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# KAGERA HEALTH AND DEVELOPMENT SURVEY

* * *

# QUESTIONNAIRE FOR HEALTH FACILITIES

# PASSAGE ONE

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FACILITY NAME:_____ FACILITY NUMBER: [ ]

LOCATION:_____ WAVE: [1]

CLUSTERS FOR WHICH FACILITY IS NEAREST:

NAME:_____ NUMBER: [ ] DISTANCE: [ ] KM

NAME:_____ NUMBER [ ] DISTANCE: [ ] KM

NAME:_____ NUMBER: [ ] DISTANCE: [ ] KM

NAME:_____ NUMBER: [ ] DISTANCE: [ ] KM

TYPE OF FACILITY: [ ]

VILLAGE HEALTH POST.....1
DISPENSARY.....2
HEALTH CENTRE.....3
HOSPITAL.....4
DISTRICT HOSPITAL.....5
DISTRICT DESIGNATED HOSPITAL.6
REGIONAL HOSPITAL.....7

INTERVIEWER:_____ CODE: [ ]

DATE: [ ][ ][ ] (DAY MO YEAR)

DAY OF THE WEEK: [ ]

MON...1 THU...4
TUE...2 FRI...5
WED...3 SAT...6
SUN...7

TIME STARTED: [ : ] TIME COMPLETED: [ : ]

SUPERVISOR:_____ CODE: [ ]

DATE CHECKED: [ ][ ][ ] (DAY MO YR)

OUTCOME: [ ]

COMPLETED/SATISFACTORY....1
COMPLETED/UNSATISFACTORY..2
INCOMPLETE.....3

REMARKS/FOLLOW-UP MEASURES: _____

_____

_____

**INSTRUCTIONS:** **COMPLETE THIS QUESTIONNAIRE FOR THE NEAREST HEALTH FACILITY TO EVERY CLUSTER. RESPONDENTS ARE AS FOLLOWS:**
**PART A: RESPONDENT IS MEDICAL PERSON IN CHARGE**
**PART B: RESPONDENT IS PHARMACIST**
**PART C: TO BE LEFT WITH MEDICAL PERSON IN CHARGE TO COMPLETE**

**PART A: TO BE COMPLETED BY INTERVIEWER**

**RESPONDENT: MEDICAL PERSON IN CHARGE**

**NAME:** _____

## I. CHARACTERISTICS OF THE FACILITY

1. Who owns and operates this facility?

GOVERNMENT.....1
MISSION.....2
PRIVATE.....3
DESIGNATED.....4

2. In what year was this facility built? 19

3. In what year did services begin? 19

4. Does this building have electricity?

YES....1
NO.....2 (» 8 )

5. Is the current from an electric company or your own generator?

ELECTRIC COMPANY.....1
OWN GENERATOR.....2 (» 7 )

6. How many power cuts have you had in the past 4 weeks?

(» 8 ) NUMBER:

7. How many days in the past 4 weeks have you been out of fuel for the generator?

NUMBER OF DAYS:

8. What is the main source of water for this facility?

PUBLIC WATER SYSTEM....1
WELL WITH PUMP.....2
OPEN WELL.....3
LAKE, RIVER.....4
RAINWATER.....5
OTHER (SPECIFY).....6

9. Is housing provided by this facility for its employees?

YES.....1
NO.....2 (» 15)

10. How many of the employees have housing provided by this facility?

NUMBER HOUSED:

11. Do the employees pay in rent or through salary deductions to pay for this housing?

YES, RENT.....1
YES, DEDUCTIONS..2
NO.....3

12. Are the employee houses electrified?

YES.....1
NO.....2 (» 14)

13. Who pays the electric bill?

GOVERNMENT.....1
TENANT.....2

14. What is the main source of water for the employee housing?

PUBLIC WATER SYSTEM....1
WELL WITH PUMP.....2
OPEN WELL.....3
LAKE, RIVER.....4
RAINWATER.....5
OTHER (SPECIFY).....6

15. Is there an operating room in this facility?

YES....1
NO.....2 (» 17)

16. Can the following operations be performed in the operating room?

A. Circumcision? YES...1 NO...2

B. Caesarean? YES...1 NO...2

C. Appendectomy? YES...1 NO...2

17. Is there a surgical fee?

YES...1
NO....2 (»19)

18. How much is the surgical fee?

ANSWER WHICHEVER APPLIES:

STANDARD FEE FOR ALL OPERATIONS: (AMOUNT)

LOWEST SURGICAL FEE (AMOUNT):

HIGHEST SURGICAL FEE (AMOUNT):

19. Is there a laboratory to do tests?

YES...1
NO....2 (» SECTION II)

| 20. Do you perform the following tests? YES...1 NO....2 (»NEXT TEST) | | 21. How much must clients pay for them? IF FREE, PUT ZERO. AMOUNT |
|---|---|---|
| A. Stools? | | |
| B. Blood test for malaria? | | |
| C. HIV test? | | |
| D. Pregnancy test? | | |
| E. Urine test? | | |
| F. Skin snip test? | | |

## II. PERSONNEL

| COMPLETE ALL CELLS; IF THE ANSWER IS NONE, WRITE 0. | 1. How many ..[ ].. work in this facility? NUMBER | 2. How many ..[ ].. are working at this moment? NUMBER | 3. How many ..[ ].. worked in the past 24 hours? NUMBER |
|---|---|---|---|
| A. Medical doctors | | | |
| B. Assistant medical doctors | | | |
| C. Medical assistants | | | |
| D. Rural medical aides | | | |
| E. Dentists | | | |
| F. Assistant dental officers | | | |
| G. Dental assistants | | | |
| H. Pharmacists | | | |
| I. Pharmaceutical assistants | | | |
| J. Pharmaceutical attendants | | | |
| K. Health officers | | | |
| L. Health assistants | | | |
| M. Registered nurses | | | |
| N. MCH aides | | | |
| O. Nurse Assistants | | | |
| P. Midwives or nurse/midwives | | | |
| Q. Paramedics | | | |
| R. Orderlies/ Cleaners | | | |
| S. Drivers | | | |
| T. Administrators | | | |
| U. Labourers | | | |
| V. Other?_____ | | | |

## III. EQUIPMENT

1. Does this facility have any vehicles? ☐

YES...1
NO....2 (» 4)

| COMPLETE ALL CELLS; IF THE ANSWER IS NONE, WRITE 0. | 2. How many ..[ ]... do you have in this service? NUMBER | 3. How many ..[ ].. are in working condition today? NUMBER |
|---|---|---|
| A. Light vehicles, cars/jeeps/4WD | | |
| B. Buses | | |
| C. Ambulances | | |
| D. Motorcycles/ Mopeds | | |
| E. Bicycles | | |
| F. Other vehicles | | |

4. Does this facility have a refrigerator? ☐

YES.....1
NO......2 (» 8)

5. Does the refrigerator run on electricity, kerosene or solar power? ☐

ELECTRICITY.....1
KEROSENE.....2
BOTH.....3
SOLAR POWER.....4

6. Is the refrigerator working today? ☐

YES.....1
NO......2

7. Was the refrigerator bought with Government funds or was it given by another program, like EDP, EPI, MBH, etc.? ☐

GOVERNMENT.....1
ANOTHER PROGRAM...2

8. Does this facility have any air conditioners? ☐

YES...1
NO....2 (» 10)

9. Do the air conditioners work? ☐

YES.....1
NO.....2
SOME OF THEM...3

10. Does this facility have equipment for sterilization of syringes? ☐

YES...1
NO....2 (» SECTION IV)

11. What types of sterilization equipment does this facility have, how many of each type and what is the capacity of each type (number of syringes that can be sterilized)?

| TYPE OF STERILIZER | NUMBER OF STERILIZERS | CAPACITY OF STERILIZERS (ALTOGETHER) |
|---|---|---|
| A. Candle | | |
| B. Kerosene | | |
| C. Electric | | |

## IV. SERVICES

| 1. Now I would like to know about the services offered by your facility. Do you offer... YES...1 NO....2 (»NEXT) | | 2. On which days of the week do you offer this service and for how many hours each week? HOURS EACH DAY. ROUND TO THE NEAREST HOUR. SUN | MON | TUE | WED | THU | FRI | SAT | 3. Must the clients pay for this service? YES...1 NO....2 (»NEXT SERVICE) | 4. How much must they pay? (UNIT CODES BELOW) AMOUNT | UNIT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A. Outpatient consultations? | | | | | | | | | | | |
| B. Deliveries? | | | | | | | | | | | |
| C. Maternal and child health? | | | | | | | | | | | |
| D. Family planning? | | | | | | | | | | | |
| E. Programs for malnourished children? | | | | | | | | | | | |
| F. Mobile clinics ? | | | | | | | | | | | |
| G. Other? _____ | | | | | | | | | | | |

UNIT CODES: CONSULTATION...1 IMMUNIZATION...2 DAY.....3 PER ILLNESS..4 PER BIRTH.....5 ONE TIME CHARGE...6 OTHER...7

## V. IMMUNIZATIONS

1. Do you offer immunizations in this facility?

YES....1
NO.....2 (» SECTION VI)

| | | 2. Do you usually offer ...[ ]...? YES...1 NO....2 (»NEXT IMMUN.) | 3. Do you have ...[ ]... in stock today? YES...1 NO....2 | 4. How much must clients pay for the complete vaccine? ALL DOSES AMOUNT |
|---|---|---|---|---|
| A. BCG? | 1 | | | |
| B. DPT? | 2 | | | |
| C. Tetanus? | 3 | | | |
| D. Measles? | 4 | | | |
| E. Meningitis? | 5 | | | |
| F. Polio? | 6 | | | |
| G. Other? _____ | 7 | | | |

## VI. FAMILY PLANNING

1. INTERVIEWER: DOES THIS FACILITY OFFER ANY FAMILY PLANNING SERVICES? REFER TO SECTION IV.

YES....1
NO.....2 (» SECTION VII) ☐

2. How many days a month does this facility offer family planning services?

DAYS: ☐

| | 3. Does this facility offer ...[ ]...? YES...1 NO....2 (»NEXT METHOD) V | 4. Do you have ..[ ].. in stock today? YES...1 NO....2 | 5.When did you receive your last supply of ..[]. ? DAY | MON | YR | 6.When do you expect to get your next supply of ..[]. ? DAY | MON | YR | 7. Must clients pay for ..[ ].. ? YES...1 NO....2 (»NEXT METHOD) | 8. How much must they pay? AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|
| a. Condoms? | 1 | | | | | | | | | |
| b. Spermicides? | 2 | | | | | | | | | |
| c. Diaphragms? | 3 | | | | | | | | | |
| d. Contraceptive pills? | 4 | | | | | | | | | |
| e. IUD? | 5 | | | | | | | | | |
| f. Contraceptive injection? | 6 | | | | | | | | | |
| g. Other?_____ | 7 | | | | | | | | | |

## VII. INPATIENT SERVICES

1. Does this facility have any inpatient beds?

   YES...1
   NO....2 (»SECTION VIII) [ ]

2. How many beds are in this facility? TOTAL BEDS: [ ]

   OF WHICH MATERNITY BEDS: [ ]

   GENERAL/SURGICAL: [ ]

3. How many of these beds are usable? NUMBER USABLE: [ ]

4. How many beds were occupied last night? NUMBER OCCUPIED: [ ]

5. How many patients slept here last night? NUMBER INPATIENTS: [ ]

6. Do you know what your facility's bed occupancy rate was for the past 12 months or past calendar year?

   YES...1
   NO....2 (» 8) [ ]

7. What was the bed occupancy rate?

   [ ] PERCENT FOR THE PERIOD [ ][ ] TO [ ][ ]
   MO YR MO YR

8. Must inpatients pay for staying here?

   YES...1
   NO....2 (» 10) [ ]

9. How much must they pay per night? AMOUNT: [ ]

10. Are their private beds or rooms (grade one one for government facilities) in this facility for which patients must pay?

    YES...1
    NO....2 (» 12) [ ]

11. How much must one pay for a private bed or room per night?

    AMOUNT: [ ]

12. Does this facility provide food for inpatients?

    YES...1
    NO....2 (» SECTION VIII) [ ]

13. How much must inpatients pay for food per day? (IF FREE WRITE 0)

    AMOUNT: [ ]

## VIII. DEMAND

1. During what time of day and what days of the week do you receive the most patients currently?

MARK AN X IN THE CELLS WITH THE MOST PATIENTS.

| | SUN | MON | TUE | WED | THU | FRI | SAT |
|---|---|---|---|---|---|---|---|
| A. MORNING | | | | | | | |
| B. NOON | | | | | | | |
| C. AFTERNOON | | | | | | | |
| D. EVENING | | | | | | | |

2. During which months of the year do you have the most clients?

UP TO THREE ANSWERS. LEAVE BLANK IF LESS THAN 3.

JANUARY...1 JULY.....7
FEBRUARY..2 AUGUST....8
MARCH.....3 SEPTEMBER.9
APRIL.....4 OCTOBER..10
MAY.....5 NOVEMBER.11
JUNE.....6 DECEMBER.12

FIRST: [ ]
SECOND: [ ]
THIRD: [ ]

## IX. EXEMPTIONS

1. INTERVIEWER: REVIEW THE PREVIOUS SECTIONS. DOES THIS FACILITY CHARGE FOR ANY OF ITS SERVICES?

   FOR EXAMPLE... CONSULTATIONS, HOSPITALIZATIONS, DRUGS, IMMUNIZATIONS, FAMILY PLANNING, LABORATORY TESTS?

   YES....1
   NO.....2 (» SEE INSTRUCTIONS BELOW)

2. Are some people exempted from paying fees?

   YES...1
   NO....2 (» 4)

3. Are the following patients exempted from paying?

   YES...1
   NO....2

| | |
|---|---|
| A. Paupers? | |
| B. Mentally ill? | |
| C. Blind? | |
| D. TB patients? | |
| E. Leprosy patients? | |
| F. Accident victims? | |
| G. AIDS patients? | |
| H. Infants? | |
| I. Other? | |

4. If someone cannot pay immediately, may they pay later?

   YES...1
   NO....2

5. If someone cannot pay in cash, may they pay in kind?

   YES...1
   NO....2

INTERVIEWER: END OF PART A INTERVIEW. EXPLAIN PART C AND LEAVE IT WITH THE RESPONDENT (MEDICAL PERSON IN CHARGE) TO BE COMPLETED.

**PART B: TO BE COMPLETED BY INTERVIEWER**

**RESPONDENT: PHARMACIST**

**NAME:** _____

**DRUG SUPPLY**

| | 1. Does this facility normally carry ...[ ]...? ASK OF ENTIRE LIST BEFORE GOING TO 2-4. YES...1 NO....2 | 2. Is ...[ ].. in stock today? YES...1 NO....2 | 3. How much must patients pay for ...[ ]..? UNIT CODES: COURSE...1 TABLET...2 BOTTLE...3 PACKET...4 OTHER....5 QTY: MG..1 ML..2 OTHER..3 | | | | | 4. How much time did your last stock of ...[ ]... last before it was depleted? |
|---|---|---|---|---|---|---|---|---|
| | | V | PRICE | NO | UNIT | SIZE | QTY | DAYS |
| A. | Aspirin tabs, 300 mg | 1 | | | | | | |
| B. | Paracetamol tabs, 500 mg | 2 | | | | | | |
| C. | Chlorphonamine tabs, 4 mg | 3 | | | | | | |
| D. | Metronidazole tabs, 250 mg | 4 | | | | | | |
| E. | Mebendazole tabs, 100 mg | 5 | | | | | | |
| F. | Tetracycline tabs, 250 mg | 6 | | | | | | |
| G. | Benzyl Penicillin Inj. 5 mu vial | 7 | | | | | | |
| H. | Procaine penicillin fort. inj 4mu | 8 | | | | | | |
| I. | Penicillin-V tabs, 250 mg | 9 | | | | | | |
| J. | Water for injections, 30 ml vial | 10 | | | | | | |
| K. | Benzyl benzoate conc. 0.5L | 11 | | | | | | |
| L. | Magnesium compound | 12 | | | | | | |
| M. | Co-trimox, 240mg/5ml | 13 | | | | | | |
| N. | Tetracycline 1%, 5 g tube | 14 | | | | | | |
| O. | Chlorpromazine tab 25mg | 15 | | | | | | |

DRUG SUPPLY (continued)

| | 1. Does this facility normally carry ...[ ]...?<br><br>ASK OF ENTIRE LIST BEFORE GOING TO 2-4.<br><br>YES...1<br>NO....2 | V | 2. Is ...[ ].. in stock today?<br><br>YES...1<br>NO....2 | 3. How much must patients pay for ...[ ]..?<br><br>UNIT CODES: QTY:<br>COURSE...1 MG..1<br>TABLET...2 ML..2<br>BOTTLE...3 OTHER..3<br>PACKET...4<br>OTHER....5 | | | | | 4. How much time did your last stock of ...[ ]... last before it was depleted? |
|---|---|---|---|---|---|---|---|---|---|
| | | | | PRICE | NO | UNIT | SIZE | QTY | DAYS |
| P. | Oral rehydration salts | 16 | | | | | | | |
| Q. | Chloroquine tabs, 150 mg | 17 | | | | | | | |
| R. | Chloroqine inj., 40mg/ml | 18 | | | | | | | |
| S. | Ferrous sulfate tabs 200 mg | 19 | | | | | | | |
| T. | Folic acid tabs, 1 mg | 20 | | | | | | | |
| U. | Chloroquine syrup, 50mg/5ml | 21 | | | | | | | |
| V. | Reusable syringe, 5cc | 22 | | | | | | | |
| W. | Disposable syringe, 5cc | 23 | | | | | | | |
| X. | Needles, intramusc. no. 1 | 24 | | | | | | | |
| Y. | Rubber gloves | 25 | | | | | | | |
| Z. | Disposable gloves | 26 | | | | | | | |
| AA. | Cotton wool | 27 | | | | | | | |
| BB. | Gauze | 28 | | | | | | | |
| CC. | Soap | 29 | | | | | | | |
| DD. | Outpatient cards | 30 | | | | | | | |

DRUG SUPPLY (continued)

| | 1. Does this facility normally carry ...[ ]...? ASK ENTIRE LIST BEFORE GOING TO 2-4. YES...1 NO....2 | V | 2. Is ...[ ].. in stock today? YES...1 NO....2 | 3. How much must patients pay for ...[ ]..? UNIT CODES: COURSE...1 TABLET...2 BOTTLE...3 PACKET...4 OTHER....5 QTY: MG..1 ML..2 OTHER..3 | | | | | 4. How much time did your last stock of ...[ ]... last before it was depleted? |
|---|---|---|---|---|---|---|---|---|---|
| | | | | PRICE | NO | UNIT | SIZE | QTY | DAYS |
| EE. Thermometer | | 31 | | | | | | | |
| FF. Cotrimoxazole,480mg | | 32 | | | | | | | |
| GG.Gentian violet,150mg | | 33 | | | | | | | |
| HH.Nyastatin 500000iu | | 34 | | | | | | | |
| II.Cloxacillin, 250mg | | 35 | | | | | | | |
| JJ. Rifampicin 600 mg | | 36 | | | | | | | |
| KK. Streptomycin, 1gm | | 37 | | | | | | | |
| LL.Pyrazinamide 500 mg | | 38 | | | | | | | |
| MM. Isoniazid 300 mg | | 39 | | | | | | | |
| NN. Hydrocortisone 1% | | 40 | | | | | | | |
| OO.Chlorpheniramine 4mg | | 41 | | | | | | | |
| | | 42 | | | | | | | |
| | | 43 | | | | | | | |

5. Does this facility receive EDP kits?

YES....1
NO.....2

6. When did you last replenish your stock of drugs or receive your EDP kit?

DAY MO YR

7. How often are your stocks replenished?

NUMBER TIMES EVERY TIME UNIT: DAY...1
WEEK..2
MONTH.3

8. When do you expect to get your next stock of drugs?

DAY MO YR

9. Does this facility buy any drugs locally?

YES....1
NO.....2 (» END OF PART B)

10. How much did this facility spend on its last local purchase of drugs?

AMOUNT:

11. How many times in the past 12 months (since...) did this facility buy medicines locally?

TIMES:

END OF PART B INTERVIEW

# KAGERA HEALTH AND DEVELOPMENT SURVEY: HEALTH FACILITY QUESTIONNAIRE

## PART C: TO BE COMPLETED BY MEDICAL PERSON IN CHARGE

RESPONDENT: _____

Instructions: There are two sections in this form -- Section I on Outpatient Consultations and Section II on Inpatient Admissions. Please complete the tables in both sections by consulting the records of your establishment. Complete this form with a lead pencil, if possible. Please write only numbers in the tables and rub out all erasures completely. If your establishment does not have inpatient services, leave Section II blank. Thank you for your cooperation.

Please turn the page.

## I. OUTPATIENT CONSULTATIONS

How many outpatient consultations did this facility have in the past 7 days?

Please note the day and month of each of the last 7 days in the top of this table, then note the number of new outpatients and reattendances during these days.

| | SUNDAY | | MONDAY | | TUESDAY | | WEDNESDAY | | THURSDAY | | FRIDAY | | SATURDAY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Note the day and month here-------> | DAY | MO | DAY | MO | DAY | MO | DAY | MO | DAY | MO | DAY | MO | DAY | MO |
| 1. New Outpatients | | | | | | | | | | | | | | |
| 2. Re-attendances | | | | | | | | | | | | | | |

3. How many new outpatients were seen in the past calendar month for the following conditions?
Please note the last complete calendar month here--------> MONTH: [ ] YEAR: 19 [ ]

Write the number of new cases here->

| | | MALE <15 | MALE 15-49 | MALE 50+ | FEMALE <15 | FEMALE 15-49 | FEMALE 50+ | TOTAL |
|---|---|---|---|---|---|---|---|---|
| 01 | Diarrhoeal diseases | | | | | | | |
| 02 | Malaria | | | | | | | |
| 03 | Measles | | | | | | | |
| 04 | Acute poliomyelitis | | | | | | | |
| 05 | Whooping cough | | | | | | | |
| 06 | Neonatal tetanus | | | | | | | |
| 07 | Adult tetanus | | | | | | | |
| 08 | Intestinal worms | | | | | | | |
| 09 | Skin diseases | | | | | | | |
| 10 | Nutritional disorders | | | | | | | |
| 11 | Anaemias | | | | | | | |
| 12 | Normal pregnancy, minor complaints | | | | | | | |
| 13 | Complications of pregnancy, childbirth and puerperium | | | | | | | |
| 14 | Gonorrhea | | | | | | | |
| 15 | Upper respiratory infections | | | | | | | |
| 16 | Pneumonias | | | | | | | |
| 17 | Accidents (incl. burns, fractures) | | | | | | | |
| 18 | Schistosomiasis | | | | | | | |
| 19 | Eye diseases | | | | | | | |
| 20 | Ear diseases | | | | | | | |

(Continued on next page )

I. OUTPATIENT CONSULTATIONS (Continued)

| Write the number of new cases here-> | | MALE <15 | MALE 15-49 | MALE 50+ | FEMALE <15 | FEMALE 15-49 | FEMALE 50+ | TOTAL |
|---|---|---|---|---|---|---|---|---|
| 21 | Mental disorders | | | | | | | |
| 22 | All other diagnosed diseases | | | | | | | |
| 23 | Symptoms and ill-defined conditions | | | | | | | |
| 24 | TOTAL NEW CASES | | | | | | | |
| 25 | TOTAL REATTENDANCES | | | | | | | |
| 26 | TOTAL REFERRALS | | | | | | | |

Please turn the page.

## II. INPATIENT SERVICES

Please note the day and month of each of the last 7 days in the top of this table, then note the number of inpatients, new admissions, discharges and occupied beds for each of these days.

| | SUNDAY | | MONDAY | | TUESDAY | | WEDNESDAY | | THURSDAY | | FRIDAY | | SATURDAY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Write day and month here--> | DAY | MO | DAY | MO | DAY | MO | DAY | MO | DAY | MO | DAY | MO | DAY | MO |
| SERVICE | | | | | | | | | | | | | | |
| 1. Inpatients | | | | | | | | | | | | | | |
| 2. New admissions | | | | | | | | | | | | | | |
| 3. Discharges | | | | | | | | | | | | | | |
| 4. Occupied beds | | | | | | | | | | | | | | |

5. How many inpatients were admitted in the past calendar month for the following conditions?

Please note the last complete calendar month here--------> MONTH: [ ] YEAR: 19 [ ]

| Please note the number of inpatients for that month here----------> | | MALE <15 | MALE 15-49 | MALE 50+ | FEMALE <15 | FEMALE 15-49 | FEMALE 50+ | TOTAL |
|---|---|---|---|---|---|---|---|---|
| 01 | Anemia | | | | | | | |
| 02 | Tuberculosis | | | | | | | |
| 03 | Childbirth | | | | | | | |
| 04 | Leprosy | | | | | | | |
| 05 | Aids | | | | | | | |
| 06 | Malnitrition | | | | | | | |
| 07 | Malaria | | | | | | | |
| 08 | Diarrhea | | | | | | | |

6. How many deaths have there been in this facility in the past calendar month?

ADULT DEATHS: [ ]

CHILD DEATHS: [ ]

Thank you for your cooperation.