International Social Determinants of Health Baseline Assessment Tool

(Draft)

Dear Reviewers,
After you review the international SDOH baseline assessment tool below, you can send your comments to the following email address.
(support@sdohproject.org).

The SDOH Baseline Assessment Tool

Contact and demographic information

1. Full Name: _____
2. DOB: _____ Age (in full years) _____
3. Gender: _____ ☐Male ☐Female
4. Address: _____
5. City: _____ State _____ Zip: _____
6. Phone #: _____Email: _____
7. Are you a veteran? ☐Yes ☐No
8. Do you have an emergency contact? ☐Yes ☐No
   If yes, fill out the information below:
9. Primary emergency contact

First name: …… Last name: ……. Address: ……

City: …… State …….. Zip: ….....

Relationship: …….. Phone: …… Email: ……

10. Secondary emergency contact

First name: ……. Last name: ……..…… Address: ……..

City: ……. State: ……. Zip: ……

Relationship: …….. Phone: ……. Email: ……

11. Marital status ☐ Married ☐Single ☐ Separated/divorced/widowed.
12. Educational status

☐Unable to read and write ☐Able to read and write ☐Primary school

☐Secondary and preparatory ☐Diploma and above

13. Religion

☐ Christianity ☐ Islam ☐ Buddhism ☐ Hinduism ☐ Judaism ☐Other (specify)……..

Employment

1. What is your current employment status?

☐Self-employed ☐Government employee ☐private organization

☐Farmer ☐daily laborer ☐ Housewife ☐ Retired

☐ Student ☐not employed ☐ other (specify)……

If employed, fill out the below information:

2. Employer's information

Employer: ……Contact number: …….. Address: ……

3. Do you work full-time or part-time? ☐Full-time ☐ Part-time ☐Date of employment: …
4. What language(s) can you speak? _____
5. What is the Source of your/ your Household income? (Multiple answers possible)

☐Payment from work ☐ Agriculture ☐ From family ☐Other (specify)….....

6. What is your Monthly household income (estimate in birr) ----------
7. If the source of income is agriculture, estimate /calculate the annual product (sale price) and report in ETB. ----------
8. Estimate of how much you spend (ETB/month): ☐To buy Food ……

☐To pay for a house …….....

☐To pay for school …….....

☐ Medical care ……...

☐To pay bills (Electric, water, fuel, etc.) …….

☐For saving …….

☐Other (Specify) _____

9. How many people live in your household? ☐<5 years_____

☐5-18 years_____

☐ >18 years_____

10. Do you have children? ☐ Yes ☐ No

11. If yes, do you send your children to school? ☐ Yes, All

    ☐Yes, some

    ☐No, none

12. What was the reason if any of your children are not going to school?
    ☐ Unable to pay for school ☐Child disability ☐Family Disability

    ☐ Gender role-based reason ☐ other (specify)……

13. How hard is it for you to pay for the very basics like

☐Food	o Very hard	o somewhat hard	o Not hard at all
☐Housing	o Very hard	o somewhat hard	o Not hard at all
☐Medical care	o Very hard	o somewhat hard	o Not hard at all

Food, water, and the environment

1. Weight in kilograms ……..
2. Height in centimeters ……
3. BMI (kg/m^2) ……..
4. How do you describe your diet
   ☐Nutritional ☐ poor nutritional ☐do not know
5. How often do you get it?

   ☐Fruit and vegetables a) Always b) sometimes c) not at all

   ☐ Potatoes, bread, rice, pasta, and other starchy carbohydrates. a) Always b) sometimes c) not at all

   ☐ Beans, pulses, fish, eggs, meat, and other protein a) Always b) sometimes c) not at all

   ☐ Dairy and alternatives a) Always b) sometimes c) not at all

   ☐ Oils and spreads a) Always b) sometimes c) not at all
6. How many sodas and sugar-sweetened drinks (regular, non-diet) did you drink each day? ☐3 or more servings ☐2 ☐1 ☐0
7. Within the past 12 months, you worried that your food would run out before you got money to buy more.

   ☐ Often true ☐ Sometimes true ☐Never true

8. What is the main source of drinking water for members of your household?
   - ☐ Piped water
   - ☐ Piped water/community stand
   - ☐ Protected (borehole, spring, well)
   - ☐ Unprotected (open source well, spring, river)
   - ☐ Bottled water
   - ☐ Other
9. Do you treat your drinking water consumption? ☐Yes ☐No

10. If yes, which treatment method do you use?
    - ☐ Boil
    - ☐ Add bleach/chlorine.
    - ☐ Strain through a cloth
    - ☐ Use a water filter (ceramic/ sand/composite/etc.)
    - ☐ Solar disinfection
    - ☐ Let it stand and settle
    - ☐ Other (specify) ……
    - ☐ Do not know

11. Do you live around factories, highways, or near to a street with a lot of pollution or smog?
    - ☐ Yes
    - ☐ No

12. Is your occupation making you vulnerable to

    ☐ Musculoskeletal diseases ☐ work related stress ☐occupational Asthma
    ☐ chemical/ radiation exposure ☐ other (specify)…

13. Do you have any work or living environment that relates to your health condition?

    ☐Yes ☐No

    If yes, please list …….

Housing and living situations

1. What is your living situation today?
   - I own a house
   - Rented house
   - Staying with friends/family
   - Nursing home
   - Refugee camp
   - Private shelter
   - I do not have a steady place to live (living outside on the street, under unfinished constructions/in a simply built shelter or shade)
2. How many sleeping rooms does your house have? ……
3. Where is the cooking usually done?
   - In the house
   - In a Separate building
   - Outdoors
   - Does not cook at home
   - Others (specify) ……
4. If in the house, does it have a smoke extractor? ☐Yes ☐No ☐ Don't know

5. What type of fuel or energy source is used in this cook stove?
    - ☐ Alcohol/ethanol
    - ☐ Gasoline/diesel
    - ☐ Kerosene/paraffin
    - ☐ Coal/lignite
    - ☐ Charcoal
    - ☐ Wood
    - ☐ Straw/shrubs/grass
    - ☐ Agricultural crop
    - ☐ Animal dung/waste
    - ☐ Processed biomass (pellets)
    - ☐ Garbage/plastic
    - ☐ Sawdust
    - ☐ Other (specify) ……
6. Where do you dispose of your solid wastes?
    - o Pit at home
    - o Open field
    - o Municipally collected
    - o Other (specify)…….
7. Where do you dispose of your liquid wastes?
    - o Open field
    - o Septic tank
    - o Dispose of municipal sewer line
    - o Pond/river
8. What type of toilet facilities do your household members use?
    - o Pit latrine
    - o Ventilated improved pit latrine
    - o Flush toilet
    - o Communal latrine
    - o No facility/field
    - o Other (specify)……
9. Do you have disease-causing vectors inside your house?
    - o Yes
    - o No
10. If yes, what type of disease-causing vectors are there?
    - ☐ Flies
    - ☐ Fleas
    - ☐ Cockroach
    - ☐ Bed bug
    - ☐ Rat
    - ☐ Others (specify) ……..

11. Do you live in a malaria-endemic area?
    - Yes
    - No

12. If yes, do you use the LONG-LASTING INSECTICIDE-TREATED NET (LLIN)?
    - Yes
    - No

Substance Abuse

1. Do you use any substances?
    - Yes
    - No
2. If yes, what kind?
    - ☐ Khat
    - ☐ Alcohol
    - ☐ Cigarette
    - ☐ Glue
    - ☐ Marijuana/cannabis
    - ☐ Methamphetamine
    - ☐ Cocaine/crack
    - ☐ Heroin
    - ☐ LSD (Acid)
    - ☐ Other (specify)……..
3. For what purpose do you use a substance?
    - For working motivation
    - For Pleasure
    - In a gathering/festivals
    - To relieve food need
    - Other (specify)……..
4. Have you ever blacked out due to a substance overdose?
    ☐Yes ☐No
5. Overdose on drugs: ☐Yes ☐No
6. Have you ever received treatment for alcohol or drug abuse (e.g. 12-step, detox)
    ……

Primary care information, Health Status, and Access to health service

1. Doctor's information ☐ None

Name: …… contact number: ……. Address: ……

2. Therapist's information: ☐ None

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Name: …… contact number: …… Address: ……

3. Medical information
   A. Heart disease (survived/current): ☐Yes ☐ No if yes, specify……..
   B. Cancer (survived/current): ☐Yes ☐ No if yes, specify…….
   C. Diabetes: ☐Yes ☐No If yes, last FBS/RBS result……
   D. Hypertension: ☐ Yes ☐ No If yes, last BP measurement result (sys/dias), (mm, HG) ……
   E. Allergies: ☐ Yes ☐ No If yes, list all allergies……
   F. History of seizures/epilepsy: ☐Yes ☐No If yes, list date(s)…….
   G. History of anemic condition/current ☐Yes ☐ No
   H. Last TB test: ☐Positive ☐Negative when……where ……
   I. Last STDs test: ☐ Positive ☐Negative when……where ……
   J. Linked to dentist for check-up: Date: …… Agency contact ……
   K. Linked to optometrist for check-up: Date: …… Agency contact ……
   L. List all medication(s) currently being taken/for which illness: ……
   M. Immunization history (if there is a child under 10) ……
   N. List your previous medication(s)/for which illness they were taken, if any: ……
   O. Family planning ☐ Used ☐Never used ☐ Discontinued
   P. Last physical examination: Date: …… location: ……
   Q. Date of last medical hospitalization…….. reason: ……..
   R. For woman only: A. Pregnant: ☐Yes ☐No B. MD/Phone # or prenatal check-up: ……..
   S. Any health condition(s) currently: ……..
   T. Last dental examination: …… Dental issues: ……
   U. Nutritional issues: ……

1. Do you have any known health complication/s? (e.g. chronic illness)
   ☐Yes ☐ No
2. If yes, please specify the health complication/s that you have.

   ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Other (specify)……

3. If you have any known health complication/s from the above alternatives, how long have you lived with it?

   ☐Yes ☐ No

4. Where do you seek care in case of illness? (Multiple responses possible)

   ☐Medical care ☐ Religious ☐Traditional ☐others (specify)……..

5. Have you or any of your household members had an illness in the past 2 weeks? Months? ☐Yes ☐ No
6. If yes, where did you go to be treated? ☐ Medical ☐ non-medical
7. If medical care, where?
   ☐Private clinic ☐Public health facility
8. If non-medical, what barriers held you back to go to medical care?

   ☐Transportation ☐negligence ☐not having Health insurance.

   ☐Not interested to go ☐Language barrier ☐stigma ☐ others (specify)……
9. Do you feel safe at home or around your streets/neighborhoods?
   ☐Yes, I feel safe ☐ yes, somehow ☐No, I do not feel safe
10. If not, is it a barrier not to get medical care at night, early in the morning, or even in daylight? ☐ Yes ☐ No
11. If you have health insurance, what kind of insurance do you have?
    - Community-based health insurance
    - Private Insurance
    - Employment Based Reimbursement
    - No health insurance
12. How long does it take you to reach a healthcare facility near you (one way)

    ☐ <30min ☐ 30min-1hr ☐1hr
13. Do you have transportation access to the nearest healthcare facility?

    ☐ Yes ☐No
14. If yes, can you make it to the healthcare facility this easily?
    ☐ Yes ☐ No

Mental health

1. Have you ever been diagnosed with a mental health illness? ☐ Yes ☐ No
   if yes, proceed to the questions below. If no, please proceed to answer the SRQ-20 on the next page.
2. Do you have a mental illness? If yes, proceed to the next questions.
3. Frequency: …… Type of treatment: ……
4. Current Diagnosis: …… Previous Diagnosis: ……..
5. Previous psychiatric hospitalization(s)/reason: ……..
6. Previous outpatient treatment/ crisis services: ……..
7. Psychotropic medication: ……
8. History of homicidal thoughts/aggressive behavior: ……..
9. History of SI/SA: ☐ Yes ☐ No If yes, list date(s)……
10. Any Physical disability: ☐Yes ☐ No If yes, please specify……

11. Mental health disability ☐ Yes ☐No If yes, please specify…….

Respondents were asked to remember whether these symptoms had been experienced during the last 30 days. Each item consists of two answer choices, "yes" and "no". "Yes" answer will be given a score of 1 and "No" answer will be given a score of 0. Mental distress Will be screened by using the SRQ-20 items with cut-off point 10 and above scores. Scores below 10 points are recorded as “No Mental Distress” and scores 10 and above are recorded as “Yes for Mental Distress [35].

The mental health measurement using SRQ-20.

1. Do you often have headaches?	☐ Yes	☐ No
2. Is your appetite poor?	☐ Yes	☐ No
3. Do you sleep badly?	☐ Yes	☐ No
4. Do you find it difficult to enjoy your daily activities?	☐ Yes	☐ No
5. Do you feel tired all the time?	☐ Yes	☐ No
6. Are you easily tired?	☐ Yes	☐ No
7. Do you find it difficult to make decisions?	☐ Yes	☐ No
8. Is your daily work suffering?	☐ Yes	☐ No
9. Are you unable to play a useful part in life?	☐ Yes	☐ No
10. Do you feel unhappy?	☐ Yes	☐ No
11. Do you feel that you are a worthless person?	☐ Yes	☐ No
12. Has the thought of ending your life been on your mind?	☐ Yes	☐ No
13. Is your digestion poor?	☐ Yes	☐ No
14. Do you have uncomfortable feelings in your stomach?	☐ Yes	☐ No
15. Are you easily frightened?	☐ Yes	☐ No
16. Do your hands shake?	☐ Yes	☐ No
17. Do you feel nervous, tense, or worried?	☐ Yes	☐ No
18. Do you have trouble thinking clearly?	☐ Yes	☐ No
19. Have you lost interest in things?	☐ Yes	☐ No
20. Do you cry more than usual?	☐ Yes	☐ No

Follow-up actions needed

- What support do you need to access services such as medical care, employment, or supportive services such as; transportation, language translator, ETC (from the mentioned barriers to getting health care)

  ……

- ❖ Which of the following would you like to receive help with at this time? (Select 3 or below that apply)

☐ Food
☐ Housing
☐ Transportation
☐ Utilities (heat, electricity, water, etc.)
☐ Medical care, medicine, medical supplies
☐ Dental services
☐ Vision services
☐ Applying for public benefits (WIC, SSI, SNAP, etc.)
☐ More help with activities of daily living
☐ Childcare/other child-related issues
☐ Debt/loan repayment
☐ Legal issues
☐ Employment
☐ Other
☐ I don't want help with any of these

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