Tanzania Reproductive and Child Health Facility Survey, 1999

National Bureau of Statistics
Dar es Salaam, Tanzania

and

MEASURE Evaluation
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This report presents results from the 1999 Tanzania Reproductive and Child Health Survey (TRCHS) which was undertaken by the National Bureau of Statistics in collaboration with the Reproductive and Child Health Section of the Ministry of Health. Financial assistance for the survey was provided by the U.S. Agency for International Development (USAID/Tanzania), UNICEF/Tanzania, and the United Nations Population Fund (UNFPA/Tanzania). Technical assistance with the survey was provided by MEASURE *Evaluation.*

Additional information about the TRCHS may be obtained free of charge from the National Bureau of Statistics, P.O. Box 796, Dar es Salaam (telephone: 2135-602; fax: 2135-601). Information about the MEASURE *Evaluation* project may be obtained from MEASURE *Evaluation*, Carolina Population Center, 123 West Franklin St., Suite 304, University Square East, University of North Carolina, Chapel Hill, NC 27516-3997 (telephone: 919-966-7482; fax 919-966-2391).

Foreword

The National Bureau of Statistics takes pleasure in presenting this report on the survey of Health Facilities included in the 1999 Reproductive and Child Health Survey (TRCHS). The 1999 TRCHS Facility Survey follows facility surveys performed in the 1991/92 Tanzania Demographic and Health Survey (TDHS), the 1994 Tanzania Knowledge, Attitudes, and Practices Survey (TKAPS), and the 1996 Tanzania Service Availability Survey (TSAS).

This report contains findings from the 1999 TRCHS regarding data from the health facilities visited. The tables and text cover the most important indicators and should be of use to policy makers and program administrators who need up-to-date data for evaluating their activities and planning future directions. Findings from the survey of households included in the 1999 TRCHS are presented and discussed in a separate report.

The successful completion of the 1999 TRCHS was made possible through the joint efforts of a number of organisations and individuals, whose participation we acknowledge with gratitude. First is the U.S. Agency for International Development (USAID)/Tanzania, which has long supported the collection and utilisation of data to evaluate family planning and health programmes in Tanzania, initiated planning for this survey, and provided the bulk of the funding to implement it. UNICEF/Tanzania and UNFPA/Tanzania also contributed substantially both to survey design and funding. Many other organisations contributed to the questionnaire content and/or the field staff training, including the Reproductive and Child Health Section at the Ministry of Health, the Tanzania Food and Nutrition Centre, the National AIDS Control Programme, Mount Meru Hospital, and the Intrah Regional Office, Nairobi. We would also like to thank the MEASURE *Evaluation* Project of the University of North Carolina, U.S.A., for providing technical assistance in all phases of the project. The survey would not have gotten off the ground without exemplary and tireless efforts of the staff at the National Bureau of Statistics. Their many days of overtime work have served to make this effort a success. Similarly, the nurses who acted as interviewers for the survey deserve our heartfelt thanks. Finally, we are ever more grateful to the survey respondents who generously contributed part of their time to provide crucial data for our country's future planning.

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Executive Summary

The 1999 Tanzania Reproductive and Child Health Facility Survey (TRCHS) collected information on the availability and use of selected reproductive and child health services in Tanzania. This report presents results from the facility survey, which was conducted by the National Bureau of Statistics (NBS) from June 1999 to February 2000.[1] The facility survey was carried out in conjunction with a national household survey, also conducted by the NBS, with the technical assistance of MEASURE *DHS*+. The sampling strategy of the household and facility survey will facilitate further assessments of the impact of health services on health outcomes.

Context

According to the World Bank, Tanzania is one of the poorest countries in the world with a GNP per capita of $240 in 1999. In the WHO World Health Report 2000, per capita expenditure on health in Tanzania is estimated at $36 per year, which ranks Tanzania as 174 among 191 countries. During the nineties a number of policy and program changes took place that may have affected the availability and quality of reproductive and child health services. In 1992, the government developed its first National Population Policy. By 1997, the government had taken several steps to integrate family planning programs into maternal and child health programs, including the initiation of a reproductive and child health program. During the nineties privatisation of health services was common throughout Tanzania, and many small private clinics were opened in urban and even rural areas. The government initiated the process of health sector reform, although implementation by 1999 was still limited to a small number of districts.

Beyond the policy changes, the epidemiological context for health programs also changed dramatically during the nineties, with HIV spreading throughout the country and infecting an estimated 8 percent of the adult population by the late nineties. In the field of maternal and child health, available data on mortality, morbidity and nutrition suggest that only limited or no progress was made. The greatest progress has been made in the field of family planning with modern contraceptive use nearly tripling and fertility starting to decline for the first time in decades.

Survey Design

This survey included three types of facilities, both in the government sector and those operated by non-governmental or private organisations: hospitals, health centres and dispensaries. Special attention was given to UMATI and Marie Stopes clinics, key NGO/private providers in Tanzania that were included in previous facility surveys in 1991, 1994 and 1996. In the previous surveys, family planning was the main focus. In the 1999 survey, additional information was collected about other reproductive and child health services, while consistency with previous surveys' collection of family planning information was maintained.

The 1999 facility survey consisted of six survey instruments, each designed to target a specific perspective of health services and health care provision. Questionnaires were administered to collect information on the community, facility, facility inventory, service provider, pharmacy inventory, and district health management team. A new sampling strategy was used. This sampling design aims to capture the market of facility services provision and permits further analysis through linking facility, community, and individual data in secondary analyses that are not presented here.

This report presents data on various indicators of the availability and quality of services in 1999 from 260 government and 185 NGO/private health facilities in mainland Tanzania. In addition, data are presented on trends in selected services

[1] Contributors to the planning, funding, and design of the facility survey include the National Bureau of Statistics (NBS), Planning Commission, and the Reproductive and Child Health Section (RCHS) of the Ministry of Health, the United States Agency for International Development (USAID) mission in Dar es Salaam, Tanzania, the USAID-funded MEASURE *Evaluation* Project at the Carolina Population Center at the University of North Carolina, Chapel Hill; the United Nations Population Fund (UNFPA); and the United Nations Children's Fund (UNICEF).

between 1996 and 1999 for 207 health facilities that could be matched. This executive summary focuses on mainland Tanzania results, unless otherwise noted.

Main Findings

- The NGO/private sector plays a major role in health services provision in Tanzania. Nearly half of all hospital beds are in NGO/private facilities, and such facilities tend to have higher proportions of more qualified staff than government facilities. However, government facilities, mostly dispensaries, are still providing the lion's share of outpatient services (80 percent).
- Health facilities scored fairly well, and often slightly better than in 1996, on supplies of modern contraceptives (condoms in particular), vaccines (with the exception of polio), and key antibiotics, but there is still considerable scope for improvement.
- Health workers have been receiving continuing education on a variety of topics during the nineties, and large numbers of facilities now have a provider trained in family planning, HIV counselling and testing, post-abortion care, syndromic management of STDs, and/or integrated reproductive and child health skills. However, in 1999 still more than half of the dispensaries – the largest provider of outpatient services with an average of 32 patients per day – had no provider trained in many of these 'new' skills. Furthermore, dispensaries are least commonly visited by the district health management team.
- There were significant increases in numbers of family planning clients since 1996, with the government providing 82 percent of family planning services. Training levels and supplies also improved and kept up with the increased volume of clients. Government dispensaries are the main source of contraceptive methods.
- Voluntary counselling and HIV testing were only provided in hospitals and some NGO/private health centres. Stockouts of HIV tests were fairly common. Laboratory facilities in most hospitals are adequate for STD testing, but very few health centres have such facilities. Even though STD knowledge levels among health workers were fairly high, self-reported STD diagnosis and treatment practices were not adequate in most cases. Training of health workers in the syndromic approach leads to improvement of STD management practices, but still falls well short of adequate practices in most cases, indicating the need for continued education and supervision, and perhaps improvement of the training courses.

Facility characteristics and staffing

- ✓ The NGO/private sector is a significant provider of in-patient care, accounting for 42 percent of all hospital beds in mainland Tanzania.
- ✓ Outpatient care is largely provided by the government sector (80 percent of all patients), and nearly two-thirds of all outpatient visits are made at government dispensaries, where on average 32 clients are seen every working day.
- ✓ NGO/private hospitals have higher proportions of more qualified staff than government hospitals: doctors, assistant medical officers and clinical officers make up 10 percent of the staff of government hospitals and 16 percent of NGO/private hospitals.
- ✓ Adequate privacy is available at 75 percent of health facilities for counselling sessions and at 74 percent for physical examinations.
- ✓ Sterilisation practices are adequate in most facilities: 72 percent of facilities use appropriate sterilisation equipment, mostly an electric sterilizer; 90 percent and 85 percent of facilities reported that they discard disposable gloves and needles respectively after first use.
- ✓ Laboratory facilities are lacking in government hospitals and health centres: only 27 percent of hospitals and 13 percent of health centres had a functioning lab. Most facilities have a refrigerator, except 48 percent of the NGO/private dispensaries. Only 15 percent of government dispensaries offer malaria testing.

Logistics

- ✓ Condoms are offered in 92 percent of the government facilities, but only 31 percent of NGO/private facilities.

- ✓ Pharmacies are a common alternative source of condoms, as 68 percent had any type of condom with 62 percent having Salama condoms in stock.
- ✓ Stockouts of contraceptives (pill, injection or condom) during the last 30 days were less common in 1999 compared with 1996; overall, 13 percent of government facilities and 8 percent of NGO/private facilities reported such stockouts in 1999.
- ✓ Most facilities that offer immunisation had vaccines in stock: 89 percent had measles, 88 percent TT, 86 percent BCG and 84 percent DPT. Polio vaccine was most commonly out of stock (62 percent of all facilities offering immunisations).
- ✓ NGO/private facilities generally had a much wider range of anti-malarial drugs in addition to chloroquin than government facilities: 42 percent of government facilities had Fansidar and 65 percent had quinine in stock.
- ✓ Among pharmacies, 61 percent had oral rehydration solution packets and 28 percent vitamin A capsules in stock.
- ✓ The availability of some antibiotics increased between 1996 and 1999. Doxycycline availability increased from 51 percent to 85 percent, but availability of other antimicrobial drugs commonly used in the syndromic management of STDs did not increase in matched facilities (erythromycine 59 percent, benzathine-penicillin injections 63 percent and cotrimoxazole 79 percent) and remains low.

Training and supervision

- ✓ A wide range of continuing education courses are available for health workers. The most common topics covered were HIV counselling and testing (19 percent of providers had received such training since 1993), syndromic management of STDs (19 percent), basic family planning skills (10 percent), comprehensive family planning skills (9 percent), integrated reproductive and child health skills (8 percent), and treatment of incomplete abortion (8 percent).
- ✓ Considerably higher proportions of staff were trained in Zanzibar in almost all training courses: 66 percent were trained in HIV counselling and testing, 58 percent in syndromic management of STDs, 35 percent in integrated reproductive and child health skills, and 34 percent in basic family planning skills.
- ✓ Training of staff in integrated reproductive and child health skills has resulted in 38 percent of mainland health facilities with at least one trained provider and 15 percent with at least two trained providers.
- ✓ In Zanzibar, 64 percent and 33 percent of facilities have at least one and two providers trained in integrated reproductive and child health skills respectively.
- ✓ More than half of health facilities on the mainland have at least one provider who completed HIV/AIDS counselling training (61 percent), with government facilities having more trained providers than NGO/private facilities (70 percent and 52 percent respectively). In Zanzibar, 74 percent of facilities had a trained provider.
- ✓ 32 percent of facilities on the mainland and 42 percent in Zanzibar can provide post-abortion care by a trained health worker.
- ✓ Eighty-nine percent of hospitals, 65 percent of health centres and 48 percent of dispensaries on the mainland have at least one provider on staff who has completed in-service training in the syndromic management of STDs. NGO/private facilities are much less likely to have a trained provider. In Zanzibar, 88 percent of all facilities had a trained provider.
- ✓ Many of the matched mainland facilities now have two trained family planning providers, including 88 percent of hospitals, 66 percent of health centres and 26 percent of dispensaries, which is a significant increase since 1996.
- ✓ Supervisory visits by a member of the district health management team were made to half of government facilities and 31 percent of NGO/private facilities on the mainland, and to 79 percent of facilities in Zanzibar. The dispensaries were least frequently visited by all types of supervisors. For instance, the district medical officers had visited only 25 percent of dispensaries in the last six months.

Family planning

- ✓ Between 1996 and 1999 the average number of new and re-supply family planning clients

increased for hospitals, health centres, dispensaries, and all types combined in the matched sample. There was a 15 percent increase in new users and 31 percent in re-supply clients, with most of the increase occurring in government facilities.

- ✓ Among new family planning acceptors in the month preceding the survey, 82 percent were provided supplies by government clinics, including 59 percent in government dispensaries. Marie Stopes and UMATI clinics provided an estimated 5 percent of new users with modern contraceptives in 1999.
- ✓ Despite the increase in family planning users, availability of specific contraceptive methods remained high in all facilities offering the services. During 1996-1999 the percentage of matched facilities with stockouts at the time of the survey declined to none for the pill, 6 percent for injectables, 8 percent for intrauterine contraceptive devices and 5 percent for condoms.

Maternal and child health

- ✓ All hospitals, 82 percent of health centres and 83 percent of dispensaries in the government sector reported that they were adequately equipped for normal deliveries. The NGO/private sector has a less prominent role with only 62 percent of health centres and 41 percent of dispensaries equipped for normal deliveries.
- ✓ Emergency obstetric care (for hemorrhage and obstructed labour) was reported to be available in nearly all hospitals. Of the facilities equipped for normal deliveries, 42 percent of government health centres, 33 percent of government dispensaries and 46 percent of NGO/private health centres reported offering emergency obstetric services.
- ✓ Management of post-abortion or post-partum complications was available in all hospitals, 82 percent of health centres and 63 percent of dispensaries.
- ✓ Vitamin A supplementation to women in the post-partum period was offered in 68 percent of all facilities.
- ✓ Treatment of childhood respiratory disease was offered by 85 percent of facilities.

HIV/STDs

- ✓ Seven out of 10 government hospitals and 45 percent of NGO/private hospitals reported offering HIV/AIDS voluntary counselling and testing (VCT). Below the hospital level, virtually no health centres or dispensaries reported offering VCT, with the exception of some NGO/private health centres.
- ✓ Among the government hospitals that offer VCT, 21 percent had no stock of valid (unexpired) HIV antibody tests; among NGO/private hospitals 45 percent had no tests in stock.
- ✓ Most hospitals can make a laboratory diagnosis of gonorrhea and syphilis (90 percent and 80 percent respectively). But only half of health centres have laboratory facilities for the diagnoses of these STDs. In particular, government health centres lack such capacity. Less than 10 percent of government dispensaries have laboratory facilities for either STD.
- ✓ STD management knowledge levels, based on 8 questions, were fairly adequate. The mean knowledge score was higher among trained providers than untrained providers: 90 percent of the questions were answered correctly by trained providers, but by only 80 percent of the non-trained providers.
- ✓ Provider practices in the management of STDs were inadequate. Based on interviews, only one-fourth of providers appropriately described history taking; 30 percent and 44 percent properly described examination of a male and female client with STD complaints respectively; 38 percent gave proper advice on condom use and partner notification; 49 percent and 20 percent correctly described syndromic treatment of a male with urethral discharge and a female with genital ulcer respectively. There were only minor differences between government and NGO/private providers.
- ✓ Providers trained in STD syndromic management had better practices than those who had not been trained, although there is still considerable room for improvement. For instance, 68 percent of providers correctly described treatment for men with urethral discharge; 37 percent correctly described treatment for women with genital ulcers. Among untrained

providers all scores on history taking, physical exam, counselling and advice, and treatment were lower than among trained providers.

Management, information and costs

- ✓ Almost all government facilities reported using MTUHA (Tanzanian Health Management Information System) registers regularly. In NGO/private sector all hospitals, 92 percent of health centres and 75 percent of dispensaries in the NGO/private sector also reported using MTUHA.
- ✓ Problems in using MTUHA were reported by 39 percent of hospitals, 25 percent of health centres, and 17 percent of dispensaries.
- ✓ Only 3 percent of the District Medical Officers reported that decentralisation had been completely implemented in their district, but 43 percent reported that decentralisation was underway.
- ✓ No government facilities charge or request a donation for family planning services, although 8 percent charge for MCH services (such as delivery), and 22 percent for STD/HIV services. In the NGO/private sector, 12 percent of facilities solicit payment for family planning new acceptors, 8 percent for re-supply, 51 percent for MCH services, and 47 percent request payment or a donation for the provision of STD/HIV services.

Chapter One: Introduction

The 1999 Tanzania Reproductive and Child Health Survey (TRCHS) gathered information about health service provision and use in Tanzania. Descriptive statistics in this report present many facets of the strengths and weaknesses of reproductive and child health (RCH) services provision, which includes (1) family planning and contraceptive options, for men and women, (2) maternity and delivery care, (3) immunisations and treatment for childhood diseases, and (4) counselling, care, and treatment for sexually-transmitted infections, including HIV/AIDS. Where appropriate in the chapters that follow, service provision results from the 1999 TRCHS are compared to results from a matched (identical) sample of facilities surveyed in 1996.

1.1 Background

Tanzania is located on the eastern coast of Africa and consists of a mainland (previously Tanganyika) and offshore islands (including Zanzibar, which consists of the islands of Unguja and Pemba). Its continental neighbours include Kenya, Uganda, Rwanda, Burundi, Democratic Republic of the Congo (formerly Zaire), Zambia, Mali, and Mozambique; its eastern border meets the Indian Ocean. Since independence, and unlike many African countries, Tanzania has not experienced a coup d'état or indeed any period of unconstitutional rule, but it remains economically underdeveloped. In addition to the chronic health concerns typically encountered under conditions of widespread poverty, Tanzanians also confront threats posed by a serious HIV/AIDS epidemic.

At the time of the 1991 Demographic and Health Survey, Tanzania had a population of approximately 27 million people and an overall total fertility rate (TFR) of 6.3 children.[2] These factors, combined with Tanzania's relatively high under-five mortality rate (141 per 1,000) and low per capita GNP, motivated the government of Tanzania (GOT) to develop a National Population Policy (NPP) in 1992. The NPP and subsequent population policies have been implemented by the Family Planning Unit of the Ministry of Health, later renamed the Reproductive and Child Health Unit, and now the RCH Section, with financial and technical support from donors. Government and donor interventions have contributed, and are continuing to contribute, to many improvements in the health infrastructure and in the health care experiences of Tanzanians.[3]

By 1999, the GOT had taken a number of steps to integrate family planning (FP) programs with other efforts to facilitate safe and healthy pregnancies, deliveries and children. FP programs have also begun to incorporate services for STD prevention and treatment. Goals with respect to facility-based health care provision include (1) training providers in technical knowledge and other aspects of quality care, (2) extending information, education and communication (IEC) efforts to reach all Tanzanians and communities, and (3) improving logistical and managerial support for services at all levels. Additionally, the GOT has committed itself to the Cairo agenda developed at the International Conference on Population and Development in 1994, including ideals such as the integration of services and expansion of emergency obstetric care. Ongoing monitoring and periodic evaluation of all of these national efforts will be crucial factors in continuing to improve health behaviours and outcomes for Tanzanians in the years to come.

This report focuses on these substantive issues in three types of facilities: hospitals, dispensaries, and health centres. Hospitals are the largest service delivery points (SDPs), and are categorised by jurisdiction or scope (district, regional, or consulting). Hospitals are large enough to have specialised RCH departments and providers. Dispensaries are the smallest SDPs. They are staffed mainly by medical aides and auxiliary staff, and refer more complicated or specialised cases to

[2] The most recent census in Tanzania was conducted in 1988. Preparations to conduct a new census are currently underway.

[3] World Factbook estimates for Tanzania for 1999 include a population of 31,270,820 and TFR of 5.4 (http://www.odci.gov/cia/publications/factbook/tz.html). The under-five mortality rate is 137/1000 for 1995-1999.

hospitals or health centres. Health centres are between hospitals and dispensaries in size and complexity and typically have at least one assistant medical or clinical officer, as well as aides, nurses and auxiliaries.

This report also presents current information on two networks of private clinic operations in Tanzania, UMATI and Marie Stopes. UMATI clinics are affiliated with International Planned Parenthood (IPPF), and have increased in number from ten at the time of the Tanzania Service Availability Survey (TSAS, 1996) to the 14 surveyed in 1999. The 1996 TSAS covered five of the then six clinics affiliated with Marie Stopes International (MSI), while the current report includes all 12 Marie Stopes clinics in operation in 1999. Five of these are in the region of Dar es Salaam. While these special categories are important enough to present separately in most data tables for 1999 results, they are generally not separated in related trends data because of their very small numbers in the matched sample.[4]

It is also important to recognise that an essential role of the 1999 TRCHS was to produce results comparable with previous national facility surveys (1991/92 Tanzania Demographic and Health Survey; 1994 Tanzanian Knowledge, Attitude and Practices Survey; 1996 TSAS). As previous surveys have strongly focused on FP service delivery, the TRCHS survey instruments had to be developed from that base, adding RCH elements to previous versions. The weight of this legacy resulted in arguably sub-optimal coverage of some RCH issues, a balance of interests that could be improved in future facility surveys.

1.2 1999 TRCHS Facility Survey

The facility portion of the TRCHS consists of the following questionnaires that are included at the end of this reports: (1) Community, (2) Facility Interview, (3) Facility Inventory, (4) Service Provider (long and short form), (5) Pharmacy Inventory, and (6) District Health Management Team. The application of these instruments on the mainland and in Zanzibar followed protocols designed to collect nationally representative facility data (see Appendix A for details of sampling and weighting results). Each of the facility-level survey instruments targets a specific perspective of health services and health care provision—covering market characteristics as well as the experiences of facility staff—that together combine to create a comprehensive picture of health needs and opportunities in rural and urban Tanzania.

1.2.1 Sampling plan (a brief overview)

The heart of the TRCHS sampling plan uses an improved strategy developed by MEASURE *Evaluation* that efficiently combines two fundamental goals of most national data-collection efforts: to gather as much useful information as possible, and to keep costs low. Compared to previously standard sampling plans (e.g., the thirty kilometre range criterion), this new and improved sampling strategy allows expanded possibilities for data analysis through its linking of facility, community and individual data at no additional cost under certain relatively common circumstances. This strategy provides an accurate description of the health-services supply environment relevant for a representative sample of households and valid estimates of characteristics in the universe of facilities represented in the sample.[5]

In short, the TRCHS sampling strategy captures the market of facility service provision in a survey designed to cover nationally representative facilities, providers, and client populations. Rather than selecting the closest facility of a given type within thirty kilometres of a given population, and assuming that the population uses it, this strategy captures information about all facilities within a reasonable geographic range. In the Tanzanian case, that range, which reasonably serves as the

[4] UMATI clinics are located in Dar es Salaam (2), Mwanza (2), and ten other regions; Marie Stopes clinics are located in Dar es Salaam (5), Iringa (2), and five other regions, including Mjini Magharibi (Zanzibar).

[5] Turner, Anthony G.; Gustavo Angeles; Amy O. Tsui; Marilyn Wilkinson; Robert Magnani, *Sampling Manual for Facility Surveys. For Population, Maternal Health, Child Health and STI Programs in Developing Countries* (MEASURE *Evaluation*, 2000). The technical details and advantages of this strategy are further discussed in Appendix A, and will soon be published in full detail separately, along with other reports scrutinising the specifics of the Tanzanian pilot effort, and a step-by-step manual for performing surveys and analysing data within this sampling framework.

population's health care provision "market", was defined as being in the surveyed population's Enumeration Area (EA) or within one of the next two rings, or tiers, of surrounding EAs. In other words, survey instruments were applied at all facilities in the index EA, all facilities in any EA sharing a boundary with the index EA (the first tier), and all facilities in any EA sharing a boundary with any EA in that first ring (the second tier). Under such survey circumstances, which allow the co-ordination of information collection from individuals, communities and the facilities comprising their health services market, this strategy yields data that are analytically tractable through both complex multivariate methods and straightforward cross-tabulations such as those presented throughout this report.

Identification of the TRCHS sample of facilities, providers and pharmacies thus began with a subset of the nationally representative EAs originally identified for the 1991/1992 Demographic and Health Survey (DHS). The individual portion of the TRCHS covers a representative sampling of individuals from these 146 EAs on the mainland and 30 EAs in Zanzibar. The TRCHS covers all facilities in these EAs, plus all facilities in the two rings, or tiers, of EAs surrounding the index EA.[6] Because health outcomes in the index population may not be linked to the nearest facility when alternatives exist, this strategy is an improvement on sampling methods that identify only the facility or facilities nearest the population. Furthermore, since larger facilities are highly likely to receive referrals outside the surrounding EA rings of the index cluster population, facilities such as district and regional hospitals can be included in the 'market' for linked analysis even when they fall outside EA ring structures. Rather than assuming that all of the population probably uses the nearest facility, this new sampling strategy generates linked survey results that are both much richer and more useful for the study and analysis of health services, intervention impacts and population outcomes, by capturing the market of facilities from which the index population may choose health services.

This strategy accurately represents the facility environment available to a representative sample of the population – ideally, it provides a census of those facilities. Another advantage of the new strategy is that it amasses all of the information necessary to adjust data from the facility sample to yield nationally representative results. Properly weighted, results from the survey can be appropriately understood as representing the characteristics of the entire facility environment in the country, as shown by the following logic: In the population sampling plan, a probability of selection exists for each EA that is based on the population of that EA, the population of that EA's stratum (rural or urban), and the number of EAs chosen from that stratum. The probability of a facility being surveyed, then, depends on the population-based selection probabilities of all of the EAs surrounding that facility. In other words, where EAs are more likely to be selected for the population sample, facilities in the surrounding EAs are more likely to be surveyed for the health services market sample. The inverse of this probability of selection is the weight associated with data from that facility, and can be conceptualised as how many facilities of a similar type its data represent in the results. Therefore, the weights used in the calculations presented in this report yield nationally representative facility results, regardless of the facilities' associations with specific, localised populations. Appendix A discusses this strategy and its advantages in more detail.

1.2.2 Implementation

As mentioned previously, the National Bureau of Statistics (NBS) oversaw implementation of the facility portion of the TRCHS in Tanzania. As the first implementation of this sampling strategy, the experience was a fruitful one. The survey instruments themselves used both standard and uniquely designed questions for data collection, as described generally below. Eventually all of the appropriate surveys were completed as required, and both government and donor collaborators plan

[6] The sampling strategy described here was used for all of Tanzania except Dar es Salaam and Zanzibar. For the TRCHS results presented throughout this report, this probability of selection was corrected for urban characteristics for Dar es Salaam facilities, and for the certain inclusion (probability = 1) of District Hospitals, Marie Stopes facilities, and UMATI clinics. Appendix A presents in fuller detail the technical description of both the overall strategy and the modifications necessary for implementing the TRCHS in those two areas.

to further analyse the rich results in forthcoming studies.

- Community Questionnaire: Collects information from a group of key informants on the physical situation of the community (e.g. infrastructure and utilities), economic activities and health care options. Facility and pharmacy lists provided here were expanded with information from officials at the district level, in order to develop a comprehensive listing for administration of the other instruments.

- Facility Interview Questionnaire: Records the staffing and operational characteristics for all hospitals, health centres, dispensaries, and clinics in the sample. Services covered include family planning, maternal and child health, STD/HIV, and others such as IEC and Blood Bank, with questions on supervision and record-keeping practices also included.

- Facility Inventory Questionnaire: Concentrates on the physical features and working equipment at each facility, with additional attention to stocks of medicines and other supplies. This includes a pharmacy section if applicable, as well as one on IEC materials.

- Service Provider Questionnaire (long and short forms): Covers services, training, and practices. At facilities with more than six providers, two providers from each of three strata (doctors, nurses, and aides)[7] were interviewed using the long form, with all others completing the short form.

- Pharmacy Inventory Questionnaire: Captures stock availability information for pharmacies (those located outside hospitals or other SDPs).

- District Health Management Team Questionnaire: Explores decentralisation and management issues. This questionnaire was especially designed for the 1999 TRCHS to capture previously elusive information about changing parameters of local planning, management and supervisory activity. As an initial investigation of these issues, many of the questions are necessarily open-ended, and the Swahili answers have not yet been translated for analysis. While some pre-coded results are included in this report, the most interesting and important data is likely to emerge through later qualitative analysis.

1.2.3 Linkage to 1996 TSAS

The 1999 TRCHS expands on earlier facility surveys carried out in Tanzania. A previous series of three facility surveys attempted to collect longitudinal data from the same facilities at three different times.[8] Those facilities were selected according to the usual Demographic and Health Survey sampling strategy for EAs (also known as clusters), and according to the limitations of the 30-kilometer range for finding only the nearest SDP of each type providing family planning.

The new sampling strategy employed for the 1999 TRCHS began from the same EAs but as explained above ignored the old idea of finding only the nearest hospital, health centre, and dispensary providing family planning within 30km (if any). Therefore, the TRCHS often included facilities that had been included in previous facility surveys, but not always; and owing to irregular shapes and sizes of the EAs, some previously surveyed facilities within 30km fell outside the two rings of EAs that were covered by the TRCHS. A description of the overlapping samples is included in the following section.

[7] The stratum for Doctors includes the survey provider categories of Doctors, Assistant Medical Officers, Clinical Officers, and Assistant Clinical Officers; the Nurses stratum includes Nursing Officers, Nurse/Midwives, and Public Health Nurse B's; and the Aides stratum covers MCH Aides and Nurse Assistants/Medical Assistants.

[8] The facilities in each of these prior survey samples were not always literally identical, owing to factors such as refusal rates and other practical or pragmatic hindrances. For a complete discussion of related details, please see the Tanzania Service Availability Survey 1996 final report (December 1997), funded by USAID and printed by the Bureau of Statistics, Government of Tanzania, and The Evaluation Project, Carolina Population Center, UNC Chapel Hill.

1.2.4 Sample sizes and comparability

The 1996 TSAS only surveyed facilities on the mainland, like the 1994 survey before it, so tables throughout this report follow convention by presenting results from the mainland sample of facilities covered by the TRCHS separately from the Zanzibar results. The TRCHS mainland sample includes EAs from all twenty regions on the mainland. Since the TRCHS also covered EAs in the five regions of Zanzibar, however, separate tables and figures presenting Zanzibar results are included wherever appropriate. For ease of reference, all of the Zanzibar material is also repeated in Appendix Z.

Table 1.1 presents the TRCHS sample by type and sector. Hospitals, health centres, and dispensaries are standard Tanzanian facility types; Marie Stopes and UMATI facilities have separate rows as key clinic networks of clinics in Tanzania. The row for "Other" covers those facilities whose identifying data on the completed questionnaires was insufficient to ascertain their specific facility type with certainty; in most tables presenting results, the category is omitted since the interpretation of the data is problematic. The column for the government sector includes those facilities of any type that are primarily or completely financed and managed by the government of Tanzania; the NGO/private column includes all types of facilities that are run by private organisations of any kind, whether for profit or not for profit.

Table 1.1: Number of facilities in 1999 TRCHS sample, mainland

	Government	NGO/Private	Combined
Hospitals	77	11	88
Health Centres	40	22	62
Dispensaries	138	117	255
Other	5	10	15
UMATI Clinics	--	14	14
Marie Stopes	--	11	11
All Types	260	185	445

Table 1.2: Number of pharmacies in 1999 TRCHS sample, mainland and Zanzibar

	Urban EAs	Rural EAs	'Mixed' EAs	All EAs Combined
Mainland	118	88	100	306
Zanzibar	22	9	0	31
All Regions	140	97	100	337

Figure1.1: Facility proportions, by type, mainland Tanzania

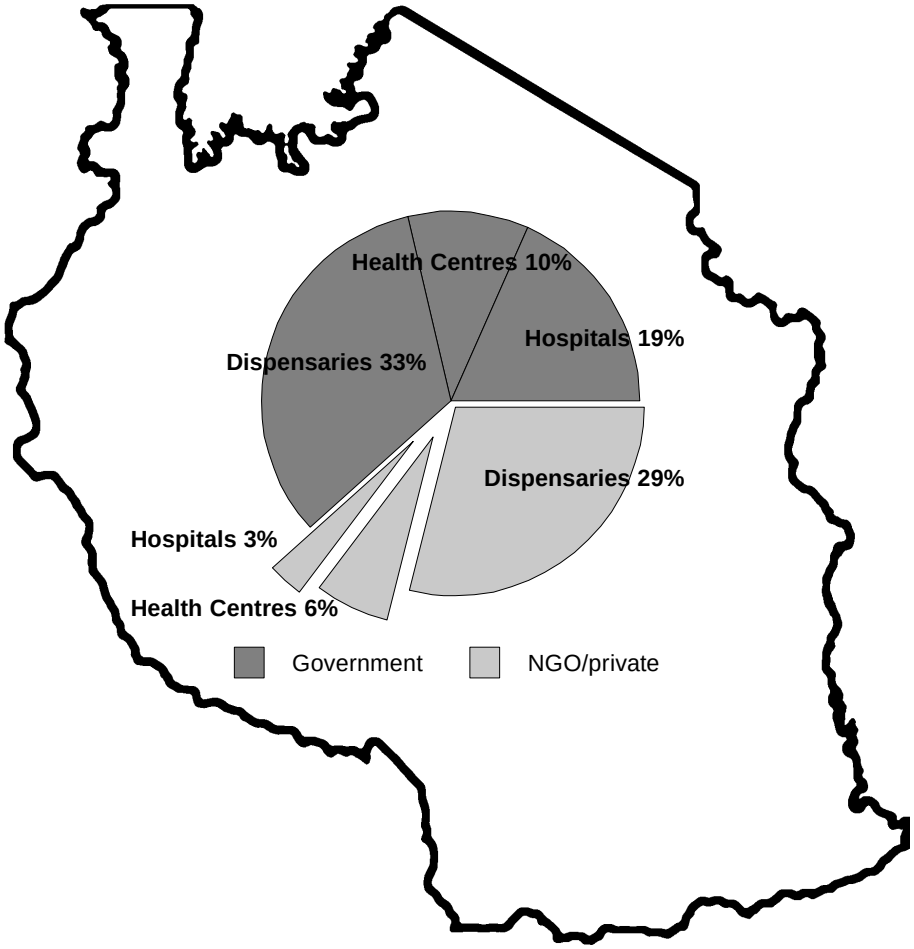


Table 1.3: Number of provider respondents in sample, by facility type and category, mainland

	Government	NGO/Private	Combined
Hospitals	2661	179	2840
Health Centres	506	176	682
Dispensaries	532	429	961
Other	50	61	111
UMATI Clinics	--	35	35
Marie Stopes	--	75	75
All Types	3749	955	4704

Table 1.4: Number of facilities in matched sample (1996 TSAS & 1999 TRCHS, mainland)

	Government	NGO/Private	Combined
Hospitals	59	5	64
Health Centres	31	7	38
Dispensaries	79	11	90
Other	3	0	3
UMATI Clinics	--	8	8
Marie Stopes	--	4	4
All Types	172	35	207

Table 1.5: Number of facilities in 1999 TRCHS sample, Zanzibar

	Government	NGO/Private	Combined
Hospitals	8	1	9
Health Centres	20	2	22
Dispensaries	0	11	11
Other	1	8	9
UMATI Clinics	--	0	0
Marie Stopes	--	1	1
All Types	29	23	52

Table 1.6: Number of provider respondents in sample, by facility type and category, Zanzibar			
	Government	**NGO/Private**	**Combined**
Hospitals	190	6	196
Health Centres	83	12	95
Dispensaries	n/a	102	102
Other	78	41	119
UMATI Clinics	--	n/a	n/a
Marie Stopes	--	8	8
All Types	351	169	520

Government hospitals include three consultant hospitals and 61 district hospitals. Note that UMATI and Marie Stopes clinics are all in the NGO/private category. Tables and graphs in the next seven chapters use dashes (--) to indicate where there are no facilities fitting certain cross-tabulated categories, or cells, as in the "Government" column of the Marie Stopes and UMATI rows of the table above. The dashes distinguish at a glance those cells from, for instance, percentages of zero that may occasionally be reported for other (non-empty) cross-tabulated categories. Where results are not available for certain categories, those spaces will be marked "n/a," for "not available." This can occur when answers for certain questions for a set of facilities are statistically missing, due to skip patterns in the questionnaires, for example

Some results in later chapters are presented in terms of market share; in other words, the new sampling strategy's usefulness in capturing the market of health services provision for representative populations allows some interpretation of results in terms of the percentage of facilities in a given sector (government versus NGO/private) versus the percentage of services offered or provided to these populations by that sector. These kind of results can be highly relevant for policy choices or allocation of resources and targeted interventions. Accordingly, the raw numbers for the TRCHS facility sample can also be understood to show proportional market share, as shown in Figure 1.1. For instance, 33 percent of all facilities on the mainland of Tanzania are government dispensaries.

Private pharmacies, outside of facilities, can be important sources for medicines, condoms, and other health supplies. Chapter Three, covering logistics and supplies, includes several graphs presenting pharmacy data. The TRCHS sample includes 337 pharmacies, located through the same two-tiered sampling strategy used to identify the sample of service delivery facilities (described more fully in Appendix A). Table 1.2 presents the TRCHS pharmacy sample by EA category for the mainland and Zanzibar. Table 1.3 presents the number of provider respondents by facility type and category. The mainland sample total totalled 4,704 provider respondents.

1.2.5 Comparison of 1996 and 1999 results

The grid of the types of mainland facilities represented in the 1999 TRCHS sample can be compared to the TSAS facilities. As mentioned above, the TSAS facility sample did not include Zanzibar. The 1996 TSAS sample included 481 facilities, including 10 UMATI and 5 Marie Stopes clinics.

Because of the new strategy that was used to identify facilities in a community's relevant health services market for the TRCHS, the overlap between previous samples and this survey's sample is somewhat less than in the previous, intentionally longitudinal, series. Nonetheless, 207 identical facilities were surveyed both in 1996 and in

1999. This matched sample is used for all trends presented in this report. (Tables and figures presenting results from the matched sample generally have titles beginning with the word “Trends”.) Trends tables and figures throughout this report portray comparative results from the 1996 (TSAS) and 1999 (TRCHS) facilities shown in Table 1.4.

1.2.6 Zanzibar results

As mentioned previously, Zanzibar facilities have not routinely been included in prior facility surveys or subsequent analyses; it is therefore sometimes difficult to know the full context in which Zanzibar results should be understood. The 1999 TRCHS was able to include coverage of Zanzibar because of funding provided by UNICEF and the UNFPA. While Zanzibar is densely populated, it is small compared to the mainland, and the 1999 TRCHS Zanzibar sample is likewise small compared to its mainland counterpart. Thus, in the following chapters some of the results for Zanzibar do not provide sufficient data for each cell in the usual table layout. Cells that may be empty or may include too few facilities for statistically significant results, due to skip patterns or other missing data, are marked “n/a” for “not available." The Zanzibar sample, results from which are presented both throughout the text and repeated in Appendix Z, includes 52 facilities (Table 1.5) and 520 provider respondents (Table 1.6). There are no government dispensaries or UMATI clinics in the Zanzibar sample.

1.2.7 Organisation of the Report

Subsequent chapters present details of the TRCHS Facility Series results. Chapter Two focuses on facility characteristics, while Chapter Three analyses facility data from a logistical and operational point of view. Results related to staff training and supervision are presented in Chapter Four. Chapters Five and Six target the substantive issues of FP/MCH, IEC and HIV/STDs. Chapter Seven describes a number of loosely related management issues, including some results from the District Health Management Team instrument, as well as information management and user costs.

Chapter Two: Facility Characteristics in Tanzania

This chapter provides information on the basic characteristics of health facilities in Tanzania. Physical features of service delivery points (SDPs), patient flows and staffing information depict the structures of service provision in this country today. Key comparisons across time provide a broader picture of shifts in service delivery by showing changes in facility characteristics between 1996 and 1999.

2.1 Number of Beds

The number of beds is one aspect of the ability to provide in-patient and maternity care in a facility. Beds may be used for admissions or overnight stays, or for out-patient or temporary bed rest as needed. Hospitals, which are the largest facilities and which typically handle the most serious illnesses, have the most beds, but health centres and even dispensaries, as well as private clinics, often have at least a few beds for their clients (Table 2.1). Of all beds in facilities, 58 percent are found in government facilities (Figure 2.1). This proportion is close to the government's overall market share; however, although NGO/private hospitals account for only 3 percent of the total facility market, 22 percent of facility beds are found in NGO/private hospitals.

For facilities surveyed both in 1996 and in 1999, the median number of beds has decreased modestly. This decline is slight in all categories except health centres, which shows a 42 percent drop, from a median of 24 to 14 beds (Figure 2.2). However, some of this apparent change may be due to more accurate counting (only beds with mattresses) in the TRCHS.

Table 2.1: Number of beds in facilities, mainland

	Government		NGO/Private		Combined	
	Mean	**Median**	**Mean**	**Median**	**Mean**	**Median**
Hospitals	185	156	97	66	172	150
Health Centres	16	14	20	14	17	14
Dispensaries	4	4	7	6	7	6
UMATI Clinics	--	--	10	10	10	10
Marie Stopes	--	--	10	9	10	9
All Types	128	100	20	8	78	20

Figure 2.1: Proportion of beds in government versus NGO/private sector facilities, mainland

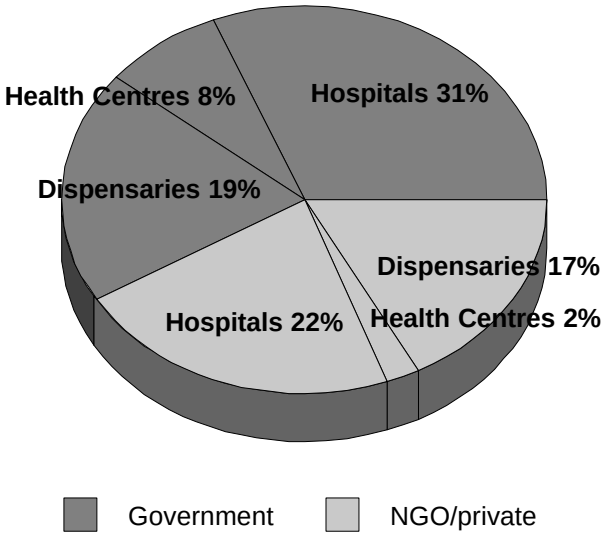
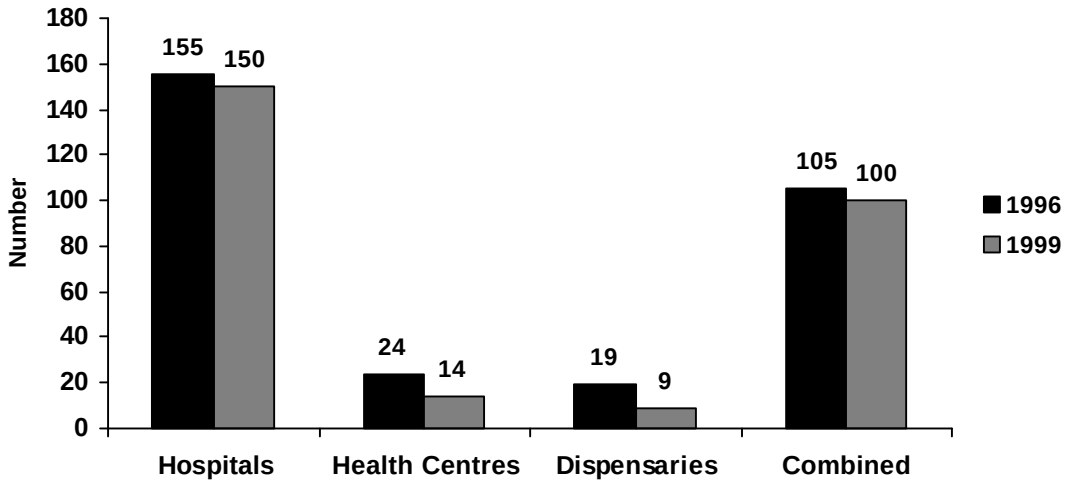


Figure 2.2: Trends in median number of beds in facilities, matched mainland facilities



2.2 Client Volume: Outpatients

The volume of patients passing through facilities on a routine basis provides some indication of the population that is actively relying on facility services.[9] The TRCHS survey checked facility records of visits and revisits of outpatients, generally for treatment and follow-up purposes. For all facility types and services, government facilities provide services to larger numbers of outpatients. For instance, government hospitals on average see over twice as many outpatients as NGO/private hospital records show (Table 2.2). An average outpatient department in a government hospital handles 301 patients per week, or about 60 per workday. Government health centres process about 1.6 times the number of outpatients that dispensaries do, with an average dispensary totalling approximately 32 outpatients per day.

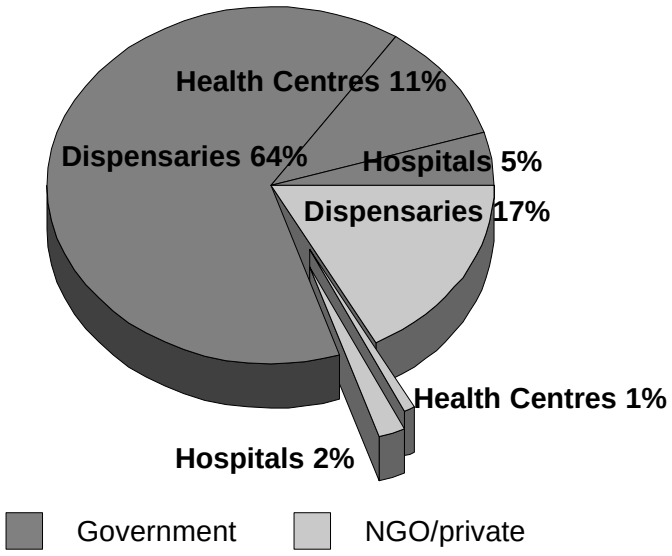
The 1999 TRCHS sampling strategy, which captures the service provision market, yields further information about relative contributions of government and NGO/private sector facilities to outpatient care. Comparing shares of outpatients to market share by sector and facility type shows that for most of these categories, NGO/private health facilities generally provide services to disproportionately fewer numbers for specific services. Of all outpatients in the year preceding the survey, 80 percent visited government facilities, and 20 percent went to facilities in the NGO/private sector (Figure 2.3). For instance, although NGO/private health centres comprise 36 percent of the market supply of health centres, only 6 percent of outpatients visiting health centres chose NGO/private sector health centres. Comparison of the outpatient proportions for dispensaries shows a similar disproportion: a much higher percentage of outpatients visit government dispensaries than its market share would suggest; a similar skew shows up for the overall sectoral comparison. An exception is that NGO/private sector hospitals comprise only about one-eighth of the hospital market, but over a third of recorded outpatients seeking care at hospitals choose to go to NGO/private sector facilities.

Table 2.2: Number of outpatients seen at facilities (in the past year), mainland

	Government		NGO/Private		Combined	
	Mean	**Median**	**Mean**	**Median**	**Mean**	**Median**
Hospitals	15,664	13,452	6,796	2,420	14,464	11,860
Health Centres	13,325	12,223	5,117	4,380	9,856	8,050
Dispensaries	8,379	7,429	4,157	2,643	6,095	4,991
UMATI Clinics	--	--	204	0	204	0
Marie Stopes	--	--	6,428	5,161	6,428	5,161
All Types	11,065	8,876	4,424	3,272	7,941	5,829

[9] Both means and medians are presented to show both the statistical average number of clients (the mean) and the midpoint number, with half of the facilities having that number or more clients and half having that number or fewer (the median). A median significantly lower than the mean, then, indicates relatively many facilities having relatively low numbers of clients, or a small number of outliers with very large numbers of clients. A median higher than the mean, of course, indicates the opposite.

Figure 2.3: Proportion of outpatients seen at government versus NGO/private sector facilities (in the past year), mainland



2.3 Staffing

Along with the number of clients and beds, the availability of staff is also an important part of the service provision environment in Tanzania. Staff numbers remain relatively unchanged from previous years, so here we present the breakdown of percentages of staff in five staff categories. For each type of facility, the Figures 2.4 to 2.6 show the government staffing mix versus the NGO/private staffing mix. In general, NGO/private facilities have higher proportions of technical medical staff, and government facilities have higher proportions of medical aides and assistants.

The makeup of these provider categories consists of the following staff cadres from the TRCHS Facility Interview questionnaire: "Doctors" includes Doctors and Assistant Medical Officers; "Clinical Officers" includes Clinical Officers and Assistant Clinical Officers; "Nurses" includes Nursing Officers, Nurse/Midwives, Public Health Nurse Bs, aides, MCH Aides, and Nurse Assistants/Medical Assistants. Figure 2.7 shows the proportions of these kinds of staff in terms of their employment in government versus NGO/private sectors.

Figure 2.4: Staffing mix at hospitals, mainland

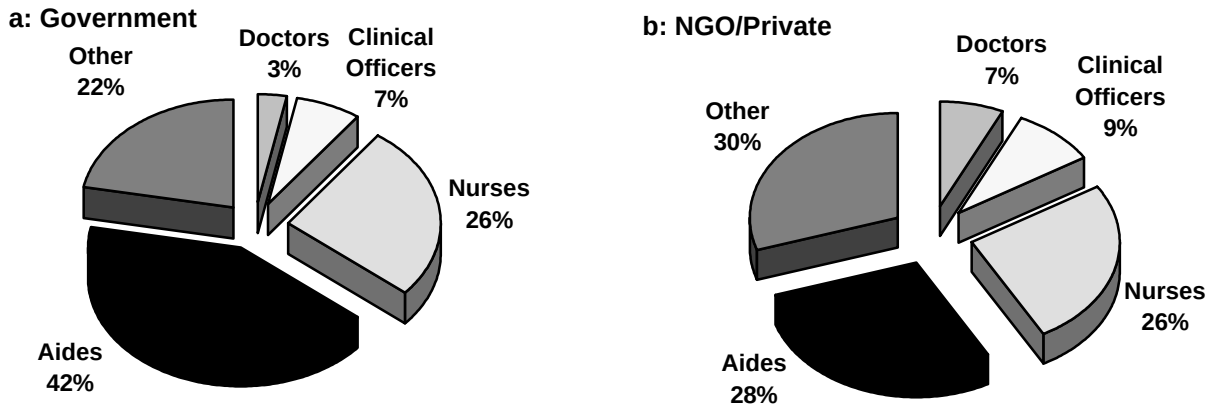


Figure 2.5: Staffing mix at health centres, mainland

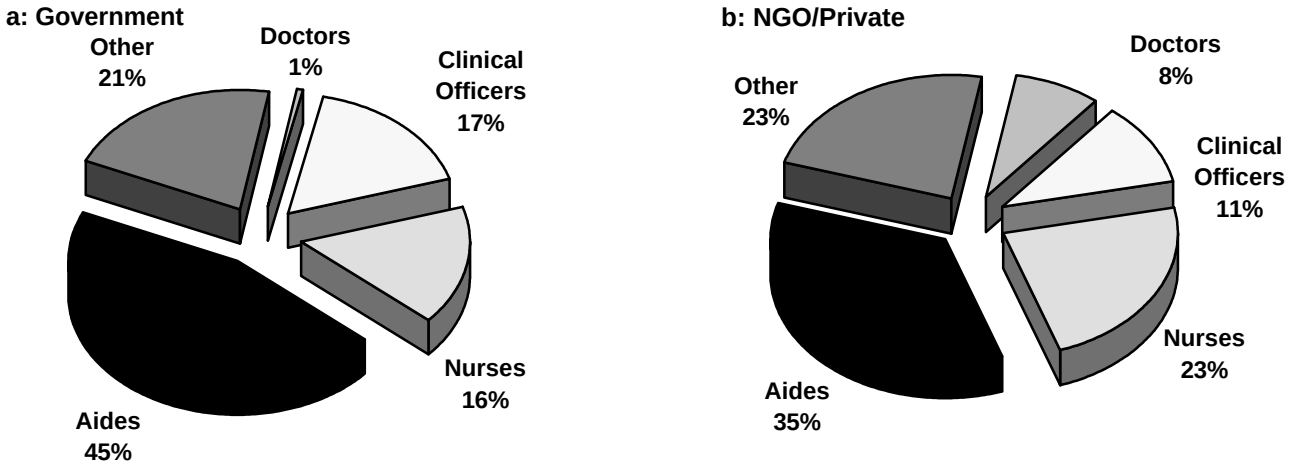


Figure 2.6: Staffing mix at dispensaries, mainland

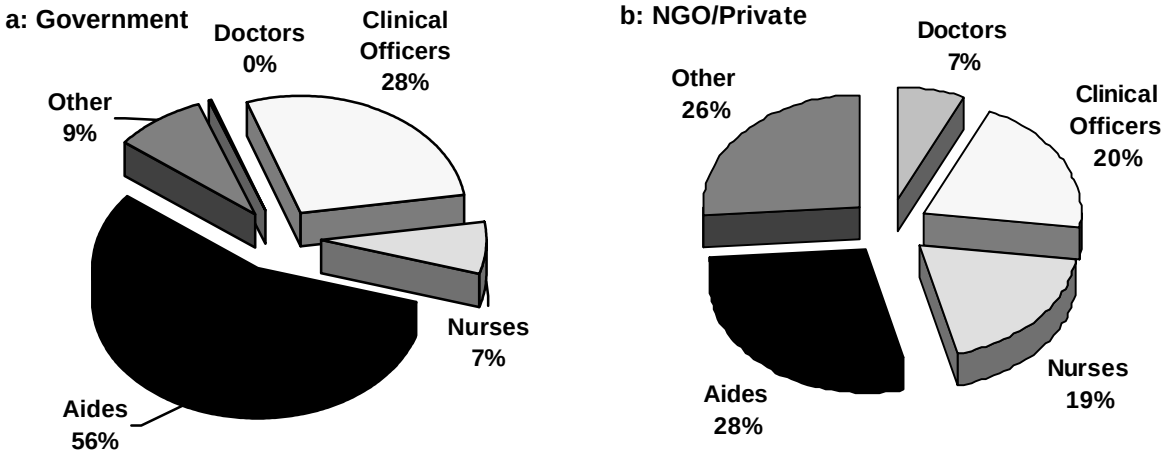
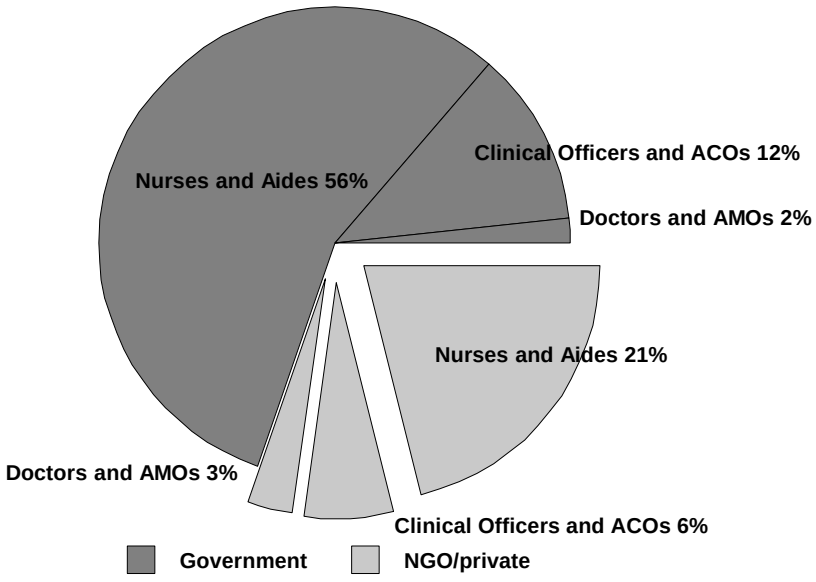


Figure 2.7: Proportion of staffing employed in government versus NGO/private sector facilities, mainland

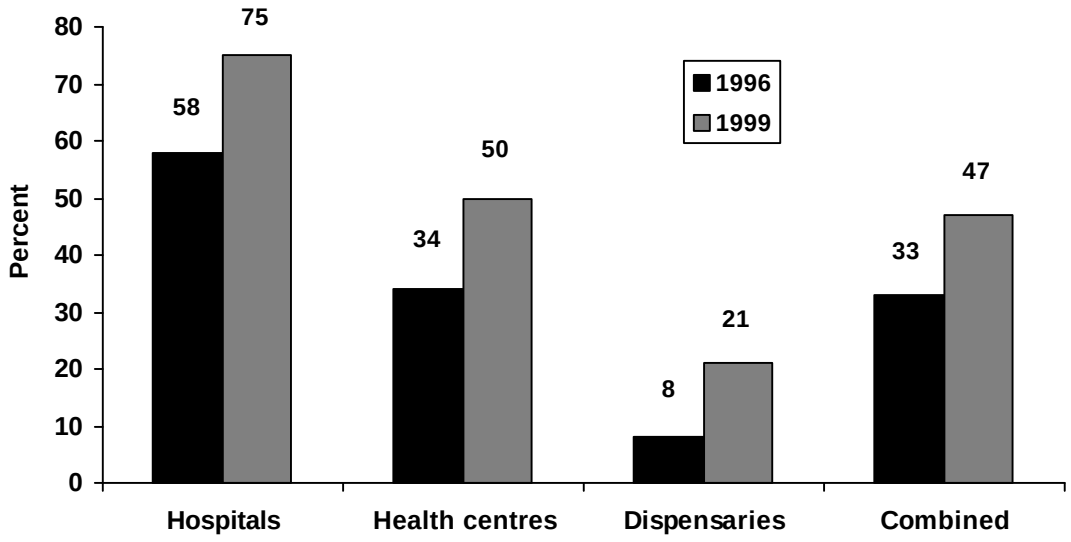


2.4 Workload

Staffing numbers in relationship to a facility's client load is another important ingredient in the provision of quality care. Beyond the physical presence of facility employees, it is important to know whether or not those staff members are trained in important care functions for providing the best quality of care. Chapter Four focuses in detail on this topic. Figure 2.8 displays, for this discussion, an example of the change in the availability of providers who have completed training in family planning.

With at least two trained providers, even small facilities are more likely to be able to offer trained care in family planning at most times. Fortunately, the number of FP-trained providers seems to be going up unequivocally in all facility types.

Figure 2.8: Trends in percent of facilities with at least two family planning trained providers, matched mainland facilities



2.5 Examination and Counselling Privacy

Privacy is an important element of quality care. While the ideal situation might be complete privacy for every client interacting with a provider, it can be difficult for many facilities to provide adequate private space for all provider-client interactions. TRCHS interviewers recorded the kinds of privacy available for clients during their counselling sessions and during their examinations. The possibilities included that clients have (1) aural privacy, (2) visual privacy, (3) both aural and visual privacy, and (4) neither aural nor visual privacy. These data were recorded separately for counselling and examinations. Results shown in Tables 2.3 and 2.4 show that most facilities that offer any privacy do manage to offer both aural and visual privacy for their clients. NGO/private hospitals provide the most privacy, while only government dispensaries fall below 75 percent on providing both aural and visual privacy for clients during counselling sessions and for clients during examinations.

Where only one kind of privacy is offered, it is more likely to be aural than visual privacy. Aural privacy might be considered more important for counselling sessions; on the other hand, visual privacy for clients during examinations would certainly be an equally valid concern in terms of quality care. These tables show that as many as 25 percent of some facility types (NGO/private health centres) offer aural privacy; smaller percentages in most facility categories provide only visual privacy during client-provider interactions. The facility type with the largest percentage of SDPs that offer neither aural nor visual privacy is government dispensaries (15 percent offer no privacy for either counselling sessions or client examinations).

Table 2.3: Percent of facilities with privacy for clients during counseling sessions, mainland

	Government				NGO/Private				Combined			
	Aural	Visual	Both	Neither	Aural	Visual	Both	Neither	Aural	Visual	Both	Neither
Hospitals	7	8	84	1	0	0	100	0	7	7	86	1
Health Centres	16	6	78	0	25	0	75	0	20	3	77	0
Dispensaries	17	7	60	15	18	1	77	3	18	4	70	8
UMATI Clinics	--	--	--	--	9	9	82	0	9	9	82	0
Marie Stopes	--	--	--	--	9	0	91	0	9	0	91	0
All Types	14	7	71	8	18	1	79	2	16	4	75	5

Table 2.4: Percent of facilities with privacy for clients during examinations, mainland

	Government				NGO/Private				Combined			
	Aural	Visual	Both	Neither	Aural	Visual	Both	Neither	Aural	Visual	Both	Neither
Hospitals	9	3	87	1	0	0	100	0	8	3	89	1
Health Centres	18	4	77	1	25	0	75	0	21	3	76	0
Dispensaries	20	4	60	15	20	1	76	3	20	2	70	8
UMATI Clinics	--	--	--	--	9	9	82	0	9	9	82	0
Marie Stopes	--	--	--	--	9	0	91	0	9	0	91	0
All Types	16	4	71	8	19	1	78	2	17	3	74	6

Table 2.5: Most frequently used sterilization method for medical instruments, mainland

	Electric sterilizer	Autoclave	Steam sterilizer	Kerosene stove	Charcoal/ wood stove	Other
Hospitals	44	35	8	11	2	0
Health Centres	53	9	8	25	5	0
Dispensaries	38	8	4	44	6	1
UMATI Clinics	36	55	0	9	0	0
Marie Stopes	45	45	0	9	0	0
All Types	42	13	5	34	5	0

Table 2.6: Percent of facilities that dispose of (do not reuse) disposable gloves or needles, mainland

	Government		NGO/Private		Combined	
	Gloves	Needles	Gloves	Needles	Gloves	Needles
Hospitals	62	73	68	84	62	75
Health Centres	91	78	91	94	91	85
Dispensaries	96	77	96	93	96	86
UMATI Clinics	--	--	100	100	100	100
Marie Stopes	--	--	100	100	100	100
All Types	85	77	94	93	90	85

2.6 Equipment Sterilisation and Sanitary Procedures

Increased awareness of anti-infection procedures is fundamental to providing safe and effective health care services. The necessary second step is to practice infection prevention procedures in facilities. TRCHS data indicate that facilities in Tanzania have room for improvement in these areas.

2.6.1 Sterilisation of medical instruments

Table 2.5 presents the means by which facilities sterilise medical instruments. The survey teams asked the following multiple-choice question: "What is the method **most** frequently used for the sterilisation of medical instruments (not linens)?" There were seven possible answers; six are listed below because no facilities reported using "none". No verification of the sterilisation mechanism or its effective usage was included in the TRCHS implementation. The percentages shown in Table 2.5 show the percentage distribution using each method for each facility type (rows sum to 100 percent).

Table 2.6 compares percentages of facilities that dispose correctly of disposable needles and gloves. The questions were "Does this facility normally use disposable gloves?" and "Does this facility ever have to reuse disposable gloves?" The questions on disposable needles were phrased in a similar manner. Only those facilities that normally use the disposable items were asked about disposal practices.

Another way of interpreting these results is to correlate facility practices in these related areas. The optimal practice is combining effective sterilisation of medical equipment with appropriate disposal of any and all items that should be used only once. Since the TRCHS did not fully investigate sterilisation procedures or verify mechanical operations, the figures presented in Tables 2.7 and 2.8 are illustrative rather than conclusive data; in these tables, preferred equipment sterilisation is limited to use of either an autoclave or an electric or steam sterilizer. Only 46 percent of all mainland facilities reported that equipment was always sterilised and disposable needles were never reused. Forty-two percent of facilities on Zanzibar followed these sanitary practices (Table 2.8).

Table 2.7: Percent of facilities reporting all preferred practices (equipment sterilized and disposables not reused), or reporting no preferred practices (do not sterilize equipment and may reuse disposables), mainland

	Government		NGO/Private		Combined	
	Both	Neither	Both	Neither	Both	Neither
Hospitals	34	6	51	0	36	5
Health Centres	50	27	67	7	57	19
Dispensaries	26	40	57	11	44	24
UMATI Clinics	--	--	82	0	82	0
Marie Stopes	--	--	91	0	91	0
All Types	34	28	60	20	46	19

On the mainland, NGO/private facilities perform best, with 51 percent of the hospitals, and even higher percentages of facilities of all other types in this sector, both sterilising equipment and refraining from reusing disposable needles and gloves. Government health centres also performed fairly well. However, nearly every category of facility demonstrated considerable room for improvement. The same is true for facilities on Zanzibar. Although the sample responding to these questions in the NGO/private sector is too small to draw strong conclusions, the government sector and combined figures show that similar improvement in sterilisation practices could certainly benefit clients seeking care in Zanzibar facilities.

2.6.2 Water supply and treatment

The TRCHS also inquired about any treatment of the supply of water being used in facilities. In combination with information from the community survey on community water supply and sources for potential contamination, Tables 2.9 and 2.10 present an overview of water cleanliness at health care facilities in Tanzania. Most mainland facilities do not treat their water in any way, with the NGO/private sector performing slightly better in most categories. The opposite holds true for Zanzibar facilities, except health centres, with most reporting that they do treat their water in some way. One unexplored issue may be the use of bottled water in some of the facilities reporting no water treatment. Although this strategy may turn out to be rare, questions on water treatment and usage in facilities could benefit from further attention and revision to complement information elicited on cleanliness and sanitation.

As for the sources of water in the communities linked with these facilities, the TRCHS found that 43 percent of communities reported their primary source of water was piped, while 9 percent reported it was from a covered well or borehole (Figure 2.9). Although 55 percent of communities reported no contamination sources to be locally present, these communities also reported a variety of potential contaminants of community water (Figure 2.10). The most commonly cited potential contaminant is livestock waste (36 percent), although human waste is reported nearly as frequently (34 percent).

Table 2.8: Percent of facilities reporting all preferred practices (equipment sterilised and disposables not reused), or reporting no preferred practices (do not sterilise equipment and may reuse disposables), Zanzibar

	Government		NGO/Private		Combined	
	Both	Neither	Both	Neither	Both	Neither
Hospitals	75	12	0	0	67	11
Health Centres	27	9	100	0	34	8
Dispensaries	--	--	70	0	70	0
Marie Stopes	--	--	100	0	100	0
All Types	34	28	60	0	42	7

Figure 2.9: Primary sources of community drinking water, mainland

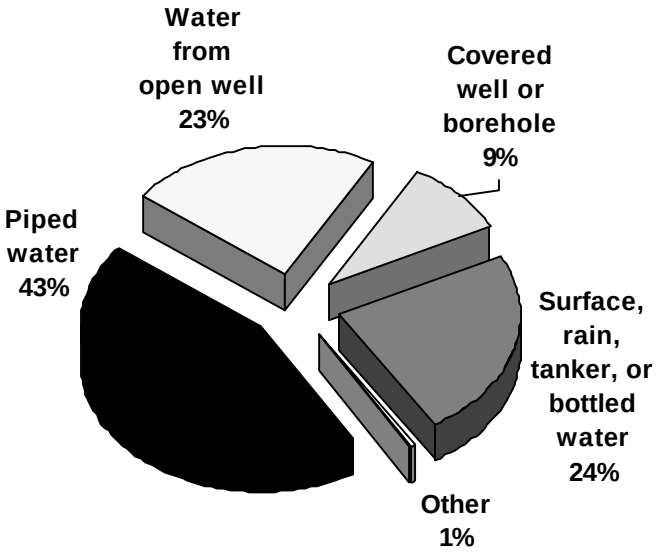


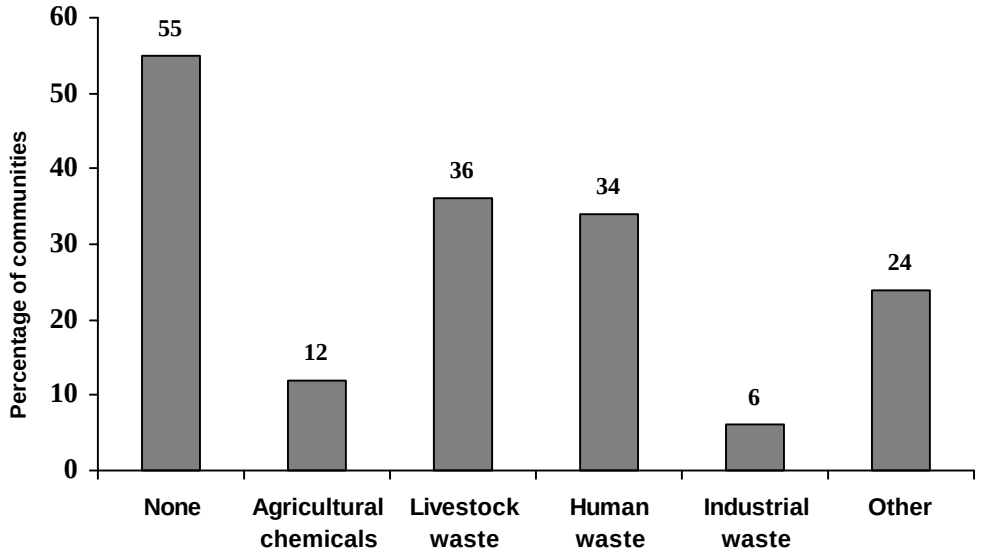
Table 2.9: Percent of facilities treating their water supply in any way, mainland

	Government	NGO/Private	Combined
Hospitals	25	48	28
Health Centres	13	12	12
Dispensaries	8	18	13
UMATI Clinics	--	9	9
Marie Stopes	--	18	18
All Types	15	17	16

Table 2.10: Percent of facilities treating their water supply in any way, Zanzibar

	Government	NGO/Private	Combined
Hospitals	63	n/a	63
Health Centres	24	50	27
Dispensaries	--	100	100
Marie Stopes	--	100	100
All Types	27	85	44

Figure 2.10: Potential sources for community water contamination, mainland

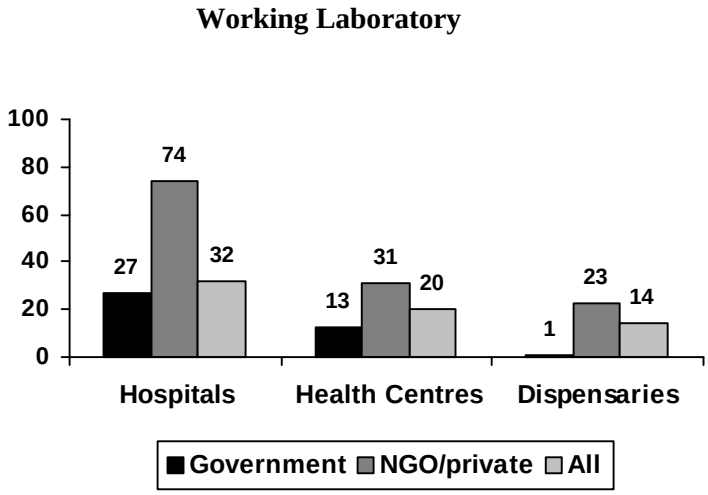


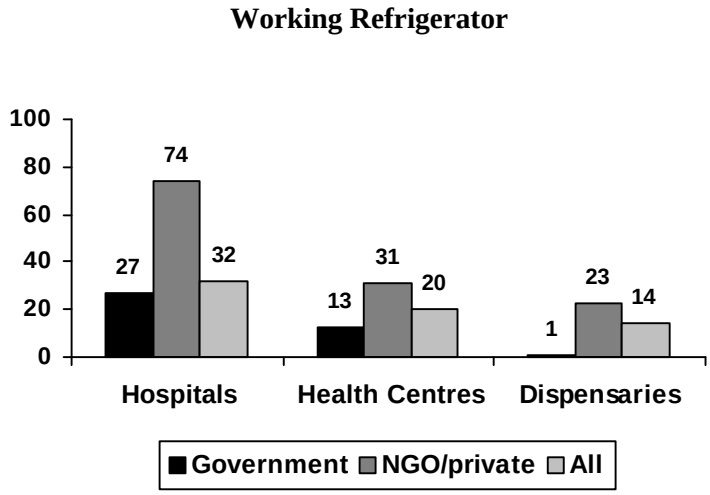
2.7 Working Equipment

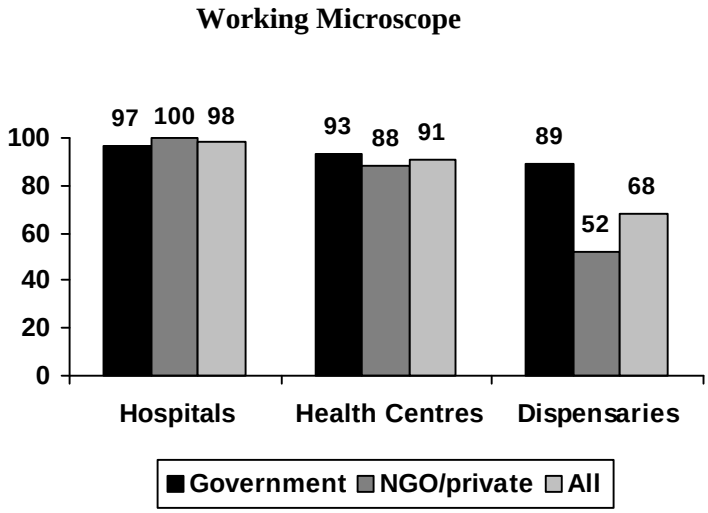
Beyond the basics of clean water and supplies, some basic items of equipment enable facilities to provide all appropriate services for their clients. A working lab opens the possibilities for some basic testing to be done, even at small facilities, while a working refrigerator extends the usable life of medicines. A working light source is needed for many examinations, and a microscope for many laboratory diagnostics. For each of the items presented in Figure 2.11, the TRCHS interviewer visually verified that the equipment was physically present and in working order.

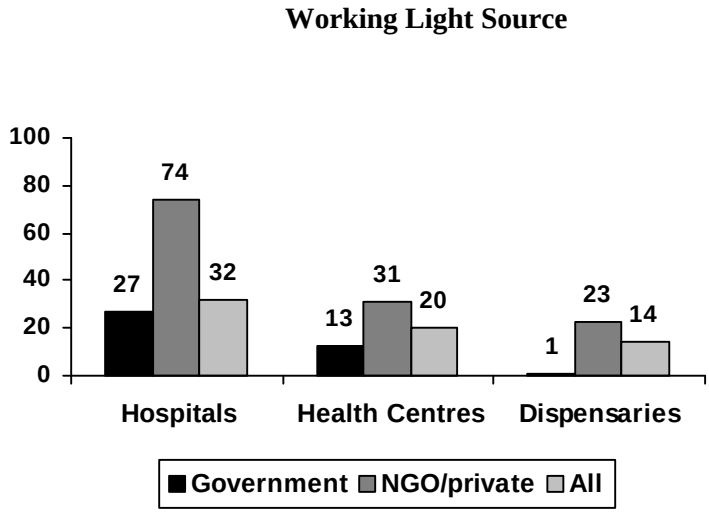
NGO/private hospitals take the lead in the items presented here except for, surprisingly, the availability of a working light source. The greatest room for improvement exists in facilities that lack working labs. Although many of the smaller facilities cannot be expected to have a full lab, only 27 percent of government hospitals reported having one, as opposed to three-fourths of NGO/private hospitals.

Figure 2.11: Percent of facilities with working lab, refrigerator, microscope, light source (lamp or torch), mainland









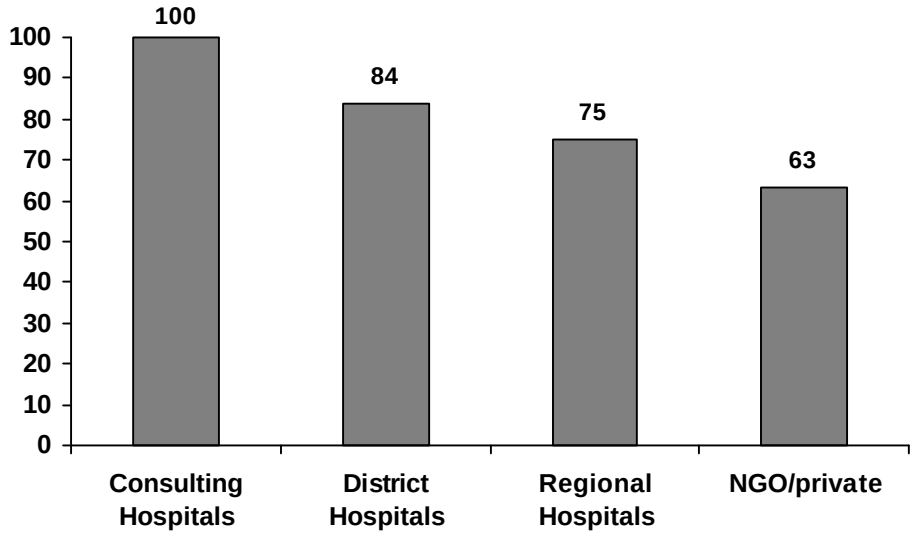
2.8 Blood Transfusions Availability

Blood transfusions are generally offered only at hospitals, so Figure 2.12 presents information about facilities that offer this service by category of hospital. Government hospitals are categorised as consulting, district or regional; all NGO/private hospitals are grouped together.

2.9 Summary

This overview points the way toward many possible improvements in basic characteristics of the Tanzanian health care sector. While the government facilities tend to be larger, and therefore represent facilities that many Tanzanians use, they fall behind in most basic measures of service characteristics and quality, including client privacy, sanitary procedures and the availability of equipment.

Figure 2.12: Percent of hospitals offering blood transfusions, mainland



Chapter Three: Reproductive Health Care Logistics

During the 1990s, investigating the supply side of service utilisation in Tanzania became recognised as an important step toward improving family planning service provision. This heightened awareness of the importance of the logistics of health service provision led to the inclusion of a number of related logistical queries in the 1999 TRCHS.

Given the evolving understanding of the importance of integrating health services to better serve client needs, the TRCHS was designed to inquire about the provision of many kinds of care. Facilities offering a "core service package" in this context means those that provide a basic yet comprehensive array of the most significant RCH services: oral contraceptives, contraceptive injections, and male condoms; maternity care and child immunisations; and HIV/STD services (including counselling). Facilities supplying all of these services are shown by the percentages in Table 3.1. Hospitals naturally lead in the provision of the full core service package, but at a relatively low level. No Zanzibar health centres or dispensaries offer the full range of core RCH services (Table 3.2).

3.1 Contraceptives Available

3.1.1 Transportation

As mentioned above, problems in the supply of family planning commodities sparked the ongoing interest in logistics and the bottlenecks that may interfere with quality service provision. Transportation systems and the ease or difficulty with which facilities can maintain their readiness to provide services are often significant factors in the quality of care that facility clients experience. Figure 3.1 shows the percentage of facilities providing family planning services that must pick up family planning supplies, for instance from regional warehouses. NGO/private health centres and dispensaries bear the brunt of this burden, although the percentage is significant in most categories.

Table 3.1: Percent of facilities providing core service package, mainland

	Government	NGO/Private	Combined
Hospitals	75	25	68
Health Centres	20	2	13
Dispensaries	6	1	3
UMATI Clinics	--	0	0
Marie Stopes	--	9	9
All Types	29	2	16

Table 3.2: Percent of facilities providing core service package, Zanzibar

	Government	NGO/Private	Combined
Hospitals	63	0	56
Health Centres	0	0	0
Dispensaries	--	0	0
Marie Stopes	--	100	100
All Types	3	1	3

3.1.2 Condom availability

The availability of condoms has significance for both family planning and STDs/HIV/AIDS. Tables 3.3 and 3.4 show the percentage of facilities that offer condoms to their clients. Fifty percent or fewer of NGO/private facilities, with the exception of UMATI and Marie Stopes, reported offering condoms, while between 90 and 100 percent of government facilities reported offering them.

3.1.3 Stockouts

Choice of family planning methods is not only a vital element of quality health service provision, but also an essential requirement for those clients who may need a specific method for personal or health reasons. Access to family planning services is undermined when facilities are out of the client's desired method of contraceptive protection. While stockouts thus are not desirable, sometimes they indicate that a facility is used by many clients, meaning that results on stockouts can be a somewhat ambiguous indicator. Ideally, of course, even high-volume facilities would not experience stockouts, but realistically they will sometimes occur.

Tables 3.5 and 3.6 present self-reported stockouts of facilities in the thirty days prior to the TRCHS interview, for the contraceptives most used in Tanzania. Government facilities report experiencing more problems keeping family planning commodities in stock. Tables 3.7 and 3.8 compare stockout percentages across the matched facility sample. There was a slight upward trend in nearly all facilities' ability to keep a continuous stock of FP supplies.

Figure 3.1: Percent of family planning facilities that must pick up family planning supplies, mainland

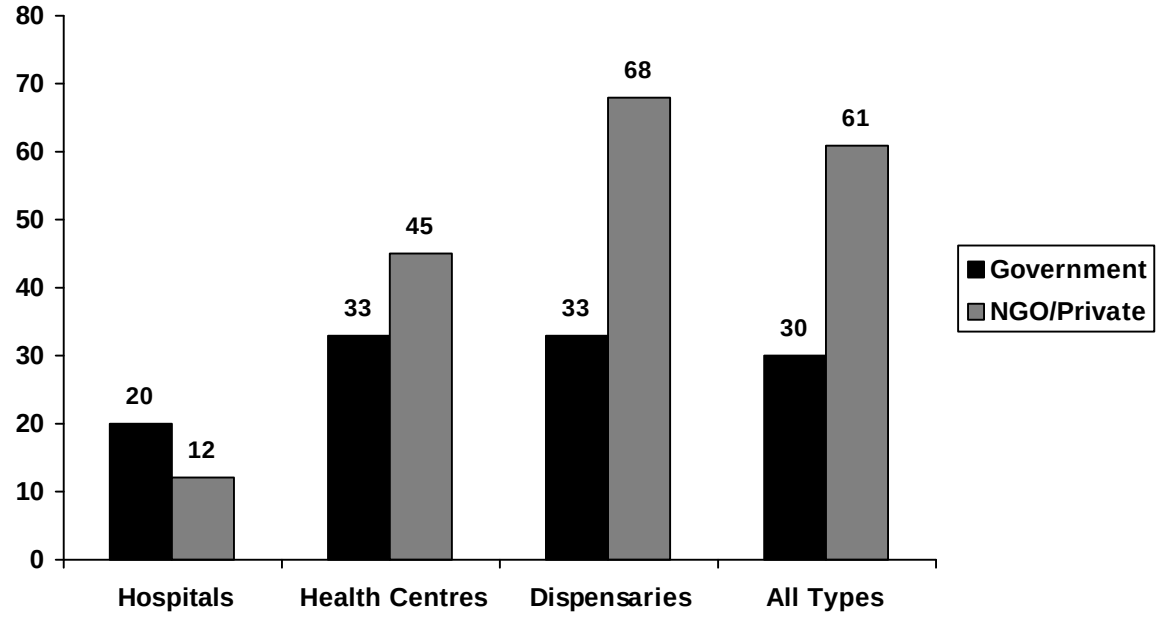


Table 3.3:	Percent of facilities offering condoms, mainland		
	Government	**NGO/Private**	**Combined**
Hospitals	93	47	87
Health Centres	93	38	71
Dispensaries	91	26	53
UMATI Clinics	--	79	79
Marie Stopes	--	100	100
All Types	92	31	62

Table 3.4:	Percent of facilities offering condoms, Zanzibar		
	Government	**NGO/Private**	**Combined**
Hospitals	100	0	89
Health Centres	92	0	84
Dispensaries	--	12	12
Marie Stopes	--	100	100
All Types	92	7	66

Table 3.5:	Percent of facilities offering pills, injections, and condoms with stockouts of any of the three contraceptives (in the last 30 days), mainland		
	Government	**NGO/Private**	**Combined**
Hospitals	10	0	10
Health Centres	16	0	13
Dispensaries	15	3	11
UMATI Clinics	--	0	0
Marie Stopes	--	0	0
All Types	13	8	12

Table 3.6:	Percent of facilities offering pills, injections, and condoms with stockouts of any of the three contraceptives (in the last 30 days), Zanzibar		
	Government	**NGO/Private**	**Combined**
Hospitals	0	n/a	0
Health Centres	15	n/a	15
Dispensaries	--	0	0
Marie Stopes	--	0	0
All Types	14	0	14

Table 3.7: Trends in percent of family planning facilities by sector continuously in stock (in the last 30 days), matched mainland facilities

	Government		NGO/Private		Combined	
	1996	**1999**	**1996**	**1999**	**1996**	**1999**
Pills	87	93	100	94	89	93
Injections	81	92	94	100	83	93
Condoms	90	93	100	100	91	93
IUCDs	99	100	100	100	99	100

Table 3.8. Trends in percent of family planning facilities by type continuously in stock (in the last 30 days), matched mainland facilities

	Hospitals		Health Centres		Dispensaries	
	1996	**1999**	**1996**	**1999**	**1996**	**1999**
Pills	89	94	90	90	86	93
Injections	84	94	90	90	76	91
Condoms	98	96	92	96	84	89
IUCDs	98	100	100	100	100	100

3.1.4 Alternative sources of contraceptives

If the facility a client visits is out of stock of pills, condoms or injections, the primary alternative supply sources are pharmacies and the market. Since the survey collected data from pharmacies in the same manner as the other facilities, a community-wide average of the availability of FP supplies in community pharmacies, shown in Figure 3.2, gives an idea of the overall availability of contraceptive methods outside of medical facilities. The availability of each method in each pharmacy was averaged for all of the pharmacies in that cluster (EA), after which the average of the cluster averages was taken to provide the overall national perspective. Pharmacies are shown to be a good alternative source of condoms, but not necessarily for pills and injections.

Figure 3.2: Percent of pharmacies with family planning methods seen in stock, mainland

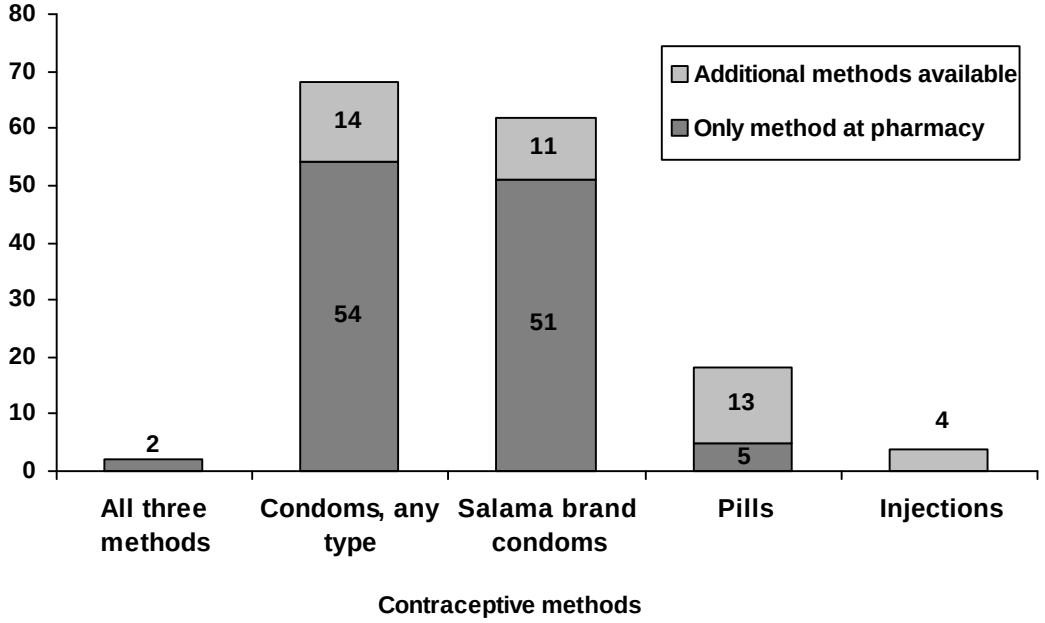


Table 3.9: Percent of facilities offering malaria testing, mainland

	Government	NGO/Private	Combined
Hospitals	96	80	94
Health Centres	67	98	80
Dispensaries	19	86	56
UMATI Clinics	--	14	14
Marie Stopes	--	91	91
All Types	49	85	66

Table 3.10: Percent of facilities offering malaria testing with anti-malarials seen in stock, mainland

	Government	NGO/private	Combined
Chloroquin	93	100	97
Fansidar / Metakelvin	42	77	64
Quinine	65	91	81
Halfan	1	17	10
Other	6	26	18

3.2 Medications and Services Available

In addition to the importance of logistics for family planning, questions relating to supply chains, in-stock medicines, and other available materials can be significant for understanding the level of quality care in the provision of other types of RCH services. Tables 3.9-3.12 indicate some of this logistical information for a variety of preventative and curative applications for diseases or conditions prevalent in Tanzania at this time, using all facilities in each category as the denominators. Visual verification of working equipment by the interviewer was not required for some areas; thus, except where "seen in stock" is specifically noted, the data represent percentages of facilities that self-reported offering the specified service(s). In some areas, the TRCHS collected both self-reported and visually verified information about services. Comparing the two can suggest possibilities for further investigation or improvement of services through improved logistics. As shown here, both malaria testing (Table 3.9) and anti-malarials (Table 3.10) are reliably available at many hospitals, both in the government and NGO/private sectors. NGO/private facilities tend to have more reliable stocks of anti-malarials in addition to Chloroquin.

As an example of the need for improvement in logistics, the following two tables demonstrate that, while 91 percent of all government facilities report they offer measles vaccination (Table 3.11), only 89 percent of those facilities had measles vaccine in stock at the time of the TRCHS interview (Table 3.12). A discrepancy in the other direction occurs in the NGO/private sector, with a higher percentage of facilities having the vaccine in stock than actually claim to offer the service.

Figure 3.3 shows stocks of four commonly needed prophylactic and other health supplies in private pharmacies around the country. The availability of each item (if found in stock during completion of the TRCHS Pharmacy Inventory questionnaire) is given as an average over all of the surveyed pharmacies, by the surveyed areas (index cluster and two surrounding tiers of EAs). These figures show the average availability in nationally repre-

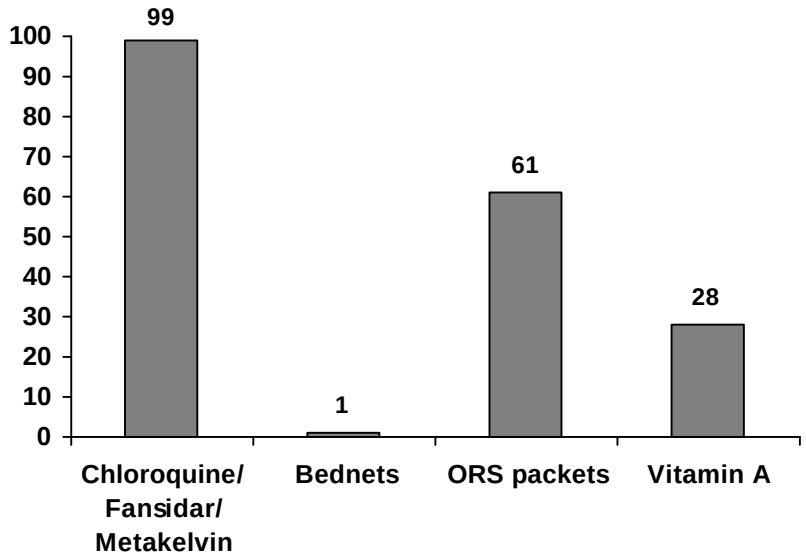
Table 3.11: Percent of facilities offering measles vaccination, mainland

	Government	NGO/Private	Combined
Hospitals	93	80	91
Health Centres	94	54	77
Dispensaries	89	29	56
UMATI Clinics	--	7	7
Marie Stopes	--	91	91
All Types	91	36	65

Table 3.12: Percent of facilities offering child immunizations with vaccines seen in stock, mainland

	Government	NGO/Private	Combined
Measles	89	89	89
Polio	64	58	62
BCG	86	88	86
DPT	86	86	84
TT	89	86	88

Figure 3.3: Percent of pharmacies offering medicines and supplies, where seen in stock, mainland



sentative supply markets, or in other words, pharmacy stocks on average as experienced by residents of representative index clusters. This depicts the population's average access to these stocks across a nationally representative sample of supply markets. Bednets, which are especially important for preventing malaria in children, were only found in 1 percent of pharmacies. However, there are many other sources for bednets which were not included in this survey. Anti-malarial medications were found in 99 percent of pharmacies. Two out of three pharmacies surveyed were found to have ORS in stock.

STD services and syndromic management are discussed in full detail in Chapter Seven. Syphilis and gonorrhea are STDs of key concern in Tanzania both because they are relatively common and because they may be a cofactor in the spread of HIV/AIDS across sexual partners. Trends shown in Table 3.13 cover the 207 facilities in the matched sample (see Chapter One for details). These results are mixed, with doxycycline showing the most improvement, in all three types of facilities, while benzathine penicillin and cotrimoxazole show slight declines or no improvements in in-stock availability. The availability of Erythromycin declined in hospitals while increasing in health centres and, to a lesser extent, in dispensaries also. Fewer than half of pharmacies offer any of these antibiotics.

3.3 Summary

The utilisation of services depends on many factors, but one barrier can be simple supply-side logistics. Clients need reliable access to materials required for treatments and services that facilities claim to offer, and facilities need reliable supply systems to be able to keep appropriate amounts of needed supplies on hand. While the attention to FP logistics seems to have yielded benefits in more widespread availability of many contraceptive supplies, similar improvements have yet to occur for other essential medicines and supplies. Attention to these details and their management can be a vital element of improving the health services environment in Tanzania.

Table 3.13: Trends in percent of facilities with selected antibiotics used in syndromic management of STDs seen in stock, matched mainland facilities

	Doxycycline		Erythromycin		Benzathine Penicillin		Co-trimoxazole	
	1996	**1999**	**1996**	**1999**	**1996**	**1999**	**1996**	**1999**
Hospitals	72	89	90	80	90	79	95	88
Health Centres	38	77	38	54	60	60	96	76
Dispensaries	34	83	17	23	46	43	78	73
All Types	51	85	60	59	69	63	88	79
Pharmacies	--	18	--	19	--	9	--	41

Chapter Four: Training and Supervision

To complement the capacities implied in facility characteristics and logistics, and provide quality reproductive and child health (RCH) care, facilities need trained and competent providers on their staff. This chapter explores in some detail TRCHS results related to provider training, especially focusing on the distribution of trained providers across the range of health care facilities both on the mainland of Tanzania and in Zanzibar. Further examination of results relating specifically to provider practices in STD and HIV/AIDS services can be found in Chapter Six.

4.1 Background

A key objective of the national training strategy was to improve access to RCH services by increasing the number of facilities with trained providers. The impetus for developing a training strategy was an earlier finding that, although a relatively high percentage of facility staff overall had received training in important family planning skills, those providers tended to be found primarily at facilities in urban areas. Facilities in rural areas seemed to be gaining little benefit from programs and interventions aimed at training family planning staff. Although descriptive training statistics often focus on national averages for the percentage of staff trained in certain skills or specialties, the more pertinent matter for Tanzanians seeking health services is whether or not the average facility is likely to have one of those trained providers on staff who is available for consultation.

The government of Tanzania and interested donors accordingly agree on the importance of training at least two providers at each site in key functions in order to provide continuous availability of many important services in both urban and rural areas. Progress has been made toward greater dispersion of trained staff, and in many key areas of care the percentage of facilities with at least one provider or with at least two providers who have received in-service training since 1992 has increased. Having one provider per facility who has been trained in a given service is essential for clients to have a chance of receiving trained service, but having at least two trained providers means clients would likely be able to see an appropriately trained provider even at smaller facilities and in peripheral areas.

The 1999 TRCHS was designed to include interviews of all reproductive and child health services providers at each facility in the sample. At larger facilities, with more than six RCH providers, two providers were chosen randomly from each of three categories: doctors, nurses and aides.[10] These providers were asked an extensive set of questions, including many related to in-service training. The remaining providers at each facility responded to a shorter questionnaire with a strong focus on in-service training. Providers responding to either the short or the long questionnaire were asked whether or not they had received any in-service training, and if they had, they were asked what year they had received which kind(s) of training.[11]

[10] "Doctors" includes the TRCHS provider categories of Doctor, Assistant Medical Officer, Clinical Officer, and Assistant Clinical Officer. "Nurses" includes the TRCHS provider categories of Nursing Officer, Nurse/Midwife, and Public Health Nurse B. "Aides" includes the TRCHS provider categories of MCH Aide and Nurse Assistant/Medical Assistant.

[11] When reviewing this data, it is important to keep in mind that a substantial proportion of providers did not provide data for the TRCHS. Approximately one-fourth (23 percent) of providers listed as offering RCH services at the facilities surveyed did not complete questionnaires for TRCHS interviewers (roughly the same rate of response as the 1996 TSAS). Reasons offered include illness, vacation, and attending training off-site at the time of the survey. Even if the providers who were interviewed are representative of all RCH providers, these results may not fully capture the availability of trained providers per facility in the national RCH provider pool.

Figure 4.1: Percent of providers with in-service training covering specific topics, 1993 or later, mainland

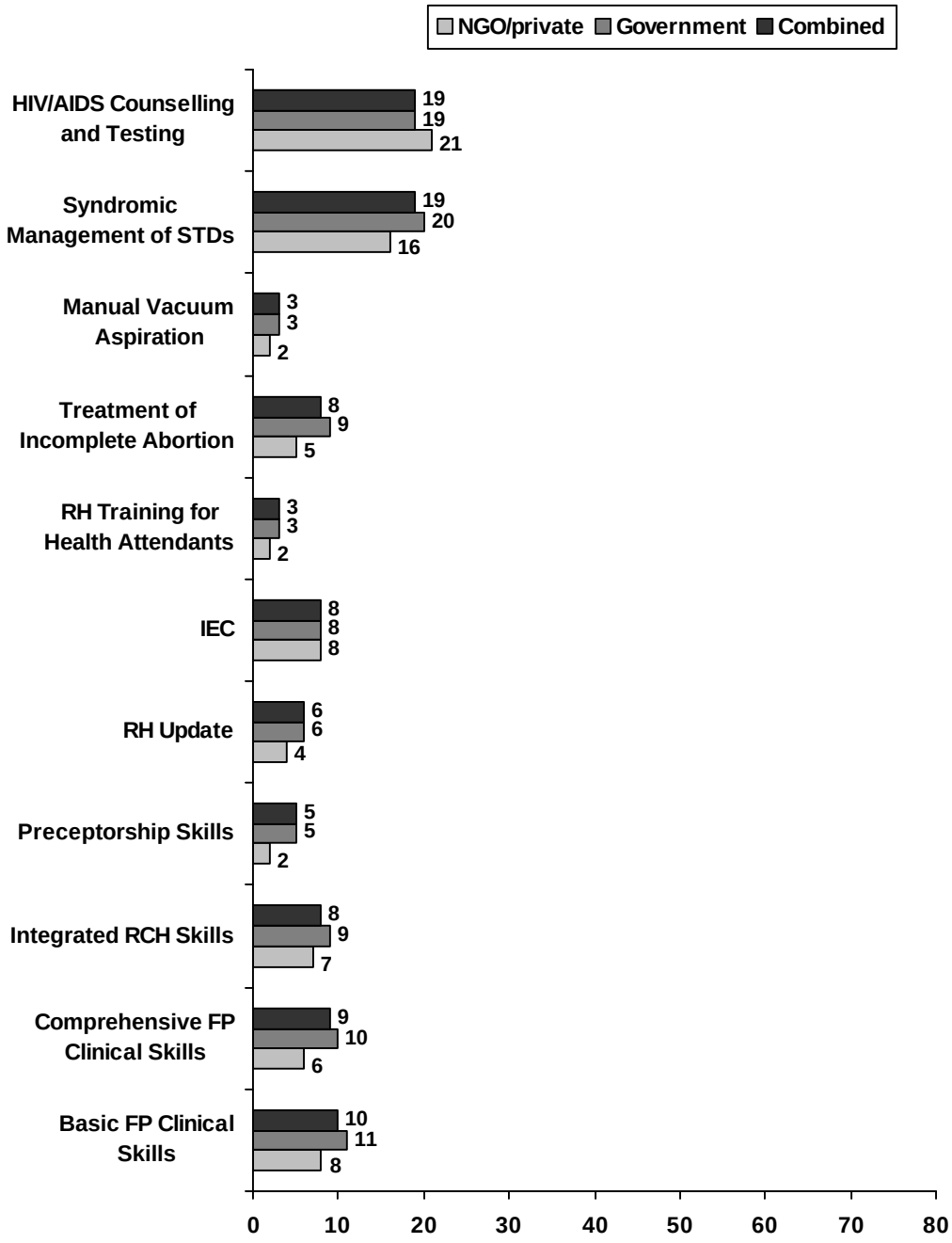


Figure 4.2: Percent of providers with in-service training covering specific topics, 1993 or later, Zanzibar

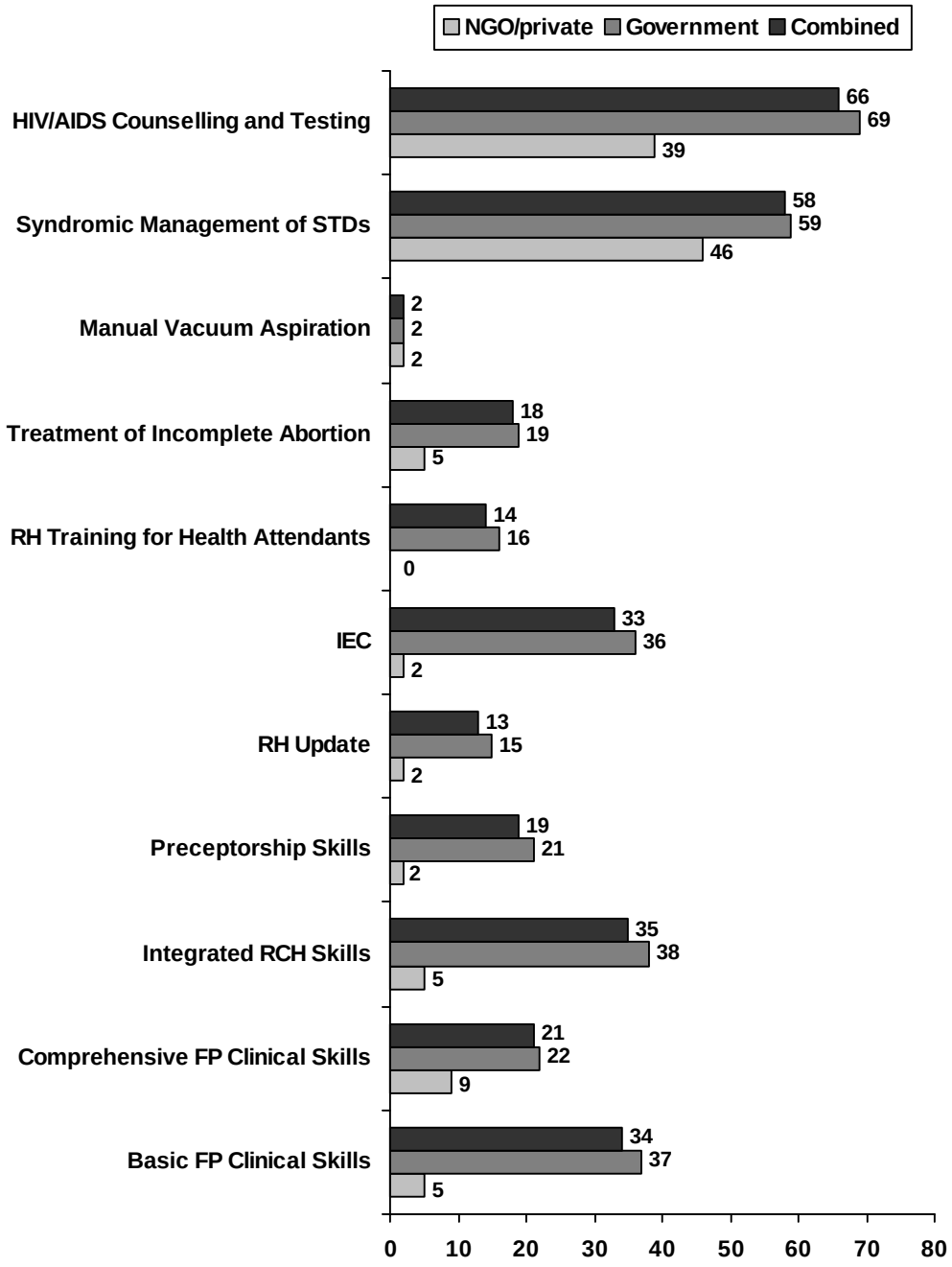


Table 4.1: Percent of facilities with at least one or two providers with any type of in-service training in the past 2 years, mainland

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	99	94	87	69	98	91
Health Centres	94	73	55	17	77	49
Dispensaries	76	41	45	14	59	26
UMATI Clinics	--	--	100	45	100	45
Marie Stopes	--	--	100	82	100	82
All types	86	63	51	19	70	42

Table 4.2: Percent of facilities with at least one or two providers with any type of in-service training in the past 2 years, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	100	100	100	0	100	89
Health Centres	99	63	0	0	94	60
Dispensaries	--	--	32	12	32	12
Marie Stopes	--	--	100	100	100	100
All Types	99	65	34	7	85	53

Earlier in-service training curricula were replaced in 1992 with a standardised training system, and the TRCHS collected data on providers exposed to any of these courses. In this chapter, therefore, a trained provider is one who has received in-service training through this newly standardised curriculum in or after 1992. The restriction is deliberate in order to focus on evaluating the results of 1992-1999 efforts.

4.2 Any In-Service Training in the Past 2 Years

The provider instruments included in-service training questions that focused on specific courses or topics.[12] Figures 4.1 and 4.2 display provider percentages for each topic.

The most common topic for providers on the mainland to cover in any in-service training in recent years were HIV/AIDS/STD counselling and testing (19 percent) and syndromic management of STDs (19 percent). The next most common courses were basic family planning clinical skills (10 percent), and comprehensive FP clinical skills (9 percent). In most areas, the percentage of government providers that have taken courses covering the subjects exceeds NGO/private sector providers.

In Zanzibar, the percentage of providers that have taken courses covering these topics in recent years tends to be higher than on the mainland. Topics covered by the highest percentage of providers include HIV/AIDS counselling and testing (66 percent) and syndromic management of STDs (58 percent). About one-third of respondents had covered each of the following areas in their in-service training: integrated reproductive and child health skills, basic family planning clinical skills and

[12] Providers may enroll in specific courses on the topics listed. The TRCHS question, however, was slightly more general: "Have you attended in-service training courses? (IF YES) Did your in-service training include [TOPIC]?"

reproductive health training for health attendants. NGO/private sector providers lag behind government providers in recent in-service training on all topics. Topics with relatively low overall coverage for Zanzibar include manual vacuum aspiration (2 percent), RH update (13 percent), and RH training for health attendants (14 percent).

The resulting distribution of providers with some or any kind of in-service training is fairly even across facilities (Tables 4.1 and 4.2). Most government facilities both on the mainland and in Zanzibar had at least one provider who had taken at least one of the training courses within the past two years. Providers trained in at least one area are somewhat less likely to be found at NGO/private facilities. Almost all government hospitals both on the mainland and Zanzibar had at least two providers on staff who had taken at least one course.

4.3 Integrated Reproductive and Child Health Skills

Integrated Reproductive and Child Health (IRCH) training aims to improve providers' skills and facilities' capacities to manage or appropriately refer cases according to the problems presented. It is part of the effort to establish and entrench broad knowledge and awareness of the relationships between antenatal, maternal, neonatal, and child care among providers for the general improvement of family health, as well as to encourage healthier behaviours in the community. Hospitals and UMATI clinics have the highest percentages of facilities with at least one provider trained in IRCH, but only hospitals in the government sector have at least two IRCH-trained providers at a slight majority of facilities (52 percent) (Table 4.3 and 4.4). Provider access to IRCH training has been limited, but as it expands, subsequent availability of IRCH-trained providers should similarly increase.

Table 4.3: Percent of facilities with at least one or two providers trained since 1992 in integrated reproductive and child health skills, mainland

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	75	52	51	17	73	48
Health Centres	63	26	18	2	44	16
Dispensaries	43	12	14	1	28	6
UMATI Clinics	--	--	64	27	64	27
Marie Stopes	--	--	27	18	27	18
All types	55	25	19	3	38	15

Table 4.4: Percent of facilities with at least one or two providers trained since 1992 in integrated reproductive and child health skills, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	100	75	100	0	100	67
Health Centres	78	41	0	0	75	39
Dispensaries	--	--	12	0	12	0
Marie Stopes	--	--	0	0	0	0
All Types	80	42	7	0	64	33

According to providers who responded to the TRCHS, the IRCH course had reached 11 percent of RCH providers in mainland facilities and 29 percent in Zanzibar facilities by 1999. While the total number of providers who have been trained is relatively small, their distribution is broad. Most mainland government hospitals and health centres, as well as a substantial percentage of dispensaries, have at least one provider who has received IRCH in-service training since 1992. About half of NGO/private hospitals and most UMATI clinics also have at least one trained provider. Among facilities with at least two trained providers, however, only government hospitals are well represented. In Zanzibar, all eight government hospitals in the sample and most government health centres had at least one IRCH-trained provider, and most government hospitals had at least two. The one NGO/private hospital in the sample had one trained provider.

4.4 HIV/AIDS Counselling and Testing

During the nineties, Tanzania made a major effort to make voluntary counselling services available. Providers were trained in HIV counselling and were advised to refer clients to a laboratory for actual testing. There were only a limited number of centres, mostly large hospitals, where both counselling and testing were available.

Overall, nearly one-quarter of RCH service providers in mainland facilities have received in-service training through a course in HIV/AIDS counselling (Figure 4.1). Providers trained in counselling are distributed fairly well, with almost all hospitals, most health centres, and about half of all dispensaries having at least one HIV/AIDS/STD trained counsellor on staff (Table 4.5).

Table 4.5: Percent of facilities with at least one provider trained since 1992 in HIV/AIDS/STD counselling and testing, mainland

	Government	NGO/Private	Combined
Hospitals	92	87	92
Health Centres	82	60	73
Dispensaries	53	46	49
UMATI Clinics	--	82	82
Marie Stopes	--	82	82
All Types	70	52	61

Table 4.6: Percent of facilities with at least one provider trained since 1992 in HIV/AIDS/STD counselling and testing, Zanzibar

	Government	NGO/Private	Combined
Hospitals	100	0	89
Health Centres	83	0	79
Dispensaries	--	63	63
Marie Stopes	--	100	100
All Types	84	35	74

The situation in Zanzibar (Table 4.6) is similar for counselling. Most government hospitals and health centres have at least one provider on their staff who has taken the HIV/AIDS/STD counselling training course. Other facilities in Zanzibar, however, are much less likely to have a provider who is trained in HIV/AIDS counselling, while no dispensaries have a provider with this training on staff.

4.5 Incomplete Abortion (Post-Abortion Care)

About 12 percent of providers overall have taken the training course in Treatment of Incomplete Abortion (Post-Abortion Care). Most of the training has been since 1995, and more providers have been trained in Zanzibar (18 percent) than on the mainland (11 percent). These providers are much more highly concentrated in government facilities than NGO/private SDPs (Tables 4.7 and 4.8). In Zanzibar this skewed distribution is especially noticeable, with almost no NGO/private facilities having even one provider trained in post-abortion care. In addition, larger facilities, especially hospitals, are more likely than smaller SDPs to have at least one provider who has taken the training course on treatment of incomplete abortion. Interestingly, 57 percent of the 153 mainland dispensaries that do not have a trained provider in incomplete abortion treatment nevertheless report that they do offer post-abortion care, but only 64 percent of the 47 dispensaries with a provider trained in this treatment offer the service. Other factors, such as lack of equipment or supplies, may impede their ability to offer complete abortion care.

4.6 Syndromic Management of STDs

On the mainland, 23 percent of providers have been trained in the syndromic treatment of sexually transmitted diseases, with 54 percent trained in Zanzibar. Most of this training has taken place since 1992 on the mainland, but only since 1997 in Zanzibar. The distribution of providers with this training is reasonably even, with most government facilities on the mainland and almost all government facilities in Zanzibar having at least one trained provider (Table 4.9 and 4.10). Eight of the eleven NGO/private dispensaries and the only NGO/private hospital in the TRCHS Zanzibar sample have at least one trained provider. Trained providers are not as widespread among NGO/private facilities on the mainland.

One element helpful for appropriate treatment of STDs is a set of guidelines for appropriate syndromic management. Of the 88 percent of facilities that offer STD treatment, 64 percent on the mainland but only 40 percent in Zanzibar have a copy of some set of guidelines for appropriate syndromic treatment. The presence of a trained provider correlates with having a copy of guidelines: 76 percent of mainland facilities with a trained provider had a copy of guidelines available, versus 38 percent of those without a trained provider. In Zanzibar, while fewer facilities had a copy of guidelines, those with a trained provider were more likely to have a copy available when asked.

4.7 Family Planning Training and Trends

As mentioned in Chapter Two, the importance of family planning and provider training in family planning has been recognised for some time in Tanzania. Figures 4.3 and 4.4 show changes between 1996 and 1999 in training levels in family planning at the 207 identical facilities (mainland only) surveyed for both the TSAS and the TRCHS.[13] Full provider training in family planning consists of having completed three of the standard courses: Basic FP Clinical Skills, Comprehensive FP Clinical Skills, and Reproductive Health Update. If a provider reported having taken any one of these courses since 1992, however, the provider is counted for the following graphs as a trained family planning provider. The number of facilities with at least one trained provider in family planning has risen quite noticeably in the 1996-1999 period.

[13] Results presented here separate facility types and facility sectors in two graphs, to avoid the exaggerated percentage changes for cross-tabulated cell sizes that are too small to be fairly representative. (For example, the matched facilities include only 5 NGO/private hospitals, a sample size far too small for generalizable results. If only one of these hospitals changed between 1996 and 1999, the graph would show a difference of 20 percent, statistically unlikely to be an accurate representation of overall trends.)

Table 4.7: Percent of facilities with at least one or two providers trained since 1992 in post-abortion care, mainland

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	77	57	29	19	72	53
Health Centres	54	25	18	6	39	17
Dispensaries	27	12	11	1	18	6
UMATI Clinics	--	--	91	27	91	27
Marie Stopes	--	--	73	45	73	45
All Types	47	27	15	4	32	17

Table 4.8: Percent of facilities with at least one or two providers trained since 1992 in post-abortion care, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	88	75	0	0	78	67
Health Centres	49	8	0	0	47	7
Dispensaries	--	--	12	0	12	0
Marie Stopes	--	--	100	0	100	0
All Types	51	12	7	0	42	9

Table 4.9: Percent of facilities with at least one or two providers trained since 1992 in STD syndromic management, mainland

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	91	80	79	57	89	78
Health Centres	85	71	38	6	65	44
Dispensaries	59	27	39	7	48	16
UMATI Clinics	--	--	91	45	91	45
Marie Stopes	--	--	91	73	91	73
All Types	72	49	42	11	58	32

Table 4.10: Percent of facilities with at least one or two providers trained since 1992 in STD syndromic management, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	100	100	100	0	100	89
Health Centres	99	56	0	0	94	53
Dispensaries	--	--	74	12	74	12
Marie Stopes	--	--	100	0	100	0
All Types	99	59	50	5	88	47

Figure 4.3: Trends in percent of facilities by sector with at least one or two trained family planning providers, matched mainland facilities

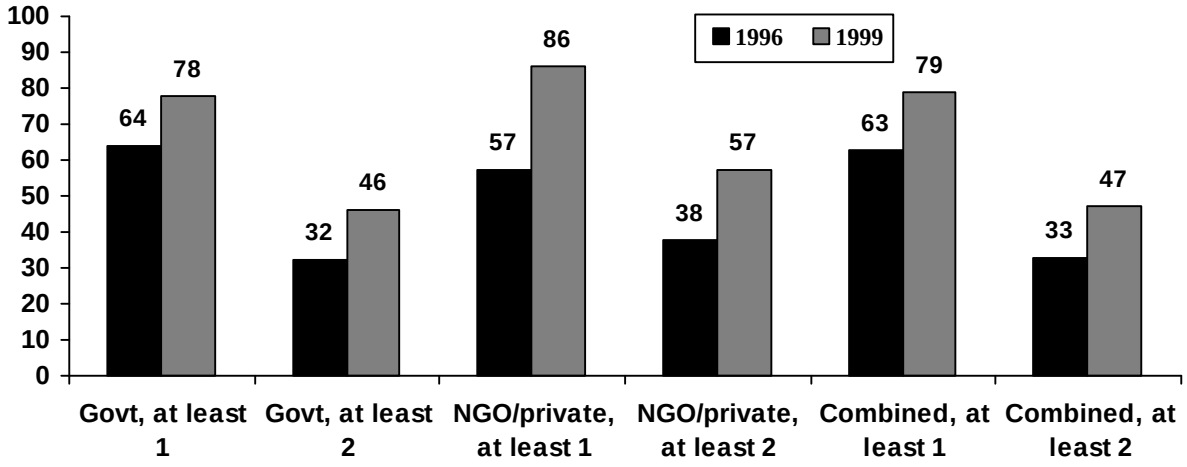
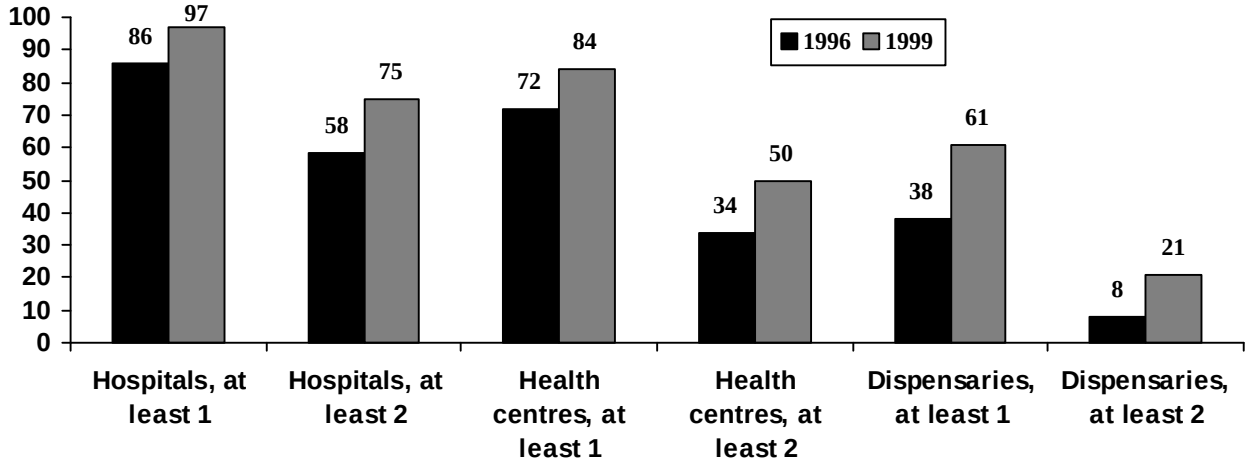


Figure 4.4: Trends in percent of hospitals, health centres, and dispensaries with at least one or two trained family planning providers, matched mainland facilities



4.8 Supervision by District Health Management Teams

Part of the decentralisation process of health care currently underway in Tanzania involves a reorganisation of supervision at the district level. Whereas district-level health managers made visits individually in the past, the effort now is toward a team approach to facility supervision. Tables 4.11-4.14 present the frequency of visits to facilities by the DHMT as well as the composition of the teams by the specific DHMT officers making those visits.

Table 4.11 presents the percent of facilities receiving a DHMT visit during the past month. District hospitals are not included, however, because the DHMT is normally headquartered there. Government health centres have been most often visited recently, both on the mainland and in Zanzibar. About half of all government facilities on the mainland had been visited by members of their DHMT during the previous month, and about one-third of the NGO/private facilities. In Zanzibar, all of the NGO/private facilities answered "not applicable" to this question because only government facilities (hospitals and health centres) on Zanzibar anticipate visits from Zanzibar DHMTs (Table 4.12).

Tables 4.13 and 4.14 show the percentage of facilities visited at any time during the previous six months by various officers who are members of the DHMTs. (Only the makeup of the most recent visit is tabulated here.) The abbreviations are

- **DMO**: District Medical Officer
- **DNO**: District Nursing Officer
- **DHO**: District Health Officer
- **DMCHC**: District Maternal and Child Health Co-ordinator
- **DTBLC**: District Tuberculosis and Leprosy Co-ordinator
- **DAC**: District AIDS/STD Co-ordinator
- **DCCC**: District Cold Chain Co-ordinator
- **DHS**: District Health Supervisor

On the mainland, the Maternal and Child Health Co-ordinator visited the most facilities most recently, being present at nearly half of the most recent facility visits of all types. The Health Supervisor made the fewest of these visits. The Medical Officer, Nursing Officer, Health Officer, and Cold Chain Co-ordinator were present at about one-third of the most recent visits to facilities. In Zanzibar, only two non-district hospitals are in the sample, and both had visits from four DHMT members during their most recent visit.

4.9 Summary

Provider training is a crucial element of the provision of quality health care in any country. The curricula inaugurated in 1992 seems to be reaching Tanzanian providers, and the distribution across facility types and through the country is improving in many service areas.

Table 4.11: Percent of facilities visited within the last month by the District Health Management Team members, mainland

	Government	NGO/Private	Combined
Hospitals	18	30	21
Health Centres	64	52	59
Dispensaries	49	29	38
UMATI Clinics	--	10	10
Marie Stopes	--	22	22
All Types	49	31	39

Table 4.12: Percent of facilities visited within the last month by the District Health Management Team members, Zanzibar

	Government
Hospitals	50
Health Centres	80
Dispensaries	--
Marie Stopes	--
All Types	79

Table 4.13: Percent of facilities visited by each type of District Health Management Team member during the team's most recent visit within the last 6 months, mainland

	DMO	DNO	DHO	DMCHC	DTBLC	DAC	DCCC	DHS	OTHER
Hospitals	50	48	34	68	4	7	34	0	14
Health Centres	56	54	39	62	28	13	47	4	22
Dispensaries	25	34	34	43	14	9	37	5	24
All Types	34	39	33	49	16	10	39	4	23

Table 4.14: Percent of facilities visited by each type of District Health Management Team member during the team's most recent visit within the last 6 months, Zanzibar

	DMO	DNO	DHO	DMCHC	DTBLC	DAC	DCCC	DHS	OTHER
Hospitals	100	100	100	50	0	0	0	100	50
Health Centres	53	58	87	78	22	32	18	15	60
All Types	54	59	87	77	22	32	17	16	60

Chapter Five: Family Planning and Maternal and Child Health

Family planning (FP) has been a key focus for improvements in the Tanzanian health care system since the early 1990s. Although the significance of STDs and HIV/AIDS is increasing, FP and maternal and child health (MCH) concerns remain high on the shared agenda of the Tanzanian government and many involved donors. This chapter presents a series of TRCHS results most relevant to these areas of interest. Because FP has been a high priority through the different facility survey rounds, many of those results are directly comparable to the 1996 TSAS data.

5.1 Family Planning

The most basic means of monitoring an available service include tracking the numbers of new and continuing users of the service. Table 5.1 presents the trend in the number of new acceptors, and Table 5.2 the trend in re-supply FP acceptors. Figure 5.1 presents the average growth by patient and facility type. In both means and medians, both the government new acceptor and re-supply numbers have been rising while the NGO/private numbers at hospitals, health centres and dispensaries have been falling.[14] This is surprising, but is partially offset by the expanded presence of the Marie Stopes and UMATI facilities, which seem to be absorbing most of the growth in FP services for the relatively more affluent NGO/private customers. Marie Stopes clinics report especially high numbers of FP users (Table 5.3).

Table 5.1: Trends in number of new acceptors at facilities offering family planning services, in the last year, matched mainland facilities

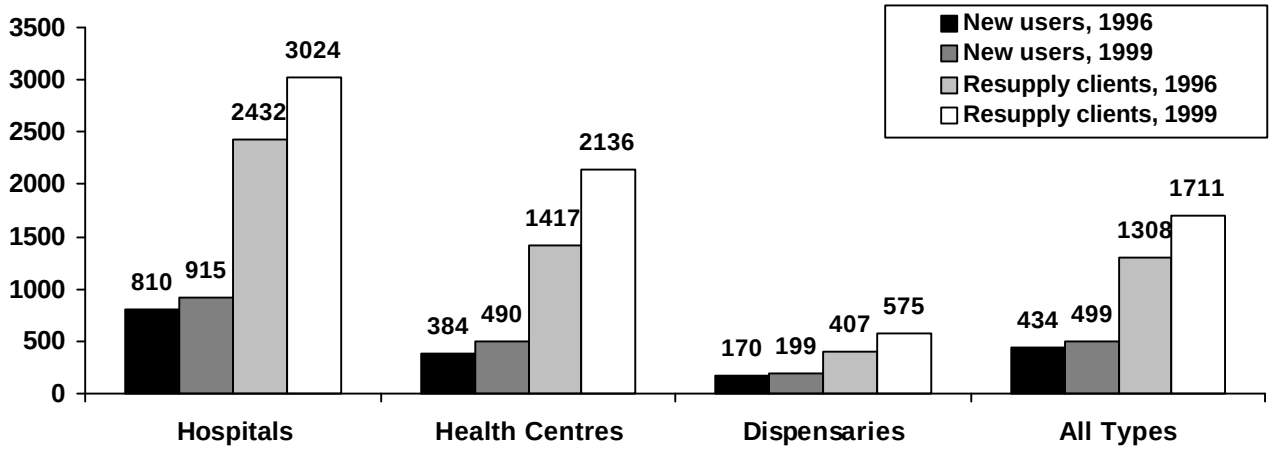
		Government		NGO/Private		Combined	
		1996	1999	1996	1999	1996	1999
Hospitals	Mean	824	956	542	139	810	915
	Median	512	673	236	171	504	649
Health Centres	Mean	423	551	91	31	384	490
	Median	182	235	40	22	159	201
Dispensaries	Mean	164	196	294	253	170	199
	Median	73	96	292	147	199	96
All Types	Mean	444	525	288	151	434	499
	Median	196	210	134	159	195	193

[14] Both means and medians are presented to show both the statistical average number of clients (the mean) and the midpoint number, with half of the facilities having that number or more clients and half having that number or fewer (the median). A median significantly lower than the mean, then, indicates relatively many facilities having relatively low numbers of clients. That is the case for most categories of facilities according to these results. A median higher than the mean, of course, indicates the opposite (many facilities having relatively high numbers of clients, in this case).

Table 5.2: Trends in number of re-supply clients at facilities offering family planning services, in the last year, matched mainland facilities

		Government		NGO/Private		Combined	
		1996	**1999**	**1996**	**1999**	**1996**	**1999**
Hospitals	Mean	2485	3161	1428	430	2432	3024
	Median	1904	2697	350	464	1853	2644
Health Centres	Mean	1575	2401	230	156	1417	2136
	Median	431	842	102	128	402	602
Dispensaries	Mean	401	588	524	361	407	575
	Median	170	263	399	302	172	270
All Types	Mean	1352	1814	663	310	1308	1711
	Median	426	657	330	277	403	546

Figure 5.1: Trends in average number of new and re-supply clients at facilities offering family planning services, in the last year, matched mainland facilities



5.2 The FP Facilities Market

As Figures 5.2 and 5.3 show, the government sector bears a larger load of new FP acceptors, with the share especially skewed for dispensaries. Re-supply acceptors show a similar pattern on the mainland, although for this service the sectoral distribution for hospitals almost exactly matches the sectoral distribution of the client load. Table 5.4 shows that in Zanzibar NGO/private dispensaries reported the greatest number of new acceptors.

As mentioned before, it seems that Marie Stopes and UMATI clinics are beginning to absorb some of the NGO/private facilities' market share of new and re-supply acceptors. In the month before the survey, Marie Stopes clinics saw an average of 376 new acceptors per facility compared to the combined average of 74 for all other NGO/private facility types (Table 5.3). Government health centres had the highest average for a government facility type with an average of 78 new acceptors per facility. The average number of re-supply acceptors at Marie Stopes clinics was 429, which was higher than any other facility type, government or NGO/private (Table 5.5). Although Marie Stopes clinics represent only a small portion of the market share, in the month before the survey they reported serving more modern FP users per clinic than any other facility type.

Table 5.3: Number of new acceptors of modern family planning (in the previous month), mainland

	Government		NGO/Private		Combined	
	Mean	**Median**	**Mean**	**Median**	**Mean**	**Median**
Hospitals	64	49	16	6	60	45
Health Centres	78	25	8	3	59	20
Dispensaries	27	11	13	3	23	9
UMATI Clinics	--	--	37	25	37	25
Marie Stopes	--	--	376	135	376	135
All Types	48	22	18	4	40	14

Table 5.4: Number of new acceptors of modern family planning (in the previous month), Zanzibar

	Government		NGO/Private		Combined	
	Mean	**Median**	**Mean**	**Median**	**Mean**	**Median**
Hospitals	11	9	n/a	n/a	11	9
Health Centres	4	2	n/a	n/a	4	2
Dispensaries	--	--	31	50	31	50
All Types	4	2	31	50	5	2

Figure 5.2: Proportion of new acceptors of modern family planning at government versus NGO/private sector facilities (in the previous month), mainland

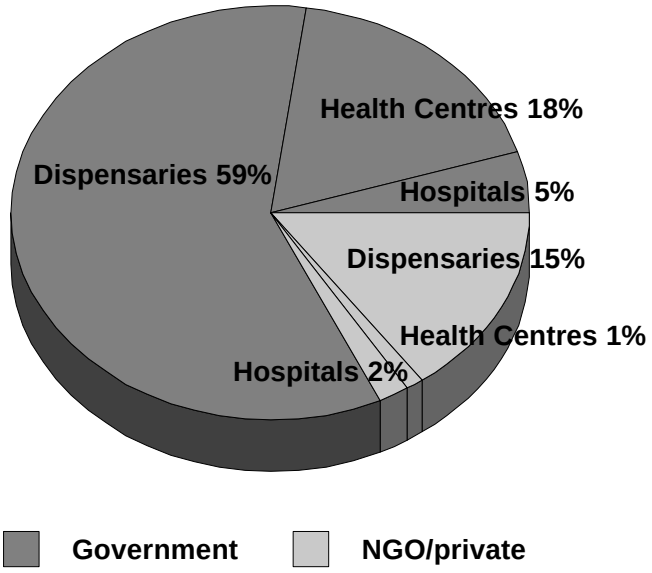


Figure 5.3 : Proportion of re-supply acceptors of modern family planning at government versus NGO/private sector facilities (in the previous month), mainland

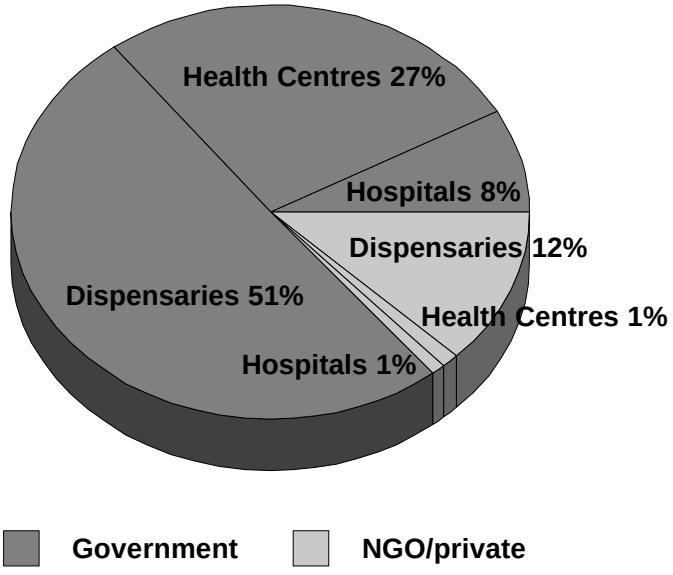
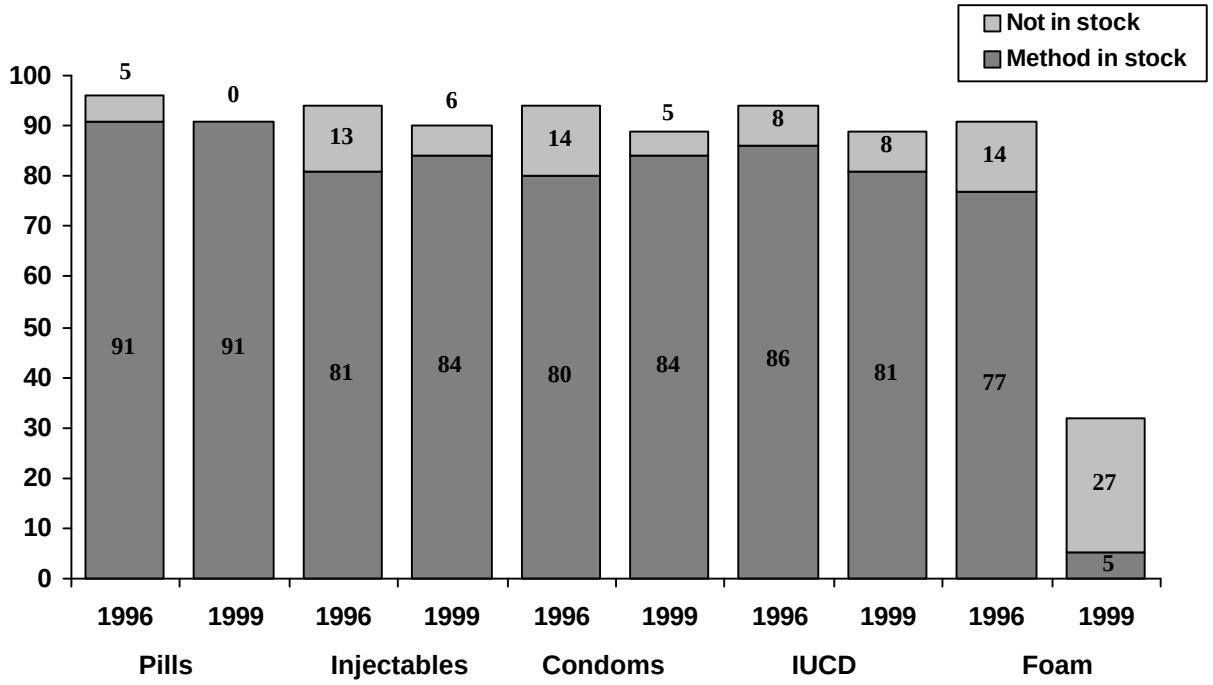


Table 5.5: Number of re-supply acceptors of modern family planning (in the previous month), mainland

	Government		NGO/Private		Combined	
	Mean	**Median**	**Mean**	**Median**	**Mean**	**Median**
Hospitals	308	256	41	42	283	239
Health Centres	353	133	25	29	264	48
Dispensaries	70	26	32	12	58	20
UMATI Clinics	--	--	116	69	116	69
Marie Stopes	--	--	429	483	429	483
All Types	195	70	41	16	152	42

Figure 5.4: Trends in percent of hospitals offering specific family planning methods (in stock or not seen in stock), matched mainland facilities



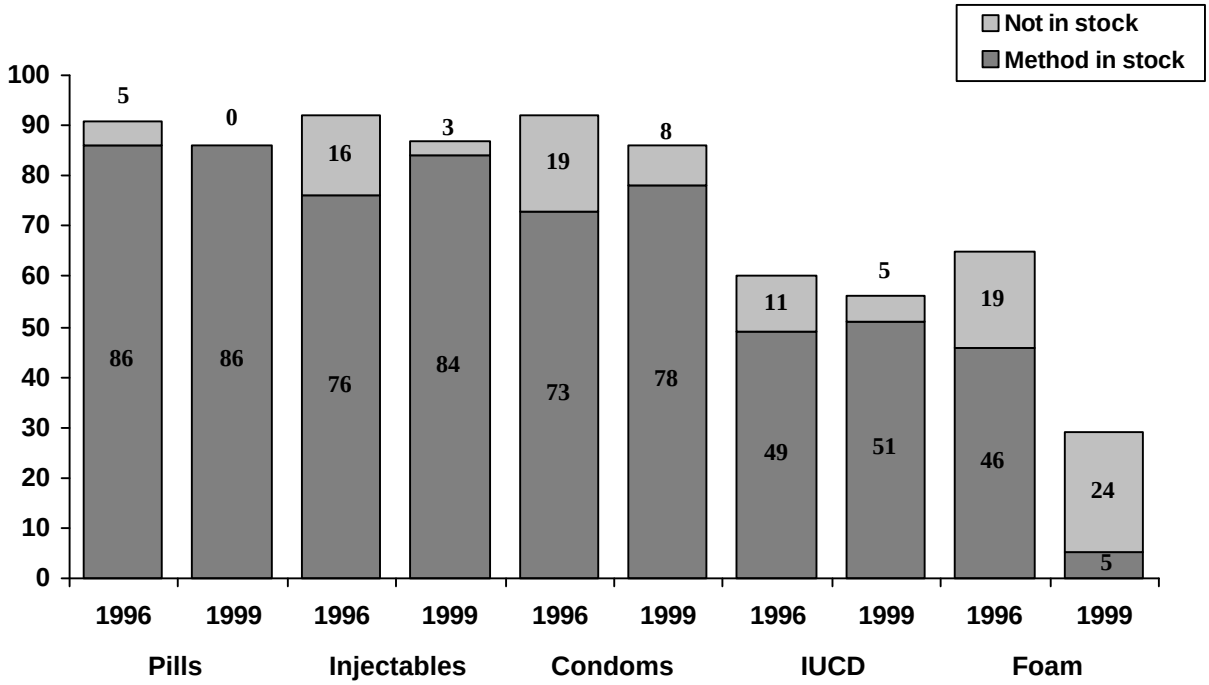
5.3 Methods Available and In Stock

Figures 5.4 to 5.6 present the trend in the availability of specific methods of contraception offered in hospitals, health centres and dispensaries between 1996 and 1999. While the absolute number of FP clients has been rising considerably, stockouts in offered methods have not increased. In fact, in-stock availability of offered FP methods has increased. Besides a slight decline in IUCD in-stock availability in hospitals, from 86 percent in 1996 to 81 percent in 1999, the only exception to the trend is the huge drop in the availability and stock of spermicidal foam, across all facility types.

5.4 IEC

Throughout the 1990s, a number of information, education, and communication (IEC) campaigns promoted family planning in Tanzania. Although popular appreciation of the need for changed health behaviours neither instantly nor automatically translates into changed lifestyles, IEC campaigns are commonly held to be one of the most necessary foundations that can gradually lead toward meaningful, sustainable health improvements on a national level. Encouraging a population to adopt healthier behaviours often begins with raising popular awareness and understanding of the risks of some behaviours versus the benefits of others. FP IEC efforts have included media campaigns, posters, slogans, and grassroots communications. Comparable national-level attention and resources have not yet been devoted to IEC focusing broadly on RCH promotion.

Figure 5.5: Trends in percent of health centres offering specific family planning methods (in stock or not seen in stock), matched mainland facilities



5.4.1 Trends in facility outreach programs

Concerted national campaigns focused on family planning promotion had largely been completed by the close of the decade, and at least a temporary decline in facilities reporting that they have an outreach program for IEC can be seen in the TSAS/TRCHS comparative sample. Of the 207 facilities in the matched sample (see Chapter One), the percentage not offering community health education or making other self-defined IEC outreach efforts has increased noticeably (Figure 5.7). We cannot draw strong conclusions from such a small sample, but the direction of apparent change may be cause for concern, and motivation for renewed energy and attention to be focused on this area. Table 5.6 shows that two out of three UMATI clinics and over 90 percent of Marie Stopes clinics reported supervising community-based distributors (CBDs).

5.4.2 Facility outreach programs, mainland 1999

Looking at the distribution of outreach programs across facility types, Figure 5.8 shows that the smallest yet most numerous facilities, dispensaries, support the lion's share of IEC outreach. Health centres represent slightly less than 20 percent of the total of outreach-providing facilities, while hospitals comprise just under a quarter of the total. UMATI clinics provide just under a half of a percent with Marie Stopes clinics providing just over three-quarters of a percentage point.

Figure 5.6: Trends in percent of dispensaries offering specific family planning methods (in stock or not seen in stock), matched mainland facilities

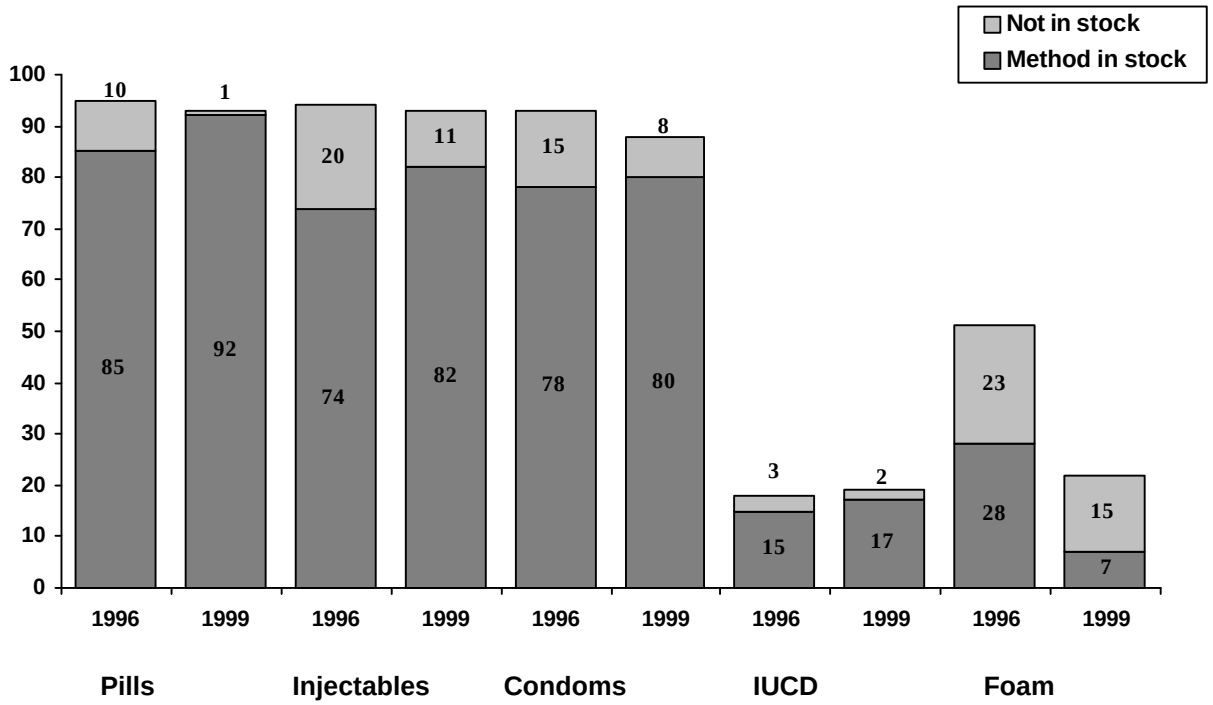


Figure 5.7: Trends in number of facilities not offering IEC outreach programs, matched mainland facilities

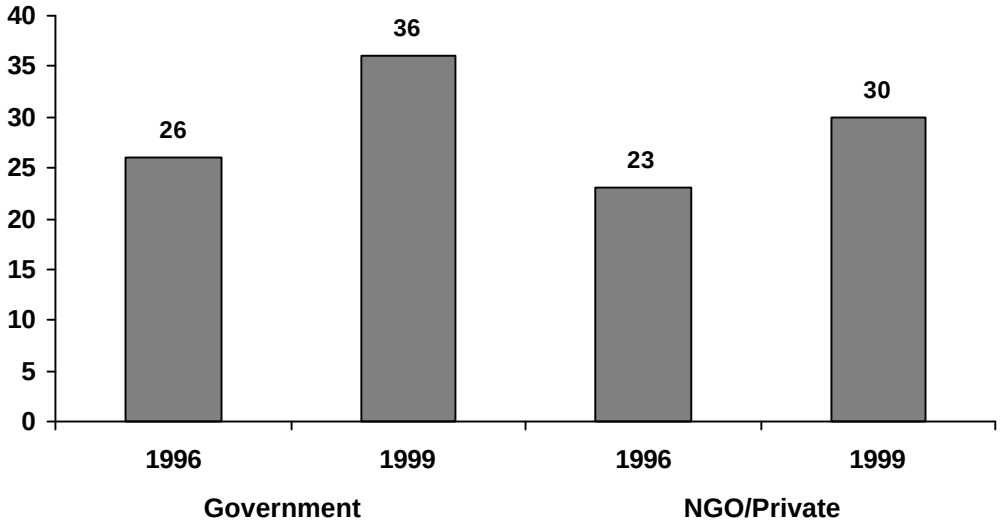


Table 5.6: Percent of facilities that supervise CBDs, mainland

	Government	NGO/Private	Combined
Hospitals	21	0	18
Health Centres	13	2	8
Dispensaries	16	5	10
UMATI Clinics	--	64	64
Marie Stopes	--	91	91
All Types	17	5	11

Figure 5.8: Facility mix of outreach providers, mainland

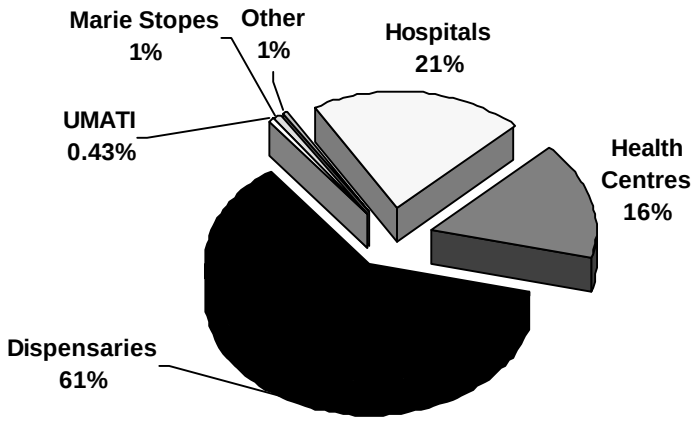


Table 5.7: Percent of facilities with at least one provider with IEC training, mainland

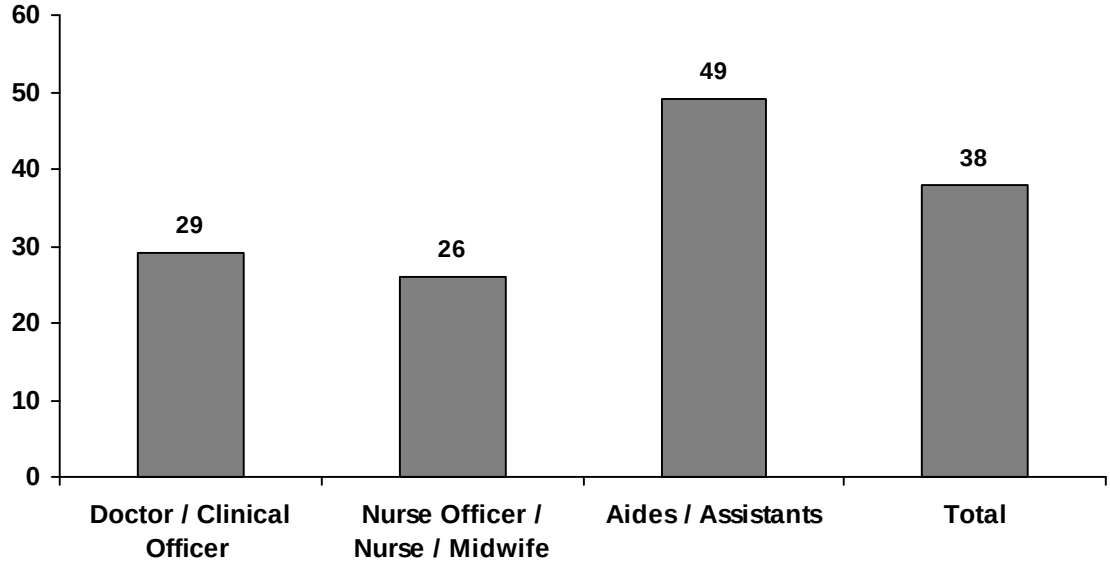
	Government	NGO/Private	Combined
Hospitals	69	50	67
Health Centres	57	19	44
Dispensaries	33	14	23
UMATI Clinics	--	91	91
Marie Stopes	--	50	50
All Types	48	21	36

5.4.3 IEC training

IEC can also be an important element of health care provision at service delivery points. Facilities may provide information, offer talks, or sponsor other educational activities. Provision of these IEC services can be greatly enhanced where there is an IEC-trained provider at each facility, and where providers are equipped with materials such as a "Service Provider's Toolkit". Table 5.7 shows that many facilities do have at least one provider with IEC training, although only the UMATI clinics and government hospitals have notably strong percentages in this area. Less than one-third of doctors, just over one-fourth nurses and about half of aides/assistants reported having a "Service Provider Toolkit" (Figure 5.9).

IEC activities often provide critical momentum toward improvements in a population's behaviour, not only encouraging people to take responsibility for protecting their own health, but also informing them about when and how to seek care from professionals when they need it. Preventive care and health-seeking behaviours can have dramatic and long-lasting benefits, and this is particularly true in the areas of reproductive and child health. At this time, however, IEC outreach seems to be waning in the field, and the effects of this are becoming apparent across all facility types and sectors.

Figure 5.9: Percent of providers with "Service Provider's Toolkit", mainland



5.5 Obstetric Care

5.5.1 Normal deliveries

As presented in Table 5.8, 100 percent of hospitals reported that they were capable of handling normal deliveries. Except for Marie Stopes clinics and health centres, fewer than half of all other NGO/private facilities reported being equipped for normal deliveries. Over three-fourths of all government facility types were equipped for handling normal deliveries.

5.1.2 Obstetric complications

As might be expected, TRCHS results show that higher percentages of facilities of every type are equipped for normal deliveries than for offering emergency care for obstetric complications (bleeding or prolonged or obstructed labour). In many cases, the percentage drops by roughly half (Table 5.9). UMATI clinics never provide this service, and only hospitals, both government and NGO/private, offer emergency obstetric care in nearly all facilities.[15]

[15] The question used here comes from the Facility Interview questionnaire, and reads: "Is [emergency care for bleeding and prolonged or obstructed labor] available to clients at this facility?"

5.5.3 Neonatal resuscitation

Being equipped for neonatal resuscitation is even rarer for all facility types. Government hospitals have a high percentage of facilities equipped for neonatal resuscitation, and 85 percent of NGO/private hospitals are equipped for this service (Table 5.10). Again, no UMATI clinics can provide this service, and only three percent of dispensaries, either government or NGO/private, can.

5.5.4 Vacuum extraction

Vacuum extraction equipment is only rarely to be found outside of hospitals. Most government hospitals are equipped for this procedure, while just over two-thirds of NGO/private hospitals are thus equipped (Table 5.11). No UMATI clinics and a extremely small percentage of dispensaries, both government and NGO/private, are equipped for vacuum extraction. A small percentage of health centres and Marie Stopes clinics reported having the equipment to perform vacuum extraction.

Table 5.8: Percent of facilities equipped for normal deliveries, mainland

	Government	NGO/Private	Combined
Hospitals	100	100	100
Health Centres	82	62	74
Dispensaries	83	41	63
UMATI Clinics	--	35	35
Marie Stopes	--	56	56
All Types	87	38	70

Table 5.9: Percent of facilities equipped for normal deliveries offering emergency care for obstetric complications, mainland

	Government	NGO/Private	Combined
Hospitals	97	90	96
Health Centres	42	46	44
Dispensaries	33	17	27
UMATI Clinics	--	0	0
Marie Stopes	--	27	27
All Types	52	29	44

Table 5.10: Percent of facilities equipped for neonatal resuscitation, mainland

	Government	NGO/Private	Combined
Hospitals	91	85	90
Health Centres	16	27	20
Dispensaries	3	4	3
UMATI Clinics	--	0	0
Marie Stopes	--	22	22
All Types	26	13	20

Table 5.11: Percent of facilities equipped for vacuum extraction, mainland

	Government	NGO/Private	Combined
Hospitals	97	71	94
Health Centres	11	20	14
Dispensaries	1	0	1
UMATI Clinics	--	0	0
Marie Stopes	--	11	11
All Types	27	6	18

Table 5.12: Percent of facilities offering treatment for post-abortion, post-partum complications, mainland

	Government	NGO/Private	Combined
Hospitals	100	100	100
Health Centres	79	85	82
Dispensaries	61	67	63
UMATI Clinics	--	20	20
Marie Stopes	--	91	91
All Types	75	72	74

5.6 Other Maternal and Child Services

Well-rounded RCH facilities should be able to offer a variety of other services, both in preventive and emergency care. Tables 5.12 to 5.14 provide some overview of the responses to the TRCHS inquiries about basic yet comprehensive FP and MCH services and their availability at Tanzanian facilities of all types.

5.6.1 Post-abortion and post-partum complications

Treatment for post-abortion or post-partum complications is available fairly widely. All hospitals in both sectors offer treatment for such complications. Nearly all NGO/private health centres, large percentages of government health centres, dispensaries, and nearly all Marie Stopes clinics offered this treatment. The only facility type with a fairly poor showing in this area of service provision is UMATI clinics, which is in line with their lower percentages in several other MCH services described in this section.

5.6.2 Vitamin A supplementation and child respiratory disease services

Tables 5.13 and 5.14 provide information on post-pregnancy vitamin A supplementation and child respiratory disease services.[16] Large proportions of facilities of most types report that they offer services for child respiratory disease. While vitamin A supplements are somewhat less widely available overall, most hospitals, health centres, and dispensaries do offer vitamin A for their post-pregnancy clients.

5.7 Summary

The TRCHS represents an evolution of 1990s facility surveys, from an almost exclusive focus on FP to new attempts to gather facility-level data on a full range of RCH capacities. The FP trends data presented in this chapter are a reminder that vigilance and continued effort will be required to maintain or increase access to and quality of FP services. Many of the MCH results may serve as baselines for similar efforts to further improve the health services environment in Tanzania.

Table 5.13: Percent of facilities offering post-pregnancy vitamin A supplementation, mainland

	Government	NGO/Private	Combined
Hospitals	75	75	75
Health Centres	94	54	78
Dispensaries	82	30	63
UMATI Clinics	--	20	20
Marie Stopes	--	18	18
All Types	82	40	68

[16] The questions used come from the Facility Interview questionnaire, and read: "Is [Vitamin A supplementation **after** pregnancy] available to clients at this facility?" and "Is [child respiratory disease (service)] available to clients at this facility?"

Table 5.14: Percent of facilities offering child respiratory disease treatment, mainland

	Government	NGO/Private	Combined
Hospitals	85	100	87
Health Centres	93	100	96
Dispensaries	80	82	81
UMATI Clinics	--	20	20
Marie Stopes	--	82	82
All Types	84	88	85

Chapter Six: STDs and HIV/AIDS

STDs and HIV/AIDS have become serious concerns as their prevalence has climbed in Tanzania. Tanzania's National AIDS Control Programme (NACP) estimated in 1998 that only about 20 percent of the true number of AIDS cases were reported.[17] The low percentage of reporting is often attributed to an inadequate number of facilities with the capacity and training to test for AIDS, incomplete knowledge in the population and subgroups that may be particularly at risk, and stigma still associated with the disease. Health-seeking behaviours with respect to other STDs among the population also may need to be supported and encouraged through expanding the availability of testing, counselling, and necessary supplies at facilities throughout the country. This chapter discusses key TRCHS results related to service provision for STD treatment and voluntary counselling and testing (VCT).

6.1 Service Provision

For STDs and HIV/AIDS, service provision encompasses more than just provision of the medical treatment requested for recognised conditions or existing disease. Ideally, facilities and service providers should serve as points for individual and community education about preventive behaviours and the promotion of sexual health, without further stigmatising those who may suffer from sexual infections or diseases. Of course, the basic issues of diagnosis and treatment form the primary layer of effective facility provision of services. In Tanzania, national policy promotes syndromic management of STDs, which does not require laboratory diagnostic capabilities. Some facilities are nonetheless equipped to offer diagnosis and treatment of some widespread STDs.

6.1.1 STDs

Tables 6.1 and 6.2 provide information with respect to service provision for two specific STDs, gonorrhea and syphilis. These results show the percentage of facilities reporting that they offer STD treatment services and that they are equipped to test for the specific STD. Syphilis and gonorrhea are of special concern both because they are relatively common and because they may tend to promote the sexual transmission of HIV. Hospitals and NGO/private health centres lead in offering services for gonorrhea. A relatively small number of Marie Stopes facilities provide gonorrhea services, although a significant percentage do offer syphilis services. NGO/private health centres are less likely to offer services for syphilis, on the other hand, than for gonorrhea. Finally, availability of services for these two STDs is least common in government and NGO/private dispensaries, government health centres and UMATI clinics. The overall availability of these services is small in large part because national policy advocates the syndromic approach, which needs no lab diagnosis.

The small size of the Zanzibar sample does not allow us to draw strong conclusions on a statistical basis. Depending on incidence and prevalence rate, however, the markedly low results in these areas may be cause for concern. While hospitals and Marie Stopes clinics do offer some diagnosis and treatment of these STDs, most other facilities barely offer syphilis and gonorrhea services. The overall rates (All Types) are not encouraging for those clients who are relying on health services in Zanzibar (Table 6.3).

[17] UNAIDS estimates the adult (ages 15-49) prevalence rate of HIV infection at 8.09 percent, with approximately 140,000 adults and children dying of AIDS in 1999. The UNAIDS report on HIV/AIDS and STIs in Tanzania is available at: <http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/tanzania.pdf> .

6.1.2 HIV/AIDS voluntary counselling and testing (VCT)

Voluntary counselling and testing services for HIV/AIDS is rising in significance as the disease becomes increasingly entrenched in many segments of the Tanzanian population. Although a reliable system of referrals is a less costly alternative for all facilities striving to provide VCT, it is considered by many to be a key intervention in facility-based services for limiting the impact and spread of HIV/AIDS. Facilities offering VCT should have sufficient trained staff to meet population demands for these services.

On the mainland, 70 percent of government hospitals and 45 percent of NGO/private hospitals reported offering VCT (Table 6.4). Of these, only 79 percent of the government hospitals and 55 percent of the NGO/private ones had tests in stock that were not expired (Table 6.5). The only other facility type on the mainland with more than 10 percent of facilities reporting to offer VCT was NGO/private health centre at 30 percent.

Table 6.1: Percent of facilities offering laboratory diagnosis and treatment of gonorrhea, mainland

	Government	NGO/Private	Combined
Hospitals	89	100	90
Health Centres	27	85	52
Dispensaries	4	51	30
UMATI Clinics	--	10	10
Marie Stopes	--	45	45
All Types	34	56	44

Table 6.2: Percent of facilities offering laboratory diagnosis and treatment of syphilis, mainland

	Government	NGO/Private	Combined
Hospitals	79	92	80
Health Centres	46	58	51
Dispensaries	7	44	28
UMATI Clinics	--	10	10
Marie Stopes	--	91	91
All Types	37	49	43

Table 6.3: Percent of facilities offering diagnosis and treatment of syphilis or gonorrhea, Zanzibar

	Government		NGO/Private		Combined	
	Syphilis	**Gonorrhea**	**Syphilis**	**Gonorrhea**	**Syphilis**	**Gonorrhea**
Hospitals	50	75	n/a	n/a	50	75
Health Centres	0	0	0	0	0	0
Dispensaries	--	--	0	7	0	7
Marie Stopes	--	--	100	0	100	0
All Types	3	4	10	18	4	8

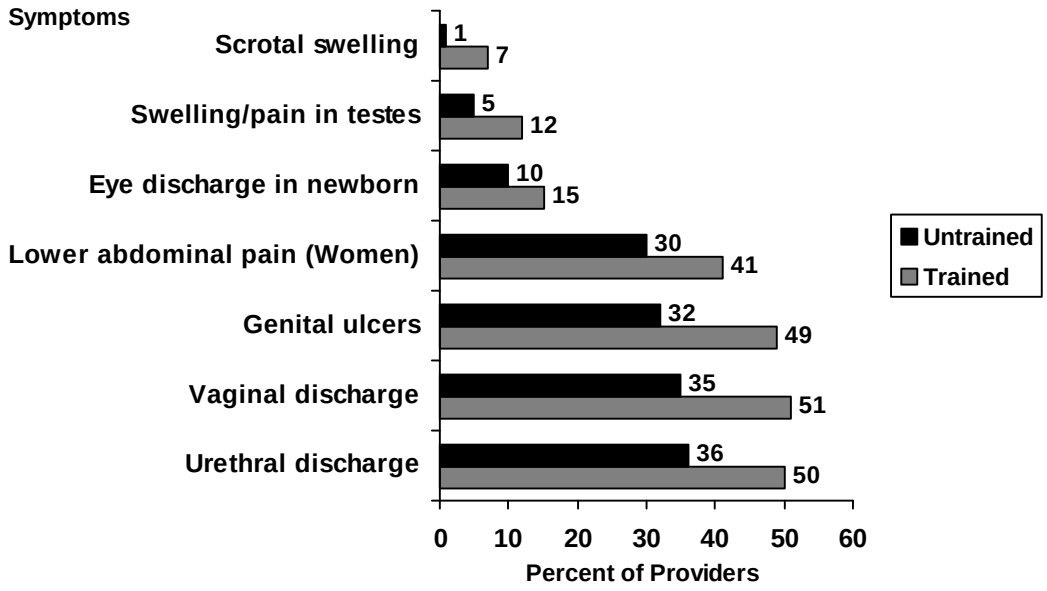
Table 6.4: Percent of facilities offering HIV/AIDS voluntary counselling and testing (VCT), mainland

	Government	NGO/Private	Combined
Hospitals	70	45	68
Health Centres	1	30	13
Dispensaries	0	3	2
Other	28	0	7
UMATI Clinics	--	9	9
Marie Stopes	--	0	0
All Types	21	8	15

Table 6.5: Percent of facilities offering HIV/AIDS voluntary testing where unexpired tests seen in stock, mainland

	Government	NGO/Private	Combined
Hospitals	79	55	77
Health Centres	100	100	100
Dispensaries	n/a	100	100
Other	100	n/a	100
UMATI Clinics	--	0	0
Marie Stopes	--	n/a	n/a
All Types	79	83	80

Figure 6.1: Percent of trained and untrained providers mentioning symptoms (unprompted) as STD signs or symptoms, mainland



6.2 Provider Practices

Trained service providers increase the benefits of health services for clients and the general population. The other side of the equation is that providers of limited expertise and quality are unlikely to affect health outcomes as positively as the government and donors would like. The TRCHS included questions from a variety of perspectives to try to uncover the relative quality of the STD and HIV/AIDS services being offered throughout Tanzania.

6.2.1 Identifying symptoms

Most providers were readily able to identify various symptoms that are helpful in diagnosing the likely presence of STDs (Figure 6.1). Although providers were seldom able to identify three or more of these signs or symptoms, the ones most often mentioned include the most critical indicators of the likely presence of STDs. Moreover, the results of STD training in improving providers' recognition of all of these symptoms is noticeable. Interviewers for the TRCHS did not prompt the responding providers in any way for any particular symptoms.

6.2.2 Knowledge of STD characteristics and treatment

Providers were asked to respond to eight questions on STD characteristics and treatment in the Service Provider Questionnaire. The series included six true/false questions on transmission, symptoms, etiology, and interactions with clients, plus two multiple-choice questions about the appropriate topics to include in client counselling and the important STD syndromes in Tanzania. Although a strong majority of providers from all types of facilities answered six, seven or eight questions correctly, 10 to 15 percent in each grouping answered five or fewer STD questions correctly. The questions are listed here, with the percentage of providers (overall) that answered each one correctly given in parentheses. The lowest percentage of correct answers was for question 3, with 50 percent of providers missing a true-false question regarding gonorrhea symptoms. All other questions were answered correctly by more than 80 percent of providers, with four of these seven answered correctly by more than 90 percent of providers. This dispersion indicates that provider mistakes were spread fairly evenly among these questions.

Table 6.6: Percent of providers reporting appropriate STD diagnostic and counselling practices, mainland

	Adequate History Taken		Physical Exam (Male)		Physical Exam (Female)		Offer Advice, Education	
	Trained	**Untrained**	**Trained**	**Untrained**	**Trained**	**Untrained**	**Trained**	**Untrained**
Hospitals	17	6	21	3	27	15	25	12
Health Centres	17	8	31	4	35	10	29	8
Dispensaries	23	7	34	8	36	9	28	10
UMATI Clinics	35	0	34	0	44	13	37	12
Marie Stopes	26	4	41	7	39	9	41	9
All Types	19	7	26	4	31	13	27	11

True/False:

1) The chief mode of transmission of HIV and other STDs is sexual intercourse. (97%)
2) A number of illnesses which have a similar set of symptoms and signs are referred to as a syndrome. (88%)
3) A client with signs and symptoms of gonorrhoea will complain of sores and pain on the genitals. (50%)
4) The main causes of urethral discharge are gonococcal and chlamydia urethritis. (93%)
5) When taking a history from a client with an STD, you should not let the client do most of the talking. (81%)
6) Gonococcal ophthalmia neonatorum may lead to blindness in babies. (95%)

Multiple Choice:

7) Clients with STDs should be counselled regarding all of the following with **one exception**. Please identify the exception: A. Informing partners; B. Complications of infection; C. How to talk to people; D. Compliance to treatment; E. Modifying sexual behaviour. (88%)
8) All of the following statements **except one** refer to the most important STD syndromes in Tanzania. Please identify the exception: A. Urethral discharge; B. Vaginal discharge; C. Lower abdominal pain; D. Vaginal bleeding; E. Genital ulcer. (93%)

Overall, trained providers answered 90 percent of the questions correctly, while untrained providers answered 80 percent correctly.

6.3 Treatment Practice Assessment

6.3.1 Prevention practices and syndromic management

In addition to the STD "quiz", providers were asked four questions about examining and advising clients. Their unprompted responses were recorded by the interviewers, and later scored as correct if they spontaneously mentioned most of the appropriate actions or follow-up treatments for the given hypothetical situation, with their answers scored as incorrect otherwise.[18] The results, provided in Tables 6.6 and 6.7, are quite low.

[18] The first question was "What questions do you ask if a patient complains of STD-like symptoms?" The response was scored as correct if the provider spontaneously mentioned 3 of the following 4 possibilities: present symptoms; onset or duration of symptoms; recent sexual contacts; other symptoms.
The second question, conditional on the provider's reporting routine performance of a physical examination on male STD patients, was "Please describe each step of how you would examine a male STD client after taking his history." The question was scored as correctly answered if the provider spontaneously mentioned: undressing to fully expose the genitals; checking for urethral/penile discharge; and retracting the foreskin to check for lesions.
The third question, conditional on the provider's reporting routine performance of a physical examination on female STD patients, was "Please describe each step of how you would examine a female STD client after taking her history." The question was scored as correctly answered if the provider spontaneously mentioned at least five of the following: undressing to fully expose the genitals; asking the patient to lie down; checking for vaginal discharge; looking for vaginal/vulval lesions; performing a speculum examination; performing a bimanual examination.

Providers were also able to demonstrate their proficiency in STD-related care by describing appropriate syndromic management for STDs. In this section of the provider survey, the interviewer mentioned a symptom, and providers described their first choice of treatment in the absence of any definitive diagnosis. Those responses were scored afterwards as correct or incorrect (1 or 0) by a medical professional at the RCH Section of the Ministry of Health. The treatment for male urethral discharge is described appropriately by the highest percentages of providers, with significant minorities giving the correct treatment response for some of the other symptoms as well. (Table 6.8)

6.3.2 Treatment of STDs

Further results of interest are shown in Table 6.9. Many providers in Tanzania have received training in syndromic management, and this table shows that their training is being appropriately applied in many facilities. Responses were scored by a medical professional at the RCH Section of the Ministry of Health. For hospitals, health centres and dispensaries, providers who have had training in syndromic management of STDs demonstrate significantly higher rates of correct syndromic management (self-reported) of STDs. Less encouraging percentages in the UMATI and Marie Stopes trained provider results may be an anomaly due to small sample sizes.

Table 6.7: Percent of providers, by sector, reporting appropriate STD diagnostic and counselling practices, mainland

	Adequate History Taken	Physical Exam (Male)	Physical Exam (Female)	Offer Advice, Education
Government	25	29	45	39
NGO/Private	28	36	40	35
Combined	26	30	44	38

Table 6.8: Percent of providers reporting correct syndromic treatment of STDs, mainland

	Urethral Discharge (M)	Genital Ulcer (M)	Genital Ulcer (F)	Vaginal Discharge (F)	Lower Abdominal Pain (F)
Hospitals	51	19	18	33	38
Health Centres	56	27	26	39	27
Dispensaries	46	26	23	31	29
UMATI Clinics	71	25	8	42	88
Marie Stopes	0	31	0	31	0
All Types	49	21	20	33	34

The fourth question was "Do you give any special education/advice to your STD patients?" The answer was scored as correct if the provider spontaneously mentioned: advising the patient to use condoms; and advising the patient to tell their sex partners about getting treatment.

6.4 Summary

Given the interrelationship between behaviour and risks for both STDs and HIV/AIDS, and the growing concern in the health community regarding these problems in Tanzania, the need for appropriate training and care at the facility level is also growing. These results indicate room for improvement on many fronts.

Table 6.9: Percent of providers, untrained vs. trained in syndromic management, reporting correct syndromic treatment of STDs, mainland

	Urethral Discharge (M)		Genital Ulcer (M)		Genital Ulcer (F)		Vaginal Discharge (F)		Lower Abdominal Pain (F)	
	Not trained	Trained	Not trained	Trained	Not trained	Trained	Not trained	Trained	Not trained	Trained
Hospitals	40	67	12	30	11	32	20	54	24	59
Health Centres	35	88	9	56	8	55	23	66	13	49
Dispensaries	36	59	16	39	7	43	18	48	9	54
UMATI Clinics	100	50	40	14	0	14	30	50	100	79
Marie Stopes	0	0	0	100	0	0	44	0	0	0
All Types	37	68	12	36	9	37	19	54	20	56

Chapter Seven: Management, Information and Costs

Effective information management and the efficient use of financial resources are fundamental to a health system's reliable and sustainable provision of quality services. These important processes, however, often prove difficult to quantify, which can pose obstacles to objective aggregate analysis. In an attempt to continue to probe these matters, the TRCHS design included questions related to management and costs within several of the survey instruments. Not all of these questions were meant to yield data suitable for cross-tabulations; for instance, the DHMT instrument purposefully included many open-ended questions that will require more in-depth and qualitative analysis in order to understand the meaning and implications of the responses. However, some questions on management and costs are appropriate to include in the descriptive statistics of this report.

7.1 MTUHA

The MTUHA (Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya) system is the Government of Tanzania's Health Management Information System (HMIS). Records are kept at each facility in MTUHA registers, which are designed not only for reporting to district and central levels, but also to organise useful data retained at the facility level. The registers also contain blank forms (with carbon copies) to prompt the compiling and comparison of this data both for local use and in order to report relevant statistics or trends, at intervals, to district levels. District officers then compile facility data further, report aggregate data upward to regions, and eventually the data are collected at the central or national level. MTUHA is not the only means of gathering RCH data, but it is an important element in Tanzania for routine monitoring, especially for government facilities.

While the system seems reasonably well designed, some imperfections have emerged in its actual operations. Facility-level data do not reliably make it to the national level in a regular or timely fashion. This makes national statistics from the MTUHA system somewhat unreliable at any given time, and therefore prevents the data from being used for their intended analytical and program planning purposes. Furthermore, the figures collected may not be systematically comparable year to year, as different facilities districts, and regions may have contributed data to the national level. This unreliability handicaps both government planners and donors, and renders national monitoring and evaluation (M&E) of program results and health outcomes more difficult. Another obstacle is that a facility usually has intervention or impact data, such as immunisation records, but almost never has data on the full population, for example, the percentage of children who have been immunised. Therefore, MTUHA data tend to be highly inadequate with respect to the denominators that health administrators need to calculate requested indicators. Several issues that may be related to these and other kinds of MTUHA problems are raised in various instruments of the TRCHS. Questions include many opportunities for qualitative or discursive responses and represent an effort to establish some baseline information about the system's operation. This substantive commentary from MTUHA users should be analysed later and used to help focus and direct further investigation and improvement of the system.

Tables 7.1 to 7.4 present an overview of MTUHA users and a general idea of their present experiences with the MTUHA system. Table 7.1 presents the percentage of each type of facility that reports using the MTUHA system to record or report facility activity. Table 7.2 reports the conditional percentage of facilities that use MTUHA without encountering any problems with the data-collection or data-reporting systems.

Table 7.1: Percent of facilities using the MTUHA system			
	Government	**NGO/Private**	**Combined**
Hospitals	100	100	100
Health Centres	100	92	97
Dispensaries	99	75	86
UMATI Clinics	--	36	36
Marie Stopes	--	100	100
All Types	100	80	90

Table 7.2: Percent of facilities using MTUHA without problems			
	Government	**NGO/Private**	**Combined**
Hospitals	61	66	61
Health Centres	74	77	75
Dispensaries	86	81	83
UMATI Clinics	--	100	100
Marie Stopes	--	100	100
All Types	77	80	78

As should be expected, practically all of the government facilities report using the government HMIS. It is interesting to note the extremely high percentages of NGO/private facilities also using MTUHA. Given the potential benefits from widespread use of this record-keeping and reporting system, it is important to understand and try to resolve the problems that any significant percentages of facilities may be encountering in its implementation.

As Table 7.2 indicates, while the majority of facilities in all categories are not encountering any problems with using MTUHA, a significant subset does indicate some problems implementing the system. Reporting that problems are being encountered seems to be associated with the size or complexity of facilities: the percentage of facilities reporting no problems is lowest for dispensaries, rises for health centres, and rises still further for hospitals.

Further investigation of the problems encountered would be useful. The TRCHS probed this issue just slightly, by giving respondents an open-ended chance to describe problems using MTUHA. These responses are not suitable for quantitative description or analysis in this report, but qualitative analysis should prove enlightening, and further analysis of many types could become possible. Some improvements to MTUHA could greatly expand the reliability, and thus the utility of routinely-collected national statistics.

Tables 7.3 and 7.4 present the percentage of facilities that use the MTUHA system and that had appropriately completed the registers for the services they provide at the time of the survey. While the above portrayal of problems or lack of problems with the MTUHA system is based on a self-reported perception, these tables indicate the degree to which facility implementation of MTUHA is observed to be somewhat problematic in practice. The registers of facility activity seem to pose little problem for facility staff, but the compilation of data into tables or overall results for aggregate reporting up to higher levels clearly needs significant improvement.

Table 7.3: Percent of facilities using all applicable MTUHA registers regularly			
	Government	**NGO/Private**	**Combined**
Hospitals	88	87	88
Health Centres	94	86	91
Dispensaries	87	77	82
UMATI Clinics	--	75	75
Marie Stopes	--	100	100
All Types	89	81	85

Table 7.4: Percent of facilities compiling all applicable MTUHA data tables regularly			
	Government	**NGO/Private**	**Combined**
Hospitals	12	23	13
Health Centres	8	16	11
Dispensaries	17	11	14
UMATI Clinics	--	0	0
Marie Stopes	--	0	0
All Types	14	13	14

7.2 Management and Decentralisation

Survey investigation of district management and decentralisation processes is in development. The TRCHS included a survey instrument specifically to collect data on these topics from the District Health Management Team, a potentially vital element in improving these aspects of the Tanzanian health care environment. As described briefly in Chapter One, the DHMT Questionnaire was specifically designed to capture information regarding the changing parameters of local planning, district management and integrated supervisory activity. As in the MTUHA questions, this initial investigation of some of these issues warranted the use of many intentionally open-ended responses, and the qualitative data embedded in the answers has not yet been fully analysed. Some questions were written pre-coded for quantification, however, and these results provide some insight into the overall mechanics of DHMT operations in the districts and the ongoing challenges of decentralisation. It is likely that many more interesting and important results will emerge from the qualitative analysis of the fuller responses solicited in other questions in this instrument.

Around 65 percent of DHMTs reported little to no involvement in decentralisation planning, but Figure 7.1 shows that almost half of the DHMTs surveyed report that decentralisation is currently underway or completed in their districts. On the other hand, nearly all (92 percent) of the DHMTs report some involvement to full involvement in District Workplan preparation.

Figure 7.1: Progress on decentralisation as reported by DHMTs, mainland

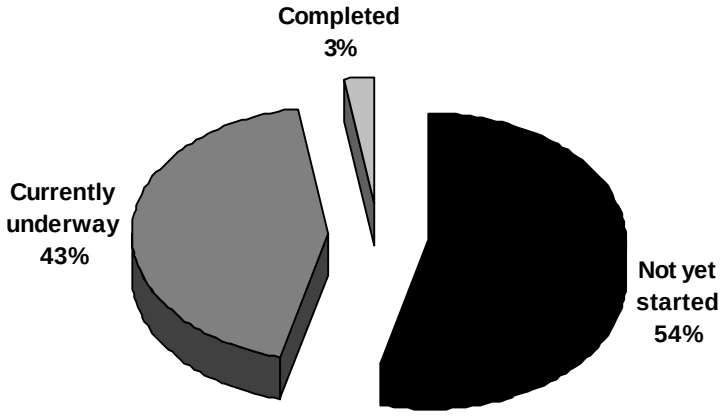


Table 7.5: Percent of facilities that charge (or request donations) for services

	Government	NGO/Private	Combined
FP New Acceptors	0	12	4
FP Re-supply	0	8	2
Maternal and Child Health	8	51	23
STD/HIV	22	75	47

7.3 Fees and Support

Cost efficiency is an increasingly important issue, but it is very difficult to attempt to measure cost efficiency across such a diversity of facilities. In addition, unlike the 1996 TSAS, the TRCHS did not attempt to collect enough information to utilise methods such as comparative couple-years protection (CYPs), or other output measures of facility costs. However, the TRCHS did collect information about direct costs to the consumers of these services. Table 7.5 provides the percentages of facilities that charge for specific services. Traditionally, FP services at government facilities have been free, but for more complicated services there is quite often a fee charged or at least a donation solicited. This is exactly the pattern we see in the following table. For all facility types, a smaller percentage of government facilities charge for services. In light of the increasing severity of the HIV/AIDS epidemic, it is interesting to note that STD services are by far the most likely to be costly to the users.

7.4 Summary

A great deal of useful work remains to be done in the areas of management and costs. The TRCHS qualitative data, at both the district and facility level, remain to be fully investigated. The design of future health services surveys could certainly benefit by building on these results to discover further details and help the government of Tanzania and donors to develop better tactics and tools in this area. Creativity and further research and analysis on the most fruitful ways to study and improve management operations and cost efficiency in facilities of varying types should also be a high priority.

Appendix A: The TRCHS Sampling Strategy

A.1 The Linked Sample Approach, as Implemented in Tanzania

This appendix describes the sampling strategy used to implement the facility portion of the 1999 Tanzania Reproductive and Child Health Survey (TRCHS). The strategy chosen for using TRCHS instruments to collect facility data in Tanzania served as a pilot implementation of MEASURE *Evaluation's* new linked sample survey design.[19] As explained in Chapter One of this report, this survey strategy aims to "capture the market" of health services provision for a (linked) population. The results are highly encouraging, clearly demonstrating that this new method can indeed be used to provide unbiased estimates of important indicators while also providing a crucial link to population-based data for impact analysis.

A.1.1 Introduction

Gauging the appropriateness of any sampling methodology depends on the purposes of the surveys involved. Facility surveys typically have the purposes of either program monitoring or impact evaluation, or both. The new sampling methodology used here is appropriate for these purposes, and provides unbiased, nationally representative estimates for facilities and their characteristics, while simultaneously being linked directly to the same areas sampled for household survey data. The unbiased representative estimates and the potential for linkage, thus more complex analysis, significantly expands the value and usefulness of results obtained through these methods.

Key ingredients for operationalizing the TRCHS linked sampling experience in Tanzania include

1. identification of index clusters (census Enumeration Areas, EAs) from a Demographic and Health Survey (DHS), serving as the foundation of overall survey design (household/individual and facility), and the determinants of DHS sample selection
2. identification of two concentric rings of clusters (EAs) around the index clusters, as areas to seek the additional facilities readily available to index cluster populations
3. compilation of a list frame, to use for large and/or special-purpose facilities
4. compilation of population data for all index and tier EAs and all other relevant strata, such as regions, needed to calculate weights (the inverse of the probability of selection into the facility sample) to produce accurate survey results (unbiased estimates).[20]

Drawing on these sources of information, the facility portion of the TRCHS surveyed all of the Tanzanian facilities selected into the sample through one of the following two modes of identification:

1. *linked area* facilities and pharmacies, or those located in or near the index EAs, urban and rural.
2. *list* facilities, or special and/or large facilities playing important or unusual roles on the supply side of the health services market available to index EA populations.

A.1.2 The area sample: linked primary sampling units

The primary sampling units (PSUs) for this survey are Enumeration Areas, or EAs, also known as clusters. The process of selecting the area-based sample of facilities in Tanzania began with consideration of the EAs used in the 1988 Population Census in Tanzania. A total of 327 nationally

[19] Turner, Anthony G., Gustavo Angeles, Amy O. Tsui, Marilyn Wilkinson, and Robert Magnani, *Sampling Manual for Facility Surveys. For Population, Maternal Health, Child Health and STI Programs in Developing Countries* (MEASURE *Evaluation*, 2000).

[20] In fact, constructing facility weights requires population data for the two tiers of EAs surrounding any EA where a facility is located, which may be the index cluster or may be any EA in the index tiers. If possible, a good strategy is to arrange access to population data for the entire sampled area (in this case, all of Tanzania) by the lowest geographical unit of selection relevance (in this case, census Enumeration Areas) prior to defining the facility sample, extracting the relevant EAs' population figures after the EA locations and surrounding EA tiers have been ascertained for all facilities covered in the survey for use in calculating facility weights.

representative EAs had been identified (using probability proportional to size calculations) for the 1991/1992 Demographic and Health Survey in Tanzania (TDHS). While the facility portions of the Tanzania Knowledge, Attitudes and Practices Survey (TKAPS) in 1994 and the Tanzania Service Availability Survey (TSAS) in 1996 deliberately aimed to cover the same (mainland) facilities, by using the same EA sample and the same selection strategy, there was no practical way to combine that panel approach with the new linked-sample strategy used for the TRCHS. The TRCHS therefore used a subset (153 EAs) for its area sampling frame.[21] This subset was a systematic sub-sample, two-thirds "rural" and one-third "urban", of the 327 PSUs originally identified for the 1991/1992 TDHS.[22] The TRCHS index clusters consist of these 153 EAs (146 on the mainland and 7 in Zanzibar). Also included in the PSUs for the facility portion of the TRCHS are the two tiers, or concentric rings, of EAs that surround each index EA.

While the household/individual instruments were applied only in the index EA, facility instruments were applied to all health facilities found in the index EA, any EA sharing a border with the index EA (the first tier), and any EA sharing a border with any EA in that first surrounding ring (the second tier). All facilities located in any index or index-tiered cluster (any linked PSU) were included in the sample for the TRCHS, in all regions except Dar es Salaam.[23] In the sampled areas, a census was taken of all identified proximate facilities.

The linked sampling strategy or method ideally promotes the use of only one ring, in order to contain costs and avoid undue complexity. In Tanzania, however, two rings became necessary when a pre-test indicated that, if the sample space were restricted to a one-ring design, the average number of facilities found per index cluster would be less than one. In order to build a sufficient sample size of facilities of diverse and representative types, for reliable and nationally representative analysis, therefore, the method was expanded to include two rings in Tanzania. The survey procedure thus called for canvassing the total geographic area defined by the index EA plus two rings, and identifying all facilities (except in Dar es Salaam).

The first stage in locating all proximate facilities required using district-level or smaller scale maps with EA boundaries indicated in order to identify the two-tiered sample spaces for each index cluster, meanwhile compiling for each index cluster a list of all facilities named by community informants on community questionnaires. Next, TRCHS interview teams visited the District Medical Officers (DMOs) in each district containing an index cluster. DMOs assisted in completing the facility census lists by adding any new or unlisted facilities, deleting any no longer in operation, and assisting as much as possible with precise locations for all of the facilities within two rings of any index cluster.[24] Where EAs in the two tiers of the sample space were occasionally located in adjoining districts, the ideal strategy would be to pursue accurate facility information for those clusters with both the index cluster's DMO and the tier cluster's (or clusters') DMO. Alternatively, such EAs could have been visited directly to conduct a community informant interview regarding the facilities found within that EA's boundaries. Ultimately, a variety of tactics are appropriate to compile a comprehensive list of all facilities in the linked PSU area frame.[25]

[21] The TKAPS (1994) had also used a subset of the original 327 EAs for its household portion. As it turned out, the TRCHS canvassed a slightly higher number of facilities than the TSAS on the mainland (507 compared to 481), and also for the first time includes 52 Zanzibar facilities. The matched set of facilities, however, is fairly small (207). See Chapter One for details.

[22] Strictly speaking, the census EAs were classified as rural, urban, or mixed. However, for the purposes of identifying mixed EAs' appropriate strata, each mixed EA received further scrutiny and was assigned to the rural or urban category based either on an assessment relayed from Macro International (DHS) or on the attributes of the next-largest geographical/population unit (in Tanzania, the next level up is the ward).

[23] Only pharmacies were sampled by cluster areas in the city of Dar es Salaam; other types of health facilities in Dar es Salaam were selected from an available listing, according to methods described in the following section.

[24] Only facilities found to be within the two-tiered sample space, not all of the facilities that had been identified by community informants, were actually canvassed.

[25] For the 16 index clusters of Dar es Salaam, the area frame and community questionnaire were used only to identify

Table A. Sampling Parameters - Dar es Salaam

	Description	Total Number of Facilities	Selection Rate	Ideal Sample	Actual Sample
1	District and consultancy hospitals	5	All	5	4
2	Health centers and "other" hospitals	40	1 in 4	10	9
3	Dispensaries, clinics, and "unknown" facilities	478	1 in 8	60	35
	Total	523		75	48

A.1.3 The list sample: special roles in the facilities market

In addition to the facility census in the area sample, the TRCHS included coverage of other facilities selected from a list frame. The list frame, or sample, is designed to ensure adequate representation of facilities in the following categories: Marie Stopes and UMATI clinics, District Hospitals, and Dar es Salaam facilities (not including pharmacies).

Marie Stopes and UMATI clinics were included on a census basis (12 and 13 facilities, respectively) regardless of their location or proximity to index clusters. District hospitals were likewise not sampled, strictly speaking; instead, any large hospital in a district that included any index cluster was automatically included in the facility sample. (The original intent was to include a census of district hospitals; however, implementation costs of that strategy would have been excessive in Tanzania.) These adjustments to the sampling strategy were made in order to capture the health services market more accurately, as these three types of facilities play special roles and provide important services for the utilisation of nearby populations, even though literal distances from a sampled community may be greater than those covered by linked PSU space.

For Dar es Salaam, facilities were sampled from a master list of all 523 facilities. Merely covering the facilities in two tiers around an index EA would not have fairly represented the true health services market utilised by the population in this extensive urban area. Residents of Dar es Salaam and surrounding areas tend to be relatively mobile and may often use facilities near their places of employment or otherwise more convenient for any reason. In addition, the population density of Dar es Salaam means that EAs tend to be geographically quite compact, resulting in an inappropriately small (or negligible) number of facilities identified in the linked PSU spaces. The alternative strategy described below was used in order to identify a sufficient number and range of facilities to provide reliable data for Dar es Salaam as a single domain or in combination with the rest of the country for national-level estimates.

The facility list breaks into three strata: the five largest facilities (district hospitals and consultancy/teaching) hospitals; other hospitals and health centres; and dispensaries and miscellaneous uncategorised facilities The sample strategy varied for each stratum.

pharmacies, as facilities were identified through the list frame method described below. No DMO reviewed the Dar es Salaam listing (of 23 pharmacies).

A.1.4 Staff sample design

At each facility included in the TRCHS, teams interviewed at least one manager to complete the facility interview questionnaire and the inventory questionnaire. In addition, staff were surveyed, with the method of selection varying according to the size of the facility. In facilities with reproductive and child health (RCH) staff numbering six or fewer, all providers were interviewed using the long form of the provider questionnaire. In facilities with more than six RCH providers, however, staff were sampled. Three strata of providers were constructed: doctors, nurses, and paramedics.[26] For each stratum, two providers were selected randomly (by pulling names out of a hat, literally) for interviews using the long form. All others were requested to complete the short form of the provider questionnaire. If one stratum in an over-6 facility contained only one provider, that provider would be selected for the long form with certainty, of course, but no substitution was made to build up the stratum sample size to 2 (or more), regardless of the numbers of staff in the other two strata.

A.2 Sample Weighting for Unbiased and Nationally Representative Results

The linked design requires the application of weights to raw data results, in order to generate nationally-representative results. Appropriate methods of calculating facility weights account properly for the probability of selection for each (kind of) facility; TRCHS weights take a value according to each facility's (and provider's) mode of inclusion in the TRCHS sample. The weight for any unit of analysis is simply the inverse of its probability of selection into the sample.

A.2.1 Probabilities of selection and weights

Weighting the results from list sample facilities is purely straightforward (for example, the three strata in Table A require simple weights of 1, 4 and 8, respectively). Additional or compound weights for the staff sample are generally not required for results presented by facility; for example, results for tables presenting percentages of facilities with at least one provider trained in a certain skill or procedure will be weighted according to the probability of selecting the facility, since the probability of selecting the provider (for any question covered on both the short and the long provider questionnaire), once the facility is selected, is in principle 1 (certainty). In cases where provider weights are appropriate, they apply only for facilities with more than six RCH providers (as smaller facilities' staff are selected for the long form of the questionnaire with probability=1), and only for results depending on data collected only through the long form. In those few special cases, weights are calculated by strata, with the probability of any provider in a stratum with more than two providers being selected for the long form as the inverse of the number of providers in that stratum at that facility.

Survey weights for the area sample (linked PSUs) facilities deserve a more detailed explication, as their selection method is at the heart of the new survey strategy. Basically, weights for these results are a function of the probabilities of selection of the clusters in which the facilities are located. (Once the EA is selected into the area sample, the probability of selecting a facility in that EA becomes 1, or certainty.) Each cluster has a specific probability of selection as an index cluster, proportional to its size (*pps*); however, because the facility's cluster may have been selected merely because it is adjacent (within two rings) to a selected index cluster, all of the clusters surrounding the facility's cluster must be taken into account when calculating its probability of selection. In other words, the overall probability of that facility's specific cluster being in the TRCHS PSU area sample frame is a function of the likelihood of any EA within two tiers around that cluster having been selected, originally, as a DHS index cluster.

All sample facilities within a given cluster thus will have the same weight, which will be the inverse of the sum of the probabilities of all surrounding clusters (two tiers' worth), while those in any different clusters will have a different

[26] The Doctor stratum includes Doctors, Assistant Medical Officers, Clinical Officers, and Assistant Clinical Officers. The Nurse stratum includes Nursing Officers, Nurses/Midwives, and Public Health Nurses. The Paramedic stratum includes MCH Aides, Nursing Assistants, and Medical Assistants.

weight, also calculated according to its particular surrounding cluster set. Accordingly, the actual index cluster that in fact resulted in the selection of the facility's cluster is given no special weight – the significant factor is only the theoretical probability of any relevant cluster's selection into the set of 153 index clusters.

In Tanzania, regions contain districts, and districts contain wards which contain EAs. The EAs selected for the 1991/1992 TDHS sample are the index clusters of primary interest for correctly weighting the TRCHS results. The DHS design for selecting those clusters was a two-stage process. The first stage of the DHS process selected wards in each district of each region, by urban and rural strata, according to the method known as probability proportionate to size, or *pps*. Subsequently, EAs were selected in the second stage, in the selected wards, also by *pps*.

The probability of selecting the original DHS index cluster is thus a function of the *pps* probability of selecting a ward, the *pps* probability of selecting an EA, and the specific details of the relevant stratum in that particular region, district, and ward. The technical calculation is :

$$P = P_1 * P_2 = \frac{a_h m_{hi}}{M_h} * \frac{a_{hi} m_{hij}}{m_{hi}} \quad [1]$$

where:

P is the calculated probability of selecting the given EA as an index cluster, which is a function of:

P_1 = the probability of selecting the given ward,

P_2 = the probability of selecting the given EA from the set of EAs in that ward, calculated using the following terms:

a_h = the number of wards selected in the h^{th} stratum,

m_{hi} = the measure of size (population) of the i^{th} ward in the h^{th} stratum,

M_h = the total measure of size (population) of the h^{th} stratum; in other words,

$M_h \equiv \sum m_{hi}$

a_{hi} = the number of EAs selected in the sample ward (1 if urban; 2 if rural), and

m_{hij} = the measure of size for the j^{th} EA of the i^{th} ward in the h^{th} stratum.

If the sample index cluster is rural, equation [1] reduces to the following:

$$P_R = \frac{2 a_h m_{hij}}{M_h} \quad [2]$$

If it is urban, then

$$P_U = \frac{a_h m_{hij}}{M_h} \quad [3]$$

Two adjustments to equations [2] and [3] are necessary. First, the measure of size, m_{hij}, must incorporate all of the EAs in the ringed space of the cluster containing the sample facility, as well as the facility's EA. Note that the latter may be the original index cluster itself, in which case the ringed space is a two-tiered ring of EAs surrounding the DHS index cluster; alternatively, the facility may be located in one of the tier EAs of the original index cluster, in which case the relevant ringed space becomes the double tier surrounding the facility's (tier) EA. In every case, the relevant measure of size is the sum of the measures of size in the two-tiered rings surrounding the EA containing the sample facility.[27]

The second necessary adjustment is the sample rate that was used to select (from the original set of TDHS clusters) the subset of index EAs actually used for the TRCHS. This ratio is equal to the number of index clusters selected for the TRCHS, by region, divided by the original number of DHS index clusters, also by region. Note that the ratio may be used because the sub-sample was selected

[27] This calculation is mathematically equivalent to adding the separate probabilities of selection for each EA in the facility's strategically relevant area. The probability of selecting the facility's EA is included along with the probability for each EA in the first and second tiers.

for use as a systematic, equal probability selection of the original sample. The ratio equals:

$b_h / 2a_h$ for rural clusters, and

b_h / a_h for urban clusters.

Making the two adjustments yields the following equations:

$$P_R = \frac{2a_h(b_h / 2a_h)}{M_h} \sum_s m_s \qquad [4]$$

$$P_U = \frac{a_h(b_h / a_h)}{M_h} \sum_s m_s \qquad [5]$$

Equations [4] and [5] reduce to the following, the formula for weighting each facility:

$$P_F = \frac{b_h}{M_h} \sum_s m_s , \qquad [6]$$

where:

P_F = the probability of selecting a sample facility which is a function of:

b_h = the number of index clusters selected for the TRCHS in the h^{th} stratum

$\sum_s m_s$ = the summed sizes of the s^{th} ringed space containing the sample facility

M_h = the total measure of size (population) of the h^{th} stratum

The *calculating formula to obtain the survey weight* for a given facility is the reciprocal of this probability:

$$W_F = \frac{M_h}{b_h \sum_s m_s} \qquad [7]$$

A.2.2 Calculating TRCHS weights

As explained previously and shown in equation [7], calculating the TRCHS facility weights requires full information regarding three parameters: (1) the total measure of size for each region (by stratum), (2) the number of index clusters selected in each region, and (3) the sum of the size measures (determining probability of selection) of the facility's EA and the two tiers of surrounding EAs.

Partial information for calculating the total measure of size came from a spreadsheet, provided by Macro International, containing the original DHS sample selection parameters. That file included the total number of households in each region (by strata), according to the 1988 Census in Tanzania. The National Bureau of Statistics (Government of Tanzania) provided population figures for each region by strata, allowing the calculation of a conversion factor for EAs in each region-stratum. Technically, either household or population figures could be used for all weighting calculations; the importance lies in not mixing inconsistent data. Weights for this report were calculated with size measures converted from population to household numbers where needed.

The number of index clusters for each region is simply the number of PSUs (index clusters) used for the TRCHS sample, in each region (by stratum). For the sum of the size measure for each facility EA, the NBS provided 1988 Census figures for EAs in the surrounding facility tiers. As noted, the conversion to household figures used region/district/ward factors calculated from the household totals on the Macro spreadsheet and the corresponding population totals, also by region and strata, provided by the NBS.

As discussed in the preceding section, the survey methodology entailed canvassing all facilities in clusters in two rings of EAs outward from the index EA. Thus, for facilities located within the index cluster their probability of selection depends on the ringed space surrounding it. For these facilities, the EAs used to calculate their weights are exactly the EAs included in the PSU linked sample space. Different EAs determine the value of the summed size variable, and thus the facility's weight, for facilities in any non-index cluster in the linked PSU sample space.

Calculating the probability of selection used to determine appropriate weights for a facility located in the first or second tier of EAs surrounding the index cluster follows an identical pattern.

The EAs whose sizes and related probabilities count for the facility cluster's selection probability, however, are those in the two tiers that surround the cluster or EA in which the facility is located. In other words, the population total for a facility within the linked sample space but not in an index EA depends on measures of size (population sums) for the *different* two-tiered ring of EAs surrounding it, rather than those surrounding the index cluster. Thus, the *sample* of facilities is determined by the two rings surrounding the index cluster, but the *probabilities* of their having been selected into the linked PSU sample are a function of the two EA rings that surround each facility's EA location (the *pps* likelihood that each of them might have been chosen as a DHS index cluster).

Since the survey methodology involved canvassing *all* clusters in the two-tiered ring irrespective of whether regional boundaries were crossed, the collected TRCHS data reflect interregional crossovers wherever they may have occurred. An alternative strategy would have been to limit EA tiers only to those within the same region, given that regions constituted relevant selection strata in the original DHS PSU design. The procedure used in Tanzania is nonetheless greatly preferable for substantive reasons, given the goal of "capturing the market" of health services provision for the index cluster's population. There is little reason to imagine that client use of facilities would necessarily be correlated with the administrative boundaries of regions, while it is quite reasonable to assume facility proximity does play a significant role in facility choice and health services utilisation.

A.2.3 Missing population data

As the TRCHS results were being calculated and prepared for this report, not all population data was available down to the EA level for all of the necessary EAs. While the final version of this report does present results weighted by generally complete data, it may be useful for future users of this sampling strategy to consider the following intermediate or alternative tactics for calculating weights with incomplete information. As a general rule, where some data needed for calculating weights were not available, the missing figures were interpolated by one of several methods. Where populations for only a few (less than 20 percent) of the EA tier set were missing, the average was taken of the known EA populations and that figure assigned to the missing populations. Where missing data exceeded 20 percent of the tier set, the average population per EA was taken at the relevant ward level, and the resulting figure assigned to the EAs missing population data. According to the level of data available, the average population available per stratum, district, or region could also be used.

For example, if a facility were located in a ringed space containing 25 EAs with population data available for 24 of the clusters (96 percent), the known populations for 24 clusters would be summed and divided by 24. That average would be multiplied by 25 (effectively placing the average population in the 25th or blank data field) to provide the estimated total population to use in calculating the facility weight. *Because the total size (population) of the linked sample space affects the weight, it is inappropriate to construct weights including any EAs for which population data is missing.* With little missing data (up to 20 percent) and interpolated corrections, however, we found very little estimation error or difference between weights calculated with incomplete data versus weights calculated later, as more complete data became available.

A.3 Summary and Conclusions

The linked-sample survey strategy worked well in the pilot implementation in Tanzania. The costs were not excessive, and the results are sound. The main difficulties revolved around several logistical and other impediments to getting all of the information about previous sampling strategies and population distributions in hand to make the mathematical calculations.

Lessons learned:

- Careful consideration of the full range of information needed for post-survey data use should not be left to the end or analytical stages, but should instead be a primary or initial task. Given the length of time sometimes required for compilation of the information from colleagues who may be travelling or who may have the information in non-

electronic format, an earlier start to this task is greatly to be preferred.

- Accurate maps are a critical element of appropriate implementation of the linked-sample strategy. Teams in the field as well as analysts constructing weights must have access to the full and accurate set of maps in order to double-check boundaries and ascertain population and market coverage.

- Some incomplete areas of information need not cripple the process. Shifting from preliminary numbers (approximately 20 percent interpolated population data) to the set of final weights (approximately 2 percent interpolated) did change many results, but the changes were slight (0 to 2 percentage points) and for the most part concerned only dispensaries and health centres.

- Further exploitation of the multilevel linked data will now be possible, enabling a much richer understanding of the true (multivariate) processes affecting and being affected by populations and their interactions in various kinds of health service markets.

Appendix Z: Zanzibar Facilities Sample Results

Zanzibar, the islands of Unguja and Pemba, has typically not been included with the mainland when facility surveys of Tanzania have been performed. Coverage of Zanzibar was made possible for the TRCHS through UNICEF and UNFPA funding. This appendix presents the results from Zanzibar that are discussed throughout this report.

Table Z.1.5: Number of facilities in 1999 TRCHS sample, Zanzibar

	Government	NGO/Private	Combined
Hospitals	8	1	9
Health Centres	20	2	22
Dispensaries	0	11	11
Other	1	8	9
UMATI Clinics	--	0	0
Marie Stopes	--	1	1
All Types	29	23	52

Table Z.1.6: Number of provider respondents in sample, by facility type and category, Zanzibar

	Government	NGO/Private	Combined
Hospitals	190	6	196
Health Centres	83	12	95
Dispensaries	n/a	102	102
Other	78	41	119
UMATI Clinics	--	n/a	n/a
Marie Stopes	--	8	8
All Types	351	169	520

Table Z.2.4b: Percent of facilities with at least two family planning trained providers, Zanzibar (supplemental to section 2.4)

	Government	NGO/Private	Combined
Hospitals	100	0	100
Health Centres	38	0	17
Dispensaries	--	0	0
Other	100	0	9
Marie Stopes	--	100	100
All Types	41	2	19

Table Z.2.8: Percent of facilities reporting all preferred practices (equipment sterilised and disposables not reused), or reporting no preferred practices (do not sterilise equipment and may reuse disposables), Zanzibar

	Government		NGO/Private		Combined	
	Both	Neither	Both	Neither	Both	Neither
Hospitals	75	12	0	0	67	11
Health Centres	27	9	100	0	34	8
Dispensaries	--	--	70	0	70	0
Marie Stopes	--	--	100	0	100	0
All Types	34	28	60	0	42	7

Table Z.2.10: Percent of facilities treating their water supply in any way, Zanzibar

	Government	NGO/Private	Combined
Hospitals	63	n/a	63
Health Centres	24	50	27
Dispensaries	--	100	100
Marie Stopes	--	100	100
All Types	27	85	44

Table Z.3.2: Percent of facilities providing core service package, Zanzibar

	Government	NGO/Private	Combined
Hospitals	63	0	56
Health Centres	0	0	0
Dispensaries	--	0	0
Marie Stopes	--	100	100
All Types	3	1	3

Table Z.3.4: Percent of facilities offering condoms, Zanzibar

	Government	NGO/Private	Combined
Hospitals	100	0	89
Health Centres	92	0	84
Dispensaries	--	12	12
Marie Stopes	--	100	100
All Types	92	7	66

Table Z.3.6: Percent of facilities offering pills, injections, and condoms with stockouts of any of the three contraceptives (in the last 30 days), Zanzibar

	Government	NGO/Private	Combined
Hospitals	0	n/a	0
Health Centres	15	n/a	15
Dispensaries	--	0	0
Marie Stopes	--	0	0
All Types	14	0	14

Table Z.4.2: Percent of facilities with at least one or two providers with any type of in-service training in the past 2 years, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	100	100	100	0	100	89
Health Centres	99	63	0	0	94	60
Dispensaries	--	--	32	12	32	12
Marie Stopes	--	--	100	100	100	100
All Types	99	65	34	7	85	53

Table Z.4.4: Percent of facilities with at least one or two providers trained since 1992 in integrated reproductive and child health skills, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	100	75	100	0	100	67
Health Centres	78	41	0	0	75	39
Dispensaries	--	--	12	0	12	0
Marie Stopes	--	--	0	0	0	0
All Types	80	42	7	0	64	33

Table Z.4.6: Percent of facilities with at least one provider trained since 1992 in HIV/AIDS/STD counselling and testing, Zanzibar

	Government	NGO/Private	Combined
Hospitals	100	0	89
Health Centres	83	0	79
Dispensaries	--	63	63
Marie Stopes	--	100	100
All Types	84	35	74

Table Z.4.8: Percent of facilities with at least one or two providers trained in post-abortion care, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	88	75	0	0	78	67
Health Centres	49	8	0	0	47	7
Dispensaries	--	--	12	0	12	0
Marie Stopes	--	--	100	0	100	0
All Types	51	12	7	0	42	9

Table Z.4.10: Percent of facilities with at least one or two providers trained since 1992 in STD syndromic management, Zanzibar

	Government		NGO/Private		Combined	
	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained	At least 1 trained	At least 2 trained
Hospitals	100	100	100	0	100	89
Health Centres	99	56	0	0	94	53
Dispensaries	--	--	74	12	74	12
Marie Stopes	--	--	100	0	100	0
All Types	99	59	50	5	88	47

Table Z.4.12: Percent of facilities visited within the last month by the District Health Management Team members, Zanzibar

	Government
Hospitals	50
Health Centres	80
Dispensaries	--
Marie Stopes	--
All Types	79

Table Z.4.14: Percent of facilities visited by each type of District Health Management Team member during the team's most recent visit within the last 6 months, Zanzibar

	DMO	DNO	DHO	DMCHC	DTBLC	DAC	DCCC	DHS	OTHER
Hospitals	100	100	100	50	0	0	0	100	50
Health Centres	53	58	87	78	22	32	18	15	60
All Types	54	59	87	77	22	32	17	16	60

Table Z.5.4: Number of new acceptors of modern family planning (in the previous month), Zanzibar

	Government		NGO/Private		Combined	
	Mean	**Median**	**Mean**	**Median**	**Mean**	**Median**
Hospitals	11	9	n/a	n/a	11	9
Health Centres	4	2	n/a	n/a	4	2
Dispensaries	--	--	31	50	31	50
All Types	4	2	31	50	5	2

Table Z.6.3: Percent of facilities offering diagnosis and treatment of syphilis or gonorrhea, Zanzibar

	Government		NGO/Private		Combined	
	Syphilis	**Gonorrhea**	**Syphilis**	**Gonorrhea**	**Syphilis**	**Gonorrhea**
Hospitals	50	75	n/a	n/a	50	75
Health Centres	0	0	0	0	0	0
Dispensaries	--	--	0	7	0	7
Marie Stopes	--	--	100	0	100	0
All Types	3	4	10	18	4	8

Questionnaires

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
COMMUNITY QUESTIONNAIRE
(corrected against Kiswahili)

IDENTIFICATION

NAME OF COMMUNITY _____

REGION . . . . .

DISTRICT . . . . .

WARD . . . . .

E.A. NUMBER . . . . .

TRCHS CLUSTER NUMBER . . . . .

DAR ES SALAAM=1, SMALL CITY* =2, TOWN=3, RURAL/VILLAGE=4 . . . . .

* Small cities are: Mwanza, Arusha, Morogoro, Dodoma, Moshi, Tanga, Iringa, Mbeya, and Tabora. All other urban areas are towns.

GPS READING		DEGREES	MINUTES	THOUSANDTHS
LATITUDE	S			
LONGITUDE	E			

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY / MONTH / YEAR
INTERVIEWER'S NAME				INTER. ID NO.
RESULT*				RESULT
NEXT VISIT: DATE / TIME				TOTAL NO. OF VISITS

*RESULT CODES:

1	COMPLETED
2	SUITABLE INFORMANTS COULD NOT BE LOCATED
3	POSTPONED
4	REFUSED
9	OTHER (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME +)))0)))*, * * *	NAME +)))0)))*, * * *	+)))0)))*, * * *	+)))0)))*, * * *
DATE .)))2)))-	DATE .)))2)))-	.)))2)))-	.)))2)))-

READ THE FOLLOWING GREETING:
Hello. I am representing the Ministry of Health. We are carrying out a survey of health facilities and communities to get a picture of services available to the communities, and to understand when and why people use health services. I would like to ask you some questions about your community and about sources of health care in it and around it as a way of better understanding how to serve the population. Please be assured that this discussion is strictly confidential and anything you tell me will be used for statistical purposes only. May I continue?

1. INFORMANT INFORMATION

Number	Question	Codes	Go to
101	PERMISSION RECEIVED TO CONTINUE?	YES . . . . . 1 NO 2	 ➜Stop
102	LANGUAGE OF INTERVIEW	KISWAHILI . . . . . 1 ENGLISH . . . . . 2 OTHER 6	
103	NUMBER OF INFORMANTS	NUMBER . . . . . +)))0)))), * * * .)))2)))-	
104	COMPOSITION OF INFORMANT GROUP. CIRCLE ALL THAT APPLY.	IMPORTANT ELDERS . . . . . A GOVERNMENT OFFICIALS . . . . . B HAMLET CHAIRPERSONS . . . . . C VILLAGE HEALTH COMMITTEE . . . . . D CBD . . . . . E TBA . . . . . F VILLAGE HEALTH WORKERS . . . . . G OTHER X	
105	SEX COMPOSITION OF INFORMANT GROUP	MEN ONLY . . . . . 1 WOMEN ONLY . . . . . 2 BOTH MEN AND WOMEN 3	

2. GENERAL COMMUNITY INFORMATION

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	CLUSTER DESCRIPTION	COMPACT . . . . . 1 DISPERSED 2	
202	What is the main access route to this community?	ALL YEAR ROAD . . . . . 1 SEASONAL ROAD . . . . . 2 WATERWAY . . . . . 3 PATH . . . . . 4 OTHER . . . . . 6 (SPECIFY)	
203	What are the main economic activities in this community? (CIRCLE ALL MENTIONED)	AGRICULTURE . . . . . A LIVESTOCK . . . . . B FISHING . . . . . C COMMERCE . . . . . D MANUFACTURING . . . . . E OTHER . . . . . X (SPECIFY)	
204	Is there an shop here where people can buy salt, sugar, kerosene?	YES . . . . . 1 NO 2	 ➜206
205	Do people from other communities come here often to buy salt, sugar, kerosene?	YES . . . . . 1 NO 2	
206	Is there a special market (gulio) held in this community every week (or every month, or at other regular intervals)?	YES . . . . . 1 NO 2	 ➜209
207	Do people from other communities come here often to buy and sell at the weekly market?	YES . . . . . 1 NO 2	 ➜210

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
208	From what communities do they come, and how far in kms are those communities? RECORD THE FIRST THREE COMMUNITIES MENTIONED	Locality Name: +)))0))), KMS . . . . . * * * .)))2)))-	
		Locality Name: +)))0))), KMS . . . . . * * * .)))2)))-	
		Locality Name: +)))0))), KMS . . . . . * * * .)))2)))-	
209	Where is the closest weekly market, and how far is it from here in km?	Locality Name: +)))0))), KMS . . . . . * * * .)))2)))-	
210	IF IT'S A VILLAGE RECORD AREA/CLUSTER ___ ↓	IF IT'S A TOWN, RECORD ARE/CLUSTER ____ ---->	➜215
210	What is the name of the nearest larger town?	_____	
211	Which is the most common type of transportation used to go to the nearest larger town?	CAR/TRUCK . . . . . 1 BUS . . . . . 2 MOTORCYCLE . . . . . 3 BICYCLE . . . . . 4 ANIMAL . . . . . 5 WALKING . . . . . 6 OTHER 7	 ➜213 ➜213
212	How often is this type of transportation available?	MORE THAN ONCE A DAY . . . . . 1 ONCE A DAY . . . . . 2 MORE THAN ONCE A WEEK . . . . . 3 ONCE A WEEK . . . . . 4 SEASONALLY . . . . . 5 OTHER . . . . . 6 (SPECIFY)	
213	How many minutes does it take to travel to the nearest town, using the most common type of transportation?	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))-	
214	How many minutes does it take to travel to the closest: a) Post office?	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))-	
	b) Public transportation station?	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))-	
	WHEN THE SERVICES ABOVE ARE AVAILABLE IN THE CLUSTER, WRITE "000". IF THIS IS NOT THE CASE, WRITE DOWN THE TIME (IN MINUTES) TO REACH THEM.	DON'T KNOW 998	
3. UTILITIES AND WATER SUPPLY			
301	Is there organized childcare that is located close enough to this community that people use it?	YES . . . . . 1 NO 2	
302	Is telephone service available here?	YES . . . . . 1 NO 2	

303	In what year did telephone become available?	YEAR . . . . . *1*9* * *	
304	Is electricity available here? (This is public lighting, not a generator owned by an individual or household.)	YES . . . . . 1 NO 2	
305	In what year did electricity become available?	YEAR . . . . . *1*9* * *	
306	What is the primary source of drinking water for this community?	PIPED WATER PIPED INTO DWELLINGS . . . . . 11 PIPED INTO YARD/PLOT . . . . . 12 PUBLIC TAP . . . . . 13 WATER FROM OPEN OR UNPROTECTED WELL . . . . . 21 WATER FROM COVERED WELL OR BOREHOLE PROTECTED DUG WELL . . . . . 31 BOREHOLE OR TUBEWELL . . . 32 SURFACE WATER SPRING . . . . . 41 POND, RIVER,STREAM . . . . . 42 RAINWATER . . . . . 51 TANKER TRUCK . . . . . 61 BOTTLED WATER . . . . . 71 OTHER 96	
307	Is the drinking water supply available all year or seasonally?	ALL YEAR . . . . . 1 SEASONALLY . . . . . 2 OTHER . . . . . 6 (SPECIFY)	
308	How do people in this community use the water from this source? CIRCLE ALL THAT APPLY.	DRINKING . . . . . A BATHING . . . . . B LAUNDRY . . . . . C IRRIGATION . . . . . D WATERING LIVESTOCK . . . . . E OTHER X	
309	What are the sources of potential contamination, if any, to this water supply?	AGRICULTURAL CHEMICALS . . . . . 1 LIVESTOCK WASTE . . . . . 2 HUMAN WASTE . . . . . 3 INDUSTRIAL WASTE . . . . . 4 NONE . . . . . 5 OTHER . . . . . 6 (SPECIFY)	
310	Is this water supply maintained by the community?	YES . . . . . 1 NO 2	
311	CHECK 306 WHETHER PIPED WATER PIPED	NON-PIPED WATER	➜ 401
312	In what year did the water system start functioning?	YEAR . . . . . *1*9* * * DON'T KNOW 98	
313	Is the water system functioning now?	YES . . . . . 1 NO 2	➜ 317 ➜ 315
314	Does this community have a piped water system?	YES . . . . . 1 NO 2	 ➜ 401

315	How long ago did it break down?	+)))0))), MONTHS . . . . . * * * .)))2)))- More than 97 months 98	
316	What is the main reason that the water system has not yet been repaired?	TECHNICIAN NOT AVAILABLE . . . . 1 SPARES NOT AVAILABLE . . . . . 2 FUNDING NOT AVAILABLE . . . . . 3 BAD WEATHER . . . . . 4 OTHER . . . . . 6 (SPECIFY)	➜ 401 ➜ 401 ➜ 401 ➜ 401 ➜ 401
317	How often does the water system break down?	WEEKLY . . . . . 1 MONTHLY . . . . . 2 YEARLY . . . . . 3 LESS OFTEN THAN YEARLY . . . . . 4 NOT YET BROKEN DOWN 5	➜ 401
318	The last time it broke down, how long was it broken before being repaired? CONVERT ANSWER TO WEEKS.	+)))0))), WEEKS . . . . . * * * .)))2)))- More than 97 weeks 98	
319	The last time it broke down, what was the main reason for a delay in its being repaired?	TECHNICIAN NOT AVAILABLE . . . . 1 SPARES NOT AVAILABLE . . . . . 2 FUNDING NOT AVAILABLE . . . . . 3 BAD WEATHER . . . . . 4 OTHER . . . . . 6 (SPECIFY)	
4. COMMUNITY-BASED HEALTH SERVICES			
401	Do people in this community use traditional healers? A traditional healer is someone who treats people who are ill, but who does not use the methods of Western medicine.	YES . . . . . 1 NO 2	➜404
402	How many traditional healers are there in this community?	+)))0))), NUMBER . . . . . * * * .)))2)))- NONE . . . . . 00 DON'T KNOW 98	
403	Why do the people in this community go to traditional healers? (CIRCLE ALL ITEMS MENTIONED)	ILLNESS . . . . . A TRUST . . . . . B INEXPENSIVE . . . . . C UNDERSTAND BETTER . . . . . D ACCEPTABLE . . . . . E CONVENIENCE . . . . . F OTHER . . . . . X (SPECIFY) DON'T KNOW . . . . . Y	
404	How many Traditional Birth Attendants are there in this community?	+)))0))), NUMBER . . . . . * * * .)))2)))- NONE . . . . . 00 DON'T KNOW 98	➜406 ➜406
405	How many of these TBAs have received formal training from the Ministry Of Health or a Non-governmental Organization?	+)))0))), NUMBER . . . . . * * * .)))2)))- NONE . . . . . 00 DON'T KNOW 98	
406	Does this community have visits from a Health Assistant (HA) or a Village Health Worker (VHW)? A HA is a government trained extension worker based in a dispensary. .A VHW is government trained but is based in the community. Both types of health workers visit communities to provide basic health care and health education.	YES . . . . . 1 NO 2	➜410

407	How often does this HA/VHW have contact in this community either through visits to a central point or to households?	WEEKLY . . . . . 1 MONTHLY . . . . . 2 QUARTERLY . . . . . 3 SEMI-ANNUALLY . . . . . 4 ANNUALLY . . . . . 5 OTHER . . . . . 6 (SPECIFY) DON'T KNOW 8	
408	Does this HA/VHW provide: a) Basic medications? b) Vitamins? c) Counseling?	YES NO MEDICATIONS . . . . . 1 2 VITAMINS . . . . . 1 2 COUNSELING 1 2	
409	In what year did this community start having visits by HA/VHW?	+)))0)))0)))0))), YEAR . . . . . *1*9* * * .)))2)))2)))2)))- DON'T KNOW 98	
410	What is the local government's position on family planning? Do you think they stongly discourage, discourage, neither discourage nor encourage, encourage, or strongly encourage family planning?	Strongly discourages . . . . . 1 Discourages . . . . . 2 Neither discourages/encourages . . . 3 Encourages . . . . . 4 Strongly encourages 5	
411	Does this community have a community-based distributor of contraceptives (CBD)? A CBD is someone working outside of facilities or pharmacies who distributes contraceptives to people in the community. He or she may be employed and/or trained by the MOH or an NGO.	YES . . . . . 1 NO 2	➜415
412	Did this community have a CBD at any time in the past?	YES . . . . . 1 NO 2	 ➜501
413	When did the CBD program in this community end?	+)))0)))0)))0))), YEAR . . . . . *1*9* * * .)))2)))2)))2)))- DON'T KNOW 98	
414	Why did the CBD program in this community end?	MOH stopped funding . . . . . 1 NGO stopped funding . . . . . 2 Other . . . . . 6 (SPECIFY) DON'T KNOW 8	➜501 ➜501 ➜501 ➜501
415	How many CBDs work in this community?	+)))0))), NUMBER . . . . . * * * .)))2)))- DON'T KNOW 98	
416	How often does a CBD visit households in the community?	WEEKLY . . . . . 1 MONTHLY . . . . . 2 QUARTERLY . . . . . 3 SEMI-ANNUALLY . . . . . 4 ANNUALLY . . . . . 5 OTHER . . . . . 6 (SPECIFY) DON'T KNOW 8	
417	Do the CBDs working in this community provide: a) Counseling? b) Condoms? d) Pill? e) Other family planning methods?	YES NO COUNSELING . . . . . 1 2 CONDOMS . . . . . 1 2 PILL . . . . . 1 2 OTHER METHODS 1 2	
418	In what year did this community first have CBDs?	+)))0)))0)))0))), YEAR . . . . . *1*9* * * .)))2)))2)))2)))- DON'T KNOW 98	

5. HEALTH FACILITIES AND PHARMACIES

Now, I would like to ask you about where people in this community can get health services. Please mention all facilities, that is, hospitals, health centres, dispensaries, and clinics that people in this community might use, but please start with the nearest facility. Then, I will ask you about pharmacies or drug shops that sell medications or contraceptive methods to the community. PROBE USING FACILITY LIST FROM MOH. LIST ONLY FACILITIES AVAILABLE TO THE RESPONDENT BY CHOICE, NOT THOSE AVAILABLE ONLY BY REFERRAL FROM ANOTHER FACILITY.

501. What is the name and location of a (facility/pharmacy) that people in this community might use?	502. RECORD WHETHER FACILITY OR PHARMACY	503. Does the typical woman of childbearing age walk or ride to FACILITY?	504. How far is FACILITY from here? RECORD ODOMETER READING IF POSSIBLE. CHECK FOR SHORTCUTS IF MOST WOMEN WALK.	505. How long does it take the typical woman of childbearing age to go to FACILITY by this means? (RECORD IN MINUTES)
1. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
2. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
3. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
4. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
5. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
6. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
7. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
8. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998
9. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998

10. _____ _____	facility 1 pharmacy 2	Walk . . . . . 1 Ride . . . . . 2 Other . . . . . 6 (SPECIFY)	+)))0)))), KMS . . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0)))), MINUTES . . . . . * * * * .)))2)))2)))- DON'T KNOW 998

6. SCHOOLS						
Now, I would like to ask you questions about schools. The purpose of this section is to identify the sources of educational services available to the community. Please mention all schools, but <u>please start with the nearest school.</u> List at least one of each type of school (if known), even if the school is very far from this community.						
601. What is the name and location of the nearest school?	602. What type of school is NAME?	603. About how many students do you think NAME has?	604. How far in Kms is NAME located from here? RECORD ODOMETER READING IF AVAILABLE.	605. How many minutes does it take to go to NAME using the most common type of transportation?	606. What is NAME's operating authority?	607. In what year did NAME open?
____________________ ____________________	Pre-school 1 Primary 2 Secondary 3 Technical 4 Other 5 (SPECIFY)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))- 1000+ . . . . 9997 DON'T KNOW 9998	+)))0))), KMS . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES * * * * .)))2)))2)))- DON'T KNOW 998	Government . . . . 1 NGO . . . . 2 Private . . . . 3 Religious . . . . 4 Other . . . . 6 DK 8	+)))0)))0)))0))), *1 *9 * * * .)))2)))2)))2)))- DON'T KNOW . . . 98
____________________ ____________________	Pre-school 1 Primary 2 Secondary 3 Technical 4 Other 5 (SPECIFY)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))- 1000+ . . . . 9997 DON'T KNOW 9998	+)))0))), KMS . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES * * * * .)))2)))2)))- DON'T KNOW 998	Government . . . . 1 NGO . . . . 2 Private . . . . 3 Religious . . . . 4 Other . . . . 6 DK 8	+)))0)))0)))0))), *1 *9 * * * .)))2)))2)))2)))- DON'T KNOW . . . 98
____________________ ____________________	Pre-school 1 Primary 2 Secondary 3 Technical 4 Other 5 (SPECIFY)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))- 1000+ . . . . 9997 DON'T KNOW 9998	+)))0))), KMS . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES * * * * .)))2)))2)))- DON'T KNOW 998	Government . . . . 1 NGO . . . . 2 Private . . . . 3 Religious . . . . 4 Other . . . . 6 DK 8	+)))0)))0)))0))), *1 *9 * * * .)))2)))2)))2)))- DON'T KNOW . . . 98
____________________ ____________________	Pre-school 1 Primary 2 Secondary 3 Technical 4 Other 5 (SPECIFY)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))- 1000+ . . . . 9997 DON'T KNOW 9998	+)))0))), KMS . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES * * * * .)))2)))2)))- DON'T KNOW 998	Government . . . . 1 NGO . . . . 2 Private . . . . 3 Religious . . . . 4 Other . . . . 6 DK 8	+)))0)))0)))0))), *1 *9 * * * .)))2)))2)))2)))- DON'T KNOW . . . 98
____________________ ____________________	Pre-school 1 Primary 2 Secondary 3 Technical 4 Other 5 (SPECIFY)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))- 1000+ . . . . 9997 DON'T KNOW 9998	+)))0))), KMS . . . . * * * .)))2)))- DON'T KNOW 98	+)))0)))0))), MINUTES * * * * .)))2)))2)))- DON'T KNOW 998	Government . . . . 1 NGO . . . . 2 Private . . . . 3 Religious . . . . 4 Other . . . . 6 DK 8	+)))0)))0)))0))), *1 *9 * * * .)))2)))2)))2)))- DON'T KNOW . . . 98

IDENTIFY 6 COMMUNITY INFORMANTS, 3 WOMEN AND 3 MEN. AT LEAST ONE INFORMANT SHOULD BE A CURRENT OR FORMER CBD WORKER IF POSSIBLE. **NONE** OF THE INFORMANTS SHOULD BE WORKING CURRENTLY IN ANY HEALTH FACILITIES OR PHARMACIES IN THE AREA. THIS INTERVIEW SHOULD BE CONDUCTED IN PRIVATE.

Hello. My name is _____and I am working with the National Bureau of Statistics. We are conducting a national survey about health facilities. We would very much appreciate your participation in this survey. I would like to ask your opinions about health facilities in this community. This information will help the government to plan health services. The questionnaire usually takes between 10 and 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?
May I begin the interview now?

Signature of interviewer: Date:

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 ▾	RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2))▸END

7. PERSONAL BACKGROUND INFORMATION

No.	Questions	Coding Classification	Go To
701	SEX OF RESPONDENT	MALE . . . . . 1 FEMALE 2	
702	How old were you on your last birthday?	+)))0))), YEARS . . . . . * * * .)))2)))-	
703	What is your marital status?	MARRIED, LIVING WITH SPOUSE . . . . . 1 MARRIED, NOT LIVING WITH SPOUSE . . 2 WIDOWED . . . . . 3 DIVORCED . . . . . 4 NEVER MARRIED 5	
704	Can you read and write Kiswahili easily, with difficulty, or not at all?	EASILY . . . . . 1 WITH DIFFICULTY . . . . . 2 NOT AT ALL 3	
705	Have you ever attended school?	YES . . . . . 1 NO 2	
706	What kind of work do you mainly do?	AGRICULTURE . . . . . 1 PROFESSIONAL/TECHNICAL . . . . . 2 SALES/SERVICES . . . . . 3 SKILLED MANUAL . . . . . 4 UNSKILLED MANUAL . . . . . 5 DOES NOT WORK . . . . . 6 OTHER 7	
707	How familiar are you with family planning services in the community? Would you say that you are totally unfamiliar, most unfamiliar, moderately familiar, very familiar, or extremely familiar?	TOTALLY UNFAMILIAR . . . . . 1 MOSTLY UNFAMILIAR . . . . . 2 MODERATELY FAMILIAR . . . . . 3 VERY FAMILIAR . . . . . 4 EXTREMELY FAMILIAR 5	
708	Are you now or have you been in the past a CBD worker?	CBD NOW . . . . . 1 CBD IN PAST . . . . . 2 NEVER 3	

8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
1.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
2.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
3.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
4.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
5.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
6.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
7.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
8.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8

8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
9.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
10.	Completely inaccessible . . . 1 Largely inaccessible . . . . . 2 Somewhat accessible . . . . . 3 Largely accessible . . . . . 4 Completely accessible 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
805	Which of these facilities, excluding pharmacies, is the (woman of childbearing age/man) most likely to use?		NUMBER	+)))0)))* * * * .)))2)))-

9. OTHER QUESTIONS

901. HOW WELL INFORMED WAS THE RESPONDENT?

0 1 2 3 4 5 6 7 8 9 10
No Knowledge — Moderately Knowledgeable — Completely Knowledgeable

902. HOW FREQUENTLY DID YOU HAVE TO PROBE THE RESPONDENT?

0 1 2 3 4 5 6 7 8 9 10
Never — Half the time — Always

903. WHO ELSE WAS PRESENT DURING THE INTERIVEW?
(E.G., FAMILY MEMBER, OTHER VILLAGE MEMBER, NO ONE, ETC.)

COMMENTS:

IDENTIFY 6 COMMUNITY INFORMANTS, 3 WOMEN AND 3 MEN. AT LEAST ONE INFORMANT SHOULD BE A CURRENT OR FORMER CBD WORKER IF POSSIBLE. **NONE** OF THE INFORMANTS SHOULD BE WORKING CURRENTLY IN ANY HEALTH FACILITIES OR PHARMACIES IN THE AREA. THIS INTERVIEW SHOULD BE CONDUCTED IN PRIVATE.

Hello. My name is _____and I am working with the National Bureau of Statistics. We are conducting a national survey about health facilities. We would very much appreciate your participation in this survey. I would like to ask your opinions about health facilities in this community. This information will help the government to plan health services. The questionnaire usually takes between 10 and 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?
May I begin the interview now?

Signature of interviewer: Date:

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 ▾	RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2))▸END

7. PERSONAL BACKGROUND INFORMATION

No.	Questions	Coding Classification	Go To
701	SEX OF RESPONDENT	MALE . . . . . 1 FEMALE 2	
702	How old were you on your last birthday?	+)))0)))), YEARS . . . . . * * * .)))2)))-	
703	What is your marital status?	MARRIED, LIVING WITH SPOUSE . . 1 MARRIED, NOT LIVING WITH SPOUSE 2 WIDOWED . . . . . 3 DIVORCED . . . . . 4 NEVER MARRIED 5	
704	Can you read and write Kiswahili easily, with difficulty, or not at all?	EASILY . . . . . 1 WITH DIFFICULTY . . . . . 2 NOT AT ALL 3	
705	Have you ever attended school?	YES . . . . . 1 NO 2	
706	What kind of work do you mainly do?	AGRICULTURE . . . . . 1 LIVESTOCK . . . . . 2 FISHING . . . . . 3 COMMERCE . . . . . 4 MANUFACTURING . . . . . 5 DOES NOT WORK . . . . . 6 OTHER 7	
707	How familiar are you with family planning services in the community?	TOTALLY UNFAMILIAR . . . . . 1 MOSTLY UNFAMILIAR . . . . . 2 MODERATELY FAMILIAR . . . . . 3 VERY FAMILIAR . . . . . 4 EXTREMELY FAMILIAR 5	
708	Are you now or have you been in the past a CBD worker?	CBD NOW . . . . . 1 CBD IN PAST . . . . . 2 NEVER 3	

8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
1.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
2.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
3.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
4.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
5.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
6.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
7.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
8.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8

8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
9.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
10.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
805	Which of these facilities, excluding pharmacies, is the (woman of childbearing age/man) most likely to use?		NUMBER	+)))0))) * * * .)))2)))-

9. OTHER QUESTIONS

901. HOW WELL INFORMED WAS THE RESPONDENT?

0 1 2 3 4 5 6 7 8 9 10
No Knowledge — Moderately Knowledgeable — Completely Knowledgeable

902. HOW FREQUENTLY DID YOU HAVE TO PROBE THE RESPONDENT?

0 1 2 3 4 5 6 7 8 9 10
Never — Half the time — Always

903. WHO ELSE WAS PRESENT DURING THE INTERIVEW?
(E.G., FAMILY MEMBER, OTHER VILLAGE MEMBER, NO ONE, ETC.)

COMMENTS:

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Signature of interviewer: Date:

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7. PERSONAL BACKGROUND INFORMATION

No.	Questions	Coding Classification	Go To
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702	How old were you on your last birthday?	+)))0)))), YEARS . . . . . * * * .)))2)))-	
703	What is your marital status?	MARRIED, LIVING WITH SPOUSE . . 1 MARRIED, NOT LIVING WITH SPOUSE 2 WIDOWED . . . . . 3 DIVORCED . . . . . 4 NEVER MARRIED 5	
704	Can you read and write Kiswahili easily, with difficulty, or not at all?	EASILY . . . . . 1 WITH DIFFICULTY . . . . . 2 NOT AT ALL 3	
705	Have you ever attended school?	YES . . . . . 1 NO 2	
706	What kind of work do you mainly do?	AGRICULTURE . . . . . 1 LIVESTOCK . . . . . 2 FISHING . . . . . 3 COMMERCE . . . . . 4 MANUFACTURING . . . . . 5 DOES NOT WORK . . . . . 6 OTHER 7	
707	How familiar are you with family planning services in the community?	TOTALLY UNFAMILIAR . . . . . 1 MOSTLY UNFAMILIAR . . . . . 2 MODERATELY FAMILIAR . . . . . 3 VERY FAMILIAR . . . . . 4 EXTREMELY FAMILIAR 5	
708	Are you now or have you been in the past a CBD worker?	CBD NOW . . . . . 1 CBD IN PAST . . . . . 2 NEVER 3	

8. FACILITY RATINGS

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NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
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704	Can you read and write Kiswahili easily, with difficulty, or not at all?	EASILY . . . . . 1 WITH DIFFICULTY . . . . . 2 NOT AT ALL 3	
705	Have you ever attended school?	YES . . . . . 1 NO 2	
706	What kind of work do you mainly do?	AGRICULTURE . . . . . 1 LIVESTOCK . . . . . 2 FISHING . . . . . 3 COMMERCE . . . . . 4 MANUFACTURING . . . . . 5 DOES NOT WORK . . . . . 6 OTHER 7	
707	How familiar are you with family planning services in the community?	TOTALLY UNFAMILIAR . . . . . 1 MOSTLY UNFAMILIAR . . . . . 2 MODERATELY FAMILIAR . . . . . 3 VERY FAMILIAR . . . . . 4 EXTREMELY FAMILIAR 5	
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8. FACILITY RATINGS

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6.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
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8.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8

8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
9.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
10.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
805	Which of these facilities, excluding pharmacies, is the (woman of childbearing age/man) most likely to use?		NUMBER	+)))0))) * * * .)))2)))-

9. OTHER QUESTIONS

901. HOW WELL INFORMED WAS THE RESPONDENT?

0 1 2 3 4 5 6 7 8 9 10
No Knowledge — Moderately Knowledgeable — Completely Knowledgeable

902. HOW FREQUENTLY DID YOU HAVE TO PROBE THE RESPONDENT?

0 1 2 3 4 5 6 7 8 9 10
Never — Half the time — Always

903. WHO ELSE WAS PRESENT DURING THE INTERIVEW?
(E.G., FAMILY MEMBER, OTHER VILLAGE MEMBER, NO ONE, ETC.)

COMMENTS:

IDENTIFY 6 COMMUNITY INFORMANTS, 3 WOMEN AND 3 MEN. AT LEAST ONE INFORMANT SHOULD BE A CURRENT OR FORMER CBD WORKER IF POSSIBLE. **NONE** OF THE INFORMANTS SHOULD BE WORKING CURRENTLY IN ANY HEALTH FACILITIES OR PHARMACIES IN THE AREA. THIS INTERVIEW SHOULD BE CONDUCTED IN PRIVATE.

Hello. My name is _____and I am working with the National Bureau of Statistics. We are conducting a national survey about health facilities. We would very much appreciate your participation in this survey. I would like to ask your opinions about health facilities in this community. This information will help the government to plan health services. The questionnaire usually takes between 10 and 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?
May I begin the interview now?

Signature of interviewer: Date:

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 ▾	RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2))▸END

7. PERSONAL BACKGROUND INFORMATION

No.	Questions	Coding Classification	Go To
701	SEX OF RESPONDENT	MALE . . . . . 1 FEMALE 2	
702	How old were you on your last birthday?	+)))0)))), YEARS . . . . . * * * .)))2)))-	
703	What is your marital status?	MARRIED, LIVING WITH SPOUSE . . 1 MARRIED, NOT LIVING WITH SPOUSE 2 WIDOWED . . . . . 3 DIVORCED . . . . . 4 NEVER MARRIED 5	
704	Can you read and write Kiswahili easily, with difficulty, or not at all?	EASILY . . . . . 1 WITH DIFFICULTY . . . . . 2 NOT AT ALL 3	
705	Have you ever attended school?	YES . . . . . 1 NO 2	
706	What kind of work do you mainly do?	AGRICULTURE . . . . . 1 LIVESTOCK . . . . . 2 FISHING . . . . . 3 COMMERCE . . . . . 4 MANUFACTURING . . . . . 5 DOES NOT WORK . . . . . 6 OTHER 7	
707	How familiar are you with family planning services in the community?	TOTALLY UNFAMILIAR . . . . . 1 MOSTLY UNFAMILIAR . . . . . 2 MODERATELY FAMILIAR . . . . . 3 VERY FAMILIAR . . . . . 4 EXTREMELY FAMILIAR 5	
708	Are you now or have you been in the past a CBD worker?	CBD NOW . . . . . 1 CBD IN PAST . . . . . 2 NEVER 3	

8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

NAME OF FACILITY COPIED FROM SECTION 5	801. From the viewpoint of (women of childbearing age/ men), **how accessible** is FACILITY? Would they say it is completely inaccessible, largely inaccessible, somewhat accessible, largely accessible, or completely accessible?	802. How would most (women of childbearing age/men) describe the **quality** of FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	803. How would most (women of childbearing age/men) describe the **training level of staff** at FACILITY? Would they say it is very poor, poor, neither poor nor good, good, or very good?	804. How would most (women of childbearing age/men) describe **how often contraceptives are out of stock** at FACILITY? Would they say contraceptives are out of stock most of the time, often, sometimes, rarely, or never?
1.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
2.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
3.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
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5.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
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8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

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805	Which of these facilities, excluding pharmacies, is the (woman of childbearing age/man) most likely to use?		NUMBER	+)))0))) * * * .)))2)))-

9. OTHER QUESTIONS

901. HOW WELL INFORMED WAS THE RESPONDENT?

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Never — Half the time — Always

903. WHO ELSE WAS PRESENT DURING THE INTERIVEW?
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COMMENTS:

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Signature of interviewer: Date:

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7. PERSONAL BACKGROUND INFORMATION

No.	Questions	Coding Classification	Go To
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703	What is your marital status?	MARRIED, LIVING WITH SPOUSE . . 1 MARRIED, NOT LIVING WITH SPOUSE 2 WIDOWED . . . . . 3 DIVORCED . . . . . 4 NEVER MARRIED 5	
704	Can you read and write Kiswahili easily, with difficulty, or not at all?	EASILY . . . . . 1 WITH DIFFICULTY . . . . . 2 NOT AT ALL 3	
705	Have you ever attended school?	YES . . . . . 1 NO 2	
706	What kind of work do you mainly do?	AGRICULTURE . . . . . 1 LIVESTOCK . . . . . 2 FISHING . . . . . 3 COMMERCE . . . . . 4 MANUFACTURING . . . . . 5 DOES NOT WORK . . . . . 6 OTHER 7	
707	How familiar are you with family planning services in the community?	TOTALLY UNFAMILIAR . . . . . 1 MOSTLY UNFAMILIAR . . . . . 2 MODERATELY FAMILIAR . . . . . 3 VERY FAMILIAR . . . . . 4 EXTREMELY FAMILIAR 5	
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8. FACILITY RATINGS

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2.	Completely inaccessible 1 Largely inaccessible . . . 2 Somewhat accessible . . 3 Largely accessible . . . . 4 Completely accessible . 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Very poor . . . . . 1 Poor . . . . . 2 Neither . . . . . 3 Good . . . . . 4 Very good 5	Most of the time . . . . . 1 Often . . . . . 2 Sometimes . . . . . 3 Rarely . . . . . 4 Never . . . . . 5 DK/NA 8
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8. FACILITY RATINGS

FOR "(WOMEN OF CHILDBEARING AGE/MEN)" IN QUESTIONS 801-805: IF THE RESPONDENT IS A WOMAN USE THE PHRASE "WOMEN OF CHILDBEARING AGE"; IF THE RESPONDENT IS A MAN, USE THE WORD "MEN."

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805	Which of these facilities, excluding pharmacies, is the (woman of childbearing age/man) most likely to use?		NUMBER	+)))0))) * * * .)))2)))-

9. OTHER QUESTIONS

901. HOW WELL INFORMED WAS THE RESPONDENT?

0	1	2	3	4	5	6	7	8	9	10
No Knowledge				Moderately Knowledgeable					Completely Knowledgeable	

902. HOW FREQUENTLY DID YOU HAVE TO PROBE THE RESPONDENT?

0	1	2	3	4	5	6	7	8	9	10
Never					Half the time					Always

903. WHO ELSE WAS PRESENT DURING THE INTERIVEW?
(E.G., FAMILY MEMBER, OTHER VILLAGE MEMBER, NO ONE, ETC.)

COMMENTS:

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
FACILITY INTERVIEW QUESTIONNAIRE
(corrected against Kiswahili)

IDENTIFICATION

NAME OF FACILITY_____

REGION . . . . .

DISTRICT . . . . .

WARD . . . . .

E.A. NUMBER . . . . .

TRCHS CLUSTER NUMBER . . . . .

IF FACILITY WAS VISITED ALREADY FOR A DIFFERENT CLUSTER, RECORD OTHER CLUSTER NUMBER AND TERMINATE INTERVIEW.

GPS READING

	DEGREES	MINUTES	THOUSANDTHS
LATITUDE	S		
LONGITUDE	E		

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY
				MONTH
				YEAR 19
INTERVIEWER'S NAME				INTER. ID NO.
RESULT*				RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:

1	COMPLETED	5	PARTLY COMPLETED
2	CANNOT LOCATE FACILITY	6	POSTPONED
3	CANNOT LOCATE IN-CHARGE	7	OTHER (SPECIFY)
4	REFUSED		

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME	NAME		
DATE	DATE		

Read greeting:
We are carrying out a survey of health facilities that provide reproductive health services to find ways of improving services. We would be interested to know from you about your experiences with providing reproductive health services. Could I ask you some questions about this? Please be assured that this discussion is strictly confidential, that everything you tell me is being used for research purposed, and that your name is not being recorded. May I continue?

1. GENERAL FACILITY INFORMATION			
No.	QUESTIONS	CODING CATEGORIES	SKIP
101	RECORD THE TIME	HOUR . . . . . * * * MINUTES . . . . . * * *	
102	What is your job title or type of cadre?	DOCTOR . . . . . 1 ASSISTANT MEDICAL OFFICER . . . . . 2 CLINICAL OFFICER . . . . . 3 ASSISTANT CLINICAL OFFICER . . . . . 4 NURSING OFFICER . . . . . 5 NURSE/MIDWIFE . . . . . 6 PUBLIC HEALTH NURSE B . . . . . 7 MCH AIDE . . . . . 8 NURSE ASSISTANT/MEDICAL ASSISTANT 9 OTHER 10	
103	Under what authority is this facility operated?	GOVERNMENT . . . . . 1 MARIE STOPES . . . . . 2 UMATI . . . . . 3 SEVENTH DAY ADVENTIST . . . . . 4 OTHER PRIVATE . . . . . 5 OTHER NON-RELIGIOUS VOLUNTARY . . . 6 RELIGIOUS-CATHOLIC . . . . . 7 RELIGIOUS-PROTESTANT . . . . . 8 RELIGIOUS-OTHER . . . . . 9 EMPLOYER BASED CLINIC . . . . . 10 OTHER 11	
104	What type of facility is this? *[Circle only one.]*	CONSULTANT HOSPITAL . . . . . 1 DISTRICT HOSPITAL . . . . . 2 REGIONAL HOSPITAL . . . . . 3 OTHER HOSPITAL . . . . . 4 HEALTH CENTER . . . . . 5 DISPENSARY . . . . . 6 CLINIC . . . . . 7 OTHER 9	
105	How many <u>days</u> per <u>week</u> is the facility open?	DAYS . . . . . * *	
106	In what year did this facility open? PROBE: This question is very important. Can you tell me how old this facility is? For example would you say it is about 5 years old? 10 years old? (etc.) FILL IN EITHER YEAR OPENED OR YEARS OLD.	YEAR OPENED . . . . . * * * * * YEARS OLD . . . . . * * * * * DON'T KNOW 9998	
107	Is this facility currently receiving support from: (1) Association for Voluntary Surgical Contraception International (2) Pathfinder (3) Family Health International (4) Marie Stopes (5) UMATI (6) United Nations Population Fund (7) Other (specify):	YES NO DK AVSC . . . . . 1 2 8 PATHFINDER . . . . . 1 2 8 FHI . . . . . 1 2 8 MARIE STOPES . . . . . 1 2 8 UMATI . . . . . 1 2 8 UNFPA . . . . . 1 2 8 OTHER 1 2 8	

108	How many permanent staff of each types (cadre) does this facility have? (1) Doctors (2) Assistant Medical Officers (3) Clinical Officers (4) Assistant Clinical Officers (5) Nursing Officers (6) Nurse/Midwives (7) Public Health Nurse B's (8) MCH Aides (9) Nurse Assistants/Medical Assistants (10) Others	DOCTORS . . . . . +)))0)))0))), * * * * .)))2)))2)))- ASSISTANT MED OFFICERS . +)))0)))0))), * * * * .)))2)))2)))- CLINICAL OFFICERS . . . . . +)))0)))0))), * * * * .)))2)))2)))- ASSISTANT CLIN OFFICERS . +)))0)))0))), * * * * .)))2)))2)))- NURSING OFFICERS . . . . . +)))0)))0))), * * * * .)))2)))2)))- NURSE/MIDWIFES . . . . . +)))0)))0))), * * * * .)))2)))2)))- PUBLIC HEALTH NURSE B'S . +)))0)))0))), * * * * .)))2)))2)))- MCH AIDES . . . . . +)))0)))0))), * * * * .)))2)))2)))- NURSE/MED ASSISTANT . . . . +)))0)))0))), * * * * .)))2)))2)))- OTHERS . . . . . +)))0)))0))), * * * * .)))2)))2)))-	

2. STAFF IN REPRODUCTIVE HEALTH

Please list the names of the staff involved in providing reproductive health services, including family planning, maternal and child health, and STD/HIV.

201. ORDER NUMBER AND NAME	202. CURRENTLY WORKING IN THIS FACILITY	204. POSITION CODE	205. SEX	How many hours per week does NAME provide services at this facility for:			
				206. Family Planning	207. Maternal Health	208. Child Health	209. STD/HIV
(01)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(02)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(03)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(04)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(05)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(06)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(07)	YES . . . . . 1 NO 2	+)))0))), * * * .)))2)))-	MALE . . . . . 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-

201. ORDER NUMBER AND NAME	202. CURRENTLY WORKING IN THIS FACILITY	204. POSITION CODE	205. SEX	How many hours per week does NAME provide services at this facility for:			
				206. Family Planning	207. Maternal Health	208. Child Health	209. STD/HIV
CODE: Doctor = 1, Nursing Officer = 5, Nurse/Med Assistant = 9, Assistant Medical Officer = 2, Nurse/Midwife = 6, Other = 10 Clinical Officer = 3, Public Health Nurse B = 7, Assistant Clinical Officer = 4, MCH Aide = 8,							
(08)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(09)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(10)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(11)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(12)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(13)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(14)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(15)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(16)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(17)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(18)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(19)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(20)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(21)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
(22)	YES ..... 1 NO 2	+)))0))), * * * .)))2)))-	MALE ..... 1 FEMALE 2	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-	+)))0))), * * * .)))2)))-
CODE: Doctor = 1, Nursing Officer = 5, Nurse/Med Assistant = 9, Assistant Medical Officer = 2, Nurse/Midwife = 6, Other = 10 Clinical Officer = 3, Public Health Nurse B = 7, Assistant Clinical Officer = 4, MCH Aide = 8,							

201. ORDER NUMBER AND NAME	202. CURRENTLY WORKING IN THIS FACILITY	204. POSITION CODE	205. SEX	How many hours per week does NAME provide services at this facility for:			
				206. Family Planning	207. Maternal Health	208. Child Health	209. STD/HIV
Check the box if another form is used: +)))), * * .)))-			Total Number of Forms: +)))), * * .)))-		Form Number: +)))), * * .)))-		

3. FAMILY PLANNING

301	Does this facility offer family planning services?	YES . . . . . 1 NO 2	–> 401

METHOD	302. Is METHOD available to clients at this facility?		303. How Many Days per Week is METHOD available?	304. What year was METHOD first offered at this facility? **Don't know = 9998**
(1) Oral Pills	YES . . . . . 1 NO 2	-> (2)	DAYS	
(2) Injectables (Depo Provera)	YES . . . . . 1 NO 2	-> (3)	DAYS	
(3) IUCDs	YES . . . . . 1 NO 2	-> (4)	DAYS	
(4) Male Condoms	YES . . . . . 1 NO 2	-> (5)	DAYS	
(5) Female Condoms	YES . . . . . 1 NO 2	-> (6)	DAYS	
(6) Foaming Tablets	YES . . . . . 1 NO 2	-> (7)	DAYS	
(7) Female Sterilization	YES . . . . . 1 NO 2	-> (8)	DAYS	
(8) Male Sterilization	YES . . . . . 1 NO 2	-> (9)	DAYS	
(9) Implants (Norplant)	YES . . . . . 1 NO 2	-> (10)	DAYS	
(10) Natural Family Planning	YES . . . . . 1 NO 2	-> 305	DAYS	

METHOD	305. How many METHOD do you usually give to a **new acceptor** on her first visit?	306. How many METHOD do you usually give to a **resupply acceptor** on her first visit?
(1) Oral Pills (number of cycles)		
(4) Male Condoms (number of pieces)		
(5) Female Condoms (number of pieces)		
(6) Foaming Tablets (number of tablets)		

307	Do you have your contraceptives delivered or must you go get them?	DELIVERED . . . . . 1 PICK THEM UP . . . . . 2 BOTH 3	-> 309
308	How far (in kilometers) must you go to get them?	KM	

309	Is this facility supplied by the Medical Stores Department (MSD) system?	YES . . . . 1 NO 2	-> 312
310	How long ago was the Medical Stores Department (MSD) system implemented at this facility?	+)))0))), MONTHS . . . . * * * .)))2)))- LESS THAN 1 MONTH 00	
311	Have you been out of stock (none left) of any contraceptives since MSD was implemented here?	YES . . . . 1 NO 2	
312	Does this facility refer clients to other health care facilities for family planning services?	YES . . . . 1 NO 2	
313	Does this facility refer family planning clients to other departments within this facility and/or to other health care facilities for STD/HIV services, cervical cancer screening, or infertility counseling?	YES . . . . 1 NO 2	
314	Are there charges for <u>new acceptors</u> of family planning?	YES . . . . 1 NO 2	-> 318

NEW ACCEPTOR METHOD	315. How much is the consultation fee for METHOD?	316. How much is the supplies fee for METHOD?	317. What percent of clients pay the charge for METHOD?
(1) Oral Pills	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(2) Condoms	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(3) Creams/foaming tablets	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(4) IUCDs	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(5) Injectables	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(6) Female sterilization	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(7) Male Sterilization	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-
(8) Implants (Norplant)	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))2)))-	+)))0)))0))), * * * * .)))2)))2)))-

318	Are there charges for <u>resupply</u> clients of family planning?	YES . . . . . 1 NO 2	-> 401

RESUPPLY METHOD	319. How much is the consultation fee for METHOD?	320. How much is the supplies fee for METHOD?	321. What percent of clients pay the charge for METHOD?
(1) Oral Pills	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(2) Condoms	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(3) Cream/foaming tablets	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(4) IUCDs	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(5) Injectables	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(6) Female Sterilization	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(7) Male Sterilization	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-
(8) Implants (Norplant)	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)))0)))0))), * * * * * * * .)))2)))2)))2)))2)))2)))-	+)))0)))0)))0)), * * * * * .)))2)))2)))-

4. MATERNAL & CHILD HEALTH SERVICES

401	Does this facility offer Maternal and Child Health services?	YES . . . . . 1 NO 2	-> 501

SERVICE	402. Is SERVICE available to clients at this facility?		403. How Many Days per Week is SERVICE available?	404. What year was SERVICE first offered at this facility? **Don't know = 9998**
(1) Ante-natal care	YES . . . . . 1 NO 2	-> (2)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(2) Post-natal care	YES . . . . . 1 NO 2	-> (3)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * * .)))2)))2)))2)))-
(3) Maternity care/delivery services	YES . . . . . 1 NO 2	-> (4)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * * .)))2)))2)))2)))-
(4) Emergency care for bleeding and prolonged or obstructed labor	YES . . . . . 1 NO 2	-> (5)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * * .)))2)))2)))2)))-
(5) Consultation for infertility	YES . . . . . 1 NO 2	-> (6)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * * .)))2)))2)))2)))-
(6) Treatment of incomplete abortion (post-abortion care)	YES . . . . . 1 NO 2	-> (7)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * * .)))2)))2)))2)))-
(7) Treatment for postpartum or post-abortion bleeding and infection	YES . . . . . 1 NO 2	-> (8)	DAYS . . . . . +)), * * .)))-	+)))0)))0)))0)))), * * * * * * .)))2)))2)))2)))-

SERVICE	402. Is SERVICE available to clients at this facility?		403. How Many Days per Week is SERVICE available?	404. What year was SERVICE first offered at this facility? **Don't know = 9998**
(8) Tetanus Toxoid immunization during pregnancy	YES . . . . . 1 NO 2	-> (9)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(9) Syphilis screening during pregnancy	YES . . . . . 1 NO 2	-> (10)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(10) Vitamin A supplementation **after** pregnancy	YES . . . . . 1 NO 2	-> (11)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(11) Iron supplementation during pregnancy	YES . . . . . 1 NO 2	-> (12)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(12) Nutrition counseling during pregnancy	YES . . . . . 1 NO 2	-> (13)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(13) Malaria prophylaxis during pregnancy	YES . . . . . 1 NO 2	-> (14)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(14) Counseling on initiating breast-feeding after delivery	YES . . . . . 1 NO 2	-> (15)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(15) Child immunization	YES . . . . . 1 NO 2	-> (16)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(16) Child growth monitoring	YES . . . . . 1 NO 2	-> (17)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(17) Child respiratory disease	YES . . . . . 1 NO 2	-> (18)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(18) Oral rehydration therapy services	YES . . . . . 1 NO 2	-> (19)	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-
(19) Family planning counseling	YES . . . . . 1 NO 2	-> 405	DAYS	+)))), * * .)))-	+)))0)))0)))0)))), * * * * * .)))2)))2)))2)))-

405	Does this health facility provide measles immunization services?	YES . . . . . 1 NO 2	
406	Does this facility refer clients to other health care facilities for emergency or difficult Maternal and Child Health services?	YES . . . . . 1 NO 2	
407	Does this facility refer MCH clients to other departments within this facility and/or to other health care facilities for STD/HIV, cervical cancer screening, family planning, or infertility?	YES . . . . . 1 NO 2	
408	Are there charges (or a requested donation) for maternal and child health services?	YES . . . . . 1 NO 2	

5. STD/HIV SERVICES

501	Are STD and/or HIV/AIDS services available at this facility?	YES . . . . . 1 NO 2	-> 601
502	Does this facility provide STD treatment services?	YES . . . . . 1 NO 2	-> 511
503	How many days per week are STD treatment services available?	DAYS . . . . . +)))), * * .)))-	

504	What year was STD treatment first offered at this facility? **Don't know = 9998**	+)))0)))0)))0))), YEAR ..... * * * * * .)))2)))2)))2)))-	
505	Does this facility contact partners of STD clients?	YES ..... 1 NO 2	-> 507
506	ASK TO SEE REFERRAL SLIPS OR OTHER EVIDENCE OF METHOD.	SEEN ..... 1 NOT SEEN 2	
507	Does this facility follow up STD clients after 7 days to assess the effectiveness of treatment?	YES ..... 1 NO 2	->509
508	ASK TO SEE RECORDS OR OTHER EVIDENCE OF FOLLOW-UP VISITS.	SEEN ..... 1 NOT SEEN 2	
509	Is a copy of the National Guidelines or some other set of guidelines for syndromic management of STDs available to service providers at this facility? IF YES, ASK TO SEE IT.	SEEN ..... 1 NOT SEEN 2	-> 511
510	RECORD NAME OF GUIDELINES:		
511	Does this facility offer voluntary HIV testing to individuals?	YES ..... 1 NO 2	-> 514
512	How many days per week are voluntary HIV testing services available?	+))), DAYS ..... * * .)))-	
513	What year was voluntary HIV testing first offered at this facility? **Don't know = 9998**	+)))0)))0)))0))), YEAR ..... * * * * * .)))2)))2)))2)))-	
514	Does this facility offer voluntary HIV counseling to individuals?	YES ..... 1 NO 2	-> 517
515	How many days per week are HIV counseling services available?	+))), DAYS ..... * * .)))-	
516	What year was HIV counseling first offered at this facility? **Don't know = 9998**	+)))0)))0)))0))), YEAR ..... * * * * * .)))2)))2)))2)))-	
517	Does this facility provide condoms free of charge to clients with high risk of STD or HIV infection?	YES ..... 1 NO ..... 2 NOT APPLICABLE ..... 3 DON'T KNOW 4	
518	Does this facility refer clients to other health care facilities for STD/HIV services?	YES ..... 1 NO 2	
519	Does this facility refer STD/HIV clients to other departments within this facility and/or to other health care facilities for family planning, or infertility?	YES ..... 1 NO 2	
520	Are there charges (or a requested donation) for STD/HIV services?	YES ..... 1 NO 2	
6. OTHER SERVICES			
601	How many outpatients were seen at this facility during the last 12 months? FROM MTUHA SYSTEM TABLE 25A, ADD ATTENDANCES AND REATTENDANCES.	+)))0)))0)))0)))0)))0))), * * * * * * * * .)))2)))2)))2)))2)))2)))-	
602	Does this facility offer inpatient care?	YES ..... 1 NO 2	-> 604
603	How many total **beds with mattresses** are available for inpatient care in this facility?	+)))0)))0)))0)))0))), * * * * * * .)))2)))2)))2)))-	

604	Does this facility normally use disposable needles?	YES . . . . . 1 NO 2	-> 607
605	Is this facility out now or has it run out of its supply of disposable needles at any time in the last 6 months?	YES . . . . . 1 NO 2	
606	Does this facility ever have to reuse disposable needles?	YES . . . . . 1 NO 2	
607	Does this facility normally use disposable gloves?	YES . . . . . 1 NO 2	-> 610
608	Is this facility out now or has it run out of disposable gloves at any time in the last six months?	YES . . . . . 1 NO 2	
609	Does this facility ever have to reuse disposable gloves?	YES . . . . . 1 NO 2	
610	What is the method **most** frequently used for the sterilization of medical instruments (not linens)? CIRCLE ONLY ONE	ELECTRIC STERILIZER . . . . 1 AUTOCLAVE . . . . . 2 STEAM STERILIZER . . . . . 3 KEROSENE STOVE . . . . . 4 CHARCOAL/WOOD STOVE . 5 NONE . . . . . 6 OTHER 7	-> 701
611	Has the facility **not** been able to sterilize medical instruments for any reason (e.g. equipment broken, no electricity, no fuel) at any time in the last six months?	YES . . . . . 1 NO 2	
7. REPORTING AND SUPERVISION			
701	Does this facility report to the district level using the MTUHA system? (Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya)	YES . . . . . 1 NO 2	-> 708
702	What problems, if any, have you encountered when compiling reports for MTUHA? Please be specific about the name of the register or the book number and form or table with which you're having problems. RECORD PROBLEM VERBATIM. RECORD NAME OF REGISTER OR BOOK NUMBER AND TABLE NUMBER	PROBLEMS . . . . . 1 NO PROBLEMS 2	-> 706
703	PROBLEM:	REGISTER/BOOK & TABLE	
704	PROBLEM:	REGISTER/BOOK & TABLE	
705	PROBLEM:	REGISTER/BOOK & TABLE	
706	Can you show me the trend of notifiable diseases at your facility as of 1997?	SEEN . . . . . 1 NOT SEEN 2	-> 708
707	RECORD NUMBER OF MINUTES REQUIRED TO PRODUCE BOOK 2 TABLE 26.	MINUTES . . . . . * * *	
	CHECK 104: NOT A DISTRICT HOSPITAL DISTRICT HOSPITAL		▸801

708	How long ago did the District Health Management Team last visit this facility?	WITHIN LAST WEEK . . . . . 1 WITHIN LAST MONTH . . . . . 2 WITHIN LAST 3 MONTHS . . 3 WITHIN LAST 6 MONTHS . . 4 MORE THAN 6 MONTHS . . . 5 NEVER VISITED . . . . . 6 NOT APPLICABLE . . . . . 8 DON'T KNOW 9	 -> 801 -> 801 -> 801
709	Which of the following members of the DHMT visited here at that time? PROMPT: Did anyone else visit with the DHMT? (1) District Medical Officer (2) District Nursing Officer (3) District Health Officer (4) District Maternal and Child Health Coordinator (5) District Tuberculosis and Leprosy Coordinator (6) District AIDS/STD Coordinator (7) District Cold-Chain Coordinator (8) District Health Supervisor (9) Other (SPECIFY) _____ (10) Other (SPECIFY)	YES NO DMO . . . . . 1 2 DNO . . . . . 1 2 DHO . . . . . 1 2 DMCHC . . . . . 1 2 DTBLC . . . . . 1 2 DAC . . . . . 1 2 DCCC . . . . . 1 2 DHS . . . . . 1 2 OTHER . . . . . 1 2 OTHER 1 2	
8. INFORMATION, EDUCATION, AND COMMUNICATION			
801	Do you have an outreach program for IEC (Information, Education and Communication)?	Yes . . . . . 1 No 2	 -> 804
802	How many villages or communities do you regularly visit?	+)))0))), NUMBER . . . . . * * * .)))2)))-	
803	About how often do you visit those villages or communities?	MONTHLY . . . . . 1 QUARTERLY . . . . . 2 ANNUALLY . . . . . 3 OTHER 4	
804	Does this facility give health talks for members of the community?	Yes . . . . . 1 No 2	 -> 807
805	How often does this facility give health talks?	EVERY DAY . . . . . 1 CLINIC DAYS . . . . . 2 OTHER 3	
806	How often does the topic of the health talks change?	EVERY TALK . . . . . 1 MONTHLY . . . . . 2 OTHER 3	
807	Does this facility have a sign posted with the days and times that special clinics, such as MCH, are held? May I see it?	SEEN . . . . . 1 NOT SEEN 2	
808	Does this facility supervise CBDs (community-based distributors of contraceptives)?	YES . . . . . 1 NO 2	 -> 901
809	What organization sponsors the CBDs?	MOH . . . . . 1 UMATI . . . . . 2 PATHFINDER . . . . . 3 MARIE STOPES . . . . . 4 OTHER (SPECIFY) 8	
9. BLOOD BANK			
901	Does this facility offer blood transfusions?	YES . . . . . 1 NO 2	 -> 1001
902	How many days per week are blood donation services available?	+))), DAYS . . . . . * * .)))-	
903	What year was blood donation first offered at this facility? **Don't know = 9998**	+)))0)))0)))0))), YEAR . . . . . * * * * * .)))2)))2)))2)))-	

904	Does this facility screen donated blood for HIV?	YES . . . . . 1 NO 2	-> 908
905	What organization sponsors blood screening for HIV at this facility? RECORD NAME:		
906	How many units of blood were given in the last 1 month, and how many of those were screened for HIV?	DONATED . . . . SCREENED . . .	
907	Does this facility **routinely** report the results of HIV screening to the blood donor?	YES . . . . . 1 NO 2	
908	Does this facility use selected donors (e.g., secondary school children) or relatives to reduce the chances of HIV infection in the blood supply?	YES . . . . . 1 NO 2	
909	Does this facility use verbal screening procedures to reject donors (e.g., questions about sexual behavior)?	YES . . . . . 1 NO 2	
910	Does this facility test donated blood for any of the following diseases? (1) Hepatitis B (2) Syphilis (3) Malaria	YES NO HEPATITIS B . . . . . 1 2 SYPHILIS . . . . . 1 2 MALARIA 1 2	

10. RECORDS

1001. MONTH OF RECORDS FOR 1004-1005 BELOW . . . . . * * *

1002. BEGINNING MONTH AND YEAR FOR 1006-1007 BELOW . . . . . * * ** * * * *

1003. ENDING MONTH AND YEAR FOR 1006-1007 BELOW . . . . . * * ** * * * *

METHOD	1004. NUMBER OF NEW ACCEPTORS LAST MONTH	1005. NUMBER OF RESUPPLY ACCEPTORS LAST MONTH	1006. NUMBER OF NEW ACCEPTORS LAST 12 MONTHS	1007. NUMBER OF RESUPPLY ACCEPTORS LAST 12 MONTHS
(1) Oral Pills				
(2) Injectables (Depo Provera)				
(3) IUCDs				
(4) Male Condoms				
(5) Female Condoms				
(6) Foaming Tablets				
(7) Female Sterilization				

METHOD	1004. NUMBER OF NEW ACCEPTORS LAST MONTH	1005. NUMBER OF RESUPPLY ACCEPTORS LAST MONTH	1006. NUMBER OF NEW ACCEPTORS LAST 12 MONTHS	1007. NUMBER OF RESUPPLY ACCEPTORS LAST 12 MONTHS
(8) Male Sterilization				
(9) Implants (Norplant)				
(10) Natural Family Planning				

CHECK 312, 313, 406, 518: ARE CLIENTS REFERRED TO ANOTHER DEPT IN THIS FACILITY OR ANOTHER FACILITY FOR ANY OF THESE SERVICES?

YES NO -> 1009

|

V

1008	DURING THE LAST 3 MONTHS FOR WHICH DATA ARE AVAILABLE, RECORD THE NUMBER OF REFERRALS FOR EACH OF THE FOLLOWING REASONS: (1) STD/HIV Illness (2) Cervical cancer screening (3) Family planning (4) Infertility counseling (5) Labor complications (6) Pregnancy complications (7) Post-abortion care (8) Childhood illness complications (9) STD lab tests (10) HIV lab tests (11) STD treatment (12) Pap smear (13) HAKUELEZWA (not specified)		
1009	RECORD THE “NO <20 WEEKS” FOR THE MOST RECENT QUARTER (BOOK 2, TABLE 40A).		

CHECK 405:

MEASLES IMMUNIZATIONS

NO MEASLES IMMUNIZATIONS > 1011

1010	RECORD THE TOTAL WEIGHTS AT MEASLES IMMUNIZATIONS FOR THE MOST RECENT QUARTER (BOOK 2, TABLE 44)		

CHECK 502:

STD TREATMENT SERVICES

NO STD TREATMENT > 1012

1011	HOW MANY STD CLIENTS (EXCLUSIVE OF HIV) DID THIS FACILITY SEE IN THE PAST 3 MONTHS WHO WERE THE: (1) INDEX CASE (FIRST VISIT) (2) PARTNER OF AN INDEX CASE (FIRST VISIT) (3) FOLLOW-UP VISIT 999 = DATA (STD REGISTER) NOT AVAILABLE	INDEX . . . . . PARTNER . . . . . FOLLOW-UP . .	

CHECK 511: HIV TESTING SERVICES NO HIV TESTING > 1013			
1012	HOW MANY VOLUNTARY HIV TESTS DID THIS FACILITY PERFORM IN THE PAST 3 MONTHS?	HIV TESTS	
CHECK 514: HIV COUNSELING SERVICES NO HIV COUNSELING > 1014			
1013	HOW MANY CLIENTS WERE COUNSELED ABOUT HIV USING THE 4 C'S DURING THE PAST 3 MONTHS? (THE 4 C'S ARE: 1. COUNSELING, 2. CONDOMS, 3. CONTACT , AND 4. COMPLIANCE.)	HIV COUNSEL .	
1014	RECORD THE TIME	HOUR . . . . . * * * MINUTES . . . . . * * *	

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
FACILITY INVENTORY QUESTIONNAIRE
(corrected against Kiswahili)

IDENTIFICATION

NAME OF FACILITY_____

REGION . . . . . .

DISTRICT . . . . . .

WARD . . . . . .

E.A. NUMBER . . . . . .

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY
				MONTH
				YEAR * 1 * 9 * * *
INTERVIEWER'S NAME	_____	_____	_____	INTER. ID NO.
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 CANNOT LOCATE FACILITY
3 CANNOT LOCATE IN-CHARGE
4 REFUSED
5 PARTLY COMPLETED
6 POSTPONED
7 OTHER (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME	NAME		
DATE	DATE		

1. GENERAL FACILITY INFORMATION

No.	QUESTIONS	CODING CATEGORIES	SKIP
101	RECORD THE TIME	HOUR . . . . . * * * MINUTES . . . . . * * *	
102	Does this facility have the following in working order now? VERIFY BY VISUAL INSPECTION. (1) Running water (piped) (2) Borehole well (3) Electricity (4) Solar power (5) Refrigerator (6) Emergency transportation (7) Communication to the referral level (e.g., telephone or radio)	SEEN NOT SEEN RUNNING WATER . . . 1 2 BOREHOLE WELL . . . 1 2 ELECTRICITY . . . . . 1 2 SOLAR POWER . . . . . 1 2 REFRIGERATOR . . . . 1 2 TRANSPORTATION . . 1 2 COMMUNICATION . . . 1 2	
103	Has the water supply at this facility been treated in any way to insure that it is sanitary?	Yes . . . . . 1 No . . . . . 2 Don't know 8	
104	Does this facility have a working microscope?	Yes . . . . . 1 No 2	-> 106
105	VERIFY BY VISUAL INSPECTION. (1) Microscope (2) Slides (3) Cover slips	SEEN NOT SEEN MICROSCOPE . . . . . 1 2 SLIDES . . . . . 1 2 COVER SLIPS 1 2	
106	Does this facility have a working laboratory?	Yes . . . . . 1 No 2	-> 201
107	Other than the license to operate the facility, is there a specific license for the laboratory?	Yes . . . . . 1 No 2	
108	Are the laboratory personnel registered?	Yes . . . . . 1 No 2	

2. GENERAL MCH AND FP

No.	QUESTIONS	CODING CATEGORIES	SKIP
201	Which of the following equipment and supplies does this facility have available and in working order for general MCH and FP clinic services? VERIFY BY VISUAL INSPECTION. (01) Suture, needle and holder (02) Surgical knife blade and handle (03) Tape measure (04) Tourniquet (05) Urinometer and urine test kit (06) Tongue depressor (07) Pelvimeter (08) Sphygmomanometer (09) Nasal speculum (10) Fetal stethoscope (11) Urethral catheter (12) Forceps (13) Needles and syringes (14) Scissors (15) Uterine sound (16) Vaginal speculum (17) Tubing clamp (18) Hemoglobinometer, pipette, and measuring tube (19) Light source: examination lamp or torch with batteries	SEEN NOT SEEN SUTURE . . . . . 1 2 KNIFE . . . . . 1 2 TAPE MEASURE . . 1 2 TOURNIQUET . . . . 1 2 URINE TEST . . . . . 1 2 TONGUE DEPRESS 1 2 PELVIMETER . . . . . 1 2 BP METER . . . . . 1 2 NASAL SPECULUM 1 2 FETAL STETH . . . . 1 2 URETHRAL CATH . 1 2 FORCEPS . . . . . 1 2 NEEDLE/SYRINGE . 1 2 SCISSORS . . . . . 1 2 UTERINE SOUND . 1 2 VAGINAL SPEC . . 1 2 TUBING CLAMP . . . 1 2 HEMOGLOBINOM . 1 2 LIGHT SOURCE . . . 1 2	

CONTRACEPTIVE	205. Is CONTRACEPTIVE available now?		206. Has CONTRACEPTIVE been out of stock in the last 1 month?		207. Has CONTRACEPTIVE been out of stock in the last 12 months?
(1) Combination oral contraceptives (estrogen and progestin)	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Progestin-only oral contraceptives	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) Male condoms	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) Female condoms	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) IUCD	SEEN . . . . . 1 NOT SEEN 2	-> (6)	YES . . . . . 1 NO 2	-> (6)	YES . . . . . 1 NO 2
(6) Spermicide (foam, foaming tablets, gel)	SEEN . . . . . 1 NOT SEEN 2	-> (7)	YES . . . . . 1 NO 2	-> (7)	YES . . . . . 1 NO 2
(7) Injectables (e.g., Depo Provera)	SEEN . . . . . 1 NOT SEEN 2	-> (8)	YES . . . . . 1 NO 2	-> (8)	YES . . . . . 1 NO 2
(8) Implant (e.g., Norplant)	SEEN . . . . . 1 NOT SEEN 2	-> 208	YES . . . . . 1 NO 2	-> 208	YES . . . . . 1 NO 2

VACCINE	208. Is VACCINE available now?		209. Has VACCINE been out of stock in the last 1 month?		210. Has VACCINE been out of stock in the last 12 months?
(1) Measles	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Polio	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) BCG	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) DPT	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) TT	SEEN . . . . . 1 NOT SEEN 2	-> 211	YES . . . . . 1 NO 2	-> 211	YES . . . . . 1 NO 2

SUPPLEMENT	211. Is SUPPLEMENT available now?		212. Has SUPPLEMENT been out of stock in the last 1 month?		213. Has SUPPLEMENT been out of stock in the last 12 months?
(1) Iron	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Folic acid	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) Fefetol (folic acid and ferrous-sulfate)	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) Vitamin A	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) Iodine	SEEN . . . . . 1 NOT SEEN 2	-> 214	YES . . . . . 1 NO 2	-> 214	YES . . . . . 1 NO 2

214	Is this facility equipped to offer **IUCD** insertion and removal?	Yes . . . . . 1 No 2	-> 216

215	Which of the following equipment and supplies does this facility have available and in working order for IUCD insertion and removal? VERIFY BY VISUAL INSPECTION. (1) Tray (2) Gallipot (3) Forceps (4) Tenaculum (5) Scissors (6) IUD removal hook (7) Uterine sound (8) Vaginal speculum	SEEN / NOT SEEN TRAY . . . . . 1 2 GALLIPOT . . . . . 1 2 FORCEPS . . . . . 1 2 TENACULUM . . . . . 1 2 SCISSORS . . . . . 1 2 IUD HOOK . . . . . 1 2 UTERINE SOUND . 1 2 VAGINAL SPEC . . . 1 2	
216	Is this facility equipped to offer **Manual Vacuum Aspiration**?	Yes . . . . . 1 No 2	-> 301
217	Which of the following equipment and supplies does this facility have available and in working order for manual vacuum aspiration? VERIFY BY VISUAL INSPECTION. (1) Vacuum syringe (2) Flexible cannulae and adapters (3) Silicone lubricant for syringe (4) Vaginal speculum (5) Tenaculum (6) Mechanical dialators (8) Curettes	SEEN / NOT SEEN VACUUM SYRINGE 1 2 CANNULAE . . . . . 1 2 LUBRICANT . . . . . 1 2 VAGINAL SPEC . . . 1 2 TENACULUM . . . . . 1 2 DIALATOR . . . . . 1 2 CURETTES 1 2	

3. STD

301	Is this facility equipped to test for **syphilis**?	Yes . . . . . 1 No 2	-> 305

TEST	302. Is TEST available now?		303. Has TEST been out of stock in the last 1 month?		304. Has TEST been out of stock in the last 12 months?
VDRL test	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
RPR test	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
TPHA test	SEEN . . . . . 1 NOT SEEN 2	-> 305	YES . . . . . 1 NO 2	-> 305	YES . . . . . 1 NO 2

305	Is this facility equipped to test for **gonorrhea**?	YES . . . . . 1 NO 2	-> 401
306	Which of the following equipment and supplies does this facility have available and in working order for gonorrhea testing? VERIFY BY VISUAL INSPECTION. (1) Gram stain (2) Swabs	SEEN / NOT SEEN GRAM STAIN . . . . . 1 2 SWABS 1 2	
307	Does this facility have the drugs necessary to control major STDs?	Yes . . . . . 1 No 2	

4. HIV

401	Is this facility equipped to test for **HIV**?	Yes . . . . . 1 No 2	-> 407
402	Which of the following equipment and supplies does this facility have available and in working order for HIV testing? VERIFY BY VISUAL INSPECTION. (1) ELISA reader (2) Needle and syringe	SEEN / NOT SEEN ELISA READER . . . 1 2 NEEDLE/SYRINGE . 1 2	

403	RECORD NUMBER OF UNEXPIRED TESTS OF EACH TYPE. (1) ELISA TEST REAGENTS (2) RAPID HIV TEST (NOT EXPIRED) (3) CONFIRMATORY TEST (SUCH AS WESTERN BLOT)	ELISA TEST . . . . . RAPID TEST . . . . . CONFIRM TEST . .	
404	RECORD THE EXPIRATION DATE OF THE OLDEST HIV TEST IN THE STOCK ROOM (DAY/MONTH/YEAR).	DD MM YY	
405	Has this facility been out of stock of HIV tests in the last 1 month?	NO TESTS AT ALL . . . . . 1 ONLY ONE TYPE IN STOCK . . 2 AT LEAST TWO TYPES IN STOCK AT ALL TIMES 3	
406	Has this facility been out of stock of HIV tests in the last 12 months?	NO TESTS AT ALL . . . . . 1 ONLY ONE TYPE IN STOCK . . 2 AT LEAST TWO TYPES IN STOCK AT ALL TIMES 3	
407	Is this facility equipped to test for **Hepatitis B**? (Hepatitis B is a form of hepatitis (liver infection) that can be transmitted by blood transfusion and sexual contact. There are other forms of hepatitis, such as Infectious Hepatitis (also called Hepatitis A) which cannot be transmitted by blood transfusion.)	Yes . . . . . 1 No 2	-> 501
408	Does this facility have Hepatitis B testing kits in stock? VERIFY BY VISUAL INSPECTION.	SEEN . . . . . 1 NOT SEEN 2	
5. MALARIA			
501	Is this facility equipped to test for malaria?	Yes . . . . . 1 No 2	-> 601
502	Which of the following equipment and supplies does this facility have available and in working order for malaria testing? VERIFY BY VISUAL INSPECTION. (1) Adult thermometer (2) Child thermometer (3) Lancets (4) Giemsa stain	SEEN NOT SEEN ADULT THERMO . . 1 2 CHILD THEMO . . . . 1 2 LANCETS . . . . . 1 2 GIEMSA STAIN . . . 1 2	
6. ANEMIA, PROTEIN IN URINE			
601	Is this facility equipped to test for anemia?	Yes . . . . . 1 No 2	-> 603
602	Which of the following equipment and supplies does this facility have available and in working order for anemia testing? VERIFY BY VISUAL INSPECTION. (1) Hemoglobinometer/calorimeter (2) Dilutants for Hb testing (3) Needle/syringe	SEEN NOT SEEN HEMOGLOBINOM . 1 2 DILUTANTS . . . . . 1 2 NEEDLE/SYRINGE . 1 2	
603	Is this facility equipped to test for protein in the urine?	Yes . . . . . 1 No 2	-> 701
604	Which of the following equipment and supplies does this facility have available and in working order to test for protein in the urine? VERIFY BY VISUAL INSPECTION. (1) Multistiks (not expired) (2) Multistiks (expired)	SEEN NOT SEEN NOT EXPIRED . . . . 1 2 EXPIRED 1 2	

7. DELIVERIES

701	Is this facility equipped for **normal deliveries**?	Yes . . . . . 1 No 2	-> 703
702	Which of the following equipment and supplies does this facility have available and in working order for deliveries? VERIFY BY VISUAL INSPECTION. (1) Tray (2) Scissors (3) Forceps (4) Dressing towels (5) Maternity pads (6) Mucus extractor (7) Cotton gauze (8) Gallipot	SEEN / NOT SEEN TRAY . . . . . 1 2 SCISSORS . . . . . 1 2 FORCEPS . . . . . 1 2 TOWELS . . . . . 1 2 MATERNITY PADS . 1 2 MUCUS EXTRACT 1 2 GAUZE . . . . . 1 2 GALLIPOT 1 2	
703	Is this facility equipped to perform **vacuum extraction**?	Yes . . . . . 1 No 2	-> 705
704	Which of the following equipment and supplies does this facility have available and in working order for vacuum extraction? VERIFY BY VISUAL INSPECTION. (1) Vacuum extractor (2) Forceps (3) Suture, needle and holder (4) Scissors (5) Urethral catheter (6) Tray (7) Gallipot	SEEN / NOT SEEN VACUUM EXTRACT 1 2 FORCEPS . . . . . 1 2 SUTURE . . . . . 1 2 SCISSORS . . . . . 1 2 URETHRAL CATH . 1 2 TRAY . . . . . 1 2 GALLIPOT 1 2	
705	Is this facility equipped to perform **neonatal resuscitation**?	Yes . . . . . 1 No 2	-> 801
706	Which of the following equipment and supplies does this facility have available and in working order for neonatal resuscitation? VERIFY BY VISUAL INSPECTION. (01) Mucus catheter (02) Endotracheal tube (03) Suction machine (04) Suction catheters (05) Infant laryngoscope (06) Ventilatory bag (07) Oxygen cylinder with manometer and flowmeter, or safety valve (08) Infant masks (09) Airways (10) Umbilical vein catheter (11) Heat source (12) Spatula (13) Sodium bicarbonate (14) Dextrose, 50% (15) Scalp vein needle and syringe (16) Gloves	SEEN / NOT SEEN MUCUS CATH . . . . 1 2 ENDOTRACH . . . . . 1 2 SUCTION MACH . . 1 2 SUCTION CATH . . . 1 2 LARYNGOSCOPE . 1 2 VENTIL BAG . . . . . 1 2 OXYGEN . . . . . 1 2 INFANT MASK . . . . 1 2 AIRWAYS . . . . . 1 2 UMBILICAL CATH . 1 2 HEAT SOURCE . . . 1 2 SPATULA . . . . . 1 2 SODIUM BICARB . . 1 2 DEXTROSE . . . . . 1 2 SCALP NEEDLE . . . 1 2 GLOVES 1 2	

8. SURGICAL PROCEDURES

801	Is this facility equipped to administer **anaesthesia**?	Yes . . . . . 1 No 2	-> 803
802	Which of the following equipment and supplies does this facility have available and in working order for anaesthesia? VERIFY BY VISUAL INSPECTION.		

		SEEN	NOT SEEN
(01)	Face mask	FACE MASK 1	2
(02)	Airways	AIRWAYS 1	2
(03)	Laryngoscope	LARYNGOSCOPE . 1	2
(04)	Endotracheal tube and pan	ENDOTRACH TUBE 1	2
(05)	Forceps	FORCEPS 1	2
(06)	Breathing system, valves, hose, and connectors	BREATH SYSTEM 1	2
(07)	Bellows or bags	BELLOWS 1	2
(08)	Anesthetic vaporizer	VAPORIZER 1	2
(09)	Intravenous set	INTRAVENOUS . . . 1	2
(10)	Spinal needle and syringe	SPINAL NEEDLE . . 1	2
(11)	Suction apparatus	SUCTION 1	2
(12)	Gloves	GLOVES 1	2
(13)	Anaesthetics	ANAESTHETICS . . 1	2

803	Is this facility equipped to offer **female sterilizations**?	Yes . . . . . 1 No 2	-> 901
804	Which of the following equipment and supplies does this facility have available and in working order for mini-laparotomies? VERIFY BY VISUAL INSPECTION.		

		SEEN	NOT SEEN
(01)	Tray	TRAY 1	2
(02)	Forceps	FORCEPS 1	2
(03)	Retractors	RETRACTORS 1	2
(04)	Gallipot	GALLIPOT 1	2
(05)	Suture, needle and holder	SUTURE KIT 1	2
(06)	Scissors	SCISSORS 1	2
(07)	Uterine elevator	UTER ELEVATOR . 1	2
(08)	Surgical knife blade and handle	SURG KNIFE 1	2
(09)	Urethral catheter	URETHRAL CATH . 1	2
(10)	Tubal hook	TUBAL HOOK 1	2

805	Which of the following equipment and supplies does this facility have available and in working order for laparotomies? VERIFY BY VISUAL INSPECTION.		

		SEEN	NOT SEEN
(01)	Tray	TRAY 1	2
(02)	Forceps	FORCEPS 1	2
(03)	Retractors	RETRACTORS 1	2
(04)	Towel clips	TOWEL CLIPS 1	2
(05)	Suture, needle and holder	SUTURE KIT 1	2
(06)	Scissors	SCISSORS 1	2
(07)	Balfour	BALFOUR 1	2
(08)	Surgical knife blade and handle	SURG KNIFE 1	2
(09)	Urethral catheter	URETHRAL CATH . 1	2
(10)	Suction tube and nozzle	SUCTION TUBE . . . 1	2
(11)	Intestinal clamps	INTESTINAL CLAPS 1	2
(12)	Ligature cord	LIGATURE CORD . . 1	2

9. HMIS (MTUHA)

901	Does this facility use the MTUHA record keeping system?	Yes . . . . . 1 No 2	-> 1001

CHECK WHETHER THE **REGISTERS** BELOW ARE AVAILABLE AND FILLED IN PROMPTLY.

REGISTER	APPLICABLE? (1)	FILLED IN? (2)	ENTRIES FOUND FOR FOLLOWING TIME PERIODS?			
			TODAY (3)	PAST 7 DAYS (4)	PAST 1 MONTH (5)	PAST 1 YEAR (6)
902. BOOK 4 (LEDGER)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
903. BOOK 5 (OUTPATIENT DEPT)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2

904. BOOK 6 (ANTENATAL CARE)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
905. BOOK 7 (CHILD)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
906. BOOK 8 (FAMILY PLANNING)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
907. BOOK 9 (DTC)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
908. BOOK 12 (DELIVERIES)	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2

CHECK WHETHER THE HEALTH FACILITY **DATA BOOK** (BOOK 2) TABLES BELOW ARE COMPILED PROMPTLY.

TABLE	APPLICABLE? (1)	FILLED IN? (2)	UP-TO-DATE? (3)
909. TABLE 5: RECORD OF ACTIONS TAKEN TO IMPROVE PERFORMANCE	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
910. TABLE 17: RECORD OF COMMUNITY OUTREACH VISITS	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
911. TABLE 18: SCHOOL VISITS	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
912. TABLE 22: DAYS OUT OF STOCK	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
913. TABLE 29: TOP TEN DIAGNOSES	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
914. TABLE 49L: ARE ALL CHILDREN RECEIVING MEASLES IMMUN. ALSO RECEIVING VIT A SUPPLEMENTATION?	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2
915. TABLE 49O: IS THE NUMBER OF NEW ACCEPTORS OF FAMILY PLANNING AT THE FACILITY TOO LOW?	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2	Yes . . . . . 1 No 2

10. IEC

1001	RECORD WHICH OF THE FOLLOWING POSTERS ARE DISPLAYED ANYWHERE IN THE FACILITY. (1) Small family norms (2) Other (specify)		SEEN NOT SEEN 1 2 1 2	

11. PHARMACY

MEDICINE	1101. Is MEDICINE available now?		1102. Has MEDICINE been out of stock in the last 1 month?		1103. Has MEDICINE been out of stock in the last 12 months?
(01) Phenobarbital	SEEN . . . . . 1 NOT SEEN 2	-> (02)	YES . . . . . 1 NO 2	-> (02)	YES . . . . . 1 NO 2
(02) Mebendazole	SEEN . . . . . 1 NOT SEEN 2	-> (03)	YES . . . . . 1 NO 2	-> (03)	YES . . . . . 1 NO 2
(03) Valium (Diazepam)	SEEN . . . . . 1 NOT SEEN 2	-> (04)	YES . . . . . 1 NO 2	-> (04)	YES . . . . . 1 NO 2
(04) Lidocaine	SEEN . . . . . 1 NOT SEEN 2	-> (05)	YES . . . . . 1 NO 2	-> (05)	YES . . . . . 1 NO 2
(05) Egometrin or Oxytocin or Syntometrin	SEEN . . . . . 1 NOT SEEN 2	-> (06)	YES . . . . . 1 NO 2	-> (06)	YES . . . . . 1 NO 2
(06) Hydralazine	SEEN . . . . . 1 NOT SEEN 2	-> (07)	YES . . . . . 1 NO 2	-> (07)	YES . . . . . 1 NO 2
(07) Lasix	SEEN . . . . . 1 NOT SEEN 2	-> (08)	YES . . . . . 1 NO 2	-> (08)	YES . . . . . 1 NO 2
(08) Crystalline penicillin	SEEN . . . . . 1 NOT SEEN 2	-> (09)	YES . . . . . 1 NO 2	-> (09)	YES . . . . . 1 NO 2
(09) PPF penicillin	SEEN . . . . . 1 NOT SEEN 2	-> (10)	YES . . . . . 1 NO 2	-> (10)	YES . . . . . 1 NO 2
(10) Chloramphenicol	SEEN . . . . . 1 NOT SEEN 2	-> (11)	YES . . . . . 1 NO 2	-> (11)	YES . . . . . 1 NO 2
(11) Gentamicin or Kanamicin	SEEN . . . . . 1 NOT SEEN 2	-> (12)	YES . . . . . 1 NO 2	-> (12)	YES . . . . . 1 NO 2
(12) Metronidazole (Flagyl)	SEEN . . . . . 1 NOT SEEN 2	-> (13)	YES . . . . . 1 NO 2	-> (13)	YES . . . . . 1 NO 2
(13) Sodium Bicarbonate	SEEN . . . . . 1 NOT SEEN 2	-> (14)	YES . . . . . 1 NO 2	-> (14)	YES . . . . . 1 NO 2
(14) Hydrocortisone	SEEN . . . . . 1 NOT SEEN 2	-> (15)	YES . . . . . 1 NO 2	-> (15)	YES . . . . . 1 NO 2
(15) Adrenaline	SEEN . . . . . 1 NOT SEEN 2	-> (16)	YES . . . . . 1 NO 2	-> (16)	YES . . . . . 1 NO 2
(16) Saline infusion (Ringers)	SEEN . . . . . 1 NOT SEEN 2	-> (17)	YES . . . . . 1 NO 2	-> (17)	YES . . . . . 1 NO 2
(17) Dextrose infusion	SEEN . . . . . 1 NOT SEEN 2	-> (18)	YES . . . . . 1 NO 2	-> (18)	YES . . . . . 1 NO 2
(18) Oral rehydration solution packets	SEEN . . . . . 1 NOT SEEN 2	-> (19)	YES . . . . . 1 NO 2	-> (19)	YES . . . . . 1 NO 2
(19) Water for injections	SEEN . . . . . 1 NOT SEEN 2	-> 1104	YES . . . . . 1 NO 2	-> 1104	YES . . . . . 1 NO 2
ANTI-MALARIAL	1104. Is ANTI-MALARIAL available now?		1105. Has ANTI-MALARIAL been out of stock in the last 1 month?		1106. Has ANTI-MALARIAL been out of stock in the last 12 months?

(1) Chloroquine	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Sulfadoxine + Pyrimetharine (Fansidar)	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) Quinine	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) Metakelvin	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) Halfan	SEEN . . . . . 1 NOT SEEN 2	-> (6)	YES . . . . . 1 NO 2	-> (6)	YES . . . . . 1 NO 2
(6) Other antimalarial drugs (specify)	SEEN . . . . . 1 NOT SEEN 2	-> 1107	YES . . . . . 1 NO 2	-> 1107	YES . . . . . 1 NO 2

1107	Does this facility have the medicines needed for **syndromic management** of STDs?	Yes . . . . . 1 No 2	-> 1201

ANTIBIOTIC	1108. Is ANTIBIOTIC available now?		1109. Has ANTIBIOTIC been out of stock in the last 1 month?		1110. Has ANTIBIOTIC been out of stock in the last 12 months?
(01) Benzathine penicillin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (02)	YES . . . . . 1 NO 2	-> (02)	YES . . . . . 1 NO 2
(02) Procaine penicillin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (03)	YES . . . . . 1 NO 2	-> (03)	YES . . . . . 1 NO 2
(03) Streptomycin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (04)	YES . . . . . 1 NO 2	-> (04)	YES . . . . . 1 NO 2
(04) Gentamicin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (05)	YES . . . . . 1 NO 2	-> (05)	YES . . . . . 1 NO 2
(05) Doxycycline	SEEN . . . . . 1 NOT SEEN 2	-> (06)	YES . . . . . 1 NO 2	-> (06)	YES . . . . . 1 NO 2
(06) Erythromycine	SEEN . . . . . 1 NOT SEEN 2	-> (07)	YES . . . . . 1 NO 2	-> (07)	YES . . . . . 1 NO 2
(07) Tetracycline	SEEN . . . . . 1 NOT SEEN 2	-> (08)	YES . . . . . 1 NO 2	-> (08)	YES . . . . . 1 NO 2
(08) Clotrimazole pessaries	SEEN . . . . . 1 NOT SEEN 2	-> (09)	YES . . . . . 1 NO 2	-> (09)	YES . . . . . 1 NO 2
(09) Co-trimoxazole (Septrin)	SEEN . . . . . 1 NOT SEEN 2	-> (10)	YES . . . . . 1 NO 2	-> (10)	YES . . . . . 1 NO 2
(10) Nizoral cream	SEEN . . . . . 1 NOT SEEN 2	-> (11)	YES . . . . . 1 NO 2	-> (11)	YES . . . . . 1 NO 2
(11) Nizoral pessaries	SEEN . . . . . 1 NOT SEEN 2	-> (12)	YES . . . . . 1 NO 2	-> (12)	YES . . . . . 1 NO 2
(12) Nizoral tablets	SEEN . . . . . 1 NOT SEEN 2	-> (13)	YES . . . . . 1 NO 2	-> (13)	YES . . . . . 1 NO 2
(13) Nystatin ointment	SEEN . . . . . 1 NOT SEEN 2	-> (14)	YES . . . . . 1 NO 2	-> (14)	YES . . . . . 1 NO 2
(14) Nystatin pessaries	SEEN . . . . . 1 NOT SEEN 2	-> (15)	YES . . . . . 1 NO 2	-> (15)	YES . . . . . 1 NO 2
(15) Gentain Violet (GV) paint	SEEN . . . . . 1 NOT SEEN 2	-> (16)	YES . . . . . 1 NO 2	-> (16)	YES . . . . . 1 NO 2
(16) Podophylline	SEEN . . . . . 1 NOT SEEN 2	-> (17)	YES . . . . . 1 NO 2	-> (17)	YES . . . . . 1 NO 2

(17) Ciprofloxacin	SEEN . . . . . 1 NOT SEEN 2	-> (18)	YES . . . . . 1 NO 2	-> (18)	YES . . . . . 1 NO 2
(18) Ceftriaxone	SEEN . . . . . 1 NOT SEEN 2	-> (19)	YES . . . . . 1 NO 2	-> (19)	YES . . . . . 1 NO 2
(19) Spectinomycin	SEEN . . . . . 1 NOT SEEN 2	-> (20)	YES . . . . . 1 NO 2	-> (20)	YES . . . . . 1 NO 2
(20) Silver nitrate eye drops	SEEN . . . . . 1 NOT SEEN 2	-> (21)	YES . . . . . 1 NO 2	-> (21)	YES . . . . . 1 NO 2
(21) Tetracycline eye ointment	SEEN . . . . . 1 NOT SEEN 2	-> 1201	YES . . . . . 1 NO 2	-> 1201	YES . . . . . 1 NO 2

12. GENERAL OBSERVATIONS

1201	RECORD WHETHER CLIENTS HAVE VISUAL PRIVACY, AURAL PRIVACY, BOTH, OR NEITHER DURING THEIR **COUNSELING** SESSIONS.	VISUAL . . . . . 1 AURAL . . . . . 2 BOTH . . . . . 3 NEITHER 4	
1202	RECORD WHETHER CLIENTS HAVE VISUAL PRIVACY, AURAL PRIVACY, BOTH, OR NEITHER DURING THEIR **EXAMINATIONS**.	VISUAL . . . . . 1 AURAL . . . . . 2 BOTH . . . . . 3 NEITHER 4	
1203	RECORD THE TIME	HOUR . . . . . : : : MINUTES . . . . . : : :	

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
SERVICE PROVIDER QUESTIONNAIRE
(Corrected against Kiswahili)

IDENTIFICATION

NAME OF FACILITY_____

REGION . . . . . .

DISTRICT . . . . . .

WARD . . . . . .

E.A. NUMBER . . . . . .

RESPONDENT LINE NUMBER FROM FACILITY ROSTER . . . . . .

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY
				MONTH
				YEAR 19
INTERVIEWER'S NAME	_____	_____	_____	INTER. ID NO.
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 CANNOT LOCATE FACILITY
3 CANNOT LOCATE IN-CHARGE
4 REFUSED
5 PARTLY COMPLETED
6 POSTPONED
7 OTHER (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME	NAME		
DATE	DATE		

0. BACKGROUND INFORMATION

No.	QUESTIONS	CODING CATEGORIES	SKIP
001	RECORD THE TIME	HOUR . . . . . +)))0)))), * * * /)))3)))1 MINUTES . . . . . * * * .)))2)))-	
002	What is your job title or type of cadre?	DOCTOR . . . . . 1 ASSISTANT MEDICAL OFFICER . . . . . 2 CLINICAL OFFICER . . . . . 3 ASSISTANT CLINICAL OFFICER . . . . . 4 NURSING OFFICER . . . . . 5 NURSE/MIDWIFE . . . . . 6 PUBLIC HEALTH NURSE B . . . . . 7 MCH AIDE . . . . . 8 NURSE ASSISTANT/MEDICAL ASSISTANT 9 OTHER 10	

1. SERVICES

	101. Do you yourself provide **(SERVICE)** to clients at this health facility?		102. For how many years in total have you provided this service? **Less than one year = 00** **Don't know = 98**	103. Do you refer clients within this facility or to other facilities for this service?
(01) Ante-natal care	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(02) Post-natal care	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(03) Maternity care/delivery services	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(04) Treatment for neonatal conjuctivitis	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(05) Counseling clients with fertility problems	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(06) Treatment of incomplete abortion (Post-Abortion Care)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(07) Child immunization	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(08) Child growth monitoring	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(09) Oral rehydration therapy services	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(10) Initiating injectable contraception (Depo provera)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(11) IUCD insertion and removal	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(12) Initiating oral contraception (contraceptive pills)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(13) Male Condom	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0)))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3

1. SERVICES

	101. Do you yourself provide **(SERVICE)** to clients at this health facility?		102. For how many years in total have you provided this service? **Less than one year = 00 Don't know = 98**	103. Do you refer clients within this facility or to other facilities for this service?
(14) Female Condom	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(15) Spermicides (foam, foaming tablets, gel)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(16) Norplant insertion and removal	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(17) Emergency contraceptive pills	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(18) Vasectomy (perform the procedure)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(19) Female sterilization (perform mini-laparotomy)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(20) Female sterilization (perform laparoscopy)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(21) LAM (Lactational Amenorrhea) counseling	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(22) Information/Education/Communication for family planning	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(23) Counseling: Informed choice of contraceptives (following standard procedure)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(24) Counseling: risks, side effects of contraceptives (following standard procedure)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(25) HIV/AIDS counseling using 4 Cs (Counseling, condoms, contact, complience)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(26) HIV/AIDS testing	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(27) Other STD counseling using 4 Cs (Counseling, condoms, contact, complience)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(28) Other STD management using syndromic method	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(29) Other STD laboratory diagnosis	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3
(30) Other curative services (e.g., prescribing drugs)	YES . . . . . 1 NO 2	-> 103	YEARS . . . . . +)))0))), * * * .)))2)))-	YES WITHIN . . . . . 1 YES OUTSIDE . . . . 2 NO 3

104	How long have you been working here at this facility? **LESS THAN ONE YEAR =00** **DON'T KNOW = 98**	YEARS . . . . . +)))0))), * * * .)))2)))-

105	How many years ago did you finish your pre-service training? **LESS THAN ONE YEAR = 00** **NO PRESERVICE TRAINING = 97** **DON'T KNOW = 98**	YEARS . . . . . +)))0))) * * * .)))2)))

TOPIC	106. Did your **pre-service** training cover TOPIC?	107. Have you attended **in-service** training courses? (IF YES) Did your **in-service** training include TOPIC?		108. What year was your most recent **in-service** training on TOPIC? **Don't know = 9998**
(01) Introduction to FP clinical skills (preservice)	Yes . . . . . 1 No 2			
(02) Basic FP clinical skills (BCS)		Yes . . . . . 1→ No . . . . . 2→	108 107(03)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(03) Comprehensive FP clinical skills (CCS)		Yes . . . . . 1→ No . . . . . 2→	108 107(04)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(04) Integrated reproductive and child health (IRCH) skills		Yes . . . . . 1→ No . . . . . 2→	108 107(05)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(05) Preceptorship skills		Yes . . . . . 1→ No . . . . . 2→	108 107(06)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(06) Basic training skills		Yes . . . . . 1→ No . . . . . 2→	108 107(07)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(07) Reproductive health update (RHU)		Yes . . . . . 1→ No . . . . . 2→	108 107(08)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(08) Information, Education, and Communication (IEC)		Yes . . . . . 1→ No . . . . . 2→	108 107(09)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(09) Reproductive health training for Health Attendants		Yes . . . . . 1→ No . . . . . 2→	108 106(10)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(10) Safe motherhood	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(11)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(11) Maternity care/midwifery	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(12)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(12) Vitamin A supplementation during pregnancy	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(13)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(13) Iron supplementation during pregnancy	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(14)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))
(14) Malaria prophylaxis during pregnancy	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(15)	+)))0)))0)))0))) * * * * * .)))2)))2)))2)))

TOPIC	106. Did your **pre-service** training cover TOPIC?	107. Have you attended **in-service** training courses? (IF YES) Did your **in-service** training include TOPIC?		108. What year was your most recent **in-service** training on TOPIC? **Don't know = 9998**
(15) Post-natal care (routine)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(16)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(16) Infertility counseling	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(17)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(17) Emergency contraception	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(18)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(18) Treatment of incomplete abortion (Post-Abortion Care)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(19)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(19) Manual vacuum aspiration (MVA)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(20)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(20) Child health (immunization and growth monitoring)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(21)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(21) Exclusive breastfeeding counseling	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(22)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(22) Oral rehydration therapy services	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(23)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(23) Voluntary surgical contraception	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(24)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(24) Norplant implant insertion and removal	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(25)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(25) Natural family planning	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(26)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(26) Facility management	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(27)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(27) Supervision	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(28)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(28) Record Keeping (MTUHA)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(29)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(29) Supplies Management	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(30)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-

TOPIC	106. Did your **pre-service** training cover TOPIC?	107. Have you attended **in-service** training courses? (IF YES) Did your **in-service** training include TOPIC?		108. What year was your most recent **in-service** training on TOPIC? **Don't know = 9998**
(30) STD syndromic management	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(31)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(31) Laboratory diagnosis of syphilis	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(32)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(32) Laboratory diagnosis of gonorrhea	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(33)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(33) HIV/AIDS/STD counseling	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 106(34)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(34) HIV/AIDS testing	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	108 109(1)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-

METHOD	109. Is there a minimum age below which you will not offer METHOD?		110. What is that age?	111. Is there a maximum age above which you will not offer METHOD?		112. What is that age?	113. Is there a minimum number of children a woman must have before you will offer METHOD?		114. What is that minimum number of children?	115. Would you offer METHOD to an unmarried person?	116. Do you require a partner's consent before you will provide METHOD?
(1) Pill	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(2) Male condom	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(3) Female condom	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(4) IUCD	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(5) Injectable	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(6) Female sterilization	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(7) Vasectomy	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(8) Norplant	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(9) LAM	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3
(10) Natural FP	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	110 111 111	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	112 113 113	+)))0))), * * * .)))2)))-	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	114 115 115	+)))0))), * * * .)))2)))-	Yes . . . . . 1 No . . . . . 2 N/A 3	Yes . . . . . 1 No . . . . . 2 N/A 3

METHOD	117. Are there medical conditions for which you will not offer METHOD?		118. What are those conditions?	119. Are there medical conditions for which you would offer METHOD with caution?		120. What are those conditions?	121. Is it important to examine and/or test a client before providing METHOD?		122. What types of examinations/tests are important?
(1) Pill	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	118 119 119	Unexplained vaginal bleeding . . . . . 1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	120 121 121	History of high blood pressure . . . . . 1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	117(2) 117(2) 117(2)	
(2) Male condom	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	118 119 119	None . . . . . 1 Any condition 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	120 117(3) 117(3)	History of allergy to latex/rubber . . . . . 1 Other/none 2			
(3) Female condom	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	118 119 119	None . . . . . 1 Any condition 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	120 117(4) 117(4)	History of allergy to latex/rubber . . . . . 1 Other/none 2			
(4) IUD	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	118 119 119	Immediately after septic abortion . . . . 1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	120 121 121	Iron deficiency . . . . . 1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	122 117(5) 117(5)	Exclude infection and pregnancy . . . . . 1 Other/none 2
(5) Injectable	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	118 119 119	Client has breast cancer currently . . 1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	120 121 121	Diabetes mellitus . . . 1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	117(6) 117(6) 117(6)	
(6) LAM	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	118 119 119	Breastfeeding, menses has returned1 Other/none 2	Yes . . . . . 1→ No . . . . . 2→ N/A . . . . . 3→	120 123 123	Client unable to follow instructions . . . . . 1 Other/none 2			

123	If a client comes to you for family planning, she is breastfeeding a child of less than six months, and she is not menstruating, what advice do you give her: **DO NOT READ LIST.** - Treat her like any other FP client - Advise her to stop breastfeeding and start using a contraceptive method - Advise her to continue breastfeeding and also to start using a contraceptive method at 6 months - Advise her to continue breastfeeding fully and not to use a method until her menses start - Other	(CIRCLE ONLY ONE ANSWER) TREAT HER LIKE ANY OTHER FP CLIENT . . . . . 1 STOP BREASTFEEDING & USE CONTRACEPTIVE . . . 2 CONTINUE BREASTFEEDING & USE CONTRACEPTIVE AT 6 MONTHS . . . . . 3 CONTINUE BREASTFEEDING & NO FP METHOD UNTIL MENSES . . . . . 4 OTHER (Specify) . . . . . 5 _____ DON'T KNOW 8

124	What do you do for a new client who wants the pill or another hormonal method but is not having her menses? DO NOT READ; PROBE WITH "Anything else?"	Mentioned Spontaneously	Not Mentioned
	(1) Examine, question, and/or test to exclude pregnancy	1	2
	(2) Tell her to come back at next menses	1	2
	(3) Try to induce menses	1	2
	(4) Supply condoms and ask her to return with menses	1	2
	(5) Supply hormonal method if reasonably certain she is not pregnant	1	2
	(6) Supply hormonal method and condoms and ask her to use condoms till her menses	1	2
	(7) Other (specify)	1	2

125	How many cycles of combined pills do you routinely supply to a pill client who has successfully used the pill for one year or more?	+)))0)))), CYCLES . . . . . * * * .)))2)))- 99 = NO RESPONSE
126	Have you received the IEC materials called the "Service Provider's Toolkit"? VERIFY BY VISUAL INSPECTION.	SEEN . . . . . 1 NOT SEEN 2

2. REPRODUCTIVE HEALTH PRACTICES

201	If a pill client comes for a check-up/resupply and assessment indicates she is at risk of infection with an STI or HIV/AIDS, what advice would you give? **DO NOT READ LIST.** - Continue to use the pill alone - Continue with the pill but use a condom also - Continue with the pill but use a condom also, and provide STI syndromic counseling - Switch from the pill to the condom - Stop using any type of contraception - Other (specify)	(CIRCLE ONLY ONE ANSWER) CONTINUE PILL ALONE . . . . . 1 CONTINUE PILL, ADD CONDOM . . . . . 2 CONTINUE PILL, ADD CONDOM, COUNSELING . . . . . 3 SWITCH FROM PILL TO CONDOM . . . . . 4 STOP USING CONTRACEPTION . . . . . 5 OTHER (Specify) . . . . . 6 _____ DON'T KNOW 8

202	What kinds of questions do you ask clients to decide whether they have STDs? DO NOT PROMPT; CIRCLE 1 IF MENTIONED, 2 IF NOT MENTIONED.		Yes	No
		SMELLY DISCHARGE	1	2
		LOWER ABDOMINAL PAIN	1	2
		ITCHING IN GENITALS	1	2
		PAINFUL SCROTUM (ROTATED OR ELEVATED PENIS)	1	2
		DURATION OF SYMPTOMS	1	2
		RISK ASSESSMENT ACCORDING TO LOCAL STANDARDS	1	2

203	How would you decide that a client is suffering from STDs? DO NOT PROMPT; CIRCLE 1 IF MENTIONED, 2 IF NOT MENTIONED.		Yes	No
		URETHRAL DISCHARGE	1	2
		VAGINAL DISCHARGE	1	2
		GENITAL ULCERS	1	2
		LOWER ABDOMINAL PAIN IN WOMEN	1	2
		EYE DISCHARGE FROM NEWBORN	1	2
		SWELLING AND PAIN IN TESTES	1	2
		SCROTAL SWELLING	1	2
		FEVER OF 38+ C	1	2

Please tell me whether each of the following statements is true or false.		
204	The chief mode of transmission of HIV and other STDs is sexual intercourse.	True . . . . . 1 False 2
205	A number of illnesses which have a similar set of symptoms and signs are referred to as a syndrome.	True . . . . . 1 False 2
206	A client with signs and symptoms of gonorrhoea will complain of sores and pain on the genitals.	True . . . . . 1 False 2
207	The main causes of urethral discharge are gonococcal and chlamydia arthritis.	True . . . . . 1 False 2
208	When taking a history from a client with an STD, you should not let the client do most of the talking.	True . . . . . 1 False 2
209	Gonococcal ophthalmia neonatorum may lead to blindness in babies.	True . . . . . 1 False 2
210	When a vaginal discharge is profuse, offensive, or frothy, the client probably has trichomonal or bacterial vaginitis.	True . . . . . 1 False 2
211	Clients with STDs should be counseled regarding all the following with **one exception**. Please identify the exception. **READ THE LIST.** F. Informing partners B. Complications of infection C. How to talk to people D. Compliance to treatment E. Modifying sexual behavior	(CIRCLE ONLY ONE ANSWER) INFORMING PARTNERS . . . . . 1 COMPLICATIONS . . . . . 2 HOW TO TALK TO PEOPLE . . . . . 3 COMPLIANCE . . . . . 4 MODIFYING BEHAVIOR 5
212	All of the following statements **except one** refer to the most important STD syndromes in Tanzania. Please identify the exception. **READ THE LIST.** A. Urethral discharge B. Vaginal discharge C. Lower abdominal pain (PID) D. Vaginal bleeding E. Genital ulcer	(CIRCLE ONLY ONE ANSWER) URETHRAL DISCHARGE . . . . . 1 VAGINAL DISCHARGE . . . . . 2 LOWER abdominal PAIN . . . . . 3 VAGINAL BLEEDING . . . . . 4 GENITAL ULCER 5

213	If you think that a client has a HIV/AIDS/STD, what do you do for her? DO NOT READ ANSWERS; PROBE BY ASKING “Anything else?”	Mentioned spontaneously	Not mentioned
	(1) Provide counseling	1	2
	(2) Refer for counseling	1	2
	(3) Diagnose	1	2
	(4) Refer for diagnosis	1	2
	(5) Refer for laboratory tests	1	2
	(6) Treat	1	2
	(7) Refer for treatment	1	2
	(8) Provide condoms	1	2
	(9) Issue a contact or partner notification slip	1	2
	(10) Other (specify)	1	2

223	Do you request a VDRL or RPR test for antenatal clients you see at this health facility?	YES . . . . . 1 NO 2	
224	How comfortable are you discussing sexual behavior related to STD/HIV with clients? Would you say you are very uncomfortable, somewhat uncomfortable, comfortable, or very comfortable?	VERY UNCOMFORTABLE . . . . . 1 SOMEWHAT UNCOMFORTABLE . . . . . 2 COMFORTABLE . . . . . 3 VERY COMFORTABLE 4	
225	As far as you know, do women come to this facility for advice on termination of pregnancies?	YES . . . . . 1 NO . . . . . 2 DON’T KNOW 8	

226	As far as you know, do women come to this facility for medical treatment as a consequence of an incomplete, induced abortion?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
227	When a patient reports symptoms which you suspect to be an STD, do you routinely ask the patient any questions?	YES . . . . . 1 NO 2	-> 229
228	What questions do you ask if a patient complains of STD-like symptoms?	Mentioned Spontaneously / Mentioned after probe / Not Mentioned	
	(1) Present symptoms	1 2 3	
	(2) Onset/duration of symptoms	1 2 3	
	(3) Recent sexual contacts	1 2 3	
	(4) Other symptoms	1 2 3	
229	Do you routinely perform a physical examination on your male STD patients?	Yes . . . . . 1 No . . . . . 2 N/A* . . . . . 3 (*respondent does not see male patients)	-> 231 -> 231
230	Please describe each step of how you would examine a male STD client after taking his history.	Mentioned Spontaneously / Mentioned after probe / Not Mentioned	
	(1) Ask the patient to undress so that genitals are fully exposed	1 2 3	
	(2) Examine the patient for urethral/penile discharge	1 2 3	
	(3) Examine the genitals for lesions after retracting the foreskin	1 2 3	
231	Do you routinely perform a physical examination on your female STD patients?	Yes . . . . . 1 No . . . . . 2 N/A* . . . . . 3 (*respondent does not see female patients)	-> 233 -> 233
232	Please describe each step of how you would examine a female STD client after taking her history.	Mentioned Spontaneously / Mentioned after probe / Not Mentioned	
	(1) Ask the patient to undress so that genitals are fully exposed	1 2 3	
	(2) Ask the patient lie down	1 2 3	
	(3) Examine the vulva and labia for lesions	1 2 3	
	(4) Look for vaginal discharge	1 2 3	
	(5) Perform a speculum examination	1 2 3	
	(6) Perform a bimanual examination	1 2 3	
233	What type of diagnosis do you base your treatment on? • an etiologic diagnosis such as gonorrhea or syphilis or • a syndromic diagnosis such as urethral discharge or genital ulcer disease?	ETIOLOGIC . . . . . 1 SYNDROMIC . . . . . 2 BOTH 3	
234	Does this facility have a microscope in working order?	YES . . . . . 1 NO 2	-> 236
234a	Do you perform laboratory tests?	YES . . . . . 1 NO 2	-> 236
235	Do you perform: **READ THE LIST.** (1) Wet-mount microscopy to diagnose STDs? (2) Gram Stains to diagnose STDs? (3) VDRL, RPR, or other lab tests for syphilis? (4) Darkfield microscopy?	YES NO WET MOUNT . . . . . 1 2 GRAM STAINS . . . . . 1 2 VDRL/RPR . . . . . 1 2 DARKFIELD 1 2	
236	Do you usually send your STD patients (or specimens) to another facility for laboratory investigation?	YES . . . . . 1 NO 2	-> 238
237	Which tests have you requested most often in the past month? (MAXIMUM OF THREE TESTS)	1. 2.	

		3.	

SYNDROMIC MANAGEMENT (LEAVE THE "SCORE" COLUMN BLANK)
In the absence of a definitive diagnosis, what is the first of choice treatment that you usually prescribe for:

SYNDROME	DRUG NAME	QUANTITY	DOSE [A]	ROUTE [B]	DURATION	SCORE
238. A male patient with a urethral discharge?						
239. A male patient with a genital ulcer?						
240. A female patient with a genital ulcer?						
241. A female patient with vaginal discharge?						
242. A female patient with lower abdominal pain?						

[A] daily=1 bd=2 td=3 qd=4 other=5
[B] IM=1 oral=2 topical=3

243	Do you give any special education/advice to your STD patients?	Mentioned Spontaneously / Mentioned after probe / Not Mentioned	
	(1) Tell your patients to take all the medications you have prescribed	1 2 3	
	(2) Advise your patients to use condoms	1 2 3	
	(3) Advise your patients to tell their sex partners about getting treatment	1 2 3	
	(4) If you do advise your patients to tell their sex partners to get treatment, do you use contact cards or referral slips?	1 2 3	
	(5) Tell your patients to return for follow up in 7 days	1 2 3	
244	Do you follow any specific treatment guidelines in your management of STD patients?	YES . . . . . 1 NO 2	-> 246
245	Which guidelines do you follow?	1.	
		2.	
246	Have you received a copy of the STD treatment schedules recommended by the National STD Control Programme?	YES . . . . . 1 NO . . . . . 2 N/A 3	
247	Do you have written copies of any STD treatment guidelines? RECORD NAMES OF WRITTEN GUIDELINES SEEN	1.	
		2.	
		3.	
248	Do you provide drugs to PREVENT your clients from contracting STDs (STD prophylaxis)?	YES . . . . . 1 NO 2	

3. SOCIODEMOGRAPHICS

301	To end with, I would like to ask you a few questions about yourself. How old are you?	+)))0))) AGE IN YEARS . . . . . * * * .)))2)))- DON'T KNOW = 98	
302	How many living children of your own do you have?	+)))0))) NUMBER OF CHILDREN . . . . . * * * .)))2)))- NO RESPONSE = 99	
303	What is your religion?	PROTESTANT . . . . . 1 CATHOLIC . . . . . 2 MOSLEM . . . . . 3 NONE . . . . . 4 OTHER (SPECIFY) . . . . . 5 DON'T KNOW 8	
304	What method(s) of family planning are you or your partner currently using? DO NOT READ LIST; PROBE BY ASKING "What else?"	Mentioned Spontaneously / Mentioned after probe / Not Mentioned	
	(01) Combined pill	1 2 3	
	(02) Progestin-only pill	1 2 3	
	(03) IUCD	1 2 3	
	(04) Injectable	1 2 3	
	(05) Norplant implant	1 2 3	
	(06) Male condom	1 2 3	
	(07) Female condom	1 2 3	
	(08) Spermicide	1 2 3	
	(09) Female sterilization: mini-laparotomy	1 2 3	
	(10) Female sterilization: laparoscopy	1 2 3	
	(11) Vasectomy	1 2 3	
	(12) Natural family planning	1 2 3	
	(13) LAM	1 2 3	
	(14) None	1 2 3	
	(15) Not sexually active	1 2 3	
305	In which salary group do you fall? SHOW RESPONDENT THE LIST OF MONTHLY SALARY CATEGORIES. < 20,000 01 20,000 - 29,000 02 30,000 - 39,000 03 40,000 - 49,000 04 50,000 - 59,000 05 60,000 - 69,000 06 70,000 - 79,000 07 80,000 - 89,000 08 90,000 - 99,000 09 100,000 - 149,000 10 150,000 - 199,000 11 200,000+ 12	+)))0))) * * * .)))2)))-	
306	RECORD THE TIME	+)))0))) HOUR . . . . . * * * /)))3)))1 MINUTES . . . . . * * * .)))2)))-	

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
SERVICE PROVIDER QUESTIONNAIRE (SHORT FORM)
(corrected against Kiswahili)

IDENTIFICATION

NAME OF FACILITY_____

REGION . . . . .

DISTRICT . . . . .

WARD . . . . .

E.A. NUMBER . . . . .

RESPONDENT LINE NUMBER FROM FACILITY ROSTER . . . . .

RESPONDENT JOB TITLE OR TYPE OF CADRE

DOCTOR 1
ASSISTANT MEDICAL OFFICER 2
CLINICAL OFFICER 3
ASSISTANT CLINICAL OFFICER 4
NURSING OFFICER 5
NURSE/MIDWIFE 6
PUBLIC HEALTH NURSE B 7
MCH AIDE 8
NURSE ASSISTANT/MEDICAL ASSISTANT 9
OTHER 10

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY
				MONTH
				YEAR * 1 * 9 * * *
INTERVIEWER'S NAME	_____	_____	_____	INTER. ID NO.
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 CANNOT LOCATE FACILITY
3 CANNOT LOCATE IN-CHARGE
4 REFUSED
5 PARTLY COMPLETED
6 POSTPONED
7 OTHER (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME	NAME		
DATE	DATE		

TOPIC	1. Did your **pre-service** training cover TOPIC?	2. Have you attended **in-service** training courses? (IF YES) Did your **in-service** training include TOPIC?		3. What year was your **in-service** training on TOPIC? **Don't know = 9998**
(01) Introduction to FP clinical skills (preservice)	Yes . . . . . 1 No 2			
(02) Basic FP clinical skills (BCS)		Yes . . . . . 1→ No . . . . . 2→	3 2(03)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(03) Comprehensive FP clinical skills (CCS)		Yes . . . . . 1→ No . . . . . 2→	3 2(04)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(04) Integrated reproductive and child health (IRCH) skills		Yes . . . . . 1→ No . . . . . 2→	3 2(05)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(05) Preceptorship skills		Yes . . . . . 1→ No . . . . . 2→	3 2(06)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(06) Basic training skills		Yes . . . . . 1→ No . . . . . 2→	3 2(07)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(07) Reproductive health update (RHU)		Yes . . . . . 1→ No . . . . . 2→	3 2(08)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(08) Information, Education, and Communication (IEC)		Yes . . . . . 1→ No . . . . . 2→	3 2(09)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(09) Reproductive health training for Health Attendants		Yes . . . . . 1→ No . . . . . 2→	3 1(10)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(10) Treatment of incomplete abortion (Post-Abortion Care)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	3 1(11)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(11) Manual vacuum aspiration (MVA)	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	3 1(12)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(12) Voluntary surgical contraception	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	3 1(13)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(13) STD syndromic management	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	3 1(14)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(14) HIV/AIDS/STD counseling	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	3 1(15)	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-
(15) HIV/AIDS testing	Yes . . . . . 1 No 2	Yes . . . . . 1→ No . . . . . 2→	3 STOP	+)))0)))0)))0))), * * * * * .)))2)))2)))2)))-

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
PHARMACY INVENTORY QUESTIONNAIRE
(corrected against Kiswahili)

IDENTIFICATION

NAME OF PHARMACY_____

REGION . . . . . .

DISTRICT . . . . . .

WARD . . . . . .

E.A. NUMBER . . . . . .

TRCHS CLUSTER NUMBER . . . . . .

IF PHARMACY WAS VISITED ALREADY FOR A DIFFERENT CLUSTER, RECORD OTHER CLUSTER NUMBER AND TERMINATE INTERVIEW.

GPS READING		DEGREES	MINUTES	THOUSANDTHS
	LATITUDE	S		
	LONGITUDE	E		

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY MONTH YEAR **1 9**
INTERVIEWER'S NAME	_____	_____	_____	INTER. ID NO.
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 CANNOT LOCATE FACILITY
3 CANNOT LOCATE IN-CHARGE
4 REFUSED
5 PARTLY COMPLETED
6 POSTPONED
7 OTHER (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME	NAME		

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
DATE	DATE		

1. ENERAL PHARMACY INFORMATION

No.	QUESTIONS	CODING CATEGORIES	SKIP
101	RECORD THE TIME	HOUR . . . . . . MINUTES	
101a	What type of license does this pharmacy have?	Part I . . . . . 1 Part II . . . . . 2 HAFAHAMU 3	
102	In what year did this pharmacy open? PROBE: This question is very important. Can you tell me how old this pharmacy is? For example would you say it is about 5 years old? 10 years old? (etc.) FILL IN EITHER YEAR OPENED OR YEARS OLD.	YEAR OPENED . . . . YEARS OLD . . . . . . DON'T KNOW 9998	
103	How many hours per day is the pharmacy open?	HOURS PER DAY	
104	How many days per week is the pharmacy open?	DAYS PER WEEK	
105	Is there a trained pharmacist here?	YES . . . . . 1 NO 2	--> 106
106	How many hours per week does the trained pharmacist work here?	HOURS PER WEEK	

2. GENERAL MCH AND FP

MEDICINE	201. Is MEDICINE available now?		202. Has MEDICINE been out of stock in the last 1 month?		203. Has MEDICINE been out of stock in the last 12 months?
(01) Phenobarbitol	SEEN . . . . . 1 NOT SEEN 2	-> (02)	YES . . . . . 1 NO 2	-> (02)	YES . . . . . 1 NO 2
(02) Mebendazole	SEEN . . . . . 1 NOT SEEN 2	-> (03)	YES . . . . . 1 NO 2	-> (03)	YES . . . . . 1 NO 2
(03) Valium（Diazepam）	SEEN . . . . . 1 NOT SEEN 2	-> (04)	YES . . . . . 1 NO 2	-> (04)	YES . . . . . 1 NO 2
(04) Lidocaine	SEEN . . . . . 1 NOT SEEN 2	-> (05)	YES . . . . . 1 NO 2	-> (05)	YES . . . . . 1 NO 2
(05) Egometrin or Oxytocin or Syntometrin	SEEN . . . . . 1 NOT SEEN 2	-> (06)	YES . . . . . 1 NO 2	-> (06)	YES . . . . . 1 NO 2
(06) Hydralazine	SEEN . . . . . 1 NOT SEEN 2	-> (07)	YES . . . . . 1 NO 2	-> (07)	YES . . . . . 1 NO 2
(07) Crystalline penicillin	SEEN . . . . . 1 NOT SEEN 2	-> (08)	YES . . . . . 1 NO 2	-> (08)	YES . . . . . 1 NO 2
(08) PPF penicillin	SEEN . . . . . 1 NOT SEEN 2	-> (09)	YES . . . . . 1 NO 2	-> (09)	YES . . . . . 1 NO 2
(09) Chloramphenicol	SEEN . . . . . 1 NOT SEEN 2	-> (10)	YES . . . . . 1 NO 2	-> (10)	YES . . . . . 1 NO 2
(10) Gentamicin or Kanamicin	SEEN . . . . . 1 NOT SEEN 2	-> (11)	YES . . . . . 1 NO 2	-> (11)	YES . . . . . 1 NO 2

(11) Metronidazole (Flagyl)	SEEN . . . . . 1 NOT SEEN 2	-> (12)	YES . . . . . 1 NO 2	-> (12)	YES . . . . . 1 NO 2
(12) Oral rehydration solution packets	SEEN . . . . . 1 NOT SEEN 2	-> (13)	YES . . . . . 1 NO 2	-> (13)	YES . . . . . 1 NO 2
(13) Water for injections	SEEN . . . . . 1 NOT SEEN 2	-> 204	YES . . . . . 1 NO 2	-> 204	YES . . . . . 1 NO 2

CONTRACEPTIVE	204. Is CONTRACEPTIVE available now?		205. Has CONTRACEPTIVE been out of stock in the last 1 month?		206. Has CONTRACEPTIVE been out of stock in the last 12 months?
(1) Combination oral contraceptives (estrogen and progestin)	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Progestin-only oral contraceptives	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) Male condoms	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) Salama Male condoms	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) Female condoms	SEEN . . . . . 1 NOT SEEN 2	-> (6)	YES . . . . . 1 NO 2	-> (6)	YES . . . . . 1 NO 2
(6) IUCD	SEEN . . . . . 1 NOT SEEN 2	-> (7)	YES . . . . . 1 NO 2	-> (7)	YES . . . . . 1 NO 2
(7) Spermicide (foam, foaming tablets, gel)	SEEN . . . . . 1 NOT SEEN 2	-> (8)	YES . . . . . 1 NO 2	-> (8)	YES . . . . . 1 NO 2
(8) Injectables (e.g., Depo Provera)	SEEN . . . . . 1 NOT SEEN 2	-> (9)	YES . . . . . 1 NO 2	-> (9)	YES . . . . . 1 NO 2
(9) Implant (e.g., Norplant)	SEEN . . . . . 1 NOT SEEN 2	-> 207	YES . . . . . 1 NO 2	-> 207	YES . . . . . 1 NO 2

SUPPLEMENT	207. Is SUPPLEMENT available now?		208. Has SUPPLEMENT been out of stock in the last 1 month?		209. Has SUPPLEMENT been out of stock in the last 12 months?
(1) Iron	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Folic acid	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) Fefetol (folic acid and ferrous-sulfate)	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) Vitamin A	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) Iodine	SEEN . . . . . 1 NOT SEEN 2	-> 301	YES . . . . . 1 NO 2	-> 301	YES . . . . . 1 NO 2

3. STD

ANTIBIOTIC	301. Is ANTIBIOTIC available now?		302. Has ANTIBIOTIC been out of stock in the last 1 month?		303. Has ANTIBIOTIC been out of stock in the last 12 months?
(01) Benzathine penicillin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (02)	YES . . . . . 1 NO 2	-> (02)	YES . . . . . 1 NO 2
(02) Procaine penicillin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (03)	YES . . . . . 1 NO 2	-> (03)	YES . . . . . 1 NO 2
(03) Streptomycin (injection)	SEEN . . . . . 1 NOT SEEN 2	-> (04)	YES . . . . . 1 NO 2	-> (04)	YES . . . . . 1 NO 2
(04) Doxycycline	SEEN . . . . . 1 NOT SEEN 2	-> (05)	YES . . . . . 1 NO 2	-> (05)	YES . . . . . 1 NO 2
(05) Erythromycine	SEEN . . . . . 1 NOT SEEN 2	-> (06)	YES . . . . . 1 NO 2	-> (06)	YES . . . . . 1 NO 2
(06) Tetracycline	SEEN . . . . . 1 NOT SEEN 2	-> (07)	YES . . . . . 1 NO 2	-> (07)	YES . . . . . 1 NO 2

(07) Clotrimazole pessaries	SEEN . . . . . 1 NOT SEEN 2	-> (08)	YES . . . . . 1 NO 2	-> (08)	YES . . . . . 1 NO 2
(08) Cotrimoxazole (Septrin)	SEEN . . . . . 1 NOT SEEN 2	-> (09)	YES . . . . . 1 NO 2	-> (09)	YES . . . . . 1 NO 2
(09) Nizoral cream	SEEN . . . . . 1 NOT SEEN 2	-> (10)	YES . . . . . 1 NO 2	-> (10)	YES . . . . . 1 NO 2
(10) Nizoral pessaries	SEEN . . . . . 1 NOT SEEN 2	-> (11)	YES . . . . . 1 NO 2	-> (11)	YES . . . . . 1 NO 2
(11) Nizoral tablets	SEEN . . . . . 1 NOT SEEN 2	-> (12)	YES . . . . . 1 NO 2	-> (12)	YES . . . . . 1 NO 2
(12) Nystatin ointment	SEEN . . . . . 1 NOT SEEN 2	-> (13)	YES . . . . . 1 NO 2	-> (13)	YES . . . . . 1 NO 2
(13) Nystatin pessaries	SEEN . . . . . 1 NOT SEEN 2	-> (14)	YES . . . . . 1 NO 2	-> (14)	YES . . . . . 1 NO 2
(14) Gentain Violet (GV) paint	SEEN . . . . . 1 NOT SEEN 2	-> (15)	YES . . . . . 1 NO 2	-> (15)	YES . . . . . 1 NO 2
(15) Podophylline	SEEN . . . . . 1 NOT SEEN 2	-> (16)	YES . . . . . 1 NO 2	-> (16)	YES . . . . . 1 NO 2
(16) Ciprofloxacin	SEEN . . . . . 1 NOT SEEN 2	-> (17)	YES . . . . . 1 NO 2	-> (17)	YES . . . . . 1 NO 2
(17) Ceftriaxone	SEEN . . . . . 1 NOT SEEN 2	-> (18)	YES . . . . . 1 NO 2	-> (18)	YES . . . . . 1 NO 2
(18) Spectinomycin	SEEN . . . . . 1 NOT SEEN 2	-> (19)	YES . . . . . 1 NO 2	-> (19)	YES . . . . . 1 NO 2
(19) Silver nitrate eye drops	SEEN . . . . . 1 NOT SEEN 2	-> (20)	YES . . . . . 1 NO 2	-> (20)	YES . . . . . 1 NO 2
(20) Tetracycline eye ointment	SEEN . . . . . 1 NOT SEEN 2	-> 401	YES . . . . . 1 NO 2	-> 401	YES . . . . . 1 NO 2

4. MALARIA

ANTI-MALARIAL	401. Is ANTI-MALARIAL available now?		402. Has ANTI-MALARIAL been out of stock in the last 1 month?		403. Has ANTI-MALARIAL been out of stock in the last 12 months?
(1) Chloroquine	SEEN . . . . . 1 NOT SEEN 2	-> (2)	YES . . . . . 1 NO 2	-> (2)	YES . . . . . 1 NO 2
(2) Sulfadoxine + Pyrimetharine (Fansidar)	SEEN . . . . . 1 NOT SEEN 2	-> (3)	YES . . . . . 1 NO 2	-> (3)	YES . . . . . 1 NO 2
(3) Quinine	SEEN . . . . . 1 NOT SEEN 2	-> (4)	YES . . . . . 1 NO 2	-> (4)	YES . . . . . 1 NO 2
(4) Metakelvin	SEEN . . . . . 1 NOT SEEN 2	-> (5)	YES . . . . . 1 NO 2	-> (5)	YES . . . . . 1 NO 2
(5) Halfan	SEEN . . . . . 1 NOT SEEN 2	-> (6)	YES . . . . . 1 NO 2	-> (6)	YES . . . . . 1 NO 2
(6) Other antimalarial drugs (specify)	SEEN . . . . . 1 NOT SEEN 2	-> (7)	YES . . . . . 1 NO 2	-> (7)	YES . . . . . 1 NO 2
(7) Njozi Njema brand bednets	SEEN . . . . . 1 NOT SEEN 2	-> (8)	YES . . . . . 1 NO 2	-> (8)	YES . . . . . 1 NO 2
(8) Other brand of bednets (specify)	SEEN . . . . . 1 NOT SEEN 2	-> (9)	YES . . . . . 1 NO 2	-> (9)	YES . . . . . 1 NO 2

(9) Ngao brand mosquito repellent for bednets	SEEN . . . . . 1 NOT SEEN 2	-> (10)	YES . . . . . 1 NO 2	-> (10)	YES . . . . . 1 NO 2	
(10) Other brand of repellent (specify)	SEEN . . . . . 1 NOT SEEN 2	-> 404	YES . . . . . 1 NO 2	-> 404	YES . . . . . 1 NO 2	
404	RECORD THE TIME		HOUR . . . . . . MINUTES			

TANZANIA REPRODUCTIVE AND CHILD HEALTH SURVEY
DISTRICT HEALTH MANAGEMENT TEAM QUESTIONNAIRE
(corrected against Kiswahili)

IDENTIFICATION	
REGION	
DISTRICT	

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY MONTH YEAR **1 9**
INTERVIEWER'S NAME	_____	_____	_____	INTER. ID NO.
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 CANNOT LOCATE FACILITY
3 CANNOT LOCATE IN-CHARGE
4 REFUSED
5 PARTLY COMPLETED
6 POSTPONED
7 OTHER (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME	NAME		
DATE	DATE		

ASK TO INTERVIEW THE **DMO** IF HE/SHE HAS BEEN AT THE SITE AT LEAST ONE YEAR; OTHERWISE ASK ANOTHER MEMBER OF THE **DHMT** WHO HAS BEEN THERE AT LEAST ONE YEAR. MORE THAN ONE MEMBER OF THE DHMT CAN PARTICIPATE IN THE INTERVIEW.

1. DECENTRALIZATION PROCESS

No.	QUESTIONS	CODING CATEGORIES	SKIP
101	RECORD THE TIME	HOUR . . . . . . MINUTES	
102	Would you say that the decentralization of health care planning in your district is: not yet started? currently underway? completed?	NOT STARTED . . . . . 1 UNDERWAY . . . . . 2 COMPLETED 3	-> 103 **-> 104** **-> 105**
103	How many months from now do you expect the process of decentralization will start in this district?	MONTHS FROM NOW . . .	**-> 106**
104	How many months ago did the process of decentralization start in this district?	MONTHS AGO	**-> 106**
105	How many months ago did the process of decentralization finish in this district?	MONTHS AGO	**-> 109**
106	Would you say that you have been involved in planning for decentralization in your district a lot, some, very little, or not at all?	A LOT . . . . . 1 SOME . . . . . 2 VERY LITTLE . . . . . 3 NOT AT ALL 4	
107	Does your district have a forum for planning that involves the local government and/or donors?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 3	 -> 109 -> 109
108	How transparent is the planning process within that forum? By "transparent" I mean how clear, rational, and justified the decisions are that come from this planning process, and how available and accessible the information is that has gone into the planning.	VERY TRANSPARENT . . . . . 1 NOT VERY TRANSPARENT . . 2	
109	Would you say that the district health management team works together as a team very well, moderately well, or not well at all?	VERY WELL . . . . . 1 MODERATELY WELL . . . . . 2 NOT WELL AT ALL 3	

2. BUDGET

201. What are your sources of funding for the current fiscal year?	202. Please give me the approximate percent from each source (these should total 100%).
(1)	PERCENT . . . . .
(2)	PERCENT . . . . .
(3)	PERCENT . . . . .

203	Approximately what percent of the budgeted district health funds can you allocate as you choose, i.e., what percent is not earmarked for salaries or specific programs by the MOH or donors?	PERCENT	
204	What process do you use when assigning budget priorities for various health services? (RECORD VERBATIM)		
205	How would you rank **the importance** of the following health service categories for budget purposes, i.e., in your opinion, which should have top priority, which second, etc? Please rank them relative to each other on a scale from 1-6, where 1 is most important. (1) Family planning (2) Maternal health (3) Child health (4) STDs (5) HIV/AIDS (6) Tuberculosis (7) Malaria	FP . . . . . . Maternal Health . . . . . . Child Health . . . . . . STD . . . . . . HIV/AIDS . . . . . . TUBERCULOSIS . . . . . . MALARIA	
206	How would you rank the **growth in the budgets** for these service categories over the past 3 years? Please rank them relative to each other on a scale from 1-6, where 1 is highest growth rate. (1) Family planning (2) Maternal health (3) Child health (4) STDs (5) HIV/AIDS (6) Tuberculosis (7) Malaria	FP . . . . . . Maternal Health . . . . . . Child Health . . . . . . STD . . . . . . HIV/AIDS . . . . . . TUBERCULOSIS . . . . . . MALARIA	

207	How would you rank **the importance** of the following drug/medicine groups for budget purposes, i.e., in your opinion, which should have top priority, which second, etc? Please rank them relative to each other on a scale from 1-10, where 1 is most important. (1) Contraceptives (2) Child immunization vaccines (3) Other vaccines (4) Medicines for diarrhea (5) Antibiotics for STDs (6) Antibiotics for ARI, pneumonia, tuberculosis (7) Other antibiotics (8) Vitamin/mineral supplements (9) Medicine/supplies for deliveries (e.g., blood, oxytocins, anesthetics) (10) Medicines for malaria (11) Other (specify)	CONTRACEPTIVES . . . . CHILD IMMUNIZ . . . . . . OTHER VACCINES . . . . DIARRHEA . . . . . . STD . . . . . . TUBERCULOSIS . . . . . . OTHER ANTIBIOTICS . . SUPPLEMENTS . . . . . . DELIVERIES . . . . . . MALARIA . . . . . . OTHER	
208	How would you rank the **growth in the budgets** for these drug/medicine groups over the past 3 years? Please rank them relative to each other on a scale from 1-10, where 1 is highest growth rate. (1) Contraceptives (2) Child immunization vaccines (3) Other vaccines (4) Medicines for diarrhea (5) Antibiotics for STIs (6) Antibiotics for pneumonia, tuberculosis (7) Other antibiotics (8) Vitamin/mineral supplements (9) Medicine/supplies for deliveries (e.g., blood, oxytocins, anesthetics) (10) Medicines for malaria (11) Other (specify)	CONTRACEPTIVES . . . . CHILD IMMUNIZ . . . . . . OTHER VACCINES . . . . DIARRHEA . . . . . . STD . . . . . . TUBERCULOSIS . . . . . . OTHER ANTIBIOTICS . . SUPPLEMENTS . . . . . . DELIVERIES . . . . . . MALARIA . . . . . . OTHER	

3. WORK PLANS			
301	Is the DHMT involved in workplan preparation for district health activities?	YES . . . . . 1 NO 2	-> 303
302	How? (RECORD VERBATIM)		
303	Are there any impediments to implementation of activities in your annual work plan?	YES . . . . . 1 NO 2	**-> 305**
304	What are the major impediments? (RECORD VERBATIM)		
305	Do you feel that existing guidelines from the MOH are sufficient for work plan preparation?	YES . . . . . 1 NO 2	**-> 308**
306	Are the guidelines too restrictive?	YES . . . . . 1 NO 2	
307	Do you feel that you need more explicit performance targets?	YES . . . . . 1 NO 2	
308	Do you have an annual district conference with donors?	YES . . . . . 1 NO 2	
309	Does coordination between your district, donors, and the government need to be improved?	YES . . . . . 1 NO 2	**-> 401**
310	How could it be improved? (RECORD VERBATIM)		
4. BOTTOM-UP HEALTH PLANNING			
401	Does this district engage in bottom-up health planning?	YES . . . . . 1 NO 2	**-> 406**
402	At what levels does this planning occur? (1) Village (2) Ward (3) Other (specify)	YES NO VILLAGE . . . . . 1 2 WARD . . . . . 1 2 OTHER 1 2	
403	Does this planning process involve planning committees?	YES . . . . . 1 NO 2	
404	Does this planning process involve community participation?	YES . . . . . 1 NO 2	

405	How would you rate bottom-up planning overall? Would you say it has been very successful, somewhat successful, no change, somewhat unsuccessful, or not at all successful?	VERY SUCCESSFUL . . . . . 1 SOMEWHAT SUCCESSFUL . . 2 NO CHANGE . . . . . 3 SOMEWHAT UNSUCCESS . . . 4 NOT AT ALL SUCCESSFUL . . . 5	
406	Are there arrears in payments to any health care providers in your district?	YES . . . . . 1 NO 2	**-> 501**
407	For how many months are arrears owed?	MONTHS	
408	What is your best estimate of the total amount in arrears owed in your district? (RECORD AMOUNT IN TSH)		

5. RESULTS

501. How would you rank the following aspects of district health care activities? Would you say they are poor, fair, average, good, or very good?

ITEM	POOR	FAIR	AVERAGE	GOOD	VERY GOOD	NOT APPLICABLE
Resources:						
(01) Availability of donor funds in timely manner	1	2	3	4	5	8
(02) Availability of funds from district level to implementors	1	2	3	4	5	8
(03) Availability of Treasury funds in timely manner	1	2	3	4	5	8
(04) Accountability for funds	1	2	3	4	5	8
(05) Coordination with donors	1	2	3	4	5	8
(06) Preparation of annual workplans	1	2	3	4	5	8
(07) Implementation of workplan activities	1	2	3	4	5	8
(08) Flexibility in resource allocation	1	2	3	4	5	8
(09) Technical assistance from central MOH departments	1	2	3	4	5	8
(10) Training of health workers	1	2	3	4	5	8
(11) User fee collection	1	2	3	4	5	8
Outputs:						
(12) Quality of curative services	1	2	3	4	5	8
(13) Immunization rates among children	1	2	3	4	5	8
(14) Health status of district population	1	2	3	4	5	8
(15) Utilization of government health services	1	2	3	4	5	8
(16) Costs of activities	1	2	3	4	5	8
Personnel:						
(17) Attracting/retaining quality staff	1	2	3	4	5	8
(18) Payment of staff salaries on time	1	2	3	4	5	8
(19) Control over location of staff	1	2	3	4	5	8
(20) Control over hiring/firing staff	1	2	3	4	5	8
(21) Control over staff salaries and incentives	1	2	3	4	5	8
(22) Intersectoral collaboration	1	2	3	4	5	8
(23) Accountability of district health officials	1	2	3	4	5	8

502. Would you say that the following district health care activities are currently receiving little attention, some attention, or much attention?

ITEM	LITTLE ATTENTION	SOME ATTENTION	MUCH ATTENTION	NOT APPLICABLE
(01) Civil works	1	2	3	8
(02) Training/capacity building	1	2	3	8
(03) Support supervision	1	2	3	8
(04) Quality assurance	1	2	3	8
(05) Child health	1	2	3	8
(06) Maternity care	1	2	3	8
(07) Family planning	1	2	3	8
(08) Other primary health care	1	2	3	8
(09) STD care	1	2	3	8
(10) HIV/AIDS care	1	2	3	8
(11) Hospitals	1	2	3	8

6. REPORTING

	How many reports were obtained and how many expected in 1998 for the following Book 10 forms? USE DISTRICT PROCESSING FILE OR PHYSICAL COUNT OF RETURNED FORMS.	601. NUMBER OF REPORTS OBTAINED	602. NUMBER OF REPORTS EXPECTED
	(1) FORM F001, 1998, EMPLOYEES/STAFF ROSTER		
	(2) FORM F002, 1998, INVENTORY		
	(3) FORM F003, 1998 (GOVERNMENT FACILITIES ONLY)		
	(4) FORM F004, ALL QUARTERS 1998		
	(5) FORM F005, 1998, ANNUAL REPORT		
	(6) FORM F006, 1998, ANNUAL REPORT (GOVERNMENT FACILITIES ONLY)		

603	What was the major problem as shown in your last compilation of data? RECORD VERBATIM.

604	Could you verify the problem through records or data? VERIFY BY INSPECTING THE DISTRICT PROCESSING FILE.	YES . . . . . 1 NO 2	
605	Did the District Health Management Team discuss the problem?	YES . . . . . 1 NO 2	-> 607
606	What forum did the DHMT use to discuss the problem?	REGULAR DHMT MEETING . . 1 AD HOC DHMT MEETING . . . . 2 DISTRICT PHC . . . . . 3 DISTRICT MANAGEMENT TEAM MEETING . . . . . 4 OTHER (SPECIFY) 5	
607	Can you show me the trend of notifiable diseases in 1997?	SEEN . . . . . 1 NOT SEEN 2	-> 701
608	RECORD IN MINUTES HOW LONG IT TOOK THE RESPONDENT TO OBTAIN THE TREND FOR YOU.	MINUTES TO OBTAIN . . .	

7. CONCLUSIONS

701	IF DISTRICT IS NOT DECENTRALIZED: To summarize, what do you think **will be** the most important **positive** impacts of decentralization in your district? (RECORD VERBATIM) IF DISTRICT IS DECENTRALIZED: To summarize, what do you think **are** the most important **positive** impacts of decentralization in your district? (RECORD VERBATIM)
702	IF DISTRICT IS NOT DECENTRALIZED: What do you think **will be** the most important **negative** impacts of decentralization in your district? (RECORD VERBATIM) IF DISTRICT IS DECENTRALIZED: What do you think **are** the most important **negative** impacts of decentralization in your district? (RECORD VERBATIM)
703	What **changes** would you like to see in your district with respect to decentralization? (RECORD VERBATIM)

8. RESPONDENT CHARACTERISTICS

801	RECORD THE TITLES OF THE RESPONDENTS	YES NO DMO . . . . . 1 2 DMCHC . . . . . 1 2 DHO . . . . . 1 2 DNO . . . . . 1 2 DTBLC . . . . . 1 2 DAC . . . . . 1 2 DHS . . . . . 1 2 OTHER (SPECIFY) . . . 1 2	
802	RECORD THE TIME	HOUR . . . . . . MINUTES	