FOR CENTRAL OFFICE USE ONLY: Write down the no in the “id” column of Excel data entry screen. ID:

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| **REFERRAL SYSTEM AND REFERRAL CASES AUDIT FORM** | | | | |
| **Informed Consent**  “Good \_\_ (MORNING / AFTERNOON). My name is \_\_\_\_\_\_\_\_\_\_\_. I work with the Emory university KMC project. Our team is talking to women about their referral experiences for their pre-mature or small baby in order to try to improve the referral process and quality of the service. I would like to talk with you and ask you some detailed questions about referral. To do this, I will need about half an hour of your time. Your answers will be private. Many other women will be interviewed and the information you give will be combined with theirs to be reported as a group. You will not be personally identified in the project report. You may ask any questions you like, refuse to do the interview or refuse to answer any question or end the interview at any time. You may also agree to the interview at a time convenient to you. Do you have any questions? Would you like to participate in our interview?” Yes 🞏 No 🞏 | | | | |
| **S.N** | **I. Document Review at Referring Facility** | | | |
| **1** | **Name of health facility:** |  | | |
| **2** | **Serial No (Referral register):** |  | | |
| **3** | **Name of mother/baby referred:** |  | | |
| **4** | **Address:** | Woreda: | Kebele: | Gote: |
| **5** | **Address:** | Tel #: | HDA-network: | |
| **6** | **Delivery date:** |  | | |
| **7** | **Place of delivery:** |  | | |
| **8** | **Birth weight:** | \_\_\_\_\_\_\_gm | | |
| **9** | **Date of referral initiated** |  | | |
| **10** | **Name of receiving HF where referral was sent** |  | | |
| **11** | **Reasons for referral** |  | | |
| **12** | **Care elements given for the mother/baby before referral** | Practice Breast feeding 🞏 Wrap the baby 🞏 Practice SSC 🞏  Provided with antibiotic injection 🞏 Counseling 🞏 Hygiene 🞏  Follow-up care 🞏 | | |
| **13** | **Provided with referral slip** | Yes 🞏 No 🞏 | | |
| **14** | **Advance call to the receiving HF before referral?(Referral sent with communication to receiving facility)** | Yes 🞏 No 🞏 | | |
| **15** | **Feedback received from receiving facility:** | Yes 🞏 No 🞏 | | |
| **16** | **Know the status of newborn baby:** | Yes 🞏 No 🞏 | | |
| **17** | **Follow-up care given to baby** | Yes 🞏 No 🞏 | | |
| **II. Mothers Interview:** | | | | |
| **18** | **Mother’s age** | \_\_\_\_\_years I don’t know 🞏 | | |
| **19** | **Educational status** | Unable to read and write 🞏 Can read and write 🞏  Attended school 🞏 if attended, How many years?: \_\_\_\_\_\_\_\_\_ years, or Don’t Know 🞏 | | |
| **20** | **Gravidity and Parity:** | How Many Pregnancies Have You Had in Your Life (including recent):\_\_\_\_\_\_\_\_\_\_  How Many of Your Pregnancies Ended in a Live Birth (including the recent): \_\_\_\_\_ | | |
| **21** | **Antenatal care (ANC)** | Total Number of ANC Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Counseled about Premature baby/small baby: Yes 🞏 No 🞏  Counseled about KMC/care of premature baby/small baby: Yes 🞏 No 🞏 | | |
| **22** | **Date of Delivery** | Day\_\_\_\_\_\_\_ Month \_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **23** | **Place of Delivery** | Home 🞏 Health Post 🞏 Health Center 🞏 Hospital 🞏 Other 🞏 | | |
| **24** | **Attendant** | Skilled health personnel 🞏 HEW 🞏 TBA/HDA 🞏 Relative 🞏 | | |
| **25** | **Birth weight of your baby** | Birth weight of your baby: \_\_\_\_\_\_\_\_\_\_\_\_ gm  Where was the weight taken: Home 🞏 HP 🞏 HC 🞏 Hospital 🞏 | | |
| **26** | **Referral History:** | From what level you got referred? Home 🞏 HP 🞏 HC 🞏 Hospital 🞏  To what level you were referred?  HP 🞏 HC 🞏 Hospital 🞏  Did the HWs give you referral slip? Yes 🞏 No 🞏  Did the HWs tell you the reason for referral? Yes 🞏 No 🞏  What were the reasons for referral?  Baby was too small Yes 🞏 No 🞏  Unable to breast feed Yes 🞏 No 🞏  Unable to breath Yes 🞏 No 🞏  Baby body temperature cold Yes 🞏 No 🞏  Lack of oxygen at the hospitals Yes 🞏 No 🞏  Lack of drug at the hospitals Yes 🞏 No 🞏  No materials and drugs to support the baby at the HC Yes 🞏 No 🞏  No materials and drugs to support the baby at the HC Yes 🞏 No 🞏  Others (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **27** | **Care provided before referral** | Did the HWs provide you any care before referral? Yes 🞏 No 🞏 | | |
| **28** | **What care elements did the HWs give you before referral?** | Practice Breast feeding 🞏 Wrap the baby 🞏 Practice SSC 🞏  Provided with antibiotic injection 🞏 Counseling 🞏 Hygiene 🞏 Follow-up care 🞏 | | |
| **29** | **Satisfaction level** | Could you please rate your satisfaction level (for the service you get at referring facility)  Fully Satisfied 🞏 Partially satisfied 🞏 Neither Satisfied nor Dissatisfied 🞏  Partially Dis-satisfied 🞏 Fully Dis-satisfied 🞏 | | |
| **30** | **Receiving facility** | Did you go to the health facility where you referred? Yes 🞏 No 🞏 | | |
| **31** | **Reason** | If the answer to question # 30 is No, what were the reasons you didn’t go to the receiving HF?  Small baby has no chance of survival 🞏  Too far 🞏  It costs too much 🞏  The father/family members don’t allow 🞏  Others reasons(specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **32** | **Transportation** | If the answer to question # 30 is yes, how long did it take you to arrive to the receiving health facility? \_\_\_\_\_\_\_\_\_ hours  What type of transport did you use?  Ambulance from HF 🞏  Through walking 🞏  Public transport (bajaj, minibus…) 🞏  Other transport means (mule, horses) 🞏 | | |
| **33** | **Admission weight** | Did the HWs take the weight of your baby while you arrive at the HF? Yes 🞏 No 🞏  Did the health workers tell you the weight of the baby? Yes 🞏 No 🞏  If yes, what was the weight \_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **34** | **NICU admission** | Did your baby admitted to NICU? Yes 🞏 No 🞏  If yes for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days | | |
| **35** | **KMC service** | Did your baby get KMC service (EBF and SSC)? Yes 🞏 No 🞏  If yes for how long/How many days?  At hospital \_\_\_\_\_\_\_\_\_\_ days At home \_\_\_\_\_\_\_\_\_\_\_\_ days | | |
| **36** | **What was the outcome of the baby?** | Improved 🞏 No change 🞏 the condition get worsened 🞏 Died 🞏 | | |
| **37** | **Discharge counseling** | Continue Breast feeding 🞏 Continue SSC 🞏 Danger signs of small babies 🞏  Hygiene 🞏 Follow-up care 🞏 EPI 🞏 | | |
| **38** | **Linkage** | Did the health facility give you notification card to link with HCs/HEWs? Yes 🞏 No 🞏 | | |
| **39** | **HEWs visit** | Did the HCs/HEWs visit you after you got discharged from hospital? Yes 🞏 No 🞏 | | |
| **40** | **Satisfaction level** | Could you please rate your satisfaction level (for the service you get at the receiving facility)  Fully Satisfied 🞏 Partially satisfied 🞏 Neither S nor DS 🞏  Partially Dis-satisfied 🞏 Fully Dis-satisfied 🞏 | | |
| **III. Document Review at receiving facility** | | | | |
| **41** | **Name of receiving facility** |  | | |
| **42** | **Weight taken** | Yes 🞏 No 🞏 Don’t know 🞏 If yes, How much? \_\_\_\_\_\_\_gm | | |
| **43** | **Admitted to NICU** | Yes 🞏 No 🞏 Don’t know 🞏 | | |
| **44** | **KMC service provided** | Yes 🞏 No 🞏 Don’t know 🞏  If yes, how many days KMC initiated after arrival? \_\_\_\_\_\_\_\_\_days | | |
| **45** | **Counseled during discharge** | Yes 🞏 No 🞏 Don’t know 🞏 | | |
| **46** | **Baby outcome** | Improved 🞏 Not improved 🞏 the condition get worsened 🞏 Died 🞏 | | |
| **47** | **Linked with HEWs/HCs** | Yes 🞏 No 🞏 Don’t know 🞏 | | |
| **48** | **Feedback provided** | Yes 🞏 No 🞏 Don’t know 🞏 | | |
| **IV. CLOSING** | | **Today you have told me that… summarize**  **Is there any other information that you would like to share that we have not already discussed?**  **Thank you very much for you meeting with me today! The information you have given will help us improve the health of premature and small babies in this area.** | | |
| **V. Notes and Comments about the interview setting, participants, or stories they told.** | |  | | |