**SELF-REGULATORY QUALITY IMPROVEMENT SYSTEM (SQIS+)**

**PRELIMINARY INFORMATION DATA COLLECTION TOOL**

The Private Sector Foundation Uganda has partnered with MasterCard Foundation to support UHF through the COVID-19 Economic Recovery and Resilience Response Program (CERRRP) to digitize the Self-regulatory Quality Improvement system (SQIS+). The Information collected will be directly uploaded to the upgraded system to complete the registration process as the first step before self-assessment.

# A. Health facility Details (To be completed by all facilities)

**i)**

Facility Name……………………………………………………………………………….………

Plot Number………………………………………… Ward………………………………………..

Division……………………………………………….Sub county………………………………...

County…………………………………………………District……………………………………

# ii)

Facility Contact Number……………………………………………………………………………

Facility WhatsApp Contact Number….……………………………………………………………

Facility Email Address……………………………………………………………………………

Facility Website……………………………………………………………………………………

# iii)

Name of Facility Owner (Registered Director……………………………………………………

Phone Number of Facility Owner (Registered Director)…………………………………………

Email of the Facility Owner (Registered Director)….……………………………………………

# iv)

Name of the Technical Supervisor at the Health facility…………………………………………

Phone Number of the Supervisor at the Health facility……………………………………………

Email of the Technical Supervisor at the Health facility…………………………………………

Registration certificate Number of Technical supervisor …………………………………………

Annual Practicing License number of the Technical Supervisor…………………………………

Registering Authority (Technical Supervisor)……………………………………………………

# v)

Facility Ownership Type

i) PHP ii) PNFP

iii) Public Facility

HMIS/DHIS2 number………………………………………………………………………………

Services provided (Select one)

i) Out Patient ii) Outpatient and inpatient

Single or Multiple Service Facility (select one)

i) Single ii) Multiple

Facility Registration certificate Number……………….…………………………………………

Annual Operating License Number ………………………………………………………………

Trading License……………………………………………………………………………………

Facility Registering Authority

i) UMDPC ii) UNMC iii) AHPC iv) Pharmacy

Multiple service facility (standalone) (select those that apply)

i) Laboratory ii) Dental iii) Radiology iv) Pharmacy/ Dispensary v) Ophthalmology vi) Ambulance Services vii) General medicine viii) Specialist ix) Others (Specify)

Single service facility (standalone) (select those that apply)

i) Laboratory ii) Dental iii) Radiology iv) Pharmacy/ Dispensary v) Ophthalmology viii) Specialist medicine

ix) Others (Specify)

***If a health facility offers multiple services, fill section B only. If a health facility offers single service fill only section C.***

# B. HEALTH FACILITY WITH MULTIPLE SERVICES

Number of Beds.…….…………………………..………………………………………………...…………

Number of Nurses……………….………………………………………………………………...…………

Number of Medical officers…….………………...………………………………………………………….

Number of specialists full time………………………………………………………………………………

Number of specialists part time……………...………………………………………………………………

Others (Specify)……………………………..……………………………………………………………….

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

Specialist Services (Tick all that apply)

|  |  |
| --- | --- |
| **Service** | **Tick(**✔) |
| Cardiology |  |
| Pathology |  |
| Clinical research |  |
| Dental |  |
| Dermatology |  |
| Endocrinology |  |
| ENT |  |
| Forensic medicine |  |
| Gastroenterology |  |
| General Surgery |  |
| Hematology |  |
| Internal medicine |  |
| Nephrology |  |
| Nutrition |  |
| Obstetrics and Gynecology |  |
| Oncology |  |
| Orthodontics |  |
| Orthopedics |  |
| Pediatrics |  |
| Palliative care |  |
| Pathology |  |
| Physiology |  |
| Plastic and reconstructive surgery |  |
| Psychiatry |  |
| Urology |  |
| General practice |  |

**General Services (Select those that apply)**

# 1. Maternal/ Child Health

i) Deliveries ii) ANC iii) Immunization iv) Family Planning v) Caesarian Section vi) Nutrition

**2. TB**

i) TB diagnosis ii) TB treatment

# 3. HIV

i) ART ii) HCT iii) CD4 testing iv) Viral

load

**4. Radiology**

i) X-ray ii) Ultra Sound iii) CT/MRI

# 5. Laboratory

i) Malaria RDT ii) HIV iii) Dipstick for protein urine iv) Urine glucose v) Immunology

vi) Parasitology

# 6. Specialist Services

i) ICU ii) Neonatal Unit iii) Renal Unit iv) Fertility Unit

# C. SINGLE SERVICE

Number of Beds……………………………………………………………………………………...……………

Number of Nurses…………………………………………………………………………………...…………….

Number of Medical officers……………………………………………………………………………………….

Number of specialists full time……………………………………………………………………………………

Number of specialists part time……………………………………………………………………………………

Specialist Services (Tick those that apply)

|  |  |
| --- | --- |
| **Service** | **Tick(**✔) |
| Cardiology |  |
| Pathology |  |
| Clinical research |  |
| Dental |  |
| Dermatology |  |
| Endocrinology |  |
| ENT |  |
| Forensic medicine |  |
| Gastroenterology |  |
| General Surgery |  |
| Hematology |  |
| Hepatology |  |
| Internal medicine |  |
| Nephrology |  |
| Nutrition |  |
| Obstetrics and Gynecology |  |
| Oncology |  |
| Orthodontics |  |
| Orthopedics |  |
| Pediatrics |  |
| Palliative care |  |
| Pathology |  |
| Physiology |  |
| Plastic and reconstructive surgery |  |
| Psychiatry |  |
| Urology |  |
| General practice |  |

**Support Services**

# 1. Radiology

1. X-ray
2. Ultra Sound iii) CT/MRI

iv) Others (Specify)

# 2. Laboratory

i) Malaria RDT ii) HIV iii) Dipstick for protein urine iv) Urine glucose v) Immunology vi) Parasitology

vii) Others (Specify)

Respondent’s Names………………………………………………………………………………..

Respondent’s Signature…………………………… ………………………………………………

Interviewer’s Names………………………………………………………………………………..

Interviewer’s Signature……………………………………...Date:…...…………………………...