

COUNTRY HEALTH DATA PLATFORM

QUESTIONNAIRE A:

1. Date of data collection
D D M M Y Y
2. Data collector ID Position of interviewee _____
3. Name of facility: _____
4. Location of facility: (e.g. city,town,village) _____
5. District 6. Province/region
-

GPS Information:

7. Waypoint ID Altitude
8. Latitude
N/S Deg
9. Longitude
E/W Deg
-

10. Distance (kms) from transport route:
- Tarred Road
- Gravel (all weather) w/ regular transport
- Gravel w/ difficult access

11. Most reliable method of communication: (tick all that are available)

- Two-way radio
- Telephone (landline)
- Cell-phone (facility based)
- Cell-phone (personal)
- Email (facility)

NB. Record details, frequencies, numbers & Email addresses where appropriate

12. Facility Managing Authority (country specific)

- 01 Government (MoH)
- 02 Government (Other Ministry)
- 03 Faith-based (specify according to list)
- 04 Non-government
- 05 Private (corporate linked)
- 06 Other Private
- 07 Community

e.g. FBO category

- * catholic
- * protestant
(CC member)
- * protestant
(independent)

13. Does this facility (or its managing authority) belong to a network or Association
If yes, name: ___(e.g. CHAK, KEC..)_____ Y/N

14. Source of Facility Electricity (tick all that apply) National electric grid
Solar
Electric generator

15. Source of Facility Water (tick all that apply) Piped from utility co.
Local protected source
Local Unprotected source
Other source

16. Is water for the facility available within 500 meters (Y/N)

17. How many functional motorized vehicles are based at the facility?

2 wheel motorcycles 4 wheel ambulances

18. Where do you initially send your statistical reports?

District Health Office
District Administrator
Facility Manager
Health Association
National HMIS Office

Services Available

19. Please tick services that are routinely available at this facility:

Family Planning	<input type="checkbox"/>	Casualty/emergency care	<input type="checkbox"/>
Ante-Natal	<input type="checkbox"/>	Surgery	<input type="checkbox"/>
Deliveries	<input type="checkbox"/>	Outreach	<input type="checkbox"/>
Post-Natal	<input type="checkbox"/>		
Immunizations	<input type="checkbox"/>		

20. Does the facility have inpatient beds Y/N if Yes, #

21. How many full-time clinicians work at this facility?

Nurses registered w/ Nursing Council
Doctors & clinical Officers registered w/ Medical Council