Questionnaire serial number |___|___|___|

Stawisha Maisha Impact Evaluation
Baseline Survey

HEALTH FACILITY QUESTIONNAIRE

To be completed for all primary health care facilities in the district. Do not complete for tertiary care facilities such as local, district or regional hospital.

Region	_____	Region code ☐☐☐
District	_____	District code ☐☐☐
Village Health Facility is Located	_____	Village Code ☐☐☐
Additional Villages Serviced by Health Facility:	_____	☐☐☐
	_____	☐☐☐
	_____	☐☐☐
Primary Health Care Facility	_____	MoH Code ☐☐☐
Facility type	*Village health post = 1; Dispensary = 2; Health Center = 3; Other (specify)*	☐
GPS coordinates	Latitude N |___||___||___|.|___||___||___||___||___|	
	Longitude E / W |___||___||___|.|___||___||___||___||___|	
	Accuracy	
Enumerator	_____	Enumerator Code ☐☐
Supervisor	_____	Supervisor Code ☐☐
Date of interview (DD/MM/YY)		☐☐ / ☐☐ / ☐☐
Time started (24 hour clock)		☐☐ : ☐☐
Time ended (24 hour clock)		☐☐ : ☐☐

Questionnaire serial number |___|___|___|

Respondent Name	Gender	Role/Status	Years Worked at Facility

Questionnaire serial number |___|___|___|

PART A: CHARACTERISTICS OF FACILITY

	QUESTION	CATEGORY AND CODE	RESPONSE
BASIC CLIENT AMENITIES			
1	What year was this facility built?	(YYYY)	|__|__|__|__|
2	Do you have an estimated size of the catchment population that this facility serves, that is, the target population or total population living in the area served by this facility?	(Enter estimated catchment population) Don't Know.....-99	|__|__|__|__|__|__|__|
3	Is housing provided by this facility for its employees?	Yes, all…….1; Yes, Some….2, No……..3	|__|
4	How many days per week is this facility open for outpatient adult and/or child curative services?	(Enter number of days) Don't know……-99	|__|
5	On average, how many hours per day is this facility open?	4 hours or less.....1 5 to 8 hours.....2 9 to 16 hours.....3 17 to 23 hours.....4 24 hours..... …….5	|__|
6	Is there a trained health provider present at the facility at all times (24 hours/day)	Yes, always present ..... 1>>Q8 No 2	|__|
7	Is there a trained health provider available on call at all times after hours? IF YES, ASK TO SEE DUTY SCHEDULE	Yes, duty schedule seen..... 1 Yes, duty schedule not seen..... 2 No 3	|__|
8	Is there a room with auditory and visual privacy available for patient consultations?	Auditory privacy only ..... 1 Visual privacy only ..... 2 Both auditory and visual privacy..... 3 No privacy. 4	|__|
9	What is the *most commonly used* source of water for the facility *at this time*? OBSERVE THAT WATER IS AVAILABLE FROM THE SOURCE OR IN THE FACILITY ON THE DAY OF THE VISIT. E.G. CHECK THAT THE PIPE IS FUNCTIONING.	Piped into facility .....1>>Q11 Piped onto facility grounds.....2>>Q11 Public tap/standpipe ..... 3 Tubewell/borehole..... 4 Protected dug well ..... 5 Unprotected dug well ..... 6 Protected spring..... 7 Unprotected spring ..... 8 Rainwater collection..... 9 Bottled water .....10>>Q11 Cart w/small tank/drum .....11>>Q11 Tanker truck .....12>>Q11 Surface water..... 13 Other (specify).....-96 Don't know ..... -98>>Q11 No water source..... -95>>Q11	|__|
10	Is water available from this source on facility premises?	Yes, inside the facility ..... 1 Yes, within the ground of the facility ..... 2 No, outside the facility grounds..... 3	|__|
11	Is there a toilet (latrine) on premises in functioning condition that is	Flush toilet..... 1 Ventilated improved pit latrine	

	accessible for general outpatient client use? IF YES: What type of toilet? IF MULTIPLE TOILETS ARE AVAILABLE, CONSIDER THE MOST MODERN TYPE OBSERVE THAT THE TOILET (LATRINE) IS ACCESSIBLE (UNLOCKED OR KEY AVAILABLE) AND FUNCTIONING	(vip) ..... 2 Pit latrine with slab ..... 3 Pit latrine without slab/open pit ..... 4 Composting toilet. ..... 5 Bucket ..... 6 Hanging toilet/ hanging latrine. ..... 7 No facilities on premises/bush/field 8	|__|
12	Does this facility have any guidelines on standard precautions for infection prevention? IF YES, ASK TO SEE THE DOCUMENT	Yes, observed ..... 1 Yes, reported not seen ..... 2 No 3	|__|
POWER SUPPLY			
13	Does your facility have electricity from any source (e.g. electricity grid, generator, solar, or other) including for stand-alone devices (EPI cold chain)?	Yes..... 1 No ..... >>Q23	|__|
14	What is the facility's main source of electricity?	Central supply of electricity (national) .....1>>Q18 Central supply of electricity (community grid).....2>>Q18 Fuel-based generator .....3 Battery-operated generator .....4 Solar system .....5>>Q17 Other (specify).....6>>Q18	|__|
15	Is the generator functional?	Yes..... 1 No ..... 2 Don't Know..... 9	|__|
16	Is there fuel or a charged battery available today?	Yes.....1>>Q18 No .....2>>Q18 Don't Know.....9>>Q18	|__|
17	Is the solar system functional?	Yes, functioning ..... 1 Partially, battery needs Servicing/replacement ..... 2 No, not functional ..... 3 Don't know..... 9	|__|
18	Other than the main or primary source, does the facility have a secondary or backup source of electricity? **SELECT ALL THAT APPLY**	No secondary source .....0>>Q22 Central supply of electricity (national) .....1>>Q22 Central supply of electricity (community grid).....2>>Q22 Fuel-based generator .....3 Battery-operated generator .....4 Solar system .....5>>Q21 Other (specify).....6>>Q22	|__|
19	Is the generator functional?	Yes..... 1	

		No ..... 2 Don't Know 9	|__|
20	Is there fuel or a charged battery available today?	Yes ..... 1>>Q22 No ..... 2>>Q22 Don't Know ..... 9>>Q22	|__|
21	Is the solar system functional?	Yes, functioning ..... 1 Partially, battery needs Servicing/replacement ..... 2 No, not functional ..... 3 Don't know 9	|__|
22a	During the past 7 days, was electricity available at all times from the main source when the facility was open for services?	Always available (no interruptions) ..... 1>>Q23 Often available (interruptions of less than two hours per day) ..... 2 Sometimes available (frequent or prolonged interruptions of more than 2 hours per day) 3	|__|
22b	During the past 7 days, when electricity was not available from the main source, which backup source did you use?	No secondary source ..... 0>>Q23 Central supply of electricity (national) ..... 1 Central supply of electricity (community grid) ..... 2 Fuel-based generator ..... 3 Battery-operated generator ..... 4 Solar system ..... 5 Other (specify) 6	|__|
22c	Was this backup a reliable source of electricity during all outages?	(Yes…….1; No……..2)	|__|
COMMUNICATIONS			
23	Does this facility have a <u>functioning land line telephone</u> that is available to call outside at all times client services are offered?	(Yes…….1; No……..2)	|__|
24	Does this facility have a <u>functioning cellular telephone</u> or a private cellular phone that is supported by the facility?	(Yes…….1; No……..2)	|__|
25	Does this facility have a <u>functioning short-wave radio</u> for radio calls?	(Yes…….1; No……..2)	|__|
26	Does this facility have a <u>functioning computer</u>?	(Yes…….1; No……..2)	|__|
27	Is there access to email or internet within the facility today?	(Yes…….1; No……..2)	|__|
AMBULANCE/TRANSPORT FOR EMERGENCIES			
28	Does this facility have a functional ambulance or other vehicle for	Yes ..... 1 No 2	

	emergency transportation for clients that is stationed at this facility or operates from this facility?		|__|
29	Does this facility have access to an ambulance or other vehicle for emergency transport for clients that is stationed at another facility or that operates from another facility in near proximity?	Yes.....1 No.....2	|__|
30	Is fuel for the ambulance or other emergency vehicle available today?	Yes.....1 No.....2 Don't Know.....9	|__|

PART B: FACILITY EQUIPMENT

	QUESTION	CATEGORY AND CODE	RESPONSE
1	Is there any operating room/theatre at this facility?	Yes……1 No…….2 >>Q4	|__|
2	Can caesarean sections be performed in this facility?	Yes……...1 No…….2 >>Q4	
3	How much is the surgical fee?	In Tanzanian Shillings (Write 0 if there is no fee)	|__|__|__|__|__|__|__|__|
4	Is there a laboratory to do tests?	Yes……..1 No……..2 >>Q6	|__|
5	Do you perform the following tests? (Yes……1; No……2) READ EACH OPTION….	A. General microscopy/wet-mounts B. Haemoglobin testing C. Stools D. Blood test for malaria - RDT E. Blood test for malaria – MPS F. HIV test G. Pregnancy test H. Urine test I. Skin snip test J. STIs other than HIV (Chlamydia, RPR for syphilis, etc.) K. Pap smear (HPV) L. Anemia M. Other test not listed	A. |__| B. |__| C. |__| D. |__| E. |__| F. |__| G. |__| H. |__| I. |__| J. |__| K. |__| L. |__| M. |__|
6	Does this facility have malaria rapid diagnostic test kits (with valid expiration date) in stock in this service site today? CHECK TO SEE IF VALID (NOT EXPIRED)	Yes, Observed…..1 Yes, Reported not seen…..2 No……3	|__|

7a	Does this facility have a working refrigerator to store biomedical samples, vaccinations, or medications?	Yes…….1; No……..2	|__|
7b	Does this facility have a working refrigerator for any other facility needs (non biomedical)?	Yes…….1; No……..2	|__|
8	Please tell me if the following basic equipment and supplies used in the provision of client services are available and functional in this facility today. ASK TO SEE THE ITEMS Yes, Observed…..1 Yes, Reported not seen…..2 No……3	A. Adult weighing scale B. Length/height measuring equipment C. Child weighing scale- 250 gram gradation D. Infant weighing scale – 100 gram gradation E. Measuring tape-height board/stadiometer F. Growth charts G. Thermometer H. Stethoscope I. Blood pressure apparatus (may be digital or manual sphygmomanometer with stethoscope) J. Light source (flashlight acceptable) K. Light microscope L. Glass slides and cover slips M. Latex gloves in stock	A. |__| B. |__| C. |__| D. |__| E. |__| F. |__| G. |__| H. |__| I. |__| J. |__| K. |__| L. |__| M. |__|
9	What methods are used for disinfecting other medical equipment (e.g. surgical instruments)? Check categories A-C Yes, Observed…..1 Yes, Reported not seen…..2 No……3	A. Autoclave B. Dry heat sterilization C. Steam sterilization D. Boiling only E. Chemical only F. Boil and chemical G. Other_____ H. None	A. |__| B. |__| C. |__| D. |__| E. |__| F. |__| G. |__| H. |__|

Questionnaire serial number |___|___|___|

PART C: SERVICES

Now I would like to know about the services offered at this facility.

	QUESTION	CATEGORY AND CODE	RESPONSE
ANTENATAL SERVICES			
1	Does this facility offer antenatal care (ANC) services?	Yes.....1 No.....2 >>Q6	|__|
2	Do ANC providers provide any of the following services to pregnant women as part of routine ANC services? (Yes…..1, No……2)	A. Iron supplementation B. Folic acid supplementation C. Intermittent preventive treatment in pregnancy (IPTp) for malaria D. Tetanus toxoid immunization E. Monitoring for hypertensive disorder of pregnancy F. HIV Testing	A. |__| B. |__| C. |__| D. |__| E. |__|
3	Have you or any provider(s) of ANC services received any ANC training in the last two years?	Yes.....1 No.....2	|__|
4	Have you or any provider(s) of ANC services received any training in IPTp in the last two years?	Yes.....1 No.....2	|__|
5	Please tell me if the following documents are available in the facility today: IF AVAILABLE, ASK TO SEE THE DOCUMENT Yes, Observed…..1 Yes, Reported not seen…..2 No……3	A. National ANC guidelines B. Any ANC check-lists and/or job-aids C. IPTp guidelines, check-lists and/or job-aids (including wall charts) ACCEPTABLE IF PART OF ANC GUIDELINES.	A. |__| B. |__| C. |__|
OBSTETRIC AND NEWBORN CARE SERVICES			
6	Does this facility offer delivery (including normal delivery, basic emergency obstetric care, and/or comprehensive emergency obstetric care) and/or newborn care services?	Yes.....1 No.....2 >>Q8	|__|
7	Please tell me if the following interventions are routinely carried out by providers of delivery services in this facility: (Yes…..1, No……2)	A. Administration of oxytocin injection immediately after birth to all women for the prevention of post-partum haemorrhage B. Monitoring and management of labour using partograph C. Immediate and exclusive breastfeeding D. Hygienic cord care (cut with sterile item and	A. |__| B. |__| C. |__|

		apply disinfectant to tip and stump, and no application of other substances) E. Thermal protection (drying baby immediately after birth and wrapping)	D. |__|
CHILD PREVENTATIVE AND CURATIVE CARE SERVICES			
8	Does this facility offer preventative and curative care services for children under 5?	Yes.....1 No.....2>>Q13	|__|
9	Please tell me if this facility provides the following services: (Yes…..1, No……2)	A. Diagnose and/or treat child malnutrition B. Provide vitamin A supplementation C. Provide iron supplementation D. Provide ORS to children with diarrhoea E. Provide zinc supplementation to children with diarrhoea F. Child growth monitoring G. Treatment of pneumonia H. Administration of amoxicillin for the treatment of pneumonia in children I. Treatment of malaria in children	A. |__| B. |__| C. |__| D. |__| E. |__| F. |__| G. |__| H. |__| I. |__|
10	Please tell if the following documents are available in the facility today: IF AVAILABLE, ASK TO SEE THE DOCUMENT Yes, Observed…..1 Yes, Reported not seen…..2 No……3	A. IMCI (Integrated management of childhood illness) guidelines for the diagnosis and management of childhood illnesses B. National guidelines for growth monitoring C. Any check-lists and/or job-aids for IMCI	A. |__| B. |__| C. |__|
11	Have you or any provider(s) of curative care services for sick children received any training in the Integrated Management of Childhood Illnesses (IMCI) in the last two years?	Yes.....1 No.....2	|__|
12	Have you or any provider(s) of growth monitoring services for children received any training in growth monitoring in the last two years?	Yes.....1 No.....2	|__|
COLLABORATIONS			
13	Did the facility participate in a child health day/immunization campaign in the last 6 months?	Yes.....1 No.....2	|__|
14	Does your facility participate in or collaborate with NGOs or health outreach providers for nutrition related services?	Yes.....1 No.....2	|__|

15	Does your facility participate in or collaborate with NGOs or health outreach providers for antenatal care services?	Yes..... 1 No..... 2	|__|
16	Did any of your health workers participate in any type of training provided by any NGO or UNICEF?	No..... 00 Yes, (enter number of staff trained)	|__|__|
17	Does your facility participate in or collaborate with any NGO or UNICEF to specifically improve maternal, infant and young child feeding practices?	Yes..... 1 No..... 2	|__|
18	Did any of your health workers participate in a training provided by any NGO or UNICEF to improve maternal, infant and young child feeding practices?	No..... 00 Yes, (enter number of staff trained)	|__|__|
19	What were the topics of these trainings? (Yes…..1, No……2)	A. IMAM (Integrated Management of Acute Malnutrition) B. IYCF (Infant and Young Child Feeding practices) C. NACS (Nutrition Assessment, Counselling and Support) D. Nutrition Care and Support for PLHIV E. Other (Specify)	|__| |__| |__|

20. Do you offer..…? Yes…..1 No……2 >>next service		21. How many hours do you offer each service during a regular week? (Not including on call hours) [Indicate number of hours each day. Round to nearest hour. Enter 0 for no service on that day.]						
		SUN	MON	TUE	WED	THU	FRI	SAT
A. Outpatient consultations								
B. Deliveries								
C. Well baby clinics								
D. Antenatal clinics								
E. Family Planning								
F. Mobile clinics								
G. Treatment for acute malnutrition for children								
H. Gender Based Violence (GBV) services								
I. Immunization services								
I. OTHER (Specify)								

PART D: DRUGS AND MEDICAL SUPPLIES

1. Does this facility normally carry……..? (Yes…..1, No……2 >>next item)		2. Is […..] in stock today? (Yes…..1 >> next item No……2)	3. How many days does it normally take to replenish the stock?
A. Condoms	|__|	|__|	|__|__|
B. Spermicides	|__|	|__|	|__|__|
C. Contraceptive Pills	|__|	|__|	|__|__|
D. Intra-uterine device (IUD)	|__|	|__|	|__|__|

E. Injectable contraceptive (Depro-provera, etc.)	|__|	|__|	|__|__|
F. Contraceptive implants (Implanon, nexplanon, etc.)	|__|	|__|	|__|__|
G. Paracetamol/Panadol	|__|	|__|	|__|__|
H. Aspirin	|__|	|__|	|__|__|
I. Oral Rehydration Salt	|__|	|__|	|__|__|
J. Amoxicillin 250 mg or 500 mg dispersible K. tablet or syrup/suspension	|__|	|__|	|__|__|
L. Coartem	|__|	|__|	|__|__|
M. Fansidar	|__|	|__|	|__|__|
N. Iron tablets for pregnant women	|__|	|__|	|__|__|
O. Folic Acid tablets	|__|	|__|	|__|__|
P. Oxytocin injection (maternal health) (If no, Q>>)	|__|	|__|	|__|__|
Q. Is the oxytocin stored in cold storage?	|__|	|__|	|__|__|
R. Magnesium sulphate injection	|__|	|__|	|__|__|
S. Misoprostol 200µg tablets	|__|	|__|	|__|__|
T. SP (Sulfadoxine + Pyrimethamine)	|__|	|__|	|__|__|
U. Normal saline IV solution	|__|	|__|	|__|__|
V. Ringers lactate IV solution	|__|	|__|	|__|__|
W. 5% dextrose IV solution	|__|	|__|	|__|__|
X. Penicillin injection/tablets	|__|	|__|	|__|__|
Y. Co-trimoxazole syrup/suspension	|__|	|__|	|__|__|
Z. ARVs for adults	|__|	|__|	|__|__|
AA. BCG injection	|__|	|__|	|__|__|
BB. DPT injection	|__|	|__|	|__|__|
CC. Tetanus toxoid vaccine	|__|	|__|	|__|__|
DD. Measles injection	|__|	|__|	|__|__|
EE. Polio injection	|__|	|__|	|__|__|
FF. Meningitis injection	|__|	|__|	|__|__|
GG. Zinc sulphate tablets	|__|	|__|	|__|__|
HH. Zinc sulphate syrup or dispersible tablets	|__|	|__|	|__|__|
II. Insecticide treated bed nets for patients and their families and households	|__|	|__|	|__|__|
JJ. Micronutrient Powder (MNP)	|__|	|__|	|__|__|
KK. Ready-to-use Therapeutic Food (RUTF)	|__|	|__|	|__|__|
LL. Deworming medicines (mebendazole /albendazole)	|__|	|__|	|__|__|
MM. Vitamin A (retinol) capsules	|__|	|__|	|__|__|
NN. Vitamin A droplets	|__|	|__|	|__|__|
OO. Antibiotic eye ointment for newborn	|__|	|__|	|__|__|
PP. Ampicillin powder for injection	|__|	|__|	|__|__|
QQ. Gentamicin injection	|__|	|__|	|__|__|
RR. Ceftriaxone injection	|__|	|__|	|__|__|
SS. Procaine benzylpenicillin injection	|__|	|__|	|__|__|
TT. Dexamethasone injection	|__|	|__|	|__|__|
UU. Betamethasone injection	|__|	|__|	|__|__|
VV. Skin disinfectant	|__|	|__|	|__|__|
WW. Newborn bag and mask size 1 for term babies (for newborn resuscitation)	|__|	|__|	|__|__|
XX. Newborn bag and mask size 0 for pre-term babies (for newborn resuscitation)	|__|	|__|	|__|__|
YY. Electric suction pump (for suction apparatus)	|__|	|__|	|__|__|
ZZ. Suction catheter (for suction apparatus) for suctioning newborn	|__|	|__|	|__|__|
AAA. Suction bulb, single use	|__|	|__|	|__|__|
BBB. Suction bulb, sterilizable multi-use	|__|	|__|	|__|__|

PART E: PERSONNEL

1. I have a few questions on staffing for this facility. Please tell me how many staff with each of the following qualifications are currently assigned to, employed by, or seconded to this facility. Please count each staff member only once, on the basis of the highest technical or professional qualification. For doctors, I would also like to know, of the total number, how many are part-time in this facility.

	ASSIGNED/ EMPLOYED/ SECONDED (INCLUDING PART TIME)	PART TIME ONLY
A. Generalist (non-specialist) medical doctors	|__|__|__|	|__|__|__|
B. Specialist medical doctors	|__|__|__|	|__|__|__|
C. Non-physician clinicians/paramedical professionals	|__|__|__|	
D. Nursing professionals	|__|__|__|	
E. Midwifery professionals	|__|__|__|	
F. Pharmacists	|__|__|__|	
G. Laboratory technicians (medical and pathology)	|__|__|__|	
H. Community health workers	|__|__|__|	