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CHILD SURVIVAL PROJECT
HEALTH INFORMATION SYSTEM
ADVENTIST DEVELOPMENT AND RELIEF AGENCY
MALAWI

A Report Prepared By PRITECH Consultants:
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ABBREVIATIONS

1. ADRA: Adventist Development and Relief Agency
2. CCCD: Combatting Childhood Communicable Diseases Program
3. CDC: Center for Disease Control
4. CHW: Community Health Worker
5. CS: Child Survival
6. FVA/PVC: Foreign Voluntary Assistance/Private Voluntary
Cooperation Office of US AID
7. HEALTHCOM: Communication for Child Survival
8. MOH: Ministry of Health
9. ORS: Oral Rehydration Salts Solution
10. ORT: Oral Rehydration Therapy
11. PAHM: Private Hospital Association of Malawi
12. PRITECH: Technologies for Primary Health Care
13. PHC: Primary Health Care
14. SSS: Sugar and Salt Solution
15. UNICEF: United Nations Children Fund
16. US AID: United States Agency for International Development
17. VHW: Volunteer Health Worker
18. WHO: World Health Organization

EXECUTIVE SUMMARY

The Adventist Relief and Development Agency (ADRA) received a Child Survival grant from US AID in October, 1985 to enhance and expand ADRA's efforts to decrease morbidity and mortality of young children in Malawi. The grant will provide increased resources of personnel, equipment and supplies, and training to expand Child Survival activities which serve a population within a 5 mile radius catchment area of 12 Clinics/Maternal Health Centers. These services are located in rural areas of the Northern and Southern Regions of the country in which an estimated 102,000 people live.

Through PRITECH, a consultant team was recruited by US AID/Washington in response to a request for technical assistance from ADRA/Washington to (a) devise an information system which could provide essential information for project monitoring and for project management; and (b) to assist in the design and conduct of the baseline survey.

During the 27 day consultation, in close collaboration with ADRA/Malawi and ADRA/Washington staff, a comprehensive, functional information collections system was devised.

Since a baseline survey had already begun in all the clinic areas prior to the arrival of the consultant team, major emphasis was placed upon (a) obtaining the optimum benefit from the survey underway; (b) devising a baseline survey instrument designed to provide the foundation for periodic surveys and data collection throughout and beyond the grant period; (c) revising the forms used to collect information monthly from clinics and communities; and (d) instructing appropriate ADRA staff in methods of collecting, tabulating, presenting and using the information.

Upon the request of ADRA/Washington and ADRA/Malawi, observations and recommendations were made about other components of the project. This was considered quite practical since an information system should relate to all major components of any such project.

Outputs of the consultancy include : (a) detailed forms for the collection of baseline and periodic surveys and for the ongoing collection of data related to project activities and impact; (b) key ADRA staff learned new skills in information management; (c) revisions of project timetable (d) strategies and plans for reaching more remote, underserved segments of the catchment area; (e) a foundation for enhanced collaboration with health institutions in Malawi; and (f) refinement of procedures for the management and supervision of the project staff.

As a result of intense discussion and the enthusiastic efforts of the Project Director, ~~deliberation~~ many of the recommendations which emerged from the consultancy were acted upon by the Project Director before the team departed. Therefore significant changes in information collection were promptly incorporated into the ongoing project.

Close collaboration with ADRA/Washington staff before, during and after the field visit enhanced considerably the efficiency and impact of the consultancy.

The value of targeted technical assistance, in information management, provided early in a project, was demonstrated and can

be considered by US AID in other similar Child Survival projects involving PVOs.

TERMS OF REFERENCE

"To assist the Adventist and Development Relief Agency Project Staff in Malawi in conducting a baseline survey. Consultants will design a reporting system including forms and schedules and guide the initial phase of the baseline survey, integrated with project design, and plans for on-going monitoring of child survival interventions in the community"

SCHEDULE OF ACTIVITIES

Twenty-seven days were allocated for this consultancy, including 4 days of orientation and debriefing sessions, and 17 days working in-country with the ADRA/Malawi Project staff. An outline of the Consultants' schedule of activities is as follows:

1. Assignment Orientation and Preparation. Discussions were held with the following organizations and individuals prior to departure:
 - a. US AID FVA/PVC Office. Doris Storms, Hope Sukin, John Grant. Discussions involved US AID orientation, and explanation of the task assignment.
 - b. ADRA. Ken Flemmer, Gordon Buhler, David Syme, Rudolf Maier, Sharon Tobing, Carla Battle. Discussions involved orientation to ADRA information needs and general concerns related to the field situation in Malawi.
 - c. Management Sciences for Health. Henry Elkins. Discussions were held on survey considerations and sampling methods.
 - d. PRITECH. Jane Brown, Danielle Grant. Orientation was received on the logistical considerations of the consultancy.
 - e. General phone contacts were also made to organizations involved in health work in Malawi. The contacts included Howard University, CDC in Atlanta, Georgia, and the HEALTHCOM Project.
2. ADRA/East Africa Region Orientation. A general visit was made to the ADRA/East Africa Regional Office in Harare, Zimbabwe to discuss concerns and expectations related to the Malawi project.
3. On-site orientation to the Malawi/Child Survival Project. The Project Director and his wife, Dr. and Mrs. Anthony and Bernadette Rockwell, explained the status of the Project and accompanied the Consultant Team on site visits to two Project Clinic areas. Observations were made on the general project organization and activities, and the survey work. Preliminary work was begun on information systems and survey design. Arrangements were made for a training session for the Project Regional Supervisors and

headquarters staff.

4. Organizational Assistance/Coordination/Collaboration visits. Visits were made to several organization to investigate the possibility of assistance, coordination and/or collaboration with the ADRA/Malawi Project. Specific insights were sought on survey work and information systems in addition to other areas that might be useful and relevant to the ADRA/Malawi Project.

- a. Malawi Ministry of Health. Dr. Jeff Lungu. Discussions were held relating to MOH policies which were relevant to ADRA and other PVOs in Malawi.
- b. PAHM. Dr. Tony Klouda, Mr. P.S.R. Kantunda. Discussions were held on the role of PAHM with PVOs, and points of past and possible future assistance to the ADRA work.
- c. CCCD. Mr. Reggie Hawkins, Dr. David Heyman. Discussions related to CCCDs work in the area, and possible points of interface with the ADRA project. Comments were also entertained on specific constraints of doing survey work in Malawi and possible alternatives for addressing these difficulties.
- d. UNICEF. Mr. Ramesh Shresta. Discussion were held on UNICEFs efforts in the area, both present and planned. Comments were also elicited on health data and and survey work in Malawi, and possible areas of assistance for PVOs.
- e. HEALTHCOM. Ms. Deborah Herlitzer-Allen. A draft survey instrument was reviewed and suggestions for improvement were elicited. Discussions were made relating to possible points of collaboration between ADRA/Malawi and the HEALTHCOM Project.
- f. US AID/Malawi Mission. A courtesy visit was made to Dr. Charles Guerney to infomally discuss the ADRA/Malawi US AID centrally funded project.

5. Development of information system, survey process, and general management considerations. An information system and survey process was developed based on: the site visits, discussions with other organizations in Malawi, and talks with the Project Director, the ADRA Evaluator, and the two Project Regional Coordinators. Considerable and helpful discussions evolved from a training workshop in which the Consultant Team explained the survey process, the ongoing clinic information system, and areas related to the overall management of the project. Many decisions were made by the Project Director based on these discussions.

6. Debriefing and report write-up. On returning to Washington D.C., the Consultant Team debriefed with US AID and ADRA personnel. After a review of survey materials with PRITECH staff (Dr. Robert Northrup, Dr. Polly Harrison, Dr. Deborah Blum), the report was written.

BACKGROUND

Malawi Health Problems

The major health problems of Malawi and the conditions which influence those problems are similar to those of many developing countries. 80% of the population of approximately 7,000,000 is rural. The GNP/person is between US \$300 and \$400. Political stability since independence has facilitated steady economic growth. A political commitment to preventive as well as curative health services has fostered the growth and development of Primary Health Care. Recent emphasis on Child Survival is consistent with the long term emphasis on the health of children and mothers. The expanding PHC services along with increased access to potable water, growing literacy, fertile land, increased income have all resulted in a decrease in infant mortality and malnutrition.

In spite of all these advances the infant mortality as of several years ago was estimated to range between 140 and 220.

Children under 5 years, especially those in their first year, are considered the most critical segment of the population.

UNICEF reports varying degrees of complete vaccination coverage throughout the country ranging from 30 to 55%. The latter figure is considered high.

Health Systems

Government health services include hospitals, outpatient clinics and maternal health centers located throughout the country in centers of population density. In spite of personnel and financial constraints, health services are mostly free with patients sometimes paying for subsidized medication and hospitalization. Private practitioners and private hospitals are available to those with the ability to pay.

Almost half of the health services are provided by church related health institutions working in close collaboration with and partially supported by the Ministry of Health.

Most outpatient services are provided by medical assistants and nurse midwives working from Clinics and Maternal Health Centers. These health workers are usually quite experienced and have had several years of formal training following their completion of the equivalent of high school.

Major international institutions with program support for PHC and Child Survival activities include UNICEF, WHO, CCCD, Peace Corps, HEALTHCOM and US AID.

Cooperation and collaboration between the MOH and nongovernment health institutions is facilitated by the Private Hospital Association of Malawi (PAHM) which has strong program emphasis on

PHC and community based health services.

The government and international organizations provide all the vaccines, cold chain equipment (and repair), ORS packets and growth charts. Periodic training in Child Survival intervention for various levels of health personnel is provided on a regular basis by several organizations.

A new Malawi based growth chart will be distributed within the next 2 months. Under 5 Clinics are encouraged but not yet developed throughout the country.

The present national ORT program provides standard WHO packets for use in the clinics and hospitals. Sugar and Salt Solution (SSS) is recommended for home use. Expansion of the use of packets beyond the clinics as recommended by WHO is under consideration by the MOH.

PVOs are encouraged by the MOH to devise and test, on a small scale, innovations related to the expansion and refinement of PHC/CS services.

Understandably, the collection of health related information and the statistics which follow from such information are uneven in their accuracy. More accurate and up to date information is anticipated from a census which is scheduled for 1987.

Adventist Health Services

The Adventists have an excellent reputation for providing high quality hospital and clinic services for over 60 years. Spread throughout the rural areas of Northern and Southern regions of Malawi are 13 outpatient clinics. Eight of these clinics have adjacent maternity clinics which provide antepartum and delivery services.

In 1985, the Adventist began a new thrust of promoting and providing primary health care in rural village areas. Funding for a three year child survival grant was received from the FVA/FVC office of US AID. This effort is expected to initiate a long term direction towards community oriented primary health care.

ADRA/Malawi Child Survival Proposal

History

In October 1985, US AID funded an ADRA International 3 year Child Survival project in Malawi. The proposal, written by the then Director of Adventist Medical Clinics, emphasized interventions in immunization, ORT, growth monitoring, and nutrition and home gardening.

As a consequence of personal changes, there was no permanent Project Director until January 1986. At that time, Dr. Anthony Rockwell took up the position of Project Director. Dr. Rockwell has had extensive experience in Adventist medical and community health activities. This is his first US AID supported project.

Initial activities included: the recruitment and training of staff at the headquarters level, and at each clinic, 13 Medical Assistant Field Supervisors and a Community Health Worker (CHW); the organization of health committees and voluntary health workers at the village level. After a brief training period, CHWs began a health survey in early June 1986.

Goals and Objectives

The proposal aims to lower morbidity and mortality among Malawian children in the five mile radius areas surround each of the 13 Adventist clinics. With a total catchment population of 102,000, services will focus on the estimated 21,000 children in the area, who are below five years of age. Specific objectives are outlined in the original logical framework (Appendix 41).

The original overall goal assumed that morbidity and mortality would be reduced among all children in Malawi as a consequence of project activities being replicated on a nation wide basis. At present, the Project Director is reviewing and revising the original goal, objectives and targets outlined in the proposal logical framework, based upon an assessment of the present field situation.

Implementation Strategy

The basic infrastructure for the project is the Adventist rural clinic network. At present, this includes 13 clinics, 6 in the Northern Region and seven in the Southern Region of Malawi. 15 clinics are expected to be in operation by the end of the project. As new clinics become operational, child survival activities will be implemented promptly.

In addition to the normal clinic personnel, the major addition in the child survival strategy is a paid CHW. She serves as the primary interface between the clinic services and the interventions which the child survival proposal promotes. She is selected through a process by which the villages and clinic Medical Assistants choose several candidates for final selection by the Project Director. Criteria include acceptance by the community, basic English literacy, and a desire to serve. While assisting in Under 5 Clinics and conducting the initial baseline survey, her work will be mainly in the villages. Her tasks include health education on both the individual and community levels, identification and monitoring of high risk patients, referral of patients to the clinic, home gardening promotion, and records keeping (See Appendix 32 for specific responsibilities of the CHW).

The CHW is supported in three ways:

- 1) On a day to day basis, the CHW receives support from unpaid Volunteer Health Workers (VHW). The VHWs consist of five to six women selected from the village areas surrounding the clinic. Their selection is based on acceptance by the community, a willingness to serve without pay, and the Medical Assistants' judgment of her ability to perform the job. Basic English literacy

is not a requirement for VHWs. Allowing for the VHWs volunteer nature, the part-time VHW performs a similar role as the CHW, but on a more modest scale. VHWs are supervised by the CHW (See Appendix 34 for VHW responsibilities).

2) On a village organizational basis, the CHW and VHWs both receive support from and provide support to a village health committee. This committee consists of both traditional, formal, and informal leaders who are chosen because of their influence among the communities in the clinic catchment areas. Their key role is to organize and mobilize the communities for health related activities. They also serve as the key village organization in which health concerns and feedback can be channeled between the community and project personnel.

3) The CHW's receive guidance and support from two project superiors: their immediate superior, the Medical Assistant at each clinic; and a regional child survival supervisor, one for the northern clinics and another for the clinics in the south. Supervisors are mature experienced Medical Assistants with familiarity with culture, language and health problems.

The project is coordinated in Blantyre by the Project Director and two staff members, a secretary and bookkeeper. The project director makes periodic visits to all clinics. Clinic and project staff are visited regularly by both the Regional Supervisors and the Project Director.

The implementation strategy adopted by the Project Director during the visit of the Consultant Team and the ADRA Assistant Director of Program Support Services and Evaluation is to implement health activities in villages in two phases. Phase I will concentrate on villages identified within a three mile radius of the clinics. Present child survival activities will be expanded and improved under Phase II. Phase II will provide mobile health services, such as Under 5 Clinics in the three to five mile peripheral area of the defined catchment area. The actual selection of peripheral villages will be based on discussions with the village health committees, logistical considerations, and assessment of need.

Monitoring and Evaluation

Monitoring and evaluation will be both formal and informal. The formal system is based upon information collected through a baseline survey, ongoing clinic records, CHW generated village registers, and records kept and updated at the project headquarters in Blantyre. As information is channeled from the village to the clinic, clinic to headquarters, a reporting system is conceived in which relevant reports will be fed back to personnel at different levels of the project. The formal system also includes a mid-term review and an end of project review.

Informal monitoring and evaluation is planned based upon the ongoing management activities of the project. Thus, the Project Director, Regional Supervisors, Medical Assistants, and CHWs will participate in periodic monitoring and evaluation.

For its part, ADRA/Washington DC sees the role of evaluation

as a participative process in which all parties seek to better understand and improve their role in the project effort. Towards such an end, ADRA/Washington DC senior staff will make a limited number of trips to the Malawi child survival project.

ONGOING DATA COLLECTION AND BASELINE SURVEY

Information Requirements

In the development of a health information system several factors must be considered: requirements of the government; requirements of supporting organizations; information for project management and for periodic evaluation.

Project Requirements

Project needs are identified in the Logical Framework and other management tools which ADRA/Malawi uses. A review of the Logical Framework indicated that some changes occurred since the Project was originally designed several years ago.

ADRA/Malawi will be recommending to ADRA/Washington changes to the Log Frame based on conditions and realities of the present. Appendix 42 indicates changes which were recommended by the Consultant Team. The Project Director plans to recommend a number of changes to ADRA/Washington for consideration and eventual discussion with US AID.

US AID Specifications

US AID specifications have been stated in documents distributed to PVOs. Revisions to these original specifications are in process and apparently will be circulated in the near future. The information system recommended in this report referenced the most current US AID specifications available at the start of the consultancy.

ADRA Specifications

Since the AID specifications are quite comprehensive, ADRA - Washington apparently has determined that AID specifications will also meet ADRA Child Survival reporting requirements. Contingent on issues of ease of collection and usefulness, ADRA is considering other requirements.

The recommendations by the Consultant Team about information items considered practical and possible to collect are noted in several sections of this Report and in the Appendix section.

Information System

Overall Purpose

The purpose of the recommended information system is three-fold: 1) To help the Project better manage its general primary health care work and child survival efforts 2) To lay a baseline for future monitoring and evaluation of child survival efforts and 3) To satisfy information requirements for the child survival grant outlined by US AID.

Information Objectives (Indicators) of the Information System

The information objectives or "indicators" for the child survival information system were derived using the US AID Tier 1, 2, and 3 indicators as a point of departure, and adding, deleting and modifying this list based upon a discussion of the use and relevancy of the US AID indicators and other information objectives to the Project. Those involved in the discussions included the Project Director, the ADRA Assistant Director of Program Support Services and Evaluation, and the Consultant Team.

The indicators were broken down into four subject categories: General Demographic, Diarrhea Control, Immunization, and Growth Monitoring and Breastfeeding. For collection purposes, the indicators were also viewed in terms of their source. These sources are three fold: 1) information determined by the Project Director, 2) information amenable to collection by survey, and 3) information available from the ongoing Clinic system, which includes information collected in the clinic area villages by the community health workers.

A list of the US AID indicators which were accepted are shown in Appendix 1. Appendix 1 shows the indicators according to subject category and source. The entire list of US AID information indicators are not given as it includes a significant amount of information which is not directly relevant to the child survival efforts.

Ongoing Data Collection

Existing Clinic Information System

The Director of each Clinic and Maternal Health Center submits a one page report to the MOH and a one page report to the Director of Adventist Health Services (also Project Director). The information sent to the MOH includes total patients treated, diagnosis by age category: Under 5 Years; Over 5 Years.

Information sent to the Project Director includes: patients treated, immunization, Clinic income, deaths, referrals, inpatient days. Maternal Health Center information includes births, complications, referrals, prenatal visits, inpatient days, health education, community health activities.

All forms, both MOH and ADRA have been used without revision for over 5 years.

At the present time there is minimal periodic feedback of information analysis from either the MOH or ADRA to the Clinics. ADRA supervisory staff does use the monthly reports as guidelines for discussions during supervisory visits to Clinics.

The Project Director visits each Clinic several times a year. During those visits information collection and results are discussed. However other time consuming responsibilities often preclude discussions about Clinic and community activities. These responsibilities are: a detailed review of Clinic financial records, and a detailed inventory of the drug supply.

Revisions to Existing Clinic Information System

The Clinic Directors appear to have the time and required skills to collect information which will be useful for program supervision, for impact measurement and for specific requests from US AID and ADRA for monitoring the Child Survival Project.

Information now recorded about Under 5 Clinics is not adequate to meet the Child Survival Project requirements. Growth cards are given to mothers. No duplicate is retained at the Clinic, There is no organized High Risk information system at the present time. Immunization and cold chain monitoring is incomplete.

Monthly Reports from the Clinics and Maternal Health Centers are the most practical method for the collection of information on an ongoing basis. This method is already in use.

The Medical Assistants in charge of each Clinic and the nurse midwife in charge of Maternal Health Centers appears competent to collect information and complete the monthly report forms.

Because of the requirements for increased information collection from the Clinics and the community, the report forms were extensively revised and instructions added (See Appendices 21 to 31 for the specific report forms).

Essential information from the communities can be collected by the CHW and the VHW. Appropriate forms and instructions were devised which will enable the information collected from the community to be included in the Monthly Reports to the Project Director (See Appendices 32 to 35).

Specific details related to completion of the revised report forms were reviewed with the Supervisor of the Southern Region and with the Project Director.

Recommendations for revised reports are included as separate items in the Appendix. In this way the Project Director can review and modify each recommended revision, thereby facilitating the printing of revised forms.

The Project Director made a number of decisions about changes and additions to the report forms already in use. These changes will be made during the month of August. The Supervisor of the Southern Region has been assigned responsibility to explain the use of the new forms to each Clinic Director.

Clinic information is also required by the MOH to be submitted each month on a separate form. It is not practical at this time to change this necessary reporting procedure. It would be hoped, however, that suggestions could be submitted through PAHM for changes in the MOH report forms based on experience in the ADRA Clinics during the next year.

Monthly Reporting and Feedback

The results of the Monthly Report from each Clinic can be combined by ADRA staff to produce a comprehensive Report of all Clinics and Maternal Health Center each month.

Appendix 36 suggests practical ways to use the information from each clinic and the cumulative data from all Clinics as a management tool. Prompt feedback of relevant information to each Clinic from the Project Management Team within 3 weeks to submit-

sion of the Monthly Report can reinforce to the Clinic personnel the perceived importance of the information as well as provide a useful guide for the progress of ongoing Clinic activities and Project impact.

A major review and evaluation of Project progress is recommended at the mid point of the Project. (Appendix 39)

Constraints of the System

Major constraints of the system for ongoing data collection include:

- time involved in collecting data and completing forms
- ability of staff to collect information with accuracy and consistency
- awareness of personnel of the importance and use of the information for the benefit of the Project and for the communities involved
- motivation of personnel to spend the necessary time and concentration to complete the work as requested
- skill in tabulation and presentation of the Project wide reports by the bookkeeper.

All these issues were discussed at length with the Director and appropriate Project staff. It is recommended that these constraints be reviewed by the Project Director upon his return in September and by ADRA/Washington staff during their periodic visits to Malawi.

Information Collected through Survey

The survey portion of the information system should be initiated in two phases. Phase I of the survey reflects the Project's strategy which focuses on villages within a 3 mile radius of the Project Clinics during the early portions of the Project. Phase II reflects the strategy of selectively extending services to villages in the peripheral 3 to 5 mile radius area of the Project. Details on the Phase I and Phase II survey are given below.

Phase I Survey

Modifications

The Phase I survey was one week in progress when the Consultant Team arrived. After reviewing the questionnaire and observing the administration of the questionnaire by one of the interviewers, the Consultant Team noted some deficiencies in the survey and recommended changes to the questionnaire and survey procedure. Since the survey was already underway in 12 clinic areas the Project Director decided to continue with the original

survey questions, and to modify procedures relating to asking the questions. This decision was based on the feeling that changes to the questionnaire and survey procedure would be unduly confusing to the interviewers.

Purpose of Survey

The purpose of the survey was not explicitly defined by the Project. A child survival oriented questionnaire was received from ADRA/Washington with the explanation that it had been used in several countries and a request that a survey be started promptly.

Information Objectives of the Survey

The information which the Phase I questionnaire seeks to gather have been categorized according to four general subjects: General Demographic, Immunization, Diarrhea Control and ORT, and Growth Monitoring and Breastfeeding. The following sections list: (a) the information objectives of the questionnaire and (b) the information requested by US AID which are not on the questionnaire.

General Demographic

1. Number and % of 0-5 children, by age.
2. Number and % of 0-5 deaths, by age.
3. Cause of death (family assessment).
4. Diarrhea related deaths.
5. Infant mortality rate (calculated).
6. 1-5 mortality rate (calculated).
7. Diarrhea associated 0-5 mortality rate (calculated).
8. Number and % of stillborn and livebirths.
9. Number and % of 0-5 children having "Health Cards" (Growth monitoring and immunization).

Immunization

10. Number and % of 0-5 children immunized with DPT 1,2,3, Polio 1,2,3, BCG, Measles vaccines.
11. Number and % of children completely immunized.
12. Number of women aged 15-45 receiving at least one tetanus toxoid shot.

Diarrhea Control and ORT

13. Number and % of children having diarrhea in past 2 weeks (mother/guardians recall).
14. Number and % of children having diarrhea in past 2 weeks who received either: Oral Rehydration Salts, Sugar and Salt Solution, home fluids, other remedies, or nothing.
15. Frequency liquid offered to child during the diarrhea compared to when the child is well.
16. Frequency food offered to child during the diarrhea

compared to when the child is well.

Growth Monitoring and Breastfeeding

17. Number and % of 0-5 children weighed in last 6 months.
18. Number and % of 0-5 children who have been categorized according to nutritional status as "nourished" or "undernourished" (based upon growth card, if available, or interviewers visual judgement).
19. Number and % of 0-5 children who have ever breastfed.
20. Length that 0-5 children were breastfed.

Child survival indicators requested by US AID for a Tier Two PVO not included on the Phase I survey include:

Immunization

1. Number and % of 0-1, 1-2 children immunized with DPT 1,2,3, Polio 1,2,3, BCG, Measles vaccines.
2. Number of women aged 15-45 receiving two tetanus toxoid shots.
3. Number and % of mother/guardians with knowledge about immunization this year.

Diarrhea Control and ORT

4. Number of mother/guardians with knowledge about ORT at this time.
5. Number and % of mother/guardians who have ever used oral rehydration therapy.

Growth Monitoring and Breastfeeding

6. Number and % of 0-1, 1-5 children weighed in last 3 months.
7. Number and % of 0-5 children malnourished in Project area.
8. Number and % of 0-5 children breastfeeding and eating solid foods at 6 months age.

Phase I Questionnaire

Modifications

Apparently, the questionnaire used in the Phase I survey was developed by staff of the ADRA/Washington DC office (See Appendix 3). This questionnaire was administered by the field Project without translation into the local language, or a pretest for appropriateness, clarity, and possible bias.

Within the constraint that the questionnaire itself not be changed, the Project Director approved the consultants recommendation that: 1) the questionnaire be translated into the language in which it was being administered, and 2) a set of clarifying instructions be written and translated for questions that the Project Director, Supervisors, and Consultant Team jointly felt were ambiguous.

Sample Method

The original plan was to do a census of all households in the defined 5 mile Project radius area for each of the 12 clinics. This would involve an estimated 10,000 households. After reassessing time and resource constraints, the Project Director accepted the strategy of focusing on all households within a 3 mile radius of each Clinic. Phase II would concentrate on villages in the peripheral areas of the 5 mile Project radius. Government maps would be used in this process to identify Phase I survey sites

Questionnaire Administration

The questionnaire is being administered by 12 community health workers, one from each clinic site. The CHW's were trained on the survey during one day of a one week child survival training seminar. Since the first language of the CHW's is not English, and the questionnaire was not translated from English to the local languages, the training involved considerable efforts by the Project Director to help the CHW's understand the meaning of each item on the questionnaire. The training was participative and included questionnaire role-playing.

The survey is being performed under the auspices of Regional Supervisors in the north and south of Malawi. Pragmatically, because of the considerable distances between the Regional Supervisors and the Clinic areas in which the CHW's are administering the questionnaires, the Medical Assistants overseeing each Clinic are in the best position to play the survey supervisory role for the clinic CHW's.

A degree of uncertainty remains with the consultants as to the degree that the CHW's are properly administering the questionnaire and the extent that adequate supervision is occurring to facilitate reasonably valid and reliable data. For example, in a field visit, it was observed that the interviewer did not correctly follow the instruction to interview mothers individually--she was doing interviews in groups--nor did she completely understand the procedure in which she was to record information.

Tabulation

A tabulation form was designed by the Consultant Team and a tabulation process outlined and discussed with the staff person selected by the Project Director to be the Project Information Coordinator. In summary, the interviewers will be tabulating each days work. At the end of the week, they will submit the tabulated questionnaires to the Clinic Medical Assistants. The Medical Assistants will take the interviewers' tabulation forms and make a summary tabulations for the overall Clinic area. On a weekly basis, the Medical Assistants will submit the overall Clinic tabulation to the Information Coordinator. At the end of each month and at the end of the phase I survey, the Information Coordinator will prepare a tabulation of each Clinic, the Northern and Southern Regions, and the overall Project. The

Tabulation Form and Tabulation Instructions found in Appendix 5 and 6, respectively.

Reporting of Information

The information gathered in this survey will be used to prepare two kinds of reports. The first kind of report describes the survey results. In Appendix 9, a report form is shown which summarizes the information. Since the information is tabulated by hand, the report consists of single frequency distributions of the survey data. The information has been organized in a manner that facilitates managerial analysis and decision making. The information needed to complete the report will only be available after the tabulation is complete and the subsequent calculations in Appendices 7 and 8 are finished.

The second kind of report concerns the periodic reports required by ADRA to satisfy US AID reporting requirements. These report forms and the process in which they are to be completed and filed will be determined by ADRA/Washington DC. Relative to required survey information, the information asked by ADRA/Washington DC should be similar to the survey information listed in Appendix 2 (Accepted US AID Information Indicators Suitable to Baseline Survey).

The Phase I survey will gather some, but not most of the information specified in Appendix 2. The Phase II survey will gather all of the information specified in Appendix 2. It should be noted that the Phase I and Phase II surveys may give different answers for similar information indicators. This is understandable since differences exist in the groups surveyed, the timing of the surveys, and the manner in which the data is collected. A reporting concern arises in regard to US AID information requests. ADRA/Washington will need to decide which figures are to be reported when differences are found for the same indicators. One solution is to report both figures, and to indicate the source of each figure.

Limitations of the Survey Information

One of the important caveats that must be observed in analyzing the results of the survey, are the limitations of the information. Since a census was done of the villages surveyed, the Project Director does not need to be concerned that a non-representative sample was taken of the survey areas. To the extent that the questionnaires were administered in a manner suitable to collecting valid information, all the information can be used in the management decision-making process.

The Consultant Team is concerned, however, that some of the information may not have been collected in a proper fashion. Weaknesses were observed in the survey process on the questions related to growth monitoring, tetanus immunization of women, immunization coverage for children, and child deaths. When the results of the Phase I survey are available for review, the Project Director should weigh the affect of survey problems (ie. interviewers not understanding the meaning of a question, or improperly recording certain questions), and use his best judge-

ment in deciding which data can be reasonably used for Project management.

Phase II Survey

Design

The following outline is the recommendation by the Consultant Team for the Phase II survey in the peripheral areas of the Project area. In reviewing this outline and the related documents and procedures, ADRA and the Project Director may find it appropriate to make modifications. The Phase II survey covers the baseline survey information requirements of both US AID (Tier Two PVO) and ADRA.

This outline was written taking in consideration the many useful discussions with ADRA, the Project Director and his Supervisor team, PRITECH, US AID, and related inputs from the following organizations in Malawi: PAHM, CCCD, UNICEF and the HEALTHCOM Project.

Due consideration was also given to the very limited time, money, and human resources of the Project. A key concern was to design a survey process that would provide optimal benefit while being as easy to administrate as was reasonably possible.

Purpose of the Survey

The Phase II Survey seeks information specifically related to the child survival activities specified in the ADRA/Malawi Child Survival Proposal. For the most part, these activities involve immunization, diarrhea control and oral rehydration, and growth monitoring. Within the context of these activities, the purpose of the Phase II survey is three fold:

- 1) To facilitate and enhance Project management through highlighting potential areas of concern which require educational priority, or suggest the need for further investigation and action.
- 2) To set a baseline for a limited set of child survival indicators from which progress can be monitored and evaluated, and subsequent managerial decisions made.
- 3) To satisfy US AID, ADRA, and Project specified information needs which are amenable to collection by survey.

Information Objectives (Indicators) of the Survey

The information objectives of the survey have been categorized into four subject areas. These include: General Demographic, Diarrhea Control and Oral Rehydration Therapy, Immunization, and Growth Monitoring and Breastfeeding.

The information objectives include all items specified in Appendix 2 (Accepted US AID Information Indicators Suitable to Baseline Survey). Information objectives which either include or are required US AID indicators for a Tier Two PVO are designated

with an asterisk (*).

General Demographic

1. Age breakdown of population by number and % (Below 1, 1-2, 2-3, 3-4, 4-5, 5-15, Women 15-45, Men 15-45, Over 45)
2. Number and % of deaths, 0-1, 1-2, 2-3, 0-5 (one year recall)
3. Diarrhea associated deaths 0-1, 1-5 (one year recall)
4. Infant mortality rate (calculated)
5. 1-5 mortality rate (calculated)
6. Diarrhea associated death rate 0-1, 1-5 (calculated)
7. Number of live births
8. Birth rate (calculated)
- 9.* Number and % of 0-5 children having "Health Cards" (Growth monitoring and immunization).

Diarrhea Control and Oral Rehydration Therapy

- 10.* Number of mother/guardians with knowledge about ORT at this time ("knowledge" signified by the following:):
 - a. Awareness of sugar and salt solution for diarrhea.
 - b. Knowledge of how to properly mix the sugar and salt solution (using Ministry of Health guidelines).

(Note: Current Malawi MOH policy does not allow women to mix ORS packages themselves. This is done by a pharmacist or clinician. Recipients may never see a ORS packet when receiving a container of ORS solution)

11. Extent (frequency)to which mother/guardians feed or withhold food from their children if diarrhea was present during a 14 day recall period.
12. Extent (frequency) to which mother/guardians give or withhold liquid to their children if diarrhea was present during a 14 day recall period.
13. Extent (amount)to which mother/guardians feed or withhold food from their children during the days immediately after a recent diarrhea (14 day recall period).
14. Categorization of non-ORT diarrhea-specific treatments offered by mother/guardians to their children during a recent diarrhea case (14 day recall). Summary categories are: Homemade/traditional, Traditional-purchased, Modern-purchased, and Other.

(It is recommended that the Regional Supervisors and the Medical Assistants analyze the individual items within these categories in terms of being Harmful, Neutral, or Beneficial).

15. Breakdown of mothers who did or did not seek help outside of the home during a recent diarrhea (14 day recall).
16. Breakdown of number and percent of mothers whose outside-of-

home-help source for a recent diarrhea included visiting a traditional healer, clinic/hospital, pharmacy/store, or an "other" source (14 day recall).

17. Breakdown of the combination of sources visited by mothers seeking help outside the home into the following categories: traditional healer-only, clinic/hospital-only, pharmacy/store-only, "other"-only, 2 sources visited, 3 or more sources visited.
18. Breakdown of children who had diarrhea in last 14 days by age categories (month): 1-12, 13-24, 25-36, 37-60 and 1-60.
19. Number and % of mothers who breastfeed their children when diarrhea is present.
- 20.* Number and % of children who were offered ORT during a recent diarrhea (ORT defined as receiving ORS, SSS, or a Home liquid remedy during a 14 day recall period).
21. Breakdown of the type of ORT received by children during a recent diarrhea (ORS, SSS, or a Home liquid remedy during a 14 day recall period).
- 22.* Number and % of children who have ever been offered ORT (defined as oral rehydration salts or sugar and salt solution offered to the children anytime during their lifetimes, as recalled by mother).

Immunization

- 23.* Number and % of mother/guardians aware of immunization as a means for protecting their children from disease.
- 24.* Number and % of children immunized with DPT 1,2,3, Polio 1,2,3, BCG, Measles vaccine, and completely immunized broken down by age (0-1, 1-2, 0-5).
25. Of children having "Health cards", number and % (to total children surveyed) which are either fully immunized, partially immunized and on schedule, or partially immunized and considered a "drop-out."
26. Of children not having a "Health card", number and % (to total children surveyed) claimed to have ever/never received an immunization.
27. Number and % of mothers having or not having a "Maternal Health card."
- 28.* Number and % of mother/guardians having none, one, or two tetanus toxoid shots (based on Maternal Health card or mothers' claim).

Growth Monitoring and Breastfeeding

- 29.* Age at which mothers completely stopped breastfeeding their most recently weaned child (by month categories: 1-3, 4-6, 7-12, 13-18, 19-24, +24 months.
30. Age at which the most recently weaned child began eating and drinking something in addition to breastmilk (by month categories: 1-3, 4-6, +6 months.
- 31.* Number and % of children breastfeeding and eating solid foods at 6 months age.
- 32.* Nutritional status of children having a "Health card" broken down by age (Using Malawi Ministry of Health designation of "Normal" and "Under nutrition", broken down by ages 0-1, 1-2, 2-3, 3-5.
- 33.* Of children age 0-1, 1-5, number and % whose weight went up, down, or stayed the same since last weighing by ages 0-1, 1-2, 2-3, 3-5.
- 34.* Of children age 0-1, 1-5, number and % who were weighed within the past 3 months.

Phase II Questionnaire

Design

A questionnaire satisfying the Phase II objectives is given in Appendix 10. After initial drafts of the questionnaire were reviewed and discussed with the Project Director and his Medical Assistants, revisions to the questionnaire were made based on input and review from personnel from the HEALTHCOM Project/Malawi and PRITECH/Washington DC. The questionnaire was assessed for content, clarity, and question order and wording bias. Due consideration was made in the formatting of the questionnaire to the fact that the tabulation would be done by hand.

It cannot be overemphasized that the questionnaire should be translated and pretested before it is generally administered out in the Project areas. Guidelines for the translation and pre-test are given in Appendix 17.

It is suggested that the English version of the questionnaire be used as the recording form for the questionnaire. Each interviewer would use the translated and pretested version of the questionnaire as the document from which they would read questions to those being interviewed.

Sample Method

The Project does not have the time or resources to do a complete census of the peripheral areas of each Clinic (the 3-5 mile range of each Clinic's 5 mile radius containment area). The Project Director has also expressed his desire that the time required to conduct the survey not last more than six weeks, using the interviewers that are available (probably one at each

Clinic).

The time limitation on the survey has some ramifications on the interpretation of the information which is to be gathered. Specifically, the limitation probably means that each Clinic interviewer will only have time to complete approximately 120 questionnaires during the allocated period. The limited sample at each of the Clinics means that less confidence can be attributed to the results of certain survey information objectives, particularly, data related to mortality. To clarify the affect of sample size on interpretation of the data, it is recommended that the statistician with CCCD in Lolongwe be consulted. It is possible that the aggregate results for morbidity at the 13 Clinics will be statistical significant, even though that is not likely to be the case at the individual Clinics (Estimated that information will be gathered on 3,100 children below age five). The statistician will be able to provide insight into the statistical worthiness of other variables as well. In general, the non-mortality variables are less sensitive to sample size. Assuming the information is collected in a reasonable manner, all the information should serve as a significant management tool. A more detailed discussion of the sampling limitation is found in Appendix 18.

Two methods of obtaining a representative sample of the target population are offered for consideration. Each method has its advantages and disadvantages. The Director may choose one or the other approach or a combination of each.

The first method is one version of what is called a "cluster sample". The method is described in greater detail in Appendix 18. In this situation, the method involves randomly selecting two to three villages from each of the defined peripheral areas of the Project Clinics (13 Clinics at present). Government maps would be used in the identification and selection of villages. In addition to aiding in the survey planning, the maps would also be used for supervisory purposes (See Appendix 40 for discussion on use of maps). A census would be done of all the households in the selected village (estimated 30-75 households per village area). The objective would be to interview at least 120 households (with children below age five) per Clinic area. This would require that each Clinic survey two to three villages in its area. Assuming that each Clinic only had one interviewer available, and she was able to do 6 interviews per day, the data collection would be done in approximately one month.

The major advantage of this method are (1) it is easier to do than the other method (discussed later) and (2) it provides a representative picture of what is happening to the overall Project.

The major disadvantage of this method is that it does not give the Project a clear idea of what is happening in each Clinic area. Since only two villages are chosen per Clinic, and there may be 20-60 villages in the peripheral areas, we do not know if the villages are a good representation of each Clinic's Project area.

The second method is called a "two-stage cluster sample." It is described in greater detail in Appendix 18. In this situation, the method involves interviewing approximately 120 households per Clinic area. The actual interviews would be spread between 10 to

26 villages in the peripheral areas of each of the Clinics. At each of the villages, an equal number of households (with children below age 5) would be interviewed. Both the villages and the households would be selected through a random process. Assuming that only one interviewer was available per Clinic, and each interviewer was able to do 6 households per day, the process would take about one month to complete.

The advantages of this method are that it provides a picture of what is happening in both the overall Project and within the separate Clinic areas in which the method is used. This information can be used in deciding which villages or areas should take selection priority during Phase II. It also provides information that each Clinic can more confidently feel is representative of the situation in the peripheral Clinic areas.

The major disadvantage of this approach is that it requires more effort and discipline. More villages must be visited than in the other approach (even though a similar amount of households are contacted in both approaches). In each selected village, the interviewers must interview households which have been randomly selected.

The Consultant Team recommends that a two-stage cluster sample method be followed. The information obtained would be considerably more useful for Project management at the Clinic level. Regardless of what method is chosen, it is highly recommended that the person coordinating the survey consult with personnel from CCCD in Lilongwe. Although Appendix 18 outlines general methodologies for a cluster sample and a two stage cluster sample, CCCD's advice will be of invaluable help since they have significant expertise and experience in sampling considerations specific to Malawi.

Questionnaire Administration and Training

The questions should be asked by the same Community Health Workers (CHWs) who have done the Phase I survey. In some instances, voluntary health workers selected for demonstrated competence might also serve as interviewers. Proper arrangements should be made by the Project Director to assure that the Regional Supervisors, Medical Assistants, and CHW-interviewers clearly understand: the purpose of the questionnaire, the individual items on the questionnaire, how to approach households and perform the questionnaire, which households are to be involved (depending on the sampling method chosen), and lastly what to do with the questionnaires after completing them (e.g. tabulation and reporting procedures).

This information could be taught to the interviewers and their superiors during a two to three day work shop. The questionnaire should be translated and pretested ahead of the training period. The first day of the work shop should focus on developing general understanding, and skill in using the questionnaire in the classroom setting.

In teaching understanding, the goal should be to develop the interviewers to the point where they can explain the general purpose of each question, and the reasons for adhering to interviewing procedures and the selection of particular villages and

households (sampling considerations). The interviewers should be presented the translated questionnaire, the English version of the questionnaire (to be used for recording), and the questionnaire instructions and clarifications. These materials should be reviewed and discussed thoroughly.

In teaching skills, the goal should be to ensure that each interviewer demonstrates the competence to properly complete the questionnaire. A suggested method for teaching competence is to have each interviewer role-play the interviewer once, and the village mother once among themselves. After completing this exercise, the Instructor would review the questionnaires, and discuss problem areas seen in the practice sessions and on the questionnaires.

The interviewers should then be exposed to the tabulation forms and instructions. The process should be reviewed and the interviewers should practice tabulating the questionnaire forms which they have completed. These forms should be reviewed by the Instructor and problem areas noted and discussed.

The second day would involve going out into a village area and testing both the interviewers and the survey in the field. After the village practice, problem areas would be discussed and appropriate clarifications made. The discussion may show that revisions to the questionnaire are necessary. Revisions should be made promptly.

In a third day, additional sessions might be spent with the Project Director, Medical Supervisors, Regional Supervisors, and the Information Coordinator. The objective would be to see that they understand their respective role in supervision, tabulation, report preparation and analysis, and kinds of action that might be pursued from the results. If possible, these sessions should be done prior to the interviewer training. They will then be in a better position to assist the interviewers as needs arise during the training workshop.

The Project Director should seriously consider doing one workshop in the Northern Region and another in the Southern Region. Ideally, the interviewers should be learning and practicing with a local translation of the questionnaire, and in a setting which is similar to the cultural environment in which they will actually do the survey.

Supervision should be given to the interviewers during the survey by the Regional Supervisors and the Medical Assistants at each Clinic. The objective of the supervision is assist the interviewers in doing their job properly, and to correct problems as soon as they arise. The Supervisors will be expected to ensure that the interviewers are: 1) going to all the households that have been assigned to them and 2) completing the questionnaire in the established manner. Specifics of supervision might involve the following:

- 1) Personal supervision during the first day(s). The Regional Supervisor or Medical Assistant should accompany each interviewer during their first day. He should continue with the interviewer until assured that the survey will be conducted properly. After the interviewers have received their initial training, this may seem unnecessary, but it is likely the interviewers will have

several things which they do not properly understand, and this will only become apparent when they go out into the village.

2) Review of the completed questionnaires with the interviewer at the the end of the day. Problems such as the interviewer not going to the right households or taking information from the wrong person will probably not be detectable by just looking at questionnaires, however, many problems will be evident.

The Medical Assistant need only take a few of the questionnaires for review. He should look for problem areas such as incomplete questions, or answers which indicate the interviewer does not understand the questions, or questionnaires which look like the interviewer may be just filling the answers in without really asking the questions, or other problem areas. The Medical Assistant will probably want to review questionnaires every day for the first week. Then, depending on the perceived ability of the interviewer, he may decide to review questionnaires less frequently.

3. Random visits to a few of the households to determine if the interviewer actually did the survey, and to check if questions were properly asked. This step is important to do as experience has shown that sometimes interviewers do not visit households or accurately record information. Once every other week, the Medical Assistant might take 5% of the questionnaires, and revisit the households. He would ask if a surveyor came by on the date indicated on the questionnaire. Only a few of the questions need to be re-asked. The reason given for the re-visit could be that some of the answers were not written clearly and that a re-visit was made to clarify the answer.

The interviewers should be told that the purpose of supervision is to help them to do their job better, not to find mistakes. Corrections should be communicated as supportively as is possible.

Training assistance for the survey might come from one or more sources. In addition to soliciting help from ADRA/Washington D.C., the Project Director should consider enrolling the help of the following agencies: PAHM (Mr. P.S.R. Kantunda), HEALTHCOM (Ms. Deborah Herlitzer-Allen), CCCD (Mr. Reggie Hawkins), and Howard University (experience in family planning surveys). These organizations have offices located adjacent to Ministry of Health in Lolongwe. Each organization has experience doing survey work in Malawi.

Tabulation

A form has been designed and a process outlined for the tabulation of Phase II (See Appendices 12 and 13). The tabulation process will be similar to Phase I with a slight variation. During Phase I, the interviewers are not asked to tabulate the questionnaires for each village separately. At present, the questionnaires for the Phase I survey are not being kept apart by village and it would be an unrealistic hardship to separate them at this point.

During Phase II, the same tabulation procedure outlined in

Phase I should generally apply, however both the interviewers and the Medical Assistants should tabulate each village's questionnaires separately. In summary, then, the interviewers will tabulate each days work, doing separate tabulations for each village visited. At the end of the week, she will submit her questionnaires and tabulations to her Medical Assistant. He will gather the tabulations and make summary tabulations for each village and for the Clinic area as a whole. Twice a month, the Medical Assistant will submit the weekly summaries of the Clinic survey to the Information Coordinator. The Medical Assistant will keep the village summaries at the Clinic. At the end of the survey, the Medical Assistant will also submit several special summary reports to the Information Coordinator. At the end of the month, the survey collection period should be complete. At such a time, the Information Coordinator will prepare tabulations for each Clinic, the North and Southern Regions, and the overall Project.

Reporting of Information

The reporting considerations discussed for the Phase I survey are the same for Phase II. Two kinds of reports will be generated from the Phase II survey. The first kind of report will summarize the survey results. Appendix 16 shows tables on which the survey results can be summarized. The information necessary to complete the tables will be available after the tabulations in Appendix 13 are complete and the subsequent calculations in Appendices 14 and 15 are finished.

The information is organized in a manner to facilitate managerial assessment and decision making. In reviewing the reports, the Project Director will inevitably find that some of the information clearly suggests the need for action while other informations indicates the need for further investigations before action is taken. Before making any decisions, the Project Director should thoroughly discuss the results with his Supervisors, and other individuals both within and outside the Project. The discussions should focus on what the results indicate needs to be done--in terms of action or further investigations--and which alternatives seem the most reasonable to pursue.

The second kind of report involves the periodic information which must be submitted to ADRA for completion of the US AID information requirements. This was discussed in detail in the "Report" section of Phase I.

Limitations of the Survey Information

Interpretive limitations on certain variables, such as mortality, have already been suggested. The Project Director should confirm with a health statistician the limits the sample size places on interpreting the various kinds of information which is collected on the survey. In these discussions, it should be clearly communicated that the purpose of the survey is not to meet rigorous research criteria, but to provide useful information to assist the Project. The objective of such consultations should be to glean suggestions of how the sample design might be improved, and to get a sense of the general confidence

the Project can place in the survey results, based on the sampling considerations alone.

The Project Director should also take note of problems that occur during the survey that potentially affect the validity of the data. In interpreting the results, and in considering how the data will be used, the Project Director should thoughtfully weigh all factors which limit the validity of the data.

MAJOR COMMENTS AND RECOMMENDATIONS

General Comments

From observations of the Project after it has completed its first 6 months of activity a number of strengths are apparent:

1. Adventist health programs in Malawi are well established, well respected by the Ministry of Health and by key non-governmental organizations.
2. As a consequence of government encouragement and support for church related health activities, the Adventist Health Services are expanding their present network of 12 Clinics/Maternal Health Centers to 13 by the end of 1986, with plans to expand by three in the next few years. (Since the the government funds the construction of these clinics, it can be assumed that the MOH is well satisfied with the work of the Adventist Health Services and would like it to continue).
3. Commitment is strong to sustain a priority emphasis on community oriented Child Survival efforts as an integral component of Primary Health Care in Adventist health services in Malawi after project funding ends.
4. The long history of established and respected Adventist health services can provide the essential foundation for community oriented health services.
5. All Project personnel are hired and apparently functioning satisfactorily.
6. Staff of the Adventist Health Programs -- both expatriate and national --are dedicated, highly motivated and share a commitment to institutionalization of project activities.
7. Project staff is open to change and accepts the key opportunity to incorporate and monitor innovations which could be useful on a country wide scale.
8. The support staff of ADRA - Washington which is responsible for evaluation, program management and technical assistance appears to be competent.
9. A positive, collaborative working relationship exists between ADRA/Malawi and the organization that coordinates NGO activities for the Ministry of Health. AID/Malawi has demonstrated active, ongoing interest and provides valuable advice and guidance about the world of AID.
10. A key strategic commitment has been made by the Project staff to extend and support community oriented health services that directly relate to Child Survival in presently underserved areas. This activity is scheduled to begin in early 1987 as Phase II,

with surveys and the eventual establishment of mobile Under 5 Clinics.

General Recommendations

The Consultant Team was encouraged by both the Project Director and the ADRA/Washington Evaluator to expand their observations and recommendations beyond the area of information systems to include other aspects of the project. The comments below are made in no particular priority order.

1. Project Duration.

Extend the Project for 1 year to Sept 1989.

2. Modify Logical Framework.

Review the Log Framework of the Project based upon experience and realities to date. Make commitment about decisions within the next several months so that final decisions would be made by Oct 1986.

3. Logical Framework Indicators.

Incorporate indicators for the Log Framework into the information system of the project.

4 Mid-Term Review

Include a Mid-Term Review in Sept-Dec 1987 to assess experience, review information collected to date and consider appropriate modifications in strategy and activities to optimize the impact of the project.

5. Project Phasing

Implement the Project in two phases. Phase I would continue present efforts of surveying and expanding present health activities in areas closest to each Clinic. Phase II would extend this effort into selected high density population centers in remote places within the 5 mile catchment area.

6. Develop High Risk Approach

Follow the guidelines of PAHM (NGO coordinating body) for introduction of the High Risk component of the Project; collect and use information as recommended by PAHM. Consider a Workshop on the High Risk Approach before the end of the year in preparation for the introduction of this activity.

7. Enhance Under 5 Clinics

Use the increased personnel assistance provided by the Community Health Worker and Volunteer Health Worker to expand the services, upgrade the activities and ensure accurate col-

lection of useful information in Under 5 Clinics and Maternal Health Clinics.

8. Information and Project Management

Establish and institutionalize a practical method of review of monthly Clinic data by the Project Management Team (Project Director, Supervisors, bookkeeper and secretary) and provide prompt feedback of information and comments to the Clinic directors

9. Institutional Collaboration

Continue to increase contact and collaboration in Malawi with national and international organizations which share common interest in promotion of PHC and Child Survival

10. Collaboration with HEALTHCOM

Consider the possibility of collaborating with HEALTHCOM in health education activities. During the discussions ensure clear expectations and commitments required by each organization before making decisions related to collaboration.

11. Remote Services

Continue the strategy of Phase II - expansion of child survival services to remote population concentrations within the catchment areas of the Clinics thru the establishment of mobile Under 5 Clinics

12. Project Innovations

Consider introducing and assessing project modifications such as: distribution of ORS packets in communities thru the collaboration of Community Health Committees and thru the assistance of Community Health Workers and Volunteer Health Workers. (The distribution of packets beyond the Clinic is not now a MOH policy); increase to 2 the number of CHWs at 3-4 of the more active Clinics

13. Transportation Requirements

Continue efforts to acquire transportation for CHWs, Supervisors and Project Director. Review the practicality of bicycles for the transportation of VHWs.

14. Use of Maps

Use maps at each clinic to facilitate program planning, data collection and monitoring. See Appendix 40.

15. Continuing Education

Encourage and facilitate continuing education for senior

staff Supervisors and the Project Director in child survival interventions, management and evaluation

16. Community Health Committee Priority

Place priority on establishing, monitoring and collaborating with Community Health Committees. Request involvement of PAHM (specifically Mr P.S.R. Kantunda) in devising a strategy and plan of action designed to increase knowledge and skills of all project staff in working with Community Health Committees and VHWs.

17. Community Health Committees and Community Development

Consider using the Community Health Committees as a basis for organizing development activities beyond the health sector. Work with them to understand both the overall needs of the project communities, and the specific role that the project staff can serve in meeting their defined priorities and agenda. Encourage and facilitate collaboration with key individuals representing government organizations and agencies, political partys, and non government groups.

18. Site Visits

Encourage and facilitate site visits by appropriate staff to projects within and beyond Malawi to learn from the experience of others having similar goals and objectives especially in Under 5 Clinics, community involvement, documentation and information systems, and project management. Consider exchange visits between project staff to enable both groups to share experience and insights from the implementation of their respective projects.

19. Project Description

Prepare and circulate a 2 page description of the ADRA-Malawi Child Survival Project to provide information and to enhance communication within the country.

Send periodic progress updates to key government and non government groups.

20. Develop Job Descriptions and Responsibilities

Develop job descriptions and responsibilities for CHW, VHW. Realistically assess the quantity of work which can be done. Limit activities to those areas which are most important and which can be effectively accomplished in the time available. Clearly define working and supervisory relationships for these various categories of health workers.

21. Periodic Review of Job Descriptions and Responsibilities

Devise a schedule and a process to review periodically and revise the work responsibilities and time availability in light of changing priorities and program emphasis.

22. Communication with Other Institutions

Make special plans, far in advance, to appraise selected officials of MOH, international agencies, of activities and accomplishments of the Project, especially as related to the Mid-Term Review.

23. Importance of Malaria

Recognize malaria as one of the most serious causes of morbidity and mortality in young children. Develop and implement a special program in collaboration with PAHM and CCCD designed to decrease infant mortality of children from malaria.

24. Additional Laboratory Test

To improve the assessment and treatment of malaria, obtain and field test appropriate equipment to determine levels of hemoglobin concentration in malaria patients. Use this test also for prenatal screening and malnutrition assessment.

25. Support for Volunteers

Develop a mechanism in which ongoing project support for the volunteer members of the health activity (VHW, Community Health Committee) will be periodically and continually demonstrated. This includes supervision, visits, education.

26. Knowledge and Competencies of Health Workers

A useful exercise for the next quarter could be the determination by the Project Management Team of the specific knowledge and competencies in child survival interventions for all levels of health workers.

27. Clarification of Terms

In order to collect consistent information over time and to be able to compare data from various projects, clarification of the terms noted in the Tabulation instructions should be obtained from AID. The clarification could then be sent to ADRA/Malawi and included in appropriate documents.

28. Definitions and Sources of Information

An extremely useful document to facilitate understanding of data requests of AID and the methods of calculating rates and ratios can be obtained in the Working Paper, Reporting System for AIDs Child Survival Action Program, Sept 1985. This paper has been distributed to all PVOs with Child Survival grants.

29. Information Collection Responsibility

Delegate responsibility and authority for information collection, tabulation, and reporting to the Project Bookkeeper. Communicate to the Project staff that the Project Bookkeeper is the Information Coordinator for the Project.

30. Reinforcement of Health Education and Training

The wife of the Project Director is a competent nurse with many years of experience in developing countries. Because of her special skills and strong interest in Health Education and Training, her creative involvement in project activities in a structured way should be considered.

Survey Related Recommendations

Specific recommendations related to survey considerations are as follows:

1. Phase I Survey Plan

Continue the plan to: (a) collect baseline survey information closest to the established Clinics (b) identify on a map those areas and villages included in the initial survey (c) complete the present Phase I Survey when appropriate in the month of August. (d) Complete the tabulation of the Survey prior to the return of the Project Director from furlough in Sept 1986.

2. Revised Survey for Phase II

Develop survey instruments based on experience of the first survey and considering the recommendations of the Consultants, to acquire baseline information prior to the initiation of mobile Under 5 Clinics in Phase II of the Project.

3. Consultation with Health Statistician for Phase II Survey

The Consultant Team has described and recommended a Two-Stage Cluster Sample design. Consult with the CCCD Statistician in Lolongwe for advice on ways to improve the recommended approach after clearly explaining the nature of the survey and the resource constraints of the Project.

Obtain practical insight on the validity and usefulness of the data to be collected given the sampling size and methodology which is proposed.

4. Ensure Survey Methodology Includes:

Translation and pretest of questionnaire.

Proper supervision for the interviewers on interviewing

proficiency, recording and tabulation ability, and adherence to random sampling requirements.

5. Organize a 2 to 3 Day Training Seminar for the Phase II Survey

To ensure that the Phase II Survey results are as accurate and useful to the project as possible, it will be important to train all involved Project staff on their respective roles and responsibilities.

The training seminar should be practical and competency based. Assistance in organizing the workshop should be solicited from ADRA/Washington and PAHM. Inputs into the training procedure should be solicited from UNICEF, CCCD, and HEALTHCOM.

6. Discussion Groups to Review Survey Results

The results of the Phase I and Phase II Surveys will raise many issues and questions that require more detailed information, investigation and action. Discuss these issues with appropriate personnel within and beyond the project to determine practical responses to the issues raised.

7. End of Project Survey

Perform a survey near the end of the project which will compare changes in information indicators between the baseline surveys and the end of the project. Use the information as part of the final evaluation.

Appendix

US AID Information Indicators
Accepted For ADRA/Malawi Child Survival Project

This appendix lists the child survival reporting information requested by US AID adjusted to the needs and constraints of ADRA and the project. The list was generated after the information requests were collectively reviewed by the Project Director, the ADRA Assistant Director for Program Support and Evaluation, and the Consultant Team.

The indicators are organized under four headings: General, Diarrhea Control and ORT, Immunization, and Growth Monitoring and Breastfeeding. Within these headings the indicators are numbered and labeled as to their source. Indicator numbers ending in:

- "a" , mean that the primary source is the Project Director.
- "c" , mean the primary source is the clinic information system, which includes the ongoing clinic reports and the reports generataed aby the Community Health Worker and Voluntary Health Worker.
- "s" , mean the primary source is community surveys

Indicators ending in combinations of "a, c, or s" mean that the information is collected from more than one source.

The columns to the right demarcate each indicator into one of four program measurement categories as defined by US AID: AID Input (In), Output (Out), Effectiveness (Eff), and Impact (Imp).

Indicators with an asterisk (*) mean that the underlined word(s) need to be clearly defined by the Project Director. Information to assist in the definitions can be obtained from US AID, although necessarily the local situation will dictate the best definition.

In designing the reports which the Project Director is to send into ADRA/Washington, the Assistant Director of Program Support and Evaluation should at least include the items in this appendix. He may wish to organize the report in a similar outline as this appendix. This will simplify the Project Directors task.

In submitting the information to US AID, the information could be reformated so that they are presented according to the four categories of program measurement for each of the respective subject areas.

1.00	General	In	Out	Eff	Imp
1.01a	Total number of health workers in project..	---	_x_	---	---
1.02sc	Mortality rate among children below 1 year and >1 year to 5 years.....	---	---	---	_x_

		In	Out	Eff	Imp
1.03sc	No. and % of children who died during the past year for the following ages				
	0 to 1 year.....	---	---	---	_x_
	>1 to 2 years.....	---	---	---	_x_
	>2 to 3 years.....	---	---	---	_x_
	>3 to 5 years.....	---	---	---	_x_
	0 to 5 years.....	---	---	---	_x_
2.00	Diarrhea Control and ORT				
2.01a	Life of project funds budgeted for ORT....	_x_	---	---	---
2.02a	Estimated expenditure on ORT this year....	_x_	---	---	---
2.03a	Total number of project funded ORS packets to be produced or procured during the life of the project.....	_x_	---	---	---
2.04a	Total number of project funded packets produced or procured this year.....	_x_	---	---	---
2.05a	Cost per packet to the project.....	_x_	---	---	---
2.06a	Price per packet to the consumer.....	_x_	---	---	---
2.07a	Total health workers to be <u>trained</u> in ORT during the life of the project*.....	---	_x_	---	---
2.08a	Total number of distribution points and service units with ORS on hand this year...	---	---	_x_	---
2.09a	Total number of distribution points and service units to be <u>covered</u> in the life of the project*.....	---	---	_x_	---
2.10a	No and % of healthworkers who can <u>demonstrate adequate ORT knowledge</u> and skills at this time*.....	---	---	_x_	---
2.11ac	Estimated number of children 0-5 years <u>covered</u> by ORT this year*.....	---	---	_x_	---
2.12c	Total number of ORS packets distributed to users this year.....	---	_x_	---	---
2.13c	Total number of project children 0-5 years who were seen at clinic and transferred to hospitals for diarrhea associated severe dehydration during the past year.....	---	---	---	_x_
2.14sc	Number of mother/guardians given <u>information</u> on ORT this year.....	---	_x_	---	---

		In	Out	Eff	Imp
2.15sc	Total number and % of children in the 0-5 year age group who have ever used ORT.....	___	___	<u>x</u>	___
2.16sc	No. and % of deaths associated with diarrhea in below 1 year old and >1 year to 5 year old children in the project area.....	___	___	___	<u>x</u>
2.17s	Total number and % of mother/guardians with <u>knowledge</u> about ORT at this time*.....	___	___	<u>x</u>	___
2.18s	In most recent survey, what was the total number and % of 0-5 year old children with diarrhea in the last 2 weeks who were given ORT.....	___	___	<u>x</u>	___
3.00	Immunization				
3.01a	Life of project funds budgeted for immunizations.....			<u>x</u>	___
3.02a	Estimated expenditure on immunizations this year.....			<u>x</u>	___
3.03a	Total number of project funded vaccine doses to be imported or locally procured during the life of the project....			<u>x</u>	___
3.04a	Total number of project funded vaccine doses prcurred or imported this year.....			<u>x</u>	___
3.05a.	Total number of service units with vaccines on hand during the life of the project.....			<u>x</u>	___
3.06a	Number of service units with vaccines on hand at this time.....			<u>x</u>	___
3.07a	Total number of health workers to be <u>trained</u> to promote and educate on immunization this year*.....			<u>x</u>	___
3.08a	Total numbear of health workers to be <u>trained</u> to promote and educate about immunization during the life of the project.....			<u>x</u>	___
3.09a	Total number of mothers/guardians to be given <u>information</u> about immunization during the life of the project*.....			<u>x</u>	___
3.10ac	Number of children 0-5 years old <u>covered</u> by immunization this year*.....			<u>x</u>	___

3.11ac	Number and % of scheduled immunization sessions actually held.....	In	Out	Eff	Imp
		---	..x	---	---
3.12c	Total number of mother/guardians given <u>information</u> about immunization this year*....	---	..x	---	---
3.13c	Number of service units with <u>effective</u> cold chain at this time*.....	---	..x	---	---
3.14c	Doses of vaccine administered this year: DPT, Polio, Measles, Tetanus Toxoid, Other.....	---	---	..x	---
3.15c	Total number of immunizable diseases reported in the clinics last year for 0-5 year old children for:				
	Polio:_____ (Cases).....	---	---	---	..x
	Measles:_____ (Cases).....	---	---	---	..x
	Neonatal Tetanus:_____ (Cases).....	---	---	---	..x
3.16sc	Number and % of all children and mother/guardians in the project area who have received immunizations				
	DPT 1 0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	DPT 3 0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	Polio 1 0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	Polio 3 0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	Measles 0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	BCG 0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	Children who have completed all immunizations				
	0-1 year.....	---	---	..x	---
	>1 to 2 years.....	---	---	..x	---
	0 to 5 years.....	---	---	..x	---
	No. and % of mother/guardians who have received two doses of tetanus toxoid.....	---	---	..x	---

		In	Out	Eff	Imp
3.17s	No. and % children 0-5 years of age with immunization cards at home.....	---	---	_x_	---
3.19s	Total number and % of mother/guardians with knowledge about immunization this year.....	---	---	_x_	---
3.20c	Total number of cases of immunizable diseases reported in the project area for 0-5 year old children.....	---	---	---	_x_
4.00	Growth Monitoring and Breastfeeding				
4.01a	Life of project funds budgeted for nutrition.....	_x_	---	---	---
4.02a	Estimated expenditure on nutrition this year.....	_x_	---	---	---
4.03a	Total number of project funded growth monitoring supplies procured or locally produced this year. Specifically:				
	Growth charts.....	_x_	---	---	---
	Weighing scales.....	_x_	---	---	---
4.04a	Total number of project funded growth monitoring supplies procured or locally produced during the life of the project. Specifically,				
	Growth charts.....	_x_	---	---	---
	Weighing scales.....	_x_	---	---	---
4.05a	No. health workers <u>trained</u> to teach proper nutrition practices (e.g. weaning, breastfeeding, Vitamin A, iron deficiencies, PEM) this year*.....				
		---	_x_	---	---
4.06a	No. health workers <u>trained</u> to teach proper nutrition practices (e.g. weaning, breastfeeding, Vitamin A, iron deficiencies, PEM) during the life of the project*.....				
		---	_x_	---	---
4.07a	Total number of service units to be <u>covered</u> with regular growth monitoring the life of the project*.....				
		---	_x_	---	---
4.08a	Total number of service units to be <u>covered</u> with regular growth monitoring this year*.....				
		---	_x_	---	---
4.09a	Total number of service units to be <u>covered</u> with regular growth monitoring during the life of the project*.....				
		---	_x_	---	---

		In	Out	Eff	Imp
4.10a	Total number of mothers/guardians to be given <u>information</u> about feeding practices and growth monitoring this year*.....			x	
4.11a	No. and % health workers <u>demonstrating</u> growth monitoring and nutrition counseling skills (on a yearly basis or a period determined by Project Director).....				x
4.12ac	Estimated number of children 0-5 years old <u>covered</u> by this intervention this year*.....			x	
4.13c	Total number of service units with regular growth monitoring services at this time.....			x	
4.14c	Total number of service units with regular growth monitoring services during the life of the project.....			x	
4.15c	Total number of project mother/guardians given <u>information</u> about feeding practices and growth monitoring this year*.....			x	
4.16c	Percent of the project children identified as high risk that received <u>follow up</u> after the last weighing.....				x
4.17sc	No. and % of 0 to 5 year old children having growth cards.....				x
4.18sc	No. and % of 0 to 1, 1 to 5 year old children who were weighed during the past 3 months.....				x
4.19sc	No. and % of children 0 to 5 years old nourished malnourished in the project area.....				x
4.20sc	No. and % of children 0 to 5 years old whose weight has increased, remained the same, decreased at last weighing..... (NOTE 4.20sc IS NOT A REQUIRED US AID INDICATOR)				x
4.21a	No. and % of children still breastfeeding at:				
	6 months.....				x
	12 months.....				x
4.22s	No. and % children eating and drinking something in addition to breastmilk at 6 months age.....				x

Accepted US AID Information Indicators
Suitable to Baseline Survey

This appendix lists the accepted US AID information indicators which are suitable to collection by surveying. These indicators are those designated with an "s" in Appendix 1 (US AID Information Indicators Accepted for ADRA/Malawi Child Survival Project).

For reference purposes, two sets of numbers are listed next to each information indicator. On the left side are US AID indicator reference numbers. These numbers match the Appendix 1 numbers used to identify the US AID indicators amenable to surveying. On the right side are calculation reference numbers. These numbers match the numbers in Appendices 7 and 14 (Calculations for Phase I and II, respectively, for US AID Information Indicators On Survey) wherein an instruction is given on how to find or calculate the information indicator from the information on the tabulation forms.

US Aid Indicator Reference No. (Appendix 1)	Calculation Reference No. (Appendices 7, 14)
1.02sc Mortality rate among children below 1 year and >1 year to 5 years.....	1
1.03sc No. and % of children who died during the past year for the following ages	
0 to 1 year.....	2
>1 to 2 years.....	3
>2 to 3 years.....	4
>3 to 5 years.....	5
0 to 5 years.....	6
 Diarrhea Control and ORT	
2.14sc Number of mother/guardians given information on ORT this year.....	7
2.15sc Total number and % of children in the 0-5 year age group who have ever used ORT.....	8
2.16sc No. and % of deaths associated with diarrhea in below 1 year old and >1 year to 5 year old children in the project area.....	9
2.17s Total number and % of mother/guardians with knowledge about ORT at this time.....	10
2.18s In most recent survey, what was the total number and % of 0-5 year old children with diarrhea in the last 2 weeks who were given ORT.....	11

3.16sc	Number and % of all children and mother/guardians in the project area who have received immunizations	
DPT 1	0-1 year.....	12
	>1 to 2 years.....	13
	0 to 5 years.....	14
DPT 3	0-1 year.....	15
	>1 to 2 years.....	16
	0 to 5 years.....	17
Polio 1	0-1 year.....	18
	>1 to 2 years.....	19
	0 to 5 years.....	20
Polio 3	0-1 year.....	21
	>1 to 2 years.....	22
	0 to 5 years.....	23
Measles	0-1 year.....	24
	>1 to 2 years.....	25
	0 to 5 years.....	26
BCG	0-1 year.....	27
	>1 to 2 years.....	28
	0 to 5 years.....	29
	Children who have completed all immunizations	
	0-1 year.....	30
	>1 to 2 years.....	31
	0 to 5 years.....	32
	No. and % of mother/guardians who have received two doses of tetanus toxoid.....	33
3.17s	No. and % children 0-5 years of age with immunization cards at home.....	34
3.19s	Total number and % of mother/guardians with knowledge about immunization this year.....	35
Growth Monitoring and Breastfeeding		
4.17sc	No. and % of 0 to 5 year old children having growth cards.....	36
4.18sc	No. and % of 0 to 1, 1 to 5 year old children who were weighed during the past 3 months.....	37
4.19sc	No. and % of children 0 to 5 years old malnourished in the project area.....	38
4.20sc	(Omitted from survey list. Item was mistakenly categorized as a US AID required indicator).	39

4.21s	No. and % of children still breastfeeding at:	
	6 months.....	40
	12 months.....	41
4.22s	No. and % children eating and drinking something else in addition to breastmilk at 6 months age.....	42

Questionnaire--Phase I

BASELINE SURVEY

For each death that occurs, answer questions 6-9. If there were none, skip to 10.

Name: _____ Person interviewed _____
 Cluster: _____ No. of persons in household _____
 If household _____ No. of married women _____

1. Are there any children <5 years old living in this household now or in the past two weeks?
 (If "No" mother is unsure of child's age, ask for names of children who have not had any teeth yet)
 Yes _____ No _____ If yes, how many? _____

2. Give the ages of all children in this household.
 If no many of these children have been included in the list, _____
 b. If no many have been categorized according to nutritional status? _____

3. Have any babies been born to women in the household in the past year?
 Yes _____ No _____ If yes, how many were live? _____ stillborn? _____

4. Be sure that live births are included in 1 or 3.
 Of children under five in this household, how many are or have been breastfed? _____

5. How long were these breast fed?
 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
 6. How many children <5 years old in this household died in the past year?
 (Use a significant local event to define one year period)
 Yes _____ No _____ If yes, how many? _____

7. State the year of death of the children in No. 6
 Child 1 _____ Child 2 _____ Child 3 _____

8. During the week before death did the child have: (check if yes)

- Diarrhea? _____
- Dysentery? _____
- Fever? (Use local terms) _____
- Cough? _____
- Let up? _____
- Rash? _____

9. Family's opinion of physical cause of death (specify): _____

10. Interviewer's decision on whether death should be considered "diarrheal-associated" death (check if yes):
 (NOTE: if child had diarrhea in week before death, and there is no other obvious cause, and there is no other cause considered "diarrheal-associated")
 Yes _____ No _____ If yes, how many? _____

11. Have any children <5 years old in this household had diarrhea that began in the past two weeks? (Use the standard local definition, or ask if any children had 3 or more loose, watery, or bloody stools in a 24 hour period)
 Yes _____ No _____ If yes, how many? _____

12. If the answer to 9 is "No", skip to 13. If answer to 9 is "Yes", ask no. 10 below.

Death 1 _____ Death 2 _____

Questionnaire--Phase I

For each child who had diarrhea answer the following questions:

What treatment did the child receive?

Check appropriate box

	Case 1	Case 2	Case 3
a. No treatment			
b. Home remedies (eg. soup, tea, rice water, fruitjuice)			
c. Specially prepared salt and sugar solution			
d. complete Oral Rehydration salts (ORS) solution			
e. Others			

11. For each child age 0-5 record the information on immunization received.

Child	DPT1	DPT2	DPT3	Polio1	Polio2	Polio3	BCG	Measles	Booster
1									
2									
3									
4									
5									

12. How many have immunization cards in hand?

Yes _____ NO _____

13. How many women 15-45 in this household have been immunized for tetanus?

Yes _____ NO _____

REMARKS:

.....

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.....

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.....

.....

12. Write the number of children having cards in the "yes" space and the number not having cards in the "no" space.

13. For each woman, aged 15 to 45, in the household, ask:

"Did you ever attend an antenatal clinic?" (If answer is "no", stop. If answer is "yes", ask:)

"Did you get an injection?" (Write the number of women getting an injection in the "yes" space. Write the number of women who did not ever get an injection at an antenatal clinic in the "no" space).

PHASE I TABULATION SUMMARY FORM

CLINIC Area _____
 Village _____
 TABULATOR NAME _____
 DATE TABULATED _____

6. Week prior to death, did child have:

	Death 1	Death 2	Death 3
(a) Diarrhea	# _____	_____	_____
(b) Dysentery	# _____	_____	_____
(c) Fever	# _____	_____	_____
(d) Cough	# _____	_____	_____
(e) Tetanus	# _____	_____	_____
(f) Rash	# _____	_____	_____

1. Are there children below five living in this household?
 # Yes _____ # No _____
 How Many? _____
 Years: 0-1 1-2 2-3 3-4 4-5

2. Ages of below five children: # _____ # _____ # _____ # _____ # _____

3. # Weighed in last 6 months. _____

4. # of Normal (N); Undernourished Children: # N _____ # U _____
 (U)

5. Any babies born in past year?
 # Yes _____ # No _____
 # live _____ # Stillborn _____

6. # of Children below five who are or have been breastfed: _____
 Below 6 months 6-12 months Above 12 months

7. Length of breast feeding: # _____ # _____ # _____

8. Any children below five died in the household in past year? # Yes _____ # No _____
 How Many? _____

9. Age of Children who died: 0-1 1-2 2-3 3-4 4-5
 # _____ # _____ # _____ # _____ # _____

7. Families Opinions of Death Cause # a _____ # b _____ # c _____ # d _____
 # e _____ # f _____ # Other _____

8. Interviewer's opinion if death Diarrhea Associated: # 1 _____ # 2 _____ # 3 _____

9. Any children below five had diarrhea that began during the past 2 weeks? # Yes _____ # No _____
 How Many? # _____

Phase I Tabulation Form

PHASE I TABULATION SUMMARY FORM

PAGE 2

10. Treatments Children given during diarrhea.

	Case 1	Case 2	Case 3
a. No Treatment			
b. Home liquid Remedy	... Revised ↑		
	→		
	↓		
	Unrevised		
c. Sugar and Salt Solution			
d. Oral Rehydration Salts			
e. Other	... Revised ↑		
	→		
	↓		
	Unrevised		

11. Immunization Status of Children

Child	DPT1	DPT2	DPT3	Polio 1	Polio 2	Polio 3	BCC	MEASLES	COMPLETE
1									
2									
3									
4									
5									

12. How many have immunization cards at hand?

Yes _____ # No _____

13. How many women 15-45 have received immunization for tetanus

Yes _____ # No _____

Instructions For Using Tabulation Summary Form:
Phase I Survey

I. Identification Information

- A. Clinic Area: List the name of the local Adventist clinic.
- B. Village: Leave Blank.
- C. Tabulator: Put name of the person doing the tabulation.
- D. Date Tabulated: List date tabulated.

II. Tabulation Form Numbers

The Tabulation Form (TF) appears very similar to the Questionnaire Form (QF). The numbers on both the QF and the TF are the same. Basically, this tabulation involves adding all the responses on the individual QFs and noting the totals on the TF. Specific instructions are given below for each question.

Tabulation Form
Number

1. Add "Yes" answers on questionnaires and put total on the TF. Do the same for "No" and "How many (children?)."
2. Count all the children aged 0 to 1 on the QF and put this total on the space titled "0-1" on the TF. Do the same for children, 1-2, 2-3, 3-4, 4-5, and 5-12.
 - a. Count the number of kids weighed from the QF and put this total on the proper space on the TF.
 - b. Count the number of children indicated as "normal" (N) and put this total on the proper space on the TF. Do the same for "undernourished" (U) and "no card" (NC).

In examining each questionnaire, if the total number of children for "undernourished", "normal", and "no card" do not add up to the "total children in family", then it is improperly recorded. Add the number of improperly recorded QFs and note the total on the proper space on the TF.

3. Count number of "yes" answers on questionnaire and put on proper TF space. Do the same for "no", "live", and "stillborn."
 - a. Count total breastfed from the QFs and put this number on the proper TF space.
 - b. From the QF count the number of children breastfed less than 6 months and put this total under the TF space titled "Below 6 months". Next, count the number of children breastfed between 6 and 12 months and put this total under the TF space titled "6-12 months". Lastly, count the number of children breastfed above 12 months and put this total on the TF space titled

"Above 12 months."

4. Count the "no" answers on the QF and put this total on the proper TF space. Do the same for "yes" and "how many" (children died).

5. Count the number of children who died between 0 and 1 from the QFs and put this total under the TF space titled "0-1". Do the same thing for children 1-2, 2-3, 3-4, and 4-5.

6. Count the number of cases of diarrhea under the "death 1" column on all of the QFs and put this total on the proper place on the TF. Do the same for dysentery, fever, cough, tetanus, and rash. Follow the same procedure for "death 2" and "death 3" on the QFs when totaling and transferring the information on to the TF.

7. Six general categories for the "families opinion of the cause of death" are provided, plus an "other" category. The letters: a, b, c, d, e, and f stand for the illnesses shown in question 6. For example, on the TF, "a" stands for diarrhea. If several QFs list diarrhea as the "cause of death", these should be added and the total number noted on the tabulation space labeled "a".

Answers other than a,b,c,d, and e should be totaled and noted on the "other" space on the TF,

8. Count the "yes" answers from all three columns on the QF and note the total on the TF.

9. Count the "yes" answers on the questionnaire and put the total on the tabulation form. Do the same for "no" and "how many" (children had diarrhea).

10. For each box of the table on the QF add the responses and put the total in the appropriate box on the TF.

For 10b and 10e, the tabulation involves special instructions:

Some QFs have "checks" in the spaces for 10b and 10e. Where this is the case, the number of checks should be added and the total number noted in the appropriate box of the row titled "unrevised."

The more recent QFs should have arrows in 10b and 10e. The arrows should be pointing "up, down, or sideways". Where this is the case, add the number of "up" arrows () and note the total in the appropriate box of the row with the arrow pointed up. Do this for all the columns (eg case 1, 2, 3, and total). Follow this procedure for the "down" () and "sideways" () arrows.

11. For this table, total the responses for each box on the QF and put the respective numbers in their appropriate boxes on the TF. For example, add the number of first children (child 1) having a DPT 1 shot on all the QFs and put this total on the TF. This procedure is then followed for all the boxes.

Note: When it is noted that a child has received the required shots on the QF, this child is considered to have a "complete" immunization and a check mark should be put under the column (incorrectly) labeled "booster". The TF column labeled "complete" is equivalent to the column labeled "booster" on the QF. To tabulate children who are completely immunized on the QF, add the number of check marks under the "booster" column for each of the "child" rows and write the respective totals on the proper rows under the "complete" column of the TF.

12. Count the numbers in the "yes" answers on each QF and put the total in the yes space on the TF, Follow the same procedure for the "no" answers.

13. Count the numbers in the "yes" answers on each QF and put the total in the yes space on the TF, Follow the same procedure for the "no" answers.

Calculations For Phase I:
US AID Information Indicators On Survey

This appendix gives instruction on how to calculate the information listed in Appendix 1 (US AID Indicators Accepted for Baseline Survey) which is available from the Phase I Survey. The unbracketed numbers listed in front of each calculation and are reference numbers relating to the numbers in Appendix 1. The bracketed numbers listed within the calculations are references relating to the tabulation numbers in Appendix 5, where the information for each calculation can be found.

Related, but non-US AID information requests, are designated with an asterisk (*).

1a. 0 to 1 year mortality rate:

$$\frac{\text{Number of deaths to children under 1 (4)}}{\text{Number of live births (3)}} = \text{-----}$$

1b. 1 to 5 years mortality rate:

$$\frac{\text{Number of deaths to children 1 to 5 (5)}}{\text{Add up ages 1-2, 2-3, 3-4, 4-5 (2)}} = \text{-----}$$

2. Number of children died, 0 to 1 year (5)..... = -----

3. Number of children died, 1 to 2 years (5)..... = -----

4. Number of children died, 2 to 3 years (5)..... = -----

5. Number of children died, >3 to 5 years (5)..... = -----

6. Number of children died, 0 to 5 years (5)..... = -----

6a. % of 0 to 1 children died to 0 to 5 children died

$$\frac{\text{\# children died 0 to 1 (5)}}{\text{children died 0 to 5 (5)}} = \text{-----}$$

6b. % of 1 to 2 children died to 0 to 5 children died

$$\frac{\text{\# children died 1 to 2 (5)}}{\text{children died 0 to 5 (5)}} = \text{-----}$$

6c. % of 2 to 3 children died to 2 to 3 children died

$$\frac{\text{\# children died 2 to 3 (5)}}{\text{children died 0 to 5 (5)}} = \text{-----}$$

6d. % of 3 to 5 children died to 0 to 5 children died

$$\frac{\text{\# children died 3 to 5 (5)}}{\text{children died 0 to 5 (5)}} = \text{-----}$$

9a.* Number of 0 to 5 diarrheal related deaths:
 Total on (8) = -----

9b.* % of 0 to 5 diarrheal related
 deaths to total 0 to 5 deaths:
$$\frac{\text{Total on (8)}}{\text{"0 to 1" in (39)}} = \text{-----}$$

11a. Number of children with diarrhea
in last 2 weeks given liquid home remedies (10b) = _____

11b. % of children 0-5 with diarrhea
in last 2 weeks given liquid home remedies:

$$\frac{(10b)}{\text{"Yes" in (9)}} = \text{_____}$$

11c. Number of children with diarrhea
in last 2 weeks given ORS:..... (10c) = _____

11d. % of children 0-5 with diarrhea
in last 2 weeks given ORS:

$$\frac{(10c)}{\text{"Yes" in (9)}} = \text{_____}$$

11e. Number of children with diarrhea in last
2 weeks given sugar and salt solution:... (10d) = _____

11f. % of children 0-5 with diarrhea in last
2 weeks given sugar and salt solution:

$$\frac{(10d)}{\text{"Yes" in (9)}} = \text{_____}$$

14a. # of Below 5 children having DPT1 =
Add up "DPT1" in (11) = _____

14b % of Below 5 children having DPT1=

$$\frac{\text{"DPT1" in (11)}}{\text{"How many?" in (1)}} = \text{_____}$$

Follow similar steps for DPT2, DPT3, Polio 1, Polio 2, Polio 3, BCG, Measles vaccine, and Complete immunizations. This accounts for Appendix 2 reference numbers 15 to 32

33e.* Number of women interviewed having
1 tetanus toxoid shots (35b)..... = _____

33f.* % of women interviewed having
1 tetanus toxoid shots = $\frac{\text{"Yes" in (13)}}{\text{"Yes" + "No" in (13)}} = \text{_____}$

34a. Number of 0 to 5 children with immunization
cards at home = "Yes" in (12)..... = _____

34b. % of 0 to 5 children with immunization
cards at home =

$$\frac{\text{"Yes" in (12)}}{\text{"Yes" + "No" in (12)}} = \text{_____}$$

34c.* Number of 0 to 5 children without immunization
cards at home = "No" in (12)..... = _____

- 34d.* % of 0 to 5 children without immunization cards at home =
$$\frac{\text{"No" in (12)}}{\text{"Yes" + "No" in (12)}} = \text{-----}$$
- 36a. Number of 0 to 5 children with growth cards at home = Same as 34a. (Above)..... = -----
- 36b. % of 0 to 5 children with growth cards at home = Same as 34b. (Above)..... = -----
- 36c.* Number of 0 to 5 children not having growth cards at home = Same as 34c*. (Above)..... = -----
- 36d.* % of 0 to 5 children not having growth cards at home = Same as 34d*. (Above)..... = -----
- 37a.* Number of 0 to 5 children who were weighed during the past six months (2a)..... = -----
- 37b.* % of 0 to 5 children who were weighed during the past six months =
$$\frac{\text{(2a)}}{\text{....."How Many" (1)}} = \text{-----}$$
- 37c.* Number of 0 to 5 children who were not weighed during the past 6 months:
 "How Many" (1) minus (2a) = -----
- 37d.* % of 0 to 5 children who were not weighed during the past six months =
$$\frac{\text{"How Many" (1) minus (2a)}}{\text{"How Many" (1)}} = \text{-----}$$

(NOTE ON CALCULATIONS RELATING TO NUTRITIONAL STATUS--38 a,b, c,d--These calculations may be inaccurate, as it was observed that the interviewers misinterpreted this question. The Consulting Team suggests that these results be used with extreme caution for operational or evaluation purposes as they may be highly misleading.)

- 38a. Of children having growth cards, number of 0 to 5 children who are "normal" (MOH standard):
 Add "N" in (2b)..... = -----
- 38b. Of children having growth cards, % of 0 to 5 children who are "normal" (MOH standards) =
$$\frac{\text{Add "N" in (2a)}}{\text{Add total "N" + "U" in (2a)}} = \text{-----}$$
- 38c. Of children having growth cards, number of 0 to 5 children who are "undernourished" (MOH standard):
 Add "U" in (2b) = -----

- 38d. Of children having growth cards, % of 0 to 5 children who are "undernourished" (MOH standards) =

$$\frac{\text{Add "U" in (2a)}}{\text{Add total "N" + "U" in (2a)}} = \text{-----}$$
- 40a. Number of children who were still breastfeeding at 6 months age:
 Add: "6-12 months" + "Above 12 months" (3b) = -----
- 40b. % of children who were still breastfeeding at 6 months age:

$$\frac{\text{Number calculated in 40a above}}{\text{Total of all categories in (3b)}} \dots = \text{-----}$$
- 40c.* Number of children who were breastfed between 0 to 6 months age:
 See "Below 6 months" (3b) ... = -----
- 40d.* % of children who were breastfed between 0 to 6 months age:

$$\frac{\text{Number calculated in 40c* above}}{\text{Total of all categories in (3b)}} \dots = \text{-----}$$
- 40e.* Number of children who were breastfed between 6 to 12 months age:
 See "6-12 months" (3b) ... = -----
- 40f.* % of children who were breastfed between 6 to 12 months age:

$$\frac{\text{Number calculated in 40e* above}}{\text{Total of all categories in (3b)}} \dots = \text{-----}$$
- 40g.* Number of children who were breastfed over 12 months age:
 See "Above 12 months" (3b)... = -----
- 40h.* % of children who were breastfed over 12 months age:

$$\frac{\text{Number calculated in 40g* above}}{\text{Total of all categories in (3b)}} = \text{-----}$$
- 40i.* Number of children who are or have been breastfed (3a)..... = -----
- 40j.* % of children who are or have been breastfed

$$\frac{\text{Number calculated in 40i* above}}{\text{Total for "How many" in (1)}} \dots = \text{-----}$$
- 40k.* Number of children who have not been breastfed "How Many" in (1) minus (3a)..... = -----

401.* % of children who have not been breastfed

$$\frac{\text{Number calculated in 40k* above}}{\text{Total for "How many" in (1)}} \dots\dots\dots = \text{-----}$$

41a. Number of children who were breastfeeding
above 12 months age:....."Above 12 months" (3b) = -----

41b. % of children who were breastfeeding above 12
months age:

$$\frac{\text{Number calculated in 40c above}}{\text{Total of all categories in (3b)}} \dots\dots = \text{-----}$$

Calculations For Phase I Survey:
Non US AID Information Indicators On Survey

This appendix gives instructions on how to calculate the non US AID requested information which is on the survey. The information source for these calculations is the tabulation sheet for the Phase I questionnaire (See Appendix 5). Numbers in parentheses () indicate the tabulation number from which the information can be obtained. Numbers used in the calculations with an asterisk (*) refer to a calculation number in this appendix (usually calculated earlier).

Demographic Information

1. Number of Survey Population, 0 to 12

- a. 0 to 1 (2).....
- b. 1 to 2 (2).....
- c. 2 to 3 (2).....
- d. 3 to 4 (2).....
- e. 4 to 5 (2).....
- f. Under 5 (Add 1a,b,c,d,d* above).....
- g. 5 to 12

2. Percent distribution for 0-5 Survey Population

- a. Of 0-5, % who are 0 to 1..... = $\frac{1a*}{1f*}$ =
- b. % of population 1 to 2..... = $\frac{1b*}{1f*}$ =
- c. % of population 2 to 3..... = $\frac{1c*}{1f*}$ =
- d. % of population 3 to 4..... = $\frac{1d*}{1f*}$ =
- e. % of population 4 to 5..... = $\frac{1e*}{1f*}$ =

3. Family Assessment of Cause of Death by Category

- a. # Assessing Diarrhea... = "Diarrhea" + "Dysentary" (7a + 7b) =
- b. # Assessing Fever..... = "Fever" (7c) =
- c. # Assessing Whooping Cough = "Cough" (7d) =
- d. # Assessing Tetanus.... = "Tetanus" (7f) =
- e. # Assessing Measles.... = "Rash" (7g) =
- f. # Assessing "Other"..... (7h) =
- g. Total Assessments--Add 3a to 3f..... =

h. % Assessing Diarrhea = $\frac{3a*}{3g*}$ =

i. # Assessing Fever = $\frac{3b*}{3g*}$ = _____

j. # Assessing Whooping Cough = $\frac{3c*}{3g*}$ = _____

k. # Assessing Tetanus = $\frac{3d*}{3g*}$ = _____

l. # Assessing Measles = $\frac{3e*}{3g*}$ = _____

m. # Assessing "Other" = $\frac{3f*}{3g*}$ = _____

4a. Number of live births: See "live" in (3) = _____

4b. Number of still births:
See "stillborn (3) = _____

4c. % of live births to still + live births
 $\frac{\text{Number calculated in 4a}}{\text{Numbers calculated for 4a + 4b}}$ = _____

4d. % of still births to still + live births
 $\frac{\text{Number calculated in 4ba}}{\text{Numbers calculated for 4a + 4b}}$ = _____

5. Breakdown of Children 0-5 who either had or did not have a diarrhea during the past two weeks

a. Number having diarrhea in past 2 weeks:
"How many" in (9) = _____

b. Number not having diarrhea in past 2 weeks:
"How many" in (1) minus "How many" in (9) = _____

c. % having diarrhea in past 2 weeks:
 $\frac{\text{Number in 5a}}{\text{Numbers in 5a + 5b}}$ = _____

d. % not having diarrhea in past 2 weeks:
 $\frac{\text{Number in 5b}}{\text{Numbers in 5a + 5b}}$ = _____

6. Extent (frequency) food offered to child during diarrhea versus when the child is well

a. Number offering food less often vs. Well:
See number with "up" arrow in (10e).... = _____

b. Number offering food same vs. Well:
See number with "sideways" arrow in (10e) = _____

- c. Number offering food more often vs. Well:
See number with "down" arrow in (10e) = _____
- d. % offering food "less often" to all categories:
$$\frac{\text{number in 6a above}}{\text{numbers in 6a} + \text{6b} + \text{6c above}} = \text{_____}$$
- e. % offering food "same" to all categories:
$$\frac{\text{number in 6b}}{\text{numbers in 6a} + \text{6b} + \text{6c}} = \text{_____}$$
- d. % offering food "more often" to all categories:
$$\frac{\text{number in 6a}}{\text{numbers in 6a} + \text{6b} + \text{6c}} = \text{_____}$$
7. Extent (frequency) liquid offered to child during diarrhea versus when the child is well
- a. Number offering liquid less often vs. Well:
See number with "up" arrow in (10b)... = _____
- b. Number offering liquid same vs. Well:
See number with "sideways" arrow in (10b) = _____
- c. Number offering liquid more often vs. Well:
See number with "down" arrow in (10b) = _____
- d. % offering liquid "less often" to all categories:
$$\frac{\text{number in 7a above}}{\text{numbers in 7a} + \text{7b} + \text{7c above}} = \text{_____}$$
- e. % offering liquid "same" to all categories:
$$\frac{\text{number in 7b}}{\text{numbers in 7a} + \text{7b} + \text{7c}} = \text{_____}$$
- f. % offering liquid "more often" to all categories:
$$\frac{\text{number in 7c}}{\text{numbers in 7a} + \text{7b} + \text{7c}} = \text{_____}$$
8. Non-Ort Treatments categories remaining on Phase I questionnaire
- a. Number receiving "No treatment":
See total for "No Treatment" in (10a) = _____
- b. Number receiving "Other" (Include totals for "Up, Sideways, and Down" arrows plus the total for "Unrevised" in (10e) = _____
- c. % of children whose mothers claim the children received "No treatment" for the child's diarrhea:
$$\frac{\text{Number in 8a above}}{\text{"How Many" in (1)}} = \text{_____}$$

- d. % of children whose mothers claim the children received an "Other" treatment for the child's diarrhea:

$$\frac{\text{Number in 8b above}}{\text{"How Many" in (1)}} = \text{-----}$$

Phase I Survey Results

Appendix 9

For: _____
 (circle one: clinic/region/project)

I. General					
1. Age Distribution of 0-5 Population		Reference	#		
		Apx 7	Apx 8		
	Number	%			
a. 0 to 1.....	-----	-----			1a,2a
b. 1 to 2.....	-----	-----			1b,2b.
c. 2 to 3.....	-----	-----			1c,2c
d. 3 to 4.....	-----	-----			1d,2d
e. 4 to 5.....	-----	-----			1e,2e
f. Total 0 to 5.....	-----	<u>100 %</u>			1f
2. Deaths, 0-5 (1 yr recall)		Reference	#		
		Apx 7	Apx 8		
	Number	%			
a. 0 to 1.....	-----	-----			2,6a
b. 1 to 2.....	-----	-----			3,6b
c. 2 to 3.....	-----	-----			4,6c
d. 3 to 5.....	-----	-----			5,6d
e. Total 0 to 5.....	-----	<u>100 %</u>			6
3. Diarrhea Associated Deaths for children aged 0 to 5: Number and Diarrhea Death Ratio:.....	-----	-----			9a,b
4. Births (1 year recall).....	Number	%	Reference	#	
			Apx 7	Apx 8	
a. Live births.....	-----	-----			4a,c
b. Still births.....	-----	-----			4b,d
c. Total births.....	-----	<u>100 %</u>			
5. Rates:			Reference	#	
			Apx 7	Apx 8	
a. 0-1 mortality, Deaths/1000 live births	-----	-----			1a
b. 1-5 mortality, Deaths/1000 1 to 5.....	-----	-----			1b
c. Diarrhea associated 0-5 mortality.....	-----	-----			9b
6. Children 0-5 having "Health Cards" (Immunization and Growth Monitoring)			Reference	#	
	Number	%	Apx 7	Apx 8	
a. Have Cards.....	-----	-----			34a,b
b. Do Not Have Cards.....	-----	-----			34c,d
c. Total.....	-----	<u>100 %</u>			
II. Diarrhea Control and ORT					
7. Breakdown of Children 0-5 who either had or did not have a diarrhea during the past two weeks			Reference	#	
	Number	%	Apx 7	Apx 8	
a. Had diarrhea.....	-----	-----			5a,c
b. Did not have diarrhea .	-----	-----			5b,d
c. Total.....	-----	-----			

8. Extent (frequency) food offered to child during diarrhea versus when child is well		Reference	#
	Number	ApX 7	ApX 8
a. Offer less often vs. Well	-----		6a,d
b. Offer same vs. Well.....	-----		6b,e
c. Offer more often vs. Well	-----		6c,f
d. Total.....	-----		
			<u>100 %</u>

9. Extent (frequency) liquid offered to child during diarrhea versus when child is well		Reference	#
	Number	ApX 7	ApX 8
a. Offer less often vs. Well	-----		7a,d
b. Offer same vs. Well.....	-----		7b,e
c. Offered more often vs. Well	-----		7c,f
d. Total.....	-----		
			<u>100 %</u>

10. Treatments received by children having diarrhea		Reference	#
	Number	ApX 7	ApX 8
a. No treatment.....	-----		8a,c
b. Home liquid remedies.....	-----	11a,b	
c. Sugar and salt solution....	-----	11e,f	
d. Oral Rehydration solution..	-----	11c,d	
e. Other.....	-----		8b,d

Note: The categories are not mutually exclusive. For example, a child who was offered ORS may have also received SSS, or a home liquid remedy.

III. Immunization

11. Children 0-5 Immunized for DPT 1,2,3, Polio 1,2,3, BCG, Measles, Complete (Card Based)		0 to 5		Reference	#
	No.	%	ApX 7	ApX 8	
a. DPT1	-----	-----		14a,b	
b. DPT2	-----	-----		(See tabulation	
c. DPT3	-----	-----		Instruction 14b	
d. Polio1	-----	-----		for other answers)	
e. Polio2	-----	-----			
f. Polio3	-----	-----			
g. BCG	-----	-----			
h. Measles	-----	-----			
i. Complete	-----	-----			

12. Mother/Guardians having at least 1, tetanus toxoid shot		Reference	#
	Number	ApX 7	ApX 8
a. Zero (0) TT shots.....	-----	33g,h	
b. One or two TT shots.....	-----	33e,f	
d. Total.....	-----		
			<u>100 %</u>

IV. Growth Monitoring and Breastfeeding

13. Children 0-5 who were ever/never breastfed by their mothers			Reference	#
	Number	%	Apx 7	Apx 8
a. Ever breastfed.....	-----	-----	40i,j	
b. Never breastfed.....	-----	-----	40k,l	
c. Total.....	-----	<u>100 %</u>		
14. Month categories at which mother stopped breast- feedings their 0-5 Children			Reference	#
	Number	%	Apx 7	Apx 8
a. Below 6 months.....	-----	-----	40c,d	
b. 6 to 12 months.....	-----	-----	40e,f	
c. Above 12 months.....	-----	-----	40g,h	
d. Total	-----	<u>100 %</u>		
15. Children 0-5 who are either "Nourished" or "Undernourished" (Based on growth card if available or interviewers visual assessment)			Reference	#
	Number	%	Apx 7	Apx 8
a. Normal.....	-----	-----	38a,b	
b. Undernourished.....	-----	-----	38c,d	
c. Total	-----	<u>100 %</u>		
16. Children 0-5 who were or were not weighed during the past 6 months			Reference	#
	Number	%	Apx 7	Apx 8
a. Weighed within 6 months....	-----	-----	37a,b	
b. Weighed longer than 6 mo...	-----	-----	37c,d	
c. Total.....	-----	<u>100 %</u>		
17. Families (Mothers mostly) Assessment of Cause of Deaths occurring in past year for 0-5 children			Reference	#
	Number	%	Apx 7	Apx 8
a. Diarrhea.....	-----	-----		3a,h
b. Fever.....	-----	-----		3b,i
c. Whooping Cough.....	-----	-----		3c,j
d. Tetanus.....	-----	-----		3d,k
e. Measles.....	-----	-----		3e,l
f. Other.....	-----	-----		3f,m
g. Total.....	-----	<u>100 %</u>		

Appendix 10
Phase II Questionnaire (Pg 65-67)

1. Do any children below 5 years live in your household? Yes ___ No ___ 1
 (If "No", skip to questions 19b, 19d, 35 and 36, then close)
2. What is the age of each child? (Identify using local past events, traditions) Month Age: 1-12 13-24 25-36 37-48 49-60 Total
 (Write "x" in proper spaces) _____ 2
3. For your most recent child who was weaned from breastmilk, at what age in months did the child completely stop breastfeeding?
 Age in months: 1-3 4-6 7-12 13-18 19-24 +24 mo.
 (Write "x")..... _____ 3
4. At what age did the child begin eating and drinking 1-3 4-6 +6 mo. something in addition to breastmilk? (Write "x").. _____ 4
5. (If child was breastfed greater than 6 months and eating and drinking other foods by 6 months, then check this space)..... _____ 5
6. There is a children's medicine that is made by mixing sugar salt and water in a container. What is this used for? (Answer: "Diarrhea Treatment." If incorrect, ask: Anything else? If stays incorrect, skip next question).....Correct ___ Incorrect ___ 6
7. How is this medicine prepared? (Answer: Mix 3 Coke or Fanta bottles filled with water, 10 sugar & 1 salt caps) Correct ___ Incorrect ___ 7
8. Have any of your children below 5 years had watery diarrhea during the past 14 days.....Yes ___ No ___ 8
 (If "No", skip to question 17, if "Yes", continue)
- a. What age are they? Age: 1-12 13-24 25-36 37-48 49-60 Total
 (Write "x" in proper age group) _____ a
- In the following questions, if one of your children under 2 had diarrhea in the past 14 days and no longer has it, think of this child. Otherwise think of the last child (below 5) who had diarrhea in the past 2 wks
9. During the diarrhea, was food offered:
 a. More often-than when the child is healthy?..... _____ 9a
 b. Less often-than when the child is healthy?..... _____ b
 c. Or about the same-as when the child is healthy?..... _____ c
10. Considering all liquids which you offered to the child during the diarrhea-Did you offer liquid:
 a. More often-than when the child is healthy?..... _____ 10a
 b. Less often-than when the child is healthy?..... _____ b
 c. Or about the same-as when the child is healthy?..... _____ c
 (Say: "All liquids" includes normal home liquids and both traditional and modern liquids used for treating diarrhea)
11. In the days after the watery diarrhea did you offer:
 a. More food-than when the child is healthy?..... _____ 11a
 b. Less food-than when the child is healthy?..... _____ b
 c. Or about the same amount of food-as when " " healthy? _____ c
12. Were you breastfeeding this child before the diarrhea? Yes ___ No ___ 12
 (If answer is "No" skip next question)
 a. Did you stop breastfeeding the child during the diarrhea? Y ___ N ___ a
13. During the diarrhea, did you seek help for the child outside the home? (If answer is "no" skip question 14)Yes ___ No ___ 13
14. Did you seek help for the child at any of the following places: 14
 a. Traditional healer? Yes ___ b. Clinic or hospital?.....Yes ___ ab
 c. Pharmacy or store? Yes ___ d. Any place else?.....Yes ___ cd
 (Circle letters given a "Yes")..... a. / b./ c./ d. e
 (Only ask next question if "d" is answered "Yes", otherwise skip)
 e. Where else did you seek help? (List: _____) f
15. As treatment during the watery diarrhea, was the child offered:
 a. ORS Solution? Yes ___ b. Homemade SSS Solution? Yes ___ 15b
 c. Home liquid remedies? (eg. soup, tea, rice water, juice) Yes ___ c
 d. (If a, b, or c, is checked "Yes", then mark this space)..... _____ d

16. Was anything else offered or done for the child to treat the watery diarrhea? (If No, skip next to question 17).....Yes ___ No ___ 16
 What else was offered or done for the child? (List responses:)
 Homemade/Traditional: _____
 Traditional-Purchased: _____
 Modern-Purchased: _____
 Other: _____
17. How many of your children have ever been offered ORS or SSS as a treatment for watery diarrhea?.....(Write number). ___ 17
18. What can you do to protect your child from getting a serious sickness such as measles, polio, or tetanus? (Ask: Anything Else?)
 a. Shows awareness of immunization..... 18a
 b. Does not show awareness of immunization..... b
- 19a. May I see each child's Health card... #Has Card ___ #No Card ___ 19
 b. And May I see your Maternal Health card? Has Card ___ No Card ___ b
 c. (If cards lacking, ask:) How many children have lost cards? ___ c
 d. Did you receive and lose a Maternal Health card? ...Yes ___ No ___ d
20. How many children without cards never had an immunization? # ___ 20
 Immunizations Status of Children Having Cards
 Age in Months: 1-12 13-24 25-36 37-48 49-60 Total
- | | | | | | | | |
|----------------------------------|------|-------|-------|-------|-------|-------|----|
| 21. DPT 1 | ___ | ___ | ___ | ___ | ___ | ___ | 21 |
| 22. DPT 2 | ___ | ___ | ___ | ___ | ___ | ___ | 22 |
| 23. DPT 3..... | ___ | ___ | ___ | ___ | ___ | ___ | 23 |
| 24. Polio 1..... | ___ | ___ | ___ | ___ | ___ | ___ | 24 |
| 25. Polio 2..... | ___ | ___ | ___ | ___ | ___ | ___ | 25 |
| 26. Polio 3..... | ___ | ___ | ___ | ___ | ___ | ___ | 26 |
| 27. BCG..... | ___ | ___ | ___ | ___ | ___ | ___ | 27 |
| 28. Measles..... | ___ | ___ | ___ | ___ | ___ | ___ | 28 |
| 29. Full Immunization | ___ | ___ | ___ | ___ | ___ | ___ | 29 |
| 30. Partial-within 3mo last shot | ___ | ___ | ___ | ___ | ___ | ___ | 30 |
| 31. Partial-longer than 3 months | ___ | ___ | ___ | ___ | ___ | ___ | 31 |
| 32. Nutritional Status (Card) | 1-12 | 13-24 | 25-36 | 37-48 | 49-60 | Total | 32 |
| a. Normal | ___ | ___ | ___ | ___ | ___ | ___ | a |
| b. Under nutrition..... | ___ | ___ | ___ | ___ | ___ | ___ | b |
| c. Weight up since last wt. | ___ | ___ | ___ | ___ | ___ | ___ | c |
| d. Weight same since last wt | ___ | ___ | ___ | ___ | ___ | ___ | d |
| e. Weight down since last wt | ___ | ___ | ___ | ___ | ___ | ___ | e |
33. Number Children Under 1 weighed in last 3 months..... 33
 34. Number Children 1-5 weighed in last 3 months..... 34
 35. Have you received any tetanus shots? Where and how many?
 a. Does Not have card and claims did not receive clinic shot. ___ 35a
 b. 1 TT injection (Card or claims received clinic shot)..... b
 c. 2 tetnus toxoid injections (Card or claims clinic shots).. c
36. How many people in your household are in the following age groups? 36
 a. 5 to (below) 15 years..... a
 b. Women 15 to 45 years..... b
 c. Men 15 to 45 years..... c
 d. Over 45 years..... d
37. How many children were born alive in this household during the past year?..... 37
38. Have any children less than 5 years of age died in this household in the past year? Include all children born alive. Yes ___ No ___ 38
 (If "No", end questionnaire, otherwise continue)
39. What age were the Children who died? (Write "x")
 Month Age: 1-12 13-24 25-36 37-60 Total 39
40. Which, if any, children had watery diarrhea in the week prior to death? (If "No" or "Can't remember" write a "0 " in spaces, otherwise, write the number having diarrhea in proper age group) 40
 a. Below 1 year..... a
 b. 1 to 5 years..... b

Interviewers Name.....
 Date of Interview.(Day/Month/Year)...../____/____

Phase II Instructions & Clarifications for Interviewers

1. General Purpose: The purpose of this questionnaire is to provide some basic information which will help the project to better perform in providing health services to the villages in the project area, especially as the services relate to ORT, Immunization, Growth Monitoring, and Breastfeeding encouragement. The information will be helpful in assessing the extent of initial needs, in managing the project efforts, in directing educational concerns, and in serving as a basis for measuring the project's progress.

2. Household Visits: Your supervisor will instruct you on which households you are to visit. You should do each interview on a one-to-one basis, and not in a group setting.

3. Definitions

a. Diarrhea: The local definition provided by the Ministry of Health should be used. If a standard definition has not been offered by the MOH, then ADRA suggests the following:

"Three or more loose, watery, or bloody stools in a 24 hour period"

b. "Food". Several questions use the word "food". In translating this concept, it should mean all things which can be eaten. In some cultures, the word "food" does not include all things which are eaten.

c. ORS = Oral Rehydration Salts (Packets)

d. SSS = Sugar and Salt Solution (Diarrhea treatment prepared in a water container by mixing capfuls of sugar and salt, and bottles--usually Coke or Fanta--of water, as specified by the MOH).

4. "Skip" instructions. Questions 1,6,8,12,14, and 16 have instructions to skip the next question if a specific response is given. Pay attention to these instructions.

5. Time periods (such as "Age") In questions involving age, the time periods are all in months, unless specifically declared as something else. A layman's notation is used for the month periods. For example, one year is designated as "1-12", with "1" standing for the first month, and "12" standing for the the 12th month; the notation for the second year is "13-24", with "13" standing for the "13th" month and "24" standing for the 24th month; etc.

6. Interviewing Style

Spend a short time explaining to the interviewed person why you are doing the questionnaire. Explain to the person that she has

been chosen as one of a few people whose interview will help the project understand the health situation of the area. She should know, then, that her honest and accurate answers are very crucial! After she understands, move on to the questionnaire.

Try not to hint at what answers are correct or more preferable. You want the persons answers, not yours! As much as possible, you should read each question exactly as it is written in the translated questionnaire. After you finish, always thank the person.

7. Clarifications on Specific Questions

a. Number 1. The question is interested in knowing which children are members of the household. Visitors are not to be included.

b. Number 3. The question is concerned about when breastfeeding was completely stopped.

c. Number 4. The question is concerned about the age at which the child began to eat or drink something in addition to breast-milk as a regular part of the diet.

d. Number 6. If the mother gives an incorrect response ask her if it is used for "Anything else?" Check the incorrect space only after you are fairly confident that she does not know what the sugar and salt solution is used for.

e. Number 8. Include all cases of diarrhea occurring in the past two weeks. Give the mother the definition of diarrhea to be sure that she understands diarrhea the way the project does.

The diarrhea questions following number 8 ask about the mothers behavior in regard to breastfeeding the child, and what her feeding behavior was towards the child immediately after the diarrhea. Because of these considerations, if the mother had a child who was below two years (probably breast feeding) and who had diarrhea in the past two weeks, but is now over it, this child is the one which we would like the mother to think about in answering the questions.

f. Number 9. The question asks whether mothers offered food, not whether the child ate the food. We are interested in knowing whether or not the mother did the right general behavior (ie offered food), not if the child was well enough to eat the food. If the concept "give" is used, and the child was "offered" but could not consume the food, then the mother may tell us that she did not give food to her child, when this was what she tried to do in offering the food to her child.

g. Number 10. The question asks whether mothers offered liquid, not whether the child drank the liquid. The same reasoning explained in "f" for number 9 applies here.

h. Number 11. The question asks about the amount of food offered

by mothers, not just the frequency of offering food. The concern of the question is to get an indication of the amount of food mothers are giving to the children. This question differs from number 9 because it is felt that children will be eating foods in greater quantities and perhaps in lesser frequencies during a post-diarrhea period versus during the diarrhea.

- i. Numbers 9,10, and 11. Emphasize during the diarrhea in numbers 9 and 10, and after the diarrhea in number 11.
- j. Number 12. Be sure the mother knows she is being asked about breastfeeding in respect to the child who had diarrhea.
- k. Number 14. For letters, a through d , write an "x" next to any answer in which the mother says "Yes". For letter e, circle the letters which the mother said "Yes" to in letter a through d.
- l. Number 15. For letters, a through c, write an "x" next to any answer in which the mother says "Yes". If the mother says "Yes" to either, a ,b, or c, then write an "x" in the space for d.
- m. Number 16. Summarize the answer in a few words. Try to categorize her answer in one of the four categories provided. If you are not sure whether if the remedy/treatment cost money, ask the mother, then categorize the answer.
- n. Number 19a,b Ask numbers 19 a and b realizing that many of the children will not have "Health cards" and many of the mothers will not have "Maternal Health" cards. Write the number of those having and not having cards in the proper place. For 19c and d, write the number of those who were issued and lost their cards.
- o. Number 20. This question is concerned about those who have never had an immunization.
- p. Numbers 21 to 32 can be taken directly off the childrens "Health Cards", if they exist. You should do each child seperately for all these questions. For example, if you have a card for a child who is two years old, mark all the spaces that apply (with an "x") for numbers 24 to 35. After you have gone through all the cards, total up the number of "x" marks for each question, and put the total number in the column titled "Total."
- q. Regarding numbers 32a and b. Consider a child undernourished if he or she is either outside the normal growth lines, or the direction of the growth line is either flat or downward sloping.
- r. Regarding numbers 32c,d, and e. Indicate whether the weight has gone up, down, or stayed the same since the last weighing.
- s. Numbers 33 and 34. This information should be taken off the health cards. Look at the date of last weighing for each of the children, and put the right number in the spaces provided.
- t. Number 35. If a woman claims she received tetanus toxoid

shots, accept this at face value if she says she received the shots at a clinic or hospital. If she does not have a card and she claims she received a tetanus toxoid shot at a place other than a clinic or hospital, record that she has "no shots." The Medical Supervisors feel confident that most if not all of the women will give an accurate account of their tetanus toxoid status. Still, if a card is available, always verify the claim.

u. Number 38, 39, 40. Sometimes mothers will not say if a child died, especially if it died soon after it was born. Communicate to the mother that this information is important, even if it is "uncomfortable."

Appendix 12

Phase II Tabulation Form (Pg 72-74)

1. Children below 5 years in household? #Yes _____ #No _____ 1
2. What is the age of each child?
 Month Age: 1-12 13-24 25-36 37-48 49-60 Total
 (Write # in each age group) _____ 2
3. Regarding your most recent child completely weaned from breast milk, at what age in months did the child completely stop breastfeeding?
 Age in months: 1-3 4-6 7-12 13-18 19-24 +24 mo.
 # in each age group.. _____ 3
4. Age child began eating food in addition to breastmilk (# in each group) Age in months: 1-3 4-6 +6 mo. _____ 4
5. (# children breastfed greater than 6 months and eating and drinking other foods by 6 months age) _____ 5
6. There is a children's medicine that is made by mixing sugar salt and water in a container. What is this used for?
 Anything else? # Correct _____ # Incorrect _____ 6
7. How is this medicine prepared? # Correct _____ # Incorrect _____ 7
8. Have any of your children under five had watery diarrhea during the past two weeks # Yes _____ # No _____ 8
 - a. What age? Month age: 1-12 13-24 25-36 37-48 49-60 Total
 # _____ a
9. During the diarrhea, was food offered:
 - a. More often-than when the child is healthy? # _____ 9a
 - b. Less often-than when the child is healthy? # _____ b
 - c. Or about the same-as when the child is healthy? # _____ c
10. Considering all liquids which you offered to the child during the diarrhea-Did you offer liquid:
 - a. More often-than when the child is healthy? # _____ 10a
 - b. Less often-than when the child is healthy? # _____ b
 - c. Or about the same-as when the child is healthy? # _____ c
11. In the days after the watery diarrhea did you offer:
 - a. More food-than when the child is healthy? # _____ 11a
 - b. Less food-than when the child is healthy? # _____ b
 - c. Or about the same amount of food-as when " " healthy? # _____ c
12. Child breastfed before the diarrhea? # Yes _____ # No _____ 12
 - a. Breastfeeding stopped during the diarrhea?. # Yes _____ # No _____ a
13. During the diarrhea, did you seek help for the child outside the home? #Yes _____ #No _____ 13
14. Did you seek help for the child at any of the following places: 14
 - a. Traditional healer? # Yes _____ b. Clinic or hosp.? # Yes _____ ab
 - c. Pharmcst or store? # Yes _____ d. Any place else? # Yes _____ cd
 - 1 letter circled, number of: "a" _____ ; "b" _____ ; "c" _____ ; "d" _____ e
 - 2 letters circled, # of: _____ 3 or more circled, # of _____
 - Where else did you seek help? (List: See Instructions _____) f
15. As treatment during the watery diarrhea, was the child offered:
 - a. ORS Solution? # Yes _____ b. Homemade SSS Solution? # Yes _____ 15b
 - c. Home liquid remedies? # Yes _____ c
 - d. (# of questionnaires in which a, b, or c was marked "Yes") _____ d

16. Was anything else offered or done for the child to treat the watery diarrhea? # Yes _____ # No _____ 16
 What else was offered or done for the child?
 (See Tabulation Instructions for 16)

17. How many of your children have ever been offered ORS or SSS as a treatment for watery diarrhea? # _____ 17

18. What can you do to protect your child from getting a serious sickness such as measles, polio, or tetanus? (Ask: Anything Else?)
 a. # Showing awareness of immunization # _____ 18a
 b. # Not showing awareness of immunization # _____ b

19a. May I see each child's Health card # Has Card _____ # No Card _____ 19
 b. May I see your Maternal Health card? # Has Card _____ # No Card _____ b
 c. How many children have lost cards? # _____ c
 d. Mothers lost Maternal Health card? # Yes _____ # No _____ d

20. How many children without cards never had an immunization? # _____ 20
 Immunizations Status of Children Having Cards

	Month age: 1-12	13-24	25-36	37-48	49-60	Total	
21. # DPT 1.....	_____	_____	_____	_____	_____	_____	21
22. # DPT 2.....	_____	_____	_____	_____	_____	_____	22
23. # DPT 3.....	_____	_____	_____	_____	_____	_____	23
24. # Polio 1.....	_____	_____	_____	_____	_____	_____	24
25. # Polio 2.....	_____	_____	_____	_____	_____	_____	25
26. # Polio 3.....	_____	_____	_____	_____	_____	_____	26
27. # BCG.....	_____	_____	_____	_____	_____	_____	27
28. # Measles.....	_____	_____	_____	_____	_____	_____	28
29. # Full Immunization.....	_____	_____	_____	_____	_____	_____	29
30. # Partial-within 3mo.....	_____	_____	_____	_____	_____	_____	30
31. # Partial-longer than 3m	_____	_____	_____	_____	_____	_____	31
32. Nutritl Status (From Card)	1-12	13-24	25-36	37-48	49-60	Total	32
a. # Normal	_____	_____	_____	_____	_____	_____	a
b. # Under nutrition	_____	_____	_____	_____	_____	_____	b
c. # Wt up since last	_____	_____	_____	_____	_____	_____	c
d. # Wt same since last	_____	_____	_____	_____	_____	_____	d
e. # Wt down since last	_____	_____	_____	_____	_____	_____	e
33. # Children Under 1 year weighed in last 3 months						_____	33
34. # Children 1-5 years weighed in last 3 months						_____	34
35. Mother received tetanus toxoid shots? Where and how many?							
a. # No card and no clinic shot						_____	35a
b. # 1 TT injection (Card or claims clinic shot)						_____	b
c. # 2 tetnus toxoid injections (Card or claims 2 shots)						_____	c
36. How many people in your household are in the following age groups?							36
a. # 5 to (below) 15 years						_____	a
b. # Women 15 to 45 years						_____	b
c. # Men 15 to 45 years						_____	c
d. # Over 45 years						_____	d
37. # children who were born alive in households during the past year						_____	37
38. Have any children less than 5 years of age died in this household in past year? Include all children born alive. #Yes _____ #No _____						_____	38
39. Age of children who died? Age: 1-12 13-24 25-36 37-60 Total # in each age group	_____	_____	_____	_____	_____	_____	39
40. Which, if any, children had diarrhea in the week prior to death? (Total up the numbers in each category. A zero (0) is not to be counted)							40
a. Below 1 year						# _____	a
b. 1 to 5 years						# _____	b

Tabulators Name _____
 Date of Tabulation (Day/Month/Year) _____/_____/_____

Phase II Tabulation Procedure and Instructions

Procedure: Interviewers, Medical Assistants, Information Coordinator

1. Interviewers. Interviewers should try to complete all assigned interviews in one village before proceeding to the next village. After each day's work, the interviewers will review the questionnaires and sum up the results on a tabulation sheet (see Appendix 12). If questionnaires have been done at more than one village in a day, separate tabulations will be completed for each village. Every day, the questionnaires for each village will be clipped together with the tabulation sheet on top. At the end of each week, the interviewers will submit this work to her supervisor, the Medical Assistant.

As discussed in the instructions for tabulation numbers 14 and 16, the interviewers will also prepare five lists per week. These lists will be part of the work submitted to the Medical Assistants (Note: Periodically, the Medical Assistants will review the questionnaires to check for mistakes and help the interviewer correct any problem areas arising).

2. Medical Assistant. After receiving the interviewers work, the Medical Assistant will sort out the tabulation summaries according to village. He will sum up these tabulations to arrive at a weekly village tabulation summary. After doing this for each village, he will add up each of the village summaries to form a weekly clinic area tabulation summary. Periodically, he will send in the weekly tabulation summary to the project Information Coordinator in Blantyre. Since there is a concern about possibly losing weekly summary if the results are mailed too frequently, the Medical Assistant, might send in the summaries every other week.

Concerning the one list generated from tabulation number 14f, the Medical Assistant will keep this information at the clinic as a tool to better understand where mothers go to treat their children. Along with the other "source-of-outside-of-home-help" information provided in question 14, the Medical Assistants will use this information to plan educational activities.

Concerning the 4 lists specified in tabulation number 16, the Medical Assistant will keep the detailed summaries at the clinic, and send in summary information to the Information Coordinator after all the required questionnaires are complete. The summary information should include the following pieces of information, Number and % of treatments which were:

- * Homemade/Traditional
- * Traditional-Purchased
- * Modern-Purchased
- * Other

The detailed summary information will be used by the Medical Assistant to analyze the kinds of non-ORT diarrhea treatments

which are being used by mothers. Within each of the defined categories, he should divide them into three categories: Harmful, Neutral, and Beneficial. Based on this analysis, he should consider appropriate educational actions.

Once all the assigned household questionnaires for a village have been completed and submitted into the medical assistant, he will prepare a final tabulation summary for each village. The information on this final village tabulation will reveal a considerable amount of information which will be useful to the Medical Assistant. However, to gain maximal use of the data, it is recommended that the Information Coordinator and the Regional Supervisors work with the Medical Assistants in developing village reports which are similar in format and calculation procedure as the report summary specified in Appendix 16 (Phase II Survey Results).

3. Project Information Coordinator. The project information coordinator will receive the weekly clinic tabulation summaries on a bi-weekly basis from each of the project clinics (13 at present). The survey should take about four weeks, therefore the Information Coordinator should receive 2 mailings of weekly summaries. The final mailings will include a summary of the items in tabulation number 16 (below) discussed in the preceding paragraphs. At the end of this period, the Information Coordinator will prepare separate tabulations for each of the clinics. He will then prepare separate tabulations for all of the clinics in the South Region. He will do the same for the Northern Region clinics. Finally, he will prepare a summary tabulation for the entire Phase II survey.

The tabulations will be the basis for completing a set of management reports. The reports can take whatever form is useful to the project staff. However, a suggested report format is given in Appendix 16 (Phase II Survey Results).

Instructions for Tabulation

The following tabulation instructions are provided for the interviewer who is tabulating the questionnaires. The Medical Assistants and the Information Coordinator will perform their tabulations slightly different than the interviewers since they will be "tabulating tabulation forms". For example, the following instructions occasionally tell the interviewers to add the "check marks". The Medical Assistants and Information Coordinator will only add numbers. In general, the instructions are the same for all levels of tabulation. The numbers below represent the numbers on the tabulation form.

1. Sum up the totals for each response and put these numbers under the proper "Yes" or "No" answer on the tabulation form.
2. Sum up the total "x" marks for each category on the questionnaires and put these totals in the proper space on the tabulation form.
3. Sum up the total "x" marks for each month category and put

these totals in the proper month category on the tabulation form.

4. Same instruction as number 3.

5. Count up the "x" marks and put this total in the space provided.

6. Sum up the totals for each response and put these numbers under the proper "Correct" or "Incorrect" categories on the tabulation form.

7. Same instruction as number 6.

8. Same instruction as number 1.

9. Sum up the totals for each response and put these numbers under the proper "More often", "Less often", or "About the same" categories on the tabulation form.

10. Same instruction as number 9.

11. Sum up the totals for each response and put these numbers under the proper "More food", "Less food" or "About the same" categories on the tabulation form.

12. Same instruction as number 1.

13. Same instruction as number 1.

14 a, b, c, d. Count the number of "Yes" responses marked with an "x" and note this total on the proper place of the tabulation form,

14e. Count the number of "a" which are circled, and write this number on the proper space on the tabulation form. Do the same procedure for the letters "b", "c", and "d".

14f. On a separate piece of paper, neatly write each place that was mentioned as a source of outside of home help. Keep a running tally of the number of mother who visited each source of outside help. An example of an appropriate list is shown in Appendix 19. Keep this list at the clinic. Update it every week. Adding new categories as necessary, and keep the running tally current for each category. After the surveying is finished, submit this list to the Medical Assistant.

15 a, b, c, Count the number of "Yes" responses marked with an "x" and write this total on the proper place of the tabulation form.

15d. Same instruction as number 5.

16. On a separate piece of paper for each title, write the following four titles: "Homemade/Traditional", "Traditional-Purchased", "Modern-Purchased", and "Other". Separate each of the answers on

the questionnaire onto its proper category. Neatly write each out each kind of remedy that was mentioned as a type of treatment for the diarrhea-ridden child, and keep a running tally of the number of mothers who mention each kind of treatment. A similar format as the list in Appendix 19 is suggested. Keep this list in a secure place at the clinic. After, the surveying is finished, submit this list to the Medical Assistant.

17. Sum up the numbers and put this total on the tabulation space provided.

18a and 18b. Sum up the number of check marks, and put this total in the tabulation space provided.

19a and 19b. Sum up the totals for each response and put these numbers under the proper "Has Card" or "No Card" space on the tabulation form.

19c. Same instruction as 17

19d. Same instruction as 1.

20. Same instruction as number 17.

21 to 32. Same instruction as number 2.

33 and 34. Same instruction as number 17.

35. Same instruction as 18a and 18b.

36. Same instruction as 17.

37. Same instruction as 17.

38. Same instruction as number 1.

39. Same instruction as number 2.

40a and 40b. Same instruction as number 17.

Calculations For Phase II:
US AID Information Indicators Accepted For Survey

This appendix gives instruction on how to calculate the information listed in Appendix 2 (US AID Indicators Accepted for Baseline Survey). The unbracketed numbers listed in front of each calculation and are reference numbers relating to the numbers in Appendix 2. The bracketed numbers listed within the calculations are references relating to the tabulation numbers in Appendix 12, where the information for each calculation can be found.

Related, but non-US AID information requests, are designated with an asterisk (*).

- 1a. 0 to 1 year mortality rate:

$$\frac{\text{\# of deaths to children 1-12 months (39)}}{\text{\# of live births (37)}} = \text{-----}$$
- 1b. 1 to 5 years mortality rate:

$$\frac{\text{\# of deaths to children 13 to 60 months (39)}}{\text{\# of children 13 to 60 (2)}} = \text{-----}$$
- 1c.* 0 to 1 diarrhea associated mortality rate:

$$\frac{\text{\# of diarrhea associated deaths, 1-12 months (40a)}}{\text{\# of live births (37)}} = \text{-----}$$
- 1d.* 1 to 5 diarrhea associated mortality rate:

$$\frac{\text{\# of diarrhea associated deaths, 13-60 months (40b)}}{\text{Number of children 13 to 60 months (2)}} = \text{-----}$$
2. Number of children died, 1 to 12 months (39)..... = -----
3. Number of children died, 13 to 24 months (39)..... = -----
4. Number of children died, 25 to 36 months (39)..... = -----
5. Number of children died, 37 to 60 months (39)..... = -----
6. Number of children died, 0 to 60 months (Add 39)..... = -----
- a. % 0-1 children died to 0-5 children died:

$$\frac{\text{1 to 12 months (39)}}{\text{0 to 60 months (39)}} = \text{-----}$$
- b. % 1-2 children died to 0-5 children died:

$$\frac{\text{13 to 24 months (39)}}{\text{0 to 60 months (39)}} = \text{-----}$$
- c. % 2-3 children died to 0-5 children died:

$$\frac{\text{25 to 36 months (39)}}{\text{0 to 60 months (39)}} = \text{-----}$$

d. % 0-1 children died to 0-5 children died:

$$\frac{37 \text{ to } 48 \text{ months (39)}}{0 \text{ to } 60 \text{ months (39)}} = \text{-----}$$

7. Mothers/Guardians given information on ORT this year.

The survey can give part of this information. Since the project director has asked that each interviewer give an ORT talk at each interview, the total amount of interviews done represents the mother/guardians given information on ORT from the survey talks.

The complete answer for this item consists of:

total questionnaires done (total "Yes" + Total "No" (1))
plus: persons given ORT talks at other times during the year
-at the clinic, and
-out in the villages.

This sum will include possible "duplicate counting", as it is possible that the same people heard talks during the survey, at the clinic, and out in the village on separate occasions.

8a. # Children 0 to 60 months ever using ORT (16a,b)... = -----

Children 0 to 60 months ever using ORT:
$$\frac{(16a,b)}{\text{"Total" in (2c)}} = \text{-----}$$

Children 0 to 60 months never using ORT:
$$\text{"Total" in (2) minus (16a,b)} = \text{-----}$$

Children 0 to 60 months never using ORT:
$$\frac{\text{"Total" in (2) minus (16a,b)}}{\text{"Total" in (2)}} = \text{-----}$$

Number of 0 to 1 diarrhea-associated deaths (40a).. = -----

9b. % of 0 to 1 diarrhea-associated deaths to total 0 to 1 deaths:
$$\frac{40a}{\text{"1 to 12" in (39)}} = \text{-----}$$

9c. Number of 1 to 5 diarrhea-associated deaths (40b)... = -----

9d. % of 1 to 5 diarrheal related deaths to total 1 to 5 deaths:
$$\frac{40b}{\text{"Total" in (39)}} = \text{-----}$$

10a. Mothers aware of SSS = "Correct" in (6) = -----

10b. % Of all mothers aware of SSS:
$$\frac{\text{"Correct" in (6)}}{\text{"Correct" + "Incorrect" in (6)}} = \text{-----}$$

10c.* Mothers unaware of SSS = "Incorrect" in (6)..... = -----

- 10d.* % Of all mothers unaware of SSS:

$$\frac{\text{"Incorrect" in (6)}}{\text{"Correct" + "Incorrect" in (6)}} = \text{-----}$$
- 10e. Mothers know how to prepare SSS = "Correct" in (7) = -----
- 10f. % Of all mothers who know how to prepare SSS:

$$\frac{\text{"Correct" in (7)}}{\text{"Correct" + "Incorrect" in (6)}} = \text{-----}$$
- 10g.* Mothers not knowing how to prepare SSS:
 "Incorrect" in (7)..... = -----
- 10h.* % Of all mothers not knowing how to prepare SSS:

$$\frac{\text{"Incorrect" in (7)}}{\text{"Correct" + "Incorrect" in (6)}} = \text{-----}$$
- 11a. Number of children with diarrhea in last 2 weeks given ORT (eg. ORS, SSS or home liquid remedy) (15d) = -----
- 11b. % of children with diarrhea in last 2 weeks given ORT (eg. ORS, SSS, or home liquid remedy):

$$\frac{\text{(15d)}}{\text{"Yes" in (8)}} = \text{-----}$$
- 11c.* Number of children with diarrhea in last 2 weeks not given ORT= "Yes" in (8) minus (15d)..... = -----
- 11d.* % of children with diarrhea in last 2 weeks not given ORT=
$$\frac{\text{"Yes" in (8) minus (15d)}}{\text{"Yes" in (8)}} = \text{-----}$$
- 11e.* Number of children with diarrhea in last 2 weeks given ORS (15a)..... = -----
- 11f.* % of children with diarrhea in last 2 weeks given ORS:
$$\frac{\text{(15a)}}{\text{"Yes" in (8)}} = \text{-----}$$
- 11g.* Number of children with diarrhea in last 2 weeks not given ORT= "Yes" in (8) minus (15a)..... = -----
- 11h.* Number of children with diarrhea in last 2 weeks given SSS (15b)..... = -----
- 11i.* % of children with diarrhea in last 2 weeks given SSS:
$$\frac{\text{(15c)}}{\text{"Yes" in (8)}} = \text{-----}$$
- 11j.* Number of children with diarrhea in last 2 weeks given home liquid remedies (15c) = -----

11k * % of children with diarrhea
in last 2 weeks given home liquid remedies:
(15c)
"Yes" in (8) = _____

12a Number of 0 to 1 children having DPT1:
"1 to 12" for (21) = _____

12b % of 0 to 1 children having DPT1:
"1 to 12" for (21)
"1 to 12" in (2) = _____

13a Number of 1 to 2 children having DPT1:
"13 to 24" for (21) = _____

13b % of 1 to 2 children having DPT1:
"13 to 24" for (21)
"Total" for "13 to 24" in (2) = _____

14a Number of Below 5 children having DPT1:
"Total" for (21) = _____

14b % of Below 5 children having DPT1:
"Total" for (21)
"Total" for (2) = _____

Follow similar steps for DPT2, DPT3, Polio 1, Polio 2, Polio 3, BCG, Measles vaccine, and Full Immunization. This accounts for Appendix 2 reference numbers 15 to 32

33a. Number of women interviewed having
2 tetanus toxoid shots (35c)..... = _____

33b. % of women interviewed having
2 tetanus toxoid shots: (35c)
(35a)+(35b)+(35c) = _____

33c.* Number of women interviewed having
0 tetanus toxoid shots (35a)..... = _____

33d.* % of women interviewed having
0 tetanus toxoid shots: (35a)
(35a)+(35b)+(35c) = _____

33e.* Number of women interviewed having
1 tetanus toxoid shots (35b)..... = _____

33f.* % of women interviewed having
1 tetanus toxoid shots: (35b)
(35a)+(35b)+(35c) = _____

34a. Number of 0 to 5 children with immunization
cards at home = "Has Card" in (19a)..... = _____

34b. % of 0 to 5 children with immunization cards at home:

$$\frac{\text{"Has card" in (19a)}}{\text{"Has card" + "No card" in (19a)}} = \text{-----}$$

34c.* Number of 0 to 5 children not having immunization cards at home = "No card" in (19a) = -----

34d.* % of 0 to 5 children not having immunization cards at home:

$$\frac{\text{"No card" in (19a)}}{\text{"Has card" + "No card" in (19a)}} = \text{-----}$$

35a. Number of mother/guardians with knowledge of immunization (18a)..... = -----

35b. % of mother/guardians with knowledge of immunization: $\frac{\text{(18a)}}{\text{(18a) + (18b)}}$ = -----

35c. Number of mother/guardians without awareness of immunization (18a)..... = -----

35d. % of mother/guardians without awareness of immunization: $\frac{\text{(18b)}}{\text{(18a) + (18b)}}$ = -----

36a. Number of 0 to 5 children with growth cards at home = "Has Card" in (19a)..... = -----

36b. % of 0 to 5 children with growth cards at home: $\frac{\text{"Has card" in (19a)}}{\text{"Has card" + "No card" in (19a)}}$ = -----

36c.* Number of 0 to 5 children not having growth cards at home = "No card" in (19a) = -----

36d.* % of 0 to 5 children not having growth cards at home: $\frac{\text{"No card" in (19a)}}{\text{"Has card" + "No card" in (19a)}}$ = -----

37a. Number of 0 to 1 children who were weighed during the past three months (33)..... = -----

37b. % of 0 to 1 children who were weighed during the past three months: $\frac{\text{(33)}}{\text{"1-12" in (2)}}$ = -----

37c. Number of 1 to 5 children who were weighed during the past three months (34)..... = -----

- 37d. % of 1 to 5 children who were weighed during the past three months:

$$\frac{\text{"Total" (2) minus "1-12" (2)}}{(34)} = \text{-----}$$
- 38a. Of children having growth cards, number of 0 to 5 children who are "normal" (MOH standard):

$$\text{"Total" in (32a)} = \text{-----}$$
- 38b. Of children having growth cards, % of 0 to 5 children who are "normal" (MOH standards):

$$\frac{\text{"Total" in (32a)}}{\text{"Total" in (32a) + "Total" in (32b)}} = \text{-----}$$
- 38c. Of children having growth cards, number of 0 to 5 children who are "undernourished" (MOH standard):

$$\text{"Total" in (32b)} = \text{-----}$$
- 38d. Of children having growth cards, % of 0 to 5 children who are "undernourished" (MOH standards):

$$\frac{\text{"Total" in (32b)}}{\text{"Total" in (32a) + "Total" in (32b)}} = \text{-----}$$
- 38e.* Of children having growth cards, number of 0 to 1 children who are "normal" (MOH standard):

$$\text{"1-12" in (32a)} = \text{-----}$$
- 38f.* Of children having growth cards, % of 0 to 1 children who are "normal" (MOH standards) =

$$\frac{\text{"1-12" in (32a)}}{\text{"1-12" in (32a) + "1-12" in (32b)}} = \text{-----}$$
- 38g.* Of children having growth cards, number of 0 to 1 children who are "undernourished" (MOH standard):

$$\text{"1-12" in (32b)} = \text{-----}$$
- 38h.* Of children having growth cards, % of 0 to 1 children who are "undernourished" (MOH standards)

$$\frac{\text{"1-12" in (32b)}}{\text{"1-12" in (32a) + "1-21" in (32b)}} = \text{-----}$$
- 38i.* Of children having growth cards, number of 1 to 2 children who are "normal" (MOH standard):

$$\text{"13-24" in (32a)} = \text{-----}$$
- 38j.* Of children having growth cards, % of 1 to 2 children who are "normal" (MOH standards):

$$\frac{\text{"13-24" in (32a)}}{\text{"13-24" in (32a) + "13-24" in (32b)}} = \text{-----}$$
- 38k.* Of children having growth cards, number of 1 to 2 children who are "undernourished" (MOH standard):

$$\text{"13-24" in (32b)} = \text{-----}$$

38l.* Of children having growth cards, % of 1 to 2 children who are "undernourished" (MOH standards):

$$\frac{\text{"13-24" in (32b)}}{\text{"13-24" in (32a) + "13-24" in (32b)}} = \text{-----}$$

38m.* Of children having growth cards, number of 2 to 3 children who are "normal" (MOH standard):
 "25-36" in (32a)..... = -----

38n.* Of children having growth cards, % of 2 to 3 children who are "normal" (MOH standards):

$$\frac{\text{"25-36" in (32a)}}{\text{"25-36" in (32a) + "25-36" in (32b)}} = \text{-----}$$

38o.* Of children having growth cards, number of 1 to 2 children who are "undernourished" (MOH standard):
 "25-36" in (32b) = -----

38p.* Of children having growth cards, % of 2 to 3 children who are "undernourished" (MOH standards):

$$\frac{\text{"25-36" in (32b)}}{\text{"25-36" in (32a) + "25-36" in (32b)}} = \text{-----}$$

38q.* Of children having growth cards, number of 3 to 5 children who are "normal" (MOH standard):
 37-60" in (32a)..... = -----

38r.* Of children having growth cards, % of 3 to 5 children who are "normal" (MOH standards):

$$\frac{\text{"37-60" in (32a)}}{\text{"37-60" in (32a) + "37-60" in (32b)}} = \text{-----}$$

38s.* Of children having growth cards, number of 3 to 5 children who are "undernourished" (MOH standard):
 "37-60" in (32b)... = -----

38t.* Of children having growth cards, % of 3 to 5 children who are "undernourished" (MOH standards):

$$\frac{\text{"37-60" in (32b)}}{\text{"37-60" in (32a) + "37-60" in (32b)}} = \text{-----}$$

40a. Number of most recently weaned children who were still breastfeeding at 6 months age: In (3), add up the numbers in the following categories--
 7-12, 13-18, 19-24, +24 mo..... = -----

40b. % of most recently weaned children who were still breastfeeding at 6 months age:

$$\frac{\text{Number calculated in 40a above}}{\text{Total of all categories in (3)}} = \text{-----}$$

41a. Number of most recently weaned children who were still breastfeeding at 12 months age: In (3), add up the numbers in the following categories--
 13-18, 19-24, +24 mo..... = -----

41b. % of most recently weaned children who were still breastfeeding at 12 months age:

$$\frac{\text{Number calculated in 41a above}}{\text{Total of all categories in (3)}} = \text{-----}$$

42a. Number of most recently weaned children who were breastfeeding and also eating and drinking something else at 6 months age (5)..... = -----

42b. % of most recently weaned children who were both breastfeeding and eating and drinking something else at six months of age:

$$\frac{(5)}{\text{Total of all categories in (3)}} = \text{-----}$$

42c*. Number of most recently weaned children who were not breastfeeding and also eating and drinking something else at 6 months age:

$$\text{Total of all categories in (3) minus (5)} = \text{-----}$$

42d. % of most recently weaned children who were both breastfeeding and eating and drinking something else at 6 months age :

$$\frac{\text{Number calculated in 42c above}}{\text{Total of all categories in (3)}} = \text{-----}$$

Calculations For Phase II Survey:
Non US AID Information Indicators Accepted For Survey

This appendix gives instructions on how to calculate the non US AID requested information which is on the survey. The information source for these calculations is the tabulation sheet for the Phase II questionnaire (Appendix 12). Numbers in parentheses () indicate the tabulation number from which the information can be obtained. Numbers used in the calculations with an asterisk (*) refer to a calculation number in this appendix (usually calculated earlier).

I. General and Demographic Information

1. Age of Survey Population by Number and Percent

a.	Total 0 to 1 (2) (1 to 12 months).....	-----
b.	Total 1 to 2 (2) (13 to 24 months).....	-----
c.	Total 2 to 3 (2) (25 to 36 months).....	-----
d.	Total 3 to 4 (2) (37 to 48 months).....	-----
e.	Total 4 to 5 (2) (49 to 60 months).....	-----
f.	Total Under 5 (2).....	-----
g.	5 to (below) 15 (36a).....	-----
h.	Women 15 to 45 (36b).....	-----
i.	Men 15 to 45 (36c).....	-----
j.	Over 45 (36d).....	-----
k.	Total in Survey Population (Add above).....	-----

2. Percent of Survey Population

a.	% of population	$\frac{1a*}{1k*}$	=	-----
	0 to 1.....			
b.	% of population	$\frac{1b*}{1k*}$	=	-----
	1 to 2.....			
c.	% of population	$\frac{1c*}{1k*}$	=	-----
	2 to 3.....			
d.	% of population	$\frac{1d*}{1k*}$	=	-----
	3 to 4.....			
e.	% of population	$\frac{1e*}{1k*}$	=	-----
	4 to 5.....			
f.	% of popul.	$\frac{1f*}{1k*}$	=	-----
	under 5.....			
g.	% of population	$\frac{1g*}{1k*}$	=	-----
	5 to (below) 15.....			
h.	% of population	$\frac{1h*}{1k*}$	=	-----
	Women 15-45.....			

i. % of population
Men 15-45..... $\frac{1i*}{1k*} =$ _____

j. % of population
Over 15-45..... $\frac{1j*}{1k*} =$ _____

2.1 Birth Data

a. Number of births in survey population (37) = _____

b. Birth rate:
..... $\frac{2.1a*}{1k*} =$ _____

3. Of children 0-5 who have no "Health Card", Number and % whose mother/guardian claim the card was lost or imply card was never received.

a. # 0-5 children claimed with "No Card" (19a) = _____

b. % 0-5 children claimed to have "No Card" to total children 0-5
..... $\frac{3a*}{1f*} =$ _____

c. # 0-5 children, mother implies never received card = "No Card" (19a) minus (19c) = _____

d. % 0-5 children, mother implies never received card to total children 0-5
..... $\frac{3c*}{1f*} =$ _____

e. Estimate of # 0-1 children with No Card:
(Total 0-1 children) minus (0-1 children fully immunized and partially immunized) =
"1-12" (2) minus: "1-12" full immunization (29)
"1-12" partial, within (30)
"1-12" partial, longer (31)
.....equals _____

f. Estimate of # 1-2 children with No Card:
(Total 1-2 children) minus (1-2 children fully immunized and partially immunized) =
"13-24" (2) minus: "13-24" full immunization (29)
"13-24" partial, within (30)
"13-24" partial, longer (31)
.....equals _____

g. Estimate of % of 0-1 children with No Card:
 $\frac{3e*}{1a*} =$ _____

h. Estimate of % of 1-2 children with No Card
 $\frac{3f*}{1b*} =$ _____

4. Number and % of mothers having/not having a "Maternal Health" card.

a. Number having =..... "Has card" for (19b) = _____

b. Number not having =..... "No card" for (19b) = _____

c. % having card = $\frac{4a*}{4a* + 4b*} =$ _____

d. % not having card = $\frac{4b*}{4a* + 4b*} =$ _____

5. Of mothers who have no "Maternal Health" card",
 Number and % who claim the card was lost or
 imply card was never received.

a. # mothers claimed to have lost card =
 "Yes" in (19d) = _____

b. % mothers claiming to have lost card
 to total mothers surveyed =
 $\frac{\text{"Yes" in (19d)}}{\text{"Has Card" + "No Card" in (19a)}} =$ _____

c. # mothers implying never received
 card = "No " in (19d) = _____

d. % mothers who imply they never received
 card to total mothers surveyed =
 $\frac{\text{"No" in (19d)}}{\text{"Has Card" + "No Card" in (19a)}} =$ _____

II. Diarrhea Control and ORT

6. Extent to which mothers offer food to their children during
 diarrhea as compared to when children are healthy.

- a. # Offer more often (9a)..... = _____
- b. # Offer less often (9b)..... = _____
- c. # Offer about the same (9c)..... = _____

c. % having card = $\frac{4a*}{4a* + 4b*} =$ _____

d. % not having card = $\frac{4b*}{4a* + 4b*} =$ _____

5. Of mothers who have no "Maternal Health" card",
Number and % who claim the card was lost or
imply card was never received.

a. # mothers claimed to have lost card =
"Yes" in (19d) = _____

b. % mothers claiming to have lost card
to total mothers surveyed =
 $\frac{\text{"Yes" in (19d)}}{\text{"Has Card" + "No Card" in (19a)}} =$ _____

c. # mothers implying never received
card = "No " in (19d) = _____

d. % mothers who imply they never received
card to total mothers surveyed =
 $\frac{\text{"No" in (19d)}}{\text{"Has Card" + "No Card" in (19a)}} =$ _____

II. Diarrhea Control and ORT

6. Extent to which mothers offer food to their children during
diarrhea as compared to when children are healthy.

a. # Offer more often (9a)..... = _____

b. # Offer less often (9b)..... = _____

c. # Offer about the same (9c)..... = _____

d. % Offer more often = $\frac{(9a)}{(9a+9b+9c)} =$ _____

e % Offer less often = $\frac{(9b)}{(9a+9b+9c)} =$ _____

f % Offer about the same $\frac{(9c)}{(9a+9b+9c)} =$ _____

7. Extent to which mothers offer liquid to their children
during diarrhea as compared to when children are healthy.

a. # Offer more often (10a)..... = _____

b. # Offer less often (10b)..... = _____

c. # Offer about the same (10c)..... = _____

d. % Offer more often = $\frac{(10a)}{(10a+b+c)} =$ _____

e. % Offer less often = $\frac{(10b)}{(10a+b+c)}$ = _____

f. % Offer about the same $\frac{(10c)}{(10a+b+c)}$ = _____

8. Extent to which mothers offer food to their children in the days after the diarrhea as compared to when children are healthy.

a. # Offer more food (11a)..... = _____

b. # Offer less food (11b)..... = _____

c. # Offer about the same amount (11c)..... = _____

d. % Offer more often = $\frac{(11a)}{(11a+b+c)}$ = _____

e % Offer less often = $\frac{(11b)}{(11a+b+c)}$ = _____

f % Offer about the same $\frac{(11c)}{(11a+b+c)}$ = _____

9. Number and % of Children having diarrhea in past 14 days broken down by age

a. # 1 to 12 months (8a) = _____

b. # 13 to 24 months (8a)..... = _____

c. # 25 to 36 months (8a)..... = _____

d. # 37 to 60 months (8a) = _____

e. # 0 to 60 months (8a)..... = _____

f. % of 0 to 5 children having diarrhea in past 14 days..... $\frac{9e*}{1f*}$ = _____

g. Of children 0 to 5 who had diarrhea in past 14 days, % who were 0 to 1 years old $\frac{9a*}{9e*}$ = _____

h. Of children 0 to 5 who had diarrhea in past 14 days, % who were 1 to 2 years old $\frac{9b*}{9e*}$ = _____

i. Of children 0 to 5 who had diarrhea in past 14 days, % who were 2 to 3 years old $\frac{9c*}{9e*}$ = _____

j. Of children 0 to 5 who had diarrhea in past 14 days, % who were 3 to 5 years old $\frac{9d*}{9e*}$ = _____

10. Number and % of mothers who stopped/continued breastfeeding their children during a recent diarrhea episode (14 day recall)

- a. # who stopped breastfeeding during the diarrhea =....."Yes" in (12a) = _____
- b. # who continued breastfeeding during the diarrhea =..... "No" in (12a) = _____
- c. % who stopped breastfeeding during the diarrhea

$$\frac{10a*}{10a* + 10b*} =$$

- d. % who continued breastfeeding during the diarrhea

$$\frac{10b*}{10a* + 10b*} =$$

11. No. and % of mothers who were breastfeeding their children before the onset of a recent diarrhea (14 day recall)

- a. # who were breastfeeding before the diarrhea started:
 "Yes" in (12) = _____
- b. # who were not breastfeeding before the diarrhea started:..... "No" in (12) = _____
- c. % who were breastfeeding before the diarrhea started:
 during the diarrhea

$$\frac{11a*}{11a* + 11b*} =$$

- d. % who were not breastfeeding before the diarrhea started:

$$\frac{11b*}{11a* + 11b*} =$$

12. Breakdown of mothers who did or did not seek help outside of the home during a recent diarrhea episode (14 day recall).

- a. # who sought outside help:....."Yes" in (13) = _____
- b. # did not seek outside help:..... "No" (13) = _____
- c. % who sought outside help:

$$\frac{12a*}{12a* + 12b*} =$$

- d. % who did not seek outside help:

$$\frac{12b*}{12a* + 12b*} =$$

13. Breakdown of "Outside-of-home-help" sought by mothers during a recent diarrhea episode (14 day recall).

- a. # of mothers whose outside-of-home-help included visiting a traditional healer:...."Yes" in (14a) = _____

b. # of mothers whose outside-of-home-help included visiting a clinic or hospital:.... "Yes" in (14b) = _____

c. # of mothers whose outside-of-home-help included visiting a pharmacy or store:.... "Yes" in (14c) = _____

d. # of mothers whose outside-of-home-help included visiting "anything else" then a traditional healer, clinic/hospital, or pharmacy/store:
 "Yes" in (14d) = _____

e. % of mothers whose outside-of-home-help included visiting a traditional healer:

$$\frac{13a*}{\dots\dots\dots 12a* + 12b*} = \text{_____}$$

f. % of mothers whose outside-of-home-help included visiting a clinic or hospital:

$$\frac{13b*}{\dots\dots\dots 12a* + 12b*} = \text{_____}$$

g. % of mothers whose outside-of-home-help included visiting a pharmacy or store:

$$\frac{13c*}{\dots\dots\dots 12a* + 12b*} = \text{_____}$$

h. % of mothers whose outside-of-home-help included visiting "anything else" then a traditional healer, clinic/hospital, or pharmacy/store:

$$\frac{13d*}{12a* + 12b*} = \text{_____}$$

14. Partial Breakdown of the combination of "Outside of-home-help" sought by mothers during a recent diarrhea episode (14 day recall)

a. # of mothers whose outside-of-home-help only involved visiting a traditional healer:
 In the tabulation form, number (14), there is a line which reads, "1 letter circled, number of:" Write the number for "a" :..... = _____

b. # of mothers whose outside-of-home-help only involved visiting a clinic or hospital:
 In the tabulation form, number (14), there is a line which reads, "1 letter circled, number of:" Write the number for "b" :..... = _____

c. # of mothers whose outside-of-home-help only involved visiting a pharmacy or store:
 In the tabulation form, number (14), there is a line which reads, "1 letter circled, number of:" Write the number for "c" = _____

d. # of mothers whose outside-of-home-help only involved visiting "anything else" then a traditional healer, clinic/hospital, or pharmacy/store:

In the tabulation form, number (14), there is a line which reads, "1 letter circled, number of:" Write the number for "d":..... = _____

e. # of mothers whose outside-of-home-help involved visits to two sources of help:

In the tabulation form, number (14), there is a line which reads, "2 letters circled, # of:" Write the number listed: = _____

f. # of mothers whose outside-of-home-help involved visits to three or more sources of help:

In the tabulation form, number (14), there is a line which reads, "3 or more letters circled, # of:" Write the number listed:..... = _____

g. % of mothers whose outside-of-home-help only involved visiting a traditional healer:

$$\frac{14a*}{12a* + 12b*} = \text{_____}$$

h. % of mothers whose outside-of-home-help only involved visiting a clinic or hospital:

$$\frac{14b*}{12a* + 12b*} = \text{_____}$$

i. % of mothers whose outside-of-home-help only involved visiting a pharmacy or store:

$$\frac{14c*}{12a* + 12b*} = \text{_____}$$

j. % of mothers whose outside-of-home-help only involved visiting "anything else" then a traditional healer, clinic/hospital, or pharmacy/store:

$$\frac{14d*}{12a* + 12b*} = \text{_____}$$

k. % of mothers whose outside-of-home-help involved visiting 2 sources of help:

$$\frac{14e*}{12a* + 12b*} = \text{_____}$$

l. % of mothers whose outside-of-home-help involved visiting 3 or more sources of help:

$$\frac{14f*}{12a* + 12b*} = \text{_____}$$

15. Category Breakdown of Non-ORT diarrhea specific treatments offered to children during diarrhea for recent (2 wk) diarrhea cases.

a. # of "Homemade/Traditional" special treatments used:

This number is found from the completed form, "Summary of Non-Oral Rehydration Therapy Treatments" under the Total for "Homemade/Traditional". (See tabulation instructions for Phase II): = _____

b. # of "Traditional Purchased" special treatment used:

This number is found from the completed form, "Summary of Non-Oral Rehydration Therapy Treatments" under the Total for "Traditional-Purchased". (See tabulation instructions for Phase II): = _____

c. # of "Modern Purchased" special treatments used

This number is found from the completed form, "Summary of Non-Oral Rehydration Therapy Treatments" under the Total for "Modern-Purchased". (See tabulation instructions for Phase II): = _____

d. # of "Other" special treatments used:

This number is found from the completed form, "Summary of Non-Oral Rehydration Therapy Treatments" under the Total for "Other Treatments". (See tabulation instructions for Phase II): = _____

e. % of "Homemade/Traditional" special treatments used to all Non-ORT treatments used during survey period:

$$\frac{15a*}{15a+b+c+d*} = \text{_____}$$

f. % of "Traditional-Purchased" special treatments used to all Non-ORT treatments used during survey period:

$$\frac{15b*}{15a+b+c+d*} = \text{_____}$$

g. % of "Modern-Purchased" special treatments used to all Non-ORT treatments used during survey period:

$$\frac{15c*}{15a+b+c+d*} = \text{_____}$$

h. % of "Homemade/Traditional" special treatments used to all Non-ORT treatments used during survey period:

$$\frac{15d*}{15a+b+c+d*} = \text{_____}$$

III. Immunization

16a. Of children not having a "Health Card", number of children claimed (by mother/guardians) to have never had an immunization = (20) = = _____

b. Of children not having a "Health Card", number of children claimed (implicitly by mother/guardians) to have had some immunization =
 "No card" in (19a) minus (20) = _____

c. Of total children 0 to 5, % not having a "Health Card" and claimed (by mother/guardians) to have never had an immunization:
 $\frac{16a*}{1f*}$ = _____

d. Of total children 0 to 5, % not having a "Health Card" and claimed (implicitly by mother/guardians) to have had some immunization:
 $\frac{16b*}{1f*}$ = _____

17 Status of 0 to 1, 1 to 2, 2 to 5 year old children having immunization cards showing partial immunization: Number and % (to total in each age category) having a shot within or longer then 3 months.

a. Number of partially immunized
 0 to 1 children having shot within
 3 months = See "1-12" for (30) = _____

b. Number of partially immunized
 1 to 2 children having shot within
 3 months = See "13-24" for (30) = _____

c. Number of partially immunized
 0 to 5 children having shot within
 3 months = "Total" (30) = _____

d. Number of partially immunized
 0 to 1 children having shot longer
 than months = See "1-12" for (31) = _____

e. Number of partially immunized
 1 to 2 children having shot longer
 than 3 months = See "13-24" for (31) = _____

f. Number of partially immunized
 0 to 5 children having shot longer
 than 3 months = "Total" (31) = _____

g. Of all 0-1 children,
 % who had a shot
 within 3 months: $\frac{17a*}{1a*}$ = _____

h. Of all 1-2 children,
 % who had a shot
 within 3 months: $\frac{17b*}{1b*}$ = _____

i. Of all 0-5 children,
 % who had a shot
 within 3 months: $\frac{17c*}{1f*}$ = _____

- j. Of all 0-1 children
 % who had a shot longer than 3 months..... $\frac{17d*}{1a*} =$ -----
- k. Of all 1-2 children
 % who had a shot longer than 3 months..... $\frac{17e*}{1b*} =$ -----
- l. Of all 0-5 children
 % who had a shot longer than 3 months..... $\frac{17f*}{1f*} =$ -----

18. Number and % of mother/guardians aware of immunization as a means for protecting their children from disease

- a. Number aware = (18a)=..... -----
- b. Number unaware = (18b)..... -----
- c % aware = $\frac{(18a)}{(18a) + (18b)} =$ -----
- d % unaware = $\frac{(18b)}{(18a) + (18b)} =$ -----

IV. Growth Monitoring and Breastfeeding

19. Month category at which mother's completely stopped breastfeeding their most recently weaned child, by number and % .

- a. # stopped between 1-3 months (3):..... = -----
- b. # stopped between 4-6 months (3)..... = -----
- c. # stopped between 7-12 months(3)..... = -----
- d. # stopped between 13-18 months (3)..... = -----
- e. # stopped between 19-24 months (3)..... = -----
- f. # stopped after 24 mo. (3)..... = -----
- g. % stopped between 1-3 months = $\frac{19a*}{19a+b+c+d+e+f*} =$ -----
- h. % stopped between 4-6 months = $\frac{19b*}{19a+b+c+d+e+f*} =$ -----
- i. % stopped between 7-12 months = $\frac{19c*}{19a+b+c+d+e+f*} =$ -----
- j. % stopped between 13-18 months = $\frac{19d*}{19a+b+c+d+e+f*} =$ -----
- k. % stopped between 19-24 months = $\frac{19e*}{19a+b+c+d+e+f*} =$ -----
- l. % stopped between 19-24 months = $\frac{19f*}{19a+b+c+d+e+f*} =$ -----

g. % 2 to 3, increased	$\frac{22g*}{22g+h+i*}$	=	-----
h. % 2 to 3, stayed same	$\frac{19h*}{19g+h+i*}$	=	-----
i. % 2 to 3, decreased	$\frac{22i*}{22g+h+i*}$	=	-----
j. % 3 to 5, increased	$\frac{22j*}{22j+k+l*}$	=	-----
k. % 3 to 5, stayed same	$\frac{22k*}{22j+k+l*}$	=	-----
l. % 3 to 5, decreased	$\frac{22l*}{22j+k+l*}$	=	-----

Phase II Survey Results

Appendix 16

For: _____
 (circle one: clinic/region/project)

I. General

1. Age Distribution of Population

	Number	%	Reference #	
			Apx14	Apx15
a. 0 to 1 (1 to 12 months)....	-----	-----		1a,2a
b. 1 to 2 (13 to 24 months)...	-----	-----		1b,2b
c. 2 to 3 (25 to 36 months)...	-----	-----		1c,2c
d. 3 to 4 (37 to 48 months)...	-----	-----		1d,2d
e. 4 to 5 (49 to 60 months)...	-----	-----		1e,2e

f. Total under 5.....	-----	-----		1f,2f
g. 5 to 15.....	-----	-----		1g,2g
h. 15 to 45 women.....	-----	-----		1h,2h
i. 15 to 45 men.....	-----	-----		1i,2i
j. Over 45.....	-----	-----		1j,2j
k. Total Survey Population....	-----	100 %		

2. Deaths Distribution, Children 0-5 (1 yr recall)

	Number	%	Reference #	
			Apx14	Apx15
a. 0 to 1 (1-12 months).....	-----	-----	2,6a	
b. 1 to 2 (13-24 months).....	-----	-----	3,6b	
c. 2 to 3 (25-36 months).....	-----	-----	4,6c	
d. 3 to 5 (37-60 months).....	-----	-----	5,6d	
e. Total 0 to 5.....	-----	100 %		

3. Diarrhea Associated Deaths, No. and % to all Deaths for 0-1, 1-5 Children (Diarrhea Death Ratio) (1 year recall)

	Number	%	Reference #	
			Apx14	Apx15
a. 0 to 1 (1-12 months).....	-----	-----	9a,b	
b. 1 to 5 (13-60 months).....	-----	-----	9c,d	

4. Births (1 year recall).....

-----	100 %	2.1a
-------	-------	------

5. Rates:

	Reference #	
	Apx14	Apx15
a. 0-1 mortality, Deaths/1000 live births	-----	1a
b. 1-5 mortality, Deaths/1000 1 to 5.....	-----	1b
c. Diarrhea associated 0-1 mortality.....	-----	1c
d. Diarrhea associated 1-5 mortality.....	-----	1d
e. Births, per 1000 population.....	-----	2.1b

6. Children 0-5, Health Card Status

(Immunization and Growth Monitoring)

Breakdown of children who: Have card; No Card-
Claim lost; No card--imply never had one.

	Number	%	Reference	#
			ApX14	ApX15
a. Have card.....	-----	-----	36a,b	
b. No card--claim lost.....	-----	-----		3a,b
c. No card--imply never had..	-----	-----		3c,d
c. Total.....	-----	<u>100 %</u>		

II. Diarrhea Control and ORT

7. Mother/Guardians with SSS Knowledge

	Number	%	Reference	#
			ApX14	ApX15
a. Not aware of SSS	-----	-----	10c,d	
b. Aware, Can't properly mix	-----	-----	10g,h	
c. Aware, Can properly mix	-----	-----	10e,f	
d. Total.....	-----	<u>100 %</u>		

8. Extent (frequency) food offered to child during
diarrhea versus when the child is well (14 day
recall)

	Number	%	Reference	#
			ApX14	ApX15
a. Offer less often vs. Well	-----	-----		6b,e
b. Offer same vs. Well.....	-----	-----		6c,f
c. Offer more often vs. Well	-----	-----		6a,d
d. Total.....	-----	<u>100 %</u>		

9. Extent (frequency) liquid offered to child during
diarrhea versus when the child is well (14 day
recall)

	Number	%	Reference	#
			ApX14	ApX15
a. Offer less often vs. Well	-----	-----		7b,e
b. Offer same vs. Well.....	-----	-----		7c,f
c. Offered more often vs. Well	-----	-----		7a,d
d. Total.....	-----	<u>100 %</u>		

10. Extent (amount) food offered to child after
diarrhea versus when the child is well (14
day recall)

	Number	%	Reference	#
			ApX14	ApX15
a. Offer less often vs. Well	-----	-----		8b,e
b. Offer same vs. Well.....	-----	-----		8c,f
c. Offer more often vs. Well	-----	-----		8a,d
d. Total.....	-----	<u>100 %</u>		

11. Breakdown of mothers who did or did not seek
help outside of the home during a recent
diarrhea episode (14 day recall).

	Number	%	Reference	#
			ApX14	ApX15
a. Did seek outside help	-----	-----		12a,c
b. Did not seek outside help.	-----	-----		12b,d
c. Total.....	-----	<u>100 %</u>		

12. Breakdown of "Outside-of-home-help" sought by mothers during a recent diarrhea episode (14 day recall).

	Number	%	Reference #	
			Apx14	Apx15
a. Traditional Healer.....	-----	-----		13a,e
b. Clinic or hospital.....	-----	-----		13b,f
c. Pharmacy or Store.....	-----	-----		13c,g
d. Other.....	-----	-----		13d,h

Note: The figures in this table (12) only indicate the amount of mothers which included a given "help" source in their visits. Mothers may have visited other sources of help as well.

13. Breakdown of the combination of "Outside-of-home-help" sought by mothers during a recent diarrhea episode (14 day recall)

	Number	%	Reference #	
			Apx14	Apx15
a. Traditional Healer ,only.....	-----	-----		14a,g
b. Clinic or Hospital ,only.....	-----	-----		14b,h
c. Pharmacy or Store ,only.....	-----	-----		14c,i
d. Other , only.....	-----	-----		14d,j
e. Two help sources.....	-----	-----		14e,k
f. Three or more help sources...	-----	-----		14f,l
g. Total.....	-----	<u>100 %</u>		

14. Category Breakdown of Non-ORT (ORS, SSS, Home liquid remedy) diarrhea treatments offered to children during a recent diarrhea episode (14 day recall)

	Number	%	Reference #	
			Apx14	Apx15
a. Homemade/Traditional.....	-----	-----		15a,e
b. Traditional-Purchased.....	-----	-----		15b,f
c. Modern-Purchased.....	-----	-----		15c,g
d. Other.....	-----	-----		15d,h
e. Total.....	-----	<u>100 %</u>		

15. Breakdown of the number and percent of children who had diarrhea during a 14 day period by age categories: 0-1, 1-2, 2-3, 3-5, 0-5 (years)

	Number	%	Reference #	
			Apx14	Apx15
a. 0 to 1 (1-12 months).....	-----	-----		9a,g
b. 1 to 2 (13-24 months).....	-----	-----		9b,h
c. 2 to 3 (25-36 months).....	-----	-----		9c,i
d. 3 to 5 (37-60 months).....	-----	-----		9d,j
e. 0 to 5 (1-60 months).....	-----	-----		9e,f

16. Breakdown of Mothers who stopped or continued breastfeeding during a recent diarrhea (14 day recall)

	Number	%	Reference #	
			Apx14	Apx15
a. Stopped Breastfeeding....	-----	-----		10a,c
b. Continued Breastfeeding..	-----	-----		10b,d
c. Total.....	-----	<u>100 %</u>		

22. Immunization Status of Children 0-5 (Card Based)

Reference #	Number	%	Reference #	
			Apx14	Apx15
a. Fully immunized (Card)....	-----	-----	(See comment in 20)	
b. Partial-on schedule (Card)	-----	-----	17c,i	
c. Partial-dropout (Card)....	-----	-----	17f,l	
d. Some Immunization-Claimed.	-----	-----	16b,d	
e. Never Immunized-Claimed...	-----	-----	16a,c	
f. Total.....	-----	<u>100 %</u>		

Note: Fully Immunized = DPT 1,2,3; Polio 1,2,3; BCG, Measles. Partial-on schedule means the last shot was taken within 3 months. Partial dropout means the last shot was taken longer than 3 month ago. Some immunization-claimed means the mother does not have a card to verify shots, but says her child did receive some kind of immunization shot.

22. Immunization Status of Children 1-2 (Card Based)

Reference #	Number	%	Reference #	
			Apx14	Apx15
a. Fully immunized (Card)....	-----	-----	(See Comment in 20)	
b. Partial-on schedule (Card)	-----	-----	17b,h	
c. Partial-dropout (Card)....	-----	-----	17e,k	
d. No Card.....	-----	-----	3f,h	
e. Total.....	-----	<u>100 %</u>		

23. Immunization Status of Children 0-1 (Card Based)

Reference #	Number	%	Reference #	
			Apx14	Apx15
a. Fully immunized (Card)....	-----	-----	(See Comment in 20)	
b. Partial-on schedule (Card)	-----	-----	17a,g	
c. Partial-dropout (Card)....	-----	-----	17d,j	
d. No Card.....	-----	-----	3e,g	
e. Total.....	-----	<u>100 %</u>		

24. Maternal Health Card Status. Breakdown of mothers who: Have card; No card-claim lost; No card--imply never had one.

Reference #	Number	%	Reference #	
			Apx14	Apx15
a. Have card.....	-----	-----	4a,c	
b. No card--claim lost.....	-----	-----	5a,b	
c. No card--imply never had....	-----	-----	5c,d	
c. Total.....	-----	<u>100 %</u>		

25. Mother/Guardians having 0, 1, or 2, tetanus toxoid shots (Based on card/clinic shot claim)

Reference #	Number	%	Reference #	
			Apx14	Apx15
a. Zero (0) TT shots.....	-----	-----	33c,d	
b. One TT shot.....	-----	-----	33e,f	
c. Two TT shots.....	-----	-----	33a,b	
d. Total.....	-----	<u>100 %</u>		

IV. Growth Monitoring and Breastfeeding

26. Month category when mothers completely stopped breastfeeding their most recently weaned child
- | | Number | | Reference # | |
|-------------------------|--------|--------------|-------------|-------|
| | Number | % | ApX14 | ApX15 |
| a. 1 to 3 months..... | ----- | ----- | | 19a,g |
| b. 4 to 6 months..... | ----- | ----- | | 19b,h |
| c. 7 to 12 months..... | ----- | ----- | | 19c,i |
| d. 13 to 18 months..... | ----- | ----- | | 19d,j |
| e. 19 to 24 months..... | ----- | ----- | | 19e,k |
| f. + 24 months..... | ----- | ----- | | 19f,l |
| f. Total..... | ----- | <u>100 %</u> | | |
27. Month category when most recently weaned child began eating and drinking something other than breastmilk
- | | Number | | Reference # | |
|-----------------------|--------|--------------|-------------|-------|
| | Number | % | ApX14 | ApX15 |
| a. 1 to 3 months..... | ----- | ----- | | 20a,d |
| b. 4 to 6 months..... | ----- | ----- | | 20b,e |
| c. +6 months..... | ----- | ----- | | 20c,f |
| d. Total..... | ----- | <u>100 %</u> | | |
28. Breakdown of children who either did or did not eat and drink something else in addition to breastmilk at the age of 6 months
- | | Number | | Reference # | |
|--------------------------------|--------|--------------|-------------|-------|
| | Number | % | ApX14 | ApX15 |
| a. Did do, age 6 months..... | ----- | ----- | 42a,b | |
| b. Did not do, age 6 months... | ----- | ----- | 42c,d | |
| c. Total..... | ----- | <u>100 %</u> | | |
29. Of children having a "Health Card", those whose weight went "up", "down", or "stayed the same" since last weighing
- | | 0 to 1 | | 1 to 2 | | 2 to 3 | | 3 to 5 | | Reference # |
|----------|--------|-----|--------|-----|--------|-----|--------|------|---------------------|
| | No. | % | No. | % | No. | % | No. | % | |
| a. Up | ---- | --- | ---- | --- | ---- | --- | ---- | --- | ApX15 |
| b. Same | ---- | --- | ---- | --- | ---- | --- | ---- | --- | 21a,d,g,j;22a,d,g,j |
| c. Down | ---- | --- | ---- | --- | ---- | --- | ---- | --- | 21b,e,h,k;22b,e,h,k |
| d. Total | ---- | --- | ---- | --- | ---- | --- | ---- | 100% | 21c,f,i,l;22c,f,i,l |
30. Of children having a "Health Card", those "Normal" or "Malnourished" (Malawi MOH Categories)
- | | 0 to 1 | | 1 to 2 | | 2 to 3 | | 3 to 5 | | Reference # |
|-----------|--------|-----|--------|-----|--------|-----|--------|------|-------------------|
| | No. | % | No. | % | No. | % | No. | % | |
| a. Normal | ---- | --- | ---- | --- | ---- | --- | ---- | --- | ApX14 |
| b. Malno. | ---- | --- | ---- | --- | ---- | --- | ---- | --- | 38e,f,i,j,m,n,q,r |
| c. Total | ---- | --- | ---- | --- | ---- | --- | ---- | 100% | 38g,h,k,l,o,p,s,t |
31. Of children 0-1, 1-5 those who were weighed during the past 3 months.
- | | Number | | Reference # |
|--------------------------------|--------|-------|-------------|
| | Number | % | |
| a. Children 0-1 (1-12 months). | ----- | ----- | ApX14 |
| b. Children 1-5 (13 to 60 mo.) | ----- | ----- | 37a,b |
| | | | 37c,d |

Phase II Survey: Guidelines for Translating And Pretesting the Questionnaire

I. Translation

1. Why do it? Even the most experienced multilingual speakers make mistakes without a written copy in the local language at hand. Translating the questionnaire adds reliability to the results. We have greater confidence that all questions are being asked and interpreted the same way. If questions are translated only during the interview, there is the chance that different interviewers will translate the same questions differently. Such an outcome could make the results useless.
2. Translate the meaning of the words, not the exact words.
3. Translate the full questionnaire. It is important that the interviewers have a full grasp of both the questions and the instructions on the questionnaire.
4. Check the translation. After the questionnaire is translated, it is worthwhile to have someone who is unfamiliar with the questionnaire translate the meaning of the translated questions back into English. Where differences exist between the local language version and the English questionnaire, corrections would be made. If this procedure is not practical, at least try to have one or two people who are well versed in both English and the local language check the translation for accuracy and clarity, and make suitable corrections.

II. Pretesting

1. What is a pretest? A pretest involves taking the translated questionnaire and "practicing" it on several people (7 or more) who are similar to the people who will end up taking the questionnaire. In this case, this means choosing mothers or guardians of children between the ages of zero and five.
2. Why do it? The reason for a pretest is to check and see if the questionnaire is useful for accurately obtaining the desired information in an efficient and effective manner. Experience has demonstrated that most questionnaires have problem areas that don't become evident until the questionnaire is actually field tested. An untested questionnaire may have questions that are impractical to answer, difficult to understand or to explain, biased in their presentation, or a host of other problems. The questionnaire may also be impractical in its format for recording information, and subsequently tabulating results.
3. What are some key concerns to be aware of in a pretest?
 - a. Are the objectives behind the questions appropriate to the situation of concern? Are the right areas being investigated?

During a pretest it may become apparent that certain critical areas are not being investigated. It might also become clear that certain areas are being researched which are not important in the given context. For example, the decision was made to include questions on breastfeeding on the Phase II questionnaire at the expense of including other questions such as those investigating the kinds of foods given to a child after a diarrhea. A pre-test might show that the overwhelming majority of Malawians breastfeed for over 2 years. In this case, it might be worthwhile to consider exchanging some of the questions on breastfeeding to other areas which are considered more situationally important.

b. Is the respondent really asked appropriate questions for getting the desired information? In order to avoid leading questions, sometimes a respondent will be questioned in an indirect fashion. For example, question 18 of the Phase II questionnaire takes this approach in investigating mothers' awareness of immunization. This question needs to be tested. If it turns out that most mothers answer this question in a manner indicating that they are not aware of immunization, but subsequent indirect and direct questions clearly indicate that they are aware of immunization, then the question needs to be re-written.

c. Are questions uniformly and clearly understood by all? If the same question is understood differently by various respondents, then this indicates that the question should be re-written. For example, question number 2 of the Phase II questionnaire holds the potential for being unclearly understood. Mothers should be asked if they understand this question. If it is unclear, then it should be re-written.

d. Are questions asked in a manner so that respondents are likely to give honest answers? Sometimes questions are written so that respondents are led to answer the way they think the questioner wants the question answered rather than what they actually think or know to be true. Questions which show themselves to be leading, or biased towards a particular answer should be modified.

e. When the answers to questions are fixed, do they adequately permit the respondent to communicate a meaningful answer? For example, questions 9 and 10 assume that if a mother is trying to rehydrate a diarrhea-ridden child, that fixed answers related to frequency of offering food or liquid are adequate to measure the mothers intent to rehydrate. It may be that this assumption is wrong. If it turns out that mothers who offered liquid less often clearly demonstrate that they intended to rehydrate their children, but were unable, then both the question and the answers need to be re-drafted.

f. Is the questionnaire easy to understand and administer by the interviewers? It may be that instructions in the questionnaire are hard to follow (or easy to overlook) and consideration needs to be made on re-writing or restructuring the questionnaire. For example, the Phase II questionnaire includes several instructions

which ask the interviewers to "skip to the next question"; it may be that this instruction is difficult for village level interviewers to understand and follow. In this case, the questionnaire will need to be revised to reflect this constraint.

A pretest might also show that the format of the questionnaire is inadequate to meeting the needs of the interview. For example, question 14f of the Phase II questionnaire only includes a small space for recording certain kinds of help sought by mothers during a diarrhea episode. A pretest may show that this space needs to be expanded.

4. How to do a pretest. Select several individuals who clearly understand the reasons for doing a pretest and are aware of the potential questionnaire problem areas that need to be investigated. These individuals should test the questionnaire with individuals who are similar to the ones who will eventually take the questionnaire (mothers of children who are less than five). If possible, the pretest should be done in a village environment which is similar to the places in which the actual survey will be done. Each member of the pretest group should make note of any problem areas as they occur (ie. carry a note-pad and write the problems down). After each member of the pretest group has completed several questionnaires, the group should reconvene immediately and discuss the questionnaire while it is fresh on their minds. They should discuss weaknesses which they have found and suggest changes in writing which would improve the questionnaire.

Changing the translated questionnaire, or the original English questionnaire version, may mean that changes will also need to be made to the tabulation sheets, calculation forms, and report materials. Therefore, before changes are made, there should be a clear agreement that the need for change is important.

Sampling Considerations and Methods

This appendix discusses some key considerations related to sample size and the resource limitations of the project. It also outlines two methods for gathering a representative sample of the project target group. In discussing the specific sampling methodologies, this appendix draws considerably from the publication "Sampling: How To Select People, Households, Places To Study Community Health, A Guide for Health Workers," (International Epidemiological Association, 1982). This publication explains sampling methodology in layman terms. A copy of this publication was given to the Associate Director for Field Evaluation and Support. It is recommended that this publication be referenced during the sample planning.

Sample Size And The Resource Limitations Of The Project

The resource limitations of the ADRA/Malawi project heavily influences decisions related to sampling. In particular, the Project Director has indicated that the project cannot afford to have the survey last longer than 6 weeks. Indirectly, this limitation establishes an upper limit for the number of completed questionnaires and sets a potential constraint in interpreting some of the results of the survey.

Based on the experience of the Phase I survey, a 6 week time limitation means that approximately 1,500 completed questionnaires is a realistic upper boundary of what can be accomplished. This number assumes that the 13 CHW-interviewers will work four weeks on the interviews (6 interviews per day times 20 work days) and two weeks will be needed to complete the reports, analyze the data, and account for slow periods. One thousand-five-hundred completed questionnaires means that information will be collected on approximately 3,100 children below the age of five (Assuming average household sizes of ten persons and 20% of the population below five).

The limit of gathering information on a maximum of 3,100 children, ages 0 to 5, may have ramifications for interpreting some of the questionnaire data, particularly for child mortality rates. For example, the World Health Organization (1984) indicates that in establishing an adequate diarrhea-associated baseline rate for children between 0 and 5 years, it may require gathering information on 3,500 to 35,000 children in that age group, with the actual number depending on several considerations. If the required number of children are not surveyed, then one cannot have confidence in the validity of the rates or draw conclusions based on comparisons between the initial rate and mortality rates estimated at a later time.

The limitation of gathering information on 3,100 children between 0 and 5 years of age means that confidence probably cannot be given to the mortality rates established for the individual clinic areas. The clinic sample sizes will be too small. It is possible, however, that the mortality rates will be valid for the overall project. The only other area that the

sample size limitation is likely to affect is estimates of immunization coverage.

The statistician at the CCCD office in Lolongwe will be able to provide insight into the level of (statistical) confidence that can be put in the mortality and immunization coverage results, as well as other items on the questionnaire. The Consultant Team highly recommends that the CCCD statistician in Lolongwe is consulted before the sample size and the sampling methodology is fixed. Even if changes cannot be made, the statistician will be able to clarify the limitations of the approach on interpreting the results of the survey.

Two Methodologies For Sampling

A. Cluster Sampling.

In this case, the cluster sample involves randomly selecting two or three villages from each clinic area and interviewing every household in the two or three villages. Three steps are involved:

1. Divide the clinic area into "clusters." In this case, each village is a cluster. Using a government map, outline the boundaries of each village. In some case, households will not belong to a particular village. If it is at all practical, include these households among the cluster boundaries of a nearby village. If this is not practical, make separate clusters of the outlying households which are nearby to each other. It is important that each household in the clinic area belong to only one cluster. Households should not belong to more than one cluster.

The boundaries should be clearly identifiable by the interviewers. This will probably mean that someone will have to go out into the villages to determine the boundary points between one cluster and another cluster. Talking to local people will be of considerable help in defining boundaries. Often, the local people will be able to identify the boundaries between one area and another when a boundary is not apparent.

During the visits to the establish boundaries, two other objectives can be accomplished. First, the visiting "boundary person" can use this time to familiarize him or herself with the local people. Friendly relationships should always be a hallmark of the project. Second, it will be important to confirm the average number of households in a cluster area. Since the objective is to interview about 120 households, it will be important to know the average number of households in a village. The confirmation of households per village cluster will be used to determine if more than the present estimate of two villages is needed to obtain the target of 120 completed interviews for each clinic area.

After the boundaries have been clearly charted, label each cluster with a number on the map.

2. Draw a random sample of village clusters. The number of village clusters to be randomly selected depends on the average

number of households per cluster. If the average village cluster size is between 50 and 75, two villages will be sufficient. If the average size of village clusters is below 50, then three villages should be selected per clinic area. It is acceptable if this procedure leads to a different number of completed interviews than the target of 120 questionnaires.

The two or three villages to be selected should be chosen using an established random sample method. This might involve the use of a random sample table or selecting numbers from a box following specific guidelines. The appendix to the International Epidemiological Association publication referenced at the end of this section discusses both of these methods in detail.

3. Arrange for the CHW-interviewers to visit each and every one of the households within the selected village clusters. Households without children in the 0 to 5 age range should be included.

B. Two-Stage Cluster Sample.

Four general steps are involved in performing a two-stage cluster sample.

1. Form village clusters at each clinic area as described for cluster sampling.

2. Select the number of clusters to be chosen at each clinic area. The procedure for selecting the number of village clusters with two-stage cluster sampling is not the same as for cluster sampling. In two-stage cluster sampling, the number of village clusters to be selected depends on two considerations:

- (a) the total number of village clusters identified in the first step...and
- (b) a preliminary estimate of the likely value of the most important "proportion" which this survey is concerned with. "Proportion" refers to the percent of persons who are expected to have a particular characteristic. In this survey, the "most important proportion" is probably the percent of children who had diarrhea within a two week period prior to the interview (Most of the survey questions are dependent on there being a child in the household who had diarrhea in the past two weeks).

After the two considerations above have been addressed, look up the desired number of village clusters from Table 1 of this appendix. For example, if 50 village clusters have been formed, and the percent of children expected to have diarrhea during the survey is 20 %, then at least 15 village clusters should be surveyed. If it is not possible to get a reasonable estimate of the percent of children that will have diarrhea during the survey, the lowest estimate, or 5 %, should be made assumed. In the latter example, a clinic area with 50 village clusters and a

Table 1
Sample Size for Cluster Sampling
Proportion (Percent) Expected

Total Number Of Clusters Formed	5% or (95%)	10% or (90%)	15% or (85%)	20% or (80%)	25% or (75%)	30% or (70%)	35% or (65%)	40% or (60%)	45% or (55%)	50% or (50%)
Over 400	26	24	23	21	20	18	17	15	14	13
400	25	24	22	21	19	18	17	15	14	13
300	25	23	22	21	19	18	16	15	14	12
250	24	23	22	21	19	18	16	15	14	12
200	24	23	21	20	19	17	16	15	14	12
150	23	22	21	19	18	17	16	14	13	12
100	22	10	19	18	17	16	15	14	13	12
90	21	20	19	18	17	16	15	14	12	11
80	20	19	18	17	16	15	14	13	12	11
70	20	19	18	17	16	15	14	13	12	11
60	19	18	17	16	15	14	14	13	12	11
50	18	17	16	15	15	14	13	12	11	10
40	16	16	15	14	14	13	12	12	11	10
35	15	15	14	14	13	12	12	11	10	10
30	14	14	13	13	12	12	11	11	10	9
25	13	13	12	12	11	11	10	10	9	9
20	12	12	11	11	10	10	10	9	9	8
15	10	10	9	9	9	9	8	8	8	7
10	8	8	7	7	7	7	7	7	6	6

Source: International Epidemiological Association, 1982. pp. 96-98.
(1). The table was modified to show proportions as percentages (e.g. 5% instead of 0.05).

5 % diarrhea expectation would select at least 18 villages.

In practice, it is worthwhile to increase the sample size indicated from the table by at least 20%. The latter example would therefore be increased from 18 to 20 village clusters.

3. Determine the number of households (with children between ages 0 and 5) to be selected from each cluster sample. Since the project only has the time and resources to complete approximately 120 interviews per clinic area, divide 120 by the number of village clusters selected in the preceding step. The resulting quotient is the number of households with children below age five that need to be interviewed.

4. Draw a random sample of the village clusters. The number of village clusters to be sampled should be selected using an established random sampling method. The use of a random number table or selecting numbers from a box, as described by the International Epidemiological Association (See reference) are two adequate alternative.

5. Draw a random sample of the households in the selected village clusters. The following two methods are suggested for randomly selecting households in a cluster.

a. Use an existing list or create a list, and randomly select households from this list. In this method, each of the households would be numbered on a list. Households would be selected through the use of a random number table (This procedure is discussed in detail in the appendix of the International Epidemiological Association referenced at the end of this section). Although only 6 completed surveys are desired it will be necessary to select at least twice that amount of households to allow for households without children below age 5, and households with no one home.

b. "Spin-The-Bottle" method. This method is suggested by CCCD (1986) when it is impractical to use a list. First, a central location in the village area is selected (e.g. Headman's home, village discussion area, market area etc.); from there, randomly select the direction (e.g. by spinning a bottle), in which the first house will be located. Once the direction is selected, count the number of houses which exist in that direction line from the central location to the cluster boundary and select a random number between 1 and the total numbers of houses along the directional line selected. This will identify the first house to be visited. The random selection of the first house is critical. If chosen, this procedure should be strictly followed.

From the first house visited, go to the closest non-interviewed house and so fourth. Each household should be interviewed, including households without children below age five. The village survey should be continued, however, until 6 interviews are completed in households having children below age five.

References

- Dabis, F. "Guidelines For Practice Surveys Combatting Childhood Communicable Diseases Program" International Health Program Office. Center for Disease Control, Atlanta, Georgia. 1986.
- Lutz, W. "Sampling: How To Select People, Households, Places To Study Community Health: A Guide for Health Workers", International Epidemiological Association. Geneva, Switzerland. 1982.
- WHO/CDD/SER, "Guidelines For A Sample Survey of Diarrheal Disease Morbidity, Mortality, and Treatment Rates" WHO Programme For Control Of Diarrhoeal Diseases. June, 1986.

"Other"* Outside-of-Home Sources of Help
Sought by Mothers Having A Diarrhea-Ridden Child

Source of Help	Number of Mothers Using This Help (Write x for each mother using)	Total
1. _____:	_____	_____ 1
2. _____:	_____	_____ 2
3. _____:	_____	_____ 3
4. _____:	_____	_____ 4
5. _____:	_____	_____ 5
6. _____:	_____	_____ 6
7. _____:	_____	_____ 7
8. _____:	_____	_____ 8
9. _____:	_____	_____ 9
10. _____:	_____	_____ 10
Total All "Other" Visits:..... =		_____

* Does not include visits to a traditional healer,
clinic or hospital, or a pharmacy or store

Non-ORT* _____ Remedies
 Used By Mothers Having A Diarrhea-Ridden Child

Remedy Name	Number of Mothers Using This Help (Write x for each mother using)	Total
1. _____:	_____	_____ 1
2. _____:	_____	_____ 2
3. _____:	_____	_____ 3
4. _____:	_____	_____ 4
5. _____:	_____	_____ 5
6. _____:	_____	_____ 6
7. _____:	_____	_____ 7
8. _____:	_____	_____ 8
9. _____:	_____	_____ 9
10. _____:	_____	_____ 10

Total Number of _____ Remedies ... = _____

* Does not include homemade liquid remedies (e.g. soap, tea, juice, rice water), sugar and salt solution, or oral rehydration salts solution.

TABULATION AND CALCULATION OF CLINIC
US AID INFORMATION INDICATORS

Instructions for tabulation and calculation of information obtained from Monthly Clinic Report are noted below. The numbers coincide with those items marked "c" in the Section US AID Information Indicators Accepted for ADRA-Malawi Child Survival Project. These items can be calculated from Clinic data.

- 1.02 Total deaths 0-1 Yr for 1 Yr divided by total live births from the same population.
- Total Deaths 1 - 5 Yrs divided ;by estimated total number of children age 1 - 5 Yrs in the same population
- 1.03 Totals for 1 Yr obtained directly form Clinic Reports
- 2.11 "Covered" must first be defined
- 2.12 Directly from Clinic Reports
- 2.13 Total for 1 Yr, directly from Clinic Reports
- 2.14 "Information " must first be defined. Possibility is to use total number of mothers who were involved in health education about ORT in Clinics and villages
- 2.16 Total for 1 year, directly from Clinic Report
- 3.10 "Covered" to be defined. If "covered" is defined as completely immunized, obtain directly from Clinic Report.
- 3.11 Directly from Clinic Report.
- 3.12 If "information" means participation in health education, use total number of mothers who were involved in health education about Immunization in clinics and villages
- 3.13 "Effective" must first be defined.
- 3.14 Directly from Clinic Report
- 3.15 Directly from Clinic Report.
- 3.16 Directly from Clinic Report
- 3.20 Directly from Clinic Report
- 4.12 "Covered" must first be defined.
- 4.13 Directly from Clinic Report

- 4.14 Directly from Clinic Report
- 4.15. If "information" means participating in health education, use total number of mothers who were involved in health education aabout Nutrition in Clinics and villages.
- 4.16 From High Risk Register Report.
- 4.17 From High Risk Register report. For percent, divided by total number of children in the area in that age group.
- 4.18 Clinic Reports. Percent obtained by dividing by total number of children in area in that age group
- 4.20 Directly form Clinic Report. High Risk Register. Numbers in each category should be divided by the total number of children weighed.

BIRTH REGISTRATION

All births which occur in the Clinic area should be recorded in a Birth Register at the Maternal Health Center or at the Clinic. The Clinic Director and the nurse midwife are responsible for maintaining a complete and accurate Register.

The Register should be arranged so that the information about the child and its mother should be on opposite pages when the Register is open.

Information about the newborn could be arranged in columns and could include: Birth Number (Identification Number), Birth Weight, Born Living or Dead, BCG vaccination, Risk category.

Information about the mother could include Name, Village, Total pregnancies, Total births, Immunization status (TT #1; TT #2; None); Number of Prenatal visits; Last Child now Dead or Alive; 2nd last child now Dead or Alive (See Appendix 21 Estimation of 0 - 2 yr Mortality Rate and 0-5 Yr Mortality Rate as determined by history of deaths of recently delivered mother.

The form below is recommended to provide essential information related to the birth. Several extra columns should be available in the Register to permit the addition of other important pieces of information.

Mother Register Format

				Tetanus		
Name				Total Pregnancies	Total Births	Immun Status
-----				-----	-----	-----
Prenatal Visits	Last child Alive	2nd Last child Alive	Last child Dead	Village	Delivery Site	
-----	-----	-----	-----	-----	-----	-----

Notes: Birth weights noted in grams

Tetanus immunization status should be recorded as:

TT 2 (2 immunizations during pregnancy)
 TT 1 (1 immunization during pregnancy)
 0 No immunization during pregnancy
 C Complete immunization according to Maternal Health Record from previous pregnancy

Place of Delivery H -- Home
 Other -- Describe Other

Birth Register Format

Number	Name	Sex	Birth Weight	Born Alive	Dead	BCG	High Risk
--------	------	-----	--------------	------------	------	-----	-----------

Recording Births in Villages

The CHW is responsible for recording of all village births.

Information about Births can be obtained by a responsible person or the Community Health Committee, by a VHW. or by the CHW.

It is essential that information about every birth be known at the Clinic and that the appropriate information be included in the Birth Register of the Clinic or the Maternal Health Center.

A full page form similar to the pages in the Register could be used by the CHW to permit registration of all births in a month. This Report would then be submitted to the Clinic each month.

Example of Village Birth Form

Name of Recorder _____ Year ____ Month ____ Day ____

Birth Register

Name	Sex	Weight	Alive	Dead	BCG	Risk
------	-----	--------	-------	------	-----	------

Mother Register

Name	Total Pregnancies	Total Births	Tetanus Immun Status
------	-------------------	--------------	----------------------

Prenatal Visits	Last child Alive	Last child Dead	2nd Last child Alive	2nd Last child Dead	Village	Delivery Site
-----------------	------------------	-----------------	----------------------	---------------------	---------	---------------

Note: A scale can be used to determine birth weight. The scale can be given to the person responsible for obtaining the birth information.

DEATH REPORT

All deaths must be carefully investigated. The VHW is responsible for reporting death. She informs the CHW and the MA. Within 2 weeks of the death the MA will interview the mother or guardian of the child. The Death Report will be completed by the MA and the information included in the Monthly Clinic Report.

Clinic _____ Month _____; Year _____

Interviewer _____ Position _____

Name of patient who died _____

Village _____ Age at death(1) _____

Physical signs during the week before death:

Fever____; Cough____; Diarrhea____; Vomiting____; Injury____

Other conditions _____

Other major events during the last week

Cause of death as diagnosed by Mother _____

Cause of death as diagnosed by M A _____

If the cause of death was related to any of the conditions noted below, indicate with a check mark

Diarrhea _____ Malaria _____ Tetanus _____

Measles _____ Other _____

Total young children in family (include the recent death)

	0-1	1-2	2-3	3-4	4-5	5-14	Total
Living	_____	_____	_____	_____	_____	_____	_____
Dead	_____	_____	_____	_____	_____	_____	_____

(1) Age at death in years. For age before 1 year, use age in months / 12.

Example: 5 months is 5/12 years

If diarrhea occurred during the week before, death where was the child treated? at the Clinic____; at the Hospital_____.

If the child had diarrhea during the last week, did the child receive ORT?

Yes___ No___

Last visit to the Under 5 Clinic was ___ months before death

Vaccination history: None___; Partial___; Complete ___

Was child weaned by age 6 months? Yes___; No___

Months between most recent pregnancies:

less than 12_____;

between 12 and 18_____:

between 18-and 24_____:

Over 24_____

High Risk during 6 months before death: Yes___; No_____

Age and cause of death has been noted on Monthly Report _____

Diagnosis Summary (continued)

Neo Tetanus _____
 Pertussis _____
 Polio _____

Referrals of Children 0-5 yrs to Hospital

Total referrals _____ Referrals for Diarrhea _____
Inpatients: Total Beds _____; In Patients Treated _____; Deaths _____
 Total Patient - Days _____; Other _____

Health Education

Topics	<u>Number of People Taught</u>			<u>Hours of Group Teaching</u>		
	Clinic	Village	Total	Clinic	Village	Total
ORT	_____	_____	_____	_____	_____	_____
IMM	_____	_____	_____	_____	_____	_____
Nutr	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____

Total Home Visits _____; Total High Risk Visits _____

Equipment and Supplies

ORS Packets: On hand at beginning of month _____
 Received during month _____
 Distributed during month _____
 Balance on hand at end of month _____

Supply difficulties _____

Cold Chain Operation:

Number of days refrigerator not operating in month _____
 Other cold chain indicators _____

Vaccines (Individual Doses)

	On hand begining of Month	Received	Used	Outdated	On Hand End of Month
DPT	-----	-----	-----	-----	-----
Polio	-----	-----	-----	-----	-----
Measles	-----	-----	-----	-----	-----
BCG	-----	-----	-----	-----	-----
Tetanus	-----	-----	-----	-----	-----

Community Information

Deaths Under Age 5:

0 - 1	1 - 5	Total	Diarrhea Related	Other
-----	-----	-----	-----	-----

Births:

			Birth Weight in grams	
Live	Dead	Total	Above 2500	Below 2500
-----	-----	-----	-----	-----

Community Health Committees:

Number of Meetings -----

Major decisions/Actions -----

Home Visits by Purpose:

High Risk	-----
Pregnancy	-----
Drop Outs	-----
Survey	-----
Other	-----
Total	-----

UNDER 5 CLINICS

Dates Scheduled for this Month _____; _____; _____

Dates Clinic was actually Held _____; _____; _____

Dates Scheduled for next Month _____; _____; _____

High Risk Children

Number of High Risk Children

Beginning of month	newly diagnosed	returned to Normal	End of month
--------------------	-----------------	-----------------------	-----------------

-----	-----	-----	-----
-------	-------	-------	-------

Number of High Risk children visited in their homes			-----
---	--	--	-------

Information from High Risk Register

Number of Children

Total examined -----

With Repeated Growth Failure-----

Newly diagnosed as High Risk-----

With Growth Monitoring Cards-----

Diagnosed as High Risk and now Improved-----

MONTHLY CLINIC REPORT - INSTRUCTIONS

Clinic Visits

All cases of diarrhea in children should be noted under Diarrhea, not Gastrintestinal Diseases.

Degrees of severity of diarrhea, mild, moderate, and severe, should be classified according to WHO standards - described on the wall chart.

Note: Suspected cases of Polio should be reported immediately to the Project Director and to the Ministry of Health.

In patients

To calculate Total patient-days: add number of days of hospitalization of each patient.

Health Education

Record only group teaching sessions conducted in villages.

Include Growth Monitoring teaching under Nutr.

Record all teaching sessions that last more than 15 minutes

Nutrition

Weight for Age and Weight Change will be collected for all children who are weighed. Therefore the Total will be the same for each - the total number of children weighed.

High Risk

Detailed information about collecting and recording High Risk information is presented in the PAHM booklet Primary Health Care

MONTHLY MATERNITY SERVICES REPORT

Name of Unit _____ Month _____; Year _____

Midwife _____ Total Income _____

<u>Births</u>		Weight (grams)		Compli- cations	Deaths	High Risk
Live	Dead	Total	Over 2500			
_____	_____	_____	_____	_____	_____	_____

<u>Ante Natal Visits</u>				Immunizations			
First	Subsequent	Other	Total	Referrals	TT 1	TT 2	None
_____	_____	_____	_____	_____	_____	_____	_____

Maternal Complications Total _____; Deaths _____

List the complications/how they were handled/problems faced

Infant Complications Total _____; Neonatal Deaths _____

List the complications/how they were handled/problems faced

Maternal Inpatients

Total Patients Beds Total Patient-Days

----- ----- -----

Maternal Health Education Total Health Talks _____; Total Audience _____

Health Topics Covered _____

Community Health Activities related to Maternal Health

Evangelistic Program _____

MONTHLY REPORT: COMMUNITY HEALTH WORKER

Clinic _____ Month _____

Medical Assistant _____ Year _____

Community Health Worker _____

Births in Villages

Live	Dead	Total	Birth Weight (grams)		Noted in Register	Delivery Trained TBA
			Above 2500	Below 2500		
---	---	---	---	---	---	---

Child Deaths Age 0 - 5 Years in Villages

Age		Total	Diarrhea Related	Other Causes	Died at Home
0 - 1	1 - 5				
---	---	---	---	---	---

Village Visits

Name of Village	Total Visits		Name of VHW
	Dates (1)	_____	
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----
-----	-----;-----	-----	-----

(1) Visits may be made to the same village several several times in a month. Indicate only under 'Date' the day of the month.

Health Education

Topics	<u>Number of People Taught</u>		<u>Hours of Teaching</u>		<u>Numbers Who were Taught</u>	
	Village	Home	Village	Home	VHW	Committee
ORT	-----	-----	-----	-----	---	----
IMM	-----	-----	-----	-----	---	----
Nutr	-----	-----	-----	-----	---	----
Other	-----	-----	-----	-----	---	----
Total	-----	-----	-----	-----		

Clinic Assistance

Under 5 Clinics: Dates attended _____ ; _____ ; _____ ; _____

Maternal Health Clinics: Dates attended _____ ; _____ ; _____

Other Assistance _____

Mobile Under 5 Clinics Supervised

Village	Date	- - - Visits - - -		
		First	Repeat	Total
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----

Other Information _____

Note: Included with this Report from the Community Health Worker would also be her Activity Schedule indicating activities during the past month and her Planning Schedule to indicate activities and schedule for the next month.

MONTHLY REPORT: VOLUNTEER HEALTH WORKER (VHW)

Clinic_____ Month_____

Village_____ Year_____

VHW Name(s)_____

Births

Name _____ Number _____

Village_____; Weight_____grams

Delivered by: Nurse midwife___; Trained Birth Attendent___;

Untrained Birth Attendent___; Registered in Clinic___;

Date for first Under 5 Clinic visit_____

Health Education: Immunization___; ORT___; Nutrition/Feeding___;

Risk Status: Normal___; High___; Referred to Clinic___;

Previous Children	Alive	Dead
-------------------	-------	------

Last Child	----	----
------------	------	------

Next to last child	----	----
--------------------	------	------

Child Deaths

Name _____ High Risk___; Age_____;

Mother Name_____ Village_____

Where died: Hospital___; Home___; Clinic_____

Home visits

Number of Visits___; Number of Health Cards checked___;

Purpose: Routine ___; High Risk ___; Survey ___; Pregnant___;

Drop Outs - Immunization _____

Drop Outs - Growth Monitoring _____

High Risk Patients

Beginning of Month___; Added during month___; End of Month___;

Note A 'Drop Out' has missed 3 or more scheduled sessions

Note: Each month as a result of the High Risk Register and Drop Out Register at the Under 5 Clinic, a list of names of specific children and mothers and their villages will be given to each VHW by the CHW.

If during the month other children have been identified at the Clinic or at the Under 5 Clinic who requires special care and attention, the CHW will notify the VHW.

ADDITIONS TO THE QUARTERLY REPORT

For management and reporting purposes, the information noted in the Quarterly Report could include not only numerical indicators but also subjective comments related to project operation. An outline of items to be covered could include:

Major problem or constraints

Strategies and plans to overcome these conditions

Changes in the target population

Major revisions of activities or timetable of the Annual Work Plan

Useful information for inclusion in the First Year Report to US AID could be:

Major activities and accomplishments in the establishment of the project

Obstacles encountered from within the project and conditions which have recently arisen that influence the project activities

appropriate changes from the original project proposal in strategies and plans as a consequence of implementation realities

Any suggested changes in project duration of Logical Framework

Information collection system now in place and plans for modification in the future.

COMMUNITY HEALTH WORKER ACTIVITIES

The following were the activities of Community Health Workers as described by the Project Director:.

- Provide instruction and demonstration in the use of ORT.
- Provide instruction and motivation for immunization.
- Provide nutrition instruction including feeding practices, growth monitoring, cooking and gardening.
- Provide information and promotion of child spacing.
- Collect Survey information.
- Participate in Under 5 Clinics by:
 - Assisting in teaching weighing, advising, recording
 - Counselling for High Risk children
- Collect information about births and deaths of children.
- Participate as a member of the Community Health Committee.
- Assist in the transportation of patients to the Clinic or to the hospital
- Supervise and assist with the training of Volunteer Health Workers.
- Make home visits to High Risk mothers and children.
- Participate in personal periodic training and continuing education.
- Organize and supervise mobile Under 5 Clinics.
- Supervise and collaborate closely with the Volunteer Health Workers

COMMUNITY HEALTH WORKER - ACTIVITY SCHEDULE

Name of CHW _____ Month _____ Year _____

Location

Day	1st Week	2nd Week	3rd Week	4th Week	5th Week
Sun	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Mon	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Tue	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Thu	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Fri	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Major Activities _____

Vacation Days taken _____ Supervisor Review _____

Note: The Activity Schedule is a record of a summary of the activities of the CHW during a given month. It should be submitted at the end of each month along with the Planning Schedule of anticipated activities planned for the next month. The supervisor of the CHW (Clinic Director) thereby knows what the CHW has done during the previous month, and at the beginning of each month can discuss and plan what she will do during the following month.

The Planning Schedule could have the same format as the Activity Schedule except for:

- (a) a change in title "Community Health Worker - Planning Schedule";
- (b) a change in the vacation line to "Vacation Days scheduled: from _____ to _____"

VOLUNTEER HEALTH WORKERS ACTIVITIES

The following activities of Volunteer Health Workers were described by the Project Director:

Collect Vital Statistics

Births (Including Birth Weights)

Deaths

Permanent Movement of people in and out of Villages

Notify the Director of the Clinic (Medical Assistant) of Births and Deaths that occurred in the villages.

Assist in the operation of Under 5 Clinics at the Clinic or in Villages

Support and assist the work of the Community Health Committee

Visit families of High Risk children and mothers. Reinforce instructions of the Medical Assistant to mother of High Risk children. Follow instructions given by the Medical Assistant to the VHW related to special care of High Risk children.

Encourage regular attendance at Under 5 Clinics of all children up to age 5 years.

Encourage regular attendance at Maternal Health Clinics of all mothers who are pregnant or who have recently been delivered.

Follow up immunization and growth monitoring dropouts.

Conduct health education sessions in the villages.

Collect specific information and assist in Surveys as requested.

Encourage and support ORT in the villages thru instructions for the treatment of diarrhea (and provision of ORS packets to mothers, if and when approved by the MOH, PAHM and ADRA)

TRAINING INFORMATION ABOUT HEALTH WORKERS

A separate folder in the Project Director's office, Training-Health Workers, could be used to record training activities of project personnel.

The following could be included in the Training folder.

TRAINING COURSES

For each Training Course or Training Session conducted in the Project, include, course title; date; course outline; topics covered; participants; leaders; duration; evaluation; materials used; relevant bibliography.

TRAINING OPPORTUNITIES

Information about future training opportunities both within and beyond the country.

PERSONNEL TRAINING SUMMARY

For periodic statistics, include a summary page which will indicate the name of the health worker, hours of training and topics covered, competencies demonstrated

The form below could be considered. The names of project personnel could be printed on a permanent form with space to complete the quarterly information. A new form could be used for every reporting quarter.

Personnel Training - Quarterly Record

Name of Health Worker	Position	Hours of Training by Topic				Total
		ORT	IMM	Nutr	Other	
-----	-----	---	---	---	-----	-----
-----	-----	---	---	---	-----	-----
-----	-----	---	---	---	-----	-----
-----	-----	---	---	---	-----	-----
Total Hours		---	---	---	-----	-----

Note: The definition of "hour of training" could be at least one hour of didactic and/or field training in the topics indicated.

INFORMATION FEEDBACK

The information collected from Clinics and villages will be used to enhance the impact of the project thru monitoring of indicators of project impact, effectiveness and efficiency.

An essential component of the information system is feedback to the field staff who are actually implementing the project and who collect and tabulate most of the information.

Purpose

- Provide a foundation for management and operating decisions
- Provide a practical method for maintaining productive communication with field workers.
- Serve as a basis for discussion, education and motivation among the villages in which the work is done.
- Acknowledge receipt and demonstrate the usefulness of Clinic and personnel reports.
- Emphasize the value of information collection.
- Encourage continued collection of accurate, useful information

Method

- 1 Medical Assistants would send monthly reports from all clinics to the project office by the 10th of the following month.
- 2 The Project staff person responsible would tabulate the results, prepare a project wide report, and would graph appropriate information to facilitate comparison and analysis.
- 3 The Supervisory Team (Project Director and the 2 Supervisors) would review and analyze the information collected.
- 4 An information Packet would be prepared by the Supervisory Team and sent to each Clinic by the 25th of every month. Packet contents would include:
 - Results of past month activities, tabulation of Clinic reports and graphs of selected information.

- Comments by the Supervisory Team:

Observations, analyses and conclusions

Recommendations and special emphasis for the future.

- New technical information and publications which have been received during the month. This activity would form the foundation for the continuing education of the field staff.

- Teaching material for VHW, mothers and families.

- Planned project activities:

In detail for the next month

In general for the next 4 months.

- Separate information for each clinic, including the financial review and update.

In a similar way the feedback cycle which will be used for the Clinics can be used for ADRA and for US AID. It would be expected that these organizations would also respond promptly with observations and comments that could be incorporated into subsequent project operation.

INFORMATION COMPONENTS OF HIGH RISK ACTIVITIES

High Risk and Child Survival

One of the fundamental principles of population based Primary Health Care/Child Survival activities is the identification of those members of a given population who are at greatest risk of sickness and death. When resources of equipment, supplies, facilities and trained personnel are severely limited as they are in developing countries, a focus on children and mothers who are considered high risk is an essential, practical, and justifiable strategy.

The High Risk approach in health services can (and should) be incorporated into Under 5 Clinics and community health services. With the expansion of Under 5 Clinic activity, and the increase of community involvement related to the new child survival initiative, the Adventist Health Services have a unique opportunity to innovate and set an example in their catchment areas. The information and experience gained could enhance the establishment of High Risk activities throughout the country.

The Primary Health Care section of the Private Hospital association of Malawi. (PAHM), has already begun High Risk activities on a small scale and is actively encouraging their member organization to add this strategy to their present health programs.

The High Risk experience of PAHM has been described quite clearly in the PAHM publication, Primary Health Care. Since this description relates to Malawi children and mothers and Malawi practices, the procedure recommended by PAHM could be adopted in this project, used and monitored for a year and evaluated. On the following pages are excerpts from Primary Health Care which describe the High Risk approach are included on Pages 2-6 of this Appendix.

A Workshop on the Risk Approach in Primary Health Care attended by all MAs, Supervisors, and CHWs could provide the guidance and motivation to begin High Risk activities before the end of 1986.

As noted in the PAHM publication, a commitment to High Risk will require a special Register, recorded and kept at the Clinic. Practical follow up of High Risk patients in the community by the VHWS and the CHW will be possible.

High Risk Register

As recommended by PAHM, a Register must be used to permit follow up of those children identified as High Risk.

Information noted in the Register will include:

Identification number for each child

Name of the child's mother or guardian

Address

Date of birth of the child

Complete immunization

Growth failure (malnutrition identification)

Mother-guardian's ability to deal with (diagnose, treat and/or carry to a clinic) diarrhea, malaria, pneumonia.

When properly conducted the Register will indicate each month:

Number of children

- with repeated episodes of growth failure
- at Risk;
- with completed immunization
- with cards;
- who have improved;
- who have died

Note: The High Risk Register which is recommended can provide some of the information required by US AID and ADRA. After using the Register for several months, other activities and information considered appropriate for the project could be added.

REPORTING TIMETABLE

Noted below on the left hand column is the reporting schedule established by ADRA and US AID.

Possible Project Extension

For consideration by ADRA/Malawi and ADRA/Washington is a one year extension of the project with no increase in US AID funding. Such an extension is quite common in 3 year AID supported PVO projects. For understandable and acceptable reasons most projects require up to 6-8 months before full scale project implementation begins. Moreover, beneficial change - either by addition or modification - resulting in a significant long term impact usually requires more that 2 -3 years,

For this project, informal comments by AID staff in both Malawi and in the PVO office in Washington indicated that a extension could be quite acceptable, probably useful.

If an extension of the project were to be sought, it should be considered by the time of the Annual Report in October, 1986.

A 1 year extension could have the following benefits:

- 1 More time to make and measure the desired and projected impact.
- 2 Adequate time to gain operational experience, to analyze this experience and to make appropriate changes designed to improve project operation and impact.
- 3 More time for Child Survival activities to become institutionalized within the Adventist Health Services.
- 4 An extra year would provide an opportunity for orderly and planned transition of the child survival activities into the ongoing health program of ADRA-Malawi
- 5 Optimum use of entire grant funds.

Report Timetable

<u>Year</u>	<u>Month</u>	<u>Current Schedule</u>	<u>Alternate Schedule</u>
1985	Oct	- - - - Beginning	of Project - - - -
1986	Jul	ADRA	
	Oct	ADRA	AID
1987	Jan	ADRA	Alternate schedule would include a mid-project review to replace the scheduled annual report in Oct 1987.
	Apr	ADRA	
	Jul	ADRA	
	Oct	ADRA	
			<u>Mid Term Review</u>
1988	Jan	ADRA	
	Apr	ADRA	
	Jul	ADRA	
	Oct	Final Report	

Scheduled End of 3 year Project

Schedule for possible extension

1989	Jan	ADRA
	Apr	ADRA
	Jul	ADRA
	Oct	Final Report

Note: During the discussions involving the Project Director, ADRA Evaluator and the Consultant Team, the decision was made by ADRA staff to recommend a one year addition to the project - to Oct 1989.

MID-TERM REVIEW

Background

In all development projects, the original project operational strategy and plans should be modified periodically. This exercise will provide an opportunity and a motivation to review all aspects of the project after at least one year of operation. Possible modifications can be discussed and the Project Director encouraged to make appropriate changes and/or additions.

These changes would be implemented for at least 1 year - and assessed again at the End of Project Review.

Following a decision to extend the project for one year, it is timely to consider a Mid Term Review two years after the project beginning activities related to it.

Purpose

- Improve the impact of the Child Survival Project and of activities related to it.
- Identify and report activities during the preceding 1 1/2 years that could be useful for health programs beyond the project - both within and beyond Malawi.
- Exchange experience and documents with others who are involved with child survival projects.

Methods

1 Conduct a 3 - 4 day Review Workshop to assess and analyze results.

2 Workshop Activities

Field visits to clinic sites preferably during a scheduled Child Health Clinic, and a village to attend a Community Health Committee meeting.

Review of collected reports and data.

Review and discussion of methods and procedures in managing specific activities such as Under 5 Clinics, Village Health Committees collaboration, community health worker motivation and supervision, village health education - in this projects and in other similar projects within and beyond Malawi.

Recommendations for changes designed to enhance the impact and increase the sustainability of the project.

On the final day, present results to key Malawi government and non-government officials,

Publish a report of the proceedings.

3 Participants

Health personnel with experience in CS activities within Malawi - both in the PVO and the government.

Health personnel with experience in CS and related project operation from beyond Malawi

Representatives of international agencies and funding sources.

Key decision makers/political figures in Malawi.

Key project personnel, including regional supervisors and medical assistants.

Schedule

The Mid-Term Review should be scheduled after at least 1 year of project operation with time remaining in the project to justify, monitor and evaluate mid-term changes.

USE OF MAPS IN PRIMARY HEALTH CARE AND CHILD SURVIVAL PROGRAMS

The use of maps was demonstrated and reviewed with the Supervisors and the Project Director during one of the working sessions. Excellent maps with a scale of 1:50,000 are available in Malawi, therefore the addition of a map at all Clinics is quite possible.

Catchment Area

The fundamental premise of PHC and related child survival activities is that the health of all the people living in a defined geographic area is of primary concern.

A Community Map will clearly identify the catchment area and the population to be included in project activities.

Use of Maps in Information Systems

Maps can be used beneficially in a number of ways:

Identify the number and general location of the people to be served.

Facilitate the planning and conduct of surveys.

Identify the geographical areas of responsibility for the Health Committees and the VHWs.

Identify concentrations of High Risk children and mothers.

Identify concentration of specific diseases - epidemic surveillance.

Plan project travel activities.

Explain the project area and activities to visitors and representatives of other organizations involved and interested in PHC/CS.

Identify key landmarks in the catchment area.

Items which can be included on the Map

Population estimate including the target population of children 0-5 years and women ages 15 - 45.

Names of the Clinic Staff.

Location of Clinics and other sites where health services are provided such as hospitals and maternal health centers.

Location of homes of staff and of VHWs.

Items which can be included on the Map

Names and location of members of the Community Health Committees.

Grid for identification of locations on the Map.

Outline of areas of geographic responsibility of Health Committees and affiliated VHWs.

Areas where a baseline population census-survey has been conducted.

Location of Weighing sites in the villages.

Other items can be added as required

Note: Valuable guidance in the use of maps in primary health care services can be obtained from CCCD project personnel in Lilongwe.

ADRA INTERNATIONAL

LOGICAL FRAMEWORK MATRIX

CHILD SURVIVAL HEALTH GRANT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	MAJOR ASSUMPTIONS
<p><u>Higher Goals</u> Improved health status of children and mothers in Malawi.</p>	<ol style="list-style-type: none"> 1. Decreased infant mortality rate. 2. Decreased infant morbidity rate. 3. Decreased incidence rate of infant communicable diseases. 	<ul style="list-style-type: none"> -National Mortality Data -National Morbidity Data -National Health Statistics 	<ul style="list-style-type: none"> -Projects replicated on nation-wide scale. -No major disasters.
<p><u>Project Goals:</u> Reduced infant mortality in the villages within a five mile radius of 12 ADRA clinics, Malamulo Hospital and selected villages in the Shire Valley, Malawi</p>	<ol style="list-style-type: none"> 1. 35% decrease local infant mortality rate by December 1988 2. 35% decrease local toddler mortality rate by December 1988 3. Decrease disease incidence rate with morbidity specificity (measles, gastroenteritis, etc.) by December 1988 	<ul style="list-style-type: none"> - Pre and post project child mortality surveys in selected target villages conducted by ADRA staff and contracted independent evaluation 	<ol style="list-style-type: none"> 1. Political stability maintained. 2. No major disasters, war or famine. 3. Normal weather patterns maintained.
<p><u>Outputs:</u></p> <ol style="list-style-type: none"> 1. Village Health Workers and Volunteer Community Services training completed 2. ORT Promotion Program 	<ol style="list-style-type: none"> 1. 12 weeks VHW training completed by December, 1986 2. 20 VHW working in villages by March, 1986 3. AHS Implementation training completed by March, 1986 4. 2 weeks continuing education (CE) per year 80% of mothers trained in skills of preparing and administering home mix ORS by December, 1986 80% of mothers utilizing ORT 80% of cases presenting dehydration referred to local health centers Number of ORT packets sold 	<ol style="list-style-type: none"> 1. Curriculum 2. Certificates presented <ul style="list-style-type: none"> - Demonstration and questioning - Home visits (60-100 per wk.) - Monthly supervisors reports - Clinic records - Shop sales records 	<ul style="list-style-type: none"> - Contracted services delivered as specified -Availability ORS maintained -ORS demands

ADRA INTERNATIONAL

LOGICAL FRAMEWORK MATRIX

CHILD SURVIVAL HEALTH GRANT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	MAJOR ASSUMPTIONS
<p>3. EPI Program delivered</p>	<p>1. 80% of referrals to health care for vaccination</p> <p>2. 80% of children under 5 yrs. of age completing course of vaccination in: a. Polio c. DPT b. Measles d. BCG</p> <p>3. 12 Clinics with functional cold-chain systems</p>	<p>Immunisation inventories</p>	<p>- Availability of vaccines maintained by government</p>
<p>4. Maternal Child Health and Nutrition</p>	<p>1. 80% of mothers participated in MCH training</p> <p>2. 70% of children at risk by categories of malnutrition enrolled in the program</p> <p>3. 75% of children gaining weight</p> <p>4. 80% of pregnant mothers receiving tetanus toxoid in the 1st trimester of pregnancy</p>	<p>- 60-100 Home visits per week</p> <p>- Monitoring of quarterly reports</p> <p>- Monthly weight monitoring</p> <p>- Clinic records</p>	<p>- Mothers retain and utilize training</p> <p>- PL-480 Title II commodities remain available to selected program</p>
<p>5. 15-25 PNC/MCH Activities</p>	<p>- 80% of mothers in the community aware of family planning methods</p> <p>- % of families using child spacing methods</p> <p>- % water supplies protected</p> <p>- % of latrines constructed</p> <p>- % of home gardens</p>	<p>- Clinic records</p> <p>- As requested in the community</p> <p>- Home visits</p>	<p>- Availability of supplies-contraceptives, latrines, wells</p> <p>Note: These interventions are not part of the child survival Health Grant, but plan to be achieved through local means.</p>

LOGICAL FRAMEWORK MODIFICATIONS

It is possible and practical to consider modifications in the Logical Framework at this time in the life of the project. These changes can be based on the assessment of project realities after 6 months of operation.

With the appropriate changes, the Log Frame can be used as a valuable guide in project management.

Since the Log Frame will be considered extensively in project evaluation by US AID, it is important that objectives, inputs, outputs and indicators be as accurate as possible.

Changes were discussed with the Project Director. Noted below are recommendations by the Project Director for consideration by ADRA for revision of the Logical Framework. In only a few instances - as noted in footnotes - is there a difference between the recommendations of the Project Director and the Consultant Team.

All targets, unless noted, are projected to the end of the project October, 1989 - assuming the 1 year extension will be recommended and approved.

Narrative Summary

Reduced Infant Mortality in the villages within the 5 mile radius catchment area of all 13 ADRA Clinics

Project Goals

Change to "20% decrease in IMR by Oct 1989 (1)

Change to "20% decrease in mortality rate of children 1-5 years

Verification - Add "ongoing clinic based data collection"

Outputs

Upgraded Clinic Staff

Trained and functioning CHW

Trained and functioning VHW

Mobile Under 5 Clinics

Functioning Community Health Committees

(1) Recommend 25% decrease in Infant Mortality Rate

Child Survival activities an integral component of the Adventist Health Services - Malawi.

Indicators for the above Outputs

20 CHWs with a total of 6 weeks formal training

90 VHWs with a total of 6 weeks formal training

A minimum of 15 mobile Under 5 Clinics in operation every month throughout the catchment area of the Project

At least 13 Health Committees meeting a minimum of every 2 months

Child Survival activities incorporated (a) into the job description and continuing education of health workers and (b) into the ongoing service activities of all functioning Clinics

ORT Indicators

ORS Packets available at all times from every Clinic, and from at least 3 sites beyond each Clinic (2)

75% of mothers with knowledge of ORT

75% of children (0 - 5 years) with diarrhea treated with ORT

All health workers with appropriate skills in treatment and teaching ORT

ORT included in the Clinic Treatment Protocol in all Clinics

50% decrease in clinic diagnosis of severe dehydration from diarrhea

70% of mothers with adequate skills in ORT

75% of children under 5 years who were treated with ORT during the last diarrhea episode

(2) Recommend 25% decrease in mortality rate of children 1-5 years. Note that malaria is a significant health problem in young children. Mortality related to malaria will probably not be influenced significantly by this project - at least during the first 2 years.

75% increase in the number of packets distributed in the Clinics (3)

Immunization

Output

- Functioning, comprehensive immunization program for children and mothers in all Clinics

Indicators

- 80% decrease in incidence of vaccine preventable diseases
- 75% of children with complete immunization by 12 months; and 80% by 24 months
- 80% ever pregnant women with complete tetanus immunization
- All Clinics providing complete immunization services, available during all clinic hours.
- A functioning cold chain over 85 % of the time in all Clinics and for all Under 5 Clinics (4)
- All health workers with appropriate knowledge of immunization
- 85% of mothers with appropriate knowledge of immunization

Nutrition

Outputs

- Functioning comprehensive health monitoring and nutrition promotion for children 0 - 5 year.

Indicators

- 80% of children enrolled in Under 5 Clinics
- 50% decrease in undernourished children age 1 - 3 yrs
- High Risk Register and a High Risk Program established in all Clinics

(3) Recommend packets available from at least 9 sites beyond each Clinic. In order for the ORS packets program to be optimally effective, increased accessibility in more remote areas is essential. If and when the MOH approves packet distribution beyond the clinics, distribution points can be developed.

(4) Recommend functioning cold chain over 90% of the time as a result of improvement of ADRA and MOH maintenance and repair services.

Monthly Under 5 Clinics operating in every Clinic area with at least 3 mobile Weighing Clinics or Under 5 Clinics in at least 50% of the areas

60% of pregnant mothers attending prenatal Clinics at least 3 times during their recent pregnancy

60% of High Risk children visited at home by CHW or VHW

All health workers demonstrating growth monitoring and nutrition skills

All health workers trained to teach proper nutritional practices

over 95% of infants breast fed at birth

95% of infants breast fed at 6 months

95% of infants breast fed and eating solid foods by 6 months

80% of infants breast fed at least 12 months

Means of Verification

Home visits by Volunteer and Community Health Workers

Monthly Clinic Reports

Periodic Village Surveys

Records of Training Programs

Note: At the Mid-Term Review the components of the Log Frame should be reviewed and revised as indicated based on project results, and changes in conditions and activities.