

Trip Report on visit to the Integrated Social Services Project, Menoufia
Egypt, March 21-30, 1980 as part of USAID Contract No. AID/DSPE-C-0055

Prepared By: Dr. Richard Osborn
and
Dr. Robert Parker

Topics covered in report:	<u>Page</u>
1. Objectives	1
2. Meeting with USAID-Cairo Staff	2
3. Oralyte Utilization Survey	3
4. Field trip - Review of Oralyte Distribution	5
5. Measurement of Mortality	8
6. Integrated Social Services Program	10
7. Social Demographic Survey	11
8. Cost Efficiency	15
9. Evaluation of Existing Health Services	16
10. Miscellaneous Items	18
11. Future Role of JHU	20

1'

Initial Objectives of the Visit

1. Overall project review with Dr. Gadallah and staff.
2. Observe the field program in operation during a visit to Menoufia Governorate.
3. Review progress of the oral rehydration intervention and its evaluation.
4. Review the Integrated Social Services component of the Menoufia project and determine how the evaluation of activities is proceeding.
5. Review the progress of the descriptive study of health services in the project area.
6. Explore the potential for cost/effectiveness studies of the Menoufia program.
7. Determine the type of assistance JHU can provide to the project, especially in the areas of evaluation and analysis.

Meeting with USAID-Cairo Staff

At the beginning of the visit to Egypt we met with Tom Reese and Laura Slobey of USAID-Cairo. It was clear from both that strengthening contraceptive usage on a nationwide basis is the primary goal of the mission. Therefore, limited projects like Menoufia, while interesting and important in galvanizing the national family planning program into action, are not the highest priority of USAID-Cairo. This O.R.sop project seems to have been happily left under the watchful eyes of AID-Washington and the Cairo USAID staff have a limited interest in its outcomes.

USAID-Cairo is seeking to assist the Population Development Project (PDP) which is run by the family planning board. The UNFPA is significantly assisting in the implementation of PDP programs and is concerned with possible ways of evaluating program effects. The field program is complex and includes a significant level of participation by the councils at the village level in social welfare and family planning activities. Part of the field structure includes an outreach worker with responsibility for regular contact with about 600 couples.

We did not meet with the Family Planning Board staff and suggest this would be a valuable visit if there is an occasion for a further visit to Egypt. There are numerous similarities between the Menoufia and national program which may lead to closer linkages in the future.

Some questions concerning contraceptive method acceptance were discussed with Tom Reese. It was his view that a substantial tradition for vaginal barrier methods exists in Egypt and the foaming tablet "Neosampoon" might gain wide acceptance. This would be particularly valuable when the

pill is not acceptable. One recent survey in Rural Egypt shows that 60 out of 188 women who know about the pill report that they are afraid of it. This result is from a recent KAP survey that is part of a USAID grant supported program to the Egyptian State Information Service. The consultant to that population information and communication program is Bob Higgins.

Other parts of the USAID-Cairo discussions are seen in the CPS section of this report.

Oralyte Utilization Surveys

Two different sources of information measuring the use of Oralyte are available in the project, the "mini" survey carried out in a sample of Phase I villages last October (1979) and the final section of the socio-demographic (S-D) survey which includes villages in Phase I and Phase III areas (see separate section discussing this survey as a whole).

1. The "Mini" Survey

The survey, its preliminary findings and future analysis, were discussed, primarily with Dr. Nosseir. Because of the timing of the canvass, ending only in June-July, the occurrence of Ramadan shortly thereafter, and then August vacations, the survey (or any future surveys of this nature) could only be done in October. Unfortunately this misses the diarrhea season peak. This plus the long recall (a minimum of two months since distribution) produced levels of reported diarrhea only a third of what one might expect during the diarrhea season. (Based on five episodes of diarrhea per child under five per year, with three of these occurring during the peak months of May-August. This would be an average

of 1.5 episodes per child over the two month recall period or an expected total of 1122 episodes in the sampled households in contrast to the 348 episodes reported). In order to compensate for the relatively uncertain recall over an indeterminate period of time (as much as six months this year between distribution and survey), if the "mini" survey is to be done in Phase II villages, we have recommended it should have an added question(s) measuring those episodes in the prior two weeks and the actions related to them. In addition these question(s) should be worded similar to those suggested for the S-D survey (see below).

Although the use of Oralyte in reported cases of diarrhea was over 60 percent in Phase I villages, the probable underreporting of cases, the finding that only 11 percent of women (whether their child had diarrhea or not) knew the correct amount to give, and the finding that only 13 percent of cases seeing doctors (both health unit and private) were advised to use Oralyte, makes the possible impact of the Oralyte intervention in these villages somewhat problematic. With the attempts to improve the support of the health units, better communication with the villages, use of better trained canvassers and in the final two counties putting the Oralyte distribution first, it is hoped that more appropriate utilization and a significant impact on mortality will occur. Repeating the "mini" survey in Phase II villages is important to document the hoped for improvement in utilization. If the survey is done (and Dr. Nasseir has been proposing that it should) the strata for sampling should include a split between villages where contraceptives were distributed first and those where Oralyte came first.

Since the completion of the hand tabulations of the "mini" survey in December a coding key was developed to transfer the data onto punch cards and tape. Coding was just beginning the week of March 24 but should be completed fairly quickly. Dr. Nosseir plans to bring the punched cards or tape to Hopkins this summer to work on the analysis at that time. The general data related to each mother and all her children under five are being coded on one card for each interview (473 cards). Each diarrheal episode is coded on a separate card (348 cards) with the sequence number of episodes indicated if more than one episode is related to the same child. Potential cross tabs being planned by Dr. Nosseir include use of Oralyte by the mother's or child's characteristics (age, sex, etc.), by villages with and without health units, by bottle availability, and by knowledge about use. She plans to develop the details of the analysis and send them to us for comments and suggestions before this summer.

Field Trip--Review of Oralyte Distribution

One of the initial activities we participated in upon our arrival at the field office in El Bagaur county was a meeting of the Oralyte distribution staff. Unlike last year, the Oralyte "canvassers" are college graduates recruited centrally in Menoufia. These young women (there were about 16-20 at the meeting) are all unmarried, enthusiastic and very animated in their participation in the discussion. The SRC staff seem to be quite happy with their performance to date. They have recently begun field work in the first county (El Bagaur) in the Phase II area, and have just completed the first five villages. They work as one team, sweeping through villages recently covered by the contraceptive canvassers. We sat in on their review of the work in these five villages and were able to ask a number of questions. Some of the points coming out of this discussion follow:

1. At first in Phase II, in order to distinctly separate the Oralyte canvassers from the contraceptive canvassers, the former were not taught anything pertaining to contraception. They were to refer any woman asking questions about contraceptives to the health units. However, since they are well educated, come from outside the village and are looked upon as health care providers, many village women have been asking them questions about the contraceptives recently distributed and expecting answers. The decision was made, therefore, to give the canvassers some basic knowledge about family planning which was to be done on the day of our visit. (Because of this training session, they did not go to the field and we were unable to go along on any home visits for Oralyte distribution).

2. At present the canvassers only demonstrate the actual making of a liter of oral rehydration fluid (ORF) in homes where women do not seem to understand the verbal presentation, in homes where some doubt is expressed about taste or safety (the woman is encouraged to taste it or the canvasser drinks some to reassure the woman), and in homes where the mother volunteers that a child has diarrhea. In the latter case the canvasser also demonstrates the cup and spoon feeding technique, first giving ORF to the child herself and then watching the mother do it. Some problems have been encountered when children in these situations won't take the ORF. We spent a little time therefore discussing feeding techniques and the probability that the child will eventually experience thirst and start drinking ORF if he/she is losing significant fluids. In these cases the mothers should be advised to continue trying. (Later in our visit Dr. Nossair mentioned that a change in procedure will be introduced in the next two counties of Phase II, which will include, in addition to other

changes, the determination whether any child has diarrhea at the time of the visit. Thus, the canvasser will not depend on the mother volunteering the information. This will provide more demonstration opportunities as well as a point prevalence indicator of diarrhea).

3. A much more intensive and apparently effective effort (from early indications) has been made to involve and gain the support and backup of health unit staff, especially doctors. Whenever possible the units are the sites for the bottle storage and distribution, doctors are involved in village meetings and nurses are encouraged to accompany the canvassers as time permits. However, in spite of the attempts to orient the doctors to the advice being given by the canvassers and convince them of its validity, there are still some topics where the canvassers and the health unit doctors are giving mothers conflicting messages. Fortunately this does not involve the use of Oralyte per se, but include doctors advising stopping breast feeding throughout the diarrheal episode and the use of only boiled water for mixing the Oralyte, both opposite to the canvassers' message. In addition, some women are still receiving Rehydrans from physicians and confusing its preparation with that of Oralyte. A number of women also state they will give Oralyte only when the doctor advises it.

4. Initial contacts in the villages had been very encouraging with almost total acceptance of the Oralyte and no reoccurrence of rumors experienced in Phase I. However, in the fifth village similar rumors appeared. In several cases the women were quite skeptical that the ORF wouldn't harm their children and kept asking "why do you want to make our children healthy?" It remains to be seen whether this is an isolated event or more widespread suspicion exists. In either case Dr. Nosseir informed us later that a decision has been taken to reverse the distribution order

(Oralyte before contraceptives) in the other two counties in Phase II, both to reduce suspicion and more importantly to get Oralyte into the homes sooner due to the beginning onset of the diarrhea season. This involves some changes in the canvassing procedures and forms which are currently being revised. (The addition of a point prevalence measure of diarrhea was mentioned earlier).

Measurement of Mortality

Changes in child mortality under five years of age is the major health outcome measure of the ORF intervention. According to Dr. Belgin Tekçe, the consultant in charge of mortality data collection, pre-project levels of mortality in Phase I and Phase III areas will be estimated using data from the first round S-D surveys (Brass estimates of mortality). Changes in mortality between rounds will be based on special questions determining changes in household membership between S-D surveys, outcome of pregnancies detected on prior rounds and births and deaths of the same infant occurring between rounds. All deaths under five identified occurring between rounds will be investigated by one or two specially trained physicians to determine the cause of death using structured "Verbal Autopsy" forms similar to those used in the Strengthening of Rural Health Delivery project. Dr. Tekçe hopes to have Dr. Kielmann train these physicians in this data collection technique. Data from routine death registration will not be used as originally suggested by Dr. McCord because of probable variability in reporting expected between the few villages included in each area's sample. In addition the complexities of matching deaths in dual reporting systems was another deterrent.

The original survey design called for baseline S-D surveys in both test (Phase I) and control (Phase III) villages. However, it was not possible to carry out the interviews in both areas in the spring of 1979, so test villages were done then and control village interviews were postponed until November-January, 1979-1980. Unfortunately this change has made the measurement of mortality in the control area using the change in household membership method unavailable for the 1979 diarrhea season. Comparisons will only be possible between pre-project estimates and test village mortality in 1979. Another problem is that recall of intervening events between surveys will tend to be better for control villages as their interviews follow sooner after the diarrhea season, thus leading to some problems of interpretation of differences in deaths in infants. (If this bias is significant, infant deaths should be lower in test villages with everything else held constant). Relatively comparable measures of mortality will be available for both areas covering the 1980 diarrhea season. However, the probability of a continuing effect of the ORF intervention into the second year, given the problems with the distribution summarized under the section on utilization measures, makes this second year data less likely to be of any use for program evaluation.

Considering these data problems and the hoped for improvement in the ORF intervention in Phase II, it is indeed unfortunate that no mortality measures have been planned for these villages. Hopefully a "mini" utilization survey of a sample of women in this area will indicate whether a mortality impact would be probable. We would also suggest the consideration of the use of age specific (post-neonatal and second year) mortality data collected from the death registration system on a countywide basis in Phase II and Phase III areas for the years 1979-1980-1981 if the "mini"

survey suggest the potential of a significant mortality impact of the ORF. Cause specific data would not be used, but an impact on diarrhea deaths should be reflected in changes in total mortality.

Integrated Social Services Program (ISS)

The major objective of the Menoufia project is the increase in social and health services at all levels in the governorate. This is to be brought about by increasing the number of service providers, upgrading of present personnel through retraining and the improvement of facilities and equipment. This set of functions represents an area of special cooperation between AUC/SRC and the Governorate of Menoufia. Chemicals, pharmaceuticals and clinic equipment are to be provided for each health unit according to a list of essential items. Support for social services is less common in the area and a major effort has been made to create or strengthen a variety of activities including: nurseries, women's clubs, mothers' councils, female adult literacy classes, loans for equipment or purchase of animals to change family productivity levels, working shops for production of items for market and male and female vocational training. All of these are under village level Community Development Societies (CDS). The emphasis throughout is upon local involvement and decision making. To date the ISS program has been extended to 102 villages including 50 health units and 98 CDS units.

Several approaches will be made to evaluate the ISS program. A comparison of the items present in the health unit compared to the list of what should be found will measure availability of supplies. Further efforts to review health unit activities are discussed elsewhere in this report.

Twelve months after funds are received by a CDS an evaluation is undertaken. Eighteen villages have been evaluated and by the end of 1980 the remaining units will be reviewed. Approximately 80 CDS units remain to be reviewed. As part of the evaluation of the health units, level of participation and utilization by village residents is examined from records at the health unit. For each of the CDS activities mentioned above the evaluation will consist of a budget review, measurement of participation levels, examinations of qualifications and responsibilities of each activity leader. An additional evaluation component is contained in the Social Demographic Survey where knowledge and use of ISS functions are emphasized.

Social Demographic Survey (SDS)

The principal evaluation tool of the Menoufia project is a series of 3 large scale surveys carried out in 12 villages in 2 types of areas. The design is as follows:

<u>Type of Area</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Test	Baseline Survey April-May, 1979	Follow-up Survey I April-May, 1980	Follow-up Survey II April-May, 1981
	Health & Family Planning Intervention April-July 1979		
Control	Baseline Survey October-November, 1979	Follow-up Survey I Oct.-Nov., 1980	Follow-up Survey II Oct.-Nov., 1981
		Health & Family Planning Intervention Feb.-June, 1981	

Extra Surveys: Utilization of Oralyte completed Fall, 1979. Mortality study planned for latter part of 1980. (See details in other sections of this report).

Each of the test and control areas includes two villages where health and social services are present, two where only health services are found and two without either service.

Year 1 surveys in both test and control areas have been undertaken and coding is nearing completion. Data collection for the year 2 surveys is about to commence.

During our visit to Egypt we received a briefing of the contents, codes and current status of the year 1 survey and participated in discussions reviewing the final form of the year 2 survey questionnaire.

Prior to starting the second round SDS in Phase I villages. modifications of the questions were developed for different sections of the survey by SRC staff. We were invited to participate in a planning meeting to discuss and agree upon changes. We were able to make specific suggestions for a standardized definition of diarrhea to be asked in addition to the term for diarrhea which was left to the mother to interpret. More specific questions about utilization of ORF were also developed. These were to be circulated and modified, if needed, and incorporated into the questionnaire. (Copies of the wording are appended in Attachment A). In order to assure that a denominator of all children under five was available to calculate diarrheal prevalence rates, instructions to the investigators to record the names of all children whether sick or not under this question and then procedures for coding this denominator later were agreed upon.

A significant problem exists in data processing for the SDS. The computer facility at AUC is unable to punch, verify, place on tape and

clean large data sets in less than 1 to 2 years from completion of coding. One result is the initiation of the year 2 surveys without any review or analysis of the first year survey materials. By the time data are available much of value in providing guidance to the Menoufia project will be lost. The long interval between initiation of a project and availability of data also means that much of the interest and enthusiasm of the research staff has been dissipated by the time analysis can begin. Other computing facilities are known to exist in Cairo, such as that of Al Ahram, but the availability and quality of these services is unknown and the cost will be quite high. One empirically based estimate reviewed in Egypt puts costs per generated table at a level 10 times that found in the United States.

Test and control areas are approximately equal in population with slightly over 3300 women, aged 15 to 49 years, married with husband present in the households included in the test area sample. The sample design chosen called for complete enumeration of the selected villages and interviews with all eligible respondents in the village. The method of selection of sample villages is not known to the authors of this report.

Data in the survey include basic demographic items, a summary of reproductive experience, contraceptive use, and experience and knowledge of community social and health services. The health data include use of MCH services, mortality of children and morbidity and treatment of diarrheal disease in children. Approximately 40,000 data cards are produced by the surveys in test and control areas.

Three surveys are planned for each area at one year intervals. Point prevalence measures will be taken and comparison made between the observed levels of contraceptive use in each survey. No attempt will be made to link a women's responses across the three rounds of data collection although the possibility of linkage is present from face sheet data.

The SDS activity should be strengthened in several ways:

1. There are too many risks in maintaining a follow-up survey when the results from the initial baseline data collection are not known. Unless turn-around time can be reduced consideration should be given to postponing the second field survey.
2. There is a reluctance to use precoded interview schedules. This increases data reduction costs and adds a significant amount of error from the need to code and transcribe on coding sheets. Some savings in time could also be achieved in the receipt of data for analysis.
3. The original design calls for a highly clustered sampling of 6 test and 6 control villages in the first and third phases of the project. Phase 2 will be unevaluated although both the order of the contraceptive and oralyte field distribution will be altered and some other features of the field program have changed.
4. There is no rapid feedback system for monitoring and evaluating the field program. The SDS is a large scale experimental design which is not intended to provide field surveillance. A method of providing monitoring data is needed and JHU and AID Washington should discuss the nature of such a system with Dr. Gadallah.

Cost Efficiency

Cost analyses were discussed with Drs. Gadallah and Nosseir. Apparently records at AUC since 1978 are in such a state of confusion following the death of the previous comptroller that it would be extremely difficult if not impossible to retrieve exact expenditures for the AUC part of the project since that date. Menoufia governorate expenditures (in Arabic) are available, but again would take considerable effort to abstract them. Good records are being maintained of all inputs (financial and materials) going into the social welfare organizations and health facilities. Our general conclusion was that reasonably good estimates could be developed for most of the project costs from:

- a) these latter records,
- b) governorate records
- c) indirect and retrospective building up of AUC expenses through knowledge and records of the AUC part of project activities.

This synthetic approach would probably require the assigning of a research assistant specifically to this task for two to three months, plus the willing cooperation of project leadership. At present, Dr. Gadallah is yet to be convinced of the usefulness of such an exercise. He is particularly concerned that effectiveness measures that would be used inevitably for cost/effectiveness calculations would not reflect the real impact of the project over the long run (e.g., the ripple effect of development, health and family planning education and services in changing attitudes and future behavior not measured by the immediate contraceptive acceptance rates). In any case, whether convinced or not, he would be unwilling to embark on additional studies such as this or any other (e.g., additional output or outcome measures in Phase II villages) without the commitment of additional funds to cover the expenses of these additional evaluation components.

Later aspects of the project, in particular the creation and expansion of ISS activities are amenable to cost efficiency analysis. Costs of items supplied and summary costs of program elements, for each village and for the governorate as a whole can be calculated. These can be examined in relation to the number of village participants and to effects on improvements in social services and community functioning.

Evaluation of Existing Health Services

As part of the project, a detailed descriptive study of existing health services in Menoufia is being carried out by Dr. El-Nomroussey and a research assistant, Mr. Zakaria Ghoneim. The study is concentrating on the counties (districts) of the Phase I and III areas and nine selected villages in each of these areas (three with health and social welfare facilities, three with health facilities only and three with neither). Six of these villages in each area are the same as the SDS villages. Data were collected in the Phase I area starting in May 1979 and were completed in the Fall of 1979. Thereafter, data collection was started in the Phase III area and is just now being finished. The findings are currently being analyzed and will be written up in a report type format by the end of this year. The major categories of information collected include:

1. An inventory of all district level health services and facilities including hospitals, public health units, specialized dispensaries,

rural services, etc. Maps, population, number of beds, types of services, prevalence of major endemic diseases and other background material has been collected.

2. Village profiles of the 18 study villages include information on communications, transport, roads, health services and facilities, other service organizations, population served, environmental conditions, etc.
3. Village health unit/center data is made up of descriptive statistics of recorded activities and services, staffing, physical plant, equipment, supplies, etc.
4. Health unit/center personnel data include background, training, supervision, perceived responsibilities, and opinions from interviews. An important part of the interview includes judgements about the adequacy of the type and amount of equipment, medicine and supplies provided through the project. Information about the individuals' future plans is also collected.
5. Extensive information on the private health sector in the area has also been collected. In Phase I villages, seven private practitioners and one pharmacy were identified, while about nine practitioners and two pharmacies were found in the nine Phase III villages. These are above and beyond the government physicians who also consult privately outside the health units. Interestingly the other private practitioners usually chose the villages with government units for their clinics, often as many as two such practitioners locating their practices there. On an average these practitioners stated they made 3-5 home visits per day at LE 2 per visit and had 30-50 clinic patients per day, charging about LE 1 per visit. (Thus making more in one day than government physicians receive in one month).

6. Finally information was collected from each of the social welfare organizations present in the study villages concerning any health activities they engaged in. (This is separate from the more detailed and systematic study of the overall function of these organizations carried on as another part of the project evaluation).

Miscellaneous Items

1. While in the field we were able to abstract some data from the field logs derived from the canvassing forms of the first nine villages covered by the contraceptive distribution program. In these villages 7116 women were interviewed. (The total number of eligible women under 45 was not abstracted in the logs we were able to use, but this will be done when the forms are tabulated more completely at the project headquarters. A rough estimate using the proportions found in the Phase I area would be about 5080). The total new contraceptive acceptors and those currently using and accepting re-supplies numbered 1195 in these villages. Of these, 287 or 24 percent were given foam tablets, while the remainder were provided oral contraceptives. These figures provide the basis for estimating about 22 percent ($\frac{1100}{5080} \times 100$) of women either currently using or accepting contraceptives at the time of the canvass. (Subtracting about 8 percent for current users and acceptors over 45 years of age from 1195 total). A similar figure from Phase I villages at the time of their canvass was about 26 percent.
2. We also found that the plan to strengthen inputs in terms of re-training and improving relationships with the health units serving as re-supply sources for the nine (six for S-D survey) study villages in the Phase I area was not carried out. Apparently a decision was finally made to

not treat these villages any differently than the rest of the area, but concentrate efforts in the Phase II villages to improve the project-health system interactions.

3. Met with Ann Way (Chicago trained demographer out of Bogue's shop) who is discussing the possibility of sub-national CPS in Egypt. Westinghouse had an AID contract to conduct these studies. Research design usually calls for 2 or 3 surveys over a 5 to 7 year period in a country requesting the service. Discussions in Egypt are with Family Planning Board and USAID-Cairo. Possibility of including one of the governorates scheduled for work by AUC is under discussion as is participation by Dr. Gadallah in planning for the PDP project run by the Family Planning Board (FPB) with UNFPA and other external supports.

During the week of March 20, Dr. J. M. Stycos was a consultant to UNFPA FPB to recommend an evaluation scheme for FPB activities. The results of his discussions is a complex research design with an overly optimistic completion date. The proposed schedule calls for a very large sample to be interviewed during October-November, 1980, keypunching and verification December-January, data cleared and on tape, analysis in February and a mini-report by March. The computer facilities at Al Ahram will be used.

The role of Westinghouse in the general survey is not clear but they may turn out to be the major vehicle for undertaking the survey. Other institutions and individuals (including the Battele population group) were previously invited to propose evaluation designs. We will receive a trip report from the current visit from Ann Way.

The question of a more systematic linkage between Westinghouse and JHU was broached. There is a reluctance on the part of Westinghouse for affiliations with other groupings. This is particularly so for ties to universities. In part this may stem from a perception on the part of the Westinghouse group of real or imagined concerns from academics about Westinghouse competence to do prevalence studies.

Future role of JHU

1. Expansion of Menoufia activities to other areas is under discussion. Funding has been arranged from AID for activities in 2 additional governorates. These activities will include participation from AUC/SRC, one or more of the Egyptian national universities and the ministries of health and social affairs as well as the involvement by the affected governorate. It is not clear at present who will have the major role in directing activities in the additional areas. Discussions as to participation by JHU, if any is to occur, must await decisions as to the organization of the program in expansion areas. We presume that AID Washington, may wish some continuing JHU involvement but this is qualitatively different from participation directly with the ongoing program.
2. Substantial quantities of data are available which require analysis. These include the first surveys in control and test villages in the SDS study, further analyses of the data collected from the "38 villages study" in Menoufia, and other data sets including the Oralyte utilization "mini" survey and the evaluation of the ISS program. If Drs. Gadallah and Nosseir are at JHU during the summer of 1980 specific plans are being formulated for pursuing studies from these materials.

Diarrhea Questions (Rewording to be fitted into the current questionnaire.)

1. Within the last two weeks did _____ (use name of child) suffer from diarrhea?
2. Within the last two weeks did _____ have 3 or more watery stools a day at any time?
3. Within the last two weeks did _____ suffer from vomiting or dysentery? If yes to either and child had diarrhea: Was this (were these) at the same time as the diarrhea?

Treatment for Diarrhea (To be asked specifically if the child had diarrhea, watery stools or dysentery.)

1. When _____ (use name of child) had diarrhea, watery stools or dysentery, did you give him/her the mixture made from either of these types of packets? (Show mother actual packets of Oralyte and Rehydrans.)

IF YES: a) How many days after the diarrhea, etc., began did you start giving the mixture? _____

b) How many bottles/packets did you use? _____

c) Where did you get these packets? _____

2. When _____ had diarrhea did you stop feeding the child for more than one day: Breast milk? Yes _____ No _____ DNA _____
Other milk? Yes _____ No _____ DNA _____
Other food? Yes _____ No _____ DNA _____

3. Did you take _____ to the health unit/center, to a private doctor, to a hospital or any other source of care? Did the doctor/practitioner give or prescribe oral rehydration salts (ORS packets), IV fluids, sugar and salt solution, stop feeding advice, medicines or other treatment?

Given or Prescribed:

a. Taken to:

Health unit/
Center doctor

Private
doctor

Hospital

Other
(Specify)

None

b.

ORS	IV	SUGAR & SALT	STOP FEEDING	MEDS.	OTHER (specify)	NONE
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						

28