

Form ID	Province ID		District ID		Clinic ID	

FORM 1: BACKGROUND INFORMATION ON THE PHYSICAL FACILITIES, EQUIPMENT AND EMERGENCY TRANSPORT MEANS AT DISTRICT HOSPITALS/HEALTH CENTERS/PROVINE HOSPOITALS/INTERDISTRICT POLICLINICS IN 2014

BACKGROUND	
Province	.....
District	.....
District general hospital/District health center/Interdistrict polyclinic/Province hospital (<i>"hospitals"</i>)	.....
Reported by:	.....
Tel	.....
Email	.....
GPS position (to be filled in by the study team)	.....
Data provided on	Date Month Year

A. PHYSICAL FACILITIES		
1.	Distance from the District hospital to a province hospital	..... km
2.	Time travelling by car from the district hospital to a province general hospital	..... minutes
3.	Time travelling by car from the district hospital to the Health Department	..... minutes
4.	Area of the land currently occupied by the district hospital	..... m ²
5.	Built-up area	..... m ²
6.	Total built-up area of clinical wings (<i>outpatient care, inpatient care, laboratory investigation</i>)	..... m ²
7.	Total number of clinical departments in the district hospital	..... departments
8.	Regular power supply for the district hospital (<i>select ONE option only</i>)	1. Grid power 2. Generator 3. Others (specify):
9.	Backup power used by the district hospital (<i>MULTIPLE choices are allowed</i>)	1. Other local generators 2. Hospital's generators 3. Wind power, solar power

		<p>4. Others (specify):</p> <p>5. None</p>
10.	In the last three months, did the district hospital ever lose access to electricity power for two consecutive hours or longer?	<p>1. Yes, outage in the entire hospital</p> <p>2. Yes, but some departments/functions still had backup power</p> <p>3. No → Move to question 12</p>
11.	If yes, in the last three months, how many cumulative days was the district hospital in that situation?	..... days
12.	What is the district hospital's main water supply? (select ONE option only)	<p>1. Piped water led to the hospital</p> <p>2. Public piped water</p> <p>3. Drilled wells</p> <p>4. Protected dug wells</p> <p>5. Unprotected dug wells</p> <p>6. Protected gravity-driven water</p> <p>7. Unprotected gravity-driven water</p> <p>8. Purchased water (in bottles/vases/tanks/small tank trucks)</p> <p>9. Rain water</p> <p>10. Others (specify):</p>
13.	In the last three months, was the district hospital ever lacking/cut off from water supply?	<p>1. Yes</p> <p>2. No → Move to question 16</p>
14.	If yes, in the last three months, how many cumulative days was the district hospital in that situation?	..... days
15.	In those days with limited/no water, did the hospital have access to water from a reserve tank?	<p>1. Yes</p> <p>2. No</p>
16.	Do medical/clinical departments have enough toilets for patients' use?	<p>3. Yes</p> <p>4. No</p>
17.	What is the hospital doing with wastewater? (MULTIPLE choices are allowed)	<p>1. With a concentrated sewage treatment system</p> <p>2. Laboratory sewage treatment only</p> <p>3. Direct disposal to public sewage systems</p> <p>4. Others (specify):</p>
18.	What is the hospital doing with solid medical wastes? (MULTIPLE choices are allowed)	<p>1. With specialized incinerators</p> <p>2. Open-pit incineration (within the hospital compound)</p> <p>3. Open-pit incineration (outside the hospital compound)</p> <p>4. Landfill (within the hospital compound)</p>

		5. Landfill (outside the hospital compound) 6. Contracting a sanitation company/hospital for disposal 7. Others (specify):
19.	Is there a guideline on medical waste management in the hospital?	1. Yes 2. No
20.	What is the status of the LAN system for hospital information management? (select ONE option only)	1. Used in the entire hospital 2. Used in a few functions only 3. Not yet available
21.	Is there software or applications for patient management in the hospital?	1. Yes 2. No
22.	Does the hospital have Internet connection?	1. Yes 2. No
23.	Does the district hospital have ambulances (of its own)? If yes, what type? (select ONE option only)	1. Yes, fully-equipped ambulance → Move to question 25 2. Yes, normal ambulance → Move to question 25 3. None
24.	Does the district hospital use contracted institutional or individual carriers for emergency transport services? If yes, which means of transport? (select ONE option only)	1. Yes, a vehicle on standby within the hospital compound 2. Yes, a vehicle will be sent whenever needed 3. No
25.	Is there a functional land line telephone in use at the hospital?	1. Yes 2. No
26.	Is there a functional hotline in use at the hospital?	1. Yes 2. No
27.	Are there short-frequency/walkie-talkie used at the hospital?	1. Yes 2. No

B. MEDICAL EQUIPMENT

No.	Name of equipment	Yes/No (If No, move to the next equipment item)	Functional equipment	Non-functional/broken equipment
I. ESSENTIAL EQUIPMENT				
1.	Adult scale	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
2.	Child scale (250g gauge)	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
3.	Infant scale (100g gauge)	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
4.	Thermometer	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....

5.	Stethoscope	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
6.	Pinard horn	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
7.	Sphygmomanometer	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
8.	Vaccine cold chain (refrigerator, vaccine flask)	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....

II. EMERGENCY AND RESUSCITATION CARE EQUIPMENT

9.	Monitor	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
10.	Portable oxygen concentrator	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
11.	Medical ventilator	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
12.	Child ventilator	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
13.	Infant incubator	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
14.	Anesthesia machine	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
15.	Defibrillator and pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
16.	ECG device	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
17.	C-section toolkit	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....

III. DIAGNOSTIC IMAGING / PROBE TESTING

1.	X-ray machine	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
2.	Ultrasound	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
3.	CT scanner	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
4.	ECG	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....

LABORATORY TESTING EQUIPMENT

1.	Blood analyzer	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
2.	Blood biochemical analyzer	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
3.	Capable of HbA1C testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....

Thank you!