

### Global HIV/AIDS Initiatives in Zambia

#### Structured Interview with Health Facility Level Manager / NGO Manager Phase 2 – June 2008

##### Instructions

- To be administered at the Health Facility
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement.
- Circle the code corresponding to the response and fill the code of the response in the space provided against each question.
- Particular attention should be paid to skips and interviewer instructions throughout the questionnaire.

|   |   |
|---|---|
| <b>Questionnaire No.:</b> [ ][ ][ ][ ][ ] <i>Office use only</i>      |   |
| <b>Date of Interview (dd/mm/yyyy):</b> [ ][ ] / [ ][ ] / [ ][ ][ ][ ] |   |
| <b>Name of Facility</b>   | _____   |
| <b>Location of Facility</b>   | _____   |
| <b>Type/level of Facility</b>   | <br>1 Provincial Hospital<br>2 District Hospital<br>3 Hospital<br>4 Health Centre<br>5 Health Post<br>6 VCT Centre<br>7 Fixed Outreach [ ]<br>8 Home-based care<br>9 Other<br>Specify _____ |
| <b>Rural or urban facility</b>  | 1 Urban<br>2 Rural [ ]  |
| <b>Managing Authority</b>   | 1 Government<br>2 NGO/CBO<br>3 FBO/Mission [ ]<br>4 Other<br>Specify _____  |
| <b>Result Code</b>  | 1 Completed<br>2 Respondent not available<br>3 Refused [ ]<br>4 Partially completed<br>5 Other<br>Specify _____   |
| <b>Research Interviewer (RI)</b>                                      | [ ][ ]  |
| <b>RI Sign.</b> _____   | <b>Checked by Supervisor</b> _____ <b>Date</b> [ ][ ] / [ ][ ] / [ ][ ]   |

**Start time** \_\_\_\_\_

| Section 1: Facility / services information |  |   |     |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
|--|--|---|-----|-------------------------|-----------|--|----------------------|---|---|-----|---------------------------------|---|---|-----|-------------------------|---|---|-----|----------------------|---|---|-----|---------------------------|---|---|-----|-----------------|---|---|-----|----------------------|---|---|-----|------------------|---|---|-----|------------------|---|---|-----|----------|---|---|-----|--|--|
| 101  | Which Year and Month did you come to this facility   | Year _____ Month _____  |     |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| 102  | What is your professional qualification?   | Medical Doctor (General) <b>01</b><br>Medical Doctor (Specialist) <b>02</b><br>Clinical Officer <b>03</b><br>Registered Nurse (ZRN) <b>04</b><br>Registered Nurse (ZRN) Midwife <b>05</b><br>Enrolled Nurse (ZEN) <b>06</b><br>Enrolled Nurse (ZEN) Midwife <b>07</b> [ ] [ ]<br>Pharmacist <b>08</b><br>Pharmacy Technician <b>09</b><br>Laboratory Technician <b>10</b><br>Records/ Registry <b>11</b><br>Other <b>66</b><br>Specify _____  |     |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| 103  | Are you personally involved in the provision of ART?   | Yes <b>1</b><br>No <b>2</b><br>There is no ART at facility <b>3</b>   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| 104  | Do you have an estimate of the size of the catchment population that this facility serves, that is, the size of the population living in the area served by this hospital? | Yes <b>1</b><br>No <b>2</b><br>No catchment area <b>3</b><br>Don't know catchment population <b>4</b>   | [ ] | <b>If No, go to 106</b> |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| 105  | <i>IF YES:</i> what is the population size, that is how many people?   | > 50,000 <b>1</b><br>10,000 – 49,999 <b>2</b><br>1,000 – 9,999 <b>3</b><br>100 – 999 <b>4</b><br>< 100 <b>5</b>   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
|  |  | Also Record number:[_____]  |     |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| 106  | Does this facility provide the following services?<br><br><b>READ out and circle 1 or 2 from each option</b>   | <b>Yes=1; No=2</b><br><table border="0"> <thead> <tr> <th></th> <th><u>Yes</u></th> <th><u>No</u></th> <th></th> </tr> </thead> <tbody> <tr> <td>a) Delivery (normal)</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>b) Delivery (Caesarian Section)</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>c) Antenatal Care (ANC)</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>d) Tuberculosis Test</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>e) Tuberculosis treatment</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>f) Malaria test</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>g) Malaria treatment</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>h) Minor surgery</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>i) Major surgery</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> <tr> <td>j) Other</td> <td>1</td> <td>2</td> <td>[ ]</td> </tr> </tbody> </table> Specify _____ |     | <u>Yes</u>              | <u>No</u> |  | a) Delivery (normal) | 1 | 2 | [ ] | b) Delivery (Caesarian Section) | 1 | 2 | [ ] | c) Antenatal Care (ANC) | 1 | 2 | [ ] | d) Tuberculosis Test | 1 | 2 | [ ] | e) Tuberculosis treatment | 1 | 2 | [ ] | f) Malaria test | 1 | 2 | [ ] | g) Malaria treatment | 1 | 2 | [ ] | h) Minor surgery | 1 | 2 | [ ] | i) Major surgery | 1 | 2 | [ ] | j) Other | 1 | 2 | [ ] |  |  |
|  | <u>Yes</u>   | <u>No</u>   |     |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| a) Delivery (normal)                       | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| b) Delivery (Caesarian Section)            | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| c) Antenatal Care (ANC)                    | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| d) Tuberculosis Test                       | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| e) Tuberculosis treatment                  | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| f) Malaria test                            | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| g) Malaria treatment                       | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| h) Minor surgery                           | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| i) Major surgery                           | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |
| j) Other                                   | 1  | 2   | [ ] |                         |           |  |                      |   |   |     |                                 |   |   |     |                         |   |   |     |                      |   |   |     |                           |   |   |     |                 |   |   |     |                      |   |   |     |                  |   |   |     |                  |   |   |     |          |   |   |     |  |  |

| Section 1: Facility / services information |   |  |               |                          |
|--|---|--|---------------|--------------------------|
| 107  | Does this facility provide <b>ART</b> services  |  | Yes 1<br>No 2 | <input type="checkbox"/> |
| 108  | What year were ART services first provided in this facility?  | Year: _____  |               |                          |
| 109  | Does this facility provide <b>VCT</b> services?   |  | Yes 1<br>No 2 | <input type="checkbox"/> |
| 110  | What year were VCT services first provided in this facility?  | Year: _____  |               |                          |
| 111  | Does this facility provide <b>PMTCT</b> services?   |  | Yes 1<br>No 2 | <input type="checkbox"/> |
| 112  | When were PMTCT services first provided at this facility?   | Year: _____  |               |                          |
| 113  | Which of the following support services does this facility provide to people infected with HIV and their families?<br><br><b>(Read out the answers)</b> | <b>Yes=1; No=2</b>   | <b>Yes No</b> |                          |
|  |   | a) Counselling (for people who are HIV positive)   | 1 2           | <input type="checkbox"/> |
|  |   | b) Food/nutritional support  | 1 2           | <input type="checkbox"/> |
|  |   | c) Income generating projects  | 1 2           | <input type="checkbox"/> |
|  |   | d) Fee exemptions  | 1 2           | <input type="checkbox"/> |
|  |   | e) Support for schooling/education   | 1 2           | <input type="checkbox"/> |
|  |   | f) Information and Educational materials (contraception, HIV/AIDS, STIs, nutrition, pregnancy) | 1 2           | <input type="checkbox"/> |
|  |   | g) Home Based Care   | 1 2           | <input type="checkbox"/> |
|  |   | h) Clothing  | 1 2           | <input type="checkbox"/> |
|  |   | i) Support to families of people living with HIV/AIDS  | 1 2           | <input type="checkbox"/> |
|  |   | j) Support to widows/widowers  | 1 2           | <input type="checkbox"/> |
|  |   | k) Support for orphans   | 1 2           | <input type="checkbox"/> |
|  |   | l) Spiritual support   | 1 2           | <input type="checkbox"/> |
|  |   | m) Other   | 1 2           | <input type="checkbox"/> |
|  |   | Specify _____  |               |                          |
| 114  | Does this facility have a working relationship with any HIV/AIDS service providers (government/ NGO)  |  | Yes 1<br>No 2 | <input type="checkbox"/> |
|  |   |  |               | If 2, Or 3, go to 116    |
| 115  | What is the nature of this relationship?<br><br><b>Record all that apply</b>  | <b>Yes=1; No=2</b>   | <b>Yes No</b> |                          |
|  |   | a) Referral  | 1 2           | <input type="checkbox"/> |
|  |   | b) Supervision   | 1 2           | <input type="checkbox"/> |
|  |   | c) Training  | 1 2           | <input type="checkbox"/> |
|  |   | d) Supply of commodities   | 1 2           | <input type="checkbox"/> |
|  |   | e) Laboratory services   | 1 2           | <input type="checkbox"/> |
|  |   | f) Other   | 1 2           | <input type="checkbox"/> |

| Section 1: Facility / services information |   |   |                          |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
|--|---|---|--------------------------|---|-----------|--|-------------------------------------|---|---|--------------------------|------------------------|---|---|--------------------------|----------------------|---|---|--------------------------|---------------------|---|---|--------------------------|-------------------------|---|---|--------------------------|---------------------|---|---|--------------------------|----------------------|---|---|--------------------------|-----------------------------|---|---|--------------------------|---------------------------------|---|---|--------------------------|--------------------|---|---|--------------------------|----------|---|---|--------------------------|--|--|
|  |   | Specify _____<br>Specify2 _____   |                          |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 116  | Do you refer patients/clients who are HIV positive to any of the following facilities?<br><br><b>(Read out each and circle which one applies)</b> | <p><b>Yes=1; No=2</b></p> <table border="0"> <thead> <tr> <th></th> <th><u>Yes</u></th> <th><u>No</u></th> <th></th> </tr> </thead> <tbody> <tr> <td>a) National Referral Hospital (UTH)</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>b) Provincial Hospital</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>c) District Hospital</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>d) Mission Hospital</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>e) Health Centre/clinic</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>f) Health Post</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>g) NGO</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>h) CBO</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>i) Fixed Outreach</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>j) Home-based care</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>k) Other</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p>Specify _____</p> |                          | <u>Yes</u>                                | <u>No</u> |  | a) National Referral Hospital (UTH) | 1 | 2 | <input type="checkbox"/> | b) Provincial Hospital | 1 | 2 | <input type="checkbox"/> | c) District Hospital | 1 | 2 | <input type="checkbox"/> | d) Mission Hospital | 1 | 2 | <input type="checkbox"/> | e) Health Centre/clinic | 1 | 2 | <input type="checkbox"/> | f) Health Post      | 1 | 2 | <input type="checkbox"/> | g) NGO               | 1 | 2 | <input type="checkbox"/> | h) CBO                      | 1 | 2 | <input type="checkbox"/> | i) Fixed Outreach               | 1 | 2 | <input type="checkbox"/> | j) Home-based care | 1 | 2 | <input type="checkbox"/> | k) Other | 1 | 2 | <input type="checkbox"/> |  |  |
|  | <u>Yes</u>  | <u>No</u>   |                          |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| a) National Referral Hospital (UTH)        | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| b) Provincial Hospital                     | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| c) District Hospital                       | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| d) Mission Hospital                        | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| e) Health Centre/clinic                    | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| f) Health Post                             | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| g) NGO                                     | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| h) CBO                                     | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| i) Fixed Outreach                          | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| j) Home-based care                         | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| k) Other                                   | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 117  | For what specific services do you refer the patients/clients?<br><br><b>(Read out and circle 1 or 2)</b>  | <p><b>Yes=1; No=2</b></p> <table border="0"> <thead> <tr> <th></th> <th><u>Yes</u></th> <th><u>No</u></th> <th></th> </tr> </thead> <tbody> <tr> <td>a) Home-based care</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>b) VCT</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>c) CD4 Count</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>d) ART</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>e) PMTCT</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>f) Support Services</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>g) Management of OIs</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>h) Non-HIV-related services</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>i) Other (HIV-related services)</td> <td>1</td> <td>2</td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p>Specify1 _____<br/>Specify2 _____</p>  |                          | <u>Yes</u>                                | <u>No</u> |  | a) Home-based care                  | 1 | 2 | <input type="checkbox"/> | b) VCT                 | 1 | 2 | <input type="checkbox"/> | c) CD4 Count         | 1 | 2 | <input type="checkbox"/> | d) ART              | 1 | 2 | <input type="checkbox"/> | e) PMTCT                | 1 | 2 | <input type="checkbox"/> | f) Support Services | 1 | 2 | <input type="checkbox"/> | g) Management of OIs | 1 | 2 | <input type="checkbox"/> | h) Non-HIV-related services | 1 | 2 | <input type="checkbox"/> | i) Other (HIV-related services) | 1 | 2 | <input type="checkbox"/> |                    |   |   |                          |          |   |   |                          |  |  |
|  | <u>Yes</u>  | <u>No</u>   |                          |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| a) Home-based care                         | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| b) VCT                                     | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| c) CD4 Count                               | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| d) ART                                     | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| e) PMTCT                                   | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| f) Support Services                        | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| g) Management of OIs                       | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| h) Non-HIV-related services                | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| i) Other (HIV-related services)            | 1   | 2   | <input type="checkbox"/> |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 118  | Does this facility distribute <b>condoms</b> ?  |   | Yes 1<br>No 2            | <input type="checkbox"/>                  |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 119  | Does this facility have a pharmacy?   |   | Yes 1<br>No 2            | <input type="checkbox"/> If no, go to 121 |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 120  | When did you first have the pharmacy at this facility?  | Year _____ Month _____  |                          |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 121  | Does this facility provide laboratory services?   |   | Yes 1<br>No 2            | <input type="checkbox"/> If no, end here  |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |
| 122  | When did you start providing laboratory services?   | Year _____ Month _____  |                          |   |           |  |                                     |   |   |                          |                        |   |   |                          |                      |   |   |                          |                     |   |   |                          |                         |   |   |                          |                     |   |   |                          |                      |   |   |                          |                             |   |   |                          |                                 |   |   |                          |                    |   |   |                          |          |   |   |                          |  |  |

### Section 1: Facility / services information

I would now like to find out more information regarding the following:

- Human Resources
- Laboratory services
- Pharmacy services
- Records/register review for outpatient/inpatient services, ART, VCT, PMTCT, condom numbers.

Please let me know if you are the most appropriate person to speak with or if I should speak with the person in charge of these departments.

**Interviewer:** move to sections mentioned above, asking the manager to introduce you to the most appropriate person.