FACILITY QUESTIONNAIRE (BASELINE)

PHC NAME: _____ DATE: _____

IDENTIFICATION

Q.#	QUESTIONS	CODES	GO TO Q.
1.	Name of respondent	----------	
2.	Job title of respondent	**Officer-in-charge (OIC) .....1** **Deputy OIC .....2** **Other (specify):_____3**	
3.	Does respondent have a GSM number?	**Yes .....1** **No 2**	**→ Sec. B**
4.	GSM Number of respondent:	___ ___ ___--___ ___ ___ ___--___ ___ ___ ___	

FACILITY QUESTIONNAIRE (BASELINE)

PHC NAME: _____ DATE: _____

Q.#	QUESTIONS	CODES	GO TO Q.
1.	What is the source of electricity for this facility? CIRCLE ONE OPTION	**NEPA/PHCN .....1** **Solar .....2** **No electricity.....3** **Other 4**	
2.	Is there running water in this facility?	**Yes .....1** **No 2**	
3.	How many beds in total are available for patients in this facility (include both inpatient and maternity beds)?		
4.	What is the name of the nearest referral hospital that provides surgical care?		
5.	Estimated travel time to referral hospital	_____ HOURS _____ MINUTES	
6.	Is this facility open 24 hours a day/7 days a week?	**Yes .....1** **No 2**	
7.	Does this facility have a laboratory?	**Yes .....1** **No 2**	
8.	Does the lab offer testing for Malaria?	**Yes .....1** **No 2**	
9.	Does the lab offer Hemoglobin Test (Hb or PCV)?	**Yes .....1** **No 2**	
10.	Does the lab offer Urine Test (protein, sugar)?	**Yes .....1** **No 2**	
11.	Are PMTCT services provided in this facility?	**Yes .....1** **No 2**	
12.	Does this facility provide inpatient admissions?	**Yes .....1** **No 2**	
13.	Does this facility have a pharmacy?	**Yes .....1** **No 2**	
14.	Does this facility do caesarean sections?	**Yes .....1** **No 2**	
15.	Does this facility do blood transfusions?	**Yes .....1** **No 2**	

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PHC NAME: _____ DATE: _____

Please give me the names and cadres of each health provider in this facility that regularly sees patients (i.e., provides patient consultations)

Q.#	QUESTIONS	CODES	GO TO Q.
1.	Name of Provider	----------	
2.	Cadre	**Doctor .....1** **Nurse .....2** **Midwife .....3** **Nurse/midwife .....4** **CHO .....5** **CHEW .....6** **J-CHEW .....7** **Other (specify): _____8**	

Does the facility have the following _____

Q.#	QUESTIONS	CODES	GO TO Q.
1.	Sphygmomanometer (BP cuff)	**Yes .....1** **No 2**	
2.	Adult stethoscope	**Yes .....1** **No 2**	
3.	Fetal stethoscope	**Yes .....1** **No 2**	
4.	Rectal thermometer for newborn	**Yes .....1** **No 2**	
5.	Examination couch	**Yes .....1** **No 2**	
6.	Labor/delivery table	**Yes .....1** **No 2**	
7.	Newborn resuscitation table	**Yes .....1** **No 2**	
8.	Oxygen/resuscitation set	**Yes .....1** **No 2**	
9.	Incubator	**Yes .....1** **No 2**	
10.	Delivery Set/Pack	**Yes .....1** **No 2**	
11.	Ambu (ventilatory) bag	**Yes .....1** **No 2**	
12.	Autoclave/sterilizer	**Yes .....1** **No 2**	
13.	Anti-shock garment	**Yes .....1** **No 2**	

Q.#		Month1	Month2	Month3	Month4	Month5	Month6
1.	Number of deliveries in the last six calendar months						

FACILITY QUESTIONNAIRE (BASELINE)

PHC NAME: _____ DATE: _____

OBSERVATION MODULE

Q.#	QUESTIONS	CODES	GO TO Q.
1.	What is the general condition of the clinic building(s)?	**Poor (requires major rehabilitation) .....1** **Fair (requires some rehabilitation) .....2** **Good (requires no rehabilitation) .....3** **Excellent (like new or almost new) 4**	
2.	How clean is the inside of the clinic?	**Very dirty .....1** **Somewhat dirty ..... 2** **Clean .....3** **Very clean 4**	
3.	Is there a functional fan/air conditioning in delivery room?	**Yes .....1** **No 2**	