

**Baseline Assessment Tool**

Name of Interviewer …………………………………………

1. **Facility Identification**
	1. Facility code ………………………………………..
	2. Name of facility …………………………………….
	3. District ………………………………………………
	4. Health sub-district…………………………………..
	5. Sub-county/Division ………………………………..
	6. Parish/Ward………………………………………….
	7. Village/Cell………………………………………….
	8. **Type of facility**

 Hospital . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 1

 Clinic/Medical centre/Nursing home . . . . . . . . . . . . . . . 2

* 1. **Location of facility**

Rural …...1 Urban …...2

**Interview Result:**

Completed ………………………… 1

Partially Completed ………………. 2

Declined ………………………….. 3

**RESPONDENT’S DETAILS**

1. Position:

1. Owner
2. In-charge
3. Other (specify)…………………………

2. Sex:

1. Male
2. Female
3. For how long have you worked in this facility? 1.
4. Years ……………
5. Months…………..
6. Weeks …………..

4. What is your qualification?

Medical officer.................1

Clinical officer.................2

Comprehensive Nurse….3

Enrolled Nurse................4

Enrolled Midwife............5

Registered Nurse.............6

Registered Midwife….....7

Nursing Assistant .…….............. 8

Other (Specify)………………………………… 9

**STAFFING LEVEL OF THE FACILITY**

**Indicate the number of staff in each cadre**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Cadre** | **Number** | **Cadre** | **Number** |  |
| Specialist |  | Nursing Assistant |  |  |
| Medical Officer |  | Laboratory Technologist |  |  |
| Clinical Officer |  | Laboratory Technician |  |  |
| Comprehensive Nurse |  | Laboratory Assistant |  |  |
| Registered Nurse |  | Microscopist |  |  |
| Registered Midwife |  | HMIS Focal Point |  |  |
| Enrolled Nurse |  | Accounts Assistant |  |  |
| Enrolled Midwife |  | Other |  |  |

**SECTION 1: MALARIA CASE MANAGEMENT**

1. Define Malaria ………………………………………………………………………………..

2. Mention the types of malaria do you know

a) …………………………………….. b) ……..........................................................

3. How do you define

a) Uncomplicated malaria

...............................................................................................................................................

…………………………………………………………………………………………………………………………………………

b) Severe malaria

…………………………………………….………………………………………

………………………………………………...........................................................

4. What is the first line treatment for:

a) Uncomplicated malaria ……………………………………………………….

 …………………………………………………………………………………

b) Severe Malaria

 ………………………………………, …………………………………………

 ………………………………………………………………………………….

c) How would you manage a patient with fever who wants only an anti-malarial drug and s/he is not interested in malaria test due to little funds or because it is his will. **(Tick where the response corresponds)**

 i) Will help and give anti-malarial drugs without a test

 ii) Will counsel the patient and not to give antimalarial drugs without a test

5. Have you heard about the malaria test and treat policy?

 1. Yes 2. No

6. If yes, do you apply in this facility?

 1. Yes 2. No

7. Which anti-malarial drugs do you use in this facility?

i) ………………………………………. ii) ………………………………………….

iii) ……………………………………... iv) …………………………………………

8. Where do you get information on managing malaria?

……………………………………………………………………………………………….

………………………………………………………………………………………………..

9. If there is new information on malaria management, how would you get such information?

………………………………………………………………………………………..

………………………………………………………………………………………..

10. How would you want to get this information?

……………………………………………………………………………………….

11. How many times have you had any anti-malarial drug stock-outs in the last three months?

………………………………………………..

12. Have you had any training in malaria case management during your current practice?

1. Yes 2. No

13. If yes, who organized the training?

……………………………………………..

14. When did you get the training?

…………………………………………….

15. How many staff have had the above-mentioned training?

………………………………………………

16. Does the health facility offer Antenatal services?

 Yes……..1 No………2

17. If yes, which anti-malarial prophylactic treatment is given to pregnant women?

…………………………………………………………………………………

18. At what gestational age, do you normally initiate the prophylactic treatment?

……………………………………………………………………………..

19. How often do you give the prophylactic treatment?

………………………………………………………………………….

20. How do you give the above treatment to the pregnant women?

1. The medicine (tablets) are packed and the mother swallows it from home

2. They swallow the medicine from here in the watch of the health worker (DOT)

21. How often do you give clients information on malaria prevention?

………………………………………………………………

22. What is the source of your drug supplies?

1. Joint medical stories 2. Medical Access

3. Private Pharmacies 4. Donations 5. Other (specify) ……………………..

23. Does you facility use any of the following in drug stock management?

1. Order form
2. Dispensing log
3. Stock card
4. Stock book

24. If any of the above are available, are they updated?

Yes ……….1 No …………….2

25. Are they filled correctly?

Yes ……….1 No …………….2

 26. How do you refer your malaria patients to the next care point? (score the explanation)

a) Appropriate explanation b) Inappropriate explanation

27. Which services do you have that target adolescents and young adults

……………………………………., ……………………………………

28. What challenges do you face while offering malaria services?

……………………………………………………………………………….

………………………………………………………………………………

29. What possible solutions do you suggest for the above challenges?

………………………………………………………………………..

………………………………………………………………………..

30. Does this facility have any malaria treatment protocols /guidelines?

Yes…………1 No…………..2

31. Do you have access to the protocols whenever you need them?

Yes…………1 No…………..2

32. Do you use it or any other protocol?

Yes…………1 No…………..2

33. Have you been trained on how to use the protocol(s)?

Yes…………1 No…………..2 .

34. List any protocols you have or use in your facility (tick as mentioned)

i) National Treatment Guidelines on Treatment of severe and complicated malaria

ii) Uganda Clinical guideline 2016

iii) Integrated Malaria Management (IMM) guidelines

iv) Malaria in pregnancy guidelines

v) Malaria Management Algorithm 2011

**SECTION 2: LABORATORY SERVICES**

1. Do you offer any malaria laboratory services/ testing?

Yes……..1 No…………2 **(If no, go section 3)**

**If yes, find the most senior health worker involved in the delivery of lab services to respond to this section**

2. Which types of malaria test do you use?

Microscopy ……..1, Malaria RDTs…….2, Both…………3

3. Have you had any training in malaria testing during your current practice?

1. Yes 2. No

4. If yes, what aspect were you trained in?

1. Malaria Microscopy 2. RDT 3. Both 4. Other (specify)…………………………

5. When was the training? Year……………… and Month………………………….

6. How many staff have been trained in malaria microscopy & or RDT?

 Malaria microscopy…………, RDT……………., Both……………….

7. Have you received any support supervision in last 6 months on malaria microscopy and RDT? 1. Yes 2. No

8. If Yes, by which organization?

1. MOH 2. District 3. Implementing Partner

9. Do you have adequate/ designated space for carrying out malaria microscopy/RDT?

 1. Yes 2. No

10. Does the facility have protocols available in the lab for malaria testing?

Available, seen………1 Available, not seen ....….2, Not available ……3

11. Do you have laboratory personnel available all the time?

Yes ..........1 No...............2

12. What type of microscope(s) do you use in your laboratory?

Monocular …………1 Binocular …………2

13. How often do you service your microscope?

…………………………………………………..

14. Who prepares the stains you use in the laboratory?

1. Commercially prepared 2. Regional Referral Hospital 3. In-house preparation

16. How do you manage the laboratory result records?

1. Lab registers 2. No Lab register/ record

17. How do you dispose of your medical or laboratory waste? (Tick as mentioned)

1. Incinerator 2. Open burning 3. Waste management company 4. Pit latrine

**SECTION 3: HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)**

|  |  |  |
| --- | --- | --- |
| 1 | Do you have a person designated for your facility records?  | Yes……………………………..1 No………………………………2  |
| 2 | If Yes, has the person had a formal training in records?  | Yes ………………………………1 No ……………………………… 2  |
| 3 | How does the facility manage the record of its patients/clients? | HMIS registers…..……….……1Improvised registers…….……..2No record ………………………3 |
| 4 | If 1, who provides you with the registers? | Districts………………………..1Implementing Partner………….2JMS…………………..………...3 |
| 5 | Is there proper documentation of patient data in the registers? | Yes……………………………1Partially done………………….2Not done……………………….3 |
| 6 | Do you compile your patients’ data? | Yes…………………………1 No…………………………..2  |
| 7 | If yes, how often? | Daily………………………..1Weekly……………………..2Monthly…………………….. 3 |
| 8 | Do you submit this data to any office | YesNo |
| 9 | If yes, which office(s)? | DHOMunicipal Health officeImplementing PartnerOther………………………Don’t know |
| 10 | How often do you submit this data to the above office? | Weekly……………………..1Monthly…………………….. 2Quarterly……………………..3 |
|  | Do you utilize the compiled data internally | Yes……………………1No……………………..2 |
| 11 | Is there evidence of data analysis and utilization? ( Check for Malaria graph)  | Malaria graph observed…..………1 Other evidence …………………...2 (specify) No ……….…………………….….3  |

**SECTION 4: QUALITY IMPROVEMENT**

|  |  |  |
| --- | --- | --- |
| 1 | Have you heard about “quality improvement in health care”?  | Yes …………………………….1 No ……………………………..2  |
| 2 | If yes, from where?….…………..……………… ……………..…………………………………………… |
| 3 | Do you have any quality improvement initiative or mechanism in this facility? | Yes……………………………..1No………………………………2 |
| 4 | If yes, what quality improvement initiative (s) are you implementing…………………………………………………………………………………………..……………………………………………………………………………………………. |
| 5 | How often do you hold staff meetings?  | Monthly or more often …………1 Every 3 months …………………2 Every 6 months …………………3 More than every 6 months...........4 We do not have meetings……….5 |
| 6 | Do you have any system for receiving clients’ opinions about you services? **1. Yes 2. No**If Yes, which system? **Circle methods that are applied.**  | Suggestion box...........................1 Client survey forms.................2 Client interviews.........................3 Informal client discussion………4 No client feedback.........................5Other……………………………. 6  |

**SECTION 5: LEGAL & PROFESSIONAL COMPLIANCE**

1. a) Do you know the process of registering a clinic or applying for a practicing license?

1. I know 2. I do not know

b) What about renewing a practicing license?

1. I know 2. I do not know

3. Are there any barriers you have experienced in:

a) Registering

……………………………………………………………………….

……………………………………………………………………….

b) Renewing

………………………………………………………………………………..

…………………………………………………………………………………..

4. Which solutions would you suggest for the above-mentioned barriers?

…………………………………………………………………………..

…………………………………………………………………………..

………………………………………………………………………….

|  |  |  |
| --- | --- | --- |
| 5. | Does your facility have a current practicing license? ***View certificate*** | Yes, Observed……………………….1 Yes, Not Observed…………………2 No……………………………….…...3  |
| 6. | Specify the licensing authority  | Uganda Medical and Dental Practitioners Council …1 Allied Health Professionals Council………………..2Uganda Nurses & Midwives Council ……………...3 |
| 7.  | What date was the last registration? ***View or ask if no certificate***  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ DD / MM /YYYY  |
| 8. | Are you (*respondent*) a member of any professional bodies/Association?  | Yes………………………………….1 No…………………………………..2 If 1, Specify………………………………… |
| 9. | Do you carry out any trainings or CME internally | Yes……………………………………………1No…………………………………………….2 |

**\*\*END\*\***

**Thank you very much for your response and time!**

**Interviewer:**

Name:

Signature:

**Respondent:**

Name:

Telephone contact:

Signature:

Date: