

Baseline and Endline Data Collection Tool
Tool #2: MCSP RMC Client Exit Survey¹

Thank you for taking the time to complete this survey. Please mark your responses visibly inside the boxes.

By completing this survey you indicate your consent to participate in this study, and have completed a consent form provided to you along with this survey.

After completing the survey, place it in the envelope provided and seal the envelope. The survey will be collected by a representative of MCSP Guatemala. Please make sure to place the completed survey in a separate envelope from the signed consent form.

This section to be completed by the research team.

Survey Code

Date

Hospital code:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Locality:	Urban [1]
	Semi-urban [2]
	Rural..... [2]
Date of Interview: (dd/mm/yy)	___ / ___ / _____

¹ Adapted from the Heshima client exit interview tool, Staha client exit interview tool, and questions included/adapted from Afulani et al. (2017).

Section 1: Demographics		
1.	How long have you been living continuously in (name of village)?	_____ (years; if less than 1 year record '00') <input type="checkbox"/> Do not know <input type="checkbox"/> NR/RF
2.	How old are you?	_____ <input type="checkbox"/> DK <input type="checkbox"/> NR/RF
3.	Have you ever attended school?	<input type="checkbox"/> Yes <input type="checkbox"/> No → SKIP TO 5
4.	What is the highest level of school you attended?	<input type="checkbox"/> None <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> University
5.	What language do you normally speak at home?	Check all that apply: <input type="checkbox"/> Ixil <input type="checkbox"/> <input type="checkbox"/> Spanish <input type="checkbox"/> Other
6.	What other languages do you speak?	Check all that apply: <input type="checkbox"/> Ixil <input type="checkbox"/> <input type="checkbox"/> Spanish <input type="checkbox"/> Other
7.	What is your marital status?	<input type="checkbox"/> Never married <input type="checkbox"/> Currently married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabiting <input type="checkbox"/> Do not want to answer
8.	What is your occupation, that is, what kind of work do you do? Circle all that apply.	<input type="checkbox"/> Homemaker <input type="checkbox"/> Farming <input type="checkbox"/> Teaching <input type="checkbox"/> Business <input type="checkbox"/> Small sales <input type="checkbox"/> Crafts or trades <input type="checkbox"/> Services <input type="checkbox"/> Health work <input type="checkbox"/> Student <input type="checkbox"/> Not employed <input type="checkbox"/> Other (specify) <input type="checkbox"/> Refused to answer
9.	How many times have you given birth?	_____#_ (if 0 SKIP TO #13) <input type="checkbox"/> Do not know <input type="checkbox"/> NR/RF
10.	Of your prior births, how many were:	

	a) At this facility	_____
	b) At another facility	_____
	c) At a health post	_____
	d) With a TBA in a home	_____
11.	Did you receive antenatal care during this pregnancy? If yes, Interviewer, please ask the following:	<input type="checkbox"/> Yes → proceed to 16 <input type="checkbox"/> No → Skip to 19
12.	How many antenatal visits did you have at this hospital?	_____
13.	How many antenatal visits did you have at a health post?	_____
14.	How many antenatal visits did you have with a TBA?	_____
15.	What day of the week did you deliver your baby?	<input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday
Section 2: Delivery Characteristics		
INTERVIEWER TO READ: “Now I’m going to ask you some questions about your recent delivery in this health facility.”		
16.	Have you used this hospital for health care for yourself, your children or your spouse before?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
17.	Before you went into labor, had you already decided to come to this facility for childbirth?	<input type="checkbox"/> Yes → continue to #22 <input type="checkbox"/> No → skip to #23
18.	If yes, who decided that you would give birth in this hospital?	<input type="checkbox"/> I made the decision <input type="checkbox"/> My husband made the decision <input type="checkbox"/> My mother made the decision <input type="checkbox"/> My mother in law made the decision <input type="checkbox"/> Other _____
19.	If you did not plan in advance to give birth in this facility, what changed your mind? (read each of the following options) :	

	a) Referred by a TBA because of a complication or problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	b) Referred from a health post because of a complication or problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	c) Decided on my own when my labor started	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
20.	Did the cost of delivery influence the decision about where you gave birth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
21.	Approximately how many hours did it take you to travel to this hospital?	_____ (round up to the nearest half hour) <input type="checkbox"/> Do not know <input type="checkbox"/> Do not want to answer			
22.	How many days have you been in the hospital? INTERVIEWER: IF MOTHER REPORTS HOSPITAL STAY OF OVER 72 HOURS FIND OUT THE REASON WHY _____	_____ (round up to the nearest half day) <input type="checkbox"/> Do not know <input type="checkbox"/> NR/RF			
23.	Did you experience any of the following complications? (please read each option)				
	a) Too much bleeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	b) Infection or fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	c) C-Section?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	d) High blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	e) Labor lasting more than 1 day	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
24.	Did your baby experience any of the following complications after delivery? (Please read each option)				
	a) Trouble breathing after delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	b) Infection or fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	c) Born too early or very small	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Section 3: Perceived Quality and Satisfaction					
INTERVIEWER TO READ: "I would like to ask you some more questions about your experience of giving birth in this facility. Please remember that nothing you tell us will be shared with anyone, including the staff in the health facility, and your responses will not affect health care for you or your children in the future. There are no right or wrong answers, we just want to understand your experience."					
25.	Did you think that the labor or postnatal wards were crowded?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>

26.	Do you think there were enough staff to care for you and the other patients?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
27.	Did you think the facility was very clean, clean, dirty or very dirty?	<input type="checkbox"/> Very dirty <input type="checkbox"/> Dirty <input type="checkbox"/> Clean <input type="checkbox"/> Very clean <input type="checkbox"/> DK <input type="checkbox"/> Refused to answer			
28.	When you needed water, did you have access to water?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
29.	Was there a toilet you could easily use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
30.	Did you feel that the equipment and supplies needed were available?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
31.	During your stay in the facility did the health care workers speak to you in a language you could understand?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
32.	If they were not able to speak to you in a language you understand, did they arrange for someone to translate when they spoke to you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
33.	Were you kept warm most of the time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
34.	Did the health care providers explain to you why they were doing examinations or procedures on you, or giving you medicine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
35.	Did the health care workers ask your permission/consent before doing procedures or exams on you (e.g. vaginal exams) or giving you medicine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
36.	At any point during your time at this facility, did any provider explain to you what to expect and what was happening?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
37.	Did you feel you could ask any questions about your care?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
38.	Did you want to have someone with you as a companion during labor?	Yes	No	Do not know	Do not want to answer

		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		(If No, skip to #55)			
39.	If yes, were you able to have that person with you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
40.	Did you want to have someone with you as a companion during birth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
		(If No, skip to #57)			
41.	If yes, were you able to have that person with you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
42.	While in labor and when giving birth, were you covered with a cloth or blanket or screen so that you did not feel exposed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
43.	Did the health care workers treat you with respect?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
44.	Did the health care workers treat you in a warm and friendly way?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
45.	Do you feel the providers did everything they could to control your pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
46.	Do you feel the providers did everything they could to help you be more comfortable?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
47.	Do you feel that the providers took the best care of you that they could?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
48.	When you needed help, did you did you ask for help?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
		(If No, skip to #65)			
49.	If you asked for help, did you feel that health workers paid attention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>

Section 4: Experience of Disrespect

INTERVIEWER TO READ: "SOME WOMEN TELL US THAT WHEN THEY GIVE BIRTH THEY ARE TREATED POORLY OR WITH DISRESPECT. WE WOULD LIKE TO KNOW HOW COMMON THIS PROBLEM IS, SO WE WOULD LIKE TO ASK YOU YOUR OWN EXPERIENCES WITH CHILDBIRTH. THERE IS NO RIGHT OR WRONG ANSWERS TO THESE QUESTIONS. IT IS ONLY IMPORTANT TO US THAT WE UNDERSTAND YOUR EXPERIENCES. YOUR RESONSES WILL NOT BE SHARED WITH ANYONE INCLUDIG THE STAFF IN THE FACILITY. NOTHING YOU TELL US WILL BE LINKED TO YOUR NAME, YOUR CHILDREN'S NAMES, OR THE ABILITY OF YOU OR YOUR FAMILY MEMBERS TO ACCESS HEALTH CARE IN THE FUTURE. SOME OF THESE QUESTIONS MAY BE UPSETTING OR STRESSFUL. AS I SAID BEFORE, YOU CAN SKIP ANY QUESTION YOU ARE NOT COMFORTABLE ANSWERING, AND YOU CAN STOP THE INTERVIEW AT ANY POINT."

50.	At any time during your stay in the facility did you feel you were treated roughly physically by a health provider (e.g. slapped, pinched, or punched)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
(If No, skip to #67)					
51.	If Yes, what exactly happened? (DO NOT READ, Circle all that apply, prompt for any more)	<input type="checkbox"/> Kicked	<input type="checkbox"/> Pinched	<input type="checkbox"/> Slapped	<input type="checkbox"/> Tied to the delivery bed/delivery coach
		<input type="checkbox"/> Pushed	<input type="checkbox"/> Intimidating/threatening gestures	<input type="checkbox"/> Beaten	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer			
52.	At any time during your stay in this facility did you feel that the health workers talked to you in a rude or humiliating way (for example, shouted at, screamed at, insulted, scolded, or mocked you)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
(If No, skip to #69)					
53.	If yes, what exactly happened? (DO NOT READ, Circle all that apply, prompt for any more)	<input type="checkbox"/> Scolded	<input type="checkbox"/> Yelled or Screamed at	<input type="checkbox"/> Threatened	<input type="checkbox"/> Taunted/made fun of/called names
		<input type="checkbox"/> Blamed	<input type="checkbox"/> Other _____	<input type="checkbox"/> Do not know	<input type="checkbox"/> Refused to answer
54.	At any point, were you restrained so that you couldn't move?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
55.	At any point, was forceful downward pressure placed on your abdomen before the baby came out (fundal pressure)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>

56.	Did any health worker or other staff threaten that if you did not comply, you or your baby would not be healthy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
57.	Did any health worker or other staff blame you for something that happened to you or your baby during your time in the health facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
58.	Did any health worker or other staff make negative comments to you regarding your sexual activity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
59.	Did any health worker or other staff sexually harass you or make sexual advances (for example, inappropriate touching or sexual comments that made you feel uncomfortable)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
60.	Did any health providers discuss your private health information in a way that others could hear?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
61.	Did you give birth without a health care provider helping you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
62.	Did any health providers or other staff ask for a bribe or informal payment for better care?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
63.	Did any health provider threaten not to take care of you because you could not pay or did not have required supplies (including delivery kit)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
		Not applicable <input type="checkbox"/>			
64.	Did anything else disrespectful happen to you that we did not ask about?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
		(If No, skip to #81)			
65.	What exactly happened?	_____ _____ _____			
66.	<i>[ask only if respondent said yes to any abuse above in this section]</i> Do you think that the poor treatment you described was influenced by any of the following? Interviewer: Please read the list and circle any that apply	<input type="checkbox"/> Your ethnicity <input type="checkbox"/> Your religion <input type="checkbox"/> Your political beliefs or other beliefs <input type="checkbox"/> Lack of money or wealth <input type="checkbox"/> Age <input type="checkbox"/> Number of children		<input type="checkbox"/> Marital status <input type="checkbox"/> Your gender <input type="checkbox"/> Other (specify) <input type="checkbox"/> N/A <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer	

67.	If you felt disrespected at any point during what did you do?	<input type="checkbox"/> Told the provider <input type="checkbox"/> Formally filed a complaint <input type="checkbox"/> Complained to a supervisor or other staff person	<input type="checkbox"/> Took no action <input type="checkbox"/> Other (specify) <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer
68.	INTERVIEWER TO READ: “I know some of the questions I just asked may have been upsetting. We are almost finished with this survey. Would you like to take a short break from answering questions?”	<input type="checkbox"/> Yes → wait a few minutes) <input type="checkbox"/> No → Proceed	
69.	[After waiting a few minutes] “Is it alright if we continue with the survey?”	<input type="checkbox"/> Yes → GO TO 85 <input type="checkbox"/> No → END SURVEY	

Section 5. Looking Forward

INTERVIEWER TO READ: “Thank you. Now I would like to ask you about your plans to choose health care facilities in the future.”

70.	How likely is it that you would choose to give birth in this facility again?	Definitely <input type="checkbox"/> Maybe <input type="checkbox"/> Probably Not <input type="checkbox"/>	<input type="checkbox"/> Do not know <input type="checkbox"/> Do not want to answer
71.	How likely are you to recommend this facility to other women for delivery?	Definitely <input type="checkbox"/> Maybe <input type="checkbox"/> Probably Not <input type="checkbox"/>	<input type="checkbox"/> Do not know <input type="checkbox"/> Do not want to answer

Section 6: Asset Index

INTERVIEWER TO READ: “Thank you. Now I have a few short questions about your home to help us understand your economic background. None of this information will be linked to your name or shared with anyone at the facility or in your community.”

72.	Does your household have the following items?				
	a) A refrigerator	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
	b) A washing machine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
	c) A microwave	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
	d) A computer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>

73.	Does any member of your household have a car or truck?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do not know <input type="checkbox"/>	Do not want to answer <input type="checkbox"/>
74.	What type of toilet do members of your household typically use?	<input type="checkbox"/> Connected with sewer (not shared with others) <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer			
75.	What is the main source of drinking water used by members of your household?	<input type="checkbox"/> Bottled water <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer			
76.	What type of fuel does your household mainly use for cooking?	<input type="checkbox"/> Propane gas <input type="checkbox"/> Wood <input type="checkbox"/> Other (specify) <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer			
77.	What is the main material of the roof of your dwelling?	<input type="checkbox"/> Slab/Terrace <input type="checkbox"/> Other <input type="checkbox"/> Biogas <input type="checkbox"/> Paraffin/kerosene <input type="checkbox"/> Charcoal <input type="checkbox"/> Wood	<input type="checkbox"/> Dung <input type="checkbox"/> Crop residuals <input type="checkbox"/> Solar <input type="checkbox"/> Other (specify) <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer		
78.	What is the main material of the exterior walls of your dwelling?	<input type="checkbox"/> Cement block <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer			
79.	What is the main material of the floor of your dwelling?	<input type="checkbox"/> Earth/sand <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> Refused to answer			

Please thank the woman and end the interview.