to explain the item to the client							
When to take	70	77	76	74	70	79	75
Menstrual changes	42	49	35	44	48	52	41
Side effects	14	18	13	22	34	15	16
What to do if she forgets	15	24	14	31	34	26	19
Mentioned followup visit	76	79	83	78	83	77	80
Client reported that the provider shared the indicated information							
Explained how to use the method	72	76	71	85	86	88	75
Explained about possible side effects	50	58	53	65	69	78	57
Explained what to do for problems	48	53	49	55	67	72	53
Mentioned followup visit	87	81	86	84	83	88	85
For all pill and injection clients, percentage who knew correct response for question asked about method	98	99	97	99	98	94	98
Weighted number of observed and interviewed FP pill/injection clients	149	118	377	87	42	54	828

Table A-5.30 Details on observed education provided and client knowledge regarding different methods of contraception other than pills or injections

Among clients who received condoms, IUD, implants, or emergency contraceptives, the percentage who were observed being told critical information about the method, and percentage who, during the exit interview knew the correct response to a critical question asked about using their method, percentage clients receiving condoms, IUD, implants, or emergency contraceptives who reported they were instructed by the provider on how to use their method, about side effects, what to do for problems, and when to return for followup, Egypt SPA 2002

Item	Percentage of eligible observed and interviewed clients
Condom user	
Client was observed being told:	
Use one time	18
Leave space at top	60
About lubricant	11
Can use as backup method	3
About dual protection	2
Interviewed client received condom and knows to use condom only once	94
Number of clients receiving condom	48
IUD user	
Client was observed being told:	
To check string	31
About possible heavy bleeding	39
Interviewed client received IUD and knows how to check IUD	77
Number of clients receiving IUD	663
Implant user	
Client was observed being told:	
Implant is good for five years	34
Menstrual changes that might occur	29
Initial side effects that might occur	9
Interviewed client received implant and knows how long implant lasts	74
Number of clients receiving implants or prescription for implant	15
Emergency contraceptive user	
Client was observed being told:	
Need another dose if vomit in 2 hrs	17
If no period within 4 weeks, return to clinic	17
Number of clients receiving emergency contraception	8
Summary of interviewed client responses	
Client knew the correct response for the survey question about their method	77
Client reported provider explained how to use the method	57
Client reported provider explained about possible side effects	63
Client reported provider explained what to do for problems	68
Client reported provider told about a follow-up visit	75
Client reported all four messages were provided	39
Number of other family planning clients (weighted) ¹	734

¹ Other family planning clients are condom, IUD, implant, and emergency contraception users.

Table A-5.31 Client feedback on services

Percentage of observed and interviewed family planning (FP) clients who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2002

Client service issue	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Behavior/attitude of provider not good	2	1	1	0	0	0	1
Inability to discuss concerns with provider	4	4	3	3	0	1	3
Explanation about methods or problems not sufficient	4	3	3	3	0	0	3
Poor quality of examination and treatment	3	2	2	3	0	0	2
Waiting time to see provider too long	9	9	11	0	4	9	8
Lack of availability of medicines or supplies	7	6	8	3	6	5	6
Opening hours of facility inconvenient	2	3	4	4	1	3	3
Lack of cleanliness of facility	1	1	0	0	2	1	1
Lack of visual privacy	2	2	1	2	2	3	2
Lack of auditory privacy	2	2	1	3	2	3	2
Cost is too high	0	0	1	0	0	2	1
Time too long between start and completion of consultation	2	1	2	1	0	1	1
Waiting time for laboratory results too long	1	0	0	0	0	1	0
Number of interviewed FP clients (weighted)	314	320	608	188	85	169	1,684

Table A-5.32 Reasons observed family planning clients chose this facility for services

Among observed and interviewed family planning (FP) clients, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of FP clients agreeing item was a factor in choosing facility								Number of interviewed FP clients (weighted)
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well treated	Has the Gold Star	Facility is nearby	Good reputation	
Type of facility									
GS hospital	13	29	3	21	26	0	43	25	314
MCH/urban HU	18	28	2	25	30	0	42	24	320
Rural HU	14	22	1	24	28	1	64	17	608
Mobile unit	32	13	0	27	26	0	42	25	188
Health office	22	35	1	34	47	0	47	18	85
NGO facility	43	40	2	18	42	1	32	33	169
Region									
Urban Governorates	32	35	3	27	24	0	53	23	272
Lower Egypt	18	29	1	22	33	0	47	24	802
Upper Egypt	17	17	1	24	29	1	51	20	610
Total	20	26	2	24	30	0	50	23	1,684

Table A-5.33 Personal characteristics of family planning clients

Among family planning (FP) clients whose consultation was observed and who were interviewed, percent distribution by employment status, and among employed family planning clients, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2002

Background characteristics	Among all FP clients, percentage who are:		Number of interviewed FP clients (weighted)	Among employed FP clients, percentage who:							Number of interviewed FP clients who are employed (weighted)
	Employed	Not employed		Work for:			Receive:				
				Family member	Some-one else	Self	Salary in cash	Salary in kind	Salary both in cash and in kind	No salary	
Type of facility											
GS hospital	14	86	314	10	59	31	82	2	5	12	45
MCH/urban HU	16	84	320	16	67	17	83	3	1	12	52
Rural HU	12	88	608	16	47	37	72	3	0	25	74
Mobile unit	7	93	188	25	63	13	75	0	0	25	13
Health office	20	80	85	0	88	12	96	4	0	0	17
NGO facility	15	85	169	0	87	13	100	0	0	0	25
Region											
Urban											
Governorates	14	86	272	2	78	20	96	0	2	2	38
Lower Egypt	17	83	802	15	52	33	75	2	1	23	137
Upper Egypt	8	92	610	11	80	9	89	6	1	3	52
Total	13	87	1,684	12	63	25	82	2	1	15	227

Table A-5.34 Personal 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 and region, Egypt SPA 2002

Background characteristics	Among interviewed FP clients, percentage with:				Number of interviewed FP clients (weighted)	Percentage of interviewed FP clients with primary or no education who:			Number of interviewed FP clients with primary or no education (weighted)
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write		
							Can read and write		
Type of facility									
GS hospital	58	9	6	28	314	76	5	19	208
MCH/urban HU	39	11	10	39	320	66	4	30	162
Rural HU	59	7	4	30	608	82	3	15	399
Mobile unit	55	10	12	23	188	79	5	16	122
Health office	33	8	13	46	85	52	4	43	35
NGO facility	35	4	8	53	169	76	0	24	66
Region									
Urban									
Governorates	30	10	15	45	272	58	9	33	109
Lower Egypt	50	7	6	38	802	77	2	22	455
Upper Egypt	61	9	7	23	610	81	5	14	429
Total	51	8	7	34	1,684	77	4	20	993

Chapter 6

Table A-6.1 Availability of antenatal care and other family health services on the day of the survey

Percentage of facilities offering antenatal care (ANC) on the day of the survey, and offering ANC and tetanus toxoid 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 immunization (EPI), on the day of the survey; by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering the indicated services the day of the survey						Number of facilities offering ANC (weighted)
	ANC	ANC and TT vaccine	ANC and FP	ANC and SC	ANC and FP and SC services	ANC and EPI	
Type of facility							
GS hospital	87	31	83	87	80	9	51
MCH/urban HU	86	63	85	83	79	12	57
Rural HU	61	34	59	53	51	10	364
Mobile unit	100	0	100	58	57	0	28
NGO facility	90	12	88	47	45	1	58
Region							
Urban Governorates	98	35	94	77	71	10	50
Lower Egypt	77	35	75	65	62	13	268
Upper Egypt	59	30	58	49	47	4	240
Total ¹	71	33	69	59	56	9	559

¹ Includes data from one health office offering ANC

Table A-6.2 Availability of antenatal care and tetanus vaccine services

Among facilities offering antenatal care (ANC), percentage offering ANC 1-2 days, 3-4 days or 5 or more days per week, percentage of facilities offering no tetanus toxoid vaccine (TT), percentage offering TT 1-2 days, 3-4 days, or 5 or more days per week, and percentage of facilities where tetanus toxoid vaccine is reported offered every day ANC is offered, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:								Number of facilities offering ANC (weighted)
	ANC services offered the indicated number of days per week:			TT services offered the indicated number of days per week				TT every day ANC is offered	
	1-2 days	3-4 days	5+ days	Not offered	1-2 days	3-4 days	5+ days		
Type of facility									
GS hospital	22	2	76	35	44	1	19	41	51
MCH/urban HU	32	3	65	2	49	4	45	75	57
Rural HU	52	2	46	3	72	4	21	66	364
Mobile unit	0	0	100	98	2	0	0	0	28
NGO facility	13	11	76	86	2	0	12	13	58
Region									
Urban Governorates	5	7	88	46	16	2	34	35	50
Lower Egypt	29	4	67	15	58	6	21	51	268
Upper Egypt	60	2	38	18	62	1	19	65	240
Total ¹	40	3	57	19	56	4	21	56	559

¹ Includes data from one health office offering ANC

Table A-6.3 Availability of items to support quality antenatal care services

Percentage of facilities that offer antenatal care (ANC) services where there are items to support quality (client health cards, treatment standards and protocols, visual aids for health education), items for infection control, infrastructure for physical examination, and equipment and medicines for basic ANC services, in or adjacent to the consultation or examination room, by type of facility, Egypt SPA 2002

Items	Percentage by type of facility					Total percentage
	GS hospital	MCH/ Urban HU	Rural HU	Mobile Unit	NGO facility	
Items to support quality						
Individual client health cards	48	83	81	3	24	68
Written ANC protocols or guidelines	12	19	13	0	4	12
Visual aids for health education	26	32	32	0	5	27
All items to support quality counseling ¹	6	18	10	0	2	9
Group health education sessions	3	22	8	6	12	10
Items for infection control						
Soap	38	41	31	58	72	39
Water	89	77	85	75	93	85
Clean latex gloves	51	41	42	51	54	44
Disinfecting solution	70	61	70	95	80	71
Sharps box	53	74	73	42	35	66
All items for infection control ²	15	17	12	12	18	14
Covered waste receptacle with plastic liner ³	20	28	24	27	40	26
All items for infection control plus waste receptacle	6	11	6	5	17	7
Physical examination						
Visual and auditory privacy ⁴	71	74	78	86	85	78
Visual privacy ⁵	82	81	87	93	91	86
No privacy	18	19	13	7	9	14
Examination bed ⁶	96	84	86	100	98	89
Examination light ⁷	70	54	65	71	97	68
All elements for physical examination ⁸	52	39	52	61	81	54
All elements for physical examination and specific components for infection control present ⁹	17	19	13	15	29	16
Essential supplies for basic ANC						
Blood pressure apparatus	92	97	89	98	100	91
Fetoscope (Pinard)	72	64	65	58	76	67
Iron tablets ¹⁰	85	83	83	34	5	73
Folic acid tablets ¹⁰	50	66	64	24	3	55
Iron and folic acid combined tablet	46	60	62	21	2	52
Tetanus toxoid vaccine	43	81	64	0	10	55
All basic ANC equipment and medicines ¹¹	17	34	26	0	0	22
Number or facilities offering ANC (weighted) ¹²	51	57	364	28	58	559
¹ Individual client health cards, written ANC protocols or guidelines, and visual aids for health education.						
² Soap, water, gloves, disinfecting solution for decontaminating reusable items, and sharps box						
³ While important for infection control, and listed in the MoH maternity standards, this is not an item that has been commonly introduced and thus was not included in the aggregate for infection control.						
⁴ Private room.						
⁵ Private room or room with screen or curtain that can be pulled for visual privacy.						
⁶ May be any type of bed where woman can lie down flat.						
⁷ May be examination light, flashlight or other spotlight source						
⁸ Visual and auditory privacy, examination light, bed.						
⁹ Visual and auditory privacy, examination light, bed, and all infection control items, excluding sharps box.						
¹⁰ Iron and folic acid may be separate tablets, or one combined tablet.						
¹¹ Blood pressure apparatus, fetoscope, iron and folic acid, tetanus toxoid vaccine.						
¹² Includes data from one health office offering ANC						

Table A-6.4 Availability of specific medicines and protocols for antenatal care services

Among facilities offering antenatal care services (ANC), percentage with indicated medicines for managing common complications during pregnancy, percentage that routinely provide the indicated medicine or test as a component of ANC, and percentage with a thermometer and an infant scale for PNC, by type of facility and region, Egypt SPA 2002

Items	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Medicines for managing common complications during pregnancy						
Antibiotic ¹	73	80	78	7	6	66
Mebendazole (antihelminth)	61	54	61	2	3	51
Metronidazole (trichomoniasis)	73	78	74	31	7	65
Ceftriaxone (gonorrhea)	18	6	3	0	2	4
Ciprofloxacin (gonorrhea)	6	2	4	7	3	4
Doxycycline (chlamydia, syphilis)	5	3	11	0	3	8
Tetracycline (chlamydia, syphilis)	56	40	53	2	2	44
Erythromycin (chlamydia, syphilis)	14	15	16	2	5	14
Penicillin (syphilis)	97	100	96	46	9	85
All medicines for sexually transmitted infections ²	13	3	4	0	3	5
Nystatin suppository	8	9	5	3	0	5
Methyldopa (aldomet)	10	4	2	0	3	3
All medicines for ANC complications ³	0	1	0	0	0	0
Routine ANC service						
Prescribe STI treatment by ANC providers	90	89	87	81	92	87
Test blood for anemia	89	95	90	2	63	83
Test urine for protein	89	96	89	2	59	82
Test urine for sugar	89	96	89	2	61	83
Blood group and Rh factor	66	79	35	0	65	44
Ultrasound investigation	3	18	5	7	9	7
Routine discussion about family planning	45	63	48	54	46	49
Equipment related to postnatal care						
Thermometer	64	75	78	25	83	75
Infant scale	45	68	72	0	22	61
Number of facilities offering ANC (weighted) ⁴	51	57	364	28	58	559
¹ Amoxicillin or cotrimoxazole						
² At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis						
³ At least one broad-spectrum antibiotic, at least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis, mebendazole, and nystatin suppository all present						
⁴ Includes data from one health office offering ANC						

Table A-6.5 Facility capacity to provide anemia screening with antenatal care				
Among facilities offering antenatal care (ANC) percentage with the capacity to test for anemia, percentage where the facility has a standard to routinely screen ANC clients for anemia, and percentage where the facility routinely tests ANC clients for anemia and testing capacity for anemia exists, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct anemia test ¹	Facility has standard to screen ANC clients for anemia	Facility has standard to screen ANC clients for anemia and facility has capacity to conduct anemia test	
Type of facility				
GS hospital	84	89	74	51
MCH/urban HU	88	95	85	57
Rural HU	85	90	79	364
Mobile unit	10	2	2	28
NGO facility	63	63	55	58
Region				
Urban Governorates	78	76	72	50
Lower Egypt	80	86	73	268
Upper Egypt	78	82	72	240
Total	79	83	73	559
¹ Any anemia test. Specific tests assessed were use of a hemoglobinometer or colorimeter (did not include presence or absence of drabkin solution), centrifuge and capillary tubes for hematocrit, or any of the blotting paper tests.				
² Includes data from one health office offering ANC				

Table A-6.6 Facility capacity to provide test for urine protein with antenatal care				
Among facilities offering antenatal care (ANC), percentage 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 routinely tests ANC clients for urine protein and testing capacity for urine protein exists, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct urine protein test ¹	Facility has standard to screen ANC clients for urine protein	Facility has standard to screen ANC clients for urine protein and facility has capacity to conduct urine protein test	
Type of facility				
GS hospital	79	89	72	51
MCH/urban HU	86	96	84	57
Rural HU	71	89	66	364
Mobile unit	10	2	2	28
NGO facility	63	59	52	58
Region				
Urban Governorates	79	75	73	50
Lower Egypt	76	84	70	268
Upper Egypt	60	81	55	240
Total	69	82	64	559
¹ Clinistix (Campus 3 or Campus 9 sticks) or flame, acetic acid and test tube for testing urine albumin.				
² Includes data from one health office offering ANC				

Table A-6.7 Facility capacity to provide test for urine glucose with antenatal care				
Among facilities offering antenatal care (ANC), percentage with the capacity to test urine for glucose, percentage where the facility has a standard to routinely screen ANC clients for urine glucose, and percentage where the facility routinely tests ANC clients for urine glucose and testing capacity for urine glucose exists, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct urine glucose test ¹	Facility has standard to screen ANC clients for urine glucose	Facility has standard to screen ANC clients for urine glucose and facility has capacity to conduct urine glucose test	
Type of facility				
GS hospital	47	89	44	51
MCH/urban HU	67	96	65	57
Rural HU	41	89	38	364
Mobile unit	10	2	2	28
NGO facility	59	61	53	58
Region				
Urban Governorates	75	73	67	50
Lower Egypt	47	84	42	268
Upper Egypt	36	83	34	240
Total	45	83	41	559
¹ Dipstix (Campus 3 or Campus 9) were assessed.				
² Includes data from one health office offering ANC				

Table A-6.8 Facility routinely provides blood grouping with Rh factor with antenatal care				
Among facilities offering antenatal care (ANC), percentage with the capacity to determine blood group and Rh factor, percentage where the facility has a standard to routinely offer blood grouping and Rh factor determination for ANC clients, and percentage where the facility has a standard to routinely offer the blood grouping and Rh factor determination to ANC clients and laboratory capacity to conduct test exists, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ²
	Facility offers ANC and has capacity to conduct blood grouping and Rh factor test ¹	Facility has standard to offer blood grouping and Rh factor test to ANC clients	Facility has standard to offer blood group and Rh factor test for ANC clients and facility has capacity to conduct blood grouping and Rh test	
Type of facility				
GS hospital	60	66	51	51
MCH/urban HU	54	79	51	57
Rural HU	15	35	13	364
Mobile unit	0	0	0	28
NGO facility	43	65	36	58
Region				
Urban Governorates	76	74	70	50
Lower Egypt	18	41	15	268
Upper Egypt	22	40	20	240
Total	25	44	22	559
¹ Anti-A, Anti-B, and Anti-D blood grouping materials and glass slides.				
² Includes data from one health office offering ANC.				

Table A-6.9 Facility capacity to conduct ultrasound examination with antenatal care				
Among facilities offering antenatal care (ANC), percentage with an ultrasound machine, percentage with a provider trained in obstetric ultrasound, and percentage with both the ultrasound machine and a trained provider, by type of facility and region, Egypt SPA 2002				
Background characteristics	Percentage of facilities offering ANC services			Number of facilities providing ANC (weighted) ¹
	Facility has ultrasound machine	Facility has trained provider in obstetric ultrasound	Facility has both ultrasound machine and trained provider	
Type of facility				
GS hospital	45	49	41	51
MCH/urban HU	50	51	46	57
Rural HU	17	15	13	364
Mobile unit	88	76	76	28
NGO facility	42	44	39	58
Region				
Urban Governorates	62	64	59	50
Lower Egypt	24	21	19	268
Upper Egypt	28	28	24	240
Total	29	28	25	559

¹ Includes data from one health office offering ANC

Table A-6.10 Statistics on utilization of antenatal care and postnatal care services for facilities in the ESPA				
Median average monthly antenatal care (ANC) clients (new and repeat), median average monthly postnatal care (PNC) clients for the 12 months preceding the survey, by type of facility, Egypt SPA 2002				
Background characteristics	Median monthly ANC visits	Number of facilities reporting ANC data	Median monthly PNC visits	Number of facilities reporting PNC data
Type of facility				
GS hospital	97	38	123	31
MCH/urban HU	164	55	136	49
Rural HU	58	360	63	320
Mobile unit	41	13	65	1
Health office	3	1	-	0
NGO facility	9	17	2	1
Total ¹	63	484	67	404

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 ANC and PNC clients per month.

Table A-6.11 Information on user fees for antenatal care services

Among facilities offering antenatal care services (ANC), percentage that have user fees for ANC and percentage where the indicated practices exists for publicly posting fees, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities charging for the indicated item							Number of facilities providing services (weighted)	Percentage posting fees publicly			Number of facilities having any routine charges for ANC services (weighted)
	Fixed fee for ANC or health card	Fixed fee for each consult	Fixed fee for all ANC	Fixed fee for all ANC visits plus delivery	Charge for medicines and tests	Other routine charges	No charges or don't know		All fees are posted	Some fees are posted	No fees are posted	
Type of facility												
GS hospital	1	45	2	0	11	0	44	51	17	3	81	29
MCH/urban HU	5	24	4	2	8	1	60	57	32	3	66	23
Rural HU	1	20	1	1	8	0	71	364	20	1	79	104
Mobile unit	0	27	0	5	22	12	44	28	13	0	87	16
NGO facility	9	78	16	0	29	2	4	58	47	6	48	56
Region												
Urban												
Governorates	11	52	7	1	19	2	27	50	42	10	48	36
Lower Egypt	1	30	3	1	9	0	59	268	32	1	66	109
Upper Egypt	1	23	2	1	12	1	66	240	14	1	86	82
Total¹	2	29	3	1	11	1	59	559	27	2	70	228

¹ Includes data from one health office offering ANC

Table A-6.12.1 Out-of-pocket payments for antenatal care services-first-visit clients

Among first-visit ANC clients whose consultation was observed and who were interviewed, percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey; among the clients who paid any fees for services, median amount (piasters) paid on the day of the survey, by type of facility and region, Egypt SPA 2002

Type of facility	Percentage of interviewed first-visit ANC clients paying any out-of-pocket fees	Number of interviewed first-visit ANC clients (weighted)	Median out-of-pocket payment (piasters) by first-visit ANC clients who paid anything for ANC services day of survey ¹	Number of interviewed first-visit ANC clients providing valid responses for out-of-pocket payments (weighted)
GS hospital	78	66	111	50
MCH/urban HU	72	72	101	50
Rural HU	42	254	101	105
Mobile unit	67	28	500	19
NGO facility	91	24	500	22
Total	57	445	101	246

¹ Includes any amount paid out-of-pocket, including consultation, laboratory test, medicines, or other

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 (piasters) 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 ² (weighted)
GS hospital	65	70	101	45
MCH/urban HU	61	117	101	71
Rural HU	29	263	101	75
Mobile unit	67	19	500	13
NGO facility	81	57	500	44
Total²	48	529	105	251

Background characteristics	Percentage of interviewed ANC providers who:				Number of interviewed ANC providers ² (weighted)
	Received in-service training during the past 12 months ¹	Were personally supervised in past 6 months	Both received in-service training during the past 12 months and were personally supervised during the past 6 months	Most recent in-service training was 13-59 months preceding survey	
Type of facility					
GS hospital	20	88	16	45	187
MCH/urban HU	25	95	24	45	222
Rural HU	25	94	25	41	924
Mobile unit	25	97	23	59	40
NGO facility	31	64	22	41	88
Region					
Urban Governorates	31	86	28	46	112
Lower Egypt	17	92	16	43	745
Upper Egypt	34	91	31	41	608
Total	25	91	23	43	1,465

Table A-6.14.1 Supportive management: In-service training for antenatal care service providers

Among interviewed antenatal care (ANC) service providers, percentage who received in-service training¹ on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed ANC providers who received in-service training on specific topics														Number of interviewed ANC service providers (weighted) ⁴
	Basic training for service provision		ANC service		ANC counseling		Risk pregnancies		Lifesaving skills		PMTCT ²		PNC ³		
	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	
Type of facility															
GS hospital	1	11	3	24	4	19	4	22	2	12	2	7	3	14	187
MCH/urban HU	4	10	7	19	8	19	7	15	4	4	4	8	8	13	222
Rural HU	4	12	6	18	8	20	7	15	2	4	3	8	6	15	924
Mobile unit	1	13	1	15	2	15	1	18	0	2	5	10	1	12	40
NGO facility	5	15	6	22	5	24	5	20	1	3	3	18	5	16	88
Region															
Urban															
Governorates	4	14	9	22	8	22	8	24	4	5	7	20	7	20	112
Lower Egypt	4	9	4	16	5	20	3	14	1	5	2	8	4	13	745
Upper Egypt	3	14	8	23	10	19	11	17	3	5	3	8	8	15	608
Total⁴	4	12	6	19	7	20	7	16	2	5	3	9	6	14	1,465

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.
² Prevention of mother-to-child transmission (PMTCT) for HIV/AIDS.
³ Postnatal care (PNC).
⁴ Includes 3 providers from health offices where ANC is provided.

Table A-6.14.2 In-service training for antenatal care service providers

Among interviewed antenatal care (ANC) service providers, percentage who received training¹ on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed ANC providers who received in-service training on specific topics						Number of interviewed ANC service providers ² (weighted)
	Family planning		STI		Breastfeeding		
	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	
Type of facility							
GS hospital	12	33	3	13	3	9	187
MCH/urban HU	12	33	5	14	6	17	222
Rural HU	16	31	6	11	7	14	924
Mobile unit	19	58	7	21	1	8	40
NGO facility	24	43	7	22	5	11	88
Region							
Urban Governorates	16	43	12	27	10	23	112
Lower Egypt	10	32	3	12	6	11	745
Upper Egypt	22	33	7	11	6	15	608
Total²	15	33	5	13	6	14	1,465

¹ This refers to structured in-service sessions, and does not include individual instruction received during routine supervision.
² Includes 3 providers from health offices where ANC is provided.

Table A-6.15 Supportive supervision for antenatal care service providers

Among interviewed antenatal care (ANC) service providers who were personally supervised during the past 6 months, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2002

Background characteristics	Median number of times staff were supervised in past 6 months	Number of interviewed ANC service providers ¹	Percentage of providers reporting the indicated activities of the supervisor during the last supervisory visit						Number of ANC service providers who were supervised in past 6 m (weighted)
			Checked records	Observed work	Provided feedback	Provided updates	Discussed problems	Wrote on unit note	
Type of facility									
GS hospital	8	187	96	96	91	80	83	82	164
MCH/urban HU	9	222	99	96	91	73	79	85	210
Rural HU	9	924	98	98	96	82	87	87	867
Mobile unit	6	40	100	97	93	78	85	88	39
NGO facility	6	88	89	88	88	73	84	80	56
Region									
Urban									
Governorates	13	112	95	94	91	73	78	94	96
Lower Egypt	9	745	98	97	94	82	87	95	687
Upper Egypt	8	608	97	97	95	79	83	73	555
Total¹	9	1,465	98	97	94	80	85	86	1,339

¹ Includes 3 providers from health offices where ANC is provided

Table A- 6.16 Characteristics of observed antenatal care clients

Among ANC clients whose consultation was observed, percentage for whom this was their first ANC visit, percentage for whom this was a followup ANC visit, percentage who were estimated to be less than 5 months pregnant, at least 5 months pregnant, and at least 8 months pregnant, by type of facility and region, Egypt SPA 2002

Background characteristics	Characteristics of observed ANC clients						Number of observed ANC clients (weighted) ¹
	First ANC visit for this pregnancy	Follow-up ANC visit ¹	First pregnancy	Month of pregnancy			
				<5 m	≥5 m	≥8m	
Type of facility							
GS hospital	48	52	35	24	76	34	136
MCH/urban HU	38	62	44	21	79	25	191
Rural HU	49	51	35	22	78	21	517
Mobile unit	59	41	31	21	79	28	47
NGO facility	31	69	37	45	54	22	83
Region							
Urban Governorates							
Urban Governorates	37	63	40	31	69	27	165
Lower Egypt	43	57	41	15	85	27	388
Upper Egypt	51	49	32	29	71	21	424
Total¹	46	54	37	24	76	24	977

¹ Includes 3 observed ANC clients from health offices

Table A-6.17 General assessments, examinations, and interventions for observed first-visit ANC clients

Percentage of observed first-visit antenatal care (ANC) clients whose consultation was observed, percentage where the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Prior history and client characteristics						
Client age	62	60	74	53	55	68
Date of last menstrual period	86	81	89	80	97	87
Any aspects related to prior pregnancy ¹	87	80	83	85	78	83
Any aspects of complications during prior pregnancy (if had prior pregnancy) (N=259)	54	48	72	41	47	63
Medications client currently taking	26	21	32	28	37	29
All relevant elements for client history ²	18	14	26	13	24	22
Laboratory tests and examination						
Measure blood pressure	67	92	93	73	92	84
Urine test	52	69	66	5	43	60
Blood test	50	73	68	0	36	60
Preventive interventions						
Give or prescribe iron tablets	52	58	45	30	41	47
Give or prescribe tetanus toxoid vaccine	23	40	55	5	9	42
Weighted number of first-visit ANC clients ³	66	73	254	28	25	446
Among women with prior pregnancies, specific prior complications discussed:						
Stillbirth	32	16	38	24	31	33
Infant mortality first one week after birth	16	15	24	16	26	21
Severe bleeding during labor or postpartum	9	5	7	16	10	8
Assisted delivery	35	31	51	33	42	44
Previous abortion	46	37	68	33	47	58
Number observed first-visit ANC clients with prior pregnancy (weighted)	42	39	174	18	13	286
¹ This includes any questions that would indicate whether the client had a prior pregnancy.						
² Client age, last menstrual period, medicines, any prior pregnancy, and, if there was a prior pregnancy, any questions related to complications during prior pregnancies						
³ None of the observed ANC clients at health offices were first-visit clients.						

Table A-6.18 Assessment of current health status for all observed antenatal care clients

Among antenatal care (ANC) clients whose consultation was observed, percentage where the indicated assessment, examination, or intervention was a component of their consultation, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Client questioned regarding						
Vaginal bleeding	10	6	5	12	17	7
Fetal movement (at least 5m pregnant)	33	43	49	36	65	46
Any other problems	62	64	61	53	82	63
Basic physical examination						
Measured blood pressure	80	97	95	84	92	92
Palpated abdomen for fetal position (at least 8m pregnant)	49	58	67	37	66	60
Either palpate or ultrasound (at least 8m pregnant)	67	72	78	50	93	75
Listened for fetal heart (at least 5m pregnant)	23	18	18	10	30	19
All questioning and basic examination ¹	3	2	2	2	10	3
Ultrasound examination	17	11	14	52	31	17
All questions and basic examination plus ultrasound	0	0	0	1	4	1
Additional physical examination						
Measured weight	57	91	85	22	70	78
Palpated or measured fundal height	48	56	55	39	59	54
Palpate or measure fundal height or ultrasound	57	60	61	74	81	63
Laboratory tests						
Urine test	44	70	58	5	30	54
Blood test	46	71	60	2	21	54
Preventive interventions						
Give or prescribe iron tablets	41	54	42	24	46	44
Give or prescribe tetanus toxoid vaccine	19	32	42	3	8	32
Counseled on risk: vaginal bleeding	6	3	2	0	13	3
Number of observed ANC clients at least 5 months pregnant (weighted)	103	150	406	37	45	744
Number of observed ANC clients at least 8 months pregnant (weighted)	47	47	108	13	18	235
Number of observed ANC clients (weighted) ²	136	191	517	47	83	977

¹ Client was questioned regarding vaginal bleeding, fetal movement (if at least 5 months pregnant), blood pressure was measured, abdomen was palpated or ultrasound performed (if at least 8 months pregnant), and provider listened for fetal heart (if at least 5 months pregnant).

² Includes 3 observed ANC clients from health offices

Table A-6.19 Components of standard antenatal care received by first-visit clients

Among first-visit antenatal care (ANC) clients whose consultation was observed, percentage where the indicated number of standard ANC items (measure blood pressure, counsel on risk sign of vaginal bleeding or asking about vaginal bleeding, test urine) were components of this ANC visit, and percentage where the three routine components plus a blood test were components by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage where indicated number of standard ANC activities were provided					Number of observed first-visit ANC clients (weighted)
	0	1	2	3	4 ¹	
Type of facility						
GS hospital	17	35	43	5	5	66
MCH/urban HU	3	24	68	5	4	73
Rural HU	2	30	64	3	3	254
Mobile unit	22	68	10	0	0	28
NGO facility	3	38	46	13	10	25
Region						
Urban Governorates	3	27	63	7	7	61
Lower Egypt	8	37	52	4	3	167
Upper Egypt	5	32	59	4	4	218
Total ²	6	33	57	4	4	446

¹ Counsel on vaginal bleeding or ask about vaginal bleeding, measure blood pressure, test urine, and test blood.
² Includes 3 observed follow-up visit ANC clients from health offices

Table A-6.20 Components of standard antenatal care received by all observed clients

Among ANC clients whose consultation was observed, percentage where the indicated number of component of standard ANC (measure blood pressure, counsel on risk sign of vaginal bleeding, test urine) that were components of this ANC visit by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage where indicated number of standard ANC activities were provided				Number of observed ANC clients (weighted)
	0	1	2	3	
Type of facility					
GS hospital	13	45	38	5	136
MCH/urban HU	2	24	69	5	191
Rural HU	4	35	57	4	517
Mobile unit	22	69	7	1	47
NGO facility	4	52	36	8	83
Region					
Urban Governorates	3	35	58	5	165
Lower Egypt	8	38	49	5	388
Upper Egypt	5	38	54	4	424
Total ¹	6	37	52	4	977

¹ Includes 3 observed follow-up visit ANC clients from health offices

Background characteristics	Percentage receiving iron or folic acid		Number of ANC clients who received iron or folic acid (weighted) ¹	Percentage receiving tetanus toxoid vaccine where provider explained purpose	Number of ANC clients who received tetanus toxoid vaccine (weighted) ²
	Provider explained purpose	Provider explained how to take			
Type of facility					
GS hospital	19	60	56	3	26
MCH/urban HU	28	53	103	7	60
Rural HU	25	54	218	13	216
Mobile unit	37	81	11	49	1
NGO facility	27	52	38	12	6
Region					
Urban Governorates	33	65	70	11	28
Lower Egypt	43	54	178	19	121
Upper Egypt	6	53	181	6	163
Total	26	55	429	11	311

Counseling topic	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
First-visit ANC client						
Nutrition	24	30	14	20	67	21
Progress of pregnancy	30	27	35	45	51	35
Any risk symptoms for seeking help	14	7	3	2	16	6
Specific risk: vaginal bleeding	10	4	2	0	16	4
Specific risk: fever	5	1	0	0	3	1
Specific risk: short breath; excess tired	1	3	1	0	3	1
Specific risk: swelling hands or face	7	3	2	2	0	3
Specific risk: headache or blurred vision	5	5	2	0	0	3
Delivery plans	12	2	16	8	5	12
Exclusive breastfeeding	1	0	3	0	0	2
Family planning after birth	5	2	6	8	3	5
Number of first-visit ANC clients	66	73	254	28	25	446
Follow-up visit ANC client						
Nutrition	22	26	20	11	39	24
Progress of pregnancy	29	25	41	52	61	39
Any risk symptoms for seeking help	5	8	9	0	16	8
Specific risk: vaginal bleeding	2	2	2	0	11	3
Specific risk: fever	0	1	0	0	7	1
Specific risk: short breath; excess tired	0	3	2	0	9	2
Specific risk: swelling hands or face	2	5	7	0	9	6
Specific risk: headache or blurred vision	3	5	4	0	9	4
Delivery plans	11	10	17	7	9	13
Exclusive breastfeeding	0	0	2	0	1	1
Family planning after birth	2	4	6	7	3	5
Number of follow-up visit ANC clients (weighted) ¹	71	118	263	19	57	531
Provider used any visual aids (first or follow-up visit)	0	2	3	0	2	2

Counseling topic	Percentage by region			Total percentage
	Urban Governorates	Lower Egypt	Upper Egypt	
Nutrition	42	27	11	23
Progress of pregnancy	48	20	48	37
Any risk symptoms for seeking help	10	10	4	7
Specific risk: vaginal bleeding	5	3	3	3
Specific risk: fever	3	1	1	1
Specific risk: short breath; excess tired	3	2	2	2
Specific risk: swelling hands or face	5	7	2	4
Specific risk: headache or blurred vision	6	5	2	4
Delivery plans	10	8	16	12
Exclusive breastfeeding	1	1	2	1
Family planning after birth	3	3	8	5
Number of interviewed ANC clients (weighted)	165	386	424	974

Issue discussed during current/previous visit	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Counseling on risk signs						
Client said provider mentioned any warning signs	22	20	22	10	40	22
Warning signs mentioned by client:						
Bleeding	11	10	9	5	29	11
Fever	4	3	3	2	5	3
Swollen face or hands	7	5	10	4	14	9
Tiredness or breathlessness	3	5	7	0	5	6
Headache or blurred vision	8	8	10	3	16	10
What client was told to do if warning sign occurs						
Seek care at facility	20	17	19	6	35	20
Decrease activity	1	1	0	0	5	1
Change diet	1	1	1	0	3	1
Other counseling						
Exclusive breastfeeding	8	12	9	10	14	10
Exclusive breastfeeding for 6 months	0	3	1	3	1	1
Delivery plans	13	17	14	21	12	14
Supplies to prepare for delivery	3	1	2	0	2	2
Using family planning after birth	9	11	10	12	10	10
Number of interviewed ANC clients (weighted) ¹	136	189	517	47	82	974

Table A-6.25 Reported health education received and knowledge				
Percentage of observed and interviewed antenatal care (ANC) clients who stated that a provider had mentioned any warning signs for pregnancy, percentage who named any of the indicated symptoms as warning signs, percentage who stated that a provider had discussed exclusive breastfeeding, percentage of clients who said they were asked about their delivery plans, and percentage with whom family planning was discussed during this visit or a previous visit, by region, Egypt SPA 2002				
Issue discussed during current/previous visit	Percentage by region			Total
	Urban Governorates	Lower Egypt	Upper Egypt	
Client said provider mentioned any warning signs	20	26	16	22
Warning signs mentioned by client				
Bleeding	15	14	6	11
Fever	5	4	2	3
Swollen face or hands	8	14	5	9
Tiredness or breathlessness	3	11	2	6
Headache or blurred vision	11	14	5	10
Client reported provider discussed				
Exclusive breastfeeding	8	12	10	10
Family planning after birth	9	10	11	10
Delivery plans	18	15	13	14
Number of interviewed ANC clients (weighted)	165	386	424	974

Table A-6.26 Client plans for place of delivery					
Among observed and interviewed antenatal care (ANC) clients, percentage who reported plan for where they will deliver, by type of facility, Egypt SPA 2002					
Background characteristics	Percentage of ANC clients who plan to deliver at:				Number of Interviewed ANC clients (weighted) ¹
	This facility	Other facility	Home	Don't know	
Type of facility					
GS hospital	28	18	16	37	136
MCH/urban HU	8	40	12	40	189
Rural HU	3	28	35	35	517
Mobile unit	0	33	12	55	47
NGO facility	10	27	10	53	82
Region					
Urban Governorates	16	30	8	46	165
Lower Egypt	6	40	17	37	386
Upper Egypt	6	19	38	37	424
Total	8	29	25	39	974
¹ Includes 3 interviewed ANC clients from health offices					

Table A-6.27 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 and region, Egypt SPA 2002

Background characteristics	Percentage of ANC consultations where:				Number of first-visit ANC clients (weighted)	Number of followup visit ANC clients (weighted) ¹
	Provider looked at client card during consultation		Provider wrote on client card at end of visit			
	First visit	Followup visit	First visit	Followup visit		
Type of facility						
GS hospital	38	45	36	43	66	71
MCH/urban HU	73	88	82	90	73	118
Rural HU	65	70	72	68	254	263
Mobile unit	13	15	20	26	28	19
NGO facility	19	38	22	40	25	57
Region						
Urban						
Governorates	50	75	54	74	61	104
Lower Egypt	56	67	63	61	167	221
Upper Egypt	59	59	64	64	218	206
Total	57	65	62	65	446	531

¹ Includes 3 observed ANC clients from health offices

Table A-6.28 Outcome of observed consultations

Among antenatal care (ANC) clients whose consultations were observed, percentage who went home, were referred elsewhere in the same facility, were admitted to the facility, were referred outside the facility, and whose status was uncertain, at the end of the observed components of the consultation, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of ANC consultations where:				Number of observed ANC clients (weighted) ¹
	Client went home	Client referred: same facility	Client admitted to facility	Client referred elsewhere	
Type of facility					
GS hospital	83	10	5	1	136
MCH/urban HU	85	13	0	2	191
Rural HU	96	2	0	1	517
Mobile unit	98	0	0	2	47
NGO facility	91	7	0	2	83
Region					
Urban Governorates	72	25	1	2	165
Lower Egypt	95	3	0	2	388
Upper Egypt	97	1	1	0	424
Total	92	6	1	1	977

¹ Includes 3 observed ANC clients from health offices

Table A-6.29 Client feedback on services

Among ANC clients whose consultations were observed, percentage who said that they considered specific items as big problems for them the day of the visit, by type of facility, Egypt SPA 2002

Client service issue	Percentage by type of facility					Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	NGO facility	
Behavior/attitude of provider not good	2	4	2	0	0	2
Inability to discuss concerns with provider	8	8	7	6	2	7
Not sufficient comment on progress of pregnancy	7	9	5	3	2	6
Poor quality of examination and treatment	5	6	6	3	1	5
Waiting time to see provider too long	10	14	11	8	6	11
Lack of availability of medicines or supplies	13	10	11	9	4	10
Opening hours of facility inconvenient	2	2	4	1	1	3
Lack of cleanliness of facility	0	3	1	0	0	1
Lack of privacy	3	6	2	1	3	3
Cost is too high	2	1	1	2	2	1
Time too long between start and complete consultation	1	5	3	0	2	3
Waiting time for laboratory results too long	1	2	2	0	0	2
Number of interviewed ANC clients (weighted) ¹	136	189	517	47	82	974

¹ Includes 3 interviewed ANC clients from health offices

Table A-6.30 Reasons antenatal care clients chose this facility for services

Among antenatal care (ANC) clients, whose consultations were observed, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of ANC clients agreeing item was a factor in choosing facility								Number of interviewed ANC clients (weighted) ¹
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well-treated	Facility is nearby	Good reputation	Other response	
Type of facility									
GS hospital	3	28	7	20	18	47	21	11	136
MCH/urban HU	9	29	3	21	27	41	23	15	189
Rural HU	4	17	1	26	30	61	18	13	517
Mobile unit	29	18	0	36	16	52	48	6	47
NGO facility	43	43	1	19	33	30	30	5	82
Region									
Urban Governorates	21	33	5	27	18	48	30	7	165
Lower Egypt	6	25	2	25	29	50	19	19	386
Upper Egypt	8	18	1	22	30	56	22	8	424
Total	9	24	2	24	27	52	22	12	974

¹ Includes 3 interviewed ANC clients from health offices

A-6.31 Personal characteristics of antenatal care clients by employment status

Among antenatal care (ANC) clients whose consultation was observed and who were interviewed, percent distribution by employment status, and among employed ANC clients, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2002

Background characteristics	Among all ANC clients, percentage who are:		Number of interviewed ANC clients (weighted) ¹	Among employed ANC clients, percentage who:						Number of interviewed ANC clients who are employed (weighted)
	Employed	Not employed		Work for:			Receive:			
				Family member	Someone else	Self	Salary in cash	Salary in cash and in kind ²	No salary	
Type of facility										
GS hospital	11	89	136	5	77	18	86	0	13	15
MCH/urban HU	12	88	189	15	68	18	74	3	24	22
Rural HU	8	92	517	19	65	15	73	5	29	43
Mobile unit	5	95	47	0	67	33	100	0	0	2
NGO facility	12	88	82	0	87	13	100	0	0	10
Region										
Urban										
Governorates	12	88	165	0	89	11	97	3	0	20
Lower Egypt	12	88	386	14	58	28	70	4	28	47
Upper Egypt	6	94	424	23	73	5	77	0	25	25
Total	9	91	974	11	72	17	81	3	21	92

¹ Includes 3 interviewed ANC clients from health offices

² None of the interviewed clients received only in-kind payment.

A-6.32 Personal characteristics of antenatal care clients by education

Among antenatal care (ANC) clients, whose consultations were observed and who were interviewed, percent distribution by education level and, among clients with no or primary education, percent distribution by literacy status, indicating their education and literacy status as noted below, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of all ANC clients				Number of interviewed ANC clients (weighted)	Percentage of ANC clients with primary or no education who			Number of interviewed ANC clients with primary or no education (weighted) ¹
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write	Can read and write	
Type of facility									
GS hospital	40	11	11	38	136	72	3	26	69
MCH/urban HU	27	10	13	50	189	60	6	34	70
Rural HU	54	7	5	34	517	81	3	16	319
Mobile unit	39	12	21	28	47	56	9	35	24
NGO facility	28	7	8	57	82	69	2	29	29
Region									
Urban Governorates									
Urban Governorates	24	11	16	49	165	48	14	38	57
Lower Egypt	39	5	5	51	386	77	2	21	169
Upper Egypt	57	11	9	24	424	79	3	18	287
Total	44	8	8	39	974	75	4	21	513

¹ Includes 3 interviewed ANC clients from health offices

Table A-6.33 Emergency maternity transportation systems

Percentage of facilities with emergency maternity transportation systems, having indicated means of transportation and median transportation time (in minutes) by type of facility and region, Egypt SPA 2002

Background characteristics	Among facilities having emergency transportation, percentage in which means for transportation is:				Median transportation time (minutes) to referral facility using most common mode of emergency transportation ⁴	Number of facilities supporting emergency transportation (weighted) ⁵
	Dedicated vehicle ¹	Vehicle at other facility ²	Multipurpose vehicle at facility	Other arrangement ³		
Type of facility						
GS hospital	79	48	34	30	21	18
MCH/urban HU	80	56	38	32	11	21
Rural HU	45	74	28	37	20	22
Region						
Urban Governorates	64	75	39	34	11	12
Lower Egypt	71	43	29	17	20	22
Upper Egypt	66	65	34	48	16	27
Total	68	59	33	34	16	62

Note: Emergency maternity transportation systems are any planned program where facility takes some responsibility for ensuring client reaches referral location. Where client must find transport and must pay the total cost, the facilities do not have an emergency transportation system.

¹ Ambulance or other vehicle that stays at the facility.

² Facility calls for dedicated vehicle from other facility to collect emergency patient.

³ Any other plan where the facility arranges for the emergency transport or contributes toward the cost of rental vehicles.

⁴ Transportation time does not vary by season.

⁵ Includes data from one NGO facility that report supporting emergency transportation.

Table A-6.34 Availability of specific equipment and supplies for quality delivery services					
Among facilities that offer delivery services, percentage where there are infection control items, other items to support quality of services, and infrastructure for quality delivery, by type of facility Egypt SPA 2002					
Items to support quality services	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Infection control					
Soap	49	49	33	74	41
Water	89	95	83	100	87
Clean latex gloves	74	63	54	83	61
Disinfecting solution	70	64	71	91	70
Sharps box	58	66	72	48	67
All items for infection control ¹	26	39	20	32	25
Covered waste receptacle with plastic liner	27	38	25	57	29
All items for infection control plus waste receptacle	14	23	2	32	9
Infrastructure for delivery					
Visual privacy and auditory privacy	92	86	88	91	89
Visual privacy	92	95	92	91	93
No privacy	8	5	8	9	7
Delivery bed ²	99	98	97	100	98
Examination light ³	83	77	86	100	84
All elements of infrastructure ⁴	78	64	80	91	77
Other items to support quality services					
Blank partograph	10	11	3	0	6
Protocols for management of complications	10	11	9	8	9
Delivery provider (physician) on site 24 hours	75	69	46	41	56
Delivery provider (physician) on call 24 hours	0	7	0	9	1
All other items to support quality ⁵	2	4	0	0	1
Number of facilities offering delivery services (weighted)	49	35	129	8	221
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 Protocols, partograph, and delivery staff available 24 hours per day with duty schedule observed					

Table A-6.35 Details for processing equipment in delivery service area									
Among facilities offering delivery services, percentage that process equipment and/or store processed equipment for reuse in the delivery service area, in the main facility sterilization area ¹ , in the family planning service area or another service area, by type of facility and region, Egypt SPA 2002									
Background characteristics	Among facilities offering delivery services, percentage where:								Number of facilities offering delivery services (weighted)
	Equipment is processed in indicated area ¹			Processed equipment is stored in the indicated area					
	Delivery service area	Main facility area	Family planning area	Delivery service area	Main facility area	Family planning service area	Other service area ²	No storage location of sterilized items reported	
Type of facility									
GS hospital	62	28	10	62	27	10	1	0	49
MCH/urban HU	58	20	22	56	19	23	0	2	35
Rural HU	12	54	34	8	52	39	0	1	129
NGO facility	25	67	8	16	76	8	0	0	8
Region									
Urban Governorates	61	19	20	56	24	20	0	0	25
Lower Egypt	34	30	36	26	29	42	0	3	81
Upper Egypt	22	58	20	22	56	21	1	0	115
Total	31	43	26	28	42	29	0	1	221
¹ Main facility processing area and delivery processing area may be the same location in small facilities.									
² General outpatient area.									

Table A-6.36 Details for processing delivery equipment

Among facilities offering delivery services, percent distribution by, highest level of processing for which the functioning equipment is available and the correct processing procedure is known, and the percentage with written guidelines for sterilization or high-level disinfecting observed, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities where the indicated method was the highest level for which equipment and knowledge of correct processing procedure was available in location where delivery equipment is processed				Percentage with written guidelines for sterilization or high level disinfecting procedures observed	Number of facilities offering delivery services
	Dry heat ¹	Autoclave ²	Boil/steam or chemical ³	None: equipment or knowledge missing		
Type of facility						
GS hospital	48	16	12	24	14	49
MCH/urban HU	50	6	12	32	34	35
Rural HU	51	8	20	22	32	129
NGO facility	57	14	14	14	29	8
Region						
Urban						
Governorates	64	4	8	24	58	25
Lower Egypt	48	16	18	18	30	81
Upper Egypt	48	7	17	28	23	115
Total	50	10	17	24	29	221

Note: Results refer to area in facility where delivery equipment is processed.

¹ Temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 120 minutes, or automatic.

² Process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.

³ Boil or steam at least 20 minutes. Includes one facility using chemical means: chlorine based or glutaraldehyde with soaking at least 20 minutes.

Table A-6.37 Details for processing equipment in delivery service area

Among facilities offering delivery services and that process equipment in the delivery service area, highest level of processing for which the functioning equipment is available and the correct processing procedure is known, and percentage with written guidelines for sterilization or high-level disinfecting procedures, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities where the indicated method was the highest level for which equipment and knowledge of correct processing procedure was available for equipment processed in delivery service area				Percentage of facilities with written guidelines for sterilization or HLD procedures observed	Number of facilities offering delivery services and processing equipment in delivery service area (weighted)
	Dry heat ¹	Autoclave ²	Boil/steam or chemical ³	None: equipment or knowledge missing		
Type of facility						
GS hospital	45	10	13	32	14	30
MCH/urban HU	40	5	10	45	35	20
Rural HU	35	0	47	18	32	16
NGO facility	50	0	50	0	29	2
Region						
Urban						
Governorates	53	0	12	35	56	16
Lower Egypt	36	11	29	21	30	27
Upper Egypt	38	4	21	38	23	25
Total	41	6	23	30	29	68

¹ Temperature at least 170°C and process at least 60 minutes or temperature 160-169°C and process at least 120 minutes, or automatic.

² Process 20 minutes unwrapped, 30 minutes wrapped (temperature and pressure not included), or item is automatic.

³ Boil or steam at least 20 minutes. Includes one facility using chemical means: chlorine based or glutaraldehyde with soaking at least 20 minutes.

Table A-6.38 Details for storing processed equipment in delivery service area

Among facilities offering delivery services and having processed equipment store in the delivery service area, percentage where the indicated conditions were observed, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities where the indicated conditions were found				Number of facilities offering delivery services with stored processed items in delivery service area (weighted) ³
	Sterile storage conditions ¹	Clean storage conditions ²	Processing date indicated on stored items	Sterile storage and processing date	
Type of facility					
GS hospital	19	76	15	9	30
MCH/urban HU	16	71	16	10	19
Rural HU	0	40	0	0	10
NGO facility	100	100	50	50	1
Region					
Urban Governorates	36	83	40	28	14
Lower Egypt	3	64	3	0	21
Upper Egypt	17	65	7	5	26
Total	17	69	14	9	61

¹ Items are wrapped and sealed with time-steam-temperature (TST) sensitive tape or are in a sterile/HLD box that clasps shut.
² Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer or autoclave, or sitting in disinfecting solution.
³ Most facilities had no equipment stored in the delivery service area.

Table A-6.39 Delivery service providers

Among facilities offering delivery services, percentage of facilities where doctors are available on site or on call for 24-hour duty to conduct deliveries, and where a duty schedule was observed and where there was no duty schedule, and where a staff member with the indicated qualification most commonly conducts deliveries at night, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities with:							
	Doctor available 24 hours, with observed duty schedule		Doctor available 24 hours, with no observed duty schedule		Provider most commonly on duty to conduct deliveries at night ¹			Number of facilities offering delivery services (weighted)
	On site	On call	On site	On call	Doctor	Nurse trained in midwifery	Graduate nurse	
Type of facility								
GS hospital	75	0	12	8	10	1	5	49
MCH/urban HU	69	7	4	11	13	13	11	35
Rural HU	46	0	39	11	9	4	7	129
NGO facility	41	9	24	17	35	0	0	8
Region								
Urban Governorates	81	0	13	4	2	6	4	25
Lower Egypt	53	1	23	14	16	3	12	81
Upper Egypt	53	2	33	10	9	5	4	115
Total	56	1	27	11	11	5	7	221

¹ May be more than one type of staff in a facility who routinely conduct night deliveries.

Table A-6.40 Availability of specific equipment and supplies for quality delivery services

Among facilities that offer delivery services, percentage where supplies for basic delivery services, basic medicines and supplies, and emergency medicines for delivery services are available either in the delivery room (DR) area or in the facility (DR or pharmacy), by type of facility, Egypt SPA 2002

Equipment and supplies	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Basic medicines and supplies for delivery					
Scissor or blade	91	82	74	91	79
Cord clamp or tie	52	80	35	74	47
Suction apparatus (bulb or machine)	89	82	57	92	69
Suction bulb	43	51	32	50	38
Suction machine	76	62	35	86	50
Antibiotic eye ointment for newborn (delivery room)	6	29	29	29	24
Antibiotic eye ointment for newborn (pharmacy or delivery room)	74	67	65	16	65
Skin disinfectant for perineum	92	78	89	91	88
All basic supplies for delivery ¹	31	44	12	8	21
Additional medicines and supplies for managing common complications of delivery					
Syringes and needles in DR	82	82	54	88	66
Syringes and needles in facility	86	85	78	91	82
Intravenous solution and perfusion set in DR	75	55	22	74	41
Intravenous solution and infusion set in facility	83	82	62	100	73
Oral antibiotic ² in facility	78	76	83	16	78
Injectable oxytocic medication in DR	75	74	40	63	53
Injectable oxytocic medication in facility	76	74	41	63	55
Suture material in DR	75	61	37	91	51
Needle holder in DR	94	76	69	82	76
All basic treatment interventions ³	49	33	5	16	20
Additional medicines and supplies for managing serious complications					
Valium or magnesium sulfate in DR	43	2	2	48	13
Valium or magnesium sulfate in facility	53	2	2	48	15
Broad spectrum injectable antibiotic in facility	65	41	52	13	52
Ampicillin	49	35	40	8	40
Procaine penicillin	59	42	56	8	53
Gentamicin	50	21	31	16	33
All other medicines for complications ⁴	39	0	2	16	10
Injectable hydralazine in DR	6	2	0	25	2
Number of facilities offering delivery services (weighted)	49	35	129	8	221
¹ Scissor or blade, cord clamp, suction bulb, antibiotic eye ointment for newborn, and skin disinfectant for perineum					
² Oral amoxicillin, ampicillin, or cotrimoxazole					
³ 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					
⁴ Injectable: Anticonvulsant (Valium or magnesium sulfate) in delivery room area, and antibiotic (penicillin and ampicillin, or gentamicin) in delivery room area or pharmacy					

Infrastructure, equipment and supplies	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Delivery room conditions					
Tiled floor	86	85	69	83	76
Windows with screens in good condition	40	45	41	41	42
Room free of dust, dirt or spider webs	84	91	80	83	83
Separate labor (predelivery) room or recover room (postpartum) present	76	69	29	84	48
Equipment and infrastructure for delivery room					
Air conditioner	22	11	5	66	12
Water heater	44	42	27	74	35
24-hour functioning light source	85	84	85	100	85
Diagnostic and treatment materials					
One full oxygen cylinder	68	59	19	100	39
Oxygen cylinder regulator	65	57	22	100	40
Blood pressure apparatus	85	84	84	100	85
Adult stethoscope	87	84	86	100	86
Fetal heart detector (sonicaid)	58	59	48	84	53
Gel for fetal heart detector	56	61	42	66	49
Neonatal stethoscope	26	29	24	32	25
Fetal stethoscope (Pinard)	80	74	54	57	63
Other materials for delivery services					
Clean Mackintosh oilcloth for delivery	74	74	32	84	50
Sterile gloves	71	62	34	82	48
Sterile Foley catheter size 18/20 (plastic)	64	43	8	66	28
Sterile straight urinary catheter size 18/20 (plastic)	55	49	13	74	30
Two forceps (Kocher)	92	78	68	91	76
Additional administrative forms					
Referral forms	22	43	23	0	25
Delivery sheet	65	20	3	33	20
Number of facilities offering delivery services (weighted)	49	35	129	8	221

Background characteristics	Percentage of facilities offering delivery services with indicated capacity								Number of facilities offering delivery services (weighted)
	Assist labor		Remove retained products		Blood transfusion services	Caesarean section	Emergency support for newborn		
	Forceps	Vacuum extractor	Vacuum aspirator	D&C kit			Newborn respiratory support ¹	External heat source ²	
Type of facility									
GS hospital	44	45	12	48	60	71	44	56	49
MCH/urban HU	2	0	0	0	0	0	15	42	35
Rural HU	0	5	0	0	0	0	8	5	129
NGO facility	41	50	16	57	34	63	32	49	8
Region									
Urban Governorates	19	17	7	22	19	28	27	43	25
Lower Egypt	14	19	5	16	19	23	21	23	81
Upper Egypt	8	11	1	8	10	12	13	20	115
Total	12	15	3	13	15	18	18	23	221

Table A-6.43 Capacity to conduct caesarean section

Among facilities that offer caesarean section, percentage where the indicated item was available by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering caesarean section, with indicated item:									Number of facilities offering caesarean section (weighted)
	Basic items				All basic items observed ⁴	Additional components			Provider for conducting caesarean section on duty 24-hours	
	Operating table	Operating light	Scrub area adjacent to OR	Sterilized instruments		Sterile gowns/towels/sheets	Anesthetist	Anesthesia-giving set		
Type of facility										
GS hospital	100	100	93 ¹	84 ²	82	89 ³	68 ⁵	95	76	35
NGO facility	100	100	88	100	88	100	100	100	25	5
Region										
Urban										
Governorates	100	100	91	100	91	100	89	100	66	7
Lower Egypt	100	100	90	78	78	87	74	94	77	19
Upper Egypt	100	100	96	91	87	91	61	96	61	14
Total	100	100	92	86	83	91	72 ⁶	95	69	40

¹ An additional 2 percent of facilities reported the scrub area was present but it was not observed.

² An additional 5 percent of facilities reported the sterilized instruments were available but they were not observed.

³ An additional 2 percent of facilities reported the gowns, towels and sheets were present but they were not observed.

⁴ Operating table, operating light, scrub area, and sterilized instruments.

⁵ Duty schedule observed. An additional 23 percent of facilities reported they had an anesthetist but there was no duty schedule.

⁶ An addition 20 percent of facilities they had an anesthetist but there was no duty schedule.

Table A-6.44 Newborn care practices

Among facilities offering delivery services, percentage that report the indicated item is a routine component of newborn care, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility				Total percentage
	GS hospital	MCH/urban HU	Rural HU	NGO facility	
Routine newborn care practices					
Routine suction with catheter	91	87	58	100	72
Full immersion bath within 24-hours after birth	24	45	16	25	23
Weigh newborn	71	91	83	91	82
Infant scale available	53	78	71	84	68
Provide vitamin A to mother	70	85	70	16	71
Vitamin A in delivery area	54	70	63	24	61
Vitamin A in pharmacy or delivery area	75	80	79	25	76
Provide OPV to newborn	17	21	21	0	19
Provide BCG to newborn	11	9	11	0	10
Provides vitamin K to newborn	27	20	17	24	20
Vitamin K in delivery service area	56	47	40	49	45
Provides prelacteal liquids to newborn	31	9	6	8	12
Practices rooming in ¹	97	92	83	92	88
Care of the umbilical cord					
70 percent alcohol	74	93	88	82	85
Betadine	40	20	16	9	22
Dry dressing only	29	23	25	9	25
Number of facilities offering delivery services (weighted)	49	35	129	8	221

¹ Newborn stays with mother.

Table A-6.45 Utilization of delivery services by facilities included in the ESPA

Median average monthly home delivery clients, median number of vaginal deliveries, and median number of caesarean sections conducted by facilities having data available on the day of the survey, by type of facility, Egypt SPA 2002

Type of facility	Median monthly vaginal deliveries	Number of facilities reporting vaginal delivery data (weighted)	Median monthly home deliveries	Number of facilities reporting home delivery data (weighted) ¹	Median monthly caesarean sections	Number of facilities reporting caesarean section data (weighted)
GS hospital	30	41	14	11	10	33
MCH/urban HU	6	33	11	22	na	0
Rural HU	1	94	8	84	na	0
NGO facility	5	4	na	0	4	3
Total	2	172	9	117	10	37

¹ Data are from health information system monthly reports available at the facility the day of the survey. Data were collected for the 12 months preceding the survey; however, frequently some months were missing. Information from the number of months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.
na = Not applicable

Table A-6.46 Information on routine charging practices for delivery services

Among facilities offering delivery services, percentage that have routine charges for services and percentage where each of the indicated fee systems is utilized, and among facilities with routine fees, percent distribution by type of fee posting, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering delivery services where fee system involves:				Number of facilities providing services (weighted) ¹	Percentage of with public posting of fees			Number of facilities having any routine charges for delivery services (weighted)
	Fixed fee for all delivery costs	Fixed fee ANC plus delivery	Charge for medicines and tests	No routine charges		All fees posted	Some fees posted	No fees posted	
Type of facility									
GS hospital	15	0	2	83	49	7	2	91	8
MCH/urban HU	56	4	0	44	35	25	0	75	19
Rural HU	28	0	0	72	129	8	0	92	48
NGO facility	100	0	16	0	8	32	8	60	8
Region									
Urban Governorates	51	2	3	49	25	46	6	48	13
Lower Egypt	22	0	0	78	81	19	0	81	20
Upper Egypt	34	1	1	65	115	4	0	96	50
Total	32	1	1	68	221	14	1	85	83

¹ Three percent of facilities reported that they had no routine charges; charges vary depending on the case.

Table A-6.47 Supportive management for providers of delivery services

Among interviewed delivery service providers, percentage who received in-service training related to delivery services in the past 12 months, percentage who were personally supervised in the past 6 months, percentage who received both personal supervision in the past 6 months and in-service training in the past 12 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed delivery service providers who:				Number of interviewed delivery service providers (weighted)
	Received in-service training during the past 12 months ¹	Were personally supervised in past 6 months	Were both personally supervised during the past 6 months and received in-service training during the past 12 months	Received most recent in-service training 13-59 months preceding the survey	
Type of facility					
GS hospital	12	73	8	38	115
MCH/urban HU	22	93	21	31	73
Rural HU	21	96	21	32	146
NGO facility	40	38	16	26	5
Region					
Urban Governorates	19	83	19	22	37
Lower Egypt	12	88	12	34	118
Upper Egypt	23	87	19	35	184
Total	18	87	17	34	339

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

Table A-6.48 Supportive management: In-service training for delivery service providers

Among interviewed delivery service providers, percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed service providers who received in-service training on specific topics														Number of interviewed delivery service providers (weighted)
	Delivery care		Use of partograph		Lifesaving skills		PMTCT ¹		Exclusive breastfeeding		Care of normal newborn		Neonatal resuscitation		
	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	
Type of facility															
GS hospital	4	25	4	16	3	20	4	13	1	18	1	11	4	6	115
MCH/urban HU	14	12	11	10	8	8	5	15	10	18	9	14	8	13	73
Rural HU	11	20	8	14	10	11	4	10	7	22	8	15	7	11	146
NGO facility	8	19	32	12	16	12	0	19	8	12	8	12	8	12	5
Region															
Urban Governorates	12	8	12	2	8	7	2	16	13	10	9	8	10	7	37
Lower Egypt	3	18	3	12	3	16	5	14	2	16	3	13	4	12	118
Upper Egypt	13	24	10	17	9	13	4	10	7	24	7	14	7	9	184
Total	9	20	8	14	7	14	4	12	6	20	6	13	6	10	339

¹ Prevention of mother-to-child transmission.

Table A-6.49 Supportive supervision for delivery service providers

Among interviewed delivery service providers, who received such a supervisory visit during the past 6 months, median number of times staff were supervised, and percentage who report specific activities of the supervisor during the last visit, by type of facility and region, Egypt SPA 2001

Background characteristics	Median number of times staff were supervised in past 6 months	Number of interviewed delivery service providers	Percentage of providers reporting indicated activities of the supervisor during the last supervisory visit					Number of delivery service providers who were supervised in past 6 months (weighted)	
			Checked records	Observed work	Provided feedback	Provided updates	Discussed problems		Wrote on unit note
Type of facility									
GS hospital	6	115	92	90	86	66	74	77	153
MCH/urban HU	12	73	97	95	93	74	79	87	174
Rural HU	11	146	97	97	95	82	87	83	202
NGO facility	10	5	100	91	95	76	91	95	21
	3		96	77	85	62	81	77	26
Region									
Urban Governorates	15	37	94	94	90	75	80	94	89
Lower Egypt	3	118	97	93	91	74	79	89	238
Upper Egypt	4	184	96	93	91	74	83	75	285
Total	9	339	96	93	91	74	81	83	508

Chapter 7

Table A-7.1 Availability of services for sexually transmitted infections in facilities reporting no services			
Among facilities reporting they do not offer services for sexually transmitted infections (STIs), percentage where service providers for antenatal care and family planning indicated they offer STI diagnosis and treatment to their clients, by type of facility and region, Egypt SPA 2002			
Background characteristics	Percentage of facilities where providers report STI services are offered to clients attending the indicated service		Number of facilities reporting no STI services (weighted)
	Family planning services	Antenatal care services	
Type of facility			
GS hospital	81	67	20
Fever hospital	0	0	6
MCH/urban HU	86	69	26
Rural HU	68	71	141
Mobile unit	78	67	12
Health office	62	7	18
NGO facility	68	68	21
Region			
Urban Governorates	82	60	25
Lower Egypt	65	57	111
Upper Egypt	70	71	109
Total	69	63	245

Table A-7.2 Availability of system components, infrastructure, and resources to support quality services for sexually transmitted infections

Among facilities that offer services for sexually transmitted infections (STIs) percentage where there are system components (a written confidentiality policy, a system for partner follow up) to support utilization of services, items to support quality counseling (infrastructure to provide privacy, diagnostic and treatment guidelines, visual aids for health education, condoms) items for quality physical examination (items for infection control, privacy, an examination bed, and an examination light), by type of facility, Egypt SPA 2002

Item	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Items to support utilization of sti services								
Written confidentiality policy	0	0	1	1	0	0	0	1
Active partner follow-up system	1	6	5	3	3	0	3	3
Passive partner follow-up system	42	29	34	37	37	26	28	36
No follow-up system for partners	57	65	61	60	60	74	69	62
Items to support quality counseling								
Visual and auditory privacy	80	58	72	79	77	64	86	78
Visual privacy only	87	65	82	85	84	73	87	84
No privacy	13	35	18	15	16	27	13	16
Any guidelines or protocols for STIs	21	3	20	22	13	18	11	19
Guidelines for syndromic diagnosis STIs	4	0	5	4	5	0	3	4
Any visual aids or educational materials	44	3	35	50	39	27	13	41
Educational materials specific for HIV/AIDS	0	0	6	3	0	5	1	2
Condoms at service delivery site	51	0	61	63	74	65	33	58
Condoms anywhere in facility	94	0	95	91	97	100	60	87
All items to support quality counseling ¹	11	0	16	10	11	5	5	10
Items for infection control								
Infection control								
Soap	45	8	72	50	55	52	69	53
Water	91	59	94	93	84	87	95	92
Clean latex gloves	61	14	62	49	47	64	53	52
Disinfecting solution for contaminated equipment	90	21	95	91	100	95	81	90
Sharps box	64	47	80	81	53	87	33	71
All items for control of infection ²	21	0	41	22	11	38	21	23
Waste receptacle	23	9	44	25	24	42	43	29
5 or more 2/3 ml disposable syringes with needles	75	58	92	88	95	95	80	86
All items for control of infection, including syringes and waste receptacle	3	0	25	7	5	21	20	10
Items for physical examination								
Infrastructure and furnishing for examination								
Visual and auditory privacy ³	85	53	79	83	84	69	86	82
Visual privacy ⁴	90	59	92	90	87	87	89	89
No privacy	10	41	8	10	13	13	11	11
Examination bed ⁵	92	40	98	97	100	96	96	96
Examination light ⁶	88	9	99	90	74	100	95	89
All items for examination	76	3	76	76	61	69	81	74
All items for infection control and physical examination ⁷	18	0	36	19	8	30	20	20
Number of facilities offering STI services (weighted)	44	7	39	226	26	14	49	405

¹ Visual and auditory privacy (private room), any guidelines or protocols, 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.

Table A-7.3 Highest level of processing capacity for STI equipment

Among facilities offering services for sexually transmitted infections (STIs) and in the area where STI equipment is processed, percentage with functioning equipment and knowledge of the processing time for sterilization, and where equipment and knowledge for sterilization are not available, those with the equipment and knowledge of processing time for steam, boil, or chemical processing (high level disinfecting (HLD)) STI equipment, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities offering STI services where the indicated processing method was the highest level for which equipment and knowledge of correct processing procedure was available for equipment processed in STI services area			Percentage of facilities with written guidelines for sterilization or HLD procedures observed	Number of facilities offering STI services (weighted)
	All conditions for either dry sterilization or autoclave ¹	All conditions for steam, boil, or chemical processing ¹	No equipment or no knowledge of processing time		
Type of facility					
GS hospital	75	9	16	23	44
Fever hospital	26	0	74	0	7
MCH/urban HU	83	10	7	41	39
Rural HU	58	23	19	29	226
Mobile unit	85	0	15	16	26
Health office	47	20	33	36	14
NGO facility	54	4	42	20	49
Region					
Urban Governorates	74	2	24	48	40
Lower Egypt	64	22	14	30	204
Upper Egypt	58	12	30	19	161
Total	62	16	22	28	405

¹ Functioning equipment available, and knowledge of minimum processing time.

Table A-7.4 Availability of specific tests and medicines for diagnosis and treatment of sexually transmitted infections

Among facilities that offer services for sexually transmitted infections (STIs), percentage with indicated equipment and tests for etiological diagnosis of STIs, and percentage where indicated medicines for treating STIs are available, by type of facility, Egypt SPA 2002

Equipment, test, medicine	Percentage by type of facility							Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Items for etiologic examination								
Vaginal speculum	90	0	86	95	95	100	95	92
Swab stick for specimen	2	6	5	1	0	0	10	2
Syphilis test capacity ¹	16	0	12	1	0	0	11	5
Gonorrhea test capacity ²	9	29	2	0	0	0	7	2
Wet mount testing capacity ³	30	35	17	2	0	0	16	8
HIV/AIDS testing capacity ⁴	23	23	2	0	0	0	9	4
All four laboratory tests	5	0	0	0	0	0	4	1
Medicines for treatment								
Metronidazole (trichomoniasis)	74	82	84	76	29	21	4	63
Ceftriaxone (gonorrhea)	21	23	3	1	0	0	0	3
Ciprofloxacin (gonorrhea)	10	53	0	3	5	0	0	4
Doxycycline (chlamydia, syphilis)	3	12	3	10	3	4	0	7
Tetracycline (chlamydia, syphilis)	62	65	40	60	5	0	0	46
Erythromycin (chlamydia, syphilis)	10	26	11	17	0	0	1	12
Penicillin, benzathine (syphilis)	69	53	47	62	3	0	1	48
Penicillin, procaine (syphilis)	67	68	37	53	5	0	3	42
All medicines for sexually transmitted infections ⁵	18	35	2	3	0	0	0	4
Nystatin suppository (candidiasis)	10	0	8	7	3	4	0	6
Number of facilities offering STI services (weighted)	44	7	39	226	26	14	49	405

¹ Either VDRL test and functioning microscope, or RPR test kit.

² Gram stain reagents and functioning microscope or culture capacity.

³ Functioning microscope.

⁴ ELISA, Western Blot, or Rapid test.

⁵ At least one medicine for treating trichomoniasis, gonorrhea, chlamydia, and syphilis.

Table A-7.5 Information on user fees for services for sexually transmitted infections

Among facilities offering services for sexually transmitted infections (STIs) among facilities with user fees, percentage that have user fees for services, percentage where each of the indicated fee systems is utilized, and percentage publicly posting fees by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of facilities charging for the indicated items					Number of facilities providing services (weighted)	Percentage of facilities posting fees publicly			Number of facilities having any user fees for STI services (weighted)
	Fixed fee for health card	Fixed fee for each consult	Charge for medicines and tests	Other routine charges	No charges or don't know		All fees posted	Some fees posted	No fees posted	
Type of facility										
GS hospital	0	81	3	0	19	44	18	4	78	33
Fever hospital	0	76	0	3	24	7	11	0	89	5
MCH/urban HU	0	70	5	2	27	39	23	2	75	27
Rural HU	0	67	0	0	33	226	9	3	87	147
Mobile unit	0	23	5	0	71	26	9	0	91	7
Health office	0	22	0	0	78	14	0	0	100	3
NGO facility	1	86	17	0	12	49	44	6	49	43
Region										
Urban										
Governorates	2	70	11	0	30	40	46	13	41	28
Lower Egypt	0	68	2	0	30	204	13	3	84	135
Upper Egypt	0	64	2	0	36	161	15	2	83	104
Total	0	67	3	0	32	405	17	4	79	267

Table A-7.6 Supportive management for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received in-service training related to STI services in the past 12 months, who were personally supervised during the past 6 months, and whose most recent in-service training was 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed providers of STI services who:				Number of interviewed providers of STI services (weighted)
	Received in-service training during the past 12 months	Were personally supervised in past 6 months	Both received in-service training during the past 12 months and were personally supervised during the past 6 months	Received their most recent in-service training 13-59 months preceding the survey	
Type of facility					
GS hospital	3	84	2	20	158
Fever hospital	28	84	25	32	9
MCH/urban HU	13	93	13	18	89
Rural HU	12	98	12	21	338
Mobile unit	9	97	9	23	25
Health office	10	94	10	31	21
NGO facility	12	60	5	24	55
Region					
Urban Governorates	15	84	13	30	63
Lower Egypt	7	94	6	21	395
Upper Egypt	15	87	13	19	238
Total	10	91	9	21	697

Table A-7.7 Supportive management: In-service training for providers of services for sexually transmitted infections

Among interviewed providers of services for sexually transmitted infections (STIs), percentage who received in-service training on specific topics during the past 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed providers of STI services who received in-service training on specific topics										Received training in STI services during basic pre-service training	Number of interviewed STI service providers (weighted)
	Counseling for and/or prevention of STIs		Clinical diagnosis and treatment for STIs		Syndromic approach for diagnosing and treating STIs		Any course related to HIV/AIDS		Specific course related to PMTCT ¹			
	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m		
Type of facility												
GS hospital	1	15	2	12	1	14	2	10	3	3	49	158
Fever hospital	10	14	13	14	13	8	27	23	21	13	86	9
MCH/urban HU	5	16	4	13	7	12	2	10	3	4	61	89
Rural HU	7	15	7	11	4	11	2	10	4	3	52	338
Mobile unit	7	15	2	17	4	15	3	9	5	3	79	25
Health office	8	17	6	18	10	25	0	16	0	2	46	21
NGO facility	9	20	9	16	10	13	5	10	2	8	77	55
Region												
Urban Governorates	12	26	7	23	10	19	4	14	4	9	69	63
Lower Egypt	3	16	3	12	4	13	3	11	3	2	48	395
Upper Egypt	8	12	9	10	4	11	2	8	4	5	66	238
Total	6	15	6	12	4	13	3	10	4	4	56	697

¹ Prevention of mother-to-child transmission (of HIV/AIDS).

Table A-7.8 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 and region, Egypt SPA 2002

Background characteristics	Median number of times staff were supervised in past 6 months	Number of interviewed STI service providers	Among supervised STI service providers, percentage where indicated activities were conducted during the last supervisory visit					Wrote note on unit record	Number of STI service providers who received supervision in past 6 months (weighted)
			Checked records	Observed work	Provided feedback	Provided updates	Discussed problems		
Type of facility									
GS hospital	7	158	94	94	90	73	83	86	133
Fever hospital	5	9	83	84	80	68	69	64	8
MCH/urban HU	7	89	99	96	94	81	82	91	83
Rural HU	9	338	98	95	95	75	86	86	331
Mobile unit	6	25	100	97	93	65	83	91	24
Health office	13	21	100	96	98	90	93	98	20
NGO facility	5	55	77	78	81	54	78	70	33
Region									
Urban									
Governorates	13	63	95	91	92	73	79	95	53
Lower Egypt	7	395	99	95	94	77	86	95	373
Upper Egypt	9	238	93	93	91	69	82	67	206
Total	7	697	96	94	93	74	84	86	632

Table A-7.9 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 and region, Egypt SPA 2002

Background characteristics	Median average number of STI clients per month ¹	Number of facilities (weighted) ²
Type of facility		
GS hospital	17	7
Fever hospital	0	2
MCH/urban HU	16	4
Rural HU	4	33
Mobile unit	14	4
Health office	0	2
NGO facility	5	3
Region		
Urban governorates	0	1
Lower Egypt	5	37
Upper Egypt	5	17
Total	5	55

¹ Data are from health information system monthly reports available at the facility the day of the survey. Data were asked for the 12 months preceding the survey; however, frequently some months were missing. Information from the number of months for which data were available was summed and an average monthly number of clients calculated for each facility. This number was then used to calculate the median number of clients per month.

² All facilities did not have data available.

Table A-7.10 Service area where client was observed for sexually transmitted infection

Among clients who were assessed for possible sexually transmitted infections (STIs) and were observed, percentage who had come to the ANC clinic for ANC, percentage who had come to the FP clinic for FP services, and percentage whose primary reason for visiting the facility was for an assessment for reproductive tract infection (RTI) or STI, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of observed STI clients who came to facility primarily for:			Number of observed STI clients (weighted)
	FP services	ANC services	STI/RTI assessment	
Type of facility				
GS hospital	24	6	70	115
Fever hospital	No observed STI clients			0
MCH/urban HU	42	6	52	105
Rural HU	45	18	37	51
Mobile unit	32	10	59	63
Health office	65	0	35	20
NGO facility	34	9	57	90
Region				
Urban Governorates	36	6	59	128
Lower Egypt	37	4	59	143
Upper Egypt	34	13	53	173
Total	36	8	56	444

Table A-7.11 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, Egypt SPA 2002

Observed items	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Reassured about confidentiality	4	6	8	3	5	7	6
Client history elicited:							
Client symptoms	97	93	100	97	84	97	97
How long symptoms have been present	68	67	72	73	52	69	69
History of recent sexual contact	4	3	11	11	5	12	8
Symptoms in husband	15	11	13	13	16	11	13
Marital status ¹	3	1	0	0	0	2	1
All elements of client history ²	0	0	0	0	0	0	0
Examination							
External genitalia examined	82	71	66	70	79	80	74
Pelvic examination conducted	79	80	73	88	95	88	81
Any physical examination conducted	86	85	83	93	100	98	88
Types of laboratory tests mentioned							
Any laboratory test	15	10	3	3	0	5	7
Blood test	3	2	2	2	0	1	2
Urinalysis	12	9	3	2	0	4	6
Microscopic examination of specimen	1	0	0	0	0	0	0
Number of observed female STI clients (weighted)	90	85	120	56	15	78	444

¹ Married, husband absent, husband has other wife.

² Client symptoms, how long symptoms have been present, history of recent sexual contacts, symptoms in husband, and marital status.

Table A-7.12 Observed physical examination for female clients assessed for sexually transmitted infections

Among observed female clients assessed for sexually transmitted infections (STIs) who had a physical examination,¹ percentage for whom the indicated items were components of the physical examination, by type of facility, Egypt SPA 2002

Observed items	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Conditions during physical examination							
Visual privacy assured	88	85	91	97	89	96	91
Visual and auditory privacy assured	86	78	89	93	89	95	88
Provider washed hands with soap prior to examination	4	4	5	3	0	0	3
Provider wore clean latex gloves	68	74	72	67	79	69	71
Genitals were fully exposed	94	84	80	73	79	80	82
Client was lying down	95	85	80	73	79	81	83
Labia were inspected	89	81	77	73	73	79	80
All elements of examination ²	1	2	5	0	0	0	2
Female client had a pelvic examination	91	95	89	95	95	90	92
Number of observed female clients having any physical examination (weighted)	78	72	99	52	15	76	392

¹ These clients may have had only an external examination or may have also had a pelvic examination.

² Visual and auditory privacy assured, provider washed hands with soap prior to examination, provider wore clean latex gloves, genitals were fully exposed, the client was lying down, and labia were inspected.

Table A-7.13 Observed pelvic examination for female sexually transmitted infections clients

Among observed clients assessed for sexually transmitted infections (STIs) who had a pelvic examination, percentage for whom the indicated items were components of the examination, by type of facility, Egypt SPA 2002

Observed items	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Provider treatment of client							
Visual privacy assured	87	84	90	98	89	96	90
Auditory privacy assured	85	77	87	95	89	95	87
Explained procedure before starting	6	5	0	2	5	5	3
Asked client to relax	26	23	41	30	39	25	30
Infection control procedures							
Provider washed hands with soap prior to examination	3	5	6	4	0	0	3
Provider wore clean gloves	68	74	69	69	83	69	70
Used sterilized or HLD instruments	81	94	91	81	100	73	85
Prepared all instruments before starting	83	90	87	82	100	84	86
Used items placed in decontaminating solutions	76	90	83	81	89	58	78
Provider washed hands after removing gloves	16	13	22	9	28	18	17
Contaminated surfaces wiped with disinfectant	13	8	3	7	5	15	9
Procedures utilized							
Used speculum	93	94	91	89	100	90	92
Explain speculum procedure	0	2	0	2	0	2	1
Inspected cervix	78	92	74	59	84	85	78
Performed bimanual examination	49	25	52	34	22	59	44
Conducted all elements of examination ¹	0	1	0	0	0	1	0
Number of observed clients receiving pelvic examinations (weighted)	71	68	89	50	14	69	360

¹ Used speculum, explained the speculum procedure, used sterilized or HLD instruments, prepared all instruments before starting, inspected the cervix, and performed a bimanual examination.

Table A-7.14 Observed testing and counseling content of observation of clients assessed for sexually transmitted infections

Among clients whose consultation for sexually transmitted infection (STI) was observed, percentage for whom the indicated items were components of counseling, by type of facility, Egypt SPA 2002

Observed items	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Components of counseling							
Any mention of client diagnosis	84	90	83	95	95	90	87
Any mention of relationship between the infection and sexual activity	13	19	14	17	37	24	18
Client received prescription or medication	98	94	100	98	95	99	98
Client received prescription or medication for sexual partner	11	13	5	18	0	20	12
Client instructed about medications	51	59	64	57	37	67	59
Husband referral encouraged	4	6	0	0	5	9	4
Follow-up appointment discussed	37	54	63	46	42	70	55
Components of health education							
Discuss condoms for prevention	0	3	2	0	6	6	2
Instruct how to use condom	0	3	2	2	6	3	2
Offer condoms	2	6	4	0	6	2	3
Any discussion of condoms or HIV/AIDS	2	7	4	2	6	9	5
Visual aids used	1	0	0	0	5	0	0
Wrote on client health card	26	33	29	19	63	27	29
Number of observed STI consultations (weighted)	90	85	120	56	15	78	444

Table A-7.15 Information from client exit interviews: Reported knowledge and experience related to condom use

Among clients whose consultation for a sexually transmitted infection (STI) was observed¹ and who were interviewed, percentage receiving services for STIs, percentage who reported they had used a condom before, percentage who agreed, when asked, that specific items were contributing factors for why people do not use condoms, and among clients who reported a specific item as a problem with using condoms, percentage who reported discussing the issue with a provider, Egypt SPA 2002

Item	Percentage of clients
Client and husband have used condom before	19
Client agrees indicated item may be a major contributing factor to lack of use of condoms	
Embarrassing to purchase	20
Problem with disposal	11
Embarrassing to discuss with husband	18
Reduces own sexual satisfaction	11
Reduces husband's sexual satisfaction	19
Client identified any of the above items as contributing to lack of use of condoms	38
Health workers talked about condoms today	6
Client received condoms today	4
Number of interviewed STI clients	441
Among clients who reported any items as contributing to lack of use of condoms, percentage who discussed the issue with provider	7
Number of interviewed STI clients who identified an item as contributing to lack of use of condoms (weighted)	166

¹ All were female clients.

Table A-7.16 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 big problems for them the day of the visit, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	MCH/urban HU	Rural HU	Mobile unit	Health office	NGO facility	
Behavior/attitude of provider not good	2	4	2	0	0	1	2
Inability to discuss concerns with provider	5	3	7	2	0	0	4
Insufficient explanation about problem	4	4	4	0	0	1	3
Poor quality of examination and treatment	4	6	4	0	6	0	3
Waiting time to see provider too long	14	7	13	3	0	7	9
Lack of availability of medicines or supplies	17	17	12	13	11	6	13
Opening hours of facility inconvenient	4	6	2	3	0	1	3
Lack of cleanliness of facility	0	3	2	0	0	0	1
Lack of visual privacy	0	1	4	2	0	1	2
Lack of auditory privacy	0	0	2	2	0	1	1
Cost is too high	1	1	0	0	0	0	0
Time too long between start and completion of consultation	1	1	5	0	0	2	2
Waiting time for laboratory results too long	0	0	0	0	0	1	0
Number of interviewed STI clients (weighted)	89	83	120	56	15	77	441

Table A-7.17 Reasons clients observed for sexually transmitted infections chose this facility for services

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percentage who agreed that specific items influenced their decision to choose the facility, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of STI clients agreeing item was a factor in choosing facility							Number of interviewed STI clients (weighted)
	Female physician	Efficiency of the physician	Availability of all specialties	Availability of the service	Clients are well-treated	Facility is nearby	Good reputation	
Type of facility								
GS hospital	10	40	6	19	15	42	26	89
MCH/urban HU	25	23	6	23	28	41	14	83
Rural HU	24	32	0	9	35	54	14	120
Mobile unit	44	8	0	22	24	43	30	56
Health office	21	53	0	26	31	53	21	15
NGO facility	44	38	0	9	32	40	36	77
Region								
Urban								
Governorates	38	29	4	20	20	48	20	106
Lower Egypt	29	40	1	15	26	46	28	159
Upper Egypt	19	24	2	15	33	43	19	175
Total	27	31	2	16	27	45	22	441

Table A-7.18 Personal characteristics of STI clients by employment status

Among clients whose consultation for a sexually transmitted infection (STI) was observed and who were interviewed, percent distribution by employment status, and among employed STI clients, percent distribution by type of work and type of compensation, according to type of facility and region, Egypt SPA 2002

Background characteristics	Among all STI clients, percentage who are:		Number of interviewed STI clients (weighted)	Among employed clients, percentage who:						Number of STI clients who are employed (weighted)
	Employed	Not employed		Work for:			Receive:			
			Family member	Someone else	Self	Salary in cash	Salary in kind	No salary		
Type of facility										
GS hospital	19	81	89	5	64	31	86	5	10	17
MCH/urban HU	11	89	83	10	71	20	80	0	20	9
Rural HU	10	90	120	0	40	60	100	0	0	12
Mobile unit	3	97	56	0	50	50	50	0	50	2
Health office	16	84	15	0	67	33	100	0	0	2
NGO facility	16	84	77	0	93	7	100	0	0	12
Region										
Urban										
Governorates	11	89	106	0	75	25	100	0	0	11
Lower Egypt	22	78	159	2	60	38	90	0	10	36
Upper Egypt	5	95	175	10	81	10	81	10	10	8
Total	13	87	441	3	66	31	91	1	8	55

Table A-7.19 Education status and literacy status of STI clients by education

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 and region, Egypt SPA 2002

Background characteristics	Among interviewed STI clients, percentage with:				Number of interviewed STI clients (weighted)	Percentage of interviewed STI clients with primary or no education who:			Number of STI clients with primary or no education (weighted)
	No education	Primary	Preparatory	Secondary or higher		Cannot read or write	Can read, cannot write	Can read and write	
Type of facility									
GS hospital	52	13	6	29	89	76	3	21	58
MCH/urban HU	44	6	13	37	83	70	0	30	41
Rural HU/Other	58	9	4	29	120	84	0	16	80
Mobile unit	57	9	16	17	56	76	0	24	37
Health office	32	11	5	52	15	25	0	75	6
NGO facility	34	3	11	51	77	64	6	30	29
Region									
Urban Governorates	37	8	18	37	106	63	2	35	48
Lower Egypt	50	5	5	41	159	82	0	18	87
Upper Egypt	55	12	8	25	175	75	2	23	117
Total	49	8	9	34	441	75	1	24	252

Table A-7.20 Numbers of facilities reporting HIV/AIDS service activities

Numbers of facilities reporting that they provide the indicated service related to HIV/AIDS, by type of facility and region, Egypt SPA 2002

Background characteristics	Number of facilities reporting they provide the indicated service (unweighted)			Number of facilities with HIV testing capacity (unweighted)	
	Any HIV/AIDS related services	Counseling and testing ¹	Treatment or medical follow-up of HIV-infected clients	Facility reports	
				Facility reports counseling and testing ¹	Facility reports not providing VCT
Type of facility					
GS hospital	8	3	1	3	14
Fever hospital	11	5	5	3	2
MCH/urban HU	2	2	1	1	0
Rural HU	6	0	0	0	0
NGO facility	1	1	1	1	6
Region					
Urban Governorates	5	4	3	3	1
Lower Egypt	15	4	3	3	8
Upper Egypt	8	3	2	2	13
Total	28	11	8	8	22

¹ The facilities reported they provide voluntary counseling and testing (VCT) services, but there were no VCT programs in Egypt at the time of the survey; the response is interpreted to mean the facility provides or refers clients for HIV testing.

Table A-7.21 Supportive management: In-service training for HIV/AIDS service providers

Among interviewed HIV service providers, percentage who received any HIV-related in-service training in the past 12 months, and among those who received any related in-service training, percentage who received training on specific topics during the 12 months or 13-59 months preceding the survey, by type of facility and region, Egypt SPA 2002

Background characteristics	Percentage of interviewed HIV/AIDS service providers receiving in-service training on topic																Number of interviewed HIV/AIDS service providers (weighted)
	Counseling and prevention of STIs		Counseling for prevention of HIV/AIDS		Clinical diagnosis and treatment of STIs	Syn-dromic approach for STIs	Specific course related to PMTCT		Counseling and social support for HIV/AIDS positive clients		Anti-retroviral treatment		Medical management for HIV/AIDS positive clients		Tuber-culosis		
	12 m	13-59 m	12 m	13-59 m	12 m	12 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	12 m	13-59 m	
Type of facility																	
GS hospital	0	0	0	0	100	100	0	0	0	0	0	0	0	0	25	0	4
Fever hospital	9	14	18	27	100	100	27	36	27	23	23	27	27	23	0	9	22
MCH/urban HU	0	33	0	33	100	100	0	33	0	33	0	17	0	33	0	17	6
Rural HU	33	33	33	0	100	100	67	0	33	0	33	0	33	0	0	33	3
Mobile unit	0	67	0	33	100	100	0	0	0	0	0	33	0	33	33	33	3
Health office	0	50	0	50	100	100	0	50	0	0	0	0	0	0	0	50	2
NGO facility	9	64	9	18	100	100	9	55	0	27	0	27	0	18	0	45	11
Region																	
Urban Governorates	9	52	9	30	100	100	17	39	4	26	4	22	4	26	0	35	23
Lower Egypt	14	14	14	29	100	100	14	43	29	14	14	29	29	14	0	14	7
Upper Egypt	5	14	14	14	100	100	19	24	19	14	19	19	19	14	10	10	21
Total	8	31	12	24	100	100	18	29	14	20	12	22	14	20	4	22	51

Table A-7.22 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, second-line, and prophylactic treatment for TB, by type of facility, Egypt SPA 2002

Item	Percentage by type of facility						Total percentage
	GS hospital	Fever hospital	MCH/urban HU	Rural HU	Health office	NGO facility	
Ability to conduct sputum test for TB	26	42	0	2	0	100	6
Availability of medicines							
Isoniazid (INH)	24	42	15	10	0	0	12
Pyrazinamide	24	29	15	4	0	0	7
Rifampin	20	72	15	12	0	0	14
Ethambutal	21	29	0	4	0	0	6
Remactazid (rifampin & INH)	30	13	0	4	0	0	7
Streptomycin	29	72	0	12	0	0	14
All first-line treatment available	20	29	0	2	0	0	4
All second-line treatment available	16	29	0	0	0	0	2
Number of facilities providing TB services (weighted)	15	1	4	100	1	1	123
Facility has DOTS and all first-line treatment medicines in stock (N=81)	25	0	0	3	0	0	5
Facility does not have DOTS and has all first-line treatment medicines in stock (N=41)	12	32	0	0	0	0	2

MEASURE Service Provision Assessment

Facility Resources Questionnaire

FACILITY IDENTIFICATION	
Name of the facility _____ Facility Location _____ Governorate _____ District _____ Code of the facility Type of Health Facility and Operating Authority Governmental: 11 = General Hospital 21=MCH Center 12=District Hospital 22=Rural health unit 13= Fever Hospital 23=Urban health unit 14= Complimentary 24=Health Office 25=Mobile Unit 26=Other Non-Governmental: 31 =CSI 32= EFPA 33=other non-governmental	QTYPERES GOV <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DISTRICT <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY TYPE..... AND OPERATING AUTHORITY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Date: _____ Name of the interviewer _____	DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> INTERVIEWER CODE.. <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
NO. OF Q Sick child obs..... Exit for sick child..... F.P obs..... Exit for F.P..... ANC obs..... Exit for A.N.C..... STI. Obs Exit for STI..... Service Provider..... Inject. Obs.....	 <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>

TURN ON AND WAIT UNTIL SATELLITE PAGE CHANGES TO "POSITION"

- 1 WRITE ALTITUDE
- 2 PRESS MARK
- 3 HIGHLIGHT "AVERAGE" AND PRESS ENTER
- 4 HIGHLIGHT WAYPOINT NUMBER AND PRESS ENTER
- 5 ENTER FACILITY CODE (6 DIGITS)
- 6 WAIT 5 MINUTES
- 7 HIGHLIGHT " SAVE" AND PRESS ENTER
- 8 PAGE TO MAIN MENUE AND HIGHLIGHT "WAYPOINT LIST" AND PRESS ENTER
- 9 HIGHLIGHT YOUR WAYPOINT
- 10 COPY INFORMATION FROM WAYPOINT LIST PAGE- THIS IS THE AVERAGE OF ALL THE SATTELITE READINGS
- 11 BE SURE AND COPY THE WAYPPOINT NAME FROM THE WAYPOINT LIST PAGE TO VERIFY YOU ARE ENTERING THE CORRECT WAYPOINT INFORMATION ON THE DATA FORM

POSITION											
WAYPOINT NAME			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15px; height: 15px;"></td> </tr> </table>								
ALTITUDE			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15px; height: 15px;"></td> </tr> </table>								
LATITUDE	N/S/W/E	DEGREES	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15px; height: 15px;"></td> </tr> </table>								
LONGITUDE	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> <td style="width: 15px; height: 15px;"></td> </tr> </table>				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15px; height: 15px;"></td> </tr> </table>						

Section 1a. General Information: Management

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
	<p>FOR OUTPATIENT SERVICES: FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR OUTPATIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely confidential and is not identified with any facility name. We are asking for your help to ensure that the information collected is accurate. If there are sections where someone else is the most appropriate person to provide information, we would appreciate your introducing us to that person. I will ask questions and then for many topics I will ask to see some record related to the question. You may choose to stop the interview at any time.</p> <p>Do you have any questions for me? Do I have your agreement to participate?</p>		
	<p>_____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p>	<p>_____ DATE</p>	
100	May I begin the interview?	YES 1 NO 2	→ STOP
101	Routinely, how many days each week is the facility open for outpatient adult curative services?	NUMBER OF DAYS <input style="width: 30px; height: 20px;" type="text"/> DON'T KNOW 8	
102	Is there a physician present (assigned) at the facility at all times (24 hours/day) for emergency services? IF YES, ASK TO SEE DUTY SCHEDULE.	YES, SCHEDULE SEEN 1 YES, SCHEDULE NOT SEEN 2 NO, 3	→ 104 → 104
103	Is there a physician available away from the facility, but officially on call at all times after hours for emergency services? IF YES, ASK TO SEE ON CALL DUTY SCHEDULE.	YES, SCHEDULE SEEN 1 YES, SCHEDULE NOT SEEN 2 NO 3	
104	Does this facility routinely admit inpatients for treatment?	YES 1 NO 2	→ 106
105	Does this facility have beds for overnight observation?	YES 1 NO 2	
106	Does this facility have routine meetings for reviewing management or administrative issues?	YES 1 NO 2 DON'T KNOW 8	→ 109 → 109
107	How often do meetings to discuss the facility management/administrative issues take place?	MONTHLY 1 QUARTERLY 2 SEMI-ANNUALLY 3 OTHER 6	
108	Is an official record of meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES/NOTES) FROM THE MOST RECENT MEETING	YES, RECORD OBSERVED 1 YES, REPORTED, NOT SEEN 2 NO RECORD MAINTAINED 3	
109	Are there any <u>routine</u> meetings about facility activities or management issues that include both facility managers and community members?	YES 1 NO 2 DON'T KNOW 8	
110	Does this facility have any system for determining client opinion about the health facility or services? IF YES, CIRCLE ALL METHODS FOR ELICITING CLIENT OPINIONS THAT ARE USED	SUGGESTION BOX A CLIENT SURVEY FORM B CLIENT INTERVIEW C OTHER X (SPECIFY) NO CLIENT FEEDBACK Y DON'T KNOW Z	→ 113 → 113

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
111	Is there a procedure for collecting and reporting on client opinion? IF YES, ASK TO SEE A REPORT OR FORM WHERE DATA IS COMPILED.	YES, REPORT SEEN.....1	YES, NO REPORT SEEN.....2	NO.....3		
112	In the past 3 months have any changes been made in the program as a result of client opinion? IF YES, DESCRIBE THE CHANGES MADE.	YES, _____ .1 (SPECIFY)	NO.....2	DON'T KNOW.....8		
113	Does this facility provide services according to quality criteria? This refers to a <u>routine</u> program for quality assurance.	YES.....1	NO.....2	DON'T KNOW.....8		→117 →117
114	Is this system implemented throughout the facility, or is it within specific services only?	THROUGHOUT FACILITY.....1	ONLY SPECIFIC SERVICES.....2			
115	Are any of the following methods for quality assurance used? IF YES, ASK TO SEE SOME DOCUMENTATION (REPORT/ MINUTES/ ETC). FOR THE METHOD IMPLEMENTATION.					
	METHOD	METHOD USED				
		1 DOCUME NT SEEN	2 DOCUME NT NOT SEEN	3 METHOD NOT USED	8 NOT DETERMINED	
	1) Supervisory checklist for health system components (e.g. service specific equipment, meds, and records)	1	2	3	8	
	2) Supervisory checklist for health service provision (e.g. Observation Check list)	1	2	3	8	
	3) Facility-wide review of mortality	1	2	3	8	
	4) Periodic audit of medical records or service registers	1	2	3	8	
	5) Quality Assurance committee/team?	1	2	3	8	
	6) Quality Improvement Program (QIP)	1	2	3	8	
	7) Other (SPECIFY)	1	2			
116	Who is responsible for reviewing findings and taking action from quality activities? CIRCLE ALL THAT APPLY AND INDICATE IF THE PERSON(S) ARE POSTED INTERNAL (IN) TO THE FACILITY OR EXTERNAL (OUT) OR BOTH	1 PERSON S INTERNA L TO FACILITY	2 PERSON S EXTERNA L TO FACILITY	3 BOTH INTERNA L AND EXTERNA L	4 NOT USED	8 DON'T KNO W
	1) Individual Supervisors.....	1	2	3	4	8
	2) Management Committee.....	1	2	3	4	8
	3) Special Quality Assurance committee or team.....	1	2	3	4	8
	4) Governorate or district Management Team....	1	2	3	4	8
	5) Other.....	1	2	3		
117	When was the last time a supervisor from <u>outside</u> this facility visited the facility?	WITHIN THE LAST 6 MONTHS 1				
		MORE THAN 6 MONTHS AGO.... 2				→119
		NEVER SUPERVISED FROM OUTSIDE FACILITY..... 3				→119

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
118	The most recent time within the last 6 months that a supervisor from outside the facility visited, did the supervisor:	YES NO DK	
	1) Check some registers/books?.....	CHECKED REGISTERS1	2 8
	2) Discuss problems?	DISCUSSED PROBLEMS...1	2 8
	3) Discuss policy/administrative issues?.....	DISCUSSED POLICY1	2 8
	4) Discuss technical protocols or issues related to service delivery practices?	DISCUSSED TECHNICAL MATTERS1	2 8
	5) Hold an official staff meeting?.....	HELD STAFF MEETING1	2 8
	6) Observe individual staff providing services? ...	OBSERVE SERVICE PROVISION1	2 8
	7) Record observations in supervision book	RECORD IN BOOK.....1	2 8
	8) Do anything else?	OTHER_____1 (SPECIFY)	2 8
119	Is there a standard form used for clients referred to other facilities? ASK TO SEE THE FORM. (IF THE FACILITY IS THE REFERRAL FACILITY, THEN CIRCLE "4" FOR REFERRAL FACILITY.	YES, FORM SEEN 1 YES, FORM NOT SEEN 2 NO FORM USED 3 REFERRAL FACILITY..... 4 DON'T KNOW 8	→121 →121 →121
120	Does the referral form have a section requiring client information explaining the reason for the referral?	YES 1 NO 2 DON'T KNOW 8	
121	What is the primary source(s) from which equipment, supplies, other goods required for services are made available for this facility.	GOVERNMENT (MoH)..... A DONORS..... B CLIENT REVENUES C OTHER _____ X DON'T KNOW Z	
122	What are the primary sources of funds for your facility. BUDGET MEANS AN ANNUAL AMOUNT OF MONEY AVAILABLE TO THE FACILITY FOR NORMAL RUNNING COSTS	ANNUAL BUDGET (MOH) A MOH, BUT NOT THROUGH ANNUAL BUDGET B ANNUAL BUDGET (DONORS) C DONORS, NOT ANNUAL BUDGET D CLIENT REVENUES E OTHER _____ X DON'T KNOW Z	
123	Does this facility have a specific system for maintenance and repair of the building or infrastructure (e.g. plumbing or electric) ? IF YES, Who authorizes repairs?	IN-CHARGE OF FACILITY A IN-CHARGE OF UNIT REQUIRING REPAIR..... B OTHER _____ X (SPECIFY) NO SYSTEM Y DON'T KNOW Z	→125 →125
124	Who makes repairs for the building or infrastructure?	ON-SITE STAFF 1 HIRE FROM OUTSIDE 2 BOTH ON-SITE AND OUTSIDE... 3 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO	
125	Does this facility have a program for routine preventive maintenance for major equipment such as a generator or sterilizing equipment? This means the equipment is checked periodically even if there is no problem. IF YES: Who is responsible for the maintenance?	YES, ON-SITE STAFF 1 YES, OUTSIDE SUPPORT 2 YES, BOTH ONSITE AND OUTSIDE 3 NO ROUTINE MAINTENANCE 4 DON'T KNOW 8		
126	What is the system for repairing or replacing small equipment (blood pressure cuffs, stethoscope, etc). (CIRCLE ALL THAT APPLY).	ON-SITE MAINTENANCEA PETTY CASH FOR REPLACING..B SEND ELSEWHERE FOR REPAIR.....C OTHER _____X (SPECIFY) NO SYSTEMY DON'T KNOWZ		
127	Does this facility have a budget line-item in the current budget, or use funds from service improvement box for equipment maintenance?	YES, BUDGET LINE ITEMA YES, SERVICE IMPROVEMENT BOXB NOY DON'T KNOWZ	→ 129 → 129	
128	Is the budget and/or funds from the service improvement box adequate to meet normal needs of your facility for maintaining large equipment and repairing or replacing small equipment ?	APPEARS SUFFICIENT 1 UNCERTAIN IF WILL BE SUFFICIENT 2 NOT SUFFICIENT 3 DON'T KNOW 8		
129	Does this facility routinely charge for adult outpatient curative consultation services? IF YES, WHAT SYSTEMS APPLY?	YES, FEE VARIES BY DAY OR TIME OF DAY A YES, ECONOMIC AND FREE SECTION B YES, DISCOUNT OR EXEMPTION FOR SOME CLIENTS C YES, FIXED FEE, VARIES BY TYPE OF CLIENT D YES, PREPAY FOR MULTIPLE VISITS FOR ONE SERVICE E OTHER _____ X (SPECIFY) NOY DON'T KNOWZ	→ 136 → 136	
130	CIRCLE ALL CHARGING PRACTICES USED	ECONOMIC	FREE SECTION	
	1 Fixed fee for registration ticket or consultation	A	B	NO
	2 Fixed fee health card	A	B	Y
	3 Charge for medications	A	B	Y
	4 Charge for tests	A	B	Y
131	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges? [GO TO AREA AFTER COMPLETING INTERVIEW WITH DIRECTOR]	YES ALL FEES POSTED 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8		
132	CHECK QUESTION 129 C. DOES THE FACILITY OFFER EXEMPTIONS OR DISCOUNTS FOR SOME CLIENTS?	YES 1 NO 2 DON'T KNOW 8	→ 136 → 136	
133	Who is in charge of making the final decision on whether a client receives a discount of exemption?	IN-CHARGEA SOCIAL WORKERB OTHER _____X DON'T KNOWZ		
134	Is there a book or register where discounted fees are collected and exemptions are listed? IF YES, ASK TO SEE THE REGISTER.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER 3 DON'T KNOW 8	→ 136 → 136 → 136	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
135	What is the most recent date for an exemption or discount?	WITHIN 7 DAYS 1 >7 DAYS WITHIN 30 DAYS 2 MORE THAN 30 DAYS 3	
136	Does this facility receive any reimbursement for services to discounted or exempted clients from sources outside of the routine running budget or direct client fees? This may include reimbursement from insurance companies, from charities or communities that reimburse for poor clients, or other systems the facility may participate in. IF YES, INDICATE WHICH PLANS APPLY.	CHARITY FUND FOR POOR.....A INSURANCE/PRE-PAYB HIO/SHIP.....C MOH FUNDD OTHER SYSTEM _____ ..E (SPECIFY) OTHER _____X (SPECIFY) NOY DON'T KNOWZ	
137	Does this facility have an active women's Club? IF YES, ASK TO SEE ANY RECORD OF ACTIVITIES OR SCHEDULE OF ACTIVITIES FOR THE PRIOR MONTH OR THE CURRENT MONTH	YES, DOCUMENT SEEN 1 YES, NO DOCUMENT SEEN..... 2 NO 3 DON'T KNOW 8	
138	Does this facility have a working phone or short-wave radio for calling outside?	YES 1 NO 2	→140
139	Is there a phone or short-wave radio within five minutes time from the facility that staff can use in an emergency? IF YES: Is that phone or short-wave radio available 24 hours a day?	YES, AVAILABLE 24 HOURS 1 YES, NOT AVAILABLE 24 HOURS 2 NO, NONE WITHIN 5 MINUTES ... 3	
140	Does this facility ever have electricity? (from any source)	YES 1 NO 2	→142
141	Is the electricity always available during the times when the facility is providing services or is it sometimes interrupted? IF SOMETIMES INTERRUPTED, ASK: On how many <u>days</u> during the past week was the electricity <u>not available for two (2) or more hours</u> ?	ALWAYS AVAILABLE 0 <input type="checkbox"/> # OF DAYS NOT AVAILABLE PAST WEEK	
142	What is the <u>most commonly used</u> source of water for the facility <u>at this time</u> ?	PIPED 10 PROTECTED WELL/ BOREHOLE 20 UNPROTECTED WELL / BOREHOLE 21 RIVER/LAKE /POND 30 OTHER _____ _96 (SPECIFY) NO WATER SOURCE..... 00	→145
143	Is water outlet from this source available on-site (that is, within 500m) of the facility?	YES, ON-SITE..... 1 NO..... 2	
144	Does this source of water for the facility vary seasonally?	YES 1 NO 2 NO NORMAL SOURCE 3	

Section 1b. General Information: Resources

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO					
	ASK TO GO TO THE MAIN AREA WHERE EQUIPMENT IS CLEANED AND STERILIZED OR DISINFECTED AND ASK TO SPEAK WITH THE PERSON MOST KNOWLEDGEABLE OF THE PROCESSES USED. I want to ask you about how you process used medical equipment such as surgical equipment, forceps, speculums, or other equipment that must be processed before reusing.							
150	What procedure is used for cleaning contaminated equipment prior to final processing for reuse?	SOAKED IN DISINFECTANT SOLUTION BRUSH SCRUBBED WITH SOAP AND WATER1 BRUSH SCRUBBED W/ SOAP AND WATER AND THEN SOAKED IN DISINFECTANT2 BRUSH SCRUBBED WITH SOAP AND WATER3 SOAKED IN DISINFECTANT ONLY, NOT SCRUBBED4 OTHER6 NONE7 DON'T KNOW8	→162					
151	After cleaning, what is the final process most commonly used for disinfecting or sterilizing medical equipment (e.g., surgical instruments) prior to reuse? IF DIFFERENT METHODS ARE USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE DIFFERENT METHODS.	DRY HEAT STERILIZATION A AUTOCLAVE B STEAM STERILIZATION C BOILING D CHEMICAL E OTHER X NONE Y	→159					
GO TO WHERE EQUIPMENT IS STERILIZED AND ASSESS AVAILABILITY OF EQUIPMENT REQUIRED FOR PROCEDURES INDICATED IN QUESTION 151.								
152	ITEM	(a) AVAILABILITY	(b) FUNCTIONING					
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER
	1 Electric dry heat sterilizer	1→b	2→b	3↓	8↓	1	2	8
	2 Electric autoclave (pressure; wet heat)	1→b	2→b	3↓	8↓	1	2	8
	3 Pot with cover (for steaming or boiling)	1	2	3	8			
	4 Other method <u> </u> (SPECIFY)	1	2	3	8			
153	Heat source (stove/Cooker w/fuel or power present) For steaming, boiling, or using non-electric autoclave)	1→b	2→b	3↓	8↓	1	2	8
154	Automatic timer (MAY BE ON MACHINE)	1→b	2→b	3↓	8↓	1	2	8
155	TST Indicator strips (Tape indicating sterilization)	1	2	3	8			
156	Biological indicator for testing effectiveness of sterilization	1	2	3	8			
157	Written guidelines for disinfection and sterilization	1	2	3	8			

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMI NED	
159	ASK TO SEE WHERE CENTRALLY PROCESSED ITEMS ARE STORED AFTER PROCESSING, AND INDICATE FOR EACH OF THE BELOW IF THIS WAS OBSERVED OR REPORTED AS A PRACTICE:					
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8	
	2) Stored in sterile container with lid which clasps shut	1	2	3	8	
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8	
	4) On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8	
	5) In container with disinfectant or antiseptic	1	2	3	8	
	6) Other _____ (SPECIFY)	1	2	3	8	
160	Is the date of sterilization for the stored items indicated?	1	2	3	8	
161	Is the storage area for sterilized items clean and dry?	1	2	3	8	
162	Is there a generator for the facility? IF YES, INDICATE IF THE GENERATOR FUNCTIONS OR NOT.	YES, FUNCTIONING 1 YES, NOT FUNCTIONING 2 NO 3 DON'T KNOW 8				→ 164 → 164
163	Is fuel available for the generator? IF YES, ASK TO SEE WHERE THE FUEL IS STORED.	YES, OBSERVED 1 YES, NOT SEEN 2 NO 3 DON'T KNOW 8				
164	Is there a waiting area for clients, where they are protected from sun and rain?	YES 1 NO 2				
165	Is there a toilet (latrine) in functioning condition which is available for use of clients?	YES, OBSERVED 1 YES, NOT SEEN 2 NO 3				→ 167 → 167
166	Is there soap and water available in the toilette?	YES, OBSERVED SOAP & WATER 1 YES, WATER ONLY 2 NO 3				
167	How does this facility dispose of paper waste or common trash (e.g. not contaminated waste)?	BURNED IN INCINERATOR 01 COLLECTED AND DISPOSED EXTERNALLY 02 BURNED IN OPEN PIT 03 BURNED AND BURIED 04 BURNED NOT BURIED 05 THROW IN TRASH/OPEN PIT.... 06 THROW IN PIT LATRINE 07 OTHER 96				
168	How does this facility dispose of potentially contaminated waste and items which are not reused (e.g. bandages, syringes)?	BURNED IN INCINERATOR 01 COLLECTED AND DISPOSED EXTERNALLY 02 BURNED IN OPEN PIT 03 BURNED AND BURIED 04 BURNED NOT BURIED 05 THROW IN TRASH/OPEN PIT.... 06 THROW IN PIT LATRINE 07 OTHER 96				
169	INTERVIEWER: ASK TO SEE PLACE USED FOR WASTE DISPOSAL (AND IF APPLICABLE, WHERE CONTAMINATED WASTE IS STORED EXTERNAL TO SERVICE DELIVERY AREA PRIOR TO DISPOSAL) AND INDICATE THE CONDITION THAT APPLIES WHEN YOU CONSIDER BOTH SITES)	WASTE VISIBLE, <u>NOT</u> PROTECTED 1 WASTE VISIBLE, PROTECTED 2 NO WASTE VISIBLE 3 WASTE SITE NOT INSPECTED... 8				

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
170	ASSESS GENERAL CONDITION OF FACILITY AND INDICATE IF ANY OF THE ITEMS LISTED WERE NOTED	BROKEN WINDOWSA BROKEN DOORSB BROKEN WALLSC LEAKING PLUMBINGD OTHERX NO MAJOR PROBLEMS.....Y	
171	ASSESS GENERAL CLEANLINESS OF FACILITY ■ A FACILITY IS CLEAN IF THE FLOORS ARE SWEEPED, COUNTERS/TABLES ARE WIPED AND FREE FROM OBVIOUS DIRT OR WASTE. ■ A FACILITY IS NOT CLEAN IF THERE IS OBVIOUS DIRT/WASTE/BROKEN OBJECTS ON FLOORS OR COUNTERS	FACILITY CLEAN..... 1 FACILITY NOT CLEAN 2	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO	
<p>ASK TO SEE THE VACCINES AND VITAMIN A. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR NON-SHADED VACCINES (#1,5-8) , CHECK ALL TO VERIFY IF (A) THEY ARE ARRANGED BY EXPIRY DATE, (B) WERE THERE ANY EXPIRED UNITS PRESENT, AND (C) VERIFY THAT INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY REGISTER OR PRESCRIPTION AND SUBTRACT THESE FROM INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:</p>				
210	VACCINE AND VITAMIN-A	<p>(a) AVAILABILITY OF VACCINES 1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED</p>	<p>(b) VALIDITY 1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW</p>	<p>(c) SUPPLY AND INVENTORY (W/REGISTER) SAME 1=YES 2=NO 8=DON'T KNOW</p>
	1) Tetanus Toxoid	1→b 2 3 8	1 2 8	1 2 8
	2) BCG and Dilutant	1 2 3 8		
	3) Oral Polio (OPV)	1 2 3 8		
	4) DPT	1 2 3 8	1 2 8	1 2 8
	5) Measles & Dilutant	1→b 2 3 8	1 2 8	1 2 8
	6) Hepatitis B	1→b 2 3 8	1 2 8	1 2 8
	7) Hep-DPT ("square)	1→b 2 3 8	1 2 8	1 2 8
	8) MMR	1→b 2 3 8	1 2 8	1 2 8
	9) Vitamin A	1 2 3 8		
211	Were the vaccines organized according to expiry date "first expire first out" in the fridge/cold box? (VERIFIED WHEN COMPLETING 210)	<p>YES, VERIFIED..... 1 NO..... 2 DON'T KNOW 8</p>		
212	Does this facility determine the amount of vaccines required and order this amount, or is the amount that you receive determined elsewhere?	<p>DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE..... 2 OTHER 6 (SPECIFY)</p>		→214a
213	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the quantity you receive vary with the activity level that you report?	<p>QUANTITY BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8</p>		→216 →216 →216
214a	When was the last time that you received a routine supply of vaccines ?	<p>WITHIN PRIOR 4 FULL WEEKS ... 1 WITHIN PRIOR 12 FULL WEEKS . 2 MORE THAN 12 WEEKS AGO..... 3 DON'T KNOW..... 8</p>		

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
214b	<p>Routinely, when you order vaccines, which best describes the system you use to determine how much of each to order:</p> <p>1) Do you review the amount of each vaccine remaining, and order to bring the stock amount to a pre-determined (fixed) amount?</p> <p>2) Do you order the exact same amount each time?</p> <p>3) Do you look at the amount used since the previous order, and plan based on prior utilization and expected future activity?</p> <p>4) Others</p> <p>5) RESPONDENT FAMILIAR WITH ORDERING SYSTEM IS NOT AVAILABLE</p>	<p>ORDER TO MAINTAIN FIXED STOCK LEVEL.....1</p> <p>ORDER SAME AMOUNT2</p> <p>ORDER BASED ON UTILIZATION.....3</p> <p>OTHER.....6 (SPECIFY)</p> <p>DON'T KNOW.....8</p>	<p>→ 215a</p> <p>→ 215a</p> <p>→215a</p> <p>→216</p>
214c	<p>When deciding how much of each vaccine to order, based on prior utilization and planned activities, do you have a mathematical formula for calculating how much to use, or do you use your judgment?</p>	<p>MATHEMATICAL FORMULA1</p> <p>JUDGMENT.....2</p>	
215a	<p>Which of the following best describes the system for deciding when to order vaccines?</p> <p>1) Whenever stock levels fall to a predetermined level</p> <p>2) There is a fixed time that orders are accepted. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS.</p> <p>3) An order is placed at no fixed time, but rather whenever there is a need.</p> <p>4) Other</p>	<p>PREDETERMINED LEVEL.....1</p> <p>EVERY <input type="text"/> <input type="text"/> WEEKS.....2</p> <p>ORDER AS NEEDED3</p> <p>OTHER.....6 (SPECIFY)</p>	
215b	<p>If there is a shortage of specific vaccine between routine orders, what is most common procedure followed by this facility?</p> <p>1) Submit special order to normal supplier.</p> <p>2) Tell client to return when vaccine is available.</p>	<p>SPECIAL ORDER.....1</p> <p>CLIENT MUST RETURN2</p> <p>NO SHORTAGE.....3</p>	
216	<p>During the past 3 months, how often have you received the amount of vaccines (s) that you order (or that you are suppose to routinely receive)?</p>	<p>ALWAYS1</p> <p>SOMETIMES.....2</p> <p>ALMOST NEVER3</p> <p>D.K.....8</p>	
217	<p>How many vaccine carriers do you have available?</p>	<p>ONE1</p> <p>TWO OR MORE2</p> <p>NONE.....3</p>	<p>→219</p>
218	<p>Are there ice packs for the vaccine carriers (4-5 per carrier)?</p>	<p>YES, ONE SET1</p> <p>YES, TWO OR MORE SETS.....2</p> <p>NO, USE PURCHASED ICE3</p> <p>NO4</p>	

Section 2b. Child Health Services-vaccinations

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
219	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis?	YES 1 NO 2	→ 300
<p>FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF CHILD CURATIVE HEALTH SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING PREVIOUSLY, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 220.</p> <p>READ TO CHILD HEALTH SERVICES INFORMANT (IF DIFFERENT FROM PREVIOUS INFORMANT):</p> <p>Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about the child health services provided through this facility. Please be assured that the information is completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate?</p> <p style="text-align: center;"> _____ _____ INTERVIEWER'S SIGNATURE DATE (Indicates respondent's willingness to participate) </p>			
220	May I begin the interview?	YES 1 NO 2	→ 300
<p>Now, I would like to ask you specifically about child health services. For each of the following services please tell me if the service is offered by your facility, and if yes, how many days per month the service is provided <u>at the facility</u>.</p>			
221	CHILD HEALTH SERVICE	(a) # Days per week service provided <u>at</u> <u>facility</u>	(b) # Days per month service provided through outreach (village level)activities
	1) Consultation / curative services for the sick child?	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="checkbox"/> 0=NO SERVICE
	2) Growth monitoring or growth promotion (where the <u>healthy child</u> is routinely weighed and weight is charted on growth chart?)	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="checkbox"/> 0=NO SERVICE
	3) Immunization services for children? Don't include (BCG)	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="checkbox"/> 0=NO SERVICE
	4) BCG Immunization?	# DAYS <input type="checkbox"/> 0=NO SERVICE 8=LESS THAN ONCE A WEEK	# DAYS <input type="checkbox"/> 0=NO SERVICE
222	CHECK 221a (3) AND INDICATE IF CHILD IMMUNIZATIONS ARE EVER PROVIDED AT THE FACILITY	YES 1 NO 2	→ 235
223	Are immunization services being offered at the facility today?	YES, ALL 1 YES, ALL BUT BCG 2 NO 3 OTHER _____ 6 (SPECIFY)	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
224	Are immunizations offered in the facility on every day that sick child consultations are provided?	YES 1 NO 2 DON'T KNOW 8	
225	Does this facility routinely charge for any vaccination services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR EPI CARD.. A YES, FIXED FEE FOR VACCINE SESSION B YES, VARIABLE FEE PER VACCINE C OTHER X (SPECIFY NO CHARGES Y DON'T KNOW Z	→227 →227
226	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW 8	
ASK TO SEE THE ROOM WHERE IMMUNIZATIONS ARE PROVIDED			
227	WAS ROOM ALREADY OBSERVED FOR ITEMS IN 228 and 229? IF YES, INDICATE WHICH SECTION INFORMATION FOR THE ROOM IS IN.	YES, INJECTION ROOM [243-244] 1 NOT PREVIOUSLY ASSESSED 2	→230
FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE SERVICE IS BEING PROVIDED OR IN AN IMMEDIATELY ADJACENT ROOM.			
228	ITEMS REQUIRED TO PROVIDE IMMUNIZATION SERVICES	1 OBSERVED 2 REPORTED AVAILABLE 3 NOT AVAILABLE 8 NOT DETERMINED	
	1) Safety box for needles	1 2 3 8	
	2) 5 or more 0.5 or 1 ml disposable syringes (w/needles).	1 2 3 8	
	3) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1 2 3 8	
	4) Waste receptacle with lid and plastic liner	1 2 3 8	
	5) Hand-washing items (soap, towel)?	1 2 3 8	
	6) Water for hand-washing?	1 2 3 →230 8 →230	
229	How is water made available for use in the immunization area in the facility <u>today</u> ?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN 3	
230	OTHER ITEMS REQUIRED TO PROVIDE IMMUNIZATION SERVICES	1 OBSERVED 2 REPORTED AVAILABLE 3 NOT AVAILABLE 8 NOT DETERMINED	
	1) Blank, individual child immunization cards	1 2 3 8	
	2) Immunization tally/register sheets	1 2 3 8	
231	What is the current estimate for your annual DPT dropout rate?	DPT DROPOUT RATE (%) <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
232	Do have an estimate of the total number of the target population for child immunizations in the facility catchment area? IF YES: How many children is that?	TARGET POPULATION . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NO CATCHMENT AREA 99995 DON'T KNOW TARGET POPULATION SIZE 99998	→235 →235

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
233	What is the current annual estimate for your measles coverage?	MEASLES COVERAGE (%)..... <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	
234	RECORD THE SOURCE(S) OF INFORMATION FOR % COVERAGE AND DROPOUT RATE ESTIMATES	WRITTEN REPORT A WALL GRAPH B OTHER X (SPECIFY) NO COVERAGE RATES Y SOURCE NOT KNOWN Z	

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
		(a) AVAILABILITY				
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	
241	PROTOCOLS/TEACHING MATERIALS					
	1) Medical Protocols for treating CHILD ILLNESS	1	2	3	8	
	2) IMCI Chart Booklet	1	2	3	8	
	3) IMCI counseling cards for provider to use	1	2	3	8	
	4) IMCI mothers cards (to give to caretaker)	1	2	3	8	
	5) Other Visual aids for teaching caretaker	1	2	3	8	
	ASK TO SEE THE ROOM WHERE THERAPEUTIC (TREATMENT) INJECTIONS ARE PROVIDED FOR SICK CHILDREN.					
242	WAS ROOM ALREADY OBSERVED FOR ITEMS IN 243 and 244? IF YES, INDICATE WHICH SECTION INFORMATION FOR THE ROOM IS IN.	YES, IMMUNIZATION ROOM [228-229] 1 NO INJECTION ROOM 2 NOT PREVIOUSLY SEEN..... 3				→245 →245
	FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE SERVICE IS BEING PROVIDED OR IN AN IMMEDIATELY ADJACENT ROOM.					
243	ITEMS REQUIRED TO PROVIDE INJECTION SERVICES	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	4 NOT DETERMINED	
	1) Safety box for needles	1	2	3	8	
	2) 5 or more 0.5 or 1 ml disposable syringes (w/needles).	1	2	3	8	
	3) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8	
	4) Waste receptacle with lid and plastic liner	1	2	3	8	
	5) Hand-washing items (soap, towel)?	1	2	3	8	
	6) Water for hand-washing?	1	2	3 →245	8 →245	
244	How is water made available for use in injection room in the facility <u>today</u> ?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN 3				
245	Is there a <u>routine</u> system for providing the first dose of oral antibiotic for the child by someone other than the provider who examines the child? IF YES, ASK TO SEE WHERE THE FIRST DOSE IS PROVIDED.	YES, OBSERVED CHILD RECEIVING DOSE 1 YES, REPORTED, NOT SEEN 2 NO 3 DON'T KNOW 8				
246	Is there a patient register where information on each child consultation is written? IF YES, ASK TO SEE REGISTER. REGISTER MUST HAVE CHILD AGE AND DIAGNOSIS TO BE VALID.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3				→248 →248
247	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS 1 > 7 DAYS BUT WITHIN 30 DAYS 2 > 30 DAYS 3				
248	How many sick children (below 5 years of age) received consultation services during the previous twelve (12) completed months?	NUMBER OF CHILDREN <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				→250
		DON'T KNOW 99998				
249	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... <input type="text"/> <input type="text"/>				
250	Are individual child health cards /records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD	YES, OBSERVED CARD 1 YES, CARD NOT SEEN 2 NO INDIVIDUAL CARDS 3				

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
251	Does this facility routinely charge for consultation services for the sick child? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR HEALTH CARDA YES, FIXED FEE EACH CONSULTB YES, CHARGE FOR MEDICATIONS/TESTS C OTHER _____.....X (SPECIFY) NOY DON'T KNOW.....Z	 →300 →300
252	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME,NOT ALL FEES POSTED2 NO POSTED FEES3 DON'T KNOW..... 8	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO	
CONTRACEPTIVES: FOR EACH METHOD THAT THE FACILITY OFFER (QUESTION 303) ASK TO SEE THE METHOD AND PROVIDE THE INFORMATION REQUESTED BELOW. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR COMBINED ORAL PILL, DPOPROVERA, AND CONDOMS, CHECK ALL TO VERIFY IF (A) THEY ARE ARRANGED BY EXPIRY DATE, (B) WERE THERE ANY EXPIRED UNITS PRESENT, AND (C) VERIFY THAT INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY REGISTER OR PRESCRIPTION AND SUBTRACT THESE FROM INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:				
305	Contraceptive Methods	(a) AVAILABILITY OF METHODS 1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED	(b) VALIDITY 1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW	(c) SUPPLY AND INVENTORY (w/ REGISTER) SAME 1=YES 2=NO 8=DON'T KNOW
1	Combined Oral Pill	1→b 2↓ 3↓ 8↓	1 2 8	1 2 8
2	Oral Pill (progesterone only)	1 2 3 8		
3	Injectable (3 monthly) Depoprovera	1→b 2↓ 3↓ 8↓	1 2 8	1 2 8
4	Injectable(monthly) Mesigyna	1 2 3 8		
5	Norplant	1 2 3 8		
6	Condom (male)	1→b 2↓ 3↓ 8↓	1 2 8	1 2 8
7	Intrauterine device (IUD)	1 2 3 8		
8	Emergency contraceptive pill	1 2 3 8		
9	Spermicide (tablet or foam)	1 2 3 8		
10	Diaphragm	1 2 3 8		
306	WERE THE METHODS ORGANIZED ACCORDING TO EXPIRY DATE, ("FIRST-EXPIRE FIRST-OUT) ON THE SHELVES? (VERIFY WHEN COMPLETING 1,3 and 6 for question 305).	YES, VERIFIED 1 NO..... 2 DON'T KNOW 8		
307	ARE CONTRACEPTIVE SUPPLIES STORED IN THE GENERAL PHARMACY WITH OTHER MEDICINES?	YES..... 1 NO..... 2		→311
OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE CORRECT RESPONSE FOR EACH OF THE FOLLOWING CONDITIONS:				
308	ARE THE METHODS OFF THE FLOOR AND PROTECTED FROM WATER?	YES..... 1 NO..... 2 DON'T KNOW 8		
309	ARE THE METHODS PROTECTED FROM THE SUN?	YES..... 1 NO..... 2 DON'T KNOW 8		
310	IS THE ROOM CLEAR OF ANY EVIDENCE OF PESTS (RATS, BATS, ETC.)	YES..... 1 NO..... 2 DON'T KNOW 8		
311	Do you have the logistic protocol? IF YES, ASK TO SEE THE PROTOCOL	YES, OBSERVED 1 YES, NOT SEEN..... 2 NOT AVAILABLE 3 DON'T KNOW 8		

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
312	Does this facility determine the amount of each contraceptive required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE..... 2	→314a
313	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 8	→316 →316 →316
314a	When was the last time that you received a routine supply of contraceptive methods ?	WITHIN PRIOR 4 FULL WEEKS ... 1 WITHIN PRIOR 12 FULL WEEKS .2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8	
314b	Routinely, when you order contraceptive methods , which best describes the system you use to determine how much of each to order: 1) Do you review the amount of each contraceptive method remaining, and order to bring the stock amount to a pre-determined (fixed) amount? 2) Do you order the exact same amount each time? 3) Do you look at the amount used since the previous order, and plan based on prior utilization and expected future activity? 4) Others 5) RESPONDENT FAMILIAR WITH ORDERING SYSTEM IS NOT AVAILABLE	ORDER TO MAINTAIN FIXED STOCK LEVEL..... 1 ORDER SAME AMOUNT 2 ORDER BASED ON UTILIZATION..... 3 OTHER _____ ..6 (SPECIFY) DON'T KNOW 8	→315a →315a →315a →316
314c	When deciding how much of each contraceptive method to order, based on prior utilization and planned activities, do you have a mathematical formula for calculating how much to use, or do you use your judgment?	MATHEMATICAL FORMULA 1 JUDGMENT 2	
315a	Which of the following best describes the system for deciding when to order contraceptive methods ? 1) Whenever stock levels fall to a predetermined level 2) There is a fixed time that orders are accepted. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. 3) An order is placed at no fixed time, but rather whenever there is a need. 4) Other	PREDETERMINED LEVEL..... 1 EVERY <input type="text"/> <input type="text"/> WEEKS..... 2 ORDER AS NEEDED 3 OTHER _____ ..6 (SPECIFY)	
315b	If there is a shortage of specific contraceptive method between routine orders, what is most common procedure followed by this facility? 1) Submit special order to normal supplier. 2) Facility purchases from private market 3) Clients must purchase from outside the facility.	SPECIAL ORDER..... A FACILITY PURCHASE B CLIENT PURCHASE C NO SHORTAGE.....D	

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
316	During the past 3 months, have you received the amount of each contraceptive supply that you order (or that you are suppose to routinely receive)?	ALWAYS	1	SOMETIMES.....	2	
		ALMOST NEVER	3	DON'T KNOW	8	
	IF YOU ARE NOT IN THE SERVICE DELIVERY AREA FOR FAMILY PLANNING, ASK TO GO TO THE SERVICE DELIVERY AREA AND EXPLAIN THAT YOU WOULD LIKE TO ASK QUESTIONS ABOUT HOW THE SERVICES ARE OFFERED AND SEE THE SERVICE DELIVERY CONDITIONS.					
317	How many days in a week are family planning services provided at the facility.	# DAYS	<input type="text"/>			
318	Are family planning services being provided today?	YES.....	1	NO	2	
319	Does this facility have a system where measurements or activities are routinely carried out for FP clients prior to seeing the primary service provider?	YES	1	NO.....	2	→ 321
		DON'T KNOW	8			→ 321
320	IF YES, ASK TO SEE WHERE FAMILY PLANNING CLIENTS ARE SEEN PRIOR TO THE CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.					
	PART OF ROUTINE SERVICES	1 OBSERVED	2 REPORTED DONE, NOT OBSERVED	3 NOT DONE ROUTINELY	8 DON'T KNOW	
	1) Take weight	1	2	3	8	
	2) Take blood pressure	1	2	3	8	
	3) Group health education	1	2	3	8	
	6) Other (SPECIFY)	1	2			
321	If a family planning client has a reproductive tract infection (RTI) or a sexually transmitted infection (STI), is treatment provided from this clinic, or is the client referred to elsewhere?	ROUTINELY TREATS RTI/STI	1	REFERS ELSEWHERE	2	
		NO TREATMENT/NO REFERRAL.....	3	TREATS SOME AND REFERS SOME..	4	
322	ASK TO SEE WHERE COUNSELING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM.....	1	ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER.....	2	
		ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER.....	3			
	Are any of the following available, in the counseling or the examination room?	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	4 NOT DETERM INED	
323	VISUAL AIDS FOR TEACHING					
	1) Samples of different family planning methods	1	2	3	8	
	2) About family planning issues (side-effects, how method works, etc.)	1	2	3	8	
	3) About STIs	1	2	3	8	
	4) About HIV/AIDS	1	2	3	8	
	5) About hepatitis	1	2	3	8	
	6) Model for demonstrating use of condom	1	2	3	8	
	7) Posters on family planning	1	2	3	8	
324	INFORMATION BOOKLET/PAMPHLET FOR CLIENT TO TAKE HOME					
	1) On family planning	1	2	3	8	
	2) On STIs	1	2	3	8	
	3) On HIV/AIDS	1	2	3	8	
	4) On Hepatitis	1	2	3	8	
325	SERVICE DELIVERY PROTOCOLS					
	1) Reproductive health guidelines / protocols	1	2	3	8	
	2) WHO Guidelines for Syndromic Approach diagnosis and treatment of STIs	1	2	3	8	
	3) Guidelines for clinical diagnosis of STIs	1	2	3	8	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.		
326	If same examination room has already been observed for items in 327-329 note for which section the room was assessed:	ANTENATAL [410-412]1 DELIVERY [451-453].....2 STI [510-512].....3 NOT PREVIOUSLY SEEN4	→330 →330 →330
327	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER3	
	FAMILY PLANNING SUPPLIES	(a) AVAILABILITY	(b) FUNCTIONS
328	FACILITY AND EQUIPMENT	1 OBSERVED 2 REPORTED AVAILABLE 3 NOT AVAILABLE 8 NOT DETERMINED	1 YES 2 NO 8 NOT DETERMINED
	1) Spotlight source (flashlight or examination light accepted)	1→b 2→b 3↓ 8↓	1 2 8
	2) Table for gynecological exam	1 2 3 8	
	3) Clean gloves	1 2 3 8	
	4) Safety box for needles	1 2 3 8	
	5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1 2 3 8	
	6) Decontamination solution for clinical equipment	1 2 3 8	
	7) Waste receptacle with lid and plastic liner	1 2 3 8	
	8) Hand-washing items (soap and towel)	1 2 3 8	
	9) Water for hand-washing	1 2 3→330 8→330	
329	How is water made available for use in the family planning examination area today?	PIPED.....1 BUCKET W/ TAP.....2 BUCKET/BASIN3	
	SPECIFIC ITEMS FOR FAMILY PLANNING SERVICES	(a) AVAILABILITY	(b) FUNCTIONS
330	EQUIPMENT (may be in room where measure is taken)	1 OBSERVED 2 REPORTED AVAILABLE 3 NOT AVAILAB LE 8 NOT DETERMINED	1 YES 2 NO 8 NOT DETERMINED
	1) Blood pressure apparatus	1→b 2→b 3↓ 8↓	1 2 8
	2) Stethoscope	1→b 2→b 3↓ 8↓	1 2 8
	3) Weighing scale	1→b 2→b 3↓ 8↓	1 2 8
331	CHECK 303 (5) AND (7) AND INDICATE IF THE FACILITY OFFERS EITHER THE IUD OR NORPLANT. IF YES, CHECK FOR AVAILABILITY OF EQUIPMENT	YES1 NO2	→337
332	EQUIPEMENT AND SUPPLIES FOR BOTH PROCEDURES	1 OBSERVED 2 REPORTED AVAILABLE 3 NOT AVAILABLE 8 NOT DETERMINED	
	1) Sterile gloves	1 2 3 8	
	2) Antiseptic solution (e.g.Iodine)	1 2 3 8	
	3) Sponge holding forceps	1 2 3 8	

NO.	QUESTIONS		CODE CLASSIFICATION		GO TO
333	INDICATE IF THE IUD IS OFFERED.			IUD OFFERED.....1 IUD NOT OFFERED2	→335
334	MATERIALS FOR IUD	OBSERVED	REPORTED	NOT AVAIL.	NOT DETERMINED
	1) Speculum	1	2	3	8
	2) Tenacula	1	2	3	8
	3) Uterine sound	1	2	3	8
	4) Curved scissor	1	2	3	8
	5) Crocodile forceps	1	2	3	8
	6) handling forceps	1	2	3	8
335	INDICATE IF NORPLANT IS OFFERED.			NORPLANT OFFERED..... 1 NORPLANT NOT OFFERED . 2	→337
	MATERIALS FOR NORPLANT	OBSERVED	REPORTED	NOT AVAIL.	NOT DETERMINED
336	1) Local anesthetic (E.g. lidocaine)	1	2	3	8
	2) Sterile syringe and needle	1	2	3	8
	3) Canula and trochar for inserting NORPLANT	1	2	3	8
	4) scalpel with blade	1	2	3	8
	5) Mosquito forceps (2)	1	2	3	8
	6) Other forceps for grasping implant (artery forceps or only 1 mosquito forceps)	1	2	3	8
337	After completing an examination, what procedures does this service follow for initial handling of contaminated equipment (such as used speculums, scalpel handles, etc) that will be reused another time? (IF THE UNIT PROCESSES SOME EQUIPMENT AND SENDS OTHER EQUIPMENT ELSEWHERE, INDICATE THE PROCEDURE FOR EQUIPMENT PROCESSED IN THIS SERVICE DELIVERY UNIT)		SOAKED IN DISINFECTANT SOLUTION AND BRUSH SCRUB WITH SOAP AND WATER..... 1 SOAK IN DISINFECTANT SOLUTION AND SEND ELSEWHERE..... 2 PUT IN CONTAINER WITHOUT DISINFECTANT SOLUTION AND SEND ELSEWHERE..... 3 BRUSH SCRUB W/ SOAP AND WATER AND THEN DSINFECT ... 4 BRUSH SCRUB WITH SOAP AND WATER..... 5 OTHER..... 6 DON'T KNOW 8		→339 →339 →339 →339
338	INDICATE THE RELEVANT INFORMATION FOR THE DECONTAMINATION PROCEDURE	338_1 CHEMICAL CHLOR (8 OR 9%)... 1 BETADINE2 ALCOHOL.....3 SAVLON.....4 OTHER 6 (SPECIFY) DON'T KNOW.....8	338_2 MINUTES (SOAKING) <input type="text"/> <input type="text"/> <input type="text"/> 998 DON'T KNOW	338_3 SOLUTION PARTS 1) DISINFECTANT PARTS..... <input type="text"/> 2) WATER PARTS <input type="text"/> <input type="text"/> DON'T KNOW..... 98	
339	Where is this equipment then processed prior to reuse? IF THE SYSTEM AT THAT LOCATION HAS ALREADY BEEN SEEN INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "4" AND CONTINUE.		SECTION 1b [158] 1 DELIVERY [470-472]2 STI [518-520].....3 NOT PREVIOUSLY SEEN..... 4		→346 →346 →346
340	After cleaning, what is the final process most commonly used for disinfecting or sterilizing equipment prior to reuse? IF MORE THAN ONE METHOD IS USED CIRCLE ALL METHODS THAT THIS UNIT CARRY OUT. AND PROVIDE THE PROCESSING INFORMATION INDICATED IN QUESTIONS 341-343.		DRY HEAT STERILIZATION..... A AUTOCLAVE B STEAM STERILIZATION C BOILING..... D CHEMICAL..... E OTHER..... X NONE..... Y		→344

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
341-342	341 (1) METHOD 1 <input type="checkbox"/>	342 (1) METHOD 2 (IF APPLICABLE) <input type="checkbox"/>	COMMON CODES
	(2) TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/> <input type="text"/>	(2) TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED.....995 DON'T KNOW998 AUTOMATIC -666
	(3) PRESSURE POUND/IN <input type="text"/> <input type="text"/> ATM <input type="text"/>	(3) PRESSURE POUND/IN <input type="text"/> <input type="text"/> ATM <input type="text"/>	NOT USED.....995 DON'T KNOW998 AUTOMATIC -666
	(4) MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	(4) MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED.....995 DON'T KNOW998 AUTOMATIC TIMER-666
	(5) MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	(5) MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED.....995 DON'T KNOW998 AUTOMATIC TIMER-666
343	Are there written guidelines for disinfection and sterilization present where equipment is processed or in an immediately adjacent room?	YES, OBSERVED..... 1 YES, NOT SEEN 2 NO 3 DON'T KNOW..... 8	
344	INDICATE STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (E.G. SPECULUM, FORCEPS) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN SEEN INDICATE WHICH MODULE THE INFORMATION IS IN.	SECTION 1b [159-161]1 DELIVERY [474-476]2 STI [522-524]3 NOT PREVIOUSLY SEEN4	→348 →348 →348
345	STORAGE CONDITIONS FOR PROCESSED EQUIPMENT	OBSERVED REPORTED AVAILABLE NOT AVAILAB E	ND
	1) Wrapped in sterile cloth, sealed with TST tape.	1 2 3	8
	2) Stored in sterile container with lid which clasps shut	1 2 3	8
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1 2 3	8
	4) On tray, covered with cloth or wrapped without TST sealing tape	1 2 3	8
	5) In container w/ antiseptic/disinfectant	1 2 3	8
	6) Other _____ (SPECIFY)	1 2	
346	Is the date of sterilization for the stored items indicated?	1 2 3	8
347	Is the storage area for sterilized items clean and dry?	1 2 3	8
348	Does this facility routinely charge for any family planning consultation services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR FP CARD . A YES, FIXED CONSULT FEE B YES, CONSULT FEE VARIES BY METHOD C YES, CHARGE FOR METHOD/ LAB TESTS D OTHER X (SPECIFY) NO Y DON'T KNOW.....Z	→350 →350
349	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES 3 DON'T KNOW..... 8	
350	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE REGISTER. REGISTER MUST HAVE METHOD AND NEW/CONTINUING STATUS INDICATED FOR EACH CLIENT, TO BE VALID.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT 3	→352 →352

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
351	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS..... 2 > 30 DAYS..... 3	
352	How many <u>total</u> clients (new and continuing) received family planning services during the previous twelve (12) completed months?	NUMBER OF FP CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998	→ 354
353	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... <input type="text"/> <input type="text"/>	
354	Are individual client cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD.	YES, OBSERVED CARD 1 YES, CARD NOT SEEN 2 NO INDIVIDUAL CARDS..... 3	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
408	If an ANC client has a reproductive tract infection (RTI) or a sexually transmitted infection (STI), is treatment provided from this clinic, or is the client referred elsewhere?	ROUTINELY TREATS RTI/STI 1	REFERRED ELSEWHERE 2	NO TREATMENT/NOREFERRAL.....3	TREATS SOME AND REFERS SOME.4			
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.								
409	If same examination room has already been observed for items in 410-412, indicate for which section the room was assessed:	FAMILY PLANNING [327-329] 1	DELIVERY [451-453]..... 2	STI [510-512]..... 3	NOT PREVIOUSLY SEEN 4	→413 →413 →413		
410	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM..... 1	ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2	ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER..... 3				
411	ITEMS FOR EXAMINATION FOR ANC/POST NATAL CARE	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Spotlight source (flashlight or examination light accepted)	1→b	2→b	3↓	8↓	1	2	8
	2) Table for gynecological exam	1	2	3	8			
	3) Clean gloves	1	2	3	8			
	4) Safety box for needles	1	2	3	8			
	5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8			
	6) Decontamination solution for clinical equipment	1	2	3	8			
	7) Waste receptacle with lid and plastic liner							
	8) Hand-washing items (soap and towel)	1	2	3	8			
	9) Water for hand-washing	1	2	3→413	8→413			
412	How is water made available for use in the antenatal care service area <u>today</u> ?	PIPED 1				BUCKET W/ TAP 2		
						BUCKET/BASIN..... 3		
413	OTHER EQUIPMENT (may be in room where measure is taken)	(a) AVAILABILITY				(b) FUNCTIONS		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	1) Blood pressure apparatus	1→b	2→b	3↓	8↓	1	2	8
	2) Stethoscope	1→b	2→b	3↓	8↓	1	2	8
	3) Fetal Stethoscope	1→b	2→b	3↓	8↓	1	2	8
	4) Thermometer	1→b	2→b	3↓	4↓	1	2	8
	5) Infant scale	1→b	2→b	3↓	4↓	1	2	8
	6) Ultrasound machine	1→b	2→b	3→416	4→416	1	2	8
414	Is there a provider trained in using ultrasound who works in this service?	YES 1				NO 2		
						DON'T KNOW..... 8		
415	Is ultrasound routinely conducted for each ANC client?	YES 1				NO 2		
						DON'T KNOW..... 8		

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
		Observed	Reported Available	Not Available	Not Determined	
416	PROTOCOLS/TEACHING MATERIALS					
	1) Guidelines/protocols for maternal health care	1	2	3	8	
	2) Teaching aids for ANC	1	2	3	8	
417	Does this facility have a formal relationship with traditional birth attendants where training or other types of support are provided to the TBAs?			YES 1 NO 2		→419
418	Is there any documentation available on the TBA program, e.g. lists of affiliated TBAs or TBA training records? IF YES, ASK TO SEE DOCUMENTATION			YES, DOCUMENT SEEN 1 YES, DOCUMENT NOT SEEN..... 2 NO DOCUMENTATION..... 3		
419	Is there a register where client information from ANC visits is recorded? IF YES, ASK TO SEE REGISTER. ANC STATUS (1 ST OR FOLLOW-UP) MUST BE INDICATED FOR THE REGISTER TO BE VALID.			YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT..... 3		→421 →421
420	How recent is the date of the most recent entry for ANC?			WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS BUT WITHIN 30 DAYS ..2 > 30 DAYS.....3		
421	How many antenatal visits (new and follow-up) took place during the previous twelve (12) complete months?			NUMBER ANC <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> VISITS DON'T KNOW 99998		→423
422	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.			MONTHS OF DATA..... <input type="text"/> <input type="text"/>		
423	Is there a register where client information from postpartum visits (BOTH FOR OUTREACH AND FOR FACILITY PP CARE) is recorded? IF YES, ASK TO SEE REGISTER. DAYS PP AND WHETHER COMPLICATIONS WERE PRESENT OR NOT SHOULD BE INDICATED FOR THE REGISTER TO BE VALID.			YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT..... 3		→425 →425
424	How recent is the date of the most recent entry for postpartum care?			WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS..... 2		
425	How many postpartum visits took place during the previous twelve (12) complete months?			NUMBER OF PP VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998		→427
426	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.			MONTHS OF DATA..... <input type="text"/> <input type="text"/>		
427	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment area?			NUMBER OF BIRTHS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 99998 NO CATCHMENT AREA 99995		→431 →431
428	What is the estimate for the annual antenatal coverage rate for this facility?			ANC % COVERAGE <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998		→431
429	What is the definition used by this facility when calculating the antenatal coverage for a pregnant women?			AT LEAST 1 VISIT 1 AT LEAST 4 VISITS 2 OTHER 6 (SPECIFY) DON'T KNOW 8		

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO		
430	RECORD THE SOURCE OF INFORMATION FOR % ANTENATAL COVERAGE ESTIMATES	WRITTEN REPORTA WALL GRAPHB OTHERX (SPECIFY) NOT KNOWNZ			
431	What is the average number of visits for ANC clients?	AVERAGE NUMBER <input type="text"/> <input type="text"/> DON'T KNOW 98			
432	Are individual ANC cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD?	YES, OBSERVED BLANK CARD.. 1 YES, NO BLANK CARD OBSERVED..... 2 NO INDIVIDUAL CARDS..... 3			
433	Does this facility routinely charge for antenatal care consultation? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR ANC/ HEALTH CARD..... A YES, FIXED FEE EACH CONSULT B YES, FIXED FEE FOR ALL ANC SERVICES C YES, FIXED FEE FOR ALL ANC SERVICES + DELIVERY D YES, CHARGE FOR MEDICATIONS/TESTS..... E OTHER X (SPECIFY) NO Y DON'T KNOW Z	→435 →435		
434	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED.....1 YES, SOME,NOT ALL FEES POSTED2 NO POSTED FEES.....3 DON'T KNOW8			
435	What is the most common means by which women are transported from home to this facility for help during obstetric emergencies? IF MORE THAN ONE MOST COMMON MEANS, CIRCLE ALL THAT APPLY.	PEOPLE CARRYA ANIMAL DRAWN VEHICLEB MOTOR VEHICLEC COMBINATION OF ABOVED OTHERX (SPECIFY) NEVER RECEIVE OBSTETRIC CASES Y DON'T KNOW Z	→441		
436	Does this facility have a procedure for transporting women to another facility if necessary in an obstetric emergency? IF THIS IS THE REFERRAL FACILITY, RECORD "4" FOR "REFERRAL FACILITY".	YES 1 NO 2 REFERRAL FACILITY 4 DON'T KNOW 8	→439 →441 →439		
437	Which of the following emergency transportation procedures are commonly used by this facility? PROVIDE A RESPONSE FOR EACH POSSIBILITY	AVAILABILITY			
		24 Hours	Normal facility hours (<24 Hours)	No set times	Not used
	1) Emergency vehicle onsite at facility	1	2	3	8
	2) Multi-use vehicle available at facility. May be used for emergencies	1	2	3	8
	3) Call other facility to send emergency vehicle	1	2	3	8
	4) Rental/hire vehicle arrangement when needed (with facility financial support)	1	2	3	8

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
438	Is the vehicle available and operational today? If yes, may I see the vehicle?	YES SEEN/FUNCTIONING..... 1 YES SEEN/NOT FUNCTIONING .. 2 VEHICLE AWAY FOR EMERGENCY 3 NOT SEEN 4	→440 →440 →440 →440 →440
439	What is the most common means by which women are transported from this facility to the nearest referral facility to receive help during an obstetric emergency?	PEOPLE CARRY.....A ANIMAL DRAWN VEHICLEB MOTOR VEHICLEC COMBINATION OF ABOVED OTHER.....X DON'T KNOWZ	
440	How long does it take, using this form of transportation, to get to the nearest referral facility? (NOTE: IF CALL ELSEWHERE TO OBTAIN VEHICLE, RECORD AVERAGE TIME FROM CALL TO PATIENT ARRIVAL AT REFERRAL FACILITY)	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO			
451	DESCRIBE THE SETTING FOR THE DELIVERY ROOM	PRIVATE ROOM..... 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER..... 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER..... 3							
452	ITEMS REQUIRED TO PROVIDE DELIVERY SERVICES	(a) AVAILABILITY				(b) FUNCTIONS			
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED	
		1) Spotlight source (flashlight or examination light accepted)	1→b	2→b	3↓	8↓	1	2	8
		2) Table for gynecological exam	1	2	3	8			
		3) Clean gloves	1	2	3	8			
		4) Safety box for needles	1	2	3	8			
		5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8			
		6) Decontamination solution for clinical equipment	1	2	3	8			
		7) Waste receptacle with lid and plastic liner	1	2	3	8			
		8) Hand-washing items (soap and towel)	1	2	3	8			
9) Water for hand-washing	1	2	3→454	8→454					
453	How is water made available for use in the delivery area today?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN 3							
454	OTHER EQUIPMENT AND SUPPLIES REQUIRED FOR DELIVERY SERVICES	(a) AVAILABILITY				(b) FUNCTIONS			
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILA- BLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED	
		1) Air conditioner	1→b	2→b	3↓	8↓	1	2	8
		2) Water Heater	1→b	2→b	3↓	8↓	1	2	8
		3) 24-hour functioning light source	1→b	2→b	3↓	8↓	1	2	8
		4) 1 full oxygen cylinder	1→b	2→b	3↓	8↓	1	2	8
		5) Oxygen cylinder regulator	1→b	2→b	3↓	8↓	1	2	8
		6) Blood pressure apparatus	1→b	2→b	3↓	8↓	1	2	8
		7) Adult Stethoscope	1→b	2→b	3↓	8↓	1	2	8
		8) Fetal Heart Detector (Sonicaid)	1→b	2→b	3↓	8↓	1	2	8
		9) Gel for fetal heart detector	1	2	3	8			
		10) Neonatal stethoscope	1→b	2→b	3↓	8↓	1	2	8
		11) Fetal stethoscope (Pinard)	1	2	3	8			
		12) 2 Forceps (Kocher)	1	2	3	8			
		13) Sterile scissors/blade	1	2	3	8			
		14) Needle Holder	1	2	3	8			
		15) Clean Mackintosh oilcloth for delivery table	1	2	3	8			
		16) Sterile gloves	1	2	3	8			
		17) Sterile Foley catheter size 18 or 20 (plastic)	1	2	3	8			
		18) Sterile straight urinary catheter size 18 or 20 (plastic)	1	2	3	8			
		19) Suture material w/needle	1	2	3	8			
20) Skin antiseptic (e.g. betadine, chlorhexadine (savlon); dette	1	2	3	8					

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO		
		Observed	Reported	NA	ND			
	MEDICATIONS							
	21) Intravenous: either Ringers lactate, D5W, or NS infusion (w/valid expiry date)	1	2	3	8			
	22) IV infusion set w/ cannula	1	2	3	8			
	23) Injectable ergometrine/ methergine w/valid expiry date)	1	2	3	8			
	24) Syntocin/oxytocin	1	2	3	8			
	25) Injectable diazepam or magnesium sulfate	1	2	3	8			
	26) Hydralazine (apresoline) INJ	1	2	3	8			
	27) Vitamin K (1 mg)	1	2	3	8			
	28) Antibiotic Eye drops (NO CHLORAMPHENICOL]	1	2	3	8			
	29) Syringes and needles?	1	2	3	8			
	30) Vitamin A	1	2	3	8			
	SUPPLIES REQUIRED FOR NEONATAL CARE	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABL E	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	31) Resusiteur (Radiant Warmer)	1→b	2→b	3↓	8↓	1	2	8
	32) Suction device for resuscitation (foot or electric power)	1→b	2→b	3↓	8↓	1	2	8
	33) Heat source for baby	1→b	2→b	3↓	8↓	1	2	8
	34) Incubator	1→b	2→b	3↓	8↓	1	2	8
	35) Bag and mask or tube and mask (baby) for resuscitation	1→b	2→b	3↓	8↓	1	2	8
	36) Resuscitation table for baby	1	2	3	8			
	37) Baby scale	1→b	2→b	3↓	8↓	1	2	8
	38) Bulb Mucus extractor	1→b	2→b	3↓	8↓	1	2	8
	39) Pediatric suction catheters	1	2	3	8			
	40) Cord ties	1	2	3	8			
	41) Measuring tape	1	2	3	8			
	42) Towel/blanket to wrap baby	1	2	3	8			
455	PROTOCOLS/EDUCATIONAL MATERIALS							
	1) Essential Obstetric Care Protocols	1	2	3	8			
	2) Basic Essential Obstetric Care Service Standards	1	2	3	8			
	3) Other guidelines for delivery care/emergency care?	1	2	3	8			
	4) Referral Forms	1	2	3	8			
	5) Partographs	1	2	3	8			
	6) Delivery Sheet	1	2	3	8			
	7) Delivery Register	1	2	3	8			
456	Is rooming-in the normal practice in this facility? That is, does the baby stay in the same room with the mother?	YES.....1 NO.....2 DON'T KNOW8						
457	Does this facility routinely provide Vitamin A to the mother prior to discharge?	YES.....1 NO.....2 DON'T KNOW8						
458	Is there routine counseling to newly delivered women to encourage breast-feeding within the first few hours of birth?	YES.....1 NO.....2 DON'T KNOW8						

NO.	QUESTIONS	CODE CLASSIFICATION			GO TO			
459	Now I want to ask you about routine practices for the newborn infant at this facility. This means the activity is conducted for essentially all newborns. Indicate for each of the following if it is done routinely for newborns:							
		1 YES	2 NO	8 DON'T KNOW				
	1) Suction newborn using catheter or bulb mucus extractor	1	2	8				
	2) Weigh newborn	1	2	8				
	3) Give full bath (immerse in water) within first 24 hours (or prior to discharge if less than 24 hours postpartum)	1	2	8				
	4) Give pre-lacteal liquids?	1	2	8				
	5) Give vitamin K (1 mg) prior to discharge?	1	2	8				
	6) Give first dose of OPV prior to discharge?	1	2	8				
	7) Give BCG prior to discharge?	1	2	8				
460	How does this facility routinely care for the umbilical cord?	70% ALCOHOLA BETADINE.....B ANTIBIOTIC OINTMENTC DRY DRESSING ONLYD OTHERX (SPECIFY) DON'T KNOW.....Z						
461	Does the facility participate in regular reviews of maternal or newborn deaths or "near miss deaths"?	YES, FOR MOTHERS 1 YES, FOR NEWBORNS 2 YES, FOR BOTH 3 NO DO NOT PARTICIPATE 4						
462	Does this facility handle assisted deliveries, that is using forceps or ventous (vacuum extractor?)	YES 1 NO 2			→464			
463	CHECK IF THE FOLLOWING EQUIPMENT IS AVAILABLE IN THE DELIVERY ROOM OR AN IMMEDIATELY ADJACENT ROOM	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Forceps?	1→b	2→b	3↓	8↓	1	2	8
	2) Ventouse (vacuum extractor)?	1→b	2→b	3↓	8↓	1	2	8
464	Is this facility able to perform vacuum aspiration for post-abortion cases when necessary?	YES1 NO2						→466
465	ASK TO SEE EQUIPEMENT	Observed	Reported Available	Not Available	Not Determined	Yes	No	ND
	1) Manual vacuum aspirator (MVA)	1→b	2→b	3↓	8↓	1	2	8
	2) Dilate and curettage (D&C) kit	1→b	2→b	3↓	8↓	1	2	8
	6) Other (specify)	1→b	2→b			1	2	8
466	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)	SOAKED IN DISINFECTANT SOLUTION AND BRUSH SCRUB WITH SOAP AND WATER 1 SOAK IN DISINFECTANT SOLUTION AND SEND ELSEWHERE 2 PUT IN CONTAINER WITHOUT DISINFECTANT SOLUTION AND SEND ELSEWHERE 3 SCRUB W/ SOAP AND WATER AND THEN DISINFECT 4 BRUSH SCRUBBED WITH SOAP AND WATER 5 OTHER 6 DON'T KNOW 8						→468 →468 →468 →468

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO		
467	INDICATE THE RELEVANT INFORMATION FOR THE DECONTAMINATION PROCEDURE	467_1 CHEMICAL CHLOR (8 OR 9%)...1 BETADINE2 ALCOHOL3 SAVLON.....4 OTHER6 (SPECIFY) DON'T KNOW.....8	467_2 MINUTES (SOAKING) <input type="text"/> <input type="text"/> <input type="text"/> 998 DON'T KNOW 467_3 SOLUTION PARTS 1) DISINFECTANT PARTS..... <input type="text"/> 2) WATER PARTS..... <input type="text"/> <input type="text"/> DON'T KNOW.....98		
468	Where is this equipment then processed prior to reuse? IF THE SYSTEM AT THAT LOCATION HAS ALREADY BEEN SEEN INDICATE WHICH SECTION THE INFORMATION IS IN. IF NOT YET SEEN, CIRCLE "4" AND CONTINUE.	SECTION 1b [158] 1 FAMILY PLANNING [341-343] 2 STI [518-520] 3 NOT PREVIOUSLY SEEN 4	→473 →473 →473		
469	After cleaning, what is the final process most commonly used for disinfecting or sterilizing equipment prior to reuse? IF MORE THAN ONE METHOD IS USED CIRCLE ALL METHODS THAT THIS UNIT CARRY OUT. AND PROVIDE THE PROCESSING INFORMATION INDICATED IN QUESTIONS 481 and 482.	DRY HEAT STERILIZATIONA AUTOCLAVEB STEAM STERILIZATION C BOILING D CHEMICALE OTHERX NONEY	→473		
470-471	470 (1) METHOD 1 <input type="text"/>	471 (1) METHOD 2 (IF APPLICABLE) <input type="text"/>	COMMON CODES		
	(2) TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/>	(2) TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/>	NOT USED 995 DON'T KNOW 998 AUTOMATIC TIMER- 666		
	(3) PRESSURE POUND/IN <input type="text"/> <input type="text"/> ATM <input type="text"/>	(3) PRESSURE POUND/IN <input type="text"/> <input type="text"/> ATM <input type="text"/>	NOT USED 95 DON'T KNOW 98 AUTOMATIC TIMER- 666		
	(4) MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	(4) MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED 995 DON'T KNOW 998 AUTOMATIC TIMER- 666		
	(5) MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	(5) MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED 995 DON'T KNOW 998 AUTOMATIC TIMER- 666		
472	Are there written guidelines for disinfection and sterilization present where equipment is processed or in an immediately adjacent room?	YES, OBSERVED 1 YES, NOT SEEN 2 NO 3 DON'T KNOW 8			
473	INDICATE STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (E.G. speculum, forceps) READY FOR REUSE. IF LOCATION HAS ALREADY BEEN SEEN INDICATE WHICH SECTION THE INFORMATION IS IN.	SECTION 1b [159-161] 1 FAMILY PLANNING [345-347] 2 STI [522-524] 3 NOT PREVIOUSLY SEEN 4	→477 →477 →477		
474	STORAGE CONDITIONS FOR PROCESSED EQUIPMENT	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 ND
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8
	2) Stored in sterile container with lid which clasps shut	1	2	3	8
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8
	4) On tray, covered with cloth or wrapped without TST tape	1	2	3	8
	5) In container w/ antiseptic/disinfectant	1	2	3	8
	6) Other _____ (SPECIFY)	1	2		
475	Is the date of sterilization for the stored items indicated?	1	2	3	8
476	Is the storage area for sterilized items clean and dry?	1	2	3	8

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
477	Does this facility conduct blood transfusion? IF YES, IS THERE A BLOOD BANK OR ARE THERE TRANSFUSION SERVICES ONLY?	YES, BLOOD BANK 1 YES, TRANSFUSION, NO BLOOD BANK 2 NO BLOOD TRANSFUSION 3				
478	Do facility staff routinely provide home-deliveries or attend home delivery emergencies as a part of the facility service?	YES, ROUTINELY 1 YES, EMERGENCY ONLY 2 NO 3				→485
479	Is there bag where supplies for home deliveries are kept? IF YES, ASK TO SEE THE DELIVERY BAG	YES, BAG SEEN 1 YES, BAG NOT SEEN 2 NO 3				→481 →481
480	ASK TO SEE THE EMERGENCY DELIVERY BAG AND INDICATE WHETHER THE ITEMS LISTED ARE PRESENT OR NOT.	ITEM PRESENT		NOT PRESENT		NOT DETERMINED
		STERILE	NOT STERILE			
	1) Sterile instrument package	1	2	3	8	
	2) 1 Scissors (straight) (maybe in packet)	1	2	3	8	
	3) 2 Forceps (Kocher) (maybe in packet)	1	2	3	8	
	4) 1 Fetal Stethoscope		2	3	8	
	5) 1 Mucous Suction Bulb		2	3	8	
	6) 1 Adult Thermometer		2	3	8	
	7) 1 Plastic gown		2	3	8	
	8) 1 Macintosh oilcloth/plastic for under mother		2	3	8	
	9) Sterile dressings, Cotton, Gauze	1	2	3	8	
	10) Betadine solution		2	3	8	
	11) Alcohol		2	3	8	
	12) Antibiotic eye drops [NO CHLORAMPHENICOL]		2	3	8	
	13) Syringe and needle (sterile)	1	2	3	8	
	14) Soap		2	3	8	
	15) Measuring tape		2	3	8	
	16) Newborn scale (hanging)		2	3	8	
	17) 2 pair sterile gloves	1	2	3	8	
	18) Disposable plastic gloves		2	3	8	
	19) Cord clamp/ cord ties		2	3	8	
481	Is there a register where information on home deliveries conducted by facility staff is recorded?	YES, OBSERVED 1 YES, NOT SEEN 2 NO REGISTER 3				→483 →483
482	WHAT IS THE MONTH AND YEAR OF THE LAST HOME DELIVERY CONDUCTED THROUGH THIS FACILITY?	MONTH..... <input type="text"/> <input type="text"/>				
		YEAR..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
483	How many home deliveries were conducted from this facility during the previous twelve (12) completed months?	HOME DELIVERIES <input type="text"/> <input type="text"/> <input type="text"/>				
		DON'T KNOW 998				→485
484	INDICATE NUMBER OF MONTHS REPRESENTED IN DATA	MONTHS OF DATA..... <input type="text"/> <input type="text"/>				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO					
485	Is there a register where client information from deliveries conducted by facility staff is recorded? IF YES, ASK TO SEE REGISTER. BIRTH OUTCOME FOR MOTHER AND INFANT MUST BE INCLUDED TO BE VALID.	YES, REGISTER SEEN..... 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT..... 3	→487 →487					
486	How recent is the date of the most recent entry for a delivery conducted at this facility?	WITHIN THE PAST 30 DAYS..... 1 > 30 DAYS..... 2						
487	How many women delivered at this facility during the previous twelve (12) completed months? (VAGINAL DELIVERIES)	# DELIVERIES ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→489					
488	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED .	MONTHS OF DATA..... <input type="text"/> <input type="text"/>						
489	What percentage of deliveries in your catchment area are conducted in this facility? (e.g. your annual coverage rate?).	% COVERAGE <input type="text"/> <input type="text"/> DON'T KNOW 98 NO CATCHMENT AREA 00	→491 →491					
490	RECORD THE SOURCE OF INFORMATION FOR DELIVERY COVERAGE ESTIMATE	WRITTEN REPORT A WALL GRAPH B OTHER X (SPECIFY) NOT KNOWN Z						
491	Does this facility routinely charge for normal deliveries? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR ALL DELIVERY COSTS..... A YES, FIXED FEE FOR ANC PLUS DELIVERY..... B YES, CHARGE FOR MEDICATIONS/ TESTS C OTHER X (SPECIFY) NO Y DON'T KNOW Z	→493 →493					
492	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED..... 1 YES, SOME, NOT ALL FEES POSTED 2 NO POSTED FEES..... 3 DON'T KNOW 8						
493	Does this facility <u>ever</u> perform Caesarean Section?	YES 1 NO 2	→500					
ASK TO SEE THE ROOM WHERE CAESAREAN SECTIONS ARE PERFORMED. CHECK WHETHER THE FOLLOWING EQUIPMENT & SUPPLIES ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT ROOM								
494	FACILITY AND EQUIPMENT	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Operating table	1→b	2→b	3↓	8↓	1	2	8
	2) Operating light	1→b	2→b	3↓	8↓	1	2	8
	3) Scrub area adjacent to or in the operating room	1	2	3	8			
	4) Tray, drum, or package with sterilized instruments ready for use	1	2	3	8			
	5) Drum with sterile gowns and towels/sheets for surgery	1	2	3	8			
	6) Anesthesia giving set	1	2	3	8	1	2	8
	7) Anesthetist	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
495	Does this facility have a provider who can perform a caesarean section present in the facility or on call 24 hours a day (including weekends) . IF YES, ASK TO SEE SCHEDULE.	YES, PRESENT,SCHEDULE SEEN 1 YES, PRESENT SCHEDULE NOT SEEN 2 YES, ON CALL, SCHEDULE SEEN 3 YES, ON CALL, SCHEDULE NOT SEEN 4 NO 5	
496	How many caesarean sections were conducted at this facility during the past twelve (12) completed months?	NO. CAESAREAN .. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→498
497	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... <input type="text"/> <input type="text"/>	
498	What is the date of the last caesarean section? TAKE THE DATE FROM A REGISTER OR REPORT FORM.	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR .. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW99999998	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO			
		OBSERVED	REPORTED	NOT AVAILABLE	NOT DETERMINED			
508	Service Delivery Protocols							
	1) Clinical guidelines for diagnosing and treating RTIs or STI?	1	2	3	8			
	2) Guidelines for using syndromic approach for diagnosing and treating RTIs or STI's	1	2	3	8			
	3) Guidelines for diagnosing HIV/AIDS?	1	2	3	8			
	4) Clinical guidelines for treating HIV/AIDS? (e.g. opportunistic infection, anti-retroviral therapy)	1	2	3	8			
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR RTIS or STIS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.								
509	If same examination room has already been observed for items in 510-513 indicate for which section the room was assessed:	FAMILY PLANNING [327-329]1 ANTENATAL [410-412]2 DELIVERY [451-453].....3 NOT PREVIOUSLY SEEN4				→513 →513 →513		
510	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER 3						
511	ITEMS REQUIRED FOR STI EXAMINATION	(a) AVAILABILITY				(b) FUNCTIONS		
		1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED	1 YES	2 NO	8 NOT DETER- MINED
	1) Spotlight source (flashlight or examination light accepted)	1→b	2→b	3↓	8↓	1	2	8
	2) Table for gynecological exam	1	2	3↓	8↓			
	3) Clean gloves	1	2	3	8			
	4) Safety box for needles	1	2	3	8			
	5) 5 or more 2 or 3 ml disposable syringes (w/ 21 gauge needles)	1	2	3	8			
	6) Decontamination solution for clinical equipment	1	2	3	8			
	7) Waste receptacle with lid and plastic liner							
	8) Hand-washing items (soap and towel)	1	2	3	8			
	9) Water for hand-washing	1	2	3→513	8→513			
512	How is water made available for use in the STI service area today?	PIPED 1 BUCKET W/ TAP 2 BUCKET/BASIN 3						
513	OTHER EQUIPMENT	1 OBSERVED	2 REPORTED	3 NOT AVAILABLE	8 NOT DETERMINED			
	1) Speculum	1	2	3	8			
	2) Swab sticks	1	2	3	8			

NO.	QUESTIONS		CODING CLASSIFICATION	GO TO
514	After completing an examination, what procedure does this service follow for initial handling of contaminated equipment prior to final processing for reuse? (IF THE UNIT PROCESSES SOME EQUIPMENT AND SENDS OTHER EQUIPMENT ELSEWHERE, INDICATE THE PROCEDURE FOR EQUIPMENT PROCESSED IN THIS SERVICE DELIVERY UNIT)		SOAKED IN DISINFECTANT SOLUTION AND BRUSH SCRUB WITH SOAP AND WATER..... 1 SOAK IN DISINFECTANT SOLUTION AND SEND ELSEWHERE..... 2 PUT IN CONTAINER WITHOUT DISINFECTANT SOLUTION AND SEND ELSEWHERE 3 SCRUB W/ SOAP AND WATER AND THEN DISINFECT 4 BRUSH SCRUBBED WITH SOAP AND WATER..... 5 OTHER 6 DON'T KNOW 8	→516 →516 →516 →516
515	INDICATE THE RELEVANT INFORMATION FOR THE DECONTAMINATION PROCEDURE	515_1 CHEMICAL CHLOR (8 OR 9%)...1 BETADINE2 ALCOHOL3 SAVLON.....4 OTHER6 (SPECIFY) DON'T KNOW.....8	515_2 MINUTES (SOAKING) <input type="text"/> <input type="text"/> <input type="text"/> 998 DON'T KNOW 515_3 SOLUTION PARTS 1) DISINFECTANT PARTS <input type="text"/> 2) WATER PARTS <input type="text"/> <input type="text"/> DON'T KNOW98	
516	Where does the final processing of equipment for this service (e.g. speculum, forceps) , prior to reuse, take place? IF LOCATION HAS ALREADY BEEN ASSESSED INDICATE WHICH SECTION THE INFORMATION IS IN.		GENERAL FACILITY [158]..... 1 FAMILY PLANNING [341-343] 2 DELIVERY [470-471]..... 3 NOT PREVIOUSLY ASSESSED ... 4	→521 →521 →521
517	After cleaning, what is the final process most commonly used for disinfecting or sterilizing equipment prior to reuse? IF MORE THAN ONE METHOD IS USED CIRCLE ALL METHODS THAT THIS UNIT CARRY OUT. AND PROVIDE THE PROCESSING INFORMATION INDICATED IN QUESTIONS 518-520.		DRY HEAT STERILIZATION A AUTOCLAVE B STEAM STERILIZATION C BOILING D CHEMICAL E OTHER X NONE Y	
518-519	518 (1) METHOD 1 <input type="text"/>	519 (1) METHOD 2 (IF APPLICABLE) <input type="text"/>	COMMON CODES	
	(2) TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/>	(2) TEMPERATURE CENTIGRADE <input type="text"/> <input type="text"/>	NOT USED..... 995 DON'T KNOW 998 AUTOMATIC TIMER- 666	
	(3) PRESSURE POUND/IN <input type="text"/> <input type="text"/> ATM <input type="text"/>	(3) PRESSURE POUND/IN <input type="text"/> <input type="text"/> ATM <input type="text"/>	NOT USED..... 995 DON'T KNOW 998 AUTOMATIC TIMER- 666	
	(4) MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	(4) MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED..... 995 DON'T KNOW 998 AUTOMATIC TIMER- 666	
	(5) MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	(5) MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>	NOT USED..... 995 DON'T KNOW 998 AUTOMATIC TIMER- 666	
520	Are there written guidelines for disinfection and sterilization present where equipment is processed or in an immediately adjacent room?		YES, OBSERVED 1 YES, NOT SEEN.....2 NO3 DON'T KNOW8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
521	INDICATE STORAGE CONDITIONS IN THIS SERVICE DELIVERY AREA FOR PROCESSED EQUIPMENT (E.G. speculum, forceps) , READY FOR REUSE. IF LOCATION HAS ALREADY BEEN ASSESSED INDICATE WHICH SECTION THE INFORMATION IS IN.	GENERAL FACILITY [159-161]1 FAMILY PLANNING [345-347].....2 DELIVERY [474-476]3 NOT PREVIOUSLY ASSESSED....4				→525 →525 →525
522	STORAGE CONDITIONS FOR PROCESSED EQUIPMENT	OBSERVED	REPORTED AVAILABLE	NOT AVAILABLE	ND	
	1) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8	
	2) Stored in sterile container with lid which clasps shut	1	2	3	8	
	3) Stored unwrapped inside autoclave or dry heat sterilizer	1	2	3	8	
	4) On tray, covered with cloth or wrapped without TST sealing tape	1	2	3	8	
	5) In container w/ antiseptic/disinfectant	1	2	3	8	
	6) Other _____	1	2			
523	Is the date of sterilization for the stored items indicated?	1	2	3	8	
524	Is the storage area for sterilized items clean and dry?	1	2	3	8	
525	How are diagnoses of STIs made in this facility? CIRCLE ALL THAT APPLY	SYNDROMIC/CLINICALA ETIOLOGIC (LABORATORY).....B				
526	Does this facility have protocols on the following: IF YES, ASK TO SEE A COPY.	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILA BLE.	4 NOT DETERMINED	
	1) Confidentiality Protocol for STI clients?	1	2	3	8	
	2) Informed Consent Protocol for STI testing?	1	2	3	8	
527	Does the facility normally perform partner notification or follow-up for sexually transmitted infections? IF YES, Is the follow up ever active (where the facility makes contact with the partner) or is it only passive (where the facility asks the client to inform or bring their partner(s)).	YES, SOMETIMES ACTIVE.....1 YES, ONLY PASSIVE2 NO.....3				→529 →529
528	Do you have a form/referral form or register where clients for active follow-up are listed? IF YES, ASK TO SEE.	YES, FORM SEEN.....1 YES, REGISTER SEEN2 YES, FORM/REGISTER NOT SEEN.....3 NO FORM/REGISTER4				
529	Is there a register where RTI/STI consultation information is recorded? IF YES, ASK TO SEE REGISTER. CLIENT NAME, AGE, SEX, AND DIAGNOSIS MUST BE INDICATED FOR REGISTER TO BE VALID.	YES, REGISTER SEEN1 YES, REGISTER NOT SEEN.....2 NO REGISTER KEPT3				→532 →532
530	Does the register indicate a specific type of RTI/STI diagnosed?	YES.....1 NO.....2				
531	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS1 >7 BUT WITHIN 30 DAYS.....2 > 30 DAYS3				
532	RECORD THE NUMBER OF CLIENTS WHO RECEIVED RTI/STI SERVICES DURING THE LAST TWELVE (12) COMPLETED MONTHS	NUMBER OF RTI/STI CLIENTS ... <input type="text"/> <input type="text"/> <input type="text"/>				
		DON'T KNOW998				→534
533	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DAT <input type="text"/> <input type="text"/>				
534	Do you submit an official report externally (usually to the MoH or a communicable disease department) for cases of VENERAL DISEASES (SYPHILIS, GONORRHEA) OR HIV/AIDS. IF YES, is the report generated from consultation records or from the laboratory?	YES, CONSULTATION1 YES, LABORATORY.....2 YES, BOTH3 NO.....4 DON'T KNOW8				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
535	Does this facility routinely charge for RTI/STI consultation services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR HEALTH CARDA YES, FIXED FEE EACH CONSULTB YES, CHARGE FOR MEDICATIONS/TESTSC OTHER _____X (SPECIFY) NOY DON'T KNOWZ	→537 →537
536	Are the indicated fees posted in the area where fees are collected in a manner that the client can easily see the official charges?	YES ALL FEES POSTED.....1 YES, SOME,NOT ALL FEES POSTED2 NO POSTED FEES.....3 DON'T KNOW.....8	
537	Does this facility provide treatment for any Tuberculosis patients? If Yes, Does the facility follow DOTS protocol?	YES, DOTS TREATMENT..... 1 YES, NOT DOTS..... 2 NO..... 3	
538	Now I want to ask you specifically about any services related to HIV or AIDS. Does this facility offer any services related to HIV/AIDS? This includes diagnosis, treatment, or counseling.	YES 1 NO 2	→563
539	Does this facility offer voluntary counseling and testing (VCT) for HIV? This means testing upon request <u>and</u> providing counseling regarding HIV prevention and treatments.	YES 1 NO 2	→546
540	Are VCT services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC..... 1 GENERAL OUTPATIENT..... 2 OTHER _____ 6 (SPECIFY)	
541	When a VCT client is found to be positive, indicate how often clients are referred elsewhere or services are provided by the facility for the following:	REFERRED OR SERVICE IS PROVIDED ALWAYS SOMETIME RARE/ S S NEVER 1 2 3 8 2 2 3 8 3 2 3 8 4 2 3 8 5 2 3 8 6 2 3 8 7 2 3 8	DON'T KNOW
542	Is there a register where VCT client information is recorded? IF YES, ASK TO SEE REGISTER. DATE AND RESULT OF TEST SHOULD BE INDICATED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 NO REGISTER KEPT..... 3	→544 →544
543	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS..... 2	
544	RECORD THE NUMBER OF NEW CLIENTS WHO RECEIVED VCT SERVICES DURING THE LAST TWELVE (12) COMPLETED MONTHS	NUMBER OF VCT CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998 NOT RECORDS.....995	→546 →546
545	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA <input type="text"/> <input type="text"/>	
546	Does this facility provide any diagnostic, follow-up, or treatment for HIV/AIDS, apart from VCT?	YES 1 NO..... 2	→563

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO	
547	FOR EACH OF THE FOLLOWING HIV/AIDS RELATED SERVICES, INDICATE IF THE FACILITY PROVIDES THE SERVICE, REFERS ELSEWHERE, OR DOES NOT PROVIDE THE SERVICE OR REFERRAL.	PROVIDE SERVICE			Refer else where	No service/ no referral	Don't Know
		Out Patient	In Patient	Both out and in			
	1) Tuberculosis diagnose & treat	1	2	3	4	5	8
	2) Opportunistic infections/ diagnose & treat	1	2	3	4	5	8
	3) Palliative (management of pain and terminal care)	1	2	3	4	5	8
	4) Family planning services	1	2	3	4	5	8
	5) Counseling on prevention of mother to child transmission	1	2	3	4	5	8
	6) Psychosocial services	1	2	3	4	5	8
	7) Counseling/training for home care	1	2	3	4	5	8
548	ASK TO SEE WHERE CONSULTATION FOR HIV/AIDS CLIENTS IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER3 SAME ROOM AS STI CLIENTS4				→551	
549	Are any of the following available, in the counseling or the examination room?	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED		
	Visual Aids for Teaching						
	1) About STIs	1	2	3	8		
	2) About HIV/AIDS	1	2	3	8		
	3) About hepatitis	1	2	3	8		
	4) Model for demonstrating use of condom	1	2	3	8		
	Information Booklet/Pamphlet for Client to take home:						
	5) On STIs	1	2	3	8		
	6) On HIV/AIDS	1	2	3	8		
	7) On hepatitis	1	2	3	8		
	8) Are there Condoms present in the room?	1	2	3	8		
550	Service Delivery Protocols						
	1) Clinical guidelines for diagnosing and treating STI?	1	2	3	8		
	2) Guidelines for using syndromic approach for diagnosing and treating STI's	1	2	3	8		
	3) Guidelines for diagnosing HIV/AIDS?	1	2	3	8		
	4) Clinical guidelines for treating HIV/AIDS? (e.g. opportunistic infection, anti-retroviral therapy)	1	2	3	8		
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR HIV/AIDS CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.						
551	If <u>same examination room</u> has already been observed for items in 552-554 indicate for which section the room was assessed.	FAMILY PLANNING [327-329].....1 ANTENATAL [410-412].....3 DELIVERY [451-453]2 STI [510-512]4 NOT PREVIOUSLY SEEN5				→555 →555 →555	
552	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM.....1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER.....2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER.....3					

553	Are any of the following available, in the examination room or immediately adjacent?	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED
	1) Clean gloves	1	2	3	8
	2) Hand-washing items (Soap, Towel)	1	2	3	8
	3) Water for hand-washing	1	2	3→555	8→555
554	How is water made available for use in the service area today?	PIPED..... 1 BUCKET W/ TAP..... 2 BUCKET/BASIN 3			
555	Does this facility have protocols on the following? FOR EACH ASK IF THE PROTOCOL EXISTS AND ASK TO SEE A COPY	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETER- MINED
	1) Confidentiality protocol for HIV/AIDS Clients?	1	2	3	8
	2) Informed consent protocol for HIV/AIDS Clients?	1	2	3	8
	3) Written protocols for referrals for HIV/AIDS clients for care and support services?	1	2	3	8
556	Is there a register where information for HIV/AIDS clients receiving treatment is recorded? IF YES, ASK TO SEE REGISTER. DIAGNOSIS AND TREATMENT MUST BE RECORDED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN 2 →558 NO REGISTER KEPT..... 3 →558			
557	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS..... 2			
558	RECORD THE TOTAL NUMBER OF CLIENTS (NEW AND RETURNED) WHO RECEIVED ANY HIV/AIDS SERVICES DURING THE PRIOR TWELVE (12) COMPLETED MONTHS (EXCLUDE VCT CLIENTS)	NUMBER OF HIV CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998 →560			
559	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA <input type="text"/> <input type="text"/>			
560	Does the facility have a mechanism to follow-up on referrals? IF YES, ASK TO SEE RECORD OR FORM RELATED TO FOLLOW-UP MECHANISM. IF NO REFERRALS ARE MADE BECAUSE THIS IS REFERRAL FACILITY, INDICATE "4".	YES, OBSERVED FORM..... 1 YES, NO FORM SEEN..... 2 NO..... 3 REFERRAL FACILITY..... 4 DON'T KNOW 8			
561	Does the facility have a list of care and support services to which clients can be referred? IF YES, ASK TO SEE LIST.	YES, LIST SEEN 1 YES, LIST NOT SEEN..... 2 NO..... 3 DON'T KNOW 8			
562	Does the facility have a formal partnership with a support group for Persons Living with HIV/AIDS ?	YES 1 NO..... 2			
563	Does this facility have the capacity to run the following tests? IF NOT: Do you collect the specimen and send it elsewhere for the test or does the client have to go somewhere else for the test?(check section6 for equipment and supplies required for any test conducted in the facility)	1 CONDUCT TEST	2 COLLECT SPEC-IMEN	3 SEND CLIENT ELSE- WHERE	4 TEST NOT UTILIZED
	1) Syphilis?	1	2	3	4
	2) Gonorrhea?	1	2	3	4
	3) Sputum test for Tuberculosis	1	2	3	4
	4) HIV/AIDS?	1	2	3	4
	5) CD4 Count? (HIV)	1	2	3	4
	6) HIV Viral Load?	1	2	3	4
	7) Bedside Test for STI's?	1	2	3	4

Section 7. Essential Medications And Supplies For Providing Services For Sick Clients Children, Maternal Health Clients , and Clients With some Infectious Diseases

FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR PHARMACEUTICAL SERVICES AT THE OUTPATIENT FACILITY. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF.

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
700	Do you have a system that allows you to check the amount of each contraceptive method that is available daily? IF YES, ASK TO SEE THE RECORDS AND INDICATE THE METHOD FOR WHICH YOU OBSERVED RECORDS.	INVENTORY NOT UPDATED DAILY WITH REGISTER OF DISTRIBUTED METHODS KEPT DAILY 1 INVENTORY UPDATED DAILY 2 NO INVENTORY RECORDS SEEN 3 NO PHARMACY IN THE FACILITY...5	→ 800

ASK TO SEE THE MEDICINE STORE. FOR ALL ITEMS, CHECK THAT AT LEAST ONE VALID UNIT IS AVAILABLE. FOR NON-SHADED MEDICINES, CHECK ALL TO VERIFY IF (A) THEY ARE ARRANGED BY EXPIRY DATE, (B) WERE THERE ANY EXPIRED UNITS PRESENT, AND (C) VERIFY THAT INVENTORY AND SUPPLY MATCH. IF NECESSARY, ADD ITEMS FROM DAILY REGISTER OR PRESCRIPTION AND SUBTRACT THESE FROM INVENTORY TO DETERMINE THE SUPPLY THAT SHOULD BE AVAILABLE TODAY. NOTE: IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:

701	Medications	(a) AVAILABILITY OF MEDICATIONS				(b) VALIDITY			(c) STOCK AND INVENTORY (W/ REGISTER) SAME		
		1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED	1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW	1=YES 2=NO 3=DON'T KNOW							
	Oral										
1	Amoxicillin oral ^{1,2}	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
2	Aspirin oral ^{1,2,3}	1 2 3 8									
3	Ciprofloxin PO ³	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
4	Cotrimoxazole oral ^{1,2}	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
5	Doxycycline PO ^{2,3}	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
6	Ergometrine/methergine ²	1↓ 2↓ 3↓ 8									
7	Erythromycin oral ^{2,3}	1 2 3 8									
8	Ethambutol PO ⁴	1 2 3 8									
9	Folic acid ²	1 2 3 8									
10	Iron ^{1,2}	1 2 3 8									
11	Iron with Folic Acid ²	1 2 3 8									
12	Isoniazid ⁴ /inhbex	1 2 3 8									
13	Mebendazole oral ^{1,2}	1 2 3 8									
14	Methyldopa ²	1 2 3 8									
15	Metronidazole ^{2,3} (FLAGYL)	1 2 3 8									
16	Multivitamins ¹	1 2 3 8									
17	Naladixic acid oral ^{1,2}	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
18	Paracetamol oral ¹	1 2 3 8									
19	Penicillin oral ^{1,2}	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
20	Pyrazinamide PO ⁴	1 2↓ 3 8									
21	Rifampicin ⁴	1 2↓ 3 8									
22	Remactazid/Riozid	1 2 3 8									
23	Tetracycline oral ^{2,3}	1→b 2↓ 3↓ 8↓	1	2	8	1	2	8	1	2	8
24	Vitamin A high dose (200,000 iu) ^{1,2}	1 2 3 8									
25	Vitamin A low dose ^{1,2} (25,000 or 50,000iu)	1 2 3 8									
26	Oral rehydration salts ¹	1 2 3 8									

		(a) AVAILABILITY OF MEDICATIONS				(b) VALIDITY			(c) STOCK AND INVENTORY (W/REGISTER) SAME		
		1=OBSERVED AT LEAST ONE VALID, 2 REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED				1=ALL VALID 2=SOME EXPIRED 8=DON'T KNOW			1=YES 2=NO 8=DON'T KNOW		
	OTHER MEDICINE										
27	Nystatin Vaginal Tablet ³	1	2	3	8						
28	Antibiotic eye Ointment ¹ [NOT CHLORAMPHENICOL]	1	2	3	8						
	INJECTIONS										
29	Ampicillin. ²	1→b	2↓	3↓	8↓	1	2	8	1	2	8
30	Benzathine benzyl pen ^{1,3}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
31	Benzyl Penicillin (Procaine) ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
32	Ceftriaxone ³	1	2	3	8						
33	Diazepam ²	1	2	3	8						
34	Ergometrine/oxytoxin ²	1	2	3	8						
35	Gentamycin ^{1,2}	1→b	2↓	3↓	8↓	1	2	8	1	2	8
36	Magnesium sulfate ²	1	2	3	8						
37	Streptomycin ⁴	1	2	3	8						
38	Xylocaine or lidocaine 1% ^{2,5}	1	2	3	8						
	INTRAVENOUS										
39	Normal Saline ²	1	2	3	8						
40	Dextrose and water ^{1,2}	1	2	3	8						
41	Ringers Lactate ^{1,2}	1	2	3	8	1	2	8	1	2	8

- 1) Child Health
- 2) Maternal Health
- 3) Reproductive tract Infections
- 4) Tuberculosis
- 5) Family Planning

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
702	Were the medications organized according to expiry date "first-expire first-out" on the shelf? (VERIFY WHEN COMPLETING 801-888 FOR INDICATED MEDICINES)	YES..... 1 NO 2 DON'T KNOW..... 8	
	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE CORRECT RESPONSE FOR EACH OF THE FOLLOWING CONDITIONS:		
703	ARE THE MEDICINES OFF THE FLOOR PROTECTED FROM WATER/DAMPNESS?	YES..... 1 NO 2 DON'T KNOW..... 8	
704	ARE THE MEDICINES PROTECTED FROM THE SUN?	YES..... 1 NO 2 DON'T KNOW..... 8	
705	IS THE ROOM CLEAR OF ANY EVIDENCE OF PESTS?	YES..... 1 NO 2 DON'T KNOW..... 8	
706	Does this facility determine the amount of each medication required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS 1 NEED DETERMINED ELSEWHERE 2	→708a
707	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL..... 1 STANDARD FIXED SUPPLY 2 DON'T KNOW..... 8	→710 →710 →710
708a	When was the last time that you received a routine supply of medications ?	WITHIN PRIOR 4 FULL WEEKS... 1 WITHIN PRIOR 12 FULL WEEKS. 2 MORE THAN 12 WEEKS AGO 3 DON'T KNOW 8	
708b	Routinely, when you order medicines , which best describes the system you use to determine how much of each to order: 1) Do you review the amount of each medicine remaining, and order to bring the stock amount to a pre-determined (fixed) amount? 2) Do you order the exact same amount each time? 3) Do you look at the amount used since the previous order, and plan based on prior utilization and expected future activity? 4) Others 5) RESPONDENT FAMILIAR WITH ORDERING SYSTEM IS NOT AVAILABLE	ORDER TO MAINTAIN FIXED STOCK LEVEL 1 ORDER SAME AMOUNT 2 ORDER BASED ON UTILIZATION 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	→709a →709a →709a →710
708c	When deciding how much of each medicine to order, based on prior utilization and planned activities, do you have a mathematical formula for calculating how much to use, or do you use your judgment?	MATHEMATICAL FORMULA..... 1 JUDGMENT 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
709a	<p>Which of the following best describes the system for deciding when to order medicines?</p> <p>1) Whenever stock levels fall to a predetermined level</p> <p>2) There is a fixed time that orders are accepted. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS.</p> <p>3) An order is placed at no fixed time, but rather whenever there is a need.</p> <p>4) Other</p>	<p>PREDETERMINED LEVEL 1</p> <p>EVERY <input type="text"/> <input type="text"/> WEEKS..... 2</p> <p>ORDER AS NEEDED 3</p> <p>OTHER _____ 6 (SPECIFY)</p>	
709b	<p>If there is a shortage of specific medicines between routine orders, what is most common procedure followed by this facility?</p> <p>1) Submit special order to normal supplier.</p> <p>2) Facility purchases from private market</p> <p>3) Clients must purchase from outside the facility.</p>	<p>SPECIAL ORDERA</p> <p>FACILITY PURCHASEB</p> <p>CLIENT PURCHASEC</p> <p>NO SHORTAGE.....D</p>	
710	<p>During the past 3 months, have you received the amount of each medication that you order (or that you are suppose to routinely receive)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p> <p>D.K.....8</p>	

Section 8. Supplies

800	SUPPLY ITEM	1 OBSERVED	2 REPORTED AVAILABLE	3 NOT AVAILABLE	8 NOT DETERMINED
1	Disinfectant for cleaning surfaces (bleach or other cleaning solution)	1	2	3	8
2	Sterile gloves	1	2	3	8
3	Clean gloves	1	2	3	8
4	Swab containers with sterile swabs or sterile gauze	1	2	3	8
5	Skin antiseptic (iodine or chlorhexidine)	1	2	3	8
6	I.V. giving set	1	2	3	8
7	I.V. canulae	1	2	3	8
8	Injection needles (19 or 21 gauge)	1	2	3	8
9	Sterile syringes (3 or 5 ml)	1	2	3	8

Provider Interview

100 **OBSERVER:** INTRODUCE YOURSELF TO THE PROVIDER.

Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. I would like to ask you some questions about this subject.

This information is completely confidential. You may choose to stop the interview at any time.

Do you have any questions for me at this time? Do I have your agreement to participate?

INTERVIEWER'S SIGNATURE
(Indicates respondent's willingness to participate)

DATE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
1. Provider Training and Experience			
100a	May I continue?	YES.....1 NO.....2	→ STOP
101	In what year did you start working in this facility?	YEAR <input style="width: 20px; height: 20px;" type="text"/>	
102	Now I would like to ask you some questions about your educational background. How many years in total of primary and secondary education did you complete?	YEARS..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
103	What is your current technical qualification?	OB/GYN PHYSICIAN11 FAMILY PLANNING PHYSICIAN12 PEDIATRICIAN.....13 FAMILY PHYSICIAN14 OTHER PHYSICIAN SPECIALIST15 GENERAL PRACTITIONER.....16 NURSE WITH MIDWIFRY21 NURSE22 MIDWIFE23 NURSE ASSISTANT24 RAIDA REFIA25 SOCIAL WORKER31 OTHER96 (SPECIFY)	
104	What year did you graduate with this qualification?	YEAR <input style="width: 20px; height: 20px;" type="text"/>	
105	How many years of study was required for the technical qualification in question 103? (AFTER COMPLETING BASIC EDUCATION DESCRIBED IN Q102)? (If less than 1 year, write "00" in years and indicate number of months).	YEARS..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTHS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ 201

2. Child Health Care

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	Do you currently personally provide child health care services?	YES.....1 NO2	→301
202	For how many years in total have you provided this service? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
203	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) EPI/cold chain? B) ARI treatment? C) Diarrhea treatment? D) Nutrition/micro-nutrient deficiencies? E) Mother to child transmission of HIV/AIDS? F) Integrated Management of Childhood Illness (IMCI)? G) Genetic/hereditary illnesses? W) Other _____?..... (SPECIFY)	YES YES NO PRIOR PRIOR 12mo 13-59mo EPI/COLD CHAIN 1 2 3 ARI 1 2 3 DIARRHEA 1 2 3 NUTRITION 1 2 3 MTC TRANSMISSION..... 1 2 3 IMCI 1 2 3 GENETIC/HEREDITY..... 1 2 3 OTHER _____ 1 2 3	

3. Family Planning

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Do you currently personally provide family planning services?	YES.....1 NO2	→401
302	For how many years in total have you provided this service? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
303	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Basic Training for Service Provision? Additional training aside from Basic Training: B) Family planning counseling? C) Any contraceptive technology (CT)? D) STI Syndromic Management? E) Other, STI diagnosis and treatment W) Other _____? (SPECIFY)	YES YES NO PRIOR PRIOR 12mo 13-59mo BASIC TRAINING 1 2 3 FP COUNSELING 1 2 3 ANY CT 1 2 3 STI SYNDROMIC 1 2 3 OTHER STI..... 1 2 3 OTHER _____ . 1 2 3	

4. Maternal Health

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO												
401	Do you currently personally provide antenatal care?	YES.....1 NO2	→404												
402	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>													
403	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Basic Training for Service Provision? Additional training aside from Basic Training: B) Antenatal care? C) Counseling/health education for maternity clients? D) Management of risk pregnancies? E) Mother to child transmission of HIV/AIDS? F) Postnatal care? G) Family Planning? H) Sexually transmitted infections? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td></td> <td style="text-align: center;">PRIOR</td> <td style="text-align: center;">PRIOR</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">12mo</td> <td style="text-align: center;">13-59mo</td> <td></td> </tr> </table> BASIC TRAINING..... 1 2 3 ANTENATAL CARE 1 2 3 COUNSELING/ HEALTH EDUCATION ... 1 2 3 MGMT RISK PREGNANCIES..... 1 2 3 MTC TRANSMISSION... 1 2 3 POSTNATAL CARE 1 2 3 FAMILY PLANNING 1 2 3 STIS..... 1 2 3 OTHER _____ 1 2 3		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		
	YES	YES	NO												
	PRIOR	PRIOR													
	12mo	13-59mo													
404	Do you currently personally provide delivery care? By this, I mean conducting the actual delivery?	YES.....1 NO2	→409												
405	For how many year in total have you conducted deliveries? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>													
406	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Care during labor or delivery? B) Use of partograph? C) Life saving skills/emergency complications? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td></td> <td style="text-align: center;">PRIOR</td> <td style="text-align: center;">PRIOR</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">12mo</td> <td style="text-align: center;">13-59mo</td> <td></td> </tr> </table> DELIVERY CARE 1 2 3 PARTOGRAPH USE 1 2 3 LIFE SAVING/EMERG ... 1 2 3 OTHER _____ 1 2 3		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		
	YES	YES	NO												
	PRIOR	PRIOR													
	12mo	13-59mo													
407	Approximately how many deliveries have you assisted as the principal provider, in the last 6 months? (INCLUDE DELIVERIES CONDUCTED FOR PRIVATE PRACTICE AND FOR FACILITY)	TOTAL DELIVERIES.... <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>													

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
408	When was the last time you used a partograph?	NEVER0 IN PAST WEEK1 IN PAST MONTH.....2 IN PAST 6 MONTHS3 6 MONTHS AGO OR LONGER.....4 DON'T KNOW.....8	
409	Do you currently personally provide either newborn care or postpartum care or both?	YES, NEWBORN1 YES, POSTPARTUM.....2 YES BOTH.....3 NO NEITHER.....4	→501
410	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
411	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Care of the normal newborn? B) Neonatal resuscitation? C) Mother to child transmission HIV/AIDS? D) Exclusive breast-feeding? W) Other _____? (SPECIFY)	YES YES NO PRIOR PRIOR 12mo 13-59mo NORMAL NEWBORN 1 2 3 NEONATAL RESUSCIT .. 1 2 3 MTC TRANSMISSION.... 1 2 3 BREAST FEEDING 1 2 3 OTHER _____ .1 2 3	
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
5. SPECIFIC INFECTIOUS DISEASES			
501	Do you currently personally provide care for clients with reproductive tract infections or sexually transmitted infections? (STIs)?	YES.....1 NO2	→503
502	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
503	Do you currently personally provide care for clients with tuberculosis?	YES.....1 NO2	→505
504	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	
505	Do you currently personally provide care for clients who are HIV/AIDS positive?	YES.....1 NO2	→508
506	Which type of care do you provide? CIRCLE ALL THAT APPLY	INITIAL DIAGNOSIS..... A MEDICAL MANAGEMENT OF CONCURRENT ILLNESS B ANTI-RETROVIRAL THERAPY C COUNSELING/SOCIAL SUPPORT D OTHER _____ X (SPECIFY)	
507	For how many years in total have you provided any services for HIV/AIDS clients? IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
508	IS YES CIRCLED FOR EITHER Q501 OR Q503 or 505?	YES.....1 NO2	→600
509	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Did you received training in (SUBJECT) as a part of the basic training for your current technical qualification (pre-service training)?		YES NO DK
	a) How to counsel for prevention of STIs	STI COUNSELING 1	2 8
	b) Clinical diagnosis and treatment of STIs	STI CLINICAL DX & TX 1	2 8
	c) Syndromic diagnosis and treatment of STIs	STI SYNDROMIC DX & TX 1	2 8
	d) How to counsel for prevention of HIV/AIDS	PREVENTION OF HIV/AIDS 1	2 8
	e) Counseling and social support needs for HIV/AIDS infected clients?	COUNSEL/SUPPORT HIV/AIDS... 1	2 8
	f) Medical management of HIV/AIDS	MEDICAL MGMT HIV/AIDS 1	2 8
	g) Anti-retroviral therapy for HIV/AIDS?	ANTI-RETROVIRAL TX 1	2 8
	h) Diagnosis and treatment of TB?	TB DX AND TX 1	2 8
510	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?		YES YES NO PRIOR PRIOR 12mo 13-59mo
	a) Counseling for prevention of STIs?	STI COUNSELING/ PREVENTION 1	2 3
	b) Clinical diagnosis and treatment of STIs?	CLINICAL DX & TX..... 1	2 3
	c) Syndromic diagnosis and treatment of STIs?	SYNDROMIC DX & TX.... 1	2 3
	d) Counseling for prevention of HIV/AIDS?	PREVENTION HIV/AIDS . 1	2 3
	e) Mother to Child transmission?	MOTHER TO CHILD TRANSMISSION 1	2 3
	f) Counseling/social support for HIV/AIDs infected clients?	COUNSEL/SUPPORT HIV/AIDS 1	2 3
	g) Medical management of HIV/AIDS infected clients?	MEDICAL MGMT HIV/AIDS 1	2 3
	h) Anti-retroviral therapy for HIV/AIDS infected clients?	ANTI-RETROVIRAL TX... 1	2 3
	i) Diagnosis and treatment of Tuberculosis	TUBERCULOSIS..... 1	2 3
	w) Other _____? (SPECIFY)	OTHER _____ .. 1	2 3

MEASURE Service Provision Assessment

OBSERVATION OF CONSULTATION FOR SICK CHILD

Provider Information	
QTYPE OF _____ Name of the facility _____ Facility Location _____ Governorate _____ District _____ Code of the facility _____ Type of Health Facility and Operating Authority Governmental: 11 = General Hospital 21=MCH Center 12=District Hospital 22=Rural health unit 13=Fever Hospital 23=Urban health unit 14= Complimentary 24=Health Office 25=Mobile Unit 26=Other Non-Governmental: 31 =CSI 32= EFPA 33=other non-governmental	QTYPEOSC GOV..... <input type="text"/> <input type="text"/> DISTRICT <input type="text"/> <input type="text"/> FACILITY CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FACILITY TYPE <input type="text"/> <input type="text"/> AND OPERATING AUTHORITY
Provider Information	
Provider category: 11=OB/GYN Physician ;12=Family Planning Physician; 13=Pediatician; 14=Family physician; 15=Other physician specialist; 16=General Practitioner; 21=Nurse w/ midwifry; 22=Nurse; 23=Midwife; 24=Nurse assistant; 25=Raida Refia; 31=Social worker; 96=other (_____) (SPECIFY) Sex of Provider: (1= male; 2= female) Code for Provider (should be the same as that used for the Provider Interview): _____	PROVIDER CATEGORY <input type="text"/> <input type="text"/> SEX OF PROVIDER..... <input type="text"/> PROVIDER CODE <input type="text"/> <input type="text"/>
Date: _____ Name of the interviewer _____ Time observation started: _____ Child Code _____	DAY..... <input type="text"/> <input type="text"/> MONTH..... <input type="text"/> <input type="text"/> YEAR..... <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="2"/> INTERVIEWER CODE..... <input type="text"/> <input type="text"/> HOUR..... <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/> CHILD CODE..... <input type="text"/> <input type="text"/>

Observation of Sick Child Consultation

READ TO PROVIDER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. I would like to observe your consultation with this child in order to better understand how health care is provided in this country.

This information is completely confidential. You may choose to stop the interview at any time. Do you have any questions for me? May I be present at this consultation?

 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

 DATE

100	PERMISSION RECEIVED FROM PROVIDER	YES..... 1 NO 2	→ STOP
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READ TO CHILD'S CARETAKER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide services to women and children. I would like to observe your consultation with this Provider in order to better understand how health care is provided.

This information is completely confidential and will not affect the level of care you receive here now or in the future. After the consultation, my colleague would like to talk with you about your experiences here today.

You may tell me to stop the interview at any time. Do you have any questions for me? May I be present at this consultation?

 INTERVIEWER'S SIGNATURE
 (Indicates respondent's willingness to participate)

 DATE

101	PERMISSION RECEIVED FROM CARETAKER?	YES..... 1 NO 2	→ STOP
102	SEX OF CHILD	MALE 1 FEMALE 2	
103	Visit type (THIS REFERS TO <u>THIS</u> SICKNESS)	FIRST VISIT 1 FOLLOW-UP VISIT 2	

1. Provider Interaction with Child and Caretaker

NO.	QUESTIONS	CODING CLASSIFICATION			
		YES	NO	UNSURE	NA
104	Does the Provider ask about or the Caretaker mention if the child has any of the following major symptoms ?				
	1) Cough or difficult breathing?	1	2	8	
	2) Diarrhea?	1	2	8	
	3) Fever or body hotness?	1	2	8	
	4) Ear pain or discharge?	1	2	8	
	5) Throat problems?	1	2	8	
	6) If the child is unable to drink or breastfeed at all?	1	2	8	
	7) If the child vomits everything?	1	2	8	
	8) If the child has had convulsions with this sickness?	1	2		
	9) Did the provider ask about any other problems?	1	2	8	
105	Does the Provider perform any of the following physical examinations ?				
	1) Take temperature using thermometer?	1	2	8	
	2) Feel the child for fever or body hotness?	1	2	8	
	3) Count respiration (breaths)?	1	2	8	
	4) Use stethoscope on chest or back?	1	2	8	
	5) Check skin turgor for dehydration (pinch abdominal skin)?	1	2	8	
	6) Check for pallor by looking at palms?	1	2	8	
	7) Check for pallor by looking at lower lip of mouth?	1	2	8	
	8) Check throat with tongue depressor, using no light?	1	2	8	
	9) Use light and tongue depressor, to check throat?	1	2	8	
	10) Look in ear and feel behind ear?	1	2	8	
	11) Press both feet (checking for edema)?	1	2	8	
	12) Remove or partially remove clothing and check arms and shoulders, thighs and buttocks for muscle/body status?	1	2	8	
	13) Weight the child? IF YES:	1	2→106	8→106	
	14) Plot weight on a growth chart?	1	2	8	5
106	Does the Provider ask about or perform other assessments of the child's health?				
	1) Offer the child something to drink or put the child to the breast? (TO VERIFY IF THE CHILD CAN DRINK OR NOT)	1	2	8	
	2) Ask about normal feeding practices when the child is not ill?	1	2	8	
	3) Ask about normal breast feeding practices when the child is not ill?	1	2	8	
	4) Ask about feeding/breast feeding practices for the child during this illness?	1	2	8	
	5) Mention the child's weight or growth to the caretaker, or discuss the growth chart with the caretaker?	1	2	8	

NO.	QUESTIONS	CODING CLASSIFICATION			
		YES	NO	UN-SURE	NA
	6) Look at the immunization card or ask caretaker about the vaccination history?	1	2	8	
	7) Tell the caretaker where and when to take the child for immunization?	1	2	8	
	8) Look at the child health card either before beginning the consultation or while collecting information from the caretaker or when examining the child? (THIS MAY BE THE VACCINATION CARD OR ANOTHER HEALTH CARD)	1	2	8	
107	Does the Provider provide any of the following advice when counseling the caretaker?				
	1) Counsel the caretaker about feeding and/or breast-feeding the child when not sick?	1	2	8	
	2) Give extra fluids to the child during this sickness?	1	2	8	
	3) Continue feeding the child during this sickness?	1	2	8	
	4) Tell the caretaker what illness(es) the child has?	1	2	8	
	5) Describe signs or symptoms in the child for which the caretaker should <u>immediately</u> bring the child back to the facility?	1	2	8	
108	Was the child referred to another provider (ether inside or outside this facility), or for a laboratory test?	1	2 →110	8 →110	
109	IF YES: Did the provider explain why the referral was made?	1	2	8	5
110	Were any oral medications prescribed or provided during the consultation? IF YES: DID A PROVIDER:	1	2 →111	8 →111	
	1) Explain how to administer oral treatment(s)?	1	2	8	5
	2) Ask the caretaker to repeat instructions on how to administer the oral medications?	1	2	8	5
	3) Give the first dose of any oral medicines?	1	2	8	5
	4) Was an oral antibiotic prescribed?	1	2	8	5
	5) Was the child given the first dose of the oral antibiotic by a provider?	1	2	8	5
111	Did the Provider use any visual aids when providing health education or counseling the caretaker about the child?	1	2	8	
112	Did the Provider write on the child health card?	YES 1 NO 2 NO CHILD HEALTH CARD USED..... 3 DON'T KNOW 8			
113	OUTCOME OF CONSULTATION	CHILD SENT HOME 1 CHILD REFERRED TO LAB OR OTHER PROVIDER AT SAME FACILITY..... 2 CHILD ADMITTED TO SAME FACILITY..... 3			

NO.	QUESTIONS	CODING CLASSIFICATION
		CHILD REFERRED TO OTHER FACILITY 4 DON'T KNOW 8
114	Did the provider discuss a return appointment for when the child should be brought back for follow-up?	YES 1 NO 2 DON'T KNOW 8
115	RECORD TIME CONSULTATION ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>

2. Diagnosis and Classification and Treatment

ASK THE PROVIDER TO TELL YOU THE DIAGNOSIS. EXPLAIN THAT FOR ANY DIAGNOSIS OR SYMPTOM YOU WANT TO KNOW IF THE PROBLEM WAS SEVERE, MODERATE, OR MINOR. THEN ASK ABOUT THE TREATMENT PRESCRIBED OR PROVIDED.

DIAGNOSIS OR MAIN SYMPTOMS (IF NO DIAGNOSIS)		1 SEVERE	2 MODERATE	3 MINOR	4 NO	5 DID NOT ASK	8 UNSURE
RESPIRATORY SYSTEM	A) PNEMUONIA (PNEUMONIA)	1	2		4	5	8
	B) BRONCHO-PNEUMONIA	1	2		4	5	8
	C) BRONCHITIS	1	2	3	4	5	8
	D) COUGH OR COLD ONLY	1	2	3	4	5	8
	E) RESPIRATORY ILLNESS DIAGNOSIS UNCERTAIN	1	2	3	4	5	8
	F) COUGH, DIAGNOSIS UNCERTAIN	1	2	3	4	5	8
Digestive system	I) PERSISTENT DIARRHEA	1	2	3	4	5	8
	J) DIARRHEA	1	2	3	4	5	8
	K) DYSENTERY	1	2	3	4	5	8
	L) OTHER DIARRHEA _____ (SPECIFY)	1	2	3	4	5	8
DEHYDRATION	M) DEHYDRATION	1	2	3	4	5	8
FEVER	N) FEVER	1	2	3	4	5	8
	O) PROBABLE BACTERIAL FEVER	1	2	3	4	5	8
	P) PROBABLE VIRAL FEVER	1	2	3	4	5	8
	Q) MEASLES	1	2	3	4	5	8
	R) MEASLES WITH EYE OR MOUTH COMPLICATIONS	1	2	3	4	5	8
EAR	S) MASTOIDITIS	1	2	3	4	5	8
	T) ACUT EAR INFECTION	1	2	3	4	5	8
	U) CHRONIC EAR INFECTION	1	2	3	4	5	8
THROAT	V) STREPTOCOCCAL SORE THROAT	1	2	3	4	5	8
	W) NON-STREPTOCOCCAL SORE THROAT	1	2	3	4	5	8
	X) OTHER THROAT OR EAR DIAGNOSIS _____	1	2	3	4	5	8
X1 OTHER DAGNOSIS _____		1	2	3	4	5	8

202 ASK ABOUT PRESCRIPTION, TREATMENT AND ACTIONS TAKEN FOR ILLNESS AND PROB "ANY THING ELSE"		YES	NO	UNSURE
TREATMENTS FOR VARIETY OF ILLNESSES	A) IMMEDIATE REFERRAL TO OTHER FACILITY	1	2	8
	B) ADMIT TO THIS FACILITY	1	2	8
	C) NO TREATMENT OR REFERRAL	1	2	8
	D) BENZATHINE PENICILLIN INJECTION	1	2	8
	E) OTHER ANTIBIOTIC INJECTION	1	2	8
	F) OTHER INJECTION	1	2	8
	G) ANTIBIOTIC TABLET/SYRUP	1	2	8
	H) ASPIRIN, PARACETAMOL, VITAMINS, COUGH SYRUP, OTHER ORAL MEDICINE FOR SYMPTOMATIC TREATMENT	1	2	8
RESPIRATORY	I) NEBULIZED MEDICATION	1	2	8
	J) ORAL BRONCHODILATOR	1	2	8
	K) DRY EAR BY WICKING	1	2	8
DEHYDRATION	L) HOME ORT	1	2	8
	M) INITIAL ORT IN FACILITY (4 HOURS)	1	2	8
	N) INTRAVENOUS FLUIDS	1	2	8
MEASLES	O) VITAMIN A	1	2	8
	P) FEEDING SOLID FOODS	1	2	8
	Q) FEEDING EXTRA LIQUIDS	1	2	8
	R) FEEDING BREAST MILK	1	2	8
	X) OTHER TREATMENT _____ (SPECIFY)	1	2	8
203	CHECK RESPIRATORY ILLNESSES IN 201. IF ANY CATEGORIES ARE CIRCLED, CLARIFY WITH THE PROVIDER IF THERE WAS WHEEZING OR NOT.	YES, WHEEZING..... 1 NO WHEEZING..... 2 NOT CERTAIN..... 8		
204	Did you giver or refer the child for an immunization?	PROVIDER GAVE 1 PROVIDER REFERRED..... 2 NOT DUE FOR IMMUNIZATION 3 NOTHING ABOUT IMMUNIZATION 4 DON'T KNOW 8		
205	RECORD TIME OBSERVATION ENDED.	HOUR..... <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>		
206	OBSERVER COMMENT			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	How many days ago did the problem which you brought (NAME) here begin? RECORD 00 IF LESS THAN ONE DAY	DAYS AGO..... <input type="text"/> <input type="text"/> DON'T KNOW 98	
108	Did the Provider tell you what illness (NAME) has?	YES 1 NO 2 DON'T KNOW 8	
109	Were you told about any signs or symptoms for which you must immediately bring the child back? IF NECESSARY, PROBE "were there any serious or danger signs or symptoms for which you were told to Immediately bring (NAME) back? CIRCLE THE SYMPTOM MENTIONED BY THE CARETAKER.	FEVER A DIFFICULT BREATHING..... B POOR/NOT EATING C POOR/NOT DRINKING D BECOMES SICKER E BLOOD IN STOOL F OTHER X (SPECIFY) NO Y DON'T KNOW Z	
110	Were you told anything about returning to the facility with (NAME) for follow-up?	YES 1 NO 2 CHILD REFERRED OR ADMITTED 3 DON'T KNOW 8	→ 112 → 112 → 112
111	What were you told about returning for follow-up? CIRCLE ALL RESPONSES MENTIONED BY THE CARETAKER	GAVE A TIME TO RETURN A RETURN FOR MORE MEDICATIONS..... B RETURN IF CHILD DOES NOT BECOME BETTER C OTHER X (SPECIFY) NO Y DON'T KNOW Z	
112	Did the Provider give or prescribe any medicines for (NAME)?	YES, GAVE MEDS 1 YES, GAVE PRESCRIPTION 2 GAVE MEDS AND PRESCRIPTION 3 NO 4	→ 119
113	ASK TO SEE ALL MEDICATIONS WHICH WERE RECEIVED AND ANY PRESCRIPTIONS WHICH HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS/PRESCRIPTIONS SEEN.	HAS ALL MEDS 1 HAS SOME MEDS, SOME UNFILLED PRESCRIPTIONS 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY 3	
114	INDICATE IF ANY OF THE PRESCRIPTIONS ARE FOR THERAPEUTIC INJECTIONS.	YES 1 NO 2 DON'T KNOW 8	
115	Did someone at the facility explain to you how to give those medicines to (NAME) at home?	YES 1 NO 2 DON'T KNOW 8	
116	Do you feel comfortable that you know how much of each medication to give (NAME) and how often to give it each day?	YES 1 NO 2 NOT SURE 8	
117	Was (NAME) given a dose of any of these medications [THIS REFERS TO THE MEDICATIONS THE CARETAKER WILL PROVIDE AT HOME] here at the facility already? SPECIFICALLY CHECK FOR ANY ANTIBIOTIC.	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
118	Was (NAME) given an injection here at the facility for treating the sickness?	YES 1 NO 2 DON'T KNOW 8	
119	What will you do if (NAME) still has this problem or it becomes worse over the next few days?	RETURN TO FACILITY 1 GO TO OTHER FACILITY 2 GO TO OTHER HEALTH WORKER/HEALER/ PHARMACY 3 WAIT 4 DON'T KNOW 8	
120	Since becoming ill, has the way that (NAME) eats/drinks changed from normal? IF YES, CLARIFY IF THE CHILD IS TAKING MORE OR LESS THAN NORMAL	MORE THAN NORMAL 1 SAME AS NORMAL 2 LESS THAN NORMAL 3 NOT EATING/DRINKING 4 DON'T KNOW 8	
121	What did the Provider tell you about feeding (NAME) during this illness?	GIVE LESS THAN USUAL 1 GIVE SAME AS USUAL 2 GIVE MORE THAN USUAL 3 GIVE NOTHING/NOT FEED 4 DIDN'T DISCUSS 6 DON'T KNOW 8	
122	What did the Provider tell you about giving fluids (or breast milk, if breast fed) to (NAME) during this illness?	GIVE LESS THAN USUAL 1 GIVE SAME AS USUAL 2 GIVE MORE THAN USUAL 3 GIVE NOTHING/NOT FEED 4 DIDN'T DISCUSS 6 DON'T KNOW 8	
123	Did any Provider today ask you about the types of foods and amounts that you normally feed (NAME) when not sick?	YES 1 NO 2 DON'T KNOW 8	
124	Did anyone at the health facility weight (NAME) today?	YES 1 NO 2 DON'T KNOW 8	
125	Did anyone talk to you about (NAME'S) weight and how s/he is growing?	YES 1 NO 2 DON'T KNOW 8	
126	CHECK QUESTION 102-103. IS THE CHILD 24 MONTHS OLD OR YOUNGER?	YES 1 NO 2	→ 201
127	Now I want to ask you some questions about (NAME). When (NAME) is not sick, does (NAME) take breastmilk? IF YES, do you normally give other fluids or foods along with the breastmilk?	ONLY BREASTMILK 1 BREASTMILK AND LIQUIDS 2 BREASTMILK AND OTHER FOODS AND LIQUIDS 3 NO BREASTMILK 4 DON'T KNOW 8	→ 129 → 129
128	Did any provider today discuss anything specifically about breast feeding, such as how often you should breastfeed (NAME) or what else you should give [NAME]? IF YES, What advise did the provider give you? PROBE TO DETERMINE IF THE CARETAKER RECALLS BEING ADVISED HOW MANY TIMES IN A DAY BREASTMILK SHOULD BE PROVIDED AND WHETHER OTHER OTHER FLUIDS SHOULD BE PROVIDED OR NOT.	EXCLUSIVE BREASTFEED A BREASTFEED AT LEAST 8 TIMES W/I 24 HR B ADD OTHER FLUIDS WITH BREASTMILK C OTHER X (SPECIFY) NO ADVISE ABOUT BREASTFEEDING Y DON'T KNOW Z	
129	Was (NAME) given a vaccination today?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO	
130	Do you have the (NAME)'S vaccination card with you?	YES 1 NO 2	→201	
131	ASK TO SEE THE CHILD'S VACCINATION CARD AND CHECK IF THE CHILD RECEIVE A VACCINATION TODAY?	YES, VACCINATED TODAY 1 NOT VACCINATED TODAY 2		
132	COMPLETE THE TABLE BELOW USING THE INFORMATION FROM THE CARD. RECORD IN COLUMN 1 WHETHER THE CHILD HAS EVER RECEIVED ANY OF THE FOLLOWING VACCINATIONS. RECORD THE DATE IN COLUMN 2. IF NO DATE IS RECORDED ON THE CARD, ENTER "66" FOR THE DAY AND MONTH AND "6666" FOR THE YEAR.			
	CHILD EVER RECEIVED VACCINATION	DATE		
		DAY	MONTH	YEAR
POLIO-0 (AT BIRTH)	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
BCG	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO-1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEP-1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-HEP 1	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO-2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEP-2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-HEP 2	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO-3	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
DPT-3	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEP-3	YES 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>

DPT-HEP 3	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
POLIO 4	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
MEASLES	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
MMR (9 MONTHS)	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
POLIO BOOSTER (18 MONTHS)	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
DPT BOOSTER	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
DPT-HEP BOOSTER	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
VITAMIN A _1 (9m)	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						
VITAMIN A _2 (18m)	YES	1	<input type="checkbox"/>					
	NO/NO RECORD	2						

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO		
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the child health services.									
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw (NAME) for the consultation?	MINUTES.....		<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						
		SAW PROVIDER IMMEDIATELY.....000 DON'T KNOW.....998								
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems									
		SPONTANEOUS		PROMPT						
		BIG	SMALL	BIG	SMALL	NO	DK/NA			
1	Time you waited?	1	2	3	4	5	8			
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8			
3	Time it takes to receive results from tests?	1	2	3	4	5	8			
4	Ability to discuss problems or concerns about your child's health with the health worker?	1	2	3	4	5	8			
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8			
6	Quality of the examination and treatment provided?	1	2	3	4	5	8			
7	Privacy from others seeing exam?	1	2	3	4	5	8			
8	Privacy from others hearing discussion?	1	2	3	4	5	8			
9	Availability of medicines at the facility?	1	2	3	4	5	8			
10	The hours/days of services?	1	2	3	4	5	8			
11	Cleanliness of facility?	1	2	3	4	5	8			
12	How staff treated you?	1	2	3	4	5	8			
13	Cost of services?	1	2	3	4	5	8			
14	Other _____ (SPECIFY)	1	2			5				

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
203	Do you participate in any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility? This includes if you prepay for a package of services or if you received a discounted price or an exemption from paying. IF YES, what type of program do you participate in?	YES, HIO/SHIP A YES, OTHER SYSTEM..... B YES, PREPAY AT FACILITY FOR PACKAGE OF SERVICES..... C YES, DISCOUNT/EXEMPT STATUS..... D OTHER X (SPECIFY) NO Y DON'T KNOW Z	
204	What is the total amount for all staff, services, or treatments which you paid for (NAMEs) consultation today?*	1) LAB L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY00000 NOT APPLICABLE.....99995 DON'T KNOW99998	
	Please include any money you paid for staff services, laboratory tests, or medicines you received.	2) MEDICINE OR METHOD L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY00000 NOT APPLICABLE.....99995 DON'T KNOW99998	
		3) CONSULT OR PROCEDURE L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY00000 NOT APPLICABLE.....99995 DON'T KNOW99998	
		4) OTHER L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		5) TOTAL AMOUNT L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY00000 NOT APPLICABLE.....99995 DON'T KNOW99998	
205	Have you ever visited this facility before? (either as a patient or visiting or accompanying a patient?)	YES.....1 NO2	
206	There are many reasons people choose different health facilities for services. Can you mention some of the reasons you selected this facility for the services you sought today?	FEMALE PHYSICIAN A EFFICIENCY OF THE PHYSICIANS B AVAILIABIITY OF ALL SPECIALITIES..... C AVAILABILITY OF THE SERVICE D CLIENTS ARE WELL TREATED E HAS THE GOLD STAR..... F A NEAR BY FACILITY G GOOD REPUTATION H OTHER X (SPECIFY)	

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	What is your relationship to (NAME)?	MOTHER1 FATHER2 SIBLING.....3 AUNT/UNCLE4 GRAND FATHER/MOTHER.....5 OTHER:.....6 <p style="text-align: center;">(SPECIFY)</p>	
301	Could you tell me how old are you?	AGE IN YEARS..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW98	
302	Have you ever attended school?	YES.....1 NO2	→304
303	What is the highest level of school (certificate) you have successfully completed?	NONE1 PRIMARY.....2 PREPARATORY3 SECONDARY4 ABOVE SECONDARY5 UNIVERSITY6 ABOVE UNIVERSITY7	→306 →306 →306 →306 →306
304	Have you ever attended any literacy classes?	YES.....1 NO2	
305	Can you read or write?	YES, READ ONLY1 YES, READ AND WRITE2 NO3	
306	Are you currently employed?	YES.....1 NO2	→309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER.....1 FOR SOMEONE ELSE2 FOR HERSELF3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASE1 BOTH2 KIND3 NOTHING4	
309	Do you live in a city or a village?	CITY.....1 VILLAGE.....2	
310	Which governorate do you live in?	<input style="width: 100px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

1. Client Counseling

NO.	QUESTIONS	CODING CLASSIFICATION		
	OBSERVER: PLEASE COMPLETE THE FOLLOWING ITEMS FOR ALL CLIENTS.			
101	INDICATE WHETHER THE CLIENT HAD ANY PREVIOUS CONTACT WITH A PROVIDER AT THIS FAMILY PLANNING CLINIC.	YES.....	1	
		NO	2	
		NOT DETERMINED	8	
	Client information and history: Indicate below whether the provider asked about /client offered information for each of the following items:			
102	INDICATE IF THE CLIENT HAS EVER BEEN PREGNANT	YES.....	1	
		NO	2	
		DON'T KNOW.....	8	
103	CLIENT HISTORY	YES	NO	UNSURE
	1) Age of client?	1	2	8
	2) Number of living children?	1	2	8
	3) Last delivery date/ Last abortion date?	1	2	8
	4) Age of youngest child?	1	2	8
	5) History of complications with pregnancy?	1	2	8
	6) Current pregnancy status?	1	2	8
	7) Desire for a child or more children?	1	2	8
	8) Desired timing for birth of next child?	1	2	8
	9) Breast feeding status?	1	2	8
	10) Regularity of menstrual cycle?	1	2	8
	11) Smoking?	1	2	8
	12) Symptoms of STIs (e.g. abnormal discharge)?	1	2	8
	13) Chronic illnesses (heart disease, diabetes, hypertension, liver /jaundice problem; breast cancer)?	1	2	8
104	EXAMINATION			
	1) Take Blood pressure?	1	2	8
	2) Take weight?	1	2	8
	3) Take urine specimen?	1	2	8
	4) Take blood specimen?	1	2	8
105	DID THE PROVIDER			
	1) Ensure VISUAL PRIVACY?	1	2	8
	2) Ensure AUDITORY PRIVACY?	1	2	8
	3) Assure CLIENT of CONFIDENTIALITY?	1	2	8
	4) Ask about questions or CONCERNS WITH METHODS discussed or with currently used method?	1	2	8
	DISCUSS:			
	5) Husband/wife attitude toward family planning ?	1	2	8
	6) Husband/wife status: (Husband have more than one wife? Husband away for extended periods of time?)	1	2	8
	7) Discuss risk of STIS?	1	2	8
	8) Discuss use of condoms to prevent STIs?	1	2	8
	9) Discuss using condoms WITH another method (dual method) for preventing STIs?	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
106	INDICATE WHICH METHOD(S) WERE PRESCRIBED DURING THIS VISIT. IF CONDOM WAS PRESCRIBED WITH ANOTHER METHOD, CIRCLE BOTH METHODS. [IF CONTINUING CLIENT RECEIVED REFILL FOR PILLS, REPEAT INJECTION, OR REPLACEMENT FOR IUD DURING THIS VISIT, CIRCLE THAT METHOD]	ORAL PILLA CONDOM.....B IUD C SPERMICIDE.....D DIAPHRAGME INJECTABLEF NORPLANT IMPLANT G NATURAL METHODS (RHYTHM) H BREASTFEEDING/LAMI FEMALE STERILIZATION J EMERGENCY CONTRACEPTIONK OTHER.....X NO METHODY	→ 108
FOR THE METHOD(S) IN QUESTION 106 INDICATE IF THE RELEVANT INFORMATION INDICATED WAS ASSESSED/DISCUSSED			
107	METHOD	INFORMATION	YES NO UNSURE
	PILLS/ INJECTIONS	1) When to take (PILL DAILY; INJECTION EITHER EVERY 1 OR 3 MONTHS)	1 2 8
		2) Changes which may occur with menstruation (decrease; spotting or amenorrhea)	1 2 8
		3) Initial side-effects which may occur (nausea; weight gain, breast tenderness)	1 2 8
		4) What to do if forget pill/do not get injection on time.	1 2 8
	NORPLANT	5) Good for 5 years	1 2 8
		6) Changes which may occur with menstruation (decrease; spotting)	1 2 8
		7) Initial side-effects which may occur (nausea; weight gain, breast tenderness)	1 2 8
	EMERGENCY CONTRACEPTI ON	8) If vomit within 2 hours need another dose	1 2 8
		9) If next period unusually light or not within 4 weeks, return for pregnancy check	1 2 8
	IUD	10) Check string	1 2 8
		11) May have HEAVY BLEEDING/SPOTTING	1 2 8
	STERILIZATIO N	12) Permanent: -will not become pregnant again	1 2 8
		13) May be slight discomfort at incision site	1 2 8
	CONDOMS	14) Any allergy to latex	1 2 8
		15) Use only one time	1 2 8
		16) Leave space at the top of the condom	
		17) Can use lubricant (water soluble only)	1 2 8
		18) Use as back-up if you fear other method failure	1 2 8
		19) Dual protection (pregnancy and STI)	1 2 8
	SPERMICIDE/ FOAM	20) May cause irritation	1 2 8
		21) Insert before each occurrence of intercourse	1 2 8
	RHYTHM/ PERIODIC ABSTINENCE	22) How to identify fertile period	1 2 8
		23) Should not have intercourse during fertile period without alternate method (condom/spermicide)	1 2 8

NO.	QUESTIONS		CODING CLASSIFICATION			GO TO
	METHOD	INFORMATION	YES	NO	UNSURE	
	LACTATIONAL AMMENORRHEA	24) Slight risk of pregnancy at time shortly before restarting menstruation	1	2	8	
		25) Most effective with exclusive breast-feeding	1	2	8	
		26) Not effective after menstruation begins again	1	2	8	
108	Did the provider refer to or look at the individual client record either prior to or during the consultation?	YES 1 NO 2 DON'T KNOW 8				
109	Were any visual aids or models used for health education or counseling about different methods?	YES 1 NO 2 DON'T KNOW 8				
110	DID THE PROVIDER DISCUSS A RETURN VISIT?	YES 1 NO 2 DON'T KNOW 8				

2. CLINICAL OBSERVATION

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	INDICATE IF ANY CLINICAL PROCEDURE WAS CONDUCTED DURING THIS VISIT.	PELVIC EXAM A IUD INSERTED B IUD REMOVAL C GIVEN INJECTABLE D NORPLANT INSERTED E NORPLANT REMOVAL F BREAST EXAMINATION G NO PROCEDURE Y	→301
202	INDICATE IF CLINICAL PROVIDER SAME PERSON WHO PROVIDED COUNSELING	YES 1 NO 2	→205a
<p>READ TO PROVIDER: Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities that provide health services with the goal of finding ways to improve service delivery. I would like to observe the procedure you will conduct. [Mrs. _____] has agreed that she has no objection to my presence. Observing all components of the services provided to [Mrs. _____] will help us better understand the how health services are provided.</p> <p>Any information from this examination is completely confidential. Do you have any questions for me? May I be present during this procedure?</p> <p style="text-align: center;">_____ DATE</p> <p style="text-align: center;">INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate)</p>			
203	PERMISSION RECEIVED FROM PROVIDER	YES 1 NO 2	→STOP
204	Provider performing most of clinical examination	OB/GYN DOCTOR 11 FAMILY PLANNING PHYSICIAN 12 PEDIATRICIAN 13 FAMILY PHYSICIAN 14 OTHER PHYSICIAN SPECIALIST 15 GENERAL PRACTITIONER 16 NURSE W/ MIDWIFERY 21 NURSE 22 OTHER _____ 96 (SPECIFY)	
205	Sex of provider conducting clinical examination	MALE 1 FEMALE 2	
205a	Did the provider examine the breasts?	YES 1 NO 2 DON'T KNOW 8	→206 →206
205b	Did the provider teach the client how to conduct self breast exam?	YES 1 NO 2 DON'T KNOW 8	
206	INDICATE CLINICAL PROCEDURE(S) CONDUCTED DURING THIS VISIT.	PELVIC EXAM A IUD INSERTED B IUD REMOVAL C GIVEN INJECTABLE D NORPLANT INSERTED E NORPLANT REMOVED F NO CLINICAL PROCEDURE Y	→207 →208a →208a →209 →210 →210 →301

PELVIC EXAM

207	DID THE PROVIDER:		YES	NO	N A
	1) ENSURE CLIENT HAS VISUAL PRIVACY?	VISUAL PRIVACY.....	1	2	
	2) ENSURE CLIENT HAS AUDITORY PRIVACY?	AUDITORY PRIVACY	1	2	
	3) EXPLAIN PROCEDURE PRIOR TO BEGINNING?	EXPLAIN PROCEDURE	1	2	
	4) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
	5) USE STERILIZED OR HIGH-LEVEL DISINFECTED INSTRUMENTS ?	DISINFECTED INSTRUMENTS	1	2	
	6) WASH HIS/HER HANDS, USING SOAP, BEFORE THE EXAM?	WASHED HANDS.....	1	2	
	7) PUT ON NEW OR DISINFECTED GLOVES <u>BEFORE</u> EXAM?	PUT ON GLOVES	1	2	
	8) ASK THE CLIENT TO TAKE SLOW, DEEP BREATHS, AND RELAX ALL MUSCLES?	ASK CLIENT TO RELAX MUSCLES	1	2	
	9) INSPECT THE EXTERNAL GENITALIA?	INSPECT GENITALIA.....	1	2	
	10) (IF USED) EXPLAIN SPECULUM PROCEDURE?	EXPLAIN SPECULUM	1	2	5
	11) INSPECT THE CERVIX AND VAGINAL MUCOSA? (AIM LIGHT INSIDE INSERTED SPECULUM)	INSPECT CERVIX	1	2	5
	12) PERFORM BIMANUAL EXAM (ONE HAND INSIDE VAGINA, OTHER PALPATING UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM.....	1	2	
	13) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER.....	1	2	
	14) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA.....	1	2	
	15) PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE? (ASK THE PROVIDER)	DECONTAMINATE GLOVES/INSTRUMENTS...	1	2	

Cheek 206 if there is another procedure skip to it or other wise skip to 301.

IUD INSERTION AND REMOVAL

208a	INDICATE PROCEDURE CONDUCTED	IUD INSERTION..... 1 IUD REMOVAL..... 2			
208b	DID THE PROVIDER:		YES	NO	NA
	1) ENSURE CLIENT HAD VISUAL PRIVACY?	VISUAL PRIVACY.....	1	2	
	2) ENSURE CLIENT HAD AUDITORY PRIVACY?	AUDITORY PRIVACY.....	1	2	
	3) (NEW CLIENT) RECONFIRM THE METHOD CHOICE?	RECONFIRM CHOICE	1	2	5
	4) EXPLAIN PROCEDURE PRIOR TO BEGINNING?	EXPLAIN PROCEDURE	1	2	
	5) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
	6) USE STERILIZED/HIGH-LEVEL DISINFECTED INSTRUMENTS?	STERILE INSTRUMENTS ..	1	2	
	7) WASH HANDS WITH SOAP <u>BEFORE</u> PUTTING ON GLOVES?	WASH HANDS BEFORE	1	2	
	8) GLOVE HANDS (STERILE GLOVES)?	STERILE GLOVES.....	1	2	
	9) GLOVE HANDS (CLEAN GLOVES)?	CLEAN GLOVES.....	1	2	
	10) SPECULUM EXAM FOR REPRODUCTIVE TRACT INFECTIONS/STIS <u>BEFORE</u> BIMANUAL EXAM?	SPECULUM EXAM	1	2	
	11) CONDUCT BIMANUAL PELVIC EXAM? (ONE HAND INSIDE VAGINA OTHER PALPATE UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM.....	1	2	5
	12) VISUALIZE CERVIX DURING CLEANING? (SHINE LIGHT IN INSERTED SPECULUM)	VISUALIZE CERVIX.....	1	2	
	13) USE TENACULUM?	USE TENACULUM.....	1	2	5
	14) SOUND THE UTERUS <u>BEFORE</u> IUD INSERTION?	SOUND UTERUS.....	1	2	
	15) USE THE NO-TOUCH TECHNIQUE FOR INSERTING THE IUD?	NO-TOUCH TECHNIQUE	1	2	
	16) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER	1	2	
	17) ENSURE NO VAGINA BLEEDING AFTER IUD INSERTION AND BEFORE LEAVING THE EXAMINATION TABLE?	ENSURE NO BLEEDING	1	2	
	18) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA.....	1	2	
	19) PLACE REUSABLE INSTRUMENTS OR GLOVES IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE?	DECONTAMINATE GLOVES/INSTRUMENTS...	1	2	
	20) SHOW REMOVED IUD TO THE CLIENT?	SHOW REMOVED IUD.....	1	2	5
	21) DISCUSS RETURN VISIT AFTER NEXT CYCLE?	DISCUSS RETURN VISIT	1	2	

→301

INJECTABLE

209	WHEN GIVING THE INJECTABLE , DID THE PROVIDER:		YES	NO	N A
	1) (NEW CLIENT) RECONFIRM METHOD CHOICE?	RECONFIRM CHOICE	1	2	5
	2) (NEW CLIENT) VERIFY CLIENT NOT PREGNANT?	NOT PREGNANT	1	2	5
	3) (CONTINUING CLIENT) CHECK CLIENT CARD (TO ENSURE GIVING INJECTION AT CORRECT TIME)?	CORRECT TIME	1	2	5
	4) WASH HANDS <u>BEFORE</u> INJECTION?	WASH HANDS	1	2	
	5) USE NEW NEEDLE AND SYRINGE?	NEW NEEDLE.....	1	2	5
	6) SEE PROVIDER OPEN NEW PACKET WITH NEEDLE AND SYRINGE?	SEE SYRINGE PACKET	1	2	5
	7) STIR/MIX BOTTLE <u>BEFORE</u> DRAWING DOSE? (DEPO)	STIR BOTTLE	1	2	5
	8) CLEAN AND AIR-DRY INJECTION SITE <u>BEFORE</u> INJECTION?	CLEAN AND AIR DRY SITE	1	2	
	9) DRAW BACK PLUNGER <u>BEFORE</u> INJECTION?	DRAW BACK PLUNGER	1	2	
	10) MASSAG INSTEND OF ALLOWING DOSE TO SELF-DISPERSE?	MASSAGE.....	1	2	
	11) DISPOSE OF SHARPS IN PUNCTURE RESISTANT CONTAINERS?	DISPOSE OF SHARPS.....	1	2	
	12) INDICATE IF THE NEEDLE AND SYRINGE WERE PROVIDED BY THE FACILITY OR PROVIDED BY THE CLIENT	PROVIDED BY FACILITY 1 PROVIDED BY CLIENT 2 DON'T KNOW 8			

➔301

3. Client's Family Planning Status

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	INDICATE CLIENT'S FAMILY PLANNING STATUS AT THE BEGINNING OF THE CONSULTATION.	CURRENT USER..... 1 NONUSER, USED IN PAST 2 NONUSER, NO PAST USE 3 NOT DETERMINED..... 8	→304 →306 →306
302	INDICATE PRINCIPAL REASON FOR VISIT.	RESUPPLY/ROUTINE FOLLOWUP 1 WANT METHOD CHANGE- NO PROBLEM 2 DISCUSS PROBLEM WITH CURRENT METHOD 3 DISCUSS OTHER HEALTH PROBLEM (NOT METHOD) 4 WANT TO DISCONTINUE FP (NO PROBLEM) 5 OTHER _____ 6 (SPECIFY)	
303	INDICATE OUTCOME OF VISIT.	CONTINUED WITH CURRENT METHOD..... 1 SWITCHED METHOD, RECEIVED TODAY 2 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, CONTINUED USE OF CURRENT METHOD..... 3 PLANNED METHOD SWITCH, NOT RECEIVED TODAY, DISCONTINUED CURRENT METHOD..... 4 DECIDED TO STOP USING FAMILY PLANNING..... 5	→308 →308 →307 →307 →308
304	INDICATE TIMING OF CLIENT'S MOST RECENT USE OF CONTRACEPTION.	WITHIN PAST 6 MONTHS 1 SIX MONTHS OR MORE AGO..... 2 NOT DETERMINED..... 8	
305	INDICATE OUTCOME OF VISIT.	RESTARTED PRIOR METHOD 1 ADOPTED DIFFERENT METHOD RECEIVED TODAY 2 PLANNED DIFFERENT METHOD, NOT RECEIVED TODAY 3 RECEIVED INFORMATION/ COUNSELING ONLY..... 4 NOT DETERMINED..... 8	→308 →308 →307 →308 →308
306	INDICATE OUTCOME OF VISIT.	RECEIVED/PREScribed METHOD 1 PLANNED METHOD, NOT RECEIVED TODAY 2 DID NOT DECIDE ON METHOD 3	→308 →308
307	WHY WAS METHOD NOT RECEIVED TODAY?	VAGINAL INFECTIONA PREGNANCY STATUS UNSURE...B WILL CHECK WITH HUSBAND C METHOD NOT IN STOCK..... D OTHER _____ X (SPECIFY)	
308	Did the provider write in an individual client record or card after the consultation?	YES 1 NO 2 DON'T KNOW 8	

309	TIME OBSERVATION ENDED.	HOUR..... <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>
310	Observer Comment:	

MEASURE Service Provision Assessment

Exit Interview for Family Planning Client

FACILITY IDENTIFICATION

QTYPE OF _____ Name of the facility _____ Facility Location _____ Governorate _____ District _____ Code of the facility _____ Type of Health Facility and Operating Authority Governmental: 11 = General Hospital 21=MCH Center 12=District Hospital 22=Rural health unit 13= Fever Hospital 23=Urban health unit 14= Complementary 24=Health Office 25=Mobile Unit 26=Other Non-Governmental: 31 =CSI 32= EFPA 33=other non-governmental	QTYPE XFP GOV <input type="text"/> <input type="text"/> DISTRICT <input type="text"/> <input type="text"/> FACILITY CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FACILITY TYPE <input type="text"/> <input type="text"/> AND OPERATING AUTHORITY
--	---

INFORMATION ABOUT INTERVIEW

Date: _____ Name of the interviewer _____ Time observation started: _____ FP Client Code _____	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR..... <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 2 INTERVIEWER CODE . <input type="text"/> <input type="text"/> HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/> FP CLIENT CODE..... <input type="text"/> <input type="text"/>
---	---

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
108	Had you thought about switching methods, and which method to switch to before you came today?	YES1 NO2	→110 →112
109	Had you thought about what method you wanted to use to before you came today?	YES1 NO2	→112
110	What method was that? (CIRCLE ALL METHODS MENTIONED)	COMBINED PILL A PROGESTIN-ONLY PILL B PILL (TYPE UNSPECIFIED) C MALE CONDOM D IUD E SPERMICIDE F DIAPHRAGM G INJECTABLE DEPO H INJECTABLE MESGYNA I NORPLANT IMPLANT J NATURAL METHODS (RHYTHM) K BREASTFEEDING/LAM L EMERGENCY CONTRACEPTION M FEMALE STERILIZATION N OTHER X (SPECIFY)	
111	Did the Provider talk about the (method(s) mentioned in question 110)?	YES1 NO2 DON'T KNOW8	
112	What (other) 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 IUD E SPERMICIDE F DIAPHRAGM G INJECTABLE DEPO H INJECTABLE MESGYNA I NORPLANT IMPLANT J NATURAL METHODS (RHYTHM) K BREASTFEEDING/LAM L EMERGENCY CONTRACEPTION M FEMALE STERILIZATION N OTHER X (SPECIFY) NONE Y DON'T KNOW Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
113	<p>What method did you receive or were you given a prescription or referral for?</p> <p>CIRCLE ALL METHODS CLIENT HAS RECEIVED (REC) OR HAS PRESCRIPTION OR REFERRAL (PRES) FOR. IF THE CLIENT IS CONTINUING WITH PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION OR REFERRAL THIS VISIT, CIRCLE "O".</p> <p>IF THE CLIENT DECIDED ON A METHOD BUT WILL START THE METHOD OR RECEIVE THE METHOD LATER, AT THE ADVICE OF THE PROVIDER, CIRCLE THAT METHOD AS "PRES" (PRESCRIBED)</p>	<p style="text-align: right;">REC PRES</p> <p>COMBINED PILL..... A A PROGESTIN-ONLY PILL B B PILL (TYPE UNSPECIFIED) C C MALE CONDOM D D IUD E E SPERMICIDE F F DIAPHRAGM..... G G INJECTABLE DEPO..... H H INJECTABLE MESGYNA..... I I NORPLANT IMPLANT J J NATURAL METHODS (RHYTHM)..... K K BREASTFEEDING/LAM..... L L EMERGENCY CONTRACEPTION M M FEMALE STERILIZATION N N NO METHOD REC OR PREC, CONTINUING W/ METHOD IN QUESTION 103..... O A METHOD WAS PRESCRIBED BUT NOT RECEIVED..... P OTHER _____ X (SPECIFY) NO METHOD..... Y →115</p>	
114	Does your method (the method in 113) provide any protection against STDs and AIDS?	YES 1 NO 2 DON'T KNOW 8	
115	During your consultation, did the provider: <ol style="list-style-type: none"> 1) Explain how to use the method? 2) Talk about possible side effects? 3) Tell you what to do if you have any problems? 4) Tell you when to return for follow-up? 5) Teach you how to conduct a self breast exam? 	<p style="text-align: right;">YES NO DK</p> <p>HOW TO USE 1 2 8 TALK ABOUT SIDE EFFECTS 1 2 8 TELL WHAT TO DO ABOUT PROBLEMS 1 2 8 TELL WHEN TO RETURN..... 1 2 8 TEACH SBE 1 2 8</p>	

116	MARK BELOW THE METHOD THAT IS CIRCLED IN 113 OR 103. AFTER ASKING THE CLIENT THE RELEVANT QUESTION		
	1. Pill	How often do you take the pill?	TAKE A PILL ONCE A DAY 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	2. IUD	What should you do to make sure that your IUD is in place?	CHECK STRINGS 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	3. Injectable (e.g., Depo Provera)	How long does the Depo Provera injection provide protection against pregnancy?	3 MONTHS 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	4. Injectable (mesgyna)	How long does the Mesgyna injection provide protection against pregnancy?	1 MONTH 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	5. NORPLANT	How long does NORPLANT provide protection against pregnancy?	5 YEARS 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	6. Female Sterilization	Once you have been sterilized, could you ever become pregnant again?	NO 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	7. Condom (Male)	How many times can you use a condom?	ONCE 1 OTHER 6 DON'T KNOW 8
	8. Spermicide/ Foam	Approximately how long before intercourse should you insert the vaginal tablet?	BETWEEN 15 MINUTES AND 1 HOUR 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8
	9. Periodic Abstinence/Rhythm	How do you recognize the days on which you should <u>not</u> have sexual intercourse?	BODY TEMPERATURE RISES .. A MUCUS IN VAGINA B DAYS 12-16 OF THE MENSTRUAL CYCLE C OTHER _____ X (SPECIFY) DON'T KNOW Z
	10. LAM	Can you use this method if your menstrual period has returned?	YES 1 NO 2 DON'T KNOW 8
	11. Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	AT LEAST SIX HOURS (BUT NO LONGER THAN 24 HOURS) 1 OTHER _____ 6 (SPECIFY) DON'T KNOW 8

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the family planning services.							
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY 000 DON'T KNOW 998						
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems							
		SPONTANEOUS		PROMPT				
		BIG	SMALL	BIG	SMALL	NO	DK/NA	
1	Time you waited?	1	2	3	4	5	8	
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8	
3	Time it takes to receive results from tests?	1	2	3	4	5	8	
4	Ability to discuss problems or concerns about the method used with the health worker?	1	2	3	4	5	8	
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8	
6	Quality of the examination and treatment provided?	1	2	3	4	5	8	
7	Privacy from others seeing exam?	1	2	3	4	5	8	
8	Privacy from others hearing discussion?	1	2	3	4	5	8	
9	Availability of medicines at the facility?	1	2	3	4	5	8	
10	The hours/days of services?	1	2	3	4	5	8	
11	Cleanliness of facility?	1	2	3	4	5	8	
12	How staff treated you?	1	2	3	4	5	8	
13	Cost of services?	1	2	3	4	5	8	
14	Other _____ (SPECIFY)	1	2			5		

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Could you tell me how old are you?	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW 98	
302	Have you ever attended school?	YES 1 NO 2	→ 304
303	What is the highest level of school (certificate) you have successfully completed?	NONE 1 PRIMARY 2 PREPARATORY 3 SECONDARY 4 ABOVE SECONDARY 5 UNIVERSITY 6 ABOVE UNIVERSITY 7	→ 306 → 306 → 306 → 306
304	Have you ever attended any literacy classes?	YES 1 NO 2	
305	Can you read or write?	YES, READ ONLY 1 YES, READ AND WRITE 2 NO 3	
306	Are you currently employed?	YES 1 NO 2	→ 309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER 1 FOR SOMEONE ELSE 2 FOR HERSELF 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH 1 BOTH 2 KIND 3 NOTHING 4	
309	Do you live in a city or a village?	CITY 1 VILLAGE 2	
310	Which governorate do you live in?	<input style="width: 100px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

MEASURE Service Provision Assessment

Observation of Antenatal Care Consultation

FACILITY IDENTIFICATION

QTYPE OF _____ Name of the facility _____ Facility Location _____ Governorate _____ District _____ Code of the facility _____ Type of Health Facility and Operating Authority Governmental: 11 = General Hospital 21=MCH Center 12=District Hospital 22=Rural health unit 13=Fever Hospital 23=Urban health unit 14=Complimentary 24=Health Office 25=Mobile Unit 26=Other Non-Governmental: 31 =CSI 32= EFPA 33=other non-governmental	QTYPEOANC GOV <input type="text"/> <input type="text"/> DISTRICT..... <input type="text"/> <input type="text"/> FACILITY CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FACILITY TYPE <input type="text"/> <input type="text"/> AND OPERATING AUTHORITY
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Provider Information

Provider category: 11=OB/GYN Physician ;12=Family Planning Physician; 13=Pediatrician; 14=Family physician; 15=Other physician specialist; 16=General Practitioner; 21=Nurse w/ midwifery; 22=Nurse; 23=Midwife; 24=Nurse asistant; 25=Raida Refia; 31=Social worker; 96=other (_____) (SPECIFY) Sex of Provider: (1= male; 2= female) Code for Provider (should be the same as that used for the Provider Interview): _____	PROVIDER CATEGORY..... <input type="text"/> <input type="text"/> SEX OF PROVIDER..... <input type="text"/> PROVIDER CODE..... <input type="text"/> <input type="text"/>
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INFORMATION ABOUT INTERVIEW

Date: _____ Name of the interviewer _____ Time observation started: _____ ANC Client Code _____	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> Y EAR..... <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 2 INTERVIEWER CODE.. <input type="text"/> <input type="text"/> HOUR..... <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/> CLIENT CODE <input type="text"/> <input type="text"/>
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No	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	UNSURE	
101	INDICATE WHETHER THIS IS THE CLIENT'S FIRST VISIT FOR ANTENATAL CARE AT THIS FACILITY FOR THIS PREGNANCY.				
	IF THE PROVIDER DOES NOT ASK ABOUT OR THE CLIENT DOES NOT PROVIDE THE INFORMATION, RECORD 8 UNSURE.	1	2	8	
102	INDICATE IF THIS IS THE FIRST PREGNANCY FOR THE CLIENT	1	2	8	
DOES THE PROVIDER ASK OR THE CLIENT PROVIDE THE FOLLOWING INFORMATION:					
103	CLIENT HISTORY	YES	NO	UNSURE	
	1) Client AGE?	1	2	8	
	2) Date of LAST MENSTRUAL PERIOD?	1	2	8	
	3) Number of PRIOR PREGNANCIES?	1	2	8	
	PRIOR PREGNANCY HISTORY				
	4) Any PRIOR STILLBIRTH(S)?	1	2	8	
	5) Any INFANT(S) DIED in the first week?	1	2	8	
	6) Any HEAVY BLEEDING During or after delivery with a PRIOR PREGNANCY?	1	2	8	
	7) Any PREVIOUS ASSISTED DELIVERY? (Caesarean-section, ventouse, or forceps)	1	2	8	
	8) Any PREVIOUS ABORTIONS?	1	2	8	
104	SYMPTOMS DURING THIS PREGNANCY				
	1) Any BLEEDING during this pregnancy	1	2	8	
	2) If the woman has FELT THE BABY MOVE?	1	2	8	
	3) If there are any OTHER SYMPTOMS OR PROBLEMS the woman thinks might be related to this pregnancy?				
	4) MEDICATIONS woman is currently taking?	1	2	8	
105	WERE ANY OF THE FOLLOWING CLIENT EXAMINATIONS OBSERVED:	YES	NO	UNSURE	
	1) Measure blood pressure?	1	2	8	
	2) Palpate abdomen for fetal presentation/ position?	1	2	8	
	3) Palpate or measure abdomen for fundal (uterine) height?	1	2	8	
	4) Listen to the client's abdomen to hear fetal heartbeat?	1	2	8	
	5) Measure weight of client?	1	2	8	
	6) Examine abdomen by sonar?	1	2	8	
	7) was a urine sample taken or laboratory examination ordered for the client?	1	2	8	
	8) was a blood sample taken or laboratory examination ordered for the client?	1	2	8	
	9) Did the provider look at client's health card either before beginning the consultation or while collecting information or examining the client?	1	2	8	

No	QUESTIONS	CODING CLASSIFICATION			GO TO
	WERE ANY OF THE FOLLOWING TREATMENTS OR COUNSELING PROVIDED:				
106	TREATMENTS	YES	NO	UNSURE	
	1) Prescribe or give iron pills and/or folic acid (IFA)?	1	2→107	8→107	
	2) Explain the purpose of iron/folic?	1	2	8	
	3) Explain how to take iron/folic pills?	1	2	8	
107	1) Prescribe or give tetanus toxoid (TT) injection?	1	2→108	8→108	
	2) Explain the purpose of TT injection?	1	2	8	
108	ADVICE OR COUNSEL ABOUT PREGNANCY				
	1) Quantity and quality of food to eat during pregnancy?	1	2	8	
	2) Mention the following signs and symptoms as risk factors for which the woman should return to the facility?				
	a) Vaginal bleeding?	1	2	8	
	b) Fever?	1	2	8	
	c) Excessive tiredness or breathlessness?	1	2	8	
	d) Swollen hands and face?	1	2	8	
	e) Severe headache or blurred vision?	1	2	8	
	3) Inform the client about the progress of the pregnancy?	1	2	8	
109	DOES THE PROVIDER PROVIDE ADVISE OR COUNSEL ABOUT DELIVERY OR INFANT CARE				
	1) Ask the client where she will deliver?	1	2	8	
	2) Counsel the client to use a skilled health worker during delivery?	1	2	8	
	3) Discuss with client about items to have on hand at home, for delivery?	1	2	8	
110	Advise exclusive breastfeeding for up to 6 months?	1	2	8	
111	Discuss birth control/ family planning, for after delivery?	1	2	8	
112	Ask if the client has any questions and encourage questions?	1	2	8	
113	Use any visual aids during consultation?	1	2	8	
114	Did the Provider write on the woman's health card?	YES.....1 NO.....2 NO HEALTH CARD USED.....3 DON'T KNOW.....8			
115	Did the provider discuss when the woman should return for her next visit?	YES.....1 NO.....2 DON'T KNOW.....8			
116	HOW MANY WEEKS PREGNANT IS THE CLIENT?	WEEK OF PREGNANCY	<input type="text"/> <input type="text"/>	DON'T KNOW.....98	
117	OUTCOME OF CONSULTATION	CLIENT SENT HOME.....1 CLIENT REFERRED (TO LAB OR OTHER PROVIDER) AT SAME FACILITY.....2 CLIENT ADMITTED TO SAME FACILITY.....3 CLIENT REFERRED TO OTHER FACILITY.....4 DON'T KNOW.....8			

No	QUESTIONS	CODING CLASSIFICATION	GO TO				
118	RECORD TIME CONSULTATION ENDED	HOUR..... <table border="1" data-bbox="1144 205 1255 254"> <tr> <td></td> <td></td> </tr> </table> MINUTES..... <table border="1" data-bbox="1144 260 1255 308"> <tr> <td></td> <td></td> </tr> </table>					
119	OBSERVER COMMENTS:						

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
111	What warning signs or symptoms have been mentioned? (CIRCLE ALL THOSE MENTIONED.) PROBE: Anything else?	BLEEDING A FEVER B SWOLLEN FACE/HAND..... C TIREDNESS/BREATHLESSNESS D HEADACHE/BLURRED VISION.... E OTHER _____ X (SPECIFY)	
112	What did the Provider advise you to do if you experienced any of the warning signs? CIRCLE ALL MENTIONED	SEEK CARE AT THE FACILITY A DECREASE ACTIVITY B CHANGE DIET C OTHER _____ X (SPECIFY)	
113	During this (or previous) visits has a Provider given you advice on the importance of exclusive breastfeeding, i.e. about give your baby nothing apart from breast milk?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOW Z	→115 →115
114	For how many months, did the provider recommend that you breastfeed exclusively?	MONTHS..... <input type="text"/> <input type="text"/> DON'T KNOW 98	
115	During this or previous visits did a provider discuss family planning methods or birth spacing methods for use after this birth?	YES 1 NO 2 DON'T KNOW 8	
116	During this or previous visits, did the Provider talk to you about where you plan to delivery?	YES 1 NO 2 DON'T KNOW 8	
117	Have you decided where you will have your delivery? IF YES, PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY OR AT HOME.	AT THIS HEALTH FACILITY 1 AT OTHER HEALTH FACILITY... 2 IN A PRIVATE HOME 3 DON'T KNOW 8	
118	During this (or previous) visits has a Provider discussed supplies you should have at home or other preparations you should make for the delivery?	YES 1 NO 2 DON'T KNOW 8	→120 →120
119	ASK CLIENT TO MENTION SOME OF THE SUPPLIES OR PREPARATIONS FOR DELIVERY WHICH HAVE BEEN MENTIONED. CIRCLE ALL THAT APPLY. PROBE: Are there any other items? Anything else you have been advised to prepare before delivery?	SOAP A STERILE BLADE B SCISSOR C TIES FOR UMBILICAL CORD D PLASTIC FOR UNDER WOMAN E PLAN FOR TRANSPORTATION TO FACILITY F OTHER _____ X (SPECIFY)	
120	ASK TO SEE THE CLIENTS ANC CARD AND INDICATE IF THERE IS A NOTE INDICATING ANY FINDINGS FROM THE EXAMINATION TODAY?	YES, FINDINGS RECORDED 1 YES, CARD, FINDINGS NOT RECORDED 2 NO CARD 3 DON'T KNOW 8	→201 →201
121	CHECK THE ANC CARD OR TETANUS IMMUNIZATION CARD AND INDICATE IF THERE IS ANY NOTE OR RECORD OF THE WOMAN HAVING RECEIVED TETANUS TOXOID	YES, 1 TIME 1 YES, 2 OR MORE TIMES..... 2 PRESCRIBED TODAY 3 NO 4 DON'T KNOW 8	

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO		
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the maternal health services.									
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES.....		<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						
		SAW PROVIDER IMMEDIATELY..... 000 DON'T KNOW..... 998								
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems									
		SPONTANEOUS		PROMPT						
		BIG	SMALL	BIG	SMALL	NO	DK/NA			
1	Time you waited?	1	2	3	4	5	8			
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8			
3	Time it takes to receive results from tests?	1	2	3	4	5	8			
4	Ability to discuss problems or concerns about your pregnancy with the health worker?	1	2	3	4	5	8			
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8			
6	Quality of the examination and treatment provided?	1	2	3	4	5	8			
7	Privacy from others seeing exam?	1	2	3	4	5	8			
8	Privacy from others hearing discussion?	1	2	3	4	5	8			
9	Availability of medicines at the facility?	1	2	3	4	5	8			
10	The hours/days of services?	1	2	3	4	5	8			
11	Cleanliness of facility?	1	2	3	4	5	8			
12	How staff treated you?	1	2	3	4	5	8			
13	Cost of services?	1	2	3	4	5	8			
14	Other _____ (SPECIFY)	1	2			5				

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
203	Do you participate in any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility? This includes if you prepay for a package of services or if you received a discounted price or an exemption from paying. IF YES, what type of program do you participate in?	YES, HIO/SHIP A YES, OTHER SYSTEM B YES, PREPAY AT FACILITY FOR PACKAGE OF SERVICES C YES, DISCOUNT/EXEMPT STATUS D OTHER _____ X (SPECIFY) NO Y DON'T KNOW Z	
204	What is the total amount for all staff, services, or treatments which you paid for the consultation today?*	1) LAB L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 2) MEDICINE OR METHOD L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 3) CONSULT OR PROCEDURE L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998 4) OTHER L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 5) TOTAL AMOUNT L.E Piaster <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> PAID NO MONEY 00000 NOT APPLICABLE 99995 DON'T KNOW 99998	
205	Have you ever visited this facility before? (either as a patient or visiting or accompanying a patient?)	YES 1 NO 2	
206	There are many reasons people choose different health facilities for services. Can you mention some of the reasons you selected this facility for the services you sought today?	FEMALE PHYSICIAN A EFFICIENCY OF THE PHYSICIANS B AVAILIABIITY OF ALL SPECIALITIES C AVAILABILITY OF THE SERVICE D CLIENTS ARE WELL TREATED E HAS THE GOLD STAR F A NEAR BY FACILITY G GOOD REPUTATION H OTHER _____ X (SPECIFY)	

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Could you tell me how old are you?	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW..... 98	
302	Have you ever attended school?	YES..... 1 NO..... 2	→304
303	What is the highest level of school (certificate) you have successfully completed?	NONE..... 1 PRIMARY..... 2 PREPARATORY..... 3 SECONDARY..... 4 ABOVE SECONDARY..... 5 UNIVERSITY..... 6 ABOVE UNIVERSITY..... 7	→306 →306 →306 →306 →306
304	Have you ever attended any literacy classes?	YES..... 1 NO..... 2	
305	Can you read or write?	YES, READ ONLY..... 1 YES, READ AND WRITE..... 2 NO..... 3	
306	Are you currently employed?	YES..... 1 NO..... 2	→309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER..... 1 FOR SOMEONE ELSE..... 2 FOR HERSELF..... 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH..... 1 BOTH..... 2 KIND..... 3 NOTHING..... 4	
309	Do you live in a city or a village?	CITY..... 1 VILLAGE..... 2	
310	Which governorate do you live in?	<input style="width: 100px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

104	EXAMINATION CONTINUED:				
	7) WERE LABIA SEPARATED AND INSPECTED TO INSPECT FOR LESIONS/DISCHARGE?	LABIA SEPARATED AND INSPECTED.....	1	2	5
	FOR MALE CLIENT NOT CIRCUMCISED:				
	8) WAS FORESKIN RETRACTED TO INSPECT FOR LESIONS/DISCHARGE?	FORESKIN RETRACTED...	1	2	5
105	IF CLIENT IS FEMALE: INDICATE WHETHER PROVIDER CONDUCTED A PELVIC EXAM.	YES1 NO2 MALE CLIENT.....3			→107 →107

106 PELVIC EXAM

	DID THE PROVIDER:		YES	NO	NA
1	ENSURE CLIENT VISUAL PRIVACY?	VISUAL PRIVACY	1	2	
2	ENSURE CLIENT AUDITORY PRIVACY?	AUDITORY PRIVACY	1	2	
3	EXPLAIN PROCEDURE PRIOR TO BEGINNING?		1	2	
4	PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS	1	2	
5	USE STERILIZED OR HIGH-LEVEL DISINFECTED INSTRUMENTS ?(ASK THE SERVICE PROVIDER)	DISINFECTED INSTRUMENTS	1	2	
6	WASH HIS/HER HANDS BEFORE THE EXAM?	WASHED HANDS.....	1	2	
7	PUT ON NEW OR DISINFECTED GLOVES <u>BEFORE</u> EXAM?	PUT ON GLOVES.....	1	2	
8	ASK THE CLIENT TO TAKE SLOW, DEEP BREATHS, AND RELAX ALL MUSCLES?	ASK CLIENT TO RELAX MUSCLES.....	1	2	
9	INSPECT THE EXTERNAL GENITALIA?	INSPECT GENITALIA.....	1	2	
10	(IF USED) EXPLAIN SPECULUM PROCEDURE?	EXPLAIN SPECULUM.....	1	2	5
11	INSPECT THE CERVIX AND VAGINAL MUCOSA? (AIM LIGHT INSIDE INSERTED SPECULUM)	INSPECT CERVIX	1	2	
12	PERFORM BIMANUAL EXAM (ONE HAND INSIDE VAGINA, OTHER PALPATING UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM	1	2	
13	WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER.....	1	2	
14	WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA	1	2	
15	PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE? (ASK THE PROVIDER)	DECONTAMINATE GLOVES/INSTRUMENTS .	1	2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	Was a specimen taken or a laboratory examination ordered for the client?	YES.....1 NO.....2 DON'T KNOW.....8	→110 →110
108	IF YES, WERE ANY OF THE FOLLOWING TYPES OF TESTS MENTIONED? 1) BLOOD TEST? 2) URINE ANALYSIS? 3) MICROSCOPIC EXAMINATION OF SPECIMEN OF VAGINAL OR URETHRAL DISCHARGE? 4) HIV/AIDS TEST?	<p style="text-align: center;">YES NO UNSURE</p> BLOOD TEST.....1 2 8 URINE ANALYSIS... 1 2 8 MICROSCOPIC EXAM OF DISCHARGE1 2 8 HIV/AIDS TEST.....1 2 8	
109	Did the provider at any time ask for the client's agreement or permission for ordering or taking a specimen to check for infection or specifically mention a STI (e.g. syphilis or HIV/AIDS)?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
110	Did the provider discuss the diagnosis with the client?	YES..... 1 NO..... 2	
111	Did the provider mention any relationship between the infection and sexual activity?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
112	Did the provider give the client a prescription or medications?	YES..... 1 NO..... 2	→115
113	Did the provider give the client a prescription or medications for the sexual partner?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
114	Did the provider instruct the client on the importance of completing the full course of treatment?	YES..... 1 NO..... 2	
115	Was the client encouraged to refer his/her partner(s) for treatment?	YES..... 1 NO..... 2	
116	Did the provider give a follow-up date to return for re-examination?	YES.....1 NO.....2	
117	Were any visual aids used for client education about STIs or HIV/AIDS?	YES.....1 NO..... 2	
118	Was the risk of HIV/AIDS mentioned?	YES..... 1 NO..... 2	
119	Did the provider: 1) Talk about the role of condoms in prevention of STIs and HIV/AIDS transmission? 2) Instruct the client on how to use Condom? 3) Demonstrate how to put on condom? 4) Offer condoms to the client?	<p style="text-align: center;">YES NO DK</p> DISCUSS CONDOMS AND STI/HIV PREVENTION... 1 2 8 INSTRUCT HOW TO USE CONDOM 1 2 8 DEMONSTRATE HOW TO PUT ON CONDOM... 1 2 8 PROVIDE CONDOM 1 2 8	
120	Did the Provider write on the client's health card?	YES.....1 NO.....2 NO HEALTH CARD USED3 DON'T KNOW.....8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO				
121	RECORD TIME OBSERVATION ENDED.	HOUR MINUTES..... <table border="1" data-bbox="1214 212 1308 302" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					
122	OBSERVER COMMENTS						

Exit Interview for RTI/STI Clients

Section 1. Visit Information

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT</p> <p>Hello. In order to improve the services offered by this facility, we would like to know about your experience here. All the information given to me will be kept strictly confidential and future care that you receive at this facility will in no way be affected by your participation or non-participation in this interview. You can refuse to answer any question and may stop the interview at any time.</p> <p>Do you have any questions for me at this time? Do I have your agreement to participate?</p> <p style="text-align: center;">_____ INTERVIEWER'S SIGNATURE (Indicates respondent' willingness to participate)</p> <p style="text-align: center;">_____ DATE</p>		
100a	May I begin the interview?	CLIENT AGREES 1 CLIENT REFUSES 2	→ STOP
101	Did the health worker give you a diagnosis for your problem today, that is, did he/she tell you what is causing the problem?	YES..... 1 NO 2 DON'T KNOW..... 8	
102	Were you given a prescription or medications today?	YES..... 1 RECEIVED INJECTION BUT NO OTHER MEDICATIONS OR PRESCRIPTION 2 NO 3	→ 105 → 105
103	ASK TO SEE ALL MEDICATIONS WHICH WERE RECEIVED AND ANY PRESCRIPTIONS WHICH HAVE NOT YET BEEN FILLED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS OR PRESCRIPTIONS SEEN	HAS ALL MEDS..... 1 HAS SOME MEDS, SOME PRESCRIPTIONS NOT SUPPLIED 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY 3	
104	How long do you plan to take these medications?	UNTIL SYMPTOMS DISAPPEAR 1 UNTIL MEDICATION IS COMPLETED 2 OTHER _____ 6 (SPECIFY) DON'T KNOW..... 8	
105	Did the health worker talk to you about how to protect yourself against reproductive tract infections or HIV/AIDS?	YES..... 1 NO 2 DON'T KNOW..... 8	
106	What are some of the ways that you can protect yourself from reproductive tract infections transmitted through sexual activity?	USE CONDOMS..... A HAVE ONLY ONE PARTNER B OTHER _____ X (SPECIFY) DON'T KNOW..... Z	

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO			
107	Have you ever used condoms before?	YES.....	1				
		NO	2				
108	Some people do not want to use condoms. I would like to hear your opinion on reasons that some people would not want to use condoms or issues that might inhibit people from using condoms? FOR EACH ITEM MENTIONED, ASK: Do you think that is a big or a small problem for using condoms? PROBE WITHOUT PROVIDING ANY ANSWERS. AFTER IT APPEARS THE RESPONDENT HAS NO MORE ANSWER, ASK: I want to ask you about your opinion now about some other reasons people may <u>not</u> use a condom. As I mention each item, please tell me if you think that it might be, or has been, a reason you might not use condoms. Tell me if you think it has been or could be a big problem, a small problem, or not a problem for you to when deciding whether to use condoms or not..						
	POSSIBLE PROBLEMS WITH USING CONDOMS	SPONTANEOUS		PROMPT			
	1) It is embarrassing to purchase/obtain condoms?	BIG	SMALL	BIG	SMALL	NO	DK
	2) Disposal of the condom is a problem	1	2	3	4	5	8
	3) It is embarrassing to discuss use of condom with partner?	1	2	3	4	5	8
	4) The condom reduces your own [RESPONDENT] sexual satisfaction?	1	2	3	4	5	8
	5) The condom reduces partner's sexual satisfaction?	1	2	3	4	5	8
	6) OTHER _____ (SPECIFY)	1	2			5	
109	Did you discuss any of the issues related to using condoms that were mentioned above with the provider?	YES.....	1	→111			
		NO	2				
		NA.....	8				
110	Did the provider talk to you about condoms or mention condoms today?	YES.....	1				
		NO	2				
		DON'T KNOW.....	8				
111	Were you given any condoms today?	YES.....	1				
		NO	2	→113			
112	Did a provider demonstrate to you how the condom is used?	YES.....	1				
		NO	2				
113	Did you receive a blood test or did the health worker take a specimen for laboratory examination today?	YES.....	1				
		NO	2	→201			
114	Did the health worker explain to you what the laboratory test was for? IF YES, What was the test for?	YES, INFECTION/STI.....	A				
		YES, HIV/AIDS	B				
		YES, OTHER	X				
		(SPECIFY)					
		NO	Y				
		DON'T KNOW.....	Z				

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the health services.							
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES..... <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY..... 000 DON'T KNOW..... 998						
202	Often people can identify particular issues that they either don't like or feel are problems that may affect whether they are satisfied with the health services they receive. Can you name any issues that you think were problems with your experience here at this facility today? FOR EACH ISSUE THE RESPONDENT IDENTIFIES ASK: Do you consider this a big problem or a minor problem? WHEN THE RESPONDENT CAN NO LONGER NAME ISSUES, PROBE FOR EACH ISSUE LISTED BELOW THAT WAS NOT MENTIONED. Now I want to ask you about a few other issues that other clients have identified. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems							
		SPONTANEOUS		PROMPT				
		BIG	SMALL	BIG	SMALL	NO	DK/NA	
1	Time you waited?	1	2	3	4	5	8	
2	Time it takes to complete all parts of the consultation once initially seen?	1	2	3	4	5	8	
3	Time it takes to receive results from tests?	1	2	3	4	5	8	
4	Ability to discuss problems or concerns about your health with the health worker?	1	2	3	4	5	8	
5	Amount of explanation you were given about the problem or treatment?	1	2	3	4	5	8	
6	Quality of the examination and treatment provided?	1	2	3	4	5	8	
7	Privacy from others seeing exam?	1	2	3	4	5	8	
8	Privacy from others hearing discussion?	1	2	3	4	5	8	
9	Availability of medicines at the facility?	1	2	3	4	5	8	
10	The hours/days of services?	1	2	3	4	5	8	
11	Cleanliness of facility?	1	2	3	4	5	8	
12	How staff treated you?	1	2	3	4	5	8	
13	Cost of services?	1	2	3	4	5	8	
14	Other _____ (SPECIFY)	1	2			5		

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
		GOOD REPUTATION.....H OTHER _____.....X (SPECIFY)	

Section 3. Personal Characteristics of Client

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
301	Could you tell me how old are you?	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW..... 98	
302	Have you ever attended school?	YES..... 1 NO..... 2	→304
303	What is the highest level of school (certificate) you have successfully completed?	NONE..... 1 PRIMARY..... 2 PREPARATORY..... 3 SECONDARY..... 4 ABOVE SECONDARY..... 5 UNIVERSITY..... 6 ABOVE UNIVERSITY..... 7	→306 →306 →306 →306 →306
304	Have you ever attended any literacy classes?	YES..... 1 NO..... 2	
305	Can you read or write?	YES, READ ONLY..... 1 YES, READ AND WRITE..... 2 NO..... 3	
306	Are you currently employed?	YES..... 1 NO..... 2	→309
307	Do you work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER..... 1 FOR SOMEONE ELSE..... 2 FOR HERSELF..... 3	
308	Do you earn your wage or salary in the form of cash or kind or both, or you don't take any?	CASH..... 1 BOTH..... 2 KIND..... 3 NOTHING..... 4	
309	Do you live in a city or a village?	CITY..... 1 VILLAGE..... 2	
310	Which governorate do you live in?	_____ <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
311	TIME INTERVIEW ENDED.	HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
312	INTERVIEWER COMMENTS		

1	INDICATE TYPE OF INJECTION BEING PROVIDED	VACCINATION 1 CURATIVE..... 2			
2	INDICATE ROUTE OF INJECTION	INTRAMUSCULAR..... 1 INTRADERMAL OR SUB-CUTANEOUS 2 I.V..... 3 DON'T KNOW..... 8			
3	INDICATE SOURCE OF SYRINGE	FACILITY STOCK..... 1 PATIENT PROVIDED..... 2 DON'T KNOW..... 8			
4	INDICATE AGE OF CLIENT RECEIVING INJECTION	CHILD < 5 YEARS..... 1 OTHER _____ 6 (specify)			
	WHEN GIVING THE INJECTION DID THE PROVIDER:		YES	NO	NA
5	WASH HANDS <u>BEFORE</u> INJECTION?	WASH HANDS	1	2	
6	PREPARE INJECTION IN AREA WITH CLEAN TABLE OR TRAY TO SET ITEMS ON?	CLEAN PREPARATION AREA	1	2	
7	USE NEW SYRINGE AND NEEDLE FROM A STERILE SEALED PACKET?	NEW SYRINGE AND NEEDLE	1	2	
8	DID YOU SEE THE PROVIDER OPEN THE NEW PACKET WITH SYRINGE AND NEEDLE?	SEE OPEN PACKET	1	2	
9	REMOVE NEEDLE FROM MULTIPLE DOSE VIAL EACH TIME?	REMOVE NEEDLE.....	1	2	5
10	CLEAN SKIN WITH ANTISEPTIC?	CLEAN SKIN	1	2	
11	DRAW BACK PLUNGER <u>BEFORE</u> INJECTION?	DRAW BACK PLUNGER	1	2	5
12	USE SCOOP TECHNIQUE TO RECAP NEEDLE ?	SCOOP RECAP	1	2	
13	RECAP NEEDLE USING TWO HANDS?	TWO-HAND RECAP	1	2	
14	NOT RECAP NEEDLE?	NO-RECAP	1	2	
15	DISPOSE OF NEEDLES IN PUNCTURE RESISTANT SAFETY CONTAINERS?	DISPOSE OF SHARPS.....	1	2	

Urban Governorates

Cairo

<u>Unit Name</u>	<u>Unit Type</u>
Abnaa El Zaytoon El Sharkaia	EFPA
El Helal El Ahmar-Helwan	EFPA
Happy Childhood - El Sayeda	EFPA
The Development of The Society-Ramlet Bolak Helwan	EFPA
El Maasara H.O	Fever Hosp
El Nasr H.O.	Health Office
El Koba H.O.	Health Office
Koba 2	Health Office
El Abasia H.O	Health Office
El Ezab H.O	Health Office
El Azhar H.O	Health Office
Bolak 2 H.O	Health Office
El Zawia El Gdida H.O	Health Office
Helwan 1 M.C.H	M.C.H
Shobra 2 M.C.H	M.C.H
El Maadi M.C.H	M.C.H
El Darb El Ahmer M.C.H	M.C.H
El Saida M.C.H	M.C.H
Ein Shams 1	Mobile Clinic
El Salam 2	Mobile Clinic
El Mataria 1	Mobile Clinic
Manshaat Naser 1	Mobile Clinic
El Nahda Charity Association	Other NGO
Egyption Association For Population Service	Other NGO
Islamic Association Clinic	Other NGO
Family Planning Clinic In El Anba Barsoom Hospital - El Maasara	Other NGO
Petrol Hospital	Other NGO
The Clinic of Social Islamic Development	Other NGO
El Erada Medical Center	Other NGO
The Womanhood of Hoda Sharawy Association -El Sayeda Zeinab	Other NGO
The Medical Center In Badr El Din Association-El Gamalaya	Other NGO
El Helal El Ahmar-Ein El Seira	Other NGO
The Womanhood Association Unit For Health- Abdein	Other NGO
Ebn Kaseer El Islamaya Clinic In Dar El Salam - El Basateen (Cop)	Other NGO
Family Planning Clinic In El Abagaya Association - El Khalifa (Cop)	Other NGO
El Kazendara	Public/Dest.Hospital
Shobra	Public/Dest.Hospital
El Monira.	Public/Dest.Hospital
El Mrazik	R.H.U
Atlas M.C	U.H.U
Hadaak Helwan M.C	U.H.U
Ain Elsira M.C	U.H.U
El Tonsy El Gdid MC	U.H.U

El Marg H.C	U.H.U
El Marg El Garbia	U.H.U
El Delta H.C	U.H.U
El Bsatn Garb M.C	U.H.U
El Hgana M.C	U.H.U
Mahmsha H.C	U.H.U
Misr El Gdida M.C	U.H.U
Monshaat Naser	U.H.U
15 MAY M.C	U.H.U
Zenhom M.C	U.H.U
El Nozha El Gdida M.C	U.H.U

Alexandria

<u>Unit Name</u>	<u>Unit Type</u>
Sporting Center	CSI
El Shatby University Hospital	EFPA
Derbala Center For Productive Health Services	EFPA
Family Planning Clinic - Gheit El Enab	EFPA
Mohsin	Family Health Unit
El Nasr	H.I.U
Abo El Nawater	Health Office
Semoha H.C	Health Office
El Seyouf H.O.	Health Office
Dana H.C.	Health Office
El Anfoshy H.O.	Health Office
Ambrozr H.O	Health Office
Karmoz H.O	Health Office
El Nawatia M.C.H	M.C.H
El Labaan M.C.H.	M.C.H
El Kbary M.C.H	M.C.H
Montazah 3	Mobile Clinic
Middle Alexandria 1	Mobile Clinic
Nour El Islam Dispensary	Other NGO
Abou Kir	Public/Dest.Hospital
Ras Eltin	Public/Dest.Hospital
Borg El Arb	Public/Dest.Hospital
Fawzy Maaz	Public/Dest.Hospital
Ghon	R.H.U
Khorshid	R.H.U
Abees 7	R.H.U
El Zraa El Bahry	R.H.U
El Agmy	R.H.U
Bangr El Soker 2	R.H.U
El Nasria	U.H.U
Borg El Arab M.C	U.H.U
Alexandria El Tebee	
El Araby	

Port Said

<u>Unit Name</u>	<u>Unit Type</u>
Port Said 1 H.O.	Health Office

Port Said 1
El Mtwtna Hospital .
El Kewit M.C
Port Fouad

Mobile Clinic
Public/Dest.Hospital
U.H.U
U.H.U

Suez

Unit Name
El Ghareeb
Amer Village
Suez
Suez M.C.H
El Ganain 1
Attaka 2 A
Family Planning In Sayed El Badawy
El Gabalayat Medical Center
Family Planning In Suez Petrol Company
Suez
Shandora
Mobark M.C

Unit Type
EFPA
EFPA
Fever Hosp
M.C.H
Mobile Clinic
Mobile Clinic
Other NGO
Other NGO
Other NGO
Public/Dest. Hospital
R.H.U
U.H.U

Lower Egypt

Damietta

Unit Name
Kafr Saad
Child Garden
El Zarka
Faraskour
El Khiata
Damietta 4 MCH
Kafr Saad M.C.H
Damietta 2
Kafr Saad 3
Ezbat El Borg Hospital
El Zarka
El Anania Clinic
Kafr Meet Abo Ghaleb
Saef El Dein
El Ghawaben

Unit Type
CSI
EFPA
EFPA
Fever Hosp
Integrated Hospital
M.C.H
M.C.H
Mobile Clinic
Mobile Clinic
Public/Dest.Hospital
Public/Dest.Hospital
R.H.U
R.H.U
R.H.U
R.H.U

Dakahlia

Unit Name
Sherbeen
Family Planning Clinic - El Ferdous
Standard Center - Nabaroh
The Development of the Society-Meet Soweed
The Development of the Society-El Mokattaa
Shobrahour
Belkas
Aga H.O.

Unit Type
CSI
EFPA
EFPA
EFPA
EFPA
Fever Hosp
Fever Hosp
Health Office

Sherbeen H.O	Health Office
Mansoura 3 H.O.	Health Office
Koom El Nour H.O	Health Office
Mataria H.O	Health Office
Magmoaa Batra	Integrated Hospital
Ekhtab	Integrated Hospital
Monsha Abd El Rohman	Integrated Hospital
Meet Ghareta	Integrated Hospital
Mehla Demna	Integrated Hospital
Demas	Integrated Hospital
El Roba	Integrated Hospital
El Bsrat	Integrated Hospital
Bsndila	Integrated Hospital
Dekernes M.C.H	M.C.H
Mansoura 1 M.C.H.	M.C.H
Manzala 2 M.C.H.	M.C.H
Sherbeen 1	Mobile Clinic
Mataria 1	Mobile Clinic
Talkha 1	Mobile Clinic
Meet Ghamr 1	Mobile Clinic
Shobra El Baho El Zeraaia	Other NGO
Dekernes Hospital	Public/Dest.Hospital
Nabrwa Hospital .	Public/Dest.Hospital
El Manzla Hospital	Public/Dest.Hospital
Meet Salseal	Public/Dest.Hospital
Meet Anter	R.H.U
Tanamel El Gharb	R.H.U
Meet Dafer	R.H.U
Shobra Kebala	R.H.U
Karkera	R.H.U
El Aiadia	R.H.U
Magmoaa Dreen	R.H.U
Bark El Ezz	R.H.U
Meet Aly	R.H.U
Kafre El Bramon	R.H.U
Sernga	R.H.U
Tamy El Amdid	R.H.U
Meet El Khouly	R.H.U
El Amra	R.H.U
Klabsho	R.H.U
El Samahia	R.H.U
Ezab EL Etehad	R.H.U
El Esaaf	U.H.U

Sharkia

<u>Unit Name</u>	<u>Unit Type</u>
El Sharkia- The Location of The Managerial Office	CSI
Kafr Sakr	CSI
El Ghazaly	EFPA
El Dahtamoon	EFPA
Mashtool El Sook	EFPA

Belbes	Fever Hosp
Hehya	Fever Hosp
El Saidia	Fever Hosp
Kafr Sakr H.O.	Health Office
Abo Kabeer H.O	Health Office
El Slam Hosp	Integrated Hospital
Safour Hospital	Integrated Hospital
El Haswa R. HOSP	Integrated Hospital
Shembart Almaymona	Integrated Hospital
Belbes 1 M.C.H	M.C.H
Mashtol El Souk M.C.H	M.C.H
Zagazig 2 M.C.H	M.C.H
Belbes 1	Mobile Clinic
Menia El Kamh 2	Mobile Clinic
Abo Kabeer 1	Mobile Clinic
El Zagazeg 1	Mobile Clinic
Hehia	Public/Dest.Hospital
El Korein H.O.S	Public/Dest.Hospital
El Salehia El Gadida	Public/Dest.Hospital
Zagazeg	Public/Dest.Hospital
El Zwamel	R.H.U
Meet Mala	R.H.U
El Hwamda	R.H.U
Magmoaa Snhout	R.H.U
El Naamna	R.H.U
Karmout Sahbra	R.H.U
Alim Unit	R.H.U
Magmoaa El Sahfa	R.H.U
Manshat Radwan	R.H.U
Al Nawfaa	R.H.U
El Talata	R.H.U
Bany Hassan	R.H.U
Om El Zein	R.H.U
Om Ramad	R.H.U
El Malakien El Bahrya	R.H.U
El Masaid	R.H.U
EL Asher Men Ramadan M.C.	U.H.U
Hehia M.C.	U.H.U
El Kenayat M.C.	U.H.U

Kalyubia

<u>Unit Name</u>	<u>Unit Type</u>
El Kanater El Khayraya	CSI
El Ramla	EFPA
Kaluob El Balad	EFPA
Nobar	EFPA
Tookh	Fever Hosp
Bahteem	Fever Hosp
Banha 1 H.O.	Health Office
Shobra 3 H.O.	Health Office
Shebin El Knaater H.O	Health Office

Tookh H.O	Health Office
Sandabis	Integrated Hospital
Shobra M.C.H.	M.C.H
Kaha M.C.H	M.C.H
Kafr Shokr 2	Mobile Clinic
Kaluob 1	Mobile Clinic
Masged El Islam Hospital	Other NGO
Kaluob Hospital .	Public/Dest. Hospital
Kaha Hospital .	Public/Dest. Hospital
El Shemout	R.H.U
Zawyet El Nager	R.H.U
Bahada	R.H.U
Kafr El Shorafa	R.H.U
Tasfa	R.H.U
Abo Hosam	R.H.U
Aghoor	R.H.U
Banha Midical Canter	U.H.U
Osman M.C.	U.H.U
Gezeret Al Shaer M.C.	U.H.U
El Ewaa	U.H.U

Kafr El-Sheikh

<u>Unit Name</u>	<u>Unit Type</u>
El Hamool	CSI
Daminka	EFPA
Beyala	Fever Hosp
Motobs H.O	Health Office
Shbas El Shohadaa	Integrated Hospital
Sidy Ghazy	Integrated Hospital
Kafr El Mrazka	Integrated Hospital
Borg El Boroles	Integrated Hospital
Sidy Mobarek	M.C.H
El Hamool M.C.H	M.C.H
Kafr El Sheikh 1	Mobile Clinic
Fewa 1	Mobile Clinic
El Reiad 1	Mobile Clinic
Monshaet Zaalook	Other NGO
Kafr El Sheikh Hospital	Public/Dest. Hospital
El Hamool Hospital	Public/Dest. Hospital
Ebto	R.H.U
El Shamarka	R.H.U
Rewana	R.H.U
Meet El Deeba	R.H.U
Shamshera	R.H.U
El Kafr El Sharky	R.H.U
El Rsif	R.H.U
Doma	R.H.U
Abo El Azaim	R.H.U
El Banaain	R.H.U
El Riad	U.H.U

Gharbia

<u>Unit Name</u>	<u>Unit Type</u>
El Mahala El Kobra	CSI
El Helal El Ahmar	EFPA
Sekt Tanta	EFPA
Zefta	Fever Hospital
Tanta 1 H.O.	Health Office
El Mahala 2 H.C	Health Office
Zefta U.H.C	Health Office
Meet Hway	Integrated Hospital
Mahalet Menof Hospital	Integrated Hospital
Samool	Integrated Hospital
El Dlgamoon Hospital	Integrated Hospital
Mehla Ziad	Integrated Hospital
Sinbo. El Kubra	Integrated Hospital
Damat	Integrated Hospital
Ganag	Integrated Hospital
Tanta 1 M.C.H	M.C.H
Tanta 5 M.C.H	M.C.H
Zefta M.C.H	M.C.H
El Santa 2	Mobile Clinic
Kafr El Ziat 1	Mobile Clinic
Kotour 1	Mobile Clinic
Agriculture Tatay	Other NGO
El Menshawi Hospital .	Public/Dest. Hospital
Smanod	Public/Dest. Hospital
Sibarbay	R.H.U
Berma	R.H.U
El Dwakhlia	R.H.U
Senbara	R.H.U
Kafr Dema	R.H.U
Koleep Ebyar	R.H.U
Sandabast	R.H.U
Nesheel	R.H.U
Abo Hamer	R.H.U
Hay El Salam Clinic	U.H.U

Menoufia

<u>Unit Name</u>	<u>Unit Type</u>
Tella	CSI
El Wehda El Sakanaya	EFPA
El Bagoor	EFPA
Sheben El Koum	Fever Hosp
Ashmoun	Fever Hosp
El Helal	H.I.U
Tala H.O.	Health Office
Ashmoon H.O	Health Office
Shobra Bas H.O.S	Integrated Hospital
Kafr Nafra	Integrated Hospital
Taliway Hospital	Integrated Hospital
Berka El Saba M.C.H.	M.C.H

Ashmoon M.C.H	M.C.H
Quesna 1	Mobile Clinic
Menouf 1	Mobile Clinic
Family Planning-Manshaat El Sadat	Other NGO
Tala	Public/Dest. Hospital
El Bagour Hospital	Public/Dest.Hospital
Kafr El Babaton	R.H.U
Kafr Tanbady	R.H.U
Kafr Tanbady	R.H.U
Ganzour	R.H.U
Kafr El Sokaria	R.H.U
El-Naseria (Gamal Nasar)	R.H.U
Sharanees	R.H.U
Quesna El Balad	R.H.U
Kafr Taha Shoubra	R.H.U
Kafr Ashma	R.H.U
Estanha	R.H.U
Semman	R.H.U
Sengerg	R.H.U
Tamalai	R.H.U
Shamma	R.H.U
Shanshor	R.H.U
Talia	R.H.U
Mahalat Dobk	R.H.U
Manial El Aros	R.H.U
Kafer Abo Mahmoud	R.H.U
Meet Khakan	U.H.U
Quesna M.C	U.H.U

Beheira

<u>Unit Name</u>	<u>Unit Type</u>
Health Improvement	EFPA
Fazara	EFPA
Ety El Baroud	Fever Hosp
Kom Hamada	Fever Hosp
Kafr El Dawar 1 H.O.	Health Office
El Markaz H.O	Health Office
Badr H.O	Health Office
Kom Hamada H.O	Health Office
Dmisna	Integrated Hospital
Monshat Bolin	Integrated Hospital
El Naser Hospital	Integrated Hospital
El Nagah	Integrated Hospital
Shobrakheit	M.C.H
Abo-Abd Allah M.C.H	M.C.H
Edko	M.C.H
El Mahmoudia Baby Care	M.C.H
Abo Homes 1	Mobile Clinic
Abo El Matamer 1	Mobile Clinic
El Tahreir 1	Mobile Clinic
Misr Textile Firm	Other NGO

El Akrisha Association Unit	Other NGO
Abnaa El Islam Association Unit	Other NGO
Abdel Halim Mahmoud Association Unit-Gharb Elnoubaraya	Other NGO
El Rahmania Hospital .	Public/Dest.Hospital
Central Hospital	Public/Dest.Hospital
Shobrakheit	Public/Dest.Hospital
Adko	Public/Dest.Hospital
Kom Hamada	Public/Dest.Hospital
Mahala Keel	R.H.U
Maania	R.H.U
Genbway	R.H.U
Kom El Berka	R.H.U
El Omara	R.H.U
Trabmba	R.H.U
El Horia	R.H.U
El Mahdia	R.H.U
El Kony	R.H.U
Abo El Hema	R.H.U
Magmoa Tiba	R.H.U
Ain Galot	R.H.U
El Maasra	R.H.U
Shobra Osim	R.H.U
Othman Ebn Affan	R.H.U
Kom Aziza Clinic	U.H.U
Clinic of Hai 2 - Kafr El Dawar	U.H.U
Salah El Din M.C	U.H.U
Rasheid Center	U.H.U

Ismailia

<u>Unit Name</u>	<u>Unit Type</u>
Nahdet Orthodox	EFPA
Services Raidat-El Kantara Gharb	EFPA
Ismailia	Fever Hosp
Kantra Shark 1	Mobile Clinic
El Tal El Kebier Hospital .	Public/Dest.Hospital
El Gezira El Khadra	R.H.U
Abo Swir	U.H.U
El Manaif	U.H.U
El Kantara Gharb M.C.	U.H.U

Upper Egypt

Giza

<u>Unit Name</u>	<u>Unit Type</u>
El Saf	CSI
El Gamaia El Sharaia Clinic	EFPA
Zaneen	EFPA
El Omal City	EFPA
Meet Kardak	EFPA
Embaba	Fever Hosp
El Monera El Gharbia 2.	Health Office

Oseim Health Office
 El Badrashein H.O.
 El Giza 1 H.O
 El Haram H.O
 Nahia
 Shobrament
 El Hawamdia M.C.H.
 El Badrashein M.C.H.
 Etfeih M.C.H.
 North Giza 1
 El Badrashein 1
 Giza 1
 El Omrania 1
 El Gharieb Hospital
 Islamic Center - El Sabah
 El Hawamdia
 6 Oct
 Atfeeh
 Mazgona
 Gerza
 Beedf
 El Menia
 El Salheia
 Monsha Radwan
 Ezbaa El Mofty
 El Hay 3 Clinic
 Nzla El Sman
 El Markz El Hadry El Monib

Health Office
 Health Office
 Health Office
 Health Office
 Integrated Hospital
 Integrated Hospital
 M.C.H
 M.C.H
 M.C.H
 Mobile Clinic
 Mobile Clinic
 Mobile Clinic
 Mobile Clinic
 Other NGO
 Other NGO
 Public/Dest.Hospital
 Public/Dest.Hospital
 Public/Dest.Hospital
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 U.H.U
 U.H.U
 U.H.U

Beni Suef

Unit Name
 Ahnassia
 El Dawalta
 Beba
 Beni Suef
 Semosta
 Ahnasia H.O.
 Barout
 Alfent
 Abd El Salam Aref M.C.H
 El Wasta
 Beba 3
 El Wasta 1
 Beni Suef Hospital .
 Naser
 Bayad El Arab
 Kambeesh El Hamra
 Shanra
 Magmoaa El Awawna
 Tamam Kabas
 El Nawames

Unit Type
 CSI
 EFPA
 EFPA
 Fever Hosp
 Fever Hosp
 Health Office
 Integrated Hospital
 Integrated Hospital
 M.C.H
 M.C.H
 Mobile Clinic
 Mobile Clinic
 Public/Dest.Hospital
 Public/Dest.Hospital
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 R.H.U
 R.H.U

El Shantor
El Ghamrawy M.C.

R.H.U
U.H.U

Fayoum

Unit Name

El Sheikh Mousa
El Salayeen
Masaret Arafa
Etsa M.C.H.
Fayoum 1
Etsa 3
Ebshway 1
M.C.H.Culture Project
Tamia
Demo
El Sonbat
Mohamed Fahmy El Saied
El Hesania
Gabla
El Brany
El Mkrany
El Rian
El Hadka M.C.

Unit Type

EFPA
EFPA
EFPA
M.C.H
Mobile Clinic
Mobile Clinic
Mobile Clinic
Other NGO
Public/Dest.Hospital
R.H.U
R.H.U
R.H.U
R.H.U
R.H.U
R.H.U
R.H.U
R.H.U
U.H.U

Menya

Unit Name

Clinic B
Health Improvement- Melwy
Maghagha
El Fekraia
Der Mawas
El Edwa H.O.
Samalout H.O.
Malawy 2 H.O.
Damshir
Sandafa El Faar
Beni Ebed
Menia 1 M.C.H
Matay M.C.H
Maghagha 1
Beni Mazar 2
Abo Kurkas 2
El Fath El Islamy Dispansary
Omer Bn El Khatab Hospital
Family Planning Clinic In El Sayaida El Azraa Church
Family Planning Clinic In Mar Morkos Church -Malawy (Orth)
Family Planning Clinic In Dair El Malak Church
Family Planning Clinic In El Azraa Church - Dair Mawas - (Orth)
Family Planning Clinic In Mar Mena Church
El Menia Hospital
Malawy

Unit Type

CSI
EFPA
Fever Hosp
Fever Hosp
Fever Hosp
Health Office
Health Office
Health Office
Integrated Hospital
Integrated Hospital
Integrated Hospital
M.C.H
M.C.H
Mobile Clinic
Mobile Clinic
Mobile Clinic
Other NGO
Other NGO
Other NGO
Other NGO
Other NGO
Other NGO
Public/Dest.Hospital
Public/Dest.Hospital

Beni Warkan	R.H.U
Zahra	R.H.U
Hehia	R.H.U
Beni.Wlems	R.H.U
El Tahrir	R.H.U
Mankatin	R.H.U
Kom El Rahib	R.H.U
Abou Guerg	R.H.U
El Garnous	R.H.U
Edkak El Mesk	R.H.U
Sengerg	R.H.U
Menshat Al Nasr	R.H.U
Gueris	R.H.U
El Rahmania	R.H.U
Beni El Elm	U.H.U
Maghagha	U.H.U
Tambou	U.H.U
Abou Korkas M.C.	U.H.U

Assuit

<u>Unit Name</u>	<u>Unit Type</u>
Mobark Family Planing Clinic	EFPA
El Wasta	EFPA
Manfalout	Fever Hosp
El Badary	Fever Hosp
El Dewar	Fever Hosp
El Walidia H.O	Health Office
Health Office 1	Health Office
Abo Teeg H.O.	Health Office
El Moabda	Integrated Hospital
Olwan	Integrated Hospital
Bany Mor	Integrated Hospital
Bany Shkeer	Integrated Hospital
El Walidia M.C.H	M.C.H
Kolta M.C.H	M.C.H
Manfalout M.C.H.	M.C.H
Assuit 2	Mobile Clinic
El Quseia 1	Mobile Clinic
Manfalout 2	Mobile Clinic
Belal Bn Rabah Clinic	Other NGO
Health Care Center-Assuit University	Other NGO
Engelical Charity Dispensary	Other NGO
Assuit Hospital	Public/Dest.Hospital
El Badary Hospital .	Public/Dest.Hospital
Masrea	R.H.U
El Adr	R.H.U
Awaga	R.H.U
Arab Moter	R.H.U
Rezka El Deer	R.H.U
Arrab Moter	R.H.U
Om El Kosour	R.H.U

El Masody	R.H.U
Mgrees	R.H.U
El Sadat	U.H.U
El Gama El Kebier	U.H.U

Souhag

<u>Unit Name</u>	<u>Unit Type</u>
Main Souhag	CSI
Tema	CSI
Family Service	EFPA
Akhmim Charity Association	EFPA
El Balyana	Fever Hosp
Sakolta	Fever Hosp
El Maragha	Fever Hosp
Sohag 4 H.O.	Health Office
Gerga 2 H.O.	Health Office
Awlad Hamza	Integrated Hospital
Nida	Integrated Hospital
M.C.H Sohag Shark	M.C.H
El Monshah M.C.H	M.C.H
Sakolta M.C.H	M.C.H
Sohag 2	Mobile Clinic
El Monshah 1	Mobile Clinic
El Balyana 1	Mobile Clinic
El Shaheid Association Dispensary	Other NGO
El Maragha Hospital	Public/Dest.Hospital
Tema	Public/Dest.Hospital
Sakolta	Public/Dest.Hospital
El Shekh Youssef	R.H.U
El Salaa	R.H.U
Shatowra	R.H.U
Bany Amar	R.H.U
El Hadika	R.H.U
Naza El Heesh	R.H.U
El Rashaida	R.H.U
El Koraan	R.H.U
Kom Eshkilo	R.H.U
Bany Hmeel	R.H.U
El Riaina	R.H.U
El Kormat Shark	R.H.U
Ngoa Bany Wasel	R.H.U
Abar El Molk	R.H.U
Awlad Salm Bahary	R.H.U
Naga Taiaa	R.H.U
Naga Helal	R.H.U
El Amri Health Clinic	U.H.U

Qena

<u>Unit Name</u>	<u>Unit Type</u>
Nagaa Hamady	CSI
El Sayed Abdel Rahim	EFPA

El Kalalsa	EFPA
Esna	Fever Hosp
Abo Tesht	Fever Hosp
El Wakf	Fever Hosp
Nakada H.O	Health office
El Helfaia Bahary	Integrated hospital
El Zenia	Integrated hospital
Armant M.C.H	M.C.H
Esna M.C.H	M.C.H
Luxor M.C.H	M.C.H
Esna 1	Mobile clinic
Nakada 1	Mobile clinic
Farshout 1	Mobile clinic
Luxor 3	Mobile clinic
Farshout Hospital .	Public/Dest.hospital
Abo Tesht Hospital	Public/Dest.hospital
Luxor Hospital .	Public/Dest.hospital
Abnod	R.H.U
El Mashroh El Oropy	R.H.U
El Osirat	R.H.U
Abo Dghar	R.H.U
El Halfaia Kebly	R.H.U
El Kasr	R.H.U
El Klabia	R.H.U
El Halila	R.H.U
Belad El Mal Kebly	R.H.U
El Samta Bahry	R.H.U
Naga Saeed El Gededa	R.H.U
El Aiaisha	R.H.U
El Hogirat	R.H.U
Rhc El Baghdadi	R.H.U
Sidy Omar M.C.	U.H.U
Gzera Armant El Heat	U.H.U
El Twab	U.H.U

Aswan

<u>Unit Name</u>	<u>Unit Type</u>
Aswan H.I.S.	EFPA
El Koba Gharb	EFPA
Edfo	Fever Hosp
Kalabsha Hospital	Integrated Hospital
El Manshia El Gdeda	Integrated Hospital
El Romady Bahry	Integrated Hospital
Nasr M.C.H	M.C.H
Naser 2	Mobile Clinic
Keima Company Clinic	Other NGO
El Naseria Clinic - El Hakarouf	Other NGO
Saidy Abo El Hagag Association	Other NGO
Draw	Public/Dest.Hospital
Nasr	Public/Dest.Hospital
Ngaa Wens	R.H.U

El Kobania
Algnina wa El shebak
Fares
El Akarmia
Hager Abo Khalifa
El Dakadeek
Draw M.C
UHC Alsil

R.H.U
R.H.U
R.H.U
R.H.U
R.H.U
U.H.U
U.H.U

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