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REPORT ON SHORT-TERM CONSULTANCY
FOR OMANI-AMERICAN JOINT COMMISSION

A Report Prepared By PRITECH Consultant:
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BACKGROUND:

In 1984, with considerable assistance from WHO, the Ministry of Health (MOH) in Oman undertook a national child health survey. The primary purpose of the survey was to assess the level of infant and child morbidity and mortality, particularly as it related to diarrhoeal disease and other preventable diseases. The survey was designed using WHO recommended cluster sample methodology and the survey instruments (in Arabic) were carefully pre-tested to ensure validity of responses. In implementation, the survey covered a considerable portion of the native Omani population (estimates vary widely, but the most widely used estimate is 1 million) - 7,500 households with a total of 18,000 children, under 5 years of age. The survey was completed by November 1984.

When the survey was planned it was intended that the Statistics Unit of the MOH would undertake all the analysis of the survey data. Indeed, the Statistics Unit did a selective manual analysis of the data, and presented their results to senior MOH staff. However, this was insufficient and a need was felt for further analysis of the survey; analysis which would necessitate the use of a computer. The Statistics Unit did not have access to a computer. Furthermore, the Unit did not have the requisite manpower that could be made available for a computer analysis of the survey. Thus, it seemed as though further analysis of the survey would not be possible.

In June, 1985 at the request of the MOH, the Omani-American Joint Commission (OAJC) decided to consider the possibility of helping the MOH complete the analysis of the child health survey. It was agreed that a short-term consultant, with experience in health survey analysis, would visit Oman and determine the best strategy for the analysis of the survey. The consultants recommendations were to be presented to the OAJC for its consideration. This report represents the recommendations of the consultant.

TERMS OF REFERENCE:

The Terms of Reference for this consultancy were clearly specified at an initial in-country meeting with OAJC Chief, Mr. Gary Towery. These were as follows:

1. To determine the objectives of the MOH, as specified by the Senior Pediatric Consultant and National Coordinator of Child Health Programs, Dr. El-Bualy, with respect to the child health survey.
2. To make an independent assessment of what could and ought to be done with the survey.

If the conclusions in step (2) were that the survey should be further analysed, then the next steps were:

3. To determine whether resources were available locally to carry out this analysis.
4. To propose a plan-of-action, with as much detail as possible, for the analysis of the survey.

It was agreed that the consultant would present a draft report, summarising her findings, to the OAJC before leaving Oman.

ACTIVITIES/FINDINGS:

The following discussion of activities and findings is organised in sections, corresponding to the four terms of reference described above.

1. Determination of MOH Objectives vis-a-vis the Child Health Survey.

In his role as National Coordinator of Child Health Programs, Dr. El-Bualy represents the driving force behind the MOH efforts in the area of primary health care. He met with me to discuss the MOH interest in the analysis of the survey. From our discussion I learned that Dr. El-Bualy was extremely interested in having the survey analysed as expeditiously and effectively as possible. He feels that the MOH needs the survey results, which would provide baseline data on infant/child morbidity and mortality, for several important reasons:

- a. The data would be an essential input for the Five Year National Child Health Plan that is currently being prepared, since they would point to the areas that require greater primary health care activities. For example, if the data show that a significant portion of children suffer from measles, then immunization activities could be accelerated.
- b. The data could be used several years from the present time as the basis for measuring the progress made in delivering child and infant health services.
- c. The data would provide the MOH with "hard facts" regarding the current status of child and infant health in the nation, thereby allowing them to respond clearly to queries and assertions from foreign and international agencies.
- d. The data would provide the MOH with the factual basis for reporting to the Government and to the people of Oman, on the health status of children in the country.

Of the four reasons cited, clearly Dr. El-Bualy was most concerned with the first two. Having baseline data to use in planning primary health care services and then in monitoring progress, is essential. Thus, the MOH would very much like to have the survey analysed as soon as possible.

Dr. Hector Traverso, the WHO Medical Epidemiologist at the MOH, also provided me with insights into the MOH objectives with respect to the child health survey. He essentially echoed Dr. El-Bualy's comments, while further emphasising the need to get the survey analysed as quickly as possible. They would like to have it analysed soon and use the results for planning and future program monitoring.

2. Independent Assessment of the Child Health Survey.

After carefully studying the survey instrument, discussing the survey design and methodology with Dr. Traverso, and talking to Mr. Shamshad Ahmed, the Chief Statistician at the Statistics Unit I came to the conclusion that the survey is very important and must be analysed. The survey was designed and conducted following WHO guidelines, and every attempt was made to eliminate probable pitfalls. The survey instrument was designed in English, translated into Arabic, modified, tested, and then modified again. It was also approved by the Regional WHO Office. The team of interviewers - three for each cluster (including a supervisor) - were trained for three days in Muscat, before they went into the field. It would appear that the survey data are of good quality and should provide meaningful results after being cleaned and analysed.

This is not to say that there are not several foreseeable difficulties with analysing the survey. For one thing the large size of the sample makes any analysis of it quite expensive. The expenses include the cost of coding (by Arabic and English readers), data cleaning, computer program preparation and actual computer processing. Since the survey has to be processed in Oman (for confidentiality of data) these costs are even higher than they would be in the United States. However, the value of the data does seem to justify the analysis of the survey - at least upto a certain level of cost.

In terms of timing I think that it is important that the survey be analysed soon. The MOH should have this baseline data now as they produce their five year child health plan. This is the time of major ORT and Immunization interventions world-wide, and Oman should be planning its activities at the same time, so that it can participate in international discussion and exchange of experience. It cannot do this without a clear knowledge of where their relative strengths and weaknesses are. In short, the MOH needs the survey analysed now.

3. Determination of In-country Resources/Capability for Analysing the Survey.

Given my conclusions outlined in the section above, I proceeded to determine whether there were local resources available for analysing the survey. My research and findings are as follows.

The first alternative that I considered was the Statistics Unit at the MOH. It seemed that they would be the natural choice for analysing the survey, particularly since they had done some preliminary analysis and were familiar with the data. My thought was that the OAJC could provide the computer facilities (perhaps an IBM-AT microcomputer and some survey processing software) and the training for the Unit staff. In this way, we would be getting the job done and also achieving a longer term effect of organisational strengthening and human resource development. In addition, I thought that this could be the way to get the Statistics Unit started on the routine reporting system that Dr. El-Bualy wants to improve.

However, this does not appear to be a viable alternative in terms of getting the survey analysed in the short term. The Statistics Unit does not have the staff time available currently for doing any preliminary data-cleaning and coding work on the survey. The staff has very limited experience working with computers (there is no computer in the Unit at this time though there are plans to procure WANG microcomputers) and so it would take a considerable amount of lead-up training time before any data entry or processing could take place. In general, it is felt (by Dr. El-Bualy among others) that having the Statistics Unit work on the survey would involve an enormous time delay of anywhere upto six to nine months. Thus it does not seem possible to follow this alternative.

The next major alternative I considered was having the survey analysed elsewhere in the Government system. I met with Mr. Colin Lee, the Computer Advisor to the Ministry of Finance and Mr. George Spencer, the UNIDO Advisor to the Ministry of Commerce to discuss this possibility. Both these people have been responsible for guiding their own, as well as other Ministries, in their computer-related activities. The Ministry of Finance has a large computer facility where they process, among other things, the majority of the civil service payroll (50,000 employees in total). The Ministry of Commerce also has a good-sized computer facility, with skilled staff who include computer training of other Government employees among their duties.

Unfortunately, both Mr. Lee and Mr. Spencer were unable to recommend any government office that could process the survey in the next two or three months. Mr. Lee did suggest that the Pharmaceuticals Directorate General of the MOH, which is having a mainframe computer installed in the next month, could possibly process the survey. But here too there would have to be some training of the staff before anything could be done, and so we would once again end up with a considerable delay. Thus, the Government approach did not really yield any feasible solutions.

The final alternative I considered was having the survey analysed by a private sector organisation. There are several large computer services companies in Oman, and contracting with one of these firms would seem to be one simple way of getting the survey analysed fast. On the recommendations of Mr. Lee and Mr. Spencer I have narrowed the options to two such companies - MHD and IMTAC. These companies are reputable and well-respected and have had previous experience working with Government surveys and databases. They have also been responsible for installing and supporting computer systems in several ministries.

Through discussions with the managers of these two firms (Mr. Spencer talked to the IMTAC manager who was in Dubai during my visit) I was satisfied that they would be fully capable of processing the survey. After looking at the survey instrument and the preliminary file and report specifications that I developed (please see attachments), the companies came up with approximate estimates of time and cost. These were respectively 2 months and \$40,000. They would be able to code and enter the data, clean and consistency check, and generate any reports that were needed. However, in my opinion there will need to be detailed specification of the analysis by a Survey/Statistical specialist before handing over the job to these companies. Despite the companies' expertise in the area of survey processing, they do not have the capability to

design an analysis plan, which would include specifications for the files, coding and reports. Once this specification has been done, the company can undertake the processing without undue problems.

Thus it would appear that after my investigation of local resources for analysing the survey, I drew the conclusion that the survey can be processed expeditiously and effectively locally, by a private computer services company, following careful specification by a survey consultant.

4. Recommended Plan of Action:

In order to have the survey analysed effectively and quickly I would recommend that the OAJC undertake the following calendar of activities.

August, 1985:

- a. Identify and obtain necessary clearances for a Survey Consultant who would be able to spend 2 - 3 weeks, in September, developing the detailed specifications for the analysis of the survey. The consultant should have experience in working with Primary Health Care Surveys, and it would be very helpful if he/she had some knowledge of Arabic. More details on the consultant's terms of reference are provided below (September - item (b)).
- b. Select the company that will be given the contract for processing the survey. Not being familiar with OAJC regulations, I cannot provide any further details on this step, but I would recommend that we limit our selection process to choosing one of the two firms mentioned above. These companies clearly enjoy the trust of two experts in the area (Mr. Lee and Mr. Spencer) and I would consider that a sufficient basis for limiting our consideration to them. Both companies have been given enough information on the survey (see previous section) to permit them to submit their price bids to the OAJC. The contact persons for the two companies are:
Mr. V. Desikan at MHD Inc. and
Mr. Martin Lewis at IMTAC Inc.
- c. Arrange with the MOH for access to the survey data. The survey questionnaires are currently in the Statistics Unit of the MOH and they will have to be made available to the Consultant and then to the private company.

September, 1985:

- a. Bring the survey consultant to Oman (preferably in the first 2 - 3 weeks of the month) to develop the specifications for the survey analysis and to convey these specifications to the private company. These specifications must include:
 1. Data file specification
 2. Coding specification
 3. Final outputs/reports specificationThe consultant will have to work closely with the following people/parties - Dr. El-Bualy, Dr. Traverso and the private company - during his/her assignment, so the visit should be coordinated with all involved. In addition, Mr. Spencer has volunteered to act as an informal resource person on the survey analysis so the consultant should meet with him. NOTE: It is essential that items (b) and (c) outlined under the August arrangements, be made before the consultant arrives in Oman.

- b. Hand over the raw data and the finalised specifications to the private company and agree upon a timetable of work. The consultant should be responsible for reviewing whether the timetable proposed by the company is feasible. Realistically, I would think that the company will need at least 2 - 2 1/2 months to complete the work, particularly since there will be some work time lost in November during the National Day celebrations. Thus the survey processing should be complete by early December, at the very latest.

December, 1985:

Toward the completion of the survey processing it may be desirable to have the consultant return to Oman to review the status of work and wrap up the effort by writing a short report to the MOH, discussing the survey results. The report could consist of a short narrative and the tables of survey statistics produced by the private company. This is clearly not a necessary activity, and it should only be undertaken if the MOH and the OAJC decide that such a review and report is a better ending point than a set of survey statistic reports, and that it needs to be done by the consultant.

SUMMARY

The Child Health Survey contains vital information, that is needed urgently by the MOH for planning and monitoring purposes. The survey should be analysed as soon as possible and with OAJC assistance this should be feasible. Local private sector resources can be used to process the survey, and an outside consultant can plan and specify the analysis. Tentative planning would suggest that the survey could be completely analysed by the end of December, at the very latest.

ADDENDUM

In addition to discussing the analysis of the child health survey, Dr. El-Bualy talked to me about the routine reporting system for the Diarrhoeal Disease Program that he has developed. He feels that this system is also vital to the success of their activities and that it is the natural follow-up to the baseline survey. The system is currently collecting data from health facilities on a monthly basis, and the data are being compiled manually. But this process takes very long. The result is that the MOH is unable to really use the data effectively and they are unable to provide feedback to the staff at the facilities, who are collecting the data on an ongoing basis. Dr. El-Bualy feels that this reporting system needs to be computerised, to eliminate these problems. He would also like to computerise the system as soon as possible, so that a backlog of un-analysed data does not accumulate.

I did not have sufficient time on this visit to really study the reporting system in any depth. I did, however, get a chance to look at the data forms they receive from the health facilities, and to discuss the kind of reports they would like to generate from the system - for the MOH and for the health facilities. From this limited perspective I can only make the following comments:

1. The reporting system is well designed and does not really need any substantive changes. The data gathering forms and reports are clear and, more importantly, they express the data in terms that are directly comparable to the data collected in the survey. This is very important for monitoring purposes.
2. The system does need to be computerised, so that there can be a rapid turn-around in response. By "computerised" I mean that the data should be stored in a computer database, and data-entry and report generating programs should be written to facilitate use of the system. A standard microcomputer with a hard disk (for example an IBM-XT) and some database management software should be adequate for this purpose.
3. If the system is to be computerised, a person with some microcomputer skills must be available to develop and maintain the system. The person does not need to have advanced computer skills, but he/she must be able to work comfortably with database management software. If such a person is not available at the MOH, it will be well worth it to have a person trained. In the interim, the MOH could get a part-time computer consultant to develop the database and enter and analyse the previously collected data.

In summary, the Reporting System is an important component of the Diarrhoeal Disease Program and should be computerised soon. The system does not need any significant substantive changes, and it should be fairly simple to transfer it to a computer-based system.

SAMPLE REPORTS

REPORT 1: POPULATION COVERAGE AND DEMOGRAPHIC BREAKDOWN

This Report should be organised by Governates, with the following statistics included in the report:

1. Number of Households
2. Number of People (total)
3. Average Number of People per Household [item 2/item 1]
4. Number of Children <5 years old
5. Average Number of Children <5 per Household [item 4/item 1]
6. Children as a Percentage of Population [(item 4/item 2)*100]
7. Number of Infants (children <1 year old)
8. Infants as a Percentage of Population [(item 6/item 2)*100]
9. Number of Children 1 - 2 years old
10. Number of Children 2 - 5 years old

REPORT 2: HEALTH SERVICE COVERAGE

This Report should be organised by Governates, with the following statistics included in the report:

1. Number of Children <5
2. Percentage (%) of Children Delivered at Home
3. % of Children Delivered in Hospitals
4. % of Children Delivered in Health Centres
5. % of Children Delivered in "Other" Facilities/Places
6. % of Children Delivered by Family Members
7. % of Children Delivered by Doctors
8. % of Children Delivered by Nurses
9. % of Children Delivered by TBAs
10. % of Children Delivered by "Others"

REPORT 3: DIARRHOEAL DISEASE AND ORT

This Report should be organised by Governate, and should include the following statistics:

1. Number of Households
2. Number of Children <5 (NOTE: could provide the further age breakdowns as in Report 1)
3. % of Children <1 who had Diarrhoea in past 2 weeks
4. % of Children 1 - 2 yrs.old, who had Diarrhoea in past 2 weeks
5. % of Children 2 - 5 yrs.old, who had Diarrhoea in past 2 weeks
6. % of Children <5 who had Diarrhoea in past 2 weeks
7. % of Diarrhoeal Episodes Treated with Home Remedies
8. % of Diarrhoeal Episodes Treated with ORS
9. % of Diarrhoeal Episodes Treated with Intravenous Therapy
10. % of Diarrhoeal Episodes during which the Child was given some form of Milk
11. % of Diarrhoeal Episodes during which the Child was given some form of Liquids
12. % of Diarrhoeal Episodes during which the Child was given some form of Solid Food
13. % of Mothers who Know about ORS
14. Among Mothers who know about ORS, the % who heard about it from the Radio
15. Among Mothers who know about ORS, the % who heard about it from the TV
16. Among Mothers who know about ORS, the % who heard about it from reading Newspapers
17. Among Mothers who know about ORS, the % who heard about it from Medical Staff
18. Among Mothers who know about ORS, the % who heard about it from "other" sources

REPORT 4: CHILD MORTALITY

This Report should be organised by Governate, with the following statistics included:

1. Number of Children <5
2. Number of Deaths, in past 1 year, among Children <5
3. Crude Child Mortality Rate [expresses per 1000 children <5: (item 2/item 1)*1000]
4. Age-specific Child Mortality Rate: children <1 year old (more details on infant mortality rate in Report 5)
5. Age-specific Child Mortality Rate: children 1 - 2 years old
6. Age-specific Child Mortality Rate: children 2 - 5 years old
7. % of Child Deaths that are Associated with Diarrhoea
8. % of Child Deaths that are Associated with Measles
9. % of Child Deaths that are Associated with Fever/Cough/Difficulty in Breathing
10. % of Child Deaths that are Associated with "Other" Symptoms

NOTE: Could provide Items 7 - 10 as age-specific statistics.

REPORT 5: INFANT MORTALITY

This Report should be organised by Governate, and should include the following statistics:

1. Number of Livebirths in past 1 year (Infants)
2. Number of Deaths among Livebirths in past 1 year
3. Crude Infant Mortality Rate [expressed per 1000 livebirths: (item 2/item 1)*1000]
4. Age-specific Infant Mortality Rate: Infants 0 - 7 days old
5. Age-specific Infant Mortality Rate: Infants 8 - 30 days old
6. Age-specific Infant Mortality Rate: Infants over 30 days old
7. % of Infant Deaths that are Associated with Diarrhoea
8. % of Infant Deaths that are Associated with Measles
9. % of Infant Deaths that are Associated with Fever/Cough/Difficulty Breathing
10. % of Infant Deaths that are Associated with "Other" Symptoms
11. % of Infant Deaths for which a Doctor Specified the Cause of Death
12. % of Infant Deaths for which a Nurse Specified the Cause of Death
13. % of Infant Deaths for which some "Other" person Specified the Cause of Death

NOTE: Could provide Items 7 - 13 as age-specific statistics.

REPORT 6: BREAST FEEDING AND WEANING

The Breast Feeding and Weaning patterns shown in this report pertain to the youngest child of each the household surveyed. The report should be organised by Governate, and should include the following statistics:

1. Number of Households
2. % of Households in which Child was Breastfed (to some degree)
3. Among Children that were Breastfed, the Average Number of Months for which Breast Feeding was continued
4. Among Children that were Breastfed, the Average Age (in months) at which Additional Foods were Provided
5. % of Mothers who did have an opinion on how long Breastfeeding should continue Unsupplemented
6. Among those Mothers in Item 5 above, what were the Average Number of Months that they thought Breastfeeding should be Continued Unsupplemented
7. % of Mothers who did have an opinion on the Age at which Breastfeeding should Stop Completely
8. Among those Mothers in Item 7 above, what was the Average Age Recommended?

REPORT 7: VACCINATIONS

This report should be organised by Governate, with the following statistics included:

1. Number of Children 1 - 2 years old
2. % of Children (1 - 2 yrs.old) Fully Vaccinated
3. Among Children (1-2 yrs.old) Fully Vaccinated, the % vaccinated at a PHU/PHC
4. Among Children (1-2 yrs.old) Fully Vaccinated, the % vaccinated at a Hospital/Health Centre
5. Among Children (1-2 yrs.old) Fully Vaccinated, the % vaccinated at a Dispensary
6. Among Children (1-2 yrs.old) Fully Vaccinated, the % vaccinated by Mobile Teams
7. Among Children (1-2 yrs.old) Not Fully Vaccinated, the % who have not recieved the BCG Vaccination
8. Among Children (1-2 yrs.old) Not Fully Vaccinated, the % who have not recieved the DPT/Polio - 1 Vaccination
9. Among Children (1-2 yrs.old) Not Fully Vaccinated, the % who have not recieved the DPT/Polio - 2 Vaccination
10. Among Children (1-2 yrs. old) Not Fully Vaccinated, the % who have not recieved the Measles Vaccination
11. % of Mothers who know about Vaccination
12. Among Mothers who know about Vaccination, the % who heard about it from the Radio
13. Among Mothers who know about Vaccination, the % who heard about it from TV
14. Among Mothers who know about Vaccination, the % who read about it in Newspapers
15. Among Mothers who know about Vaccination, the % who heard about it from Medical Staff
16. Among Mothers who know about Vaccination, the % who heard about it from "Other" sources

File Specification

ITEM NUMBER	ITEM DESCRIPTION	SOURCE ON FORM
1	Form Number	A
2	Cluster Number	B
3	Willayat	F
4	Village	G
5	Number of People in Household	D
6	Number of Infants in Household	1c, 7a, 7b
7	Number of Children 1-2 yrs.old in Household	1c
8	Number of Children 2-5 yrs.old in Household	1c
9	Number of Children <5 in Household	1a
10	Age of Youngest Child in Household	1c
11	Number of Children Delivered in Home	1d.1
12	Number of Children Delivered in Hospital	1d.2
13	Number of Children Delivered in Health Centre	1d.3
14	Number of Children Delivered in "Other" Facs.	1d.4
15	Number of Children Delivered by Doctors	1e.1
16	Number of Children Delivered by Nurses	1e.2
17	Number of Children Delivered by TBAs	1e.3
18	Number of Children Delivered by Family Member	1e.4
19	Number of Children Delivered by "Others"	1e.5
20	Number of Children with Diarrhoea (past 2 wks)	2a, 2b
21	Number of Children with Diarrhoea, <1 yr.old	2c
22	Number of Children with Diarrhoea, 1-2 yrs.old	2c
23	Number of Children with Diarrhoea, 2-5 yrs.old	2c
24	Number Of Diar.Epis Treated with Home Remedies	3a
25	Number of Diar. Epis Treated with ORS	3b
26	Number of Diar.Epis Treated with Intravenous	3c
27	Is Mother Aware of ORS?	4a
28	If yes, state Source of Information	4b
29	Number of Diar.Epis given some type of Milk	5a
30	Number of Diar.Epis given some type of Liquids	5b
31	Number of Diar.Epis given some Solid Food	5c
32	Number of Deaths of Children <5 (past 12 mths)	6a, 6b
33	Number of Deaths among Children <1 year old	6c
34	Number of Deaths among Children 1-2 yrs.old	6c
35	Number of Deaths among Children 2-5 yrs.old	6c
36	Number of Diarrhoea-associated Deaths	6d.1
37	Number of Measles-associated Deaths	6d.4
38	Number of Deaths Assoc. with Fever/Difficulty Breathing/Cough	6d.2, 3, 6
39	Number of Deaths Assoc. with "Other" Symptoms	6d.5
40	Number of Deaths among Infants (past 12 mths)	7c
41	Number of Deaths among Infants <7 days old	7d.1
42	Number of Deaths among Infants 8-30 days old	7d.2
43	Number of Deaths among Infants 30 + days old	7d.3
44	Number of Diarrhoea-associated Infant Deaths	7e
45	Number of Measles-associated Infant Deaths	7e

46	Number of Infant Deaths Assoc. with Fever/ Difficult Breathing/Cough	7e
47	Number of Infant Deaths Assoc. with "Other" Symptoms	7e
48	Was youngest Child Breastfed?	8a
49	Number of Months Child has been Breastfed	8c,1c,8d
50	Age at which Breastfeeding was supplemented	9a
51	Number of Months Breastfeeding should be Unsupplemented - Mother's Opinion	10
52	Age at which Breastfeeding should Stop - Mother's Opinion	11
53	Does Mother know about Vaccination?	12a
54	If yes, Source of Information	
55	Is Infant Fully Vaccinated?	12d
56	Facility at which Child was Vaccinated	12.e
57	If child is not fully vaccinated, are they missing the BCG vaccination?	12f.1
58	If child is not fully vaccinated, are they missing the DPT vaccination?	12f.2
59	If child is not fully vaccinated, are they missing the Polio vaccination?	12f.3
60	If child is not fully vaccinated, are they missing the Measles vaccination?	12f.4

Ministry of Health
Department of Preventive Medicine.

A. Form Number

B. Cluster Number :

C. Person Interviewed :

D. Total Number of People :

E. Living in house-hold now :

Governate
F. Willayat :
G. Village :
H. Household Number :

1. Are there any children under 5 years living in this household now?
1.a. If yes, how many children

Yes No

maybe record as # of children born in each type of facility & by each type of person

Child No.	1	2	3	4
Name				
Age				
Place of Delivery				
1d.1 Home				
1d.2 Hospital				
1d.3 Health Centre				
1d.4 Others				
Who delivered the child				
1e.1 Doctor				
1e.2 Nurse				
1e.3 TBA				
1e.4 Family Member				
1e.5 Others.				

2.a. Have any of these children had diarrhoea in the past two weeks?

Yes No

2b. If yes, How many children .

2c. Their ages in months.

2) For each child who had diarrhoea, answer the following questions :
As treatment did the child receive

1 row/child (1)

3 a). Home remedies.
(Eg: Tea, Lime with sugar, Juices, Others).

Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No

If yes, what type of remedy :

3 b.1. Oral rehydration salts (ORS)

Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No

3b.2 If yes, Where ?

Home
Health Institution

Child 1	Child 2	Child 3

c). Intravenous Therapy.

Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No

4a 3. Does mother know about ORS

Yes No

4b. If yes, from which source did she receive the message

Radio T.V.

News Papers Medical Staff

Others

5 A. During the diarrhoeal episode was the child given

5a. A - Milk
Breast milk
Fresh milk
(Cow, Goat or Camel milk)
Artificial milk

Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No

5b. B. Liquids
Tea
Lime with sugar
Juices
Others

5c. — Solid Foods (Specify)

was there in Arabic form

5. During the diarrhoea episode did the mother stop feeding (liquid+Solid) the child?

Yes No

If no, what food did the mother give.

- Breast milk
- Fresh milk
- Artificial milk
- Tea
- Lemon with sugar
- Juice
- Solid food
- Others

Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No

6. Have any children under 5 years of age died in this household in the past 12 months?

Yes No

- 7 deaths < 5 in last 12
 If yes, How many deaths
include in household file

*Child
 dx: most*

6c Age in months at time of death

Child 1	Child 2	Child 3

For each death answer the following questions :

During the week before death, did the child have

- 6d.1 Diarrhoea
- 6d.2 Fever
- 6d.3 Difficulty in breathing
- 6d.4 Measles
- 6d.5 Other symptoms (specify)
- 6d.6 *Cough*

Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No

(Note : If the child had diarrhoea ^{one} in week before the death, that death should be considered "Diarrhoea associated" unless there was an obvious unrelated cause.)



7a Live births during last 12 months Yes No

7b. If yes, how many babies

7c. Is the child/children still living? Yes No ?

7d. If not, how old was the child, at the time of death.

0-7 days *8-30 days*
 1 week < 1 month > 1 month

7e. What was the cause of the death

spec. index? should name q 6.

7f. Who told the cause of death?

Doctor *Asst. health* workers Others (Specify)

8a. Was the last child under 5 years breast fed

Yes No

8b. If No, why?

8c. If Yes, is the child still being breast fed

Yes No

8d. If No, for how many months was the child breast fed?

8e. What was the reason for stopping breast feeding?

9a. How old was the child when food other than breast milk was given? _____ months.

9b. What type and ~~the age at which~~ the additional food was given?

Type of food	Age
Fresh milk	
Artificial milk	
Rice	
Eggs	
Bananas	
Potatoes	
Fruits	
Fish	
Chicken	
Meat	
Cereal Food	
Others	

Inf. Mort

to verify breast feeding pattern, pertain to youngest child

Warning

mother attitude toward weaning/feeding

10. For how long does the mother think breast feeding should be continued unsupplemented :
 11. When does the mother think breast feeding should stop completely :

of months
 code for - Not known
 - How many months
 - Not known

vaccination info - message from program

12a Does the mother know about vaccination

Yes No

12b. If yes, from which source did she get the message

Radio T.V.
 News Papers Health Staff

Others

12c. ^{are} ~~is~~ there any children born between October 1982 to October 1983 ?

Yes No

(check birth certificate or vaccination card)

12d. ~~is~~ ^{if yes}, is the child fully vaccinated ?

Yes No

^{if yes} (check vaccination card. Note fully vaccinated : 1 * BCG, 3 * DPT, 3 * Polio and 1 * Measles)

problem: if there are more than 2 child born in household in past year - check them!

12e. Where was the child vaccinated ?

lets treat the unit as a cluster
 PHU/PHC Hosp., H.C.
 Disp. Mobile Teams

code thus list of vaccines

12f.1. If not fully vaccinated, what are the vaccines the child did not receive

12f.2. Why was the child not fully vaccinated

classify as follows:
 - Polio/DPT-1
 - Polio/DPT-2
 - Polio/DPT-3
 - BCG
 - Measles
 and look at dropout rates

