
KAGERA HEALTH AND DEVELOPMENT SURVEY
*** * ***
QUESTIONNAIRE FOR HEALTH FACILITIES
PASSAGE THREE

FACILITY NAME: _____ FACILITY NUMBER:

LOCATION: _____ PASSAGE:

CLUSTERS FOR WHICH FACILITY IS NEAREST:

NAME: _____	NUMBER: <input style="width: 30px; height: 25px;" type="text"/>	DISTANCE: <input style="width: 30px; height: 25px;" type="text"/>	KM
NAME: _____	NUMBER: <input style="width: 30px; height: 25px;" type="text"/>	DISTANCE: <input style="width: 30px; height: 25px;" type="text"/>	KM
NAME: _____	NUMBER: <input style="width: 30px; height: 25px;" type="text"/>	DISTANCE: <input style="width: 30px; height: 25px;" type="text"/>	KM
NAME: _____	NUMBER: <input style="width: 30px; height: 25px;" type="text"/>	DISTANCE: <input style="width: 30px; height: 25px;" type="text"/>	KM

TYPE OF FACILITY:

VILLAGE HEALTH POST.....1	<input style="width: 40px; height: 40px;" type="text"/>
DISPENSARY.....2	
HEALTH CENTRE.....3	
HOSPITAL.....4	
DISTRICT HOSPITAL.....5	
DISTRICT DESIGNATED HOSPITAL.6	
REGIONAL HOSPITAL.....7	

INTERVIEWER: _____ CODE:

DATE:	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	<input style="width: 30px; height: 25px;" type="text"/>	DAY OF THE WEEK: MON...1 THU...4 TUE...2 FRI...5 WED...3 SAT...6 SUN...7	<input style="width: 40px; height: 40px;" type="text"/>
	DAY	MO	YEAR		

TIME STARTED: : TIME COMPLETED: :

SUPERVISOR: _____ CODE:

DATE CHECKED:	OUTCOME:		
<input style="width: 30px; height: 25px;" type="text"/>	COMPLETED/SATISFACTORY...1	<input style="width: 40px; height: 40px;" type="text"/>	
<input style="width: 30px; height: 25px;" type="text"/>	COMPLETED/UNSATISFACTORY..2		
<input style="width: 30px; height: 25px;" type="text"/>	INCOMPLETE.....3		
DAY	MO	YR	

REMARKS/FOLLOW-UP MEASURES: _____

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			
Assistant B. medical doctors			
C. Medical assistants			
Rural D. medical aides			
E. Dentists			
Assistant F. dental officers			
G. Dental assistants			
H. Pharmacists			
Pharmaceutical I. assistants			
Pharmaceutical J. attendants			
K. Health officers			
L. Health assistants			
M. Registered nurses			
N. MCH aides			
O. Nurse Assistants			
Midwives or P. nurse/midwives			
Q. Paramedics			
Orderlies/ R. 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
Light vehicles, A. cars/jeeps/4WD		
B. Buses		
C. Ambulances		
Motorcycles/ D. 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.							3. Must the clients pay for this service? YES...1 NO...2 (»NEXT SERVICE)	4. How much must they pay? (UNIT CODES BELOW)	
	SUN	MON	TUE	WED	THU	FRI	SAT		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	DAY.....3	PER BIRTH.....5	OTHER...7
	IMMUNIZATION...2	PER ILLNESS..4	ONE TIME CHARGE...6	

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 ...[].. ?			6. When do you expect to get your next supply of ...[].. ?			7. Must clients pay for ...[].. ? YES...1 NO....2 (»NEXT METHOD)	8. How much must they pay? AMOUNT
		DAY	MON	YR	DAY	MON	YR		

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 MO YR TO 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. ASSISTANCE

In the past 6 months (since...) has this facility received any contributions in cash or in kind from outside organizations?

YES.....1

NO.....2 (>SECTION X)

Has the facility received assistance or contribution in the form of ... in the past 6 months?		3. From which organization(s) was this ...[]... received?			4. What is the value of this contribution or assistance of ...[]... in the past 6 months?
		LUTHERANS/ELCT...1	SOCIAL WELFARE OFC..8		
		CATHOLIC CHURCH..2	TANZ RED CROSS.....9		
		7TH DAY ADVENT...3	PARTAGE.....10		
		MOSQUE.....4	WORLD VISION.....11		
		OTHER RELIGIOUS ORGANIZATION (Specify).....5	WAMATA.....12		
		PARTY ORGANIZ.....6	KHDS PROJECT.....13		
		COOPERATIVE UNIONS..7	OTHER (Specify)....14		
		FIRST	SECOND	THIRD	AMOUNT
Dressings?	YES-Ψ	01			
	X-NO				
Medical equipment?	YES-Ψ	02			
	X-NO				
Construction materials?	YES-Ψ	03			
	X-NO				
Mats/blankets/bedding?	YES-Ψ	04			
	X-NO				
Medicines?	YES-Ψ	05			
	X-NO				
Medical supplies?	YES-Ψ	06			
	X-NO				
Medical equipment?	YES-Ψ	07			
	X-NO				
Medical supplies?	YES-Ψ	08			
	X-NO				
Medical supplies?	YES-Ψ	09			
	X-NO				
Medical supplies?	YES-Ψ	10			
	X-NO				
Medical supplies?	YES-Ψ	11			
	X-NO				
Medical supplies?	YES-Ψ	12			
	X-NO				

X. 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

<p>INTERVIEWER: END OF PART A INTERVIEW. EXPLAIN PART C AND LEAVE IT WITH THE RESPONDENT (MEDICAL PERSON IN CHARGE) TO BE COMPLETED.</p>
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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: QTY: COURSE...1 MG..1 TABLET...2 ML..2 BOTTLE...3 OTHER..3 PACKET...4 OTHER....5						4. How much time did your last stock of ...[]... last before it was depleted? DAYS
			PRICE	NO	UNIT	SIZE	QTY	
A. Aspirin tabs, 300 mg	1							
Paracetamol B. tabs, 500 mg	2							
Chlorphonamine C. tabs, 4 mg	3							
Metronidazole D. tabs, 250 mg	4							
Mebendazole E. tabs, 100 mg	5							
Tetracycline F. tabs, 250 mg	6							
Benzyl Penicillin G. Inj. 5 mu vial	7							
Procaine penicillin H. fort. inj 4mu	8							
Penicillin-V I. tabs, 250 mg	9							
Water for injections, J. 30 ml vial	10							
Benzyl K. benzoate conc. 0.5L	11							
L. Magnesium compound	12							
M. Co-trimox, 240mg/5ml	13							
Tetracycline 1%, N. 5 g tube	14							
Chlorpromazine O. tab 25mg	15							

DRUG SUPPLY (continued)

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: QTY: COURSE...1 MG..1 TABLET...2 ML..2 BOTTLE...3 OTHER...3 PACKET...4 OTHER...5						4. How much time did your last stock of ...[]... last before it was depleted? DAYS
			PRICE	NO	UNIT	SIZE	QTY	
Oral rehydration P. salts	V							
Chloroquine tabs, Q. 150 mg	16							
Chloroquine inj., R. 40mg/ml	17							
Ferrous sulfate tabs S. 200 mg	18							
T.Folic acid tabs, 1 mg	19							
Chloroquine syrup, U. 50mg/5ml	20							
V.Reusable syringe, 5cc	21							
Disposable W.syringe, 5cc	22							
Needles, intramusc. X. no. 1	23							
Y.Rubber gloves	24							
Z.Disposable gloves	25							
AA. Cotton wool	26							
BB. Gauze	27							
CC. Soap	28							
DD. Outpatient cards	29							
	30							

DRUG SUPPLY (continued)

1. Does this facility normally carry ...[]...? ASK 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: QTY: COURSE...1 MG..1 TABLET...2 ML..2 BOTTLE...3 OTHER..3 PACKET...4 OTHER....5	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?

TIMES EVERY

NUMBER

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 6 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	
	DAY	MO	DAY	MO	DAY	MO	DAY	MO	DAY	MO	DAY	MO	DAY	MO
Note the day and month here----->														
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	Gonorrhoea							
15	Upper respiratory infections							
16	Pneumonias							
17	Accidents (incl. burns, fractures)							
18	Schistosomiasis							
19	Eye diseases							
20	Ear diseases							

(CONTINUED ON NEXT PAGE)

OUTPATIENT CONSULTATIONS (Continued)

Write the number of new cases here->
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.

Write day and month here--> SERVICE	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	DAY	MO	DAY	MO	DAY	MO	DAY	MO	DAY	MO	DAY	MO	DAY	MO
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

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	Malnutrition							
07	Malaria							
08	Diarrhea							
09	Accidents and injuries							
10	Pneumonia							
11	Other respiratory illness							
12	Intestinal parasites/worms							
13	Measles							
14	Neonatal conditions							
15	Pregnancy complications							
16	Other							

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

ADULT DEATHS:

CHILD DEATHS:

Thank you for your cooperation.