| Cover Page | | |
|---|---|---|
| Q1: Facility ID | Q2: Facility Name | Q4b: Time simulation started (HH:MM) |
| Q3: Observer number | Q4a: Today's date (DD/MM/YYYY) __ __ / __ __ / __ __ __ __ | __ __ : __ __ AM/PM |

Q4c: Result
☐ Interview done  ☐ Partially completed
☐ Person in charge refused interview  ☐ Person in charge is out

THIS TEST IS TO BE ADMINISTERED TO A HEALTH WORKER FROM PEDIATRIC SERVICES. EACH FOLIO (SET OF PAPERS) CORRESPONDS TO ONE HEALTH WORKER ONLY. IF YOU ADMINISTER THIS TEST TO SEVERAL HEALTH WORKERS, YOU NEED A NEW FOLIO FOR EACH HEALTH WORKER. ALSO BE SURE TO RECORD THE STAFF ID NUMBER OF THE HEALTH WORKER ANSWERING THIS TEST, BY REFERRING TO THE STAFF ROSTER TO OBTAIN THE STAFF ID NUMBER.

CHECK THE STAFF ROSTER AND SEE IF THE HEALTH WORKER IS RECORDED AS HAVING GIVEN CONSENT FOR THE RESEARCH. IF NOT YOU MUST READ THE FULL CONSENT FORM AND OBTAIN HIS/HER SIGNATURE. IF YES, REMIND HIM/HER USING THE TEXT BELOW.

Q5a: Has the health worker previously signed a consent form?   ☐ Yes → go to Q6a   ☐ No -> go to Q7a

Q6a: ASK HEALTH WORKER: I would like to ask you some questions about your knowledge of a specific medical case. Your answers will remain confidential, we will not share the result of this interview and it will not have any impact on your work or the assessment of your performance. Do I have your permission to administer this questionnaire?

☐ Yes→ go to Q8a ☐ No, consent is not given →   observation of this health worker must END; if available, approach another health worker for participation.

Q7a: READ FULL CONSENT SCRIPT TO HEALTH WORKER AND OBTAIN SIGNATURE. Did the health worker sign the form?

☐ Yes → go to Q8a   ☐ No, consent is not given → observation of this health worker must END; if available, approach another health worker for participation.

| Q8a Staff Roster ID number | Q9a Gender | Q10a: Health Worker Category Code (see below for codes) |
|---|---|---|
|  | ☐ Male    ☐ Female |  |

READ THE FOLLOWING TO THE HEALTH WORKER:

I will start asking you questions about your knowledge now. Please answer the following questions to the best of your knowledge. Most of the questions I will be asking you will require multiple responses from you. Please provide all responses that come to mind. I will probe sometimes to help you remember some more information. I may also ask you to demonstrate certain actions during the course of this interview. Finally, if you need me to repeat the question, just let me know.

| Health Worker Category Codes | | | | |
|---|---|---|---|---|
| 1. MD-Obstetrician/Gynecologist | 2. MD-Neonatologist | 3. MD-Surgeon | 4. MD- Family Physician | 5. MD - Pediatrician |
| 6. Physician's Assistant | 7. Nurse midwife | 8. Bachelor and Science of Nursing Nurse | 9. Diploma Nurse | 10. Nurse with Associate Degree |
| 11. Licensed Practical Nurse | 12. Certified midwife | 13. Midwife | 14. Nurse aide | 96.Other, please specify: |
|  |  |  |  |  |

| Management of Pediatric Diarrhea |
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THE FOLLOWING QUESTIONS CORRESPOND TO A CLINICAL CASE SCENARIO THAT THE HEALTH WORKER COULD EXPECT TO OBSERVE IN THE HOSPITAL. READ THE CASE SCENARIOS AND QUESTIONS EXACTLY AS THEY ARE WRITTEN. DO NOT READ THE OPTIONS OF ANSWERS. FOR CERTAIN QUESTIONS, MULTIPLE ANSWERS ARE POSSIBLE; IN THIS CASE, CIRCLE ALL ANSWERS GIVEN BY THE HEALTH WORKER. AFTER THE HEALTH WORKER HAS FINISHED ANSWERING THE QUESTION, ASK "ANYTHING ELSE?" IF ADDITIONAL ANSWERS ARE GIVEN AT THAT TIME, MAKE DUE RECORD OF THEM ON THE SURVEY FORM. BE CAREFUL TO FOLLOW THE SKIPS AS THEY ARE MARKED. MAKE SURE THE HEALTH WORKER CANNOT SEE THE FORM YOU ARE FILLING.

DO NOT READ OPTIONS ALOUD. FOR EACH OPTION, NOTE WHETHER THE HEALTH WORKER MENTIONED THIS ACTION OR NOT.

| RECORD TIME OF BEGINNING OF THE SIMULATION (HH:MM) | __ __ : __ __AM/PM |
|---|---|

**Scenario:** A little girl aged 25 months and weighing 10.5 kg is brought to the facility because she has been asleep since the morning and is very difficult to wake up. She hasn't eaten or drunk fluids since yesterday. When asked, the mother said that her daughter did not vomit and did not have any convulsions, but has had diarrhea for about six days. She also had fever for three days and a runny nose. You assessed the child and confirmed that the child was lethargic. You also performed a skin pinch and the skin came back very slowly. No other abnormal clinical signs were found. The family lives in a low malaria risk area, and has not traveled recently. There is no cholera in the area now.

| Question | Yes | No | Verify Present/Not Present | |
|---|---|---|---|---|
| **Q101: Assuming that all the needed drugs, supplies and equipment are in stock in the health facility, and that testing and referral facilities are available, what are ALL the actions and/or prescriptions you would take to provide this child with the most appropriate treatment?** | | | | |
| A. Recommend urgent referral to a hospital. | 1 | 0 | N/A | |
| B. Administer ringer lactate or normal saline IV solution. | 1 | 0 | 1 | 0 |
| C. Administer liquid by naso-gastric tube. | 1 | 0 | 1 | 0 |
| D. Inject one dose of an injectable antibiotic. | 1 | 0 | 1 | 0 |
| E. Inject one dose of a second antibiotic. | 1 | 0 | 1 | 0 |
| F. Prescribe injectable antibiotic for five days. | 1 | 0 | N/A | |
| G. Give one dose of oral antibiotic. | 1 | 0 | 1 | 0 |
| H. Prescribe oral antibiotics for five days. | 1 | 0 | N/A | |
| I. Inject one dose of quinine. | 1 | 0 | 1 | 0 |
| J. Give one dose of oral antimalarial. | 1 | 0 | 1 | 0 |
| K. Prescribe quinine for five days. | 1 | 0 | N/A | |
| L. Prescribe oral antimalarials for 3 days. | 1 | 0 | N/A | |
| M. Administer oral rehydration salts (ORS) at the facility. | 1 | 0 | 1 | 0 |
| N. Advise on giving oral rehydration salts (ORS) on the way to hospital. | 1 | 0 | 1 | 0 |
| O. Prescribe oral rehydration salts (ORS) for home treatment. | 1 | 0 | N/A | |
| P. Give one dose of paracetamol. | 1 | 0 | 1 | 0 |
| Q. Prescribe paracetamol for home treatment. | 1 | 0 | N/A | |
| R. Give one dose of vitamin A. | | | 1 | 0 |
| S. Treat to prevent low blood sugar. | 1 | 0 | 1 | 0 |
| T. Recommend continuing breastfeeding. | 1 | 0 | N/A | |
| U. Recommend giving food and fluids other than breast milk. | 1 | 0 | N/A | |
| RECORD TIME OF END OF THE SIMULATION (HH:MM) | | __ __ : __ __AM/PM | | |

GO BACK TO EACH ITEM IN THE SIMULATION THAT REQUIRES A PIECE OF EQUIPMENT OR A MEDICATION AND VERIFY THAT THE EQUIPMENT OR MEDICATION IS PRESENT.

| PLEASE PROVIDE ANY FURTHER COMMENTS ON THE QUALITY OF CARE: | |
|---|---|
| | |