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Evaluation of Key Child Survival Activities in Metro Cebu, The Philippines:

Results of a Baseline Survey

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Tables and Figures

Evaluation of Key Child Survival Activities in Metro Cebu, The Philippines: Results of a Baseline Survey

by Stan Becker[1] and David Peters[2]

This paper reports on the results of part of a Tier 3 evaluation of key child survival activities in Metro Cebu, The Philippines. As part of a longitudinal study to assess changes in use of primary care services and to measure the impact of the ORT and EPI programs on morbidity and mortality among children under 2 years of age, a baseline survey of 8300 mothers with children under 30 months of age was carried out in 33 barangays selected at random. This report gives results from the baseline survey. The results are presented in the following sections: background demographic and economic characteristics of respondents, prenatal care, breastfeeding, contraceptive use, immunization, nutritional status, measles, diarrhea and acute lower respiratory infection (ALRI), and knowledge and use of oral rehydration salts.

Introduction

High infant and child mortality is a problem in much of the developing world. There is a general consensus that selective primary care interventions are cost-effective for reducing these high

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mortality rates (Walsh and Warren, 1979). Two selective interventions that have been widely adopted are immunizations and oral rehydration therapy (ORT). The effectiveness of ORT for prevention of diarrheal mortality is known from clinical studies (e.g. Cash et al, 1970), but its effectiveness in a community setting is less well documented (see Rahman, et al. 1979 and National Control of Diarrheal Diseases Project, 1988). In the 1980s the Philippines Department of Health (DOH) began to encourage the use of Oresol (the local oral rehydration salt) for the treatment of diarrhea. The Philippines instituted the Expanded Program in Immunization (EPI) in 1976; estimates of its effectiveness in reducing morbidity and mortality are also needed. Therefore, to assess changes in use of primary care services and to measure the impact of the ORT and EPI programs on morbidity and mortality among children under 2 years of age, this two-year longitudinal study was designed.

Background and Methods

The study was located in Metro Cebu with a population of approximately one million. The Office of Population Studies of the University of San Carlos in Cebu, in conjunction with Johns Hopkins University (JHU) conducted the study with funding from United States Agency for International Development (A.I.D.) Bureau of Science and Technology and USAID/Manila through the JHU Institute for International Programs (JHU/IIP).

A sample size of at least 6,000 children was deemed necessary in order to detect a significant reduction of diarrheal mortality due to treatment with oral rehydration salts (ORS), using a nested case control design (Flieger and Gray, 1986). In this instance cases are deaths attributed to diarrhea and controls are children in the study who had severe diarrhea.

A stratified sample of 46 barangays in Metro Cebu was taken and a census was conducted between January 1988 and April 1988 to locate households with children under 30 months of age. It was decided to use 30 months as the age cutoff so the 6 month rounds of the prospective study would still include children who reached 2 years of age during the time interval and also to minimize exclusion due to possible reporting errors in age. The number of households enumerated in the census was found to be about 40% higher than

that recorded in the 1980 census count and the number of children enumerated was above 13,000, so a decision was made to reduce the number of barangays. The reduction of the sample was done as follows. Of the 46 sample barangays 5 were in problem areas (4 for military or security reasons and one because of high refusals in a high socio-economic area); these were excluded *a priori*. Next it was decided to equalize the urban and rural samples at 4250 mothers. The barangays to be excluded were chosen at random until a number close to 4250 was reached. Seven urban and 26 rural barangays were in the final selection.

A baseline survey was conducted in all households (in these 33 barangays) which had a child under 30 months of age. The baseline survey has been followed by interviews at 6-month intervals--periodic surveys. The objectives of the baseline survey were to obtain information on households, mothers, and children to be used in analyses of morbidity and mortality and simultaneously to serve as the first of the longitudinal rounds of study.

Ten interviewers were trained to do the survey. The field work began in July 1988. The purpose of this report is to present findings from the baseline survey on the households, mothers, and children. The results are presented in the following sections: background demographic and economic characteristics of respondents, prenatal care, breastfeeding, contraceptive use, immunization, nutritional status, measles, diarrhea and acute lower respiratory infection (ALRI), and knowledge and use of oral rehydration salts. Most of the data are displayed graphically; copies of appendix tables supporting the graphs, and the baseline questionnaire are available upon request from JHU/IIP.

Background Characteristics

We first examined the characteristics of the mother/child pairs. The number of mothers is 8330 and the number of their children < 30 months of age is 9586 yielding 1.15 children per woman. Caretakers are excluded from these analyses (<2%). Twenty percent of children also have a sibling in the study (Figure 1a). The age distribution of children is nearly uniform (Figure 1b) except for a slight decline in the oldest group. In any population the proportions of persons in successive age groups are expected to

decline due to mortality, and in a growing population like that of The Philippines, a steeper decline (than that seen) was expected. It may be that fertility has declined recently in Metro Cebu, producing this nearly flat distribution. Thus, the average age of studied children is slightly less than 15 months.

Boys outnumber girls by 109 to 100. Since the sex ratio at birth is usually in the range of 103 to 107, the value of 109 may reflect some selection effect. The distribution of mothers by age (Figure 1c), shows the modal age group to be 25-29 years. This is true in both urban and rural areas. The mean age of mothers is 28 years. As expected, the mother's duration of residence in the barangay was considerably longer in rural than in urban areas (Figure 1d). The mean number of years in residence was 11 in urban and 16 in rural areas.

Regarding the number of persons in the household, the mean was 6 and the modal value is 5; Figure 1e gives the distribution. The modal number of rooms in the household was 2 (Figure 1f), and the distribution of persons per room also has a modal value of 2 (Figure 1g).

Virtually all of the mothers had some education; the modal group was those with primary education, the median was 8 years of schooling. The proportions with secondary education or above were higher in urban areas (Figure 2a). The educational level of husbands was only slightly above that of the mothers (Figure 2b).

For the 46% of women who work outside the home, most work in production jobs (Figure 2c). This group includes spinners, toolmakers, plumbers, construction workers, etc. The second largest category in both urban and rural areas is sales. Husbands are also predominantly employed in production also (Figure 2d).

A typical home consisted of two rooms with timber walls (Figure 3a, 3b). Floors of bamboo were more common in the rural areas and combinations of wood and bamboo or cement and wood were more common in urban areas. Three-quarters of the urban households had electric lighting compared to one-half of the rural households (Figure 3c). Regarding the households' toilet facilities,

while 60% reported sealed toilets in the urban area, the comparable figure for the rural area was 39%, with 55% of households in rural areas having no fixed toilet facilities (Figure 3d).

About one-quarter of households owned some means of transport; most frequently a bicycle (Figure 4a). Televisions were owned by 29% of households, and an additional 66% owned only radios (Figure 4b).

The most common source of water in urban areas was vendors and in rural areas, a community pipe or pump (Figure 4c). For households which obtain their water outside the home, most often the source was within five minutes travel time (Figure 5a).

With respect to access to health care, the median time to the closest mananambal (traditional healer) was 15 minutes, to the nearest health clinic it was 10 minutes and to the nearest hospital 25 minutes. In both urban and rural areas, the nearest mananambal, health clinic, and hospital were within 15 minutes travel time for half of the women (Figure 5b, 5c, and 5d).

Prenatal Care

During the last pregnancy, nearly 100% of the women received some prenatal care. In the rural area most such care was given by a nurse/midwife, while in the urban area a government physician was the most common source of care (Figure 6a). However, a minority of women received care in the first trimester of pregnancy (Figure 6b); the percent receiving attention at this time in the pregnancy was higher in urban areas. The average number of prenatal visits was 7 overall, with urban women having one visit more, on average, than rural women. The modal group had 5 visits, but 10% had 2 or fewer visits (Figure 6c).

Breastfeeding

Life tables of the duration of breastfeeding were estimated from current status data on proportions still breastfeeding at given ages (Figure 7). Overall the median breastfeeding duration was approximately 12 months. Rural women breastfeed only slightly longer than urban women. The differentials by woman's educational

level are enormous; while women with primary education had a median breastfeeding duration of 16 months, those with post-secondary education had a median duration of only five months.

Contraceptive Use

Mothers were asked their current contraceptive status. The methods of sterilization, IUD, pill, and condom were defined as modern, leaving withdrawal, abstinence and rhythm as traditional methods. Only about 40% of the women were using contraception and half of the users relied on the traditional methods (Figure 8). The differences in use between urban and rural women were minor.

The highest rates of contraceptive use were among women 30-34 years of age in both urban and rural areas--nearly 50% of these women were using contraception, with slightly more than half of these using modern methods (Figure 9). Younger and older mothers are less likely to use contraception and the choices of methods are opposite in these two groups, with the younger women using predominantly modern methods and the older women using mostly traditional methods. Large differentials by education are seen (Figure 10, top panels)--women with college education were five times more likely to be using contraception than women with no formal education in urban areas; the corresponding ratio in rural areas is three. Couples with either spouse in professional occupations were most likely to be using contraception, and those in farming or with either spouse "at home" were least likely to be using contraception. There is no clear pattern in use rates according to years the woman had resided in the barangay or time to reach the nearest clinic (Figure 11a and 11c). Use rates were higher among women in households with a television and among mothers who had a private physician as their source of prenatal care (Figures 11b and 11d). Women who received no prenatal care were least likely to be using contraception.

Immunization

Mothers were asked about the immunization history of their study children. Table 1 summarizes the data according to vaccine, timing of vaccination and area of residence for children in selected age groups. The usual drop in coverage with sequential doses of oral

polio vaccine (OPV) and diphtheria, pertussis and tetanus (DPT) is clearly seen. However, the percentage receiving measles vaccine was less than the percentage receiving all three DPT and OPV vaccines. The percentages receiving any vaccine, and the percentages receiving vaccines on time were greater in rural than in urban areas.

Among all children 12 to 23 months of age, the percent that received various immunizations is shown in Figure 12. As anticipated, the percentage was lower for immunizations given at older ages, so BCG had the highest percentage and measles the lowest. The percent fully immunized was 39% in urban and 57% in rural areas.

For the following figures, a child above age 1 was considered fully immunized if he/she had received BCG, DPT 1, 2, and 3, Polio 1, 2, and 3, and measles by age 1 year. The timing of immunization below age 1 was not considered in this definition. Children who had received some immunizations, but not the complete series, were put in the group with incomplete immunizations.

As noted above, the most striking result is that full immunization levels were significantly higher in rural than in urban areas (Figure 12). Children of older mothers were slightly less likely to be fully immunized (Figure 13, top panels). Differences by years of residence in the barangay were minor (Figure 13, bottom panels).

Marked differentials were found according to educational groups (Figure 14). In the population as a whole, for children of mothers with no education, 47% had no immunizations whereas if the mothers had 12 or more years of education, only 11% had no immunizations. This educational differential was greater in the urban areas (62% vs 12% with no immunizations in the two extreme educational groups) and less in rural areas (38% vs 12% with no immunizations in the two groups). The differentials by husband's education were also large, but not as large as those found according to women's education.

The one occupational group which stands out by having relatively high levels of full immunizations is clerical workers (Figure 15). Children in households without either a radio or television were

nearly twice as likely to have had no immunizations as children in households with a television (Figure 15, bottom panel).

The distance to the public clinic made little difference in immunization rates; in rural areas the children residing more than an hour's travelling time from the clinic actually had above average levels of full immunization (Figure 16, top). Differentials as large as those seen according to educational level were found according to source of prenatal care (Figure 16, bottom). Interestingly, children whose mothers received care from a nurse had the highest rates of full coverage--above the levels for women who received care from physicians. Children of mothers who did not receive prenatal care were three times more likely to have had no immunizations than other women, but only 2% of mothers fall in the former group.

Nutritional Status

Recorded heights and weights of the children were compared with data from the National Center for Health Statistics reference population (NCHS, 1977). Using standard techniques the children were classified according to the Waterlow framework--those less than 90% of the median height-for-age were classified as stunted and those with less than 80% below the median weight-for-age were classified as wasted.

Table 2 shows the two-way distribution of children by their nutritional status according to the percentile of height and weight. Considering the marginal distributions, 20% of the children were classified as stunted, 3% were classified as wasted, and 1% as both stunted and wasted.

Figure 17a shows that the percent of malnourished children increases slightly with age of the mother, from 20% for mothers in the youngest age group to 29% for women above age 40. The differences by age of the child are striking, with less than 10% of the children 0-5 months of age malnourished, but nearly 40% of the children 18-23 months of age so classified (Figure 17b). A slight increase is seen with the number of children less than 30 months of age in the household (Figure 17c). The differentials are large according to the educational level of the parents as well, with the largest differentials found according to father's education; children of

fathers without formal education were four times more likely to be malnourished than children whose father had some college education (Figure 18).

Among the occupation groups, children of farmers are most likely to be malnourished and children of professional and clerical workers least likely. In contrast to education, the greatest differentials between occupations are found for mother's occupation. Minor differences were seen by the time needed to reach the nearest clinic (Figure 19). Children with no immunizations were 1.5 times more likely to be malnourished than children with full immunizations.

Measles

An episode of measles was defined if the mother reported her child had a rash and fever for 4 or more days in the last 3 months. The percentage of children meeting these conditions is defined as the prevalence of measles.

The prevalence of measles is highest (8%) in children 9-11 months of age and declines to half that level in the next age group (Figure 20a). The prevalence is virtually constant across the age groups of mothers (Figure 20b). As expected, the prevalence is highest in unvaccinated children. Curiously, the prevalence was lower in children vaccinated before 9 months than among those vaccinated later (Figure 20c). Nutritional status did not affect prevalence of the disease (Figure 20d).

The prevalence was slightly higher among children whose parents were without formal education (Figure 21). No pattern emerged according to the number of years of residence in the barangay, and there was only a slight increase in prevalence according to the number of persons per room.

Diarrhea and ALRI Prevalence

Mothers were asked if the child had diarrhea in the last 24 hours or in the last 2 weeks. The same questions were asked with respect to cough. If the child had diarrhea, the mother was asked the number of stools on the worst day. If the child had cough, the mother was asked if it was accompanied by fever and difficulty breathing for

more than one day. In the following analyses we tabulate prevalence of diarrhea according to whether there were 1-6 stools or 7 and above. Cough with 2 or more days of fever and difficulty breathing is defined for this study as acute lower respiratory illness (ALRI). We shall define the proportion of children who had either of these disease symptoms reported in the 2-week period as the prevalence of disease, recognizing it is a rough definition. We note that 52 percent of mothers reported that the child had some cough in the last 2 weeks.

Prevalence of diarrhea and ALRI did not vary greatly by mother's age, years she had lived in barangay, or number of persons per room (Figure 22). There were differentials in diarrheal prevalence by parent's educational groups, but the patterns varied between urban and rural areas (Figure 23) as follows. In urban areas, women with no education reported the lowest diarrheal prevalence for their children; however, if the husbands had no formal education, the child was more likely to have had diarrhea than was so among other educational groups. In rural areas the differential was greatest according to mother's education. Generally (in the total population), one notes a decline of diarrheal prevalence with educational level of the parents. ALRI prevalence patterns across education groups also vary by area of residence. In rural areas, 9% of children of mothers without any formal education had ALRI, higher than among any other group. The corresponding figure in urban areas was 2%, the lowest rate of any group.

Among occupational groups, children of farmers had the greatest prevalence of diarrhea (Figure 24), and children of parents employed in the professions or clerical work had the lowest prevalence. Variations in ALRI were relatively small across occupational groups.

Three variables were expected *a priori* to affect prevalence of diarrhea and respiratory illness--nutritional status, type of toilet, and source of water. It was the expectation that poor nutritional status, poor toilet facilities and well water would be associated with higher disease rates. As expected the children with normal nutritional status had a lower prevalence of diarrhea and respiratory illness (Figure 25a). Also children in households without toilets had a higher prevalence of both diarrhea and ALRI (Figure 25b). The prevalences were also higher in households where children got their

water from wells than among children in households with piped water (Figure 25c).

Knowledge and Use of Oral Rehydration Salts (ORS)

All of the mothers were asked if they had heard of Oresol. In addition, mothers who reported that the child had diarrhea in the 2 weeks before the interview (1590 children) were asked what they had done . This section describes variations in the percentages of mothers who have heard of Oresol and percentages who used ORS during a recent diarrheal episode of their child, by selected demographic and socioeconomic indicators. Figure 26 shows the distribution of treatment given by mothers during a recent episode of diarrhea. Only about 15% of mothers treated the episode with ORS; the predominant treatment was some form of liquid medicine, such as an anti-motility drug.

The variations in knowledge and use by mother's age and years she has lived in the Barangay were relatively small; the percentages are generally higher in the rural areas (Figure 27). On the other hand, there are large differentials in ORS use according to educational and occupational groups (Figure 28). If the mother or father had college education, the child was considerably more likely to receive ORS. Interestingly, these differences were found despite similar percentages of women who had heard of Oresol across educational groups. There were also only minor differences in the proportions who heard of Oresol according to occupational group. The highest rate of ORS use was for children in households where the husband worked as a professional (Figure 29).

Mothers in households with a radio (only) were more likely to have heard of Oresol, but not to have used ORS (Figure 30a and 30b). There were only minor differences in knowledge and use according to the type of family planning the mother used (Figure 30c and 30d). Distance from the nearest clinic and source of prenatal care also made little difference (Figure 31a and 31b).

Summary and Conclusions

As part of a longitudinal study to measure the impact of a program of ORT on mortality of children under 2 years of age in Metro

Cebu, a baseline survey of 8300 mothers with children under 30 months of age was carried out in 33 barangays selected at random. This report has given results from the baseline survey.

One way to summarize the results is to consider a typical household defined as having median levels of the variables of interest. Such a typical household is a four or five-person family living in two rooms with walls of timber and floor of bamboo, with electricity available, no water source in the house, but water within five minutes of the household, a sealed toilet in urban areas, but no toilet in rural areas, no owned means of transportation, and ownership of a radio. The mother is twenty-five to thirty years of age, has had at least primary education and has lived in the barangay 7 years in urban areas but 16 years in rural areas. She probably sought prenatal care only after the first trimester of pregnancy, had seven prenatal visits, and then breastfed for twelve months. She is not a user of contraception. She has heard of ORS, but is unlikely to have used it. Her child, under 30 months of age, has received BCG and some other vaccines, but not the complete vaccination series. Also, her child is slightly below the NCHS standard height for age and weight for age.

In the population, while 20% of the children were stunted according to Waterlow classification, only 3% were defined as wasted. About 15% of the children had diarrhea in the two weeks before the interview and three to five percent had signs of severe respiratory disease in the same period. Of those with diarrhea, the most common treatment given was liquid medicine and ORS was given in 16% of the cases. Five percent of women reported that the child had rash with fever in the last three months, which is the study definition for measles.

The data contained several surprises. First, the percentage of households in rural areas without toilets was 56%--much higher than expected. Second, the distance from the household to the closest health clinic did not make much difference with respect to use of preventive services. Among the background variables, maternal education quite consistently showed large differentials. However, even it was not an important determinant with respect to hearing about ORS, or having a fully immunized child. Thus, the health program does seem to be reaching all groups of the population with

these services, albeit at less than desired levels. Maternal education appears to be an important determinant of use of ORT and getting prenatal care in the first trimester.

Three sets of further analyses are planned with the baseline data. First, multivariate analyses will be done to identify determinants of disease and malnutrition prevalence, ORS use, immunization use, use of prenatal care, and use of family planning. This is needed because the bivariate results presented in this report may be biased due to confounding (Kleinbaum, Kupper and Morgenstern, 1982). A second set of analyses involves linking these data with what was found in the study of the quality of services at health facilities in the same area. Third, a detailed examination will be done of what treatments are currently given (by whom) for diarrhea to better characterize patterns of use and low utilization groups. Such analyses will help to better pinpoint how health messages and services can be improved in the population.

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Figure 1: Percentage distributions of the mother's age and years lived in the barangay, number of children in the household, number of rooms and persons in the household, number of persons per room and age of the study children

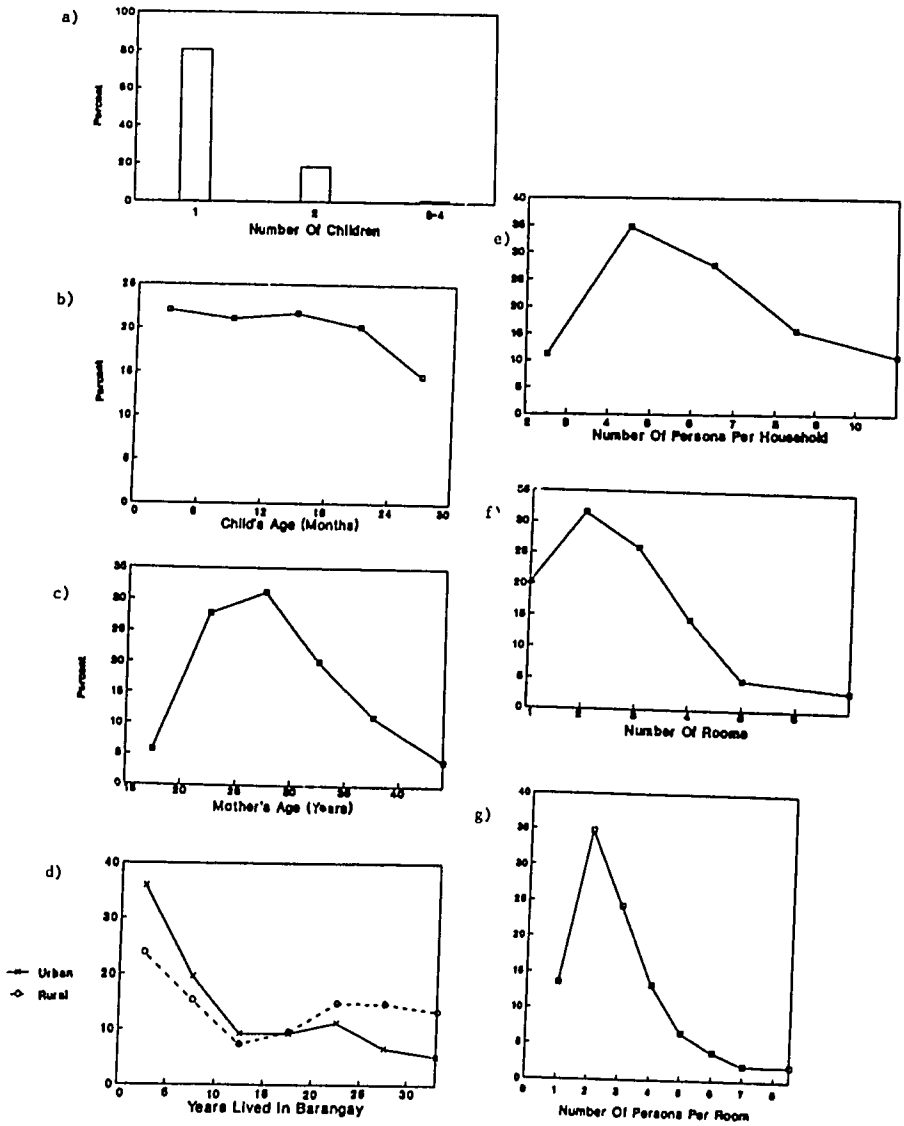

Figure 2: Distributions of mother's and father's educational level and occupational group, by area of residence

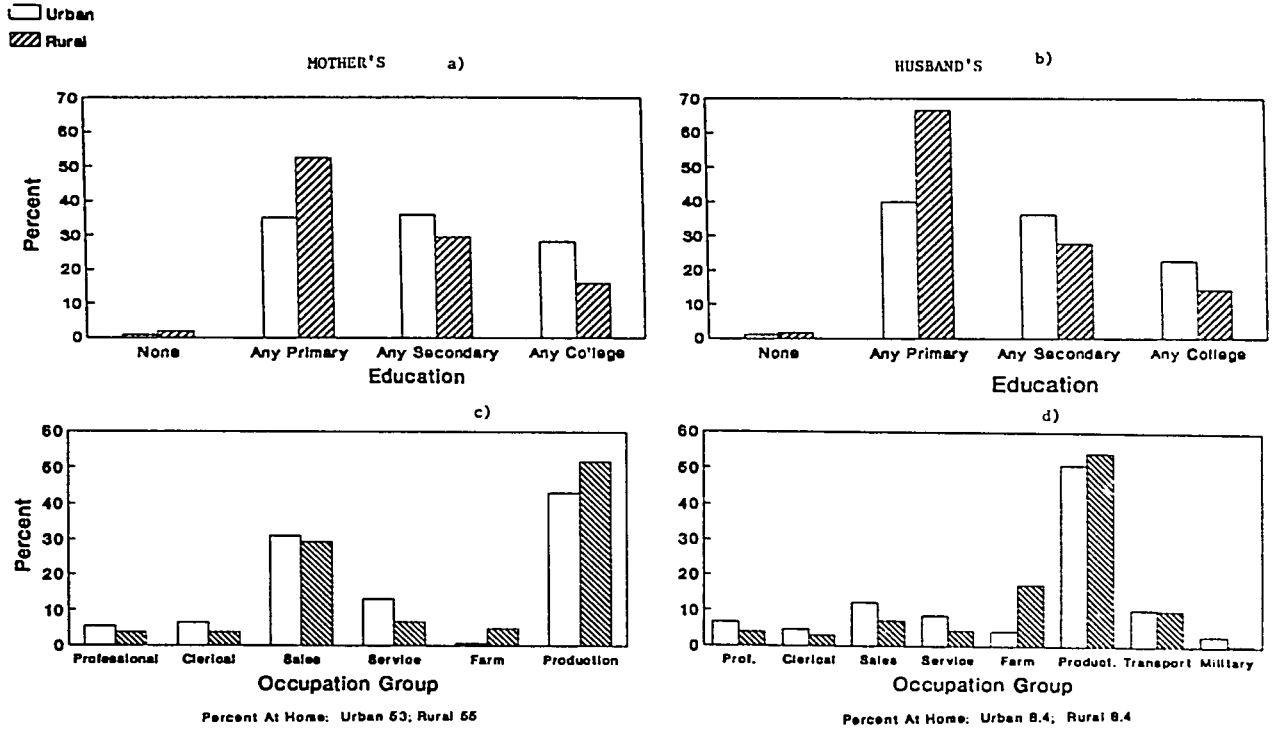

Figure 3: Distributions of types of wall construction, floor construction, lighting and toilet, by area of residence

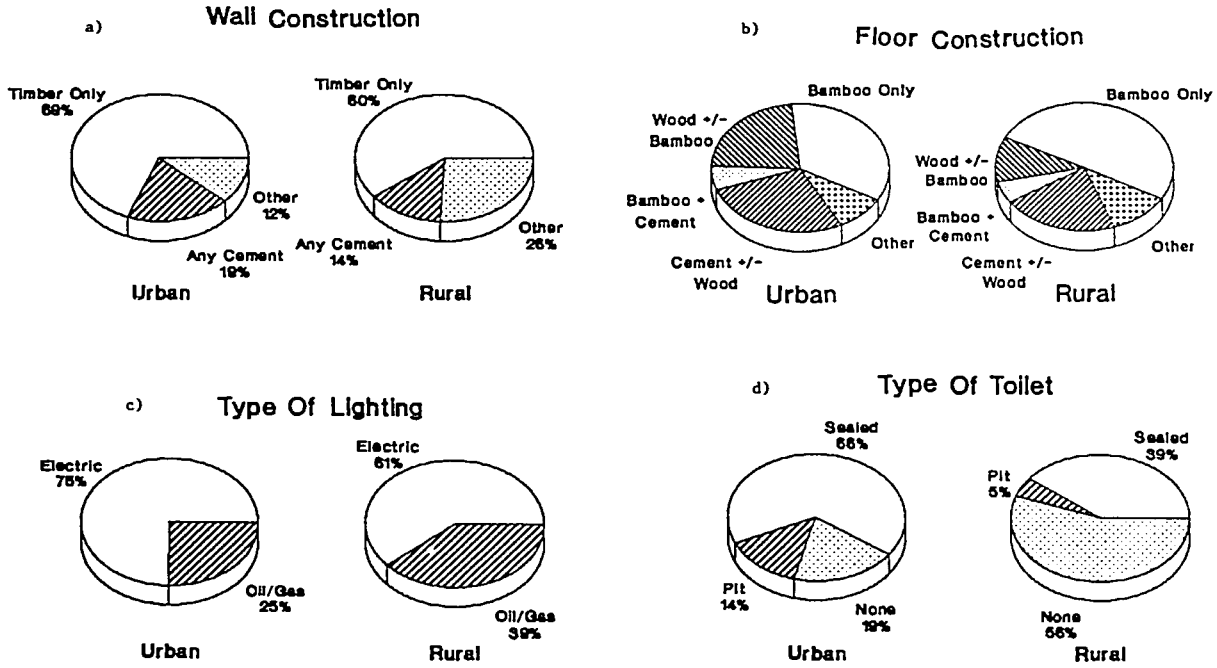

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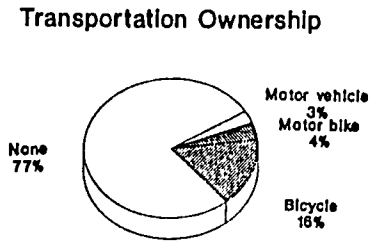
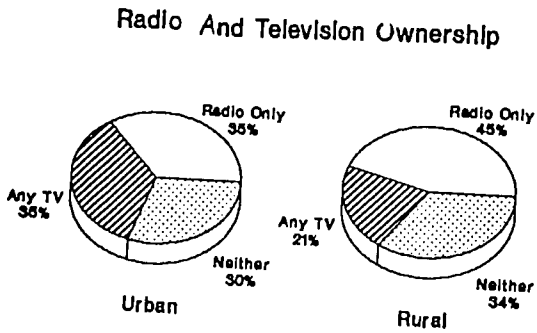
Figure 4: Distributions of transportation ownership and of radio and television ownership and water source by area of residence

a)



b)



c)

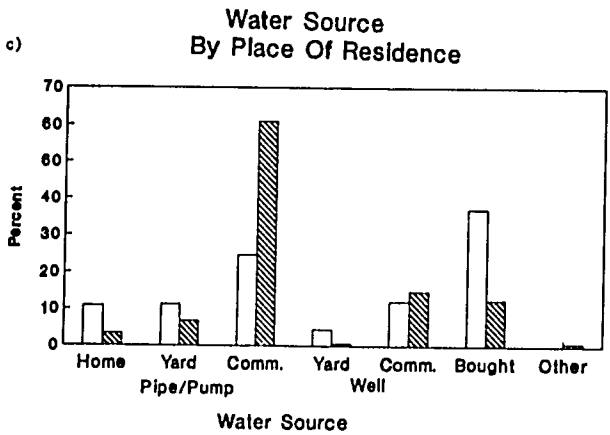


Figure 5: Distributions of time to water source, to nearest mananambal, to nearest public clinic and to nearest hospital, by area of residence

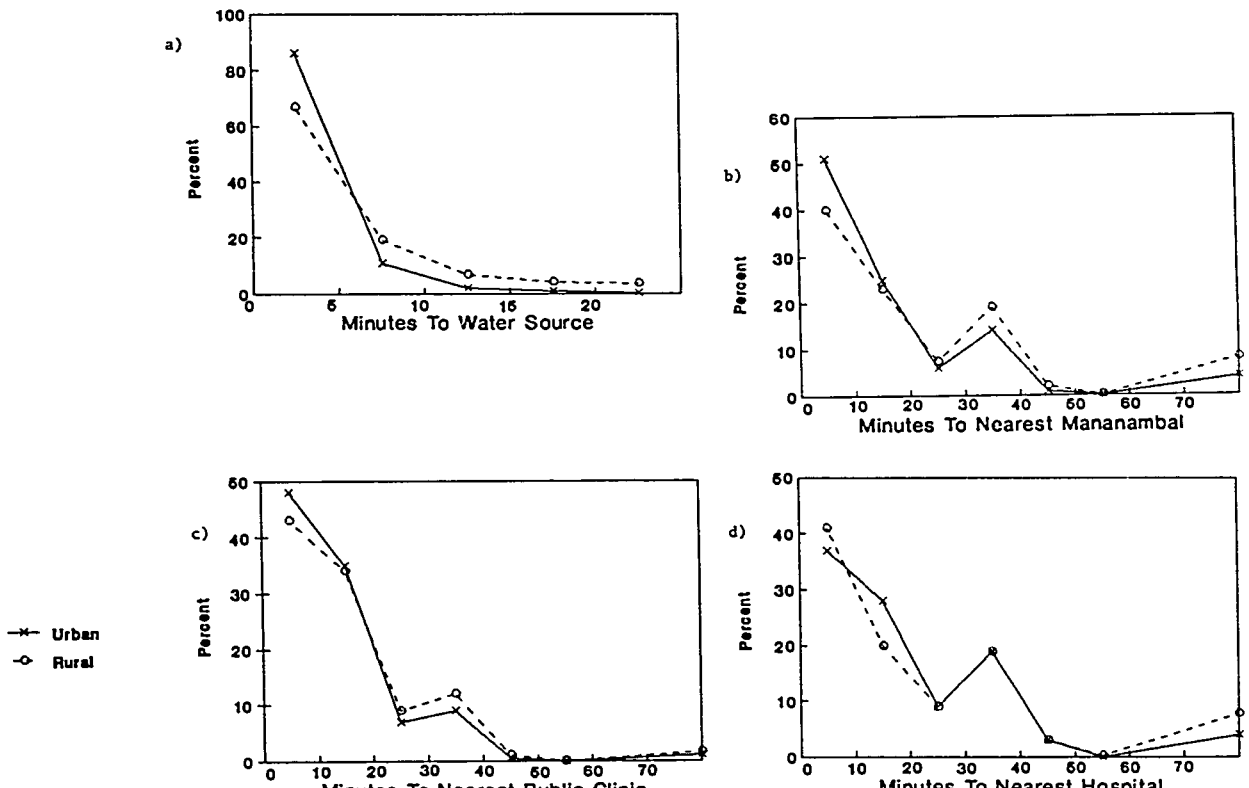


Figure 6: Use of prenatal care: Distributions of source of care, trimester of first visit, and number of visits, by area of residence

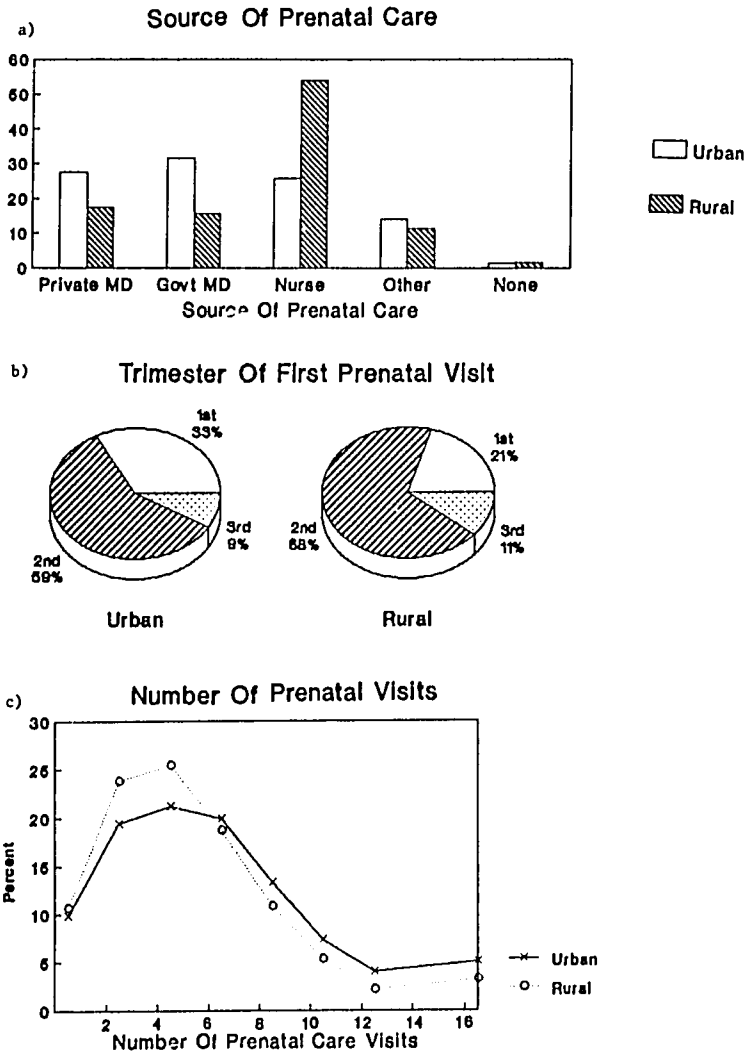
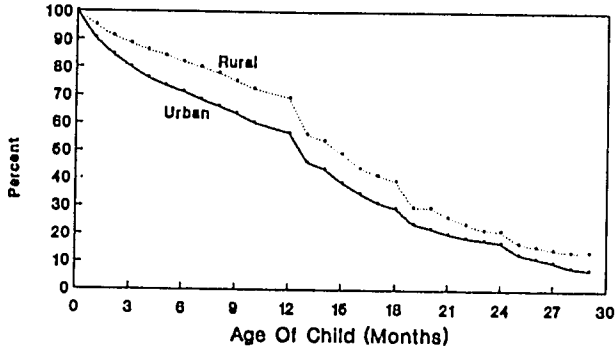


Figure 7: Percentage of women still breastfeeding the youngest child, by area of residence and education, by age of child



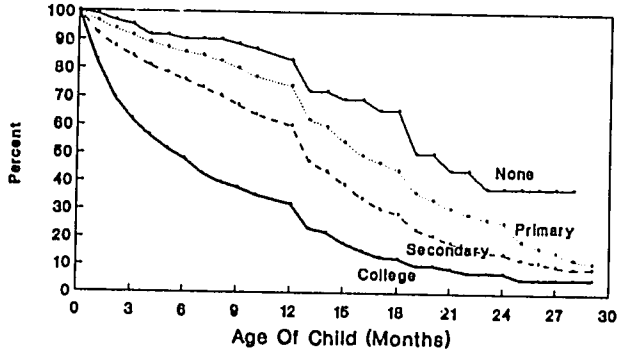


Figure 8: Percentage distribution of current family planning methods by area of residence

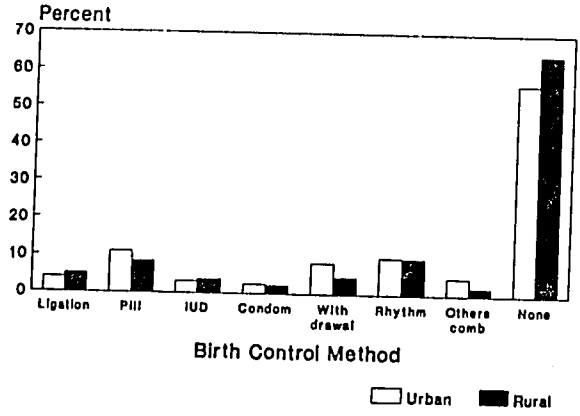


Figure 9: Percentage distribution of mother's current family planning use by her age and area of residence

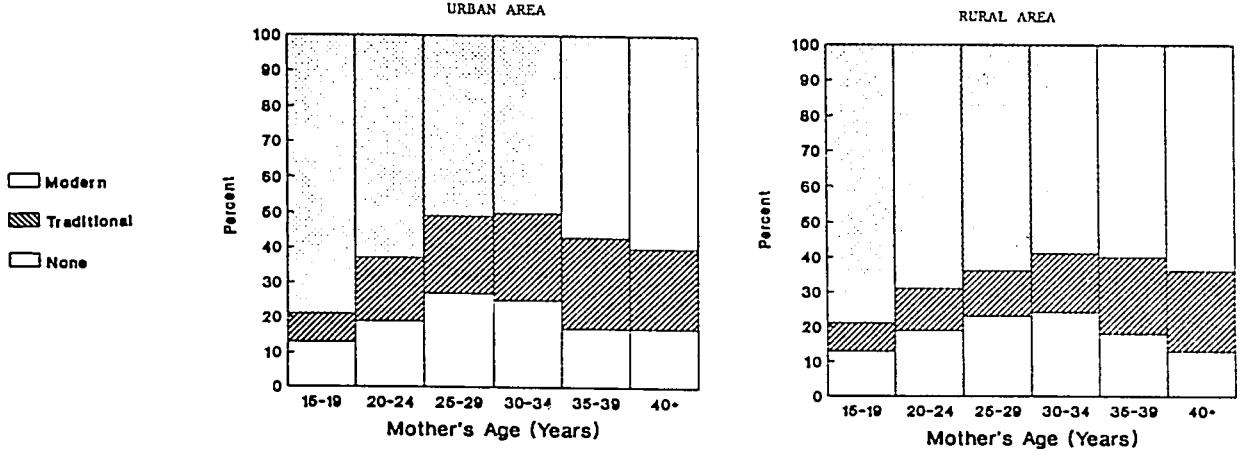


Figure 10: Percentage distribution of mother's current family planning use by her education, by her husband's education, by her occupation, and by her husband's occupation.

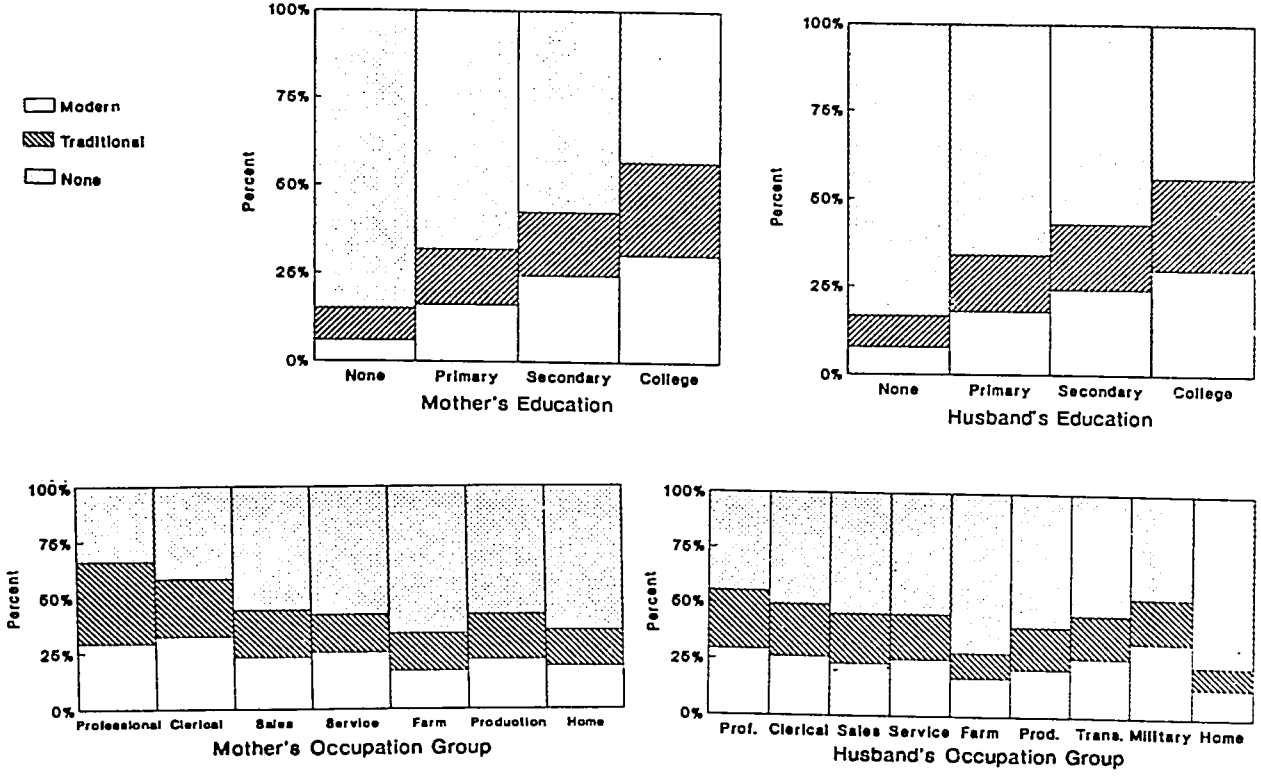


Figure 11: Percentage distribution of mother's current family planning use by years lived in the barangay, by ownership of radio and television, by time needed to reach the nearest health clinic and by source of prenatal care

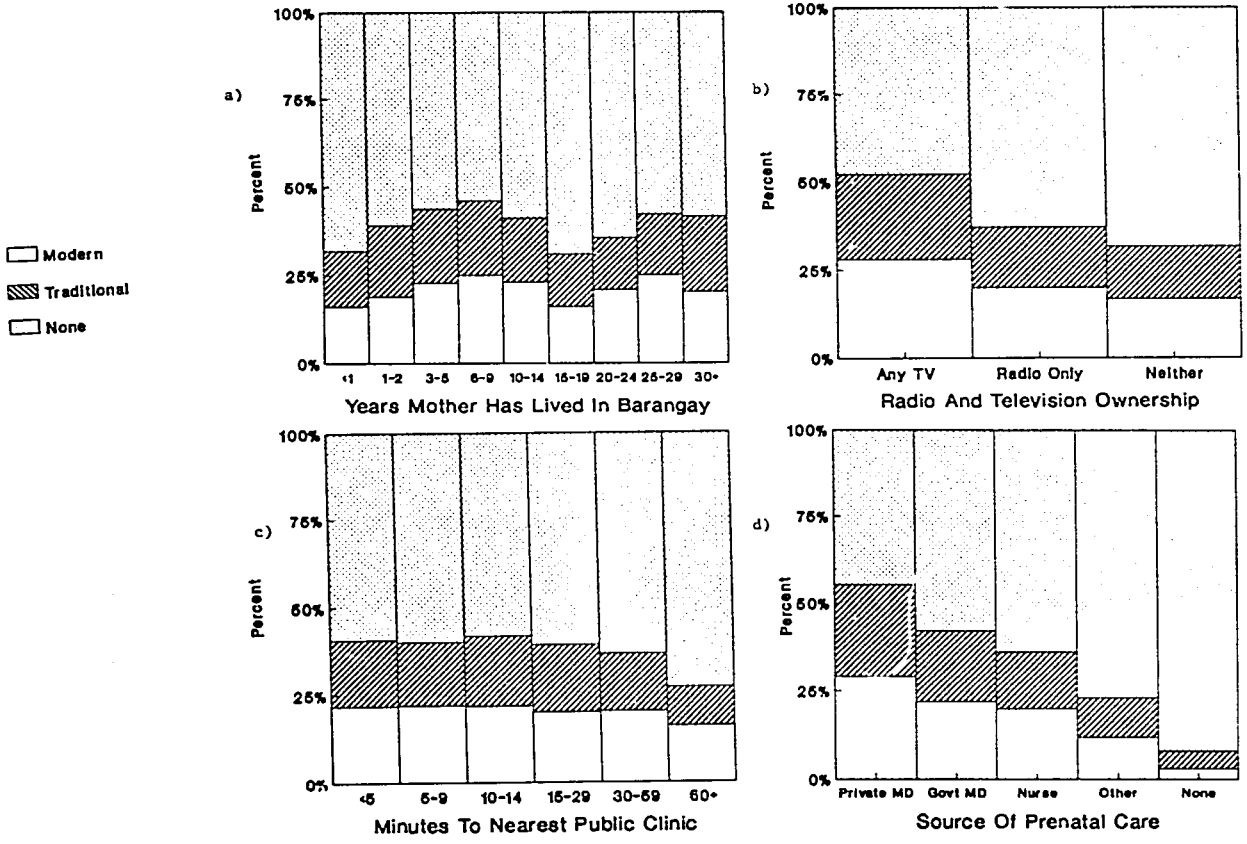


Figure 12: Percent of children aged 12-23 months immunized with specific antigens, by place of residence

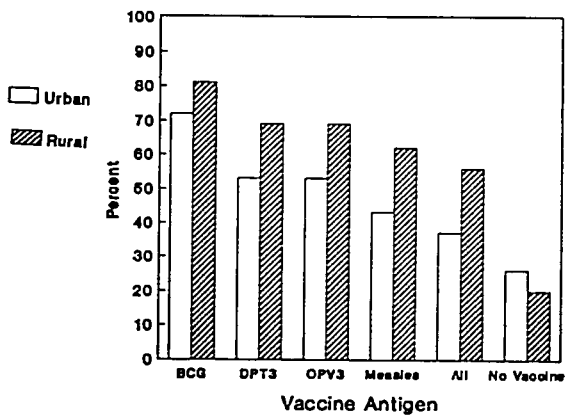


Figure 13: Percentage distribution of immunization status by age of mother and years she has lived in the barangay

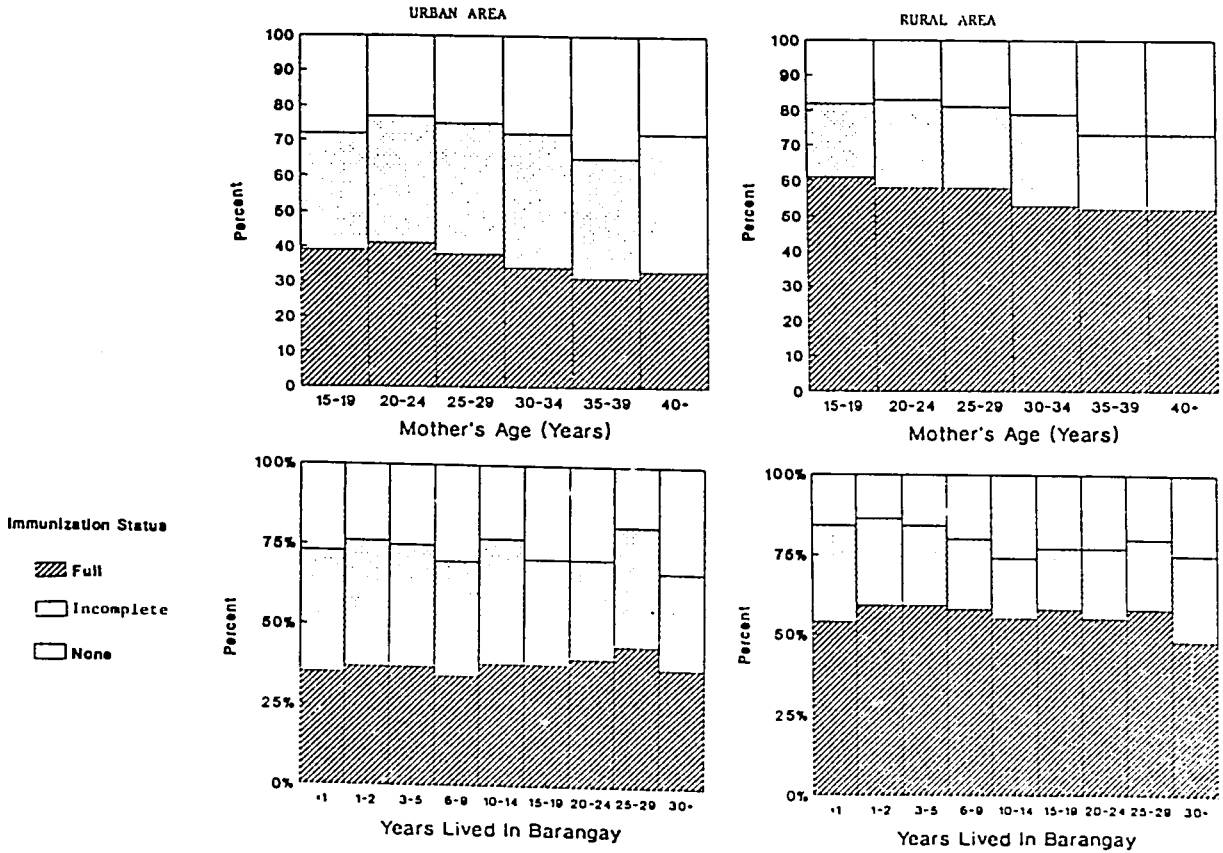


Figure 14: Percentage distribution of immunization status by mother's and father's educational level, by area of residence

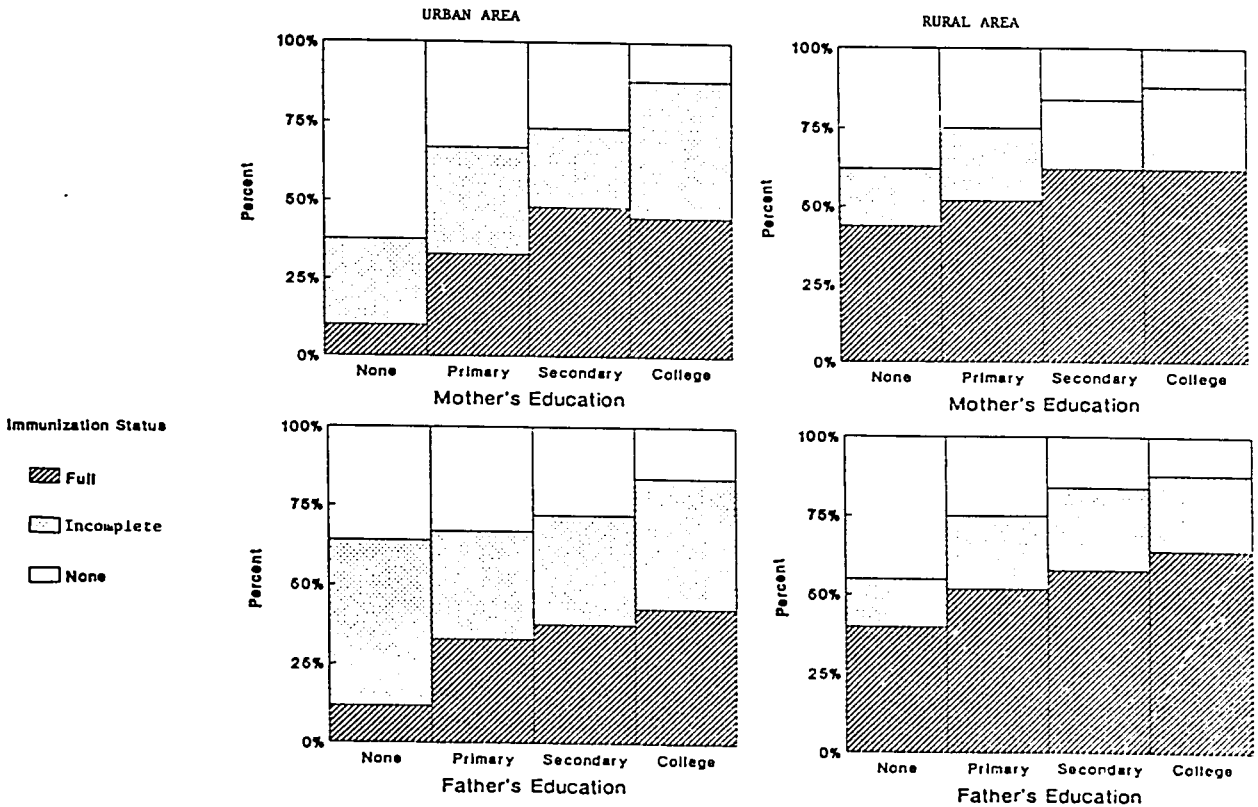


Figure 15: Percentage distribution of immunization status by mother's and father's occupational group, and ownership of radio and television, by area of residence

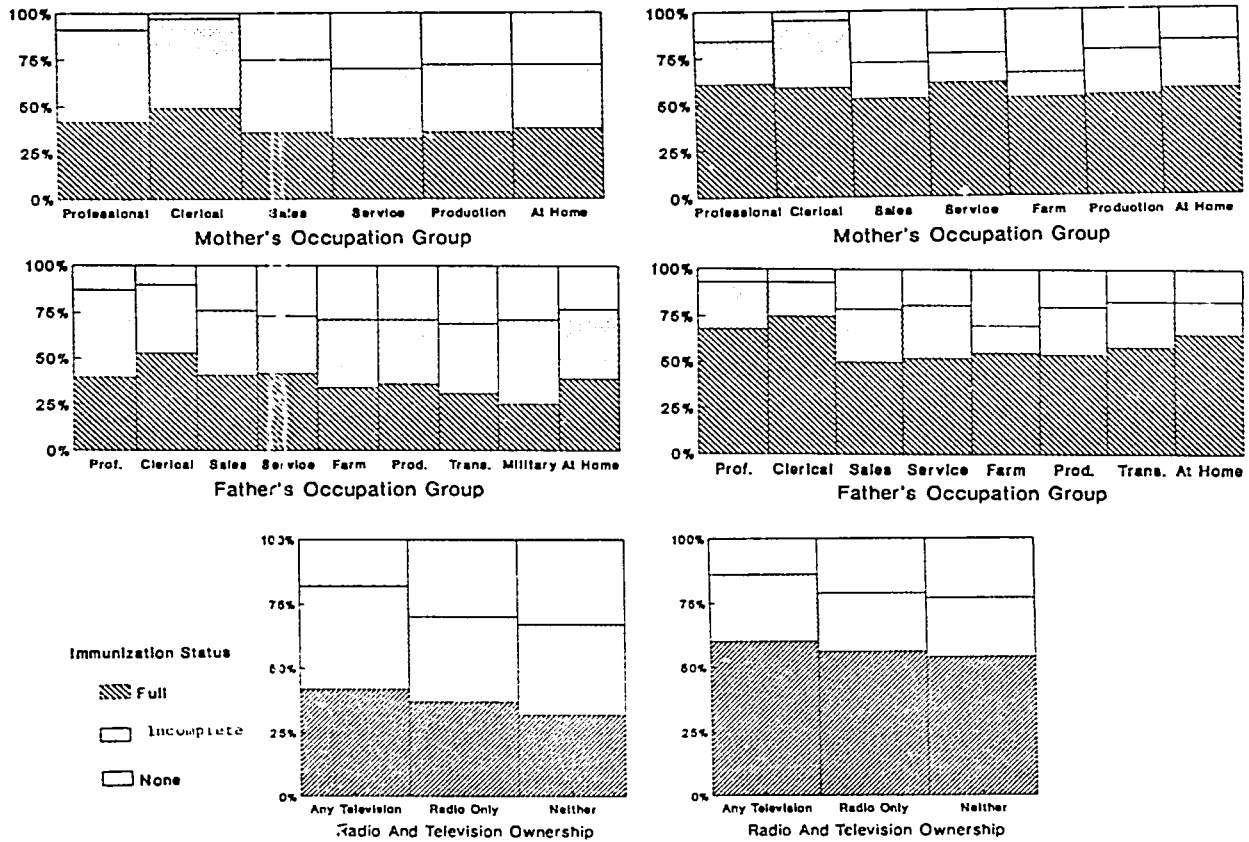


Figure 16: Percentage distribution of immunization status by time to nearest health clinic and source of prenatal care, by area of residence

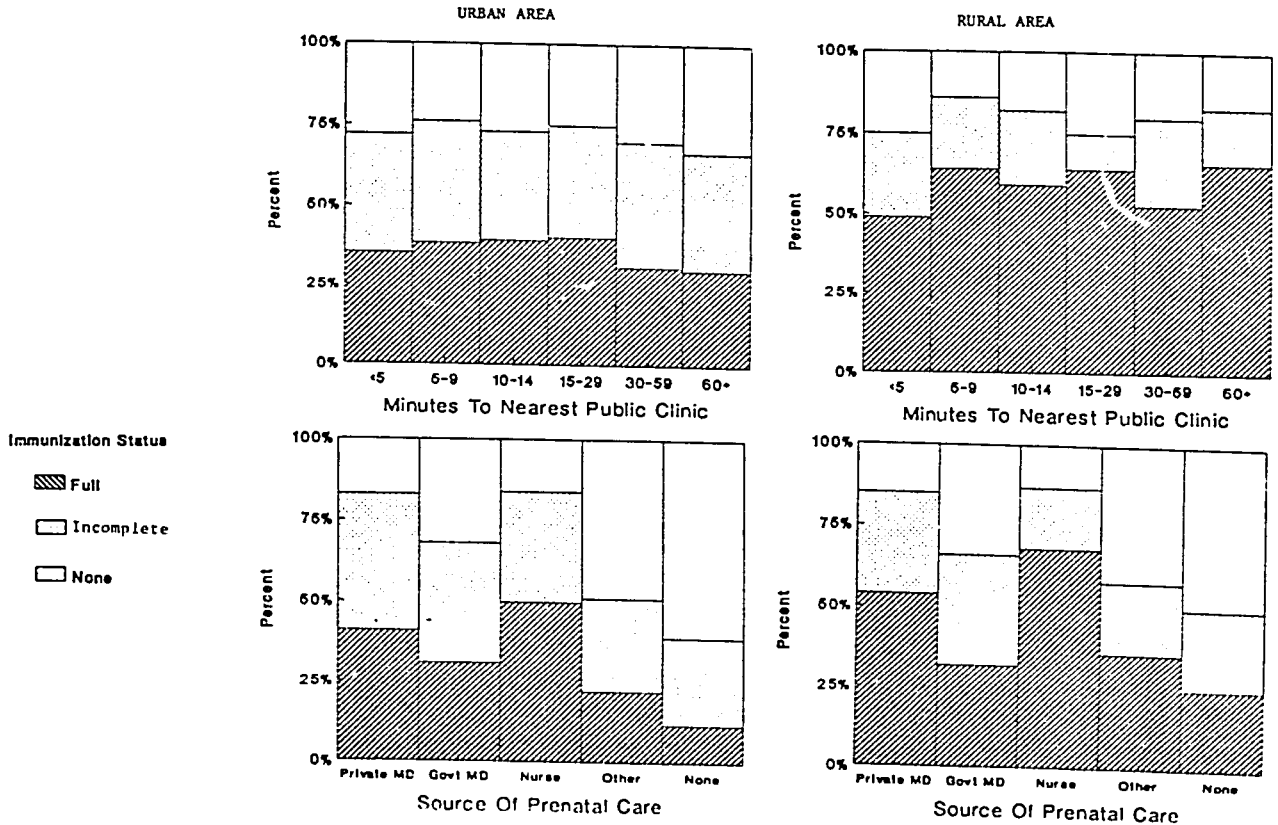


Figure 17: Percentage of children stunted, wasted and both by age of mother, age of child and number of children under 30 months of age

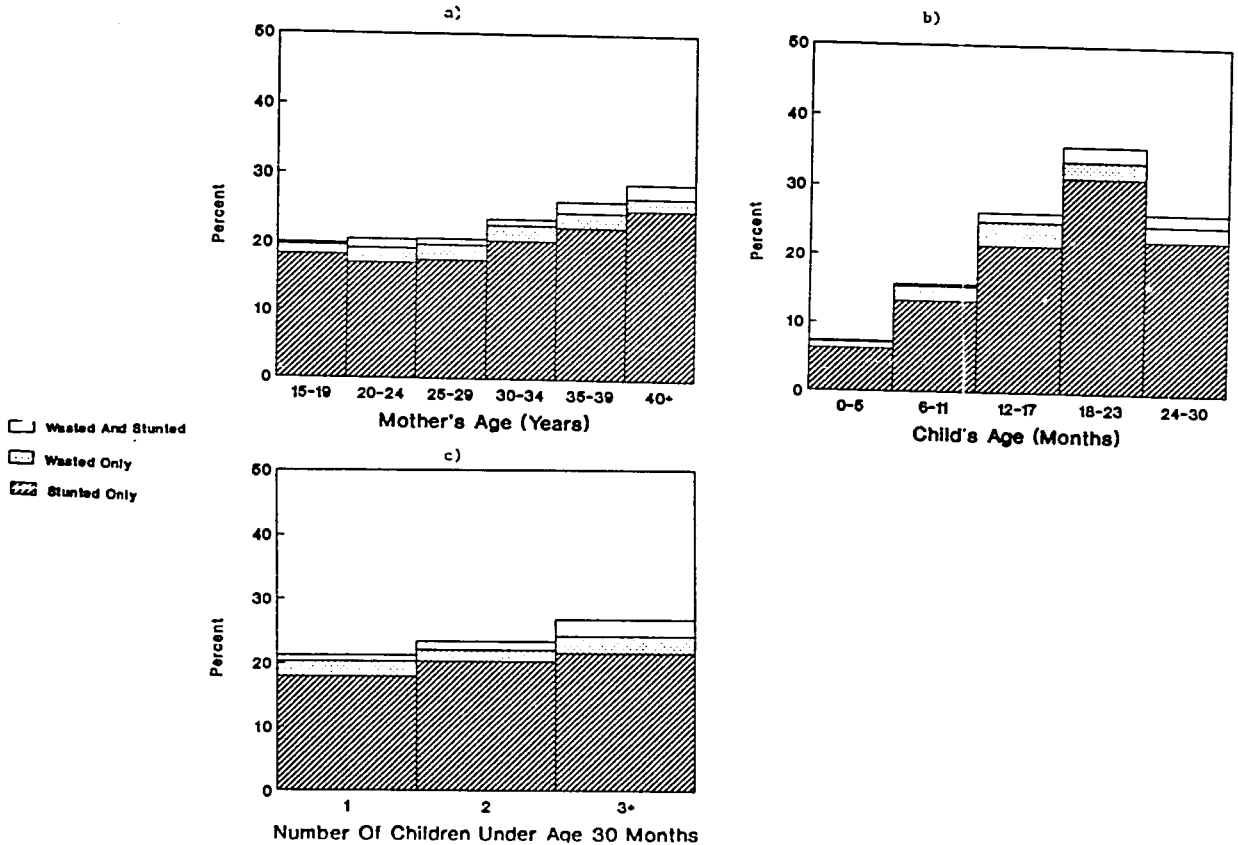


Figure 18: Percentage of children stunted, wasted and both by mother's education, father's education, mother's occupation, and father's occupation

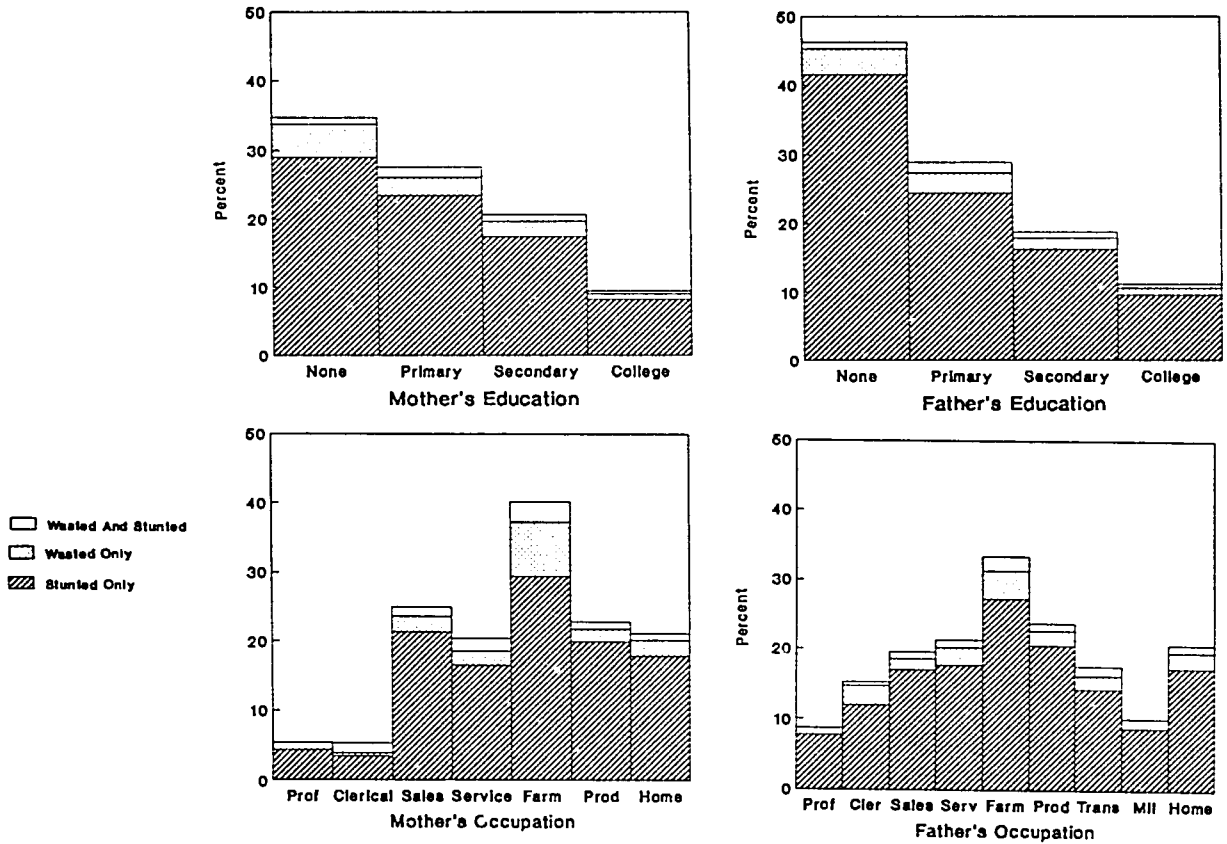


Figure 19: Percentage of children stunted, wasted and both by minutes to nearest public clinic and by immunization status (for children less than 1 year of age)

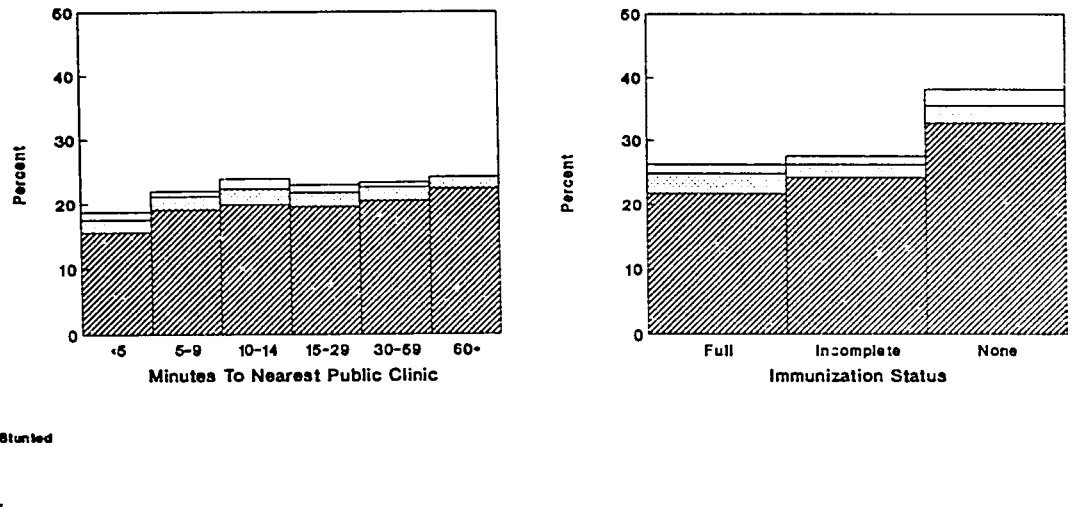


Figure 20: Percent of children 4-30 months of age with measles in the last three months by age of child, age of mother, age of measles immunization and current nutritional status

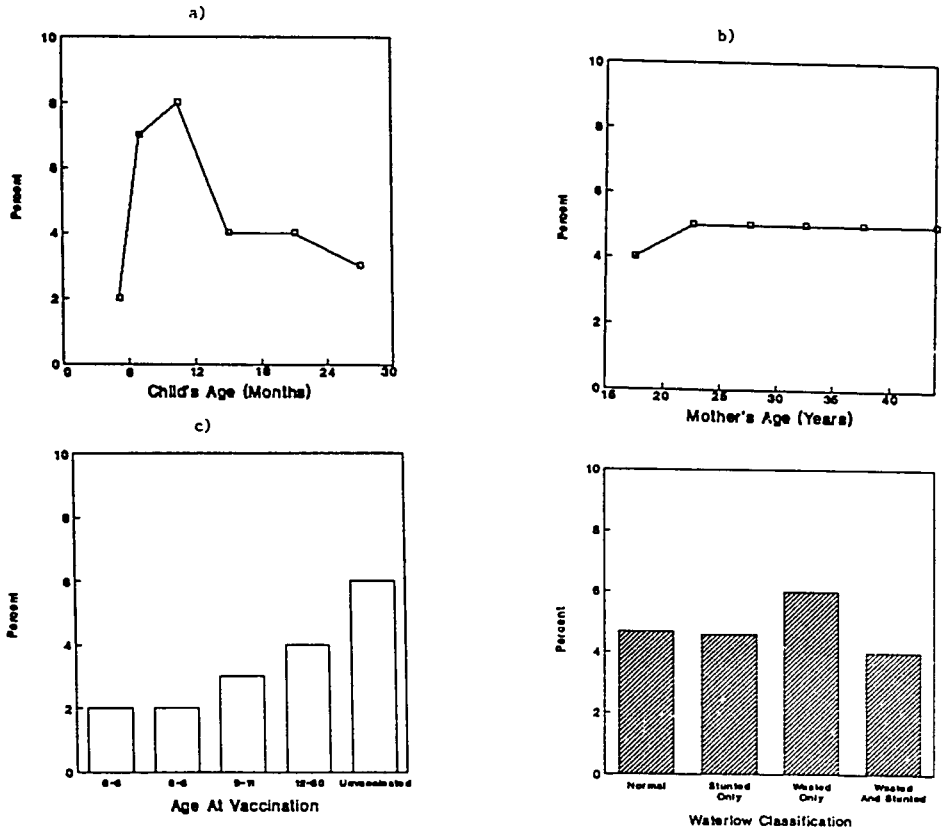


Figure 21: Percent of children 4-30 months of age with measles in the last three months by education and occupation of the parents, years the mother has lived in the barangay and number of persons per room

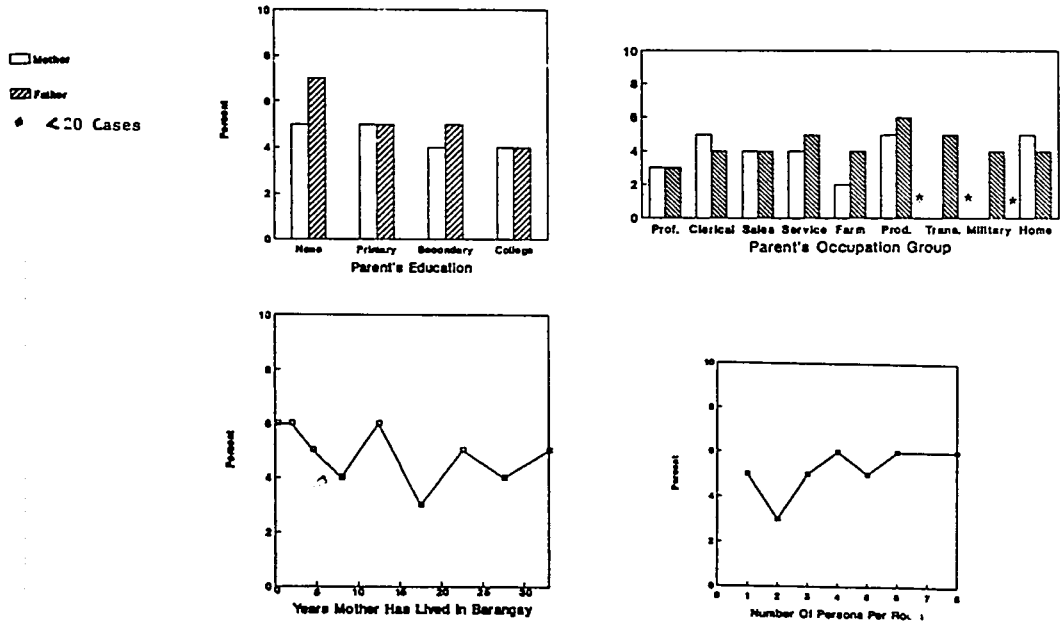


Figure 22: Percentage of children with moderate or severe diarrhea and percentage with severe respiratory infection in the last two weeks, by mother's age, by years she has lived in the barangay and by number of rooms in the house

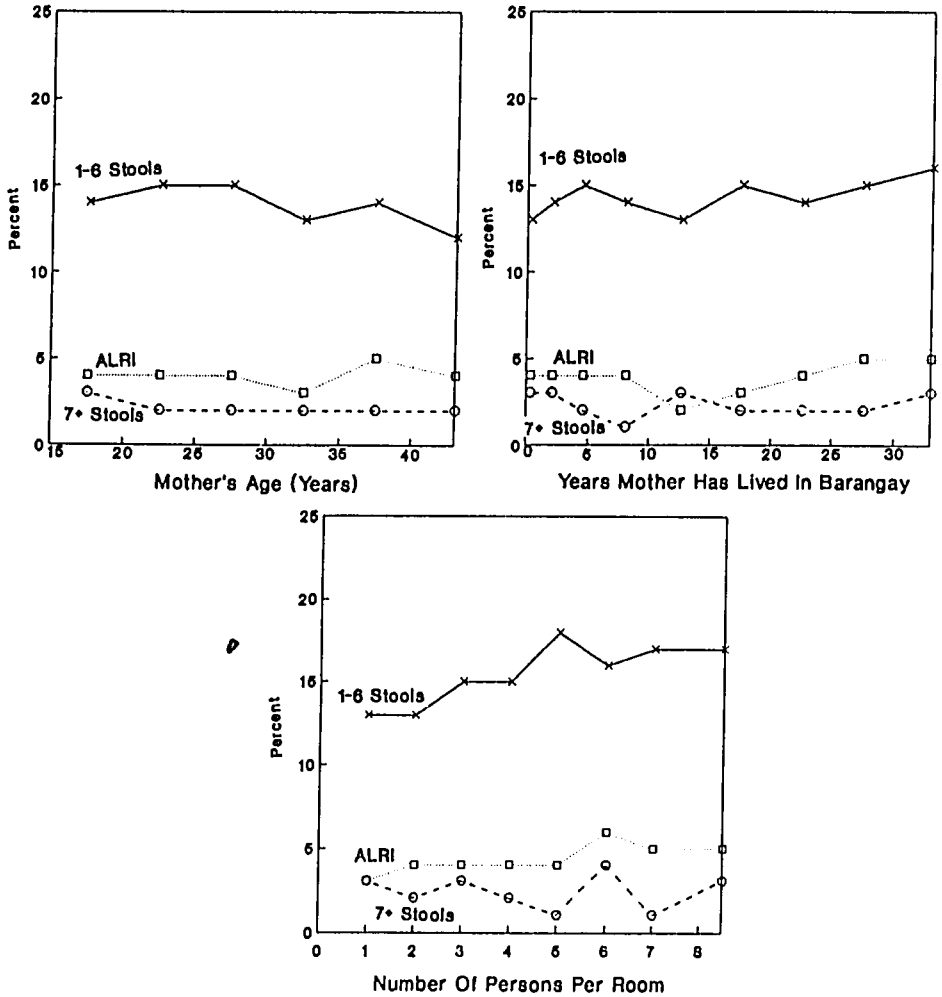


Figure 23: Percentage of children with moderate or severe diarrhea and percentage with severe respiratory infection in the last two weeks, by mother's and father's education and place of residence

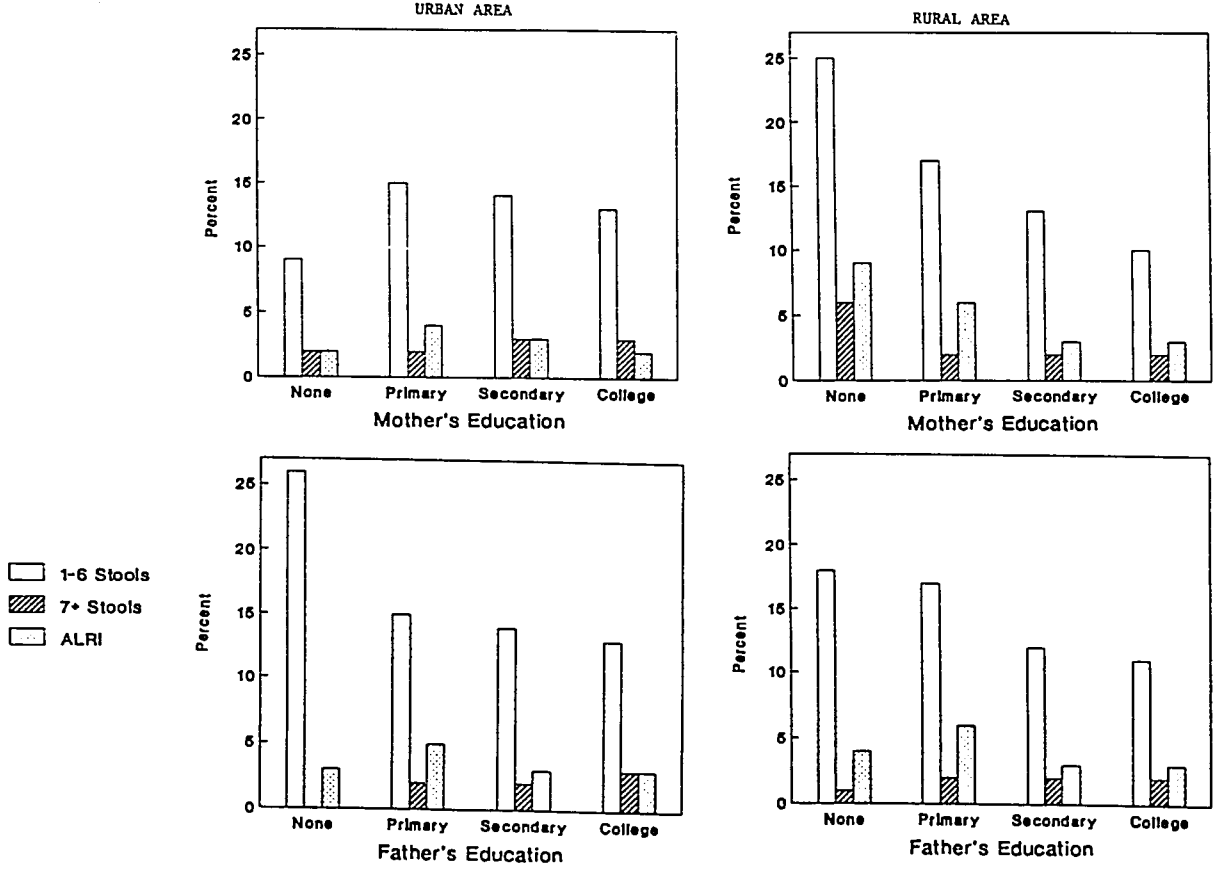


Figure 24: Percentage of children with moderate or severe diarrhea and percentage with severe respiratory infection in the last two weeks, by mother's and by father's occupational group

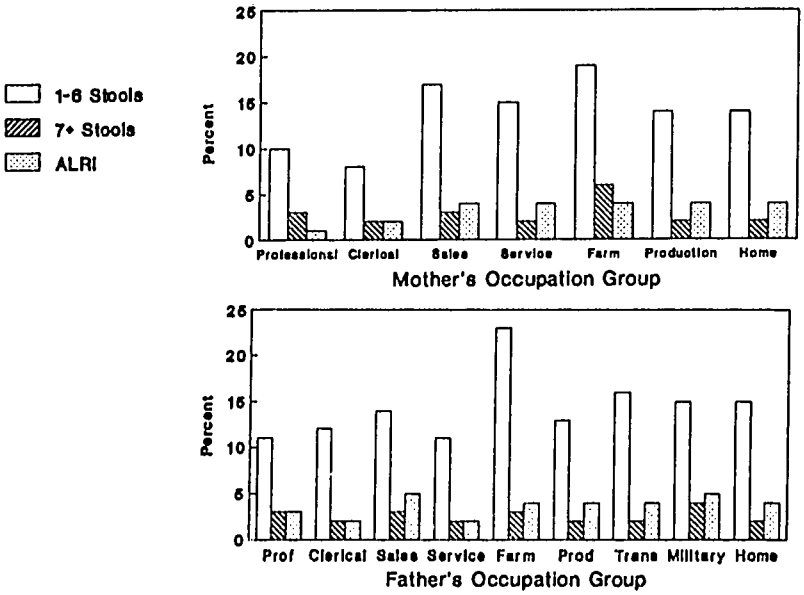


Figure 25: Percentage of children with moderate or severe diarrhea and percentage with severe respiratory infection in the last two weeks, by nutritional status of youngest child, type of toilet and source of water.

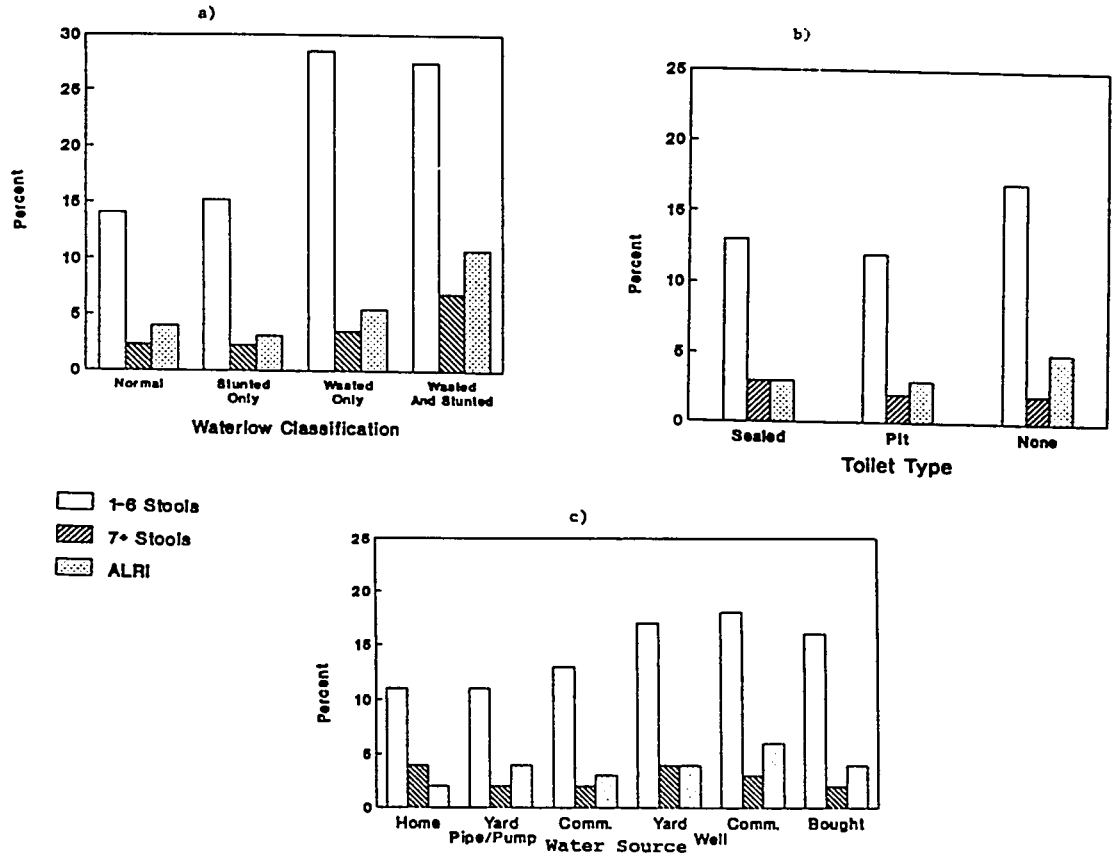


Figure 26: Percentage distribution of treatments given to children with diarrhea in the last 2 weeks, by place of residence

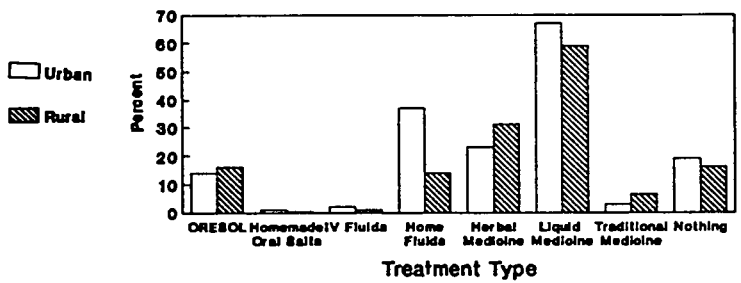


Figure 27: Percent of mothers who have heard of ORESOL and percent of diarrhea cases in children in the last 2 weeks treated with ORS, by mothers age and by years she has lived in the barangay, by area of residence.

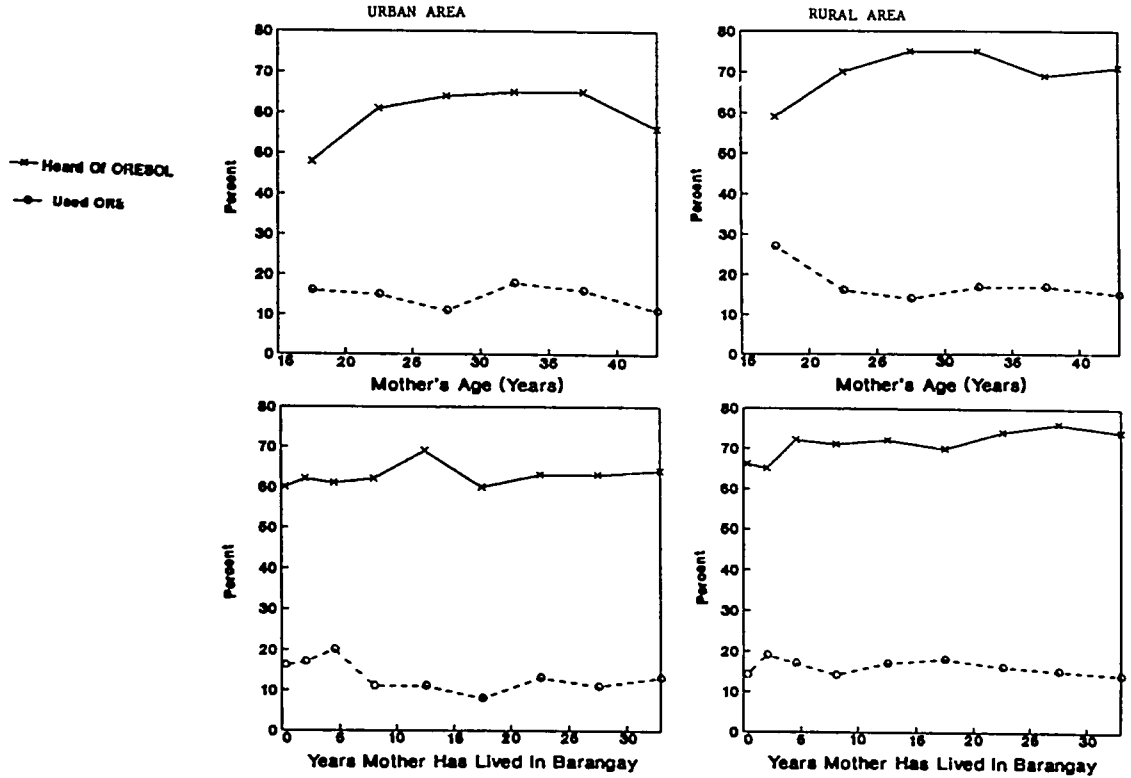


Figure 28: Percent of mothers who have heard of ORESOL and percent of diarrhea cases in children in the last 2 weeks treated with ORS, by mother's and by husband's education, by area of residence.

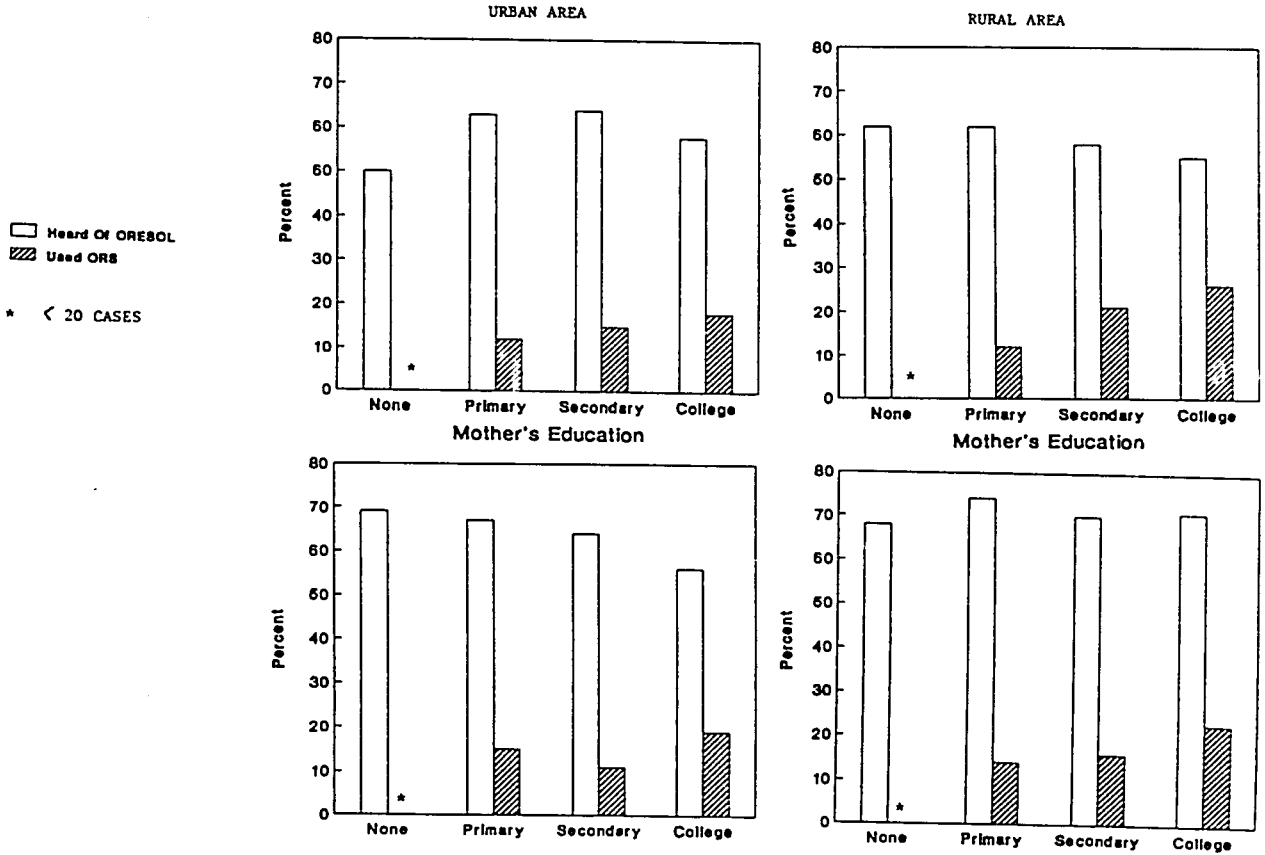


Figure 29: Percent of mothers who have heard of ORESOL and percent of diarrhea cases in children in the last 2 weeks treated with ORS, by mother's and by husband's occupation, by area of residence.

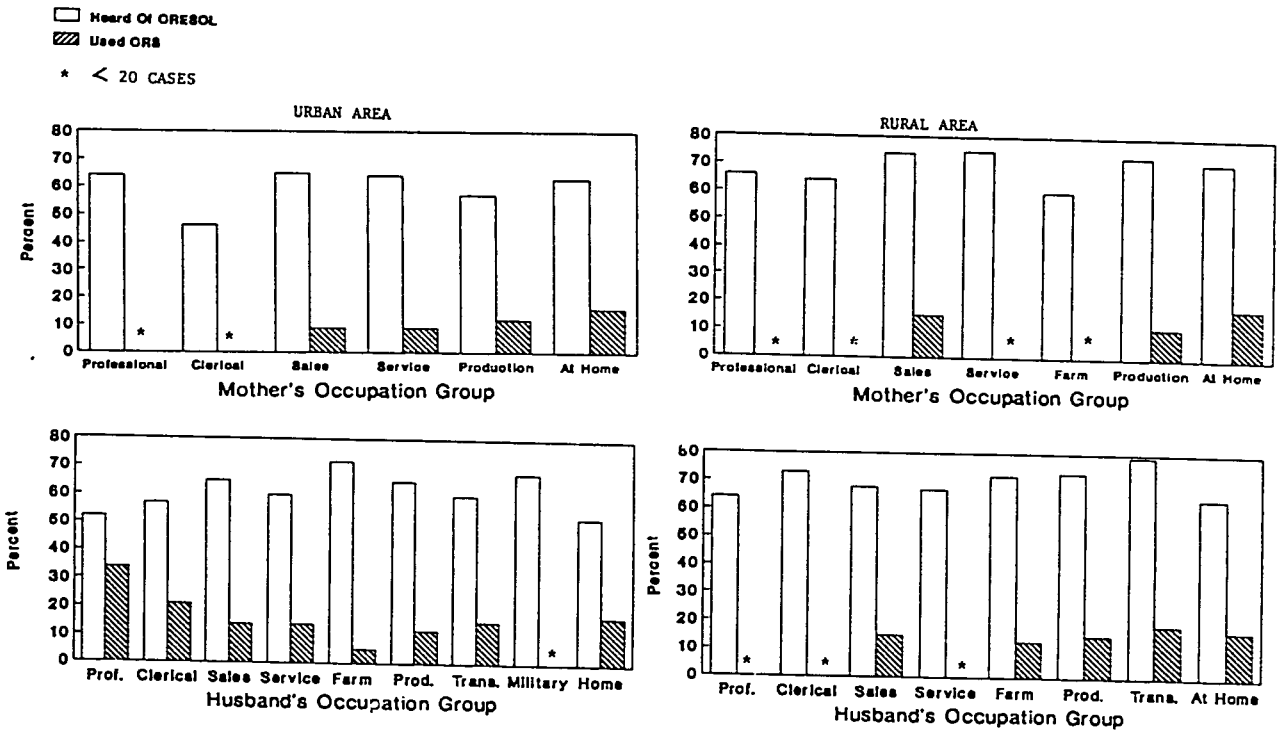


Figure 30: Percent of mothers who have heard of ORESOL and percent of diarrhea cases in children in the last 2 weeks treated with ORS, by ownership of radio and television and by current use of family planning, by area of residence.

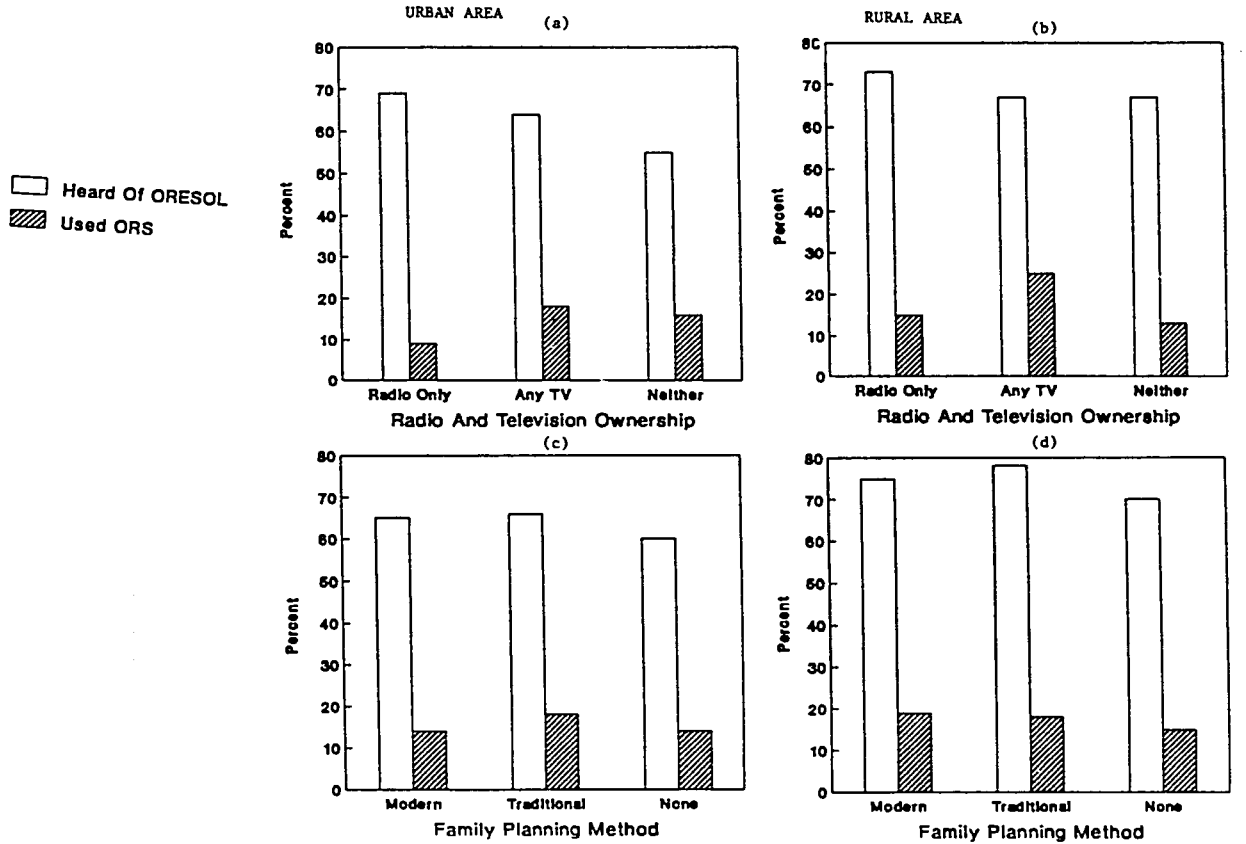


Figure 31: Percent of mothers who have heard of ORESOL and percent of diarrhea cases in children in the last 2 weeks treated with ORS, by time to reach the nearest health clinic and by source of prenatal care, by area of residence.

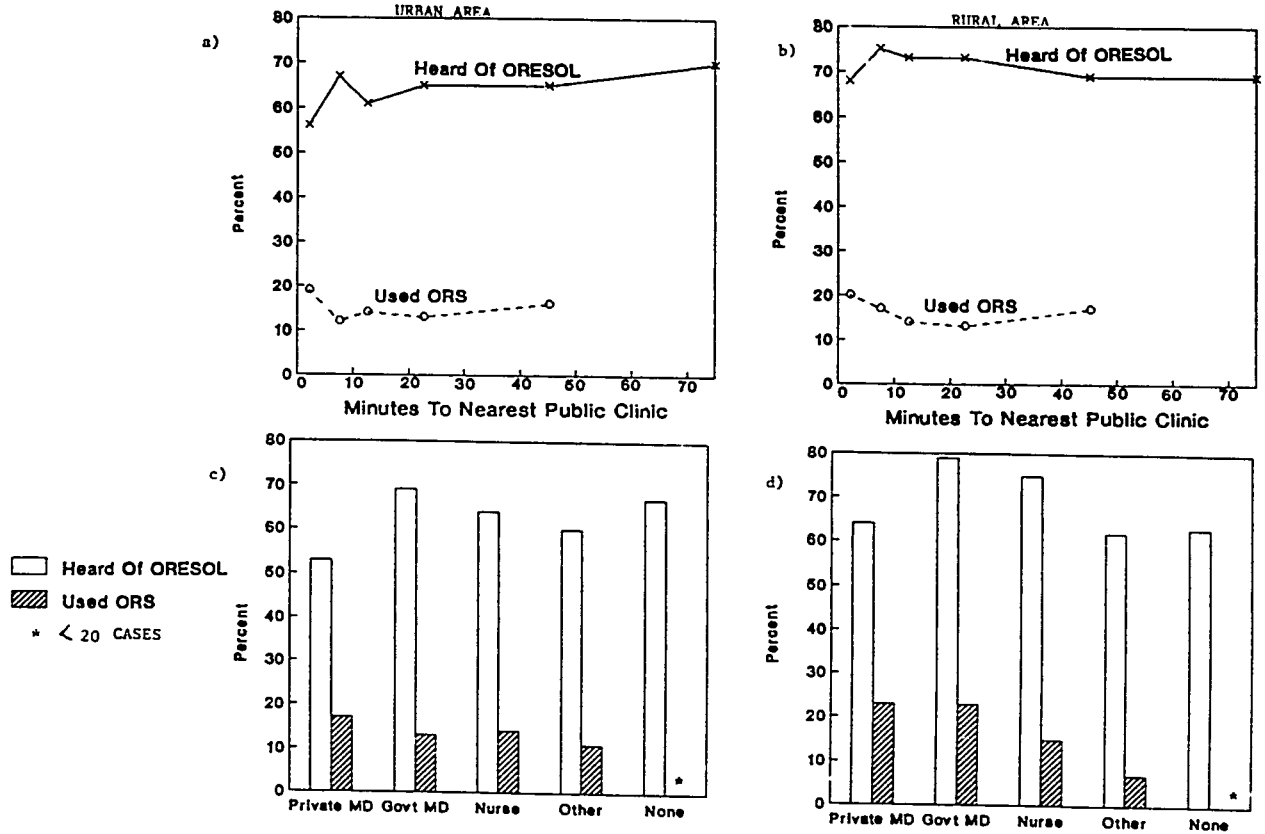


Table 1: Percentage of children vaccinated according to vaccination schedule and residence

	No. of children	Total			Urban			Rural		
		Vaccinated on time	Vaccinated not on time	Not vaccinated	Vaccinated on time	Vaccinated not on time	Not vaccinated	Vaccinated on time	Vaccinated not on time	Not vaccinated
All children	9586									
BCG		33	37	30	31	35	34	36	39	25
Children >10 weeks	8611									
DPT1		26	49	25	24	48	28	28	51	20
OPV1		26	49	24	24	48	28	29	51	20
Children >14 weeks	8277									
DPT2		15	53	32	11	51	37	20	54	26
OPV2		15	52	32	11	51	38	20	54	26
Children >18 weeks	7938									
DPT3		10	50	40	5	47	47	15	53	32
OPV3		9	50	41	5	47	48	14	54	32
Children >1 year	5353									
Measles		42	9	42	41	9	49	58	9	33

*Schedule for immunizations is: BCG - under 11 weeks; DPT1, OPV1 - 6-10 weeks; DPT2, OPV2 - 10-14 weeks; DPT3, OPV3 - 14-18 weeks; Measles - 8-12 months

Table 2: Percent of children classified by categories of height for age and weight for height using NCHS reference population

	Height for age (% of median)				
	95-105	90-94	85-89	<85	Total
Weight for height (% of median)					
> 110	5	5	2	0	12
90-110	25	25	9	2	61
80-89	8	11	5	1	25
70-79	1	1	1	0	3
Total	39	42	17	3	101*

*Totals do not add to 100 because of rounding

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